ADDIS ABABA UNIVERSITY FACULTY OF MEDICINE DEPARTMENT OF COMMUNITY HEALTH

ASSESSMENT OF THE DETERMINANTS OF MODERN CONTRACEPTIVE USE IN A DAWRO COMMUNITY (MAREKA WOREDA), DAWRO ZONE, SNNPR.

BY

TILAHUN BEZABIH (BSC)

THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH

APRIL, 2005
ADDIS ABABA, ETHIOPIA

Addis Ababa University

School of Graduate Studies

Assessment of the determinants of modern contraceptive use in a Dawro community, SNNPRS.

By

Tilahun Bezabih (BSc)

Department of Community Health

Faculty of Medicine, Addis Ababa University

Approved by examining board

Prof. Yemane Berhane _____
Chairman, Department Graduate committee

Dr. Mesganaw Fantahun _____
Advisor

_____ _____
Examiner

_____ _____
Examiner

DECLARATION

I the undersigned, declare that this is my original work, has never been presented in this or any other university and that all the source materials used for the thesis has been duly acknowledged.

Name _____

Signature _____

Place _____

Date of submission _____

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

Name _____

Signature _____

Date _____

Acknowledgement

To begin with, my heartily thanks and appreciation is to Dr. Mesganaw Fantahun for his tolerances unreserved guides and directions throughout the time of this work. Secondly my deeper thanks stretched to Dr. Alemayehu worku and Dr. Ahmed Ali, whose encouragements and best wishes I couldn't express in words, during the time of my hopelessness and stressful days. I am grateful to my wife Dege Lemma who follows me with her love and encouragements where ever I am. I want to thank my beloved children, Zerufael elder son and my little daughter Benafkot whose passions and expectations inspired me to be reserved and work hard. I would like to thank my great my mother who thought me patience from early childhood. My appreciation and thanks is forwarded to supervisors data collectors of this study, who worked courageously unbeaten by terrains and torn topography of the study area. My deep gratitude also goes to Dawro zone; health, education and finance department workers who helped me materially during my field work. I am very grateful to Tercha technical school staffs that helped me materially and emotionally again during my fieldwork. I would also like to thank and appreciate Mareka woreda capacity building, health office and education office for their best cooperation during the fieldwork. Finally my deeper appreciation and thanks goes to Tercha hospital workers where I belong for their best encouragement wishes and material help.

Table of contents

Acknowledgement.....I

Table of contents.....II

List of tables. Iii

List of figures.....IV

List of annexes.....IV

List of acronyms.....V

Abstract.....VI

1. Introduction.....I

2. Objective.....1

3. Literature review.....5

4. Methods..... 16

4.1. Study area.....16

4.2. Study design. 17

4.3 Study population.....17

4.4 Sample size.....18

4.5 Data collection.....20

4.6 Data analysis.....23

5. Result.....25

6. Discussion.....49

7. Conclusion.....53

8. Recommendation.....54

9. References.....55

List of tables

Table-1. Socio-demographic characteristics of study population …… 26

Table-2. Bivariate and multi-variate analysis of socio-demographic characteristics of study population……27

Table-3. Proxy-socio-economic indicators of study population…….29

Table-4. Reproductive characteristics of study population……30

Table-5. Communication and decision making on modern contraceptives by study population……..33

Table-6. Assessment on attitude of study population……36

List of figures

Fig.1 desire for additional children by study population……37

Fig.2 knowledge of modern contraception by study population……..38

Fig.3 reason for modern contraceptive use by study population……41

Fig.4 Reason for stopping contraceptive use by study population……42

Fig.5 reason for none use of modern contraceptives by study population……..43

Fig.6 reason for current use of modern contraceptives by study population …….44

Annexes

Annex.1 Sampling framework……..60

Annex.2 conceptual framework of factors influencing modern contraceptive use…….62

Annex.3 questionnaires……..63

List of acronyms

SNNPR Southern Nations and Nationalities People's Region

TFR Total Fertility Rate

FGAE Family Guidance Association of Ethiopia

MCH Maternal and Child Health

FHD Family Health Department

DHS Demographic and Health Survey

IMR Infant Mortality Rate

CBD Community Based contraceptive Distribution

LB Live Birth

CPR Contraceptive Prevalence Rate

FP Family Planning

MCs modern Contraceptives

WFS World Fertility Survey

OCs Oral Contraceptives

KAP Knowledge Attitude and Practice

FGDs Focus Group Discussions

DCH Department of Community Health

MOH Ministry Of Health

RHB Regional Health Bureau

IUDs Intrauterine Devices

Abstract

This study was conducted in Mareka woreda SNNPR, Dawro zone. Mareka woreda was one of the rural woredas in short of basic infrastructures like road and telecommunications until recently. A cross-sectional survey with multi-stage cluster sampling was under taken to assess the determinants of modern contraceptive use in 733 childbearing age women.

Crude odds ratio was calculated to see the association between MCs and independent variables. 95% CI and p.value were used to assess the degree of statistical association and multiple logistic regressions was also employed to control for confounding.

Religion, ethnic group, residence and marital duration were among the socio-demographic variables analyzed and were not found significant. Age of the respondents and family size were found good predictors of contraceptive use. Women with a family size of >10 members were nine times more likely to use contraceptives than those women who had one to five family members.

Proxy-socio-economic indicators like radio and ox/oxen possession and occupation were not significant predictors of contraceptive utilization in this study. But perceived economy of medium to rich was associated with less use 0f contraceptives. Reproductive factors like history of number of pregnancy a woman had was not determinant of contraceptive use.

Number of Infant loss, number of abortion, and number of live births were also not associated with contraceptive use. History of abortion, and age at first pregnancy of women were found to associate negatively with contraceptive utilization. Where women who ever had abortion use contraceptives less likely as compared to those who didn't have history of abortion and

women who started to become pregnant in their later age use contraceptives more likely than those who started early.

In this study decision on and communication about family planning use was a predictor of contraceptive use and couples who used to decide on and communicate about family planning were found to use contraceptives more likely than those who did not.

1. Introduction

Fertility is highest among sub-Saharan African countries, at an average of 5.3 children per woman; In near East and North Africa the average total fertility rate (TFR) is 4.3 children per woman. Compared with early demographic transitions else where, the transition in sub-Saharan Africa is much slower. Many factors cultural, economic, political and demographic help to explain the difference. Some researches point to continued strong cultural preference for large families to large rural populations relying on subsistence farming, and to low levels of economic development. In addition continued high rates of infant and child mortality have contributed to high fertility levels, because many couples may have "extra children" to make up for those who die young (2).

Accordingly Ethiopia is one of the sub-Saharan African countries with alarming population growth rate (2.7%) and the total fertility rate or the number of children a woman will have at the end of her reproductive age nearly 6 (3).

Experience over the last couple of decades in Ethiopia has shown that as human numbers in creased, the population carrying capacity of the environment decreased. A high population growth induces increased demand for resources and the rate at which these resources are exploited. As a step towards addressing population problems the country developed its own population policy. In the objectives of the policy stated there is: reducing the total fertility rate per woman to 4.0, by the year 2015, and increasing the contraceptive prevalence to 44% by the year 2015. The policy also outlined that a strategy to address the above policy objectives is

through expanding health institution and community based contraceptive distribution services by mobilizing public and private resources (4).

As away of tackling population growth problems, family planning programmes have been in place for more than thirty years in many regions of the world. It is agreed that increased family planning expenditures are an effective long-term investment in human capital development and family welfare. Family planning contributed to reproductive revolution in developing countries. Contraceptives prevent maternal deaths by reducing the number of times women go through pregnancy and childbirth. They also provide significant protection for women by preventing unintended pregnancies, which often end in unsafe abortions. These in turn can threaten the life of the mother or lead to infertility and related social stigma. Contraceptives also allow women to delay motherhood, space birth and protect themselves from sexually transmitted diseases including HIV/AIDS. In Ethiopia the concept of family planning has been promoted since 1966, by the initiation of concerned volunteers who established FGAE (Family Guidance Association of Ethiopia). In 1980 'MCH' coordinating office was established as a department under MOH. After ten years of its establishment, it is recognized as FHD (Family Health Department). With four teams under it of which one is family planning team, which was running family planning programs nationally until federalism took place and similar departments in all regions handed over the program activities. According to Ethiopian demographic and health survey of 2000, the knowledge of family planning is relatively high with 86% of currently married women. But use of contraceptives is very low, especially use of modern contraceptive methods, which is 6% of currently married women (5,2).

Dawro zone is one of the newly emerged zones of SNNPR. It was the most isolated and inaccessible zone except by air until 1999, when the 1st all-weather-road that made communication with Wolaita-Sodo and Jimma possible, opened. The study area Mareka woreda is at the center of the zone's 5 woredas. Majority of the health infrastructure of the zone is located in this woreda. According to a study to enhance good governance and people's participation in Dawro zone in 2003, the total fertility of the zone and Mareka woreda was found to be 7.5 and 7.2 respectively. This is higher than the region's 5.9 according to DHS 2000. From the above survey the crude birth rate of the zone and study woreda is 48 and 46/1000 population respectively. This is also higher as compared to DHS 2000's crude birth rate for rural Ethiopia, which is 43.7/1000 populations. From the same survey IMR was computed 127/1000 live births. This is higher than the region's 113/1000LB (DHS 2000). Another study by Action-aid in the same development area states that, despite, too much efforts for consecutive years by large number of health posts and CBD agents' active participation in provision of information and services related to family planning in conjunction with government health institutions, coverage levels were found to be low, CPR (10.6%)(5,6).

Researches conducted in similar setups in the region in areas supported by different NGOs and services rendered through CBD agents to increase CPR, showed higher coverages. According to a study by pathfinder international in 1999 in Hadiya and Kembta zones, CPR increased from baseline 4.1% to 36% and in Sidama zone in two different development areas by Sidama development association and FGAE, CPR increased to 40.7% and 51.6% respectively (1).

In Dawro community kinship and descent reckoning follows patrileanial system, as in many other places. Patrilineality is relevant only in some spheres of life. Patrilineality informs among

other things, rules of land inheritance and residence after marriage. Under normal condition according to Dawro traditional laws, only sons inherit land from their father, assuming that daughters will marry out. This condition can predispose to continuing child bearing until reaching this desired number of sons and stopping after that. And this is reflected in decisions to use contraception or to have an additional child, contingent on the sex composition of the children already born (8,9).

Therefore this study will try to bring to light some of very important socio-cultural, socio-demographic and economic factors that deter the use of modern contraceptives in this woreda. And will help policy makers, program planning bodies and service providers to remove the obstacles and improve CPR to attain intended control over population growth and also helps as a baseline for future studies.

2. Literature Review

It was Malhtus who in 1824 called attention to the fact that mankind, like other Organisms increase exponentially if food supply and environment permit. However, until modern time's conditions of life were difficult, and only through the exploitation of woman's fecundity did the species maintain foothold. Nature pruned the weak, the old and the very young. The average number of children surviving to breed in each family must have been very close to two. Disaster in the form of famine plagues and war frequently struck. But now it seems clear that, humanity must adapt to a new kind of situation, a situation that requires ideas and actions that run counter to traditions and beliefs which have come to us from a very different past. Death control has been remarkably successful. But fertility remains to be high relative to mortality (9).

In developed countries decline in birth rate, which began with decline in death rate, was not fully understood and it took 100 years. Among the probable causes of decline were late marriage and birth control. The most common method birth control prior to 20th century is thought to have been coitus interrupts. But condom also was widely used. The goal of FP is to assist the family in achieving the number of children desired, with appropriate spacing and timing to ensure optimal growth and development of each family member (9).

FP has played an important role in reducing fertility through out the world. Programs of FP affect fertility primarily by raising contraceptive prevalence or the share of married women of reproductive age who use modern contraceptive to prevent pregnancy. By reducing fertility levels, and hence the total amount of per capita social expenditures necessary just to maintain the economic status quo, family planning can help rise living standards

Family planning has also multitudes of health benefits. Some are:

2.1.1. It assists in determining family size. Perinatal mortality infant mortality, stillbirth, neonatal mortality and maternal mortality all increase after the fourth birth and are lowest for second and 3rd pregnancies.

2.1.**2. Population-** although the individual is the focus of voluntary family planning efforts, the over all effect of population on the individual is significant. The reduction in over all population growth requires the interaction of a large number of variables of which family planning is but one.

2.1.3. Unwanted births- the single most important goal of family planning is a reduction in the number of unwanted births. Forsman and Thurve studied 120 children of women who applied for and refused therapeutic abortion. They found a relation ship between mental health, social adjustment and educational level of unwanted children. The unwanted children run a greater risk of insecurity in child hood, were in greater need of psychological services, and were educationally subnormal as compared to controls.

