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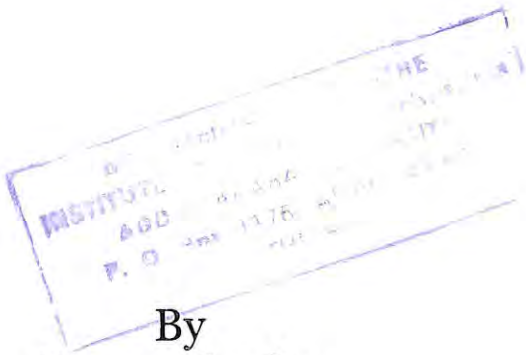
Correlates of Contraceptive Use Among Currently Married Women In Assosa Town of Benishangul Gumuz Regional State, Ethiopia



By
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July 2005
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THE CORRELATES OF CONTRACEPTIVE USE AMONG CURRENTLY MARRIED WOMEN IN ASSOSA TOWN OF BENISHANGUL GUMUZ REGIONAL STATE, ETHIOPIA

By

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Abstract

Ethiopia, the second largest populous country in the near future, where the rate of population growth is still among the highest, and measures taken to control the rapid growth of population and thereby the practice of modern contraceptive use is being at its lowest stage than other countries, challenges the pace of socio economic development and the wellbeing ness of the countries population.

The study was carried out among one of the newly emerging urban centre, Assosa, Benishangul Gumuz region. The development of the city was highly associated with migrants and businessmen of individuals coming from the surrounding and other urban centres of Ethiopia. The decentralization system of the existing political regime plays a profound role to the current development of the town. And a number of civil servants and job seekers had been residing in the town.

According to CSA report more than 75 Percent of people living in the town were migrants of other places with diversified demographic, socio cultural economic characteristics/backgrounds.

For the study 600 samples of individual who are currently married women aged 15-49 taken to investigate factors associated with the practice of contraceptive use. Of which 60 percent of married women were currently using contraceptives, while the remaining ones were not using any methods due to several factors including breast feeding, in fecundity and health related problems particularly fear of side effects and so forth.

During the data analysis different demographic socio economic and cultural factors were reported as the major inhabiting factors of contraceptive practice for users, including lack of knowledge, husband disapproval, opposed to FP, religion prohibitions, etc.

Logistic regression, which helps to predict the presence or absence of a characteristics or outcomes, based on the value of a set of predictor variables that is more suited to model where the dependent or response variables is dichotomous, had been applied to major factors/predicting variables of the study population.

Family planning programs ,which has been targeting to increase the prevalence of contraceptive use should focusing not only repeating similar kinds of program execution rather the existing specific context of the area should be taken in to account and studied. Hence to expand the program activities the existing female-oriented family programs should incorporate the involvement/participation of male as well. The finding indicates that thee is urgency for an organized and integrated FP information, education and communication programs and strategies aiming at encouraging husband-wife FP communication, changing husband's attitude and their active involvement in the program.

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FP: Family planning
STD: Sexually transmitted diseases
MOH: Ministry of health
UN: United Nation
WHO: World health organization

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CHAPTER ONE

1.1 Introduction

Ethiopia is one of the countries having the largest population size in Africa, which is around 71 million and placed in a near future at the second raw of the African nations. This larger size of Ethiopian population number had composed from over 70 different ethnic groups (nations, nationalities and peoples) and characterized by diversified socio-linguistic historical and cultural values.

The country at present had been classified into eleven regional administrative, basically on the basis of ethnic affiliations. Of these, Benishangul Gumuz Regional State is the one, located in north western side of Ethiopia with the area of 49,289.46 square kilometres. In the western side, the region has been shared an international boundary with the Sudan and with other regional states of the country, Amhara, Oromia and Gambela regions in the north, east and south respectively.

The region is constituted into different ethnic groups. Among those, five groups are referred as 'indigenous" of the region- Gumuz, Shinasha, Berta, Mao and Komo, and another several other ethnic groups are living in the regions includes like Oromo, Amhara, Kembata, Tigrie etc.

The regions are subdivided into three administration zones namely; Metekel, Kemashie and Assosa zone and twenty Woredas. According to the 1994

population and housing census result the total population size living in the region (Benishangul Gumuz) was 460,459. Out of these populations, 233,013 were males and 227,446 were females. The urban – rural distribution of the population of Benishangul Gumuz region indicate that the overwhelming majority of the population is living in rural areas. About 85 per cent of the population reside in the rural area of the region, which is very far from the provision of basic services like education, health and other social services including services of reproductive health and family planning and thereby contraceptives.

Therefore, the vast majority of the population were living in rural areas, engaged in traditional way of life and agricultural practices especially using hand digging tools like spade, stick, pick axe for the production of different agricultural food crops. Apart from traditional way of agriculture crop production, they were also involved in domestic animal husbandry specially keeping small animals like sheep and goats and collecting different forest fruits and roots from their surrounding forest resources, one of the potential forest areas of the country.

This research is mainly focusing on Assosa town having a population of more than 20,000 and different indigenous and other married people, with respect to the varying socio cultural and economic means. Due to differences in the living style, the people have different attitudes about their family size and contraceptive use. The married people with in the age group of 15 – 45 are characterized as a potentially active group of reproductive life (Markos and Seyoum: 1998:97) for the study.

1.2 Statement of the Problem

Sub – Saharan Africa will constitute the most important family planning frontiers of the twenty – first century because fertility is still high in all its sub-regions except South Africa, and contraceptive prevalence is far lower than that of any other world region, partly because of low level of socio economic development and partly due to strong cultural resistance to family planning practices (Caldwell: 2002).

On the other hand development researches are expected to have taken into account not on the theoretical formulation while the respective circumstances and the socio cultural practice of the peoples and the economic contexts as well. This is also true for any reproductive health related research. The pitfall of this kinds of research on some of the contemporary period particularly among third world countries including Africa thereby Ethiopia is due to the fact that not only because of poor and lack of theoretical formulation but rather the failure to place reproductive health and related issues within its local socio cultural and economic context.

The component of reproductive health activities, family planning and adoption of modern contraceptive methods, has been under the influence and the level of socio-cultural and economic status of the given society. Hence, the individual couple's perception and attitude towards family planning and adoption of contraceptive, were rationally behaved and governed by their respective demographic socio-cultural and economic arena, and which by large far might be different from those of policy makers and implementing agencies (Dilnesaw Asrat 1995).

Therefore, the fertility behaviour of any given family would be influenced by various demographic and socio – cultural and economic factors like age, sex, education, occupation, type of residence, family type, number of living children by sex etc. There is also further more factors that are related to fertility behaviour thereby use of contraceptives like the number of services that are intended to provision of the needed services as well as trained and qualified personnel in the area. In general, the family size of the individual households would be affected by various other psychological and societal values.

On the other hand fertility, the ability to reproduce (Markos and Seyoum: 1998) has not associated only wit child birth but it has so many implications on health status of the mother in particular and the child, the family and the community in general(Allan R.:1987,1). However, the health problems of mother and children in relation to fertility behaviour could be minimized through the practice and Intervention of family planning programs especially by using modern contraceptives.

A prominent feature of patriarchal society, like an indigenous peoples of Benishangul Gumuz region is characterized by gender inequality and the subordinate status of women, which it contributes to high fertility due to the fact that male oriented societies generates strong preference for off spring, especially for sons by limiting women reproductive roles, rights and by fostering on a complete dependence of women upon men for protection and economic support on one hand, and limits the autonomy of women and thus their willingness to engage in innovative behaviour that require for the adoption of contraception (Dyson and Moore: 1983:35).

The above features and the problem of adoption and practice of family planning methods, contraceptive, are largely existed among the Benishangul gumuz region, especially women, and hence their fertility behaviour has been normally governed by nature than practising of modern FP methods to maintain the desired number of family size. This in turn brought to the large extent of tremendous problems of socio-economic and psychological problems with in the family.

According to the 2000 Ethiopia DHS Report, in the given region of the study area, there are only two hospitals with 259 beds, 4 & 66 health stations, and Clinics respectively. When we look at the corresponding numbers of medical personnel, only a total of 417 medical personnel's were working in the region, of which 21, 19,201 and 2 are doctors, health officers, nurses and pharmacists respectively and others are junior nurse, laboratory and x-ray technicians. When we compared with other regions the region is characterized by having the least number of medical personnel of the country. (CSA: 2003,).This implies that one doctor serves to 28,286 persons and one bed available to more than 2113 individuals. However, the region is characterized by different top leading mortality and morbidity including high level of maternal and infant death, HIV\AIDS infections, Tuberculosis, and other environment related diseases like malaria and so forth (Ibid).

The tendency of high fertility rate among the majority of the Ethiopian women (5.7 and 6.3 children in urban and rural areas respectively), has been subjects health status of women to various maternal and child health problems as well as to different social and economic introubles. These in turn undermines the possibilities of maintaining mothers life' and children from the risk of danger (due to high fertility rate) through the practice of modern contraceptive by spacing and

postponing child bearing and thereby reducing the level of maternal and infant mortality as well (Trussel).

1.3 Significance of the Study

Available evidence portrays that by the 1970's the rate of population growth in most of the countries of the African region was high owing to high fertility. Ethiopia is one of the countries with large population size due to high rate of fertility and quite lower level of contraceptive prevalence rate. Rapid population growth due to high rate of fertility and slight decline of mortality would brought about an adverse consequences in all spheres of development, specifically unemployment which implied high dependency burden and affects consumption patterns, capital formation , poor economic performance, high demand for social services ,and a decrease in resources (National Research Council 1993).

To avoid the adverse consequences of rapid population growth, many countries had developed regulations to their own country. Ethiopia is one of a country having high rate of population growth. The nation had developed her population policy in 1993 with the aim of reducing the current TFR of 7.7 children per women to approximately 4.0 by increasing the prevalence of contraceptive use from the current rate of 4.0 Percent to 44 Percent by the year 2015 (population, sustainable natural resource & and development in Ethiopia: 1996, 15).

Access to reproductive health care has been the major concern in Ethiopia. The health statuses of Ethiopians, especially Ethiopian women are extremely below the normal standard.

The high level of fertility Ethiopian in general and Assosa town in particular has, thereby, causes a serious of health problem on married women and child health. In Ethiopia, too many births, closely spaced (less than two years apart), and too early pregnancies were common phenomena, which in turn deteriorates the health status of many mothers (Markos and Seyoum, 1998). This is due to the fact that unmet need for family planning is very high. The major cause for the existing problem is, lack of access to family planning services, lack of knowledge, or level of women education, fear of side effects of contraceptive, husband disapproval of family planning use and other factors including socio – cultural and economic factors.

The problems were predominant in the region, Benishangul Gumuz regional state, which are characterized by lower level of socio – infrastructure development viz, poor development of health and educational institutions, lack of adequate and qualified personnel, lower standard of living of people in the town and educational status in general, and subordinate position of women to men, inequalities in terms of access to various social and economic values, including enrolment to various levels of education, access to basic reproductive health services to women in particular.

According to MOH report (1995), there is a total of 85 hospitals with 9675 beds, 187 health centres and 2470 health stations in the country. Among these only 2 hospitals, 4 health stations and 33 clinics were found in the region (Benishangul Gumuz regional state). Even though the facilities which are located in the areas that are inaccessible to the majority of people living in the rural areas, and nevertheless inadequate services they offer to urban peoples, these small number of institutions are found in two or three specific urban areas of the region.

Therefore, in the given region married couples had poorly practiced contraceptives because of not only due to poor access of contraceptives on average of 9.1 percent (DHS: 2000, 42) but also faced poor reproductive health and other services. So a number of couples lack access to knowledge of family planning services needed to space or prevents their pregnancy. These inadequate health facilities would also leads the people to vulnerable for various fertility related complications including abortion, infection, sever bleeding during labour and child mortality and generally to illness and death from unwanted and complications of pregnancies. However, it is believed that accessibility and affordability to family planning services will prevent pregnancy and reduce the fertility level as well as helps to protect the women's and child health, and preserves the well-being of the whole family which offers an opportunity to determine the number and spacing of the children, which is essential to well growth of the children as well.

