

Addis Ababa University

College of Health Sciences

School of Public Health

ASSESSMENT ON FAMILY PLANNING UTILIZATION AMONG MODEL AND NON MODEL FAMILY WOMEN ENROLLED IN URBAN HEALTH EXTENSION PROGRAM IN KIRKOS SUB-CITY ADMINISTRATION

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES

OF

ADDIS ABABA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH

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Declaration

I The Under signed declare that this thesis is my original work, has not been Presented for a degree in this or any other university and all source materials used for the thesis have been duly acknowledged.

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This thesis has been submitted for examination with my approval as University advisor. **DR. MESFIN ADDISSIE (MD,** MPH)

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DATE_____

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Abbreviations/Acronyms

AA	Addis Ababa
AAHB	Addis Ababa Health Bureau
AAU	Addis Ababa University
AIDS	Acquired Immunodeficiency Syndrome
CHWs	Community Health Workers
CI	Confidence interval
CP	Contraceptive
CPR	Contraceptive Prevalence Rate
CBRHAs	Community Based Reproductive Health Agents
DHS	Demographic and Health Survey
FHI	Family Health International
FP	Family Planning
HEP	Health Extension Program
HSDP	Health Sector Development Program
KSHO	Kirkos Sub-city Health Office
L10K	**T**he Last Ten Kilometres
MDGs	Millennium Development Goals
OR	Odds ratio
TFR	Total Fertility Rate
TTBAs	Trained Traditional Birth Attendants
UHE-Ps	Urban Health Extension Professionals
UHEP	Urban Health Extension Program
WrHO	Woreda Health Office
X_2	Chi-square

Abstract

Background

In 2003, the Ethiopian Federal Ministry of Health (FMOH) launched a new health care plan, the "Accelerated Expansion of Primary Health Care Coverage," through a comprehensive Health Extension Program (HEP).Recognizing the huge gap between need and health care services available, the FMOH has focused on "providing quality promotive, preventive, and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children (10).

Objective

To assess on family planning service utilization among model and non model family women enrolled in urban health extension program of kirkos sub-city administration.

Method

A cross sectional study design using a quantitative method was used .A total of 424 (212 model families and 212 non-model families) participated the study. To establish associations between dependent and independent variables, P values were used. Chi-square test was used to select associated independent variables for multiple logistic regressions. Adjusted ORs that controls the confounding effects of other covariates were calculated using the multiple logistic regression models of SPSS version 16 statistical programs. Statistical significance was considered at P-value less than 0.05.

Result

More in model than non model families (100% versus 93.4% respectively) have heard about cp methods (with p value=0.0002). From those ever use one of contraceptive methods, large proportion study population 210(81.08%) [109(78.4%)) and 101 (84.1%),) model and non model respectively] were they prefer to be informed by health professional and followed by other (like friend husband..) were 27(10.42%) [18(12.9%) and 9(7.5%) for model and non model families respectively] , media (radio and Tv) were 15(5.79%) [5(3.59) and10 (8.33%) for model and non model families respectively] and finally and the lest referred choice of study population were7 (2.7%) [7(5%) and 0 (0) for model and non model families respectively] with X^2 =4.21, p value =0.000021.

Conclusion

the contribution of UHEP on FP utilization can be measured by considering the provision of the program in all aspects of FP service utilization like let the community to inform about the service and then to be as the major preferable informed choice for them. By this measurement the UHEP programs lacks the aspects expected to be done, as we have mentioned earlier.

Recommendation

FMOH should see the implementation strategies of UHEP on providing and upgrading family planning service.

1. Introduction

1.1Background

In 2003, the Ethiopian Federal Ministry of Health (FMOH) launched a new health care plan, the "Accelerated Expansion of Primary Health Care Coverage," through a comprehensive Health Extension Program (HEP). Recognizing the huge gap between need and health care services available, the FMOH has focused on "providing quality promotive, preventive, and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children. The policy places particular emphasis on establishing an effective and responsive health delivery system for those who live in rural areas. (10).

The Ethiopia government's has ten years of experience in implementing the rural health extension program which was adapted for the urban setting and is an explicit part of the current Health Sector Development Plan (HSDP) IV. Ethiopia's Urban Heath Extension Program is an innovative government plan to ensure health equity by increasing demand for essential health service through the provision of health information at a household level and access to service through referral to health facilities(7).

Urban Health Extension Program is one of the components of General Urban Health Service system. It is contained in primary health service tier (Health Centre and Health Extension program) and implemented at Kebele level. The number of Urban Health Extension Professionals varies in accordance with the population of the town. An Urban Health Extension Professional provides service to 500 households (2500 people) and, schools and youth centers in the area. Therefore, there will be eight Health Extension Professionals for a Kebele with 4000 households (20,000 people) (8).

The package of intervention is in four primary areas: Hygiene and Environmental Sanitation, Family Health Care, Prevention and Control of Communicable and Non-Communicable Disease and Injury Prevention, Control, First Aid, and referral. While many intervention are similar to the rural program, some key differences from the rural setting include the prevention and control of non-communicable disease, mental health, and violence and injury prevention, as these are expected to the urban populations more significantly(9).

Unlike the rural setting, the government choose to use clinical nurse professionals with three years of nursing education in private colleges as the primary outreach workers and provided them an additional three months training to develop their public health skills(9).

Health Extension Program service delivery is different from other health service deliveries in that the delivery process is changed from facility based to community based. This means the community gets the service not in health facilities, rather the Health Extension Professionals and Vanguard Health Associates bring the service to the community(8).

HEP is initially implemented in what are called '**Model Families'** identified by HEWs from within community members. The model families are required to have "acceptance and credibility" by the community, and then the HEWs assist them to be "early adopters of desirable health practices to become role models in line with heath extension packages" .Once they have adopted these health practices, the model families are presumed to diffuse health messages "leading to the adoption of the desired practices and behaviours by the community" FMOH: Health Extension and Education Center: 2007: 12).

