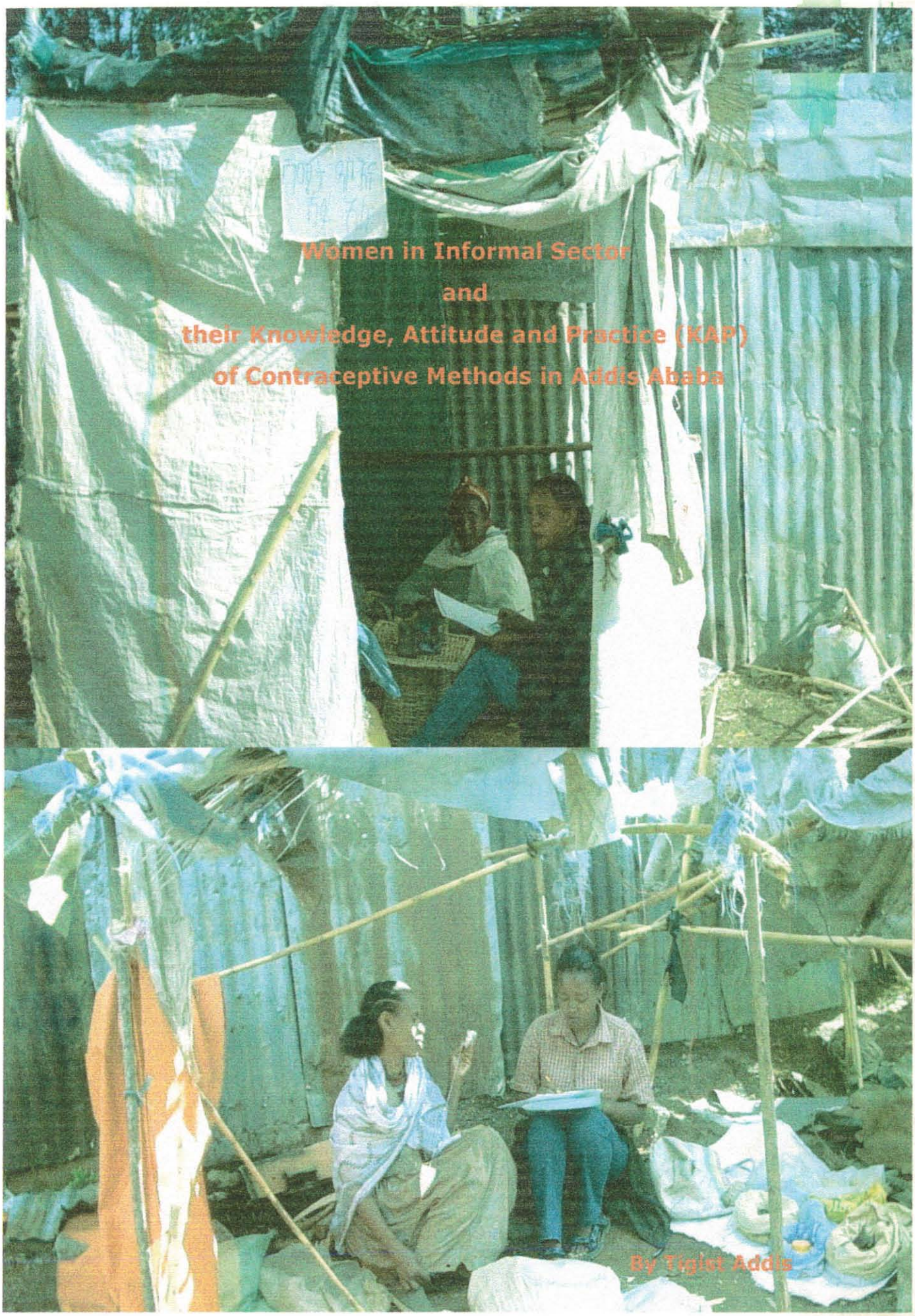

Women in Informal Sector and their Knowledge, Attitude and Practice (KAP) of Contraceptive Methods in Addis Ababa

By Tigist Addis

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

WOMEN IN INFORMAL SECTOR AND THEIR KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) OF CONTRACEPTIVE METHODS IN ADDIS ABABA

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of Addis Ababa University in Partial Fulfillment
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BY

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DEDICATION

I would like to dedicate my work for women in the informal sector, who want to stop child bearing but don't know how and for those who have been working so hard to provide food and clothing for the large number of children.

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List of Abbreviations

AIDS: Acquire Immune Deficiency Syndrome

CSA: Central Statistics Authority

DHS: Demographic and Health Surveys

FGAE: Family Guidance Association of Ethiopia

FGDs: Focus Group Discussions

HIV: Human Immunodeficiency Virus

ICPD: International Conference on Population and Development

ILO: International Labor Organization

IUD: Intrauterine Devise

KAP: Knowledge Attitude and Practice

NGO: Non Governmental Organization

TFR: Total Fertility Rate

UN: United Nations

UNECA: United Nations Economic Commission for Africa

UNFPA: United Nations Fund for Population Aid

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ABSTRACT

Women's informal sector employment concentrated in areas that are well-matched with their reproductive role, particularly child-rearing, and often extensions of their domestic responsibilities within the household.

The survey has attempted to see the knowledge, attitude and practice of contraceptive methods and different demographic and socio economic factors that contribute to the low practice of contraception by women in informal sector.

The survey has been conducted in Addis Ababa, in Addis Ketema and Arada Kifle Ketemas, which have high concentration of informal sector. Using literature review as a setting to the problem, questionnaires were administered to 654 women and 16 women through FGDs.

In general, the data revealed that knowledge of contraception is high, 98% but still low when compared to DHS 2000 Ethiopia, for all women in Addis Ababa, which was 99.2% for all methods. Overall contraception use in the survey is 44.8 percent. Modern contraception is used more by the age groups 20-24, 25-29 and 30-34, currently married women, women who have had a junior secondary (grade 7-8) level of education, and women who have relatively higher income. Modern contraceptive methods are more widely known and practiced than traditional ones.

Although DHS 2000 Ethiopia *reveals that Addis Ababa is below – replacement fertility level, it is still be a paradox that this change occur without a significant socio- economic development in a poor country like Ethiopia. So here based on the outcome of the study, some suggestions have been forwarded which might help governmental and non-governmental organizations to observe and help women in informal sectors to decide freely and correctly the number and spacing of their children and to have the information and means to do so.*

CHAPTER ONE

1. Introduction

1.1 Background

Ethiopia is the second largest populous country in Africa with a total surface area of 1,104,000 square kilometres. Ethiopia's total population grew from 38 million in 1980 to 63 million in 1999, representing an average annual growth rate of 2.95 percent and recently the growth rate has been declined to 2.75 percent. The country's population density is 63 per sq. km, which is much higher than the average for Sub-Saharan Africa, 27per square kilometre. The country's population is estimated to double every 23 years, reaching 130 million by 2030 (Aklilu; 2001).

According to the 2000 Ethiopia Demographic and Health Survey (DHS), Total Fertility Rate is 5.9 per women and Crude Birth Rate is 41.3 per 1000 populations in 2000 in Ethiopia.

One way of addressing the multiple challenges in Africa such as hunger, disease, illiteracy, unemployment, and poverty is to deal with the rapid rate of population growth specifically aggravated by a high rate of fertility (UNECA; 1997).

Poverty has been the common factor in Ethiopia and rapid population growth is one of the major factors for the occurrence of poverty in the country. For the underlying cause of poverty in urban areas, one must begin with the analysis of employment opportunities of the poor, given that the limited potential of formal sector in most urban developing countries to absorb labour, the informal sector that has been absorbing the additional labour due to high population growth rates and mass migration to urban areas. So it is not surprising that the informal sector is a critical and invisible urban employment opportunity (ILO, 1995).

Although there is no simple relationship between working in the informal sector and being poor or working in the formal sector and escaping poverty, there is an overlap between working in the informal sector and being poor: a higher percentage of people working in the informal sector, relative to the formal sector, are poor. This overlap is even greater for women than for men. And it is also true that the poor have more number of children because of the economic value they have for their parents and other social values and low cost of rearing children.

Studies in sexual composition of the work force in the informal sector found that more women than men are involved in this sphere of economic activity (Young and Moser; 1981).

According to ILO, 1995 the number of women working in the informal sector was estimated to have risen and the participation rates were high in Africa. Most of the workers in this sector are often beyond the protection offered by ILO standard and classified as self employed or family workers.

Women in informal sector are obliged by poverty and deprivation to seek an income outside home and they are found at the bottom line of poverty. Therefore, their conditions need immediate attention for improvement.

For many women, the informal sector is the only sector, which provides opportunity for work, if they have few skills to offer. Especially in urban areas of most developing countries like Ethiopia informal sector are means of creating employment for the unemployed due to rapid population growth, high rural to urban migration and job scarcity.

Women's employment in the informal sector differ from that of men's in a variety of ways: firstly, they are concentrated in areas that are well-matched with their reproductive role, particularly child-rearing, and often extensions of their domestic responsibilities within the household; secondly, they are with few exceptions, concentrated in areas with lesser growth potential mainly because they spent up to 80 per cent of their income on food (Young and Moser; 1981).

The number of women and their economic contributions to the sector are likely to be underestimated because they engage in home-based work and street vending, activities which are the most difficult to document and their activity is 'invisible' or is not counted as work. So it will be difficult to assess the exact extent of women involvement in informal sector. Where they are accessible, they have not been derived from a consistent definition or using the same data-gathering techniques (ILO; 1995).

Within the informal sector, women are generally found in low- income activities, which barely guaranties survival. This is likely to be in self-employment or in causal or seasonal paid labour, often of an unskilled and physically demanding nature, with low productivity, long hours, and little opportunity for upward mobility or for acquiring of improving skill. Typical activities for women

are petty trading and street vending (of vegetables, poultry, processed food or hand craft), paid domestic work, causal employment in unregulated small enterprises, and on construction sites and as commercial sex workers. Such work is rarely protected by labour legislation, and its unstable nature makes women an easy victim and vulnerable. Often women are involved in illegal economic activities such as unauthorised street trading, brewing of alcohol, and commercial sex workers, which makes them even more vulnerable to discrimination and harassment, while some women do succeed in setting up profitable business (JASPA; 1993).

Information about contraceptive is direct interest to policy makers and demographers. This information can be attained through different surveys of women in reproductive ages about contraceptive practice, the contact of these women with family planning programmes, attitudes towards and knowledge about birth control methods and preference of particular methods.

In particular, women's status, education, health and production activities are considered to be central determinants of fertility levels; unless there are changes in these areas, fertility rates are unlikely to decline in high fertility rates (ILO; 1984).

1.2. Statement of the Problem

According to Central Statistics Authority (CSA), report on Urban Informal Sector, 2003 reveals that 997,380 persons engaged in the informal sector, of which 598,296 were females (59.99 per cent) and 399,084 (40.01 per cent) were males in Ethiopia. Whereas the number of persons engaged in informal sector in Addis Ababa, were 128,598 of which 65,719 (51.01 per cent) were females and 62,879 (48.90 per cent) were males (CSA; 2003).

Despite the fact that girls frequently enter much earlier into marriage and motherhood, they have also less access to education and training and less access to information than their male peers. This has serious and continuing effects upon their employment opportunity, as well as having far reaching effect upon occupational safety and health. Many studies have conducted and identified the relationship between women's economic empowerment and their fertility and health seeking behaviour. All these studies motivated and concluded that there is direct relationship between women's economic empowerment and their decisions to use health care and family planning services as resources to improve their lives. But the featuring fact in developing countries many

women work in low- paying, labour intensive jobs, mainly informal sector in urban areas (Studies in Family Planning; 1998).

Mostly, women in informal sector are uneducated, overworked, and powerless in addition to these women have unequal access to resources. Women's health is harmed by lack of access to and the poor quality of reproductive services and studies indicate that there are many married women who want no more children but are not using contraception in many developing countries. This could be due to various reasons such as women's lack of decision-making power in the family, opportunity costs involved in seeking contraception, fear of child death, lack of information and poor quality of contraceptive service, all play an important role.

Women in informal sector work with little security and benefit and these women retain responsibilities for domestic and child rearing roles and also work to seek an income outside the home, either as the sole bread-winners, or to supplement male earning (JASPA; 1993). Thus, these women may have little time available for seeking for family planning services.

Poorer people tend to want more children than richer people and women in informal sector may see the advantages in having more hands for subsistence income and hope for their old age because people who have been working in the informal economy are unlikely to have made provision for their income security in old age.