Furthermore, the problem is more intensified in the region, like other Ethiopian societies. It is due to the fact that women in the region are traditionally involved in different endangering cultural and societal practices like circumcision and other forms of genital mutilation. All these practices lead to death acute pain, infections, mental trauma, painful intercourse, and complications during childbirth. The women are also usually faced multiple discriminations on the basis of age, sex and income status. So they are facing segregated from some of the socially prevailed and economically valued activities that make them disadvantageous, like access to basic health service including the availability of contraceptives and to education and other services, just because they are women!

Much has been said about the region, their settlement pattern, the process of socio cultural interactions of each other including Shinasha, Agew Oromo, Amhara, and others (Tewodros S.1981) ethno cultural study (Bender M:1987), the type of language (Tamer W, 1986). However, it is possible to say that no work on the reproductive health aspects specifically the practice of family planning for the region especially on married couples is carried out so far. To sum up, it is being increasingly realized that development could not be achieved without healthy status of the society, especially women and children.

Therefore, the socio cultural factors of the region in urban town of Assosa in relation to the practice of contraception of married women and unmet needs of family planning methods will be assessed in this study. This study also aims to fill the gap on describing and analysing the practices of contraceptives among the women of reproductive age group of the town, and accordingly to point out the potentialities for the institutions to sustainable interventions by explaining the major hindering factors in a defined area.

Furthermore, the researcher has made attempt of initiation for this region which was not so far touched by various researchers to give their due attention to women in particular and the region in general. Finally, it is expected that that the findings of this research study will become a source of information to further works by governmental, non-governmental or individual researchers to explore and find out the potentiality of the region for the benefits of the individuals living in the region.

1.4 Objective of the Study

1.4.1 General Objectives

- The major objective of this study is to assess and identify the factors associated with contraceptive use of married couples aged 15-45 years in Assosa town.

1.4.2 Specific Objective

- To examine the patterns of contraceptive use among currently married couples.
- To examine the decision making about the use contraceptive among couples with in the family.
- To assess their KAP of contraception.
- To identify the major social, cultural economic and demographic factors of family planning practices among married couples.
- To examine availability, accessibility and demand of FP in the town.

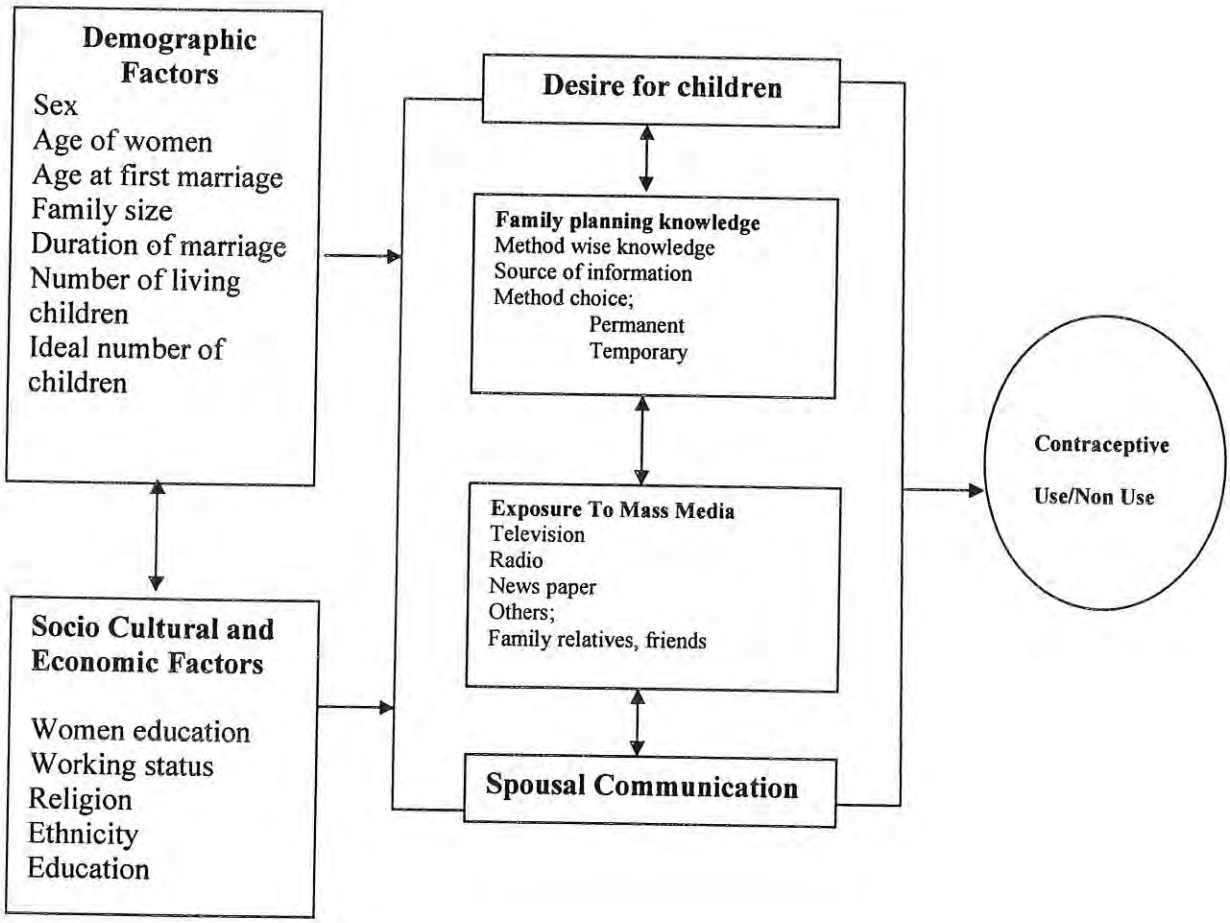
1.5 Hypothesis

To study the patterns of contraceptive use and identify the associated factors the following hypothesis were employed.

- Married women who desire to have more children are expected to have relatively lower percent of contraceptive use.
- Increasing availability of FP service generally will increase the likelihood of contraceptive use.
- Women education is positively associated with knowledge towards contraceptive methods.
- Communication with husbands on family planning issue positively affects the contraceptive use.

1.6 Analytical Framework

Based on the review of the literature and objectives of the study the analytical framework of this research is;



Source: Developed by the author

1.7 Limitation of the study

The study was carried out at Assosa town of Benishangul Gumuz regional state of Ethiopia. The study population have composed of peoples from different socio economic characteristics, of which over half of them were practicing different types of family planning services.

Demographic data obtained from such cases might have distorted by so many problems due to the fact that the influence of socio cultural factors affects the individuals behaviours to express the actual matters of their life .The number of children, as one of the demographic variables is the one that influence the use/non use of contraceptives among women.

In the study area due to strong traditional believes ,i.e. specifying the exact number of living children would endangering the life's of their living children, direct ways of questions were not intended to ask women during the survey.

There is also expected a greater tendency of the respondents which were prone to underreport short intervals of contraceptive use because of recall lapse, religion factors and so forth. This was clearly shown the method they currently using and the time period they were using without interruption.

Meanwhile, possible efforts had been made during surveyors training to reduce the magnitude of errors thereby to generate reliable information from the respondents of the study area.

CHAPTER TWO

2.1 REVIEW OF RELATED LITERATURE

2.2 Introduction

Most of developing countries, characterized by rapid population growth, family was the centre of economic and social life and land is the source of economic base, which predominantly belongs to men. This in turn determines the relative dependence of women upon men (population sustainable natural resource and development in Ethiopia 1996.). On the other hand inheritance which is one of the sources of inequalities particularly in developing countries is largely through the mal kin. This gender bias is often enforced by religion which limits a women's likelihood to engage in innovative behaviour such as on contraception and the acquisition of other ideas and tests which are inimical to high fertility and thus enhance contraceptive use (ibid.).

Reproductive health interventions targeted at specific groups of the societies, are relatively new phenomena in Africa, established in the late 1970s. Most of the programmes are educational and are delivered via youth centres, peers, media, and schools. Few of these programs provide sexual reproductive health services essentially after a recent alarming rate of HIV/AIDS infections in young adults (Annabel L, 2004).

According to Join &William (2002) there is an estimated 111.6 million women in developing world who have unmet needs for contraception. About 113.4 million married couples (of whom 55.6 million wish to space births and 49.8 million wish to limit further childbearing), 8.4 million women are unmarried. Asia contains 61

million married women with unmet need, or 587 million of the total for the developing world. Sub-Saharan Africa contains 42 million (22 percent of the total), mostly because of the large population of Nigeria, Ethiopia, South Africa, Egypt and the democratic republic of the Congo (Bongaarts and Brucel 1995: 139).

2.3 DEMOGRAPHIC, SOCIO-CULTURAL, ECONOMIC DETERMINANTS

2.3.1 DEMOGRAPHIC FACTORS:

2.3.1.1 *Age and Marriage*

Demographic variables are the major determinants of the fertility regulation thereby contraceptive uses. Age is one of the demographic factors that socially and biologically associated with fertility period of the individuals. Different studies reveal that as the level of age increases information on reproductive health, the type and uses of FP methods of individuals will be increasing. In most of African society, the level of age is strongly associated with the formation of marriage, and currently married women have the greatest degree of exposure to the risk of pregnancy and to continuous procreative life except in cases where the husband is absent for a long period of time (Guffikin L,1988: 17). Also, with the increase of age slightly increase knowledge of FP methods recorded among all women and men (DHS: 2000,47).

2.3.1.2 Number of Children Alive & Decision-Making

Decision on the use of contraceptives and the number of children alive are other determinants of FP use or not .One of the important use of FP is for either spacing or limiting births, avoid mistiming or unwanted pregnancies. Younger women with no children, their contraception use at lower parities are generally lower than older

women and urban. In addition, educated women are found more likely in urban than rural areas to make an independent decision on current use of contraceptives (EDHS: 2004, 59).

2.3.2 SOCIO ECONOMIC & CULTURAL FACTORS:

2.3.2.1 Individual's Behaviours, Societal Values, And Religion

The behaviour of all human beings is by and large an outcome of so many forces. Socially determined behaviours, even though not primarily directed towards the use and non-use of FP practices, can nevertheless have an important effect on the practice of contraceptives. In developing countries, including Ethiopia, the socio-economic and psychological values of children had been strongly associated with the traditional norms of women in their community and procreation of many children considered to be a blessing of God instead of checking their birth through contraceptive uses.(Marcos & Seyoum:1998.259).

The individual behaviours and their fertility regulation could also be affected by cultural norms, values and taboos of their respective societies; for example, society dictates the standard behaviour with regard to marriage, the frequency of sexual intercourse, the use and non use of contraceptives (Ronald L: 1996, 12).

In countries where the dominant religion is pro-natalist, and religious belief is strong, it is positively associated with contraceptive uses and regulation of their fertility level. Islam, for example, favours the large family but not against the use of contraception, but against permanent contraceptives (Ibid, 20). However, in many third world countries people do not speak about determining the number of children

they will have because "only God knows "how many children a women will bear (Gaffikin L: 1988,89).

By considering these and other factors different countries had been set their own national population policies, to maintain the desired number of their population size to the corresponding sustainable use of their natural resources. Apart from the importance of IEC in national development and enhancement of the process of socio-economic, political and cultural changes, FP service delivery become one of the action programme, which enables the individual and couples to have children by choice and also ensure the survival of mothers and children's (population, sustainable natural resources & and development in Ethiopia: 1996,18).

2.3.2.2 Education

Education is one of the most pervasive impacts on fertility of women among the various socioeconomic variables, which affects fertility through reducing the duration of exposure to conception by delaying age of entry in to marriage, and decreasing traditional ways demand for more children. The impact of education has been positively associated with contraceptive practice; thought has negative impact on breast feeding. On the other hand different literature revealed that education has strongly influenced women by exposing to new ideas and skills that enhance their marketability in the modern labour market (ibid. ;65).

