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Dept. of Community Health
Faculty of Medicine

COMPARISON OF CBD, NON-CBD, AND FORMER CBD AREAS TO ASSESS EFFECTIVENESS OF COMMUNITY BASED FAMILY PLANNING SERVICES

A THESIS PRESENTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH

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December, 2000.

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

Assessment of quality of CBD Family Planning Services

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DEDICATION:

In memory of my beloved mother Desta Odda and my brother Alemu Genna, whose loss was painful experience for me.

"God has made everything beautiful in its time" Ecclesiastes, 3:11.

Acknowledgment

I would like to forward my deepest appreciation and thanks to my advisors Dr. Mesganaw Fantahun and Dr. Yemane Berhane, for their unreserved help in reviewing my thesis work and giving me constructive criticism and advice, as well as pointing and providing me with relevant references, from the start to the completion of this study.

I would also acknowledge staffs of FHD/MOH, FGAE central office and its Eastern Showa Zone branch office, for their keen assistance in providing the necessary information and facilitating conditions while I was carrying out this study. Especially to Dr Ermias Getaneh, Mr Fikadu Chala, Mr. Anteneh Habtamu and Mr Getachew Bekele from head office; and ,Mr Adane Husein and Mr.Tilaye Tesfaye from branch office of FGAE. Also, to Mr. Aklilu Aberra for he has exerted all his effort in helping me all the way starting from selection of interviewers and strictly supervising them until the work is completed. I would like to forward my thanks to all interviewers for their concerned and cautious work, especially to Mr. Awoke.

My thanks also goes to Mr. Lemma Gonfa for his great assistance in searching for relevant references. I thank Mr. Negusu worku, Mr. Wondwosen Bekele, Mrs. Ethiopia Mekonnen and Miss Beki Asfaw for their help in my computer work. Also I would like to express my gratefulness to all my instructors in giving me their expert advice while conducting this study.

I also like to express my gratitude to my brothers, sisters and friends for their moral support while making every move to pursue my study. Finally, I thank the school of Graduate studies of Addis Ababa University for sponsoring me to carry out this study.

Table of Contents **Pages**

1. Acknowledgment.....i

2. Table of Contents.....ii

3. List of Tables..... iii

4. List of annexes.....iv

5. List of Figures.....v

6. List of Abbreviations.....vi

7. Abstract.....vii

8. Introduction.....1

9. Literature review.....5

10. Objectives.....12

11. Subjects and methods.....13

12. Results I Quantitative study.....23

II. Qualitative study.....38

13. Discussions.....40

14. conclusions.....50

15. Recommendations.....52

16. References.....54

List of Tables

A. Quantitative part Page

Table 1 Socio-demographic characteristics of CBD, FCBD and NON-CBD areas, Eastern Showa Zone, Ethiopia, 2000.....24

Table 2 Reproductive characteristic of CBD, FCBD and NCBD areas, Eastern Showa Zone, Ethiopia.....25

Table 3 Comparison of knowledge, attitude, and practice of family planning service between CBD and NCBD areas, Eastern Showa Zone, Ethiopia, 2000.....28

Table 4. Comparison of knowledge, attitude and practice of family planning service between CBD and FCBD areas, Eastern Shows zone, Ethiopia, 2000.....29

Table 5. Comparison of contraceptive users view about the quality of FP- service , between CBD and NCBD area, Eastern Showa Zone, Ethiopia, 2000.....31

Table 6. Comparison of reasons for non-use and discontinuing MCM use, between CBD and NCBD areas, Eastern Showa Zone, Ethiopia, 2000.....34

Table 7. Comparison of reasons for non- use and discontinuing MCM use, between CBD and FCBD areas, Eastern Showa Zone, Ethiopia, 2000.....35

Table 8. Logistic regression analysis result of possible explanatory variables for current use of MCM, Eastern Showa Zone, Ethiopia, 2000.....37

List of annexes

Annex 1. Summary results of focus group discussions.....59

Annex 2. Structured questionnaires for quantitative study.....62

Annex 3. Semi-structured questionnaires for qualitative study 71

List of Figures **Page**

Figure 1. Study architecture.....18

List Of Abbreviations

1. MOH	-	Ministry of Health
2. MOA	-	Ministry of Agriculture
3. FGAE	-	Family Guidance Associations of Ethiopia.
4. FP	-	Family planning
5. PAs	-	Peasant associations.
6. CBD	-	Community based distribution
7. MCM	-	Modern Contraceptive Methods
8. AAU	-	Addis Ababa university
9. TFR	-	Total fertility rate
10.HIV/ AIDS	-	Human immuno deficiency virus /Acquired Immuno deficiency syndrome
11. MCH	–	Maternal and child health
12. UNFPA	-	United nations population fund agency.
13. CPR	–	Contraceptive Prevalence Rate.
14. FHD	-	Family health department.
15. OR	-	Odds ratio
16. NACID	-	Nazareth Children's center Integrated community development.
17. SD	-	Standard deviation
18. STD	-	Sexually transmitted diseases
19. CI	-	Confidence interval
20. FGD	-	Focus Group Discussion
21. IUD	-	Intra-uterine Device
22. HHs	-	House holdes
23.USAID	-	United States Agency for International Development.
24.CSA	-	Central Statistical Authority
25.COFAP	-	Consortium of family planning NGO's in Ethiopia.

Abstract

This is a retrospective cohort study designed to assess the effectiveness of community based Family planning services in Eastern Showa Zone. The study was carried out in 30 PAs selected from five districts, where ten PAs were randomly selected from three areas: Community based distribution (CBD), Former community based distribution (FCBD) and Non-Community based distribution (NCBD) areas.

A multistage sampling technique was used to select 310 women in the reproductive age groups(15-49 years)for interview in each of the study areas. A questionnaire survey and focus group discussions were the methods of data collection. Focus group discussion was conducted among women aged 25-35 years and 45-55 years, as well as among community representatives selected from the study areas.

Knowledge about modern contraceptive methods was significantly higher in the CBD communities, proportion of women knowing one method being 89.1% in CBD area compared to 76.6% in FCBD and 32.2% in NCBD. The most widely known MCM was pill followed by injectable hormone. The proportion of women who ever used MCM was significantly higher in CBD area. Ever use rate of of MCM was 57.2% in CBD, 39.2% in FCBD, and 18.3% in NCBD communities; Where as 43.4% , 22.7% , and 7.6% of the respective areas were current users, which was also a significant difference. In all areas over 65% of those who never used MCM expressed intention to use in the future.

Although, clients in the CBD area generally claim to be satisfied with the service, they complained of being influenced by service provider. Most respondents approved family planning use. CBD area clients were found to use MCM relatively longer than NCBD area clients. Forty two percent of CBD, 33.3% of FCBD, and 35.3% of NCBD area clients used their method at least for one year.

Lack of adequate information in non-CBD area and need for more children in CBD area were the major reasons for non-use of family planning methods. Need for (more) children and side-effects were the major reasons mentioned for use discontinuation in all of the three study areas.

Controlling for possible confounders the presence of community based family planning service was found to be the most important explanatory variable for increased current use of MCM. Therefore, a quality community based FP service is highly recommended in NCBD areas and further study is necessary to look for feasible mechanisms to sustain the service.

1. INTRODUCTION

World population is projected to reach between 8 billion and 12 billion people by the middle of the 21st century. More than 90% of world population growth is occurring in less developed regions. The population size of Africa is projected to more than double between 1995 and 2050, from 720 million to 2 billion, while the population of Latin America is expected to grow from 477 million to 810 million, and the population of Asia from 3.4 billion to 5.4 billion. In contrast Europe's population is expected to decline over this period from 728 million to 638 million, because of low birth rates and an ageing population (1,2).

Fertility rate are substantially low in the industrialized countries. In the mid 1990s, the average TFR was 1.4 children per women in Europe, 1.9 in North America, and 1.5 in Japan. United Nation projection shows the TFR in these countries rises to about two children per woman by 2050 (1,3,). The total fertility rate(TFR) in less developed countries declined from 6.2 children in 1950s to about 3.4 children in 1997. The total fertility rate is still well above the 3.4 average in most of Sub Saharan Africa, and 3.8 children per woman in South central Asia (1,2,3). According to the 1999, health and health related indicator report, Ethiopia has a high TFR and Rate of natural increase which are 6.74 child and 2.9% respectively with an estimated population of 61.7 million (4).

Most demographers expect fertility to decline in less developed countries, but the pace of that decline may depend on a number of social, political and economic factors that influence motivation and ability to limit family size(1,6).

Over 100 millions acts of sexual intercourse take place each day. These results in 910,000 conception and 356,000 sexually transmitted bacterial and viral infections. About 50% of conception are unplanned and about 25%are definitely unwanted (5). In developing countries outside Sub Saharan Africa, between one- tenth and one-third of all recent births are reported to be unwanted , and similar percentages are reported mistimed. Even in Sub Saharan Africa, where desired family size is still large about one-fifth of births are reported to be mistimed (6).

Family planing allow women and men to control the number and spacing of their children, preserve their health and fertility and contribute to the improvement of overall quality of their lives. This will help to improve family well-being, nations development and limit world's population and consequences of unchecked population growth(5,6).

The availability of safe, convenient and effective family planing methods would help people to exercise their reproductive choice. It is estimated that 87 million married women would start practicing contraception if their need for spacing and limiting births could be fully satisfied. If individuals who do not live in marital unions are added ,the total unmet need for contraception in developing countries would be close to or in excess of 100 million (3,7).

The need for dual protection against unwanted pregnancies and HIV/AIDS poses a challenge to the field of contraceptive research and development. The HIV-pandemic is more serious than previously thought .About 30 million people are now living with HIV. There are 16,000 new infections each day. The majority of new infections are among young people aged 15-24 years and girls appear to be especially vulnerable(3,8).

In western Europe, North America and most of East Asia access to FP services is almost universal, contraceptive use is between 65% and 80%(2,6).The proportion of couples using some form of modern contraceptive methods has risen from 15% in 1960 to nearly 60% in 1990, across most of the developing countries. However, family planning services are still not widely available in most of Sub Saharan African countries, contraceptive use is below 15% and women bear on average 6 or more children(6,9).

Reproductive health programs should place a high priority in meeting the growing need for FP services through safe access to a range of contraceptive methods through clinical and non clinical channels(CBD, Market places, Places frequented by adolescents etc.).

In Ethiopia the concept and practice of FP has been promoted since 1966, when a group of concerned volunteers established the FGAE. In 1980 'MCH' coordinating office under departments of MOH was established, and became fully functional in 1983.After 10 years of its establishment it has been recognized as Family Health Department(FHD) having 4 teams under it ,one of which is FP team. Family planning activities under MOH are conducted as country programs funded by UNFPA. Three country programs were under taken until 1997 each covering a period of five years(10,11).

In spite of the long history and efforts made, the CPR remains low with high TFR. The government adopted the National Population Policy in April 1993, with an objective of improving the low level of CPR(4.2%) to 44% by the year 2015(13).In regard to this FP services are integrated in most of health facilities and their out reach activities. Results from survey conducted by FHD/MOH, 1997 showed that 88.9% of hospitals, 92.3% of health centers and 80% of health

stations surveyed provide FP services; and 59.5% of hospitals, 53.9% of health centers and 38.6%of health stations surveyed provide FP services during their out reach activities(12).

