



Addis Ababa University
College of Health Science
School of Public Health

By

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Exploration of Barriers related to family planning use among pastoralist communities of Ethiopian Somali region, Eastern Ethiopia: Qualitative study.

Addis Ababa, Ethiopia

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Table of Contents

Table of Contents	III
List of Tables	IV
List of Figures	IV
Acknowledgement	V
Abstract	VII
1. Introduction.....	1
1.1. Background.....	1
1.2. Statement of the problem	2
1.3. Significance of the study.....	4
2. Literature review.....	5
2.1. Finding from Quantitative study.....	5
2.2. Finding from qualitative study.....	7
3. Conceptual framework.....	10
3.1 General Objective	11
3.2 Specific objectives	11
4. Methods	11
4.1. Study setting.....	11
4.2. Study approach.....	12
4.3. Participants.....	13
4.4. Sampling	13
4.5 Data collection guides and procedures.....	14
4.6 Data Analysis procedures.....	15
4.7. Trustworthiness.....	15
4.8 Ethical consideration.....	16
4.9. Operational Definition	16
4.10. Dissemination of results.....	16
5. Results.....	17
6. Discussions	29
7. Limitations	34
8. Conclusions.....	35
9.Recommendations.....	36

10. References.....	37
11. Annexes.....	39

List of Tables

<i>Table 2:-Guides for FGD of WRA group.....</i>	<i>40</i>
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List of Figures

<i>Figure 1. Conceptual framework</i> _____	<i>10</i>
<i>Figure 2. Summary of finding</i> _____	<i>28</i>

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Acronyms

CPR: Contraceptive prevalence rate

EDHS: Ethiopian Demographic and Health Survey

FP: Family planning

FGAE: Family guidance association of Ethiopia

FMOH: Federal ministry of health

FGD: Focus group discussion

FPMs: Family planning methods

HIV: Human immunodeficiency virus

HEW: Health extension worker

HW: Health worker

IUCD: Intrauterine contraceptive device

KII: Key informant interview

LMCIs: Low- and Middle-Income Countries

LARM: Long acting and reversible methods

NGO: Non_Governmental organization

OWDA: Ogaden development association

PI: Principal investigator

RMNH: Reproductive maternal and neonatal health

RHB: Regional Health Bureau

RH: Reproductive Health

RIF: Reproductive innovative fund

TFR: Total fertility rate

WoHO: Woreda Health office

Abstract

Background: Rapid population growth is a threat to wellbeing in the poorest countries. In Ethiopia there was a dramatic increase in contraceptive prevalence rate (CPR) from 8.2% to 36% in 2016. Although such encouraging results have been achieved, there are significant variations among the regions, with very low coverage in the pastoralist regions ranging from 1.5 percent in Somali region to 56 percent in Addis Ababa. No studies in Somali region have qualitatively explored for barriers accessing and utilizing family planning from the pastoralist community perspective.

Objectives: The objective of this study was exploring barriers related to family planning use among pastoralist communities of Ethiopian Somali region.

Methods: Qualitative inductive content analysis through purposive sampling with maximum variation mixed with snow ball were used to conduct four FGD among married women and their husbands, fifteen KII among programmers, service providers and community chiefs. On top this 6 facility observation were undertaken. Data analysis was done using Open code version 4.02.

Results: Six major themes were emerged during the study: Religion prohibition, socio cultural factors, limited access to family planning services, gender roles and social pressure, myths and misconceptions related to family planning and provider negative attitude affected family planning service uptake.

Conclusions: Poor women empowerment and limited male involvement, Religion prohibition, Cultural barriers such as clan leaders influence affected family planning service uptake. Women and girls remain largely marginalized in terms of development and full participation in the health program as a whole family planning in particular which contributes to low service uptake at the household and community levels due to underdevelopment, low literacy and prevailing socio-cultural perceptions.

Recommendations: Massive community mobilization, women empowerment and male involvement through chiefs and religious leaders, Capacity building on family planning program, new service provision modality that will fit to mobile community is crucial to increase family planning service uptake.

1. Introduction

1.1. Background

With a population of 94,351,001(CSA 2017 projection), Ethiopia is Africa's second most populous nation after Nigeria, and remains one of the world's most impoverished and rural countries. In Ethiopia between 2000 and 2005, reported use of modern contraceptive methods among married women of reproductive age rose from 6% to 14%, and jumped again to 35% in 2016. During this period, the greatest surges in contraceptive use were in rural areas, even where severe poverty, female illiteracy, and early female age of marriage are largely entrenched. Between 2000 and 2016, the national fertility rate declined from 5.5 to 4.6. Although such encouraging results have been achieved, in 2016 a quarter of women still had unmet need for contraceptives in Ethiopia and use continues to be low in some of the more remote areas.[1-7]

Use of long-acting contraceptive methods, particularly implants, is growing steadily. However, many family planning users are continuing to rely on short-term methods—mainly the injectable contraceptive partly because of misconceptions about side-effects from longer-term methods such as implants and intrauterine devices, which include widely held beliefs that these devices can weaken women's bodies and impair their ability to perform manual labour.[1]

In 2000 the country had an unmet need level of 36% among currently married women, which has declined to 34% in 2005 and further to 22% in 2016. Unmet need is higher among rural women as compared to that of urban women (24.4 versus 11.3).[3-5]

Globally implementation of voluntary family planning programmes has been the main policy response to high fertility and rapid population growth. Despite a range of efforts to improve access and quality of FP Nationally through expansion of contraceptive method mix, increasing uptake of LAFP and task shifting utilization of FP in pastoralist regions remains extremely low.

No studies in Ethiopian Somali region have qualitatively investigated factors that contribute to family planning use, barriers to care, myths and misconception and quality of services from the pastoralist community perspective. The objective of this study was exploring barriers related to family planning use among pastoralist communities of Ethiopian Somali region, Eastern Ethiopia.[8]

1.2. Statement of the problem

Globally in 2015, 76% of women of reproductive age who were married or in-union had their need for family planning however; a quarter of them lacked access to modern contraception. Contraceptive use in developing countries is low, unmet need for FP in low and middle income countries range between 20 % and 58 %. The method mix is dominated by pills and injectables. In Ethiopia, according to EDHS there was a dramatic increase in contraceptive prevalence rate (CPR) from 8.2% to 36% in 2016. Total Fertility Rate (TFR) has also dropped from 5.5 children per woman in 2000 to 4.6 in 2016. Although such encouraging results have been achieved; there are significant variations among the regions, with very low coverage in the pastoralist region. TFR ranges from 1.7 children per woman in Addis Ababa to 7.3 children per woman in Somali region which is the highest fertility rate in the country. Similarly, CPR ranges from 1.5% in Somali region to 56 % in Addis Ababa. In the mean time, use of any modern contraceptive lowest in the Somali region 1.4%. [2-6, 9]

Several quantitative studies were conducted looking at the barriers to modern contraceptive use in Ethiopia. Religion prohibition, illiteracy and living in rural areas respectively found to be the predominantly stated factors preventing women from using family planning services in the country. In the country the studies conducted so far are mainly from agrarian regions. On top this others barriers identified include desire to have more children, husband's objection, commodities' insecurity, complaints related to providers, methods, diet and workload, a shortage of some medical equipment, trained staffs, and information education and communication materials (IEC), wife or partner refusal, fear of side effects, lack of awareness about contraceptives and the perception that it is the only issue for women commonly mentioned. [10-14]

Studies also identified enablers to family planning use were women who had a positive attitude towards family planning utilization, owning radio, being literate, women whose partners completed primary and secondary plus level of education, increase of monthly income, living in urban areas, those with no child death, women discussing about contraception with partners, men approval, Clients' perception on adequacy of information during consultation, ease of getting the clinic site, short waiting time, Opinion about family planning services and current use of family planning methods were more likely to use family planning methods as compared to their counterparts. [10-13]

Although different barriers to modern contraceptive use have been identified from quantitative studies little is known about the socio-cultural factors that influence modern contraceptive use particularly in pastoralist areas. Few qualitative studies previously conducted in Ethiopia in refugees reported that culture, religion and health system barriers are main factors for poor uptake of modern FP methods.[15, 16]

In this study we propose to generate evidence on the supply and demand side determinants of family planning service to qualitatively explore enablers and barriers of family planning use in pastoralist areas.

1.3. Significance of the study

While Ethiopia has made remarkable gains in contraceptive coverage, unmet need for family planning is high, and barriers, myths and misconception to accessing and utilizing family planning services still prevailing. Contraceptive prevalence rate is only 1.5% in Somali region which is the lowest prevalence in the country and TFR is 7.3 the highest fertility rates in the country. According to Ethiopia Service Provision Assessment plus Survey 2014 percentage of hospital and health center offering any modern method of FP services 79% and only 1 percent of hospitals are providing permanent methods of family planning in the region. No studies in Somali region have qualitatively explored for factors that contribute to family planning use, barriers to care, myths and misconception of services from the pastoralist community perspective. This study was conducted to uncover the major determinants of family planning services utilization in pastoralist communities of Ethiopian Somali region. The finding of this study will help policy maker/program managers for designing program/project in the context of the region which will contribute for future planning and advocacy to increase demand for and use of family planning services.

2. Literature review

2.1. Finding from Quantitative study

Rapid population growth is a threat to wellbeing in the poorest countries. The mapping of global trends in population growth from 2005–10 shows four distinct patterns. Most of the poorest countries, especially in sub-Saharan Africa, are characterized by rapid growth of more than 2% per year. Moderate annual growth of 1–2% is concentrated in large countries, such as India and Indonesia, and across North Africa and Western Latin America. Whereas most advanced-economy countries and large middle-income countries, such as China and Brazil, are characterized by low or no growth (0–1% per year), most of Eastern Europe, Japan, and a few western European countries are characterized by population decline.[8]

Fertility declines are associated with an increase in women's health, earnings, and participation in paid employment and the children of women who have had frequent home access to family planning and health services are healthier and better educated children than are those of women without such access.[17]

Poor access and low contraceptive prevalence are common to many Low- and Middle-Income Countries (LMICs) .Unmet need for FP range between 20 % and 58 %.[9]

According to trends in contraceptive need and use in developing countries an analysis of national surveys showed in 2003, 2008, and 2012: the number of women wanting to avoid pregnancy and therefore needing effective contraception increased substantially, from 716 million (54%) of 1321 million in 2003, to 827 million (57%) of 1448 million in 2008, to 867 million (57%) of 1520 million in 2012. Most of this increase (108 million) was attributable to population growth. Use of modern contraceptive methods also increased, and the overall proportion of women with unmet need for modern methods among those wanting to avoid pregnancy decreased from 29% (210 million) in 2003, to 26% (222 million) in 2012. However, unmet need for modern contraceptives was still very high in 2012, especially in sub-Saharan Africa (53 million [60%] of 89 million), south Asia (83 million [34%] of 246 million), and western Asia (14 million [50%] of 27 million).[18]

Increasing contraceptive use in developing countries has cut the number of maternal deaths by 40% over the past 20 years, merely by reducing the number of unintended pregnancies. A further 30% of maternal deaths could be avoided by fulfillment of unmet need for contraception.[19]

In Ethiopia 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).[3]

Knowledge of contraceptive methods is nearly universal. By far the most popular modern method, used by 23 percent of currently married women, is injectable. Use of modern methods among currently married women has increased from 6 percent in 2000 to 35 percent in 2016—largely due to the sharp increase in the use of injectable, from 3 percent to 23 percent. 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. [2, 3, 6]

In Ethiopia the TFR differs highly among rural and urban areas rural area exceeds the TFR in urban areas by more than two children per woman (5.5 and 2.6 children per women respectively in 2011 and 5.2 and 2.3 children per woman, respectively in 2016). The improvements were more visible among higher-income groups and urban populations and there are wide variations in access to and utilization of family planning services among pastoralists. [3, 6]

Study conducted in pastoralist community of Afar region, eastern Ethiopia showed that the prevalence of family planning utilization in Afar region was 8.5 %. Majority of the women (92.2 %) had used injectable. The most common reasons mentioned in the non-use of family planning methods were religion-related (85.3 %), desire to have more children (75.3 %), and husband's objection (70.1 %)[10], In Butajira Current contraceptive prevalence rate among married women is 25.4%. Unmet need of contraception is 52.4%. Contraception is 2.3 times higher in urbanites compared to rural highlanders. Married women who attained primary and secondary plus level of education have about 1.3 and 2 times more risk to contraception.[11]

Study conducted in Jimma showed the concept of family planning was well known in the studied population. Sex-stratified analysis showed pills and injectable were commonly known by both sexes, while long-term contraceptive methods were better known by women, and traditional methods as well as emergency contraception by men. In general, only 4 out of 811 men ever used contraception, while 64% and 43% females ever used and were currently using

contraception respectively.[13] The mean waiting time at the service delivery points and consultation duration were 16.4 and 10.5 minutes, respectively. The providers used at least one information education and communication material in 33.3% of the consultation sessions. The overall satisfaction score was 8.64. [12]

2.2. Finding from qualitative study

According to study conducted with low-income, African-American and white women aged 18–45 recruited from reproductive health clinics in Pittsburgh, Pennsylvania to explore factors that influence women’s pregnancy-related behaviors finding showed that, First, women do not always perceive that they have reproductive control and therefore do not necessarily formulate clear pregnancy intentions. Second, the benefits of a planned pregnancy may not be evident. Third, because preconception intention and planning do not necessarily occur, decisions about the acceptability of a pregnancy are often determined after the pregnancy has already occurred. Finally, even when women express a desire to avoid pregnancy, their contraceptive behaviors are not necessarily congruent with their desires. [20]

A Qualitative Study in Rwanda’s Southern Kayonza District showed (1) fertility beliefs: participants recognized the benefits of family planning but often desired larger families for cultural and historical reasons; (2) social pressures and gender roles: young and unmarried women faced significant stigma and husbands exerted decision-making power, but many husbands did not have a good understanding of family planning because they perceived it as a woman’s matter;(3) barriers to accessing high-quality services: out-of-pocket costs, stock-outs, limited method choice, and long waiting times but short consultations at facilities were common complaints; (4) side effects: poor management and rumors and fears of side effects affected contraceptive use. These themes recurred throughout many participant narratives and influenced reproductive health decision making, including enrollment and retention in family planning programs.[21]

Study done in rural Mozambique showed Positive associations were detected between contraceptive use and education, household wealth, and perceived HIV infection status. Distance to the clinic was negatively associated with contraceptive use. These effects were additive, with some varying by type of contraceptive method. Examination of qualitative data highlighted frequent cognitive dissonance between service providers and users.[22]

