CHARACTERISTICS INFLUENCING USAGE OF MODERN CONTRACEPTION

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Characteristics Influencing Usage of Modern Contraception

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURE

LIST OF ABBREVIATIONS

CBR - Crude Birth Rate

CPR - Contraceptive Prevalence Rate

CPS - Contraceptive Prevalence Survey

df - Degree of freedom

DMPA - Depot Medroxyprogesterone Acetate

FP - Family Planning

IMR - Infant Mortality Rate

IUD - Intrauterine Device

MC - Modern Contraception

MD - Medical Doctor

MMR - Maternal Mortality Rate

OC - Oral Contraceptive

SD - Standard Deviation

STD - Sexually Transmitted Disease

TFR - Total Fertility Rate

WFS - World Fertility Survey

WHO - World Health Organization

X^2 - Chi Square

Summary

A case control study has been conducted in Tegulet and Bulga Awraja/district, Northern Shoa Administrative Region. The purpose of the study was to assess the various characteristics influencing modern contraception usage among users as compared to never-users and dropouts from family planning clinics. A total of 848 women ages 15 - 49 were interviewed. Among these, 41.4% were users while 42.1% and 16.5% were never-users and dropouts, respectively. In addition, husbands of 150 users, 115 never users and 49 dropouts were interviewed.

Examination of the various socio-demographic and reproductive characteristics showed significant differences in most of the variables between users and never-users. Compared to never-users, users were older (mean age 27.1 years versus 25.9 years), more likely to be married (56% versus 47%) or divorced (31% versus 25%), have a higher mean educational level (grade 5.3 versus 4.8), are more likely to work outside the home for cash payment (43% versus 28%), belong to the high income class (30% versus 17%) and have more children (2 live-children or more) (72% versus 45%).

The vast majority of users (95%) scored 3 and above in modern contraception knowledge whereas only 51% of the never-users scored so high. Ninety percent of the users' husbands scored 3 and above on modern contraceptive knowledge while only 71% of never-users' scored this high. A higher approval of modern contraception and sex education to school children was seen among users' husbands (99% and 88%, respectively) as compared to never-users (77% and 74%, respectively). Husband-wife communication on family planning was significantly higher among users (41%) than never-users (15%).

Of the variables tested between users and dropouts very few significant differences were demonstrated. Current users had used modern contraception for a mean period of 23.5 months while dropouts had used it for a mean period of 17.9 months. A higher proportion of dropouts were found to be dissatisfied with the method refill interval compared to users (19% versus 10%).

Multiple regression showed that of the variables measured, the number of pregnancies a woman had had, modern contraception knowledge and age, were the main predictors of usage of modern contraception (R^2 = .13).

Desire to have more children (40%), having no husband/sexual partner (19%) and fear of adverse effects of modern contraceptives (15%) were given as the major reasons for nonuse of modern contraceptives by the never-users.

Dropouts cited the desire to have additional children (27%), becoming pregnant (21%), fear of adverse effects of modern contraceptives (21%), no method refill (12%) and husband opposition (7%) as the major reasons for discontinuation of modern contraception.

Recommendations have been given based on the outcome of the study.

INTRODUCTION

People practice family planning or contraception for various reasons. Some feel they have achieved the desired size of their family, others practice for birth spacing and to avoid unwanted pregnancies, and still others for health reasons. In addition, some people use contraception to protect themselves from sexually transmitted diseases.

Throughout the world, experts and governments agree that population growth is one of the serious issues confronting mankind at present. There is debate about the consequences of this growth on the future availability of basic necessities, such as food and drinking water, or for the preservation of the environment in terms of desertification, deforestation and soil erosion. In Ethiopia, with its marginal food supply, the population doubling time is currently about 24 years.

However, the impact of family planning goes far beyond the issues of population growth and economic development; it is an important tool to improve the health status of the population. The World Health Organization suggests that "family planning, through appropriate timing, spacing and limitation of the number of pregnancies, can promote the health and well-being of the family and also reduce the risk of ill health and death for mothers and children"(1). It would also reduce the number of illegal abortions and their health hazards.

Estimates for developing countries show that if all births were spaced at least two years apart, infant mortality could be reduced by 10% and the child death rate (ages 1 to 4) by 16%. Evidence from the World Fertility Survey shows babies born less than two years after their next older brother or sister are twice as likely to die as babies born after at least a two year interval. The older brother or sister is also more likely to die - one and a half times more likely on average - if a new infant is born within two years of the older child's birth.

Today, governments widely support access to and knowledge of family planning on the grounds of health improvement, human rights and as a demographic measure. However, data from the World Fertility Survey for developing countries indicate that, among women who wanted no more children and were exposed to the risk of pregnancy, over half were not using contraception. In several African countries, contraception is hardly used at all, and the crude birth rate, reflecting this, varies between 39 and 51 per thousand.

In 1980-81, 68% of married women of reproductive age were using contraception in developed countries, as contrasted to 38% in developing countries. Usage varied from 69% in East Asia to 11% in Africa. Even today, approximately 300 million couples who do not want more children are not using any method of family planning.

As in most of the developing countries, Ethiopia has a high infant mortality rate, 139 per 1000 live-births. Although the maternal mortality rate for the whole country is not known exactly, it has been estimated for the capital, Addis Ababa to be 5.66 per 1000 live births. The fertility rate, 47 per 1000 population, is also very high as in most of the developing countries.

Couples and individuals are unable to regulate their fertility effectively due to various factors. Lack of access to the necessary information and services is one of the major factors. Even when family planning is easily available, social, economic, cultural, and psychological factors further influence the use of existing methods of fertility regulation. Therefore, if such factors determining the practice of contraception are known in a community or country, it may help planners and health authorities to create a strategy in order to increase the service coverage by family planning, and ultimately, promote the health status of children, women, and the family as a whole.

There are very few studies done in Ethiopia regarding the practice of contraception and its determinants. Hence, little is known about factors contributing to the usage and nonusage of modern contraception among the population. This study was carried out on an urban and semiurban population of the district, Tegulet and Bulga, in the Northern Shoa Administrative Region. Besides the hospital and the health

center, two health stations/clinics run by health assistants provided a family planning service consisting mainly of contraceptive pills and condoms. However, the hospital and the health center run by nurses trained on family planning provide all types of modern contraceptive methods. The hospital, in addition, performs female and male sterilization. At all levels services are primarily clinic based (as opposed to outreach) and are free of charge except for sterilization. Users of modern contraceptive methods as estimated in a sample survey done in 1988 were 0.96% of all women ages 15-49 (2).

The study was conducted in order to identify the characteristics of women in the fertile age group, 15 through 49, and their husbands with respect to their use of modern contraception. The study looks at various possible determinants of contraceptive use such as demographic, socioeconomic, and reproductive characteristics, and the knowledge of, attitude towards, and practice of modern contraception among users, as compared to never-users and former users. Although physical access is certainly well accepted as one of the important factors determining contraceptive use, this study does not address this issue, as it was carried out in towns where family planning services are available.

OBJECTIVES OF THE STUDY

GENERAL: To determine characteristics of women and their husbands in relation to current status of modern contraception practice in Tegulet and Bulga Awraja

SPECIFIC: To determine differences between current users, never-users and dropouts of modern contraception with respect to:

1. demographic and socioeconomic characteristics
2. reproductive characteristics of women
3. women`s knowledge of modern contraception
4. women`s attitude towards modern contraception
5. husdand`s knowledge of modern contraception
6. husband`s attitude towards modern contraception.

LITERATURE REVIEW

In this chapter various issues will be dealt with as they relate to MC usage. The first section deals with health indices, (1) fertility rate, and (2) maternal, infant and child morbidities and mortalities. Following this, health issues as they relate to necessity of MC and use rate of MC are discussed. The last section reviews determinants of MC usage.

HEALTH INDICES

1. Fertility Rate

Eighty five percent of the world's births take place in developing countries. Fertility is also high in these countries compared to that of the developed countries. The Crude Birth Rate (CBR) in these countries ranges from 51.2 per 1000 population in Senegal to 28.3 per 1000 population in Sri Lanka. In contrast, it is very low for developed countries such as USA and Japan with 16 and 13 per 1000 population, respectively (3,4). The level of fertility has been high in Ethiopia and showed a rise of the CBR from 42.8 per 1000 population in 1970 to 47.6 per 1000 population in 1981. The Total Fertility Rate (TFR) rose from an average of 5.8 children per woman in 1970 to 7.5 children per woman in 1981 (5).

At the observed rate of growth, 2.97% per year, the 1985 Ethiopian population of 47.3 million will double in about 24 years. If no formal FP intervention is taken to

reduce fertility, the base population of 1985 is expected to reach 95.5 million by the year 2010 and will skyrocket about 251.2 million by 2035. However, if extensive FP is introduced, the population will reach about 90 million by 2010 and 165.3 million by the end of the projection period of 2035 (5). Hence, it is essential to formulate and implement a population policy consistent with the long term objectives of the country.

2. Maternal, Infant, and Child Morbidity and Mortality

The same developing countries with high levels of fertility suffer 95% of the world`s infant deaths and 99% of all maternal deaths (3). The World Health Organization (WHO) has estimated that at least 500,000 women die each year as a result of pregnancy and childbirth (6,7). WHO calculates that, in certain developing countries, each time a woman becomes pregnant, she runs a 200 times greater risk of dying than if she had lived in a developed country (3). Consequently, the Maternal Mortality Rate (MMR) for Africa is over 436 deaths per 100,000 live births, whereas in developed countries like the U.S.A. it is 9 deaths per 100,000 live births (8). Kwast and her colleagues in their community based study in Addis Ababa have found an MMR of 566 deaths per 100,000 lives births (9). Moreover, Yoseph and Kifle in their review of maternal deaths in a teaching hospital in Addis Ababa, and Tekalegne in his community study in Addis Ababa showed an MMR of 960 and 700-900 deaths per 100,000 live births, respectively (10,11).

In addition to those who die, many women suffer from serious illnesses related to pregnancy, abortion, or childbirth. A survey done in India between 1974 and 1979 showed that, for each maternal death, there were 16.5 illnesses related to pregnancy, childbirth and the puerperium (12).

HEALTH BENEFITS OF CONTRACEPTIVE USE

Changes that might take place in reproductive behaviour in response to FP include less frequent higher order births, longer birth intervals, lower births below the age of 20 and after 35, and declining fertility due to increased contraceptive use (6,13).

Eliminating all births from women under 20 and over 35 years of age would result in prevention of 30% of births and over half of maternal deaths (6,12). Eliminating all births at parities above five would reduce the number of maternal deaths by 26%. This would result in the prevention of 14% of all births. Eliminating both groups at risk (high and low age and high parity) reduces the number of deaths by 56%. This will also prevent 43% of all births (6,13,14). The Nigerian data by Zaria has shown that if no other change in the birth rate or age specific fertility rate occurs, if no births occurred to women under age 15 or over age 30 and over parity 5, and all pregnancies received antenatal care, about 90% of maternal mortality would be eliminated (6).

In an analysis of the World Fertility Survey (WFS) data from 25 developing countries, spacing of births at least 24 months apart would alone lower infant death rates by 10% and death rates among children aged 1-4 by 16% (3,12). Trussel and Pebley, using data from Matlab, Bangladesh, estimated a median reduction in infant and child mortality of 24% and 13%, respectively, if all births were spaced at least 2 years apart (15).

High levels of induced abortion in much of the world also demonstrate women`s desire to avoid pregnancy. MC can reduce the number of abortions by offering women an alternative way to control their fertility. In Chile, for example, between 1964 and 1978 contraceptive use by women aged 15-44 increased from 3.2% to 23%. At the same time, the number of hospitalizations due to complications of illegal abortions fell by one-third with no change in abortion laws. The rate of maternal mortality due to abortion declined from 118 deaths per 100,000 livebirths to 42 deaths per 100,000 livebirths (12).

Some contraceptive methods provide benefits beyond the control of fertility. Condoms and spermicides prevent the spread of venereal disease. Oral Contraceptives (OC) reduce some menstrual problems and help to protect against pelvic inflammatory disease, cancer of the uterine lining, cancer of the ovaries, and anemias (12). But long term complications of continuous use of OC pills cannot be ruled out.

In summary, increased contraceptive use is likely to result in lower maternal, infant, and child mortality because of a reduction in the number of deaths per number of births (13). Both the number of childern born to a woman and the interval between birth and conception can be planned by MC use. Thus, the provision of FP programmes has the potential for a large impact on health indices. However, use in most of the developing world is not widespread for many reasons.

CONTRACEPTIVE PREVALENCES

Difference in contraceptive use among countries and regions are striking. According to the WFS data, current use of family planning ranges from less than 1% of married women of childbearing age in Mauritania to 66% in Costa Rica. Among developed countries who participated in the WFS, Contraceptive Prevalence Rate (CPR) among women of reproductive age ranged from 51% in Spain to 85% in Belgium. In about three-fourths of African countries, the CPR was below 20% (3,4,16). In 1987, it was reported that 2% of married women of childbearing age in Ethiopia were using contraception (3). In two city studies in Ethiopia, Gondar in 1981 and Addis Ababa in 1988, a CPR of 17% was reported among women 15-49 years of age (11,17). These figures are quite high when compared to that of the country as a whole (3).

Data from the WFS for developing countries indicate that among women who wanted no more children and were

exposed to the risk of pregnancy, over half were not using contraception (18).

In over 80% of the countries participated in the WFS, about half of all users chose oral contraceptives (OC), voluntary female sterilization, or intrauterine device (IUD). These methods were especially prevalent in Latin America and the Caribbean, where they were used by more than 70% of clients. Worldwide, OC was the most widely used method in the majority of developing countries surveyed. Male sterilization was widely favoured only in Nepal (67% of users); and female sterilization was frequently the method of choice in Fiji, Sri Lanka and the Dominican Republic. Coitus Interruptus was the predominant method in Lesotho, Haiti and the Philippines (4,16). Among the urban Nigerian new acceptors, pills were the most popular method (69%), followed by injectable methods, 18% (19). In Addis Ababa OC was by far the preferred method (64% of users), followed by the IUD, 19% (11).

Among Zambian MC acceptors, one year after enrollment only 24% of the female acceptors were still attending the clinic. The percentage of clients active at the end of the year ranged from zero to 40% in the different clinics (20). In contrast, a high continuation rate was observed among the Nigerian acceptors. About 80% and 88% of 1978 and 1979 acceptors, respectively, were still attending the FP clinic in 1980 (19).

Women who discontinued modern FP in Bangkok, Thailand, mentioned side effects of methods as the main reason for contraceptive discontinuation (49%, 67% and 49% for pill, DMPA and IUD, respectively). Other important reasons mentioned were wanting another child and personal reasons (21). Grubb, in his study in eight developing countries pointed out that 20% to 60% of users had stopped taking OC because they were worried about its safety, and a lower or similar percentage of nonusers, for each sample, said they had not taken the pill for this reason (22). Therefore, misinformation about the pill's safety lead to discontinuation of use to at least as great an extent as it prevents initial acceptance of the pill.