2.1.4. Birth intervals- perinatal mortality, neonatal mortality, stillbirth, ratio of maternal mortality all are adversely affected by shortened (less than one year) or prolonged (> 4 years) birth intervals. Through the appropriate use of family planning techniques and methods, optimal birth intervals can be planned and can thus increase the health and safety of another child.

2.1.5. Maternal age- an area where family planning has perhaps had its greatest impact is that of maternal age. Studies repeatedly showed that maternal age has a profound effect up on fetal death, perinatal mortality, and infant mortality. Very young mothers and mothers over 35 year expose themselves and their offspring to greater risks.

2.1.6. Genetic diseases- as more and more genetic diseases are identified; it becomes increasingly important that family planning resources become available to assist families on voluntary basis in the prophylaxis against these disorders (10).

The factors that may affect the use of modern methods of contraceptive which have been studied may be grouped as follows:

2.2.1 Health service determinants

2.2.2 Socio-cultural factors

2.2.3 Socio-economic factors

2.2.4 Demographic

2.2.5 Reproductive

2.2.6 Knowledge and attitude to wards modern methods (10)

2.2.1. Health service factors- in the area of health service, the time spent to travel from the potential user to the clinic or FP center (clinic) has been shown to be important. Cornelius and Novak demonstrated in five developing countries the effect of time to source up on use of modern contraceptives. A service quality study done in Latin America and the Caribbean indicated that the areas of quality that most often received more than 5% negative response from clients (termed negative response cases) were waiting time (mentioned in 70% of the surveys with a mean dissatisfaction level of 20%), ease of reaching clinic (in 54%, with average dissatisfaction level of 12%) and price of services (in 47% of the surveys and 10% average dissatisfaction level)(10,13).

2.2.2. Socio- cultural factors: - Culture is that whole which includes knowledge, belief, custom, art, morals, law and any other capabilities and habits acquired by man as a member of the society. As a member of a culture, people learn the values (attitudes) and beliefs (knowledge) of their parents and grand parents. The culture is transmitted through religion and through the education system.

Currently, there have been notable socio-cultural changes in sub-Saharan African region, but failure to increase contraceptive use has been observed. The role of religion as a fertility determinant has been the subject of considerable discussion. Sub-Saharan Africa may well offer greater resistance to fertility decline than any other world region. The reasons are cultural and have much to do with a religious belief system that operates directly to sustain high fertility. But, that also has molded a society in such a way as to bring rewards for high fertility. Through out sub-Saharan Africa, traditional religious beliefs and practices are embedded in lineage and descent systems that structure society and sustain high fertility. Two-thirds of all sub-Saharan Africans are now either Christian or Muslim, but most retain a belief in ancestral forces and in the concern of those spirits for fecundity and reproduction. High fertility (considerable number or surviving children) is associated with joy, the right life, divine approval and approbation by both living and dead ancestors. Conversely, low fertility is only too easily interpreted as evidence of sin and disapproval. Because reproduction and its context was the central pillar of African traditional religion, much disquiet surrounds fertility control practice that has not been long sanctioned. Innovative behavior is likely to be regarded as unnatural and, hence, sinful. It is also likely to have unpleasant sequelae. These may take the usual form of divine or ancestral punishment such as bareness, sickness, or child death. Much of the apprehension about FP in sub-Saharan Africa can be understood only in the context of attitudes toward infertility, sub fertility, miscarriage and infant death. These phenomena are not clearly separated and are the major indicators of divine or ancestral disapproval or malevolence from humans or spirits. After seeking information from a wide range of anthropologists who had worked in east Africa, Molnos concluded: the paramount objective of having children was that there should always be a

living descendant to remember and honor the departed. Children meant the continuation of the lineage and the perpetuation of the family name and spirit. A study in Sudan stressed the importance of beliefs regarding the role of ancestors and God in the creation of children and high fertility as a barrier to contraceptive use. In Ethiopia, the study conducted among urban youth in 1990 showed that Christians were the highest (84.2%) ever users of contraceptives. In this country the impact of religion on family planning services may not be considered to be negative. However, very little is known about differences in attitudes toward the practice of contraception as a function of religious identity (13, 14, 15, 16, 17, 18, 19, 20).

2.2.3. Socio-economic factors – Economic status is one of the important factors of contraceptive use. There is some evidence that women who have been employed outside there home are more likely to use MC than other women. Study conducted in a Peruvian high land community revealed that more women who use MCs work full time than non-users (93% versus 58%). Similarly a study done in Bas, Zaire indicated that economic status was positively correlated with use of a modern method. Also a number of studies done in different parts of the world, for instance, in 1993 in Lao people's democratic republic; multivariate analysis of factors affecting contraceptive use in Bangladesh, showed that the economically better of use modern contraceptive than the poor ones. Economic development affects fertility behavior. Employment in general and female employment in particular affects economic status of the family. Decreased fertility is mostly met with working women. According to a study by researchers in Egypt on the utilization of family planning methods among females in Kalyoubia Governorate, the majority of women utilizing FP methods were working and university educated (73.63% and 35.72%) respectively. The majority of women utilizing FP methods were wives of educated and working

husbands. Level of education was found to be significant, current contraceptive users in a study on factors that determine utilization of MCs in east, central and southern Africa. A survey on socio-demographic factors in southwestern Ethiopia in 1993 revealed, using odds of contraceptive use among illiterate women as a reference, all groups of women with higher levels of education have a much chance of being a contraceptive user. The mean years of education for contraceptive users was, 5.7, is also higher than 4.9 years for non-users. In this study also women who are office workers tend to use contraceptives. More over women of higher family monthly incomes have a much higher increased chance of contraceptive use compared to women with low monthly incomes of less than 50 Birr or between 50 and 99 Birr per-month. Another study in SNNPR by Dennis p-Hogan et al stated that working women in rural areas more often desire to limit their births, and more often use or intend to use contraceptives than do women who do not work for pay (14, 20, 23, 24, 25, 26, 27, 28,29,30).

2.2.4. Demographic Determinants- In this group, women's age, residence and marital status are important. Fertility rates differ by women's ages. These differences reflect reproductive preferences, the ability to act on these preferences, sexual behavior and fecundity. Age patterns of fertility differ considerably among regions, countries, and different groups with in countries. In most countries fertility peaks among women aged 20 to 24. In nearly half of sub-Saharan African countries surveyed, WFS, however, this peak extends to age 29. In addition in sub-Saharan Africa women continue to have children at older ages than elsewhere. In this region, women over 40 contribute to an average 0.5 children, which can be explained by lack of availability and use of contraceptive sterilization. A prospective study between 1995 and 1998 in Rakai district Uganda found women practicing family planning for prevention were predominantly in the age 20-39 years and were married. In all countries surveyed since 1990, the TFR is lower in urban

areas from a difference Just 0.1 child per woman in Mauritius to 3.4 children in Uganda. Urban residents usually have more interest in FP, because of their more access to MCs. Significantly higher proportion of married women were currently using MCs (31.6%) compared with single women (19.6%), according to a study in east, central and southern Africa, in 1996. from this study it was also possible to notice lowest contraceptive use among teenagers (15-19 Years) with prevalence of 16.5%, and use rate almost doubled for women in age category, 20-34 years (31.3%) and those who were 35 or more (31.7%). Ethiopian DHS data of 2000 also revealed that current use varies by women's age and is lowest among currently married age 15-19 and highest among women age 35-39. From this data currently married women in urban areas are nine times more likely to use a modern method (2, 29, 26, 3, 20, 24).

2.2.5. **Reproductive factors**- FP methods may be used either for spacing or limiting births to avoid mistimed or unwanted pregnancies. Hence a prospective study in Rakai district Uganda, out lined contraceptive use was higher among women who desired fewer children, among those who wished to space or terminate child bearing and among women with previous experience of unwanted births or abortion. In another survey in east, central and southern Africa, among women who had no children, 16.5% indicated that they had used some form of MCs. Of those who had between 1 and 4 children 32.4% said they had used contraception. And among those who had 5 or more children, 31.7% stated they had used contraception. A bivariate analysis from Bangladeshi study brought forth that those who do not desire additional children are more likely to be current users than those who desire additional children. In this study multivariate analysis showed that the prevalence of current Contraceptive use varies with the sex composition of living children. Couples who have only daughters are less receptive to the idea of FP and contraceptive use than their counterparts who have at least one son in addition to daughters. The 2000 Ethiopia

DHS reported that younger women report first use of contraception at lower parities than older women. Contraceptive use among women with no living children, for instance, is more than seven times for those age 20-24 than among those age 35-39 years, suggesting a shift to ward the early use of contraception and the desire to delay childbearing among the Ethiopian. A survey in southwestern Ethiopia in 1993 showed that the mean number of pregnancies, live births and living children for registered contraceptive users were 4.3,4.0 and 3.3 compared to 3.1, 2.7 and 2.2 for non-users. The difference is statistically significant ($P<0.001$). In this study a substantial increase in contraceptive use was noticed with increase in number of living children. According to a survey done in Sidama zone in 2003, among reproductive characteristics, only history of childbirth, desired number of children and number of living children were positively associated with current contraceptive use. In addition to the desire, current alive male children were also positively associated with current contraceptive use (31, 26, 24, 3, 29, 1).

2.2.6. Awareness and attitude of modern contraceptives- In order to use contraception, people must know about it, regard its use as beneficial, and be able to obtain the methods that they want to use. Surveys find that awareness of contraception is nearly universal among married women in developing countries and that most people approve of family planning. In most countries the mass media, especially television and radio are key sources of information about FP.

In 37 of 60 developing countries surveyed, at least 95% of married women know of at least one contraceptive method (modern or traditional). In 36 countries, at least 95% know of at least one modern method. Even in rural areas, 70% or more of married women are aware of at least one modern contraceptive method except in several African countries. Urban rural differences in awareness of contraception tend to be smaller than urban rural differences in contraceptive use. Awareness of specific contraceptive methods varies substantially among surveyed countries.

Awareness of oral contraceptive is wide spread, but in few countries less than one half of married women know about OCS. And similarly male condoms are among the best known methods in the world. While awareness of at least one contraceptive method is necessary for use, knowledge of range of effective methods is essential to informed choice of FP and makes contraceptive use more likely. Approval of FP as observed in demographic studies, in 27 of 50 countries more than half of married women say that they approve of FP and think that their husband also approve of it. Among 24 developing countries out side sub-Saharan Africa, only Mauritania, Pakistan and Yemen does joint approval fall below 50%. In sub-Saharan African approval among women, regardless of husband approval averages 74%. The 2000 Ethiopia DHS found that 82% of all women age 15-49 and 86% of all men age 15-59 know at least one method of family planning. Knowledge is slightly higher among currently married women and men (86% and 92%).

The pill is the most widely known by currently married women and men (82% and 85%) respectively followed by injectables which are known by seven in ten married women and men. From this survey differences by place of residence, region and education is marked about contraceptive knowledge. And knowledge of modern contraceptives among currently married women and men was higher in urban areas than rural (98% verges 84% for women and 98% versus 88% for men). The Ethiopia DHS also showed that less than one in four women stated that using contraception was mainly their decision alone; two thirds stated that using contraception was mainly a joint decision with their husband or partner, and one in ten mentioned the husband or partner as a decision maker. Concerning exposure to FP messages through mass media, the Ethiopian DHS reported that 17% of women and 29% men said they had heard or seen FP message on the radio or television or both during few months prior study. And radio was by far more important in 4% of women and 8% men respectively. Use of effective contraceptive

methods is facilitated when couples have positive attitude toward family planning. Attitudinal data were collected by asking women whether they approve of couples using FP and what they perceived as their husband's attitude to ward family planning.

In this survey women approval but husband disapproval (13%) and the reverse was found to be (1%). Urban women approve more likely than rural ones, educated women than women with informal education. A case-referent study in Butajira area showed, modern contraceptive practiced if when decision is made by both couples and when they freely discuss on the matters of family planning. A KAP study done around Gondar town northern Ethiopia indicated that, 99% of the respondents believe that FP is important 74.9% female and 77.4% males had knowledge about FP. (2, 3, 13,).

3. Objectives of the study

3.1. General objective

To assess the socio-cultural, demographic, and economic factors that influence modern contraceptive use in Mareka woreda.

