ADDIS ABABA UNIVERSITY SCHOOL OF COMMERCE

DEPARTMENT OF MARKETING MANAGEMENT

GRADUATE PROGRAM UNIT

THE IMPACT OF SOCIAL MARKETING STRATEGIES ON WOMEN'S CONTRACEPTIVE CHOICES

THE CASE OF MARIE STOPES INTERNATIONAL ETHIOPIA

THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY SCHOOL OF COMMERCE IN PARTIAL FULFILLMENT FOR THE AWARD OF MASTER OF ARTS (MA) IN MARKETING MANAGEMENT

PREPARED BY: GETANEH ASFAW

ADVISOR: TEMESGEN BELAYNEH (PhD)

MAY, 2016

ADDIS ABABA, ETHIOPIA

ADDIS ABABA UNIVERSITY SCHOOL OF COMMERCE

DEPARTMENT OF MARKETING MANAGEMENT

GRADUATE PROGRAM UNIT

THE IMPACT OF SOCIAL MARKETING STRATEGIES ON WOMEN'S CONTRACEPTIVE CHOICES

THE CASE OF MARIE STOPES INTERNATIONAL ETHIOPIA

BY

GETANEH ASFAW

Approval Board Committee

Research Advisor	**Signature**
_____	_____
External Examiner	**Signature**
_____	_____
Internal Examiner	**Signature**
_____	_____

STATEMENT OF CERTIFICATION

This is to certify that Getaneh Asfaw T/Mariam has carried out his research work on the topic entitled “The Impact of Social Marketing Strategies on Women’s Contraceptive Choices; The Case of Marie Stopes International Ethiopia” is his original work and is suitable for submission for the award of Masters Degree in Marketing Management.

_____

Temesgen Belayneh (Ph.D)

(Advisor)

May, 2016

DECLARATION

I, Getaneh Asfaw Teklemariam, hereby declare that the thesis work entitled "The Impact of Social Marketing Strategies on Women's Contraceptive Choices; The Case of Marie Stopes International Ethiopia" submitted in partial fulfillment of the requirements for Master of Arts (MA) in Marketing Management to Addis Ababa University School of Commerce, is the outcome of my own effort and that all sources of materials used for the study have been duly acknowledged.

This study has not been submitted for any degree in this University or any other University.

Name: Getaneh Asfaw

Signature: _____

Date: _____

Table of Contents

ACKNOWLEDGEMENT

I have been fortunate to get the support of many individuals throughout the entire process of writing this thesis paper. The lion's share of the support and guidance goes to my advisor, Dr. Temesgen Belayneh; thank you!

The completion of this study would not have been realized without the help of others and I would take this opportunity to thank everyone who helped me in this thesis. My family members, my parents, my brothers and sisters, and my children extended their kind encouragement throughout the process and I would not thank them enough for that. My special gratitude goes to my wife, Bethelhem, who has supported me a lot by taking care of the other responsibilities of life and by editing The research work. I would also like to thank the Monitoring and Evaluation and the Integrated Marketing team members of Marie Stopes International Ethiopia who have extended their support throughout the process to ensure this study informs the program intervention in addition to its academic purpose. Without their kind cooperation, this study would not have come to reality.

ACRONYMS

ASRH: Adolescent Sexual and Reproductive Health

CPR: Contraceptive Prevalence Rate

EMDHS: Ethiopia Mini Demographic and Health Survey

FMOH: Federal Ministry of Health

FP: Family Planning

HIV: Human Immunodeficiency Virus

HSDP: Health Sector Development Program

LARC: Long Acting Reversible Contraceptive

MSI: Marie Stopes International

MSIE: Marie Stopes International Ethiopia

PFS: Public Facility Support

RHCS: Reproductive Health Commodity Security

SAC: Short Acting Contraceptives

SRH: Sexual and Reproductive Health

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

WHO: World Health Organization

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

The problem of population growth, with steady growth of economy, social services and limited resources are contributing to increasingly challenging socio-economic situation of developing countries. Effective contraception intervention is one of the recommended strategies to mitigate the challenge of population size increase. Social marketing is one of the preferred interventions to mitigate this challenge as it involves the acceptability of ideas or practices in a target group. Identifying determinants of contraceptive choice of option, assessing community awareness on contraceptives, and exploring service delivery channel are very important to have a planned population growth and never burden ground socio-economic situation of the country. This study was initiated to assess the social marketing factors that contribute to the contraceptive choice of women and identify the relationship of social marketing strategies in determining the contraceptive choice of women. The study followed Cross Sectional Survey Explanatory; it answers the question why, what contributes to the factor, and the marketing strategies to the choice of contraceptives to women. A total of 118 respondents were selected using skip pattern sampling technique to collect the data from 5 Marie Stopes clinics located in Addis. The data obtained through a client exit questionnaire was analyzed and tested using statistical models including descriptive and Chi-square association. Based on the statistical analysis pricing, location accessibility, and age were found to have significant effect on women's choice of contraceptives. Nonetheless, no significant relationship was established between availability of supplementary services, promotion media, and marital status and women's choice of contraceptives. Most previous studies of this kind have not in-depth tackled the issues of contraceptive choice and preferences as a research issue. Most of them have studied this as a subsidiary to the large aspect of contraceptive use and prevalence. This research is one of the attempts to see the association between different social marketing parameters and key demographic factors on contraceptive choices of women in order to make informed decision as to what could be done to expand access to FP / SRH products and services tailored to the specific needs of the different user groups.

Keywords: contraceptives, marketing contraceptive services, family planning

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Unwanted pregnancy among women is a worldwide health problem that affects girls, their families, and society. It can result from unprotected sex, contraceptive failure or from sexual violence (rape). Women who give birth during adolescence face higher risks of maternal morbidity and mortality, and their infants are at higher risk of negative outcomes (Jensen & Thornton 2003).

Social marketing is among the preferred strategies to mitigate this challenge. Social marketing applies marketing principles and techniques to create, communicate, and deliver value in order to influence target audience behaviours that benefit society (public health, safety, the environment, and communities) as well as the target audience (Kotler and Nancy 2006). Social marketing programs have proved to be successful in promoting contraceptives throughout the world. The social marketing of reproductive health products and services has several unique advantages. Social marketing is fast because it relies to a great extent on existing commercial and health service delivery networks, it can be scaled up quickly, providing contraceptives to tens of thousands of outlets in just a year or two. Social marketing contraceptives are not perceived as a "program" by consumers. Rather, they are seen as normal commercial goods that offer consumers a benefit at an affordable price and as such it is non-patronizing. Social marketing is highly cost-effective. Because social marketing products and services are purchased, they are more likely to be used than those given away for free.

Young people constitute one-third of the total population in Ethiopia. The reproductive health problems of young people in Ethiopia are multifaceted and interrelated. Childbearing begins at an early age: 45 percent of the total births in the country occur among adolescent girls and young women. The situation is aggravated by the overall poor socioeconomic environment and harmful traditional practices.

Adolescent and youth have unintended pregnancy due to limited access to get correct information about contraceptives. Compared to adult women, young women are less likely to use contraceptives. Young women had a limited knowledge where to get and how to use contraceptives. The use of modern contraception among youth aged 15-24 years is still very low 12percent; compared with women of age 25-49 which is 23percent. (FMOH, 2015)

Promoting contraceptive use in adolescents globally is necessary to prevent early and unintended pregnancies, and the health and social consequences of such pregnancies. Accurate and age appropriate sexuality education must be combined with respectful contraceptive service provision, which acknowledges the unique needs and preferences of adolescents "A variety of approaches will be needed to reach different adolescent groups, and particular attention should be paid to ensure that marginalized and vulnerable adolescents are not excluded." (WHO, 2012).

Apart from the National Population Policy which was designed in 1993, other policies such as the country's Health Policy and the National Policy on Ethiopian Women support the expansion of family planning programs in Ethiopia for instance, The Federal Ministry of Health (FMOH) has committed in its Health Sector Development Program (HSDP IV) policy to increase the Contraceptive Prevalence Rate (CPR) from 29.2 percent in 2011 to 66 percent in 2015. As a result in recent years, considerable progress has been made toward reproductive health commodity security (RHCS) in Ethiopia, and much of the success can be attributed to a high level of commitment from the Federal and Regional Governments to improve and expand service provision and strengthen the contraceptive supply chain.

According to 2014 EMDHS report, the public sector continues to be the major source of modern contraceptive methods in Ethiopia and serves 87 percent of users. In contrast, only 12 percent of users were sourced contraceptive methods from the private medical sector-including NGOs.

Marie Stopes International Ethiopia (MSIE) is a non-governmental and non-profit making organization that has been providing family planning (FP) and other Sexual and Reproductive Health (SRH) services in Ethiopia for close to two and half decades operating in almost all the regions.

MSIE is one of the key players in the sexual and reproductive health (SRH) sub sector of Ethiopia. Since 1990 it has been working on delivering high quality FP, and maternal, and child

health services through a diverse range of service delivery channels. It delivers a range of SRH services to adolescent and adults. This research is intended to assess the appropriateness of MSIE's marketing practices to meet contraceptive needs of women in to selecting the contraceptive method of their choice.

1.2 STATEMENT OF THE PROBLEM

Reproductive age is a time for sexual exploration and expression. For many women sexual relations begin in adolescence, in or outside of marriage. The consequences of unprotected sex for women include too early and unwanted pregnancy, and sexually transmitted infections, including HIV. As a result of this the need for a tailored marketing approach to adolescents is eminent.

Limited knowledge of sexual physiology, early marriage, limited use of contraceptives, limited access to reproductive health information and education, and girls' limited agency over their sex lives all contribute to the high rate of unwanted pregnancy. (FMOH, 2005)

The age structure of the household population in Ethiopia is a typical of a society with a young population. According to the EMDHS 2014, adolescents, in the 15-19 age groups, account for 10.6% of the total population. SRH services are provided by MSIE to address the adolescent age groups. The proportion of these service users, which is 13%, reflects a similar proportion within the population. (MSIE Exit Interview, 2014)

Programs, services, service modalities at MSIE are meeting, to some extent, the needs of the adolescent groups. This happens by default but not by design. Thus conducting a study to understand the needs of adolescents and craft strategies to improve access to and utilization of a service modality to meet the specific needs of this segment is mandatory considering their significant proportion amongst the overall customer.

Studies undertaken on SRH for women in Ethiopia emphasize on the supply factors and often the needs of the client are ignored. Studies aimed at proposing marketing strategies/interventions on this particular matter is lacking. When we take MSIE as a case

in point, a study on the demand side of ASRH is completely lacking. On the other hand MSIE is one of the leading service providers targeting, though it is by default, this group.

Age of clients is a critical component that must be considered in designing and implementing reproductive health programs, including those which seek to expand the use of contraceptive. It is believed that to be most effective, to most accurately reflect their needs and desires, and to respect their rights, women's age should be considered in the design and implementation of programs that affect them. Implementation of age specific sexuality education is timely and important to protect adolescent and youth from undesired sexual health complications and other social evils. (FMOH 2015)

Ethiopia's effort in expanding sexual and reproductive health over the past two decades has been commendable. It is also one of the few countries to advance towards meeting the maternal and reproductive health related MDGs. This owes to the concerted efforts of both the government and developmental partners. Notwithstanding however, sexual and reproductive health issues still remain a priority for this underdeveloped nation who is also dealing with a number of socio-economic bottlenecks. Both the government and developmental partners have come a long way to advocate family planning and sexual and reproductive health ever since the first few steps were laid out half a century ago by pioneer institutions in this regard such as the Family Guidance Association of Ethiopia. Since then, a growing number of likeminded parties have taken part in expanding such services by devising innovative programs and strategies all aimed at increasing family planning use by the community. A common theme all those strategies is availing comprehensive information about all contraceptive options to support personal decision making regarding family planning by users.

Achieving this objective requires developing programs which takes into consideration the context of the target group as opposed to a one-size-fits-all approach. This is due to the fact that a number of factors determine contraceptive use and choice of users which need to be properly studied and taken into consideration upon designing of the social marketing strategies. Malhotra and Sunitha (2014) indicated that main strategies for family planning going forward should be to (a) expand the basket of contraceptives: (b) expand the access,

both financial and physical acceptance of contraceptive: (c) increase knowledge and awareness of providers and acceptors This knowledge, in turn, should translate into increased contraceptive use which all require well-crafted marketing strategy.

It is therefore with this background that this study aimed at studying the association between key marketing and sociodemographic dimensions with behavioral attributes of contraceptive users which is their contraceptive choices in order to inform designing of FP or SRH related program and strategies going forward. Being one of the leading family planning and sexual and reproductive health service proponent and service provider in Ethiopia and its other branches in the world, Marie Stopes International Ethiopia (MSIE) has been selected for this case study.