But even in poor families, there are couples who wish to delay or avoid a birth using modern contraception. But in many parts of the world, patterns of contraceptive use may be a reflection, at least in part, of differential access to family planning services. Access can most easily be measured by physical proximity (in time and distance) and information to service. In this respect, DHS 2000 Ethiopia, data on service availability reveal that women in Sub-Saharan Africa generally have the least access to family planning facilities, where as those in Asia and Latin America have relatively greater access (UNFPA; 2004).

In addition to the above reasons there is contraceptive failure for those couples that are using contraception and these failures could be either failure to use properly or the failure of contraceptive to work. But failure in the effectiveness to preventing pregnancy for the modern methods of the contraception is not significant. Most women may not take pills and other contraceptive methods correctly especially those in informal sector with low level of education.

Both the failure to use contraception properly and contraceptive failure could cause unwanted pregnancies. Unwanted pregnancy or if the woman becomes pregnant unintentionally, she is more likely to obtain abortion. Especially in countries like Ethiopia in which abortion is illegal (legally permitted only in case when the woman's life or health is in grave danger), the women tend to ignore the legal status of abortion and are often willing to risk unsafe abortion.

> "Every year nearly 80 million unintended pregnancies occur worldwide, and more than half of these pregnancies end in abortion. An estimated 150 million women in developing countries say they would prefer to plan their families but are not using contraception, and another 350 million women lack access to effective family planning methods (Population Action International; 2001:25).

Accordingly, the study designed to answer the extent of knowledge women in informal sector on both traditional and modern contraceptive methods, the attitude of these women on modern contraceptive methods, the methods of contraception and for what purpose, to achieve the desired size of their family, birth spacing, to avoid unwanted pregnancies or health reason, they are using it, how they obtain the contraceptive, the basic social, economic, and demographic factors that hinder women in informal sector from using modern contraceptive methods, level of induced abortion and lastly but not least the study tries to assess partner's approval in using contraceptive methods.

1.3. Rationale of the Study

Many studies done on the influence of working status of the women on contraceptive use has been well indicated that office work is associated with a higher chance of contraceptive use, while women in informal sector and those who are unemployed are poor in utilization of contraception and hence these groups of women are known to have higher risk of unwanted pregnancy and induced abortion.

A United Nations study (1987), which separates modern and traditional jobs, found significant fertility differentials by type of work. This evidence, in which the role of mothering, labour force participation and fertility, for women in higher economic stratum and those who have higher levels of education shows that a strong negative relation between their labour force

participation and fertility. But the relation between women in informal sector and their fertility is rarely considered in the analysis.

It is well known that fertility is higher among low-income women. Likewise, it is the acute problems associated with their participation in the labour force. They are more likely to be unemployed or to be engaged in informal sector, most unstable jobs. Women's work has been systematically undercounted especially in rural areas and in traditional activities such as those of the informal sector. These activities are precisely where undecided or uncertain results with regard to the relation between women's work and fertility have been found (United Nations; 1996).

Women who work in informal sector, in urban areas, are more likely to do so in lower status occupation and are more likely to have lower levels of education. Education has a positive impact on access to knowledge, information and new ideas, it enhances overall efficiency.

For example, studies done in the urban informal sector, in Zambia, Kenya and Swaziland shows that the main reasons for the involvement of these women in informal sector are that women are not receiving sufficient financial support from their husbands due to their husbands' drinking habit and spending on other women for their enjoyment in stead of their family development: as a result of that economic dependency of women have been increasing.

Therefore, these studies concluded that, women are working in informal sector, because of their poorness, of their mothering obligations to their children's development and because of their husband's consumption and irresponsible behaviours etc. pushed them to work in informal sector(UNECA; 1997). The study also added that many women in informal sector have large number of family size. And the source of their poverty might be because they had to provide food and clothing for a large number of small children.

The DHS of many African countries shows that there is a wide gap between the knowledge and practice of contraceptive methods. These surveys also indicated some reasons for the gap like, the availability of methods, opportunity cost, the women ignorance on methods, objections from their husbands and other reasons.

But more recently, it is common to see that new ideas slowly gaining acceptance, as contraception has spread more widely and has been adapted increasingly for the control of the spacing as well as for control of the total number of births.

As we know there is no strong and effective national family planning programmes in Ethiopia. But DHS, 2000 Ethiopia indicated that the Total Fertility Rate (TFR) in Addis Ababa has declined to 1.9 children per woman. This has been a contradictory on this change has been occurred without significant economic development and with the absence of strong and effective national family planning program.

There is also a difference between the living standard of women in Addis Ababa i.e. between the upper and lower classes, women who are relatively in the upper class have better exposure to and information about family planning methods and money to the purchase of contraceptives. These differences between women have been influencing the practice of contraceptives.

Therefore, the study tries to separate women in informal sector from the other group of women in Addis Ababa and tries to identify the levels of knowledge, attitude and current use of contraception according to their age, educational level, marital status and other socio-economic and demographic factors.

1.4. Objectives of the Study

The general objective of the study is to investigate the extent of Knowledge, Attitude and Practice (KAP) of both traditional and modern contraceptives methods on one hand and to investigate socio - economic and demographic factors influencing the use of family planning methods among women in the informal sector on the other.

Based on this general objective, the study tries to see the following specific objectives:

- To examine these women's knowledge of contraceptive by method,
- To analyse the purpose of contraceptive use, limit family size, child spacing or health problem, among the current users
- To investigate the reasons for not using any methods among the non-users
- To look at the extent of induced abortion among women who experienced unwanted pregnancies.

1.5. Research Questions

Based on the statement of the problem and the objectives set, the following research questions are formulated:

1) What is the extent of their knowledge, attitude and practice on short and long term modern contraceptive methods?
2) Does educational attainment of women in informal sector affect the practice of modern contraceptives?
3) Are there any differentiations in income and the practice of modern contraceptives by these women?
4) Does the number of living children that these women have affect the practice of contraceptive methods?
5) Are current users among women in informal sector use contraceptive for the purpose of child spacing or limiting the number of children?

1.6. Literature Review

One of the major aims of this study is to assess the socio – economic and demographic variables that affect women's knowledge, attitude and practice of contraceptive methods in the informal sector. Therefore, the following paragraphs presented briefly some of demographic and socio-economic factors related with the KAP of contraceptive methods for women in general and women in informal sector in particular.

As seen in many countries past experience, it was important to see fertility goals as part of the more general goal of improving the living conditions of the nation and allowing women to take part in economic and social life. For example, the basic cases of fertility decline in Hungary are increasing the economic activity of women, increasing educational attainment of women and knowledge and availability of birth control methods (ILO; 1984).

There has been a positive action in Ethiopia in promoting girls' education, through which it increases women's empowerment and their labor force participation and their visit to family planning services, which can be taken as the major factors in fertility reduction. For example, the net enrolment ratio for female labor force participation in non-agricultural activities, which was 12.4 per cent in 1984, increased to 28 per cent in 1999. The rate of urbanization also

increased about 9 per cent in the early 1970's to more than 15 per cent in 2000 (IRP-CNT and CSA; 2001). These factors are contributing to fertility reduction in one-way or another.

1.6.1 Demographic Variables

Any efficient intervention of family planning program will increase rapid expansion of contraception use and to this, effective family planning services will result in immediate birth rate decline in Sub-Saharan Africa (SSA), because of the effect of 'population momentum' (Ware; 1981). Therefore, there is an urgent need to consider the effective family planning programs in Sub-Saharan Countries.

Contraceptive practice patterns differ substantially by age. The demand for contraception is likely to be relatively low among very young women who still have small families and while women aged over 40 may be at reduced risk of pregnancy because of infrequent sexual intercourse, and many women aged 45-49 have reached menopause.

The pattern of contraceptive use also differs by age in developing and developed countries, contraceptive use is comparatively low among women aged 30 and younger and rises substantially after that. The greatest period of use is between 25 and 39 years and is seen more in the women in Africa and Asia compared to those of Latin America and the Caribbean. In the more developed countries, on the other hand, the pattern is relatively even among all married women aged 15-24. There is, in fact, a clear tendency for women in most developing countries to use contraceptive in an effort to stop child bearing altogether rather than for child spacing. Women in developed countries make greater use of contraception to post pone the first birth and to space subsequent births (Landy & S. Ratuam; 1986).

The age pattern of both current contraceptive uses is probably influenced by recent trends in availability and social acceptability of contraception (UN; 1987).

Ideal family size is a demographic and hypothetical situation, which the women give an idea about the total number of children women who have not started child bearing, will have in the future and for the older and who have many children. It helps to measure the level of unwanted fertility (DHS; 2000)

The extent to which actual family size exceeds desired family size defines the level of unwanted fertility and is best reflected by the experience of women aged 40 or over that have essentially

completed their child-bearing. Obviously, better-educated women in developing countries know more about fertility regulation and are better able to exercise their preference (UNFPA; 1995).

Women who do not want another birth within the next two years, or ever, but are not using a method of contraception can be referred by unmet needs (UNFPA; 2004). Unmet need is a disconnection between a woman's fertility preferences and what she does about them: she wants to avoid conceiving but fail to do what is needed to prevent pregnancy. The concept is usually applied to married women but also can apply to sexually active unmarried women (R. Omran: 1984).

Approximately one in four births in the developing countries is unwanted. At least 50 million induced abortions occur every year. However, an estimated 20 million unsafe abortion take place every year in places where safe abortion is limited (UNFPA; 1995). In countries where safe abortion services are scarce, only wealthy women who can afford the costs of a private doctor could have safe abortion, but poorer women who are so determined to make an abortion and willing to risk their health and life in seeking unsafe and secret service (Bankole, Singh and Hass; 1998).

Unmet needs results from various barriers to contraceptive use like: lack of knowledge, lack of access to family planning services, lack of community or husband's approval, financial constraints and other barriers.

1.6.2 Socio – Economic Variables

> "Millennium Development Goal 3, "promote gender equality empower women" reflects the ICPD's objectives. Its main target for measuring progress, though is rather limiting, eliminating gender education by 2005, and at all education levels by 2015 (UNFPA; 2004:7)".

An increase in the level of education has positive influence on women's contraceptive knowledge and decision on use of contraceptive (DHS; 2000). Educated women control economic independence and control over their own incomes. Better-educated women are less fatalistic and are more exposed to television and reading materials. As a result, they have better access to modern ideas and information about a variety of subjects, including family planning services and also contraception (United Nations; 1996).

Educational attainment is strongly related to both fertility and labour force participation. Higher levels of education among women are directly related to reduced fertility as well as to increased participation in the work force.

The relationship between female education and fertility is not always an inverse one. In poor countries with relatively low levels of literacy, education may at first serve to raise fertility. This is because; the traditional constraints upon sexual intercourse and the practice of prolonged breast-feeding, are often abandoned by women who have acquired education relatively (Ware, 1981).

The experience in the three sub-Saharan countries, Kenya, Botswana and Zimbabwe, registered the most rapid decline in fertility is totally different from the experiences observed in Asian countries, where industrialization, a high proportion of urban dwellers and a relatively high per capita income were prerequisites for fertility decline. African fertility would remain the highest by world standards as a result of a number of cultural and economic factors favouring child bearing and rearing. Limited education, predominance of rural residence, low income, low status of women, the need of children for economic support and old age security, early marriage, strong family ties, high infant and child mortality, limited contraceptive use and like are real circumstances that could maintain still for a long time the high fertility levels of the region (United Nations; 1996).

Even when actual family size equals or exceeds the desired number, large numbers of women do nothing to prevent unwanted pregnancies. In many settings, there are suggestion that the most important effect of education is to enable women to prevent unwanted pregnancies (UNFPA; 2004).

The lack of education and adequate training interns hindered the opportunities for the employment of women. In fact, the pattern of high fertility in most developing countries means that women are burdened with frequent childbearing as well as the responsibility of caring for and rearing the many children they produce.

It has often been argued that participation of women in the labour force contributes to lower fertility through such factors as delayed marriage, increased education, and reduction of ideal family size and increased adoption of family planning practices.

The type of work in which women engage is a key to understand the relation it bears to their fertility. The proportion of the labour force engaged in informal sector occupation increased in developing countries, women's participation in these sector are disproportionate and has been increasing more than that of men. In addition, women are more likely to engage in unpaid family

work (United Nations; 1996). In general women in informal sector are poor and differences between poor and rich population access to family planning are overwhelming. In sub- Saharan African countries, for example, women in the richest fifth of the population are five times more likely to have access to and use contraception than women in poorest fifth (Landy & S. Ratnam: 1986).

