MAJOR FACTORS AFFECTING CONTRACEPTIVE USE AMONG ZAY COMMUNITY MEMBERS

A Thesis Submitted to the School of Graduate Studies, Addis Ababa University

In Partial Fulfillment of the Requirements for the Degree of Master of Arts in Counseling Psychology

By

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July, 2009

Acknowledgements

For the success completion of this thesis, so many people were involved in various ways while I undertake this research. Of all,my sincere and heartfelt appreciation goes to my advisor, Dr. Sintayehu Tadesse who encouraged and initiated me in undertaking this research in this area. Besides, his generosity, patience and valuable suggestions, constructive criticism and dedication of his precious time in reading and correcting this thesis from the beginning to the end I would like to owe my special thanks.

I should also like to offer my heartfelt thanks to all my respondents to fill the questionnaire in patience. Additionally, my special thank goes to Abera Kefeni, Alemu Beriso, Alemu Tufa, Bekele Ararsso, Kufa Ourgessa, Mihret Huluka, Assefa Midakso, Shashine Burka, Tsegaye Buki, Abrham Barke, Birhan Bekere and others who were assisted me while I was collecting data both from urban and rural areas in difficult circumstances.

While it is impossible to list all their names, I offer my deepest thanks to Birhanu Midekso, Sibhat Bedadi, Shanko Chura, Getu Gebissa and Serkalem Ejigu,Adanech Bedadi ,Kasa Galana and others who helped me morally, in material and financially for the completion of this thesis work.

I also owe my thank to my heartfelt friends Ato Ebabush Yirdaw , Thomas Ayana, Tatek Mola and Misaye Mulate for their unreserved assistance and encouragement while analysing data of the study.

I equally wish to extend my gratitude to my brothers and sisters particularly Ato Mergo Wako and Midakso Semagn for all they had done for me.

Finally, my deepest grateful and thanks goes to my fiance Abebech Kabeto. It was her unflagging patience and rigor of mind over six years which made this study possible.

At last but not least I would like to extend my heartfelt gratitude thanks to w/t Wosen Shikur for typing this thesis work.

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Abbreviations

ANOVA- Analysis of Variance

CDC- Center for Disease Control and Prevention

CELADE- Centro Latino Americano de Demografia

CFSC- Community and Family Study Center

CSA – Central Statistics Authority

DF-Degree of Freedom

EDHS- Ethiopian Demographic and Health Survey

F- Critical value of F

IUD- Intra Uterine Device

KAP -Knowledge, Attitude, and Practice

NDHS- Nepal Demographic and Health Survey

SPSS-Statistical Package for Social Science

TGE- Transitional Government of Ethiopia

$\overline{X}$- Mean value

Abstract

The overall objective of this study was to investigate major factors associated with contraceptive use among married Zay community members. The study involves 179(91 male and 88 female) randomly selected married men and women from two Island settlers, two Kebeles, and two towns where the community settles.

Analysis of the data collected was made using quantitative analysis: percentile, Chi-Square, One Way ANOVA, Inter-correlations, and Stepwise regression analysis. Results of the analysis indicated that except sex, all variables (residence, religious attendance, educational level, age at first marriage, age of respondents and number of living children) were significantly associated with contraceptive use. Besides, there is significant difference between contraceptive users and non users on value of children, couples communication, concepts toward contraceptives and perception towards family planning counseling. Furthermore, analysis of the stepwise regression revealed that residential place, couples communication, age of marriage, distance in kilo meter to get the service, and educational level were the most powerful predictors of contraceptive use.

Implication of this study is that concerned organizations both governmental and nongovernmental organizations should involve providing contraceptives and related family planning services in community based manner. Besides, expanding education will enhance couples communication and reduce early marriage in the community.

CHAPTER ONE

1. INTRODUCTION

Everybody has the right to give birth as he/she required. The same is true in regulating fertility. This right to regulate ,to plan the size and spacing of the family size was originally agreed at the International Conference on Human Right held at Tehran in 1968 (UNFPA,1999).

Even though it is the right of individuals to reproduce, this reproduction is not just a question of biology but also a phenomenon that is highly influenced by societal arrangements. Therefore, the structure and culture of the society have great impact in individual's biological capacity to reproduce. Accordingly, in different nation's different groups are urging actions to be taken to slow down the present rapid rates of population growth. Because, the late 20th century witnessed extraordinary population growth in the history of world. For instance, in world population history, higher rate increase is observed in 1960s and largest annual increment is also seen in the 1980s (Glasier and Gabbier, 2000). For this rapid population growth, one research done in Latin America at the beginning of 1970s recommended special efforts to be made to inform all married adults about spacing children as they wish and to limit their family size to a desired number. Because, such excessive population growth has significant impact on the social and economic development of one nation (CELADE&CFSC, 1972).

Even if different international agencies involved in attitude change in fertility regulation behaviors, there are problems in carrying out the programs effectively. For this, concerning fertility regulating variables influencing individual behaviors remains a point of debate (Maclean, 2001).

One side argues that such programs can legitimize preferences for smaller families and help meet latent demand for fertility regulation in high-fertility societies (Freedman R. and Berelson B, 1992). The diffusion of contraception through family planning programs thus helps reduce some of the costs of obtaining services by lowering both monetary and

psychosocial costs. For example, according to an analysis of family planning use in Sub-Saharan Africa, improved availability of services (as evaluated by distance to sources and availability of specific services) was generally associated with higher levels of modern contraceptive methods use (Ainsworth M, 1994).

The other side of the debate is the idea that a country's socioeconomic development will be the ultimate factor in fertility decline and contraceptive prevalence. The case of Brazil is often cited as an example in this argument; that the country experienced rapid fertility decline over the last three decades in the absence of a national family planning program, but in the presence of rapid urbanization and industrialization (Bulatao R and Lee R, 1983). Whereas, most demographers agree that fertility is determined ultimately by social, economic and cultural factors (Hinde, 1998). Others give more credibility for the introduction of modern family planning technologies in regulating fertility behavior of individuals. What is compelling in research findings as stated in Maclean (2001) is that many couples all over the world want fewer children. According to UNFPA report, if women could have only the number of children they wanted, the total fertility rate in many countries could fall nearly to one third per women (UNFPA, 2000). Because, the fewer the children women want, the more time they spend in need of contraception and the more services are required. This report added that even though so many options are available and introduced as of 1960s women do not always get the support they need to fulfill their reproductive intention. From this one could understand that women need to regulate their fertility as they desired. But, they couldn't do so due to different factors.

In relation to the use of contraceptive methods to regulate fertility, UNFPA (1999) report pointed out that although the use of contraceptive to regulate fertility in developing countries increased, the need is unmeet. Particularly, the level of this unmet need is higher in sub-

Saharan Africa. For these differences, researchers put down different factors as hindrance agents. And these factors vary from region to region; country to country.

Theories that attempt to explain the pattern of contraceptive use in Africa tend to be based on cultural or institutional factors, economic, and individual socio-demographic characteristics (e.g. education and age at marriage) (United Nations, 1987). The cultural theses argue that the prevailing practices and norms encourage large families (Caldwell, 1982; Appiah, 1985; Caldwell & Caldwell, 1987) and reduce the motivation for couples to use contraceptives.

Ethiopia is one of the sub-Saharan Africa countries, where total fertility rate is very high and coverage of family planning is very low over the country. Accordingly, a woman bears an average of six children by the end of her reproductive life and family planning constitutes only 17.2% (Ministry of Health and WHO, 2003). This situation made the country to be characterized by higher rate of fertility. The report added that there is a regional and residential disparity in total fertility.

International communities set provision of reproductive health particularly access to a full range of safe and reliable family planning methods and related reproductive and sexual health services as one major goal to be achieved by 2015(International Conference on Population and Development(ICPD), 1994). According to The World Bank (2005) report despite the declining fertility level in Ethiopia, the rate of change is insignificant to achieve the national population policy target of four children per woman by 2015.

According to the report, in Ethiopia there is relatively higher knowledge of contraceptive methods. But the actual use of modern contraceptive even among the richest household is very low. On the other hand the report depicted that the majority of Ethiopian women and men (98%) prefer to space or limit the number of children they have. But, the Ethiopian women and men couldn't do so due to different factors. This indicates there is unmet demand

of family planning both in urban and rural part of the country. However, the report failed to explain the factors that impede the actual use of modern contraceptives among married groups. From this report, one could question as why Ethiopia could not achieve the national population policy of four children per women when there is higher knowledge in the area of reproductive health and most individuals want fewer children?

As a target to achieve the national population policy target of four children per woman by 2015(TGE,1993), conducting a research on family planning and birth control package on communities who have the same psychological and socio-cultural make-up is timely. Because, the fertility behavior of an individual is conditioned by the ethnic group and socio-cultural influence to which she/he belongs (Ezeh, 1997).

Therefore, to realize national policy it is necessary to conduct research in identifying factors involved in contraceptive use at community level before taking actual actions. This situation made the writer to do this research on this issue.

1.1. The Study Area

This study carried out in Oromia administrative region where Zay community is settled. Zay community settled in two zones and three woredas. These zones are East Shoa and Arsi zones; and the woreda's are AdamiTullu, Dugda(both of them are found in East Shoa) and Ziway Dugda woreda(which is found in Arsi zone).

To be more specific, the community resides on the islands of Lake Ziway which is 160 km south east of Addis Ababa on the main road to Awasa, the surrounding peasant association kebeles, Ziway and Meki towns. The five islands are Gelila , Debresina (both of them are found in east Shoa, Adami Tulu woreda), Debretsion (Tulugudo),Famat(Funduro) and Aysut(Tsedecha) (which are found in Ziway Dugda woreda ;Arsi zone). Besides, the kebeles' this community settled and this study covered are Bochesa kebele which is found in Adami Tulu woreda; Mekdela which is found in Dugda woreda. The towns this study included are Ziway and Meki towns. Even though there is no documented data on fertility and family planning status of the community, the zones and woreda's where the community settled have high fertility rate. According to the Central Statistics report of the 1994 population and housing census, total fertility for Arsi zone is 6.1 and 5.3 for east Shoa zone. Both zones have above total fertility rate of the region which is 4.9 children per woman in rural area. Regarding the two urban areas, Ziway and Meki town where the community settled constitute total fertility rate of 2.9 and 3.9 respectively (CSA, 1996).

Regarding provision of family planning service in the community, again there is no well documented evidence. However, at zonal level the statistics obtained from the regional health bureau indicate that Arsi zone achieved only 38.3% of it's target and East Shoa achieved 49% of it's target plan in 2000 Ethiopian fiscal year in addressing family planning service in their

zone (Oromia Regional Health Bureau,2008) . But the report failed to describe in rural kebele, town and woreda level distribution.

As far as religion of the society is concerned, almost the majority of the society is Orthodox and few of them are other type of Christian.

Like other areas of the country, the Zay community is among the highly affected area by high population growth. This over population affected the community members before the beginning of 20 th century(Paul Henze,1989). As described in Tesfaye (2000 E.C) and Paul Henze(2001), this high rate of population growth obliged the Zay community to leave their mother land islands and lives in the nearby peasant association kebeles' as of 1960s.

But regarding fertility rates and related reproductive health issues well documented sources are not available to take actions in reproductive health matters. Besides, it is the area and community were considered as isolated for about three hundred years (Henze, 1989) and well compiled research has not been done so far.

1.2. Statement of the problem

There has been a long standing concern in the social sciences with the study of fertility. Accordingly, scientists come up with different determining factors in fertility regulation mechanisms.

As stated in earlier section, in recent years there is decreasing tendency among couples to have more children in developed and developing countries. The desire to bear additional children could be attributed to so many factors. However, it varies from country to country, region to region and community to community. So, it is difficult to conclude one area 's factor as the major cause for fertility behavior of individuals in other settlement area. Besides,

such issues can not be addressed in one study. Rather they need continues investigation in the area.

When we come to the case of contraception's in community level, it could serve as not only a means to control fertility but also a means to improve the health of women, children, and families as a whole. Even though the truth is this, it's coverage to the national as well as regional level is very low in Ethiopia. For this, concerted efforts have been on by the concerned organizations to address the issue of unmet need for family planning (MOH/WHO, 2003). For example, in Oromia region in 2000 E.C fiscal year the acceptance rate of family planning increased from 27% to 37.7% which is the maximum increment during the past couples of years. However, there are still remarkable achievement gaps among zones (Oromia Regional Health Bureau, 2008).

The Ethiopian Demographic and Health Survey (EDHS)(2005) has shown that a third of women surveyed do not want any more children, 36 percent of women expressed a desire to space their next birth by at least two years and another 22 percent wanted child soon. This indicates as the majority of women in reproductive age group are not in need of children soon. Yet, EDHS failed to present the contraceptive behavior at zonal and woreda level.

Researches in the family planning area indicate that the gap is not in attitude or knowledge area; rather, the problem is in practice area. So, what happens at the community level and involvement of the community in family planning can make a difference (Wayne& Shannon, 1984). One's the problems associated with practicing elements are identified at community level, it paths the way to take action and design family planning programs in the manner to satisfy the needs of the society. Based on this assumption, this study is intended to be conducted on major factors and elements associated with contraceptive use behavior of community at large and individuals in particular. Hence, the present study will analyze both

married females and males contraceptive usage and associated factors in one selected community in Oromia regional state, namely Zay community. The focus is on socio-demographic and other factors associated with contraceptive use.

1.3. Objectives

The overall objective of this study was to investigate major factors associated with contraceptive use among married Zay community members.

The Specific objectives of the study are:

- To identify socio-demographic factors associated with contraceptive use among married women and men,
- To examine the association of accessibility of contraceptive methods and contraceptive use
- To find out if there is significant difference between contraceptive users and non users on various factors like value of children, couples communication, concepts about contraceptives and perception towards counseling.
- To recommend some practical means to reduce family size and promotion of family planning.

To this end, this study tried to answer the following questions.

What are the socio-demographic variables that affect contraceptive use?

Does availability/accessibility of contraceptive methods affect contraceptive use?

Do contraceptive users and contraceptive non users significantly differ on the various factors like value of children, couples communication, concepts about contraceptives and perception toward counseling ?

1.4. Significance of the Study

The need for a balance between resources and population size assumes the need for self-sufficiency with in a particular population. To achieve this balance, it is necessary to regulate fertility behavior. Now a days, government and international agencies are highly concerned about addressing the issue of reproductive health in different parts of the country through different means. For instance, successful experiences have been gained in Jimma, and North and South Gonder Zones by involving the community in addressing contraceptives and family planning services to the hard-to reach rural communities (Korra A.,1997; Getnet M., 2000). In line with addressing the service at community level, it is necessary to find out significant factors that contribute for fertility behavior and contraceptive behavior of individuals in the community to take appropriate action at different part of the country. Because, the reasons for changes in birth rates are difficult to determine and the availability of contraception is only one of a number of interacting factors (Loudon, 1985). As Loudon added, availability of contraception plays significant role in regulating fertility. However, adequate services to control fertility are not available in the majority of developing countries. Even there are lots of problems to use the existing methods. Hence, it is necessary to assess the factors associated with contraceptive use at community level. Therefore, this study is important for the following reasons.

1. It provides useful and up-to-date information for future programs that can be developed to regulate fertility rate in the area.
2. It may give pertinent information to Government organizations and non-government organizations concerning significant factors that influence contraceptive practice.
3. It provides information to those who are involved in family planning programs in the area; particularly for those who would like to carry out humanitarian activity.

Additionally, it will serve as a source for other researchers to conduct such type of research in the area.

1.5. Scope of the Study

Research on family planning requires a wide scale study on different groups, levels, and area of the country. However, focusing at community level helps to design appropriate intervention mechanism to cascade at wider scale of it's good practice. Besides, it is more manageable to carryout a research in specific area and community which have common psychological make-up. Accordingly, this research is delimited to one selected community in Oromia region, namely Zay Community.

When we come to the theme of the research, according to UNFPA(2000), reproductive health has five components. Among them, this research focuses only on family planning particularly, contraceptive use due to it's relation to counseling. Besides, due to different reasons, this research incorporated only information of beneficiaries but not health professionals' response.

1.6. Operational Definition

Family planning: means the use of contraception to regulate birth rates.

Zay community : In this study Zay Community members are those communities found in Zeway and Meki town, Bochessa and Mekdela kebeles and Islands of Lake Zeway.