It is unfortunate facts that in many countries adolescents and even many adults have particularly no knowledge of their own human reproductive system and how they function (Fred T.1987, 20). Education has been found to be an important socio-

cultural factor that enables women's to have knowledge and being aware of her reproductive life. The level of information among male and female population vary due to the variations on the socio-cultural and economic differentials. Nevertheless, education is one of the most important means of empowering women with knowledge, skill and self confidence thereby addressing the practical needs of women in their reproductive health, including the practice of contraceptive use (Markos & Seyoum: 1998,), but participation of female students due to the traditional value system, distance of the students residence from the school affects their awareness towards their reproductive life and then contraceptive use (Kwast et.al.,1986).

According to EDHS (2000) report educational attainment of the spouse in Ethiopia, about three fourth of women and more than half of men have no formal education.

Among both the couples who attain education 14 Percent of all women and 29 Percent of men have not completed primary education. In the case of Benishangul Gumuz, 76.4 Percent women and 46.6 percent of men have no formal education respectively, and only 2.4 percent of women and 8.2 percent of men were completed their primary school. The level of education of the individuals significantly affects their knowledge towards contraception. Information on knowledge of family planning methods provides measures of the level of awareness of contraception in the population. The effects of contraceptive knowledge have been more manifested among reproductive age groups. Knowledge is slightly higher among currently married couples than all women and men. However, Ethiopian men are more likely have heard of various contraceptive methods than women. Therefore, only 10.5 percent of women and 17.4 Percent of men had listened to the radio at least once a

week (DHS;2000) .The difference in exposure to other mass media is also significantly varied among women and men (Robert B et al 1996.)

The EDHS (2000) data indicated the knowledge of contraceptive methods among currently married women and men, about, 68.5 Percent of women and 77.6 Percent of men reported as they know any modern methods (i.e pills, IUD, injectables, diaphragm/foam/jelly condom, female and male sterilization and implants etc.),while only 8.5 Percent of married couples have been currently using any modern methods of which 2.2 Percent of pills, and 5.7 in Percent injectables.

2.3.2.3 Availability, Accessibility and Acceptability of FP Services:

The availability of the safe pregnancy termination services, that is, prevention of unwanted pregnancy is another important contribution of family planning through which it decreasing unnecessary exposure to risks of pregnancy and child birth there by decreasing child maternal mortality and morbidity. According to WHO estimation (1996), on average 450 per 100,000births of maternal mortality has been reported, that is one maternal death for every 220 births in developing countries, while the total fertility rate (the average number of births per women) in developing countries declined from 6.1 in 1965-1970 to 3.9 in 1985-1990 as the results of contraceptive use. On an average, every woman has been able to avoid 2.2 unwanted births. A rough estimate stated that in developing countries today one out of every 100 women is being safe from an unnecessary maternal death through family planning, which indicates the possible chance of decreasing the number of maternal

mortality and morbidity if the problem unmet need for contraception will eventually decreased (Charles H.1983).

It is the fact that most family planning methods that are now available have been manufactured or discovered in western countries and their availability to the countries with different needs and different organizational structures is handicapped (Fred T, 1987; 20). Contraceptive prevalence rate, which is the proportion if women of reproductive age (15 _49) who are using (or whose partner is using) a FP method at a particular point in time, determined by the Availability, acceptability & accessibility of FP services. (Markos & Seyoum: 1998, 43).

The knowledge of contraceptive use will vary among the individuals which will basically depend on the level of education, age, socio cultural availability, acceptability and accessibility of the services (ibid: 66). The delivery of FP service s is generally found to be with formal health institutions. The positive desire to have many children among the individuals would affect the availability and acceptability of the services to be used (Charles H 1983). One way of being more precise about what determines the acceptability of contraceptive methods is looking not only at its effectiveness and safety but also at the behavioural components related to its use, including behavioural questions like what part of the body is affected, how often it is used, for how long is it effective, etc. (Nancy L.1985, 258).

2.3.2.4 Information & Exposure to Mass Media

Information is one of the instruments that enable peoples to have an idea about specific things. Many conducted studies reveal that the broadcast and printed materials, like journals they read, the radio and television they listen to or watch, affect the individuals. The messages they release influence the individual in general and their sexual behaviours in particular. They play a profound role in disseminating family planning, health, and other information (DHS: 2000, 21). Apart from these, the influence of others who are similar and equal Characteristics like peers, teachers & respected others, which affect the behaviours of individuals including the use of contraceptives (Markos & Seyoum: 1998, 135). Here it is noted that the information provided by the peers might not be complete & correct and is recommended to supplement by other more reliable sources (Ibid). On the other hand many couples want and need effective contraceptive services. However a large proportion of this felt needs goes unmet. This is not only due to lack of information but also due to mismatch allocation of resources required to fulfil the needs, inefficient policies and policy maker's reluctance to fully support total effective family planning (Chaudhury, Rafique 1983).

The practice of family planning is compatible with high fertility on both an individual and a national level. Contraceptive information and services may be supplied and utilized for the planning of reproduction, but there are tools that individuals can see to any end (UN, 1975: 10). If the motivation for large number of children is high, if couples want to being child bearing early and space their children close together, and do so, then they are infact practicing "family planning" .on the

other hand low levels of fertility may be through unwanted or unintended consequence of sub fecundity, sterility or other cultural practice, rather than of deliberate attempts to limit birth (population report,1995.).

2.3.3 Family planning and Health

WHO defines health as a state of complete health, mental and social well being. This definition of health may not be readily attainable by the majority of the human individuals. On the other hand health is not merely the absence of disease or infirmity. The ability to regulate and control fertility and its relation with family planning is one of the basic aspect of which viewed in the context of positive definition of health of women. It is clear that unable to regulate and control fertility cannot consider as being in a state of complete physical, mental and social well being. On the other hand too many ,too close ,too early and too late pregnancy are the major causes of maternal, infant and child hood mortality and morbidity (UN;1984). If it is so, a women cannot have the mental joy, if pregnancy that is unwanted, avoid the mental distress of a pregnancy that is unwanted and pursue social health by planning her life, continuing her education and enjoying both a productive and a reproductive career (Mahmoud F, Fathalla,1996;203).

A woman with unwanted pregnancy cannot be consider to be in a good health, which recognize the basic role of family planning in any strategy for safe motherhood and child survival, indicates the importance of family planning and the interdependence of services for a better health of women thereby well beings of the whole family.

According to UN report (1990) half a million mothers die each year from causes related to child birth, for every mothers that dies children are left motherless, and

their chance of survival, health growth and development will be affected and thus underlined the need of responsible family planning for spacing and maintains the required family size. Maternal mortality, the scandal event of all times, has shocked the world. According to the WHO, estimation more than half million of women die each year due to complication related to pregnancy and child birth (WHO,1991). The problem have much more devastating effect in developing countries of which are characterized by poor socio-economic infrastructure including maternal and child health services of Africa, Asia, and he Caribbean countries. The tragedy of maternal mortality is that it can be possible to prevent or effectively to manage all potential life-threatening complications related to pregnancy and child birth with smaller investment on family planning (population report, 1995). Thus the world now recognized that family planning can save the lives of mothers, by preventing the exposure of women to the risks of pregnancy, which they do not want and by allowing women to plan their pregnancies to take place at times that are more favourable for safe child bearing (UN,1996:2004).

2.3.4 Barrier to Contraceptive Development

The existing developments of contraceptive methods have been passing through different challenging processes. From its relative importance, worldwide access to family planning is crucial with the current higher rates of unintended pregnancy, unsafe abortion, and poor maternal and child health, sexually transmitted disease (STD), including HIV/AIDS, and unprecedented human population growth (J. Speidel: 1996). There are various socio cultural economic, political and legal barriers which shall be addressed to improve the wider acceptance of the existing methods as well as the development of the new contraceptives.

Birth control or the practice and adaptation of family planning methods have become highly associated with political issues. It is obviously known that any methods that negatively perceives by political arena of the given system might be faced not only practical obstacles, such as the lack of funding and difficult regulatory procedures, but major moral and political controversies(ibid, 1996).

On the other hand the political burden that affects birth control has relation to human sexuality (Ullah M and Chakrabory 1993). Contraception and abortion have a broad spectrum of issues relating to human values and morality. Decisions concerning the users and development of new methods go beyond part of the users. Hence, societal beliefs influence family planning acceptance, in other cases some religious conservatives claiming that easy access to contraceptives has been encourages promiscuity.

The claims of these religious beliefs has been influences the development of new methods as well as user behaviours, for instance, in the case of catholic, any development of and access to family planning methods apart from periodic sexual abstinence have been condemned. In the case of USA, abortions were legally unacceptable unless it threatened the life of the females. Both the public and the research community in the US have often underestimated the time and the cost of contraceptive development. This tendency has been profound impact on the level of acceptance, perception towards the safeness of the methods among the users (ibid, 443).

2.3.5 The Study Area and Data collection

The central concern of this study is to access and create understanding of why women of currently married living in Assosa town use contraception while others do not, living in the age 15-49 in the given city of the study area,Assosa. They are found to be the eligible target of the study. Furthermore, fecund, non pregnant, non-amenorrheic and other sexually active women that living together with their husband was being considered for the analysis of current use of contraception. This is because these group of currently married women are more likely to use contraceptives and they are affected by factors in which the risk of exposure to conception is very high. The study is, therefore, confined to currently married women living with their husband. House hold survey was carried out to collect data on socio economic and demographic characteristics of currently married women, their KAP of contraception as well as the characteristics of their husband current use of contraception, and reasons for not using any contraception methods.

2.3.6 Field Work

The field wok activities were started from the first March 2005 and collected the relevant data /information, for the purpose,16 enumerators and four supervisors were involved of which only four of them were involved for supervision and the rest of them, were female enumerators.

This was made due to the fact that socio cultural factors become strong barrier, to make free communication on issues related to the reproductive heath and matters with opposite sexes. Female interviewers were assigned to collect data instead of males because females can easily approach to the given eligible households and may be able to generate more reliable information than males. All enumerators and supervisors were 12 grades completed and had different experience on issues related with the family planning consumption household survey.

For all enumerators and supervisors a three day intensive training was given, for the purpose of the study and the content of the questionnaire, and for the expected code of conduct during they contact at the first place with the eligible women, before the house hold survey was carried out. During the data collection, four informants/guides/ were also involved in identifying the houses of the selected household. And frequent and closely supervision was made during the household survey by supervisors. The completed questionnaire were reviewed and checked whether they filled correctly, accurately and consistently by investigator, then after the data had been prepared for the next process.

The dependent variable is women's use of any method of contraception, while, socio economic and demographic characteristics as well as family planning including accessibility, availability etc are comprised as a set of independent variables.

2.3.7 The Study Design

The study will be based on the primary data generated through a household survey of married women aged 15-49 living in Assosa town. Both qualitative and quantitative data were used, the household survey provide data for the quantitative study, and focus group discussion were held, for the qualitative data, which helps to strength the information obtained by quantitative methods, and fills the gap for the quantitative analysis.

2.3.8 Sampling Design

Households are the primary sampling units in this survey. The study covered all the kebeles of the town. The list of households (obtained from the kebele administration), is used as a sampling frame, then using PPS to each kebele, sample size of house holds were allocated. The household's selection was done by systematic random sampling method to determine the required currently married women aged 15-45 for the survey. Based on the sample size is determined, each kebeles was represented in proportion to the size of its households.

2.3.9 Sample Size Determination

The sample size for the study has been decided by following scientifically used technique. The level of contraceptive prevalence rate in the region, i.e. 9.1 percent,

according to Ethiopian 2000 DHS which is too low to use this rate as population proportion (P) in determining sample size of the study. Furthermore the study is not only designed for univariat analysis but bivariate and multivariate level of analysis also carried out .

Therefore, to meet the criteria of each expected cell frequency for each predictor in analysis and not to be less than 50, the procedure was used for determining the sample size recommended by Andrew et.al, 1991 is given below as such:

n=50/Ps, where Ps =proportion of totals cases expected in smallest categories of the Variable.

In this study Ps =0.091(proportion of couples using contraceptives in the region EDHS 2000).