In general, the quality of FP services was found to influence utilization(28,29).In Ethiopia, the quality of FP service at health facility level was found to have some drawbacks (30,31).

Therefore, this study investigates the effectiveness of community based FP services in improving CPR. Lessons learned from this study could be utilized by policy makers and program designers to improve or expand FP service else where in the country using the CBD method.

2. LITERATURE REVIEW

Community Based Family Planning Services

The international planned parenthood federation (IPPF), has played a significant role in promoting the development and expansion of FP-programmes world wide ,through encouraging its member associations to apply and utilize operation research by providing the necessary initiatives and back-up such as funding and training . Operation research (OR), initially introduced to design and test new strategies for delivering FP-services in developing countries in order to meet the changing needs of programs and managers in improving the accessibility, availability and quality of FP-services and other reproductive health services(13,14).

Given the limited number and geographic availability of physicians in developing countries, the use of non-physicians to provide FP-Service has greatly expanded FP-service delivery. In the 1970s the impact of bringing FP-services to the people where they live was evaluated. Pilot projects of FP-programs in Egypt, Morocco, Tunisia and Bangladesh used specially trained workers to deliver FP-information and supplies through home visits and community depots . The projects showed that this type of outreach, called community based FP-services, could significantly increase contraceptive use (16-18). Therefore, community based distribution (CBD) of FP-methods is acknowledged to be one of the most important contributions of operation research. Since, pilot projects of CBD of FP-methods, test innovative solutions on a small scale it could protect programs against large scale, potentially damaging and costly failure. And, these pilot projects highlight the possible national or regional impact of successful intervention. Many national programs began as a pilot projects so that, policy makers and political leaders can

appreciate its impact and become more interested in promoting its application and expansion (18,20).

CBD-programs have four essential features:

1. Community residents who are not health professionals deliver supplies and services.
2. The programs deliver services to each community or even each households, and do not depend on clinic attendance.
3. CBD workers operate relatively autonomously, without direct day to day supervision.
4. Many diagnostic, screening and record keeping procedures, although desirable, are omitted, because they are not practical for community workers (17).

For community based health services provided by community agent to be effective CBD programs should focus on:

1.Common and important health problems of the community

2.Health problems for which there are effective remedies, and

3.Services and supplies that are relatively safe and easy to deliver (6,17).

Among health services that have been considered and/or provided through CBD programs are oral rehydration therapy (ORT), Malaria treatment, intestinal parasite treatment, nutrition education and supplements and immunizations. Clinics and medically trained personnel provide necessary backup and referral, but they are not the main source of service and supplies.

CBD increases access to services and supplies in four ways:

1. By overcoming geographical barriers- accessible.

2. By over coming cost-barriers-free/charge small fee.

3. By eliminating bureaucratic barriers- minimizing long waiting time.

4. By overcoming cultural and communication barrier-convenient & acceptable to the community(14,17,18).

Family planning (FP) is one of several primary health measures that can be delivered safely, effectively and cheaply through Family planning CBD programs which began more than two decades ago (16,17). The first community based FP programs were initiated by PROFAMILIA, the family planning association in Colombia, in 1971; by BEMFAM, the family planning association in Brazil, in 1973; by American University of Cairo and the FP-association in Egypt, in 1974-75, and subsequently by other private groups in a number of countries including Srilanka, Thailand, South Korea, Guatemala and Egypt(16-18).

In Turkey, CBD program has increased the CPR to 50-74% from 21-36% (with in 4 years).The programs has shown similar results in Mali, Nigeria, and Sudan improving CPR from 1% to 11.6%, 2% to 13.9% and 6.8% to 19.8% respectively with in two to five years of their activities(19-21).

With an intention of expanding and increasing quality of existing FP services, FGAE has initiated pilot projects of CBD of contraceptive methods in different places in the country since 1991/2.The Jimma CBD project evaluation result showed that CPR increased from 1.3% to about 15% with in five years of the programs activities(22).It was the first FP-project area taken as a model for other pilot projects.

QUALITY OF SERVICES

Early family planning literatures discussed quality largely with regard to clinical operation, this approach neglected the interpersonal dimension of care, and suggested that high quality means sophisticated, expensive equipment. Quality sometimes has been counted as synonymous with the availability and/or accessibility of contraceptives. Quality has also been defined in terms of potential demographic impact. These conflicting approaches to the definition of quality and the suggestion that it is unmeasurable may have inhibited more rapid progress in this area. Although, availability, cost, and quality are related, studies of availability rarely provide descriptive material on the unit of services clients receive(26,27).

If quality of services is going to rank alongside quantity of services as an indicator of program performance the "classical" clinical dimensions of quality of care and the subjective interpersonal aspects must be brought together in a simple and generally agreed up on frame work. Donabedian (1980-1988) has provided a generic foundation for assessing the quality of health services. Based on Donabedian's technical/interpersonal model of care, Bruce has selected six elements of FP programs that together constitute quality. These are, choice of methods, information given to users, technical competence, interpersonal relations, follow up or continuity mechanisms and appropriate constellation of services. These elements reflect six aspects of services that clients experience as critical (26).

Applying these and related indicators, different countries tried to assess the quality of family planning services. A situational analysis carried out in Peru indicated that CPR was greater by 16-23% among women living in an area having higher quality of family planning services than those

living at lower quality family planning services(28) .Studies conducted in rural Bangladesh between 1975 and 1981 and a multi center study in six countries conducted by IPPF also concluded that a FP program offering a wider choice of methods, skilled counseling , rigorous follow-up, care of side effects and good referral system was more effective than one based on one or two methods served by unskilled workers (13,19).

A situation analysis of the family planning services in Ethiopian health facilities under MOH, and assessment of quality of care in Addis Ababa health institutions have revealed some draw backs related to quality of care ; such as limited choice of method, insufficient information given to clients about the available methods, their possible side effects and their management, lack of privacy during counseling and examination as well as the lack of follow up mechanisms (30,31). In contrast to this, a study carried out by the same author to assess quality of family planning service of the FGAE headquarters clinic as perceived by the client was found to be good and no major constraints were said to be identified (32).

Assessment of Effectiveness

Defining and assessing programs effectiveness is neither simple nor straightforward. A systematic consideration of the factors that contribute to this complexity may help to clarify these issues. Two classes of factors: conceptual and measurement are important, but the conceptual issues are more so. The most interesting question in this area are not technical i.e not how to measure effectiveness, they are more of conceptual, i.e. what to measure and why to measure effectiveness(33).

Most FP-programs, when trying to assess effectiveness, set quantitative targets like CPR, but little attention has been paid to assess quality of services, its sustainability and client satisfaction. Therefore, in assessing effectiveness one has to be clear whether it is based on outcomes, process or structure of the program.

Outcome indicators focus on specific characteristics of materials or objects on which the program has performed some operation such as CPR. Out come measures may present serious problems of interpretation, since outcomes are never pure indicators of quality of performance(33,34).

Process measure focus on the quantity or quality of activities carried on by the program .Gathering information on work process, however, can still be problematic. Inspection based on observation of ongoing performance is both expensive and reactive i.e likely to influence the behaviors observed, and, also many kinds of work occur under circumstances that render routine inspection impossible (26,33,34).

Structural indicators assess the capacity of the program for effective performance. Structural indicators focus on programs inputs as surrogate measure for outputs. However, it doesn't mean that quality inputs yields quality output. Thus, an emphasis put solely on structure measures may have detrimental consequences for quality outcomes (33,34).

The term effectiveness is used in a broad sense to include accessibility, continuity and quality of service. Clients who feel that they have been treated with respect, have had their questions fully answered and have received appropriate guidance are more likely to properly and consistently use FP and other reproductive health services. Program managers and policy makers increasingly

recognize that reproductive health programs are more effective when clients believe that their needs are met and that they are treated well (13,26,28). This implies that, client has to come first while trying to improve the accessibility, quality and sustainability of a particular health program (like CBD-FP-services), and to identify common challenges with their possible solutions.

Therefore, this study tried to assess effectiveness of community based FP services by comparing CBD, FCBD and NCBD areas, to see if community based FP service improves contraceptive prevalence rate(CPR).Also, quality of services was compared between CBD and NCBD areas as perceived by the clients. Moreover, use-continuation and reasons for non-use and discontinuation, which are all indicative of the level of quality FP-service were also compared.

Since client centered study based on the feeling of the clients, is the major contributory factor to use the service consistently; the results of this study helped to draw appropriate recommendations that could be useful to improve, expand and sustain effective FP services.

3. Objectives

General

-To assess the effectiveness of community based FP services in improving CPR, in rural Eastern Showa Zone.

Specific

-To compare the CPR among CBD, Non-CBD and previous CBD-areas.

-To examine the quality of FP service, from clients perspective in CBD and NCBD areas.

- To compare the use-continuation among CBD, Non-CBD and previous CBD areas

-To describe reasons for FP method use discontinuation, and

-To examine reasons for FP non-use in the three study areas.

4. Subjects and Methods

A. Study area:

The study was conducted in selected areas of rural Eastern Showa Zone. According to the 1994 population and housing census result, there were 1,223,808(73.4%) rural residents in the zone. Of these, 601,505 (49.2%) being females while 622,303 (50.8%)were males .Only 444,376 (26.6%)were living in the urban set up. The zone is divided in to 12 Woredas and there are 441 peasant associations (35,36).

There were 8 hospitals, 6 health centers, twenty eight clinics, fifty two health posts and thirty seven pharmacies in the zone. Before community based distribution of family planning methods started, only 4.7% of female and 3% of male were using contraceptive methods in the areas surveyed (25,36).

The central region coordinating office of FGAE with the help of Population Concern, has launched pilot project of CBD in five districts of the Eastern Showa Zone namely Adama, Adea, Lumme, Bosset and Borra in fifty seven peasant associations(PAs), since 1996.The population of the five woredas was 832,800, the rural population constituting 523,500 (62.9%); of which 252,200 (48%) were females and 111,900 (44.4%) of them being in the reproductive age (35). Community based FP projects in ten peasant associations (PAs) were made to continue giving services after final evaluation of its three years activities, while the rest were made to phase out in March 1998 . Additionally there were eleven PAs getting services from CBD -projects of FGAE, which started activity since 1996 funded by Pathfinder International (PFI).Therefore, there

were twenty one PAs in the Zone which were getting service from functional CBD-Project sites(25).There were also other NGOs which were providing FP-methods and information in the Zone such as: Care-International, NACID and World vision. This study is based on only FP-project sites of FGAE, in order to avoid effects of variation in service provision in the three study areas, so that we can make reasonable comparison.

B. Study Design

This study has both quantitative and qualitative part:

1. Quantitative part

The design of quantitative study was a retrospective cohort study, which is used to assess the effectiveness of community based FP-service by comparing current MCM users in CBD, NCBD and FCBD areas. It also assessed knowledge, attitude and service quality as perceived by the clients using a modified BRUCE frame work.

The study considered all Community Based-FP Project sites of FGAE in rural Eastern-Showa Zone. The organization started its activity in this area since April 1996. All PAs served by currently functional (21 PAs) and former functional (47 PAs) CBD-projects were taken as CBD and former CBD areas respectively. Adjacent PAs to selected FCBD areas were considered as NCBD areas. All women in the reproductive age groups (15-49) who were living in rural Eastern Showa Zone constituted the source population, while, random samples of source population formed the study population. This study was conducted from January to May, 2000.