Contraceptive Methods: refers to different methods appropriate for preventing fertility in a temporary or reversible way.

Contraceptive use : Application of different contraceptive methods to avoid pregnancy during their marriage period for the last one year.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

In this section, different factors and research findings related with contraceptive use were critically analyzed and presented as follow.

2.1. Socio-demographic variables and contraceptive use

Among various factors that influence contraceptive use number of living Children is one factor. As explained by Habimana (1984) African women wish to have five or more children. The justifications are in the case of high mortality out of large numbers of births, only a small number survives; the child strengthens the family group economically and socially and ensures its survival. Besides, the child eases the burden of the work done by women. Moreover, the woman ensures her fertility and responds to the pressure of the society by giving much birth. Habimana added that in general the African women wishes to have as many children as she can wishes to have and so that some will survive. Therefore, their intention to use contraceptive methods to delay or space pregnancy is low.

In contrary to African women to bear child, other culture's women's need to have additional children depends on different factors. For example, the research result in Iran by Good, Farr, and J.Good (1980) indicated that number of living children varies inversely with income, education, ownership of modern items, and occupational group. But its degree varies in urban and rural settings.

On the other hand Razzaque as cited in Biniam (2007) indicated that mean desired family size increase with the number of living children. This implies that contraceptive use of women is determined by number of living children. According to the above statement, those who have large desired family will have a large number of family and their intention or

experience about contraceptive use is determined. However, those families whose living children exceed their ideal number of children motivate to use contraception twice as those who had not yet reached their ideal number(Razzaque as cited in Biniam ,2007).In Morocco, contraceptive use was 13% among women with no children and 57% among women with four or more children (Althaus F.,1997).This research finding implies that as the number of living children increases, intention to use contraceptive methods also increase. Moreover, a study conducted in Pakistan revealed that there is a direct association between the number of living children and the use of contraception, and contraception use increases with an increase in the number of living children, and in the number of living sons, linearly(Farooqui M, 1990).

Furthermore, living number of children indirectly affects fertility behaviour and desired family size. For example, one study carried out in Turkey revealed that contraceptive was more likely not used among younger couples than in the oldest age-groups, and was positively associated with number of living children (Andrzej Kulczycki, 2008). Accordingly as number of living children increases, contraceptive use also increase. Moreover, Kulczyck suggested that couples who both wanted more than three children, and couples in which only the wife wanted three or fewer, had lower odds of using a method than did couples in which both spouses wanted three or fewer children.

In the case of Ethiopia, EDHS (2005) revealed that living number and ever born children rise monotonically with increasing age of women. Besides, the report revealed that as the number of children increases, their desire to limit childbearing increases. This means their intention to use contraceptive use increase. However, in this finding contraception use of women does not affected by number of living children. Instead, it is affected by age; and accordingly younger females use family planning than older ones.

In addition to number of living children, there is a debate as there is Gender Difference in contraception use. As stated in Kifle (1999) various research results argue for about gender reproductive decision making and contraceptive use difference. For instance, a research conducted by Emberstdt as cited in Kifle states that women consistently desire smaller families than do their husbands. In similar manner, the finding of Isiug, Abanihe(1994) and Sulva(1991) revealed that in developing nations men generally desire large families than do their wives. The UN (2001) report conducted in different regions of the world, like West Africa, come up with similar finding and suggest that men wants large family size than women. Additionally, the finding of Bankole and Singh (1998) shows that men want more children than women and also that men make ultimate decisions about the use of contraceptives and size of the family. Similar study by Reed, Fred , McBroom, and William (1986) in America suggest that men are more likely to towards fertility while women become less so. These results are in part due to differential values regarding marriage and the family.

In contrast to the above research finding, Cain as cited in Mason and Taji(1987)has indicated that there is greater desire for more children among women than men. As it is stated, the reason for such difference might be attributed for physiological difference, costs and benefits of children (Kifle, 1999).The above research findings implicitly suggest that there is gender difference regarding desired family. Consequently intentions to use or experience of using contraceptives vary in the same manner.

In a mediatory way some fertility determination theories indicate that there are plausible reasons for expecting similar fertility desires among women and men, greater desires among women, and greater desires among men in pre-transition settings. Most theories agree, however, that social, economic, or demographic modernization should reduce any pre-

existing differences. Studies Statistics show, on average, only small differences between women's and men's family size desires, with women wanting more children than men in some studies and wanting fewer in others. Thus, claims that women consistently want fewer or more children than men appear to be incorrect. In high-fertility settings, however, there is some tendency for women to express the desire to cease childbearing more frequently than men do (Mason, Karen O., Taj and Anju M, 1987).For instance, one study conducted in Turkey revealed that wives and husbands had similar preferences regarding ideal family size, with high proportions (84% and 82%, respectively) wanting three or fewer children (Andrzej Kulczycki, 2008). Just like the experience of Turkey, the desire and ideal family size in Egypt is moderate with slightly larger for husbands (Mayone, Sayed, Avery, and Fridman, 1998). Oppenheim Mason(2000) research result of five countries in Asia suggest that gender context has little net effect on couples' concordance, but influences the relative weight of husbands' and wives' preferences in determining contraceptive use. In a similar manner, Andrzej Kulczycki(2008) revealed that husband-wife inconsistencies were primarily attributable to the wife wanting fewer children than her husband would like .

Finally, Andrzej Kulczycki(2008) research reports of contraceptive method use indicated that there is slightly lower contraceptive use among husbands than among wives (68% vs. 72%), but the level of agreement suggests moderate concurrence beyond chance in Turkey.

To conclude, these research findings suggest that gender difference in desired family and contraceptive use vary from region to region and country to country. So, it requires further investigation.

In Ethiopian case, the result of EDHS (2005) indicated that majority of both sexes want no more child to have. However, men desire more children than women. In a similar manner, a study conducted in Tigray by Gebrekidan (2002) revealed that there is significant difference

in desired family size between males and females showing men needs higher proportion for desire of many children. Implicitly, these explanations depict that the desire to use contraceptives among men is low. Besides, it needs further investigation.

Concerning gender difference in this study area (Zay community) on contraceptive use, there is no documented materials that explain the existing situation. But from experience male dominance and decision making is higher in the area in many aspects like other part of Ethiopia.

In addition to the above variables, Age at first Marriage has significant influence on Contraceptive Use. However, it varies from country to country, region to region and educational level of individuals (Murthy, 1968).

It can be explained that the more a woman marries later, the more confidence she has, the more she will be able to communicate about her needs, about sex, and her feelings even in cultures where such communication is considered taboo.

Inorder to substantiate the above assumption, research carried out at different part of the world were analyzed. One study conducted in India by Reddy (1986) found that there is an inverse relationship between age at first marriage and contraceptive use. Accordingly, as age of first marriage increases, live birth decreases and their intention to use contraceptives decrease. Similar finding in Latin America states those girls who marry early bears many children, and those who marry late bear fewer children (Monsted and Parveen, 1978; Mahadevan, Reddy and Naidu, 1986).In contrary, the finding of Mahadevan, K.and Sumanga (1987) confirms that a higher age at first marriage, a decline in infant mortality, an extensive family planning infrastructure and the widespread use of contraceptive methods. This can be done because, the individuals can develop/mature in the manner to express their needs and communicate very well with their partner.

A similar pattern was noted between age at first marriage and contraceptive use in Bangladesh. Age at first marriage was found to be the most important variable explaining fertility behavior and contraceptive use .Accordingly, those married under the age of 15 years had an average of 4.22 children compared to 1.77 among those who married at 20-21 years of age and 2.65 among those marrying at age 22 years or above. Contraceptive use increased from 11% among women married below the age of 15 years to 32% among those who married at age 22 years or above(Chaudhury R,1984).In a similar manner, research result in Pakistan show that, although female age at first marriage has been gradually rising, women in unions married at younger ages and were less likely to use modern contraceptive methods (Hussain R, Bittles A.H.,1999).

Age at first marriage in influencing the use of contraceptives and fertility regulation, the experience of Ethiopia indicated that among women aged 25-49 during interview 66% of them married by age 18 and 79% married by age 20. The median age at first marriage among women age 25-49 during interview date is 16.1years.However the proportion of women married by age 15 has decreased from 38% among women age 49-49 t0 13% among women age 15-19(EDHS, 2005). However EDHS report didn't indicate the association age at first marriage has with fertility desire and contraceptive behavior of respondents.

The other influential factor in contraceptive use is educational attainment of individuals. As it can be expected, an exposure to formal education contributes a lot in reducing fertility rates. However different studies at different times in different countries have come up with contradictory results. Accordingly, some says it has significant contribution where as others said it has no effect. Let us discuss some arguments on the effect of education on contraceptive use.

As described by Castro and Jejeebhoy (1995) contraceptive use in developing countries are associated with various markers of socioeconomic status, most prominent of which is education. They further indicated that the existence of well documented link between female educational attainment plays an important role in development of family planning policies in lower income countries. This statement signifies the role of education in promoting small family size and the use of contraception. Education emerged as the variable most strongly correlated with contraceptive use ranged from 8% among those with no education to 42% among women with a secondary education or above in Bangladesh (Chaudhury R, 1984).

Another study carried out in China suggests that the most significant variables affecting fertility and contraceptive behavior are education and income among socioeconomic variables (Jiang, Zhenghua, 1986). That is parents with more education may have a comparative advantage in producing well educated children and subsequently substitute large family size with it.

In some countries even though the rate vary, it is high even among illiterate groups. For example, contraceptive use was 45% among women with no education and 66% among women with a secondary or higher education in Morocco (Althaus F. 1997).This suggests as education can make a difference in contraceptive behavior of individuals.

Additional study conducted by Mary Jo, Farr and Good(1980) in north western Iran indicated that women with greater educational attainment are apt to have more idea of family planning methods and can be able to use them to control their family size. In addition to this, the study revealed that higher education leads women to marry later and such women are less apt to be contented with large families. The effect of women's education on fertility was proved to be greater in the settings with more family planning inputs than in the settings with less inputs of family planning [and] the effect of socioeconomic development on fertility is greater among

less-privileged women than among more-privileged women in Korean society (Kim, Ik Ki,1987).Another study carried out in Columbia indicated that women with no education have three and/or more children than do women with secondary schooling (Prada et.al,1986).Implicitly, this finding suggests that those women with better educational opportunity are in a better position to plan their family size through different means.

In contrary to the above findings some study results in some countries indicated that educational attainment and family size has positive correlation result. For instance, one study conducted in rural Bangladesh by Stoeckel and Chowdhury (1980) come-up with the finding that women's with higher education and marry husbands of lower educational level has higher children than those of higher educational state of husbands. From this one might conclude that not only females education but males education matters in family size.

The experience of Ethiopia is the same with that of other countries. The result of EDHS (2005) indicated that level of fertility is inversely related to women's educational attainment. i.e., it decreases rapidly from 6.1 children among women with no education to 2.0 children among women who have at least some secondary education. After saying this about association of education and fertility rate, the report also added about the relationship of educational level and contraceptive use. As revealed in the report, current use of contraceptive is fivefold among secondary and above than those women with no education. In similar manner, research findings at different places of the country come up with similar findings. Accordingly, these researchers said that fertility preferences and contraceptive use have significant relationship and affected by educational attainment (Murad, 2006; Negussie, 2006; Worku ,1997, Tamiru, 2007).

However, the finding of Alemseged (1989) revealed that there is little fertility difference and contraceptive use between the illiterate and those who attended formal education. This

variation and insignificant effect of education might be attributed to passage of time where family planning and family life education has not get due attention.

When we come to Zay Community, even though there are no documented materials that depict contraceptive behavior and mechanisms they use to avoid or delay unwanted pregnancy, the Zay people are partly dependent on medicinal plants for the treatment and/or control of human and livestock ailments (Mirutse Giday, Zemede Asfaw, Thomas Elmqvist and Zerihun Woldu, 2002). Similar Study conducted by Haileab Zegeye, Demel Teketay, Ensermu Kelbessa(2006) indicated that the island communities are highly dependent on the natural vegetation for various purposes. What signifies the reality of the above findings is that in the rural areas where the community settled, absence of appropriate health center run by government and Non government organizations might oblige them to depend on natural vegetation for medical purposes. Therefore, it is difficult to conclude effect of education on contraceptive behavior of such community.

Scholars argue that in many situations contraceptive use is affected by religious attendance of individual. Because, all religion prohibit the use of contraceptive by citing their holly books manuscripts. But different findings come up with contradictory results regarding the impact of religious service attendance on contraceptive use. As indicated by Jennifer M. (2006) and her associates, stronger family religiosity does not translate into improved contraceptive use. However, they indicated that frequent parental religious attendance and family religious activities are related to later timing of sexual initiation, highlighting an important dimension of family environments that can help improve reproductive health outcomes for children.

Another study carried out in Canada indicated that while the role of religious affiliation in determining childbearing decisions has weakened, church attendance is considered as an influential determinant of Canadian fertility in 1984(Balakrishnan T. and Chen J. ,1993). In

the same manner consistent finding was obtained with this study by Kelly Martin and Zheng Wu (2000) suggesting that contraceptive use decreases with religious attendance. They further added that while contraceptive practice did not vary much according to religious denomination, prevalence was highest among people with no religious affiliation. Further, between 1984 and 1995, the rate of contraceptive use declined in all religious groups, as well as at all levels of church attendance.

The study carried out in Jamaica by CDC (2004) also revealed that contraceptive use also tended to decline as frequency of attendance at religious services increased. In Bangladesh, a study conducted by Nashid Kamal (1994) found that Women who are less religious have a higher (43 per cent) probability of being an acceptor compared with those who are strictly religious. Women who consider themselves average in terms of religiosity do not differ from their more religious counterparts. He added that in a predominantly Muslim society like Bangladesh, this differential is not at all surprising.

However, in contrary to the above findings, a study in United States come up with the finding suggesting that the connection between religiosity and contraceptive use is not clear(www.teenpregnanvy.org). Similarly, another study conducted in Bangladesh indicated that religious attendance and work experience of women are found to have little effect on contraceptive use (Ahmed T, Bhuyan M.,1993). Moreover, a study as cited in Whitehead, B., Wilcox, B.L., Rostosky, Randall, B., and Wright, (2001)by Zelnik and colleagues (1981) showed that while higher religiosity predicted later initiation of and less frequent intercourse, it was not related to contraceptive use or pregnancy rates. Like the above finding, another study as cited in their analysis National Longitudinal Study of Adolescent Health found no association between contraceptive use and religiosity (Bearman and Brückner, 2001). As they compiled, there is mixed finding in the area by stating that religion attendance decreased contraceptive use for females and increased use for males. Similarly, one study conducted on

religious Jewish contraceptive users in Israel indicated that the contraceptive choices of religious women are determined largely by considerations unrelated to religious doctrine. Rather combination of factors, including the suitability of specific methods to fertility control needs, peer influences, and other cultural effects, appear to modify the acceptance and application of a particular religious theology (Barbara S., 2000). Moreover, Bernhaart and others (1990) remarked that religious beliefs are widely perceived and practiced in Bangladesh, but there was no association between contraceptive use and devoutness. However, that study was limited because of its small sample size.

What can be understood from these findings is that the area needs further exploration.

Even those there is no well documented evidence on the relationship between religiosity and contraceptive use of Zay community, almost all or majority of the settlers on Island and mainland are followers of the Ethiopian Orthodox Christianity (Ronny Meyer, 2005; Paul Henze, 2001; Leslau Wolf, 1999; Paul Henze, 1989).

Rural Urban Difference in Contraceptive use is another area that draws the attention of researchers. Zay community members reside in urban and rural area. As can be expected, residential differences have great impact on contraceptive use. Accordingly, those of urban settler are better users of contraceptives than rural settlers. Because, family planning services in urban areas are perceived as more accessible (Tey Nai Peng and Abdurahaman I, 1981). In Morocco, contraceptive use occurred among 50% of women. 74% had ever used. Urban use was 64% and rural use was 39%. (Althaus F. 1997).This indicates there is residential difference in contraceptive use. However, the study carried out by Khalida P. Zaki and Nan E. Johnson (1992) in Pakistan revealed that there is no rural-urban gap in contraception for spacing purposes by literate women. Thus, the rural-urban gap in contraceptive prevalence would vanish more quickly if the national family-planning program emphasized

contraceptive methods suitable to spacing births. Another study conducted in Bangladesh by Ahmed T, Bhuyan M.(1993) indicated that, contraceptive use has no significant variation between rural urban regions.