DETERMINANTS OF CONTRACEPTIVE USE

The factors that may affect use of modern methods of contraceptives which have been studied may be broadly grouped into six categories. These are:

1. Health service determinants
2. Socioeconomic factors
3. Demographic factors
4. Reproductive factors
5. Knowledge of modern contraception
6. Attitudes towards modern contraception

1. Health Service Factors

In the area of health service, the time spent to travel from the potential user to the clinic or FP center has been shown to be important. Cornelius and Novak demonstrated in five developing countries the effect of time to source upon

use of modern contraception. In rural areas of Colombia, only one-half as many Colombian women who must travel more than one hour to a pill source are currently using MC when compared to the group closest to a source (1-15 minutes walk). In Honduras, only one-quarter as many of the group farthest removed from a source are using contraception, compared with the groups closest to a source. In both countries, the accessibility variable, time to source, is strongly associated with the use/nonuse of the pill (23). Furthermore, the WFS showed a contraceptive use of 5-10% higher among women who knew of an outlet less than half an hour from their place of abode compared to those who did not know of a place that close (4).

In the Bangkok, Thailand, study by Chumnijarakij and colleagues, clinic discontinuation because of inconvenience due to distance was very high; 36% for pill acceptors, 25% for injectable DMPA acceptors and 10% for IUD acceptors (21). Discourteous treatment given by medical personnel and limited office hours as barriers to modern contraception practice are cited in a Peruvian study (24). Furthermore, Nichols and colleagues reported turning away of clients at the initial contact to FP services due to unavailability of methods (one in every five women). This may result in the individuals inability or decision not to return for a subsequent clinic visit, or possibly an unwanted pregnancy occurring before a modern method has been adopted (25). A considerable expenditure of time, other things being equal, would tend to discourage regular users.

The unavailability of FP services to certain groups of women has created a barrier to use of modern contraception. For example, in Ghana, the FP is directed solely to married women and in Tanzania physicians are not allowed to prescribe contraceptives for unmarried individuals (26).

2. Socioeconomic Factors

There is some evidence that women who have been employed outside their home are more likely to use contraception than other women, (4,16,17,24). A study conducted in a Peruvian highland community revealed that more women who use modern contraceptives work full time than the nonusers (93% versus 58%) (24). In an urban Nigerian study traders represent the vast majority of acceptors, 97% (19). In Addis Ababa, Ethiopia, government employees and employees of aid organizations comprised the majority of modern contraception users, 33% and 27%, respectively (11).

Couples using modern contraceptives are better off financially and they have more modern commodities like televisions, record players, refrigerators, etc. than nonusers and users of traditional or natural methods (24,27). Studies in Peru, Bas Zaire, Egypt, and Addis Ababa and Gondar in Ethiopia, showed a positive relationship of economic status with use of a modern method of contraception (11,17,24,27,28). In Addis Ababa, the use among the groups with monthly income of above 200 birr was 25% compared to 14% when income was less than 200 birr (11).

Ecological studies have shown that education of the women is strongly associated with the use of modern contraception in the WFS countries. Among WFS countries in Africa, Asia and Latin America, the higher the level of education, the larger the proportion of users of contraception (4). Similarly in Lusaka, Zambia, in every age group, the acceptors were considerably better educated than Lusaka women in general (20). In Addis Ababa, higher use (on average 22%) was found among those with an educational level above grade 4 compared to those with grade 3 or below (on average a CPR of 7%) (11).

Moreover, when the husband is well educated, the couple is more likely to use contraception, regardless of the wife`s level of education (4,16).

3. Demographic Factors

Modern contraception is practiced more by women in the middle reproductive years than by older or younger women. The WFS data showed that the level of current use reached a peak in the age groups of 30 to 39 in Asian countries and somewhat earlier in the Latin American and African countries, at ages 25 to 34 and 20 to 34, respectively (4,16).

Three-fourths of urban Nigerian acceptors were between the ages of 30 and 39 (19). However, in Zambia nearly half (46%) of the female contraceptive acceptors in 1984 were in the 20-24 years of age group (20) and in Zimbabwe in 1985, 55% of the acceptors were under age of 25 and about three

fourths (76%) under the age of 30 years (29). Moreover, the CPR is highest (72%) in women aged 20-34 years in the Addis Ababa study by Tekalegne (11). In general,it is least common among the youngest women, gradually increasing and peaking during the mid to late childbearing years, then dropping off among the oldest women.

The percentage of modern contraception practice varies according to the marital status of women. In Lusaka, Zambia, a high proportion of contraceptive acceptors, 83-93% in every age group reported that they were married (20). Similarly, in Zimbabwe over 84% of the acceptors and 61% of Nigerian post-secondary students reported themselves to be currently married (29,30).

According to the WFS data, nearly in every country urban women were more likely to use modern contraception than rural women (4,16). The CPR among currently married urban women is 30% in Botswana, 19% in Kenya and 39% in Zimbabwe in contrast to 15% in Botswana, 8% in Kenya and 20% in Zimbabwe for rural dwellers (31). Similarly in the Sudan, 16% of urban women and only 3% of rural women use modern methods of FP (32).

In some studies, no difference in religion is noted concerning modern contraception (11,28). Zein, in his study in north-western Ethiopia, reported Muslims being the majority of nonusers whereas they were in the minority in the general population (17).

4. Reproductive Factors

The number of living children also appears to influence contraceptive use. According to studies based on the WFS data, in many of the study countries, women who had no children living tended not to practice contraception (4,16). From zero to low levels of use prior to the first birth, the percentage of users increased markedly, tending to reach a peak in some countries when there were three or four children and tapering off thereafter (4,16,19,28,31). In Kenya, however, the rate continues to rise as the number of living children increases (31). In some Latin American countries, however, the level of use among married childless women was in excess of 30%, indicating that in that region contraception was used to postpone the first birth (4). It is cited that, where the use of contraception is widespread, it is intended for spacing as well as for the limitation of births. Significantly, in countries where the overall level of use is particularly low, the level of use rises with the number of living children (4,11).

In the Peruvian study by Tucker, users of modern contraception had a slightly lower mean number of births than nonusers, 5 and 5.5 live-births, respectively (24). In contrast, the Indian study showed a higher number of children among modern contraception users compared to nonusers, 3.6 and 2.2 children, respectively (33).

Statistical analysis of returns for 25 WFS countries in all developing regions, demonstrated that the experience of the death of a child reduced the propensity of couples to use contraception. In 23 out of 25 cases women who had had a child die were not using a method. In Jamaica, child death reduced usage by 9.4% (4).

5. Awareness of Modern Contraception and Sources of Methods

Awareness of contraception varies markedly among countries. The WFS conducted between 1972 and 1984 and Contraceptive Prevalence Surveys (CPS) conducted from 1970-1985 have revealed that of the developing countries, knowledge was most widespread in Latin America and the Caribbean. Among currently married women of reproductive age in 25 countries, awareness of at least one method of contraception knowledge averaged 90%, ranging from 23% in Nepal to 100% in Fiji and Costa Rica (4,16).

In the African countries women who were aware of any modern methods in Africa ranged from 20% in Nigeria to 89% in Kenya (4,16,23,24,31,34,35). In 1986, 65% of the women in the reproductive age in Gondar, Ethiopia were aware of the existence of modern contraceptive methods (17). A somewhat lower figure of 49% was found in Addis Ababa (11). Similarly, Okubagzhi noted a contraception awareness of 43% in 1988 among women who had delivered within a previous year in two townships and a satellite village of Gondar Region, Ethiopia (36).

The awareness of contraception methods in general is found to be higher in urban than in rural women (32). However, knowledge of traditional methods of FP is very high among rural women in Bas Zaire (28).

Women`s age is not closely linked with knowledge of contraception in most countries. However, the very youngest and the very oldest women were least knowledgeable in many countries. This is true also for women with no children or many children, compared to women with a few, say 3 or 4 (4,11,16,37).

According to the WFS data, knowledge is most prevalent among urban, the better educated, and the women who are gainfully employed away from the home (14,15,16,37). In Nepal, awareness of contraception was more than twice as high among women with primary education as among those with no education, 94% versus 43% (4). In Addis Ababa, there is a higher level of knowledge and desire for knowledge of contraception among women with a higher level of education (11).

Worldwide, oral contraceptives were the most widely known method (4,11,38). Among male Sudanese, the pill is widely known (88%) (32). Pills and condoms are equally well known among male Liberian adolescents and Nigerian postsecondary female students (30,38). Sterilization is well known in India (35). In Gondar, Ethiopia, almost half of the women mentioned the pill as the method they knew, followed by tubal ligation (17).

Awareness of a source of MC also varies across countries. In Costa Rica and Thailand, knowledge about a contraceptive source is nearly universal with 99% of married women 15-44 years old knowing at least one source of supply (23). In Zimbabwe and Kenya where 90% and 80% of female respondents knew a method, only 71% and 48%, respectively, knew a supply source (31). Lowest figures were reported from Somalia where 1-7% of women knew a source (16).

6. Attitudes Towards Family Planning

The reasons given for FP include spacing births, prevention of unwanted pregnancies and limiting population. According to the WFS data, in Africa, spacing children was the most important reason for using family planning, while in Asia ending childbearing was the predominant reason. The percentage of Africa contraceptive users who were spacing, rather than limiting births ranged from 59% in Lesotho to 90% in Nigeria and 89% in Zimbabwe (16,29). In Zimbabwe, women were motivated to initiate contraception because of a desire to stop childbearing were in the majority only among 40 years and older. At younger ages, a substantial majority began contraceptive use with the intention of spacing their births (29).

In general, approval of family planning is very high among different countries (30,31,33,37). At the national level in India, 81% of the currently married couples approve of the use of modern contraceptives (33). Similarly, in

urban Ilorin, Nigeria, among currently married women aged 15-35 years, over 90% accept the need for FP (37). In Addis Ababa, Ethiopia, 53% of respondents had a positive attitude towards MC (11).

Approval of FP among males varied from country to country but with the exception of predominantly Muslim countries (32) is high in Africa (24). In Addis Ababa, Ethiopia, 80% of the males approved (11).

A negative male attitude towards family planning acts as a powerful barrier to use of MC. The husband`s opposition to contraceptives accounted for 32% of the reasons for nonuse among Senegalese women (25). In Ethiopia, for example, until 1982 the Ethiopian Family Guidance Association required the husband`s signed consent in order to provide contraceptives to his wife. As a result, 16% of the women who requested contraceptives were turned away for lack of spousal permission. Later, removal of the spousal permission requirement increased clinic utilization by 26% within a few months (39).

Objections to FP methods are varied. Among the Nigerian women in Ilorin, 25% cited health reasons and 22% gave moral or religious reasons for nonuse (37). On the other hand, 56% of the Hausa women in Nigeria considered the practice of MC equivalent to murder (15). Other reasons, such as fear of sterility and fear of side effects are also reported to be obstacles to practice modern family planning (22,27,30,40,41,42).

STUDY DESIGN AND METHODS

STUDY DESIGN

The study, conducted to determine the characteristics influencing usage of modern contraception, is a case referent/control study. Current users of modern contraception (MC) methods are considered here to be cases. Two other group of women are taken to be referents or controls for the cases. These are dropouts from family planning (FP) clinics and never-users of MC. In each study group, spouses of married women were included in the study

SUBJECTS

Source Population

Family planning clinics are available in only four towns in the awraja. In addition, private drug vendors and a public pharmacy distribute MC methods, condoms and oral contraceptives in the same towns where FP service is available, and in no others. The population of these four towns where the service is available were the source for the study population.

The inclusion criterion was a woman 15-49 years of age. The exclusion criteria were:

- modern contraception current user or dropout who is not available in the study area during the study period, or
- any illness of interviewee preventing the interview from proceeding, or

- a woman who does not fit the definition of modern contraceptive current user, dropout, or never user (definition will follow).

Study Population

The study population comprises three categories of people. The first category includes is women in the fertile age group of 15-49 years and their husbands who are currently using modern methods of contraception or family planning, hereafter called users. The second group is composed of women in the fertile age group of 15-49 and their husbands who have used modern methods of contraception or family planning in the past for at least two months but are not using it during the study period, hereafter called dropouts. The third group is women in the fertile age group of 15-49 and their husbands who have never used or have used methods of modern contraceptives or family planning for only one month or less, hereafter called never-users.

The former two groups of women were identified with their respective addresses from charts of FP clinics of the Ministry of Health in the awraja. Never-users were selected by finding any woman in the age group of 15-49 in the third house to the right of the case. Thus, women were not matched for age except within the broad age range of 15-49 years. If there was no such woman in that house, the households to the right of that were visited sequentially until a woman in the age group of 15-49 was found. As was

mentioned previously, the current users of FP were cases in the study, whereas, the dropouts and never-users were referents/controls.

However, at times some women originally thought to be dropouts or never-users were found to be current users and/or dropouts of modern contraception/family planning methods, respectively, when the interview was begun. In such cases, the women were classified according to their actual present status, and interviewed accordingly.

Selection Hierarchy

It is estimated that there were a total of 137,658 women 15-49 years of age in the whole awraja. Among these, 7,590 women, aged 15-49 live in the four towns where the family planning clinics are available. The selection hierarchy for the study population is summarized in figure 1.

MEASUREMENT

Outcome

The principal outcome is each woman`s current status of modern contraception usage. Thus, the outcomes are:

(i) current users of MC

(ii) dropouts (defaulters) of MC

(iii) never-users of MC

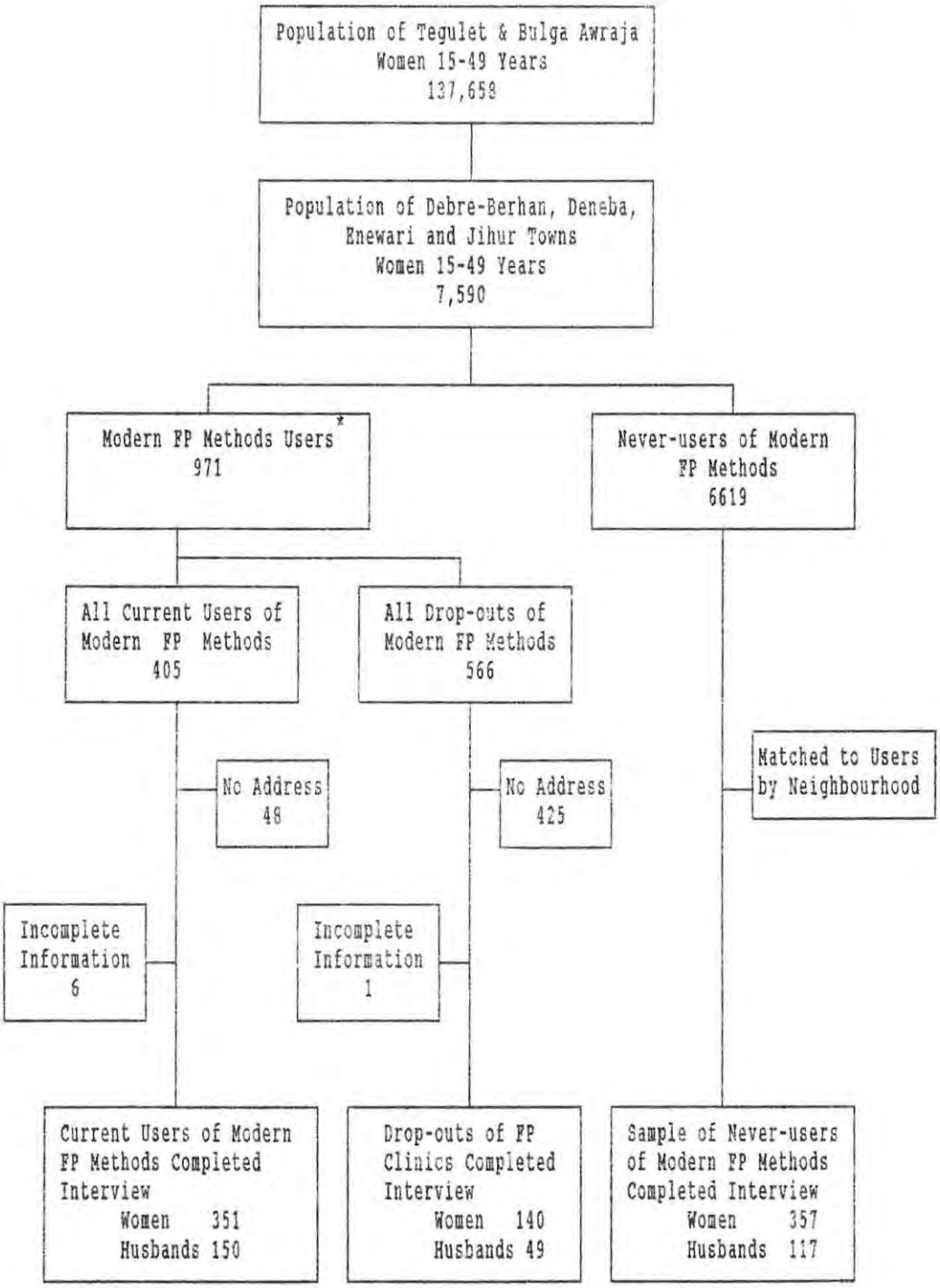

Figure 1: Sampling Design and Selection Hierarchy

*Identified from Clinic Charts and Interviews.