In Addis Ababa, there were1468 diploma nurse health extension professionals are deployed in the year 2001, in all ten sub cities of the region but through time the number of urban health extension professionals were getting reduced due to different factor.

In kirkos sub city previously 120 urban health extension professionals are deployed but currently there are only 81 urban health extensions professionals are working.

This study mainly focus on that weather or not the Urban Health Extension Program does it have been any contribution on family planning service utilization.

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1.2 Statement of the problem

According to Planned Parenthood, Ethiopia has among the highest fertility and maternal death rates in the world. Approximately 1 out of every 7 women die from pregnancy or abortion related complications. Ministry of Health (MOH, 1996) of Ethiopia provide family planning services to 8.5 million women across the country during the next years. If the program fully implemented, the plan will definitely have a positive ripple effect across the Ethiopian society. Although family planning tools are available in Ethiopia, access to them has been a major hindrance for the majority of the women. Planned Parenthood states that only 13% of Ethiopian women -and only 4% in rural areas -use modern contraception. This is despite the fact that, as studies show, approximately 60% of the women in the country approve family planning. Undoubtedly, improved access to family planning and other reproductive health services in the country could significantly combat the incidence of maternal mortality and improve the state of women. Comprehensive, high-quality sexual reproductive services can help to prevent the unnecessary deaths of women in the country. "Traditionally, women in Ethiopia have been consigned to strict societal roles, based on cooking, raising children, and a muted voice in decisions affecting them," says World Bank (2001).

Family planning, considered an essential component of PHC and RH, plays a major role in reducing maternal and newborn morbidity and mortality. It contributes to the achievement of the MDGs(4). One of targets of the Ministry of Health, with respect to improving maternal and child health, is to increase the contraceptive prevalence rate (CPR) to 66 percent by 2015. In order to achieve this target, the Ministry has given priority to the provision of safe motherhood services such as family planning in the community(11).

Use of any contraceptive method varies notably by region, ranging from 63 percent in Addis Ababa to 4 percent in the Somali region. Use of any modern contraceptive methods is highest in Addis Ababa (56 percent) and lowest in the Somali and Afar regions (4 and 9 percent, respectively).Current contraceptive use increases with women's education. Twenty-two percent of women with no education report current use of any method, compared with 68 percent of women with more than secondary education. Similarly, current use of any contraceptive method increases with wealth, from 13 percent of women in the lowest quintile to52 percent of women in the highest quintile (8).

Current contraceptive use is lower among young women and among older women (some of whom are no longer fecund) than among those at the intermediate age groups. For example, 5 percent of all women age 15-19 report current use of any contraceptive method. This proportion increases until it peaks at 29 percent in the 30-34 age group, after which it decreases steadily to 11 percent among women age 45-49. A similar pattern is observed among currently married (8).

Reproductive health interventions changes the level of current use of contraceptives among women of reproductive age group and their partners Although family planning use among women of reproductive age has been increasing from its virtually nonexistence level, it is still low in Ethiopia(23).

Contraception has been consistently lower while unmet need is higher kirkos sub city, together with other two sub cities, compared to the other sub cities found under Addis Ababa region. Besides, the urban health extension program (UHEP) launched in 2009, showed a low success rate in 2014, 20 %(Sub city's annual FP achievements).

Family planning provision to urban communities in the country is one of the 16 packages in UHEP. Urban based female health extension professional are overburdened with many activities which may deter the program’s success.

1.3 Rationale of the study

The findings or results obtained from this research could be used as a baseline for Researchers who are interested to examine further on in this area .And also for Governmental and non-governmental organizations could take intervention measures and set appropriate plans to reduce and improve the existing level of awareness and practice of family planning by identifying and giving priority for the areas which have low and poor practice.

The outcome study will show the program does it have been any contribution on family planning service utilization so far. And also use as input for MOH, policy maker and other politician and programmers to strength the implantation strategy of UHEP.

2. Literature review

In most developing countries in general, and in sub-Sahara Africa in particular, the problem of population growth and reproductive health challenges include - high maternal mortality, high population growth rate, total fertility rate and much unmet need for family planning in the world. The situation in Ethiopia is still much worse than most African countries (Ethiopia Trend Report (ETR; 2007)). In spite of the fact that family planning service delivery facilities and other supplies have increased in number in the country, a significant portion of the Ethiopian population is still living in abject poverty.

Family planning is the practice of a couple to prevent or avoid unwanted birth and control the pacing between child birth to help create a small and planned family. It is the best way to control the rapidly and massively growing population. So, family planning contributes to promote the health and welfare of the family and thus contribute effectively to the social development of a country. The health of mothers is not only affected by nutrition status but also by early marriage, frequent pregnancies, early motherhood, abortion etc. Moreover, the health of a child is also affected by the mother's health status. In this context family planning provides advices and methods to avoid the above events.

Family planning is essential to the well-being of women, men, adolescents, and the community at large. It offers women opportunities to plan and space pregnancies in order to achieve personal goals and self-sufficiency.

The controversy over abortion has influenced family planning programs and also had implications for women's health. To appreciate how the controversy has affected family programmes, some background on the relationship between family planning programmes and abortion is useful. From the earliest days of family planning programs, prevention of abortion to reduce related maternal mortality and morbidity has been an important part of the health rationale for promoting contraception(Seltzer J., 1998). Abortion is illegal in Ethiopia; studies indicate that abortion is widespread and generally performed by untrained persons. The work of Planned Parenthood Federation of America (PPFA) in Ethiopia focuses on reducing maternal death and disability by preventing unintended pregnancies and increasing the availability of affordable, safe abortion services. Despite the decriminalization of abortion, many medical providers are not offering services due to discomfort, lack of knowledge about the law, or lack of skills.