Women work in informal sector in urban areas have, the main area for social relationship. The nature of the sector offers the main opportunity in women's lives for informal exchange of information and advice on reproductive health, contraception and family planning practice, topics which these women often cannot and do not discuss with their husbands (ILO; 1984).

In relation between women's employment and fertility is either not significant or is absent in the case of women that work in informal sector. In urban areas informal sector employment doesn't seen to be related to lower levels of fertility. It is particularly true for women working in home-based activities where women can have help from their children while they work (Haile Mariam; 2002).

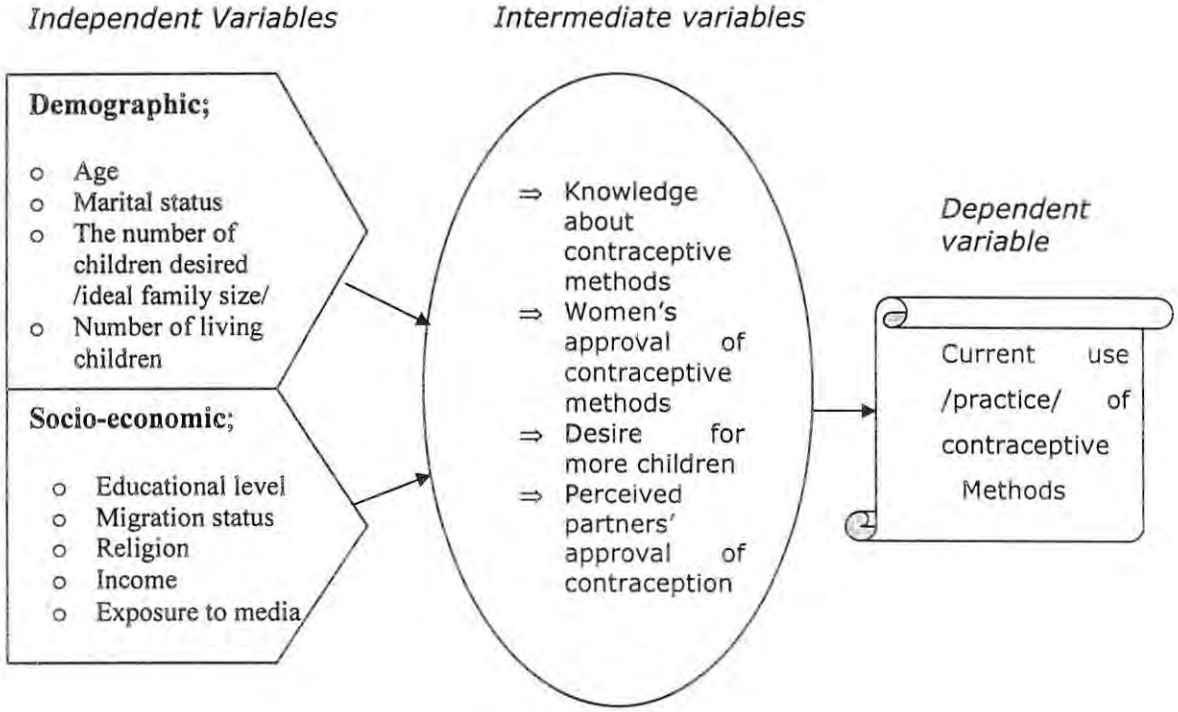
The HIV/AIDS pandemic in Ethiopia has left older women with responsibility for caring for their infected children and later on their grand children. Thus, the burden of caring for the children and grandchildren increase the women's poverty. Poverty amongst the elderly is closely related to work in the informal economies of urban areas. The majority of urban informal sector workers live in poor conditions and lack basic health and welfare services and social protection (ILO; 2003).

Knowledge and practice of family planning is strongly related to higher levels of education and to labour force participation and, of course, to fertility.

1.7 Conceptual Framework

In examining the determinants KAP of contraceptive in this study, the following socio-economic and demographic variables are considered as independent. And the intermediate variables, which directly affect the dependent variable, practice of contraception, are also considered:

Figure one: Conceptual framework of the study that shows basic factors that hinders the practice of contraceptive among women in informal sector.



Source: *Modified from: Reproductive Health Matters. Contraceptive Safety and Effectiveness No. 3 May 1994.*

Note; Migration status has been considered as a socio-economic variable instead of demographic variable because here the researcher wants to see the social and economic impact of the duration in the area. For example, women who have longer duration in the area could have been relatively higher education and income.

1.8. Definition of Key Terms

1.8.1. Conceptual Definitions

Informal sector; a set of economic activities characterized by relative ease of entry, reliance on indigenous resources, family ownership of enterprises, small scale of operations, labour intensive and adopted technology, skill acquired outside the formal school system /traditional methods/ and unregulated and competitive markets (ILO; 1984: 211-214)

KAP; knowledge, Attitude and Practice;

Knowledge is the capacity to acquire, retain and use information: a mixture of comprehension, experience and discernment and skill. The nature of knowledge rests on different modes of acquisition of ideas: perception, imagination, memory, judgement, abstraction and reasoning.

Attitude refers to inclination to react in a certain way to certain situation; to see and interpret events according to certain predispositions; or to organize opinions into coherent and interrelated structures. The foundation of all attitudes is knowledge.

Practice refers to the application of rules and knowledge that lead to action. Good practice is an act that is linked to the process of knowledge and technology and is executed in an ethical way (Department of nutrition and Health Science 1997; 1,1:8 -15)

KAP-Survey – women's knowledge, attitude towards, and practice of birth control as well as about their family size preferences. Analysis of these data sets indicated that in most cases a substantial proportion of women who wanted to stop child bearing were not practicing contraception (population and Development Review; 1988: 225-232).

1.8.2 Operational Definition

Informal Sector; are subsistence-level activity motivated for the need for survival like petty trade, which includes sale of food items, such as 'qolo', 'ambasha', 'vegetables', etc. in the local market called 'Gulit' and home based activities like preparation of dried food, such as 'injira', and local beverages such as 'tella', 'teje', 'areqe', etc. These activities are own-account workers, who own and operate one–person business, who work alone or with the help of unpaid workers, generally family members.

Modern Contraceptive Methods; refer to clinic and supply methods such as oral contraceptives, injections, the IUD, the Norplant, voluntary male/female sterilization, condoms and vaginal methods.

Traditional Contraceptive Methods; refers to non-supply method and they are safe sex period, which is called rhythm method, withdrawals, prolonged abstinence and breastfeeding methods, usually with less efficient than the modern methods.

1.9. Limitation of the study

The general economic profile of Addis Ababa doesn't indicate much about the informal economy in kind and type. So the study has been done on household base and it is concentrated on petty trade and home based activities only.

CHAPTER TWO

2. Methodology

2.1 The Study Area

According to the new city administration classification, Addis Ababa is divided into 10 Kifle Ketemas (sub-cities) and 203 Kebeles (the lower administrative units). Among the 10 Kifle Ketemas, Addis Ketema and Arada have been selected purposefully because they have the highest concentration of informal sector.

Addis Ketema Kifle Ketema is located in the northern part of Addis Ababa. Gullele borders in the north, Arada in the east, Keranio Kolfe in the west and Lideta Kifle ketema in the south. Arada Kifle Ketema is also located in the northern part of Addis Ababa. Gulele borders it in the north, Yeka in the east, Addis Ketema in the west and Lideta Kifle ketema in the southwest and Cherkos in the south (City Administration of Addis Ababa; 2003).

Addis Ketema Kifle Ketma has area coverage of 7.40 square kilometres with total population size of 320,389 and density of 43,312-population/sq. km, which is the highest from the other Kifle Ketemas.

Arada Kifle Ketema has area coverage of 9.52 square kilometres with total population size of 297,942 and density of 31,296 population/sq. km, which is the second highest next to Addis Ketema Kifle Ketema.

According to the new classification of the city administration, Addis Ketema and Arada Kifle Ketemas have 21 and 17 Kebeles respectively. Among the 21 Kebeles in Addis Ketema, Kebele 10, 11, 12, and 15, and among 17 Kebeles in Arada, Kebele 11, 12, 14, and 15 were selected purposely based on the information given by the Kifle Ketemas officials that these Kebeles have the highest concentration of women informal sector.

2.2 Source of Data

Primary sources of data have been used for this study. And the main instrument used for gathering relevant information was questionnaires. There were also Focus-Group Discussions (FGDs) held to assist the KAP information gathered through the questionnaires.

2.3 Sample Size

The sample size for this survey is 654. It was based on the estimate of current use of contraception, women in Addis Ababa, which is 45.2 (p- value), for any method from DHS, 2000 Ethiopia. The value corresponding to confidence level chosen for the study is 1.96, confidence interval Z. The maximum deviation from true proportions that can be tolerated in the study that is E is taken 0.04.

Thus, sample size (n) was determined by;

$n = P\ (1\text{-}P)\ Z^2/E^2$ (Sarantakos; 1988)

Where, P = the estimate of current use of contraception among women in Addis Ababa, which is 45.2

Z = confidence interval, which is 1.96 and,

E = the amount of error in the sample estimate that is 4%

$n = (0.452*(1\text{-}0.452)*(1.96)^2))/ (0.04)^2$+ (10% non-response rate)

$n = (0.452*(0.548)*(1.96)^2))/ (0.04)^2$+ (10% non-response rate)

n = 594.72 + 59.47 = **654.19**

2.4 Sampling Procedure

According to the new city administration classification, Kebele 10 in Addis Ketema Kifle Ketema was formed by merging the former Kebeles 02, 03 and 09. From the three former Kebeles, Kebele 09 was selected for the purpose of the study depending on the information given by the Kebele 10 officials that Kebele 09 has the highest concentration of informal sector. The same procedure was followed for the rest of Kebeles and is summarized below.

Addis Ketema Kifle Ketema

New Kebeles	Former Kebeles	Selected Kebeles
10	02	09
	03	
	09	
11	04	11
	10	
	11	
12	05	12
	06	
	12	
15	29	30
	30	

Arada Kifle Ketema

New Kebeles	Former Kebeles	Selected Kebeles
11	01	02
	02	
12	03	03
14	11	16
	15	
	16	
15	14	14
	18	

Using local guidance from the Kebeles, eligible list of households were taken for each selected Kebeles and the sample frame was prepared. Using systematic random sampling the total sample size was achieved in the sample frame.

In the selection process of women in informal sector, where there were more than one eligible women in a household, only one was taken. There were call backs for women who weren't found in the first visit and for some women who are engaged in petty trade the interviewers were forced to go to their working place mainly, the local market place called 'Gulit', to held the interview.

2.5 Data Collection and Verification

Ten female data collectors, who had completed grade 12 and above, with two supervisors were recruited for the data collection. One day training was given before the list of the household and day training before the actual data collection.

There was a pilot survey held by the researcher and supervisors before the actual data collection started in order to find out the strength and weakness of the questionnaire.

In order to minimize errors after the data entered, data cleaning was done. The data cleaning was done after developing a list of logical relationships between variables and procedures, which made the questionnaire responses valid and possible corrections were tried to be given because the correct response was still available on the questionnaire.

2.6 Method of Analysis

To analyse the data the bi-variate linear regression method was used. The bi-variate method identifies important factors that have association with the dependent variable. Logistic regression was applied in order to examine the bi-variate analysis whether it is spurious or not. The application of logistic regression was used to analyse the relationship between a set of independent variables and a dependent variable when the response variable is dichotomous (that is, 0 and 1). In this study contraceptive use or practice =1 and non-users =0. A set of demographic and socio economic factors as independent variables can influence the dependent variable, thus

Prob (Y=1) = F (X'β)

Prob (Y=0) = 1-F (X'β)

The set of parameter X' reflect the impact of changes on the practice of contraceptive methods.

The logistic function of the form;

$$P = \frac{1}{1+e^{-z}}$$

A property of the logistic function as given by the equation is that when Z becomes infinitely negative, e^{-Z} becomes infinitely large, so that P approaches to 0. When Z becomes infinitely positive, e^{-Z} becomes infinitively small, so that P approaches to 1. When Z = 0, e^{-Z} = 1, so that P = 0.5

In this study Z is a linear function of a set of predictor variables:

$$Z = b_o + b_1x_1 + b_2x_2 + ---- + b_kx_k$$

When transformed to multivariate logistic function to look at the effect (bi) if the predictor variables (xi) directly on the response P.

$$P = \frac{1}{1 + e^{-(b_0 + b_1x_1 + b_2x_2 + --- + b_kx_k)}}$$

This function could further be transformed to give logit model, i.e.,

$$\text{Logit (Pi)} = \text{Ln (Pi/1-Pi)} = b_o + b_1x_1 + b_2x_2 + ---- + b_kx_k$$

Where b_o refers to intercept in the logit model

B_i refers to the effect of X_i on the log odds that $Y_i = 1$, controlling for other X_i's.