Hence, n=50/0.091=549+10 percent contingency (54.9)

≈600

This procedure of determining sample size should fulfil the following criteria

- Allow for reliable analysis of cross tabulation
- Provide desired level of accuracy in estimates of proportions ,and
- List for significant of differences between proportions

2.3.10 Method of Analysis

The method of analysis was made by using SPSS PC and employing both descriptive and multivariate statistical technique. Logistic regression has been employed to determine the relative importance of a set of predictive factors upon the response of variables by controlling the possible confining variables , after identifying the most important factors affecting contraceptive use through bi-variate analysis. This is because the objective of this study was to explore the relationship of a dichotomous dependent variable (contraceptive use and non use) to one or more independent variables. The logistic model has two possible advantages that the analysis and interpretations are similar to the procedures of multiple regression techniques (Draper and Smith, 1991 cited in Halli and Rao, 1992) and the method is a form of dummy variable regression typically characterized by its ability to handle both non interval and nonlinear relationship.

The method is the one on which the natural logarithmic of the odds of the dependant variable is predicted by a linear function of the predictive variable. In the model a set of independent variable are expressed as a dummy variables and the dependent one with binary response (i.e. contraceptive use)

The model is stated as follows.

In (P/1-P) =Bo + B1 X1B2X2+ . . . +BkXk

WhereP/1-P-refers to odds ratio (contraceptive use/Non use

X1, X2,, . . . , Xk- a set of k continuous (and/ or dummy) predictor variables

B-Beta coefficient/regression coefficient. The logistic regression model parameters represent the decrement or increment in log odds for the category coded "one" as opposed to those coded "zero" holding all other factors constant.

The model is useful when we want to predict the presence or absence of out comes based on values of a set of predictor variables. It is suited to models where the dependent variable is dichotomous. Logistic regression coefficients can be used to estimate odds ratio for each of the independent variables in the model.

CHAPTER THREE

3.1. BACKGROUND CHARACTERSTICS OF STUDY AREA

The study is carried out in Assosa town, the capital city, and are largest population density among other urban areas of the region (Benishangul Gumuz), which is located 675 kilometres west of Addis Ababa, & a population size of more than 20,000, of which about 10, 757 are males and the rest 9, 263 are females. The town is purposely selected based on its ethnic, religious compositions and high population density. The excluded zones and special woreda (districts) have low population comprised of scattered population. Like other major towns of the country, Assosa consists of peoples from different ethnic, religious, and socio-economic groups. The major ethnic groups resides in the town are Berta, Gumuz, Shinasha, Oromo, Amhara, Agew, and others. Similarly, Muslim and orthodox Christians are the two major religions practiced in the town. Administratively the town is divided into four kebeles, the last administrative system of the town. In the town there are different socio economic and infrastructural services were established since the last ten years, including health services. Family planning services in the town started about 20 years back by the established governmental health institutions, , health station. Since then the services were mainly provided by government health institution, including health centres, hospital, clinics as part of maternal and child health program. Nowadays, modern contraceptives methods are available at the drug vendors and Red Cross pharmacy.

The fertility intention and contraceptive behaviours of women are the out comes of different back ground characteristics or factors. Of which certain socio economic and

social class, religious and ethic groups belong to certain demographic characteristics. Like age, sex, fertility preference etc. are some of the factors for the sampled women that the study was covered.

3.2. Demographic Characteristics

3.2.1. Age Composition

The largest age group of the respondents is age group 25-29 which is characterized by the peak fertile age which constitutes 31.64 percent. On the other hand the proportion of the early age groups, i.e. 15-19 is only 5.3 percent, the proportion of the respondents tends to decline with the age. For instance respondents in the age group 30-34 and 35-39 represent 19.7 percent and 12.9 percent respectively. Those in the age group40-44 and 45-49 represent 7.3 percent and 2.2 percent respectively (Table3.1).

Table 3.1 Percent distribution of respondents by age desire to additional children & intension to pregnancy, Assosa, 2005.

Age group	No	percent	Children born		Desire to have Additional children	No	percent	Delaying Next pregnancy	No	percent
			N	percent						
15-19	31	5.3	15	2.9				Yes	316	55.7
20-24	123	20.9	84	17	Yes	213	36	No	68	12
25-29	186	31.6	158	31	No	203	34.3	Don't decided	40	7.1
30-34	116	19.7	110	22	Not decided	34	5.7	God know	128	22.6
35-39	76	12.9	87	17	God knows	140	23.6	Don't know	15	2.6
40-44	43	7.3	40	8	Don't know	2	.3	group total	567	100
45-99	13	2.2.	11	2	Group total	592	100			
Total	588	100	505	100						

NB: The total number of sample population was 600. However, some of them were not fully responded to all questions and shown the missing cases in most of the table format.

In the study area information is collected on women desire for additional children and fertility size. Therefore, 36 percent of sampled women would like to have additional children while 34.3 percent do not desire to have additional children. This figure is strongly supported by the result for the question of "the main reason for not using contraception? In the case the majority of whom which is 27 percent responded as they want to become pregnant (Table 3.3). On the other hand concerning to the same questions, 5.7 percent and 3 percent of women were not decided and don't know, respectively, while 23.6 of the study population responded that they don't know but God knows the subject (Table3.1).

Concerning to their motivation towards pregnancy, 55.7 percent of women responded that they want to delay the next pregnancy, which represents more than half percent of the total respondents, while 22.6 percent were not known about the next pregnancy and 7.1 percent and 22.6 percent of respondents reported that they

had not decided until the survey was made and it is up to God, respectively (Table 3.1).

Concerning to the experience of child birth, the large number of child birth is observed among age group 25-29, followed with 30-34 age group. This indicates that the current status of women's fertility is higher among the two age groups and it goes down with the increasing of age. (Table 3.1). It was surprising to mentioned that the majority of respondents at the time of the interview would not like to state exactly their actual number of children.

It can be seen from the table 3.2, that shown 40.7 percent of the women had experienced first marriage at the age of 19 and above. This indicates that the practice of marriage in the urban centre of Assosa town was not made at teenage period but this doesn't show marital practice of all population of the region, while 29.4 percent women had practiced first marriage before age 16. This figure corresponds with the age at first birth of the women. Therefore, the large number of birth is observed with in the age group 17-19 and 20-22, which is 39.4 percent 29-8 percent respectively. With regard to the incidence of abortion, 33.7 percent of the respondents reported that their have pregnancy ended through abortion. (Table 3.2)

3.3. Socio Economic Characteristics

3.3.1. Education and Work Status

Educational distribution of the respondents presented in table 3.2, shows that 78.6 percent of women are literate and 21.4 percent can neither read nor write. Of those women who had formal schooling the majority of them are between 9-12 grade which holds (39.2 percent) of the total women while only 9.7 percent of sampled women reached 12 grades and above. This shows that educational levels of women are relatively lower. For secondary and above table 3.2 also shows the percent distribution of respondents by their occupation. Those respondents engaged in agricultural sector accounts 56.5 percent and 41.0 percent of them engaged in non agricultural activity. About 3 percent of women found to be engaged in other activity.

Regarding to the work status, women respondents indicate that more than 50 percent of them had not have work at the time of survey. The occupational classification of respondents indicates that the largest group of currently working women were engaged in small level of office work and earn below 301 birr/month which is indicated in table 3.2. Of these workers the majority of respondents were working in government offices, followed sales workers and professional works they accounts only 2.5 percent the total population studied.

Table 3.2 The Distribution Of Respondents By Selected Demographic and Socio Cultural Characteristics, Assosa, 2005.

Place of birth	N	percent	*Abortion*	N	percent	*Occupation*	N	Percent	*working for*	N	percent
			Yes	190	33.3	Agriculture	322	56.5	Self	143	42.3
Urban	310	52.3	No	381	66.7	Non Agriculture	234	41	Government	167	49.4
Rural	283	47.7	Total	571	100	Others	14	2.5	private	116	4.7
Total	593	100				Total	570	100	Others	12	3.6
			Read & write						Total	338	100
Age at first marriage			yes	463	78.6	*Income*					
			No	126	21.4	No	210	35.5	*Ethnicity*		
<16	115	20.4	Total	589	100	50-150	87	14.7	Shinasha	38	6.5
16-18	219	38.9				151-300	125	21.2	Gumuz	22	3.8
19+	229	40.7	*Highest Grade*			301-450	67	11.4	Berta	46	7.9
Total	563	100	*completed*			450+	101	17.1	Maokomo	12	2.1
						Total	590	100	Oromo	187	32.1
			<6 Grade	92	19.6				Amhara	170	29.2
Age at fist birth			6-8""	140	29.5	*Religion*			Tigre	4	0.7
			9-12"	181	39.2	Orthodox	214	36.8	Kembata	8	1.4
14-16	67	15.3	12+	41	9.7	Protestant	104	17.9	Wolita	41	7.0
17-19	173	39.4	Others	9	1.9	Catholic	35	6	Gurage	50	8.6
20-22	131	29.8	Total	463	100	Other Christian	84	14.5	Others	4	0.7
23+	68	15.5				Muslim	114	24.8	Total	582	100
Total	439	100				Total	581	100			

NB: non agricultural occupation includes women's engaged in petty cash and small scale trade activities, while others includes professionals, office workers, administrative staffs etc.

3.3.2 Ethnicity & Religion

Table 3.2 is indicates the ethnic distribution of the respondents. In the region (Benishangul Gumuz). there are 5 ethnic groups viz Gumuz, Berta, Shinasha Mao & Komo which they are characterized by natives of the region, besides, some others different ethnic group are also found in the region. Table 3.2 shows that Oromos' constitutes the largest group of the sample, (32.1 percent) followed by Amharas' 29.2 percent .Gurage 8.6 percent, Berta (7.9 percent), Shinasha (6.5 percent),Gumuz (3.8 percent) ,wolita (7 percent) and others (0.7 percent.).

The data table further reveals that the overwhelming majority of the study population was orthodox Christian (36.8 percent) while Muslims counted about 24.8 percent, protestant other Christians and Catholics constituted 17.9 percent, 14.5 percent and 6 percent respectively.

3.3.3 Income and child hood place of residence

The data on place of birth reveals that 52.3 percent of the respondent's reported that they grew up in urban areas as compared to 47.7 percent of rural areas. The larger proportions of the sampled women are urban born. Regarding to the income status of women 14.6 percent of women earn below 150 birr /month and 21.1 percent of belongs to income group 150-299 birr month. This indicates that more than one third of the study respondent had income below 300 birr /month. Another report of women's income status indicates that 17.8 percent of women earn 450 birr and more per month (Table 3.2). Information on the cost of contraception method indicated that 83.6 percent of reported that the cost of the method is cheap.

Regarding the contraceptive use, respondent asked whether they were using a contraceptive method at the time of survey. It is found that 60.8 percent (Table 3.3). Injection become the most widely used practice, followed by pills 23.5 percent then condom 1.7 percent, abstinence (4.5 percent) cultural medicines like herbs and the like (2 percent). 18.9 percent of women reported that they never used any method

(Table3) In general of the overwhelming majority of the respondents of current uses 60.8 percent depends on modern types of methods than traditional ones. (Table 3.3)

Concerning to the reason for using a method about 45.7 percent of the respondents indicated for the purpose of spacing births, while 29.8 percent were using to limit their family size and 22.2 percent were reported as to avoid any pregnancy. The proportion of the study population who are using contraception for the purpose of medication is only 2 percent (Table 3.3).

The percentage distribution of women who are exposed to risk of pregnancy but did not using any method at the time of survey is presented on table 3.3 by major reasons of not using any method of birth control. Accordingly 27.1 percent of women cited the principal reason as they wanted to become pregnant, followed by post partum or breast feeding (20.2 percent). The other reasons reported by the non users are husband disapproval (18.8 percent), in fecund (12.8 percent), religion prohibition (6.9 percent), lack of knowledge (6.1 percent) and opposed to family planning (6 percent), are indicated as major reasons by study population.