Family planning methods vary according to their convenience, cost, effectiveness, side effects, risks, and benefits for the individual. Family planning users are best able to evaluate the relative importance of these factors based on their preferences; their desired family size; stage of life which is period in the development of progress; goals of delaying, spacing, or limiting future pregnancies; health status; relationship status; and living conditions. Family planning costs are often treated as a minor issue in parents' decision making. In the developing world, 137 million women who do not want to get pregnant are not practicing contraception. The key cause of this unmet need for contraception is that contraception is often quite costly to individuals in terms of commodities (pills, condoms, IUDs, etc.), transportation, and provider fees for contraceptives and health care services, even when subsidies are provided by the government. In addition, there are significant non-economic costs, such as health concerns, social disapproval and spousal resistance, as well as unnecessary medical barriers (e.g., requiring a doctor instead of a nurse or other trained health care workers to provide contraceptives). This unmet need is in turn responsible for most of the 76 million unplanned pregnancies that occur each year. About half of these pregnancies end in abortion and the other half end in births; both contribute unnecessarily to health risks for mothers and children, to the cost of raising families and to the adverse impact of population growth(Bongaart et al., 2009).

2.1. Family planning and HEW

In most developing countries in general, and in sub-Sahara Africa in particular, the problem of population growth and reproductive health challenges include - high maternal mortality, high population growth rate, total fertility rate and much unmet need for family planning in the world. The situation in Ethiopia is still much worse than most African countries (Ethiopia Trend Report (ETR; 2007)). In spite of the fact that family planning service delivery facilities and other supplies have increased in number in the country, a significant portion of the Ethiopian population is still living in abject poverty.

Family planning is the practice of a couple to prevent or avoid unwanted birth and control the pacing between child birth to help create a small and planned family. It is the best way to control the rapidly and massively growing population. So, family planning contributes to promote the health and welfare of the family and thus contribute effectively to the social development of a country. The health of mothers is not only affected by nutrition status but also by early marriage, frequent pregnancies, early motherhood, abortion etc. Moreover, the

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Community Health Workers (CHWs) can considerably increase coverage where access to health facilities is difficult and service utilization is already low. They can play a vital role in increasing access to family planning and working within a community-based team to educate women on the importance of attending antenatal, delivery, and postnatal care with a skilled professional(7). WHO report show the effectiveness of community-based interventions with CHWs is important to increase coverage particularly HIV care, PMTCT, ARV therapy and give information to the patients(18).

The study done in Southwest Nigeria, the report show the utilize volunteer community workers to expand the availability and accessibility of primary health care services, family planning information, and non-prescription contraceptives in rural areas. These workers play a vital role in linking the village with government health facilities. The responsibilities of community health workers are promotion contraceptive and other services. After 2 years of program services in Oyo State, approval of family planning increased from 20% to 50% and the desire to postpone the next pregnancy beyond the period of postpartum abstinence increased from 15% to 34%. Knowledge of a modern family planning method rose from 24% to 45%. Current use of contraception rose from 1.5% to 4.5%(19).

A study done in Uganda show the importance of community health workers reduce morbidity and mortality in children under five and neonates; and trained traditional birth attendants may improve prenatal outcomes and appropriate referrals(20).

Assessment conducted by USAID/African bureau, USAID/Population and RH with ministry of Ethiopia, Malawi, Rwanda show health extension worker are credited with the achievement of doubling contraceptive prevalence from2005-2011(21).

A study done by L10K (the last ten kilometres) in 2009 in L10K areas show HEWs can effectively provide Family planning with a broad method mix and improvements in the contraceptive prevalence rate (CPR) exceeded rates of maternal care use with the exception of antenatal care: Amongst married women of reproductive age, there was a 32% rate in 2008/9, 29% reported in 2008 and a 16% CPR in L10K areas in 2005(17).

A study done in Jema zone show HEWs have contributed substantially to the improvement in women's utilization of family planning, antenatal care and HIV testing. However, their contribution to the improvement in health facility delivery, postnatal check up and use of iodized salt seems insignificant(16).

Family planning is one of the main sub package under UHEP, if the program have implemented properly as per the guideline , the utilization of FP service shows significance change, especially on those that have enrolled in the program before, the so called Model families than their counterpart ,Non model families, by considering other determinant factors (like income ,litracy,age marital status and other) and which is achieved by assessing in all aspects of family planning service utilization starting from providing knowledge of FP practice ,, make them to choose one of the methods of family planning service and thereby to let them to use family planning service.

The following three questions that is stated next will be addressed and critically analyzed in this study to, one weather UHEP provide as source information of communities about FP than any other sources, Second ,does UHEP contribute to informed choice for the community to choose family planning methods ,Third, does UHEP gave any contribution to use those methods.

3. Objective

3.1 General objective

To assess on family planning service utilization among model and non model family women of urban health extension program in kirkos sub-city administration.

3.2 Specific Objectives

- To determine and compare knowledge of methods of contraceptives among model and non model families
- To assess the degree of utilization of family planning service among women in model and non model families
- To assess the role of urban health extension program and associated factors on utilization of family planning service
- To asses and compare the contraceptive choice and preferences of model and non model families

4. Methodology

4.1. Study design

Cross sectional comparative study design using quantitative methods.

4.2 Study area

Kirkos subcity has 11 Woredas, . The organs of power of a Sub-City are the Sub-City Council, Sub-City Chief Executive, & Sub-City Standing Committee; and that of Woredas have Woreda Council, Woreda Chief Executive, Woreda Standing Committee, and Woreda Social Court.