A qualitative study of men and women's perceptions in two rural districts in Uganda showed five themes were identified as rationale for men's limited involvement: (i) perceived side effects of female contraceptive methods which disrupt sexual activity, (ii) limited choices of available male contraceptives, including fear and concerns relating to vasectomy, (iii) perceptions that reproductive health was a woman's domain due to gender norms and traditional family planning communication geared towards women, (iv) preference for large family sizes which are uninhibited by prolonged birth spacing; and (v) concerns that women's use of contraceptives will lead to extramarital sexual relations. In general, knowledge of effective contraceptive methods was high. However, lack of time and overall limited awareness regarding the specific role of men in reproductive health was also thought to deter men's meaningful involvement in issues related to fertility regulation.[23]

A qualitative study of family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania study showed four themes emerged during the study. First, "risks and costs" which refer to the side effects of FP methods and the treatment of side-effects as well as the costs inherent in being labeled as an unfaithful spouse. Second, "male involvement" as men showed little interest in participating in family planning issues. However, the same men were mentioned as key decision-makers even on the number of children a couple should have and the child spacing of these children. Third, "gender relations and communication" as participants indicated that few women participated in decision-making on family planning and the number of children to have. Fourth, "urban-rural differences", life in rural favoring having more children than urban areas therefore, the value of children depended on the place of residence.[24]

According to qualitative study done in Nigeria urban slums study shows that women in the selected communities expressed desire for FP adoption. Three main reasons largely accounted for the desire to use FP: perceived need to space childbirth, family's financial condition and the potential adverse effect of high fertility on the woman's health. Male partners' support for the use of FP by women was perceived to be low, which is due to misconceptions about FP and traditional pro-natalistic beliefs and tendencies. Mechanisms by which women negotiate their male-partner's cooperation for FP adoption include seeking the support of the partner's significant others and advice from older women.[25]

A Qualitative Study amongst Married Youth in Slums of Karachi, Pakistan showed that general, physical, sexual, psychological, socio-cultural and religious were the common categories which

lead to myths and fallacies related to condoms use and vasectomy among the married youth. The foremost myth amongst male and female youth was that use of both condoms and vasectomy cause impotence in males. Additionally, Condoms were thought to cause infections, backache and headache in males. Some youth of the area think that vasectomy is meant for prisoners only.[26]

A qualitative study of community perceptions about vasectomy in Southern Ghana revealed that vasectomy was perceived as an act against God, which was punishable either by death or answerable on judgment day. Vasectomy was also perceived to be a form of castration, which can make men weak and incapable, thereby unable to satisfy their wives sexually, leading to marital conflicts. Women were more concerned about the negative effects of vasectomy on men which indicate tailored awareness creation should be done to improve the knowledge of the communities [27]

According to National Reproductive health strategy of Ethiopia (2016-2020) the ministry of health planned to reduce the total fertility rate (TFR) from 4.1 to 3 children per woman and unmet need for modern contraceptive methods from 25% to 10%. Increase contraceptive prevalence rate (CPR) from 42% to 55%. Increase the long acting reversible and permanent contraceptive methods use to 50% which is ambitious and Unless the effect of myths, misconceptions and barriers on the use of family planning methods should be explored and addressed difficult to achieve desired target.

Thus, the purpose of this study was to generate evidence on the supply and demand side determinants of family planning service in the pastoralist communities for future design of relevant intervention strategies.

3. Conceptual framework

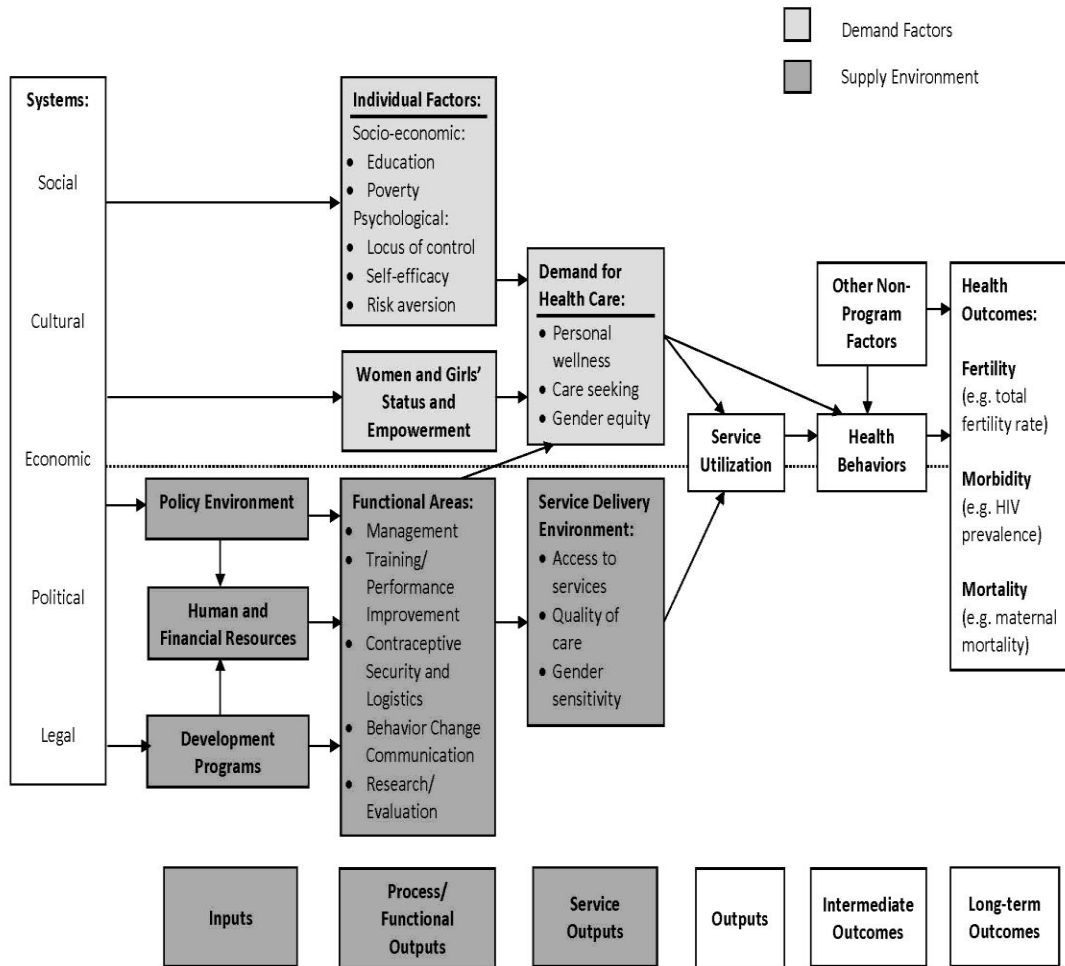


Figure 1. Conceptual framework

3. Objectives

3.1 General Objective

- ✓ To explore barriers related to family planning use among pastoralist community of Ethiopian Somali region, Eastern Ethiopia

3.2 Specific objectives

- ✓ To explore program and service related barriers of family planning services utilization in pastoralist communities of Ethiopian Somali region
- ✓ To explore culture, norm and behavior related barriers of family planning services utilization in pastoralist communities of Ethiopian Somali region
- ✓ To explore misconceptions and myths related to family planning use in Ethiopian Somali region

4. Methods

4.1. Study setting

According to Central Statistical Central Agency Pastoralist population in Ethiopia cover a wide geographic area and is estimated to be 10-12 million which is about 12% of the Ethiopian population. Ethiopian Somali regions are mainly homes for pastoralist community constituting almost half of pastoralists. The region is affected by various natural disasters mainly drought, floods that causes considerable loss of assets, damage to livelihoods & to the overall food security of the region. Ethiopia Somali region is divided into 11 zones, 93 woredas, six urban administrations and 1214 kebeles. There are 1016 health posts, 208 health centers, 10 hospitals. The total population of the region was estimated to be 5,748,998 where rural and urban population is 85.5% and 14.5% respectively. In the region according to projection from 2007 populations are living in the region of those women of reproductive age group (15-49 years) are 1,134,852.

In Ethiopia according to Ethiopia Service Provision Assessment plus Survey 2014 the proportion of facilities (Hospital and Health centers) offering any methods of family planning methods in Ethiopia Somali region are 80%. Percentage of health posts providing at least 2 temporary

modern methods were 64%. About 73% of health posts offer family planning services five or more days per week and commodity security availability were 78% on day of survey.

In the region 21% and 13%, hospitals and health center offering temporary family planning had atleast one trained staff and guidelines on family planning respectively.

Despite service availability, the coverage of family planning in Ethiopian Somali region was lowest among all regions in the country both in EDHS and National Health management information system.

National health management information system 2016/2017 Annual performance report revealed that among 1,134,852 eligible women only 140,448(12%) utilized family planning service in the region. The trends over the last five years of contraceptive acceptance rate are low even when compared with other developing regions.

The study was conducted in 2-districts (Kebribaya and Shinile) purposely selected from Fafan and Siti zones based on location the earlier district was pure pastoralist and the second district was semi pastoralist of Ethiopian Somali region; Eastern Ethiopia the capital of which, Jigjiga town, is located around 630 kilo meters from Addis Ababa the capital city of Ethiopia. Kebribaya woreda is located in Fafan zone distance from regional capital (Jigjiga) is 50 km. The woreda has 176,600 populations, five Health centers and 31 Health posts. According National health management information system 2009 EFY report contraceptive acceptance rate in the woreda was 5%. Shinile woreda is located in Siti zone distance from regional capital (Jigjiga) is 165 km. The woreda has 60,400 populations, two health centers and 16 health posts. According National health management information system 2009 EFY report contraceptive acceptance rate in the woreda was 17%. The data collection was conducted from May 21 to June 20/2017.

4.2. Study approach

Qualitative inductive content analysis study through observation of health facilities, key informant interview and semistructured FGD data collection techniques was used to explore barriers, misconceptions and myths related to family planning use.

4.3. Participants

Community leader's such as chief's /clan leader and religious leaders (Sheiks), women of reproductive age group and their husbands, Program managers/focal persons at Federal ministry of health, Somali regional health bureau and Kebribaya and Shinile district health offices, Service provider/Health professionals from shinile,Karamara Hospital, Degabhour, Kebribaya health centers&health Extension workers/ selected from two districts and development partner working in the study area are primary study population.

4.4. Sampling

Purposive sampling with maximum variation sampling procedure mixed with snow ball technique was used to select community leaders such as chiefs and religious leaders such as Sheiks to understand cultural norms in the community, women of RH group and their husbands selected with the help of woredas, health centers and health extension workers. Focal person for the family planning methods program at Federal ministry of health, regional health bureau, NGOs, selected districts and facilities were key informants representing program managers and service providers respectively working on family planning in the study region were interviewed until the idea is saturated. The district family planning/MCH focal persons helped in identifying these health extension workers and health center staffs. To represent a wide range of variation in multiple aspects community, renowned chiefs and sheiks in selected districts were interviewed until saturation of ideas was reached in each group (sheiks and chiefs). More over observation was conducted in two hospitals, 2 health centers and 2 health posts.

Separate focus group discussions were conducted among women and their husbands in each selected district until saturation of ideas is reached. The focus discussions among females was moderated by a female while the one to be conducted among the husbands was conducted by the male research team members.

The key informant interviews at Federal ministry of health, Somali Regional health bureau, Kebribaya woreda health office was conducted by the principal investigator. The rest FGD, KII and observation were conducted by research team members.

Totally 4 FGD, 15 key informant interviews and 6 observation of facilities were included in the samples. The sample size was decided based on saturation of ideas in each cluster among programmers, women, husbands, health care providers, chiefs, religious leaders among others.

4.5 Data collection guides and procedures

Key informant interview guides were used for assessing barriers for each of program manager, sheiks and clan leaders and health care providers. Besides, FGD guide was developed for married women of reproductive age group and their husbands. Moreover, observation checklist was prepared to observe family planning service provision in selected hospitals, health centers and health posts. Probing was used to obtain in-depth understanding from participant's perspective. The guide first developed in English, and translated into Somali (local language) to maintain the consistency of the guides. Hence, interviews were conducted in English and Somali. Tape recorder and field notes were used as a tool to gather relevant information in this study.

The data collection conducted through Observation, Key informant interview and FGD using open-ended guides; Data collected by research team members able to speak and listen the local language for selected districts heads/focal person, health professional/Health extension worker, religious leader and clan leader and FGD for married women of reproductive age group and husbands. At the beginning of the interview, principal investigator/research team members explained the general aim of the interview and encouraged the interviewee to express their ideas freely. The interviews were started from general questions. Then, probing questions asked, as needed to get a more in-depth understanding of the participants' exploring barriers related to family planning use among pastoralist communities. All participants were being requested to be audio-taped.

There were one female and another three male assistants in the data collection in addition to principal investigator. All of them have BSC in public health or Nursing, and they have experience in qualitative data collection and in the areas of reproductive health. One-day training was given on guides KII, FGD and Observation checklist for data collectors. Each focus group discussions lasted an average of one and half hour and key informant interview lasted about half an hour.

4.6 Data Analysis procedures

The audio recorded data was transcribed into Somali language and translated to English by the research team members. Field notes were used to augment the transcribed audio information. Transcripts for data collected by English and translation were read and re-read independently by the principal investigator and transcripts for data collected by Somali language were done by four research team members via listening the audio recorders. The draft summary data analysis was done simultaneously with data collection. This process helped to recognize the saturation point at which no new information emerged from the data. The MS Word version 7 data was converted to plain text then exported to Open Code software version 4.02 to code and categorize the data. After reading and re-reading the text data an attempt was made to create categories by combining codes formed using the software. Finally, thematic content analysis was implemented. The report presented by summarizing the themes, quoting important verbatims and visual aids utilized for summarizing main finding from observations, key informant in-depth interviews and focus group discussions.

4.7. Trustworthiness

Rigor of the study considered from selection of study approach and respondents to data analysis and report writing. To increase the trustworthiness of study participants the principal investigator and research team members were approached each study participants friendly and issues of privacy and confidentiality ensured for study participants before interview. And also the interviews were in private places which were agreed by study participants at institution and health facility level for clan and religious leader's interviews were conducted at there homes. Brief explanation about purpose of the study were given for each study participant to let them discuss freely and showed interest to participate. To ensure transferability of data, triangulation of information collected from different respondents was done. Draft summary of translation and transcription commenced concurrently the same day with data collection, field notes incorporated with transcript and data familiarized. The data collection guides designed based on literatures and accommodated to the objectives of the study. The guides-were evaluated carefully and cleared from leading questions. The overall process, procedures and all the inputs used like, audio recorded tapes, the field notes, transcription of interviews in both languages (Somali

and English), kept in secured place for confidentiality. Debriefing among PI and research team members were conducted on daily basis and summary of main points were presented to KII and FGD participants for validation during data collection period and agreed on finding on top of that missed information were also incorporated.

4.8 Ethical consideration

Ethical approval was obtained from Ethical Review Committee of Addis Ababa University School of Public Health. Privacy, confidentiality and justice was ensured and the respondents were treated with appropriate respect. Participants were informed to participate voluntarily and informed consent form provided and explained. After participants fully understood the study purpose, risks and benefits and right to withdrawal, written/Verbal informed consent was received. To keep anonymity of the participants, identification codes was given to each participant and privacy and confidentiality of the information was respected. After completion of the study, copy of the study result will be shared to the participants through regional health bureaus. The tape-recordings and written notes will be kept in a secured place and be destroyed at the end of the study.