3.4 Knowledge Attitude and practice of contraception method

The practice of contraception of women on the use or non use of contraception methods widely depends on the level of development as well as awareness of women, and the type of the methods. It is largely rely on the level of knowledge of women and the dissemination of information to the population. A women on the other hand doesn't know about contraception is not expected to use any type of contraception method. Here the level of awareness and sources are essential precondition for contraceptive use. Respondents were asked whether they have heard of ways of methods that used to delay or avoid pregnancy.

Among currently married women of reproductive ages, 86.1 percent of these reporting that they have heard of at least one method of contraception (Table 3.3). The table reveal that Injection found to be the most widely practiced by women (51. percent), followed by pills (23.5 percent ., condom (1.7 percent), safe period (9.2 percent), female sterilization (1.5 percent),IUD (1.0 percent) (Table 3.3).

During the survey the attitude of the husbands respondents towards FP method were explored. It has been seen that, 88.1 percent of husbands of women had been positive attitude towards Family Planning the use (Table 3.3), while 11.9 percent women have expressed negative attitudes of their husband towards Family Planning methods. With regard to husbands approval, 68.7 percent of women reported that their husbands have approved to use Family Planning method, and less than one third of respondents also mentioned that their husband have either disapproved or they did not know about their husbands' feeling towards the practice of contraceptive use . (Table 3.3).

Apart from knowledge of contraceptive method, a question for the number of children a husband would desire to have" were asked the women. The majority of the women reported that their husband attitude towards the number of children has to be the same with them (51.4 percent), while (25.5 percent) of women stated that their husband would like to have more children than the mothers' desire, and only 19.4 percent of women said that their husband will like to have less number of children than the women desire. (Table3.3)

Regarding the supplies of the method, the majority of the women reported that they currently obtained modern contraceptives from youth association centres (81.2 percent), followed with private pharmacy. About 1.5 percent of respondent indicated that they obtain modern contraceptive methods from government health services (Table3.3).

Table 3.3 The percent of respondents by current use, knowledge of contraception, desire of husband for subsequent child , discussions with husband, reason for not using and attitude of husband and supply of family planning, Assosa,2005.

Method knowledge		N	percent
Pills			
	yes	533	28.2
	No	67	11.2
	total	600	100
IUD			
	yes	176	29.3
	No	424	70.7
	Total	600	100
Injection			
	yes	546	91
	No	54	9
	Total	600	100
Condom			
	yes	390	65
	No	210	35
	Total	600	100
Sterilization (female)	yes	305	50.8
	No	295	49.2
	Total	600	100
Sterilization (male)	yes	192	32.1
	No	407	67.9
	Total	599	100
Rhythm	yes	176	29.4
	No	423	70.6
	Total	598	100
Withdrawal			
	yes	206	34.4
	No	392	65.6
	Total	598	100

Method use		No	Percent
Pills	yes	**141**	**23.5**
	No	459	76.5
	Total	600	100
Injection	**yes**	**306**	**51.1**
	No	293	48.9
	Total	599	100
Abstinence			
	yes	27	**4.5**
	No	572	95.5
	Total	**599**	**100**
IUD	yes	6	**1.0**
	No	593	99
	Total	**599**	**100**
Condom	yes	10	**1.7**
	No	589	98.3
	Total	**599**	**100**
Diaphragm	yes	7	**9.2**
	No	590	90.8
	Total	**599**	**100**
Rhythm	yes	55	**9.2**
	No	544	90.8
	Total	**599**	**100.0**
Sterilization	yes	9	**1.5**
	No	590	98.2
	Total	**599**	**100**
Cultural	yes	12	**1.8**
medication	No	587	98.2
	Total	599	100
Not using	yes	**113**	**18.9**
	No	486	81.1
	Total	**599**	**100**

		N	percent
Husband Desire for Child	the same with	303	51.4
	less children	114	19.4
	more children	150	25.5
	Do not know	22	3.7
	Total	589	10.0
Supplies for FP	Private	66	14
	Government	7	1.5
	Youth association	384	81.2
	Others	16	3.4
	Total	473	100
Husband Attitude			
	yes	526	88.1
	No	71	11.9
	Total	597	100
Husband approval			
	Approval	409	68.7
	Disapproval	150	25.2
	Do not know	36	6.1
	Total	595	100
Discussion with Husband	Very often	328	55.5
	some times	126	21.3
	Not common	137	6.1
	Total	591	100
Reason for not using			
	Lack Of Knowledge	14	6.4
	Want to become pregnant	59	27.1
	Opposed FP	13	5.9
	Husband disapproval	41	18.8
	Religion prohibition	15	6.9
	Breast Feeding	44	20.2
	In Connivance	2	0.9
	Too Much Cast	2	0.9
	In Fecund	28	12.8
	Total	218	100

As indicated in table 3.4 out of 574 women who had knowledge of at least one method of contraception 27 percent of women were heard about FP information from their husbands. During the survey the second known source of information mentioned by the respondents are mass gathering (21.2 percent), Followed by from their friends, families and relatives (18.7 percent), family relatives (8.9 percent),and 16.1 percent from government hospitals/clinics. The distribution of women by information on FP which was obtained by the users through mass media is another source of information. The contributions of electronic Mass Media, radio, television have less paramount, which was only 12.6 percent

Table 3.4 The distribution of respondents by major source of family planning information, Assosa, 2005

	Source of information	N	percent
Source of information about family planning	Husband	130	29.3
	Friends, family and relatives	101	18.7
	Government hospitals and clinics, private health institutions	94	16.1
	Electronic Mass Media (Television, radio,posters etc.)	85	12.8
	Mass gathering ,school	108	21.2
	Others	56	1.8
	Total	574	100

3.5 Family Planning Service Availability and Accessibility

In order to examine about FP service accessibility and availability in the study area, information was collected from the respondents were; perceived travel time to the source, convenience of the source, price of the modern methods, knowledge of contraceptive methods, awareness of sources, whether the respondents have attended family planning education or exposed to any kind of mass media, adequacy of the services given and availability of methods by type of wanted by the respondents. As it has been already indicated earlier above 81.2 percent of women obtain contraceptives from youth association centres, followed by with private pharmacy (14.0 percent). Another source of supply of contraceptives is government

institution (hospitals, clinics, health stations) which accounts only the least service providers among the rest of supply sources.

Among the respondents who have knowledge of any methods and who are currently using any methods, about 54 percent had attended FP education sessions and 46.2 percent did not attend (Table 3.5).

Table 3.5 Percent Distributions of Respondents by Source of Family Planning Services, Price, Convenience, FP Education Attendance, and Availability Assosa, 2005.

Variables	Users			Users		Non-users	
Source	N	percent	**Price**	N	percent		
Private pharmacy	66	14	Free	225	69.7		
Government Hospital, Clinics	7	1.5	Cheap	72	22.3		
Youth RH Association Centers	384	81.2	Expensive	26	8.01		
Others	16	3.4	Total	323	100		
Total	473	100	**Family Planning education Attendance**				
Convenience			Yes	191	54	96	42
Convenience	284	86.3	No	164	46.2	134	58.3
Inconvenience	45	13.7	Total	355	100	230	100
Total	329	100					
Traveling Time			**Availability**				
< 15 Minutes	91	31	Easily available	200	60.1		
15 - 30 Minutes	149	51	Not easily available	86	26.9		
> 30 Minutes	54	18	Do not known	47	14.1		
Total	294	100	Total	333	100		

Among the respondents who are currently using contraceptive methods, 69.7 percent obtain the supply freely, (Table 3.5). Women who purchase the method reported that the price of the method is cheap (22.3 percent), while only small number of cases (8 percent) reported as expensive. The price of the method reported by the users ranges from 1.50 – 140 Birr depending on the type of contraceptive.

During the survey the perceived time to the source were asked the users. The majority of the users indicated that the perceived time on an average was 22.5 minutes to obtain modern contraceptives, they did used any mode of transportation for that matter.

The table sources of information for modern contraceptives reveal that 86.3 percent of the respondents had been found the place of the source convenient while for the remaining users (13.7 percent) it was inconvenient.

3.6 Prevalence of Contraceptive Use

During the survey the target groups of married women were asked for information on contraceptive use whether they have ever used any practice of family planning method in the past or currently using a method for fertility regulations.

3.7 Current Use of Contraception

For this study current use of contraception implies to those women who were not pregnant and currently using the method at the time of survey. Among currently married women of reproductive age (15-49) interviewed during the time of survey, 60.8 percent reported that they were using a contraceptive method, the remaining 39.2 percent were not using any form of contraceptive methods. With respect to specific methods as shown in table 3.3, injectables become the most popular and widely used among currently married women of the target population of Assosa town.

The percentage of its popularity is 51.1 percent which is more than half of the practices of pills. The second most frequently used method reported by the respondents were pills which was 23.5 percent followed by safe period or rhythm method (9.2 percent), followed by sexual abstinence (4.5 percent), cultural medication (2 percent), condom (1.7 percent) . the other contraceptive methods reported by the respondents were female sterilization(1.5 percent), and 18.9 percent were not specified any method.

Table 3.6 The Distribution of Respondents Exposed the Risk of Conception By Current Method, Purpose For Use and Sources of Modern Contraceptive Method, Assosa, 2005.

Contraceptive use	N	percent		N	percent
Users	365	60.8	**Source**		
Non users	235	39.2	Private pharmacy	60	14.0
Purpose of use			Government Hospital/ Clinics, Health Centres	7	1.5
Limit family size	137	29.8	Youth and Reproductive Health Centres	384	81.2
Space birth	210	45.7	Others	16	3.4
Medication	9	2			
To avoid pregnancy	102	22.2			
Others	2	0.4			

As it can be seen from table 3.6 the majority of the current modern contraception users rely on youth reproductive health centre, which is about 81.2 percent followed by private pharmacy (14 percent), government health institutions (1.5 percent) and others (3.4 percent)

Table 3.7 Percent Distribution of Women Who are Exposed to The Risk of Conception But Were Not Using Modern Family Planning Methods By Major Reasons, Assosa, 2005.

Contraceptive use	N	percent	**Major Reason**	**N**	**percent**
Non users	235	39.2	Post Partum / Breast feeding	41	17.4
			Inconvenience to Use / Method		
Major Reason			Failure	2	0.8
Lack of knowledge	14	5.9	Too Much Cost	2	0.8
Want to pregnant	58	24.6	Others	18	7.6
Opposed to Family			Total	235	100
Planning	13	5.5			
Husband Disapproval	39	16.6			
Side effects	31	13.2			

Table 3.7 shows the percentage distribution of women who are exposed to the risk of conception but were not using modern contraception method by major reasons. The most typical reasons reported by non-users of currently married women and associated with modern contraceptives are due to wanted to become pregnant (24.6 percent). This was followed by due to post partum or breast feeding (17.4 percent). Another principal reasons cited for non-users was the disapproval of their husband to family planning(16.6 percent), lack of knowledge (5.9 percent), religious prohibition (6.3 percent), infecund and inconvenience to use were also cited as a reason by non-users .

The comparison of current users against non-users indicates that the trend level of respondent contraceptive users is high among the population in the town.

Table 3.8 The Distribution of Respondents Who Reported Major Side Effects By Selected Contraceptives Assosa, 2005.

Method	N	percent		N	percent
Pills	13	43	**Major Problem**		
Injection	14	46	Headache	5	16.6
IUD	3	0.1	Irregularity of menustration	8	26.6
Total	30	100	Blood Pressure	3	0.1
			Stomach ache and	4	13.3
			Vomiting and Skin Disease	10	33.3
			Total	30	100

The most common type of methods who perceived by the respondents as having side effects was pills. Next to pills followed by injection and IUD methods (Table 3.8). To understand further the perception of women about the symptoms of side effects of the method, those who have heard of a method were asked if there are any health problems associated with the use of contraception. About 33.3 percent of the women believed that contraceptives have side effects of skin disease and vomiting, 33.3 percent irregularity of menstruation (26.6 percent). Another side effects cited by respondents is headache which is 16.6 percent. About 0.1 percent of women reported that the method they were used brought an increase their blood pressure and 13.3 percent of them were affected by stomach ache (Table 3.8).