To classify a woman in one of the three groups, she was asked whether she is currently using a modern contraceptive or not. If she was not using, then she would be asked further whether she has used it for two months or more in the past. Thus, if she is using an MC method currently, she would be classified as a current user, if she has used family planning for two or more months in the past as a dropout; if used for one month only or not all as a never-user.

Determinants

Various characteristics of women and their husbands (whenever available) which might have a determining effect on contraceptive use were assessed during an interview using a structured questionnaire. They are classified into four groups, each consisting of a number of different variables.

(i) demographic characteristics which were age, residence, marital status, ethnicity, and religion;

(ii) socioeconomic characteristics which were educational level, income, and occupation;

(iii) reproductive history which were age reported at first pregnancy, parity, number of live births, and number of living children;

iv) knowledge and attitude regarding FP which were reason for current status of modern contraceptive usage, attitude towards FP, knowledge of type and advantages of modern contraception, and source of information about MC.

To measure these variables, a questionnaire was prepared by the principal investigator. This questionnaire had different sections of questions corresponding to the above outcome and determinant variables. Furthermore, it had a separate format for the three study groups and a corresponding questionnaire for husbands of each group. The questionnaire was prepared in English and translated into Amharic since the study areas were predominantly Amharic speaking. The questionnaire was pretested and modified wherever necessary.

Each female respondent was expected to answer 30 to 35 questions depending on the group she belonged to and based on answers that she had given to certain questions. Each male spouse was expected to answer 7 to 10 questions. The English version of the questionnaire is attached as an appendix.

DATA COLLECTION AND MANAGEMENT

Interviewers Training and Pretest

Thirteen health assistants, 9 males and 4 females, were chosen from the awraja health institutions to conduct the interview. These health assistants were chosen to be the interviewers in the belief that the respondent would feel more at ease giving sensitive and private information than to non-health personnel interviewers.

The interviewers were trained for one week regarding the study, by the principal investigator. They were briefed on the objectives and importance of the study and trained on

the content of each question of the questionnaire. They were also trained on interviewing techniques. They were oriented to the importance of privacy during an interview and confidentiality of the collected information.

In addition, an interviewer's manual was prepared in English by the principal investigator describing the duties and responsibilities of an interviewer. This was discussed and agreed upon by the investigator and interviewers.

After training the interviewers, a pretest was conducted in a pre-selected town where no family planning service was available. The pretest was conducted by the trained interviewers under the supervision of the principal investigator.

Based on the pretest, certain questions were rephrased in order to make them clearer to both the interviewer and interviewee. In addition, strategies were devised to follow-up missed respondents. Discussions were held concerning the correct reporting/filling of answers and cross-checking certain answers.

Data Collection

Before the actual collection of data was started the principal investigator discussed the objectives and purpose of the study with the city-council of Debre-Berhan town and the awraja administrator. Following these discussions, the awraja administrator wrote an official letter to the woreda administrators of the three study areas outside of

Debre-Berhan and the mayor of the city-council wrote to the nine kebeles of the town. The latters mentioned the objectives of the study and emphasized the need to collaborate with the research team.

After this, the principal investigator contacted the different officials of the kebeles and woredas and arranged a minimum of three guides for each of the kebles and woreda towns. These were in order to locate the houses of the current users` and dropouts` as required by the research team. Thus, one guide was assigned for three or four interviewers.

The actual data collection for the study started on October 27, 1988 at one of the kebeles of Debre-Berhan town. All interviewers collected data in the same kebele and when a kebele was completed, moved to the next. After covering the nine kebeles of Debre-Berhan town, the interviewers were divided into three groups and transported to the three woreda towns, namely, Denaba, Enewari and Jihur, to proceed with the data collection. After completion of the three towns, interviewers again returned to Debre-Berhan to follow up on respondents missed previously. Overall, the data collection lasted 27 days.

Quality Control

For the first four days of the data collection process, the principal investigator worked closely with the interviewers. At the end of each data collection day, the completed questionnaires were handed to the principal

investigator and were reviewed for errors and missing information. Based on this, timely corrections were made during discussions held in the mornings before the day`s work began and whenever necessary, interviewers went back to the respective respondent to correct the error or deficiency.

After this initial phase of data collection, interviewers handed over completed questionnaire at the end of each day to the principal investigator. Supervision in the field was also conducted every other day and additionally whenever necessary.

Finally, a total of 855 questionnaire were collected from the four study areas. Out of these, seven questionnaire were discarded due to the fact that they were lacking a page or more of information. Thus, 848 questionnaire were accepted for analysis.

Data Coding and Analysis

After all information was collected, the data were coded on a pre-arranged coding sheet. Three high school teachers and three general medical practitioners (MD`s) were hired to code data in addition to the principal investigator. The coding was done according to a coding manual prepared by the principal investigator.

The data were analyzed using an SPSS PC + V.20 computer programme. First, frequencies of the different variables were determined followed by cross-tabulation and chi square tests of selected variables with respect to the three main study groups (current users, never-users and dropouts). Odds ratios, and t-test were computed for the relationship selected variables and means, respectively. When odds ratios were calculated, each category was compared to the combination of all other categories of that variable. Multiple regression was carried out to assess the relative contribution of variables to the outcome.

R E S U L T S

GENERAL DESCRIPTIVES

Out of the total 848 women who completed the interview, 351 (41.4%) were currently using modern contraception, 140 (16.5%) were past users (dropouts) of modern contraception and the remaining 357 (42.1%) were never-users of modern contraception.

Sociodemographic Characteristics of Female Respondents

Table 1 summarizes the study population by selected sociodemographic characteristics. The interviewees ranged from 15 to 45 years. The mean age was 26.7 years with a standard deviation of ±6.3 years. Of the 848 female respondents 78.8% (668) were from Debre Berhan town while the rest 21.1% were from towns outside Debre Berhan.

Table 1.
The Study Population by Sociodemographic Characteristics.

Variables	No	%	Variables	No	%
Age			Education		
15-19 years	110	13.0	Illiterates	87	10.3
20-24 "	224	26.4	Completed grade 1-3	299	35.3
25-29 "	231	27.2	" " 4-6	176	20.8
30-34 "	160	18.9	" " 7-8	82	9.7
35 years and over	123	14.5	" " 9-11	102	12.0
			" " 12&over	101	11.9
			Unknown	1	0.1
Residence			Job		
Debre Berhan Enewari }	668	78.8	Home makers	329	38.8
Jihur } Deneba }	179	21.1	Bar tenders	140	16.5
Unknown	1	0.1	Government employees	105	12.4
			Students	81	9.6
Ethnicity			Jobless	79	9.3
Amhara	762	89.9	Vendors	70	8.3
Others	86	10.1	Others	44	5.2
			Monthly family income (Birr)		
Religion			Less than 50	388	45.8
Orthodox Christian	824	97.2	50-149	252	29.7
Others	24	2.8	50-299	126	14.9
Marital status			300 and over	74	8.7
Married	425	50.1	Unknown	8	0.9
Divorced	224	26.4			
Single (never-married)	170	20.0			
Widowed	29	3.4			

The majority of respondents were Amharas (89.9%). The rest 10.1% were of minorities like Oromos, Tigres and Gurages. Almost all (97.2%) of the women were Orthodox Christians while Protestant and Catholic Christians and Muslims constituted a small proportion, 2.8%, of the study population. Half of the women were currently in marriage union (50.1%) while single (never-married) women and divorced women comprised 20.1% and 26.5%, respectively, of the total respondents. Widowed women were 3.4% of the study population.

Overall 10.3% (87)of the women were illiterate while the majority, 89.6% (760), of the women had attained various levels of education (see table 1). Home makers comprised the largest proportion of women by job status (38.8%). Among women who work outside their home bar tenders made 16.5% of the total respondents followed by government employees, 12.4%. Students and vendors comprised 9.6% and 8.3%, respectively.

Almost one-half of the women (45.8%) had a monthly family income of less than 50 birr (see table 1). Women whose family income was 300 birr and over were only 8.7% of the total.

Reproductive Characteristics

1. Age at Marriage. It was found that women married for the first time as early as when they were 5 years old and as late as 27 years of age. In this society whenever marriage occurs among young children it is not normally

consummated until adolescence. Overall, a total of 692 women reported that they had ever been married. The mean age at marriage for this population was found to be 15.7 years. Of the ever-married women, 26.3% (223) married before the age of 15 years and 46.7% (396) married between the ages of 15 to 19 years. The remaining 27% (229) married at the age of 20 and over.

2. Pregnancy. The mean number of pregnancies experienced by a woman in the study group was 3.0. The distribution of the study population by the total number of pregnancies they had is shown in table 2. As shown, 118 (13.9%) women reported that they had never been pregnant at the time of the interview. About one-half of them (49%) had been pregnant 1 to 3 times while 22.8% had been pregnant 4 to 5 times and 14.4% 6 times and over. The maximum number of pregnancies reported by a single woman was 15.

The mean number of pregnancies experienced before marriage was 0.2 pregnancies for the entire population. Users of and dropouts from MC services had a mean number of 0.3 pregnancies prior to marriage while never users of modern contraception had a mean number of 0.2 pregnancies before marriage. The maximum number of premarital pregnancies observed was 6 while the minimum was zero.

3. Live-births. Only one woman reported to have had 13 live births which is the maximum figure for the entire study population. Some 130 (15.3%) women reported no live-births. Twelve percent (102) of the women had 6 and more live-births (see table 2). The mean number of live-births for the entire study population was 2.8.

Table 2.
Distribution of the Study Population by Selected Reproductive and Contraception Variables.

Variables	No.	%	Variables	No.	%
Number of pregancies			Everusers of MC by age* at first MC usage		
0	118	13.9	13 - 19 years	120	24.4
1	138	16.3	20 - 24 "	162	33.0
2	145	17.1	25 - 29 "	131	26.7
3	132	15.6	30 years and over	78	15.9
4	106	12.5			
5	87	10.3	Ever users of MC by reason for initiation* MC usage		
6 and over	122	14.4			
Number of livebirth					
0	130	15.3			
1	159	18.8	Prevention of unwanted pregnancy	240	48.9
2	148	17.5	Birth spacing	238	48.5
3	127	15.0	Others**	13	2.6
4	103	12.1			
5	79	9.3			
6 and over	102	12.0			
Number of livechildren					
0	153	18.0			
1	172	20.3			
2	160	18.9			
3	140	16.5			
4	106	12.5			
5	55	6.5			
6 and over	62	7.3			

*Ever users of MC were 491.

**Medication, prevention of STD .

4. Live-children. The mean number of live children per woman was 2.4. At the time of the interview, one woman possessed 11 live-children which is the highest figure for the study population. Twelve percent of the women reported 6 live-children or more and 15.3% of the study women had no live-children (see table 2).

5. Age at first pregnancy. Of the 730 women who had ever been pregnant, 728 women reported their age at the time of their first pregnancy. The ages vary from as early as 11 years of age to age 32 with a mean age of 17.8 years for the ever-pregnant women. In general, 8.1% (59) of these women had been pregnant for the first time when they were within the age group of 11 to 14 years. The majority of them became pregnant when they were 15 to 19 years of age (69.1%) while only 22.8% were for the first time pregnant when their age was 20 years or over.

6. Age at first sexual contact. Women in the study population reported having sexual intercourse as early as at 11 years of age and as late as 32 years of age. Out of the 837 women who responded positively to this variable almost one-third (31.8%) of them started sexual relations during the ages of 11 to 14 years; 61.4% started sexual relations at the ages of 15 to 19 while only 6.8% started after the age of 20. The mean age at first sexual intercourse for the study population in this segment was 15.6 years, excluding virgins.

Contraception Characteristics

1. Age at and reason for first modern contraception usage. Table 2 shows ever users of modern contraception by age at the first time of MC practice and the reason why they used it at that age. The mean age for all ever users of MC was 24.0 years. Overall, roughly one-half of the ever users of MC started use for prevention of unwanted pregnancy (i.e., to stop childbearing or to prevent extramarital pregnancy) and about one-half for child-spacing (to delay the next pregnancy).

2. Type of modern contraceptive method used. The vast majority (94.5%) of the ever users used OC the first time they used modern contraception. IUD, condom, spermicide, and irreversible methods were tried by the rest of the ever users (5.5%). On average ever users of MC used MC methods for 26.2 months.

3. Reason for current modern contraception use and nonuse. Out of the 351 current users of MC 53% were using MC to prevent unwanted pregnancy (to stop childbearing and prevent extramarital pregnancy) while 46% were using it for birth-spacing. Only 1% were using MC for prevention of sexually transmitted diseases (STD) and as medication. On the other hand, various reasons have been given by dropouts and never users of MC for not practicing MC at the time of the interview. It is shown in table 3 that desire to have more children was the major reason by both groups for non-use. Being pregnant and breast-feeding and fear of side

Table 3.

Reasons for Nonuse of Modern Contraception by Dropouts and never-users of Modern Contraception Services.