4.9. Operational Definition

Barrier: Demand and supply side determinants hindering client not to use family planning service.

Misconception: Lack of appropriate information about family planning definition, method choices and mechanism of action mainly due to knowledge gaps.

Myths: Rumour or negative information circulated in the community which do not have proven scientific evidence

4.10. Dissemination of results

The research findings will be submitted to Addis Ababa University, College of Health Science, School of Public Health and other concerned body in the Ministry of Health, Ethiopian Public Health Institute, Ethiopian Somali Regional Health Bureau, Ethiopian Public Health Association, NGOs working on Family Planning Program. I will also publish on-line peer review journals. I will avail for exhibition during health sector annual review meeting. These findings will be useful in decision making for interventions targeting family planning program in pastoralist regions.

5. Results

5.1. Characteristics of study participants

Four Focus group discussion (2 for married women of reproductive age groups and 2 husbands), 15 Key informant interview (FMOH, RHB, NGO, Hospital, WoHo, Religious leader and Clan leader, Health center and Health post service provider selected from both Kebribaya and Shinile woreda health office and 6 health facility (2 hospitals, 2 health centers and 2 health posts service provider). Observation were conducted on selected 6 facilities. The mean age of participants in the study was 32 years. Except religious leaders and participants selected from institutions and health facilities, all study participants had no formal education. All are Muslims and living half in urban and half in rural areas.

Women are not using family planning services due to various reasons. Based on the data, six major themes were identified; namely, religious prohibition, socio-cultural factors, limited access to family planning services, gender roles and social pressure, myths and misconceptions related to family planning and provider related factors. Moreover, each theme has subthemes.

5.2. Service and program related barriers of family planning use in Somali region of Ethiopia

In order to explore barriers related to service and program related barriers key informants from Federal ministry of Health, Ethiopian Somali Regional Health Bureau, Non_Governmental organization working on maternal and child health program, selected districts focal and service providers at all levels meaning hospital, health centers and health posts were interviewed. On top this observation also undertaken on selected facilities.

Under this section one broad thematic area was emerged which was limited access to family planning services but it has sub sections comprised of geographic and distance related barriers, lack of comprehensive method mix, shortage and turnover of trained staff, provider related factor, lack of specific strategy that fit to the context of pastoralist community and less involvement of development partners working on family planning.

5.2.1 Geographic and distance related barriers

Key informants at Federal, Regional and Non_ governmental organization mentioned that the pastoralist community in Somali region of Ethiopia live in areas where in infrastructures like road, network, electricity and other telecommunication, social service institutions such as education and health services are lacking. Pastoralists are residing in arid and hot weather where in infectious diseases are highly prevalent which claimed the lives of many Ethiopians that made the population in the area sparsely distributed in the wide area. They are seasonally mobile, and are struggling with tough environment and extreme climate which made health service delivery difficult. Somalis are living in kinship and social-network which is easy for them to share values among community members and difficult to influence their behavior towards certain health seeking behaviors and health service utilization. In addition, regional health bureau and NGO informants mentioned the issue of coverage and distance between two facilities being so vast elaborating that even the distance between two health posts ranged to vary between 30 and 90 kms. The Somali Region health bureau program manager reiterated the situation as follows.

“...The potential health service coverage of the region is 60%. If women want to use long acting family planning method, she cannot access at health post level and she has to even go much longer distance to get the service. On top of this, there is even no public transportation in the majority of areas. This will be exacerbated during rainy season where it is impossible to go anywhere.”

An NGO key informant supported this idea by mentioning

“---Ethiopian Somali region is the second largest region in the country interms of land coverage and majority of the community is living beyond the expected standard of distance from a health facility. Forexample, imagine, you may find communities living 50 kms away from any facility.”

Key informants at Kebribaya and Shinile districts supported both ideas of regional and Non_ governmental informants adding limited access to health service due to distance affected family planning service uptake.

5.2.2. Lack of comprehensive method mix provision

Key informants at all levels shared factors that causes poor maternal and newborn health outcomes includes limited availability, absence of method mix and poor quality of essential RMNH services.

The regional health bureau manager expressed his concern as follows. “...*even majority of health workers at hospitals and health centers are not trained on long acting family planning and. We planned on this year to provide the training.*”

Regional key informants mentioned that hospitals and health centers provides different methods of family planning services like condom, pills, injectable and IUCD as per the standard they should provide services beyond this including implants and permanent family planning which they are not providing. Unlike other agrarian regions health post in our region are providing only short acting family planning methods due to lack of training and low educational level of health extension workers.

5.2.3. Shortage and turnover of trained staff

Key informants from hospitals and health centers shared similar feeling that they are providing contraceptives with inadequate staff that received comprehensive family planning training and are less experienced professionals due to staff turnover.

District key informants also supported service providers’ ideas mentioning there is shortage of trained and qualified staff to provide accurate, relevant and regular education (information) on family planning to the clients and to the community as a whole. The quality of care is not also as expected since there are no trained and experienced staffs for some health facilities under the districts. The main reason here is lack of continuous training, lack of experience sharing with other areas and trained staff turnover. Negative attitude among health professional and health extension workers in some areas were also mentioned. As key informant’s majority health professional and health extension workers still believe family planning is against their religion education.

As finding from observation revealed that in all visited health facility we seen one health professional providing the family planning service in the family planning room with few years of experience which affected service uptake interms of providing appropriate family planning counselling on top of this outreach family planning were not conducted due to staff shortage.

5.2.4. Provider related factors

In the study region, health care providers did not have positive attitude towards use of family planning methods. They did not use modern family planning methods themselves and do not recommend their clients to use them due to religious reasons. This idea has been paraphrased by different key informant including those recruited from federal and regional health program leaders and district and health center focal persons on family planning service provision.

A regional health bureau program officer on family planning service provision said the following.

“...Some of health professional highly involved in religion, they are religious leader themselves and not support and advocate for family planning and we have to work on them to change their attitude, training alone does not change attitude.”

One midwife mentioned her views as follows. *“...Family planning is not appropriate for pastoralist community it is an issue of highlanders for people living in urban and agrarian areas they have to use they are enforcing us to use the service.”*

NGO key informant had echoed during 2009 Ethiopian Fiscal Year annual Somali region performance review meeting where regional and all district health office head, hospital and health center heads participated, he asked if any one is using the family planning services among attendants those responded using family planning services were very few in number he underlined that even the health professional were not using any modern method of family planning for themselves. After he told them his experience of using family planning service he recommends for them by saying as below.

“---if you want children you have to space births by using family planning methods.”

Findings from observation revealed that service providers' skills especially poor counselling and negative attitude, shortage of skilled and motivated health workers, Interruption and inadequacy of essential RMNH supplies and equipment, unavailability of user friendly Reproductive health services observed.

Review of plan against performance revealed that eventhough there were few family planning service utilizers at selected hospital and health centers there were no family planning service utilizers in visited two health post in 2009 Ethiopian Fiscal Year.

5.2.5. Lack of specific strategy fit to pastoralist community context

Service provider and programmers explained that there is no specific strategy that will fit into pastoralist community context that will address the access problem on top of this NGO key informants mentioned because most of our countries strategies are developed by a people who have agrarian background who had less experience about environment, so we need to have different strategies that can fit the pastoralist community like health service access and how to reach to this community as below.

“---for example Health extension program the strategy says all should be female and complete grade 10 in our context it is difficult for female to go far distance even within kebele to conduct home to home visit due to hardship on top of that it is difficult to get grade 10 completed women at kebele level in our cases.”

5.2.6. Limited development partners are working on family planning in the study area

Regional programmer explained the role of private sectors in family planning is limited in the region except Reproductive innovative fund programme working in the areas increasing uptake of culturally acceptable and appropriate RMNH including family planning services for women and youth, women and girl's empowerment and enhancing accountability and responsiveness of service providers to communities and women.

“...Before we talk about partner, FMOH strongly support family planning services in the region but currently Reproductive innovative fund two projects 3 years, two years' projects outsourced to Local NGO such as FGAE, OWDA and RHBs Others partners working on family planning services contribution is minimal.” RHB programmer

5.3. Cultural, norm, behavioral related barriers of family use in Somali region of Ethiopia

5.3.1. Religious prohibition

Religious prohibition was the major predominantly stated factor among all the focus group discussions and key informant interview participants hindering women for not to use family planning services in the study area. Two perceptions identified: - Family planning are not important at all and Family Planning for spacing only using lactational amenorrhea/Breast feeding method. As mentioned by both women and men discussants family planning is a way of challenging Allah's authority' (Since it is Allah who provides and takes away children), and unfaithful women practice family planning services.

"...Children are the gift of God. Why we are limiting children, we accept as it is and it depends on the will of God what the number of children do we have." FGD among women of reproductive age group, shinile woreda

A religious leader key informant interviewee in shinile opposed the idea mentioned above by saying that it is accepted in our religion that children need to be spaced when they are born, it was stated that the breast feeding is better to go on until the child age will be 2 years there are a lot of benefits if child is given a long period of breast feeding because mentally and physically will grow well but during that period only breast feeding is recommended.

However, this is not well accepted by one of the key informants from Kebribeyah district. He reiterated his views as follows.

"...Family planning services will not be openly discussed at mosque unlike Polio immunization. Initially, our community does not accept children to receive polio vaccination due to fear that it causes diseases, after open discussion at mosque they are utilizing immunization services even asking service provider if they are not vaccinated. Family planning awareness creation should be done just like immunization to increase service uptake."

Another Religious leader key informant interviewee in Kebribaya also supported ideas of earlier sheiks by saying *"---the problem is not "spacing of children" but, the problem is limiting the number of children the family will have."*

The issue of the need to spacing childbirth using breastfeeding has been emphasized even by key informants from NGOs. One of them has to say the following:

“---Here in Somali region, the Islam religion recommends breast feeding for two years and there should be at least three years of spacing since there is one year for pregnancy.”

However, a clan leader in Shinile woreda opposed the use of family planning as follows: *“I don't believe in the use family planning at all, because there are a lot of people who don't use birth controlling mechanisms and not bear any child, it is the gift of God we cannot relate use of family planning with fertility.”*

Moreover, this study showed that short acting family planning methods are preferred even among those who supported use of family planning methods in the study region. The discussants from the community do not want long acting and reversible family planning methods. A key informant from the federal MOH has to say the following:

“--if a woman utilizes IUD or implant, there is fear that her soul will not rest in peace and go to the heavens when dies; she will lose heaven/janet. Women should in principle be clean when they fast and it is very difficult for a family planning woman to fast cleanly and few women using the service will remove during fasting period.”

5.3.2. Socio cultural prohibition

As key informants at all level agreed with the fact that the Ethiopian Somali society living in kinship and social-network composed of clans. An NGO key informant mentioned that *“---the culture becomes stronger than the religion”*. According to their tradition, male children are especially needed for their heavy engagement in keeping the herd and sustaining the clan into the future generations. It is also believed that, in the Somali culture, children are sources of prestige, respect, wealth and labour in their community. In the Somali society, the most respected woman is the one who has the largest number of children in the entire community.

The key informants and FGD discussants revealed that being polygamous and having many children are highly valued among Ethiopian Somalis including health professionals recruited from the study area.

A nurse has to say the following in his own words:

“... if I had two children, and one of them dies and the surviving one is not a good person, I will be left with nothing. On the other hand, if I do have 9 children I will not be affected; currently I do have two wives if my economic status improved I will add another two of them.”

The chiefs and sheiks of the Somali community mentioned that in the old days, it used to be a taboo to have any sexual intercourse when the woman is breast feeding; it was believed that the child will be suffering from diseases if this happens. The chiefs and Sheiks also said that their community members today do not accept the old day's norm and changed their values since they are educated and understood what is good for their child. However, this argument is opposed by FGD discussants among women; they even mentioned that when the former wife delivered or if she doesn't bear children to him the husband will look for another one, mostly look for another young wife, so as to produce his off spring.

5.3.3. Gender roles and social pressure

Key informants at regional and district levels mentioned that low socio-economic empowerment of women and youth especially in rural areas have resulted in low uptake of family planning and other RMNH services which led to high fertility in the region. Male involvement and participation in family planning programs and negative perceptions of men on contraceptive, women decision making on utilization of contraceptives is weak. Males are not in favor of family planning because of certain misconceptions and myths associated with the use of family planning methods.

The chiefs and husbands exerted excessive power in deciding about sexual and reproductive health alone without involving women due to the fact that traditionally men seen as responsible for everything that will happen with in the family but when it comes to family planning they considered as only for women.

“...all living expenses are covered 100% by men and every decision will be made by husbands. Women will not decide on any issue, even few women using family planning who are from urban areas and educated were using the service secretly without informing their husbands; if the husband hear about their use, there will be violence.” Regional health bureau and Kebribaya Woreda health office focals key informant interviews

Moreover, it's a taboo to use family planning methods before marriage in the study region. Pre-marital sex is also a taboo; therefore, women will not attempt using family planning method. FGD discussants among women and men, as well as key informants who are sheiks and chiefs have the same perceptions as the one perceived by the larger community regarding when to start family planning services. They mentioned that family planning methods should be used after marriage only for the purpose of child spacing. According to them, only unfaithful women use family planning before marriage.

Women themselves accepted the social norm that they should not use family planning methods before marriage. A women FGD discussant from Shinile District has to say the following “... *It is forbidden to start family planning before marriage; but after marriage she can use it if she desires.*”

If a woman is seen using family planning methods, she will be rejected by the wider community. Therefore, they prefer private health care delivery systems for the purpose of using family planning methods. An NGO key informant mentioned that “---*most women are using private facilities for family planning to hide themselves from their husbands and other neighbors due to fear of taboos and other consequences*”. But these facilities are not networked with government system for documentation and reporting. A regional key informant also supported the idea “*due to fear of the stigma from her family, peer group, colleagues, even her child, neighbor and clan leader's women are not using family planning services.*” Also added the clan leader who said that “if a woman is not having a baby within the expected time, she will be socially excluded.”

Underdevelopment, low literacy and prevailing socio-cultural perceptions are major drivers of continued gender inequality in the region. Women and girls remain largely marginalized in terms of development and full participation in the health program as a whole family planning in particular which contributes to low service uptake at the household and community levels. Boys and girls face significant challenges to access health program; especially pastoralist boys who are often on the move in search of pasture and water for their livestock.