3.8 Differentials In Contraceptive Use

To examine further the differentials in contraceptive use by demographic socio culture and economic as well as Family Planning variables of sample population, Chi-Square test was used for tests of significance.

As it has been indicated in the literature, background characteristics of women are known and closely associated with their behaviour towards contraception practice. Respondents of the survey are classified as current users if they are currently using a contraceptive method and non-users if not, as response variable to find the association with explanatory variables.

Age is one of the important demographic variables. It is observed a curvilinear relationship between age of respondents and their contraceptive use, i.e youngest age group (15-19) and oldest age group (45-49), while it is higher comparatively between the ages 40-44.(Table 3.9)

The table 3.9 reveals that there was higher level of contraceptive use among age group 25 – 29 (69.6 percent), followed by the age group of 15 – 25, while the lowest use was observed by the ages 40 and above. The proportion of current users ranges from 1.0 percent to women who had no living children to 40.6 percent to those who have had between 3 – 4 children. The percent of current users declines to 21.5 percent afterwards of having 5 and more children. However, age wise distribution of users are not statistically significant $p<0.05$.

Table 3.9 Results of Chi-Square Test for Contraceptives Users and Non Users by Selected Demographic Variables, Assosa, 2005.

Variables	Users		Non-users			Users		Non-users	
Age	N	Percent	N	percent	Age at First Birth	N	percent	N	percent
15 – 25	97	64.7	53	35.3	14 – 16	43	66.2	22	33.8
25 – 29	128	69.6	56	30.4	17 – 19	103	60.9	66	39.1
30 – 34	65	57.5	48	42.5	20 – 22	83	65.9	43	34.1
35 – 39	38	51.4	36	48.6	23+	44	65.7	23	34.3
40 +	24	39.3	37	60.7		χ^2 =1.06 d/f=3 P=0.780			
	χ^2 =21.8 d/f=4 P=0.000				Living Children				
Want more children		0			0	2	0.7	0	0
Yes	133	1 – 2	75	36.1	1 – 2	109	37.2	73	46.8
No	129	3 – 4	67	34.2	3 – 4	119	40.6	52	33.3
Do not Decide	85	5+	88	50.9	5+	163	21.5	31	19.9
God knows	34	24.5	23			χ^2 =4.99 d/f=3 P=0.178			
	χ^2 =12.6 d/f=3 P=0.001				Desire to Delay the next pregnancy				
Age at first marriage					Yes	220	70.7	91	29.3
<16	64	58.21	46	41.8	No	31	47.7	34	52.3
16 – 18	135	62.8	80	37.2	Not Decided or God knows	83	46.9	94	51.3
19+	131	58.5	93	41.5		χ^2 =31.79 d/f=2 P=0.000			
	χ^2 =1.06 d/f=2 P=0.581								

Concerning delay of next pregnancy, the majority of the target group's contraceptive users reported that they would like to delay the next pregnancy (70.7 percent). While there is only 29.3 percent of the non users who wanted to delay the next pregnancy. As compared to non users, the association between desire to delay next pregnancy and current using of contraception was found to be statistically significant (P<0.000). (Table 3.9)

Further association between Socio economic variables and current use of contraception has been examined through chi-square test, among which education is one of the important determinant for the use of contraception. The result of table (Table 3.10) indicated that there is a significant relationship between respondents' education and current use of contraceptive. About 47.5 percent of illiterate women are current contraceptive users, and this figure rises to over 63.2 percent among literate women. The percent distribution of currently user of women according to the level of education reveals that 63.8 percent of them have primary education. Among those who had attended secondary school have currently used a method, the existed differentials by education level to contraceptives found to be significant, $p<0.000$ (Table 3.10).

TABLE 3.10 Distribution of Contraceptive Users and Non Users by Selected Socio Economic Variables and Results of Chi-Square Test.

	Users		Non-users			Users		Non-users	
Education level	N	perc ent	N	Perc ent	**Ethnicity**	N	percent	N	Perc ent
Literate	289	63.2	168	36.8	**Shinasha**	21	56.8	16	43.2
Illiterate	56	47.5	62	52.5	**Berta**	24	54.5	20	45.5
	χ^2 =9.7 d/f=1 P=0.000				**Oromo**	120	65.2	64	34.8
Highest grade level					**Amhara**	115	68.9	52	31.1
Primary	146	63.8	83	36.2	**Gurage**	19	30.8	31	62.0
Secondary	120	47.5	64	34.8	**Others**	18	55.8	38	42.2
Above 12 grade	33	61.1	21	38.9		χ^2 =18.87 d/f=5 P=0.001			
	χ^2 =0.32 d/f=2 P=0.000								
Occupation					**Childhood residence**				
Agricultural	175	71.4	127	28.6	**Urban**	195	64.6	107	35.4
Non agricultural	148	63.2	86	36.8	**Rural**	155	56.2	121	43.8
Others	7	50	7	50		χ^2 =4.27 d/f=1 P=0.01			
	χ^2 =3.16 d/f=2 P=.368				**Religion**				
Income					**Orthodox**	136	67	68	33
>300	215	63.2	125	36.8	**Protestant**	63	61.2	'40	38.2
<300	27	64.3	15	35.7	**Catholic**	18	51.4	17	48.6
	χ^2 =0.018 d/f=1 P=0.894				**other Christian**	49	60.5	32	39.5
					Muslims	73	51.4	69	48.6
						χ^2 =9.706 d/f=4 P=0.05			

There had also statistically insignificant differences were observed between current contraceptive users and never users of by occupation, current users are more likely to be non-agricultural (professionals, office workers etc), While non-users are more likely to have no occupation and engaged in agricultural related activities.

The observation between ethnicity and contraceptive use is again highly significant ($p<0.000$).the corresponding differentials by ethnicity are presented in table 3.11.

With regard to respondent's religion, 64 percent of respondents were Orthodox Christian and reported that they are currently using contraception, while the Corresponding figures for Muslims were 51.4 percent. Contraceptive users are likely to be affiliated with orthodox and others Christian. As indicated in (Table 3.10) difference in religion and ethnicity was statistically significant between the users and non use group of women.

The childhood place of residence of women has also indicated that 64.6 percent of contraceptive users were grown up in urban areas where as the corresponding proportion for rural background women were 35.97 percent. The bi-variant results showed that place of childhood residence was significantly associated with contraceptive use ($p<0.01$),this might be due to the fact that access to information about reproductive health including FP in urban areas are more likely better than the corresponding rural peoples there by the practice of family planning.

Either of respondents owns approval or their husband's approvals of family planning have a potential impact on their current use pattern. Among the respondents who approved and disapproved the use of contraception, 65.2 percent and 26.9 percent, respectively, were found to have current users of a method.

Concerning to the attitude of husbands towards family planning, the proportion of women who practice the method increased to 65.2 percent among women whose husband approved contraceptive while the corresponding figure for women whose husband disapproved and those who couldn't know the attitude of their husband were found to be 26.9 percent. A comparison of current users and non users of a method shows that non users are more likely to disapprove to the use of Contraceptive while current users had favourable attitude towards such practice and the results was statistically significant at $P<0.000$ (Table 3.11).

TABLES 3.11 Percents of Currently Married Women Using Contraception by Selected Variables on Family Planning Perception, Assosa, 2005.

Variables	Users		Non-users	
Women of approval FP	N	percent	N	percent
Approved	336	65.2	179	34.8
Disapproved	18	26.9	49	71.1
	χ^2 =36.6 d/f=1 P=0.000			
Husband Approval of FP				
Approved	335	65.2	179	34.8
Disapproved	18	26.9	49	73.1
Do not know	χ^2 =37.5 d/f=1 P=0.000			
Source of information heard:				
Husband	50	64.1	28	35.9
Friends/family/relatives	72	70.0	37	26.0
Government hospitals, clinics	69	79.1	33	20.9
Mass Media	54	54.3	40	45.7
Mass Gathering	68	56.9	49	43.1
Others	38	60.0	26	40.0
	χ^2 =34.21 d/f=5 P=0.001			

Discussion with Husband	Users N	Users percent	Non-users N	Non-users percent
Very often	227	70.3	96	29.7
Sometimes	80	65.6	42	34.4
Never	44	33.3	8	66.7
	χ^2 =55.14 d/f=2 P=0.000			
Ever Attended FP Education				
Yes	191	66.6	96	33.4
No	164	54.5	134	45.0
	χ^2 =8.13 d/f=1 P=0.000			
FP information Heard				
Yes	33	65.9	171	34.8
No	23	29.5	55	73.1
	χ^2 =37.5 d/f=1 P=0.000			

Among the respondents the highest level of current use of contraceptive method was observed in those respondents who had discussed the issue of FP with their husband very frequent. The percent of current user who had made communication very often is 70.3 percent. It was 65.5 percent who had communication with their husband sometimes, and about one third of women who had made any communication with their husband are only 33.3 percent. The association between communication with husband and contraceptive use is highly significant ($p<0.000$).

The result of the bi-variate analysis also indicated that those women who had ever attended FP education their practice to contraceptive use was comparatively higher (66.6 percent) than those women who had not attended so far (50.5 percent). This variable again showed significant relationship with the use of contraception.

Further the source of information on FP heard by women is categorized under different ways and the association between this variable with the contraceptive use is explored. It can be seen from the table that the probability of use of contraceptive was highest (79.1 percent) among women who had heard message from government hospital/clinics than any category of this particular source. The existed association between the source and contraceptive is statistically significant ($p<0.001$).Husband approval and wife's approval of FP are cross classified and found each one statistically significant.

CHAPTER FOUR

4.1 Multi-Variate Analysis of Determinants of Women Contraceptive Use

At the earlier stage the study has been identified and discussed the distribution of respondents by various demographic, socio cultural economic as well as family planning variables. The distribution of the background variables have also tested by bi-variate analysis in order to know whether or not the various types of independent variables were associated with the contraceptive practice. After identified the associations of these independent variables, a multi-variate statistical technique was employed to determine independent effects of these factors on contraceptive use, after controlling for the effect of other variables. It is being attempted also to identify the effect of correlated variables in order to determine the net effects that any factors has on contraceptive use.

To further analysis those variables showed strong significant difference between current users and non users of contraception were selected, with careful examination to treat multi co linearity effects using zero order correlation. Some variables were not included in the model because of low predictive power and using high multi-colinearity in explaining the women contraceptive behaviour.

For the analysis, the dichotomous logistic regression model was used because the dependent variables of the study involve two distinctive choices (use and non use). The model allows for the simultaneous estimation of the log adds of the two outcomes.

The multiple regression coefficients imply the reduction or increases in the log odds of being in one outcome after controlling for the effect of other predictive variables. The dependent variable, in the model, was represented by dummy variables (1 for current users otherwise 0 for non users). Similarly independent variables were coded as dummy variables.

The interpretation of each of the background variables were in comparison with the reference category.

Table 4.1 shows the logistic regression of contraceptive used status of a woman on a set of independent variables; exp. (B) is the odds for a unit change in the predictor, the effects of others being controlled. The Wald statistics refers to the square of the ratio of the coefficient (B) to its standard error; on the other hand the significance level of each predictor is determined on the basis of the results of Wald statistics.

4.2 Demographic Variables and Contraceptive Use

The two most important factors considered in the study was age and women fertility intension (desire for additional children). Although current use of contraception among women in the middle age group (25-34) were found to be statistically different from the younger age group (15-24). The multiplicative estimate indicates that women in the middle age group have the odds of contraceptive use 1.641 and 3.200 times higher than younger age groups (15-25) respectively. This may be due to the fact that the middle and the last age groups achieved their desired number of children than the younger ones number and were they relatively higher contraceptive use for younger age group. This findings shows that women in the middle and apart age groups are more likely to accept contraceptive to regulate or terminate fertility than younger ones, and taken as a target group where family planning service can easily expanded.

Taking women who desire additional children as a reference group, as the preferred number of more children increased with in family, contraceptive users showed a declining trend and for the respondents who want additional children. The difference was statistically significant ($p<0.05$).