Reasons	Dropouts		Never Users		Row Total	
	No.	%	No.	%	No.	%
Desire more children	37	27.21	142	39.78	179	36.3
Being pregnant or lactating	28	20.59	30	8.40	58	11.8
Fear of side-effects or infertility	28	20.59	54	15.13	82	16.6
No sexual partner	12	8.82	67	18.77	79	16.0
No refill or method	16	11.76	4	1.12	20	4.1
Husband disapproval	10	7.35	10	2.80	20	4.1
Being sick	5	3.68	24	6.72	29	5.9
Do not have knowledge of MC	-	-	13	3.64	13	2.6
Use traditional methods	-	-	8	2.24	8	1.6
Against religion or culture	-	-	5	1.40	5	1.0
Column Total	136*	100.00	357	100.00	493	100.0

*4 women did not respond to the question.

effects and infertility as a consequence of MC methods were the next most frequent reasons for discontinuation among the dropouts. Having no sexual partner at the time of the interview and fear of side effects and infertility due to methods of MC were the next most common reasons for nonuse among the never users of MC.

5. Method refill or replacement interval and interval satisfaction. Among the ever users of MC, the vast majority (98%) collected contraceptives monthly while only a few collected it every couple of months or more. 12.4%, (61) of the ever-users of MC were unsatisfied with the interval while the majority (87.6%) were satisfied with their refill/replacement interval of contraceptive methods.

BIVARIATE ANALYSIS

Users Versus Never-users of Modern Contraception

X^2 and t-tests were used to compare frequencies and means, respectively. Between MC users and never-users the following items showed statistically significant differences:

1. sociodemographic characteristics with the exception of ethnicity,
2. reproductive characteristics,
3. MC knowledge,
4. source of information about MC,
5. women`s sex education approval, and
6. husbands' characteristics.

The following two items showed no statistically significant differences:

1. ethnicity, and
2. age when received information about MC for the first time.

A difference of only 1.2 years ($P<0.01$) which is of little clinical significance was observed in the mean age of MC users, 27.1 years $\pm$ 5.7 S.D., and never-users, 25.9 years $\pm$ 6.8 + S.D.

There was no statistically significant association between MC usage and ethnicity. There was a significant association in marital status and MC usage between users and never-users (X^2 =21.52, d.f. =2, $p < 0.001$). Married and divorced women were more likely to use MC while single women were less likely to do so (see table 4).

Table 4.
Comparison of Users to Never-users of Modern Contraception by Sociodemographic Variables.

Variables	Users N(%)	Never-users N(%)	Odds ratio	95% Confidence interval
Age (years)				
15-19	26(7.4)	76(21.3)	0.3	0.18,0.49
20-24	99(28.2)	89(24.9)	1.12	0.84,1.68
25-29	109(31.1)	81(22.7)	1.53	1.08,2.18
30-34	71(20.2)	54(15.1)	1.42	.95,2.14
35 and over	46(13.1)	57(16.0)	.79	.51,1.23
Marital status				
Married	189(55.9)	161(46.5)	1.46	1.07,1.99
Divorced	103(30.5)	88(25.4)	1.83	1.30,2.57
Single	46(13.6)	97(28.0)	0.40	.27,0.61
Occupation				
Home makers	137(39.0)	139(38.9)	1.00	.73,1.37
Bar tenders	78(22.2)	44(12.3)	2.03	1.33,3.11
Government employees	51(14.5)	25(7.0)	2.56	1.33,3.85
Students	20(5.7)	54(15.1)	.34	.19, .60
Jobless	28(8.0)	43(12.0)	.63	.37,1.07
Vendors	25(7.1)	30(8.4)	.84	.46,1.50
Others	12(3.4)	22(6.2)	.54	.25,1.61
Monthly family income (birr)				
Less than 50	157(44.9)	178(50.4)	.80	.59,1.09
50-149	88(25.1)	116(32.9)	.69	.49, .97
150-299	58(16.6)	45(12.7)	1.36	.87,2.12
300 and over	47(13.4)	14(4.0)	3.76	1.96,7.31

A statistically significant difference ($p < 0.01$) was seen in the mean educational attainment between MC users (grade 5.3 $\pm$ 4.1 S.D.) and never-users (grade 4.8 $\pm$ 4.0.S.D).

A statistically significant difference existed between users and never-users in occupation, $X2 = 40.52$, $df = 6$, $p < 0.001$. As shown in table 4, users of MC are more likely to be women working in government and mass organizations and bar tenders compared to never-users, and were less likely to be students, the jobless and farmers.

A strong relationship was seen in the monthly family income and MC usage among users and never-users ($X^2 = 24.64$, $df = 3$, $p < 0.001$). Users had a proportionately higher monthly family income (150 Birr and over) whereas never-users were more likely to be in the low income group, a monthly family income of less than 150 birr. Analysis of MC usage by income with bar tenders removed showed the same relationship between MC use and income ($X^2 = 33.26$, $df = 3$, $p < 0.001$).

A direct relationship existed in gravidity and MC use ($X^2 = 91.67$, $df = 6$, $p < 0.001$). That is, MC users had a significantly higher number of pregnancies (2 and more) whereas never-users were more likely to have one or none (see table 5).

A statistically significant difference was seen between users and never-users in the number of live-births and live-children a woman had (X^2 = 85.00, df = 6, $p < 0.001$, and X^2 = 82.79, df = 6, $p < .001$, respectively). As shown in table 5, MC users have proportionately higher numbers of live births and live-children than never-users.

A statistically significant difference was seen in MC information source between users and never-user (X^2 = 26.63, df = 4, $p < 0.001$). As table 6 shows, a proportionately higher number of users received MC information for the first time from health institutions compared to never users. The difference is even more marked than noted in the table, if we consider that 142 never-users who reported no MC knowledge are excluded from the analysis. In fact, only 23/357, or 6.4% of all never-users received MC information for the first time from health institutions. Never-users were more likely than users to get their information from school. This was also true in the analysis with bar tenders removed, X^2 = 21.62, df = 4, $p < 0.001$.

There was no statistically significant association between age when first received MC information and current status of MC usage among users (21.0 years $\pm$ 5.4 S.D.) and never-users (20.5 years $\pm$ 5.4 S.D.).

Table 5.
Comparison of Users to Never-users of Modern Contraception by Reproductive Characteristics.

Variables	Users N(%)	Never-users N(%)	Odds ratio	95% Confidence interval
Numbe of pregnancies				
0	13(3.7)	101(28.3)	.10	.05, .18
1	55(15.7)	70(19.6)	.76	.51,1.14
2	68(19.4)	47(13.2)	1.58	1.04,2.43
3	59(16.8)	46(12.9)	1.37	.88,2.12
4	55(15.7)	32(9.0)	1.89	1.16,3.08
5	40(11.4)	28(7.8)	1.51	.88,2.59
6 and over	61(17.4)	33(9.2)	2.07	1.28,3.33
Number of live-births				
0	18(5.1)	107(30.0)	.13	.01, .22
1	64(18.2)	75(21.0)	.84	.57,1.24
2	74(21.1)	48(13.4)	1.72	1.13,2.61
3	55(15.7)	41(11.5)	1.43	.91,2.26
4	53(15.1)	32(9.0)	1.81	1.11,2.96
5	36(10.3)	25(7.0)	1.52	.86,2.67
6 and over	51(14.5)	29(8.1)	1.92	1.16,3.20
Number of live-children				
0	26(7.4)	120(33.6)	.16	.10, .25
1	72(20.5)	75(21.0)	.97	.66,1.42
2	78(22.2)	51(14.3)	1.71	1.14,2.58
3	67(19.1)	43(12.0)	1.70	1.11,2.67
4	49(14.0)	39(10.9)	1.32	.82,2.12
5	28(8.0)	14(3.9)	2.12	1.05,4.33
6 and over	31(8.8)	15(4.2)	2.21	1.13,4.38

Table 6.
Comparison of Users to Never-users of Modern Contraception by Selected Variables.

Variables	Users N(%)	Never-users N(%)	Odds ratio	95% Confidence interval
MC information source*				
Health institution/ professional	69(19.7)	23(10.7)	2.04	1.20,3.50
Friend	214(61.0)	118(54.9)	1.28	.90,1.84
Mass media/gathering	34(9.7)	24(11.2)	.85	.48,1.54
School	19(5.4)	36(16.7)	.28	.15, .53
Family	15(4.3)	14(6.5)	.64	.29,1.44
Score of MC knowledge				
2 and below	17(4.8)	175(49.2)	.05	.03, .09
3	77(21.9)	70(19.7)	1.15	.79,1.68
4	136(38.7)	82(23.0)	2.11	1.50,2.97
5	121(34.5)	29(8.1)	5.93	3.75,9.43
Women's approval of sex education				
Approved	283(80.6)	264(73.9)	1.47	1.01,2.12
Neutral	13(3.7)	32(9.0)	.39	.19, .79
Disapproved	55(15.7)	61(17.1)	.90	.59,1.37

*142 never-users who reported no MC knowledge are excluded from the analysis.

Table 7.
Comparison of Users` to Never-users` Husbands by Selected Variables.

Variables	Users N(%)	Never-users N(%)	Odds ratio	95% Confidence interval
Husband-wife communication on FP				
Yes	143(40.9)	55(15.4)	3.78	2.60,5.5
No	207(59.1)	301(84.6)	.26	.18, .38
Number of methods aware of:				
None	2(1.3)	12(11.2)	.14	.03, .70
One	59(39.3)	44(41.1)	1.56	.89,2.76
Two	4(27.3)	30(28.0)	.09	.04, .30
Three and more	48(32.0)	21(19.6)	3.02	1.58,5.80
MC knowledge score				
2 and below	17(11.4)	29(29.0)	.32	.15, .64
3	53(35.6)	29(29.0)	1.35	.76,2.42
4	67(45.0)	36(36.0)	1.45	.84,2.53
5	12(8.1)	6(6.0)	1.37	.46,4.27
Attitude towards MC				
Supported	148(98.7)	88(76.5)	22.70	5.07,68.74
Against	2(1.3)	27(23.5)	.04	.01, .20
Sex education approval				
Approved	132(88.0)	85(73.9)	2.59	1.30,5.19
Neutral	6(2.0)	15(13.0)	.28	.09, .80
Disapproved	12(10.0)	15(13.0)	.58	.24,1.38

A statistically significant proportion of husbands of current users approved MC (98.7%) as compared to husbands of never-users (76.5%), $\underline{X}^2 = 30.52$, $\underline{df} = 1$, $\underline{p} < 0.001$ (see table 7).

Husbands of current users of MC approved sex education to school girls and boys aged 10 years and older more than husbands of never-users ($\underline{X}^2 = 9.92$, $\underline{df} = 2$, $\underline{p} < 0.01$). As table 7 shows, 88% of users` partners approved of sex education while only 73.9% of never-users` partners approved.

Husband-wife communication on FP was significantly higher among users (40.9%) compared to never-users (15.4%), $\underline{X}^2 = 55.21$, $\underline{df} = 1$, $\underline{p} < 0.001$ (see table 7).

Users Versus Dropouts

There were few differences between users and dropouts in X^2 and t-tests among the independent variables investigated. The only statistically significant differences were in:

1. duration of modern contraception used,
2. satisfaction with modern contraceptives refill/ replacement interval,
3. husband-wife communication on FP,
4. husbands` attitude towards modern FP, and
5. husbands` sex education approval.

The following items showed no statistically significant differences between users and droupouts:

1. sociodemographic variables,
2. reproductive variables,
3. MC knowledge variables,
4. women`s approval of sex education, and
6. husband`s MC knowledge.

Table 8 shows current users and droputs by duration of MC use at the time of the interview. A significanlty higher proportion of dropouts used MC for a brief duration (2-6 months) while current users used MC for longer durations, a year and over ($\underline{X}^2 = 43.9$, $\underline{df}=4$, $\underline{p} < 0.001$).

A statistically significant difference between users and droputs was also seen in the mean contraceptive period ($\underline{p} < 0.001$). Users used MC for an average of 29.5 months $\pm$ 28.0 S.D. whereas the dropouts used MC for an average of 17.9 months $\pm$ 22.2 S.D.

A higher proportion of dropouts from MC services (19.3%) were found to be unsatisfied with the interval of MC method refill or replacement compared to current users, 9.7% ($\underline{X}^2 = 7.62$, $\underline{df} = 1$, $\underline{p} < 0.01$). However, the difference seems to be of little clinical significance as the majority of users and dropouts, 90.3% and 80.7%, respectively, reported they were satisfied with the refill/replacement interval (see table 8).

Table 8.

Comparison of Users to Dropouts of FP by Selected Variable.

Variables	Users N(%)	Dropouts N(%)	Odds ratio	95 % Confidence Internal
Duration of MC used (months)				
2 - 6	55(15.7)	59(42.1)	.26	.16, .41
7 - 12	86(24.5)	34(24.3)	1.01	.63, 1.64
13 - 24	74(21.1)	18(12.9)	1.81	1.01, 3.29
25 - 36	47(13.4)	8(5.7)	2.55	1.12, 6.02
37 and over	89(25.4)	21(15.0)	1.92	1.11, 3.36
Satisfaction with method refill/replacement interval				
Yes	317(90.3)	113(80.7)	2.23	1.24, 3.99
No	34(9.7)	27(19.3)	.45	.25, .81
Husband-wife communication on FP				
Yes	143(40.9)	42(30.2)	1.60	1.03, 2.48
No	207(59.1)	97(69.8)	.63	.40, .97
Husbands` attitude towards MC				
Supported	148(98.7)	42(89.4)	8.81	1.44,46.75
Against	2(1.3)	5(10.6)	.11	.02, .69
Husband's sex education approval				
Approved	132(88.0)	40(81.6)	1.65	.63, 4.27
Neutral	6(4.0)	7(14.3)	.25	.07, .89
Disapproved	12(8.0)	2(4.1)	2.04	.41,20.35

A statistically significant difference ($\underline{X}^2$ = 6.53, $\underline{df}$ = 1, $\underline{p}$ < 0.05) was seen in attitude towards MC between husbands of users and dropouts. As shown in table 8, 98.7% of users husbands approved MC compared to 89.4% of dropouts. Nevertheless, the majority in both groups approved of MC practice.

As shown in table 8, a proportionately higher percentage of users husbands approved sex education of school children 10 years and over than dropouts' husbands, 88% versus 81.6%, $\underline{X}^2$ = 6.96, $\underline{df}$ = 2, $\underline{p}$ < 0.05. However, the majority of husbands approved of sex education.

There was a statistically significant difference between users' and dropouts' husbands in spousal communication on FP ($\underline{X}2$ = 4.35, $\underline{df}$ = 1, $\underline{p}$ < 0.05). As shown in table 8, 30.2% of dropouts husbands reported to have husband-wife communication compared to 40.9% of users' husbands (see table 8).

MULTIVARIATE ANALYSIS

Once the bivariate correlates of MC usage were identified, multiple regression was used to determine the relative importance of these factors and to eliminate any that did not contribute significantly to explaining variance in MC usage, once other factors were taken into account. First, multiple regression was done with the three study groups combined and then multiple regression was done for users and never-users of MC only.

Three factors emerged from this analysis as the prime determinant of MC usage, which are, in order of importance: total number of pregnancies experienced, MC knowledge score of women and age of women (see table 9). Similarly, these same variables entered in the same order when analysis was done for users and never-users.

In the first analysis, users are classified as 1, dropouts as 2 and never-users as 3. Thus, when the beta is negative, that factor is directly associated with being a user, or negatively associated with being a never-users.

In the second analysis, users remained as 1 but never-users were changed to 2, and the same interpretation applies.