3.2 Specific objectives

3.2.1. To find out the socio-cultural factors that deter modern contraceptive use.

3.2.2. To identify the knowledge, attitude and practice level of community on modern contraceptives.

3.2.3. To determine the demographic and economic factors that influence modern contraceptive use in the woreda

4. METHODS

4.1 Study area:

The study was conducted in Mareka woreda of the southern nations and nationalities region government (SNNPR). It is located in the southwestern part of the region and in the center of the Dawro zone's five woredas. The capital for the zone is found in this woreda and is called Tercha town. This town is found about 500 kms south west of Addis the nation's capital, and 264 km west of Awassa the regional capital. The woreda total population as estimated from 1994 census report is 88,962 of which 43,858 (49.3%) are males and the remaining 45,104 (50.7%) are females. Women of childbearing age (15-49 years) are also estimated to be 21137. Of the total population of the woreda 81720 (91.9%) reside in rural and 7242 (8.1%) in urban. The major ethnicities of the woreda are the Dawro (95.3%) and the remaining are the Menna, Manja and others. In the zone there is only one all- weather- road that passes through Tercha, the woreda and zonal capital that makes road transportation to Wolaita-sodo in the East and Jimma in the North West possible. The woreda is divided into 32 rural and two urban kebeles. Considering the climatic condition of the woreda, Dega (High land>2500m) 36% Weinadega (Midland 1500-2500) 51% and kola (lowland <1500 m) 13%. Like other rural woredas in Ethiopia the economic situation is agriculture. The Dawro are predominantly sedentary farmers whose main livelihood is subsistence agricultural production, which include mainly mixed farming i.e. crop production (ensete, maize, teff, cotton, peas, beans and spices) and animal husbandry. There are eight health institutions in the woreda, which render FP service. These are one district hospital, one health center, 4 health posts and 3 rural drug venders (38,40).

4.2. Study design.

A community based cross-sectional study with internal comparison was used. This helped to investigate factors that determine the occurrence of certain characteristics of the outcome variable.

4.3. Source population.

The source population for this study is, women of reproductive age group (15-49) who reside in Mareka woreda.

4.4. The study population

These were women of childbearing age (15-49) residing in Mareka woreda and were currently married. For this study only married women were considered because in majority of the time sexual activity is associated with marriage in a rural community and then the use of contraceptives.

4.5. Sampling unit.

For the quantitative part of the study, households in the woreda were sampled using the PPS (probability proportional -to- size) multistage stratified cluster sampling method.

4.6. Study Unit

Women aged 15-49 years, currently married and living in the sampled households were taken as a study unit

4.7. Sampling strategy and Sample size determination

For the quantitative part, multi-stage stratified cluster sampling method with probability proportionate-to-size was employed. Initially the woreda was stratified by residence in to two urban and 32 rural kebeles. Out of the two urban kebeles one was randomly selected and divided in to urban zonal clusters, where one was taken by lottery method and census of the households was done till the desired sample size was achieved for the urban area. The rural kebeles were

again re-stratified by vicinity to health service institution (one hour walking distance/5 km), one Keble from each randomly chosen, clusters of villages from the two involved rural kebeles randomly taken, direction to start visiting determined, and households were visited until the desired sample size was reached.

Sample size determination

Assumption: the sample size (n) was determined by using the formula for two-population proportion. Christian (orthodox and Protestants) and followers of traditional religion were used to calculate the sample size of this study to investigate why there was a difference in the contraceptive use of these two religious groups. But it was very difficult to catch these two groups from the field during the data collection, and still the sample has the power to enable us to compare groups like knowledge of the respondents; urban (67.6%), rural (46.1%) sample = 389, current use of modern contraceptives by residence; urban (30.9%), rural (7.5%) sample = 216, and current use by literacy status of the respondents; illiterates (5.1%), literates (16.7%) sample = 548. These calculations are done without changing the power (β) and confidence level (α).

$$n = \frac{[z\,\alpha/2\sqrt{(1+1/r)\,p\,(1-p)} + z\beta\sqrt{p_1(1-p_1) + p_2(1-p_2)/r}}{(P_1-p_2)^2}$$

Power (β) = 80%

Confidence level of 95%

Proportion Christian contraceptive users, CPR (15%)

Proportion of population with traditional religion, CPR (5.4%)

Population allocation ratio of 1:1

The calculated sample size is 349

Design effect of 2 and non response rate of 5% the final sample was 733.

The qualitative part of the study

This method was utilized to explore inherent views of the participants and further build-up and supplement the results of quantitative study. Semi-structured questions were used to guide the sessions; these questions were first written in English and converted into local language for the discussions. One person from study area who knew the local language very well was trained on audio transcription and note taking and employed. Focus group discussion was employed with care providers; health workers in the health post in one group and others in health centers and district hospital, for those working on family planning in one group. Clients or married women were also involved in focus group discussions. Religious leaders from orthodox and protestant churches were involved in in-depth interviews. The 'sharechos' (the shamans) were also interviewed to elicit their religious philosophies on fertility. For both types of qualitative data collecting methods convenient sampling was applied. In FGDs homogeneity with in groups was considered. A trained moderator and note taker was used. Transcription using an audiotape recorder and note was taken during each and every discussion session.

Information from the qualitative part was analyzed by re-listening to the tape recorder several times, recording the field notes, checking organizing, transcribing data, coding, conceptualizing and categorizing.

4.8 Data collection

A structured questionnaire prepared in English and translated in to Amharic was applied to collect information on socio-demographic, cultural and socio-economic characteristics of the study units. The questionnaire was prepared by addressing all important variables for the study. Trained ten data collectors, 4 female and 6 male high school completes who know the local language very well were trained for 3 days and employed.

4.9 Eligibility criteria

For quantitative part of the study women aged 15-49 years and currently in marriage bond were considered as eligible. Where as those out side marriage bond are excluded from the study. In the qualitative part, service acceptors (married women), were eligible for focus group. The service providers; those working in the health post, and had training of three to six months and above and currently working in the health post are considered as eligible. The other group involved health workers in the health center and district hospital and working on family planning and related services for the focus group. The in-depth interview involved religious leaders from orthodox and protestant (Mekane yesus and full gospel) churches. for traditional religions, known shamans around Waka town were included.

4.10 Assurance of data quality

To achieve a good data quality:

Questionnaires prepared in English and translated into Amharic language and then back to English to keep its consistency.

- Data collectors were selected based on ability to speak the local language and previous experience of data collection. Training was provided to selected data collectors for three days about the objective and process of data collection. Vague points and other problems encountered about the questionnaire given explanations and clarifications. Closer supervision was undertaken during data collection.

- Every questionnaire was crosschecked daily by the supervisors and the principal investigator.
- Problems faced were discussed over night with data collectors and the supervisors.
- Pre-testing was done around Tercha town and near by rural Kebele and care was taken not to mix up those who already participated in pre-testing of the questionnaires.

Study variables

1. Independent variables

Clients/service acceptors

1. Attitude
2. Knowledge
3. Age
4. Marital duration
5. Parity
6. Religion
7. Sex of alive children
8. Residence
9. Educational level
10. Economic status
11. Approval of husband or important others
12. Ethnicity

Dependent variable

Modern contraceptive use

4.11 Data entry and analysis

The collected data was entered and analyzed using EPI-INFO version 6 and SPSS statistical program. Crude and adjusted odds ratios from bivariate and multi-variate analyses were used to measure association between modern contraceptive use and independent variables. Furthermore, 95% CI and p-value were used to assess the degree of statistical significance.

Operational definition

Vicinity to HS - With in a one hour walk or with in 5 km radius of the health service institution.

Modern contraceptives (MCs) - Modern contraceptive methods which include oral contraceptive pills, injectables, condoms, implants IUDS diaphragm vaginal foam and male and female sterilization.

CPR – obtained by dividing current users by total women of childbearing age in a given area.

Current contraceptive user – A woman using any one of the modern methods currently

Ever-contraceptive user – A woman who have ever used any of the modern method

None contraceptive user – a woman who is not using any of the contraceptive methods currently.

Illiterates - those respondents who didn't go to school and couldn't read and write.

Ethical consideration

Ethical clearance was obtained from DCH and other appropriate and respective authorities. All the study participants were informed about the purpose of the study, their right to refuse and assured confidentiality and informed verbal consent was obtained prior to the interview. The instruments and procedures were not causing any harm to the study subjects, the community, the data collectors and supervisors, which were involved in the survey.

Dissemination and utilization of the results

The study findings will be disseminated to relevant authorities who deserve the results; DCH, MOH, RHB, and Mareka woreda health office.

5. *Result*

In this study 733 reproductive age group women were participated. Of these, 695(94.8%) were interviewed on first visit 35(4.8%) on the second and 3(0.4%) on the third visit. Seventy-seven or 10.5% of the respondents were urban dwellers and the rest 656(89.5%) were rural residents. The Dawro/Malaa were the majority ethnic groups representing 96.3% of the study population and the remaining were the minority Manja and others like Amhara and Oromo. Protestants were the majority religious groups, which comprise 65.1%, followed by orthodox followers 33.7% and 2.2% were traditional religious groups (see table -1). The mean age of the respondents was (29.2 $\pm$ 7.6) years. Majority (69.4%) of the study population were illiterate. About half of the contraceptive users and two-third of the none-users were illiterate. Only 6.4% of the study population was educated to the level of high school and above. Seventy-eight percent of the respondents were under wedlock for five and more years. Duration lived by the respondents at the place of survey was considered and more than half (56.1%) of the current contraceptive users were living there for ten years and (54%) of the non users were also living at the place of survey for up to ten years. About 45.3% of the respondents had a family size of six and above. The mean family size of the study population was (2.7 $\pm$ 1.4). The minimum family size was 2 and maximum ten (see tabe.1).

Proxy socio-economic characteristics like monthly income in Birr, ox, land, and radio possession were included in this study. Majority of the study population (82.4%) of contraceptive users and (89.1%) of non-users were found to be housewives. Monthly income in Birr was sought for urban dwellers and 53% of the current users and 70% of the non-users in the urban area were in the category of Birr <300 per month.

Table.1 socio-demographic characteristics of childbearing age women, Mareka woreda, 2005.

Socio-demographic Characteristics	Number	Percent
Residence		
Urban	77	10.5
Rural	656	89.5
Ethnic group		
Dawro/Malaa	706	96.3
Manja	21	2.9
Others	6	0.8
Age		
15-24	200	27.3
25-34	317	43.2
>34	216	29.5
Educational status		
Illiterate	509	69.4
1-6	133	18.1
7-8	44	6.0
9 & above	47	6.4
Marital duration		
< years	161	22.0
5-10 years	219	29.9
>10 years	353	48.1
Religion		
Protestant	477	65.1
Orthodox	247	33.7
Traditional religion	9	1.2
Duration lived		
<5 years	170	23.2
6-10 years	229	31.2
11-15 years	136	18.6
>15 years	198	27.0
Family size		
1-5	401	54.7
6-10	313	42.7
>10	19	2.6

Table.2 socio-demographic characteristics childbearing age women by contraceptive use status, Mareka woreda, 2005.

Socio-demographic characteristics	Contra-ceptive Users (255)	Non users (478)	Crude OR (95% CI)	Adjusted OR (95% CI)
Residence				
Urban	39	38	1.00	
Rural	216	440	2.09(1.30,3.36)*	0.96(0.78,2.41)
Ethnic group				
Dawro/Malaa	250	456	1.00	
Manja	3	18	1.10 (0.17,8.66)	1.10 (0.17,8.66)
Others	2	4	0.33 (0.33,4.14)	0.33 (0.03,4.14)
Age				
15-24	83	117	1.00	
25-34	113	204	0.78 (0.53,1.44)	1.59 (1.01,2.48)*
>34	59	157	0.53 (0.34,0.82)*	2.42 (1.36,4.3)**
Educational status				
Illiterate	147	362	1.00	
1-6	59	74	1.96 (1.30,2.96)*	0.73 (0.36,1.45)
7-8	22	22	2.46 (1.27,4.79)*	0.57 (0.29,1.12)
9 & above	27	20	3.32 (1.74,6.38)*	1.86 (1.25,2.77)*
Religion				
Orthodox				
Protestant	88	159	1.00	
Traditional religion	164	313	0.95(0.68,1.32)	0.99(0.71,1.40)
	3	6	0.90(0.17,4.19)	1.35(0.32,5.67)
Duration lived				
<5 years	64	106	1.00	
6-10 years	79	150	0.87 (0.57,1.35)	1.08 (0.71,1.40)
11-15 years	47	89	0.87 (o.53, 1.44)	0.88 (0.53,1.44)
>15 years	65	133	0.81 (0.52,1.27)	0.88 (0.55,1.39)
Family size				
1-5	146	255	1.00	
6-10	108	205	0.92(0.67,1.27)	0.92(0.67,1.27)
>10	1	18	0.10,0.00,0.70)	8.89(1.12,70.41)*

Ox/oxen possession for rural interviewees was included and majority, (68%) users and (70.7%) non-users replied that they had no any ox and majority of current users (60.2%) were found in the category of medium-rich. Where as almost half (52.5%) of the none-users were in the category of poor relative to their neighbors.