1.3 RESEARCH QUESTIONS

The research paper has been conducted to examine the determinants of contraceptive choices for women and assess the relationships to inform tailored marketing strategies to effective marketing of contraceptives to women.

It systematically gives answers to the following research questions.

1) What are the effects of marketing strategies on the contraceptives choice of women?

2) Does age have an impact on the contraceptives choice of women?

3) Does marital status have an impact on the contraceptive choice of women?

1.4 OBJECTIVE OF THE STUDY

1.4.1 General Objective

The general objective of the study is to examine the role of social marketing strategies to the development of SRH program strategies tailored specifically to different client segments. The result of this research is believed to support MSIE to develop an informed marketing strategy to address the SRH need of women on different socio demographic characteristics.

1.4.2 Specific Objective

The study has the following specific objectives:

- To identify the different factors that affect the contraceptive choice of women
- To examine the impact of price of contraceptives on the choice of contraceptives among women
- To determine the major sources of effective information communication channels that influence contraceptive choice of women
- To find out adolescents preference on the location or accessibility of health facilities to access contraceptives
- To identify the impact of age on the choice of contraceptives for women
- To ascertain the effect of marital status on the contraceptive choice of women

1.5 HYPOTHESES OF THE STUDY

After examining various literatures critically the following hypothesis were formulated. The entire hypothesis was tested in order to achieve the general and specific objective of this study.

H1: Availability of supplementary services has implication on contraceptive choice of Women

H2: Pricing of contraceptive products / services has implication on the contraceptive choice of women

H3: Choice of promotion media has implication on contraceptive preferences of Women

H4: Location accessibility of FP/SRH clinics has implication on contraceptive choice of Women

H5: Age (adolescent Vs non-adolescent) has implication on contraceptive method preference

H6: Marital status has implication on the contraceptive method preference of Women

Type	Variable Name	Definition and measurement parameter
Independent	Product	▪ Measured by availability of supplementary services such as counseling
Independent	Price	▪ Measured by whether or not prices will be charged for the different service types
Independent	Promotion	▪ Measured by the primary source of information (media) for the respondents they frequently access
Independent	Place	▪ Measured by the accessibility of the clinics / service centers as measured by the preference of respondents that are close by their residence
Independent	Age	▪ Measured by two age categories, *i.e. adolescent age group (19 years and less) and non-adolescent group (above 19 years)*
Independent	Marital status	▪ Measured by four categories of marital status, i.e. *Single, Married, Living with partner, and Widowed/Divorced/Separated*
Dependent	**Contraceptive choice**	▪ **Measured by the primary reason the respondents visited the clinics / service centers**

Table 1.1 Definition and Measurement parameter of Hypothesis

1.6 DEFINITION OF TERMS

Adolescent: WHO defines adolescents as individuals in the 15-19-year age group and "youth" as the 15-24 year age group. The age group in the 10-14 year age group is referred to as young adolescents. These overlapping age groups are combined in the group "young people", covering the age range 10-24 years.

Adolescent refers to individuals in the 15-19 year age group for this study.

Marketing contraceptives services: The demand generation activity to inform adolescents on the different contraceptive choices and where they can be accessed.

1.7 SIGNIFICANCE OF THE STUDY

Output of the study will be useful for Marie Stopes International Ethiopia, other health institutions that provide family planning and sexual reproductive health services, the adolescent client, as well as for other researchers. Specifically, this study will help enact policies requiring the provision of accurate, age-appropriate, and comprehensive sexuality education for all adolescents. Moreover, it could serve as a base for researchers who want to make comprehensive study in the future for choice of contraceptives among women.

1.8 SCOPE OF THE STUDY

The scope of the study is limited to Marie Stopes International Ethiopia only. MSIE offers services using multiple channels. Services are provided using MSIE owned static clinics, franchised private clinics under the brand name of BlueStar, and outreach services are provided by taking services closer to hard to reach parts of the country to provide quality SRH services using public facilities as a point of service provision. The study would be limited to the static clinics of MSIE that are found in Addis Ababa.

The study is limited to address only marketing of contraceptive services to women as they constitute more than 95% of the total client. Moreover, only the four social marketing strategy variables are discussed in the study.

1.9 LIMITATION OF THE STUDY

There were few obstacles to complete this study; the major limitations include time constraint and respondents unwillingness to fill up questionnaires. Because of the time constraints the student researcher could not carry out the study at desired level and manner. Respondent's

unwillingness to fill the questionnaire were also time taking and make the study very challenging.

1.10 ORGANIZATION OF THE STUDY

This research paper consists of five chapters. The first chapter, which is the introduction, contains background of the study, background of the organization, statement of the problem, definition of terms, objective of the study, hypothesis of the study, scope of the study, significant of the study, and limitation of the study. In chapter two related literature review is made regarding service marketing strategies and empirical review was made on previous studies on service marketing strategies on marketing of contraceptives to adolescents. The third chapter is the portion that presented methodology used in the research. It makes clear to the readers on the part of questionnaire development and data collection procedures. The fourth chapter deals with detailed analysis of the responses scored through respondents of the study and focuses on the discussion of the research result. The last chapter contains major findings conclusion and recommendation given based on the analysis.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This literature review examines the major issues regarding the marketing of contraceptives to women of different age groups using the marketing strategies in service marketing as a reference sub topic. It also examines the relationship between the marketing strategies and the choice of contraceptives. The literature reviewed in this part, focuses on the objectives stated in Chapter One. The value of studying the aforementioned literature areas is to provide a meaningful discussion and analysis about the topic.

The literature review is subdivided into theoretical framework, empirical reviews, and conceptual framework. At the end of this section it is hoped that a critical understanding of key issues is exhibited, that the reader is better informed and that there is a clear justification for the research in this area.

2.1 THEORETICAL REVIEW

2.1.1 Strategy Overview

Different scholars have given different definitions to strategy. According to Tony Proctor, a strategy is a plan that integrates an organization's major goals, policies, decisions, and sequences of action into a cohesive whole. It can apply at all levels in an organization and pertain to any of the functional areas of management. Thus there may be production, financial, marketing, personnel, and corporate strategies, just to name a few. If we look specifically at marketing then there may be pricing, product, promotion, distribution, marketing research, sales, advertising, merchandising strategies. Strategy is concerned with effectiveness rather than efficiency and is the process of analyzing the environment and designing the fit between the organization, its resources and objectives, and the environment (Proctor, 2000).

Nickols (2011), asserted that strategy is a pattern of decisions in a company that determines and reveals its objectives, purposes or goals, produces the principal policies and plans for achieving those goals, and defines the range of businesses the company is to pursue, the kind of economic and human organization it is or intends to be, and the nature of the economic and non-economic contribution it intends to make to its shareholders, employees, customers, and communities.

Strategy is a coordinated plan that gives the outlines for decisions and activities of a firm and is focused on the application of the resources that a company has at its disposal in such a way that the activities have an additional value to the environment so that the firm can achieve its own goals (Gibeus et al, 2003).

An increase in service uptake requires a good strategy; sometimes that strategy is implicit, sometimes explicit; where possible it is always better to make it explicit (White, 2004).

2.1.2 Definition of Marketing Strategy

Marketing strategy refers to an organization's integrated pattern of decisions that specify its crucial choices concerning products, markets, marketing activities and marketing resources in the creation, communication and/or delivery of products that offer value to customers in exchanges with the organization and thereby enables the organization to achieve specific objectives (Varadarajan, 2009).

According to Philip Kotler, marketing strategy is the marketing logic by which the company hopes to create customer value and achieve profitable relationships. The company decides which customer it will serve through segmentation and targeting. And then decides how, by differentiation and positioning. It identifies the total market, divides it into smaller segments, selects the most promising segments, and then focuses on serving and satisfying customers in that segment. It designs a marketing mix using mechanisms under its control: product, price, place, promotion, people, process, and physical evidence. It also engages in marketing analysis, planning, implementation and control in order to find the best marketing mix and to take action. The company uses these activities to enable it to watch and adapt to the marketing environment (Kotler & Armstrong, 2011).

Subhash (1999), explains that within a given environment, marketing strategy deals essentially with the interplay of three forces known as the strategic three Cs which are: the customer, the competition, and the corporation. If what the customer wants does not match the needs of the corporation, the latter's long term visibility may be at stake.

For a longer lasting good relationship between customers and corporation there should be a positive matching of the needs and objectives of the customer and corporation. Matching the needs between the customer and the corporation should not only be positive but also it must be better and stronger than the match between the customer and the competitor. If the corporation's approach to the customer is identical to that of the competition, then the customer can't differentiate between them.

Moreover, he states that formation of marketing strategy requires the following three decisions:

1. Where to compete: it requires the definition of the market (for example, competing across an entire market or in one or more segments).
2. How to compete: it requires a means for competing (for example, introducing a new product to meet a customer's need or establishing a new position for an existing product).
3. When to compete: it requires timing of market entry (for example, being first in the market waiting until primary demand is established).

Thus, marketing strategy is the creation of a unique and valuable position, involving a different set of activities and development of marketing strategy requires choosing activities that are different from the rivals (ibid).

Market research and segmentation underlie the market targeting decision. Market targeting implies major commitments to satisfying the needs of particular customer groups through the development of specific capabilities and investment in dedicated resources. These capabilities enable the organization to create a value proposition specific to the targeted segment utilizing the elements in the marketing mix (Slater & Olson, 2001)

According to Walker, the primary purpose of a marketing strategy is to effectively allocate and coordinate marketing resources and activities to accomplish the firm's objectives within a specific product market. "Therefore decisions about the scope of a marketing strategy involve specifying the target-market segment(s) to be pursued and the product line to be offered. Then, firms seek a competitive advantage and synergy, planning a well-integrated program of marketing mix elements." (As cited by Boyd et al, 1998)

According to Slater and Olson (2001), marketing strategy is concerned with decisions related to market segmentation and targeting, and the development of a positioning strategy based on product, price, distribution, and promotion decisions.

2.1.3 Marketing Strategies for Service Firms

Christopher Lovelock (2001) defined service as an act of performance offered by one party to another. Although the process may be tied to physical product, the performance is essentially intangible and does not normally result in ownership of any of the factors of production.

Until recently, service firms lagged behind manufacturing firms in their use of marketing. Service businesses are more difficult to manage when using only rational marketing approaches. In a product business, mass produced products are fairly standardized and sit on shelves waiting for customers. But in a service business, the customer and frontline service employee interact to create the service. Thus service providers must work to interact effectively with customers to create superior value during service encounters. Effective interaction, in turn, depends on the skills of frontline service staff, and on the service production and support processes backing these employees (Kotler et al, 1999).

According to Akroush (2003), marketing strategies in service businesses are different from those that are being used in goods marketing. The literature in service marketing indicates that the unique characteristic of service creates special marketing problems and challenges, which need special marketing strategies to deal with them. Consequently, the marketing strategy in the services should include the 7Ps of the services marketing mix framework and service quality, which may have a crucial effect on companies' performance (ibid). The 7Ps of the services marketing mix framework has been advocated by the service marketing literature as a generic framework for services marketing management and, the 7Ps components are the major components to formulate a marketing strategy in service (Smith and Saker, 1992).

A company must consider four special service characteristics when designing marketing programs: intangibility, inseparability, variability, and perishability, and these major characteristics are defined in the following manner (Kotler and Armstrong, 2006).

- Service intangibility means that services cannot be seen, tasted, felt, heard, or smelled before they are bought.

- Service inseparability indicates that services are produced and consumed at the same time and cannot be separated from their providers.
- Services variability means that the quality of a service may vary greatly, depending on who provides them and when, where, and how.
- Services perishability means that services cannot be stored for later use or sale.

2.1.4 Marketing Strategies

2.1.4.1 Product

Service product is defined as the extent to which a service organization develops a comprehensive service offer to meet customer's needs and requirements in highly competitive markets (Doyle, 1999). Past researchers have clearly suggested that product influences have a significant impact on service uptake (Kazem and Heijden, 2006; Owomoyela et al, 2013). Cavusgil and Zou, (1994) and Lee and Griffith, (2004) noted that better firm performance can be obtained via adapting the product to meet requirements of export customers. Thirkell and Dau, (1998) also found that service marketing strategy had significant and positive correlation with service uptake.

The additional services offered by organizations to augment the core product/service are called supplementary services. The kind of supplementary services offered by organizations differs from one service industry to another.

2.1.4.2 Price

Service price is operationally defined as the extent to which a service organization practices pricing policies and activities in setting a service price (Zeithaml, 1998).

Kotler (2007) defines price as a cost of producing, delivering, and promoting the product charged by the organization. Zeithaml (1998) is of the view that monetary cost is one of the factors that influence consumer's perception of a product's value. In the studies of Coplan, (2006) and Owomoyela et al, (2013) they establish significant relationship between price and service uptake. The price you set for your product or service plays a large role in its marketability.