When we assess the experience of Ethiopia, there is great variation in contraceptive use between urban and rural dwellers (EDHS, 2005). Accordingly, current use is four times higher in urban than in rural areas. Can this variation hold true for Zay community?

2.2. The Effect of Contraceptive Methods Access on Contraceptive Use

A good family-planning program will ensure that beneficiaries have access to contraception and that they can raise healthy, happy families when they choose to do so. Improving access to birth control is the forefront of every concerned body's efforts to prevent unintended pregnancy.

It is widely accepted that family planning services are essential to fertility decline. The proximate determinant of ongoing fertility decline in the developing world has been the widespread adoption of contraception. Previous studies have shown that the availability and accessibility of family planning services is an important determinant of contraceptive use (Nguyen and Dang, 2002).

They find that accessibility was positively associated with contraceptive use for several subgroups of women. The result shows that, women aged 25-34, those with more education, and those with at least three children were more likely to use a modern method when services were accessible. Accessibility was negatively associated with non use of modern methods and with current use of traditional methods.

According to Nguyen and Dang (2002) in Vietnam, obtaining contraceptives has been shown to be an important factor in the success of family planning programs. In this finding the

perceived availability of contraceptive methods was strongly affecting contraceptive use of beneficiaries. Their finding further showed that ready access to any source of family planning significantly reduced nonuse of modern methods and current use of traditional methods. What can be concluded is that increased availability of contraceptive methods and information could increase use of family planning in the study area. Another study by Vernon-Carter (1982) in Egypt explained that the cost of contraception variables influence more strongly contraceptive practice variables such as ever, current, and intended future contraceptive use . In a similar manner, in Nepal, the Contraceptive Prevalence Survey data of 1981 indicated that an inverse relationship exists between the prevalence of contraceptive use and travel time to an outlet. The study indicated that unfortunately, a majority of contraceptive users in Nepal need more than 1 hour to reach an outlet. In this study, the effects of education and place of residence on contraceptive use become weaker when the analysis is confined to women who have access to an outlet within 30 minutes travel time (Tuladhar, 1987). In Bangladesh, a research conducted by Ann Levin, Bruce Caldwell and Barkat-e Khuda(1999), revealed that couples were less likely to use contraception or choose methods if the travel time to fixed clinics was greater than 30 minutes.

In contrast, there are areas were accessibility of methods is not problematic to use. Rather the way service providers accept and treat the beneficiaries is a major worry. For instance, in Mali, young women suggested that access to modern methods was not a problem (Castle S., 2003), but health services were considered inaccessible in most of the studies and they had significant fears of receiving a negative reception from clinic staff.

In a similar way a study conducted in rural Tanzania on 233 respondents indicate that the perceptive quality of family planning facility was a more important determinant of contraceptive use than accessibility measures in communities with a facility within 30

kilometer (Mroz, Bollen, Speizer, and Mancini, 1999).As they indicated, in addition to quality of service in the clinic, **factors** like time, distance, accessibility, or quality were significantly related to contraceptive use.

In another study perceived and actual measures of access did not show different effects and the evidence was also inconclusive on whether the choice of independent variables - travel time, distance to source, access to personnel, density of sources and costs - influences the results. It is emphasized that differences in travel time or distance to an outlet may not be as important an influence on contraceptive use once a population has reached a threshold level of access(Cochrane, S. H.and Gibney, L ,2006).

When we analyze accessibility of contraceptive methods situation in Ethiopian, there is no well documented materials that reveal the distance and time it takes for clients to get the service. However, one study done at rural married women in Amhara region indicated that 25% of respondents indicated as the access of methods is not convenient to use. But the majority said the methods are easily available to them. According to this finding, it is couples communication than availability matters. This research could be done in the area were family planning clinic is available in near to the beneficiaries. What this finding added is contraceptive prevalence is higher among urban than rural counter parts in the study area (Bizualem, 2005). In EDHS (2005) statement, element that used to measure availability of methods are lack of access/too far, cost too much, and method not available. As indicated in the report these elements account only 4.5% for discontinuation of contraceptives among users. What this indicates is availability indicators suggest as availability is not a major problem. But both findings failed to explain availability from the distance and time it takes to get the service in objective manner. When we analyze this situation in Zay community, again there is no documented material. But the distance it takes to get the service can be guessed.

2.3. The Value of Children and Contraceptive Use

Different values are attributed to the child in different socioeconomic contexts, and these values are differentially related to the outcome variable of child bearing.

As stated in Kagitcibasi (1996), several values attributed to children by parents could be grouped under three main value types: utilitarian, psychological, and social values. Kagitcibasi added that utilitarian values have to do basically with the economic-material benefits of children. Of special significance there is the old-age security adult offspring provide to their elderly parents. Psychological values have to do with such satisfactions as the joy, pride, love, and companionship that children provide to their parents. And social values of children refer to general social acceptance that married adults gain when they have children, in the sense that especially in traditional society people are considered to be adults when they have children, not necessarily when they get married. Continuation of the family name or family line is also a social value of children.

A comparative analysis of data from eight countries on value of children by Ergöçen (1997), found that women with five or more children and not using contraceptive methods stressed the economic value of children more than women with two or fewer children using contraceptive methods.

Low woman status, strong economic value of children, and strong son preference is also associated with high fertility. In this sense, family dynamics and functioning are closely interwoven with orientations toward children, value of children, fertility, and gender roles (Kagitcibasi, 1996). From this one could understand that, in those communities like Ethiopia where value of children is high, contraceptive use and intention to use are expected to be low. As a result fertility rate is high.

In addition, in urban and rural areas of Egypt observed that the value of children variables have a comparatively stronger effect upon reproductive ideals (desire for additional children and ideal family size), whereas the cost of contraception variables influence more strongly than contraceptive practice variables (such as ever, current, and intended future contraceptive use) (Vernon-Carter R, 1982). What this implicitly tells us is that the value the society gives for children determines ones contraceptive practice.

However, the study carried out by Tolnay, Mehryar and Jamshidi (1980) found that the perceived value of children appears unimportant, negligible in fertility and contraceptive use, and only showing a slight positive relationship between expected reliance on children for support in old age and the number of children ever born.

2.4. The Role of communication among Couples on Contraceptive Use

Communication between couples on family planning is more sensitive. It needs confidentiality because; it deals with very private matters that involve sexual behavior, children, and family relationships (Rawson-Jones& Salkeld, 1992). Communication between husband and wife enables them to know each other's attitudes toward family planning and use of contraceptives. Moreover, it allows them to voice their concerns about reproductive health issues, such as worries about unwanted pregnancies or sexually transmitted diseases (STDS). Moreover, couple communication also encourages shared decision-making and an equal role for both sexes.

Therefore, communication between couples is a key factor in achieving correct and consistent use of contraceptive methods. However, in many communities, discussions about sexual matters are taboo for men as well as for women, and couples may be afraid to raise the topic of contraception, especially at the beginning of marriage. Thus, in many societies, few couples ever talk to each other about reproductive health issues (Nyblade, 1995). For such

fear, particularly in traditional cultures, married women do not feel free to talk about contraceptive methods with their husbands. A woman's education, economic situation, age and the type of marriage affect the husband–wife relationship (Rakhshani, Niknami and Moghaddam, 2005).

The role of husband – wife communication in the adoption of contraceptive methods has been well documented (Beckman, 1978; Mukherjee, 1975; Lasee and Becker, 1997; Sharan and Valente, 2002). The successful practice of contraception to a large extent depends upon the spousal communication regarding fertility desires and contraceptive choices. Although discussion between husband and wife about contraceptive use is not a precondition for the adoption of contraception, it's absence may be an impediment to contraceptive use (NDHS, 2006). The frequency of couple's discussion is positively related to contraceptive use in general and method choice and effectiveness in particular (Bean et al., 1983; Kasarda et al., 1986; Sakyi, 1992; Ullah & Chakraborty, 1993; Nyblade and Menken, 1993). Inter-spousal communication has thus been considered as a sensitive indicator of contraceptive use due to three important reasons (Srikantan, 1993). They are: (i) child bearing, instead of being a cultural imperative, has come within the scope of conscious choice for the communicating couples, (ii) women's role are no more confined to child bearing and rearing among such couples, (iii) the wife's preferences are taken into account in making the couple's reproductive decisions.

Among married couples, communication seems to improve contraceptive use. One survey conducted in Kenya on 7,150 married women, found that 36 percent of couples who communicated frequently about sex used contraception, compared with only 12 percent of women who did not communicate with their spouses (Nyblade, 1995).

According to the finding of Widman Laura and her associates (2006), more open communication about sex from both male and female partners was associated with increased contraceptive use. Similar study on Yoruba tribes of Nigeria, indicated that spousal communication was found to affect contraceptive use: contraceptive use is higher among marital partners who discuss and take joint decisions on contraception (Feyisetan , 2000).

Similarly, a study by Andrzej Kulczycki (2008) in Turkey found that couples' contraceptive use is positively associated with the contraceptive knowledge of both spouses, as well as with their approval of family planning, spousal communication about family planning and husband-wife agreement regarding fertility preferences.

In Ethiopian situation, different research findings come up with similar result regarding the effect of couple's communication on contraceptive use. According to Antigegn (2008), high level of contraceptive use is highly correlated with high level of couples communication among rural married women. Similar study by Bizualem (2005) indicated that those couples who discuss about contraceptive methods were better users of contraceptive methods. Similarly, finding of Kifle (1999) among Guraghe community and Mulu (1996) from Tigrean women subjects also come up with the same result.

From these explanations one could understand that couples communication enhances contraceptive use. However its degree of influence differs from region to region and society to society.

2.5. Concepts about contraceptives and its impact on usage

A misconception is a mistaken interpretation of ideas or information. If a misconception is filled with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumour. Unfortunately, such rumours or misconceptions regarding contraceptive

methods are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs pertaining to family planning which they allow to impact on their professional conduct (Hamani et.al, 2007).

Frost, Singh and Finer (2004*) have identified the following misconceptions associated with contraceptives on study groups carried out in* United States. *These are*:

- Had infertility problems

- Were breastfeeding or had had a recent miscarriage

- Stated that a health care provider had told them they were unable to get pregnant

- Felt that a condition, such as endometriosis or diabetes, put them at low risk for becoming pregnant

- Thought their partner was sterile

- Thought they were too old or too young to get pregnant

They further added that *l*ack of thought or preparation or "perceived low risk for pregnancy" was the reason cited for unintended pregnancy in more than half of a study group of 1,429 women. According to this study, women who responded that the reason was lack of thought or preparation stated they just were not thinking, were careless, or run out of their method but still had sex.

Another case study conducted by Thorburn and Bogart (2005) on Afro Americans identified that many potential cultural attitudes could influence many husbands to believe that it is his wife's duty to bear children or that only promiscuous women use contraceptives. They could

lack knowledge or have misinformation about contraceptives. In addition males might afraid that contraceptives will harm women's or cause them to become infertile. The research finding carried out by Lynn Hearton (2007), reveals that women do not end up with the best form of birth control for them due to false beliefs and fears. As Hearton indicated, contraception is of paramount importance to many women of all ages, but there are many myths and misconceptions circulating about how methods work and what the side effects are. So it is imperative that each and every woman has the information, time and support to consider all these issues and make her own informed choice.

An attempt was made to compare misconception of contraceptive between users and nonusers. The result of these findings contradicts to each others. For instance research study conducted by Powell (2006) on modern contraceptive users and non users revealed that non modern contraceptive users cited more negative perceived barriers against the use of modern contraceptives and preferred larger families than their counter parts of modern contraceptive users. From this one could conclude that misconception is higher among non users of modern contraceptives. Hamani and his associates (2007) have found that the prevalence of incorrect beliefs was exceedingly high in the whole study group of users and non users and even relatively high among the physicians. In their study group, the prevalence of incorrect beliefs was comparable between combined oral contraceptive pill users and non-users, regarding the 10 misconceptions investigated. The duration of oral contraceptive pill use did not influence the prevalence of misconceptions about the pill. Besides, age did not serve as a confounding factor for all misconceptions in their study.

Low perception of risk for pregnancy is another critical factor in influencing attitudes about contraception. An analysis of data from the 2000–2002 Pregnancy Risk Assessment Monitoring System in United States revealed that 42 percent of women who had an unintended pregnancy ending in birth believed that they could not become pregnant at the

time of intercourse or that they, or their partners, were sterile (Nettleman , Chung H, Brewer J, Ayoola A, and Reed P.,2007).

Another study undertaken by Costa and Chaloub (1992) in three cities of Brazil reveals that, a large number of women, both users and non-users, attribute negative characteristics to oral contraceptives. More than half believe that the oral contraceptive is harmful, causes weight gain, headaches and dizziness, and is not an effective method. It was further stated that oral contraceptives cause cancer and are expensive. In their study Costa and Chaloub while there are also positive views about the oral contraceptive, their finding gives the impression that on the whole, women believe that use of the oral contraceptive implies hardship and damage them. As an underlying factor, Costa and Chaloub (1992) attributed some of the negative attitudes towards the place where they are purchased and counseling services offered to clients. They explained that the oral contraceptive are likely to be related to the fact that many women purchase the oral contraceptive from the pharmacy without a prescription, and generally do not receive instruction on the use and characteristics of this method. Similar problems are experienced by women who attend some public and private sector services where complete information or counseling is not provided.

2.6. Role of counseling in determining contraceptive use

Counseling is one of the critical elements in the provision of quality family planning services. Through counseling, providers help clients make and carry out their own choices about reproductive health and family planning. Good counseling leads to improved client satisfaction (Asfaw and Mekuanent, undated). A satisfied client promotes family planning, returns when s/he needs to and continues to use a chosen method.

In general and simplified term, counseling could be explained as the face-to-face, personal communication in which one person helps another to make decisions and then to act on them

(Nayak, 2004). In the context of family planning services, counseling is a process, which helps a client to decide if s/he wants to practice family planning. If s/he does, counseling helps her/him to choose a contraceptive method that is personally and medically appropriate and that s/he wants, understands how to use, and is able to use correctly for safe and effective contraceptive protection.

The sensitive nature of reproductive health/family planning requires that clients' right to privacy, confidentiality, respect, and dignity are always ensured (Pathfinder International, 1998).

Clients are more likely to be satisfied with services if all staff, not only the counselor, treats them with respect and friendliness. In turn, client satisfaction is associated with improved use-effectiveness, continuation and positive "word-of-mouth" reports (Delbanco T, Daley J. 1996; Ley P., 1982; Bongaarts J, Watkins S., 1996). Conversely, poor client Provider Interaction is associated with discontinuation and method failure. For example, research in Egypt found that client-centered vs. physician-centered consultations were associated with a three-fold higher level of both client satisfaction and continuation, even though the client-centered sessions lasted only one minute longer (Abdel-Tawab, Nahla and D. Roter, 1996). In this study they identified that clients feel more comfortable if assured that information will be kept confidential and if visual and auditory privacy is maintained during counseling and Family Planning procedures. This contributes to an atmosphere of trust in which the client and provider can explore emotional, sexuality or gender-related aspects of method choice. Providers should encourage clients to ask follow-up questions about side effects or to clarify instructions. Body language that transmits warmth and interest (e.g. giving full attention, smiling and nodding when the client speaks) and a friendly tone of voice are behaviors that enhance client provider interaction (Wells E, 1995).

According to Wells, another factor that influences a woman's contraceptive use is her level of satisfaction with her chosen method. Many women are dissatisfied with their contraceptive options. In his study, 38 percent of women chose their current method primarily because they did not like any other method. Nearly 40 percent of women were not satisfied with their method for reasons such as reduced sexual pleasure, anticipated side effects, and worry about effectiveness. The women who were not completely satisfied with their method tended to have gaps in use and to use methods incorrectly or inconsistently, putting them at increased risk for unintended pregnancy.

Another study carried out at the San Paolo Hospital of Milan for 30 minutes counseling intervention by Psychologists and gynaecologists found that knowledge, favorable attitudes and use of effective contraception increased significantly for the experimental group, whereas there was no significant change for the control group (Nobili, Piergrossi, Brusati, and Moja, undated). They conclude that the counseling intervention was found to be efficacious in improving understanding and use of contraception in women who have undergone a termination of pregnancy.