X_i is independent variable i = 1, 2, 3, ---K

2.7 Variable Specification

Demographic and Social Variables

Variable	Description	Variable labels
X_{101}	Age of respondents	1= 15-19 2 = 20-24 3 = 25-29 4 = 30-34 5 = 35-39 6 = 40-44 7 = 45-49
X_{102}	Educational attainment of respondents	1 = Illiterate 2 = Non formal 3 = primary 4 = junior secondary 5 = senior secondary
X_{103}	Ideal family size	0 = less than 3 children 1 = 4 children 2 =More than 5 children 3 = God knows

X_{104}	Number of living children	1 = Less than or equal 2 children 2 = 3-4 children 3 = Greater or equal to 5 children
X_{105}	Income of respondents	1 = Very low income 2 = Low income 3 = Medium income 4 = High income 5 = Not stated income
X_{106}	Marital status	1 = Never married 2 = Currently married 3 = Formerly married
X_{107}	Migration status	0 = Non-migrants 1 = Recent migrants 2 = Long term migrants

CHAPTER THREE

3. Background Characteristics from the Survey Findings

3.1 Demographic characteristics of the study population

3.1.1 Age

As it is shown in table one, the age has been grouped into five years age group for women in informal sector in reproductive age.

The age groups were approximately normally distributed with 46.1 percent of the women under 30 and 53.9 percent older than 30 years of age.

Table 3.1.1: Percent Distribution of Age

Age Group	Frequency	Percentage
15-19	38	5.8
20-24	137	20.9
25-29	127	19.4
30-34	112	17.1
35-39	92	14.1
40-44	79	12.1
45-49	69	10.6
TOTAL	654	100.0

3.1.2 Marital status

Table 3.1.2 reveals the marital status of the respondents. It indicates that, 43.3 percent of the respondents were currently married, 29.1 percent were single, 10.1 percent were widowed, 9.8 percent were divorced, 6.1 percent were in consensual union, living with a partner without legal marriage, and 1.7 percent of the respondents were separated without legal divorce at the time of the survey. Marriage could serve as a proxy for exposure to sexual activity and contraceptive practice.

Table 3.1.2: Percent Distribution of Marital Status

Marital Status	Frequency	Percentage
Single	190	29.1
Currently married	283	43.3
Consensual union	40	6.1
Divorce	64	9.8
Widowed	66	10.1
Separated	11	1.7
TOTAL	654	100.0

3.1.3 Ideal family size

Table 3.1.3 explains the woman's preferences regarding the ideal family size. The information was gathered depending on the DHS Ethiopia 2000, that is respondents who had no living children were asked how many children they would like to have if they could choose the number of children to have and respondents with children were asked how many children they would like to have if they could go back to the time when they did not have any children.

This could provide a comparison between child bearing attitudes and behaviours. 36.2 percent of the women who had living children said that they desired four children, 33.4 percent desired less than 3 children, 24.1 percent of respondents needed to have more than 5 children and 6.3 percent replied, "what so ever God gives".

Table 3.1.3A: Percent Distribution of Ideal family size for women who have living children

Number of Ideal Family Size	Frequency	Percentage
Less than 3 children	158	33.4
4 children	171	36.2
More than 5 children	114	24.1
God knows	30	6.3
TOTAL	473	100.0

Table 3.1.3B gives details of the ideal family size for women who have no living children. It reveals that, 61.3% of women said that they need less than three children in the future. And only 4.4% of women who have no child need more than five children in the future. We can say that in general these women are younger than the women who have living children and it is good indicator that the younger women prefer to have small number of children.

Table 3.1.3B: Percent Distribution of Ideal family size for women who have no living children

Number of Ideal Family Size	Frequency	Percentage
less than 3 children	111	61.3
4 children	58	32.0
more than 5 children	8	4.4
God knows	4	2.2
TOTAL	181	100.0

3.1.4 Number of Living Children

Number of living children a woman has influences the contraceptive practice. Taking into consideration the age pattern of the women in this survey, 46.1 percent of the women under 30 and 53.9 percent older than 30 years of age (on table 3.1.1), a significant number of women in this survey have three and above number of children, 53.5 percent.

Table 3.1.4: Percent Distribution of Living Children

Number of living children	Frequency	Percentage
Less than or equal 2 children	221	46.5
3-4children	153	32.2
greater than or equal to 5 children	101	21.3
TOTAL	475	100.0

3.2 Socio Economic Characteristics of the Study Population

3.2.1 Educational level

Education, which could be measured by number of years of schooling, is closely associated with contraceptive use. Low literacy levels appear to be more of a barrier to awareness and contraceptive adoption. Respondent's education was categorical variable indication whether women in informal sector couldn't read and write (illiterate), attended formal school and the highest grade attended. Out of the total respondents 28.3 percent could not read and write. Among the women who can read and write 10.2 percent of them did not attended formal school. Among those who have attended formal school only 21.3 percent of the respondents could reach to senior secondary level, that is, from grade 9 to 12.

Table 3.2.1: Percent Distribution of Educational level

Educational level	Frequency	Percentage
Illiterate	185	28.3
Non – formal	48	7.3
Primary (1-6)	184	28.1
Junior secondary (7-8)	98	15.0
Senior secondary and above	139	21.3
TOTAL	654	100

Note: The classification is taken from the 1990 National Family and Fertility Survey Reports.

3.2.2 Migration Status/Duration of Residence

Duration of residence in the area could be a proxy for reducing exposure to modernization and access to modern contraceptives and may make women in informal sector to disregard the use of contraceptive and casual to unplanned pregnancies. Table 3.2.2 indicates that, out of the total respondents only 20.9 percent of the respondents are non-migrant, i.e. those who live in the area since birth. According to CSA classification those who stay in the area 1-5 years are termed as recent migrants, i.e. 19.1 percent and 6 and above year's duration of residences are termed as long term migrants and they are 59.9 percent of the respondents.

Table 3.2.2: Percent Distribution of Migration status

Migration status	Frequency	Percentage
Non- migrants	137	20.9
Recent migrants	125	19.1
Long-term migrants	392	59.9
TOTAL	654	100.0

3.2.3 Religion

Table 3.2.3 reveals that the distribution of respondents by religion. It indicates that the majority of the respondents, 82.0% are orthodox Christians, 13.3% are Muslims, 4.1% Protestants and only 0.6% are Catholics.

Table 3.2.3: Percent Distribution of Religion

Religion	Frequency	Percentage
Orthodox	536	82.0
Muslim	87	13.3
Catholic	4	0.6
Protestant	27	4.1
TOTAL	654	100.0

3.2.4 Income

Income is coded into five categories: very low income (<1 Birr per day), low income (1-5 Birr per day), medium (5-10 Birr per day), and relatively high income (>10 Birr per day) and incomes that are not stated. The categories are given by the researcher after seeing the distribution of income. More than half of the respondents are in the category of low income i.e. their income per day is between 1-5 birr.

Table 3.2.4: Percent Distribution of Income

Income	Frequency	Percentage
Very low income	50	7.6
Low income	337	51.5
Medium	173	26.5
High income	81	12.4
Not stated income	13	2.0
TOTAL	654	100.0

3.2.5 Exposure to Family Planning Information

Several studies have identified exposure to message broadcast through a variety of channels is an effective way to change women's knowledge, attitude and practice of contraceptive methods. And it has been identified as an important determinant of fertility decline. The survey collected information on respondents' exposure of family planning messages by asking if they have heard or seen such information for the last three months prior to the survey. Table 3.3.3 shows that, 74.1 percent of respondents who have ever heard about contraceptive methods exposed to family planning information. Among women who have been exposed to family planning information for the last three months prior to the survey were asked further on the source of their information and, 45.8 and 23.6 percent of exposed women mentioned radio/television and government hospitals/health institutions respectively as their source.

Table 3.2.5: Exposure to Family Planning Information

Heard/see information on FP in the last 3 months	Frequency	Percentage
Yes	475	74.1
No	166	25.9
TOTAL	641	100.0

3.3 Desire for More Children

Women who have living children were asked whether they want to have additional children or not. And the variable, desire for more children, is coded into four categories indicating whether the respondent desires more children, no more children, God knows and is undecided or not sure about future children bearing. As table 3.4 revealed, the majority of the respondents, 72.0% need no more additional children.

Table 3.3: Percent Distribution of Desire for More Children

Desire for more children	Frequency	Percentage
Yes	113	23.8
No	342	72.0
God knows	15	3.2
undecided/not sure	5	1.0
TOTAL	475	100.0

3.4 Knowledge about Contraceptive Methods

As it is indicated the table below, 98 percent of the respondents said that they have ever heard about family planning method.

Table 3.4: Knowledge about contraceptive methods

Ever heard about contraceptive methods	Frequency	Percentage
Yes	641	98.0
No	13	2.0
TOTAL	654	100.0

3.4.1 First Source of knowledge of Contraceptives

Women who have ever heard about contraceptive methods were further asked about their first source of information. Table 3.4.1 indicates that, out of the total women who have ever heard about contraceptive methods, 37.8 percent mentioned government hospitals or health institutions, 33.9 percent radio or television and 10.6 percent mentioned Non governmental organizations like FGAE as their first source of knowledge.

Table 3.4.1: Respondents First Source of knowledge of Contraceptives

Source	Frequency	Percentage
Radio/television	217	33.9
Written materials	14	2.2
Spouse/partner	13	2.0
Family/relatives	24	3.7
Friends/neighbours	47	7.3
Gov't hospitals/health institutions	242	37.8
NGOs(e.g.FGAE)	69	10.8
Private Health Facility(e.g.DKT)	8	1.2
Others	7	1.1
TOTAL	641	100.0

3.4.2 Knowledge of Contraception by Method

The level of knowledge of contraception by method was measured by asking respondents to mention all the methods of contraception that they had heard. Actually knowledge is not sufficient to stimulate for fertility reduction but a simple awareness of contraceptives could be a pre - requisition for use.

As it is shown on the table below the pill is the most widely known single method and out of the total respondents who have ever heard about contraceptive methods, 86.9 percent had mentioned it. Next well known modern contraceptive methods are the injection, 65.8 percent and condom (male) 43.7 percent. Among the percentage of women who had reported knowledge of any of the traditional and non supply method rhythm or safe sex period is relatively most popular, i.e. 54.8 percent, next is breast feeding, 45 percent. But in general, traditional methods are less widely known than modern methods.

***Table 3.4.2**: Knowledge of contraception by method*

Method	Frequency	Percentage
Pill	557	86.9
IUD	159	24.8
Injections	422	65.8
Norplant	143	22.3
Condom (male)	280	43.7
Condom (female)	64	10.0
Diaphragm/foam/jelly	34	5.3
Male sterilization	25	3.9
Female sterilization	53	8.3
Emergency contraceptives	21	3.3
Rhythm	351	54.8
Withdrawals	92	14.4
Prolonged abstinence	264	41.2
Breast feeding	288	45.0

3.4.3 Knowledge about Place of Obtainment

The respondents were also asked about their knowledge of the place where they can obtain modern contraceptive methods. 95.6 percent of women in informal sector who have ever heard about contraceptive methods knew where to obtain contraceptive methods. Table 3.4.4 below lists places that the sample women cited as sources of contraceptive supplies. The government hospitals/health institutions were mentioned the most frequently as a place where these women could obtain contraceptives, 70.5 percent of the respondents.

Table 3.4.3: Places Cited to Obtain Modern Contraceptives

Places cited	Frequency	Percentage
NGOs(e.g. FGAE)	98	16.0
Government hospitals/health institutions	432	70.5
Private clinics	28	4.6
Pharmacy	50	8.2
Shops	5	.8

3.5 Ever used

Women in informal sector in the survey who had ever heard of contraceptive methods were asked their experience about contraceptive use and as it is shown on table 3.5 about 61.2 percent of them had ever used contraceptive methods.

Table 3.5: Percent Distribution of Ever users

Ever use	Frequency	Percentage
Yes	392	61.2
No	249	38.8
TOTAL	641	100.0

3.6 Current use

Women who have heard about contraceptive don't mean that they use them. There is also a difference between ever use and current use of contraceptive methods. As it is indicated on table 3.5 above, 61.2 percent of women used contraceptives, while women who know about, have ever used, and are currently using contraception are only 44.8 percent.