Interviewees were also asked to respond to reproductive variables, like; no.of pregnancy, no. of live birth, no. of abortion, no. of infant deaths, no. of living children, no. of desired children, no. of living sons; history of abortion, still birth, infant death and age at first pregnancy. The mean, minimum and maximum numbers of pregnancies of surveyed women were found to be 4.5 $\pm$ 2.9, 1 and 17 respectively. The mean number of live births of the study population is 4.1 $\pm$ 2.6 and the range is between 1 and 18 live births. From this study 26% of contraceptive users and 34% of non-users were found to have 1-3 infant deaths. The mean number of living children was found to be 3.5 $\pm$ 2.0. Requests on desired number of children produced that the mean number of desired children were 2.7 $\pm$ 1.3. The mean age at first pregnancy was found to be 17.7 $\pm$ 2.6 years (see table.4).

Knowledge of modern contraceptives was inquired in this survey, if the respondents heard about family planning and 82% replied that they heard. Probed and unprobed respondents were also asked to tell any of modern method they knew. The most Mentioned methods were oral pill, injectables, Norplant, and condom 98.4%, 89.8% 42.4%, and 20.8% by users respectively. And 63.6%, 64.2%, 20.0%, and 7.9% by non-users respectively (see fig.2).

Table.3 reproductive age women by proxy socio-economic characteristics, Mareka woreda 2005.

Proxy socio-economic variables	Contraceptive Users (255)	Non users (478)	Crude OR (95% CI)	**Adjusted OR (95% CI)**
Occupation				
Employee	16	7	1.00	
House wife	210	426	0.22(0.08,0.57)*	1.69(0.53,5.42)
Others	29	45	0.28(0.09,0.85)*	1.34(0.38,4.50)
Ox/oxen possession (Farmers)				
One pair	28	63	1.00	
Two pairs & above	12	19	1.42 (0.56,3.60)	0.78 (0.34,1.84)
Single ox	29	47	1.39 (0.70,2.78)	0.70 (0.37,1.34)
None	147	311	1.06 (0.64,1.78)	0.81 (0.49,1.35)
Perceived economy (Farmers)				
Poor	86	231	1.00	
Medium-rich	130	209	0.73 (0.50,1.05)	0.60(0.43,0.83)*
Radio possessions				
Yes	123	168	1.00	
No	132	310	0.58(0.42,0.80)*	1.31 (0.93,1.84)
Land possession				
None	89	142	1.00	
<2 hectares	94	236	0.64(0.44,0.92)*	1.67(1.16,2.34)*
2 & above hectares	33	62	0.85(0.50, 1.44)	1.40(0.84,2.33)

Table.4 reproductive characteristics of the study population, Mareka,2005.

Reproductive characteristics	Users (255)	None users (478)	Crude OR (95% CI)	Adjusted OR (95% CI)
No.of pregnancies				
1-3	128	191	1.00	
4-6	79	162	0.73(0.50,1.05)	1.52 (0.73,3.16)
7 & above	43	116	0.55(0.36,0.86)*	1.49 (0.58,3.84)
No.of live births				
1-3	136	208	1.00	
4-6	79	160	0.76 (0.53,1.08)	1.33 (0.60,2.96)
7 & above	35	101	0.53(0.33,0.84)*	2.84 (0.96,8.43)
No.of abortion				
No abortion	232	377	1.00	
1	16	60	0.43(0.23,0.79)*	1.00 (0.60,1.69)
2 & above	7	41	0.28(0.11,0.66)*	1.07 (0.56,2.03)
No.of infant deaths				
No infant death	184	287	1.00	
1-3	66	161	0.64(0.45,0.91)*	1.23 (0.86,1.75)
4 & above	5	30	0.2 (0.09,0.72)*	0.82 (0.44,1.92)
No.of living children				
1-3	148	254	1.00	
4-6	80	166	0.83 (0.58,1.17)	1.10 (0.77,1.57)
7 & above	22	44	0.86 (0.48,1.54)	1.04 (0.58,1.85)
No.of.desired children	99	162	1.43 (1.01, 2.03)*	0.78 (0.54, 1.13)
1-3	42	52	1.89 (1.16, 3.08)*	0.64 (0.39, 1.06)
4-6	109	255	1.00	
Don't want				
No.of living sons				
No any	48	88	1.00	
One	77	135	1.05 (0.65,1.68)	1.71 (1.04, 2.80)*
Two	66	116	1.04 (0.64,1.70)	1.39 (0.84, 2.31)
Three & above	64	139	0.52 (0.52,1.37)	1.42 (0.87, 2.32)

Table 4 continued…

Ever abortion				
Yes	21	101	1.00	
No	229	368	0.33(0.20,0.55)*	0.39(0.23, 0.65)*
Ever still birth				
Yes	10	34	1.00	
No	240	434	0.53(0.26,1.10)	0.85 (0.40,1.83)
Age at first pregnancy	18	80	1.00	
<15	225	369	2.71(1.54,4.82)*	0.37(0.21, 0.65)*
15-24	7	20	1.56 (0.51,4.67)	0.63 (0.22,1.78)
>24				

Reason why women use modern contraceptives was responded by majority 75.6% and 13.1% as child spacing and avoid unwanted pregnancy respectively (see fig. 3).

Desire for additional children was asked and the majority respondents 65.6% and 31.2% replied that they have few children and have few and need more sons respectively (see fig.1).

Ever users were asked why they stopped using and most 46.9%, 18.6% and 17.9% responded as desire to have more children, fear of side effects and medical problem (see fig.4)

Those not ever used were also asked why and 39.2% and 24.0% responded as want children and don't know what contraceptives are (see fig.5).

Again those currently using contraceptives said that they are using to space birth (80%) and limiting birth (20%) (See fig. 6).

BIVAIATE ANALYSES

Bivariate analysis of residence and contraceptive use status showed that urban dwelling women were two times more likely to use contraceptives than their rural counterparts [OR 2.09 (1.30, 3.36)]. Educational status was found very important in that those women who joined school and educated up to elementary, junior and high school and above were found to use contraceptives, 2.5 and three times more likely respectively [OR 1.96 (1.30, 2.96)], [OR 2.46 (1.27, 4.79)] and [OR 3.32 (1.74, 6.38)] as compared to illiterates.. Respondents aged 35 and above used contraceptives less likely than women aged 15-24 years old [OR 0.53 (0.34, 0.82)] (see table.2).

Proxy-socio-economic indicators like occupation and radio possession were found to affect contraceptive use positively. and land possession was to

Table.5 Communication and decision making on modern contraceptive utilization among study population, Mareka woreda, 2005.

Decision on FP is made by				
Me	32	64	1.00	
Both of us	190	356	1.07 (0.66,1.73)	2.25 (1.23,4.12)*
Others	33	58	1.44 (0.60,2.17)	0.99 (0.49,1.99)
Couples discuss Fp?				
Yes	226	335	2.67(1.66,4.33)*	3.60(2.02,6.43)*
No	27	107	1.00	

affect contraceptive use negatively. That is housewives and women who were in the group of others (daily laborers, petty traders, students etc…) used contraceptives less likely than employed women [OR 0.22 (0.80, 0.57)] and [OR 0.28 (0.09, 0.85)]. And also those who responded they did not possess radio and those who had less than two hectares of land were less likely to use contraceptives [OR 0.58 (0.42, 0.80)] and [OR 0.64 (0.44, 0.92)] (see table.3).

Bivariate analysis yielded negative association in women who had seven and above pregnancies, 7 & above live births, in women who had history of abortion, history of infant or child loss. This analysis also yielded positive association in women who enjoyed their first pregnancy when they were below the age of 15-24 years. Those women who were in the age range of 15-24 years were 2.7 times more likely to use contraceptives as compared to women below 15 years [OR 2.71 (1.54, 4.82)] (see table.4).

Communication on and decision about contraceptive utilization was seen and the odds of couple that made decision husband and wife together found to use contraceptives 2 times more likely than those who did not (see table.5).

Respondents were asked to respond on six positive and four negative structured attitude questions with three choices agree, disagree and neutral. Choice agree was scored as 3 for positive and 1 for negative questions. Disagree was scored as 1 for positive and 3 for negative questions. And finally the third choice neutral scored 2 on both sides. Accordingly the maximum score would be 3*10 and the minimum score would be 1*10. The mean attitude score for users and none users became 27.1$\pm$ 3.11and 27.31$\pm$ 2.91. a statistical test to see whether the two means are different suggested that there is a difference in attitude between the two groups, in that users had a good attitude towards contraceptives as compare to none users at t = 5.69, p.value (0.000). Further analysis was also attempted to see if there was

difference in attitude due to educational background and residence. Difference in attitude towards contraceptives was only observed due to difference in educational background. That is the educated ones had good attitude as compared to illiterate ones at t = 3.94 and p.value (0.000) (see table-6).

Table.6 mean score of attitude towards modern contraceptive use among childbearing age women Mareka, 2005.

ATTITUDE	N	mean	SD	t-test	p.value	95%CI
Attitude score						
Users	255	28.20	2.34			
None users	478	26.96	3.03	5.69	0.00	0.81, 1.67
Attitude by residence						
Urban	77	27.61	2.96			
Rural	656	27.37	2.86	0.70	0.49	-0.44, 0.92
Attitude by education						
Illiterate	509	27.12	2.97			
Educated	224	28.02	2.54	3.94	0.00	0.45, 1.35

FIG.1 Study population by reason for additional children,Mareka,2005.

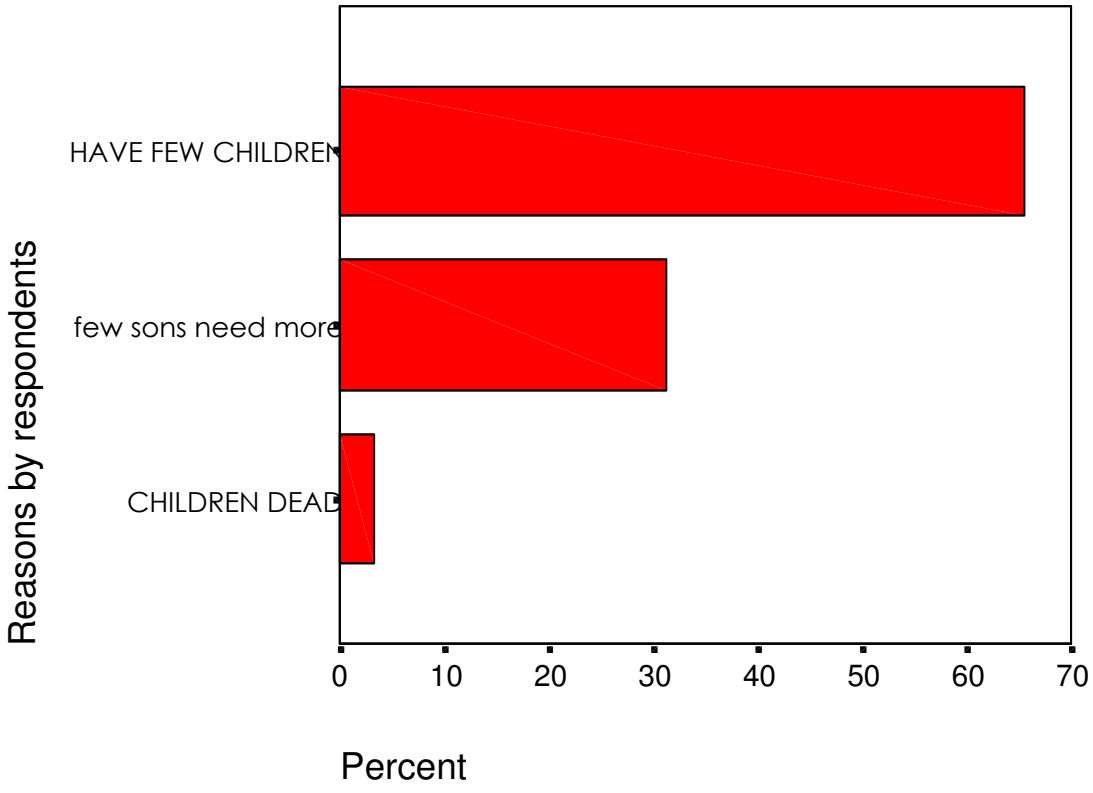
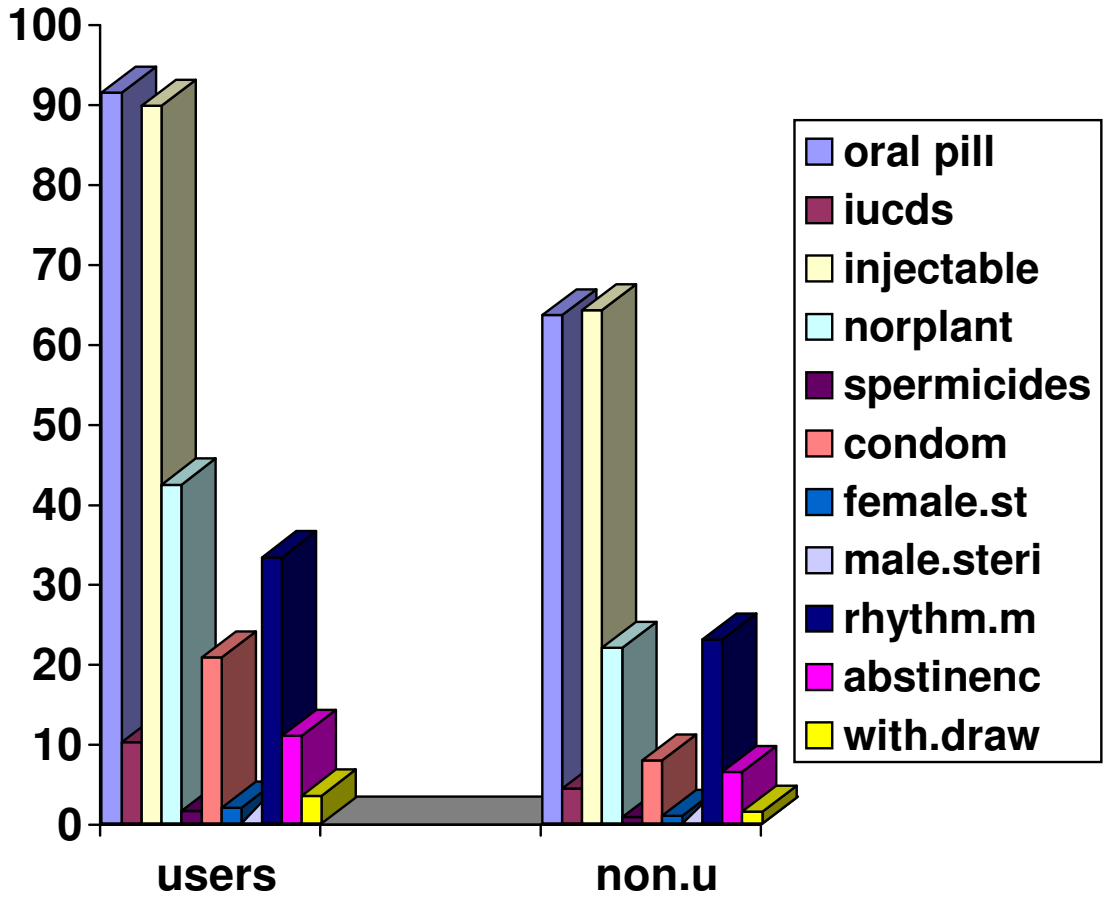