The size of the sub city is about 16.26km^2 and it is estimated that in 1 km^2 there are about 13501 populations is reside .The total projected population of Kirkos sub city is estimated to be 220,991 which is 8.07% of the entire population of the city for the year 2007 EFY (source CSA) of which 103,334 (46.5%) are males and 117,677 (53.25%) are females. The age and sex structure is of pyramidal type, which is typical of a developing country that is wide at the base and sharp at the tip. The rate of natural increase of the population is estimated be 2.6 nationwide and 2.1 for Addis Ababa (CSA 2007), considering the net migration of 1.29% the population growth rate is 2.8%.

Children Under one year of age constitute 2.24% of the total population which is estimated to be 5303, Women of childbearing age group are expected constitute 34.64% of the total population which is 76551. Dependency Ratio is calculated to be 37.4% (Addis Ababa bureau of BoFED, 2004 EFY). Religious wise 82.9 % of the population are Christians (81.4 % orthodox, 7% protestant, 0.8% Catholic) .10 % are Muslims and 0.04% are traditional and others(CSA, 2007).

In terms of literacy about 88.6 percent of the population of kirkos subcity was literate and of this 94.7% and 83.3% were male and female respectively (CSA 2007).

The health office is authorized to organize, Co-ordinate and regulate public health activities in the sub city.

As of the re-organization and decentralization process of the Kirkos Sub City Administration in 1995 EFY a new structure is put in place for the Sub city having 3 core processes , and 2 support processes at the sub city health office level. The Sub-city Health office is directly responsible for the management of the seven health centres.

KirkSubcity Health Office is responsible for the delivery of promotive, preventive, curative and rehabilitative health services in the Sub city

The health service coverage of the sub-city is 63% this coverage is attributed from 7 governmental health sectors and 90 private health sectors the number of health professionals that found in this sub city is 569, other professionals (supporters), 317 and currently 81 urban health extension professional(UHE-Ps) and 18 urban health extension professional supervisors are working.

4.3 Source of population

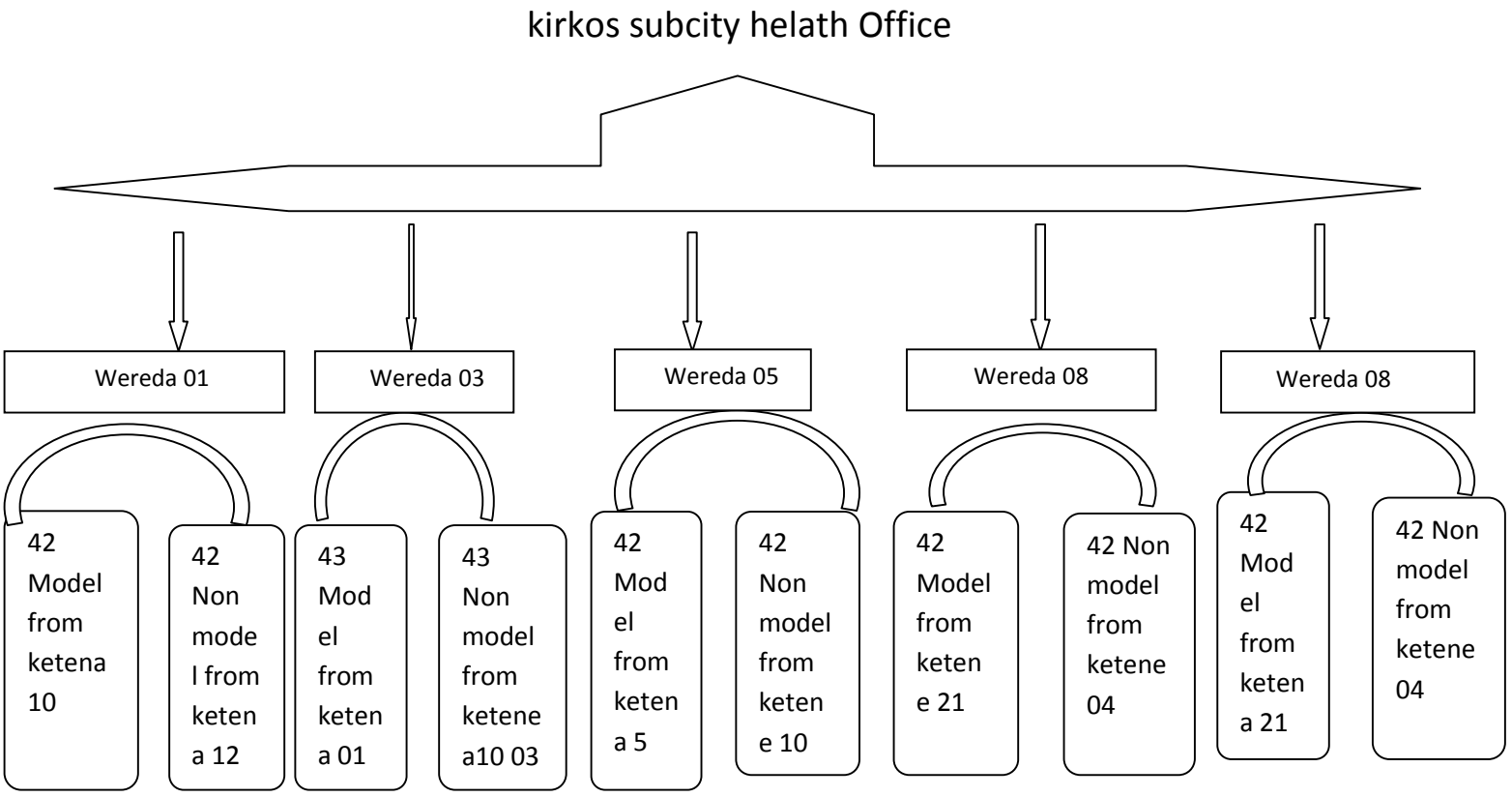
All women in kirkos sub-city administration.

4.4 Study population

Women in reproductive age group in model and non model families that enrolled in urban health extension program in selected wereda of the kirkos sub-city administration.