In multi-variate analysis, husbands desire to additional children appeared to be strong and negatively associated with women contraceptive use than women who had children of one and two, and five and above , and positively associated to those women having 3-4 children. However neither of these results were statistically significant.

4.3 Socio Economic Variables and contraceptive Use

In bi-variate analysis the test statistics showed that there is an association between women current contraceptive use and literacy. In the multivariate analysis taking literate women as a reference, the literacy appeared to be negatively associated with currently user of contraceptive method for women who had illiterate. The odds ratio is not statistically significant.

As indicated in Table 4.1, ethnic and religion affiliation were found to be for insignificant effects on their contraceptive behaviour. Among different ethnicity the variations for the effects on current use of contraception was small and insignificant. Likewise, the religions of sampled women have not shown any significant impact on contraceptive use after controlling for the effects of other predictors. However, the finding showed that being affiliated with the protestant and Muslim religions have increased the likelihood of modern contraception as compared to the orthodox Christian.

Women occupation had also insignificant statistical impact on contraceptive use. This result point outs to the fact that in the study area the majority of contraceptive users had been obtained the method of birth control freely or cheaply, and hence their level of occupation was not as such important determinant factor for the real contraceptive practice of the target population.

The study population was composed of married women from different backgrounds. The finding reveals that 78.6 percent of the study population was literate, of which 49 percent attended primary level of education and only 11.6 were high school complete. (Table 3.2). It is obviously known that education is the most important factor for every human being. Especially formal education enables individuals to acquire new ideas on personal, biological and reproductive life there by acquainting them with new ideas including family planning methods.

Being so far, the effects of formal education on women contraceptive use is found to be insignificant. This does not mean that educations have not contributed any thing to women's contraceptive use practice, while information about family planning

methods disseminate not only through formal ways. This fact was indicated by the study population that most of the informants said they obtained more information about family planning from their friends, relatives (irrespective of formal health institutions). However, due to the existing strong socio cultural believes which is behaving against contraceptive use; their perception and contraceptive practice is highly challenged.

4.4 Family Planning Variables and Contraceptive Use.

Women's attitude towards family planning was significantly related with the current use of contraception. Those married women who had practised the use of contraceptives to regulate pregnancy were found to have higher probability of contraceptive practice and the effect was statistically significant ($P<0.05$). The multiplicative effect indicates that women who approved contraceptive use, the odds of contraceptive use were 2.750 times higher as compared to for such women who disapprove the practice.

The other important prediction of women contraceptive use in the multi-variate analysis was husband's approved of family planning use. Women having a husband who approved contraceptive use had statistically higher contraceptive use than women whose husband had disapprove contraceptive use.

Another important finding emerging from the multi-variate analysis was the convenience of the place that the service delivery was taken place. Among the women who did find the place convenient the odds of contraceptive use was higher than the women for whom place was inconvenient and the result was statistically significant ($P<0.005$).Thus, women who found the place of service delivery convenient, the odds of their contraceptive use have increased by a factor of 3.3 times than those women who found the place of delivery inconvenient.

Among the variables affecting the use of modern contraceptive method the one is information heard about family planning. As (Table 4.1) shows that those women who heard information about family planning is more likely to use the method. The multiplicative effect indicates that women who have heard family planning

information have the odds of contraceptive use that are 1.139 times higher than those women not heard information about family planning. However neither of them was statistically significant with the practice of contraceptive method.

Those respondents who reported the youth RH center and friends /relatives as source of family planning information were found to have increased odds of ever use of contraception as compared to those who heard information from mass media, and the difference is statistically significant ($P<0.01$). This finding highlights the influential role of youth reproductive health (RH) centre and friends/ relatives/ mass gathering in dissemination family planning information in the study population.

The analysis of women's exposure, accessibility, travel time, price have indicated a low predictive power and variable was not found significant in the model. Although the chance of contraceptive use was higher for women to practice contraceptive the association was statistically insignificant. A similar trend was observed with regard to women attendance of family planning education those who attended the education program were found to have increased the likelihood of contraceptive use than the corresponding women who were not have attended education program.

Table 4.1 Linear multiple Logistic Regressions Coefficients and Adjusted Odds Ratios of the Contraceptive Use by Background Variables of the Women, Assosa, 2005.

Variable	Regression coefficient(B)	Standard error	Wald Value	Sig	Exp(B)
Age					
15 – 25	RC	-	-		
25 – 34	0.475	0.363	0.161	0.106	1.641
35 – 49	1.163	0.553	0.036	0.036	3.200
Literacy					
Literate	RC				
Illiterate	-0.671	0.422	2.532	0.112	0.511
Occupation					
Agricultural	RC				
Non agricultural	-0.494	0.553	0.799	0.371	0.610
Others	0.664	0.551	1.449	0.292	0.515
Husband desired additional children					
0	RC				
1-2	-0.575	1.295	0.255	0.225	0.563
3-4	-0.351	0.505	0.477	0.477	0.704
5+	-1.011	3.550	0.060	0.060	0.364
Want more children					
No	RC	-	-		
Yes	-0.969	0.372	6.789	0.009	0.937
Do not Decide/God knows	-0.035	0.353	0.810	0.092	0.687
Religion					
Orthodox	RC				
Protestant	-0.083	0.409	0.040	0.842	1.085
Catholic	-1.307	1.161	1.267	0.260	0.271
Other Christian	0.239	0.459	0.271	0.602	1.270
Muslims	-0.285	0.377	0.572	0.449	1.330
Ethnicity					
Oromo	RC				
Amhara	-0.089	0.352	0.064	0.801	0.915
Others	0.161	0.490	0.108	0.742	1.175

Table 4.2 Linear multiple Logistic Regressions Coefficients and Adjusted Odds Ratios of the Contraceptive Use by Background Variables of the Women Assosa, 2005,(continued).

Women Family Planning					
No	RC				
Yes	1.012	0.590	2.942	0.050	2.750
Husband Approval of FP					
No	RC				
Yes	0.847	0.519	6.476	0.010	2.332
Do not know	1.913	0.806	2.693	0.018	6.772
Discussion with Husband					
Very often	RC				
Sometimes	-0.502	0.405	1.537	0.376	0.605
Never	-0.043	0.555	0.006	0.215	1.044
Information Heard					
No	RC				
Yes	0.131	0.761	0.029	0.864	1.139
Convenience					
Inconvenient	RC				
Convenient	1.191	0.394	9.128	0.005	3.290
Source Of Supply					
Private Pharmacy	RC				
Government institution	0.727	1.012	0.472	0.471	2.069
Youth Association Centres	-0.140	0.395	0.777	0.722	0.869
Others	1.495	0.985	0.129	0.120	4.457
Availability					
Easily available	RC				
Not easily available	-0.029	0.356	0.007	0.934	0.971
Do not known	-0.032	0466	0.005	0.945	0.968
Source Of Information Heard					
Government Hospital	RC				
Mass Gathering	0.2301	0.3215	0.8701	0.05	1.3502
Mass Media/Magazine/poster	2.206	0.8092	7.2304	0.031	8.8105
Friends/family/relatives/private	2.3201	0.8432	7.6030	0.010	10.2040

Chapter Five

5.1 Discussion

This study is designed to investigate whether or not some of the socio economic and cultural factors have an effect on women contraceptive use in Assosa town, the central administrative city of the region of Benishangul Gumuz.

Different demographic, socioeconomic and cultural factors were used as variables of the study some of these are (Age, occupation, income, family planning education, attendance and communication, religion and ethnic background, travelling time and availability of the service etc.)

This also clearly stated during the discussion which was made with women about the effects of education on their knowledge and family planning. Similar kind of relationship has been observed between occupation and contraceptive use. Almost half of the study population has not engaged in any form of income generating activities. Moreover, some of the participants of the study population disclosed that they used to involve in petty cash trade activities but with the disapproval of their husbands they were forced to quit and remain at home. They also expressed that most of their friends were also experience the same problems from their husbands.

One of the study participant said "I had involved in a small coffee and tea trading business and earning more than 250 birr per month. However, my husband dislikes the contact I had with many of my customers. This condition forced me to leave the job besides; I have the responsibility to maintain our marital status as stable as it was."

From the above case we can observe that this situation affects the chance of women's access to information and communication from other individuals. Therefore, occupational status indirectly affects women access different kinds of information including about their reproductive health.

Religion plays both functional and dysfunctional roles in human life. Accordingly, there are different religious principles pursued with regard to the use of contraceptive methods. In this study most of the respondents are found to be followers of the most known religions in Ethiopia, Christianity and Muslim. Although, both religions are against the use of modern contraceptive methods, the respect for such principles depends on the personal choice.

The study result also reveals that different types of family planning variables have been affecting women's contraceptive use in various degrees, of which discussion with their husbands and the availability of the service in the near by health centers had shown positive influence on their practice of family planning methods Therefore, identifying factors that prevent women from practicing contraceptive methods is essential for future policy formulation.

In the case of the study population other things being equal, it is better to make programs to be area – specific during implementation process. The result also suggests that the importance of inter spousal relationship should be supported by those family planning intuitions which were only women oriented previously. Moreover during the discussion some of the participants decided to start practicing contraceptive methods and others chose to consult their husbands about the best ways for them.

Location of family planning service is also one of the major obstacles to many women who are willing to practice it. Above and beyond the centres are expected to fulfilled the standards required by the ministry of health including well staffed medical personals, supplies of alternative methods and should be located at convenient places.

Discussion about family planning variables has shown significant relationship with women contraceptive use and the distance travelled. The survey result reveals that the majority (51 percent) of users travel from their home to the service areas in less than 30 minutes. Correspondingly there was similar number of observation of women that attending family planning education there by practicing the service

(Table 3.5). However, to some of the study population the service area is too far from their home which challenges their intention to use or attend family planning education at health centres so they are forced to procure from private pharmacy and drug shops.

Demographic variables are the major determinants on women contraceptive use, of which age, number of living children, marital status, age at marriage, duration of marriage and so forth. Different studies show that the association among these demographic variables, risk of pregnancy and contraceptive use. As this study involves some of these demographic variables some of the participant of the discussion mentioned that "--- being under marital relationship does not mean the couples must have children." In this case they can use alternative ways to avoid unwanted pregnancy. Some of them on the other hand stated that even with out practicing contraceptive methods pregnancy had not occurred. Especially one women said "--- I have two children and. I did not use any kind of family planning methods now but there is no pregnancy at all while both of us have a desire for additional children. We even went through medical examination and yet pregnancy is still did not come". Such conditions and other unexpected facts mislead women's contraceptive use. This was clearly reflected on the results obtained about the relationship between demographic variables and contraceptive use in the study.

Information and exposure to mass media plays a profound role in disseminating family planning methods. Many people who reside in rural areas luck access to information through mass media, especially women fear to listen radio because they labelled as job less. Only few individuals in this study claim to have information about family planning through mass media while, informants disclose that they acquire information about contraceptive use from friends, relatives or indirectly from their husbands.

CHAPTER SIX

6.1. Summary and Conclusion

Ethiopia is one of the developing countries which had been characterized by rapid population growth with slow socio economic development. This rapid population growth brought serious challenges in the efforts achieving economic and social developments activities. The demographic structure of the country shows that the majority of the populations have been found in reproductively active age which makes more difficult the actions taken to maintain the desired family size with respect to the existing and future countries status quo.

The purpose of this study is to investigate some demographic and family planning variables associated with women contraceptive use in Assosa town of Benishangul Gumuz. 600 married women of reproductive age from the said town were selected for the study.

One of the major interests of the study was examining women's knowledge, attitude and practice of contraception. The study finding indicated that information of at least one method is almost 82 percent, while specific methods are less widely spread among study population.

Among respondents (87 percent) of the women attitudes towards contraceptive use is favourable either to limit/spacing or regulate their over all fertility.

The dissemination of information irrespective mass media/electronics and non-electronic/ has been brought a profound effect on women's contraceptive practice nearly one of every two married women have raised the issue of family planning system and discussed with their husband on the other hand lack of or husband disapproval of such practice would creates persistent and become a deferent effect on women's motivation to use modern contraceptive methods.