The other important factor in contraceptive counseling is time spent during service provision time. A survey conducted by the Association of Reproductive Health Professionals (ARHP) in United States in 1999 found that almost 70 percent of women spend fewer than 15 minutes with a clinician during visits for contraception. In a subsequent poll conducted in 1998-99, 40 percent of obstetrician/gynecologists responded that they did not have adequate time with their patients.

Indeed, the 1989 rapid evaluation of Mother Child Health/Family Planning services in Zambia found that actual staff-client contact time averaged only one to two minutes per family planning acceptor (Mbomena, 1995). Obviously, under these conditions, clients have

little opportunity to seek clarification on the methods offered or engage in any meaningful interaction with the provider. Such limited time of interaction allow few opportunities for meaningful interaction between providers and clients.

Other studies in West Africa, China, and India suggest that women who receive more counseling or information at the initiation of use have lower rates of discontinuation than those who receive little counseling.(Kravitz R, Leigh J, Samuels S, et al,2003; Pariani S, Heer D, Van Arsdo M, 1991). These findings further suggest that pre-treatment and ongoing counseling about hormonal effects and possible side effects appears to be especially important.

One study in African found that women who receive inadequate counseling about side effects are more likely to become Family Planning dropouts when they experience side effects, while those who are fully counseled on side effects are likely to continue contraception with the same method or a different, more acceptable method (Feyisetan, 2000).

In China, women who received pre-treatment counseling about side effects and ongoing support were almost four times more likely to continue with that method than women not so counseled. Women who experience side effects for which they are not adequately prepared may worry that their health is endangered or that the side effect, even if not dangerous, may be permanent and debilitating(Lei Z, Wu S, Garceau R, Jiang S, Yang Q, Wang WL, et al,1996). Another study by Nada L. Stotland (2002)indicated that women who received personalized counseling were significantly more likely to be satisfied with their counseling, to be using contraceptives, and to intend to use contraceptives than were those who received no personalized counseling (i.e., general discussion of contraception or provision of materials or videos on the topic) or no counseling . All these findings signify the importance of family planning counseling in promoting contraceptive use.

In Brazil very short consultation times observed in many clinics suggest that in many cases thorough gynaecological exams including breast examination are not conducted for family planning clients (or for women seeking other reproductive health care services). Time for individual counseling concerning method choice and instructions on method use is similarly limited when consultations are very brief. In many clinics physicians see 16 women in less than two hours rather than in the allotted four hours. This means, a client has only 7 to 8 minute to communicate with service provider (WHO, 1994). The report added that such shortage of time might contribute to frequent observations of incorrect oral contraceptive use, indicate that women do not have enough information about the appropriate use of oral contraceptives.

In addition to shortage of communication time between client and service provider, WHO survey in Brazil has identified that most settings have no formal mechanism for ensuring continuity of family planning care. Established systems for contacting clients who do not return for follow-up visits are rare, and in many clinics the scheduling system by itself is insufficient. Clients with scheduled appointments may not be guaranteed attention, and there is little ability or willingness to schedule emergency consultations for clients with complaints. Women who attend emergency room services for contraceptive complaints often receive instruction to discontinue the method rather than counseling or discussion of alternative method choices. If these women are unable to receive family planning attention within a reasonable time, their risk of unintended pregnancy is increased. With this regard, In addition to scheduling return visits, providers should tell clients that they are welcome to return to the clinic any time they have questions or concerns (Kubba A., 1995). As Bruce J. (1990) indicated, revisit schedules must be individualized based on the client's need for education, counseling, and clinical care beyond that provided at the initial and annual visit. Clients selecting hormonal contraceptives, IUDs, cervical caps, or diaphragms for the first time

should be scheduled for a revisit as appropriate after initiation of the method to reinforce its proper use, to check for possible side effects, and to provide addition information or clarification. Bruce further suggested that a new or established client who chooses to continue a method already in use need not return for this early visit unless a need for reevaluation is determined on the basis of findings at the initial visit.

In Ethiopia, eventhough there is no comprehensive research finding in the area, one study conducted on more than 500 married women in Addis Ababa who were not using any modern method and received counseling alone indicated that after one year, contraceptive use was nearly double among couples who received husband-wife counseling (33 percent), compared with use among couples in which women were counseled alone, without their husbands (17 percent) (Terefe& Larson, 1993).

To conclude problems associated in the use of contraceptives, UNFPA (2004) and WHO (2003) report in developing countries 29% 0f women have an unmet need for modern contraception. The highest proportion is in Sub-Saharan African where 46% of women are at risk of unwanted pregnancy .The report listed the following elements as barriers to use modern contraception. These are:

- Lack of information and knowledge about contraceptives and where to get them
- Fear of violence from partner/parents and pressure to have children
- Religious and Cultural norms
- Lack of accessible services, and shortages of equipment ,commodities and personnel,
- Lack of method choices appropriate to the situation of the woman and her family,
- Lack of knowledge about the safety effectiveness and availability of choices,
- Poor client provider interaction,

- Lack of community or spousal support,
- Misinformation and rumours,
- Side effects for some, and insufficient follow-up to promote method switching or ensuring proper use and dosage,
- Financial constraints,
- Inadequate confidentiality and privacy and Providers lack of sensitivity to their client's perspective.

CHAPTER THREE

3. METHODOLOGY

3.1. Sampling and Sampling Design

In this study, two types of sampling design were employed: namely purposive sampling which is used to determine the target population and study area, and systematic random sampling technique which is used to select the ultimate number of participant of the study. The sample for the study is based on the residential characteristics of respondents. Representative samples of both urban and rural areas under the study were drawn separately. The target population of the study was all currently married women aged 15-49 years and men of aged 18-60 years groups based on the following three assumptions.

1. In most Ethiopian societies couples are expected to bear children only after they contracted marriage although it is not very strange for unmarried females to have children (Reidulf Knut Molvaer, 1980). The same is true for Zay community. Sexual relationship is not expected to take place among unmarried. In Zay community, sex before marriage and childbearing is shame and not acceptable. That is why this study focuses only on married population.
2. Most studies in the area of family planning mainly focus on female and neglect the role of men. Accordingly, they come-up with one sided data (Gebrekidan M., 2002). Therefore, it is necessary to include male respondents to get comprehensive data.
3. Lastly, the reason for including men was that both sexes of couples have similar psychological make-up in matters related with decision making on fertility (Mulu, 1996). So that instead of taking both husband and wife from a family this study restricted on one sex in the family.

The places/zones and woredas were Zay community settled among the most populous (CSA, 1996) and early marriage is practiced and the researcher is familiar with the language,

culture and psychological make-up of the people. So that conducting a research would be convenient and smoother in many aspects.

In this study, majority of kebeles where the community settled were included. From Dugda woreda, two settlement area namely Mekdela farmers association kebele and Meki town were included. From Ziway Dugda woreda, residents on Debretsion /Tulugudo, Aysut/Tsedecha were included. These two islands were the most populous places (Wolf Leslau, 1999).

Bochessa kebele and Ziway town were included from Adamitulu woreda. Most residents of these two sites are from Gelila and Debresina Islands (Paul Henze, 1989).

3.2. Subjects

Regarding the number of the community members, there is no well documented material. Even the numbers given at different times contradict to each other (Wolf Leslau, 1999).For instance, Wolf estimated that number of speaker of Zay community are about 2680 to 4889. Additionally, Ronny Meyer (2005) estimated regarding the number of the community members as 14,000 and it added that CSA doesn't include the name of Zay while it undertake census at national level. Based on the above latest information and passage of time, currently the number of members of the community can be estimated up to twenty thousand.

In order to realize this research, two frames of reference were used to get list of house hold numbers. The first reference was list of Iddir members which is set up by the community to help each other during mourning. Accordingly, urban settlers of the community were selected based on this reference. The second frame of reference was list of tax payers found at each rural Farmer Kebele's Association office. Representative samples from two towns and the rest four rural Farmer's Kebele's were presented on the following table.

Table 1: Target area population and samples taken

Target Places	Population	Samples
Ziway Town	110	40
Meki Town	105	35
Bochessa Kebele	230	55
Mekdela Kebele	180	21
Tulugudu Island	120	22
Tsedecha Island	160	27
Total	905	200

As can be seen from the above table 1, in this study totally 200 sample was taken out of 905 house hold members only from six sites where the community settled for this study.

But due to different factors twenty one respondents didn't fill the questionnaire properly and it is discarded from the study. So, this study analyses only the response of 179(91 Male and 88 Female) participants.

3.3. Statistical Design and Analysis

3.3.1. Variables

Contraceptive Use Variable

Different scholars classify contraceptive use experience of individuals based on different criteria. For example Laura M. Gaudet and associates (2004), classified contraceptive users as New users (pill users for less than 1 year), Experienced Contraceptive users (pill use of 1–5 years) and long-standing contraceptive users (pill use of more than 5 years) (Laura M. Gaudet, Sari Kives, Philip M. Hahn, Robert L. Reid,2004). Additionally they describe that anyone who used contraceptive at one time in his life time is considered as contraceptive user.

On the other hand, the American Department of Health and Human Service Bureau stated that in order to be counted as a family planning client, the beneficiaries must meet the service provider face-to-face and have a document in their medical record. The bureau further added that those who have a medical record at health center and visit these centers at any time for family planning service are considered as family planning client (Unites States health Bureau, 2001). From the above explanations, one can understand that the means to categorize beneficiaries as contraceptive users and contraceptive non users is client's exposure /experience to contraceptive use at one time in their life time to avoid pregnancy purposely. Based on this assumption, the variable utilized in this study, contraceptive use experience of respondents (which is represented by Y_1), is directly taken from the study question. Participants were asked to respond in self reporting manner about their contraceptive use experience in their marriage time. The variable has two categories of self report responses indicating experience of using and experience of not using contraceptive methods.

Socio-demographic Variables

The socio-demographic variables used in this study are age of respondents, sex, residential place, educational level, age at first marriage, number of living children, religious attendance, access of contraceptive service in kilo meter to get the service, value the society attaches for children, couples communication, concepts about contraceptives, and perception towards family planning counseling. The above mentioned socio-demographic variables are taken from EDHS data and some of them like age at first marriage, religious service attendance, access of contraceptive service in kilo meter and value the society attaches for children are considered based on socioeconomic status of the community. All these variables were computed against contraceptive use experience variable.

3.3.2. Instruments and Procedures Used in the Study

Instruments of the study

In order to collect the necessary data on contraceptive experience of respondents, structured as well as open ended questionnaire, and scales were used. Background information was collected in self reporting manner from the respondents. Some of the items of scales questionnaire were a modified form of KAP survey of birth control originally developed by the Population Council (1970) and used by Mulu (1996) and Kifle (1999) so far. Accordingly, scales of Value of Children, Couples Communication, and concept about contraceptive methods were formerly used by the aforementioned individuals. But the scale designed to measure perception towards family planning counseling, all items were developed and designed by the researcher after a critical review of different literature. As far as scale of Value of children in this study is concerned, it consisted of 15 items that are Likert type in nature. The items were answered on five point scales (Strongly disagree=1,Disagree=2, Undecided=3, Agree=4 and Strongly agree=5).The possible scores

on this scale ranges between 15 to 75.Low score indicates low value the society gives for children and high score indicates high value the society gives for children by reverse scoring negatively worded statements. The same step is applied for the scale of concept of contraceptive methods. The scale consists of 15 items and the possible scores on this scale ranged between 15 to 75.Low score indicates low concept about contraceptive methods and high score indicates high concept about contraceptive methods by reverse scoring negatively worded statements.

Like the above scales, the scale designed to measure couples communication about contraceptives is a modified form and Likert type in nature. The scale consists 16 items and its possible scores range between16 to 80. High score indicates existence of high communication between couples on contraceptive use. On the opposite side low score indicate there is less communication between couples on contraceptive use by reverse scoring negatively worded statements.

As far as scale designed to measure perception towards family planning counseling is concerned, the items were Likert type in nature and answered on five point scales (Strongly disagree=1, Disagree=2, Undecided=3, Agree=4 and Strongly agree=5). The scale consists 15 items and its possible scores ranges between 15 to 75.While high score indicate positive perception towards family planning counseling, low score indicates negative perception by reverse scoring negatively worded statements.

Procedure

In order to carry out the research in objective manner, the following procedures were employed.

1. The instruments were drafted and prepared in English and translated into Amharic version by language experts from TEFL.

2. The instruments have been pilot tested for their reliability using 30 married women and men in the community. Accordingly, Cronbach Alpha were obtained 0.8782 for couples communication, 0.7504 for concepts about contraceptives, 0.7691 for perception toward family planning counseling and 0.7883 for scale of value of children. Regarding its validity, the prepared questionnaire were given to two medical doctors, two health officers ,three nurses, and four second year post graduate Sociology and Psychology students to give their own comment on the prepared questions. Then based on their comment and the results of pilot test appropriate modifications were made on instruments. Accordingly, vague, unclear, and those which have errors and difficulty were discarded from the item list.

3. The instruments were administered by ten interviewers'. To avoid inconvenience, female data collectors were assigned to interview illiterate female participants, and male data collectors were assigned to illiterate interview male respondents. The interviewers were those who completed minimum grade ten, teachers, and have acceptable conduct in the community on the basis of their acquaintance with the study area and know both Amharic and Zayinga languages to minimize language difficulty during data collection.

3.3.3 Method of Data Analysis

After the data collection process were completed, data edition were performed. Accordingly, those questionnaires which were not appropriately and completely filled were identified and excluded. Then all items were coded for computerization. Finally, the quantitative data were analyzed using SPSS version 15.0 software. In order to analyze the gathered data, both descriptive and inferential statistics were used. Descriptive statistics like mean, percentage and standard deviations were used to give general overview of the data.

In addition to descriptive statistics, inferential statistics were employed. Accordingly, Chi-Square was employed to analyze the association between socio-demographic variables and contraceptive use experience of respondents. Additionally, One Way ANOVA was employed to observe the significance differences between contraceptive users and contraceptive non users on scale of value of children, concepts of contraceptives, couples communication, and perception towards family planning counseling services.

Moreover, in order to have knowledge about the extent of relationships among different variables, inter-correlation matrix was used. At last, multiple and stepwise regression analysis was carried out to find the contribution of the predictor variables in general and the contribution of each predictor in estimating contraceptive use of respondents in particular. Test of significance were performed using alpha= 0.01 and 0.05 level of significance.

CHAPTER FOUR

4. RESULTS AND ANALYSIS

This chapter deals with the analysis and interpretation of the data obtained through questionnaire. This chapter has two parts. The first section presents results of the study. In section two, main findings of this study are explained in detail under discussion part by comparing this finding with others. The data obtained from respondents are presented and interpreted as follow.

4.1. Results

4.1.1 Characteristics of the study population

Table 2 below shows the distribution of respondents in terms of residence, sex, educational level, and religious attendance category.

Table 2: Distribution of respondents by some selected background characteristics

Background Characteristics	Frequency	Percent
Sex		
Male	91	50.8
Female	88	49.2
Total	**179**	**100.0**

Residence		
Urban	55	30.7
Rural	124	69.3
Total	**179**	**100.0**
Religious Attendance		
Daily	20	11.2
Two to three times a week	21	11.7
ones a week	92	51.4
Monthly	37	20.7
Sometimes	7	3.9
Never attended	2	1.1
Total	**179**	**100.0**
Educational level		
Not attended Formal Education	40	22.3
Primary education	83	46.4
Secondary education	33	18.4
Higher institution	23	12.8
Total	**179**	**100.0**

As can be seen from the above table, in terms of gender, 91(50.8%) of married women and 88(49.2%) of married male are involved in the study. Concerning residential place, 55(30.7%) urban dwellers and 124 (69.3%) of rural respondents were involved in this study.

Regarding religious affiliation and attendance, all respondents are Orthodox Christian follower. As can be seen from table 2 above, the majority 92(51.4%) attend the religious service ones a week, 20(11.2%) attend daily, 37(20.7%) attend monthly, 21(11.7%) attend 2-3 times per week, 7(3.9%) attend sometimes and only 2(1.1%) never attend religious services. As far as educational level is concerned, 40(22.3%) didn't attend formal education, 83(46.4%) attended primary education, 33(18.4%) attended secondary education, and lastly, 23(12%) attended higher education.

4.1.2. Contraceptive Use Experience of Respondents

Inorder to get information about contraceptive use experience of respondents, they were asked to express their experience of contraceptive use by asking" How do you express your contraceptive use experience in your marriage period?" Their self report responses were presented on the following table.