4.5 Sampling procedure

In order to select a fairly representative sample of women in reproductive age group that are found in kirkos sub-city selection of weredas and ketenes have been utilized multiple stage of probability sampling techniques schematically presented bellows (i.e from 11 woredas by simple random sampling five weredas were selected and from these five woredas two ketenas from each woredas selectede by simple random sampling ,as schematically presented)



4.6 Sample size determination

$$n_1 = Z\alpha/2 \left[\sqrt{(1+1/r)p(1-p)} + Z\beta \sqrt{p1(1-p1)+p2(1-p2)} \right]^2 \Big/ (p_1-p_2)^2$$

Where; n1 = is sample size of model families ,

n2= sample size of no model families ;

r=n2/n1 =1

p1= population proportion for model families

p2= population proportion for non model families

P= $\frac{p1+ rp2}{1+ r}$; Z α/2 =1.96 Z β=0.84

To determine the sample size the following assumptions were made: from the total model families that are graduated about 48% are women that found in reproductive age group (arbitrarily for lack of study) and from those that are not model families about 34% were women that found in reproductive age group. A 14% difference was to be detected between model and non model families. With a 95% confidence level, power of 80%, design effect of 2, non-response rate of 10% and 1:1 population allocation ratio. Calculated sample size: n1=**211.** Therefore the total population for two study population were 422.

4.7 Inclusion and Exclusion Criteria

Inclusion criteria

Those women that found in reproductive age group for both model and non model families.

For model families

Those women that are graduated because of they have fulfil all graduation criteria's.

For non model families

Those women that had never been participated in the program before.

Exclusion criteria

Those women that do not found in reproductive age group for both model and non model families.

4.8. Data collection process

A structured anonymous closed questionnaire was developed by revising questionnaires developed for similar study and adapting it to the objectives of the present study to collect quantitative data. The questionnaire was designed in English and was translated to Amharic. Then different persons with a good background in both languages translated the Amharic version back to English. Experts validated the different version so that the original meaning was retained. Finally the instrument was administered in Amharic.

The questionnaire was pre-tested in a similar setting among woredas not selected for the survey to ensure understand ability. At the end of the pre-test issues of clarity of the questions, of the skipping pattern, sensitivity of the question and the relevance of the study were discussed with the participants. In addition to a few comments on the correctable mistakes on the questionnaire, some more substantial corrections were made.

Furthermore, participants in the pre-test commented on the importance of the explanation of the objectives of the study keeping confidentiality and privacy to obtain honest responses Thus finalization of questionnaire considered all the points that arose during the pre-test and necessary changes were made to make the questions appropriate and understandable. Five degree holder data collector, they were health extension supervisor , and one field supervision engaged on of this study and they were nominated by principal investigator from their a respective woredas. Professionally they were environmental health and health education and promotion.

To further facilitate data collection, one supervisor and ten facilitators were recruited and trained intensively for three days both before and after the pre-test of the instrument. To avoid contamination of information, data from the woredas were collected on the same days. The principal investigator served as supervisor and overall coordinator of the survey and handled all administrative and logistics issues.

4.9. Data management and Analysis

After collection of data the responses was coded and entered into a computer using EPI Info version 6.4 statistical programs, after data entry finished, 10% of the responses were randomly selected and checked for consistency of data entry. Then printed frequencies were used to check for outliers and clean data. Data is leaned accordingly and then exported to SPSS version 16.0 for further analysis. To establish associations between dependent and independent variables, P values were used. Chi-square test was used to select associated independent variables for

multiple logistic regressions. Adjusted ORs that controls the confounding effects of other covariates were calculated using the multiple logistic regression models of SPSS version 16 statistical programs. Statistical significance was considered at P-value less than 0.05.

4.10. Measurement variable

Independent variable

Socio-demographic factors (age, marital status, , religion, , perceived economic status of the amily, model family status, size of family, job status,); knowledge of FP method, visited by UHEPs uring the last 12 months Family planning knowledge and Communication with husbands about contraceptive.

Dependent variable

Family planning service utilization

4.11.Ethical considerations

Ethical clearance was secured from the ethical committee of AAU medical faculty research and publication committee before the study was launched. All concerned bodies were officially have been contacted through letters and permission has been obtained at all level.

After the purposes and the procedure of the study were explained verbal consent has been obtained from all respondents. Confidentiality of the responses have been assured to the respondents by anonymity of the self-administered questionnaire, by keeping the privacy of the respondent while filling the questionnaire.

4.12. Operational definition

- **Family planning** allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

- "**Urban**" **is** a place, which has municipality or has a population of 2000 people or more, at least 50% or more of the population makes its living with activities other than agriculture, and it is implemented in places with a population more than 10,000. If the population is less than 10,000 people, the program will be implemented in other urban places selected by the concerned region (Ministry of Labour and Urban Development). (FMOH implementation manual).

- **The Urban Health Extension Program"** is a program, which is part of the general urban health services system, implemented by the integrated efforts of the society and development partners with the aim of creating healthy community, healthy residence and working environments. The program enables the delivery of health promotion, diseases prevention, basic health care and patient referral services easily to the community
- **The Urban Health Extension professional:-**Female professional diploma nurses trained on the Urban Health Extension Program for 3 month. These professionals implement Urban Health Extension Packages in family, residence areas, schools and youth centres.
- **Model family:-** those families that are found from all households under Urban Health Extension Program and these families are expected to fulfil at least 85 % all graduation criteria; and are considered as a role for other those that are expected to perform as they perform.
- **Non model family:-**those families that were found from all households they have never been enrolled in Urban Health Extension Program because they are not interested or UHE professional didn't reach them.