5.4. Myths and Misconceptions in the use of family planning in Somali region of Ethiopia

5.4.1. Myths and Misconceptions about family planning

One of the misconceptions with regards to the use of family planning in the study region is that it is a method which is used to space child birth only by using Breast feeding/Lactional amenorrhea method; its use for limiting is not specified by any one of the study participants. Study women, sheiks and chiefs mentioned the fact that they have heard about pills, injectables, breastfeeding and condoms. Chiefs defined family planning as a method that a man can make use of it with his wife and the wife will not get a pregnancy. Sheiks also share same definition and stated it is a process of delaying the child birth, until the former child will be aged 2 years and to feed his mothers breast for the time very well.

An FGD discussant among husbands mentioned the advantages of modern family planning for making the mother and child healthier, for increasing the economy and spacing of children if breast feeding fails to protect pregnancy. We went on dividing women into two, those who get pregnant during breast feeding and those who don't get pregnant during this time. According to him, women who get pregnant while breastfeeding should take contraceptives by contacting nearest health post.

One community sheik explained reason for not using family planning service as “---*I think it is a lack of knowledge, because community don't understand family planning service benefit to them and, more over family planning is new for the society, it was not known before. Community don't get encouragement from the religious leaders since religious leaders are the source of the knowledge.*” clan leader also added the problem is ignorance, the condition of being un educated or unaware of information, that is the problem for not utilizing family planning services.

Religious leader shared his experience how Female Genital Mutilation was eliminated after continuous discussions among family and community recommending that to be repeated for family planning to increase service uptake as follows:

“--- they believe that (community about family planning) it is forbidden obviously to havean open discussion about modern family planning unlike it was done about Female Genital Mutilation and based on that it was eradicated.”

Fear of side effects was also mentioned among women FGD mainly irregular menstruation, bleeding and weight gain. One woman mentioned as follows. “---obviously women using injectables become fat.”

The commonly mentioned misconceptions include Condoms, according to key informants, some women fears fall off and get stuck inside the woman’s uterus, Vasectomy is also thought to render men mentally challenged, the IUCD may rust in women ‘s body’ and that ‘IUCD causes infertility, the use of the pill delayed periods and let to complications during pregnancy. FGD among husbands also added some of the people believe that modern family planning makes you infertile; others believe if they use it they will suffer a disease because it has side effects. The regional health bureau programmer also added his concern once myths and misconception happened negative information will be rapidly disseminated through the community since there is strong relationship among the community.

“...Once women used family planning she will never give birth in the future as a result she will become infertile, there will be congenital abnormalities and skin change/color change, she will not see menses in the future.”-Focus group discussion among women of reproductive age group shinile woreda

“... I think it can cause diseases I heard that one lady was pierced with needle and suffered blood pressure disease.” Religious leader, Key informant interview

The majority respondent’s especially clan leaders mentioned that they do not have shortage of land for farming as well as grazing shares fear that unless they are many in population numbers their property, land and other resources will be taken away by other clan or external body. Having many children seen as a means protection against enemy in case of conflict. Women FGD also supported the idea explaining that family planning indirect system of reducing the number of people in our area.

“...They raise that (Clan leaders) especially for Somali community that they are living dispersely and have more land for their more children why we use birth control which is against God.” Key informant interview clan leader, shinile woreda

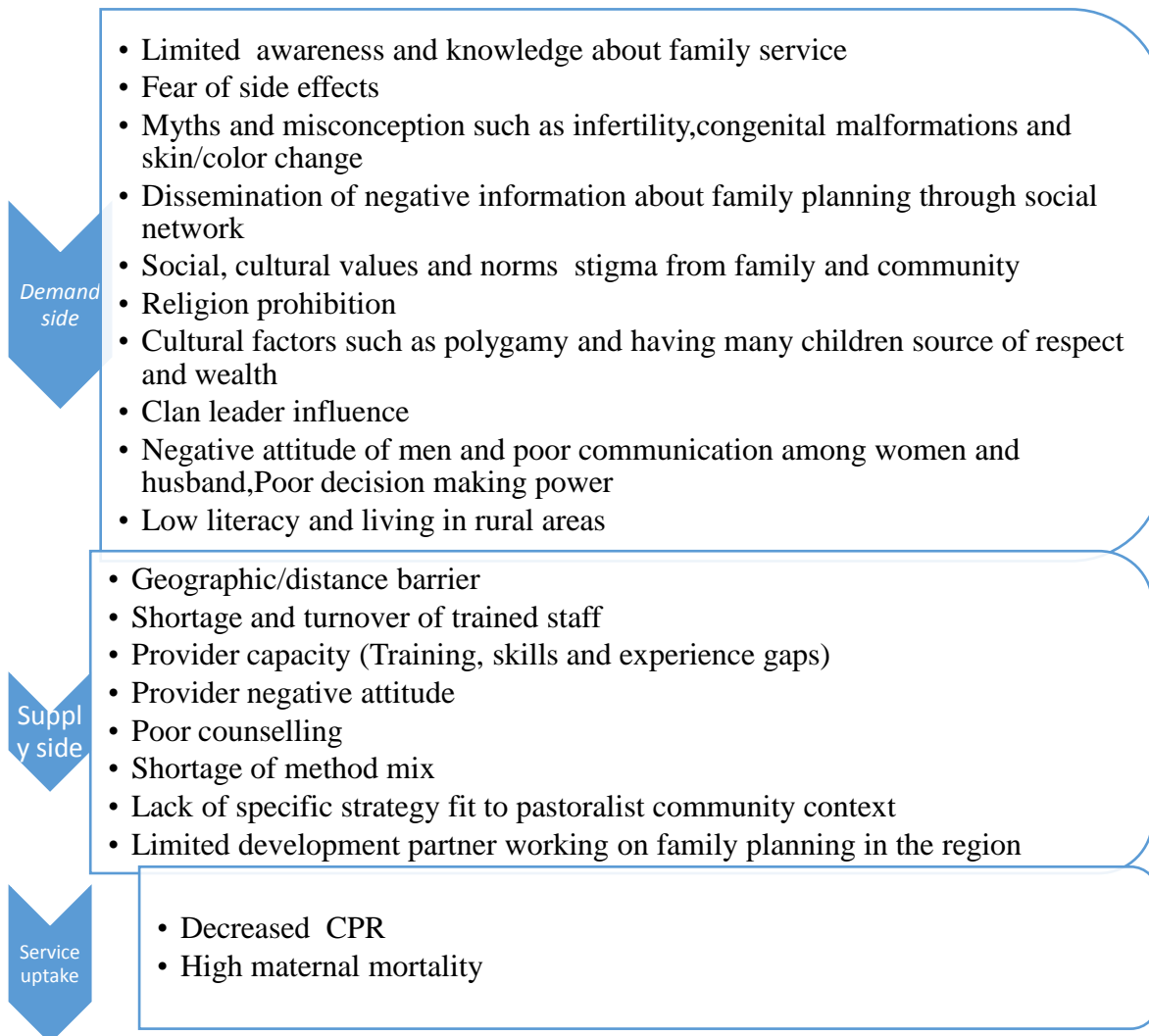


Figure 2. Summary of finding

6. Discussions

The objectives of the study were to explore barriers about family planning in Pastoralist areas of Ethiopian Somali region. National, regional health bureau, district health offices, health facilities, service provider, women of reproductive age group and husbands, community chiefs such as clan leaders and religious leaders were involved in the study. From the study six themes emerged: - key findings were presented as follows.

Religion prohibition

Under this category the issue of the need to spacing childbirth using only breastfeeding/lactational amenorrhea has been emphasized among all but no other modern method of family planning to be utilized. Moreover, this study showed that short acting family planning methods are preferred even among those who supported use of family planning methods in the study region.

Socio cultural prohibition

According to their tradition desire for having many children seen as criteria for being famous and respect. On top of that there were also sex preference being male children are especially needed for their heavy engagement in keeping the herd and sustaining the clan into the future generations.

Being polygamous and having many children are highly valued among Ethiopian Somalis including health professionals recruited from the study area.

Gender roles and social pressure

Low male involvement and participation in family planning programs and negative perceptions of men on contraceptive, lack of women decision making on utilization of contraceptives due to dominant male decision making power. Moreover, it's a taboo to use family planning methods before marriage in the study region. Pre-marital sex is also a taboo; therefore, women will not attempt using family planning method.

If a woman is seen using family planning methods, she will be rejected by the wider community. Therefore, they prefer private health care delivery systems for the purpose of using family planning methods.

Limited access to family planning services

Under this broad theme the key bottlenecks include: -geographic and distance related barriers, lack of comprehensive method mix, shortage and turnover of trained staff, provider skills and experience related factor, myths and misconceptions, lack of specific strategy that fit to the context in pastoralist community and less involvement of development partners working on family planning in the study area.

6.1. Religious prohibition

Religious prohibition was the major predominantly stated factor among all the focus group discussions and key informant interview participants hindering women for not to use family planning services in study areas. Almost all respondents share the same perceptions relating family planning service with religion. Except the breast feeding there seems to be an apparent total absence of women to use modern techniques of family planning. Particularly cultural/religious values play a great role in hindering people from using appropriate methods of modern family planning techniques. It's almost a taboo for women to discuss about family planning and mention the use of family planning due to stigma from husband and relatives as well as influence from clan leaders. There is a very big community push not to use the methods. The region has the lowest rate of acceptance of family planning/contraception that is highly dictated by culture and religion of the community. Spacing is allowed but limiting family sizes were strongly opposed, this finding is similar with study done in other African countries as well as Ethiopia.[10, 11, 14]Eventhough the Islam religion recommends family planning service use community are not utilizing the service due to religion prohibition.

6.2. Socio cultural prohibition

In Ethiopian Somali society living in kinship and social-network composed of clans. Having many children is seen in the community as source of respect and wealth among women and being polygamous is seen as source of respect among males including health professionals. Desires for having more children were initiated from the fact that there is competition among clan's interms of population number since occasional conflict between clan over land and water. Being male is preferred especially among males to share burden of workload. This finding is

consistent with study done in Kenya which revealed the influence of social network approval on the use of family planning, beyond the individual's beliefs affected service uptake. From this engagement key public figures in family planning program as change agent is crucial to have positive messages to themselves and advocate for others to increase service uptake[28]

6.3. Gender roles and social pressure

Male involvement and participation in family planning programs are limited, males influence services negatively. Males are solely the decision maker in all aspects including family planning service utilization. Discussion about family planning among husband and wife are not allowed due to cultural reasons. Majority males think that family planning is only women's matter. Women living in pastoralist areas are not using the service due to stigma from clan leader, husbands, her children, neighbor and peer groups. Few educated and women living in urban areas are using the service without notifying their husbands with consequences of violence if husbands heard. Perception that unmarried women will not use the services was widely spreaded among the community. This finding husband objections, limited male involvement, women, young and unmarried women facing stigma when using family planning, limited women decision making power is similar with study done in Afar, Debreworkos, Rwanda and Tanzania respectively which shows gender equality and empowerment are crucial to improve the service.[10, 14, 21, 24]

6.4. Myths and Misconceptions related to family planning

Generally, awareness of family planning services among religious, clan leader, women of reproductive age group and husbands are relatively good. The commonly mentioned family planning methods are short acting family planning methods such as condom, pills and injectables but no other long acting and permanent family planning methods. The widely mentioned misconceptions include condoms, according to key informants, some women fears fall off and get stuck inside the woman's uterus, the IUCD may rust in women 's body' and that 'IUCD causes infertility, family planning causes diseases like hypertension. This finding similar with study done in Rwanda and Pakistan[21, 26]. The majority respondent's especially clan leaders mentioned that they do not have shortage of land for farming as well grazing shares fear that unless they are many in population numbers their property, land and other resources will be

taken away by other clan or external body. Having many children seen as a means protection against enemy in case of conflict.

6.5. Lack of access to family planning services

Under this broader thematic area geographic and distance barrier, lack of comprehensive method mix, shortage and turnover of trained staff, provider related factor, lack of specific strategy fit to pastoralist community and limited development partner working on family planning subthemes were indentified.

Pastoralist community lives in areas with limited access to health services. Pastoralists are residing in arid and hot weather in sparsely condition. Ethiopian Somali region is mainly homes for pastoralist community. Potential health service coverage of the region is poor. Distance affected service uptake. This study finding consistent with study done in Mozambique which distance to the clinic was negatively associated with contraceptive use. Addressing health service coverage bottleneck crucial to improve service uptake [22]

Poor maternal and newborn health outcomes include factors related to health services readiness such as limited availability, shortage of method mix, inadequate staff received comprehensive family planning training and less experienced professionals due to staff turnover.

Majority of even hospitals and health centers are not providing comprehensive packages of long acting and reversebile methods as well as permanent methods due to lack of trained and experienced staffs, lack of experiences and trained staff turnover. Long acting family planning services are not cascaded to health post levels on top of this the region so wide and there is shortage of public transportation or any other means to access the services even from the health posts. This finding consistent with Ethiopia service provision assessment survey where only 21% and 13%, hospitals and health center offering temporary family planning had atleast one trained staff and guidelines respectively. The finding indicates supply side determinants played role in decreasing uptake of service [29]

6.6. Provider related factor

In study areas the majority of native health professional working on family planning even though they know about family planning, its advantage in terms reducing maternal mortality will not support and utilizing family planning services for themselves due to religious prohibition. Health

workers at regional, districts and health facility had negative attitude towards family planning. Changing attitude of health worker is equally important just like community to increase family planning service uptake. This finding is against study done in USA where clinicians were a major source of positive information. [30]

Findings from observation revealed those Service providers' skills and attitude, experience, interruption and inadequacy of essential RMNH supplies and equipment, poor counselling about methods mix, shortage of skilled and motivated health workers, and unavailability of user friendly reproductive health service observed. On top of this in both selected health posts there is no family planning service utilizers in the kebele in 2009 Ethiopian Fiscal Year. Finding consistent with study done in primary health center where there was lack of critical resources for the provision of quality family planning services in all of the primary health care centers included in the study. Intervention on addressing supply side determinants are crucial to increase service uptake [12, 29]

6.7. Lack of specific strategy fit to pastoralist community context

Although, there is a lot of interest to expand family planning services in general and utilization of long acting reversible and permanent methods in particular, there is no clear strategy on how to address pastoralist regions. Lack of focus specific to pastoralist regions and inability to define applicable implementation modalities may contribute to the significant difference in the performance of developing regions. Emphasis should be given for developing different strategies that can fit the pastoralist community to address health service access and how to reach pastoralist community. This finding is consistent with policy brief document on developing regions where lack of specific strategy affected family planning service uptake. [31]

6.8. Limited development partner working on family planning

The role of private sectors in family planning is limited in the region. Only few partners are implementing on maternal and child health program as a whole not specifically on family planning despite there is huge gap in terms demand side determinants on top of supply side barriers. This finding is consistent with study done in Gurage zone where partner supported areas had a significantly high CPR compared to non partner supported areas. [32]

Even though contraceptive prevalence rate increased from 8% to 36% more than four times over the last four rounds EDHS the variation among regions is very high. Ethiopian Somali region CPR is the lowest among all regions. According to National Reproductive health strategy of Ethiopia (2016-2020) the ministry of health planned to increase contraceptive prevalence rate (CPR) to 55%[33]achieving the target is far away unless focused tailored strategy developed and massively intervention will be undertaken.