2. Qualitative part

This study was carried out to assess attitude and knowledge of the study population regarding family planning services as supplement to quantitative study.

The design of the study was focus group discussion (FGD) among selected groups of the society in the area. There were 3 groups of participants, two groups of women (married/not married) in the age groups of 25-35 years and 45-55 years, and one group of community representatives. The third group constituted only males, so that males attitude and views can be incorporated in this study, since males involvement has substantial influence on FP-use(50).All of FGDs conducted constituted six to eight members of participants in each groups. Therefore, three groups of FGD were carried out in each of CBD, FCBD and NCBD areas. The necessary precautions were taken to carry out the FGD in a quiet place that was chosen by the participants, so that they could discuss freely with out being affected by surrounding conditions .

C. Sampling Technique

In this study a multistage sampling techniqué was applied to select study subjects. In Eastern-Showa Zone, FGAE has selected 5 woredas as project sites of community based family planning services. Therefore, initially the study areas were grouped as CBD, FCBD and NCBD, based on the activity of FGAE community based family planning service in the zone. Since its activity started in April, 1996 until this study is conducted, FGAE had 21 PAs which have active CBD sites (13 PAs in Lume, 1 PA in Adea, 5 PAs in Adama, 2 PAs in Bosset woredas) ,47 PAs which were being served by CBD-projects for about three years, and phased out a year back (19 PAs in

Adea, 3 PAs in Adama, 10 PAs in Lume, 10 PAs in Bosset, and 5 PAs in Borra Woredas). In the first stage of sampling procedure, 10 PAs from 21 PAs getting services from active CBD sites were randomly selected as CBD study areas (4 from Adama, 5 from Lume and 1 from Adea woredas), and another 10 PAs were also randomly selected from the 47 FCBD PAs (6 from Bosset and 4 from Adea) . Ten PAs were also randomly selected from adjacent areas of the ten selected peasant associations of FCBD areas as NCBD study areas (see fig.1). Systematic sampling method was employed to select 310 households (HHs) from each of CBD, FCBD and NCBD areas. The HHs were selected by non- proportional allocation using the list of HHs in the selected PAs. So that ,the sampling fraction can be increased for PAs with small number of HHs and allow more representative information to be collected , with out collecting un necessarily larger samples from PAs with larger number of HHs. Finally, one woman in the reproductive age group (15 - 49 years) who could answer the interview was randomly selected from each of those HHs. If there was no woman who could fulfill the criteria as a study subject, the nearest household was taken to get the candidate for the interview.

D. Sample size calculation

The assumptions made for the sample size determination were based on evaluation results of CBD areas and survey results of Non-CBD areas , which were about 14% and 5% respectively(22).A two sided significant level of 0.05 and power of 90% were used.

The sample size calculation was made using the following formula:

$$n(\text{each group}) = \frac{\left[(Z_{\alpha/2}\sqrt{(1+1/r)p(1-p)} + Z_{\beta}\sqrt{p_1(1-p_1)+\frac{p_0(1-p_0)}{r}}\right]^2}{(p_1-p_o)^2}$$

Key:-

$$p(\text{population proportion}) = \frac{p_1(n_1)+p_0(n_0)}{n_1+n_o}$$

n_1=study population of CBD areas, n_o=study population of NCBD areas, $r=n_1/n_0$.

p_1=Proportion of CBD area population who are current FP method users = 0.14

Po = Proportion of Non-CBD area population who are current FP-method users = 0.05

q1 = 1-P1

qo = 1-Po

95% CI ($\alpha = 0.05$)

Power = 90%

n(each group) = 259 + 20% contingency = 310

The sampling procedure is shown in figure 1.

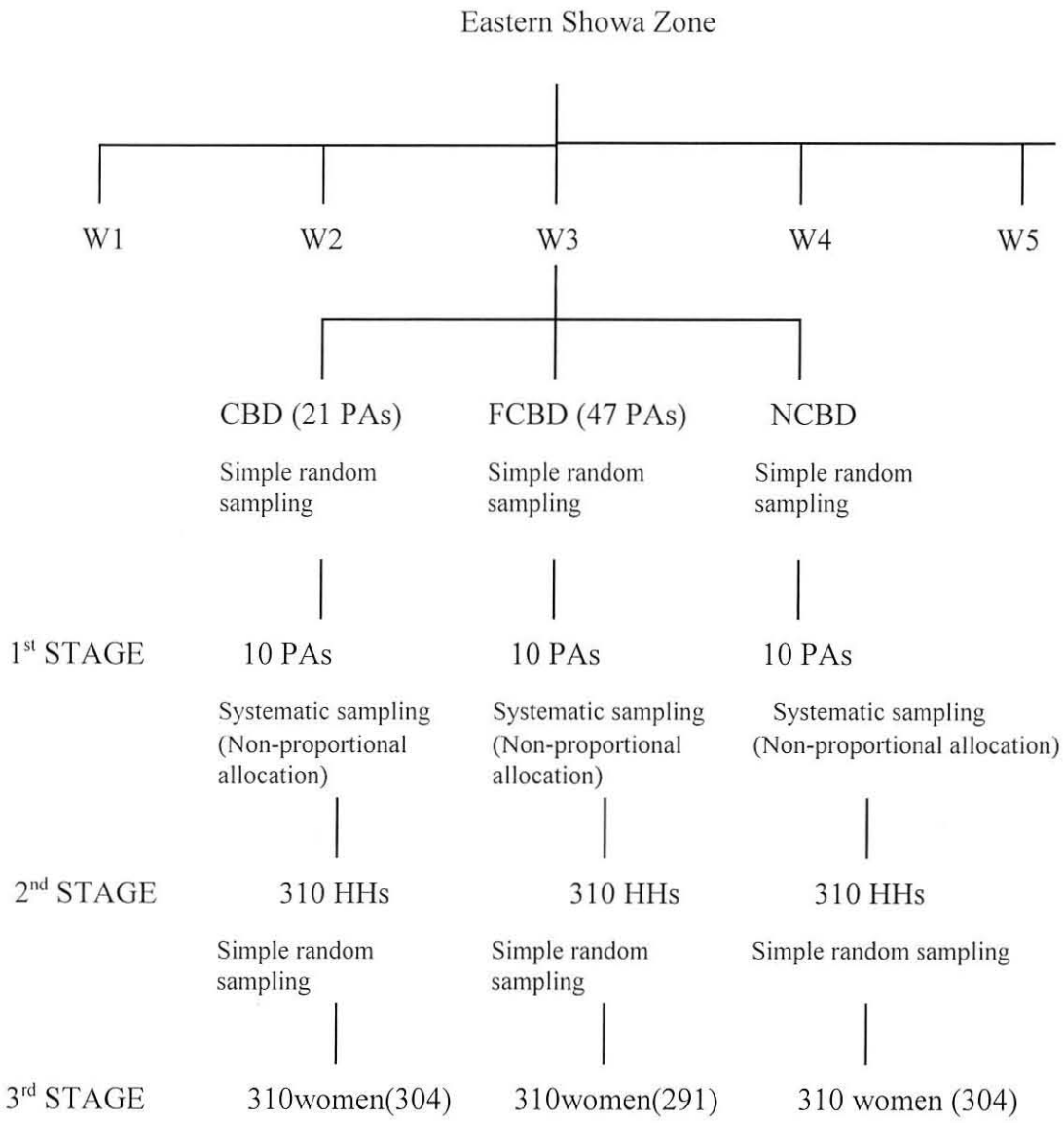


Fig.1 Study Architecture.

E. Data collection

1. Quantitative part

Data were collected by interviewing study subjects using structured questionnaire. Only one individual was selected using a lottery method if more than one person were found in the same household who fulfil the criteria (more than one woman in the reproductive age group) . The independent variables are Socio- demographic and Reproductive characteristics of the study subjects , and presence of community based family planning service. While, the dependent variable is number of current modern contraceptive method users.

Information collected regarding quality of care from clients perspective was mostly based on modified " Bruce" quality of care elements such as choice of methods, information given to clients, interpersonal relation and follow-up mechanisms.

Since the survey was conducted in a rural set up , we were obliged to use only male data collectors. They were 12^{th} grade complete and most of them with previous experience in data collection, and they were trained for 5 days on the detail of interviewing technique in respect to structured questionnaire provided.

The questionnaire was initially prepared in English and then translated in to Amharic, and was back translated to English to check consistency. The questionnaire was pretested before beginning the actual data collection process in the near by peasant associations, which were not included during the actual study, and the necessary correction was made based on the pre-test.

2. Qualitative part

Three FGD in each of the three study areas were carried out with six-eight participants involved in each groups. The PAs where the FGD was carried out were randomly chosen from each of the ten selected PAs in the respective study areas (CBD, FCBD, and NCBD). The necessary precautions were taken to conduct the discussion in a quite and comfortable place. The facilitator had previous experience in conducting FGD and can speak the local language. The principal investigator was the recorder as well as observer. All discussions were tape recorded and note was taken during discussion.

F. Data entry and Analysis

Data were entered using EPI-INFO version 6; and analyzed using EPI-INFO version 6 and SPSS stastical programme. X^2-test and Odds ratio were used to measure association, where as 95%CI and P-value were utilized to see statistical significance. Bivariate analysis was done in order to asses the effect of different explanatory variables on current use of MCM. Those explanatory variables which were found to have positive association with current use of MCM were selected. Logistic regression analysis model including the selected variables and presence of Community based FP service was done in order to assess the relative effect of the independent variables on current use of MCM.

G. Ethical Consideration

Ethical clearance was obtained from Department of Community Health / AAU/, Oromia Health Bureau, and FGAE to carry out this study. Also, informal consent was obtained from study subjects.

H. Operational Definitions

Ever use- Use of modern contraceptive methods (MCM) at any time.

Current Use - use of MCM at the time of this study.

Use - Discontinuation- Considers all women who ever used MCM and discontinued use for at least three consecutive months, during the last three years.

Use- Continuation - Includes all women who did or did not interrupt. The longest duration of ever- use of MCM before interrupting for at least three consecutive months was considered for interrupters.

- Only the longest duration of ever use was considered for a woman who use at different times. The longest duration ignores interruption of use for less than three consecutive months in this study.
- Only ever-use of MCM during the last three years was considered, to make it coincide with the start of community based FP- service by FGAE in the study area.

Future- Intention to use MCM – includes all women in the reproductive age groups, who never- used but knew at least one MCM, and intended to use in the future.

CBD- area- Peasant associations, where community- based family planning service was given by FP- project sites during the study

Former- CBD area- Peasant associations, where community based family planning service was given by FP- Project sites before this study.

Non- CBD areas-Peasant associations, which have never been served by community based family planning service project sites.

5. RESULT

I-Quantitative Study

General

Although, the target was to obtain 310 respondents from each of the groups, response was obtained from 304 women in CBD and NCBD areas, and from 291 in the FCBD area. Of the socio-demographic characteristics: ethnicity, religion, educational status and occupation showed statistically significant difference in their distribution among the three study areas where as age and marital status were not significantly different (table 1). In CBD areas there was more mix of religion and ethnic groups, and higher level of literacy. Where as in NCBD and FCBD areas Orthodox chrisitianiy and Oromo ethnic group constitute most of the population. Also majority (68.4% in FCBD and 76.3% in NCBD) were illiterate.