Fig.2 knowledge of modern contraceptive of study population, Mareka woreda, 2005.



MULTIVARIATE ANALYSES

Multiple logistic regression (enter) model was used to adjust for the effects of confounding if any existed.

On multivariate analyses socio-demographic variables like ethnic group, marital duration religion and duration lived at the place of survey showed no statistically significant difference. But age of the women and family size showed statistically significant difference. Women in the age group 25-34 were 1.5 times more likely to use modern contraceptives as compared to 15-24 years of age. And those above the of 34 were 2 times more likely to use modern contraceptives than those 15-24 years of age (see table-2). Multivariate analysis also showed significant difference for those women educated up to high school and above. Where those educated to high school level and above were to use contraceptives 2 times more than the illiterate ones.

Analysis of the family size of the study population showed that respondents who had >10 family members were 9 times more likely to use modern contraceptives than those who had 1-5 family members. Those women in the category of medium to rich perceived socio-economic status were to use contraceptives less likely than the poor ones. In this study women who ever had history of abortion were less likely to use contraceptives as compared to those who did not have history of abortion.

. Women who had their first pregnancy in the age range between 15-24 years were less likely to use contraceptives as compared to those less than 15 OR [0.31(0.17, 0.57) and p.value 0.001.(see table-4).

Respondents who responded that they decide on contraceptive use both husband and wife together, found statistically significant OR [2.29(1.25, 4.20)] and p.value 0.008. The structured questionnaire was used to illicit if couples discuss about family planning and those responded that they discuss about family planning were found statistically significant OR [3.96(2.20, 7.14)], (see table-5). Those couples who decide husband and wife in common

about utilization of FP were found to use contraceptives 2 times more likely as compared to those women who decide by themselves. And also couples who used to discuss about FP were found to contraceptives four times more than those who did not.

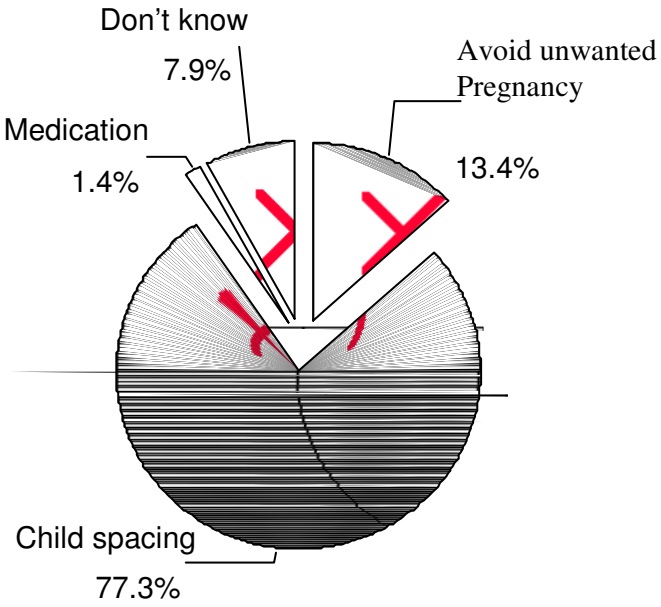


Fig.3 reason for modern contraceptive use by Study population, Mareka, 2005.

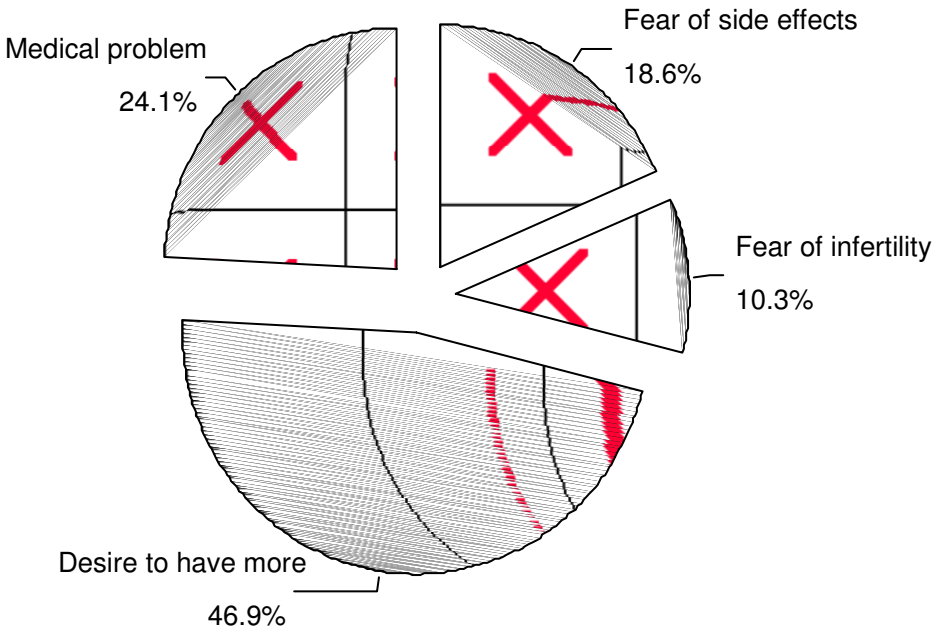
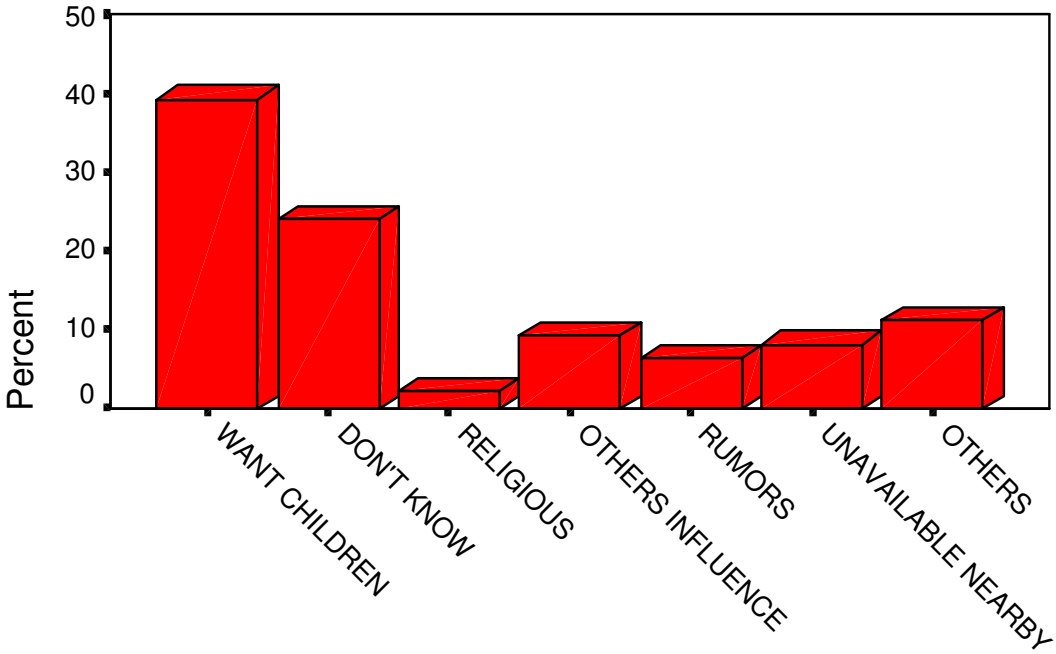


Fig.4 reason for stopping contraceptive use

by study population,Mareka,2005.

Fig.5 reason for non use of contraceptives by study population, Mareka, 2005.



reasons by respondents

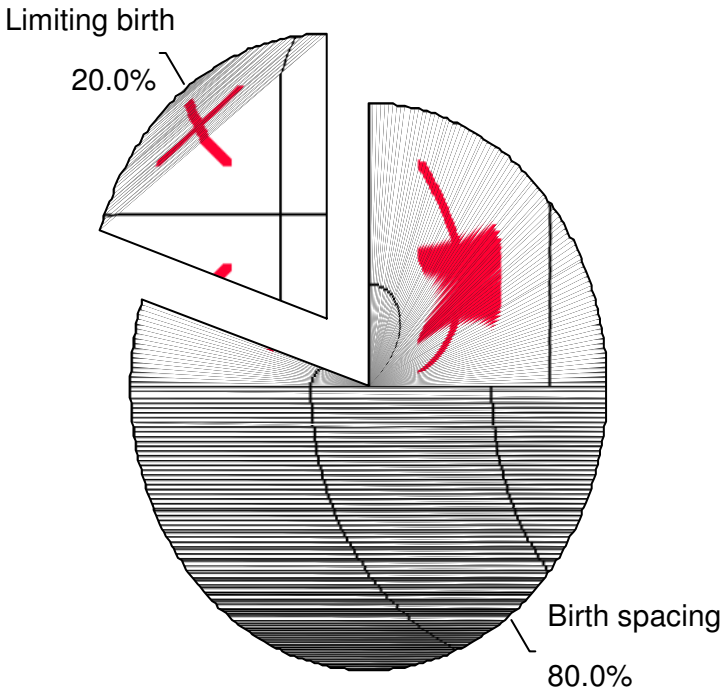


Fig.6 reason for current use of modern contraceptive use by study population,Mareka,2005.

Findings of qualitative study

In this study four focus groups were conducted and twenty discussants participated. Another two key informants and four religious leaders including the shamans participated in in-depth interviews.

Knowledge of contraceptives

The first focus group was conducted with married women. In this group the participants agreed that they know contraceptive medicines, which women take from health center and these are pills, injection for three months and a medication that is put under skin over upper arm. These methods were also the three most mentioned in the descriptive part of the study. Discussants also agreed that contraceptives are important for married women, and they reasoned out as that, contraceptives help them to limit and help us space birth this also coincide with the descriptive result where 80% and 20% of the respondents replied as birth spacing and limiting birth respectively. They added also that contraceptives help us keep our health and help us to care for our children. A middle aged woman said, "if birth is not spaced, a born child will not grow, children will be exposed to diseases, they become very small, become burden to a country, they bring hunger, and even the mother can get problem and suffering".