Table 3: Distribution of respondents by contraceptive use experience

Contraceptive use Experience	**Number**	**%**
Used Contraceptive Methods	80	44.70
Never Used Contraceptive Methods	99	55.30
Total	**179**	**100.00**

As can be seen from the above table, 80(44.7%) of respondents used contraceptive methods at one time during their marriage period or were using contraceptives during the interview of data collection. The majority of respondents i.e. 99(55.3%) never used contraceptives in their marriage life time.

4.1.3. Contraceptive Knowledge of Respondents

Inorder to know familiarity of respondents with some methods of contraceptives, participants were asked whether they have heard/familiar with the listed contraceptive methods or not heard/familiar with them .They answered their familiarity/knowledge by ticking (√) their response in self report manner.

As can be seen from table four (below), 141(78.8%) of respondents know pills as method of contraceptive. Only 67(37.4%) of respondents know IUD. Diaphragm is known by 60(33.5%) of the subjects which constitute the least position from the rest. In a better manner than Diaphragm, Norplant is known by119 (66.5%) of respondents. Regarding female sterilization and male sterilization, they are known by 72(40.2%) and 75(41.9%) of participants respectively. The majority of the respondents are unfamiliar with them. Of all methods, condom and abstinence constitute a better position. Accordingly, 149(83.2%) of respondents know/heard about condom and 144(80.4%) of respondents heard about abstinence. Coitus interruption is heard by 78(43.6%) of respondent. Concerning breast feeding 140(78.2%) of the subjects know it and only 80(44.7%) of this study participants are familiar with abortion as a method of contraceptive. From this, one can observe that condom (83.2%), abstinence (80.4%) and pills (78.8%) are better known than other methods. On the other hand, Diaphragm (33.5%), female sterilization (40.2%) and male sterilization (41.9%) constitute the last position respectively. Accordingly, majority of the subjects didn't hear of them. From this one could understand that awareness level of the society about some methods

is not satisfying when we compare it with EDHS (2005) result. As stated in EDHS result, knowledge of at least one method of contraceptive method is 84%. And it implies as much has to be done in the area by the concerned body.

Table 4: Contraceptive knowledge of respondents

S/N	Methods	frequency	% of respondents know of each methods
1	Pills	141	78.8
2	IUD	67	37.4
3	Indictable	140	78.2
4	Diaphragm	60	33.5
5	Female Sterilization	72	40.2
6	Norplant	119	66.5
7	Male Sterilization	75	41.9
8	Condom	149	83.2
9	Abstinence	144	80.4
10	Coitus Interruption	78	43.6
11	Breast Feeding	140	78.2
12	Abortion	80	44.7

Concerning sources of information about contraceptives, respondents were asked to name their favorite sources of information about contraceptives from the provided list. As can be seen from table 5 below, radio is the major 53(29.61%) sources of information concerning contraceptives.

Table 5: Sources of Information concerning Contraceptives

Source of Information	N	%
Radio	53	29.61
News Papers	4	2.23
Television	28	15.64
Friends	51	28.5
Health Professionals	43	24.02
Total	**179**	**100**

From the above table, the role of health professionals in disseminating contraceptive information is lower 43(24.02%) than those of radio (29.61%) and friends51 (28.5%). For this, absence of health centre /clinic at rural areas particularly on Islands where the community settle might contribute.

4.1.4. Association of Socio-demographic Variables and Contraceptive use

When we analyze result of the finding from gender variable dimension from table 6 on page 50, females are relatively better (47.72%) users of contraceptives than males (41.75%). But Chi-square analysis result show as there is no significant difference on contraceptive use between male and female respondents.

Table 6: Association of sex, age of respondents and age at first marriage and contraceptive use

Background Variables	Used		Not Used		Total Number		Chi-Square Test	Sig.
	N	%	N	%	N	%		
Sex								
Male	38	41.75	53	58.25	91	100		
Female	42	47.72	46	52.28	88	100	.050	.823
Total	80	44.70	99	55.30	179	100		
Age of Respondents								
15-19	8	53.33	7	46.67	15	100		
20-24	12	46.15	14	53.85	26	100		
25-29	8	36.36	14	63.64	22	100		
30-34	20	60.60	13	39.40	33	100	33.603	000
35-39	17	43.59	22	56.41	39	100		
40-44	9	39.13	14	60.87	23	100		
45-49	6	46.15	7	53.85	13	100		
Greater than 49	0	0	8	100	8	100		
Total	80	44.70	99	55.30	179	100		
Age at first Marriage								
15-19	47	60.25	31	39.75	78	100		
20-24	26	49.05	27	50.95	53	100		
25-30	11	35.48	20	64.52	31	100		
31-34	5	31.25	11	68.75	16	100		000
Greater than 34	1	100	0	0	1	100	103.430	
Total	80	43.02	99	56.98	179	100		

As it can be seen from table 6 above, as far as association of age of respondent and contraceptive use is concerned, highest number 20(60.6%) of contraceptive users are found in the age group of 30-34years.Then followed by slightly above average (53.33%) are found in age group of 15-19 years during interview time. Number of contraceptive user declined to 17(43.59%) for age group of 35-39.This declining trend to use contraceptive is also higher for age groups 20-24 which constitute 36.36% .This might be due to their intention to have more children. This trend continued to the later age groups i.e. respondents of over age 40 groups also showed small number of users. This might be attributed to their early marriage and their perception as they cannot get pregnant at these years due to approaching menopause stage. The experience of contraceptive use is absent for age group of over 49 years respondents. What can be seen from these data is majority of respondents are not user of contraceptives during high fertility time.

Concerning the association of age at first marriage and contraceptive use, majority (47 contraceptive user and 31 contraceptive non users) of respondents marry at the age between 15-19 years. These groups again take the leading (60.25%) in contraceptive use in their later years. The data in this study indicated that average age at first marriage is 21 years. Around half (49.05%) of those who marry at the age of 20-24 are users of contraceptives. But the trend in contraceptive use decrease as age of marriage increase. Further analysis of Chi-Square result revealed that age of respondents has significant difference on contraceptive use.

Contraceptive use also varies according to living number of children. As can be seen from table 7 below, among those who do not have children, majority (68.75%) are contraceptive users. Then onwards, contraceptive use trend decreases as living number of children increases. This might be due to high value attached for children

Regarding association of religious attendance and contraceptive use, among those who attend religious service more or less daily, the majority (70%) are non user of contraceptives.

Table 7: Association of Living number of children, Religious Attendance, Educational Level, and Residential Place

Background variables	Used Contraceptives				Total	%	Chi Square test	Sig.
	N	f	N	f				
Living Number of Children								
None	11	68.75	5	31.25	16	100		
1-2	26	49.06	27	50.94	53	100		
3-4	14	36.82	24	63.18	38	100		
5-6	19	45.24	23	54.76	42	100		
7-8	9	37.5	15	62.5	24	100	51.782	000
≥9	1	16.67	5	83.33	6	100		
Total	**80**	**43.02**	**99**	**56.98**	**179**	**100**		
Religious Attendance								
Daily	6	30	14	70	20	100		
2-3 times per week	34	36.95	58	63.05	92	100		
Ones a week	12	32.43	25	67.57	37	100		
Monthly	13	61.90	8	38.10	21	100	180.564	000
A few times per year	5	71.42	2	28.58	7	100		
Not Attended	2	100	0	0	2	100		
Total	**80**	**43.02**	**99**	**56.98**	**179**	**100**		
Educational Level								
Not Attended Formal Education	11	27.5	29	72.5	40	100		
Primary Education	26	31.32	57	68.68	83	100		
Secondary Education	23	69.70	10	30.30	33	100		
Higher Education	20	86.95	3	13.05	23	100	46.855	000
Total	**80**	**44.70**	**99**	**55.30**	**179**	**100**		
Residential Place								
Urban	44	80.0	11	20.0	55	100		
Rural	36	29.03	88	70.97	124	100		
Total	**80**	**44.69**	**99**	**55.31**	**179**	**100**	26.598	000

What is clearly observed from table 7 on above, as religious service attendance decreases contraceptive use increase. Chi Square result further indicated that as there is significant difference in religious service attendance and contraceptive use.

The other factor that determines contraceptive use of respondents is educational attainment of respondents. This finding revealed that as educational level increased, contraceptive use prevalence also increased. Accordingly, among those groups who attended higher institution's educational level, 86.95% used /using contraceptives. Among secondary education attendants, 69.7% used contraceptives. Besides, 31 .32% and 27.5% of primary and those who didn't attend formal school used /using contraceptives respectively. Additionally, Chi-Square result indicated that there is significant difference between educational attainment and contraceptive use variable.

When we look at contraceptive use from residential place variable, the majority (80%) of urban settlers of the subjects used/using contraceptives. Whereas, the majority (88%) of rural dwellers did not use contraceptives during their marriage period. This indicates that urban subjects are better contraceptive users than rural respondents. Moreover, Chi-Square result signifies that there is residential difference in contraceptive use.

To conclude, as can be seen from the above two tables (table 6 and 7), except sex all socio-demographic variables have an association with contraceptive use at alpha=0.05.

4.1.5. Contraceptive Use and Accessibility of Methods

Access and availability of contraceptive methods plays significant role on the behavior of beneficiaries. Accordingly, distance of availability of the methods and their relation with contraceptive use is presented as follow. Reference centres to get the service were Ziway and Meki towns. The average distance obtained from service provision centres is 12.37km. Respondents were asked to express their appropriate centre to get the service. Based on their self report response, distances to get the service were presented as follow.

Table 8: Accessibility of Methods in Kilo meter and Experience of Contraceptive Use

Distance in KM	Contraceptive Use Experience				Total	
	Used		Not Used			
	No	%	No	%	No	%
0-5 km	51	58.0%	37	42.0	88	100
6-10km	7	17.5%	33	82.5	40	100
11-15km	0	0	0	0	0	0
16-20km	0	0	0	0	0	0
21-25km	0	0	0	0	0	0
26-30km	9	56.25	7	43.75	16	100
31-35km	0	0	0	0	0	0
36-40km	13	37.14	22	62.86	35	100
Total	80	44.7%	99	55.3	179	100

As can be observed from the above table, the majority (58%) of the respondents who used/are using contraceptives get contraceptives within five kilo meter range. As distance to get the service increases, contraceptive use experiences of respondents decrease. As can be seen from the above table, as distance increased their exposure to contraceptive service and usage decrease except for those who travel about 26-30km respondents. Accordingly, the rate in contraceptive use lowered as distance of service area increased. Based on the distance, one could estimate the time it take to get the service.

To conclude the findings from the above table, distance they travel to get the service have an effect on contraceptive use of respondents.

4.1.6. Contraceptive Use and Value Attached to children by Zay Community Members

Value Zay community attach for children were assessed by comparing mean value of those who used contraceptive methods and those who didn't use contraceptives. The result was analyzed using One Way ANOVA.

Accordingly, the figures in table 9 below shows the comparison of contraceptive user respondents' contraceptive non uses and values the Zay society give for children.

Table 9: Comparison of Scores on Value of Children for contraceptive users and non users

Group	N	Mean	Std. Dev.
Contraceptive Methods Users	80	55.99	8.970
Contraceptives Methods Non Users	99	48.03	8.863

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2801.511	1	2801.511	35.278	.000
Within Groups	14055.897	177	79.412		
Total	16857.408	178			

As it can be seen from the above table, there is significant difference between contraceptive users (N=80, $\overline{X}$=55.99) and contraceptive non users on score of value of children (N=99, $\overline{X}$ =48.03) at alpha=0.05, and F= 35.278). This means value respondents of contraceptive users attach for children are different from those of contraceptive non user respondents. Accordingly, those of contraceptives users Zay community members scored higher mean scores than those of none users on the scale the community gives value for children.

4.1.8. Contraceptive Use and Concepts about Contraceptive Methods

Table 11 shows the distribution of respondents' contraceptive use and myth/misconceptions the Zay community members has on contraceptive methods. To see the existence of misconceptions mean difference between contraceptive users and non users on contraceptive methods, misconception scale questions were employed and analyzed using One Way Analysis of Variance (ANOVA).

Table 11: Comparison of contraceptive users and non users on scales of contraceptive concepts and Summery of ANOVA Results

Group	N	Mean	Std. Dev.
Used contraceptives	80	57.49	9.023
Not Used Contraceptives	99	49.61	8.336

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2748.421	1	2748.421	36.738	.000
Within Groups	13241.624	177	74.811		
Total	15990.045	178			

As it can be seen from the above table 11, there is significant difference between contraceptive users and non users on score of contraceptive concepts. This means concepts about contraceptive methods vary according to contraceptive use experience of respondents. As it is presented on the above table, contraceptive users have higher score on concepts of

contraceptive methods (N=80, $\overline{X}$=57.49) than those of non user groups (N=99, $\overline{X}$=49.61) at alpha=0.05, and F=36.738.This means, misconception is higher among contraceptive non users.

4.1.9. Contraceptive Use and perception towards family Planning Counseling

Table 12 shows the distribution of respondents' contraceptive use experience and respondents' perception towards the role of family planning counseling.

Table12: Comparison of contraceptive users and non users on scales of perception towards family planning counselling and Summery of ANOVA Results

Group	N	Mean	Std. Dev.
Used contraceptives	80	57.21	9.013
Not Used Contraceptives	99	50.18	8.351

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2187.092	1	2187.092	29.212	.000
Within Groups	13252.115	177	74.871		
Total	15439.207	178			

As indicated on the above table, the mean value difference between the scores of contraceptive user (N=80, $\overline{X}$=57.21) and none user (N=99, $\overline{X}$=50.18) on perception towards family planning counselling is statistically significant at alpha=0.05, and F=29.212. The table further reveals that those who used contraceptives have better mean score than those of non

users of contraceptives on the perception toward family planning counseling. This means, contraceptive method users have positive perception towards family planning counseling than contraceptive methods non user respondents.

Inorder to further investigate contraceptive users' interaction with contraceptive methods service providers, those who used contraceptive methods were asked about their contact period and duration of discussion time with the professionals. Their response is presented as follow.

As can be seen from table 13 below, the majority 44(55%) of contraceptive users contact service providers only once (at the beginning of service delivery).Then followed by every two month duration of contact which constitute 20(25%) of respondents. The rest 14(17.5%) and 2 (2.5%) contraceptive users contact service providers every week and every month respectively.

Table 13: Duration of contact and discussion of respondents with family planning service provider professionals and availability of professionals for help

Contact duration	Number of Respondents	%
Only at First day	44	55
Weekly	14	17.5
Every month	2	2.5
Every two Month	20	25
Total	80	100
Discussion Period during Service Delivery		
Up to 10 min.	19	23.8
Up to 20 min.	23	28.8
Up to 30 min.	20	25.0
Over 30 min.	18	22.4
Total	80	100

Availability of service providers When needed		
Yes available when needed at any time	15	18.75
Only Available during appointment time	41	51.25
Not available when needed	24	30.00
Total	80	100.00

In addition to duration of visiting family planning service providers, duration of discussion with health professionals about the service matters in the continuation and consistent use of contraceptive methods. Because, as the time of discussion increases between the client and service provider, so many things can be raised and the clients can get better understanding about contraceptive methods. As can be seen from the above table, the majority 23(28.8%) of respondents said they discuss with professional family planning service providers up to twenty minute to get appropriate instructions and guidance about the methods while they meet service providers. 20(25%) of respondent said they discuss with family planning service providers for about 30 minutes. The rest 19(23.8%) and 18(22.4%) of contraceptive users said they discussed about the methods and related issues for about ten minute and over thirty minute respectively.

The other important thing in family planning service is availability of service providing professionals when they are needed. Concerning this, the following results were obtained from contraceptive methods users (table 13 above).

As depicted on the above table 13, the majority 41(51.25%) of respondents said that they get professional service provider at the time of appointment. 24(30%) of the users said they are not able to get service providers when needed. The rest 15(18.75%) said they are able to get the service providers when they are in need of their help. What can be concluded from this

self report result is that majority of respondents get their service providers during their appointment time or at any time when they need help from service providers.

4.1.10. Factors Affecting Contraceptive Use

In the preceding section, inter-variable correlation was employed to assess the relationship and interdependency of variables among each other. Accordingly, the correlation matrix on table 14 shows the following results.

Educational level, Value of children, Communication between couples, perception toward counseling and concepts on contraceptives have negative relation with contraceptive use.