The average number of pregnancies a women had, was found to be 3.65 (SD=3.04), 3.53(SD=2.34), and 3.69(SD=3.21) in CBD, FCBD and NCBD areas respectively. This difference was not statistically significant (Table 2). The study showed that the average number of children a woman has, was found to be 3.49 (SD=2.37), 3.53 (SD=2.34) and 3.72 (SD=2.45) in CBD, FCBD and NCBD areas respectively which was not statistically significant difference. Among those women who had been pregnant, 15.1% of CBD, 9.1% of FCBD, and 4.9%of NCBD area women had history of unwanted pregnancy. Women who had history of at least one induced abortion were 9.3% in CBD, 4.9% in FCBD and 4.0% in NCBD areas. This difference among the three study areas was found to be statistically significant (table 2).

Table 1.Socio-demographic characteristics of CBD, FCBD and NCBD areas, Eastern Showa Zone, Ethiopia, 2000.

Variable	CBD N(%)	FCBD N(%)	NCBD N(%)	X^2	P-value
	N=304(100)	N=291(100)	N=304(100)		
1. Age					
15-19 years	47 (15.5)	40 (13.7)	67 (22.0)	15.26	0.1229
20-24 "	79 (26.0)	67 (23.0)	65 (21.4)		
25-29 "	65 (21.4)	69 (23.7)	64 (21.1)		
30-34 "	50 (16.4)	56 (19.2)	50 (16.4)		
35-39 "	43 (14.1)	42 (14.4)	30 (9.9)		
≥40 "	20 (6.6)	17 (5.8)	28 (9.2)		
Mean ± S.D.	27.64±17.74	26.45±17.5	27.64±17.6		
2. Martial status					
• Married	219 (72.0)	216 (74.2)	224 (73.7)	0.85	0.9321
• Not Married	51 (16.8)	47 (16.2)	52 (17.1)		
• Other	34 (11.2)	28 (9.6)	28 (9.2)		
(Divorced , Widowed)					
3. Religion					
• Orthodox	280 (92.1)	282 (96.9)	300 (98.7)		
• Protestant	16 (5.3)	9 (3.1)	1 (0.3)	**	
• Muslim	7 (2.3)	0 (0.0)	3 (1.0)	17.8	0.00014
• Catholic	1 (0.3)	0 (0.0)	0 (0.0)		
4. Ethnicity					
• Oromo	183 (60.2)	230 (79.0)	218 (71.7)	45.44	0.00001
• Amhara	101 (33.2)	60 (20.6)	84 (27.6)		
• Other	20 (6.6)	1 (0.3)	2 (0.7)		
5. Education					
• Illiterate	114 (37.5)	199 (68.4)	232 (76.3)	142.43	0.00001
• Read	59 (19.4)	44 (15.1)	37 (12.2)		
• 1-6 grades	50 (16.4)	29 (10.0)	25 (8.2)		
• 7-8 "	30 (9.9)	12 (4.1)	7 (2.3)		
• ≥ 9 "	51 (16.8)	7 (2.4)	3 (1.0)		
6. Occupation					
• Housewife	215 (70.7)	205 (70.4)	230 (75.7)	35.90	0.00008
• Family dependent	22 (7.2)	34 (11.7)	41 (13.5)		
• Farmer	16 (5.3)	22 (7.6)	17 (5.6)		
• Local drink seller	15 (4.9)	15 (5.2)	10 (3.3)		
• Student	21 (6.9)	7 (2.4)	6 (2.0)		
• Others	15 (4.9)	8 (2.7)	0 (0.0)		

Note *.* Orthodox &Others(where, Others=Protestant , Muslim&Catholic),were used to calculate x^2 & P-value.

Table 2. Reproductive characteristics of CBD, FCBD and NCBD areas, Eastern Showa Zone, Ethiopia, 2000.

Variable	CBD N=304	FCBD N=291	NCBD N=304	X^2	P-value
1.Total# of pregnancies	N (%)	N (%)	N (%)		
◊ 0	46 (15.1)	48 (16.5)	57 (18.8)		
◊ 1-3	121 (39.8)	108(37.10)	110 (36.2)		
◊ 4-6	73 (24.0)	74 (25.4)	73 (24.0)	4.72	0.78679
◊ 7-9	52 (17.1)	44 (15.1)	44 (14.5)		
◊ ≥ 10	12 (3.9)	17 (5.8)	20 (6.6)		
Mean ± S.D.	3.65±3.04	3.53±2.34	3.69±3.21		
2.Total # of Alive children	N=258*	N=243*	N=247*		
◊ 0	10 (3.9)	10 (4.1)	4 (1.6)	7.85	0.4486
◊ 1-3	127 (49.2)	127 (52.3)	125 (50.6)		
◊ 4-6	96 (37.2)	76 (31.3)	84 (34.0)		
◊ 7-9	20 (7.8)	27 (11.1)	27 (10.9)		
◊ ≥10	5 (1.9)	3 (1.2)	7 (2.8)		
Mean ± S.D.	3.49±2.37	3.53±2.34	3.72±2.45		
3. History of unwanted pregnancy					
◊ Yes	39 (15.1)	22 (9.1)	12 (4.9)	14.39	0.0007
◊ No	219 (84.9)	221 (90.9)	235 (95.1)		
4. History of induced abortion					
- At least one **					
◊ Yes	24 (9.3)	12 (4.9)	10 (4.0)	6.95	0.031
◊ No	234 (90.7)	231 (95.1)	237 (96.0)		

Note: ** Those who have no history of induced abortion were compared with those who had at least one.
* Those women who were pregnant.

Knowledge, attitude and practice of family planning Service

There was significant difference among the three study areas in regard to their knowledge of MCM (x^2=241, P=0.0001). It was found that 89.1% of CBD and 76.6% of FCBD knew at least one MCM, but only 32.2% of NCBD area study subjects did know MCM (table 3,4).

There was also significant difference in their knowledge of specific MCM when study subjects in CBD area were compared with those in NCBD areas; However, this difference was not significant when study subjects in CBD areas were compared with those in FCBD areas (Table 3,4).

The most commonly known MCM by women was pill followed by injectable hormone in all of the three study areas. However: IUD, norplant, permanent method (tubal ligation) and foam were known to a lesser extent by women in NCBD areas compared to women in CBD areas (table 3).

The proportion of women who ever used MCM significantly differs in the three study areas (x^2=124, P=0.0001). It was found that 57.2% of CBD, 39.2% of FCBD and 13.8% of NCBD area study subjects ever-used MCM; where as, 43.4%, 22.7% and 7.6% of women living in the respective area were current MCM-users, which was also a statistically significant difference (table 3).There was no significant difference in their use of specific MCM by women among the three study areas; However, injectable hormones were the most frequently used MCM followed by pills. Ninty-five percents of CBD, 93% of FCBD and 97% of NCBD areas current contraceptive users were using either injectables or pills.

It was found that 12.1% of CBD, 4.6% of FCBD and 17.4% of women in NCBD area who were using MCM, mentioned that, they had method related problems; Of these 81.3% of CBD, 33.3%

of FCBD and all (100.0%) of NCBD area clients of FP-service sought advice from their service provider. Those women who did not seek advice (of CBD and FCBD area clients) mentioned being ill (40%) and unable to go due to other problems (20%) as major reasons; while husband refusal and distance were sited as their secondary reasons.

Eighty five point two percent of CBD, 78.7% of FCBD and 75.3% of NCBD areas study population approved FP-use. The difference observed in FP-use approval between CBD and NCBD areas was significant (table 3 and 4). After controlling for religion, ethnicity, education and occupation that showed significant difference, FP approval found to be positive in CBD area (data not shown). Most of FP clients who were current MCM users in the three study areas, expressed their satisfaction with the service they are getting.

Almost equal proportion of those women who knew but never used MCM, intended to use MCM in the future in all of the three study areas (66.0%of CBD, 68.2% of FCBD and 65.5% of NCBD areas). For those women who said they do not have future intention to use MCM, a need to have (more) child (32.7% of CBD, 60.7% of FCBD and 38.5% of NCBD), lack of adequate information or knowledge about MCM (10.2% of CBD, 13.1% of FCBD, and 38.5% of NCBD), and having no male partner (14.3% of CBD, 18.0% of FCBD, and 16.9% of NCBD) were major reasons mentioned. Religion (8.2% of CBD, 8.24% of FCBD, and 1.5% of NCBD), spousal disagreement (2.0% of CBD, 8.2% of FCBD and 3.1% of NCBD), and culture (8.2% of FCBD and 1.5% of NCBD) were their secondary reasons for not having future intention to use MCM.

Table 3. Comparison of knowledge, attitude, and practice of family planning service between CBD and NCBD areas, Eastern Showa Zone, Ethiopia 2000.

Variable	CBD N=304	NCBD N=304	OR	95% C.I.	X^2	P-Value
1. Knowledge of MCM	N (%)	N (%)				
- Know	271 (89.1)	98 (32.3)	17.26	10.95, 27.32		
- Do not know	33 (10.9)	206 (67.8)				
2. Knowledge of specific MCM	*	*				
- Pills	266 (98.2)	94 (95.9)				
- Injectable	260 (95.9)	90 (91.8)				
- Condom	231 (85.2)	61 (62.2)			30.0	0.0004
- IUD	176 (64.9)	37 (37.8)				
- Norplant	187 (69.0)	30 (30.6)				
- Permanent (tubal ligation)	150 (55.4)	27 (27.6)				
- Foam	143 (52.8)	20 (20.4)				
3. Future intention to use MCM	N=97@	N=58@				
- Intended	64 (66.0)	38 (65.5)	1.02	0.49, 2.14		
- Did not intend	33 (34.0)	20 (34.5)				
4. Approval of FP use						
- Approved	259 (85.2)	229 (75.3)	1.89	1.23, 2.91		
- Did not approve	45 (14.8)	75 (24.7)				
5. Ever use MCM						
- Ever used	174 (57.2)	42 (13.8)	8.35	5.51, 12.7		
- Never used	130 (42.8)	262 (86.2)				
6. Current use of MCM						
- Users	132 (43.4)	23 (7.6)	9.38	5.66, 15.7		
- nor-users	172 (56.6)	281 (92.4)				
7. Current use of specific MCM	**N (%)	N=23 (100)				
- injectable hormones	80 (60.7)	14 (60.9)			0.38	0.82
- pills	46 (34.8)	6 (26.1)				
- others***	16 (10.1)	3 (12.9)				

Note-** N-totals greater than 132 and percentages more than 100,*Totals greater than 304 and percentages > 100, since clients can name or use more than one MCM,@study subjects who never used ,but knew at least one MCM.

***includes = Condom, IUD, Norplant, tubal ligation and Foam.

Table 4. Comparison of knowledge, attitude and practice of family planning service, between CBD and FCBD areas, Eastern Showa Zone, Ethiopia , 2000.