- **Household**: in this study households refers to all individuals residing in the same family and sharing the family dishes

5. RESULT

5.1. Socio demographic status of study population

Among 422 respondents, 211(50%) were model family and 211(50%) were non model family women. Majority of the respondent (51.2% and 44.1% model and non model respectively) were found in age group of 25-34 and the mean age of model family was 33.39 and the mean age of non model was 31.29.Highest proportion of model family 49(23.2%) are found in first levels (elementary) of education while 16(7.6%) have first degree and above, for non model family about 73(34.3%) were secondary level completed, where as only 2(0.9%) were can read and write. Majority of model and non model family 179(84.8%) and 160(75.1%) were married; and also only 2(0.9%) and 1(0.5%) were widowed, respectively.

Majority of the respondents model and non model (184(87.2%) and 183(85.9%) were orthodox respectively. About 57(27%) of model family have two children and 29(13.7%) were don't have child, while highest proportion of non model families women, 70(33.2%), don't have child and only 15(7.1%) were have more than three children.

Table 1.0 Distribution of respondents by socio demographic status of study population, in kirkos sub city May 2015

variables	Model family	Non model family	Total no.(%)
Age group			
15-24	8	41	49(11.6%)
25-34	108	94	202(47.86%)
35-44	82	56	138(32.7%)
45-49	13	20	33(7.84%)
Marital status			
Divorced	6	4	10(2.3%)
Married	179	160	339(80.3%)
Unmarried	24	46	70(16.58%)
Widowed	2	1	3(0.71%)
No. Of children			
One	35	55	90(21.32%)
Two	57	50	107(25.35%)
Three	43	21	64(15.16%)
More than three	45	15	60(14.21%)
Don't have child	31	70	101(23.93%)
Levels of education			
Not educated	11	10	21
Read and write	11	2	13
Secondary level	46	73	119
First level	49	36	85
Secondary level	38	39	77
Twelve completed	40	40	80
Diploma	16	11	27
Degree and post graduates			

5.2. Contraceptive knowledge of respondents

More in model than non model families (100% versus 93.4% respectively) have heard about cp methods (Table 1.2).Of those who heard of cp a higher proportion of model than non model (65.9% versus 57.8%) spontaneously named at least one cp, while 65.9% model and 57.8% of non model correctly identified at least one cp from the list of item. The three most frequently spontaneously named methods were injectable pills, and condom (Table 1.3). Radio, Health professional, and UHEP were the three most frequently reported source of information about cp in their respective orders (Table 1.4).

Since correctly answering yes when asked if they heard of cp or knew source of cp are less reliable knowledge, spontaneously naming at least one cp or one source of cp will be considered as knowledge for subsequent analyses.

Table 1.1 Distribution of respondents by Contraceptive knowledge of respondents, in kirkos sub city of MAY 2015

variables	Model family Number (percents)	Non Model family Number (percents)	p- value
Hear of cp			
Yes	211(100%)	197(93.4%)	0.0002
No	0	14(6.6%)	
Spontaneously named one method			
Yes	139(65.9%)	122(57.8%)	0.0001
No	72 (34.1%)	89(42.2%)	
Identified one method from the list			
Yes	139(65.9%)	122(57.8%)	0.0001*
No	72 (34.1%)	89(42.2%)	

*indicate statistical significance

Fischer exact test was used when chi-square test was not applicable

Table 1.2. Distribution of respondents by spontaneously named contraceptive methods and respondants status, in kirkos sub city of MAY 2015

Variables	Model family Number (percents)	Non Model family Number (percents)	Total Number (percents)	p- value
Injectable	27(12.8%)	41(19.4)	68	0.0001*
Pills	27(12.8%)	30(14.2%)	57	0.0001*
Condom	17(8.1%)	19(9%)	36	0.0001*
Norplant	7(3.3%)	6(2.8%)	13	0.0001*
IUD	14(6.6%)	17(8.1|%)	31	0.0001*
Natural method	16(7.6%)	8(3.8%)	24	0.0001*

P was calculated from chi-square test
* Indicate statistical significance

5.3. Source of Information

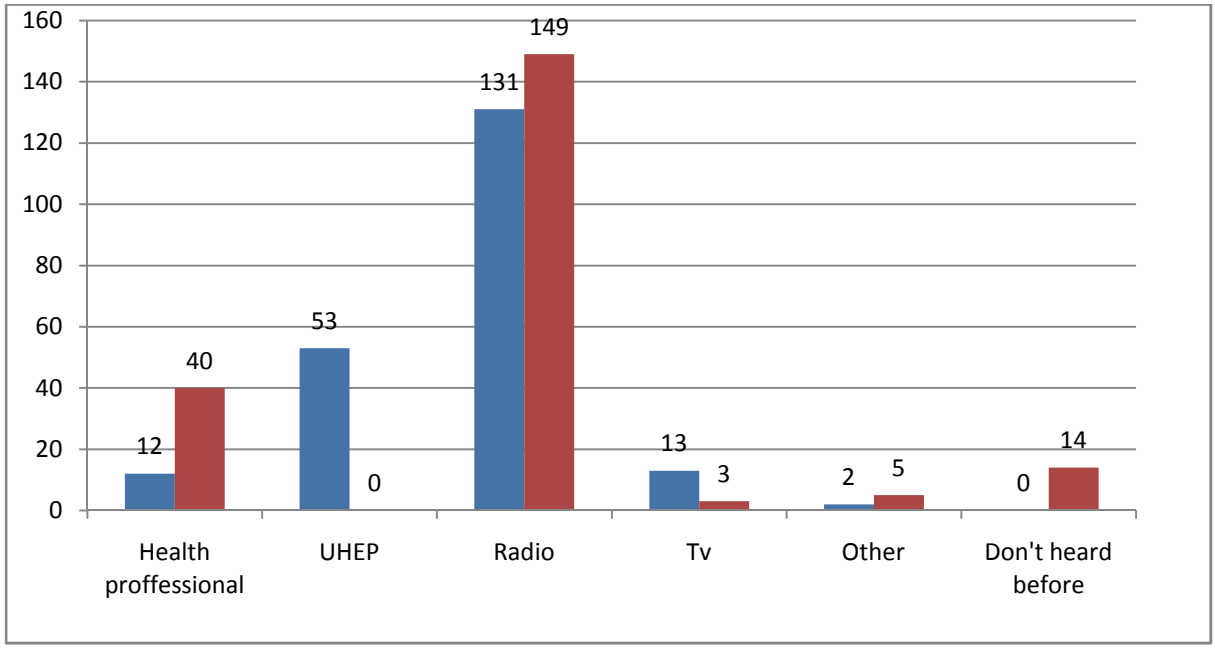
From those that have heard about contraceptive , preferred source of information for contraceptive were, Radio,UHEP and Heath canter/heath professional 280(66.35%), 53(12.55%) and 52(12.32%) with respective order. 12(5.7%) of model family women were heard from health canter/health professional with OR=2.8 (strong association ,i.e the contribution of health canter/health professional as a source of information much higher),,131(62.1%) from radio with OR=1.8 (strong association ,i.e the contribution of Radio as a source of information much higher),13(6.2%) from TV, from UHEP 53(25.1%) with OR=0.38 (weak association/preventive ,i.e. the contribution of UHEP as a source of information much weaker than any other sources) and 2(0.94%) from other (like from their friend, husband and other). (As in indicated in figure 1.1).For non model family women the source of information were, 40(18.95%) from health canter/health professional 149(70.61%) from radio, , 3(1.42%) from TV, 14(6.2%) don't heard before.