Age of respondents and contraceptive use($r = 0.147$), residential place and contraceptive use($r = 0.473$); and Number of living children and contraceptive use ($r = 0.157$) have positive relationship. On the other hand sex, age at first marriage, religious attendance, and distance in kilo meter to get the service have relationship with contraceptive use. But they are not significant.

Table 14 below further indicate that age of respondents and number of living children have strong correlation to each other($r = 0.718$) and with contraceptive use ($P<.01$).This means, as age of respondents increase, number of living children increase. Consequently, their experience in contraceptive use also increases.

Travelling distance and contraceptive use have also negative relationship. This implies that as distance the respondents travel to get the service increases, their contraceptive use experience decrease. Additionally, residential place and distance in kilo meter to get the service have positive relationship to each other and contraceptive use.

Scale values on children's value, communication between couples, perception towards family planning counseling and concepts about contraceptive methods have positive relationship to each others. All of them have negative relationship with contraceptive use of respondent.

Table14:Variables Inter-Correlation Matrix

Variables	X_1	X_2	X_3	X_4	X_5	X_6	Y_1	X_7	X_8	X_9	X_{10}	X_{11}	X_{12}
Age of respondent(X_1)	1	-.383**	.054	-.163*	.452**	.718**	.147*	-.038	-.143	-.073	-.095	-.070	-.144
Sex (X_2)		1	.049	-.086	-.601**	-.097	-.060	-.096	.007	-.098	-.075	-.078	.041
Residential place(X_3)			1	-.531**	-.117	.149*	.473**	-.217**	-.483**	-.498**	-.490**	-.364**	.532**
Educational Level(X_4)				1	.241**	-.352**	-.415**	.107	.347**	.341**	.370**	.360**	-.290**
Age at first Marriage(X_5)					1	-.006	.085	.062	.011	.112	.098	.109	-.185*
Number of Living Children (X_6)						1	.157*	-.105	-.077	-.026	-.101	-.055	-.028
Contraceptive Use(Y_1)							1	-.091	-.408**	-.415**	-.479**	-.376**	-.103
Religious Attendance(X_7)								1	.081	.127	.129	.105	-.150*
Value of Children(X_8)									1	.807**	.815**	.688**	-.231**
Concepts about Contraceptives (X_9)										1	.867**	.755**	-.256**
Couples Communication(X_{10})											1	.697**	-.244**
Perception towards Counseling(X_{11})												1	-.222**
Distance in KM(X_{12})													1

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

4.1.11. Results of Multiple Regression Analysis

This study deals with not only determining the relation of each socio-demographic variable to contraceptive use variable. It also discerns the combined effect of two or more socio-demographic variables on the contraceptive use variable. Thus, multiple regression analysis technique is considered and appropriate to be applied in this study. Accordingly, in order to evaluate the combined effect of all predictor variables (socio-demographic variables) for the prediction of criterion variable (contraceptive use), all predictor variables are employed simultaneously and the result has been presented on table 15 below (page 64). Table 15 results reveals that all the socio-demographic variables together contributed 42.5% of the explained variance of contraceptive use variable. This means, socio-demographic variables of this study all together contributed 42.5% of the explained variance in contraceptive use of subjects. The F-value (7.937) of the multiple regressions as can be seen in the below table show that of all variables, only five of them (residential place, educational level, distance in kilometre, couples communication and age at first marriage) are significant at a 0.01and0.05 level of significance.

Table 15: Results of Multiple Regression Analysis

Variables Entered	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Multiple Correlation		Standard Error of Estimate	Adjusted R Squares	Multiple F- Value
	B	Std. Error	Beta							
						R	R^2			
(Constant)	1.125	.298		3.771	.000					
Age	-.019	.032	-.073	-.599	.550**					
Sex	-.028	.077	-.028	-.359	.720					
Residential place	.344	.099	.318	3.461	.001*					
Educational Level	-.115	.042	-.216	-2.732	.007*					
Age of Marriage	.100	.046	.202	2.158	.032**					
Living Children	.028	.042	.074	.678	.499*					
Religious Attendance	.005	.029	.010	.167	.868					
Value of Children	.003	.006	.065	.546	.586*					
Concepts about Contraceptives	.008	.008	.155	1.057	.292*					
Couples Communication	-.018	.006	-.424	-3.076	.002*				.372	7.937
Perception Toward Counseling	-.007	.005	-.125	-1.297	.196*	.652	.425	.396		
Distance in KM	-.121	.076	-.393	-1.593	.113					

* significant at 0.01 level of sign ** significant at 0.05 level of sign

Y= 0.344X3 -0.018X12+0.100X5 -0.121x14- 0.115x4 +1.125

On the other hand, magnitude of standardized regression coefficient can also be described in descending order based on the significant contribution of each predictor variable predicting contraceptive use variable from the below table .As can be seen from table 15 above, the t-value indicate that residential place, couples communication, educational level, age of marriage and distance in kilometre has contribution to the prediction of contraceptive use at 0.05 and 0.01 level of significance. In general, residential pace, couples communication, and educational level have majority of the variance in contraceptive use.

4.1.12. Results of Step-Wise Regression Analysis

In order to evaluate and identify the relative contribution of each predicting variables in predicting criterion variables and to identify the strongest predictors, step-wise regression method was employed.

In this step-wise regression analysis, residential place, couples communication, age at first marriage, distance in kilometre to get family planning service, and educational level were considered. The following table shows step-wise results.

Table 16: Results of Stepwise Regression

Steps Number	Variables Entered	R	R Square	Std. Error of the Estimate	R^2 change	F-change	Sign. F-change
1	Residential place	.483	.233	.438	.233	53.264	.000
2	Couples Communication	.559	.313	.416	.079	39.553	.000
3	Age at first Marriage	.584	.342	.408	.032	29.909	.003
4	Distance in Kilometer	.605	.367	.402	.029	24.881	.016
5	Educational Level	.631	.398	.393	.025	22.647	.001

They are presented in descending order at alpha=0.05(age of marriage) and alpha=0.01 significance level (for the rest variables) .The proportion of variance they accounted for contraceptive use are residential place 23.3%, couples communication contribute 7.9%, age at first marriage has 3.2% of contribution, distance in kilometre to get family planning service constitute 2.9%, and 2.5% is accounted for educational level respectively. If the rest variables in addition to those stated above considered in the regression model, the total variance accounted for contraceptive use would have been 42.5%(see table 16).This means, the increase in contraceptive use attributed to the rest of variables than these five variables is only 2.7% . This shows that the additive effect of the variables of those which are not included in step-wise regression analysis is very little or not significant.

4.2. Discussions

The primary objective of this research was to investigate major factors that affect contraceptive use among married Zay community members. The discussion part of this section is based on the findings of the preceding chapters.

Different research findings identified that knowledge of contraceptives are universal (WHO, 2003; EDHS, 2005). However, in this research finding, condom and abstinence constitute higher position (83.2 vs 80.4) respectively than other methods. But when we compare it with the country level awareness of these methods which constitute over 84 %,(EDHS, 2005) this study shows as the knowledge level is not satisfactory. This implies that familiarity of the society with these methods is not satisfactory and needs further effort to improve the knowledge and awareness level of the community with this regard. In this study, there is no gender disparity in contraceptive use. This result contradicts with the finding of Reed, Fred, McBroom and William which states that men are more likely towards fertility while women become less so. This difference could be attributed for cultural difference.

As far as source of information is concerned, the role of health professionals in disseminating contraceptive information is lower than those of radio and friends. For this, absence of health centre /clinic at rural areas particularly on Islands where the community settle might contribute.

This research further indicates that all socio-economic and demographic variables except gender have significant association with contraceptive use.

As far as availability indicator is concerned, the distance to get the service is another determinant factor for contraceptive use. As identified in the study, contraceptive use have inverse relationship with distance in kilometre to get the service. This is consistent with Tuladhar (1987) and Ann Levin, Bruce Caldwell and Barkat-e Khuda (1999) which states that couples were less likely to use contraception or choose methods if the travel time to fixed clinics was greater than 30 minute and the distance is above 30 kilometer. Therefore, expanding health clinics and integrating family planning service with other service is important.

It is interesting to note from the mean ratings that the value Zay community attach for children is higher among contraceptive users than contraceptive non users. This might be attributed to the current cost of living condition. Accordingly, poor community members who do not plan their family might have faced difficulty to cope up the current living cost than those who were planning. The finding of this research contradicts with the finding of Ergöçen (1997) which state that women with five or more children and not using contraception stressed the economic value of children more than women with two or fewer children using contraception.

Moreover, this finding revealed and confirmed that those couples who communicate about contraceptives, family life and related sexuality issues are better users of contraceptives (Bean et al., 1983; Kasarda et al., 1986; Sakyi, 1992; Ullah and Chakraborty, 1993; Nyblade and Menken, 1993; Mulu, 1996; and Kifle, 1999). In most studies, couple's discussion is positively related to contraceptive use in general and method choice and effectiveness in particular. This finding further indicate that availability of couples communication also positively affect contraceptive use.

This finding also explained that those of users of contraceptives have higher concepts about contraceptives than contraceptive nonusers. This might be attributed to the knowledge they gain while they visit service providers and the duration they spend in discussing with professionals on the issue. This result is similar with the finding of Powell (2006) which states that non modern contraceptive users cited more perceived barriers against the use of modern contraceptives and preferred larger families than their counter parts of modern contraceptive users.

In relation with counseling service, counseling intervention would be efficacious in improving, understanding and use of contraception in women who have undergone a termination of pregnancy (Nobili, Piergrossi, Brusati, and Moja). In a similar analogy, this research finding confirms the above statement and indicates that those who used contraceptives have positive perception than those of non users towards family planning counseling service. Duration of discussion time about contraceptives with health professionals contribute a lot. Because, in this research, majority of users discuss about the methods with service providers up to 30 minutes which contradicts with the finding of WHO (1994) in Brazil where service providers spend less than eight minute with clients of contraceptives, and in the same manner finding of Mbomena (1995) in Zambia, where actual

staff-client contact time averaged only one to two minutes per family planning acceptor. However, from contraceptive users, what this study identified is that majority of contraceptive users meet their service provider once or after a long period of gap. This indicates a gap in structure to retain the clients to continue in using the methods. This trend is similar with the finding of WHO (1994) survey result in Brazil that states most settings have no formal mechanism for ensuring continuity of family planning care. Hence it needs the commitment of service provider to retain the service seekers for the effectiveness of the family planning service provision.

This research further identified that age of respondents and number of living children have strong correlation to each other and with contraceptive use($P<.01$).This means, as age of respondents increase, number of living children increase. Consequently, their experience in contraceptive use also increases. This finding is consistent with the research result of Farooqui (1990) which explains that there is a direct association between the number of living children and use of contraception, and thus, contraception use increases with an increase in the number of living children. But what is observed in this study is that the majority of respondents marry within the age range of 15-19. As it is known, if they are not able to practice contraceptives as of their early years to limit their family, and exercise at their parity might not bring the desired outcome. Additionally, this research result revealed that the higher rate of contraceptive use age category is 30-39. It is relatively lower for the younger (15-24) age groups and upper (over 40) years age groups. This finding is in line with the finding of Mulu (1996) which states that use of contraceptive is relatively lower at the lower (15-19) and older (45-49) age groups. But it is higher at the middle age (25-34) groups.

As far as education is concerned, educational level and contraceptive use have positive relationship. As educational level increases, contraceptive use also increases. Further analysis

also reveals that education has significant contribution in contraceptive use. This finding coincides with the finding of different researchers which states that fertility preferences and contraceptive use have significant relationship and affected by educational attainment (Althaus F. 1997; EDH, 2005; Murad, 2006; Negussie, 2006; Worku 1997, Tamiru, 2007).

Concerning residential place, there is significant and positive relationship between residential place and contraceptive use. As revealed in this study, urban settlers are better users of contraceptives. The result further indicates that as distance of family planning service provision area increases from residential place, contraceptive use decreases. This finding contradicts with the finding of Mroz, Bollen, Speizer, and Mancini (1999) which states that the perceptive quality of family planning facility was a more important determinant of contraceptive use than accessibility measures in communities with a facility within 30 km. This difference could be due to cultural difference of the two study population.

When we look it at the stepwise regression analysis, residential place is the most powerful predictor of contraceptive use .Additionally, couples communication, age of marriage ,distance in kilometre to get the service, and educational level are other powerful predictors of contraceptive use respectively in this study.

Value of children, perception towards family planning counseling and concepts on contraceptives have negative correlation with contraceptive use not considered as the most powerful predictor of contraceptive use in the regression analysis. This might be due to residential disparity and couples communication effect.

To explain the finding of this research result, those married people who are nearer to family planning service provision area, who marry in their latter years, who communicates with their couples on family planning and related sexual matters, and better educated groups are better users of contraceptives.

CHAPTER FIVE

5. Summary, Conclusions and Recommendations

5.1 Summary

The main purpose of this study was to find out major factors that contribute to contraceptive use among married Zay community members. The study involved 179 randomly selected respondents.

In the study, attempts were made to provide answers to the following questions.

What are the socio-demographic variables that affect contraceptive use?

Do availability/accessibility of contraceptive methods affect the contraceptive use?

Do the various factors like value society attach for children, couples communication, concepts about contraceptive methods and perception toward counseling have significant difference on contraceptive users and non users?

In order to react and deal with these basic questions, related literatures were analyzed and properly reviewed. Additionally, different scales were employed in structured questionnaire.

Based on the data obtained through questionnaire, analysis was made in relation to the existing literature in the area. After analysis of data, the following major results were obtained.

- Level of awareness of the Zay community members about contraceptive methods was not satisfactory.
- This research further indicates that all socio-economic and demographic variables have significant association with contraceptive use.
- As far as availability indicators are concerned, there is residential place (rural urban) disparity and both the distance and travelling time to get family planning service are

inversely related with contraceptive use. That means, majority of the community travels over five kilometres and 30 minutes journey to get the service.

- Couples who communicate about contraceptives, family life and related sexuality issues are better users of contraceptives.
- Residential place is the most powerful predictor of contraceptive use. Additionally, couples communication, age of marriage, distance in kilometre to get family planning service, and educational level are other powerful predictors of contraceptive use respectively in this study.
- Value of children, perception towards family planning counseling and concepts about contraceptive methods are not considered as the most powerful predictor of contraceptive use

5.2 Conclusions

Based on the finding of the research, the following conclusion were made

The research found that awareness level of the community about contraceptives is not satisfactory and it may impede the use of contraceptives

There is availability and access problem to get the service with in short distance and time. Accordingly there is great disparity between rural and urban users. For this, unavailability of health centres and clinics on the islands and nearby area contribute for non use rural community

Communication between couples about contraceptives, educational attainment and being marrying lately enhance the use of contraceptives.

5.3 Recommendations

In view of the findings of the study, and conclusions drawn, the following recommendations are forwarded:

1. As it was identified, unavailability of contraceptive services in the nearby area was the most hindering factor. Therefore, if those organizations both governmental and nongovernmental organizations provide the service in community based manner; it can improve the awareness level about the methods and addresses the unmet need of contraceptives in the community.
2. Community based campaign (activity) should be made to enhance couples communication on family planning and sexuality related issues.
3. The concerned bodies i.e both government and non government organizations should made their effort to reduce early marriage practice in the community. Because, such couples who marry in their early years of age lacks confidence and skills to discuss about sexuality and family planning services with their husband /wife.
4. Educational opportunities should be expanded for female teenagers.

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Instruction: For the following questions circle the appropriate letter

C.1. If you heard about these methods, what is your source?

A/radio B/ Newspaper C/Television D/Friends E/Health professionals

F/If others, specify----------

C.2. Have you visited health centers and get contraceptive methods for usage ? A/Yes I have visited and used contraceptives B/ No, I have never visited and used contraceptives

C.2.1. In order to get contraceptives, on average, how many Kilometers you travel? A/0-5 km B/ 6-10 km C/ 11-15km D/16-20km E/ over 20 km

C.2.2. On average how much time you travel to get contraceptives? A/ up to 30 minute B/up to one hour C/Up to two hour

D/ Up to 3 hour E/up to 4 hour F/ over 4 hour

C.3. If you experienced about using contraceptive methods, how do you explain availability of service provider professionals?