Table 9.
Results of Multiple Regression Analysis of Modern Contraception Usage.

Dependent Variables	R^2	Beta and t-test of Predictors[@]		
		No of pregnancy	Women's score of MC knowledge	Women's Age
1.Users, dropouts & never-users	.10	-.33(-3.74)*	.19(-2.99)*	.18(2.06)**
2.Users and Never-users	.13	-.38(-4.00)*	-.19(-2.72)*	.19(2.03)**

* $p < 0.01$

** $p < 0.05$

@ the t-values are given in parenthesis

DISCUSSION

Many factors contribute to the use or nonuse of modern contraception in the developing countries. In general, in our study, the differences between MC users and dropouts were few compared to the differences between MC users and never-users. It may be that users and dropouts are esentially the same group of women, with dropouts being those who stop MC in order to have another child. They may become users after their next child and present users may become dropouts. This is seen in table 3, where 59.6% of the dropouts gave reasons like desire to have more children, being pregnant or lactating and no refill/method for discontinuing MC use.

A comparison of the profiles of MC users and dropouts showed that duration of MC usage, satisfaction with refill interval, husbands' report of husband-wife communication on FP and husbands' attitude towards MC were statistically significant. Generally, there were not statistically significant differences in socio-demographic and reproductive characteristics, age and source of MC information at the first time, women's approval of sex education and husbands' MC knowledge.

Dropouts used modern methods of contraception for shorter durations when compared to current users. One of the reasons for this difference could be that dropouts might have initiated MC for preventing extra - and/or premarital

pregnancies while current users might be using MC to space birth and to limit childbearing by stopping reproduction. Furthermore, desire to have more children and being pregnant or lactating were reported by the dropouts as reasons for discontinuation of MC practice. Dropouts expressed a fear of side effects and infertility comparable to neverusers.

Although a higher proportion of dropouts were dissatisfied with the refill interval compared to users (19.3% versus 9.7%), the vast majority of both groups were satisfied with the interval, and the clinical significance of the difference is probably slight.

A difference of 10.7 percentage points is seen in interspouse communication on FP between dropouts and users. In addition to other factors, this may have contributed to a higher continuation rate among users.

Even though there is a statistically significant difference between users and dropouts in husbands' attitude towards MC, the vast majority of both groups approved of MC practice. Husbands thus play a supportive role in the use of MC and are important for its implementation.

A comparison of the profiles of MC users and never-users showed statistically significant differences in most of the variables such as women's age, marital status, socioeconomic and reproductive characteristics, MC information source, women's approval of sex education, husband-wife communication on FP and husbands'

characteristics. Ethnicity and age when women first received MC information showed no association with use and never-use of MC.

A statistically significant proportion of users were in the mid-reproductive ages (25-29 & 30-34 years) while never-users were proportionally higher in the early (15-19 years) and late (35 years and over) reproductive ages. This finding is similar to that of Tekalegne's study in Addis Ababa (11) and Brown's and Dow's studies in Zambia and Zimbabwe, respectively (20,29). Fewer women in the younger and older ages may have been sexually active than was true of women in their twenties, and therefore, fewer at risk for unwanted pregnancy. On the other hand, large numbers of the youngest and older groups may have been sexually active and in need of contraception, but for various reasons they did not attend FP clinics.

Tomas Dow et al. in Zimbabwe found the majority of acceptors to be married women (29). Our finding accords with theirs in that a slightly higher proportion of users were married while a higher proportion of never-users were single women. Single women are less likely to be sexually active, and social taboos might discourage them from practicing MC. Despite these differences, almost half of the neverusers were married and thus exposed to the risk of unwanted pregnancy.

Several studies have cited a positive relationship between women's educational status and MC usage (11,20,28,43). In accordance with these studies, MC users in the present study had a significantly higher mean educational level than never-users.

This study showed that women who are working outside the home for cash payment are more likely to use MC than the jobless, students and farmers. Tekalegne and other authors have also found similar results (4,11,16,17,24). The usual reasons given for these differences are that women working outside their homes have greater access to information about MC and that they might need to stay non-pregnant in order to hold their job.

Different studies have demonstrated a positive relationship between economic status and use of a modern method of contraception (24,27,28). Moreover, two Ethiopian studies by Tekalegne and Zein have also shown a higher CPR among the financially better off women than the lower income group (11,17). The present study, which shows a higher monthly income in the users group and a higher proportion of lower income women among the never-users strengthens the previous findings.

Our study showed a positive relationship between the total number of pregnancies, live-births and live-children a woman had and MC usage. Several studies have showed similar trends of MC usage (4,16,19,28,31). Women with larger

families are naturally more likely to use MC to limit family size than women with smaller families. Presumably the women who use it for prevention of unwanted pregnancy do not want any more children.

In accord with the results from Tekalegne's study (11), we found that more users received MC information from health institutions than never-users. Never-users were more likely than users to get this information from school. However, the majority of women in both groups got their information from friends. These finding shows the potential role of health institutions and friends in the dissemination of MC information as well as their influential role in initiation of MC practice. Moreover, a lower level of MC knowledge observed among the never-users than the users might have contributed to nonuse among the never-users.

In this study, although users were more likely than never-users to approve of sex education in school to children 10 years and older, in both groups, the majority of women and male spouses approved of it. This positive attitude towards sex education is encouraging, and may in the long run lead to better information and utilization of MC methods.

Even though, a statistically significant difference existed in the husbands MC knowledge between the study groups, this is not of clinical significance as the majority

A second problem is a selection bias which of greatest concern in two groups. These were the dropouts from FP services where only 140 out of 566 (25%) dropouts were able to be located. It is possible that these located were in someway different from those we could not locate. For example, these located may be less mobile. Similarly, of the total 425 women who were married in the study only 316 husbands (74%) were located and interviewed. The husbands we were unable to locate may have differed in areas such as occupation, income, etc. from the husbands we were able to locate. This limitation must be taken into account when looking at the results dealing with dropouts and husbands.

CONCLUSION AND RECOMMENDATION

In the present study many differences have been demonstrated between MC users and never-users whereas very few exist between users and dropouts. The findings revealed that:

1. MC usage is influenced by sociodemographic characteristics. That is, women who are younger and older (ages below 25 and over 34), single, less educated, not working outside their homes for cash payment, and belonging to the lower income class (a monthly family income of less than 150 birr) are underserved by the available FP clinics.
2. MC usage is influenced by reproductive characteristics - gravidity, the number of live-births and live-children. Those with low numbers are more likely not to practice MC.
3. Besides knowledge about MC which has a positive effect on usage, friends and health personnel play the largest role in the disemination of MC information and in the initiation of MC practice.
4. Husband's knowledge about MC and attitude towards MC have an influential role in the usage of MC.
5. Husband-wife communication on FP is positively associated with MC usage.
6. Desire to have more children, being pregnant/lactating, fear of side-effects and infertility following MC, and having no husband/sexual partner have been demonstrated to be major reasons for not using MC among the never-users.

7. Certain factors like the desire to have additional children, becoming pregnant, fear of side effects of modern contraceptives, lack of method refill/replacement have been identified as reasons for dropping out from FP clinics. Moreover, spousal opposition has been shown to be an obstacle to the continuation of MC usage.

Based on these findings we recommend that:

1. Emphasis should be placed on promoting dissemination of MC information in health institutions, schools, mass gatherings, etc. both to women and men.

2. Service providers should find ways to make MC services available to the following groups, which are not adequately served by the existing FP clinics.

- younger, sexually active women (ages 15-24),
- older women (ages 35 and over),
- unmarried adults,
- women with low educational level,
- women who are not working outside for cash payment (housewives, the jobless, students)
- women in the lower economic class.

3. Although not addressed specifically in this study, it is noteworthy that in Tegulet and Bulga awraja, MC is available only to townswomen, who constitute only 6% of all women. Thus, an important first step is to make MC available to more women by having more rural clinics dispensing contraceptives.

4. Research must proceed on almost every aspect of MC usage both in urban and rural settings in order to enable us to devise programmes which will have a meaningful effect on MC practice.

APPENDIX

QUESTIONNAIRE FOR CONTRACEPTION STUDY

A. Identification

1. Questionnaire number ☐☐☐☐

2. Identification number of interviewer ☐☐

3. Date of interview (Ethiopian Calendar) ☐☐ ☐☐ ☐☐
Day month year

B. Introduction

4. Town

1. ☐ Debre-berhan
2. ☐ Enewari
3. ☐ Deneba
4. ☐ Jihur
5. ☐ Other, specify_____

5. ☐ Kebele

6. ☐☐ Age of interviewee

7. What is your ethnicity?

1. ☐ Amhara
2. ☐ Oromo
3. ☐ Guragie
4. ☐ Tigrie
5. ☐ Other, specify_____

8. What is your religion?

1. ☐ Orthodox Christian
2. ☐ Protestant Christian
3. ☐ Catholic Christian
4. ☐ Muslim
5. ☐ Other, specify_____

9. What is your marital status?

1. ☐ Married
2. ☐ Single
3. ☐ Divorced
4. ☐ Separated
5. ☐ Widowed

10. What level of education did you reach?

0. ☐ Can't read or write
1. ☐ Ever attended literacy campaign or grade 1
2. ☐ Completed literacy campaign and has certificate, or grade 2
3. ☐☐ If grade 3 or above, enter the highest grade obtained

11. What is your occupation?

1. ☐ Jobless
2. ☐ Government employee
3. ☐ Mass organization employee
4. ☐ International organization employee
5. ☐ Farmer
6. ☐ Public service (bar, hotel, etc)
7. ☐ Self-employed/vendor
8. ☐ Housewife
9. ☐ Student
10. ☐ Other, specify_____

12. What is your approximately monthly total family income in birr?

1. ☐ Less than 50
2. ☐ 50 - 149

3. ☐ 150 - 299

4. ☐ 300 - 499

5. ☐ 500 and above

6. ☐ No response

13. If married, at what age were you married?

0. ☐ Not applicable

1. ☐☐ Enter age in years

14. At what age have you started sexual relationship?

☐☐ Enter age in years

15. How many pregnancies have you had?

☐☐ Enter the number

16. How many live-births have you had?

☐☐ Enter the number

17. How many live-children do you have?

☐☐ Enter the number

18. How old were you when you first got pregnant?

☐☐ Enter the number

19. How many pregnancies have you had before you married?

☐☐ Enter the number

20. Do you presently use any modern contraceptive method?

1. ☐ Yes - Fill Questionnaire I

2. ☐ No - Go to question 22

3. ☐ No response - Terminate interview

21. Have you ever used any contraceptive method for longer than one month?

0. ☐ Not applicable

1. ☐ Yes - fill questionnaire II

2. ☐ No - Fill Questionnaire III

1. Questionnaire for Present Modern Contraceptive Users

1. Questionnaire number ☐☐☐☐

122. How old were you when you first started to use modern contraception?

☐☐ Enter age in year

123. Why did you start to use modern contraception at that age?

1. ☐ Prevention of unwanted pregnancy
2. ☐ Child-spacing
3. ☐ Medication
4. ☐ Other, specify_____
5. ☐ don't know

124. What modern contraceptive method do you use currently?

1. ☐ Pill
2. ☐ IUD
3. ☐ Spermicide
4. ☐ Condom
5. ☐ Tubal ligation
6. ☐ Hysterectomy
7. ☐ Vasectomy
8. ☐ Other, specify_____

125. For how long have you been on this present method?

☐☐☐ Enter the period in months

126. Why do you use modern contraception at present?

1. ☐ Prevention of unwanted pregnancy
2. ☐ Child-spacing
3. ☐ Medication

4. ☐ Other, specify_____

5. ☐ Don't know

127 - 128 for pill, spermicide, condom, and IUD users only. Others go to 129.

127. What is the usual interval of your refill/replacement?

0. ☐ Not applicable

1. ☐☐ Enter the interval in months

128. Are you satisfied with the interval?

0. ☐ Not applicable

1. ☐ No

2. ☐ Somewhat

3. ☐ Yes

129. Where is the main place that you get your contraception from?

0. ☐ Not applicable (if user of operative method)

1. ☐ Family Guidance Association

2. ☐ Private clinic

3. ☐ Pharmacy/Drug vendor

4. ☐ Hospital

5. ☐ Health center

6. ☐ Health station

7. ☐ Other, specify_____

130. What do you think is the most important reason a woman should use modern contraceptive methods?

1. ☐ For prevention of unwanted pregnancy

2. ☐ For child-spacing

3. ☐ As medication
4. ☐ For prevention of sexually transmitted diseases
5. ☐ Other, specify_____
6. ☐ Do not know

Total ☐

131. What was your age when you first got information about modern contraceptive methods?

☐☐ Enter age in years

132. From whom/where did you get the information about MC mehtods?

1. ☐ Marital/sexual partner
2. ☐ Friends
3. ☐ Family
4. ☐ School
5. ☐ Mass gatherings
6. ☐ Mass media-radio, magazines, etc
7. ☐ Health institution/professional
8. ☐ Ethiopian Family Guidance Association
9. ☐ Other, specify_____

133. Which methods of modern contraception do you know about? (check box if aware)

1. ☐ Pill
2. ☐ IUD
3. ☐ Spermicide
4. ☐ Condom
5. ☐ Tubal ligation
6. ☐ Hysterectomy

7. ☐ Vasectomy

8. ☐ Injectable

9. ☐ Other, specify_____

134. What advantages/uses of modern contraception do you know?

1. ☐ Prevention of unwanted pregnancy

2. ☐ Child-spacing

3. ☐ Medical treatment

4. ☐ Prevention of sexually transmitted diseases

5. ☐ Other, specify_____

Total ☐

135. What should a woman do if she forgets to take a contraceptive pill for one day?

1. ☐ Take only the next dose

2. ☐ Take it as soon as she remembered it

3. ☐ Take it only together with the next dose

4. ☐ Discontinue to take the rest of the pill

5. ☐ Other, specify._____

6. ☐ Do not know

136. Do you approve of school sex education to children aged 10 years and over?

1. ☐ No

2. ☐ Yes

3. ☐ Do not know

11. Questionnaire for Dropout from Modern Contraception Service

1. Questionnaire number ☐☐☐☐

222. How old were you when you first started to use modern contraception?

☐☐ Enter age in years

223. Why did you start to use modern contraception at that age?

1. ☐ Prevention of unwanted pregnancy
2. ☐ Child-spacing
3. ☐ Medication
4. ☐ Other, specify_____
5. ☐ Do not know

224. What modern contraceptive were you using before stopping?

1. ☐ Pill
2. ☐ IUD
3. ☐ Spermicide
4. ☐ Condom
5. ☐ Other, specify_____

225. For how long were you on this method when you stopped?

☐☐ Enter duration in months

226. Why did you stop modern contraception?

1. ☐ Became pregnant
2. ☐ Currently breast feeding
3. ☐ Fear of side effects
4. ☐ Fear of infertility

5. ☐ No refill/replacement
6. ☐ Spouse disapproved
7. ☐ Don't have marital/sexual partner at present
8. ☐ Want to become pregnant

227 - 228 for pill, spermicide, condom and IUD past-users only; others go to question 229