Table 3.6: Percent Distribution of Current users

Current use	Frequency	Percentage
Yes	287	44.8
No	354	55.2
TOTAL	641	100.0

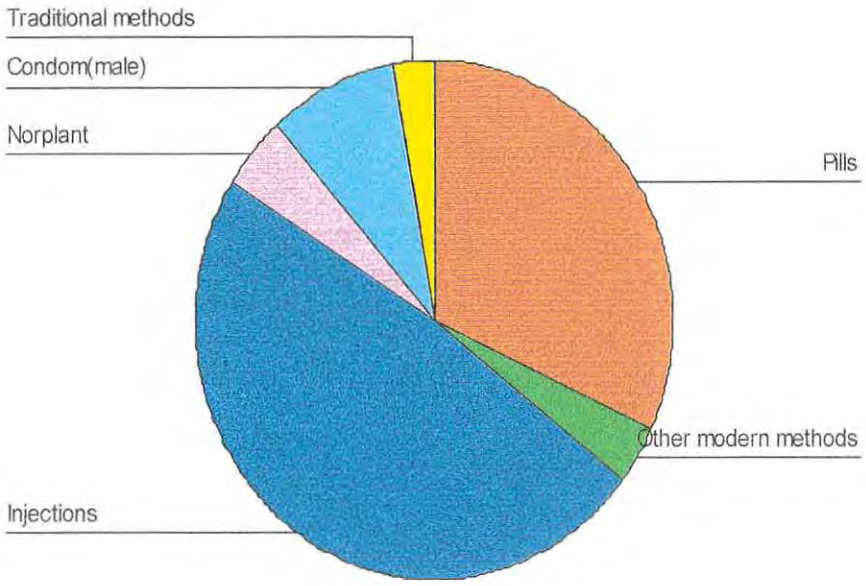
3.6.1 Current Contraceptive Use by Method

There is no great deal of variety in the specific contraceptive methods that these women know about and that they had adopted. The methods most widely known, the pill, injections and condom (male) were also the most widely used. But injections accounted approximately half of all current contraceptive use. Modern methods are more widely practised than traditional ones.

Table 3.6.1: Current contraceptive use by method

Methods	Frequency	Percentage
Pills	92	32.1
IUD	2	.7
Injections	139	48.4
Norplant	13	4.5
Condom(male)	25	8.7
Male sterilization	2	.7
Female sterilization	6	2.1
Rhythm	6	2.1
Prolonged abstinence	1	.3
Breast feeding	1	.3
TOTAL	287	100.0

Pie Chart: Current Contraceptive Use by Method



3.7 Reasons for Not Using Contraception

The reasons for not using contraception at the time of the survey were classified into two groups. The first group of women are ever users but not using at the time of the survey and the second are never users.

A frequency count and percentage was made of the various reasons why women said that they are and were not using any methods. Out of the total women who used to use contraceptive methods but are not using any contraceptive methods at the time of the survey 40% of them had mentioned "not having sex", either their partner was absent or not having any partner as a reason for their non use. 32.38% of them have mentioned "menopausal" as a reason for their non use.

Table 3.7A: Reasons for not using contraceptive methods among the past users

Reasons for not using contraception	Frequency	Percentage
Not having sex	42	40
Infrequent sex	1	0.95
Pregnant	4	3.8
Need for a child	11	10.5
Against religion	2	1.9
Partner against	3	2.9
Fear of side effects	8	7.6
Menopausal	34	32.4
TOTAL	105	100.0

Table 3.7B below shows that, the reasons for not using any contraception among the total women who have never used, 41.0% of them mentioned that they are not having sex. The other reasons mentioned by the never users are "not married" and "infrequent sex" are the major ones, 22.9% and 20.9% respectively.

Table 3.7B: Reasons for not using contraceptive methods among the never users

Reasons for not using contraception	Frequency	Percentage
Not married	57	22.9
Not having sex	102	41.0
Infrequent sex	52	20.9
Against religion	8	3.2
Partner against	4	1.6
Don't know where to find	2	0.8
Fear of side effects	21	8.4
Infertile	3	1.2
TOTAL	249	100.0

3.8 Induced abortion

Complications of illegal abortion are major cause of death among women of reproductive age in developing countries (F. Porter; 1987). In Ethiopia abortion has not been yet legalized fully. Data produced from the sampling survey was by asking if the women ever experienced induced abortion. Despite the fact that it is difficult to find accurate estimation of abortion, a considerable number of women had induced abortion i.e. 19.9 percent.

Table 3.8A: Percent Distribution of Induced Abortion

Ever had induced abortion	Frequency	Percentage
Yes	130	19.9
No	524	80.1
TOTAL	654	100.0

The main reasons listed for induced abortion in women in informal sector are problem of money to bear and rear the child and pregnancy out of marriage contributes more i.e. 29.2 and 27.7 percent respectively.

Table 3.8B: Reasons for induced abortion

Reasons for the abortion	Frequency	Percentage
Health problem	14	10.8
Rejection of partner	17	13.1
Pregnancy out of marriage	36	27.7
No money to rear and bear	38	29.2
Family/society not accepted	5	3.9
Failure to use contraceptive properly	17	13.1
Failure of the method of contraceptive to work	3	2.3

3.9 Results of Focus Groups Discussions (FGDs)

The second source of information in this survey was focus-group discussions, which allowed the researcher to collect more detailed information, conducted with women in informal sector in Addis Ketema and Arada Kifle Ketemas.

A total of two focus-group discussions were held, one in Addis Ketema and the other in Arada Kifle Ketem. The group had a subset of eight women. The first group held in Addis Ketema Kifle Ketema consists of younger women who are less than 30 years of age, not married and not having any living child. As it is shown on the table below all the participants could read and write and have attended formal school. Only two participants were at the primary educational level (grade 1-6). The majority of the group of FGD participants were Orthodox Christians, one protestant and one Muslim. Income level of the participants was also asked and half of the participants were under the category of medium income (5-10 birr per day), two under low income (1-5birr per day), one very low (< 1 birr per day) and one participant under high income category (> 10 birr per day). The other characteristic of the participants noted was their experience of contraceptive methods. Here also half of the participants were never experienced contraceptives during the discussion time. Two of the participants ever used before and the other two women in the discussion said that they are current users.

Table 3.9A: *Characteristics of first group of FGDs participants (Addis Ketema Kifle Ketema)*

No.	Age	Educational level	Religion	Income	Contraceptive experience
1	18	Senior secondary	Protestant	Medium	Never use
2	21	Senior secondary	Orthodox	Medium	Past user
3	22	Junior secondary	Orthodox	Medium	Never user
4	24	Senior secondary	Orthodox	Low	Never user
5	26	Primary	Orthodox	Low	Current user
6	27	Junior secondary	Orthodox	Very low	Past user
7	27	Primary	Muslim	High	Current use
8	30	Junior secondary	Orthodox	Medium	Never user

The second group was from Arada Kifle Ketema consisted women who are above 30 years of age, currently married or formerly married and who have living children. In this group we had two

women who are illiterate, those who can't read and write, one non - formal education, three women under the primary educational level (grade 1-6) and two of them were under junior secondary level (grade 7-8). We had only one Muslim participant; the others were Orthodox Christians. In this group we had also four women under income category of medium (5-10 birr per day), three under low income (1-5birr per day) and one under high income category (> 10 birr per day). Four of the participants in the second group of FGD were currently married at the time of discussion, two were divorced, one widowed and one separated without legal divorce. Only one participant had two living children, two of them had three children and the other five women had four and above number of surviving children. While we see the experience of contraceptive practice, four of the participants were current users, three of the women participants were past users and only one was never used any contraceptive methods.

Table 3.9B: *Characteristics of second group of FGDs participants (Arada Kifle Ketema)*

No.	Age	Educational level	Religion	Income	Marital status	Number of surviving children	Contraceptive experience
1	32	Junior secondary	Muslim	Medium	Separated	3	Past user
2	35	Primary	Orthodox	Low	Currently married	2	Current user
3	37	Primary	Orthodox	Low	Divorced	3	Past user
4	38	Junior secondary	Orthodox	High	Currently married	4	Current user
5	40	Primary	Orthodox	Medium	Currently married	5	Current user
6	42	Illiterate	Orthodox	Medium	Currently married	5	Current user
7	47	Illiterate	Orthodox	Medium	Widowed	6	Never user
8	47	Non-formal	Orthodox	Low	Divorced	4	Past user

The first issue of the discussion was about the general attitude of these women towards family planning methods.

All the participants agreed with the idea of child spacing and family size limitation. The first group of participants, who are less than 30 years of age, said that it is useful to use family planning methods because the women might need to continue her education and they said that their incomes are generally lower than those in formal employment, which can't even feed them properly. They have mentioned many living cost they have and these costs are increasing through time. So, these women need especially to control their fertility.

The second group, who are above 30 years of age, currently married or formerly married and who have living children, mentioned that they are suffering with their number of children they have unknowingly with little awareness and unavailability of contraceptive methods. They have also mentioned that, the usefulness of family planning method is limited only at the family level but also for the country's economy.

The participants were also asked about their experience on the methods. The younger group has little experience, only some of the women were taking pills and some were using condom.

Women in the second group have mentioned many of their experience. A woman, who has relatively best experience in contraceptive practice, from the other women in the second group at the age of 38 said,

> "I gave birth for my first child at the age of 18 and the second child after a year without using any method. But after my second child I tried to use the pill, but due to improper use of the pill I gave birth for the third child then I used IUD for ten year. Due to some health problem I removed the IUD and give birth for the fourth child and now I am using Norplant and I don't want to have more children so I have planned to talk to the health personnel and ask what to do".

The other women at the age of 42 said,

> "I used to use injection and after having three children then my husband was not around and I leave to take the injection but after he returns back I get pregnant. My husband is against the family planning methods but I need to stop child bearing, he said that it is against God's willingness but he doesn't understand that I have suffered a lot to rear the children. He

works outside Addis and he usually sent some money even which is not enough to rear one child so it is my duty to raise the children by what I am earning from the informal sector. After having the fourth child, he told me that, I am not going to be pregnant if I breastfeed but I did. So, I have no other option but to make induced abortion without telling him, actually it was not my first time. After having my fourth child I used Norplant for five years but the nurse told me that I don't have to do it twice it might cause cancer so I dropped to use. Then again I get pregnant and go to the Marie Stop International clinic to make induced abortion. But the nurse told me that it has some risk. Therefore I gave birth for my fifth child and make female sterilization by the help of the nurse. This was two years before and my husband still didn't know about it and we have never discussed this issue".

Although each method of contraception might have some failure and side effects that are independent of how accurately or consistently it is used, from the above women we can see that there is improper way of utilizing contraceptive methods and having unwanted pregnancies. We can see also the quantitative results on Table 3.8B, Reasons for Induced Abortion, that among the total women who have ever had induced abortion 13.1 per cent of them mentioned failure to use contraceptive methods properly as a reason of their abortion. The second woman said that the health personnel told her that it is dangerous to use the Norplant for the second time. But I have tried to contact some personnel at FGEA and they have said that it is even possible five times. Therefore, health personals in the clinics must be careful on the information they usually given for their clients.

Almost all the participants agree that the traditional methods of contraception are not reliable. Three of the women have experienced pregnancy while breast feeding. Some of them believe in rhythm or safe sex period could work if the partner is willing to cooperate with the woman.

The participants were asked about why women in informal sector have more number of children than they ever wanted. They respond that it is not lack of knowledge on the methods but most of the women are negligent to use them. All agreed that it is not worth to have child by thinking their benefit. But they said that it is good to have children to replace our self while we are gone. I have posed a question by interrupting the women "wasn't it enough to have one child to replace one self?" The women replied, "One child is like one eye. What if the child dies? So it is better to have two or more children". The other advantage of having children mentioned by the participants was social status. A woman, who has children, be recognized by the society as a mother of somebody.

Larger family size has also better love and affection in the family than those families who have only one or two children.

The participants have mentioned that it is fear of side effects and lack of trust that they are not using long term modern contraceptive methods.

The other issue of discussions was partner's approval and involvement in family planning methods. Most of the women who have partner said that their partner approves the methods but never been participated. Some also mentioned that they have never been discussed this kind of issues. One woman from the second group, aged 40 said,

> "I heard about the male sterilization in the heath institution from a woman and I told my husband, "Since we have six children why don't you make the male sterilization?" He said that he is not willing to make the sterilization since there are many simple female ways of contraception. So I was thinking he might have other women and give birth if I make myself sterilized so I quite to use".