A/ They were available whenever needed B/They are available only at date of appointment C/I couldn't get them when I am in need of them

C.3.1. If you used contraceptives, how often you meet your service provider professional? A/Only on service provision day B/Every week C/Every two week D/Every month E/If any Specify----------

C.4.1. If you used contraceptives, on average how often you discuss with service provider?----------

C.5. In general, during your marriage period, how do you explain your contraceptive use behavior? A/Mostly B/ Sometimes C/ Often D/More or less I didn't use

PPENDIX-B

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY

Under this section, the value society gives for children are presented. So, read them carefully and put (X) mark on your level of agreement under the space provided in each column.

	Sentences	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
1	Children are wealth.					
2	Children are source of power and/or prestige in the society.					
3	Couple who decides not to have children ,even if they can, are selfish					
4	Having many children is source of happiness for the family than limiting of it.					
5.	Since cost of raising children makes it hard to support a large family, it is advisable to limit number of children.					
6	Using birth control to have small number of children means making self too busy in household activities					
7	Even if the number of children I desire is met, I will continue having more children.					

8	Purposively using contraceptives indicates ones hate for children					
9	I prefer having more children to using birth control					
10	The practice of contraceptive use to prevent pregnancy is equivalent to murder					
11	I believe that every married woman should bear as many children as she can than taking contraceptives					
12	I approve of young couple to use contraceptive methods to prevent having children right after being married					
13	Contraceptives are very cost than other medicines .					
14	Whether the sex desired is made or not, usage of contraceptives is acceptable					
15	Lack of resources can not let me to use contraceptives					

APPENDIX - C

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMNT OF PSYCHOLOGY

Under this section, concepts about contraceptives are presented. So, read them carefully and put (X) mark on your level of agreement under the space provided in each column .

S/N	Sentences	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	Contraceptives make sex less pleasurable					
2	Using birth control means selfishness					
3	Modern contraceptives can affect fertility or produce sterility on user.					
4	Side effect of contraceptives can be treated easily					
5	I do not think pregnancy can occur using contraceptives					
6	I do not think that breastfeeding females can get pregnancy. So that she should not use contraceptives.					
7	Using of contraceptives creates regular health problems.					

8	It is a sign of modernity to think ahead about birth control.					
9	Using contraceptives can promote the health condition of mothers and children					
10	There are contraceptive methods that males can use.					
11	Irregular usage of contraceptives can prevent pregnancy					
12	Contraceptive usage means complete stoppage of child bearing.					
13	An individual can bear a child ones s/he stop using contraceptives.					
14	Washing immediately after sex can prevent pregnancy. So no need of contraceptives					
15	Most of the time, contraceptives aren't effective in birth control.					
16	I do not have sex often and I can't get pregnancy and no need of using contraceptives					

PPENDIX -D

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMNT OF PSYCHOLOGY

Under this section, different questions to assess couples communication on contraceptives and related sexuality issues are presented. So, read them carefully and put (X) mark on your level of agreement under the space provided in each column .

S/N	Sentences	Strongly Disagree	Disagree	Undecided	Agree	Strongly agree
1	The trouble with contraceptive use is that the mistrust my partner has to me .					
2	My partner disapproves contraceptives and hate the idea					
3	Having sex is unexpected and do not time to prepare. So, no need of discussion about to take contraceptives.					
4	Discussing about birth control with a partner is shameful.					
5	Discussing about contraceptives among couples have positive outcome for the family					
6	Since contraceptive usage is the responsibility of women, no need of discussion					
7	Whenever I raise about birth control, my partner is happy					

8	Discussing about contraceptive use with partner indicates their modernity.					
9	I and my partner discuss about how to limit our family.					
10	I wouldn't use contraceptives when my partner is at home.					
11	Discussing about contraceptive usage with partner promotes promiscuity					
12	It is wise full to discuss with partner about contraceptives.					
13	Discussing about contraceptives with partner is a sign of subspecies to each other					
14	It is embarrassing to ask my partner to use contraceptives					
15	I have regular discussion time with my partner about contraceptives					

APPENDIX-E

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMNT OF PSYCHOLOGY

Under this section, different questions that help us to know about perception of beneficiaries about contraceptive counseling are presented. So, read them carefully and put (X) mark on your level of agreement under the space provided in each column .

S/N	Sentence	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	I think service providers do not explain very well about proper use of the methods, I do not want to use them.					
2	Since service providers are not available when I am in need of them, so it is not appropriate to use contraceptives.					
3	I think that appropriate professional treatment can help me to overcome side effect of these methods.					
4	I have experienced /perceive/ that service providers do not let the method that suits my interest.					
5	I have experienced/expect that service providers do not treat well.					
6	I have no problem to use contraceptives if I am able to get contraceptive provides when I am in need of them for help.					
7	Frequently visiting contraceptive service providers to get birth control is embarrassing.					
8	Frequent visit to family planning service provider do not bring any behavioral change on my contraceptive use.					
9	I have no problem to use contraceptives if service providers do not break confidentiality.					

10	Since family planning is one aspect of health care service, attending the service is important.					
11	If I get appropriate guidance on the way to return fertility after contraceptive use, I have no problem to use contraceptives					
12	Frequent family planning service providers visit expose for discrimination. So, no need to visit them.					
13	Since nearby contraceptive providers are not well trained so that I prefer not to take contraceptives.					
14	If I am able to get appropriate private counseling, I prefer to use contraceptives					
15	Fear of stigma and discrimination can never prohibit me to use contraceptives ones I get appropriate guidance					

APPENDIX -F ኮድ---------

አዲስ አበባ ዩኒቨርስቲ

የድህረ ምረቃ ፕሮግራም

የሳይኮሎጂ ትምህርት ክፍል

አጠቃላይ መረጃ

የዚህ ጥናት አጠቃላይ አላማ ከዚህ ጥናት ተሳታፊዎች ስለቤተሰብ ምጣኔ መረጃ ለመሰብሰብ የታለመ ነዉ። ጥናቱ የሚያተኩረዉ ህብረተሰቡ በተለይም ግለሰቦች ለቤተሰብ ምጣኔ አጠቃቀም የሚሰጡትን ምክንያት ለማወቅ የቀረበ ነዉ።በዚህ መጠይቅ የሚሰበሰበዉ መረጃ ለዚህ ጥናት ብቻ የሚዉልና በሚስጢር የሚያዝ ስለሆነ ለሚጠየቁት ጥያቄዎች ነፃ ሆነዉ ትክክለኛ/እዉነተኛ ምላሽ እንዲሰጡ ይጠየቃሉ። ይህም ለጥናቱ መሳኙት ከፍተኛ አስተዋፅኦ ስላለዉ መጠይቁን በመሙላት እንዲተባበሩኝ በትህትና እለምናለሁ። ለጥያቄዎቹ የሚሰጡት ምላሽ የእርስዎን ትክክለኛ ነት ወይም ስህተት አያሳዩም። በመሆኑም የተለያዩ ጥያቄዎች የተለያየ መልስ ሊኖራቸዉ ስለሚችል በተጠየቁት መሰረት ነፃ ሆነዉ እንድመልሱ ይለመናሉ።

ስለጊዜዎትና ስለትብብርዎ በቅድምያ በጣም አመሰግንዎታለሁ።

ክፍል አንድ

መመሪያ፡ ለሚከተሉት ጥያቄዎች ትክክለኛ ምላሽ ይዘዋል በሚሉት ፊደል ላይ በማክበብ ይመልሱ።

ሀ.1. እድሜ? ሀ.15-19 ለ. 20-24 ሐ. 25-29 መ. 30-34 ሠ. 35-39 ረ.40-44 ሰ. 45-49 ሸ.>49

ሀ.2. ጾታ ሀ) ወንድ ለ) ሴት

ሀ.3. መኖሪያ ስፍራዎት ሀ) ከተማ ለ ገጠር

ሀ.4. ቀበሌ ----------

ሀ.5. ሀይማኖትዎ ሀ)ኦርቶዶክስ ለ) ፕሮቴስታንት ሐ) ሌላ ካለ ይገለጽ---------

ሀ.6. በሃይማኖት አገልግሎት ምን ያህል ይሳተፋሉ ?

ሀ) ከሞላ ጎደል በየቀኑ ለ) በሳምንት ከ 2-3 ጊዜ ሐ) በሳምንት አንድ ጊዜ

መ) በየወሩ ሠ) በአመት ጥቂት ጊዜያት ሰ/ተሳትፌ አላውቅም

ሀ.7. የትምህርት ደረጃዎ?

ሀ) መደበኛ ትምህርት አልተማርኩም ለ) 1-8 ሐ) 9-12 መ) ተቋም / ኮሌጅ/ ዩኒቨርስቲ

ሀ.8. መጀመሪያ ትዳር የመሰረቱበት እድሜ ? 15-19 ለ. 20-24 ሐ. 25-30 መ. 31-34

ክፍል ሁለት፡- የወሊድ ሁኔታን የሚመለከቱ ጥያቄዎች

መመሪያ፡ ለሚከተሉት ጥያቄዎች ትክክለኛ ምላሽ የያዘዉን ፊደል በማክበብ ይመልሱ።

ለ.1. ልጆች አለዎት ? ሀ) አዎ ለ) የለኝም

ለ.2. ልጆች ካለዎት እስካሁን ስንት ልጆችን ወልደዋል ? ሀ/0 ለ/1-2 ሐ/ 3-4 መ/ 5-6

ሠ/ 7 -8 ረ/ 9 እና በላይ

ለ.3 ከአሁን ቦኋላ ተጨማሪ ልጅ መውለድ ይፈልጋሉ ? ሀ) አዎ ለ) አልፈልግም

ሐ/እርግጠኛ አደለሁም መ/ እግዘአብሄር እንደፈቀደዉ ይሆናል

ለ.4. ከአሁን ቦኋላ ተጨማሪ ልጅ መውለድ ከፈለጉ በአማካይ ስንት ልጅ መዉለድ

ይፈልጋሉ?ሀ/0 ለ/1-2 ሐ/ 3-4 መ/ 5-6 ሠ/ከ 6 በላይ

ለ.5. ልጅ ወዳልወለዱበት ወቅት/ጊዜ ቢመለሱና በህይወት ዘመንዎ ሊኖርወት የሚፈልጉትን የልጆች ቁጥር እንዲወስኑ ምርጫ ቢሰጥዎትና ቢጠየቁ ስንት ልጆችን መዉለድ ይፈልጉ ነበር?

ክፍል ሶስት ፡ የቤተሰብ ምጣኔ አገልግሎት እዉቀትና አጠቃቀም ለማወቅ የተዘጋጁ መጠይቆች

ሐ. ከዚህ ቀጥሎ የተለያዩ የዕርግዝና ማዘግያ/መከላከያ ዘዴዎች ቀርበዋል።

የተጠየቁትን ዘዴ ሰምተዉ የሚያዉቁ ከሆነ **አዎ** *በሚለው ረድፍ ስር የ (X) ምልክት የስቀምጡ።ሰምተዉ የማያዉቁ ከሆነ* **አይደለም** *በሚለዉ ረድፍ ስር የ (X) ምልክት ያስቀምጡ።*

ተ.ቁ	የእርግዝና መከላከያ ዘዴዎች	ሰምቼ አዉቃለሁ	
		አዎ	አይደለም
1	ክኒን/እንክብል		
2	አይ.ዩ.ዲ/ሉፕ		
3	መርፌ		
4	የማህፀን ቆብ		
5	የሴቱን የማህፀን ቧንቧ መቋጠር		
6	በሴቷ ክንድ የሚቀበር		
7	የወንዱን የዘር ፍሬ ቧንቧ መቋጠር		
8	ኮንደም		
9	መታቀብ		
10	ከብልት ዉጪ ማፍሰስ		
11	ለረጅም ጊዜ ጡት ማጥባት		
12	ማስወረድ		
13	ከላይ ከተጠቀሱት በተጨማሪ ሴቶች/ወንዶች እርግዝናን ለመከላከል የሚጠቀሙበትን ሌሎች ዘዴዎችን ሰምተዉ የዉቃሉ? ካለ ይጥቀሱ		

መመሪያ፡ ለሚከተሉት ጥያቄዎች ትክክለኛ ምላሽ የያዘዉን ፊደል በማክበብ ይመልሱ።

ሐ.1. ስለእነዚህ ዘዴዎች ሰምተዉ ከሆነ ከየት ሰሙ?

ሀ/ ሬድዮ ለ/ ጋዜጣ ሐ/ ቭሌቭገርን መ/ ጓደኛ ሠ/ ጤና ባለሙያ ረ/ሌላ ትለ ይግለፁ ----

ሐ.2. በእስካሁኑ የትዳር ቆይታዎት ወቅት የእርግዝና መከላከያን ወደ ጤና ተቀዋም ሄደዉ አግኝተዉ ተጠቅመዉ ያዉቃሉ? ሀ/ ተጠቅሜ አዉቃለሁ ለ/ ተጠቅሜ አላዉቅም

ሐ.2.1. የእርግዝና መከላከያን ለማግኘት በግምት ምን ያክል ኪ.ሜ ይጓዛሉ? ሀ/0-5 ኪ.ሜ ለ/6-10 ሐ/11-15 ኪ.ሜ መ/16-20 ኪ.ሜ ሠ/ ከ20 ኪ.ሜ በላይ

ሐ.2.2. የእርግዝና መከላከያን ለማግኘት በግምት ምን ያክል ጊዜ ይጓዛሉ? ሀ/ እስከ 30 ደቂቃ

ለ/እስከ 1 ሰዓት ሐ/እስከ 2 ሰዓት መ/እስከ 3 ሰዓት ሠ/ /እስከ 4 ሰዓት

ረ/ ከ4 ሰዓት በላይ

ሐ.3. የእርግዝና መከላከያ ተጠቅመዉ የሚያዉቁ ከሆነ የአገልግሎት ሰጪ ባለሙያ መገኘትን እንዴት ይገልጻሉ? ሀ/ በፈለግሁ ጊዜ ይገናኛሉ ለ/የሚገኙጽ በቀጠሮ ቀን ብቻ ነዉሐ/በፈለግሁ ጊዜ ማግኘት አልቻልኩም

ሐ.3.1. የእርግዝና መከላከያ ተጠቅመዉ የሚያዉቁ ከሆነ ከአገልግሎት ሰጪ ባለሙያ ጋር በምን ያክል ጊዜ ይገናኛሉ? ሀ. አገልግሎቱን ያገኘሁበት ቀን ብቻ ለ.በየሳምንቱ ሐ. በየ 15 ቀኑ መ.በየወሩ ሠ. ሌላ ካለ ይግለፁ

ሐ.4. የእርግዝና መከላከያ ተጠቅመዉ የሚያዉቁ ከሆነ ከአገልግሎት ሰጪ ባለሙያ ጋር በሚገናኙበት ጊዜ በግምት ለምን ያክል ጊዜ ይወያያሉ ?----------

ሐ.5. በአጠቃላይ በትዳር ቆይታወት ወቅት የእርግዝና መከላከያ አጠቃቀምዎትን እንዴት ይገልፁሉ?