7. Limitations

- ❖ Despite different cluster of community, Service provider and programmer shared similar perception this study will be generalized to studied area only.
- ❖ The FGD facillitors were other (health professionls) since the investigator is not the fluent speaker of the local language.
- ❖ Social desirability bias

8. Conclusions

Socio cultural factors such as religion and clan leader influenced family planning service uptake. Limited male involvement, poor women decision making power and empowerment affected family planning service uptake. To increase family planning service uptake entry point should be birth spacing rather than limiting.

Cultural barriers –generally family planning methods before marriage is a taboo. Women and girls remain largely marginalized in terms of development and full participation in the health program as a whole family planning in particular which contributes to low family planning service uptake at the household and community levels due to underdevelopment, low literacy and prevailing socio-cultural perceptions are major drivers of continued gender inequality in the region which leads to low uptake of family planning.

Supply side barriers including lack of context specific (pastoralist) service provision modality, access and limited development partner support contributed for low coverage of family planning.

9.Recommendations

- Somali Regional Health Bureau should massively conduct community mobilization through chiefs and religious leaders on family planning program
- Somali Regional Health Bureau and Somali region women and children affairs should work on male involvement and women empowerment in decision making power
- Somali Regional Health Bureau and Development partner should capacitate and work on changing attitude of health care providers encouraging them to utilize the service for themselves so that they will be role model for the wider community
- Health care programmers at federal, regional and development partner should initiate new initiative/interventions tailored to the lives of pastoralist areas that will fit to mobile community should be developed & intervened.
- Federal Ministry of Health should strengthen implementation special support program for this region to ensure equity (Allocation of development partner, national budget and technical support)
- Regional health bureau and district health offices programmers should avail family planning methods choices at all level
- Health care programmers at federal, regional and development partner should develop need based messages transmit throughlocal media

10. References

1. Daniel, T., *Scaling up of family planning in low-income countries: lessons from Ethiopia*. *Lancet* 2014; 383: 1264–67.
2. CSA, I.M., *Ethiopia Mini Demographic and Health Survey 2014*. Addis Ababa, Ethiopia. .
3. CSA, I.M., *Ethiopia Demographic and Health Survey 2016*. Central Statistical Agency, Addis Ababa, Ethiopia; MEASURE DHS,.
4. CSA, I.M., *Ethiopia Demographic and Health Survey 2000, C.S.A.a.O.Macro*”, Editor. Addis Ababa, Ethiopia and Calverton, Maryland, USA; 2001.
5. CSA, I.M., *Ethiopia Demographic and Health Survey 2005, C.S.A.a.O.Macro*, Editor. Addis Ababa, Ethiopia and Calverton, Maryland, USA; 2006.
6. CSA, I.M., *Ethiopia Demographic and Health Survey 2011*. Central Statistical Agency, Addis Ababa, Ethiopia; MEASURE DHS, ICF Macro, Calverton, Maryland, USA; 2011.
7. FDRE, *Central Statistical Agency. Population Projection of Ethiopia from 2014 – 2017*.
8. Alex, C., John, B., Blessing, M., *Global population trends and policy options*. *Lancet* 2012; 380: 142–48.
9. Joseph. W., S., B., Albrecht, J., Manuela, D., *A scoping review on determinants of unmet need for family planning among women of reproductive age in low and middle income countries*. *BMC Women's Health* (2016) 16:2.
10. Alemayehu, M., Lemma, H., Abrha, K., Adama, Y., Fisseha, G., Yebyo, H., et al., *Family planning use and associated factors among pastoralist community of Afar region, Eastern Ethiopia*. *BMC Women's Health* (2016) 16:39.
11. Mekonnen, W., Worku, A., *Determinants of low family planning use and high unmet need in Butajira District, South Central Ethiopia*. *Reproductive Health* 2011, 8:37.
12. Tafese, F., Woldie, M., Megerssa, B., *Quality of family planning services in primary health centers of Jimma zone, southwest Ethiopia*. *Ethiop J Health Sci*. 2013. Vol. 23, No. 3.
13. Tilahun T, C.G., Luchters S, Kassahun W, Leye E, et al. , *Family Planning Knowledge, Attitude and Practice among Married Couples in Jimma Zone, Ethiopia*. *PLoS ONE* 8(4): e61335. doi:10.1371/journal.pone.0061335.2013.
14. Kassa, M., Alemu, A., Gedefaw, M., *Level of male involvement and associated factors in family planning services utilization among married men in Debreworkos town, Northwest Ethiopia*. *BMC International Health and Human Rights* 2014, 14:33, 2014.
15. Davidson, A., Fabiyi, C., Demissie, S., Getachew, H., Gilliam, ML. , *Is LARC for Everyone? A Qualitative Study of Sociocultural Perceptions of Family Planning and Contraception Among Refugees in Ethiopia*. *Maternal Child Health*, 2016.
16. Tilahun Y, M.S., Zerihun H, Lew C, Brooks MI, Nigatu T, et al. , *Expanding access to the intrauterine device in public health facilities in Ethiopia: a mixed-methods study*. *Glob Health Sci Pract*. 2016;4(1):16-28. <http://dx.doi.org/10.9745/GHSP-D-15-00365>.
17. David, C., Paul, S., *The economic consequences of reproductive health and family planning*. *Lancet* 2012; 380: 165–71.
18. Jacqueline, D., Susheela, S., *Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: an analysis of national surveys*. *Lancet* 2013; 381: 1756–62, 2013.
19. John , C., Agustin ,C. Herbert ,P. John ,R., Amy T., *Contraception and Health*. *Lancet*; 380: 149–56, 2012
20. Sonya, B., Cara, N., Julia, R., Lori, F., Aletha, Y., Said, I. et al., *“It just happens”: A qualitative study exploring low-income women’s perspectives on pregnancy intention and planning*. *PMC* 2016. *Contraception*. 2015 February ; 91(2): 150-156. doi:10.1016/j.contraception.2014.09.014. .

21. Farmer DB, B.L., Ryan G, Habumugisha L, Basinga P, Nutt C, et al., *Motivations and constraints to family planning:a qualitative study in rwanda's southern kayonza district*.Gloab Health Sci Pract. 2015;3(2):242-254. <http://dx.doi.org/10.9745/GHSP-D-14-00198>.
22. Victor, A., Sarah,R.,Luciana,L.,Jing,Y., *Bridging user and provider perspectives: Family planning access and utilization in rural Mozambique*.Int J Gynaecol Obstet. 2015 August ; 130(03): E47-E51. doi:10.1016/j.ijgo.2015.03.019. , 2015.
23. Allen, K., Larissa,J.,Alice,R.,Gorette,N.,James,N.,Lynn,A., *Barriers to male involvement in contraceptive uptake and reproductive health services:a qualitative study of men and women's perceptions in two rural districts in Uganda*.Reproductive Health 2014, 11:21.
24. Idda, M., Ruerd,R.,Deodatus,K., *Family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania: a qualitative study*.BMC Public Health 2013, 13:523, 2013.
25. Joshua, O., Akanni,I.,Adesegun,O., *Women's perceptions and reflections of male partners and couple dynamics in family planning adoption in selected urban slums in Nigeria:a qualitative exploration*.BMC Public Health 2014, 14:869.
26. Noureen, N., Neelofar,S.,Anum,F.,Shaneela,K.,Farid,U., *Myths and Fallacies about Male Contraceptive Methods: A Qualitative Study amongst Married Youth in Slums of Karachi,Pakistan*.Global Journal of Health Science; Vol. 5, No. 2; 2013, 2013.
27. Philip, B., Placide,T.,James,F.,Philip,T.,Nefaah,T.,Allison,S.,et.al, *"If you do vasectomy and come back here weak,I will divorce you": a qualitative study of community perceptions about vasectomy in Southern Ghana*.BMC International Health and Human Rights 2014, 14:16, 2014.
28. Rhoune, O., Mwendu, M.,Stephen,Al.,Susan,K.,Rachel.,Marleen,T.,Megan K., *Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study*.BMC Public Health (2015) 15:118.
29. Ethiopian Public Health Institute (EPHI), F.M.o.H., ICF International., *Ethiopia Service Provision Assessment Plus Survey 2014*.
30. Anderson, N., et.al., *Women's Social Communication About IUDs: A Qualitative Analysis.Perspect Sex Reprod Health*. 2014 September ; 46(3): 141-148. doi:10.1363/46e1814. .
31. Gebeyehu, A., Asnake,M.,Dibaba,Y.,Setegn,T.,Yirga,M.,Teklu,A.,Tura,G., *Barriers for Utilization of Long-Acting Reversible and PermanentContraceptive Methods, with Emphasis to Emerging Regions of Ethiopia*. 2016.
32. Sinaga, M., Mohammed,A.,Teklu,N.,Kristen,S.,Belachew,T., *Effectiveness of the population health andenvironment approach in improving familyplanning outcomes in the Gurage Zone, South Ethiopia*.BMC Public Health (2015) 15:1123, 2015.
33. Federal Democratic Republic of Ethiopia, M.o.H., *National Reproductive Health Strategy(2016-2020)*.2015.

11. Annexes

Key informant interview, FGD guides and Observation checklist

Key informant, FGD guides and Observation checklist for Addis Ababa University, MPH research project to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region, Eastern Ethiopia

Annex 1

A. English Informed information sheet for Women of RH age group

GREETING!

My name is _____, I am a ----- working ----- now I am collecting data from you for the research being conducted to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region, and we would like to improve the family planning service being provided in your area in the future. We hoped that discussion with you would be very helpful to strengthen the service and to promote the general wellbeing of both the mother and children. Hence I would like to raise some questions for discussion about the general concept of family planning and utilization of modern contraceptive methods in the community. Before the beginning of the discussion I wish to express my appreciation to all of you for your voluntary participation. Based on the purpose and objectives of the study, therefore, you are rightfully eligible for the interview. It is only an interview and does not involve anything more. I would like to ask you set of specific questions. I will be grateful if you can spend some time talking with me. The interview is consent-based voluntary, confidential, private and of approximately one hour andhalf duration. Other than a general serial code, your name and other identification aspects are not going to be recorded on the interview sheet. Everything you are going to tell will get kept strictly confidential and private. You will not get obliged to respond to one or more of the specific questions that you do not want to respond to. But so long as you find it reasonably convincing, it undoubtedly is going to be more helpful when all of the questions of the interview set will get completed.

B. Consent and contact for Women of RH age group

- Do you have any questions that you would like to ask?
- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed/verbal consent obtained-----

The purpose of the interview was explained to me and I agree that.....
 (Name of person) is interviewed.

Signature -----

Date -----

C. Guides for FGD of Women of RH age group

Section one. Population characteristics		
Can you read and write?		<ul style="list-style-type: none"> • Yes • No
Have you ever attended school?		<ul style="list-style-type: none"> • Yes • No
What is the highest level of education you completed?		<ul style="list-style-type: none"> • Primary education (1-6 grades) • Junior secondary education (7-8 grades) • Secondary education (9-12 grades) • More than secondary education
What is your religion?		<ul style="list-style-type: none"> • Orthodox • Muslim • Protestant • Catholic • Traditional • Other (specify):_____
What is your living status with your partner?		<ul style="list-style-type: none"> • Living with partner • Partner lives elsewhere
Section two	Focus group discussion guide for married women of reproductive age group	
1.Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. Have you ever heard of (METHOD)?		

Table 1:-Guides for FGD of WRA group

2. Do you know about modern contraceptive methods and what kinds of modern contraceptive do you know?		
3. Why do you and other women use modern contraceptive? Verify the reasons?		
4. How far are you aware of the family planning service in your area?		
5. Where do you get the information, which related to family planning?		
6. What is the attitude of the community regarding family planning? Probe		<ul style="list-style-type: none"> ➤ Acceptability ➤ Culture ➤ Religion ➤ Belief
7. Do you want to know more about family planning?		
8. What is the best family size in your opinion and do you agree having too large family can be harmful to the health of the mother?		
9. When the woman should start to use modern contraceptive methods?		Probing the question of age, marital status, parity and others
10. How do you think, who should decide about family size and who should take responsibility for practicing modern contraceptive methods?		
11. Discuss about men's attitude towards family planning		

12. What are the barriers for practicing modern contraceptive methods?		<ul style="list-style-type: none"> ➤ Accessibility ➤ Availability of different kinds of methods ➤ Acceptability ➤ Fear of side effects ➤ Cultural and religious opposition ➤ Lack of adequate information about family planning ➤ Spousal opposition ➤ Desire to have more children
13. Do you have intention to use modern contraceptive methods to control your future fertility?		
14. Are you currently doing something or using any method to delay or avoid getting pregnant?		
15. Are you satisfied by the current family service being provided (for currently users?)		
16. Where do you get the family planning service?		
17. Which method are you using? (for currently users?)		
18. Which modern contraceptive methods do you prefer to use? Do you get method of your choice?		<p>(Female sterilization, Male sterilization, Injectable, Implants (Implanon/Jadelle/Norplant's), Pill, Male condom, Female Condom, Standard Days Method, Lactational Amenorrhea Method (LAM), Rhythm Method, Withdrawal, Emergency Contraception) (for currently users?)</p>

<p>19. Why do you prefer for example: Female sterilization, Male sterilization, Injectable, Implants (Implanon/Jadelle/ Norplant's), Pill, Male condom, Female Condom, Standard Days Method, Lactational Amenorrhea Method (LAM), Rhythm Method, Withdrawal, Emergency Contraception (for currently users?)</p>		
<p>20. Probing different types of modern contraceptive in relation to: religion; culture; Husband disapproval; safety; effectiveness; side effects; infertility.</p>		

Annex 2

A. English Informed information sheet for husbands

My name is, I am working in research team, which is conducted MPH research project to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region. We are interviewing you to assess determinant factors that influence modern contraceptive use. We would like to improve the family planning service being provided in your area in the future. We hoped that discussion with you would be very helpful to strengthen the service and to promote the general wellbeing of the mother and children and whole family. I am going to ask you some questions that are not difficult to answer. Your name will not be written in this format and never be used in connection with any of the information you are going to tell me. You are not obliged to answer any question that you do not want to answer and you may end this interview at any time you want to. However, your honest answers to these questions will help us in identifying the determinant factors of modern contraceptive use and improve the family planning services in the future. We would appreciate your help in responding to these questions, and the interview will not take more than one and half hour minutes.

B. Consent and contact for husbands

- Do you have any questions that you would like to ask?
- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed/Verbal consent by the respondent -----

The purpose of the interview was explained to me and I agree
that..... (Name of person) is interviewed.