Variable	CBD N=304	FCBD N=291	OR	95% C.I.	X^2	P-value
1. Knowledge of MCM						
- know	271 (89.1)	223 (76.6)				
- do not know	33 (10.9)	68 (23.4)	2.58	1.56, 4.04		
2. Knowledge of specific MCM	*	*				
- Pills	266 (98.2)	215 (96.4)			6.12	0.41
- Injectables	260 (95.9)	204 (91.5)				
- Condom	231 (85.2)	163 (73.1)				
- IUD	176 (64.9)	117 (52.5)				
- Norplant	187 (69.0)	113 (50.7)				
- Permanent (tubal ligation)	150 (55.4)	104 (46.6)				
- Foam	143 (52.8)	90 (40.4)				
3. Future intention to use MCM	N=97@	N=110@				
- Intended	64 (66.0)	75 (68.2)	0.91	0.49, 1.69		
- Did not intend	33 (34.0)	35 (31.8)				
4. Approval of FP use						
- Approved	259 (85.2)	229 (78.7)	1.56	1.00, 2.44		
- Did not approve	45 (14.8)	62 (21.3)				
5. Ever use of MCM						
- . Ever used	174 (57.2)	114 (39.2)	2.08	1.48, 2.92		
- Never used	130 (42.2)	177 (60.8)				
6. Current use of MCM						
- Users	132 (43.4)	66 (22.7)	2.62	1.80, 3.80		
- Non-users	172 (56.6)	225 (77.3)				
7. Current use of specific MCM	**					
- Injectable hormones	80 (60.7)	42 (63.6)			3.98	0.14
- Pills	46 (34.8)	13 (19.7)				
- Others	16 (10.1)	11 (16.7)				

Note-*Totals >304 and 291, percentages >100,**Totals >132 and percentages > 100, since clients can name or use more than one MCM,@study subjects who never used but knew at least one MCM.

Quality of family planning service as observed by current contraceptive users:

Twenty point five percents of CBD, 19.7 % of FCBD and 8.7 % of NCBD area clients responded that they were influenced by service provider while making their method choice. But, this observed difference in the three study areas was not statistically significant when a separate comparison was made between CBD and NCBD areas (OR= 2.7, 95% CI= 0.56, 17.8) as well as CBD and FCBD areas (OR= 1.5,95%CI = 0.47, 2.35).

A significant difference was observed when current MCM users were compared between CBD and NCBD areas regarding information given to clients. Women in CBD area were found to be more informed than NCBD areas about how the method works, how to use the method, its side effects, its contraindications, possibility of switching to other MCM, about MCM which can prevent STD/HIV, and about other types of MCM than the one chosen by the client (table 5). But, only information given to clients about possibility of switching to other method showed significant difference when comparison was made between CBD and FCBD areas, even though those clients in CBD area were more informed than clients in FCBD area. Generally those women living in CBD area who were using MCM were better informed than those in NCBD area .

It was found that 89.4% of CBD, 81.8% of FCBD and 91.3% of NCBD area clients who were using MCM received oral or written appointment for their next visit.

Table 5. Comparison of Current contraceptive users view about the quality of FP-service, between CBD and NCBD area, Eastern Showa Zone, Ethiopia, 2000.

Variable	CBD N=132	NCBD N=23	OR	95%C.I.
	N(%)	N(%)		
1. Influenced by service provider				
Yes	27(20.5)	2(8.7)	2.70	0.56,17.77
No	105(79.5)	21(91.3)		
2. Information given to clients -How the method works				
Yes	122(92.4)	16(69.6)	5.34	1.56,18.70
No	10(7.6)	7(30.4)		
-How to use MCM				
Yes	125(94.7)	18(78.3)	4.96	1.20,20.11
No	7(5.3)	5(21.7)		
-Side effects of MCM				
Yes	115(87.1)	14(60.9)	4.35	1.45, 2.89
No	17(12.9)	9(39.1)		
-Contraindications				
Yes	111(84.1)	11(47.8)	5.77	2.04,16.43
No	21(15.9)	12(52.2)		
-What to do if method related problems				
Yes				
No	116(87.9)	17(73.9)	2.56	0.77,8.28
	16(12.1)	6(26.1)		
-Possibility of switching to other MCM				
Yes	119(90.2)	16(69.6)	4.00	1.23,12.94
No	13(9.8)	7(30.4)		
-MCM which can prevent from STD/HIV				
Yes	101(76.5)	8(34.8)	6.11	2.17,17.58
No	31(23.5)	15(65.2)		
-Other than the method chosen				
Yes	98(74.2)	10(43.5)	3.75	1.38,10.27
No	34(25.8)	13(56.5)		
3. Mechanism of follow-up -Appointed for next visit				
Yes	118(89.4)	21(91.3)	0.80	0.12,4.14
No	14(10.6)	2(8.7)		

Reasons and use-continuation:

Most women who were using MCM, use it for spacing in all of the three study areas(72.7% of CBD, 63.6% of FCBD and 65.2% of NCBD areas respondents). Their second reason of use was for limiting family size. Only a small proportion of women use it for delaying pregnancies (9.1% of CBD, 6.4% of FCBD and 2.3% of NCBD area study population).

Forty two percent of CBD, 33.3 % of FCBD and 35.3 % of NCBD area study subjects who ever used MCM, used their method at least for one year. Relatively more women in CBD area used their method longer than those in FCBD or NCBD areas. The observed difference in the use-continuation of MCM among ever users of MCM in the three study areas was not statistically significant(x^2= 4.01, P= 0.135). However, the use-continuation remained positive when CBD area was compared to NCBD area after controlling for possible confounders .

Reasons for non-use and discontinuing MCM:

Lack of adequate in formation about MCM, need for (more) child and no male partner were the main reasons for non-use of MCM in all of the three study areas. Spousal disagreement, culture and religion were also mentioned as secondary reasons by FCBD and NCBD area study population. It was found that their reasons were significantly different among the three study areas (x^2 =80.84, P=0.0001), that is 29.2% of CBD, 35.6% of FCBD and 66.5% of NCBD area population attributed it for lack of adequate information; 30.5% of CBD, 59.3% of FCBD and 33.8% of NCBD area population for need of (more) child; where as 34.6% of CBD, 23.2% of FCBD and 14.4% of NCBD areas for having no male partner. Women in CBD areas and in FCBD areas said that need for more children as their main reason, but women in NCBD area mentioned

lack of adequate information as a principal reason for not using MCM, followed by need for (more) child as their secondary reason (table 6).

Use discontinuation and reason for discontinuing MCM:

Significant difference was observed among the three study areas ever MCM users, who discontinued their method use for three or more consecutive months during the last 3 years (x^2 =6.92, P=0.031). It was found that 29.9% of CBD, 44.7% of FCBD and 40.5% of NCBD area clients discontinued their MCM Use.

Of those women who discontinued their MCM use during the last 3 years, the major reasons for discontinuing were need for (more) child and side effects of the methods.
In CBD areas, women attributed need for (more) child (34.6%), side effects of method (28.8%), lack of method choice (7.7%), spousal disagreement (3.8%) and lack of respect by service provider(3.8%) as reasons for discontinuing use.

In FCBD area, women mentioned need for (more) child (29.4%), side effects of method (19.6%), lack of method chosen(9.8%), distance (9.8%), long waiting time (9.8%), and spousal disagreement (5.9%) as their reasons for discontinuing use.

Women in NCBD areas expressed that need for (more) child (35.3%), spousal disagreement (17.6%),long waiting time (17.6%), side effects of methods(5.9%) and distance (5.9%) as their reasons for discontinuing using their MCM.

Table 6.Comparison of reasons for non use and discontinuing MCM use between CBD and NCBD areas, Eastern Showa Zone, Ethiopia, 2000.

Variable	CBD N=130 **	NCBD N=262 **	X2	P-value
1. Reasons for non use of MCM	N (%)	N (%)		
- need for (more) child	40 (30.5)	89 (33.8)	44.66	0.0001
- lack of adequate information/knowledge	38 (29.2)	175 (66.5)		
- no male partner	45 (34.6)	38 (14.4)		
- spousal disagreement	3 (2.3)	17 (6.5)		
- culture	3 (2.3)	5 (1.9)		
- distance	2 (1.5)	11 (4.2)		
- other	7 (5.4)	8 (3.1)		
2 Reasons for discontinuing MCM use	N=52*	N=17*		
- need for (more) child	18 (34.6)	6 (35.3)	***	0.209
- side effects	15 (28.8)	1 (5.9)		
- spousal disagreement	2 (3.8)	3 (17.6)		
- distance	1 (1.9)	1 (5.9)		
- no respect by service provider	2 (3.8)	0 (0.0)		
- long waiting time	0 (0.0)	3 (17.6)		
- no method chosen	4 (7.7)	0 (0.0)		
- others	10 (19.2)	3 (17.6)		

Note- ***Fisher's exact two tailed P- value, computed for need for(more)child and side effects only, since others cells values are very small.**Totals > 130 & 262, percentages > 100, since one individual can mention more than one reason,*number of dicontinuers .

Table 7. Comparison of reasons for non use and discontinuing MCM use, between CBD and FCBD areas, Eastern Showa Zone, Ethiopia, 2000.

Variable	CBD N=130*	FCBD N=177*	X2	P-value
1.Reasons for non use of MCM	N (%)	N (%)		
- need for (more) child	40 (30.5)	105 (59.3)		
- Lack of adequate information/knowledge	38 (29.2)	63 (35.6)	20.31	0.002
- no male partner	45 (34.6)	41 (23.2)		
- spousal disagreement	3 (2.3)	14 (7.9)		
- culture	3 (2.3)	14 (7.9)		
- distance	2 (1.5)	4 (2.3)		
- other	7 (5.4)	8 (4.6)		
2.Reasons for discontinuing use	N=52@	N=51@		
- need for (more) child	18 (34.6)	15 (29.4)		
- side effects	15 (28.8)	10 (19.6)		
- spousal disagreement	2 (3.8)	3 (5.9)	**5.34	0.254
- distance	1 (1.9)	5 (9.8)		
- no respect by service provider	2 (3.8)	0 (0.0)		
- long waiting time	0 (0.0)	5 (9.8)		
- no method chosen	4 (7.7)	5 (9.8)		
- others	10 (19.2)	8 (15.7)		

Note-**X^2-value, where: distance, no respect by provider and long waiting time=Others;*Totals > 130 & 177, percentages > 100, since one respondent could name more than one reason,@number of discontinuers.

A logistic regression analysis was carried out to control effects of possible confounding variables. Age, Marital status, and Education were found to have a significant association with current use of MCM. However, the presence of Community Based FP-service was the most important explanatory variable for current use of MCM (table 8).

Table 8. Logistic regression analysis result of possible explanatory variables for current use of MCM, Eastern Showa Zone, Ethiopia, 2000.