2.1.4.3 Promotion

Promotion is defined as the extent to which a service organization uses the components of promotion activities and elements in formulating a service promotion strategy (Akroush 2011).

Hakansson (2005), reports that promotion appears as an issue of how to create an optimal mix of marketing communication tools in order to get a product's message and brand from the producer to the consumer. Kotler, (2007) discovers that Promotions have become a critical factor in the product marketing mix which consists of the specific blend of advertising, personal selling, sales promotion, public relations, and directing marketing tools that the company uses to pursue its advertising and marketing objective.

2.1.4.4 Place

Place, also known as distribution, is defined as the extent to which a service organization uses distribution channels and activities in setting a service distribution strategy (Friars et al., 1985) The place where customers buy a product and the means of distributing the product to that place must be appropriate and convenient for the customer. The product/service should be available in the right place and at the right time.

Kotler and Armstrong (2006), define place or distribution as a set of interdependent organizations involved in the process of making a product available for use or consumption by consumers. Owomoyela et al, (2013); and Amine and Cavusgil, (2001) agree that place has a significant effect on service uptake.

2.2 EMPIRICAL REVIEW

Contraceptive is the planning of when to have children, and the use of birth control and other techniques to implement such plans. Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management. Contraceptive is sometimes used as a synonym or euphemism for the use of birth control; however, it often includes a wide variety of methods, and practices that are not birth control. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of

pregnancy (also known as spacing children). Contraceptive may encompass sterilization as well. Contraceptive services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved". (WHO, 2014).

2.2.1 Product/Service: Women's preference among the different contraceptive options

It should be acknowledged that women may have different contraceptive needs and preferences, depending on their culture, age, and socioeconomic status. (WHO Expanding Access to Contraceptive Services for Adolescents, 2012)

In line with WHO's eligibility criteria on contraceptive provision, a range of methods are appropriate for adolescents as age alone is not a contraindication for any method (apart from sterilization). Long acting reversible methods such as intrauterine devices or implants can also be good choices for adolescents depending on their needs and preferences.

The male condom is the most commonly used modern contraceptive among young people in many countries. A four-country study conducted in sub-Saharan Africa found that at least half of sexually active males aged 15–19 who reported having sex with more than one partner in the past three months said they had used a condom (Akinrinola et al, 2007). According to Bankole et al, 2007 study, condom use was highest among male adolescents in Ghana (68 percent) and lowest in Malawi (50 percent). On the contrary, data from Demographic and Health Surveys (STAT compiler) show that oral contraceptives or injectable are the most popular hormonal method among 15 to 24 year-olds in the developing world, with rates of use exceeding 20 percent in some countries. Far fewer young women use implants, with rates of use below 1 percent nearly everywhere. Data from the same surveys shows that despite the high awareness of hormonal methods among youth, there is much lower rates of use among adolescents ages 15 to 19 years than among young adults ages 20 to 24.

2.2.2 Price: Cost of Contraceptives and their implication on service uptake

Clients are generally more likely to use low-cost services. In Kenya, clients said that low costs and proximity of services were the two most important factors that attracted them to services (John, 2002). A study in Bangladesh indicated that families spent money on health care only in a crisis situation. Contraceptive side effects and related problems are rarely seen as

emergencies, so many women in the study stopped using contraception or switched methods because they could not justify the expense of dealing with side effects (Sydney, 2001). On the other hand, clients may be willing to accept higher costs if they believe that services are of high quality.

Reduce financial barriers to contraceptive services. Young people often have limited power over financial decisions and resources. Therefore, all programs should have some means for young people to access services and contraceptives free or at highly subsidized rates. Social marketing can provide highly subsidized products through a wide range of outlets and distributors. Socially marketed programs that intend to reach adolescents should develop targeted marketing and distribution strategies for this population. (WHO, High Impact Practices, 2015)

2.2.3 Promotion: Promoting Contraceptives to Adolescents

Clients want to receive information that is relevant to their needs, desires, and lifestyles. Because clients differ in their reproductive intentions, attitudes about family planning, ability to make decisions, and other factors that affect contraceptive choice, they need information that is tailored to their individual needs. Clients who are well-informed and have made their choice about a contraceptive method may not want detailed information on a range of other methods.

Promoting contraceptive use in adolescents globally is necessary to prevent early and unintended pregnancies, and the health and social consequences of such pregnancies. Accurate and age appropriate sexuality education must be combined with respectful contraceptive service provision, which acknowledges the unique needs and preferences of adolescents. (WHO Expanding Access to Contraceptive Services for Adolescents, 2012)

The UNFPA, UNICEF, WHO common agenda for action in adolescent health and development calls for the implementation of a package of actions, tailored to meet the special needs and problems of adolescents and includes the provision of information and skills, health and counselling services, and the creation of a safe and supportive environment (15). Promoting the sexual and reproductive health of adolescents involves the implementation of the same set of actions.

- Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects inaccuracies.
- Adolescents need social skills that will enable them to say no to sex with confidence and to negotiate safer sex, if they wish to. If they are sexually active, they also need physical skills such as how to use condoms.
- Counselling can help adolescents make informed choices, giving them more confidence and helping them feel in more control of their lives.
- Health services can help well adolescents stay well, and ill adolescents get back to good health.
- As adolescents undergo physical, psychological and social change and development, a safe and supportive environment in their families and communities can enable them to undergo these changes in safety, with confidence and with the best prospects for healthy and productive adulthood.

2.2.4 Place: The effect of location on uptake of contraceptives by adolescents

Make available a full range of contraceptive methods through outlets that different groups of adolescents are likely to frequent, including social marketing outlets, educational and social facilities and the health system. (WHO Expanding Access to Contraceptive Services for Adolescents, 2012)

2.2.5 Age and Its Effect on the Contraceptive Choice of Women

This refers to the age of the respondent women. Age is a continuous variable and is measured by the year a person has lived. It is hypothesized middle age women will have better access to information and is expected to become more contraceptive user. Similarly, Schultz (2007) indicated that household assets increase over the life cycle of a couple, and according to the life cycle savings hypothesis savings will tend to peak in the late middle Ages when investments in children are declining and retirement is approaching. Hence, younger age is expected to positively influence to temporary family planning service choice of options.

In terms of socio-demographic factors, the unmet need for family planning is typically stronger for younger women (Ahmad et al., 2005). Other studies, however, argued that the effect of age

differs by unmet need for spacing and unmet need for limiting (Ojakaa, 2008), with unmet need for limiting increasing with age, while that for spacing decreases for older women (Sita, 2003).

2.2.6 Marital Status and Its Effect on the Contraceptive Choice of Women

Despite the public health interest in reducing the proportion of unplanned births, the factors leading to unplanned births in the United States are not well understood. Births to women in their late twenties and thirties are more likely to be planned than births to teenagers and women in their early twenties (Henshaw 1998; Finer and Henshaw 2006). In addition, unplanned birth rates are lower for partnered women – especially married women – than for women not in co-residential relationships (Chandra et al. 2005; Finer and Henshaw 2006).

2.3 CONCEPTUAL FRAMEWORK

The explanation for building the research framework and developing the hypothesis would be provided here. It is mainly based on key findings from the literature review of the social marketing strategy research.

Social marketing strategies are concerned with taking decisions on a number of variables to influence mutually-satisfying exchange transactions and relationships. In the middle of 1990's Day (1994) stated that it is almost an article of faith within marketing that superior business performance is the result of superior skills in understanding and satisfying customers.

This research framework includes two interrelated parts, which are contraceptive choice, which is the dependent variable, and the marketing strategies along with age and marital status as independent variables influencing contraceptive choice. The marketing strategy components are investigated within the domain of marketing mix (4Ps) framework. According to Akroush (2003), the development of marketing strategy components is based on the marketing mix which outlines the major components of the marketing strategy in different businesses. The unique characteristics of services create special problems and challenges that require special marketing strategies to cope with them. The contraceptives choice of women at health facilities is used for measuring the impact of the marketing strategies and age and marital status.

Based on the social marketing strategy components and the contraceptive choice literature review, the following hypotheses have been stated;

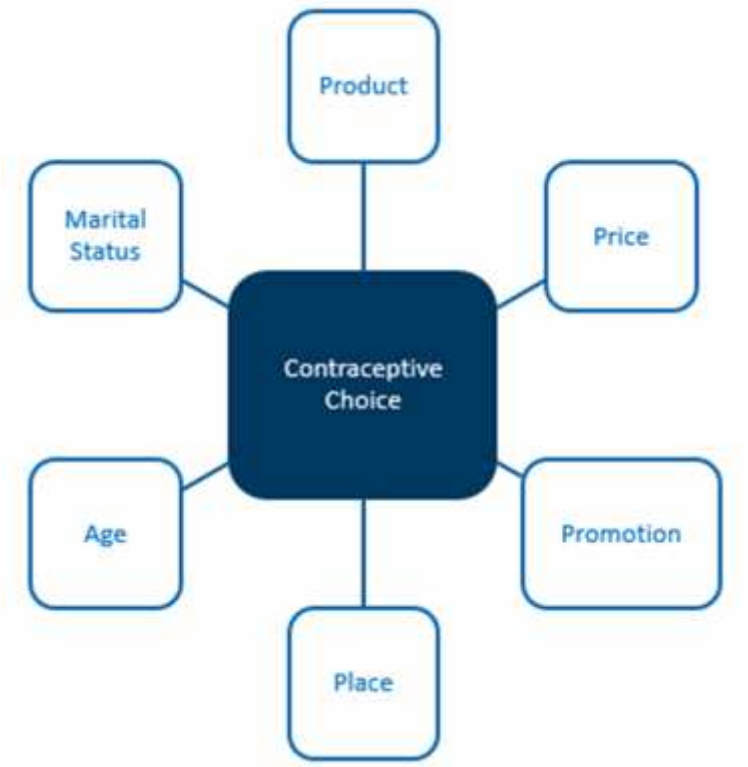


Figure 2.1 Conceptual Framework

Source: Adopted Partially from MacPhail, Pettifor, and Rees,H., (2007) and Heather, Amy, Saseendran, William, and Taraneh, (2015)

CHAPTER THREE

RESEARCH METHODOLOGY

The methods used in this thesis are discussed in this part of the study. The chapter describes the detailed research methodology used to address issues identified earlier along with the means of collecting data for analysis, and the analysis approach.

3.1 RESEARCH APPROACH

The research used quantitative approach. Quantitative Research approach is used to quantify the respondents' evaluation following the usage of service at Marie Stopes International Ethiopia by way of generating numerical data or data that can be transformed into useable statistics.

3.2 RESEARCH DESIGN

The objective of this study is to examine to examine the role of social marketing strategies to the development of SRH program strategies tailored specifically to different client segments. The research is undertaken to assess the association between social marketing strategies and women's choice of contraceptives.

Descriptive research is used to assess and analyze the demographic and background information of the respondents and the overall questions raised on the questionnaire. Whereas Cross Sectional Survey Explanatory research type was used as it answers the question why, what contributes to the factor, and the marketing strategies to the choice of contraceptives to women. It also tries to prove or disprove the stated hypothesis by comparing the relationship between the dependent and independent variables.

The survey is administered to clients after they have received services from MSIE.

3.3 POPULATION AND SAMPLING TECHNIQUES

3.3.1 POPULATION

Women, who have received services at the five clinics of Marie Stopes International Ethiopia that are found in Addis Ababa, are considered as the target population for this particular study.

3.3.2 SAMPLING TECHNIQUES

The number of respondents who fill the questionnaires at each site/facility will be proportional to the size of the facility's client flow — sites with more clients coming for services will have more clients included in the questionnaire. Clients will be selected to fill the questionnaire systematically using a skip pattern. It is common for clients at a facility to differ by time of the day, so the skip pattern allows questionnaires to be spaced throughout the day and capture a representative sample.

3.3.3 SAMPLING SIZE

The Client Exit Questionnaires is conducted on all of MSIE's service centers located in Addis Ababa with the exception of the MCH centers. In this case, 118 clients were approached to fill the questionnaire in the five facilities.

Sample sizes were calculated using MSI standard sample size determination formula:

$$n=Z\alpha 2\ pq\ /\ d^2$$

Where:

- n = number of respondents required
- $Z\alpha$=1.96 corresponding to a confidence level of 95%
- p = expected coverage for key indicator
- q = 1-p
- d = required level of accuracy, i.e. maximum size of confidence intervals

The sampling design considered that all clients should have the same chance of being selected into the sample. Moreover the sample design is sufficient enough to provide statistics with confidence intervals of +/- 5%. With this sample size, we will also be able to identify differences in contraceptive uptake between adolescents and non-adolescent age groups in the context of the

different marketing strategy. Setting the value of Z=1.96, P=50%, q=50%, and d=9%, the required sample size for this study was estimated to be 118 respondents.