Reasons for interrupting and or none use of contraceptives

Rumors, side effects of contraceptive medicines and husband's influences were among the most mentioned reasons for default and none use. Another middle-aged woman uttered, "once I took a pill and swallowed, because my body is weak (gudat alebign) it

gave me nausea and I was sick and quit to take the pill and I don't know what happened to me inside until now". These were also among the cited reasons in the descriptive part, 15% and 18.5% responded as others influence and rumors and fear of side effects.

Religious influence on contraception

From the point of view of religion it was tried to group discussants as followers of traditional religion and Christians. But it was hardly possible to get the followers of traditional religion. And this group was represented by key informants.

Women in the Christian religion group- agreed that there is no any religious influence but religion always preaches that children are gifts of God. One of the respondents said, "These days no one believes in rubbish beliefs. But if there is, no religion preaching do not produce children. Religion always preaches children are gifts of God". This disagrees with result of the descriptive part, where all the respondents replied no any religious influence on childbearing.

The key informants- responded as there is religious influence from the shamans, but because of the flourishing protestant religion in many parts of the woreda, the effect is shrinking. They also pointed out reasons why owners of traditional religion encourage childbearing and discourage contraception as:

1. The gifts of those children born to their shamanic revelations are the economic basis of the shamans.
2. The shamans also get free labor power for all their daily life activities from children born to their shamanic revelations. A key informant said, a shaman preaches, "you are

not sick, and even if you are, what about our own grasses and leaves!, therefore you shouldn't take contraceptives because (Maridonto), or the merciless will be angry so you don't be out of my words. I will beg all in behalf of you". By so doing he prevents women from using contraceptives. In-depth interviews were conducted on views of different churches on contraception. In this part, priests and church leaders from three churches kalehiwot, Mekaneyesus and orthodox were participated. All agreed on one point, that is, first of all God's word says, "Be fruitful, multiply and fill the earth". But they are different on the grip they put around contraceptive use and birth control. A young priest from Orthodox Church said, "birth control is not necessary, because it is in contravention to God's words". All responded as that any one who wants to take contraceptive can take it. A Mekaneyesus church leader said, I myself use it at home. Even some church elders use prayers to control birth. But for those who are weak like me, can use contraceptives which are produced by wisdom given to people from God too". Church leader's views seem to contradict with what the focus group discussants agreed.

Shaman's views on contraceptives - in-depth interview was conducted with two shamans one old woman and the other old man around waka town. The old male shaman replied, "I from my side do not allow some one to limit birth, my belief do not order this. Until her potential to produce children is totally exhausted, women must produce". The other shaman also said, "uthayka, palkina halooy hoee". This means even an 'inset' (false banana) erupts into a number of shoots if cut and buried, the same is true to man she said. In this study health professionals were also participated in two FGDs to discuss what are the reasons for low contraceptive use in their catchments or woreda.

The two groups pointed out and agreed on the following reasons:

1. Shortage of supplies, specially, Depo-Provera (injectable contraceptive) which most women used to take.
2. They openly discussed that women's husband influence is the always-heard problem from their clients and is reason for default.
3. Women come to them after they have all the children they want.
4. Women asked to buy Depo-Provera from RDF (revolving drug fund) pharmacy when supply was short.

A community health agent who work in Gozo-shasho health post during the discussion session spoke out as, "women usually come to us after they are bored of producing many children". And brought his registration book and showed us that the minimum number of children for his clients is two and maximum is eight children. This is also observed by the descriptive part of the study. Where those women who had their first pregnancy in the age range between 15-24 years found less likely to use contraceptives. Because they postpone contraceptive to their later ages when they have enough of their family size.

Solutions mentioned by the discussants - health professionals, married women and key informants.

-Supplies should be availed

-Integrated health service should be given at community out-reach sites and health posts which include health education on family planning, vaccination, antenatal check up, and birth control distribution.

-The health education on family planning should include husbands and male members of the community.

-Contraceptives must be free of charge.

6. Discussion

Age of the women and education status of the women were found some of the important determinants of contraceptive use in this study. An area where FP has its greatest impact is that of maternal age. Studies repeatedly showed that maternal age has a profound effect up on fetal death, perinatal mortality and infant mortality. The age at first pregnancy is also very important one in that maternal age <18years and >35years puts the woman's life and here offspring at a greater risk. In this study the mean age at first pregnancy is <18years. Teenage pregnancies are to be followed usually by in adequate ANC, and women at this age group haven't finished their own growth so, the immature pelvic capacity may predispose to cephalopelvic disproportion which may result in fetal or maternal death or vesico-vaginal fistula. In this study population Women in the age group of 25-34 and greater than 34 years use contraceptives more than those below 15-24years OR [1.59(1.01, 2.48)] and OR [2.42 (1.36, 4.30)]. A study done in Uganda, showed women practicing family planning for prevention were predominantly in age 20-39 years and were married. Another study in the former Zaire

also stated contraceptive use rate doubled for women in the age category 20-34 and in those 35 and above. The Ethiopian DHS 2000 data also revealed that current use is lowest among currently married teenagers 15-19 and highest among women aged 35-39 (24,29,3).

In this study age at first pregnancy was significant. Almost 81% of the study population became pregnant for the first time by the age range of 15-24. This is an indication of postponement of contraceptive use for later ages**.** Or women tend to use contraceptives after they had their desired family size. Immediately after marriage women are expected to show their potential of producing children usually in a rural community and hence they are influenced not to use contraceptives as early as possible.

Education was found one of the important determinant factors in this study and women educated up to high school level and above were 2 times more likely to use modern contraceptives as compared to illiterates. This agrees with studies done in this country and elsewhere in Bangladesh, Lao people's democratic republic. Literacy helps in increasing contraceptive knowledge, change attitude towards use and contraceptive use itself. Education increases women's access to information of different sources. Education also help women to get better jobs to be in a better of position economically, changes their out look of fertility and imparts them sense of trust in scientific explanations and use of technology. Level of education was found to be significant in a study on modern contraceptive utilization in east central and southern Africa by Kaona et al., in this study current contraceptive use was significantly higher among women who had attained secondary education and above (24,3,27). Women who are in a better of

position in their socio-economic status, those who are employed outside of their houses were known to use contraceptive more likely than others. Economic development affects fertility behavior, employment in general and women employment in particular affects economic status of the family and decreased fertility is met with working women. In this study occupation was not statistically significant and Women who responded they perceive they are in a medium-rich economic status were found to use contraceptives less likely than those who were poor. This might be due to the fact that majority of the respondents (86.8%) housewives (13,23,24,25,22).

But when data is disaggregated by reason for their none use majority (43.8%) were responded that they want children. In a rural community where literacy status is very low and people are fatalistic , families in a better of position economically, tend to have more children whom they inherit their properties later. History of ever abortion is negatively associated with contraceptive use in this study. Childlessness is intolerable by any means and the woman should go for another pregnancy before she thinks of contraceptives. Infant loss was found insignificant in this study. It is a well-known fact that infant/child mortality necessitates another child for replacement purpose and there by hinders contraceptive use. In this study women who had one living son were found to use contraceptives 1.7 times more likely than those without a living son p.value <0.05. This agrees with studies elsewhere and in this country. According to a study in Bangladesh contraceptive use varies with the sex composition of living children. From the same study couples who have only daughters are less receptive to the idea of FP and contraceptive use than their counterparts who have at least one son in addition to daughters. A study in southern nations, Sidama zone, also indicated that currently alive

male children were positively associated with current contraceptive use (1, 24). A key informant from this study told that, he that who has a female child is not unfertile but no one to inherit his fortunes. Families' son preference is known for its postponement of contraceptive use until the family has the number of male child it wants. Son preference, beyond its influence on contraceptive utilization, it increases family size unnecessarily and also disparity of gender.

Decision on and communication about modern contraceptives was found significant in couples who used to discuss and decide husband and wife in common. This agrees with study in Butajira, DHS 2000 and studies elsewhere concluded that contraceptive use is higher among co-decide and discuss in common (2, 3, 13).

In a rural community where women's literacy status is very low, individual decision making might be impossible. Rather influences from husband and other relatives are common. Innovations are taken as counter to tradition and family planning is purely innovation. Therefore if the couple discusses the issue of family planning between and decide in common contraceptive use is facilitated.

In order to use contraception people must know about it, regard its use as beneficial. Surveys found that knowledge of contraceptives is nearly universal among married women. The pill is the most widely known by married women and men (82% & 85%) respectively followed by injectables which are known by seven in ten married women and men. Knowledge of modern contraceptives among currently married women is higher in urban areas than rural 98% versus 84%. A KAP study done in Gondar town northern Ethiopia indicated that 99% of the respondents believe that FP is important. 74.9% female and 77.4% males had knowledge about family planning in this study. In

our study 82% of the respondents had contraceptive knowledge and mentioned at least one method (40,3,33,2).

The three most mentioned methods by respondents were oral pill (73.3%), Norplant (29.1%) and condom (12.4%). The result includes probed and unprobed ones.

Strength of the study

In this study it was tried to include all the variables that can affect modern contraceptive use. Qualitative and as well as quantitative data collection methods were utilized to triangulate data on contraceptive utilization in this study.

Limitations

It was hardily possible to get information on followers of traditional religion. It could have been good if initially exploratory studies could have been done before the quantitative study was undertaken.

The inherent characteristics of the study design as to the association of dependent and independent which come first shouldn't be forgotten too.

Deliberate selecting out of cases when the sample size for the specified kebele is achieved which is the inherent characteristic of sapling procedure.

7. Conclusion

This study conducted among childbearing age women of Mareka woreda to determine factors which affect modern contraceptive utilization is concluded as:

1. **Socio-demographic and socio-cultural factors like residence, ethnic group, marital duration, religion and duration lived at the place of the survey were not associated with current contraceptive use.**
2. **Educational status at high school level and above is positively associated with current contraceptive utilization.**

3. **Women aged 25-34 and greater than 34 years were 1.6 and 2.4 times more likely to use contraceptives.**
4. **Women with large family size of >10 members were 9 times more likely to use contraceptives.**
5. **Proxy-socio-economic indicators like occupation, possession of ox and radio were not associated with contraceptive use.**
6. **Reproductive factors like number of pregnancies, number and history of infant loss, number of living children, and ever stillbirth were not associated with contraceptive utilization.**
7. **Number of living sons, , decision on and discussion about contraceptive use by both husband and wife were found positively associated with contraceptive utilization.**
8. **Significant difference was observed between users and non-users in terms of knowledge and attitude towards modern contraceptives.**

8. Recommendation

Based on the findings of this study it is recommended that:

1. Family planning IEC programs in the woreda should target women before marriage in every possible way in schools at junior level and above. Because women in this woreda go for child spacing and birth limiting after they had all the pregnancies and number of children they wanted were born.
2. Female education shall be stressed on. Through formal and informal ways.

3. Men shall be included in family health education at out reach sites and community level to address those who are inaccessible.
4. Further exploratory and analytic study shall be under taken to find the real association of some reproductive variables and influence of traditional religion on contraceptive utilization.

9. References

1. Abraham Alano. Comparative cross-sectional survey on factors related to lower effectiveness of family planning in Sidama zone SNNPR. MPH thesis, Addis Ababa University, 2003.
2. The info project center for communication programmes the Johns Hopkins Bloomberg School of public health, population reports, 31(2); spring 2003.
3. Ethiopian, Demographic and health survey, 2000. Central statistical authority Addis Ababa Ethiopia.