Table 1.3 Distribution of respondents by source of information of study population, in kirkos sub city May 2015

Variable		model	OR	Non model	Total no.(%)	P value
Source of information on family planning practice For first time	Heath canter/heath professional	12	2.8	40	52(12.32%)	0.027*
	UHEP	53	0.38	0	53(12.55%)	
	TV	13	0.8	3	16(3.79%)	
	Radio	131	1.8	149	280(66.35%)	
	Don't heard	0	NA	14	14(3.32%)	
	Other	2	NA	5	7(1.65%)	

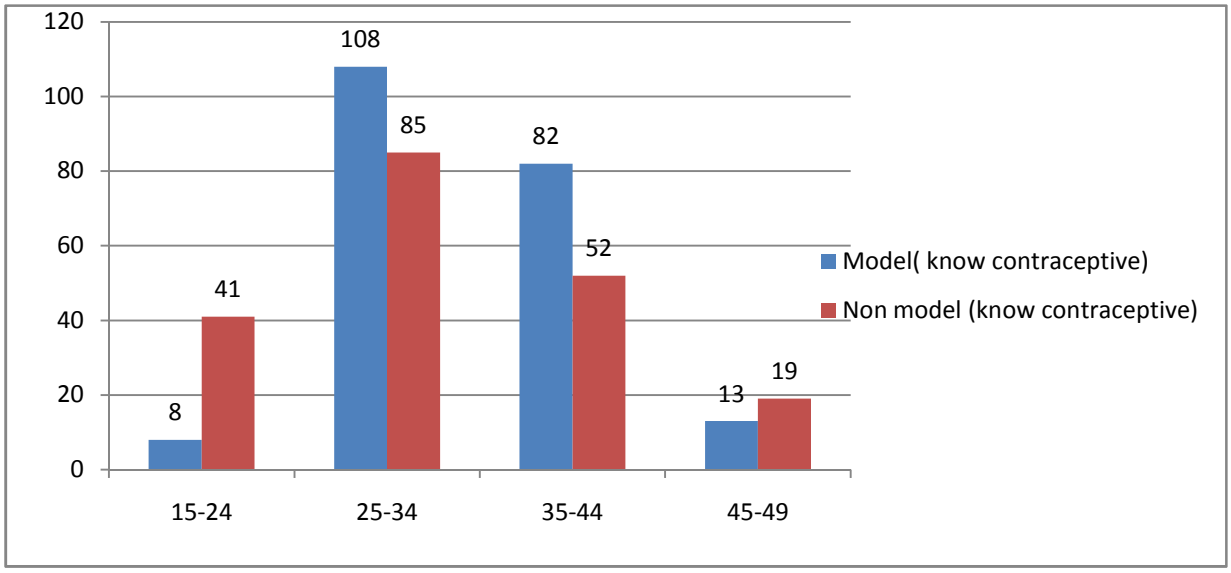
P was calculated from chi-square test
* Indicate statistical significance

Figure 1.0 distribution of respondents by Source of information for Contraceptive use , in kirkos sub city May 2015



As indicated below, on figure 1.1, the contraceptive knowledge of the study population differs with age group. The largest proportion of study population that have informed/have knowledge about contraceptive, largely accounted by women that is found in age group of 25 - 34 for both model and non model ,108 and 85, respectively.

Figure 1.1.Distribution of respondents by age group and current contraceptive knowledge of in kirkos subcity, may 2015



5.4. Contraceptive use and methods

As indicated table 1.5 from those that have heard about family planning more in model than non model, 139(65.87%) and 120(60.9%),respectively ever use of contraceptive methods.

From those that are using one of contraceptive methods, large proportion model and non model (109(78.4%)) and 101 (84.1%), of were got advise from health professional to choose those methods respectively.