227. What was the usual interval of your method refill/replacement?

0. ☐ Not applicable
1. ☐☐ Enter the interval in months

228. Were you satisfied with the interval?

0. ☐ Not applicable
1. ☐ No
2. ☐ Somewhat
3. ☐ Yes

229. Where was the main place that you got your contraceptive from?

1. ☐ Family Guidance Association
2. ☐ Private Clinic
3. ☐ Pharmacy/Drug Vendor
4. ☐ Hospital
5. ☐ Health Center
6. ☐ Health Station
7. ☐ Other, specify _____

230. What do you think is the most important reason a woman should use modern contraception method?

1. ☐ For prevention of unwanted pregnancy
2. ☐ For child-spacing
3. ☐ As medication
4. ☐ For prevention of sexually transmitted diseases
5. ☐ Other, specify _____
6. ☐ Do not know

231. What was your age when you first received information about MC?

☐☐ Enter age in years

232. From whom/where did you get the information about MC methods?

1. ☐ Marital/sexual partner
2. ☐ Friend
3. ☐ Family
4. ☐ School
5. ☐ Mass gathering
6. ☐ Mass media
7. ☐ Health institution/professional
8. ☐ Ethiopian Family Guidance Association
9. ☐ Other, specify_____

233. Which methods of MC do you know about (check box if aware)

1. ☐ Pill
2. ☐ IUD
3. ☐ Spermicide

4. ☐ Condom
5. ☐ Tubal ligation
6. ☐ Hysterectomy
7. ☐ Vasectomy
8. ☐ Injectable
9. ☐ Other, specify_____

Total ☐

234. Which advantages/uses of MC do you know?

1. ☐ Prevention of unwanted pregnancy
2. ☐ Child-spacing
3. ☐ Medical treatment
4. ☐ Prevention of sexually transmitted diseases
5. ☐ Other, specify_____

Total ☐

235. What should a woman do if she forgets to take a contraceptive pill for one day?

1. ☐ Take only the next dose
2. ☐ Take it as soon as she remembered it
3. ☐ Take it only together with the next dose
4. ☐ Discontinue to take the rest of the pill
5. ☐ Other, specify_____
6. ☐ Do not know

236. Do you approve of school sex education to children aged 10 years and over?

1. ☐ No
2. ☐ Yes
3. ☐ Do not know

III. Questionnaire for Never-users

1. Identification number ☐☐☐☐

322. Not applicable

☐ Code as 0

323. Not applicable

☐ Code as 0

324. Not applicable

☐ Code as 0

325. Not applicable

☐ Code as 0

326. Why don't you use modern contraception method at all?

1. ☐ Being pregnant
2. ☐ Being breast-feeding
3. ☐ Fear of side effects
4. ☐ Fear of infertility
5. ☐ Have medical problem
6. ☐ Spouse disapproved
7. ☐ Do not have sexual/marital partner
8. ☐ Desire to have more children
9. ☐ Religious/cultural reasons
10. ☐ Method not available in nearby health institutions
11. ☐ Not aware of modern contraceptives
12. ☐ Use traditional methods, specify_____
13. ☐ Others, specify_____

327. Not applicable

☐ Code as 0

328. Not applicable

☐ Code as 0

329-A Do you want to use modern contraceptive method in the future?

1. ☐ No - Go to Q. 330
2. ☐ Yes - Go to Q. 329-B
3. ☐ Not decided - Go to Q 329-B

329-B From where do you want to collect your contraceptive?

0. ☐ Not applicable
1. ☐ Family Guidance Association
2. ☐ Private clinic
3. ☐ Pharmacy/drug vendor
4. ☐ Hospital
5. ☐ Health center
6. ☐ Health station
7. ☐ Other, specify_____

330. What do you think is the most important reason that a woman might use modern contraceptive method?

1. ☐ Prevention of unwanted pregnancies
2. ☐ Child-spacing
3. ☐ As medication
4. ☐ Prevention of STD
5. ☐ Other, specify_____
6. ☐ Do not know

Total ☐

331. If answered 'no' in Q. 329-A, why don't you want to use modern contraceptives in the future?

0. ☐ Not applicable (if desired to use)
1. ☐ Fear of side effects
2. ☐ Fear of infertility
3. ☐ Don't want to take drugs daily
4. ☐ Don't feel safe/comfortable with the methods
5. ☐ Want to use only traditional methods
6. ☐ Have medical problem
7. ☐ Desire to have more children
8. ☐ Spouse disapproved
9. ☐ Religious/cultural reasons
10. ☐ Other, specify_____

332-A Do you know about modern contraception methods?

1. ☐ No - Go to Q. 338
2. ☐ Yes - Go to Q. 333

333-B What was your age when you first received information about modern contraception?

0. ☐ Not applicable
☐☐ Enter age in years

334. From whom/where did you get this information?

0. ☐ Not applicable
1. ☐ Sexual/marital partner
2. ☐ Friends
3. ☐ Family
4. ☐ School
5. ☐ Mass organization/gatherings
6. ☐ Mass media - radio, magazines, etc.

7. ☐ Health institution/worker
8. ☐ Ethiopian Family Guidance Association
9. ☐ Other, specify_____

335. Which modern methods of contraception are you aware of?

0. ☐ Not applicable
1. ☐ Pill
2. ☐ IUD
3. ☐ Spermicide
4. ☐ Condom
5. ☐ Tubal ligation
6. ☐ Hysterectomy
7. ☐ Vasectomy
8. ☐ Injectable
9. ☐ Other, specify_____

Total ☐

336. What advantages/uses of modern contraception do you know?

0. ☐ Not applicable
1. ☐ Prevention of unwanted pregnancy
2. ☐ Child spacing
3. ☐ Medical treatment
4. ☐ Prevention of STD
5. ☐ Other, specify_____

Total ☐

337. What should a woman do if she forgot to take a pill?

0. ☐ Not applicable
1. ☐ Take only the next dose
2. ☐ Take it as soon as she remember
3. ☐ Take the missed and the next dose together
4. ☐ Discontinue to take the rest of the cycle
5. ☐ Other, specify_____
6. ☐ Do not know

338. Do you approve of school sex education to children aged 10 years and over?

1. ☐ No
2. ☐ Yes
3. ☐ Do not know

IV. Questionnaire for Male Partners

1. Identification number ☐☐☐☐

37. Do you discuss about FP with your wife?

0. ☐ Not applicable
1. ☐ No
2. ☐ Yes

38. Do you approve of MC?

0. ☐ Not applicable
1. ☐ No - Go to Q. 39
2. ☐ Neutral - Go to Q. 40
3. ☐ Yes - Go to Q. 40

39. Why do you oppose MC?

0. ☐ Not applicable
1. ☐ Don't have any knowledge about MC
2. ☐ Fear of side effects
3. ☐ Fear of infertility
4. ☐ Spouse disapproved
5. ☐ Religious/cultural reason
6. ☐ Prefer traditional methods
7. ☐ Other, specify_____

40. Do you want to use MC in the future?

0. ☐ Not applicable
1. ☐ No
2. ☐ Yes
3. ☐ Not decided

41. Why don't you want to use MC in the future?

0. ☐ Not applicable
1. ☐ No adequate knowledge about MC
2. ☐ Fear of side effects
3. ☐ Fear of infertility
4. ☐ Spouse disapproves
5. ☐ Spouse is pregnant
6. ☐ Spouse is breast-feeding
7. ☐ Desire to have more children
8. ☐ Prefer to use traditional methods
9. ☐ Religious/cultural reason
10. ☐ Method not available in the nearby clinic
11. ☐ Other, specify_____

Total ☐

42. Which methods of MC are you aware of?

0. ☐ Not applicable
1. ☐ Pill
2. ☐ IUD
3. ☐ Spermicide
4. ☐ Condom
5. ☐ Tubal ligation
6. ☐ Hysterectomy
7. ☐ Vasectomy
8. ☐ Other, specify_____
9. ☐ None

Total ☐

43. Do you want to know about MC?

0. ☐ Not applicable
1. ☐ No - Go to Q. 44
2. ☐ Yes - Go to Q. 45

44. Why don't you want to know about MC?

0. ☐ Not applicable
1. ☐ It's only your wife's problem
2. ☐ Spouse disagrees
3. ☐ Fear of infertility
4. ☐ Desire to have more children
6. ☐ Prefer only traditional methods
7. ☐ Other, specify_____

45. From whom/where do you prefer to get information about MC?

0. ☐ Not applicable
1. ☐ Spouse
2. ☐ Friend
3. ☐ Family
4. ☐ Mass gathering
5. ☐ Mass media - radio, magazines, etc.
6. ☐ Health institution/worker
7. ☐ Pharmacy/drug vendor
8. ☐ Work place
9. ☐ Other, specify_____

46. Which uses/advantages of MC do you know?

0. ☐ Not applicable
1. ☐ Prevention of unwanted pregnancy
2. ☐ Birth spacing
3. ☐ Medical treatment
4. ☐ Prevention of STD
5. ☐ Other, specify_____
6. ☐ None

47. Do you approve of school sex education to children 10 years old and over?

0. ☐ Not applicable
1. ☐ No
2. ☐ Yes
3. ☐ Neutral

QUESTIONNAIRE IN AMHARIC

ዘመና ዊ የወሊድ ቁጥጥር ዘዴን ለመጠ ቀም ምክንያት
የሆኑትን የሕብረ ተሰብን ባሕር ያት ለማጥና ት የተዘጋጀ መጠይቅ

1. የጥና ቱ መለያ ቁጥር

2. የጠ ያቂዉ/ዋ መለያ ቁጥር ___ ___

3. መጠይ ቁ የተካና ወነበት ቀን ___ ___ ___
ቀን ወር ዓ.ም.

4. ከተማ
   1. ___ ደብረ ብርሃን
   2. ___ አነዋሪ
   3. ___ ደነባ
   4. ___ ጁሀር
   5. ___ ሌሳ፣ ይገለጽ_____

5. ___ ቀበሌ

6. ___ የተጠ ያቂዋ ዕድሜ

7. የተጠ ያቂዋ ጎሣ
   1. ___ አማራ
   2. ___ ኦሮሞ
   3. ___ ጉራጌ
   4. ___ ትግሬ
   5. ___ ሌሳ፣ ይገለጽ፣_____

8. የተጠ ያቂው ሰይማኖት
   1. ___ ኦር ቶደክስ
   2. ___ ፕሮቴስ ታንት
   3. ___ ካቶሊክ
   4. ___ እስላም
   5. ___ ሌሳ፣ ይገለጽ፣_____

9. የጋብቻ ሁኔታ
   1. ___ ያገቡ
   2. ___ያላገቡ
   3. ___ የፈ ቱ

4 ___ የተለያዩ/ ከአንድ ወር በላይ

5 ___ የሞ ተቦ ቸው

10. የትምህርት ደረጃ

0 ___ ማንበብና መጻፍ የማይችሉ

1 ___ መሠረተ ትምህርት የሚከታተሉ/ የተከታተሉ ግን ያሳጠና ቀቁ ወይም 1ኛ ክፍል የሆኑ/ያጠና ቀቁ

2 ___ መሠረተ ትምህርት ያጠና ቀቁ ወይም 2ኛ ክፍል የሆኑ ወይም ያጠና ቀቁ

3 ___ 3ኛ ክፍል ወይም ከዚያ በላይ/ተከከለኛውን የትምህርት ደረጃ ይጨሉ/

11. ሥራ

1 ___ ሥራ አጥ

2 ___ የመንግሥት ሠራተኛ

3 ___ የሕዝቢ ዲርጅት ሠራተኛ

4 ___ የዓለም አ ቀፍ ድርጅት ሠራተኛ

5 ___ ገበርና

6 ___ የሕዝብ አገለግሎት ሠጪ ድርጅት ሠራተኛ/ሆቴል/ቡና ቤት/ወዘተ/

7 ___ የግል ንግድ

8 ___ የቤኑ እመቤት

9 ___ ተማሪ

10 ___ ሌላ፤ ይገለጽ_____

12. የቤተሰብ አጠቃላይ የወር ገቢ ብር

1 ___ ከ50 ያነሰ

2 ___ ከ50-149

3 ___ ከ150-299

4 ___ ከ300-499

5 ___ 500 ወይም ከዚያ በላይ

6 ___ ለመመለስ ፈቃደኛ አይደሉም

13. አገብተው ከሆነ ሲያገቡ አጨማ ስንት ነበር?

0 ___ ጥያቄው አ የመለከታቸውም

1 ___ ___ በተቂረ አጨማያቸው ይሞላ

14. ለመጀመሪያ ገዜ ከወንዴ ጋር የግብረ ሥጋ ግንኙነት ሲያደርጉ እድሜያ ስንት ነበር?

___ ___ ትክክለኛውን እድሜ ይሙሉ

15. በአጠቃሊይ ስንት ገዜ አርግዘው ነበር?

___ ___ ትክክለኛውን ቁጥር ይሙሉ

16. በአጠቃሊይ ስንት ሌጅ ወሌደዋሌ?

___ ___ ትክክለኛውን ቁጥር ይሙሉ

17. በአሁኑ ጊዜ ስንት ሌጆች አሉያት?

___ ___ ትክክለኛውን ቁጥር ይሙሉ

18. ሇመጀመሪያ ጊዜ ነፍሰ ጡር ሲሆኑ እድሜያ ስንት ነበር?

___ ___ ትክክለኛውን እድሜ ይሙሉ

19. ከማግቢትያ በፊት ስንት ጊዜ አርግዘው ነበር?

___ ___ትክክለኛውን ቁጥር ይሙሉ

20. በአሁኑ ወቅት በዘመናዊ የወሉዴ ቁጥጥር ዘዴ የጠቀማሉን?

1. ___ አዎን ሥራመጠይቅ 1ን ይሙሉ
2. ___ የሇም ሥራወደ 21ኛው ጥያቄ ይሂዱ
3. ___ ሇመግሇጽ ፈቃዯኛ አይዯሇም_____

/ ቃሇ መጠይቁን ያቋርጡ/

21. ከዚህ ቀዯም በዘመናዊ የወሉዴ ቁጥጥር ዘዴ አከአንዴ ወር በሊይ ተጠቅመው ያውቃለን?

0. ___ [illegible] አይመሇከታቸውም

1. ___ አዎን ሥራ መጠይቅ 2ን ይሙሉ

2. ___ የሇም ሥራ መጠይቅ 3ን ይሙሉ

1፣ ዘመና ዊ የወሲዱ ቁጥር ዘዴ ለሚጠ ቁሙ

1. የጥና ት መለያ ቁጥር

122. በስንት ዓመት ያ ዘመና ዊ የወሲዱ ቁጥር ዘዴ መጠ ቀም ጀመሩ?

123. በዚያ ዕድሜ ያ ዘመና ዊ የወሲዱ ቁጥር ዘዴ መጠ ቀም ለምን ጀመሩ?

1. ___ የማይፈለግ እርግዝና ን ለመከላከል
2. ___ አራር ቅ ልጅ ለመውለዱ
3. ___ ለሕክምና ፣
4. ___ ሌላ፣ ይገለጽ_____
5. ___ ምክንያ ቱን አ ያውቁም

124. በአሁኑ ወቅት የሚጠ ቁሙት ዘመና ዊ የወሲዱ ቁጥር ዘዴ የትኛው ነው?