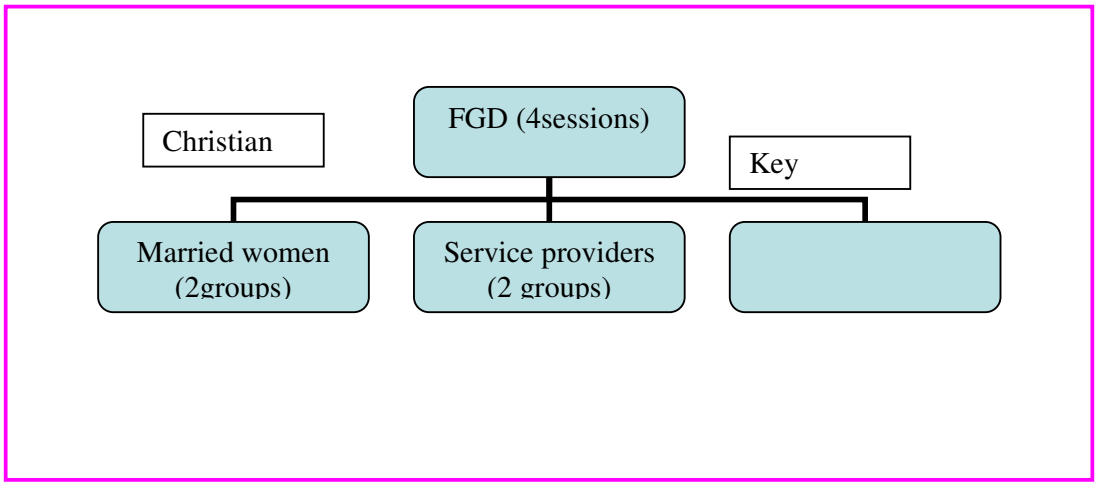
4. The transitional government of Ethiopia, National population policy, Addis Ababa, April 1993.
5. Zergu Taffese. Comparative study on modern contraceptive utilization between indigenous and non-indigenous women and factors affecting the effective utilization of program in Gambella. MPH thesis Addis Ababa University, 2003.
6. Jenny klotz and W/medhin T/Tsadik. Health status indicator survey, action-aid Ethiopia, koysha development program. Department of community health, Addis Ababa University Sept. 2000.
7. Fikru Tesfaye and Michael Dejene. Study of knowledge, attitude and practice related to STDS and HIV/AIDS in Koysha Development Area, Action-aid Ethiopia August 1999.
8. Mengistu Asnake, Tewodros Melesse, Birhanu Bibiso and Tesfaye Bedada. Follow-up evaluation of the effects of the EECMY community based reproductive health project in Hadiya and KAT zones of SNNPR, Ethiopia, Sept 1999.
9. Robert A. Hatcher, Gary K. Stewart. Felicia Guest, Richard finkelskein and Charles Godwin, contraceptive technology 1976-1977, 8th edition.
10. Fikreab Kebede. Characteristics influencing usage of modern contraception, MPH thesis, AAU 1989.
11. Helen M. Wallace and Kanfi Giri. Health care of women and children in developing countries. 1990 pp.196-199.
12. Richard. L. Day, MD. Fertility control, a social need- A medical responsibility.
13. Timothy Williams, Jessie schutt-Aine and Yvette cuca. Measuring FP service quality through client satisfaction exit interview. International family planning perspective, June 2000; 26(2): 63-71.

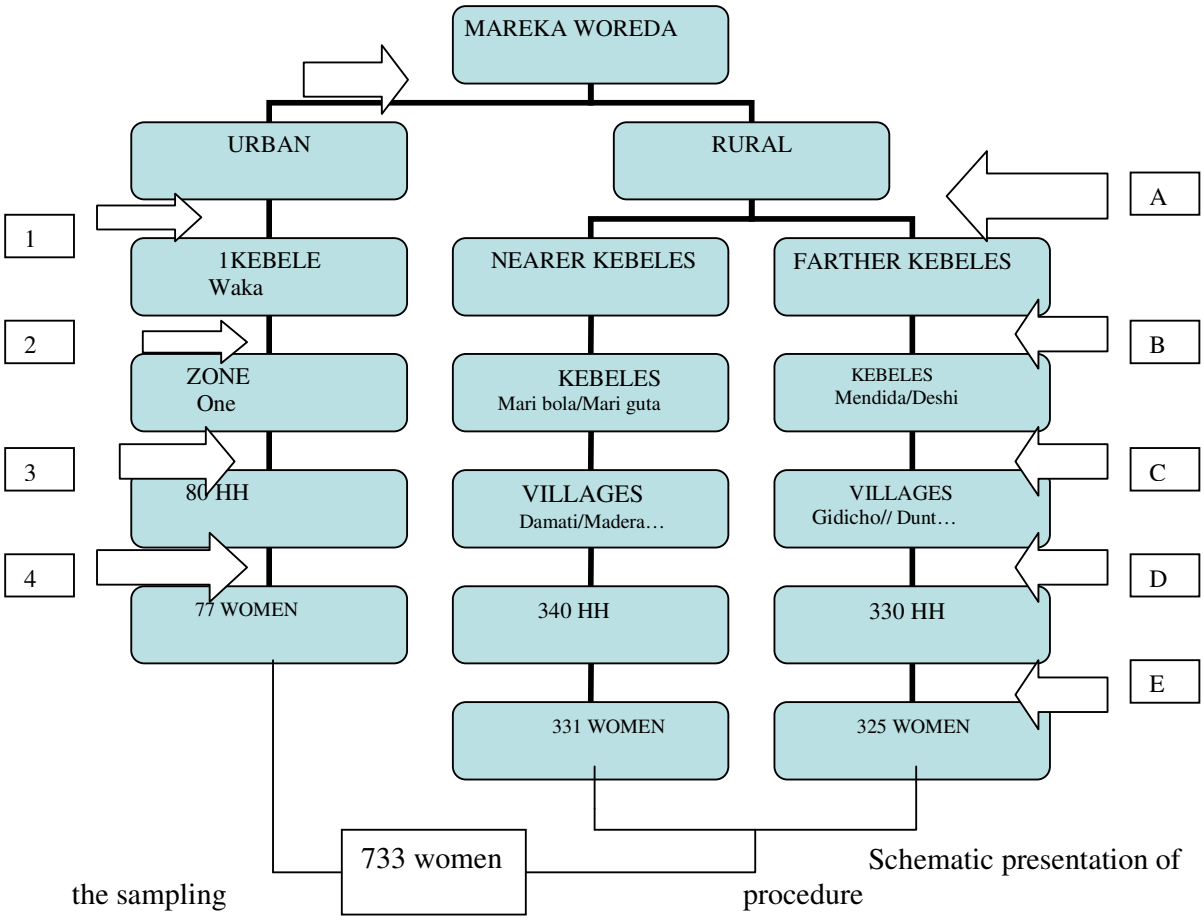
14. Tesfayi G.Selassie. Determinants of contraceptive use among urban youth in Ethiopia, Ethiop. J. Health Dev 1996, 10(2):97-104.
15. Tesfaye Umeta. Comparative study on determinants of modern contraceptive utilization among women in reproductive age group in rural Ethiopia, MPH thesis Addis Ababa University, 2001.
16. Caldwell, John C and pat Caldwell, 1987. "The Cultural context of high fertility in sub-Saharan Africa". Population and development review, 13(3): 407-437.
17. 1990b. "Cultural forces tending to sustain high fertility" in population growth and reproduction in sub-Saharan Africa. A. Bulatao. Washington DC the world bank. PP 181-199.
18. Kaona A.D. Frederick et al. Factors that determine utilization of modern contraceptives in East, central and southern Africa. Afri. J. Health sci. 1996; 3(4):133-137.
19. Philip B. Adongo, James F. Phillips, and Fred N. Binka. The influence of traditional religion on fertility regulation among kassena-nankana of Northern Gahanna, studies in family planning. 1998; 29(1): 23-40.
20. John C. Caldwell. Health transition: the cultural, social and Behavioral determinants of health in the 3rd world, soc. Sci med vol36NO.2 PP: 125-135, 1993.
21. John C. Caldwell and pat Caldwell. Is the Asian FP program model suited to Africa? Studies in family planning 1988; 19(1): 19-28.
22. Jane T. Bertrand, Nlandu Mangani, Matondo Mansilu and Evelyn G. Landry. Factors influencing the use of traditional versus modern family planning methods in Bas Zaire, studies in FP 1985; 16(6):332-342.

23. Monica Das Gupta. Why is son preference so persistent in east and south Asia? A cross-country study of china, India and the republic of Korea, development research group, World Bank mdasgupta@ World Bank org.
24. Md. Shahid ullah and Nitai charkaborty. Factors affecting the use of contraception in Bangladesh: A multivariate analysis, Asia-pacific population journal; 8(3) (1993, PP.19-30).
25. Halla M. El Hady, Adel, A. Abdul-Maksound and Mona H. El Mahdy. Study of the utilization of F/P methods among females in kalyoubia Governorate, the Egyptian journal of community medicine. 14.(1):7-14,19996.
26. Kaona A.D. Frederick et al. Factors that determine utilization of modern contraceptives in East, central and southern Africa. Afri. J. Health sci. 1996; 3(4):133-137.
27. Kotsalythoune Himmasone, Mamisone Audomevincent Fauveau, Isabelle Godin and PhonetheP. Phosena. Socio-cultural and economic Determinants of contraceptive use in Lao people's Democratic republic, Asia-pacific population journal; 9(2): 3-24, June 1994.
28. Mizanur Harman. The impact of child mortality on subsequent contraceptive acceptance and continuation. Studies in FP 1998, 29(3):268-281.
29. Meserate Shiferaw and Samuel G/Hiwot. Socio-demographic factors influencing the use of modern contraception in an urban population in south western Ethiopia, Ethiop, J. Health Dev. 1993; 7(1): 1-7
30. Denis P.Hogan. Betemaniam Berhanu and Assefa Hailemariam. Household organization, women's autonomy, and contraceptive behavior in southern Ethiopia, studies in FP 1999; 30(4):304-314.

31. UN Population bulletin, March 1999; 54(1) 11-14.
32. Thomas Latulo et al. Trends and determinants of contraceptive use. Studies in FP, 2000; 31(3): 217-227.
33. Tizaina Leone. Zoe matthens and Gianpero dalln zuanna.
34. Nicola R.Dean. A community study of child spacing, fertility and contraception in west pokot district Kenya, sic. Med vol 38(11): 1575-1584:1994.
35. Khalil, S.A.: Ismael, M.T. and youssof, A.A. Factors affecting reproductive health of women in rural community in Egypt, 1996, the Egyptian journal of community medicine, 14(1): 77-86.
36. The info project center for communication programmes the johns Hopkins Bloomberg School of public health, population reports, Vol 20(2), May 1992.
37. John C. Caldwell and pat Caldwell. Is the Asian FP program model suited to Africa? Studies in family planning 1988; 19(1): 19-28.
38. SNNPR Health profile quick reference, Dawro zone, year II. Volume II July 2002.
39. Yigzaw Abebe prevalence and Factors associated with usage of contraceptives around Gondar town – Ethiop. J. health Dev 14(3):327-334, 2000.
40. Data Dea. The challenges of integrative power. Hierarchy and political change in Dawro, Southern Ethiopia. Dissertation for the Dr.polit. Degree department of social anthropology university of Bergen, 2003.