Variables	users	non-users.	Exp(B) /Adjusted OR	95% CI
1. Age				
15-19 years	13	141	1.677	0.496, 5.67
20-24 "	60	151	3.064	1.109, 8.46
25-29 "	56	142	2.802	1.070, 7.33
30-34 "	50	106	2.844	1.142, 7.08
35-39 "	33	82	2.177	0.871, 5.44
≥40 "	9	56	1.0	
2. Marital Status				
Married	196	463	2.772	1.052, 7.30
Not married	13	137	3.257	1.032, 10.28
Other	12	78	1.0	
3. Ethnicity				
Amhara	69	176	0.301	0.058, 1.56
Oromo	137	494	0.198	0.039, 1.00
Other	15	8	1.0	
4. Education				
Illiterate	134	551	0.459	0.246, 0.86
1-6 Grades	49	55	1.843	0.873, 3.89
≥ 7"	38	72	1.0	
5. Occupation				
Housewife	192	458	1.419	0.385, 5.23
Family dependent	3	94	0.598	0.099, 3.62
Farmer	9	46	1.102	0.247, 4.92
Local drink seller	10	30	1.403	0.323, 6.09
Student	1	33	26.58	0.00, α
Other	6	17	1.0	
6. Tota # pregnancy				
1-3 pregnancies	98	241	0.625	0.248, 1.57
4-6 "	62	158	0.683	0.361, 1.29
≥ 7 "	57	132	1.0	
7. Total # alive children				
None	4	20	0.258	0.057, 1.18
1-3 children	110	269	0.838	0.318, 2.21
4-6 "	78	178	0.830	0.399, 1.72
≥ 7 "	25	64	1.0	
8. History of induced abortion				
None	200	502	1.017	0.470, 2.20
At least one	17	29	1.0	
9. Study area				
CBD	132	172	9.389	5.448, 16.18
FCBD	66	225	4.051	2.332, 7.03
NCBD	23	281	1.0	

II - FOCUS GROUP DISCUSSIONS (Summary of the results of FGD is shown in annex 1.)

Most of participants in the age groups of 45-55 years old women and community representatives desired to have five or more children, while most of those women aged 25-35 years old wanted to have less than five children. Some of CBD and NCBD participants said it is "up to God", few also said "who hates to have baby!".One participant in NCBD area said,"having many children makes your clan stronger " to explain why he said up to God. In contrary to these,"We do not have enough land to be ploughed which can support our family ", and " You know, having many children was not a problem previously, when there was enough land which was so fertile ,but that is not the case now a days!" were some of the remarks made by the participants to explain the need to limit family size. Spacing and limiting of pregnancies were mentioned by most of the participants as uses of MCM. Only few of CBD and FCBD area participants did mention delaying of pregnancy .

Pills and injectable hormones were known by most of the participants, where as condom, IUD, norplant, foam and tubal ligation were rarely known by those in NCBD area. One of the participants in CBD area mentioned that MCM use helps to be fertile, " mehatsen Yetergal" was Amharic expression used to mean MCM helps to clear the uterus , so that it can be ready for conception and enablers the woman to be fertile. Most of the participants approved FP-use, explaining its usefulness. However, many of them preferred injectable hormones saying it is easy to use but pills can be forgotten . A woman in FCBD area explained relative ease of MCM use by saying " it is not more difficult than going through the process of pregnancy, birth, and caring for the new born !".

Many of the participants rated the price of MCM as faire or reasonable, and few mentioned it is free from health center .Most of young women and some of older women rated the price as faire/reasonable, while few said it is free from health center. "If you go to a health facility to get MCM, there is cost of transportation, loss of time/from home activity, and even the chance of being stolen by thief, so considering all these, paying 1 Eth. Birr/month for pill and 3 Eth. Birr/3 months for injection is quite reasonable!", said one of the participants in CBD area.

Young married women and women with many children were said to use MCM most in CBD and FCBD areas, where as there were only few users in NCBD areas. " Most of our people, even do not know that there is FP service!" Said a woman in NCBD area to explain that there were only few users in the area.

Need for (more) children, side effects and spousal disagreement were mentioned as a reason for non-use/discontinuing MCM use . Lack of adequate information was additional reason expressed by most of NCBD area participants. Ill health following exposure to heat or strong sun light, darkening of facial skin, hypertension, weight gain, menstrual irregularities and infertility were some of MCM related problems expressed by the participants.

Most of FGD participants in CBD area said they are satisfied with the service they were getting, while those in FCBD area complained for not getting the service by CBD workers as they used to. Most of NCBD area participants did not comment on the service, since most of them were non-users.

6. DISCUSSION

The study showed that knowledge, attitude and practice of family planning was better in CBD area than FCBD and NCBD areas. The quality of service and use continuation also found to be relatively better in CBD area. Need for more children, having no sexual partner and lack of adequate information about MCM were the major reasons for non-use; while spousal disagreement, religion and culture were secondary reasons. Need for more children was the main reason expressed by most of CBD and FCBD areas, while it was lack of adequate information in NCBD area. Need for more children and side effects were major reasons for use discontinuation .

The three study areas have shown significant difference in some of the socio-demographic characteristics i.e. Ethnicity, educational status and occupation. This could be due to the relative nearness of CBD area to Urban set up.

However, there was no significant difference among the three study areas in their reproductive characteristics, except for history of unwanted pregnancy and induced abortion. 9.3% of CBD, 4.9% of FCBD and 4.0% of NCBD area study population had history of at least one induced abortion. The finding in CBD area was almost twice that of NCBD area (9.3% v_s 4.0 % respectively).This is lower than the prevalence of unwanted pregnancy and induced abortion in Nigeria ,which was 20% and 11% respectively according to a population based study conducted in two areas (44).But, it was found to be higher than Mali CBD FP project areas, where, KAP-survey results showed that 8% of rural Malian women who had undesired pregnancy (29%) reported history of induced abortion (49).The

difference observed between CBD and NCBD area could be explained by under reporting in NCBD area where higher proportion of illiterates was found (37.5% in CBD and 76.3% in NCBD area).This is because, studies have shown that those women who were single, students or educated were found to report induced abortion more frequently (44,45,49). This might also be an indication that, women desire to avoid unwellcomed pregnancies too. Also, it may have an implication for the need to improve service quality in CBD area.

It is encouraging that women in CBD area have lower number of pregnancies and alive children. This is in line with the 1993 National Population Policy Objectives of Ethiopia, which planned to reduce the total fertility rate of 7.7 children per women to approximately 4, and to increase CPR from 4.2% to 44.0% by the year 2015 (46). One of the strategies to achieve the set objectives was increasing the availability and accessibility of the service through outlets, like Community based FP-services. Community based FP- services reduced the total number of children a woman have in CBD area more than NCBD areas, where service was not there, in rural Eastern Showa Zone. Although the role of community-bared FP-service is remarkable in improving CPR, it should also be designed in such away to reduce the problems associated with unwanted pregnancies and induced abortion by addressing the needs of high risk groups. Therefore, unmarried(single), youth as well as educated women should be well informed about health risks associated with induced abortion .

A significant difference was observed in the knowledge of MCM among the three study areas. 89.1% of CBD, 76.6% FCBD and only 32.2% of NCBD area study population could name at least one MCM. The proportion of women in CBD area, who knew at least one MCM (89.1%) was similar to

the findings in Tigray (89.0%) and Bahirdar (88.4%), but higher than that of Jimma (63.3%) (22,23,37,39).

Like most of the study results in Ethiopia, pill was the most widely known MCM followed by injectable hormone in all of the three study areas (12,22,45). In this particular study, it is found that most of the study population in CBD area also knew condom, IUD, norplant, tubal ligation and foam, which is higher than NCBD area , similar to the findings in other CBD-FP- project areas compared to their baseline survey results (22,23,37).

There was significant difference among the three study areas current users of MCM. 43.4% of CBD, 22.7% of FCBD and only 7.6% of NCBD area woman in the reproductive age groups were current MCM users. The finding in CBD area (43.4%) was similar with project evaluation result of FGAE, Eastern Showa Zone (CPR increased from 4.7% to 43.8% with in three years), which is much higher than Jimma (CPR increased from 1.3% to 15.9% with in five years) and Tigray (CPR increased from 4.4% to 14.4% with in three years) (22,24,37). The CPR in CBD area (43.4%) is also higher than other African countries where community- based FP-service was implemented, like in Sudan (CPR increased from 6.8% to 19.8% with in three years), Nigeria (CPR increased from 2.0% to 13.0% with in five years), and Mali (CPR increased from 1.0 % to 11.6% with in three years) (20).

In Eastern Showa Zone CBD-FP- program is an integrated activity among FGAE, MOH and MOA. Therefore, contact farmers (CF) trained on basic concept and practice of reproductive health are the one who provide the service to the community. Contact farmers are model farmers who have other

farmers under them, and they are respected and prominent figure. This has greatly facilitated to carry out their duty properly by winning the confidence and attention of the society they are serving. They are also supervised by trained rural women development agents (RWDAs) who are employee of MOA working in the area. Even though, most of CBD workers selected by the communities in most of CBD-FP project areas, additional measures taken in Eastern Showa Zone FP CBD project areas seem markedly has been contributed for the success of the program. The highest CPR seen in CBD area could therefore be attributed to- the design of the program, strong management capacity and supervision system as well as good working morale of the staffs and CBD workers in the area (24,43). The difference observed between CBD and FCBD areas could be attributed to the projects life span in the two areas (three years in FCBD and about four and half years in CBD areas).

Pill was found to be the most widely known MCM, however, injectable hormone was the one being used by most of current users in all of the three study areas. It was also shown that despite having good knowledge of condom and other methods, only few women were using them. This calls for improvement in the method mix provided for clients as well as strengthening IEC- activities.

Since service utilization mainly depends on quality, increasingly family planning programs are making quality of care a top priority particularly from clients perspective (26,27). The contraceptive prevalence rate is often considered to be higher in an area having higher quality service than lower quality service. In Peru, CPR was greater by 16.0% to 23.0% in higher quality service areas than lower quality service areas (28).Studies done in Ethiopia health facilities, also points weak status of the quality of the service given at facility level (30,45). In this study most of current users in all of

the three study areas expressed their satisfaction with the service. However, the quality of the service was found to be better in CBD area in terms of information given to clients, which is consistent with program evaluation results of other rural CBD-FP service areas (22,23) as well as in rural set up of Kenya, where there is community based FP services (21). But, lack of method choice and influence by service provider were mentioned by some of CBD area women. Also, it was found that after having method related problems, about 19.0% of CBD area clients did not seek advice from their provider while all in NCBD areas did. This calls for great effort in order to improve the quality of service, even in CBD areas.

There is positive attitude towards FP use in all of the three study areas. However, CBD areas study population approved FP use more than those in NCBD areas (85.2% and 75.3 % respectively), which is similar with the study finding in rural Tigray (37). This could indicate the contribution of CBD FP service in generating positive attitude towards FP use.

In order to know the demand for family planning services, future intention to use MCM was assessed. Sixty-six percents of CBD, 68.2% of FCBD and 65.5% of NCBD area women in the reproductive age groups who knew but never used MCM intended to use FP-in the future. This is similar to the findings in Addis Ababa , where the unmet High Risk Birth (HRB) need among married women was 60.0%; and in Jimma (62.3%) (22,47), but higher than the National figure of rural areas (23.0%) and Bahirdar CBD-FP project areas (48.0%) (23,42).Therefore, it clearly shows that there is still high demand for FP service in the rural Eastern Showa Zone. This finding was supported by the results of FGD, where most of the participants desired to limit their family size emphasizing particularly

on the shortage of resources to bring up large family and consequences of having many children. A similar finding was reported from a study conducted in rural community of Ethiopia, where the effect of unregulated fertility was understood, people were found to have positive attitude for fertility regulation(15).