Signature -----

Date -----

C. Guides for FGD of husbands

Individual level factors (knowledge/awareness) on FP, health concerns like cancer and infertility, fear of side effects, negative attitudes towards FP, and education status)

Gender/relational barriers (partner's opposition, desire to have more children, male support, of shared decision making and women's decision making power, status of women, and discussion with partners)

Socio-cultural factors (myths and misconceptions, Cultural/religious)

What is the attitude of the community regarding family planning (Probe Acceptability, Culture, Religion and Belief)?

How do you think, who should decide about family size and who should take responsibility for practicing modern contraceptive methods?

Discuss about men's attitude towards family planning (Probe Acceptability, Culture, Religion and Belief)?

What are the barriers for practicing modern contraceptive methods?

- Accessibility
- Availability of different kinds of methods
- Acceptability
- Fear of side effects
- Cultural and religious opposition
- Lack of adequate information about family planning
- Spousal opposition
- Desire to have more children

Annex 3

A. English Informed information sheet for Community and religious leaders (Sheiks and Chiefs)

My name is, I am working in research team, which is conducted MPH research project to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region. We are interviewing you to assess determinant factors that influence modern contraceptive use. We would like to improve the family planning service being provided in your area in the future. We hoped that discussion with you would be very helpful to strengthen the service and to promote the general wellbeing of the mother and children and whole family. I am going to ask you some questions that are not difficult to answer. Your name will not be written in this format and never be used in connection with any of the information you are going to tell me. You are not obliged to answer any question that you do not want to answer and you may end this interview at any time you want to. However, your honest answers to these questions will help us in identifying the determinant factors of modern contraceptive use and improve the family planning services in the future. We would appreciate your help in responding to these questions, and the interview will not take more than half hour.

B. Consent and contact for Community and religious leaders (Sheiks and Chiefs)

- Do you have any questions that you would like to ask?
- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed/Verbal consent by the respondent

The purpose of the interview was explained to me and I agree that..... (Name of person) is interviewed.

Signature -----

Date -----

C. Guides for IDI of Community and religious leaders (Sheiks and Chiefs)

Barriers from the demand side

- Individual level factors (knowledge /awareness) on FP, health concerns like cancer and infertility, fear of side effects, negative attitudes towards FP, and education status)
- Gender/relational barriers (partner's opposition, desire to have more children, male support, of shared decision making and women's decision making power, status of women, and discussion with partners)
- Socio-cultural factors (myths and misconceptions, Cultural/religious)
- What Quran says regarding family planning use
- What is the attitude of the community regarding family planning (Probe Acceptability, Culture, Religion and Belief)?
- How do you think, who should decide about family size and who should take responsibility for practicing modern contraceptive methods?
- Discuss about men's attitude towards family planning (Probe Acceptability, Culture, Religion and Belief)?
- What are the barriers for practicing modern contraceptive methods?

Annex 4

- A. English Informed information sheet for Health programmer's/policy makers (Federal Ministry of Health and Somali Regional Health Bureau)

Good day! My name is _____. We are conducting AAU MPH research project being conducted to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region. Now I will read a statement explaining the study. Your institution was selected to participate in this study. We will be asking you questions about family planning services. Information generated will help your institution and development partner supporting services in your area for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report. Still, we are asking for your help to ensure that the information we collect is accurate. You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide the country and the region. If there are questions for which someone else is

the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

B. Consent and contact for Health programmer's/policy makers (Federal and Regional)

Do you have any questions that you would like to ask?

- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed by the respondent

The purpose of the interview was explained to me and I agree

that..... (Name of person) is interviewed.

Signature -----

Date -----

C. Guides for IDI Health programmer's/policy makers (Federal and Regional)

Barriers from the supply side

- The policy/strategy gap (Strategy on FP, Equity specific to emerging regions, lack of focus on modern method specific to emerging region and Role of the private sector)
- Facility related factors (Readiness, Access and Quality of care)
- Provider related factors (Skills/training, Experience and Attitude)

Barriers from the demand side

- Individual level factors (knowledge (awareness) on FP, health concerns like cancer and infertility, fear of side effects, negative attitudes towards FP, and education status)
- Gender/relational barriers (partner's opposition, desire to have more children (especially the male partner), male support, of shared decision making and women's decision making power, status of women, and discussion with partners)
- Socio-cultural factors (myths and misconceptions, Cultural/religious)

Annex 5

A. English Informed information sheet for Health programmer's (Wereda Focal)

Good day! My name is _____. We are conducting AAU MPH research project being conducted to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region. Now I will read a statement explaining the study. Now I will read a statement explaining the study. Your wereda was selected to participate in this study. We will be asking you questions about family planning services. Information generated will

help your wereda and development partner supporting services in your area for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other respondents participating in this study will be included in the dataset or in any report. Still, we are asking for your help to ensure that the information we collect is accurate. You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide the wereda. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

B. Consent and contact for Health programmer's (Wereda)

Do you have any questions that you would like to ask?

- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed by the respondent

The purpose of the interview was explained to me and I agree that..... (Name of person) is interviewed.

Signature ----- Date -----

C. Guides for IDI Health programmer's/ (wereda Level)

Barriers from the supply side

- Facility related factors (Readiness, Access and Quality of care)
- Provider related factors (Skills/training, Experience and Attitude)

Barriers from the demand side

- Individual level factors (knowledge (awareness) on FP, health concerns like cancer and infertility, fear of side effects, negative attitudes towards FP, and education status)
- Gender/relational barriers (partner's opposition, desire to have more children (especially the male partner), male support, of shared decision making and women's decision making power, status of women, and discussion with partners)
- Socio-cultural factors (myths and misconceptions, Cultural/religious)

Annex 6

A. English Informed information sheet for Health care providers (Health care providers & HEWs)

Good day! My name is _____. We are conducting AAU MPH research project being conducted to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region. Now I will read a statement explaining the study. Your facility was selected to participate in this study. We will be asking you questions about family planning services. Information about your facility may be used by the FMOH/SRHB, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report. Still, we are asking for your help to ensure that the information we collect is accurate. You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the region. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

B. Consent and contact for Health care providers (Health care providers & HEWs)

Do you have any questions that you would like to ask?

- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview

Declaration to be signed by the respondent

The purpose of the interview was explained to me and I agree that..... (Name of person) is interviewed.

Signature -----

Date -----

C. Guides for IDI of Health care providers (Health care providers & HEWs)

Barriers from supply side

Do you provide any FP service in your facility/MCH center?

If no, what is your reason for not providing FP service?

The health facility provides different methods of family planning (only short acting family planning for health posts)

- Condom
- Pills
- Injectable
- Implants
- IUCD
- Permanents /female and male sterilization/

Do health worker/HEWs providing contraceptives received comprehensive family planning training?

Do you have adequate supply?

- Availability of method mix
- Guidelines
- Basic equipment for family planning services (Blood pressure apparatus, Examination light, Examination bed or couch, Samples of family planning methods, Pelvic model for IUCD, Model for showing condom use)
- Are there IEC materials describing different methods of birth control?

Barriers from the demand side

- Individual level factors (knowledge /awareness) on FP, health concerns like cancer and infertility, fear of side effects, negative attitudes towards FP, and education status)
- Gender/relational barriers (partner's opposition, desire to have more children (especially the male partner), male support, of shared decision making and women's decision making power, status of women, and discussion with partners)
- Socio-cultural factors (myths and misconceptions, Cultural/religious)

Observation checklist for health facility Hospitals, Health center and Health posts using GATHER approach

		Yes	No
Greet	Welcoming and friendly		
	Treat with respect		
	Arrange for privacy		
ASK	Medical history		
	Breastfeeding		
	Living arrangements		
	Reproductive goals		
	Previous FP experience		
	FP knowledge		
	Preferred FP method		
	Concerns about FP		
	Ability to read		
	Problems with method		
	Satisfaction with method		
	Desire to switch methods		
TELL	Pill		
	Injectable		
	IUD (Intrauterine Device)		
	Spermicide		
	Diaphragm		
	Condom		
	Female sterilization		
	Male sterilization		
	Implant		
	Natural family planning		
	Lactational amenorrhea		
	Misinformation		

	Provider bias		
	Use IEC materials		
HELP	Discuss health condition		
	Reason for seeking FP		
	Discuss partner's attitude		
	Communicate understanding		
	Address client's concerns		
	Address misconceptions		
	Explain why some methods inappropriate		
	Explain physical exam		
	Encourage participation in decision making		
	EXPLAIN	How to use method	
How method works			
Managing problems			
Potential side effects			
Advantages of method			
Client repeats instructions			
Give back-up method			
RECOMMEND	Schedule next appointment		
	Ask to return for problems		
	Referral for FP Services		

Annex 7. NGO working family planning in the region

A. English Informed information sheet for NGO working family planning in the region

Good day! My name is _____. We are conducting AAU MPH research project being conducted to explore barriers related to family planning use among pastoralist community of Ethiopian Somali region. Now I will read a statement explaining the study. Your institution was selected to participate in this study. We will be asking you questions about family planning services. Information about your facility may be used by the FMOH/SRHB, your organizations and researchers for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report. Still, we are asking for your help to ensure that the information we collect is accurate. You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the region. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

B. Consent and contact for Health care providers NGO working family planning in the region

- Do you have any questions that you would like to ask?
- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed by the respondent

The purpose of the interview was explained to me and I agree

that..... (Name of person) is interviewed.

Signature -----

Date -----

B. Guides for IDI of NGO working family planning in the region

The policy/strategy gap (Strategy on FP, Equity specific to emerging regions, lack of focus on modern method specific to emerging region and Role of the private sector)

Facility related factors (Readiness, Access and Quality of care)

Provider related factors (Skills/training, Experience and Attitude)

Barriers from the demand side

Individual level factors (knowledge (awareness) on FP, health concerns like cancer and infertility, fear of side effects, negative attitudes towards FP, and education status)

Gender/relational barriers (partner’s opposition, desire to have more children (especially the male partner), male support, of shared decision making and women’s decision making power, status of women, and discussion with partners)

Socio-cultural factors (myths and misconceptions, Cultural/religious)

- ✓ Do you have reporting mechanism to the government system?
 - Yes
 - No
- ✓ In relation to service for FP, what are the biggest challenges? Specify:
- ✓ What activities and actions needed to address the challenges? Specify:
- ✓ What kind of support do you expect from the government particularly MOH to make changes in FP services? -----
- ✓ Do you have FP guideline currently in your facility?
- ✓ Are current policy and guidelines adequate for providing FP services in private sectors?
- ✓ If no, what policies and guidelines could they change? Specify:
- ✓ What recommendations would you make to improve FP service in the private /NGOs sector? Specify: _____

Translated Somali Language

Foomka Xog Uruurinta

Lifaaqa1. Foomka Ogolaanshaha Haweenka Kujira Xiliga Dhalmada

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya, bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeeayaa _____ waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim u yahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah(Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

A. Ogolaanshaha iyo Ciwaanka Haweenka Kujira Xiliga Dhalmada

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?
- Majirtaa wax`aad rabto inaad si fiican iwaydiiso ama aad rabto inaad wax badan katidhaahdo?
- Raali makatahay inaad kaqaybqaadato waraysigan?

Ogolaansho ayaa laga helay -----

Kadib markii la ii shaarxay muhiimada waraysigan ayaa waxaan raali ka ahay
..... (Magaca Qofka) ayaa lawaraystay.

Saxeexa -----

Taariikhda-----

C. Suaalaha Wadar Kooxeedka ee Haweenka Reerka Kujira Xiliga Dhalmada

Qaybgta Koobaad: Habdhaqanka Bulshada

Maqori kartaa mana akhrin kartaa?

1.Haa

2.Maya

Waligaa iskuul madhigatay?

1.Haa

2.Maya

Waa heerkee heerka ugu sareeya ee aad waxbarasho ka gaadhay?

1. Dugsi Hoose (Fasalka 1-6)
2. Dugsi Hoose Dhexe (Fasalka 7-8)
3. Dugsi Sare (Fasalka 9-12)
4. Kasaraysa Dugsi Sare

Waa maxay diintaaduu?

1. Orthodox
2. Muslim
3. Beenday
4. Kaatooli
5. Dahaqami
6. Noockale (sheeg):_____

Waa noocce wada noolaanshaha adiga iyo lamaanahaaga?

- 1.Waan isla noolnahay/ isla joognaa
- 2.Meel kale ayay kunooshahay/ joogtaa

Qaybta Labaad: Suaalaha Wadar Kooxeedka ee Haweenka Reerka leh ee Kujira xiliga Dhalmada

1. Hada waxaan rabaa inaan kahadlo noocyada kaladuwan ee qorshaynta qoyska ee ay lamaanuhu isticmaalan si ay ukala fogeeyaan/uga fogaadaan uurka, walagaana mamaqashay noocyada qorshaynta qoyska ?

2. Mataqaanaa noocyada kaladuwan ee qorshaynta qoyska ee casriga ah, keedse taqaanaa?
3. Maxay adiga iyo haweenka kalaba u isticmaalaan qorshaynta qoyska ee casriga ah? Cadee sababta?
4. Intee in leeg ayaad kawarhaysaa adeega qorshaynta qoyska ee kajira goobihiina?
5. Xageed kaheshaa xogaha kusaabsan qorshaynta qoyska?
6. Waa sidee fikirka ay kaqabaan bulshadu qorshaynta qoyska? Ogow
 - Helitaanka Adeega
 - Dhaqanka
 - Diinta
 - Aaminaada
7. Marabtaa inaad waxbadan ka ogaato qorshaynta qoyska?
8. Fikir ahaantaada maxay kulatahay tirada ugu fiican ee uu qoys ka koobnaan karo iyo makulatahay in qoys aad ufarabadan uu khatar galinkaro caafimaadka hooyada?
9. Goorma ayay haweenku bilaabi karaan isticmaalka qorshaynta qoyska ee casriga ah? Ogaanshaha suaalaha laxidhiidha Da'da, xaalada guurka, inta da'ood ee ay dhashay iyo kuwa kale
10. Yaad umalaynaysaa inuu go'aaminkaro tirada qoyska iyo qofka masuulka ka ah in la isticmaalo qorshaynta qoyska ee casriga ah?
11. Kala xaajoo raga fikirka ay ka aaminsanyihiin qorshaynta qoyska?
12. Waa maxay caqabadaha hortaagan in la isticmaalo qorshaynta qoyska ee casriga ah?
 - Helitaanka adeega
 - Helitaanka noocyada kaladuwan ee qorshaynta qoyska
 - Aqbalaada/ogolaanshaha
 - Ka cabsiga ciladaha kayimaada daawada
 - Dhaqanka iyo diinta oo kasoo horjeeda
 - Mahelin xog igu filan oo kusaabsan qorshaynta qoyska
 - Lamaanaha oo kasoo horjeeda
 - Waxaan rabaa inaan caruur badan dhalo
13. Maleedahay hadaf aad ku isticmaasho qorshaynta qoyska ee casriga ah si aad u yarayso dhalmadaada mustaqbalka?

fertility?