The allocation of sample size for exit questionnaire for each center is presented in table 3.1 below:

Table 3.1: Allocation of Sample Size for each centers

S/N	Name of the Clinic	Average clients per day	# of Client Exit Questionnaires	Skip Pattern Questionnaire every:
1.	Arada	109	40	fifth client
2.	Choice	32	13	fifth client
3.	Kirkos	67	25	fifth client
4.	Ayer Tena	79	28	fifth client
5.	Addis Ketema	34	12	fifth client
	Total	321	118	

3.4 DATA SOURCES AND TOOLS

3.4.1 DATA SOURCES

The study used both primary and secondary data sources. The primary data were collected from the clients using the structured questionnaire. The tool was used to collect raw data regarding respondents' evaluation of the different social marketing strategies.

Secondary data, collected internally from the organization's routine MIS data.

3.4.2 DATA COLLECTION TOOLS

The data collection tool the study used is questionnaire. Questionnaire was selected because, firstly, it is economical in terms of researcher time, effort and cost than most other methods. Secondly, it is more appropriate and found easy for respondents to fill and forward their feelings and responses for questions.

The questionnaire contained two parts. The first part is designed to collect respondents' demographic information. The second part is the structured questions designed to measure each social marketing strategies.

3.5 DATA COLLECTION PROCEDURES

First, the structured questionnaire was developed and distributed to the target population of 118 respondents. The number of respondents who fill the questionnaires at each site/facility will be proportional to the size of the facility's client flow — sites with more clients coming for services will have more clients included in the questionnaire. Clients will be selected to fill the questionnaire systematically using a skip pattern. It is common for clients at a facility to differ by time of the day, so the skip pattern allows questionnaires to be spaced throughout the day and capture a representative sample. The researcher plans to have 50% of the respondents in the Adolescent age group and to achieve this filter question would be used during the conducting the questionnaire.

3.6 METHOD OF DATA ANALYSIS

The primary data is collected from the questionnaire and was analyzed using both descriptive and Chi-square association. In order to do that, Statistical Package for Social Science (SPSS) software was employed.

The statistical package for social science (SPSS) 17 was used to analyze the data collected. After the data are collected it is edited, coded and then entered in to SPSS. Data collected using the questionnaire was analyzed using different statistical tools. Descriptive statistics has employed frequencies and percentages to describe the demographic characteristics of the respondents based on the frequencies and percentages that were obtained from the responses regarding the characteristics of respondents.

A measure of association using Chi-Square would be used to check the hypothesis.

3.7 VALIDITY AND RELIABILITY OF THE INSTRUMENT

Validity and reliability of the measures need to be assessed before using the instrument of data collection (Hair et al., 2003). Validity concerns whether an instrument can accurately measure, while reliability pertains to the consistency in measurement.

Due to the nature of the questionnaire construct, as varying ways were applied for measuring the different variables considered, it was not possible to apply Cronbach alpha or factor analysis to determine the statistical reliability and construct validity. In addition, the size of the sample was one constraint not to apply these statistical tests. Field (2005) recommends that the sample size necessary for factor analysis should at least be 300 or above.

According to Greener (2008), three validity measures were considered in designing the survey instruments, construct validity, face validity (external validity), and internal validity.

Construct validity is the assumption that the instruments must actually measure what they are purported to measure. To overcome this challenge, the draft survey questionnaire was pilot tested with 10 respondents and feedback from the pilot testing was incorporated into designing of the final survey questionnaire. The feedbacks obtained were instrumental in increasing the response rate for the questionnaires and ease of understandability of the questions.

As recommended by Greener (2008), triangulation was also applied to increase the reliability of the questionnaire by gathering comparable information from outsourcing vendors at the same time. Part of the recommendations made to enhance validity of research tools by Phelan and Wren (2006) include having instruments reviewed by faculty at other schools to obtain feedback from an outside party who is less invested in the instrument. Accordingly, the first draft of the survey questionnaire was critiqued by the research advisor.

External validity more often called generalizability, determines if we can generalize the results of the study to other contexts or situations. The survey to some extent may suffer from lack of external validity considering the sample size in nominal terms, the study population, and the theoretical backing by (Lau and Zhang, 2006) that it is likely that there will be different reasons

for contraceptive choice by different other factors and differences in economic and cultural setup.

Whereas internal validity, also called causality, examines whether the observed change in a dependent variable is indeed caused by a corresponding change in hypothesized independent variable, and not by variables extraneous to the research context. The study has, rather examined association between dependent and independent variables instead of causality and this was clearly discussed elsewhere in this report. Hence, the study is less likely to be susceptible to the risk of internal validity error.

3.8 ETHICAL CONSIDERATIONS

Brief description of the central objectives or purpose of the study was clearly stated in the introductory part of the questionnaire to be filled by respondents.

To maintain the confidentiality of the information provided by the respondents, the respondents were assured that the responses would be used only for academic and programmatic intervention decision making purposes and kept confidential.

CHAPTER FOUR

DATA PRESENTATION ANALYSIS AND INTERPRETATIONS

This chapter comprises the findings of the study, both hypothesis testing results and descriptive analysis, presented in different sections and sub-sections. The first section discuss the descriptive analysis results which include categorization of respondents with regard to selected socio-demographic characteristic which will input to the hypothesis testing discussion including respondents profile by service center surveyed, age, marital status, employment status, and level of education. In addition, descriptive statistical analysis results are also included in this section. The next section entirely presents the results of the hypotheses testing with detailed discussion on the implication of each result.

4.1 DESCRIPTIVE ANALYSIS OF RESULTS

4.1.1 Demographic Profile

A. Service Center Location

A total of 120 questionnaires were administered to respondents from MSIE clinics out of which 2 were administered to male respondents which were not considered in this analysis given the research is particularly focused on studying women's behaviors. Accordingly, 13 questionnaires (11%) were administered to female respondents in MSIE's Choice main clinic, 25 questionnaires (21.2%) administered to respondents in Kirkos clinic, 40 questionnaires (33.9%) in MSIE Arada clinic, 28 questionnaires (23.7%) in Ayer Tena clinic, and the remaining 12 questionnaires (10.2%) at Addis Ketema clinic. The table below summarizes the above information.

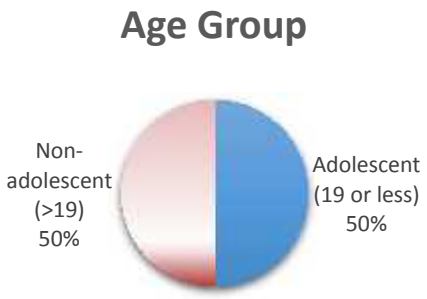
Table 4.1: Distribution of Respondents by the Service Center they visited

Service Center Location	Distribution of Respondents	
	#	%ge
Choice	13	11%
Kirkos	25	21.2%
Arada	40	33.9%
Ayer Tena	28	23.7%
Addis Ketema	12	10.2%
Total	**118**	**100%**

B. Age Group (*Adolescent Vs Non-Adolescent*)

The age group distribution of respondents is equal between adolescents, i.e. aged 19 or below and non-adolescents, aged above 19 years. The mean age of the respondents is 22 years, while the maximum and minimum years are 37 and 16 respectively. The pie chart below shows this distribution.

Figure 4.1: Age Group Distribution of Respondents



C. Employment Status

In terms of employment status, the majority of the respondents, ~66% are unemployed while the remaining 44% are employed. The table below shows this distribution.

Table 4.2: Distribution of Respondents by their Employment Status

Employment Status	Distribution of Respondents	
	#	%age
Employed	52	44.1%
Unemployed	66	55.9%
Total	**118**	**100%**

D. Level of Education

In terms of educational achievement, ~77% of the respondents have completed either primary or secondary education including TVET. Only ~8% of them have completed tertiary education while ~15% of them are illiterate. The table below shows this distribution.

Table 4.3: Distribution of Respondents by their Level of Education

Highest Level of Education	Distribution of Respondents	
	#	%ge
None / non-formal	18	15.3%
Completed primary	64	54.2%
Completed secondary, vocational or technical	27	22.9%
Some tertiary or higher education	9	7.6%
Total	**118**	**100%**

E. Marital Status and Living Children

One of the key demographic variables used to profile respondents was marital status. On this dimension, half of the respondents are single and only a small percentage of them (2%) are widowed/separated/divorced while the rest are married or living with their partners. The table below shows this distribution.

Table 4.4: Distribution of Respondents by Marital Status

Marital Status	Distribution of Respondents	
	#	%ge
Single	60	50.8%
Married	44	37.3%
Living with partner	12	10.2%
Widowed / Divorced / Separated	2	1.7%
Total	**118**	**100%**

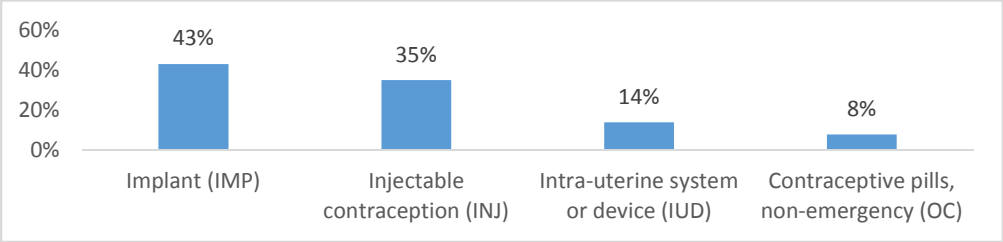
The average living children distribution among the respondents is less than 1 child with the maximum living children being 5.

4.1.2 Descriptive Analysis

A. Contraceptive Choices

Overall, ~80% of the respondents used implant and injectable contraception out of which the majority used the former.

Figure 4.2: Contraceptive Choice of Respondents



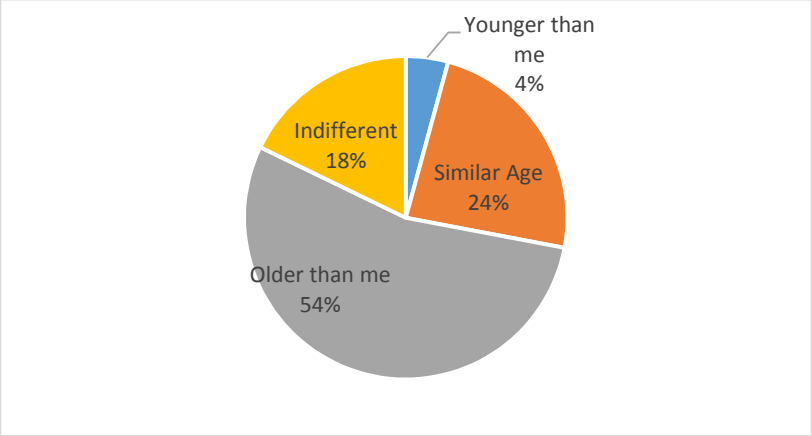
B. Contraceptive Pricing

Pricing is a key strategic component of a successful social marketing strategy design like any other business activity. Adoption of products / services irrespective of them offered for the common good will is impacted by how much they are priced. MSIE's services as of mixed types when it comes to pricing, some fully subsidized, some partially, and some none at all. ~25% of the respondents mentioned that their choice of contraceptive method in part is dependent on how much it costs. More interestingly, some 18% of respondents who probably gotten fully / partially subsidized services mentioned that they may not have used the contraceptive choices were they expected to pay for it.

C. MSIE Clinic Staff

Majority of the respondents mentioned that they were comfortable asking questions during the examination and with the age of the service providers. This is an important variable due to the sensitivity and personal nature of cases involved which some users may not fill willing to share at all unless they are comfortable with the service delivery setting. In terms of their preferences of age groups of the service providers; more than half of them prefer service providers who are older than them whereas only 4% of them said otherwise. The chart below illustrates this information.

Figure 4.3: Preference on Age of Service Providers



D. Service Processes at MSIE Clinics

Respondents were also asked to rate their experience at the MSIE clinics along five major dimensions. Accordingly the highest rating was obtained for hospitality of the centers, i.e. friendliness and respect shown by the staff. And relatively, the lowest score was given for level of privacy at the centers. In fact, ~48% of the respondents were familiar with the existence of other similar clinics but chose to get service at MSIE's for a number of reasons. The chart below depicts the process rating by respondents.

Figure 4.4: MSIE Clinics Service Process Rating

4.2 HYPOTHESIS TESTING RESULT

Due to the categorical nature of the parameters used to measure the independent as well as dependent variables, chi-square test was used to test their association. Further, Cramer's V was used to determine the strength of the association of the variables. The result of the hypothesis testing and the supporting statistical tables are presented in the sub-section below:

Hypothesis 1: Availability of supplementary services has implication on contraceptive choices of women

The first hypothesis relates availability of supplementary services such as counseling services to the core contraceptive products / services at the clinics having contribution to the contraceptive preferences of women. Accordingly, the chi-square test proves this hypothesis wrong with the p-value (0.099) exceeding the level of significance 0.05 implying that woman's contraceptive choices are not affected / determined by availability of supplementary services such as counseling and others aside from the core service. Looking at the proximity of the p-value and the sig-level, the result of this hypothesis might change if the number of observation is increased.