Most of current MCM users were married women and those in the age groups of 20-39 years, while not-married and young youths were least users. This is consistent with the findings of other studies in Tigray, Gondar and results of world fertility survey (37,38,41). In this particular study this may be explained by lack of detailed knowledge or adequate information among young and / not married women, which could be supported by the fact that women rarely used MCM to delay pregnancy. This was also strengthened by the findings of FGD, which revealed that delaying of pregnancy was mentioned by only few of the participants . However, marked difference was observed in the proportion of current users when CBD and NCBD areas were compared. In the age- groups of 15-19 years, 21.3% of CBD area population were using MCM, while none of NCBD area population who were in this age group did so. Also, 15.7% of not-married women in CBD area were using MCM, where as only 1.9% of NCBD area women who were not married were using MCM. Therefore, this difference could be explained by the presence of the Community based FP-services. This is because Community based FP- program brings the service to the people where they live including those who are not married and young youths as well as to the married and other age groups (5,14-20). But, there is still much work to be done to improve the service quality in order to make it more convenient and acceptable to the potential users and the needy ones, as well as there is a need to strengthen IEC and expand the program to NCBD areas for effective service utilization.

The use-continuation in CBD area was found to be better than NCBD area. Forty- two percents of CBD, 33.3% of FCBD and 35.3% of NCBD area ever users used their method at least for one year. A similar finding was shown in one study done at a rural health center in Ethiopia, where at least 40.0% of the FP- clients used their pill for one year (48). But, the use continuation in CBD area(42.0%) is lower than a study done in six rural areas of developing countries based on Demographic and Health Survey (DHS) data, which revealed that 60-75% of pill users used it at least for one year (40).

Therefore, the use- continuation in CBD area is comparable to that of clinic based FP service , despite most of current users having got their appointment for their next visit. Also the highest proportion of women with appointment for their next visit was seen in NCBD area, use continuation was found to be better in CBD area. Since, continuation is an indicator of service acceptability where as discontinuation marks dissatisfaction with the service, particularly due to side effects(13,40),this will additionally point toward the extent of service quality and the need to improve it, particularly by designing better follow up mechanism.

The high proportion of discontinuation in FCBD area (44.7%) compared to CBD area (29.9%) could be due to the cessation of the service in the area. This was also, supported by the findings of FGDs, where many of the participants mentioned distance, as the reason to discontinue use. So, the relatively better use continuation seen in CBD area (42.0%) compared to NCBD area (35.0%) could be attributed to the presence of Community based FP service. The main reasons for discontinuation of MCM use were need for (more) children and side effects in CBD and FCBD area, while need for

(more) children, spousal disagreement and long waiting time were mentioned in NCBD area. Similar findings were reported from a study in six developing countries (Morocco, Tunisia, Egypt, Ecuador, Indonesia and Thiland) (40) as well as from a multi center study of choice and use continuation done by IPPF (13). Strengthening IEC activities could bring about improvement in new acceptors and use continuation of FP method. After A client-provider IEC campaign in Kenya the number of new FP users seen per month increased from 1,500 to 2,000 and the percentage of current users who reported continuous use of a modern FP method for at least a year increased from 67% to 71% between 1991 and 1993 (29).

According to the results of FGD, ill health as side effect of MCM was said to occur if a woman is exposed to strong sun shine/ heat, or if she fails to get balanced diet after using MCM (mostly pill). Menstrual irregularities, hypertension and weight gain were injectable hormone related side effects mentioned by the participants of FGD. Darkening of facial skin as side effects of pills was also mentioned. Few of the participants in NCBD area also mentioned infertility as side effects, in contrast to CBD area participants where few of the FGD participants believed that MCM helps to be fertile "Mehatsen yetergal" was an Amharic expression to mean, MCM clears uterus, so that it will be ready for conception. This mis-conception about MCM use was also seen in Gondar where in-depth interview and FGD was carried out to assess the attitude and barriers towards FP-use (38).

Need for (more) children, having no male partner, and lack of adequate information (Knowledge) about MCM were major reasons for non-use, which is similar to the findings of other studies done in the country (22,23,38). Need for (more)children was expressed by most of CBD and FCBD area

study groups , while it was lack of adequate information in NCBD area . These findings were similar with the results of focus group discussion, where spousal disagreement and distance were additionally mentioned by most of NCBD area FGD- participants as a reason for none use /discontinuation.

Therefore, it can be conclude that Community based FP services have contributed greatly to bring FP methods and information to CBD area population more and above than those in NCBD area, as it is clearly demonstrated in the findings of this study.

Strength of this study are, it was conducted in rural area where larger segment of the population reside, used both quantitative and qualitative study designs and used two comparative groups both of which could help to increases the strength of the study. Also, sufficiently large sample size was used to improve validity of the study, and appropriate statistical methods utilized in order to reduce bias. More over, it incorporates quality assessment / from clients perspective to assess quality of service, beside availability.While, the limitations of this study are: grouping as CBD, FCBD and NCBD areas might create some bias, since women in NCBD/FCBD areas might visit CBD area to get MCM, although the magnitude is not expected to influence the results. Adjacent areas taken as NCBD area which is a convenient sampling method ,however lottery method (simple random sampling) was used to select PAs as NCBD area from adjacent PAs selected as FCBD area. Data collectors were all males, this may have an impact on the response of the study subjects, especially from those who are single/youth/never married, particularly on their response about history of abortion . Also, information regarding quality of care obtained from interview of current MCM users

, such retrospective data may be less valid than data collected through directly client- provider interaction and exit interviews. However, it is felt that data obtained from adequate sample of client interviews is sufficiently valid.

7. CONCLUSION

* Community based FP-service have markedly improved the knowledge, attitude and practice of MCM in CBD area more and above than NCBD area. Pills were the most widely known, while injectables being the most frequently used, and other methods were rarely used.

* There is high demand of MCM in all of the three study areas as seen from the proportion of women with future intention to use MCM.

* Although, some drawbacks were mentioned in CBD area such as influence by service provider while making method choice and lack of respect as well a method choice by some of the FP-clients, generally the quality of service was found to be better in CBD area than FCBD and NCBD areas.

* In spite of having been given appointment for their next visit was higher in NCBD than CBD area, use continuation found to be better in CBD area.

* Need for more children and side effects were the major reasons for use discontinuation in CBD and FCBD areas, while lack of adequate information, need for more children, spousal disagreement and long waiting time were mentioned by those in NCBD area.

* Need for more children, having no sexual partner and lack of adequate information about

MCM were the major reasons for non-use. Need for more children was the main reason expressed by most of CBD and FCBD areas study participants, while it was lack of adequate information by those in NCBD area.

* Integrated activities among FGAE, MOH and MOA seems has played a significant role for the success of the community based FP programme in Eastern Showa Zone.

* The proportion of women with history of unwanted pregnancies and induced abortion is higher in CBD and FCBD area. This is an indication for their desire to avoid unwellcomed pregnancies, which is supported by the relatively lower proportion of total number of pregnancies and alive children seen in CBD area than NCBD area.

8. Recommendations

* Quality community based family planning service is recommended in NCBD areas
  - To improve the low level of CPR in the area
  - To improve the low level of information seen in the area
  - To satisfy the high demand for MCM
  - To reach those under served segments of the population (single, young youths and males)

* Improve the quality of service in CBD-FP- project areas, so that
  - It will be convenient to the community
  - Clients will be provided with their own choice of methods, with out being influenced by service provider
  - Trained service provider will serve the clients who can properly handle them (Ex- give respect, provide adequate information and technically competent).

* Strengthen IEC: So that, IEC activities, which is designed to incorporate information regarding health risk of abortion, and also avoiding mis conceptions about FP methods, will be provided. This will provide high risk groups (single/ young) detailed information about the danger of induced abortion and it's complication, which could possibly minimize undertaking the procedure.

* Adopt the experience from Eastern Showa Zone Community based FP programme in similar

or other programmes : Integrated activities among different organizations and Institutions (involving other organizations or institutions, such as - Ministry of Education, Ministry of Labour and Social Affaire) for better achievement.

* Design a better follow up mechanism to improve CPR and use continuation (EX-home visits of interrupters).

* Conduct a study: which will focus to assess feasible ways to sustain the service (Ex- cost-sharing/ user- fee) ,so that the CPR will not go down after cessation of the program as it was observed in FCBD areas.

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Annex 1. Summary results of focus group discussions

Annex 1. 25-35 years old women participants view of MCM-use/FP-service, Eastern Showa Zone, Ethiopia, 2000.

Issues raised	CBD	FCBD	NCBD	Note and Cotables
1. Desired # of children	4 +++	4 +++	5+++	
2. Understands FP-method use as	-spacing +++ -Limiting +++ -Delaying + pregnancies	-spacing +++ -Limiting +++ -Delaying + pregnancies	-spacing +++ -Limiting ++ pregnancies	
3. Types o MCM known				
-pills	+++	+++	+++	
-injectables	+++	+++	+++	
-condom	+++	++	+	
-norplant	++	++	+	
-IUD	++	++	+	
-Foam	++	++		
-Tubal ligation	++	++		
4. FP-approval				
-Approved	+++	+++	++	
Do not comment			+	
5. Usefulness of MCM				
-useful	+++	+++	++	
6. Side effects of MCM				
-pills darkness face	+	+	+	few women mentioned darkening of face and infertility in each area
-ill health, if no balanced diet or exposure to heat/strong sunlight after using pills/injectables.	++	++	++	
-absence of menustral flow, weight gain and hypertension for injection users.	+	+	+	
-in fertility after injection use			+	
7. Ease of use				
-pills forgettable	++	++	+	
-injectable-simple	++	++	+	
-do not know			++	*most of NCBD participants were non-users
8. Price of MCM				
-reasonable/fair	+++	+++		
-do not know			++	
-free from health center &expensive from individuals			+	
9. Most of the users				
-married with many children	+++	+++	+	
-do not know			++	*since most were non-users in NCBD area, except few.
10. Satisfaction				
-satisfied	+++		+	
-were satisfied		+++		
-do not comment			+++	
11. Reasons for non-use/discontinuing use				
-side effects	++	++	+	
-spousal disagreement		++	+++	
-Distance		++	++	
-need for(more)child		+	+++	
-lack of adequate information about MCM		+	+++	

Key:-+++ = most of the participants,++ = some of the participants, and + = few of the participants.

Annex 1 (continued). **45-55 years old women participants view of MCM-use/ FP-service, Eastern Showa Zone, Ethiopia, 2000**

Issues raised	CBD	FCBD	NCBD	Note and Cotables
1. Desired # of children	5 ++ "up to God""++	5 ++ "up to God"++	7 +++ "up to god" ++	"who hates to have baby" "your clan will be stronger!"
2. Understand FP-method use as	-Limiting +++ -spacing++	-spacing+++ -Limiting ++	spacing ++ Limiting++	"If not for difficulty of bringing up many children , I would like to have as many as I could " -*Approval based on capacity to bring up children -*a woman in CBD said"mehatsen yetergal" in Amharic to mean it clears uterus
3. Types of MCM known	-to be fertile+			
- pills	+++	+++	++	
- injectables	+++	+++	++	
-condom	+			
-IUD	+	+		
-Norplant	+	+		
4. FP-approval approved	+++	+++	++	
5. Usefulness of MCM -useful	+++	+++	++	
6. Side effects -pills darkens face	++		++	
-ill health, if no balanced diet or exposure to heat/strong light after pill/injectable	++	++	+	
-Increased menstrual flow after pills/injectable uses		++		
-Absence of menstrual flow, increased B.P. and weight gain	++			
7. Ease of use -simple	++	++	*Do not think it is difficult ++ ++ (most non users)	" it is not more difficult than going through the process of pregnancy, birth and caring for new born", said a woman in FCBD area.
-pills forgettable	++	+		
-injectable simple		+		
-do not comment				
8. Price of MCM -Do not know	+++		+++	
-fair/reasonable	++	++	+	
-free from H.C.&expensive from pharmacy/individuals			+	
9. Most of users	young married women+++	marriedwomen with many children+++ were satisfied+++	only few users+++	*"Most of woman in NCBD area even do not know the presence of FP-service" said a participant in NCBD area.
10. Satisfaction	satisfied+++		Did not comment+++	
11. Reasons of non-use/discontinuing use			+	
- side effects	++	+	+++	
-need for (more) child	++	+++	+++	
-spousal disagreement	+	+++	+++	
-Lack of information	+	+	++	
-distance		++	+	
-culture		+		

Key:- +++ = most of the participants ,++ = some of the participants and, + = few of the participants.