14. Hada masamaysaa ama ma isticmaashaa nooc aad kukala fogayso / aad kagahortagto inaad uur qaado?

15. Maku qanacsantahay adeega qorshaynta qoyska ee aad hada qaadato (kuwa hada qaadanaya)?

16. Xageed kaheshaa adeega qorshaynta qoyska?

17. Nooc ee ayaad isticmaashaa (kuwa hada qaadanaya)?

18. Nooc ee ayaad jeceshahay inaad ka qaadato qorshaynta qoyska ee casriga ah? Maheshaa nooca aad doorato? (kuwa hada qaadanaya)?

(Nooca makaanka laxidhayo, nooca dhufaanitaanka, nooca irbada ah, nooca garabka lagaqaato, nooca kiniiniga ah, cinjirka raga/dumarka, nooca maalmo tirsiga ah, nooca kalasoobixitaanka ah, iyo nooca degdega ah)

19. Maxaad kudooratay/ku jeclaatay (Nooca makaanka laxidhayo, nooca dhufaanitaanka, nooca irbada ah, nooca garabka lagaqaato, nooca kiniiniga ah, cinjirka raga/dumarka, nooca maalmo tirsiga ah, nooca kalasoobixitaanka ah, iyo nooca degdega ah) (kuwa hada qaadanaya)?

20. Ogaanshaha noocyada kaladuwan ee qorshaynta qoyska ee casriga ah iyadoo lala xidhiidhinayo; diinta; dhaqaanka; diiditaanka raga; badbaadada; waxtarkeeda; ciladaha; dhalma la'aanta.

Foomka Xog Uruurinta

Lifaafa2. Foomka Ogolaanshaha Raga Reerka Leh

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/ lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya, bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeyaa _____ waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim uyahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsoontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah (Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

A. Ogolaanshaha iyo Ciwaanka Raga Reerka Leh

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?
- Majirtaa wax`aad rabto inaad si fiican iiwaydiiso ama aad rabto inaad wax badan katidhaahdo?

- Raali makatahay inaad kaqaybqaadato waraysigan?

Ogolaansho ayaa laga helay -----

Kadib markii la ii sharxay muhiimada waraysigan ayaa waxaan raali ka ahay
..... (Magaca Qofka) ayaa lawaraystay.

Saxeexa ----- Taariikhda-----

B. Suaalaha Wadar Kooxeedka ee Raga Reerka Leh

Saamaynta Heer Shaqsi (aqoonta uu uleeyahay qorshaynta qoyska, arimaha laxidhiidha sida: kansarka iyo dhalmo la'aanta, Ka cabsiga ciladaha kayimaada daawada, fikirada xunxun ee kusaabasan qorshaynta qoyska, iyo heerka waxbarasho)

Caqabado laxidhiidha dhanka Sinjiga (Lamaanaha oon ogolayn, rabitaanka ay rabaan inay dhalaan caruur badan (gaar ahaan raga), taageerida ay ragu kataageerayaan go'aan qaadashada haweenka, xaalada haweenka iyo laxaajoodka lamaanaha)

Saamaynta Dhaqan bulsho (Khuraafaadka & fikirada khaldan, Dhaqanka/Diinta)

Waa sidee fikirka ay kaqabaan bulshadu qorshaynta qoyska? (Adigoo ka eegaya dhanka helitaanka adeega, dhaqanka, diinta IWM)

Yaad umalaynaysaa inuu go'aaminkaro tirada qoyska iyo qofka masuulka ka ah in la isticmaalo qorshaynta qoyska ee casriga ah?

Kala xaajoo raga fikirka ay ka aaminsanyihiin qorshaynta qoyska? (Adigoo kala xaajoonaya dhanka helitaanka adeega, dhaqanka, diinta iyo aaminaada)

Waa maxay caqabadaha hortaagan in la isticmaalo qorshaynta qoyska ee casriga ah

- Helitaanka adeega
- Helitaanka noocyada kaladuwan ee qorshaynta qoyska
- Aqbalaada/ogolaanshaha
- Ka cabsiga ciladaha kayimaada daawada
- Dhaqanka iyo diinta oo kasoo horjeeda
- Mahelin xog igu filan oo kusaabsan qorshaynta qoyska
- Lamaanaha oo kasoo horjeeda
- Waxaan rabaa inaan caruur badan dhalo

Foomka Xog Uruurinta

Lifaaqa3. Foomka Ogolaanshaha Odayaasha iyo Culimo Aw diinka

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/ lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya,bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeyaa _____ waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim uyahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsoontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah (Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

B. Ogolaanshaha iyo Ciwaanka Odayaasha iyo Culimo Awdiinka

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?
- Majirtaa wax`aad rabto inaad si fiican iiwaydiiso ama aad rabto inaad wax badan katidhaahdo?
- Raali makatahay inaad kaqaybqaadato waraysigan?

Kadib markii la ii sharxay muhiimada waraysigan ayaa waxaan raali ka ahay anigoo
..... (Magaca Qofka) in la I waraysto.

Saxeexa -----

Taariikhda-----

C. Suaalaha Wadar Kooxeedka ee Odayaasha iyo Culimo Awdiinka

Caqabadaha kajira Dhanka Adeeg Soodoonashada

- Saamaynta Heer Shaqsi (aqoonta uu uleeyahay qorshaynta qoyska, arimaha laxidhiidha sida: kansarka iyo dhalmo la'aanta, Ka cabsiga ciladaha kayimaada daawada, fikirada xunxun ee kusaabasan qorshaynta qoyska, iyo heerka waxbarasho)
- Caqabado laxidhiidha dhanka Sinjiga (Lamaanaha oon ogolayn, rabitaanka ay rabaan inay dhalaan caruur badan(gaar ahaan raga), taageerida ay ragu kataageerayaan go'aan qaadashada haweenka, xaalada haweenka iyo laxaajoodka lamaanaha)
- Saamaynta Dhaqan bulsho (Khuraafaadka & fikirada khaldan, Dhaqanka/Diinta)
- Muxuu Qur'aanku kasheegay isticmaalka qorshaynta qoyska
- Waa sidee fikirka ay kaqabaan bulshadu qorshaynta qoyska? (Adigoo ka eegaya dhanka helitaanka adeega, dhaqanka, diinta IWM)
- Yaad umalaynaysaa inuu go'aaminkaro tirada qoyska iyo qofka masuulka ka ah in la isticmaalo qorshaynta qoyska ee casriga ah?
- Kala xaajoo raga fikirka ay ka aaminsanyihiin qorshaynta qoyska? (Adigoo kala xaajoonaya dhanka helitaanka adeega, dhaqanka, diinta iyo aaminaada)
- Waa maxay caqabadaha hortaagan in la isticmaalo qorshaynta qoyska ee casriga ah

Foomka Xog Uruurinta

Lifaaqa 4. Foomka Ogolaanshaha Masuuliyiinta Caafimaadka (Heer Federal iyo Heer Deegaan)

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/ lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya, bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeyaa _____waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim uyahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsoontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah (Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

A. Ogolaanshaha iyo Ciwaanka Masuuliyiinta Caafimaadka (Heer Federal iyo Heer Deegaan)

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?
- Majirtaa wax`aad rabto inaad si fiican iwaydiiso ama aad rabto inaad wax badan katidhaahdo?
- Raali makatahay inaad kaqaybqaadato waraysigan?

Kadib markii la ii sharxay muhiimada waraysigan ayaa waxaan raali ka ahay anigoo (Magaca Qofka) in la I waraysto.

Saxeexa -----

Taariikhda-----

B. Suaalaha Wadar Kooxeedka ee Masuuliyiinta Caafimaadka (Heer Federal iyo Heer Deegaan)

Caqabadaha kajira dhinaca Agabka

- Galdaloolo dhanka siyaasada/ istiraatiijiyada (Istiraatiijiyada qorshaynta qoyska, in si isle'eg loowada helo gaar ahaan deeganada sookoraya, ahmiyada oo aan lasiin qorshaynta qoyska ee casriga ah gaar ahaan deeganada sookoraya iyo doorka ay kuleeyihiin sectarada sida gaarka ah looleeyahay)
- Saamaynta dhanka goobaha adeeg bixinta (Diyaargarawga, Helitaanka, iyo Tayada adeega)
- Saamaynta dhanka adeeg bixiyayaasha (Xirfada/Tababarada, Khibrada, iyo Fikirka)
- Caqabadaha kajira Dhanka Adeeg Soodoonashada
- Saamaynta Heer Shaqsi (aqoonta uu uleeyahay qorshaynta qoyska, arimaha laxidhiidha sida: kansarka iyo dhalmo la'aanta, Ka cabsiga ciladaha kayimaada daawada, fikirada xunxun ee kusaabasan qorshaynta qoyska, iyo heerka waxbarasho)
- Caqabado laxidhiidha dhanka Sinjiga (Lamaanaha oon ogolayn, rabitaanka ay rabaan inay dhalaan caruur badan (gaar ahaan raga), taageerida ay ragu kataageerayaan go'aan qaadashada haweenka, xaalada haweenka iyo laxaajoodka lamaanaha)
- Saamaynta Dhaqan bulsho (Khuraafaadka & fikirada khaldan, Dhaqanka/Diinta)

Foomka Xog Uruurinta

Lifaaqa 5. Foomka Ogolaanshaha Masuuliyiinta Caafimaadka (Heer Degmo)

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/ lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya, bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeyaa _____waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim uyahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsoontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah (Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

A. Ogolaanshaha iyo Ciwaanka Masuuliyiinta Caafimaadka (Heer Degmo)

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?
- Majirtaa wax`aad rabto inaad si fiican iwaydiiso ama aad rabto inaad wax badan katidhaahdo?
- Raali makatahay inaad kaqaybqaadato waraysigan?

Kadib markii la ii sharxay muhiimada waraysigan ayaa waxaan raali ka ahay anigoo ah (Magaca Qofka) in la I waraysto.

Saxeexa -----

Taariikhda-----

B. Suaalaha Wadar Kooxeedka ee Masuuliyiinta Caafimaadka (Heer Degmo)

Caqabadaha kajira dhinaca Agabka

- Galdaloolo dhanka siyaasada/ istiraatijiyada (Istiraatijiyada qorshaynta qoyska, in si isle'eg loowada helo gaar ahaan deeganada sookoraya, ahmiyada oo aan lasiin qorshaynta qoyska ee casriga ah gaar ahaan deeganada sookoraya iyo doorka ay kuleeyihiin sectarada sida gaarka ah looleeyahay)
- Saamaynta dhanka goobaha adeeg bixinta (Diyaargarawga, Helitaanka, iyo Tayada adeega)
- Saamaynta dhanka adeeg bixiyayaasha (Xirfada/Tababarada, Khibrada, iyo Fikirka)
- Caqabadaha kajira Dhanka Adeeg Soodoonashada
- Saamaynta Heer Shaqsi (aqoonta uu uleeyahay qorshaynta qoyska, arimaha laxidhiidha sida: kansarka iyo dhalmo la'aanta, Ka cabsiga ciladaha kayimaada daawada, fikirada xunxun ee kusaabasan qorshaynta qoyska, iyo heerka waxbarasho)
- Caqabado laxidhiidha dhanka Sinjiga (Lamaanaha oon ogolayn, rabitaanka ay rabaan inay dhalaan caruur badan (gaar ahaan raga), taageerida ay ragu kataageerayaan go'aan qaadashada haweenka, xaalada haweenka iyo laxaajoodka lamaanaha)
- Saamaynta Dhaqan bulsho (Khuraafaadka & fikirada khaldan, Dhaqanka/Diinta)

Foomka Xog Uruurinta

Lifaaqa 6. Foomka Ogolaanshaha Xirfadlaayaasha Caafimaadka iyo Shaqaalaha
Fidinta Caafimaadka

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/ lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya, bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeyaa _____
waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim u yahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsoontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah (Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

C. Ogolaanshaha iyo Ciwaanka Xirfadlaayaasha Caafimaadka iyo Shaqaalaha
Fidinta Caafimaadka

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?
- Majirtaa wax`aad rabto inaad si fiican iwaydiiso ama aad rabto inaad wax badan katidhaahdo?
- Raali makatahay inaad kaqaybqaadato waraysigan?

Kadib markii la ii sharxay muhiimada waraysigan ayaa waxaan raali ka ahay anigoo ah (Magaca Qofka) in la I waraysto.

Saxeexa ----- Taariikhda-----

D. Suaalaha Wadar Kooxeedka ee Xirfadlaayaasha Caafimaadka iyo Shaqaalaha
Fidinta Caafimaadka

Makabixisaan xaruntiina adeega qorshaynta qoyska?

Haday Maya tahay waa maxay sababta aad labixin la`dhiin?

Xirfadlaha/ Shaqaalaha fidinta caafimaadka ee bixinaya adeega qorshaynta qoyska ma qaatay tababarka iskudhafan ee qorshaynta qoyska?

Mahaysataan agab idinku filan?