We also discussed about induced abortion. Almost half of the participant women are against abortion and its legality. Their reason was that it is sinful action religiously and since it is the mother's fault to have unwanted pregnancy, she should take the risk and give birth. Now days it is much easier to use contraceptive methods so the women should take preconditions before pregnancy instead of commit induced abortion.

The others almost half of the women on the other hand said that, abortion should be legal. They said that it should be legal because if the women insisted not to have the child she would do/seek illegal and unsafe abortion. There are also some women who have opportunity cost of having a child, younger women also want to post pone childbearing, and to obtain an abortion when a pregnancy occurs. If the abortion becomes legal we can save people dying due to unsafe abortion and some women also become disable persons due to unsafe and illegal abortion. After all, women can get pregnant while using contraception so they need to have a right to make induced abortion.

The last but not the least issue of the discussion was best ways of communicating family planning information. The women mentioned that education for youth and students in the class as a subject is necessary because now a day if the girl is in the risk of pregnancy she is also in the risk of HIV/AIDS. The other means mentioned by the women is that, the mass media has to give better coverage of family planning programmes permanently. Some of the women said that the males

should also be involved in the education. But some of the participants said that it is useless to involve men in this issue because men don't care or don't consider it as their issue, so it is wastage of time and resource.

CHAPTER FOUR

4. Patterns of Contraceptive Use by Selected Background Variables:

Bi-Variate Analysis

Many factors influence the extent to which women practice contraception. In this chapter the data analysis involved measuring relationship between the dependent variable, contraceptive use, and other demographic and socio-economic variables. A series of cross tabulations were run on variables known and chi square test for studying relationships between variables.

4.1 Contraceptive Use and Demographic Variables

4.1.1 Contraceptive use by Age

Many surveys show that age is related curvilinear to current contraceptive use, percentage of women practicing contraception lowest at the younger and older ages, and highest in the middle reproductive years. Couples are less likely to use contraceptives when fecundity is low, especially at the oldest and the youngest ages. Actually the older women and current users in this survey are probably influenced by the availability of contraception at a time when modern contraceptive was not widely available.

The proportion of users was relatively highest in the age groups 20-24, 25-29 and 30-34 (53.0%, 54.3% and 55.6% respectively). The proportion was relatively lowest among women above the age 45. The association between use of any contraception and age was statistically significant by Chi – square test ($p = 0.000$).

p=significant at $p<0.05$

Table 4.1.1: Percent Distribution of Contraceptive use by Age

Grouped age		Current use		Total
		Yes	No	
15-19	Frequency	9	28	37
	Percentage	24.3%	75.7%	100.0%
20-24	Frequency	71	63	134
	Percentage	53.0%	47.0%	100.0%
25-29	Frequency	69	58	127
	Percentage	54.3%	45.7%	100.0%
30-34	Frequency	60	48	108
	Percentage	55.6%	44.4%	100.0%
35-39	Frequency	43	49	92
	Percentage	46.7%	53.3%	100.0%
40-44	Frequency	25	53	78
	Percentage	32.1%	67.9%	100.0%
45-49	Frequency	10	55	65
	Percentage	15.4%	84.6%	100.0%
TOTAL	Frequency	287	354	641
	Percentage	44.8%	55.2%	100.0%

4.1.2 Contraceptive Use by Marital Status

Marital status is coded into three categories: never married for single women, currently married for legal marriage and consensual union and formerly married for women who are divorced, widowed and separated women. Contraceptive use was proportionally highest among currently married women (63.6%) and lowest among formerly married women, 11.6%.

The Chi – square test for marital status was also significantly associated with use of any contraception method (p= 0.000).

p=significant at p<0.05

Table 4.1.2: Percent distribution of Contraceptive use by marital status

Marital status		Current use		Total
		Yes	No	
Never married	Frequency	70	117	187
	Percentage	37.4%	62.6%	100.0%
Currently married	Frequency	201	115	316
	Percentage	63.6%	36.4%	100.0%
Formerly married	Frequency	16	122	138
	Percentage	11.6%	88.4%	100.0%
TOTAL	Frequency	287	354	641
	Percentage	44.8%	55.2%	100.0%

4.1.3 Contraceptive Use by Ideal family size

The cross tabulation of ideal family size and current contraceptive use has been done for women who have living children. This is mainly due to the extent of actual family size may defines the level of unwanted fertility and could be best reflected by the experience of women's child –bearing. Women who said that they would like to have less than three children if they could go back to the time when they did not have any children are relatively more users of contraceptive methods, 53.5 percent. As the number of children desired increases the practice of contraception decreases. The concept of "ideal family size" and determining the number of children women will have is not understood or do not speak because "only God Knows" how many children a woman will bear, especially in less educated societies. Accordingly, there were some women who respond that "God knows" and 40 percent of them were current users.

The relationship between ideal family size of women who have living children and current use of any contraceptive methods was also statistically significant in this survey (p=0.009).

p=significant at $p<0.05$

Table 4.1.3: Percent distribution of Contraceptive use by ideal family size

Ideal family size		Current use		Total
		Yes	No	
Less than 3 children	Frequency	84	73	157
	Percentage	53.5%	46.5%	100.0%
4 children	Frequency	77	91	168
	Percentage	45.8%	54.2%	100.0%
More than 5 children	Frequency	53	56	109
	Percentage	38.6%	61.4%	100.0%
God knows	Frequency	12	18	30
	Percentage	40.0%	60.0%	100.0%
TOTAL	Frequency	226	238	464
	Percentage	48.7%	51.3%	100.0%

4.1.4 Contraceptive use by Number of living children

Pattern of contraceptive use by family size has been had an association. Some studies for African countries, have found relatively highest contraceptive use mostly among women with four or more children. But here in this survey contraceptive use decline as of the number of living children increases. This could be mainly due to the age factor. Older women have relatively more children than the younger ones and the older women in informal sector are less educated than their younger counterparts, and as we have seen above education affect contraceptive use positively and these women have lower motivation to practice contraceptive methods. The other possibility is that most widowed women are older women and women who live with their partner could have infrequent sex and could reach menopausal. Thus, women who have two and less number of children are more current users of contraceptive methods, 52.5 percent.

The Chi – square test for number of living children was significantly associated with use of any contraception method (p= 0.003).

p=significant at p<0.05

Table 4.1.4: *Percent Distribution of Contraceptive Use by Number of Living Children*

Number of living children		Are you currently using any methods		Total
		Yes	No	
Less than or equal to 2 children	Frequency	116	105	221
	Percentage	52.5%	47.5%	100.0%
3-4children	Frequency	79	74	153
	Percentage	51.6%	48.4%	100.0%
Greater than or equal to 5 children	Frequency	38	63	101
	Percentage	37.6%	62.4%	100.0%
TOTAL	Frequency	233	242	475
	Percentage	48.7%	51.3%	100.0%

4.2 Contraceptive Use and Socio-Economic Variables

4.2.1 Contraceptive use by Education

Education is coded into five categories according to The 1990 National Family and Fertility Survey Reports indicating whether the respondent couldn't read and write (illiterate), didn't attend formal school (non-formal), primary (grade 1-6), junior secondary (7-8 grade) and senior secondary and above (grade 9 and above). Education is expected to increase awareness and use of contraception and contraceptive use increases as women's years of schooling rise. The proportion of current contraceptive users and education in this survey was highest relatively for junior secondary, grade 7and 8 respondents (61.9%). But it declines at the education level of senior secondary. This is mainly because, since the target groups are women in informal sector, which their educational level

is relatively low, respondents who are in the senior secondary, categories are women at the early age 15-19 and as we have seen above these age group women are less users of contraception.

The Chi – square test for education was also significantly associated with use of any contraception method (p= 0.009).

p=significant at p<0.05

Table 4.2.1: Percent Distribution of Contraceptive Use by Educational Level

Education		Current use		Total
		Yes	No	
Illiterate	Frequency	63	111	174
	Percentage	36.2%	63.8%	100%
Non-formal	Frequency	17	31	48
	Percentage	35.4%	64.6%	100%
Primary	Frequency	89	94	183
	Percentage	48.6%	51.4%	100.0%
Junior secondary	Frequency	60	37	97
	Percentage	61.9%	38.1%	100.0%
Senior secondary	Frequency	58	81	139
	Percentage	41.7%	58.3%	100.0%

4.2.2 Contraceptive use by Income

As we have seen above the most widely used contraceptive methods are the modern types in particular injections, pills and condom. These methods have some cost and as we can see from table 4.2.2 the proportion of users increase with their income.

The Chi – square test for income was also significantly associated with use of any contraception method (p= 0.019).

p=significant at p<0.05

Table 4.2.2: *Percent Distribution of Contraceptive Use by Income*

Income level		Current use		Total
		Yes	No	
Very Low Income	Frequency	15	28	43
	Percentage	34.9%	65.1%	100.0%
Low Income	Frequency	134	198	332
	Percentage	40.4%	59.6%	100.0%
Medium	Frequency	86	87	173
	Percentage	49.7%	50.3%	100.0%
High Income	Frequency	43	37	80
	Percentage	53.8%	46.3%	100.0%
Not Stated Income	Frequency	9	4	13
	Percentage	69.2%	30.8%	100.0%

4.2.3 Contraceptive Use by Exposure to Family Planning Information

Exposure to family planning information is associated with increased contraceptive practice. As it is described above data on respondents' exposure of family planning messages were collected by asking if these women have seen or heard family planning information for the last three months prior to the survey. Among the women who have exposed to family planning methods 48.8 percent of them are current users while, only 33.1 percent of women are current users among those who have mentioned that they have not heard any family planning information in the last three months prior to the survey.

The Chi – square test for exposure to family planning information was significantly associated with use of any contraception method (p= 0.000).

p=significant at $p<0.05$

Table 4.2.3: Percent Distribution of Contraceptive Use and Exposure to Family Planning Information

Exposure to Family Planning Information		Current use		Total
		Yes	No	
Yes	Frequency	232	243	475
	Percentage	48.8%	51.2%	100.0%
No	Frequency	55	111	166
	Percentage	33.1%	66.9%	100.0%
TOTAL	Frequency	287	354	641
	Percentage	44.8%	55.2%	100.0%

4.3 Contraceptive Use by Desire for More Children

It is expected that women who want no more children may have higher rates of contraceptive use than who want more or are undecided and God knows. But the percentage using contraception, among women in informal sector who wanted no more children, does tend to be low in this survey. This could be mainly due to relatively low proportions of women know about modern contraceptives, knowledge of any contraceptive methods for all women in Addis Ababa was 99.2% in DHS 2000 Ethiopia, but here in this survey it was 98%. The percentage could also be related to the level of socio economic development like educational level, income of these women and desire for more children is certainly influenced by age. Thus, women who want no more children only 44.8% of them are current users whereas women who want more children 60.6% are current users.

The Chi – square test for desire for more children was also significantly associated with use of any contraception method (p= 0.016).

p=significant at $p<0.05$

Table 4.3A: Percent Distribution of Contraceptive Use and Desire for More Children

Desire for more children		Current use		Total
		Yes	No	
Yes	Frequency	66	43	109
	Percentage	60.6%	39.4%	100.0%
No	Frequency	151	186	337
	Percentage	44.8%	55.2%	100.0%
Undecided/not sure	Frequency	10	9	19
	Percentage	52.6%	47.4%	100.0%
TOTAL	Frequency	227	239	466
	Percentage	48.7%	51.3%	100.0%

This variable, desire for more children, is also a measure of the women's motivation to practise fertility control for "limiting" or for "spacing".

> *Although many researches have shown that spacing may be more important than stopping as a motivation for contraceptive in developing countries, in particular in Africa, the serious problem is that the measure takes no account of the need for contraception to space births (F. Porter; 1987:53).*

Among the proportion of women who were current contraceptive users at the time of the survey, an estimate of the percentage of women using contraceptive for birth spacing were only 33.4 percent. Couples who want no more children have a wider choice of methods than those who want more.

Table 4.3B: Purpose of contraceptive use

Purpose of Contraceptive use	Frequency	Percentage
Limit family size	175	61.0
Child spacing	96	33.4
Health problem/Medication	16	5.6
TOTAL	287	100.0

In this survey women who have said that they want more children were asked further why they want more children. The desire for more children was highly associated with sex preference of the women. In this survey, 72.8 percent of women who want more children stated sex preference as their reason and sex preference would be a strong barrier to the contraceptive. Responses like children are God gifts and social status also were cited as reasons for wanting additional children consequently.