The result actually aligns with the notion that as FP users become more familiar with the service, their product choices, and pros and cons of each service / product / procedure, their tendency to strongly base their choice of contraceptive / service center based on availability of supplementary services such as counseling will be less likely as compared to first time users.

The chi-square and symmetrical measure results for this hypothesis are shown below.

Table 4.5 Chi-Square Test Result for Effect of Supplementary Services on Contraceptive Choice

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.795[a]	4	.099
Likelihood Ratio	7.950	4	.093
Linear-by-Linear Association	.076	1	.783
N of Valid Cases	120		

a. 4 cells (44.4%) have expected count less than 5. The minimum expected count is .23.

Table 4.6 Symmetric Measure Result for Effect of Supplementary Services on Contraceptive Choice

		Value	Approx. Sig.
Nominal by Nominal	Phi	.255	.099
	Cramer's V	.180	.099
N of Valid Cases		120	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Findings from similar studies however suggest otherwise. A study by Stover and Heaton (1995) found that women who intended to use contraception were more likely to have awareness of at least one method. A similar conclusion was made by Bongaarts and Bruce analyzed (1995) after analyzing DHS data from 27 countries from 1986 – 1990.

Related to knowing the source of contraception, other investigators have looked at the effect of IEC campaigns and the availability of methods from a program, as a determinant of contraceptive use. Availability of methods was positively related to

contraceptive use in Tunisia and community-based distribution was positively correlated with contraceptive use in Zimbabwe (Jayne and Guilkey, 1998).

Hypothesis 2: Pricing of contraceptive products / services has implication on contraceptive choices of women

Pricing of contraceptive products has been postulated to have implication on Women's contraceptive choices. As such, the chi-square test also proves this hypothesis with P<5% currently at .00 and chi-square coefficient (X^2) of 20.358.

Further looking at the strength of this association, the Cramer's v coefficient shows 0.35 implying that price has a moderate impact on the choice of contraceptives by women. Like any other commercially oriented product / service, FP / SRH products and services are also price dependent and their acceptability as well as reach will be in part dependent on this factor. Early interventions and programs by different bodies in this area used subsidized free of charge FP products and services to ensure reach and scalability to the many. This is particularly true in low economic status countries and communities such as many African countries.

The chi-square and symmetrical measure results for this hypothesis are shown below.

Table 4.7 Chi-Square Test Result for Effect of Pricing on Contraceptive Choice

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.358[a]	4	.000
Likelihood Ratio	30.046	4	.000
Linear-by-Linear Association	2.133	1	.144
N of Valid Cases	120		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.85.

Table 4.8 Symmetric Measure Result for Effect of Pricing on Contraceptive Choice

		Value	Approx. Sig.
Nominal by Nominal	Phi	.495	.000
	Cramer's V	.350	.000
N of Valid Cases		120	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Looking further into the contraceptive choice distribution by the price status of the different services as summarized in the table below, the majority of the respondents who didn't need to pay for service constituting ~50% have used Injectable contraception (INJ) whiles over 55% of those who were required to pay used Implants (IMP) over the other contractive alternatives. The distribution over pills and non-emergency alternative was somehow equivalent while the proportion paying customers who used Intra-uterine system or device (IUD) was six-fold to the non-paying customers.

Table 4.9: Contraceptives usage distribution by paying Vs non-paying customers

Contraceptive / FP Alternatives	**Payment Status**	
	Didn't Pay	**Paid**
Intra-uterine system or device (IUD)	4%	24%
Implant (IMP)	40%	56%
Injectable contraception (INJ)	47%	12%
Contraceptive pills, non-emergency (OC)	9%	8%
Total	**100%**	**100%**

Hypothesis 3: Choice of promotion media has implication on contraceptive preferences of women

Awareness about different family planning products and services by the community is one of the key determinants for utilization by different users of their choice. This in part is dependent on whether or not the intended messages about those products / services are transmitted to the target group and how well. In line with this idea, this study postulated that choice of contraceptives by women will be dependent of the kind of media they frequently access which directly relates to them getting adequate information about the different FP alternatives. The chi-square test, however, proves this hypothesis wrong as the p-value is 0.631 which exceeding the sig-level by a significant amount.

The same argument given for hypothesis 1 can also pulled here to give explanation for the above result. As such, the importance of promoting FP services and products is in fact relative to the awareness level of target users about the service. Currently, the majority of the society in Ethiopia is quite familiar with the importance of and alternatives of FP services as a result of heavy awareness creation efforts of different groups over the past several decades. This is particularly true for dwellers of the capital Addis Ababa who have better chance of accessing such efforts than people anywhere else in the country. However, this doesn't imply that promotion never had contribution to FP methods. It is an undeniable fact that the current FP service acceptance in the country owes itself to the concerted efforts of different governmental and non-governmental actors over a number of years promoting the service through a number of means and spending millions if not billions of money.

Results of this hypothesis and the implication should only be interpreted cautiously be interpreted as, at the **current state** (*location, existing level of awareness* …), choice of promotion channels have no implication contraceptive preferences of women

The chi-square and symmetrical measure results for this hypothesis are shown below.

Table 4.10 Chi-Square Test result for Effect of Promotion media on Contraceptive choice

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.627[a]	15	.631
Likelihood Ratio	14.652	15	.477
Linear-by-Linear Association	.506	1	.477
N of Valid Cases	88		

a. 20 cells (83.3%) have expected count less than 5. The minimum expected count is .24.

Table 4.11 Symmetric Measure Result for Effect of Promotion media on Contraceptive choice

		Value	Approx. Sig.
Nominal by Nominal	Phi	.379	.631
	Cramer's V	.219	.631
N of Valid Cases		88	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Previous studies in this regard has proven the strong association between showing that media has influence on awareness level of consumers and therefore the kind of choice they make. Finding of a study by Amy (2010) found that media exposure and favorable attitude toward family planning media messages were found to be positively related to current use and intention to use contraception. Similarly, a cross-sectional study, using 1990 Nigerian Demographic and Health Survey data and subsample interviews in 1993, indicated that exposure to family planning messages through the media was a significant predictor of use and intention to use contraception three years later (Bankole, Rodriguez and Westoff, 1996).

The media can exert its power on very specific levels of contraceptive decision making as is indicated in a study in Nigeria where information from the media was found to be most influential in individual choice of contraceptive method (Kojima,1993).

Hypothesis 4: Location accessibility of FP/SRH clinics has implication on contraceptive choices of women

The fourth hypothesis tested is the accessibility of clinics / service centers and their implication on Women's contraceptive choices. Based on the chi-square result in the below tables, location accessibility / proximity to the respondents' resident determine which contraceptives they will decide to use with P<5%. The Cramer's V coefficient is .226 which implies that there is close to moderate dependency between those variables.

The chi-square and symmetrical measure results for this hypothesis are shown below.

Table 4.12 Chi-Square Test Result for Effect of Location accessibility on Contraceptive choice

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.232[a]	4	.016
Likelihood Ratio	14.822	4	.005
Linear-by-Linear Association	3.029	1	.082
N of Valid Cases	120		

a. 3 cells (33.3%) have expected count less than 5. The minimum expected count is 2.25.

Table 4.13Symmetric Measure Result for Effect of Location accessibility on Contraceptive choice

		Value	Approx. Sig.
Nominal by Nominal	Phi	.319	.016
	Cramer's V	.226	.016
N of Valid Cases		120	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Distribution of contraceptive choices of respondents varied by their preferences on proximity of the clinic/service center to their residence. ~60% of the respondents prefer clinics which are not located nearby their residence and the majority of these respondents used implants and injectable as opposed to IUDs and non-emergency contraceptive pills.

Table 4.14: Contraceptives usage distribution by preferences clinic locations

Contraceptive / FP Alternatives	Clinic location preference	
	Don't prefer nearby	**Prefer nearby**
Intra-uterine system or device (IUD)	21%	5%
Implant (IMP)	36%	50%
Injectable contraception (INJ)	32%	39%
Contraceptive pills, non-emergency (OC)	11%	5%
Total	**100%**	**100%**

Hypothesis 5: Age (adolescent Vs non-adolescent) has implication on contraceptive method preferences of women

This study has tested the relationship of contraceptive choices with key demographical variables. The fifth hypothesis postulated that choice of contraceptives will be dependent on them being adolescent and non-adolescent. Age is an important factor determining contraceptive choice mainly due to the direct association it has with level exposure to sexual and reproductive risks.

Based the chi-square test result for this hypothesis, there is a different of contraceptive choice amount adolescents aged 19 and below and those aged above with P<5% at 1.7%. The Cramer's V coefficient from the second table below shows 0.261implying a lower association between the dependent and independent variables.

The chi-square and symmetrical measure results for this hypothesis are shown below.

Table 4.15 Chi-Square Test Result for the Effect of Age on Contraceptive Choice

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.179[a]	2	.017
Likelihood Ratio	8.294	2	.016
Linear-by-Linear Association	4.320	1	.038
N of Valid Cases	120		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 13.50.

Table 4.16 Symmetric Measure Result for the Effect of Age on Contraceptive Choice

		Value	Approx. Sig.
Nominal by Nominal	Phi	.261	.017
	Cramer's V	.261	.017
N of Valid Cases		120	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

According to the distribution of contraceptives usage by the two age cohorts, adolescents do not seem to frequent long term FP methods such as IUDS as frequented by non-adolescent almost by twelve fold. The majority of them rather use implants and injectable contraception alternatives, ~50% of them and ~40% respectively. In reality as well, usage of long long-acting reversible contraceptive (LARC) methods are not promoted to be the primary choices of users at this age as most of them will most likely not form families or bear children. The so-called limiters, aged between 30 and 40, are more likely to use permanent and or long term choices.

Table 4.17: Contraceptives usage distribution Adolescents and Non-adolescents

Contraceptive / FP Alternatives	Age group	
	Adolescents	**Non-adolescents**
Intra-uterine system or device (IUD)	2%	24%
Implant (IMP)	49%	38%
Injectable contraception (INJ)	39%	31%
Contraceptive pills, non-emergency (OC)	10%	7%
Total	**100%**	**100%**

Nakazzi (2002) also indicated that the age of a person determines if they will seek different type of contraceptives because of the fear and stigma attached to adolescent pregnancy from the community. These young teen therefore do not seek medical help and in addition they do not

have enough resources to meet the health provider's fee and transportation costs if they were required.

Hypothesis 6: Marital status of women has implication on their contraceptive choices

Use of contraceptives ideally would vary across marital status with married women using the services most compared to single women due to high incidences of sexual activities compared to single women. Unmarried youth have distinct contraceptive method preferences due to unsteady partnership dynamics. The positive influence of marital status on the likelihood of using family planning services could be attributed to the fact that couples might decide to postpone raising children by resorting to use of family planning services.

It was unfortunate, however, that testing results of this study has found no relation between marital status and contraceptive choice with the value of p=.551 exceeding the sig. level 5%.

Table 4.18 Chi-Square Test Result for the Effect of Marital Status on Contraceptive Choice

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.948[a]	6	.551
Likelihood Ratio	5.494	6	.482
Linear-by-Linear Association	.351	1	.554
N of Valid Cases	120		

a. 5 cells (41.7%) have expected count less than 5. The minimum expected count is .45.

Table 4.19 Symmetric Measure Result for the Effect of Marital Status on Contraceptive Choice

		Value	Approx. Sig.
Nominal by Nominal	Phi	.203	.551
	Cramer's V	.144	.551
N of Valid Cases		120	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

According to the findings of Birungi (2009), however, contraceptive prevalence rate showed a slight difference by women among marital status (married Vs un-married) with 60% and 70% among the married compared to 48% among the unmarried. The most commonly used methods included the male condom (41.4%), Injectable (38.9%), and Pills (13.69%).

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 SUMMARY OF FINDINGS

This section presents summary of the major findings of this study categorized under two sub section of hypothesis testing result summary and summary of major findings.