Another finding of the study was the level of contraceptive use among currently married women, other things being equal. Therefore during the survey 60.8 percent of married women were currently using any of modern contraceptive method..

This indicates that the practice of contraceptive just like another urban centers of Ethiopia, is high in Assosa town. Among the current users "injectables' was the one most frequently used method followed by "pills", "safe period", "condom", cultural medications (herb). The least method of practice is IUD and sterilization.

Among the respondents of the survey , the proportion of women who travel 15 – 30 minutes to the place of service delivery is 53 percent, less than 15 minutes 28 percent and between 30-60 minute 12.7 percent from the target population only 6.2 percentof women were travel more than one hour to get the service. The length of the time particularly to those women living far from the place of the service centres affects their motivation there by contraceptive use. The longer the distance the higher time taken to get not only the required service but also information about reproductive health issues, including family planning knowledge which would increase incidence of unwanted pregnancy.

Respondent who were exposed to the risk of conception and were not using any method at the time of survey was only 6 percent out of the total. About 39.2 percent of the major reasons reported by this group of non users are fear of side effects including , facial problems, vomiting, irregularities of menstruation, blood pressure, stomach ache of currently married and non users some of them mentioned that breast feeding, religion prohibition, that opposed to family planning, husband disapproval and wanted to be pregnant are indicated by the respondents. These and other reasons cited by both users and non users have their own implications on program improvements in family planning.

Regarding exposure to family planning Information the survey result reveals that the majority of respondents who obtained family planning information from their friends, relatives, mass gathering. Some of the respondents also cited as the contribution of their husband for their level of awareness on their attitude towards use of contraceptives. This calls for using informal ways of dissemination family

planning information irrespective of institutional setup and electronic and printed materials including Edir, Mahiber, and Ekub and/or other kind of places of mass gathering.

Regarding family planning service availability and accessibility in the study area, as it is stated earlier, the majority of whom obtained the method freely. Among those who paid to the service, 69.65 percent of them indicated that the price of the service is cheap. And the rest of users perceived the price of the method reasonable and only 8 percent of respondents point out that cost of the method is expensive.

The implication of this figure is that the need of addressing the method to needy couples to afford freely to all of the users on one hand and make the service easily accessible to those who desire to used but found difficulty in access related things.

The statistical technique of multi-variate analysis for women contraceptives practices was applied after examining the bi-variate relationship by chi-square test. Most of the background variables that were tested by chi-square found to be significant between current users and non-users of contraception.

Among background characteristics childhood place of residence, occupation income, and some of which showed no significantly differences between dichotomous group of women.

The most important factors that emerged from the multi variate analysis as one of prime determinant of women's contraceptive use in the study area was husband approval of family planning practice than those husbands disapproval the use of contraceptive practice..

In addition, another factor that influencing women contraceptive practice in the study area is the convenience of the service delivery place. Among the variables included in multivariate analysis, number of living children, religion desire to have additional children and occupation were found to be have low predictive power in explaining women's contraceptive use and statistically insignificant.

On the basis of above findings, it is recommended that

1. Education is one of the major components in addressing problems both reproductive and equity and equality aspects of women right. Therefore access to education at all levels should be maintained and enhanced women knowledge to sexual life and contraceptives desire for small family size and actual uses of family planning service.

2. The orientation of family planning program should incorporate the corresponding male participation which enables husbands to have positive attitude towards family planning service and IEC programs of family planning should be designed by targeting both women and men which supports to equal flow of information in family planning and is likely to increase the demand for family planning services and actual practice of the method.

3. Adequate information about the importance and side effects of contra captives, when and how to use, date and place of production could make practitioners more familiar to FP methods and enable to have choice of an appropriate method and changing of the negative attitudes on the contraceptive method.

4. IEC materials should be developed based on area specific. It should be taken in to account the exiting situation of the study area of the population including the language, culture etc. of the given community.

5. Family planning service delivery on health institutions must be expanded by increasing the involvement of private, government and non-government organization.

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Appendix I

Demographic Training And Research Centre (DTRC), Institute Of Development Research,(IDR) Addis Ababa University
(School of Graduate Studies)

Survey Questionnaire for Currently Married Women Aged 15-49 Living With Their Husband, Assosa Town 2005.

Part one

A. Identification

Town----------
Woreda----------
Kebeles----------
House number----------
Serial number of selection----------
Serial number of eligible women----------

B. Interviewers visit----------

Date----------
Interviewee's name----------
Time taken to complete----------

C. language of interview----------

Part one. General Household information

1. Name _____
2. Sex Male ---1 Female---2
3. Age _____
4. Religion Orthodox ---- 1 Muslim---- 5
   Protestant --- 2 others----- 6
   Catholic ----- 3
   Other Christian--- 4
5. Ethnicity Shinasha ---- 1 Gumuz -- 2 Berta-- 3 Mao Como---- 4
   Oromo ------ 5 Amara---- 6 Tigre-- 7 Kembata------ 8
   Wolita ------ 9 Gurage--- 10 others (specify) --------- 11

Part Two. Demographic Characteristics

6. Place of birth Urban _____
   Rural_____
7. Year and month of birth Year _____
   Month_____
8. How old are you when you first got married? Year _____
9. Have you ever give birth? Yes------ 1 No---------- 2
10. How old were you when you give birth to your first child?
    Year_____
11. How many children have you born alive? Male ----- 1 Female -------2
12. Do you want to have additional children? Yes ------ 1 No ----------2
    Not decided----- 3 God knows --- 4 Don't know------5

13. If yes, how many additional children do you want to have?

Male--------- 1 Female – 2 Total-------

14. Do you want to delay the next pregnancy? Yes ---1 Not decided --- 3

No ---------- 2 God knows -- 4 Don't know ---------- 5

15. For how long do you want to delay the next pregnancy? Year _____

16. Have you ever experienced pregnancy ended up in abortion?

Yes---------- 1 No---- 2

17. Frequency of incidence of pregnancy (specify the number of occurrence)-----

18. Through what way the incidence of abortion was ended up?

Medical personnel---------- 1 Unknown---------- 3

Traditional methods ---------- 2 others (specify) -------- 4

Part Three: Socio Economic Characteristics

19. Can you read and write? Yes------ 1 No----- 2

20. If yes, what is the highest grade you attain?

<6 grade------- 1 12 and above ------ 4

6-8 grade------ 2 other (specify) -------- 5

9-12 grade------ 3

21. What type of occupation you are currently engaged in?

Agriculture----- 1 Retail trade------- 3

Industry -------- 2 others---------- 4

22. To whom you are working for?

Self ---------- 1 Private----- ------ 3

Government ---- 2 others (specify) ------- 4

23. What is your monthly income in birr? _____

Part Four: Knowledge, Attitude and Practice of Contraception

24. Have you ever heard of family planning? Yes--- 1 No---------- 2
25. Do you support family planning? Yes--- 1 No----- ----- 2
26. Does your husband support the use of contraceptive method to avoid pregnancy?
    Yes---------- 1 No ---------- 2 do not know ---------- 3
27. How often do you discuss with your husband about family planning?
    Very often -- 1 Sometimes---- 2 Not common---------- 3
28. What is the desire of your husband to the number of children in the family as compared to your preference?
    The same as wife---------- 1 More children --- 3
    Less children ---------- 2 Don't know ---- 4
29. Which of the following methods you ever heard about?

1. Pills	Yes--------	1	No ------	2
2. Injection	Yes--------	1	No-------	2
3. IUD	Yes-------	1	No-------	2
4. Diaphragm Foam/ Jelly	Yes-------	1	No ------	2
5. Condom	Yes -------	1	No-------	2
6 Withdrawal	Yes -------	1	No ------	2
7. Rhythm	Yes -------	1	No-------	2
8. Female sterilization	Yes -------	1	No -------	2
9. Male sterilization	Yes -------	1	No --- ---	2
10. Prolonged abstinence	Yes-------	1	No -------	2
11. Others (specify)	Yes--------	1	No -------	2

30. Do you know the place where modern contraceptive methods could be obtained?
    Yes----------1 No---------- ------2

31. Which of the following methods you use currently?

1. Pills	Yes ----------	1	No ---- 2	
2. Injections	Yes ----------	1	No----- 2	
3. IUD	Yes ----------	1	No----- 2	
4. Diaphragm Foam / Jelly	Yes --------	1	No---- 2	
5. Condom	Yes --------	1	No-----2	
6. Withdrawal	Yes --------	1	No-----2	
7. Rhythm	Yes --------	1	No---- 2	
8. Female sterilization	Yes --------	1	No---- 2	
9. Male sterilization	Yes --------	1	No----2	
10. Prolonged abstinence	Yes --------	1	No---- 2	
11. Others (specify)	Yes --------	1	No----2	

32 . Where do you usually obtain the supply of these methods?

Private pharmacy -------1 Government hospital/ clinics/ health centers—2

Youth association centers—3 others (specify) ----

33. How much does the method cost? Price in birr _____

34. How costly the method is?

Cheap ---------- 1 Reasonable --- 2 Expensive ---------- 3

35. How do you go to the center you currently obtain the service?

By walking -------- 1 by car ---------- 2 others (specify) -------- 3

36. How long it takes to reach you there?

Minute ---------- 1 Hours ---------- 2

37. Would you consider the distance too far?

Convenient --------- 1 Inconvenient---------- 2

39. Is family planning service/ by method / adequately offered in the place you are currently living?

Yes ---------- 1 No---------- 2 Fair---------- 3

40. What will be the availability of the methods if you want to change other methods from the source you belong to?

Easily available ---- 1 Not easily available --- 2 Don't know -----3

41. How long have you been using the method you mentioned above
With out interruption?
Month ---------- 1 Yea---------- 2

42. What is the main reason for you to prefer this method?
To limit family size -- 1 For child spacing ---------- 2 Other (specify) ---5
To avoid any pregnancy ----------3 For medical purposes ---------- 4

43. From the kind of methods you currently aware or used before, do you feel the method cause any health problem while using?
Yes ---------- 1 No ----------2 Don't know ------ 3

44. What are these methods? (Specify)_____

45. What are the major problems/ side effects associated with these methods?
---

46. Who chose this method for you?
Self --- ---------- 1 Both ----------3 Clinic staffs ---------- 5
Your husband------- 2 Friends -------- 4 others (specify)--------- --- 6

47. From where do you get information about family planning?
Husband ------ 1 Television ---------- 5 Posters---------- 9
Friends ------ 2 Mass gathering ---- 6 Gov't /hospital clinics----- 10
School --------- 3 Family relatives --- 7 Others (specify) ---------- 11
Radio ---------- 4 Magazines/ News paper ---8

48. Which of the following specific items are possessed by household?
Radio---------- 1 Electric light ---------- 4
Television------ 2 Pipe water ---------- 5
Telephone ----- 3 Traditional cooler-------- 6

49. Have you heard any information through radio or any means of mass media about family planning ?
Yes ---------- 1 No ---------- 2

50. Have you ever attended family planning education in the place where you are Currently living?
Yes ---------- 1 No ---------- 2

51. Are you pregnant now? Yes - 1 No---------- 2

52. If no, had you ever used contraceptive methods to prevent or delay Pregnancy before?

Yes---------- 1 No ---------- 2

53. Are you currently using contraceptive methods to avoid pregnancy?

Yes ---------- 1 No ---------- 2

54. What is the main reason for not using contraceptive?

Methods?

Lack of knowledge---------- 1
Wanted to become pregnant---2
Opposed to family planning----3
Husband disproval----------4
Religion prohibition----------5
Fear of side effect----------6
postpartum/breast feeding----------7
Inconvenience to use/method failure--8
Too much cost----------9
In fecundity----------10
Other (specify) ----------

55. Do you intend to use contraceptives at any time in the future?

Yes ----------1 No ----------2

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 Yonas Abesha

Signature

Date 21/07/2005

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

Dr. R. B. Upadhyay — Advisor

R B Upadhyay — Signature

21-07-2005 — Date