4.4 Contraceptive Use by Partner's Approval

Communication between spouses has been found to an important factor influencing contraceptive practice. Among the women who currently had a partner and who their partner approve or favour the use of contraceptive methods, 76.9% of the women are current users, women who said that their partner was against contraceptive methods 37.9% are current users, women who stated that their partner doesn't know any method 31.0% are current users and among women who said that they didn't know their partner's position, 23.7% are current users.

Partner's approval of any contraceptive methods was also highly associated with use of contraception for women in informal sector (p=.000).

p=significant at $p<0.05$

Table 4.4: Percent Distribution of Contraceptive Use by partner's approval

Partner's approval		Current use		Total
		Yes	No	
Yes	Frequency	220	66	286
	Percentage	76.9%	23.1%	100.0%
No	Frequency	22	36	58
	Percentage	37.9%	62.1%	100.0%
Don't know	Frequency	18	49	67
	Percentage	26.9%	73.1%	100.0%

4.5 Contraceptive Use by Induced Abortion

Abortion incidence may decline as contraceptive use becomes more widespread and as users attain proficiency in the use of a method.

Women who have experienced induced abortion due to various reasons described about are relatively more users of contraceptive methods. Among women in informal sector who had induced abortion 57.7 percent of them are current users while women who have stated that they never experienced induced abortion 41.5 percent of them are current users of contraceptive methods. These could be an indicator that women's intention to have more children.

The current use of contraception and the practice of induced abortion were highly associated (p=.001).

Table 4.5: Percent Distribution of Contraceptive Use by Induced Abortion

Ever had Induced abortion		Current use		Total
		Yes	No	
Yes	Frequency	75	55	130
	Percentage	57.7%	42.3%	100.0%
No	Frequency	212	299	511
	Percentage	41.5%	58.5%	100.0%
TOTAL	Frequency	287	354	641
	Percentage	44.8%	55.2%	100.0%

CHAPTER FIVE

5. Correlates of Current Contraceptive Use: Results of Multivariate Analysis

As discussed in the previous chapter, a preliminary assessment using cross-tab and Chi-Square Test has been performed to determine factors, which are significantly associated with current use of contraceptive methods. However, the chi – square test is useful for determining whether an association exists between two variables but it is limited in that it doesn't provide any information concerning the nature of the association between two variables i.e. the strength, the direction, or the type of association.

Thus, at this stage further analysis using multivariate Logistic regressions procedures were used to measure the net effect of each independent predictor upon the dependent variable when the effects of all other factors and covariates are controlled.

Table 5: *Results of Demographic and Socio-Economic Correlates on Contraceptive Practice of Women in Informal Sector.*

Independent variable	B	S.E	Sig.	Exp(B)
⇒ **Age group**				
15-24	-0.896	0.191	.000	0.408**
25-34(r)	RC		.000	1.000
35+	-0.571	0.207	.006	0.565**
⇒ **Marital status**				
Currently married(r)	RC		.000	1.000
Never married	-2.590	0.290	.000	0.075**
Formerly married	-1.518	0.306	.000	0.219**
⇒ **Educational level**				
Primary	-1.057	0.251	.000	0.347**
Junior secondary(r)	RC		.000	1.000
Senior secondary	-0.519	0.204	.011	0.595**
None	-0.240	0.222	.279	0.787
⇒ **Income**				
>10birr/day(r)	RC		.022	1.000
5-10birr/day	-0.774	0.391	.047	0.461*
1-5birr/day	-0.613	0.354	.084	0.542
<1birr/day	-0.234	0.339	.491	0.792
Not stated	-1.435	0.681	.035	0.238*
⇒ **Ideal family size**				
<3(r)	RC		.010	1.000**
4	-0.783	0.225	.001	0.457**
5+	-0.476	0.221	.032	0.622*
Nonnumeric	-0.588	0.248	.018	0.556*
⇒ **Number of living children**				
0(r)	RC		.004	1.000**
1-2	0.212	0.776	.785	1.236
3-4	0.274	0.781	.726	1.316
5+	0.744	0.791	.347	2.105
⇒ **Desire for more children**				
Yes(r)	RC		.018	1.000*
No	-0.428	0.537	.425	0.652
Undecided/not sure	0.208	0.512	.684	1.232
⇒ **Exposure to FP information**				
No	-0.656	0.189	.001	0.519**
(Yes)				1.000
⇒ **Partner's approval**				
Approves(r)	RC		.000	1.000
Disapproves	-2.205	0.309	.000	0.110**
Don't know	-0.509	0.386	.188	0.601*
⇒ **Induced abortion**				
No	-0.654	0.199	.001	0.520**
(Yes)				1.000

***Significant at p<.01; *Significant at p<.05*

(r) Reference category

Age of the Respondent

As can be seen from the chi-square test, age of adolescents has significant association with their current practice of contraceptive methods. Women's age is re-categorized into three groups, 15-24, 25-34 and 35+. Here age category 25-34 was taken as a reference category, by considering that the proportion of contraceptive users were the highest from the bivariate analysis above.

The logistic regression model (in Table 5) reveals that the odds ratio (Exp(B) = 0.408) for age group 15-24 and odds ratio (Exp(B) = 0.565) for women's in age group 35+, the practice of contraception has been decreased by 59.2% and 43.5% respectively as compared to the reference category (women age group 25-34 years). The results show that women older than 35 are likely to use a contraceptive method than the women younger than 25 years. It was also observed in the focus group discussions that the participants who were younger than 30 years of age, 50% of them were either past users or current users, where as, in the second group, women 30 and above years old, 87.5 % of them were either past users or current users.

Marital status of the respondents

Marital status was significantly associated with contraceptive practice in the chi-square test (p=.000). The logistic regression model on marital status and current use of contraceptive methods reveals that the odds ratio (Exp(B) = 0.075) for never married women and odds ratio (Exp(B) = 0.219) for formerly married, separated, divorced and widowed women as compared to the reference category(married women). The results show that never married women 92.5% and formerly married women 78.1% less likely to use contraceptive methods.

Educational level of respondents

Women's education is widely recognized as a crucial determinant of reproductive behavior. Education provides women with knowledge that allows them to make informed decisions, with skill that enhance their opportunities in the wage employment sector and with exposure to new values, norms and attitudes that are likely to enhance their autonomy. For this reason the need to improve women's education has been stressed as a means of both promoting development and reducing levels of fertility in the developing world.

Women's educational attainment is found to be correlated with their practice of contraceptive methods. The reference category is women in the junior secondary level, grade 7and 8. Women who have no schooling and primary educational level are less likely to practice contraceptive methods by 21.3 and 65.3% respectively than their junior secondary educational level women. And the probability of using contraceptive methods by women who attained senior secondary educational level, grade 9 and above are 40.5% lower than the reference category.

The finding of the analysis doesn't show a consistent relationship between education and practice of contraceptive methods i.e. as the level of education increases the practice of contraceptive also increases. Rather it shows curvilinear relation in which education has been observed to be influenced by other aspects of women's situation.

Income of respondents

Although the costs of modern contraceptive methods are relatively low, these costs do have an impact on contraceptive practice of women in informal sector. Taking the higher income as a reference category the finding of the analysis on income shows that, women who have relatively higher income are also substantially more likely to use contraceptives than women in low income categories.

Ideal family size

Women who desired larger families are less likely to use contraception. The regression results indicates that women who desired more than 5 children are less likely to use contraceptive methods than those who desired less than 3 children, (Exp (B) = 0.622).

Number of living children

The number of children already born is a very important influence on the desire to stop childbearing and the practice of contraceptive methods. Number of living children demonstrates the expected relationship to contraceptive behavior; higher number of children is associated with a grater likelihood of method use overall, whether traditional or modern. Women with at least five living than those with no living children are 2 times more likely than those with no living children to use contraceptives.

Exposure to FP information

The exposure to family planning information is categorized into two, those who have exposure for the last three months (as a reference category) and those who have no exposure. The multivariate estimate of current use of contraceptive methods for women who have no exposure has decreased by a factor 0.519 times than their exposed counter parts.

Partner's approval

Partner's approval has a statistically significant association with the likelihood of seeking care; the odd rations suggest that Women whose partners disapprove of family planning are less likely to use contraceptives (Exp (B) = 0.110) than those whose partners approve of family planning.

Induced abortion

Finally, the logistic regression examined contraceptive practice subsequent to an abortion among women who had had an abortion. We expect that subsequent contraceptive use will be more likely among women who had an abortion than among those who had never experienced induces abortion. Likewise, the result indicated that contraceptive use was 48% more likely for women who had induced abortion than women never experienced induced abortion.

CHAPTER SIX

6. SUMMARY, CONCLUSION AND RECOMMENDATIONS

In this chapter of the paper, summary and conclusion of the study and relevant recommendations have been presented.

6.1 Summery

Today, rapid population growth becomes one of the greatest challenges facing humankind. The rapid population growth hinders a nation's ability to progress and to satisfy the growing demands of the people for a better life.

This problem demands the attention of all nations, while the developed countries have successfully over come this challenge, most of the developing countries has yet to be finding a solution. But some studies show that there is world wide concern and international cooperation on the consequences of rapid population growth and the impact of high fertility on maternal and child health.

There is a negative association between childbearing and women's employment because of the costs of child rearing, the value of women's time and personal goals and desires. However, women in informal sector who are relatively low educational level have limited access to health and family planning outlets have low rates of contraceptive use and large family size. And relatively less attention have been given to these women in their family planning service.

Therefore, the objective of this study is to show the extent of Knowledge, Attitude and Practice (KAP) of contraceptive methods of women in informal sector and to see socio - economic and demographic factors influencing the use of family planning methods among these women.

In this study the dependent variable is current use of contraception, which is a dichotomies variable (those who are currently using and not using). And the independent variables of the study are some selected demographic and socio-economic factors.

Both quantitative and qualitative primary data collection method was employed. In order to collect the data, 10 female enumerators and 2 supervisors who had experience in data collection and supervision was recruited. Moreover, a two-day orientation and training was given in order to familiarize them with the questionnaire and to understand the objective of the study.

In this study 654 women in informal sector were included. Also two FGDs, in Addis Ketema and Arada Kifle Ketamas, were conducted in order to support the quantitative results of the study. Addis Ketema and Arada Kifle Ketamas were selected purposively due to the fact that in these sub-cities have the highest concentrations of informal sector.

To analyze the data, bi-variate (cross-tabulation, chi-square) and multivariate analysis were applied using SPSS statistical software package.

6.2 Conclusions

According to the data collected, analyzed and findings of the study in the two sub-cities of Addis Ababa, Addis Ketema and Arada, the following conclusions are presented.

⇒ The percentages of women practicing contraception are lowest at the younger and older ages and it has a curvilinear relationship with current contraceptive use. Most studies reveal that contraceptive use is greatest among women between ages 25-34. This is also true in this study however; contraceptive use starts to increase relatively at younger age, 20-24. This could be due to the fact that women in informal sector became sexually active relatively at their early age.

⇒ The results revealed that, respondents' educational attainment is one of the determinant factors that contribute to the current contraceptive practice. Use of contraception increase with level of education and here also the practice of contraception for women in informal sector increase with their educational attainment but it shows that, current contraceptive use decrease at the senior secondary level (grade 9 and above). This is mainly because the variable educational

level has been affected by age. Most of the women in senior educational level are at the age of 15-19 and these women are less utilizes contraception.

⇒ Since most of the respondents in this survey use modern type of contraceptives, these methods incur cost. Therefore, there is a significant statistical association between the income of women in informal sector and the probability that they would use contraception.

⇒ Women who don't want to have additional children compared with the women who want to have additional children are less utilizes of contraception in this survey. This is mainly because desire for more children also affected by other variables like age, educational level and income. Most of the women who don't want additional children are the older age and less educated. And women in informal sector in this survey have relatively low knowledge about contraceptive methods and knowledge is prerequisite for the practice.

⇒ The same pattern has been seen on the variable 'number of living children'. Here in this survey contraceptive use decline as of the number of living children increases. This could be mainly due to two factors. The first factor is age, older women have relatively more children than the younger ones and the older women in informal sector are less educated than their younger counterparts. The other possibility is that most widowed women are older women and women who live with their partner could have infrequent sex and could reach menopausal.

⇒ There is a strong relationship between contraceptive practice and communication among spouses. Women whom their partner approves use of contraception are more users of contraceptive methods.