1. ___ ፒል /አንከብል/
2. ___ ሉፕ
3. ___ የወንዱ ዘር የሚገል/ፍም፣ ጄሊ፣ ከሪም፣ አንከብል/
4. ___ ኮንደም /ወንዱ ብልት ላይ የሚጠለቅ/
5. ___ የማህፀን ቱቦ በስንራሲ ዩን በማዘጋት
6. ___ ማህፀን በስንራሲ ዩን በማስወጣት
7. ___ ሺስኤክቶሚ/ የወንዱ ዘር ማስ ተላለፊ ያ ቱቦ በስንራሲ ዩን በማዘጋት፣/
8. ___ ሌላ፣ ይገለጽ_____

125. በዚህ ዘዴ መጠ ቀም ከጀመረ ስንት ጊዜ ያ ነው?

___ ___ ___ ትክክለኛ ውን ወራት ይሙሉ

126. በአሁኑ ወቅት ዘመና ዊ የወሲዱ ቁጥር ዘዴ የሚጠ ቁሙት ለምንዱነው?

1. ___ የማይፈለግ እርግዝና ን ለመከላከል
2. ___ አራር ቅ ልጅ ለመውለዱ፣
3. ___ ለሕክምና
4. ___ ሌላ፣ ይገለጽ_____
5. ___ ምክንያ ቱን አ ያውቁም

127 – 128 ፒለ፣ ስፕሚሳይድ፣ ኮንደም፣ ወይም ሎኘ ለሚጠ ቁሙ ብቻ፣ ሌሎቸ ወደ 13ኟኖው ጥያቄ ይሂዱ፣

127. የሚጠ ቁሙትን የወሊዱ ቁጥር ዘዴ በየስንት ጊዜው አገለግሎቱን ከሚያገኙበት ቦታ አየሄዱ ይወስዳሉ/ ያስ ቂይራሉ?

0. ___ ጥያቄው አይመለከታቸውም
1. ___ ትክክለኖውን ጊዜ በወር ይሙሉ

128. ከሳይ የጠ ቀሱት ጊዜ ተስማምቶያታለን?

0. ___ ጥያቄው አይመለከታቸውም
1. ___ አለ ተስማማኝም [illegible] ኟኖው ጥያቄ ይሂዱ
2. ___ ምንም አይለም [illegible]
3. ___ አያን [illegible]

129. የሚጠ ቁሙትን ዘመና ዊ የወሊዱ ቁጥር ዘዴ ከየት ያገኖሉ?

0. ___ ጥያቄው አይመለከታቸውም/ የአኘራስዩን ዘዴ ተጠ ቃሚ ከሆኑ/
1. ___ ከቤተሰብ መምሪያ ማኅበር
2. ___ ከግል ክሊኒክ
3. ___ ከፋርማሲ/መድኃኒት መደብር
4. ___ ከሆስፒታል
5. ___ ከጡና ጤቢያ
6. ___ ከመንግስት ክሊኒክ
7. ___ ሌሳ፣ ይገለጽ_____

130. አንዲት ሴት ዘመና ዊ የወሊዱ ቁጥር ዘዴ መጠ ቀም ያለቧት ዋነኖው ምክንያት ምን ይመስለ ያታል?

1. ___ የማይፈለግ እርግዝና ን ለመከሳከል
2. ___ አራር ቀ ልጁ ለመውለዱ
3. ___ ለሕክምና
4. ___ በግብረስጋ ግንኙነት ምክንያት ከሚመጣ በሽታ ለመከሳከል
5. ___ ሌሳቸ ይገለጽ_____
6. ___ አያውቁም ጠቅሳሳ ድምር _____

131. ለመጀመሪያ ጊዜ ስለዘመና ዊ የወሊዱ ቁጥር ዘዴ የቤተሰብ ምጤኒ አራር ቀ መውለዱ መረኛ ያገኙት/ የሰሙት በስንት ዓመት ያ ነው?

___ ___ ትክክለኖውን ዕድሜ ይሙሉ

132. ስለ ዘመና ዊ የወሊዱ ቁጥር ዘዴ መረኛውን ለመጀመሪያ ጊዜ ከየት አገኙ/ መን ነገረ ያት?

1. ___ ባለቤት ያ/ የወንዱ ጓደኖ ያ
2. ___ ጓደኖቸ ያ

4. ___ ት/ቤት
5. ___ አኢሴማ/አኢወማ/ ቀበሌ ስብሰባ
6. ___ ሬዲዮና ቴሌቪዝን፣ መጽሄት፣ ወዘተ
7. ___ ከጤና ደርጀት/ የጡና ባለሙያ
8. ___ የቤተሰብ መምሪያ ማኅበር
9. ___ ሌላ፣ ይገለጽ _____

133. የሚያውቋቸውን ዘመና ዊ የወሊድ ቁጥር ዘዴዎች ጠቀሱ?
1. ___ ፒል/እንክብል/
2. ___ ሉፕ
3. ___ የወንድ ዘር የሚገል/ጄሊ፣ ክሪም፣ ፍም፣ እንክብል/
4. ___ ኮንዶም
5. ___ የማሕፀን ቱቦ በእንራስ ዱን ማዘጋት
6. ___ የማሕፀን ቱቦ በእንራስ ዱን ማስወጣት
7. ___ ሽስኢክ ቶሚ
8. ___ በመር ፡ የሚወጋ/ የሚሰጥ
9. ___ ሌላ፣ ይገለጽ_____

ጠቅላላ ድምር ___

134. ስለዘመና ዊ የወሊድ ቁጥር ዘዴ የሚያውቋቸውን ጥቅሞች ጠቀሱ?
1. ___ የሣይለግ እርግዝና ስለመከላከል
2. ___ ኦራር ቅ ልጅ ለመውለድ
3. ___ ለሕክምና
4. ___ በግብረስ ግንኙነት ለመጡ የሚችሉ በሽታዎችን ለመከላከል
5. ___ ሌላ፣ ይገለጽ_____ ጠቅላላ ድምር ___

135. አንዲት ሴት የአንድ ቀን ፒል/ እንክብል መዋጥ ዋን ብትረሳ ምን ማድረግ አለባት?
1. ___ የረሱትን ትተው የሚቀጥለውን ብቻ በጊዜው መዋጥ
2. ___ አንዳስታወሱት ወዲያውኑ መዋጥ
3. ___ የረሱትንና የሚቀጥለውን ጠብቀው አንድ ላይ መዋል
4. ___ የተቀረውን መውሰድ ማቋረጥ
5. ___ ሌላ፣ ይገለጽ_____
6. ___ ምን እንደሚያደርጉ አያውቁም

136. 10 ዓመትና ከዚያ በላይ የሆኑ ቸው ልጆቸ በት/ቤታቸው ስለ ወሊድ/ወንድና ሴት ግንኙነት ትምህርት አንዲሰጣቸው ይደግፋሉ?
1. ___ አይደግፈም
2. ___ ገለልተኛ ና ቸዉ
3. ___ ይደግፋሉ
4. ___ ሀሳብ ከመስጠት ተቆጠቦ ያል

2፣ ዘመናዊ የወሊድ ቁጥር ዘዴ መጠቀም ሊቁሙ

1. የጥናቱ መለያ ቁጥር

222. በስንት ዓመትዎ ዘመናዊ የወሊድ ቁጥጥር ዘዴ መጠቀም ጀመሩ?

____ ____ ትክክለኛውን ዕድሜ ይሙሉ

223. በዚያ እድሜዎ ዘመናዊ የወሊድ ቁጥጥር ዘዴ መጠቀም ለምን ጀመሩ?

1. ____ የማይፈለግ እርግዝናን ለመከላከል
2. ____ አራርቆ ልጅ ለመውለድ
3. ____ ለህክምና
4. ____ ሌላ፣ ይገለጽ_____
5. ____ ምክንያቱን አያውቁም

224. ዘመናዊ የወሊድ ቁጥጥር ዘዴ መጠቀም ከማቆምዎ በፊት ይጠቁሙ የነበረው የትኛውን ዓይነት ነው?

1. ____ ፒል/እንክብል
2. ____ ሉፕ
3. ____ የወንድ ዘር የሚቦል
4. ____ ኮንዶም/ በወንድ ብልት የሚጠለቅ/
5. ____ ሌላ፣ ይገለጽ_____

225. በዚህ ዘዳ ለምን ያህል ጊዜ ተጠቁሙ?

__ __ ትክክለኛውን ወራት ይሙሉ

226. በአሁኑ ወቅት ዘመናዊ የወሊድ ቁጥጥር ዘዴ መጠቀም ያቆሙት ዋነኛው ምክንያት ምንድነው?

1. ____ ነፍሰ ጡር ስለሆኑ
2. ____ ጡት እያጠቡ ስለሆነ
3. ____ ለጤንነት ጠንቅ አለው ስለሚባል
4. ____ መሃን ያደርጋል ስለሚባል
5. ____ ይጠቁመኝ የነበረው ዘዴ ስለሌለ
6. ____ ባለቤት ዎ/ጋደኛዎ ፈቃደኛ ስላልሆኑ
7. ____ ባልዎ/የወንድ ጋደኛ በአሁኑ ወቅት ስለሌለዎ
8. ____ መውለድ ስለሚፈልጉ
9. ____ ሌላ፣ ይገለጽ_____

227 — 228 ጥያቄ በፕሮግራሙ የሚጠይቁ ኮንዶም ወይም ሉፕ ይጠቀሙ ለነበረ ብቻ ሌሎች ወደ 23? ኛው ጥያቄ ይሂዱ

227. ይጠቀሙበት የነበረውን የወሊድ ቁጥጥር ዘዴ በስንት ጊዜው አገልግሎቱን ከሚያገኙበት ቦታ እየሄዱ ይወስዱ/ያስቀሩ ነበር?

0. ____ ጥያቄው አይመለከታቸውም
1. ____ ____ ትክክለኛውን ጊዜ በወር ይሙሉ

228. ከላይ የጠቀሱት ጊዜ ተስማምቶዎት ነበርን?

0. ____ ጥያቄው አይመለከታቸውም
1. ____ አልተስማማቸውም
2. ____ ምንም አይል
3. ____ አዎን

229. ይጠቀሙበት የነበረው ዘመናዊ የወሊድ ቁጥጥር ዘዴ ከየት ያገኙ ነበር?

1. ____ ከቤተሰብ መምሪያ ማኅበር
2. ____ ከግል ክሊኒክ
3. ____ ከፋርማሲ/መድኃኒት መደብር
4. ____ ከሆስፒታል
5. ____ ከጤና ጣቢያ
6. ____ ከመንግሥት ክሊኒክ
7. ____ ሌላ ይገለጽ__________

230. አንዲት ሴት የዘመናዊ የወሊድ ቁጥጥር ዘዴ መጠቀም ያለባት ዋነኛው ምክንያት ምን ይመስልዎታል?

1. ____ የማይፈለግ እርግዝና ለመከላከል
2. ____ አራርቆ ልጅ መውለድ
3. ____ ለሕክምና
4. ____ በግብረ ስጋ ግንኙነት ምክንያት ከሚመጣ በሽታ ለመከላከል
5. ____ ሌላ ካለ ይገለጽ
6. ____ ምክንያቱን አያውቁም

ጠቅላላ ____

231. ለመጀመሪያ ጊዜ ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ /ቤተሰብ ምጣኔ አራርቆ መውለድ/መረጃ ያገኙት ወይም የሰሙት በስንት አመትዎ ነው?

____ ____ ትክክለኛውን እድሜ ይሙሉ

232. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ መረጃውን ለመጀመሪያ ጊዜ ከየት አገኙ/ማን ነገረዎት?

1. ____ ባለቤትዎ/የወንድ ጓደኛዎ
2. ____ ጓደኞችዎ
3. ____ ቤተሰብ
4. ____ ት/ቤት
5. ____ አኢሴማ/አኢወማ/ ቀበሌ ስብሰባ
6. ____ ሬዲዮ፣ ቴሌቭዥን፣ መጽሔት፣ ወዘተ
7. ____ ከጤና ድርጅት/ የጤና ባለሙያ
8. ____ የቤተሰብ መምሪያ ማኅበር
9. ____ ሌላ፣ ይገለጽ____________

233. የሚያውቋቸውን ዘመናዊ የወሊድ ቁጥጥር ዘዴዎች ቢጠቅሱ?

1. ____ ፒል/እንክብል/
2. ____ ሉፕ
3. ____ የወንድ ዘር የሚገል/ኬሚ፣ ክሪም፣ ፎም፣ እንክብል
4. ____ ኮንደም
5. ____ የማህፀን ቱቦ በኦፕራሲዮን ማዘጋት
6. ____ ማህፀን በኦፕራሲዮን መስወጣት
7. ____ ቫስክቶሚ/ የወንድ ዘር ማስተላለፊያ ቱቦ ማዘጋት./
8. ____ በመርፌ የሚወጋ/ የሚሰጥ
9. ____ ሌላ፣ ይገለጽ____________

234. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ የሚያውቋቸውን ጥቅሞች ቢገልጹ?

1. ____ የማይፈለግ እርግዝናን ለመከላከል
2. ____ አራርቆ ልጅ ለመውለድ
3. ____ ለሕክምና
4. ____ በግብረስጋ ግንኙነት ምክንያት ሊመጡ የሚችሉ በሽታዎችን ለመከላከል
5. ____ ሌላ፣ ይገለጽ____________ ጠቅላላ ድምር ________

235. አንዲት ሴት [illegible] ቀን ፒል/እንክብል መዋጥ ብትረሳ ምን ማድረግ አለባት?

1. ____ የረሳችን ተተው የሚቀጥለውን ብቻ በጊዜው መዋጥ
2. ____ እንዳስታወሰች ወዲያውኑ መዋጥ
3. ____ የረሳችንና የሚቀጥለውን ጠብቀው በአንድ ላይ መዋጥ
4. ____ የተቀረውን መዋጥ ማቋረጥ

5. ____ ሌላ፣ ይገለጽ_____

6. ____ ምን እንደሚያደርጉ አያውቁም

236. 10 ዓመትና ከዚያ በላይ የሆና ቸው ልጆቸ በት/ቤታቸው ስለወሲዱ/ የወንዱ ሴት ግንኙነት ትምህርት እንዲሰጣ ቸው ይደግፋሉ?

1. ____ አይደግፉም

2. ____ ገለልተኛ ና ቸው

3. ____ ይደግፋሉ

4. ____ ሀሳብ ከመስጠት ተቆጥበ የል

3፣ ዘመና ዊ የወሊዱ ቁጥጥር ዘዴ ተጠቅመው ለማያውቁ

1፣ የጥናቱ መለያ ቁጥር

322. ጥያቄው አይመለከታቸውም

____ 0 ይጨሉ

323. ጥያቄው አይመለከታቸውም

____ 0 ይጨሉ

324. ጥያቄው አይመለከታቸውም

____ 0 ይጨሉ

325. ጥያቄው አይመለከታቸውም

____ 0 ይጨሉ

326. ዘመና ዊ የወሊዱ ቁጥጥር ዘዴ ለምን ተጠቅመው አንደማያውቁ ምክንያቱን ቢገለጹሉን?