A. Summary of Hypothesis Testing Result

Table 5.1: Summary of Hypothesis Testing Result

	Description	Result
1	**Alternate Hypothesis:**	Availability of supplementary services has implication on contraceptive choices of women
	Testing Result:	X^2= 7.795; df=4; sig value=.099; Cramer's V=.180
	Conclusion:	Alternate hypothesis rejected
2	**Alternate Hypothesis:**	Pricing of contraceptive products / services has implication choices of women
	Testing Result:	X^2= 29.358; df=4; sig value=.000; Cramer's V=0.350
	Conclusion:	Alternate hypothesis **accepted**
3	**Alternate Hypothesis:**	Choice of promotion media has implication on contraceptive preferences of women
	Testing Result:	X^2=12.627; df=15; sig value=.631; Cramer's V=.219
	Conclusion:	Alternate hypothesis rejected
4	**Alternate Hypothesis:**	Location accessibility of FP/SRH clinics has implication on contraceptive choices of women
	Testing Result:	X^2= 12.232; df=4; sig value=0.16; Cramer's V=.226
	Conclusion:	Alternate hypothesis **accepted**
5	**Alternate Hypothesis:**	Age (adolescent Vs non-adolescent) has implication on contraceptive method preferences of women
	Testing Result:	X^2= 8.179; df=2; sig value=.017; Cramer's V=.261
	Conclusion:	Alternate hypothesis **accepted**
6	**Alternate Hypothesis:**	Marital status of women has implication on their contraceptive choices
	Testing Result:	X^2= 4.948; df=6; sig value=.0551; Cramer's V=.144
	Conclusion:	Alternate hypothesis rejected

X^2= Chi-square

df= Degree of freedom

Cramer's V= Coefficient to measure strength of association

B. Summary of Major Findings

- Respondents' choices of contraceptives were concentrated around implants and injectable contraception with a combined share of ~80%. IUD users constitute 14% and the remaining 8% by non-emergency contraceptive pills
- A moderate number of respondents were found to be sensitive to price changes to contraceptives with some indicating that they may alter their contraceptive choices which they probably are getting for free or small fee if they had to pay for it
- Respondents were generally satisfied with the personal service they got from MSIE clinic's staff and felt comfortable asking questions during examinations
- More than half of the respondents mentioned that they would prefer service providers who are older than they are while only 4% of the respondents mentioned that they prefer younger service providers and the rest prefer those who are at the same age they are
- More than half of the respondents mentioned that they are familiar with other similar service providers but chose MSIE for multiple reasons
- Rating of MSIE clinics' process by the respondents also revealed that the clinics are preforming best in giving hospitality service, followed by short waiting times, long operating hours, better overall experience, and lastly level of privacy they will get at the clinics.

5.2 CONCLUSIONS

The study was initiated with the general objective to examine the role of marketing strategies to the development of SRH program strategies tailored specifically to different demographic segments. The result of this research is believed to support MSIE to develop an informed marketing strategy to address the SRH need of the women of different segment groups.

Contraceptive is seen both as a fundamental right and as the central pillar of efforts to eradicate poverty. It has been one of the main goals of the Millennium Development Goals (MDG) and national health priorities of many countries including Ethiopia over the past two decades. Preventing unintended pregnancies and STIs, as such, remained key public health priorities.

Success in preventing unintended pregnancies and averting of different sexual and reproductive health problems requires long periods of effective contraceptive use; success, however, is also influenced by method type and adherence to the method's requirements for consistent and correct use. It is the fundamental basis of this study that overall success in this regard can be achieved if the right FP products and services tailored to the specific attributes of the different usage groups. This requires effective social marketing strategy in order to achieve this objective. To this end, studying key behavioral factors of contraceptive users has a vital role; especially in designing appropriate intervention. This plays a pivotal role in the fulfillment of organizational, national, as well as international developmental objectives.

Particularly in the marketing sub-sector, it is probably safe to say that academic studies which are focused on societal development are limited probably due to the strong demand from business sector for such efforts. Most previous studies of this kind have not in-depth tackled the issues of contraceptive choice and preferences as a research issue. Most of them have studied this as a subsidiary to the large aspect of contraceptive use and prevalence. This research is one of the attempts to see the association between different social marketing parameters and key demographic factors on contraceptive choices of women in order to make informed decision as to what could be done to expand access to FP/SRH products and services tailored to the specific needs of the different user groups.

The scope of this study has been de-scoped to researching the associated behavior of FP service uses in urban areas particularly in Addis Ababa due to a number of constraining factors. Despite the commendable effort put through in this study and the interesting findings thereof, the researcher strongly believes those FP service users' behaviors and reactions to different marketing strategies will also be geographically dependent. This in itself is a result of a number of factors such as access to information, access to modern and affordable services and so on. Therefore, the researcher has also noted that further research is necessary to understand wide dimensions of consumer behaviors and further enrich the social marketing concepts and principles for at least delivering of FP/SRH services and products.

5.3 RECOMMENDATIONS

Based on the findings of this study the following general and marketing mix specific recommendations are made here below:

General Recommendations

- Enact policies requiring the provision of accurate, age-appropriate and comprehensive reproductive health services and products for all adolescents and non-adolescents.
- Eliminate social and non-medical restrictions on the provision of contraceptives to adolescents.
- Make available a full range of contraceptive methods through outlets that different groups of adolescents are likely to frequent, including social marketing outlets, educational and social facilities, and the health system.
- Ensure that health information systems gather, analyze and use age-disaggregated data on the need for, and use of, contraceptives for effective designing of appropriate products and for effective tracking of changes as a result.

Implication for Product, Pricing, Promotion, and Placing Marketing Decisions (4Ps)

- User-controlled, community-based, and over-the-counter availability of next-generation contraceptives offers many advantages for women. With methods that do not require screening and follow-up by a health provider, women will be more dependent on pharmacies and community-based programs to meet their information needs, such as whether these methods provide protection against STIs and HIV. Higher quality of care leads to more consistent use, greater user confidence, satisfaction, and higher levels of continuation.
- Despite the higher level of awareness by urban dwellers which might imply little need for supplementary services as evidenced in this study, social marketing efforts of MSIE and other partners should also consider the status of underserved areas. Therefore, attention should also be given to ensuring that:
    - Auxiliary health personnel are well-trained to provide information, screening, counseling, and, if needed, referral to a health provider.

    - Product information, including brochures and package inserts, is comprehensible to low-literate women.
    - Clients are advised to use contraceptives of their choice after being well informed of their nature, pros, and cons
- The results of the study also imply a need for more focus on high quality family planning services. More attention should be paid to rural and minority areas with more promotion of contraceptive knowledge, training and capacity building of health workers.
- In addition, the key actors in this sector that including both government and developmental partners should invest in inventing more effective and low side-effect contraceptive alternatives the majority can access and easily afford.
- MSIE can explore modern counseling methods such as mobile and internet to promote more reach to customers

REFERENCES

Ahmed S, D. Gillespie, S. Radloff and Tsui, A., (2005).Unwanted Fertility among the poor: an inequity? World Health Organization. 85:100-101

Akinrinola, B. et al.,(2007). Knowledge of Correct Condom Use and Consistency of use among Adolescents in Sub -Saharan Africa: African Journal of Reproductive Health, 11(3), pp 197–220.

Akroush, N., (2003). An Integrated Approach to Marketing Strategy Formulation and Implementation. University of Huddersfield.

Akroush, N., (2011). The 7Ps of the Services Marketing Mix Revisited: An Empirical Assessment of their Generalizability, Applicability, and Effect on Performance. *Jordan Journal of Business Administration*, 7(1), pp.116.

Allison, G. Magnolia, S. & Suzzane P., (2014). Understanding the Adolescent Family Planning Evidence Base.

Amine, L.S. and Cavusgil, S.T., (2001). Export Marketing Strategies in the British Clothing Industry. *European Journal of Marketing*, 20(7), pp. 21-33.

Andrea Whittaker,(1996). Quality of Care for Women in Northeast Thailand: Intersections of Class, Gender, and Ethnicity: Health Care for Women International,17(5), pp 435-47.

Bankole, A. Biddlecom, A. Guiella, G. Singh, S. Zulu, E.,(2007). Sexual Behavior, Knowledge and Information Sources of Very Young Adolescents in Four Sub-Saharan African Countries: African Journal of Reproductive Health, 11(3), pp 28–43.

Bankole,A. Rodriguez and Westoff, C. (1996). Mass Media Messages and Reproductive Behavior in Nigeria. *Journal Of Biosocial Science*, 28(2):227-39.

Birungi Isabella, (2009). Contraceptive Utilization and Associated Factors among HIV Positive Women in Mulago ISS Clinic, Makerere University.

Bongaarts John and Bruce Judith, (1995). The Causes of Un met Need for Contraception and the Social Content of Services. Studies in Family Planning, 26: 57-75.

Boyd, W.H. Walker, C. O. Larrâechâe, & Jean Claude, (1998). Marketing Management: A Strategic Approach with a Global Orientation. 4th Edition. New York: McGraw.

Brown, G., (2012). Out of wedlock, into school: Combating child marriage through education. London: The Office of Gordon and Sarah Brown.

Cavusgil, S.T. and Zou, S., (1994). Marketing Strategy-Performance Relationship: An Investigation of the Empirical Link in Export Market Ventures. *Journal of Marketing*, 58(1), pp. 1-21.

Chandra, A.et al., (2005). Fertility, Family Planning, and the Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth. Hyattsville, MD: National Center for Health Statistics. Vital Health Statistics 23(5).

Coplan, A.M., (2006). Dynamic Effects of Product Diversity, International Scope and Keiretsu Membership of the Performance of Japan's Textile Firms in the 1990s. Asian Business and Management, 5(3), pp. 419-451.

Costello, M.,(2001). A Client-Centered Approach to Family Planning: The Davao Project, Studies in Family Planning, 32(4), pp 302-314.

Day, G.S., (1994).The Capabilities of Market Driven Organizations. *Journal of Marketing*.

Doyle, P., (1999). Managing the Marketing Mix, in Baker Michael J (ED). The Marketing Book, 4th Edition. Butterworth-Heinemmann. pp. 301-313.

EMDHS, (2014). Central Statistical Agency, Addis Ababa, Ethiopia.

Family Planning Service Expansion and Technical Support (SEATS II)/John Snow, Inc,(2000). Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services: Context and Case Studies. Washington, DC: U.S. Agency for International Development.

FIELD, A., (2005). Discovering Statistics using SPSS (2nd edition). London: Sage.

Finer, L.B. and Henshaw, S.K. (2006). Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001. Perspectives on Sexual and Reproductive Health 38(2): pp.90-96.

FMOH, (2005). *National Adolescent and Youth Reproductive Health Strategy 2006-2015*.

FMOH, (2015). *National Adolescent and Youth Reproductive Health Strategy 2016-2025.*

Friars Elieen, M. Gregor William, T. and Lucile A., (1985). Distribution: The New Competitive Weapon: The Bankers Magazine, 168(3), pp 45-52.

Gibeus, P. et al., (2003). Strategy and Small Firm Performance, Scientific Analysis of Entrepreneurship and SME. January.

GREENER, S., (2008). Business Research Methods: Ventus Publishing Aps.

Hair Jr, JF. Bush RP, Ortinau DJ., (2003). Marketing Research: within a changing information environment. New York, NY: McGraw-Hill/Irwin.

Hakansson, H. and Waluszewski, A., (2005). Developing a New Understanding of Markets: Reinterpreting the 4Ps'. *Journal of Business and Industrial Marketing*, 20(3),pp 110-117.

Heather, M. Amy, D. Saseendran, P. William, S. and Taraneh, D.,(2015). What kind of Family Planning Delivery Mechanisms increase Family Planning Acceptance in developing countries? A mixed methods Systematic Review.

Henshaw, S.K., (1998). Unintended Pregnancy in the United States. Family Planning Perspectives 30(1): pp 24-46.

Hightower, D.,(1997). Conceptualizing and Measuring Servicescape's Impact on Service Encounter Outcomes. Doctoral Dissertation. Department of Marketing, Florida State University.

Ian, A. and Martha B., (2012). Reviewing the Evidence and Identifying Gaps in Family Planning Research: The Unfinished Agenda to Meet FP 2020 Goals.

India-e-FP, Improving Access to Family Planning: Is social Marketing the Answer?

Jensen & Thornton., (2003). Early Female Marriage in the Developing World.

John, R.,(2002). Contraceptive Method Choice in Developing Countries: International Family Planning Perspectives, 28(1),pp 32-40.

Kazem, A. and Van Der Heijden, B., (2006). Exporting Firms' Strategic Choices: The Case of Egyptian SMEs in the Food Industry. *SAM Advanced Management Journal*, 71(3). pp. 21-33.

Kojima, H., (1993). The Effects of Mass Media on Contraception and Fertility in African countries. Abstract of presentation at the International Population Conference August 24 - September 1, 1993, sponsored by IUSSP.

Kotler, P. Armstrong, G. Saunders, J. and Wong, B., (1999). Principles of Marketing. Second European Edition. London: Prentice Hall.

Kotler, P. and Armstrong, G., (2006). Principles of Marketing. 11th Edition. Prentice-Hall of India Private Limited. New Delhi.

Kotler, P. and Nancy, R., (2006). Social Marketing: Influencing Behaviors for Good , Fourth Edition.

Kotler, P. Keller, K.L. and Bliemel, F., (2007). Marketing Management. 12th ed. Pearson Studium – Economic BWL.