ሀ/ በአብዛኛዉ እጠቀም ነበር ለ) አልፎ አልፎ እጠቀም ነበር

ሐ/ አንዳንዴ እጠቀም ነበር መ/ ከሞላ ጎደል ተጠቅሜ አላዉቅበ

APPENDIX-G

አዲስ አበባ ዩኒቨርስቲ

የድህረ ምረቃ ፕሮግራም

የሳይኮሎጂ ትምህርት ክፍል

ከዚህ ቀጥሎ የተዘረዘሩት አረፍተነገሮች ህብረተሰቡ ለልጆች የሚሰጠዉን ግምት ለማወቅ የተዘጋጁ ናቸዉ። በመሆኑም ካነበቡ በኋላ የእርስዎን የመስማማት ደረጃ በአረፍተነገሮቹ ፊት ለፊት ከሚገኙ ረድፎችና አማራጮች ዉስጥ በአንዱ የ X ምልክት የስቀምጡ።

	አረፍተነገር	በጣም አልስማማም	አልስማማም	መወሰን አቸገራለሁ	አስማማለሁ	በጣም አስማማለሁ
1	ልጆች ሀብት ናቸዉ					
2	በህብረተሰቡ ዘንድ ልጆች የክብርና ሀይል መሰረት ናቸዉ					
3	ልጅ መዉለድ እየቻሉ የማይወልዱ ባልና ሚስቶች ራስ ወዳድ ናቸዉ					
4	ከአነስተኛ ቁጥር ይልቅ አብዝቶ ልጅ መወለድ ለቤተሰቡ ደስታን ይሰጣል					
5	ብዙ ልጆችን ማሳደግ ወጪዉ ከባድ በመሆኑ የልጅን ቁጥር መመጠን ተገቢ ነዉ					
6	የወሊድ መከላከያዎችን ተጠቅሞ አነስተኛ የልጅ ቁጥር እንዲኖረን ማድረግ ማለት እራስን በቤት ስራዎች መጥመድ ማለት ነዉ					
7	የምመኘዉን የልጅ ቁጥር ባገኝ እንዝን ልጅ መወለድን አላቆምም።					
8	ሆን ብሎ የልጆችን ቁጥር ለመቀነስ ሲባል ወሊድ መከላከያዎችን መጠቀም ለልጅ ያለንን ጥላቻ የሳያል					
9	አሁን ካለኝ ልጅ/ልጆች በተጨማሪ ሌላ ልጅ መወለድ አፈልጋለሁ					
10	ልጅ ላለመወለድ የወሊድ መከላከያን መጠቀም ከነፍስ ግድያ ጋር ተመሳሳይ ነዉ					
11	ማናቸዉም ያገቡ ሴቶች መወለድ የቻሉትን የልጆች ቁጥር መወለድ አለባቸዉ እንጂ የወሊድ መከላከያ መጠቀም አለባቸዉ ብዬ አላምንም					
12	ብዙ የልጆች ቁጥር እንዳይኖረን የወሊድ መከላከያዎችን መጠቀምን እደግፋለሁ					
13	በቅርብ የተጋቡ ባልና ሚስት ብዙ ልጅ እንዳይኖራቸዉ እንደተጋቡ የወሊድ መከላከያ መጠቀማቸዉን እደግፋለሁ።					
14	የወሊድ መከላከያዎች ከማንኛዉም መድሃኒት የበለጠ ዋጋቸዉ ዉድ ነዉ					
15	የፈለግሁትን ያህል አገኘሁ አላገኝ የወሊድ መከላከያን መጠቀምን እደግፋለሁ					
16	የሀብት እጦት የወሊድ መከላከያን እንዳልጠቀም አያደርገኝም					

APPENDIX-II

አዲስ አበባ ዩኒቨርስቲ

የድህረ ምረቃ ፕሮግራም

የሳይኮሎጂ ትምህርት ክፍል

ከዚህ ቀጥሎ የተዘረዘሩት አረፍተነገሮች ስለወሊድ መከላከያ ዘዴዎች ያለዉን ግንዛቤ ለማወቅ የተዘጋጁ ናቸዉ። በመሆኑም ካነበቡ በኋላ የእርስዎን የመስማማት ደረጃ በአረፍተነገሮቹ ፊት ለፊት ከሚገኙ ረድፎችና አማራጮች ዉስጥ በአንዱ የ X ምልክት የስቀምጡ።

	አረፍተነገር	በጣም አልስማማም	አልስማማም	መወሰን እቸገራለሁ	እስማማለሁ	በጣም እስማማለሁ
1	የወሊድ መቆጣጠሪያ መጠቀም የወሲብ ዕርካታን ይቀንሳል					
2	የወሊድ መከላከያን መጠቀም ራስ ወዳድነት ነዉ					
3	የወሊድ መከላከያዎች ስርአተወሊድን በማዛባት መካንነትን ያስከትላሉ					
4	የወሊድ መከላከያ ዘዴዎች አሉታዊ ተዕእኖዎችን በቀላሉ መከላከል ይቻላል					
5	የወሊድ መከላከያ እየተጠቀሙ እርግዝና ይፈጠራል ብዬ አላስብም					
6	የምታጠባ ሴት ታረግዛለች ብዬ አላስብም። በመሆኑም የእርግዝና መከላከያ መጠቀም የለባትም					
7	የእርግዝና መከላከያዎች መደበኛ የጤና ችግር ያስከትላሉ					
8	ስለወለድ መከላከያ አስቀድሞ ማሰብ የስልጣኔ መገለጫ ነዉ					
9	የወሊድ መከላከያዎች የእናትንና የህፃናትን ጤና የተሻለ ያደርጋሉ					
10	ወንዶች የሚጠቀሙት የወሊድ መከላከያ ዘዴዎች አሉ					
11	የወሊድ መከላከያዎችን እንደፈለጉ መጠቀም እርግዝናን ይከላከላሉ					
12	የወሊድ መከላከያዎችን መጠቀም ማለት ልጅ መዉለድን ለአንዱና ለመጨረሻ ጊዜ ማቆም ማለት ነዉ					
13	አንድ ሰዉ የወሊድ መከላከያን ተጠቅሞ ካቋረጠ መልሶ መዉለድ ይችላል					
14	ወሲብ እንደፈፀሙ መታጠብ እርግዝናን ስለሚከላከል የወሊድ መከላከያ እንክብሎችን መጠቀም አያስፈልግም።					
15	አብዛኛዉን ጊዜ የወሊድ መከላከያዎች እርግዝናን ለመከላከል ብቁና ዉጤታማ አይደሉም					
16	በተደጋጋሚ ወሲብ አለመፈፀም ለእርግዝና ያጋልጣል ብዬ ስለማላስብ የወሊድ መከላከያ አልጠቀምም					

APPENDIX-I

አዲስ አበባ ዩኒቨርስቲ

የድህረ ምረቃ ፕሮግራም

የሳይኮሎጂ ትምህርት ክፍል

ከዚህ ቀጥሎ የተዘረዘሩት አረፍተነገሮች ባለ ትዳሮች በወሊድ መከላከያ አጠቃቀም ላይ ስለመወያየታቸዉ ለማወቅ የተዘጋጁ ናቸዉ። በመሆኑም ካነበቡ በኋላ የእርስዎን የመስማማት ደረጃ በአረፍተነገሮቹ ፊት ለፊት ከሚገኙ ረድፎችና አማራጮች ዉስጥ በአንዱ የX ምልክት የስቀምጡ።

	አረፍተነገር	በጣም አልስማማም	አልስማማም	መወሰን እቸገራለሁ	እስማማለሁ	በጣም እስማማለሁ
1	ከእርግዝና መከላከያ አወሳሰዱ ጋር ያለዉ ጭንቀት የትዳር አጋሬ እኔን አለማመኑ ነዉ					
2	የትዳር አጋሬ የእርግዝና መከላከያን አይፈቅድም/አትፈቅድም ሀላቡንም ይጠላል/ትጠላለች					
3	ወሲብ ቅፅበታዊና ጊዜ የማይሰጥ በመሆኑ ስለእርግዝና መከላከያ መነጋገር አያስፈልግም					
4	ስለወሊድ መቆጣጠርያ አጠቃቀም ከትዳር አጋር ጋር መነጋገር ያሳፍራል					
5	ባለትዳሮች ስለቤተሰብ ምጣኔ መነጋገራቸዉ ለቤተሰቡ አምንታዊ አስተዋፅዖ አለዉ					
6	የወሊድ መከላከያ መጠቀም የሴቶች ድርሻ በመሆኑ መነጋገር አያስፈልግም					
7	ስለቤተሰብ ምጣኔ ባነሳሁ ቁጥር ባለቤቴ ደስተኛ ነዉ/ናት					
8	ባልና ሚስት ስለወሊድ መከላከያ አጠቃቀም መወያየታቸዉ መሰልጠናቸዉን ያሳያል					
9	እኔና ባለቤቴ ቤተሰብን እንዴት መመጠን እንዳለብን አንወያያለን					
10	የትዳር ጓደኛዬ ቤት እያለ/ች የወሊድ መከላከያን አልወስድም/አልጠቀምም					
11	ከትዳር አጋር ጋር ስለወሊድ መከላከያ አጠቃቀም መወያየት አመንዝራነትን ያስከትላል					
12	ከትዳር አጋር ጋር ስለወሊድ መከላከያ አጠቃቀም መወያየት ብልህነት ነዉ					
13	ስለወሊድ መቆጣጠርያ አጠቃቀም ከትዳር አጋር ጋር መነጋገር አለመተማመንን ያመለክታል					
14	ባለቤቴን ስለወሊድ መከላከያ መጠየቅ ያስፈልጎቀኛል					
15	ከትዳር አጋሬ ጋር ስለ ወሊድ መከላከያ አጠቃቀም መደበኛ የዉይይት ጊዜ አለኝ					

APPENDIX-J

አዲስ አበባ ዩኒቨርስቲ

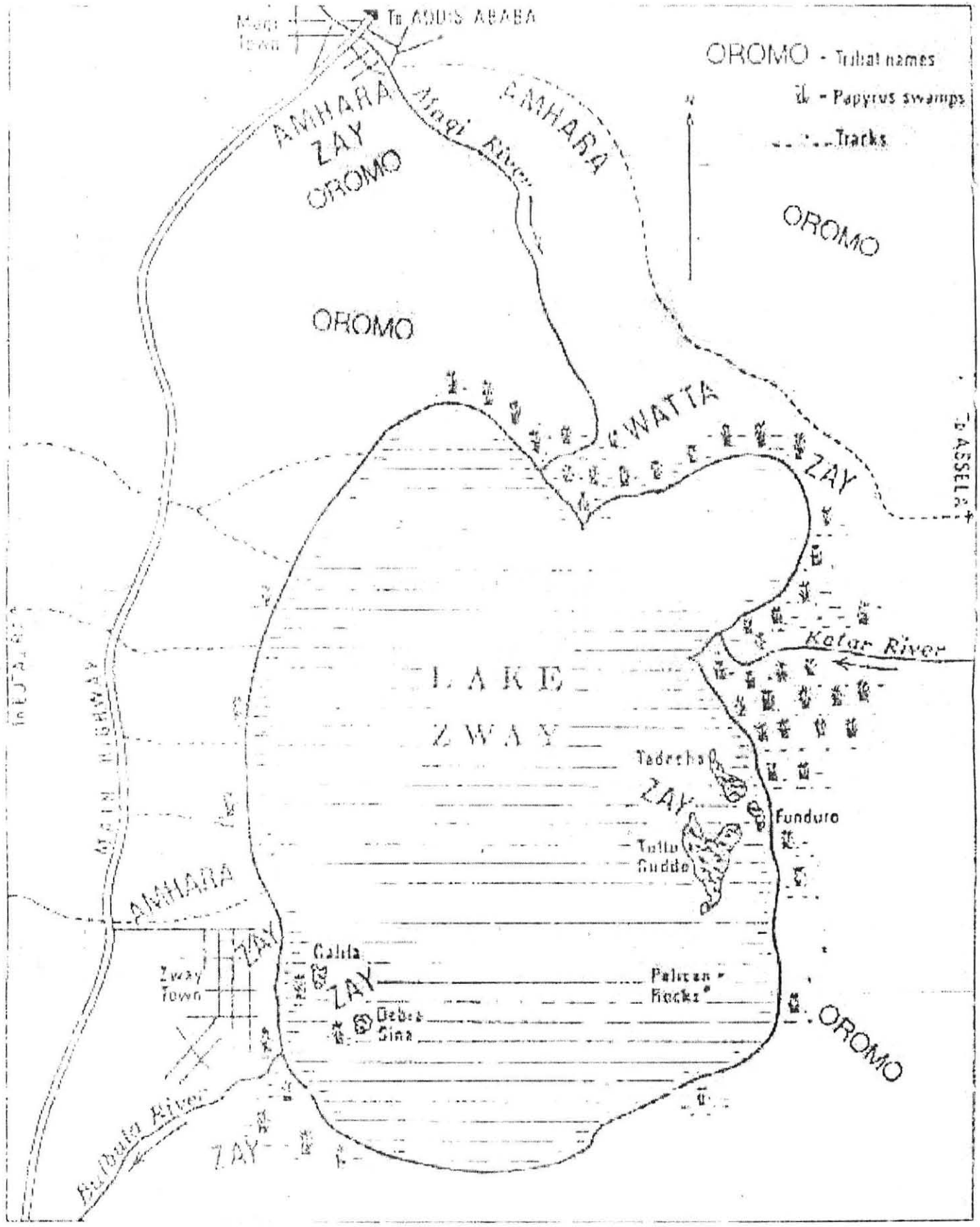
የድህረ ምረቃ ፕሮግራም

የሳይኮሎጂ ትምህርት ክፍል

ከዚህ ቀጥሎ የተዘረዘሩት አረፍተነገሮች ህብረተሰቡ ስለወሊድ መከላከያ አገልግሎት አሰጣጥ ያለዉን ግንዛቤ ለማወቅ የተዘጋጁ ናቸዉ:: በመሆኑም ካነበቡ በኋላ የእርስዎን የመስማማት ደረጃ በአረፍተነገሮቹ ፊት ለፊት ከሚገኙ ሪድፎችና አማራጮች ዉስጥ በአንዱ የ X ምልክት የስቀምጡ::

	አረፍተነገር	በጣም አልስማማም	አልስማማም	መወሰን እቸገራለሁ	እስማማለሁ	በጣም እስማማለሁ
1	የስኒ-ተዋልዶ አገልግሎት ሰጪ ሰዎች ስለአጠቃቀሙ በደንብ ስለማያስረዱ/አያስረዱም ብዬ ስለማስብ/ የወሊድ መከላከያዎችን መጠቀም አያስፈልግም አላለሁ::					
2	አገልግሎት ሰጪ ሠዎች በተፈለገበት ሰአት ስለማይገኙ የወሊድ መከላከያ መጠቀምን አልደግፍም					
3	ተገቢ የሆነ የባለሙያ ምክር የወሊድ መከላከያዎችን ተጓዳኝ ተፅእኖዎችን እንድፈታ አስችሎኛል/ የስችለኛል ብዬ አስባለሁ					
4	አገልግሎት ሰጪ ሠዎች እኔ የፈለግሁትን የእርግዝና መከላከያ ዘዴ እንድጠቀም አያደርጉም					
5	አገልግሎት ሰጪ ሠዎች ከተጠቃሚዎች ጋር በጥሩ ሁኔታ አይግባቡም እንድሁም አያስተናግዱም /ብዬ አገምታለሁ/					
6	የቤተሰብ ምጣኔ አገልግሎት ሰጪ ሠዎችን በፈለኩት ጊዜ ማግኘት ከቻልኩ የእርግዝና መከላከያዎችን እጠቀማለሁ					
7	የቤተሰብ ምጣኔ አገልግሎት ሰጪ ሠዎችን በየጊዜዉ መጎብኘት የሸማቾቃል					
8	የቤተሰብ ምጣኔ አገልግሎት ሰጪ ሠዎችን በየጊዜዉ መጎብኘት በወሊድ ዘዴዎች አጠቃቀም ባህሪዬ ላይ ለዉጥ አያመጣም					
9	የቤተሰብ ምጣኔ አገልግሎት ሰጪ ሠዎች ሚስጢር እስከጠበቁ ድረስ መጠቀሜ ችግር የለዉም					
10	የወሊድ መከላከያ መጠቀም የጤና አጠባበቅ ዘርፍ በመሆኑ ሂደቱን በየጊዜዉ መከታተል ጥሩ ነዉ					
11	የእርግዝና መከላከያ መዉሰድ ጀምሬ ካቋረጥኩ ቦኋላ እንደገና ማርገዝ ከቻልኩ የእርግዝና መከላከያ መዉሰድ ችግር የለብኝም					
12	በየጊዜዉ የቤተሰብ ምጣኔ አገልግሎት ሰጪ ሠዎችን መጎብኘት መጠቋቋሚያ ስለሚያደርግ ወደእነሱ መመላለስ አያስፈልግም					
13	በአቅራቢያዬ የሚገኙ አገልግሎት ሰጪ ሠዎች በደንብ አልሰለጠኑም ብዬ ስለማስብ የቤተሰብ ምጣኔን አልጠቀምም					
14	ተገቢ የሆነ የተናጠል የምክር አገልግሎት ማግኘት ከቻልኩ የወሊድ መከላከያዎችን መጠቀም እችላለሁ					
15	አስፈላጊዉን የምክር አገልግሎት ባገኝ የሰዉ መድሎና ማግለል አያስፈራኝም					

Appendix - K



LAKE ZWAY

DECLARATION

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

Name : **Adane Wako**

Signature 

Date of Submission _____

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

Name **Sintayehu Tadesse (Ph.D)**

Signature _____

Date of Approval _____