1. ____ ነፍሰ ጡር ስለሆኑ
2. ____ ጡት ስለሚያጠቡ
3. ____ ለጤንነት ጠንቅ አለው ስለሚባል
4. ____ መሀን ያደርጋል ስለሚባል
5. ____ የጡንነት መታወክ ስላለብያት
6. ____ ባለጉት ያ/የወንዱ ጎደኛ ያ ፈቃደኛ ስላልሆኑ
7. ____ ባል/የወንዱ ጎደኛ ስለሌለያት
8. ____ መውለዱ ስለሚፈልጉ
9. ____ ሸይማኖትያ/ባሕልያ ስለማይፈቅዱልያት
10. ____ በአካባቢያ ጤና ድርጅት ውስጥ መከላከያው ስለሌለ
11. ____ ዘዴው መኖሩን ስለማያውቁ
12. ____ ሶላ የባህል መድኃኒት ስለሚጠቁሙ፣ ይገለጽ_____
13. ____ የወር አበባያን በመቁጠር ስለሚጠቁሙ
14. ____ ሌላ፣ ይገለጽ_____

327. ጥያቄው አይመለከታቸውም ____ 0 ይጨሉ

328. ጥያቄው አይመለከታቸውም ____ 0 ይጨሉ

329. ሀ. ወደፊት ዘመና ዊ የወሊዱ ቁጥጥር ዘዴ ለመጠቀም ይፈልጋሉ?

1. ____ አልፈልግም ---ወደ 330ው ጥያቄ ይሂዱ
2. ____ አያን --- ወደ 329 ለ ጥያቄ ይሂዱ
3. ____ አያውቁም ---ወደ 329 ለ ጥያቄ ይሂዱ

329.ለ. መጠቀም የሚፈልጉትን ዘመና ዊ የወሊዱ ቁጥጥር ዘዴ ከየት ማግኘት ይመርጣሉ?

0. ___ ጥያቄው አይመለከተኝም
1. ___ ከቡተሰብ መምሪያ ማኅበር
2. ___ ከግል ክሊኒክ
3. ___ ከፋርማሲ/ከመድኃኒት መደብር
4. ___ ከሆስፒታል
5. ___ ከጤና ጠቢያ
6. ___ ከመንግሥት ክሊኒክ
7. ___ ሌላ፣ ይገለጽ

330. አንዲት ሴት መዘና ዊ የወሊዱ ቁጥጥር ዘዴ መጠቀም ያለባት ዋነኛው ምክንያት ምን ይመስልያታል?

1. ___ የማይፈለግ እርግዝና ን ለመከላከል
2. ___ አራርቆ ልጁ ለመውለዱ
3. ___ ለሕክምና
4. ___ በግብረ ሥጋ ግንኙነት ምክንያት ከሚመጣ በሽታ ለመከላከል
5. ___ ሌላ፣ ይገለጽ
6. ___ አያውቅም
7. ___ ጠቅላላ

331. በ329ኛው ሀ ጥያቄ ዘመና ዊ የወሊዱ ቁጥጥር ዘዴ ወደፊት መጠቀም ኣልፈለጉ ምክንያትዎ ምንድነው?

0. ___ ጥያቄው አይመለከታቸውም/ወደፊት መጠቀም ስለሚፈልጉ
1. ___ ለጤንነት ጠንቅ አለው ስለሚባል
2. ___ መሀን ያደርጋል ስለሚባል
3. ___ መድሃኒት በየቀኑ መዋጥ ስለማይፈልጉ
4. ___ በዘዴያቸው ሙሉ እምነት ስለሌለያት
5. ___ በባሕላዊ ዘዴያቸው ብቻ መጠቀም ስለሚፈልጉ
6. ___ የጡት ኾግር ስላለብያት
7. ___ ተጨማሪ ልጅ/ልጆች መውለዱ ስለሚፈልጉ
8. ___ ባለቤትዎ/የወንድ ጓደኛዎ ስለማይስማሙ
9. ___ ሃይማኖትዎ/ባሕልዎ ስለማይፈቅዱለዎ
10. ___ ሌላ፣ ይገለጽ_____

332. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ ያውቃሉን?
   1. ___ የለም ወደ 338ኛው ጥያቄ ይሂዱ
   2. ___ አዎን ወደ 333 ጥያቄ ይሂዱ

333. ለመጀመሪያ ጊዜ ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ/ ቤተሰብ ምጣኔና እራርቆ መውለድ/ መረጃ ያገኙት/ የሰሙት በስንት አመትዎ ነበር?
   0. ___ ጥያቄው አይመለከታቸውም
   1. ___ ትክክለኛውን ዕድሜ ይሙሉ

334. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ መረጃውን ለመጀመሪያ ጊዜ ከየት አገኙ/ ማን ነገረዎት?
   0. ___ ጥያቄው አይመለከታቸውም
   1. ___ ባለቤትዎ/ የወንድ ጓደኛዎ
   2. ___ ጓደኞችዎ
   3. ___ ቤተሰብ
   4. ___ ጤ/ቤት
   5. ___ አስፋፊ/አኢወማ/ ቀበሌ ሰብሰባ
   6. ___ ሬዲዮ፣ ቴሌቪዥን፣ መጽሔት፣ ወዘተ
   7. ___ ከጤና ድርጅት/ የጤና ባለሙያ
   8. ___ የቤተሰብ መምሪያ ማኅበር
   9. ___ ሌላ፣ ይገለጽ________

335. የሚያውቋቸውን ዘመናዊ የወሊድ ቁጥጥር ዘዴዎች ቢጠቅሱ
   0. ___ ጥያቄው አይመለከታቸውም
   1. ___ ክኒን/እንክብል
   2. ___ [illegible]
   3. ___ የወንድ ዘር የሚገል/ፎም፣ ክሬም፣ ጄሊ፣ እንክብል
   4. ___ ኮንዶም
   5. ___ የሴት ህፀን ቱቦ በኦፕራሲዮን በማዘጋት
   6. ___ ማህፀን በኦፕራሲዮን በማስወጣት
   7. ___ ቫዜክቶሚ/ የወንድ ዘር ማስተላለፊያ ቱቦ በኦፕራሲዮን ማዘጋት
   8. ___ በመርፌ የሚወጋ/ የሚሰጥ
   9. ___ ሌላ፣ ይገለጽ________

   ጠቅላላ________

336. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ የሚያውቋቸውን ጥቅሞች ቢጠቅሱ

0. ____ ጥያቄው አይመለከታቸውም
1. ____ የማይፈለግ እርግዝናን መከላከል
2. ____ ሽፈር ዋ ልጅ ለመውለድ
3. ____ ለሕክምና
4. ____ በግብረስጋ ግንኙነት ምክንያት ሊመጡ የሚችሉ በሽታዎችን ለመከላከል
5. ____ ሌላ፣ ይገለጽ____________

   ጠቅላላ____________

337. አንዲት ሴት የአንድ ቀን፣ ፒል/እንክብል መዋጥ ብትረሳ ምን ማድረግ አለባት?

0. ____ ጥያቄው አይመለከታቸውም
1. ____ የረሳችን ትተው የሚቀጥለውን ብቻ በጊዜው መዋጥ
2. ____ እንዳስታወሰች ወዲያው መዋጥ
3. ____ የረሳችውንና የሚቀጥለውን ጠብቀው በአንድ ላይ መዋጥ
4. ____ ፒሎቹን ከመውሰድ ማቋረጥ
5. ____ ሌላ፣ ይገለጽ____________
6. ____ ምን እንደሚያደርጉ አያውቁም

338. 10 ዓመትና ከዚያ በላይ የሆናቸው ልጆች በት/ቤታቸው ስለወሊድ/ ወንድና ሴት ግንኙነት ትምህርት እንዲሰጣቸው ይደግፋሉ?

1. ____ አይደግፉም
2. ____ ይደግፋሉ
3. ____ ሐሳብ ከመስጠት ተቆጥበዋል

ለባሎች/ለወንድ ጓደኞች

1. የጥናቱ መለያ ቁጥር

37. ከባለቤትዎ/ከቤት ጓደኛዎ ጋር ስለቤተሰብ ምጣኔና ስለአራርቆ መውለድ ይወያያሉ?

   0. ____ ጥያቄው አይመለከታቸውም
   1. ____ አይወያዩም
   2. ____ አዎን

38. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ/ አራርቆ ስለመውለድና ስለቤተሰብ ምጣኔ/ ያለዎት አስተያየት/አመለካከት እንዴት ነው?

   0. ____ ጥያቄው አይመለከታቸውም
   1. ____ ይቃወሟሉ —— ወደ [illegible]ኛው ጥያቄ ይሂዱ
   2. ____ ገለልተኛ ናቸው —— ወደ [illegible]ኛው ጥያቄ ይሂዱ
   3. ____ ይደግፋሉ —— ወደ [illegible]ኛው ጥያቄ ይሂዱ

39. የዘመናዊ የወሊድ ቁጥጥር ዘዴን ለምን ይቃወማሉ?

   0. ____ ጥያቄው አይመለከታቸውም
   1. ____ ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ ምንም እውቀት ስለሌለዎት
   2. ____ የጤና ጠንቅ አለው ስለሚባል
   3. ____ መሀን ያደርጋል ስለሚባል
   4. ____ ባለቤትዎ/የቤት ጓደኛዎ ፈቃደኛ ስላልሆኑ
   5. ____ ሃይማኖትዎ/ባሕልዎ ስለማይፈቅድ
   6. ____ ባህላዊ የወሊድ ቁጥጥር ዘዴ ስለሚመርጡ
   7. ____ ሌሎች ይገለጹ ______________

40. ወደፊት የዘመናዊ የወሊድ ቁጥጥር ዘዴ መጠቀም ይሻሉ?

   0. ____ ጥያቄው አይመለከታቸውም
   1. ____ አይፈልጉም —— ወደ [illegible]ኛው ጥያቄ ይሂዱ
   2. ____ አዎን —— ወደ [illegible]ኛው ጥያቄ ይሂዱ
   3. ____ አያውቁም —— ወደ [illegible]ኛው ጥያቄ ይሂዱ

41. ዘመናዊ የወሊድ ቁጥጥር ዘዴ ወደፊት ለመጠቀም ለምን አልፈለጉም?

   0. ____ ጥያቄው አይመለከታቸውም
   1. ____ ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ በቂ እውቀት ስለሌለዎት
   2. ____ መሀን ያደርጋል ስለሚባል

3. ____ የጡና ጠንቅ አለው ስለሚባል
4. ____ ባለቤት ዎ/ የሴት ጓደኛ ዎ ፈቃደኛ ስላልሆኑ
5. ____ ባለቤት ዎ/ የሴት ጓደኛ ዎ ነፍሰ ጡር ስለሆኑ
6. ____ ባለቤት ዎ/ የሴት ጓደኛ ዎ ጡት እያጠቡ ስለሆኑ
7. ____ ልጁ መውለድ ስለሚፈልጉ
8. ____ ባሕላዊ የወሊድ ቁጥር ዘዴ መጠቀም ስለሚሹ
9. ____ ሐይማኖት ዎ/ባሕል ዎ ስለማይፈቅዱልዎ
10. ____ ዘዴው በአቅራቢያዎ ባለው የጤና ድርጅት ስለማይገኝ
11. ____ ሌላ፣ ይገለጽ_____

42. የሚያውቋቸውን ዘመናዊ የወሊድ ቁጥር ዘዴዎች ቢጠቀሱ

0. ____ ጥያቄው አይመለከታቸውም
1. ____ ፒል/እንክብል
2. ____ ሉፕ
3. ____ የወንድ ዘር የሚገድል/ፎም፣ ክሪም፣ ጄሊ፣ እንክብል
4. ____ ኮንዶም
5. ____ የሴት ዘር ማስተላለፊያ ቱቦ በስንራስዋን ማዘጋት
6. ____ ማህፀን በስንራስዋን ማስወጣት
7. ____ የወንድ ዘር ማስተላለፊያ ቱቦ በስንራስዎን ማዘጋት
8. ____ ሌላ፣ ይገለጽ_____
9. ____ ምንም

ጠቀላላ _____

43. ስለዘመናዊ የወሊድ ቁጥር ዘዴ ማወቅ ይፈልጋሉ?

0. ____ ጥያቄው አይመለከታቸውም
1. ____ የለም ____ ወደ 61ኛው ጥያቄ ይሂዱ
2. ____ አዎን ____ ወደ 62ኛው ጥያቄ ይሂዱ

44. ስለዘመናዊ የወሊድ ቁጥር ዘዴ ማወቅ የማይፈልጉት ለምንድነው?

0. ____ ጥያቄው አይመለከታቸውም
1. ____ የሚስት ዎ/ የሴት ጓደኛ ዎ ችግር ብቻ እንጂ የእርስዎ ችግር ስላልሆነ
2. ____ ባለቤት ዎ/ የሴት ጓደኛ ዎ ስለማይፈቅዱ
3. ____ መሀን ያደርጋል ብለው ስለሚፈሩ
4. ____ ልጁ መውለድ ስለሚፈልጉ

5. ____ ሐይማኖት ያ/ባሕል ያ ስለማይፈቅዱ
6. ____ ባሕላዊ የወሊድ ቁጥጥር ዘዴ ብቻ መጠቀም ስለሚፈልጉ
7. ____ ሌላ፣ ይገለጽ______________

45. ስለዘመናዊ የወሊድ ቁጥጥር ዘዴ መረጃ ከየት ማግኘት ይፈልጋሉ?
0. ____ ጥያቄው አይመለከታቸውም
1. ____ ከባለቤት ያ/ከሴት ጓደኛ ያ
2. ____ ከጓደኞች ያ
3. ____ ከቤተሰብ
4. ____ ከቀበሌ/ሕዝብ ስብሰባ
5. ____ ከሬዲዮ፣ ቴሌቪዥን፣ መጽሔት ወዘተ
6. ____ ከጤና ድርጅት/ጤና ባለሙያ
7. ____ ከፋርማሲ/ መድኃኒት መደብር
8. ____ ከሥራ ቦታ/ መሥሪያ ቤት
9. ____ ሌላ፣ ይገለጽ______________

46. የሚያውቋቸውን ዘመናዊ የወሊድ ቁጥጥር ዘዴ ጥቅሞች ቢጠቅሱ ?
0. ____ ጥያቄው አይመለከታቸውም
1. ____ የማይፈለግ እርግዝናን ለመከላከል
2. ____ አራርቆ ልጅ ለመውለድ
3. ____ ለሕክምና
4. ____ በግብረሥጋ ግንኙነት አማካይነት ከሚመጡ በሽታዎች ለመጠበቅ
5. ____ ሌላ፣ ይገለጽ______________
6. ____ ምንም

47. 10 ዓመትና ከዚያ በላይ የሆናቸው ልጆች በት/ቤታቸው ስለወሊድ፣ ወንድና ሴት ግንኙነት ትምህርት እንዲሰጣቸው ይደግፋሉ?
0. ____ ጥያቄው አይመለከታቸውም
1. ____ አይደግፉም
2. ____ አዎን
3. ____ ገለልተኛ ናቸው
4. ____ ሐሳብ ከመስጠት ተቆጥበዋል

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DECLARATION

I, the undersigned, declare that this thesis is my work and that all sources of material used for this thesis have been duly acknowledged.

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Date of Submission: April, 1989