Kotler, P. and Armstrong, G., (2011). Principles of Marketing. 14th Edition. Pearson Prentice Hall

LAU, C. AND ZHANG, J., (2006). Drivers and Obstacles of Outsourcing Practices in China. International Journal of Physical Distribution and Logistics Management. vol. 36, no. 10, pp. 776-792.

Lee, C. & Griffith, D.A., (2004). The Marketing Strategy-Performance Relationship in an Export Driven Developing Economy: A Korean Illustration. International Marketing Review, 21(3).pp. 321-334.

Lovelock, C., (2001). Services Marketing: People, Technology, Strategy. 4th Edition. Pearson Education.

MacPhail,C. A. Pettifor, S. Pascoe and Rees,H., (2007). Contraceptive use and pregnancy among15-24 year old South African women: nationally representative cross-sectional survey.

Marie Stopes International Ethiopia, (2014). Exit Interview.

Nakazzi, K., (2002). Factors Influencing Utilization of Maternal Services in Uganda. (Unpublished).

Nickols, F., (2011). Strategy, Strategic Management, Strategic Planning and Strategic Thinking. Distance Consulting LLC.

Ojakaa, A.,(2008). Sexual Activity and Contraceptive use among Female Adolescents: A report from Port Harcourt, Nigeria. *African Journal of Reproductive Health*, 4(1): pp 40-41.

Owomoyela, S.K. Oyeniyi, K.O. and Ola, O.S., (2013).Investigating the Impact of Marketing Mix Elements on Consumer Loyalty: An empirical study on Nigerian Breweries Plc'. Interdisciplinary Journal of Contemporary Research in Business. 4(11), pp. 485-496.

PHELAN, C. and WREN, J., (2005-06). Exploring Reliability in Academic Assessment. UNI Office of Academic Assessment.

Population Council, Africa Operations Research and Technical Assistance Project II (Africa OR/TA Project II): Quality of Care in Family Planning Service Delivery in Kenya: Clients' and Providers' Perspectives. 1995. Nairobi, Kenya: Population Council, Africa OR/TA Project II.

Proctor, T.,(2000). Strategic Marketing: An Introduction. London: Routledge.

Schultz, V., (2007).Sexual Behavior and Practice of Family Planning in the Cambodian Uniformed Services .J. Adoles. Health. 30: pp 182-186.

Sidney Ruth Schuler,(2001). The Persistence of a Service Delivery Culture: Findings from a Qualitative Study in Bangladesh. International Family Planning Perspectives, Vol. 27, no. 4: pp. 194-200.

Sita,A. and P. Ogunjuyigbe, P., (2003). The Role of Men in Family Planning: An Examination of Men's Knowledge and Attitude to Contraceptive use among the Yorubas. African Population Studies, 18(1): pp 35-37.

Slater, F.& Olson, M., (2001). Marketing's Contribution to the Implementation of Business Strategy: An empirical Analysis. John Wiley & Sons Ltd.

Smith, G. and Saker, J., (1992). Developing Marketing Strategy in the Not-For-Profit Sector: Library Management,13(4), pp. 168-185.

Speizer, IS. Hotchkiss, DR. Magnani, RJ.,(2000). Do service providers in Tanzania unnecessarily restrict clients" access to contraceptive methods? International Family Planning Perspective, 26(1):13–20, 42.

STAT compiler: MD: MEASURE DHS. Calverton, 2009. Available at: http://www.statcompiler.com/.

Stover, J. and Heaton, L., (1995). Unmet Need in Egypt, Morocco and Jordan: What do we really know about reasons for non-use of contraception. Prepared for the ANE Bureau USAID.

Subhash, C., (1999). Marketing Planning and Strategy. 6th Edition. South Western Publisher.

The Chartered Institute of Marketing (2009). Marketing and the 7Ps: A Brief Summary of Marketing and How it Works, Maidenhead, Berkshire, UK: CIM Insights available online at [http://www.cim.co.uk/files/7ps.pdf]accessed on January 31, 2016.

Thirkell, P.C. & Dau, R., (1998). Export Performance: Success Determinants for New Zealand Manufacturing Exporters. *European Journal of Marketing*, 32(9/10), pp. 813-829.

UNFPA, (2012). Marrying too Young.

Venkatraman,C.M. et. al.,(2014). Contraception for Adolescents in low and middle income countries: needs, barriers, and success.

Varadarajan, R., (2009). Strategic Marketing and Marketing Strategy: Domain, Definition, Fundamental Issues and Foundational Premises. Academy of Marketing Science.

White, C., (2004). Strategic Management. Palgrave Mac Millan.

Whittaker, M. Mita, R. Hossain, B. Koenig, M.,(1996). Evaluating rural Bangladeshi women's perspectives of quality in family planning services: Health Care for Women International, Vol.17, 393 - 411.

WHO, (2012). From Evidence to Policy: Expanding Access to Family Planning: Improving Contraceptive Services for Adolescents.

WHO, (2014). Adolescent Pregnancy.

WHO, Orientation Program on Adolescent Health for Health Care Providers.

WHO, (2015). High Impact Practices: Improving Sexual and Reproductive Health of Young People: A Strategic Planning Guide.

Willard, Amy,(1999). Proximate Determinants of Use and Intention to Use Contraception in Women Who Would Like to Limit Childbearing in Sub-Saharan Africa: Graduate School Masters Theses 2003 - 2010.

Williams, TW.,(2000). Measuring Family Planning Service Quality Through Client Satisfaction Exit Interviews: International Family Planning Perspectives, 26(2) :pp 63-71.

Youth Friendly Services, (2002). A Manual for Service Providers. Engender Health. Zeithaml, V., (1988). Consumer Perceptions of Price, Quality, and Value: A Means-End Model and Synthesis of Evidence. *Journal of Marketing*, 52 (April): 35-48

APPENDIX I

QUESTIONNAIRE

Addis Ababa University
School of Commerce
Client Exit Questionnaire to be filled by clients of MSIE clinics in Addis Ababa

Dear Respondent,

This questionnaire has been prepared to collect raw data for a research project which shall be submitted in partial fulfilment of Masters of Art Degree in Marketing Management. The objective of the research is to examine the impact of social marketing strategies on contraceptive uptake of adolescents. The study will be conducted on all clients who have used services at Marie Stopes clinics in Addis Ababa. Any of the data (be it full or a piece) gathered through this questionnaire will be used only for academic purpose and will be kept secretly. Lastly, I would like to thank you in advance for your genuine responses and participation, given your busy day. Please do not hesitate to call or email me on any doubt on the questions included in this questionnaire. Personally, I believe that your comment will make the study output more valuable.

GETANEH ASFAW
Tell:0911225257
Email: getanehasfawabn@gmail.com

DEMOGRAPHICS		
D1 (SEX)	OBSERVE RESPONDENT'S SEX	Male .....0 Female 1
D2 (AGE)	**How old are you?** WRITE '999' IF THE RESPONDENT DOESN'T KNOW	_____ years
D3 (EDU)	**What is your highest level of education?**	None / non-formal……..…….....1 Completed primary .....2 Completed secondary, vocational or technical.....3 Some tertiary or higher .....4 Declines to answer 999
D4 (MAR)	**What is your marital status?**	Single .....1 Married .....2 Living with partner……..3 Widowed / Divorced / Separated…....4 Declines to answer.....999
D5 (CHILD)	**How many living children do you have?** WRITE '0' IF THE CLIENT HAS NO CHILDREN. WRITE '999' IF THE RESPONDENT DOESN'T KNOW.	_____ children
D6 (WOTHCHD)	**How long would you like to wait from now before the birth of (a/another) child?**	Less than 2 years……..1 More than 2 years. . . . . ..……2 After marriage . . . .……3 Don't know . . . .……..999
D7 (JOB)	**What is your occupational status?**	Unemployed/housewife/houseman……1 Employed ……..0

Product/Service			
PROD1 (SERV)	**What service did you come for today?**		
	A. Contraceptive Services…… B. Other sexual reproductive health services (SRH)..... State: _____(SRHOTH) C. Both (BOT).....	Yes No A. .....1.....0 B. .....1.....0 C. .....1.....0	
PROD2 (COUN)	**Did you receive counselling on contraceptives during your visit?**	Yes .....1 No .....0 Don't know……..999	
PROD3 (CONTR)	**Did you receive a contraceptive method during your visit?**	Yes .....1 No .....0 Don't know……..999	→ go to PROD4 → skip To PRIC1
PROD4 (CONMTD)	**What contraceptive method did you receive?** (CIRCLE ALL THAT APPLY) A. Intra-uterine system or device (IUD)..... B. Implant (IMP) ..... C. Injectable contraception (INJ) ..... D. Contraceptive pills, non-emergency (OC)...	Yes No A. ... ……...1... ……...0 B. ... ……...1... ……...0 C. .. ……...1... ……...0 D. ... ……...1.... ……...0	

Price		
PRIC1 (FEE)	**Did you pay fees for any contraceptive services you received today?**	Yes……..1 No……..0 Don't know……999
PRIC2 (FEECHO)	**Would you have used a contraceptive method of your choice if you had to pay for it?**	Yes .....1 No .....0 Don't know……..999
PRIC3 (FEEUSE)	**Does the cost of the particular contraceptive have an impact on your choice of contraceptive methods?**	Yes .....1 No .....0 Don't know……..999

Place		
PLAC1 (ANOT)	**Do you know of another provider offering Contraceptives that you could go to?**	Yes……..1 No……0 Don't know……999
PLAC2 (CLOS)	**Do you prefer clinics that are close to your residential area to use contraceptive services?**	Yes……..1 No……0 Don't know……999
PLAC3 (RENOT)	**What is the reason you did not go to that alternative provider today?**	Specify:_____ _____ _____

Promotion		
PROM1 (COM)	**Which source of information about this facility was most important to your decision to come today?**	A. Mass media like TV/Radio/Billboard.....1 B. Someone you know who has used/not used the service……2 C. Other……3 Specify _____
PROM2 (MED)	**What media did you usually use to access different services?**	A. Mass media like TV/Radio/Billboard.....1 B. Someone you know who has used/not used the service……2 C. Other……3 Specify _____
PROM3 (BMED)	**What media did you think is the best to reach you and people of your age on contraceptive services?**	A. Mass media like TV/Radio/Billboard.....1 B. Someone you know who has used/not used the service……2 C. Other……3 Specify _____

People		
PEOP1 (COMF)	**Did the provider make you feel comfortable to ask questions during the session?**	Yes .....1 No .....0 Don't know……999
PEOP2 (RMETH)	**Did you feel that you received the right contraceptive method for your needs today?**	Yes .....1 No .....0 Don't know……999
PEOP3 (NORMETH)	**Why did you not get the right method for your needs today?**	_____ _____
PEOP4 (PRAGE)	**Were you comfortable with the age of the service provider?**	Yes .....1 No .....0 Don't know……999
PEOP5 (PREAGE)	**What is your preference on the age of the service provider offering contraceptive services?**	Younger than me .....1 Similar Age .....0 Older than me……2 Don't care ……999

Process						
How would you score the service in terms of….		Very poor ←------→ Very good				
PROC1 (HRS)	**The operating hours of this facility?**	1	2	3	4	5
PROC2 (WAIT)	**The length of your waiting time to be seen after registering?**	1	2	3	4	5
PROC3 (REST)	**The friendliness and respect you received from the staff at the MSI facility?**	1	2	3	4	5
PROC4 (PRIV)	**The level of privacy during your time spent with the health care provider?**	1	2	3	4	5
PROC5 (OVERA)	**Your overall experience at the facility today?**	1	2	3	4	5

Physical Evidence		
PHEV1 (AMINFO)	**Did you feel the information given to you during your visit today was too little, too much or just about right?**	Too little……1 Too much……..2 About right……..3 Don't know…….999
PHEV2 (SIDEFF)	**Did the provider tell you about the potential side effects of the contraceptive method you received?**	Yes .....1 No .....0 Don't know……..999
PHEV3 (TECHCOUN)	**Do you prefer counselling methods on contraceptives to be using technology like mobile, i-pads, or video rather than in person to make contraceptive method of your choice?**	Yes .....1 No .....0 Don't know……..999

አዲስ አበባ ዩኒቨርስቲ
ንግድ ስራ ትምህርት ቤት
በሜሪ ስቶኘስ ኢንተርናሽናል ኢትዮጲያ ደንበኞች ድህረ አገልግሎት መረጃ ማሰባሰቢያ መጠይቅ

ጤና ይስጥልኝ
ይህ የደንበኞች ድህረ አገልግሎት መረጃ ማሠባሠብ ስራ እየተከናወነ ያለው ለገበያ አመራር ድህረ ምረቃ ትምህርት (Master of Arts in Marketing) ከፊል ማሟያነት ነው። ይህም ቃለ መጠይቅ የዚሁ ጥናት አንድ አካል ነው።