ANNEX.1- SKETCH OF THE FOCUS GROUPS

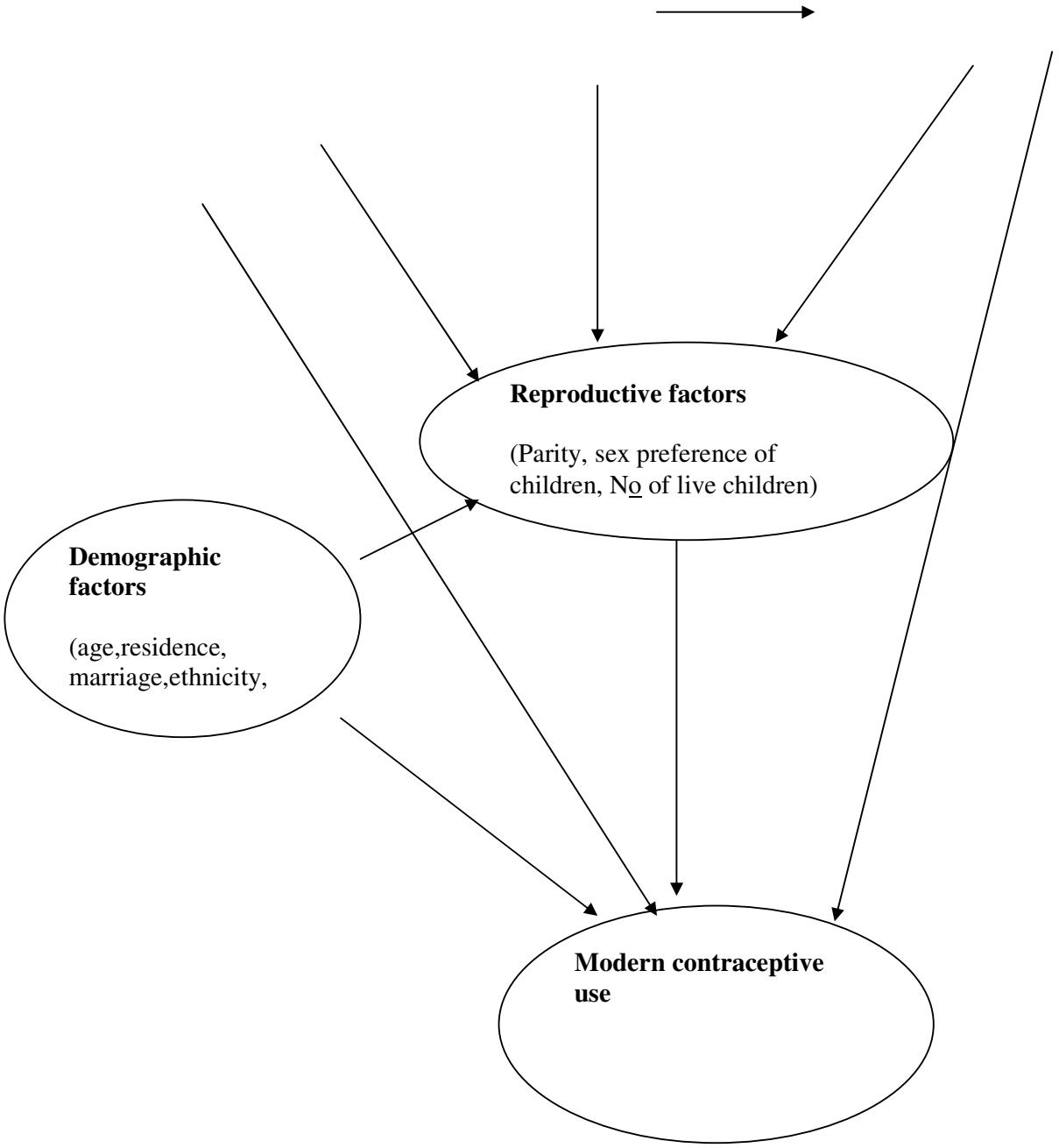




Schematic presentation of the sampling procedure

1.SRS. one kebele from two urban kebeles.	A.stratification byvicinity to health service
2.SRS.one zone selected	B.SRS.one kebele each from far and near kebeles
3.cluster sampling introduced & all HH visited	C.SRS.villages from selected kebeles
4.SRS.if two women in the same HHs.	D.HHs selected from village clusters
	E.SRS.if two women in the same HH.

Annex-2_ CONCEPTUAL FRAME –WORK FOR FACTORS INFLUENCING MODERN CONTRACEPTIVE USE



ADDIS ABABA UNIVERSITY DEPARTMENT OF COMMUNITY HEALTH

Annex.3-

Annex.3.1-For quantitative part of the study

Questionnaire on assessment of modern contraceptive use among reproductive age women (15-49) years and currently married.

001. Study area: zone _____

Woreda _____

Kebele _____

1. Urban ☐ 2.rural ☐

Village/ketena _____

002. Are you willing to participate in this study?

1. Yes
2. No

003. Signature of the interviewer, which certifies that, informed verbal consent is obtained.

Name_____

Sign _____

004. Time table of visiting/revisiting

	First	Second	Third
Date			
Result			

Result 1.completed 2. Rejected 3. No respondent 4. Partially responded
5. Other_____

PART-ONE SOCIO-DEMOGRAPHIC ASSESSMENT

NO	Questions	Responses	Code	Skip
101	How long did you live/stay here?	_____mm/yy		
102	What is your age? Enter no	_____years		
103	What is your ethnicity?	1.dawro/mala 2.mena 3.manja 4.others		
104	What is your family size?	1.male ____ 2. female ____ 3.total ____		
105	What are the no of children ever born to you?	1.Male ____ 2.Female ____ 3.Total ____		

106	Have you ever been to school? If yes, Maximum grade attained, enter no If no,	1.yes _____ 2.no _____ _____ 1.only read and write_____ 2.illiterate _____		
107	For how long are you married? Enter no in years/months	_____		
108	What is your main occupation?	1.farmer 2.government employee 3.mass org. employee 4.house wife 5.student 6.self employee 7.daily laborer 8.other, specify_____		
109	What is your religion?	1. Orthodox 2. Protestant 3. Traditional religion 4. Others, specify_____		

PART-TWO SOCIO-ECONOMIC STATUS

201	Do you have radio?	1.yes_____ 2.no _____	code	skip
202	What is your monthly income in Birr?	1. <50 2.50-149 3.150-299 4.300-499 5.500&above 6.no response		
203	(For farmers only) how many pair of oxen/ox do you have?	1.one pair 2.two pairs 3.three pairs 4.single ox		
204	What is the roof made of?	1.corrugated iron 2.thatched Bamboo reef		
205	Plot of land owned by the household	1.none_____ 2.<2hec_____ 3.2-4hec_____ 4.>4hec_____		
206	Compared to your neighbors where do you classify your household income status?	1. Poor_____ 2. Average_____ 4. Rich_____		

PART-THREE REPRODUCTIVE HISTORY

301	Have you had any pregnancy before?	1.yes_____ 2.no_____ 3.No response_____		
302	If yes to ques.301.how many pregnancies have you had? Enter no.	_____		
303	What was your age at first pregnancy? Enter no age in years	_____		
304	How many live births have you had? Enter no	1._____ 2.no response		
305	Have you ever-experienced abortion?	1.yes _____ 2.no _____		
306	How many times? Enter no	1._____ 2.no response		
307	Did you have stillbirth?	1.yes 2.no 3.no response		
308	If yes how many times? Enter no	1._____ 2.no response		
309	Did you have any child died after birth?	1.yes 2.no 3.no response		
310	If yes, how many? Enter no	1._____ 2.no response		
311	What is the sex composition of your living children? Enter no	1.male _____ 2.female _____ 3.total _____		
312	Do you want any more children?	1.yes 2.no		
313	How many? Enter no	1.male _____ 2.female _____ 3.total _____		
314	Why did you want more children?	1.have only few children 2.need more sons 3.cild/children died 4.no response 5.others speech		
315	Does your belief/religion influence the no of your children?	1.yes 2.no 3.no response		
316	If yes how does it do?	1.our God needs many children 2.ancestors happy with children		

		3.childlessness is a curse 4.no response 5.others,specify		

PART- FOUR ATTITUDES TOWARDS MODERN CONTRACEPTIVES

401	Children will have better opportunities for education, If their parents practice FP.	1. agree 2. disagree 3. neutral		
402	FP will help improve one's standard of living.	1. agree 2 disagree 3. neutral		
403	FP helps a mother to regain strength before her next baby.	1. agree 2. disagree 3. neutral		
404	Child spacing helps protect the health of children and mothers.	1. agree 1. disagree 2. neutral		
405	A woman who has too many children looks tired and wear out.	1. agree 2. disagree 3. neutral		
406	FP causes a loss of confidence between a husband and a wife.	1 . agree 2. agree 3. neutral		
407	Wives who practice FP will be abandoned by their husbands.	1 . agree 2. disagree 3. neutral		
408	A couple that practice FP will have conflict in their marriage	1 . agree 2. disagree 3. neutral		
409	. Contraceptive use may cause infertility in a woman	1 . agree 2. disagree 3. neutral		
410	A couple that practice FP has a happy family.	1. agree 2. disagree 3. disagree		
411	. Do you discuss about FP with your husband?	1 .yes 2.no 4. strongly 5. disagree		
412	Who usually makes decision about FP in the family?	1.me 2.both of us 3.our parents 4.neighbours		

		5.my husband 6.others, specify…..		

PART-FIVE MODERN CONTRACETION KNOWLEDGE

501	Have you ever heard of modern contraception?	1. yes 2. no	code	skip
502	What type of methods do you know? Method 1. pill 2. IUDs 3. Injectables 4. Implants/Norplant 5. spermicides 6. condom 7. female sterilization 8. male sterilization 9. rhythm method 10. abstinence 11.withdrawal 12.others, specify----------	Yes no ------ ------ ------ ------ ------ ------ ------ ------- ------ ------- ------ ------ ------ ------ ------ ------ ------ ------ ------ ------ ------ ------		
503.	Why do women use modern contraceptives?	1. prevention of unwanted pregnancy 2. child spacing 3. medication 4. prevention of STDs 5. I don't know 6. Others, specify----------.		

PART-SIX PRACTICE OF MODERN CONCTRACEPTIVES

601.	Would you tell me to which group you belong?	1. current user 2. ever user 3. non user 4. other, specify---------.		
602.	. If you are currently using a contraceptive method, for what purpose?	1. birth spacing 2. limiting birth 3. don't know 4. other, specify----------.		

603.	Why do you stop using the contraceptive? (for ever users)	1. Fear of side effects 2. fear of infertility 3. desire to have more children 4. religious prohibition 5. medical problem 6. preferred method not available 7. rumors 8. unacceptable in my culture 9. important others influence 10.others, specify----------		
604.	604. Why are you not using contraceptive? (for non users)	1. want children 2. I don't know what contraceptives are 3. religious prohibition 4. important others influence 5. rumors they are not good 6. unavailable in the near by 7. other, specify----------		

.

Annex. 3.2- Focus group discussion guide, 2004.

A. ***Introduction***

1. We thank you all for coming to this session.
2. Your presence is very important.
3. My name is Mr. x. and my colleague here with me is called _____we are a team from zonal health office.

B***. Purpose***

1. We will be discussing your reactions to why contraceptive use is low in your community/ why majority of the women in your community are not using modern contraceptives.
2. I am interested in all your ideas, comments and suggestions.
3. There are no wrong or right answers.
4. All comments, both positive and negative to the point of discussion are welcomed.

5. Please feel free to disagree with one another. We would like to have many points of view.

We will audiotape all your comments and opinions so that we could not miss any of your ideas while trying to take notes. And I assure you that all your comments are confidential, used for research purpose only. I want our session to be a group discussion, so you need not wait for me to call on you. Please speak one at a time, so that the tape-recorder can pick up every of your suggestions and comments. We have a lot of points to cover, so I may change the subject or move ahead. Please stop me incase if you want to add some thing more.

Each participant is asked to introduce herself and tell us something about you.

Part I. For married women

1. Do people in your community know ways to avoid becoming pregnant?
   - What are they?
   - How do they help?
   - Any health problem due to unspaced pregnancy?
2. Contraceptives are very important for every married woman. Do you agree? / Disagree? Why?
3. Why do people in your community not using modern contraceptives/

Tips, # of sons, # of living children, husband influence, important others influence.

4. Does a religion/ belief in your community something to do with the use of modern contraceptives?

Tips; 1. Our religion encourages many children.
2. Our ancestors' gods like to many children.
3. Our lineages continue if we have many children 4.not to have children/ to have few children is taken as sin.

5. What do you think should be done to improve con traceptive use in your community

Part II. **Focus group discussion guide for health workers**

1. Why do you think is contraceptive use low in this woreda?/in your catchment area?
   - Knowledge factors
   - Attitude
   - Socio-cultural
   - Demographic
   - Reproductive
   - Socio-economic

2. What do you think should be done in order to improve contraceptive use in your institution's catchment?

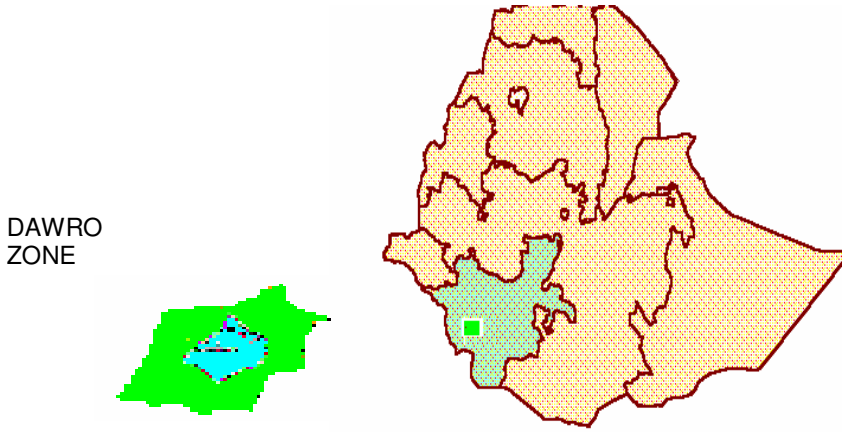
Part III. **In-depth interview guide for religious leaders**

1. How do you conceive fertility from your religion point of view?
2. Do we need to control fertility? How?
3. What do you think should be done to control fertility?
4. What do you suggest about contraceptive use in line with your religious philosophy?
5. In your religion if some one is using contraception, Does the spirit god/ 'Ayana' you believe in punish him/her? How? What does it do to him/her? (For traditional religion)

Closing

A.. Before we end, I would to go around the audience once more and ask each of you if there is anything else you would like or dislike to say about the idea of modern contraceptive use in your community we have described earlier. Any thing else you like or dislike, any thing that we have not mentioned that would be important to you in modern contraceptive use.

B. Thank you so much for coming to this session. Your time is very much appreciated and your insights have been very helpful.




H
MAREKA