- Noocyada kaladuwan ee qorshaynta qoyska
- Hagayaasha
- Agabyada muhiimka ah ee qorshaynta qoyska (Qalabka dhiiga lagucabiro, Laydhka wax lagubaadho, Sariirta baadhitaanka, Muunado kutusinaya noocyada kaladuwan ee qorshaynta qoyska, iyo qoriga lagu tuso isticmaalka cinjirka raga)
- Majiraan agabyada daabacaadaha iyo fariimaha ee kutusinaya noocyada kaladuwan ee qorshaynta qoyska
- Caqabadaha kajira Dhanka Adeeg Soodoonashada
- Saamaynta Heer Shaqsi (aqoonta uu uleeyahay qorshaynta qoyska, arimaha laxidhiidha sida: kansarka iyo dhalmo la`aanta, Ka cabsiga ciladaha kayimaada daawada, fikirada xunxun ee kusaabasan qorshaynta qoyska, iyo heerka waxbarasho)

- Caqabado laxidhiidha dhanka Sinjiga (Lamaanaha oon ogolayn, rabitaanka ay rabaan inay dhalaan caruur badan (gaar ahaan raga), taageerida ay ragu kataageerayaan go'aan qaadashada haweenka, xaalada haweenka iyo laxaajoodka lamaanaha)
- Saamaynta Dhaqan bulsho (Khuraafaadka & fikirada khaldan, Dhaqanka/Diinta)

loogutalagalay in lagusoo indha indheeyo cusbitaalada, xarumaha iyo rugaha caafimaadka

Salaan

- Soodhawayn wacan iyo lasaaxiibtan
- Si fiican in loola dhaqmo
- Utixgali danahooda

Waydii

- Caafimaadkiisa Guud
- Naas nuujinta
- Qaabkay uwada noolyihiin
- Muhiimadooda dhanka dhalmada
- Waaya aragnimadoodii hore ee qorshaynta qoyska
- Aqoontooda qorshaynta qoyska
- Nooca ay ka doorteen qorshaynta qoyska
- Waxyaabaha kakhuseeya qorshaynta qoyska
- Wax ma akhrin karaan
- Dhibaatooyinka ay leeyihiin nooca ay qaataan
- Ku qanacsanaanta nooca ay qaataan
- Rabitaanka ay rabaan in ay iska badalaan nooca ay qaataan

Usheeg

- Kiniinka
- Irbada
- Nooca makaanka lagaliyo(IUCD)
- Nooca shahwada dila

- Nooca makaanka lagaliyo (Diaphragm)
- Cinjirka Galmada
- Nooca Makaanka laxidho
- Nooca dhufaanitaanka
- Nooca garabka lagaqaato
- Nooca maalmo tirsiga ah
- Nooca ilmojaqsiinta ah
- Misinformation
- Eedaynta qofka adeega bixinaya
- Isticmaalka agabyada fariimaha iyo daabacadaha

Kacaawi

- Kala xaajoo xaaladooda caafimaad
- Sababta ay usoo raad sadeen adeega qorshaynta qoyska
- Kala xaajoo lamaanaha aragtidooda
- Laxidhiidh oo fahan
- Garo waxyaabaha uu danaynayo macmiilku
- Sooqaado waxyaabaha ismaandhaafka ah
- Usharax sababta ay kuwa qaarkood muhiim u noqon waayeen
- Usharax baadhitaanka
- Kudhiiri gali inay go'aanda ka qayb qaataan

Usharax

- Qaabka loo isticmaalo
- Qaabka uu ushaqeeyo
- Xali dhibaatooyinka
- Ciladaha kayimaada
- Faaiidooyinka
- In macmiilku dib ugusoo celiyo wixii loosheegay

Kulatali

- Jadwalka soonoqoshada
- Inay soo noqoto markasta oo ay dhibaato lasoo daristo
- In meelkale ay kaqadan karto adeega qorshaynta qoyska

Foomka Xog Uruurinta

Lifaaqa 7. Foomka Ogolaanshaha Haayadaha Aan Dawliga ahayn ee Kashaqeyya Qorshaynta Qoyska

Foom kani waa foomka xog uruurinta ee jaamacada Adhis Ababa, qaybteeda daraasaadka masterka caafimaadka bulshada. Daraasaadkan waxaa loogu talagalay in lagu ogaado/ lagusahamiyo caqabadaha, fikirada khaldan iyo khuraafaadka ee kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida Itoobiya, bariga Itoobiya.

Salaan!

Magacaygu waa _____waxaan kashaqeyyaa _____ waxaana rabaa inaan sameeyo xog uruurin kusaabsan caqabadaha, fikradaha khaldan iyo khuraafaadka ee laga aaminsanyahay ama kusaabsan isticmaalka qorshaynta qoyska ee casriga ah ee bulshada xoolo dhaqatada ah ee kunool dawlad deegaanka soomaalida itoobiya. Waxaan rabnaa inaan mustaqbalka wax kabadalno ama kahagaajino adeega qorshaynta qoyska. Waxaan rajaynayaa in wada xaajoodkeenu uu muhiim uyahay in laxoojiyo islamarkaana kor looqaado caafimaad qabka hooyada iyo caruurta.

Halkan waxaan rabaa inaan kugu waydiiyo suaalo kusaabsan fikirka guud ee ay bulshadu kaqabto isticmaalka qorshaynta qoyska ee casriga ah. Kahor intaana bilaabin suaalahayga waxaan rabaa inaan kaaga mahadceliyo sida ikhtiyaarka leh ee aad rabto inaad uga qaybqaadato daraasaadkan. Iyadoo lagaduulayo ujeedooyinka iyo muhiimada daraasaadkaan ayaa waxaad munaasib unoqotay in laguwaraysto. Waraysigan waa waraysi ay xogtiisu dhawrsoontahay, wuxuuna soconayaa mudo halsaac iyo badha ah waxa kaliya ee laqorayaa waa lambar sir ah (Code Number) loomana baahno in laqoro magaca iyo waxyaabo kalaba. Lagugumana qasbayo inaad kajawaabto suaalaha qaarkood kuwaas oo aadan rabin inaad kajawaabto.

B. Ogolaanshaha iyo Ciwaanka Haayadaha Aan Dawliga ahayn ee Kashaqeyya Qorshaynta Qoyska

- Majirtaa wax suaal ah oo aad rabto inaad iwaydiiso?

• Majirtaa wax`aad rabto inaad si fiican iiwaydiiso ama aad rabto inaad wax badan katidhaahdo?

• Raali makatahay inaad kaqaybqaadato waraysigan?

Ogolaansho ayaa laga helay -----

Kadib markii la ii shaarxay muhiimada waraysigan ayaa waxaan raali ka ahay
..... (Magaca Qofka) ayaa lawaraystay.

Saxeexa -----

Taariikhda-----

C. Suaalaha Wadar Kooxeedka ee Haayadaha Aan Dawliga ahayn ee Kashaqeeya Qorshaynta Qoyska

1. Haayadiinuu si toos ah miyay uga shaqaysaa/ ubixisaa adeega qorshaynta qoyska?
2. Hay Maya tahay waa maxay sababtaa aad ubixin/ uga shaqayn la'dihiin? Ogow ma

- Wax laga faaiidayo ayaa iskayar
- Waa wakhti lumis
- Malaha dalab/ soodoonadshada adeega
- Majiro qof u tababaran
- Wax kale (Sheeg)

3. Ma danaynaysaan inaad mustaqbalka aad bixisaan adeega qorshaynta qoyska?

1, Haa 2, Maya, Sheeg Sababta/Caqabada -----

4. Haday Haa tahay Noocee ayaad bixisaan?

- Cinjirka Galmada
- Kiniinka
- Irabada
- Nooca Garbka lagaliyo
- Nooca Makaanka Lagaliyo
- Nooca Makaanka laxidho ama Dhufaanka

5. Xagee ayaad agabka kaheshaan?

- Ma hay'ado kale ayaad si bilaash ah kaga heshaan
- Miyaad soo iibsataan
- Ma dawlada ayaad si bilaash ah kaga heshaan

- Meelkale(Sheeg) -----
6. Qaabkee ayaad usiisaan macaamiisha?
 - Si bilaash ah
 - Si iibitaan ah
 7. Majira nidaam aad xogta ugu gudbisaan dawlada?
 - Haa
 - Maya
 8. Marka laga hadlayo dhanka adeega qorshaynta qoyska maxay yihiin caqabadaha ugu waawayn? Sheeg
 9. Talaabooyin nooc ee ah ayaad qaadaan si aad u ogaataan caqabadaha jira? Sheeg:
 10. Caawimaad nooc ee ah ayaad kafilaysaan dawlada gaar ahaan wasaarada caafimaadka ee federalka si ay wax ugaga badasho adeega qorshaynta qoyska?

 11. Wakhti xaadirka xaruntiinuu maahaystaa buugaagta iyo hagayaasha qorshaynta qoyska?
 12. Miyay hagayaasha iyo boolisiyada hada jira kufilan yihiin si loogu bixiyo adeega qorshaynta qoyska ee sectarada sida gaarka ah loo leeyahay?
 13. Haday Maya tahay hagahee/ boolisiyadee ayaad wax kabadali lahayd? Sheeg:
 14. Maxaad kutala bixinaysaa si wax`looga badalo adeega qorshaynta qoyska ee hay`adaha aan dawliga ahayn iyo xarumaha sida gaarka ah looleeyahay? Sheeg:

Annex 8. Characteristics of study participants

Variable	Frequency	Percent
Sex		
Male	25	64
Female	14	36
Age (yrs)		
20-24	5	12.8
25-29	13	33.3
30-34	8	20.5
35-39	5	12.8
40-44	3	7.7
45-49	5	12.8
Religion		
Christian	1	2.6
Muslim	38	97.4
Occupation		
Farmer	23	59
Employee	16	41
Residence		
Urban	21	54
Rural	18	46
Education		
Illiterate	25	64
Diploma and above	14	36

Annex 9. Curriculum Vitae

Personal information

Full name GEMU TIRU BATI
Address P. O. Box 1234, Addis Ababa, Ethiopia
Telephone(s) +251115536302
Mobile: + 251-913-31-68-12
Nationality Ethiopian
E-mail(s) gemu.tiru@yahoo.com
gemut2010@gmail.com
Date of birth 28-05-87 GC
Gender Male

Desired employment / Occupational field Public Health

Work experience

Dates June 8/2009 –July 23/2013

Occupation or position held Health Promotion and Diseases Prevention Officer

Main activities and responsibilities

- Preparing comprehensive annual plan
- Preparing BSC (balanced score card) bi-annually
- Conducting Advocacy workshops
- Developing strategic plan, manuals and guidelines
- Developing National program, projects and initiatives
- Conducting Capacity building activities
- Monitoring and evaluating health promotion and diseases prevention activities

July 23/2013-February 1/ 2014

Maternal Health officer in Health System Strengthening Special Support Directorate

- Coordinate the National Health System Strengthening Special Support Directorate Maternal Health program at the Federal Ministry of Health

February 1/2014- Sep 11/2014

Health System Strengthening Special Support Team Coordinator

- Coordinate team deployed to provide technical support to province, districts and Health facility on Health systems building blocks

Sept 18/2015- up to date

Health System strengthening Special Support Directorate Ethiopian Somali Team Coordinator

- Coordinate the National Health System Strengthening Special Support Directorate Ethiopian Somali Team at the Federal Ministry of Health

Name and address of employer

Federal Ministry of Health

Sudan Street, Addis Ababa, Ethiopia

P.O. Box 1234

Tel: +251115536302

Type of business or sector Public Health

Education and training Dates

- January 2006- May 2009
- September 2003- June 2005
- September 2001- June 2003
- September 1993- June 2001

Title of qualification awarded

- Bachelor of Science
- Ethiopian Higher Education Entrance Certificate
- Ethiopian General Secondary School Leaving Certificate
- Ethiopian Elementary School Leaving Certificate

Principal subjects/Occupational skills covered

- BSc in Public Health
- Higher Education Preparatory School Education
- General Secondary School Education
- Elementary School Education

Personal skills and competences

Name and type of organisation providing education and training

- Jimma University
- Zeway Senior Secondary and Higher Education Preparatory School
- Batu Number 3 Junior School
- Boramo Elementary School

Mother tongue Afan Oromo

Other language(s) English, Amharic

Self-assessment

Understanding		Speaking		Writing
Listening	Reading	Spoken interaction	Spoken production	
Excellent	Excellent	Excellent	Excellent	Excellent

Social skills and competences

- I have skill in coordinating events and working in groups/teams
- Capable of conducting researches for action (program development and implementation)
- Capable of designing proposals, implementing with stakeholders and monitoring and evaluation of the implementation
- Capable of conducting trainings and workshops

Researches/Papers/Guidelines

- “Knowledge, Attitude and Practice of Women towards Female Genital Mutilation(FGM)” In Nada Town, Jimma Zone, Oromia region, Ethiopia”, a research submitted to the school of Public health, University of Jimma for the partial fulfilment of bachelor of Science in Public health (2009).
- A team member in the preparation of The health development transformation army, Equity Plan of Action from 2015 to 2020 GC, Health system strengthening special support strategic plan and in the revision of the Prevention of Mother to child transmission of HIV Guideline at the Federal Ministry of Health

- Technical committee member on developing cross-border integrated programme for sustainable peace and socioeconomic transformation: Marsabit county, Kenya and Borana and Dawa zones, Ethiopia

Computer skills and competences

- I have Excellent basic computer skills including Microsoft Word, Excel, PowerPoint and Inter net

Short course trainings/workshops attended

- Certificate on Short Course on reproductive health/family planning conducted by School of public Health, Addis Ababa University in collaboration with the Johns Hopkins University/Gates Institute (September 29- October 8,2011, Addis Ababa, Ethiopia)
- Certificate on Training of trainers on Integrated Maternal Newborn and Child Health/Prevention of Mother to Child Transmission of HIV training organized by Federal Ministry of Health in collaboration with Columbia University -International center for AIDS Care and Treatment program, (November 8-20/2010, Adama, Ethiopia)
- Certificate on District Health Service Management Training of Trainers organized by Ministry of Health/Ethiopia (01-12 August 2011, Adama, Ethiopia)
- Certificate on Training of trainers (TOT) on Provider Initiated HIV Testing and Counselling(PITC) organized by Federal Ministry of Health in collaboration with Johns Hopkins University (March 22-28/2010, Adama, Ethiopia)
- Certificate on management of combined TB and HIV/AIDS control programme for physicians and programme managers. (Sept21—oct 2,2009, Addis Ababa, Ethiopia)
- Certificate on Vaccine management training organized by Federal Ministry of Health in collaboration with World Health Organization (April 23-26/2010, Debrezeit, Ethiopia)
- Certificate on Training on Commodity Security Principles and Practices course organized by Federal Ministry of Health in collaboration with USAID/DELIVER (March 25-29/2013, Hawasa, Ethiopia)
- Attended Master Training of Trainers on Woreda-Based Annual Health Sector Planning Process (18 -25 February 2012, Adama, Ethiopia)
- Attended Master Training of trainers on Health Management Information system (1-6 February 2014, Adama, Ethiopia)

- Attended Master training on Community Based Nutrition(CBN) organized by Federal Ministry of Health in collaboration with UNICEF and World Bank (Feb 15-28/2010, Zeway, Ethiopia)
- Attended meeting on provision of home-based care to mother and child in the first week after birth, WHO, Geneva,8 to 10 February 2012
- Certificate of Participation on African Regional Workshop on: The Right to Adequate Food and Nutrition Education, Public Policy, Food fortification and Distribution Activities in Africa organized by Addis Ababa University in collaboration with Johns Hopkins Bloomberg school of Public Health (Oct 7-9,2010, Addis Ababa, Ethiopia)
- Certificate on Leadership, Management& Governance woreda level training of trainers, organized by Federal ministry of Health in collaboration with MSH-LMG Project conducted at Debrebirhan Health science college from September 15-22/2014 with the financial support from U.S. Agency for International Development(USAID).

References

Dr. Kebede Worku

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Annex 10. Declaration

The researcher, I the undersigned, declare that this thesis is my original work and has not been presented for a degree in this or any other university, and all sources of materials used for this thesis have been acknowledged.

Name: Gemu Tiru Bati (BSc in Public Health)

Signatures:

Date:

Place: Addis Ababa University, College of Health Science, School of Public Health

This thesis has been submitted with my approval as university advisor

Wubegzier Mekonnen (PhD)

Signatures:

Date:

Place: Addis Ababa University, College of Health Science, School of Public Health

Abiy Seifu (B.Sc., MPH)

Signatures:

Date:

Place: Addis Ababa University, College of Health Science, School of Public Health

Mulugeta Tamire (B.Sc., MPH)

Signatures:

Date:

Place: Addis Ababa University, College of Health Science, School of Public Health

Alemayehu Mekonnen (MD, MPH, Associate Professor)

Signatures:

Date:

Place: Addis Ababa University, College of Health Science, School of Public Health