እርስዎም በዚህ ለደንበኞቻችን በምናቀርባቸው አገልግሎቶች የማሻሻል ጥረት ላይ ዛሬ በድርጅቱ ስላገኙት አገልግሎት ለምናቀርባቸው ቀጣይ ጥያቄዎች ምላሽ በመስጠት እንዲተባበሩን በአክብሮት እንጠይቃለን።

በዚህም ቃለ መጠይቅ ላይ ምን አገልግሎት ፈልገው እንደመጡ ስላገኙትም አገልግሎት እና አገልግሎቶችን ስለስጡት የድርጅቱ ስራ ባልደረባ የሚያዋዩን ሲሆን በተጨማሪም ስለእርስዎ እድሜ፤ የጋብቻ ሁኔታ እንዲሁም የትምህርት ደረጃ መረጃዎች ያካፍሉናል።

ከዚህ መጠይቅ የሚገኘው መረጃ በሚስጥራዊነት የሚያዝ ሲሆን አገልገሎቱም ለትምህርታዊ አላማ ብቻ ነው። ለሚያደርጉልኝ ትብብር በቅድሚያ አመሰግናለሁ።

ጌታነህ አስፋው
ስልክ:0911225257
ኢሜል: getanehasfawabn@gmail.com

የተጠያቂው አጠቃላይ መረጃ		
D1 (SEX)	የተጠያቂዎን/ውን ጾታ ይመልከቱ	ወንድ----------0 ሴት----------1
D2 (AGE)	እድሜዎት ስንት ነው ተጠያዋ/ው ማልሱን/እድሜዋን/ውን ካላወቀች /999/ ይጻፉ።	_____ዓመት
D3 (EDU)	ከፍተኛው የትምህርት ደረጃ ምንድን ነው?	ምንም አልተማርኩም/ መደበኛ ያልሆነ----------1 የመጀሪያ የትምህርት ደረጃ አጠናቅቄያለሁ----------2 የሁለተኛ ደረጃን የሞያን ወይም ቴክኒክና ሙያ ስልጠናን ያጠናቀቀች----------3 የተወሰነ ሶስተኛ ደረጃ ወይም ከዚያ በላይ----------4 ለመመለስ ፍቃደኛ አይደለሁም----------999
	ተጠያቂዎ የጨረሰችውን የትምህርት ደረጃ ወይም የተከታተለችውን የተወሰነ ትምህርት ይጥቀሱ። ከፊትለፊት ያለው ቁጥርም ይከበብ	
D4 (MAR)	የጋብቻ ሁኔታ እንዴት ነው?	ያላገባች/ባ_____1 ያገባች/ባ_____2 ከጓደኛዋ ጋር የምትኖር_____3 ባል የሞተባት/የተፋታች/የተለያየች_____4 ለመመለስ ፍቃደኛ አይደለሁም----------999
D5 (CHILD)	አሁን በህይወት ያሉ ስንት ልጆች አለዎት? ተጠያቂዋ ልጅ ከሌላት “0” ይጻፉ	_____ልጆች
D6 (WOTHCHD)	ከዚህ በኋላ ሌላ ለመውለድ/ለመድገም ምን ያህል ጊዜ መቆየት ይፈልጋሉ?	ከሁለት ዓመት ያነሰ ----------1 ከሁለት-ዓመታት በሁዋላ----------2 ከትዳር በሁዋላ----------3 አላውቀውም----------999
D7 (JOB)	ስራዎት ምንድን ነው በዋነኝነት የሚሰሩት ምን አይነት ስራ ነው።	ያልተቀጠረች/የቤት እመቤት/እቤት የሚውል ወንድ----------1 ስራተኛ----------

አገልግሎት (Product/Service)					
PROD1 (SERV)	ዛሬ ምን አይነት አገልግሎት ለማግኘት ነው ወደ ተቋሙ የመጡት?				
	A. የወሊድ መቆጣጠርያ B. ሌላ ጾታዊና የስነተዋልዶ ጤና አገልግሎት C. ሌላ ጠቅላላ የጤና አገልግሎት(GEN) ግለጽ_____		አዎን A. 1 B. 1 C. 1	አይደለም 0 0 0	ተጠቃሚው ጠቅላላ የጤና አገልግሎት ለማግኘት ከመጣና ይህንን አገልግሎት ካገኘ ቃለመጠይቁን እዚህ ላይ ይጨርሱ
PROD2 (COUN)	ለአገልግሎት በመጡበት ወቅት ስለ ወሊድ መቆጣጠርያ የምክር አገልግሎት አግኝተዋል?	አዎን_____1 አላገኘሁም_____0 አላውቅም_____999			
PROD3 (CONTR)	ባሁኑ በተቋሙ ቆይታዎ የወሊድ መቆጣጠርያ አገልግሎት አይነት ተጠቃሚ ሆነዋልን?	አዎን_____1 አልሆንኩም_____0 አላውቅም_____999	ከሁለቱ አንዱ መልስ ከሆነ ወደ ጥያቄ ቁጥርPROD4 ይሂዱ		
PROD4 (CONMTD)	ለ ጥያቄ ቁጥርPROD3 መልስዎ አዎን ከሆነ ከሚከተሉት የትኛውን ዘዴ ተጠቀሙ /ከአንድ በላይ ማክበብ ይቻላል/ D. (IUD) ማህጸን ውስጥ የሚቀመጥ ሉፕ E. (IMPLANT) በክንድ ቆዳ ስር የሚቀበር F. (INJ) መርፊ (ዲፖፕሮቬራ) G. የወሊድ መቆጣጠሪያ ዕንክብል	አዎን አይደለም A. 1----------0 B. 1----------0 C. 1----------0 D. 1----------0			

የአገልግሎት ክፍያ (Price)		
PRIC1 (FEE)	ዛሬ የተጠቀሙት የወሊድ መከላከያ አይነት ክፍያ ነበረው?	አዎን_____1 አይደለም_____0 አላውቅም_____999
PRIC2 (FEECHO)	ክፍያ መክፈል ቢኖርብዎ የመረጡትን አይነት የወሊድ መቆጣጠርያ አይነት ይጠቀሙ ነበር?	አዎን_____1 አይደለም_____0 አላውቅም_____999
PRIC3 (FEEUSE)	የተለያዩ የወሊድ መቆጣጠርያ አይነቶች ዋጋ መለያየት የእርስዎን የወሊድ መቆጣጠርያ ምርጫ ይወስነዋል?	አዎን_____1 አይደለም_____0 አላውቅም_____999

የአገልግሎት መስጫ ቦታ(Place)		
PLAC1 (ANOT)	የወሊድ መቆጣጠርያ ሊያገኙበት	አዎን_____1 አይደለም_____0 አላውቅም_____999
PLAC2 (CLOS)	የወሊድ መቆጣጠርያ አገልግሎትን ለማግኘት ከመኖርዎ ራቅ ያለ ክሊኒክን የመርጣሉ?	አዎን_____1 አይደለም_____0 አላውቅም_____999
PLAC3 (RENOT)	የወሊድ መቆጣጠርያ ሊያገኙበት የሚችሉ ሌላ ክሊኒክ ያልሄዱበት ምክኒያት ምንድን ነው?	ይዘርዝሩ

አገልግሎትን ማስተዋወቂያ መንገድ (Promotion)		
PROM1 (COM)	ዛሬ ወደዚህ ስመምጣት ስመወሰንም በአንደኝነት ጥሩ መረጃ ሆኖ ያገኙት የቱን ነው?	A. ቴልቪዥን/ራዲዬ _____ 1 B. ጓደኛ ነግሮኝ /ከዚህ በፊት እዚያ የተገለገለ/ያልተገለገለ_____2 C. ሌላ(ይጥቀሱ)_____3
PROM2 (MED)	ለባለፉት ሁለት ሣምንታት ምን አይነት የዜና/ ኢንፎርሜሽን ማሰራጫዎችን ይከታተሉ ነበር?	አዎን አይደለም A. ጋዜጣ ----------1 0 B. ቴሌቬገርን----------1 0 C. ሬድዬ----------1 0 D. መጋዚን----------1 0 E. ኢንተርኔት (Internet)----------1 0 F. ሌላ ሚዲይ----------1 0 G. ሚዲይ አልከታተልም----------1 0 H. መልስ ለመስጠት ፍቃደኛ አይደለሁም /መልስ የለኝም----------1 0
PROM3 (BMED)	በእርስዎ እድሜ ላለ ሰው ስለ የወሊድ መከላከያ ስማስተዋወቅ ተመራጩ መንገድ የቱ ይመስልዎታል?	A. ቴልቪዥን/ራዲዬ _____ 1 B. ጓደኛ ነግሮኝ /ከዚህ በፊት እዚያ የተገለገለ ሰው_____2 C. ሌላ(ይጥቀሱ)_____3

አገልግሎት ሰጪ ሰዎች(People)		
PEOP1 (COMF)	በተቋሙ ቆይታዎ አገልግሎት ሰጪዎ ጥያቄ እንዲጠይቁ ሁኔታዎችን አመቻችታለች?	አዎን_____1 አይደለም_____0 አላውቅም_____999

PEOP2 (RMETH)	በተቋሙ ቆይታዎ የፈለጉትን የወሊድ መቆጣጠርያ አገልግሎት አግኝቻለሁ ብለው ያስባሉ?	አዎን_____1 አይደለም_____0 አላውቅም_____999
PEOP3 (NORMETH)	ካላገኙ፤ የፈለጉትን የወሊድ መቆጣጠርያ አገልግሎት ያላገኙበት ምክኒያት ምንድን ነው?	
PEOP4 (PRAGE)	በተቋሙ ቆይታዎ በአገልግሎ	አዎን_____1 አይደለም_____0 አላውቅም_____999
PEOP5 (PREAGGE)	የወሊድ መቆጣጠርያ አገልግሎት ሰጪዋ እድሜ እንዴት ቢሆን ይመርጣሉ?	ከእኔ እድሜ ያነሰ----------1 ከእኔ ጋር ተመሳሳይእድሜ--2 ከእኔ እድሜ የሚበልጥ----- 3 ግድ የለኝም ----------999

የአገልግሎት አሰጣጥ ሂደት (Process)

በተቋሙ ውስጥ የሚሰጡ የተለያዩ አገልግሎቶችን በጣም መጥፎ፤ መጥፎ፤ ምንም የማይል፤ ጥሩ፤ ወይም በጣም ጥሩ እያሉ እንዲመድቡልን እፈልጋለሁ፡፡

- እንዴት ነው ለዚህ ተቋም የምትሰጡት ነጥብ_____ በጣም መጥፎ_____ በጣም ጥሩ

		በጣም መጥፎ ⟷ በጣም ጥሩ በጣም መጥፎ፤ መጥፎ፤ ምንም የማይል፤ ጥሩ፤ በጣም ጥሩ				
PROC1 (HRS)	ተቋሙ የሚሰራበት የስራ ሰዓት	1	2	3	4	5
PROC2 (WAIT)	ከተመዘገቡ በኋላ አገልግሎቱን ለማግኘት የጠበቁት ሰዓት	1	2	3	4	5
PROC3 (REST)	በ MSI ሰራተኞች በኩል በደረሱበት ወቅት ያገኙት መልካም አቀባበል እና አያያዝ /ክብር/	1	2	3	4	5
PROC4 (PRIV)	ከጤና አገልግሎት ሰጪው ጋር ባደረጉት ቆይታ ወቅት የነበረው የሚስጥር ጠባቂነት ሁኔታ	1	2	3	4	5
PROC5 (OVERA)	አጠቃላይ ዛሬ በተቋሙ ውስጥ የነበሮት ቆይታ/ ያገኙት አገልግሎት አጠቃለይ ምልከታ	1	2	3	4	5

(Physical Evidence)

PHEV1 (AMINFO)	በተቋሙ ቆይታዎ በአገልግሎት ሰጪዋ የሰጠችዎ መረጃን እንዴት ይገመግሙታል?	በጣም ያነሰ ----------1 በጣም የነዛ ----------2 በቂ ----------3 አላውቅም_____999
PHEV2 (SIDEFF)	በተቋሙ ቆይታዎ አገልግሎት ሰጪዋ ስለወሰዱት የወሊድ መቆጣጠርያ አይነት ጎንዮሽ ነገረችዎ?	አዎን_____1 አይደለም_____0 አላውቅም_____999
PHEV3 (TECHCOUN)	የወሊድ መቆጣጠርያ የምክር አገልግሎት ቴክኖሎጂን ሞባይል አየፓድ ወይም ቪዲዮበመጠቀም ቢሆን ፊት ለፊት ከሚደረገው የልቅ የመረጡትን የወሊድ መቆጣጠርያ ለመጠቀም ያግዛል፡፡	አዎን_____1 አይደለም_____0 አላውቅም_____999