⇒ From the result we can conclude that women who have experienced induced abortion are relatively more users of contraceptive methods.

⇒ In this study contraceptive use for birth spacing is low. It has been indicated that, the common determinants of contraceptive use for birth spacing and limiting are the extent of availability and the quality of family planning services, and knowledge about and attitudes towards the practice of birth control. And we can say that there are limited accesses to family planning services in Addis Ababa, especially for women in informal sector.

⇒ We can also observe from the result that women who were exposed to family planning information for the last three months prior to the survey are relatively more users of contraception than those who didn't.

6.3 Recommendations

Based on the above-indicated results of the study, and in light of the research questions, the following recommendations are forwarded.

⇒ In this study modern methods are more widely practised than traditional ones. Although traditional methods are less effective than the modern types of contraception, they have no physical side effects, no cost incurred and these methods don't have religious objection. With the knowledge and practice of traditional contraceptive methods, women can avoid pregnancy. So the family planning programmes should also include traditional methods. Advertising of contraception in the mass media is only particularly of specific brands but it should also been used to promote other traditional methods. For example, breast feeding should be the rule for every child and a lactating mother could prevent another pregnancy until her child is at least two years old.

⇒ Although some scholars said that, at least nominal amount should be charged for modern contraceptive methods, so that the user credits the contraceptive with more value. But when we consider the condition of women in informal sector in Addis Ababa contraceptives must be distributed entirely free of cash payment for these groups. Because from the study one can understand that cost has been a hindrance to use contraception for these groups of women.

⇒ Most of the respondents indicated that their centre for contraceptive methods supply are government hospitals/health institutions and, therefore, increased efforts should be made to establish them as distribution centres for all methods of contraception.

⇒ Women in informal sector may have relatively low level of education but they are intelligent enough to choose and live with care for their existing children, if they have given the opportunity and enough information about the concept of family planning services. Now days, it is urgent and necessary to make available family planning services to all people and especially to women in informal sector. The best method which can tackle women in informal sector is door to door service of contraception. It is the experience of many Asian countries and it has been successful in increasing the use of contraception.

⇒ Voluntary female sterilization has gained recognition in many parts of the world. And in this study many women who don't want additional children are not using contraception. And female sterilization is surgical method of family planning for women who are sure that they will not want more children. So it will be effective if we could have proper distribution and accessibility of the services to women in informal sector. It is very effective, convenient and permanent method. However, it requires counselling and proper informed consent.

⇒ As we can see from the data, current users of contraception are more or less concentrated on some specific methods like injections, pills and condom. For example, out of the total respondents only 3.3 percent of them had mentioned that they have ever heard about emergency contraceptives. So, it is suggested that each woman in informal sector should know about emergency contraceptive and should be available in case they needed. So that through emergency contraceptive method we could decrease the number of unwanted pregnancies and abortion could be avoided.

⇒ Abortion has been a controversial issue in many countries, including developed ones. In Ethiopia induced abortion is permitted in special cases, particularly if it is done in order to save the life of the mother. Legal status of abortion doesn't appear to affect levels of abortion; in reality the actual practice of induced abortion has been continued. Actually illegal abortion should be prevented through accessible, safe and effective contraceptive methods. Moreover, we could also reduce maternal mortality resulting from illegal induced abortions by making abortion legal.

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Appendix I: Questionnaire for Women in Informal Sector and their Knowledge, Attitude and Practice of Contraceptive Methods in Addis Ababa.

Part 1: Basic Information /Identification/

No.	Questions and filters	Coding categories	Skip to	Codes
	Kifle Ketema	----------		_____
	Kebele	----------		
	House number	----------		_____
This survey only interviews women in informal sector aged 15-49. If the respondent is younger than 15 or older than 49, do *not* interview this woman. Check eligibility status: This woman is legible [___] This woman is illegible [___]				
101	Type of activity	Petty trade - 1 Home based activity - 2 Other (specify)----------		
102	Age	Year of birth----------		
103	Can you read or write?	Yes - 1 No - 2	If no skip to 106	
104	If the answer to Q 103 is yes, did you attend formal school?	Yes - 1 No - 2	If no skip to 106	
105	If the answer to Q104 yes, what is the highest grade you attended?	_____		
106	Ethnic Group	Amhara - 1 Oromo - 2 Tigre - 3 Gurage - 4 Other (specify)_____		
107	Religion	Orthodox - 1 Muslim - 2 Catholic - 3 Protestant - 4 Traditional - 5 Other (specify).....		

108	Marital Status	Single - 1 Currently Married - 2 Consensual union - 3 Divorced - 4 Widowed - 5 Separated - 6 Other (specify).....		
109	Income per day?	_____Birr/ day		
110	For how long have you stayed in this area?	_____ Years		

Part II: Knowledge, Attitude and Practice of contraceptive methods

201	Have you ever heard about family planning methods?	Yes - 1 No - 2	If no Skip to 301	
202	If the answer for Q 201 is yes, from where did you hear about family planning for the first time?	Radio /Television - 1 Magazines/newspaper/Posters- 2 Spouse/partner - 3 Family /Relatives - 4 Friends/neighbors - 5 Gov' hospital/health institutions- 6 NGOs (e.g. FGAE) - 7 Private health facility (e.g. DKT) 8 Other(Specify)_____		
203	Which modern methods of contraception have you heard about? (Circle all that apply, more than one response is possible; → do not read the responses)	Yes No Pills 1 2 IUD 1 2 Injections 1 2 Norplant 1 2 Condon (male) 1 2 Condom (female) 1 2 Diaphragm 1 2 Male sterilization 1 2 Female sterilization 1 2 Emergency contraceptives 1 2		

204	Which traditional methods of contraception have you ever heard about?	Yes No Rhythm or safe sex period 1 2 Withdrawals 1 2 Prolonged Abstinence 1 2 Breastfeeding 1 2 Other (Specify)_____		
205	Have You ever Heard /See information regarding the Family Planning in the last three months?	Yes - 1 No - 2	If no skip to Q 207	
206	If the answer for Q205 is Yes, from where did you hear/see about family planning? (Circle all that apply, more than one response is possible; → do not read the responses)	Radio - 1 Television - 2 Posters/Leaflet - 3 Health Worker - 4 Mobile Drama/Show - 5 Other(Specify) _____		
207	Do you know a place where you can obtain modern contraceptive methods?	Yes - 1 No - 2	If no Skip to 209	
208	If the answer for question 207 is yes; where did you go to obtain modern contraceptive methods?	NGOs (e.g. FGAE] - 1 Government hospitals / health institutions / - 2 Private Clinics - 3 Pharmacy - 4 Shop - 5 Other(Specify)_____		
209	Have you ever used any of the following methods of contraception?	Yes - 1 No - 2	If no Skip to Q 211	

210	If the answer for Q 210 yes, which method have you ever used?	Yes No Pills 1 2 IUD 1 2 Injections 1 2 Norplant 1 2 Condom (male) 1 2 Condom (female) 1 2 Diaphragm/foam/jelly/ 1 2 Male sterilization 1 2 Female sterilization 1 2 Emergency contraceptive 1 2 Rhythm or safe sex period 1 2 Withdrawals 1 2 Prolonged Abstinence 1 2 Breast feeding 1 2 Other(Specify)_____		
211	Are you/Partner/ **currently** using any of the following methods of contraceptive to prevent pregnancy?	Yes - 1 No - 2	If no Skip to Q 213	
212	If the answer for Q211 is yes, which Method are you using Currently? [only one answer,]	Pills 1 IUD 2 Injections 3 Norplant 4 Condom (male) 5 Condom (female) 6 Diaphragm 7 Male sterilization 8 Female sterilization 9 Emergency contraceptives 10 Rhythm or safe sex period 11 Withdrawals 12 Prolonged Abstinence 13 Breast feeding 14 Other (Specify)_____		
213	If the answer for question 211 is **no**, what is the reason that you are not using any of contraception methods? (Circle all that apply, more than one response is possible; → do not read the responses)	Not married - 1 Not having sex - 2 Infrequent Sex - 3 Need for child - 4 Don't have the money - 5 Don't know where to find - 6 Partners against - 7 Against religion - 8 Fear of side effects - 9 Other (Specify) - 10		

214	If the answer for question 211 is yes, for what reason you have used the method? (Circle all that apply, more than one response is possible; → do not read the responses)	To limit family Size - 1 For child spacing - 2 Health Problem /Medication/-3 Other (Specify)_____		
		Part Three: FERTILITY		
301	Have you ever given birth?	Yes - 1 No - 2	If no Skip to Q 311	
302	Number of children ever born?	Sons_____ Daughters_____ Total_____		
303	Number of children surviving?	Sons _____ Daughters _____ Total_____		
304	Would you like to have more children In the future?	Yes - 1 No - 2 Only God knows - 3 Undecided/not sure.....4	If no Skip to 307	
305	If the answer for question 304 is yes, how many more children do you like to have?	Boys_____ Girls_____ Total_____		
306	When do you want to have the next child?	As soon as possible(<1year) 1 1-2years 2 2-4 years 3 >4 years 4 Undecided/not sure 5 Up to god allows 6		
307	If the answer for question304 is no, are you using any contraceptive method to prevent pregnancy?	Yes - 1 No - 2	If Yes skip to Q 309	

308	If the answer for question 307 is **no**, what is the reason that you are not using any method? (Circle all that apply, more than one response is possible; → do not read the responses)	Not having sex - 1 Against religion - 2 Society against - 3 Partner against- 4 Don't know any method- 5 Fear of side effects - 6 Don't have money - 7 Other(Specify)_____		
309	If the answer for question 304 is **yes**, why do you want to have additional children? (Circle all that apply, more than one response is possible; → do not read the responses)	Social status - 1 Sex preference - 2 Psychological advantage - 3 Benefits from children - 4 God gifts - 5 Other(specify)_____		
310	(For those who have living children) If you could go back to the time you didn't have any children and could choose exactly the number of children to have in your whole life, how many would that be?	_____		
311	(For women who have no living children) if you could choose exactly the number of children to have in your whole life, how many would that be?	_____		
	Part III: Induced Abortion			
401	Have you ever heard of case of induced abortion?	Yes - 1 No - 2	If no Skip to 404	
402	Have you ever had an Induced Abortion?	Yes - 1 No - 2	If no Skip to 404	
403	If the answer for question 402 is yes, what was the reason for your abortion?	Health problem - 1 Rejection of partner - 2 Pregnancy out of marriage - 3 No money to rear and bear - 4 Family /society not accepted - 5 Failure to use contraceptive properly 6 Failure of the method of contraceptive to work - 7 Other(Specify)_____		

404	(Only for women using any contraceptive methods). Have you ever experienced contraceptive failure due to inappropriate use or failure of contraceptive to work and had unwanted pregnancy?	Yes - 1 No - 2		
405	What measure would you taken, in case pregnancy occurs while using contraceptive?	Nothing and give birth - 1 Make an abortion - 2 Don't know - 3 God knows - 4 Other(specify)_____		
Part IV: Husband's/Partner's characteristics (only for women who are married)				
501	Can your husband read or write?	Yes 1 No 2	If no Skip to 504	
502	If the answer to Q 501 is yes, did he attend formal school?	Yes 1 No 2	If no Skip to 504	
503	If the answer to Q 502 is yes, What is the highest grade he attended?	_____		
504	What is your husband's Occupation?	Government employer -1 Non-Government employer -2 Farmer -3 Trader -4 Self Employed -5 Vending/Trading -6 Daily Labor -7 Other (Specify) _____		
505	Have You ever discussed about family planning with your husband?	Yes -1 No -2		
506	Does your husband approve using any method of contraception?	Yes -1 No -2 Don't know -3 Other(Specify)_____		

Appendix II: Issues Raise on the Focus Group Discussions

1) What do you know about family planning methods?
2) What do you think the advantages and disadvantages of using any family planning methods?
3) Are you against or pro on family planning methods?
4) What is your opinion on long term contraceptive methods like male/female sterilization and others?
5) Some women in the informal sector have more number of children than they ever wanted.
   - What do you think could be the reason?
6) In some countries of our world induced abortion has been legalized and in our country it is legalized under some preconditions. Induced abortion has been also considered as one of the methods of family planning. What is your opinion on this issue?
7) What is your opinion regarding the best method of communicating family planning information?

THANK YOU FOR YOUR PARTICIPATION IN THE DISCUSSION

DECLARATION

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

Name Tigist Adola

Signature

Date July 17, 2005

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

Dr. J. Narasimha Rao		18/7/2005
Advisor	Signature	Date