Annex 1 (Continued). Community representatives (all male) view of MCM-use/FP-service, Eastern Showa Zone, Ethiopia, 2000

Issues raised	CBD	FCBD	NCBD	Note and Cotables
1. Desired # of children	"up to God"'++ 12 ++ 4++	"up to God"'++ 6 child ++	"up to God"'++ four ++	"children are fruits of your home"
2. Understand FP-method use as	-spacing +++ -limiting+++ -delaying+	-spacing +++ -limiting+++ -delaying+	-Limiting ++ -spacing++ -delaying+	"you will tackle problems if you have wide family"
3. Types of MCM known - pills - injectables -condom -IUD -Norplant	 +++ +++ +++ ++ ++	 +++ +++ ++ ++ ++	 +++ +++ +	"God is the one who gives and takes" "no enough land to be ploughed"
4. FP-approval approved	+++	++	++	
5. Usefulness of MCM -useful	+++	++	++	
6. Side effects -ill health, if not taken with neutricious (balanced) diet or exposed to heat/strong light after pill use	++	++		*"condom use calls for faith fulness" said one of CBD area participant.
-Increased menstrual flow after pill use.		+	+	
-Absence of menstrual flow, increased B.P. and weight gain after MCM use		+	++	
-using MCM for long leads to infertility			+	
7. Ease of use -simple -pills forgettable -injectable simple -Do not know	 +++ ++	 ++ ++	 + 	"It is just to take pills once daily and injectables once every three months, that is all!"
8. Price of MCM -fair/reasonable -cheep -free from H.C. -do not know	 ++	 + +	 ++ +	
9. Most of users	+	++	+++	*Most of the women are non users(NCBD)
10. Satisfaction	young married+++ satisfied +++	young women ++ were satisfied ++	few mid-age++ Did not comment +++	
11. Reasons of non-use/discontinue use - fear of side effects -need for (more) child. -spousal disagreement -lack of adequate information -distance -culture	 ++ ++ ++	 ++ ++ ++ + ++	 + ++ +++ +++ +++ +	

Key-:+++= most of the participants,++= some of the participants,and + = few of the participants.

Annex 2. Strucured questionnaires for quantitative study

STRUCTURED QUESTIONNAIRE

Greeting:

Hello.I would like to ask you a few questions about family planning and your modern contraceptive practice; This will help us to improve the service provided to you based on your answer to our question. I would be grateful if you could spend sometime with me answering questions related to family planning. All of your answers will be kept confidential. Do I have your permission to start my interview?

1. Study Area: 1. CBD
   2. Former-CBD
   3. NCBD

2. Registration No._____

3. Identification

   Name _____

   Age (years)_____

   Address Woreda _____Peasant association----------

4. Marital status :1. Not married 3.Divorced

2. Married 4.Widowed

5. Religion: 1. Orthodox

2. Protestant

3. Catholic

4. Muslim

5. Other, Specify _____

6. Ethnicity: 1. Amhara 2. Oromo

3. Tigray 4. Other, Specify _____

7. Educational status:

1. Illiterate 3. 1-6 grades 5. 9-12 grades

2. Read and write 4. 7-8 " 6. >12 "

8. Occupation

1. Farmer 4. Government employee 7. Merchant

2. House-wife 5. Student 8.family dependent

3. Local drink seller 6. Daily laborer 9.Other, specify----------

9. How many pregnancies have you had?

---

10. Were all pregnancies wanted? 1.Yes 2.No

11. How many alive children do you have now? ---

12. How many induced abortions do you have? ---

13. Do you know any type of modern contraceptive methods?

1. Yes 2. No

14. If yes, to ques 12, what type of contraceptive methods do you know?

1. Pills 1) yes 2. No

2. Condom 1) yes 2. No

3. Injectable 1) yes 2. No

4. IUD 1)yes 2. No

5. Norplant 1) yes 2. No

6. Permanent: tubal ligation/ male sterilization

1. Yes 2. No

7. Foam tablets 1. Yes 2. No

8. Other, specify _____

15. Have you ever used any type of modern contraceptives?

1. Yes 2. No (to Q.28)

16. Are you using modern contraceptive method now?

1. Yes 2. No

17. If yes to ques 14 or 15, what type of modern contraceptive method are/were you using?

1. Pill 1. Yes 2. No

2. Condom 1. Yes 2. No

3. Injectable 1. Yes 2. No

4. IUD 1. Yes 2. No

5. Norplant 1. Yes 2. No

6. Permanent: tubal ligation 1. Yes 2. No

7. Foam tablets 1. Yes 2. No

8. Other, specify_____

18. Have you received your own choice of contraceptive method

1. Yes 2. No.

19. Were you influenced by service provider (CBD-agent) in your choice of contraceptive method? 1. Yes 2. No

20. For what purpose were are you using the contraceptive method?

1. For child spacing 1.Yes 1.No

2. For limiting family size 1.Yes 2.No

3. To delay pregnancy 1.Yes 2. No

4. For medical reason 1.Yes 2.No

5. Other, specify _____

21. Did the service provider/ CBD-agent inform you about

1. How the method works 1. Yes 2. No

2. How to use the method 1. Yes 2. No

3. Side effects of the method 1. Yes 2. No

4. Contraindications of the method 1. Yes 2. No

5. What to do if method related problems arise? 1. Yes 2. No

6. Possibility of switching to other method? 1. Yes 2. No.

7. Which methods protect against STD/HIV 1. Yes 2. No

8. Methods of contraceptive, other than the one you are using now?

1. Yes 2. No(to Q.24).

9. The next visit appointment/orally or verbally 1. Yes 2. No.

22 While you use the contraceptive method have you had any method related problems?

1. Yes 2. No

23. If yes to ques 21, did you seek for an advice or assistance from service provider/ CBD agent? 1. Yes 2. No.

24. If no to quest. 22, why not?

1. Service provides/CBD agent did not give chance to ask question or to raise concern
   1. Yes 2. No
2. Lack of confidence on the skill of service provider/CBD agent 1. Yes 2. No
3. Too short time is spent with 1. Yes 2. No
4. Service provider is not friendly 1.yes 2. No
5. Other, specify _____1. Yes 2. No.

25. Have you discontinued using your contraceptive method at least for three consecutive months during the last 3 years?

1. Yes 2. No

26. With out interrupting at least for three consecutive months, for how long have you used your MCM ?(the longest period for interrupters)

1. 0-3 months 2. 4-6 months 3. 7-9 months
4. 10-12 months 5. 13-24 months 6. 25-36 months
7. >3 years

27. What was/were the reasons that made you to discontinue using contraceptive methods?

1. Side effects of contraceptive methods 1. Year 2. No

2. Lack of getting contraceptive method chosen 1. Year 2. No

3. Rumors about ill effects of contraceptive methods 1. Yes 2. No

4. Not treated with respect by service provider 1. yes 2. No

5. Spousal disapproval 1. Yes 2. No

6. Desired to have child 1. Yes 2. No

7. Costly to buy 1. Yes 2. No

8. Source is far form home 1. Yes 2. No

9. Long waiting time to get contraceptive method from health units depot 1. Yes 2. No

10. Inconvenient time when CBD-agent visits (hours/days) 1. Yes 2. No

11. Other specify _____

28. Are you satisfied with the service you are receiving? 1. Yes 2. No

29. Do you support if friends or relatives seek your advice to use FP-methods?

1. Yes 2. No

30. If the answer is no to quest 16, why did you not start using contraceptive methods?

1. Need for more children 1. Yes 2. No

2. Religious prohibition 1. Yes 2. No

3. Lack of information/knowledge abut Fp 1. Yes 2. No

4. Source is too far 1. Yes 2. No

5. Price is costly 1. Yes 2. No

6. Method chosen unavailable 1. Yes 2. No

7. Husband refusal 1. Yes 2. No

8. Service provider is male 1. Yes 2. No

9. Cultural prohibition 1. Yes 2. No

10.No sexual/male partner 1. Yes 2. No

11. Other, specify _____

31. Do you have intention to use contraceptive method in the future?

1. Yes 2. No

32. If no to ques. 31, why not?

1. Need for more children 1. Yes 2. No

2. Religious prohibition 1. Yes 2. No

3. Still lack information/knowledge about Fp 1. Yes 2. No

4. Costly price 1. Yes 2. No

5. Far to get 1. Yes 2. No

6. Chosen method not available 1. Yes 2. No

7. Husband refusal 1. Yes 2. No

8. Service provider is male 1. Yes 2. No

9. Cultural prohibition 1. Yes 2. No

10.No male partner 1. Yes 2. No

11. Other, specify_____

End of the interview, express your thanks to the study subject for her cooperation.

Name of data collector_____

Signature _____

Date _____

Annex 3. Semi-structured questionnaires for qualitative study

Focus Group Discussion

Greeting

" Hello. I would like to ask you a few questions about family planning and your modern contraceptive practice; This will help us to improve the service provided to you based on your answer to our question. I would be grateful if you could spend sometime with me answering questions related to family planning.

1. What is the best family size in your opinion?

2. What do you understand when somebody is talking about family planning?

   Probing question spacing vs limiting

3. What kinds of modern contraceptive methods do you know? (ex. pills, condom etc)

4. Do you advice/like using modern contraceptive methods?

5. What do you say about their effectiveness?

6. Is it difficult to use?

7. Is it expensive to get/buy?

8. For those using modern contraceptive methods &/ non-users are you satisfied by the current FP method service given in your area?

   Probing - reasons for dissatisfaction

   - Possible solutions raised by participants

9. What would you advice if somebody ask your opinion to use modern contraceptive?

10. What are the reasons which you think are barriers for using modern contraceptives use?

- side effects
- husband /relative influence
- religious ground
- need for large family size
- availability
- lack of adequate information about FP
- cost
- Dislike/lack of confidence on skill of service

provider/CBD-agent, probe why?

11. In your area, among those women in the reproductive age groups ,who are currently using MCM most? (Young/married, women with many children etc).

DECLARATION

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

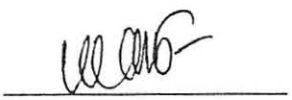
Name Shimeles Genna, MD

signature 

Place Addis Ababa, Ethiopia

Date of submission:_____

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

Dr. Misganaw Fantahun 

Advisor's name Signature