Table 1.4 Distribution of respondents by current contraceptive use and methods of study population in kirkos sub city, may 2015

Variables	Contraceptive use		Total Number (percents)	X^2	P value
	Yes Number (percents)	No Number (percents)			
Model family	139(65.9%)	120(60.9%)	259(63.48%)	3.47	0.00021***
Non model family	72(34.1%)	77(62.63%)	149(36.52%)		

* Indicate statistical significance

As indicated in table 1.6, the most common modern method used by each group of women were injectables 98(37.06%) [57(41%) for model and 41(32.5%) for non model [with X^2= 3.46 and p value=0.0001]. followed by long-term, 68(26.25%) [23(16.5%) and 45(62.5%) for model and

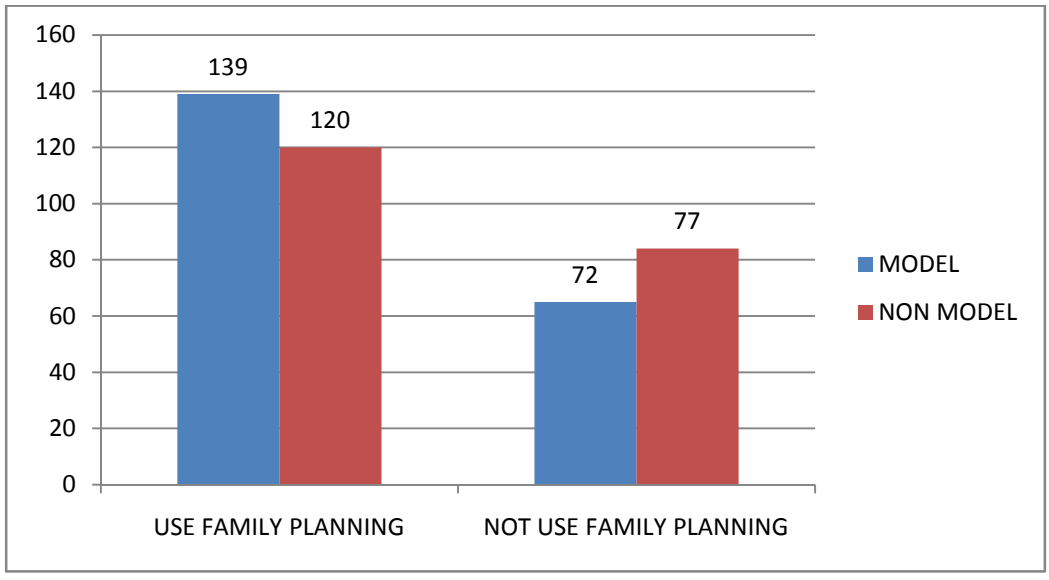
non model families respectively] and pills 40(15.44%) [26(18.7%) and 14(19.44%) for model and non model family respectively, with p value =0.0001.

Table 1.5 Distribution of respondents by Current Contraceptive use for model and non model familes in kirkos subcity May 2015

Variables	Model family Number (percents)	Non model family Number (percents)	X^2	P value
Methods				
Pills	26(18.7%)	14(19.44%)		
Condom	17(12.2%)	11(15.27%)		
Injection	57(41%)	41(32.5%)	5.46	0.0001**
Long term	23(16.5%)	45(62.5%)		
Natural method/safe period	16(11.5%)	8(11.11%)		
Withdrawal	0(0)	1(1.38%)		
Total	139	72		

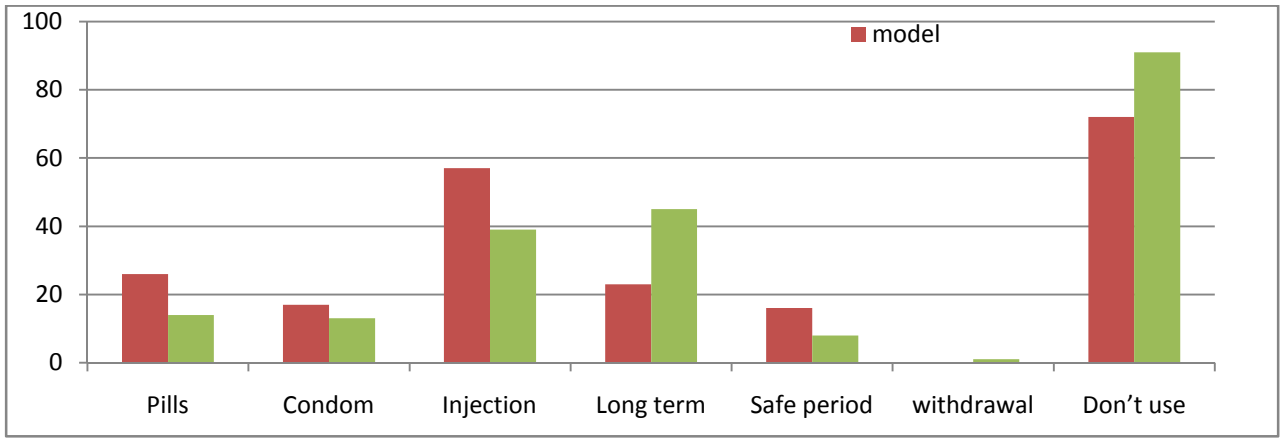
* Indicate statistical significance

Figure 1.2, Distribution of respondents by Current Contraceptive use for model and non model familes in kirkos subcity May 2015



As indicated,in figure 1, the most common modern method used by each group of women were injectables 98(37.06%) [57(41%) for model and 41(32.5%) for non model [with X^2= 3.46 and p value=0.0001

Figure 1.3, Distribution of respondents by contraceptive methods for model and non model families in kirkos subcity May 2015



5.5. Preferred informed choice

As indicated in table 1.6 from those ever use one of contraceptive methods, large proportion study population 210(81.08%) [109(78.4%)) and 101 (84.1%),) model and non model respectively] were they prefer to be informed by health professional and followed by other (like friend, husband..) were 27(10.42%) [18(12.9%) and 9(7.5%) for model and non model families respectively] , media (radio and Tv) were 15(5.79%) [5(3.59) and10 (8.33%) for model and non model families respectively] and finally and the lest referred choice of study population were7 (2.7%) [7(5%) and 0 (0) for model and non model families respectively] with X^2 =4.21, pvalue =0.000021.

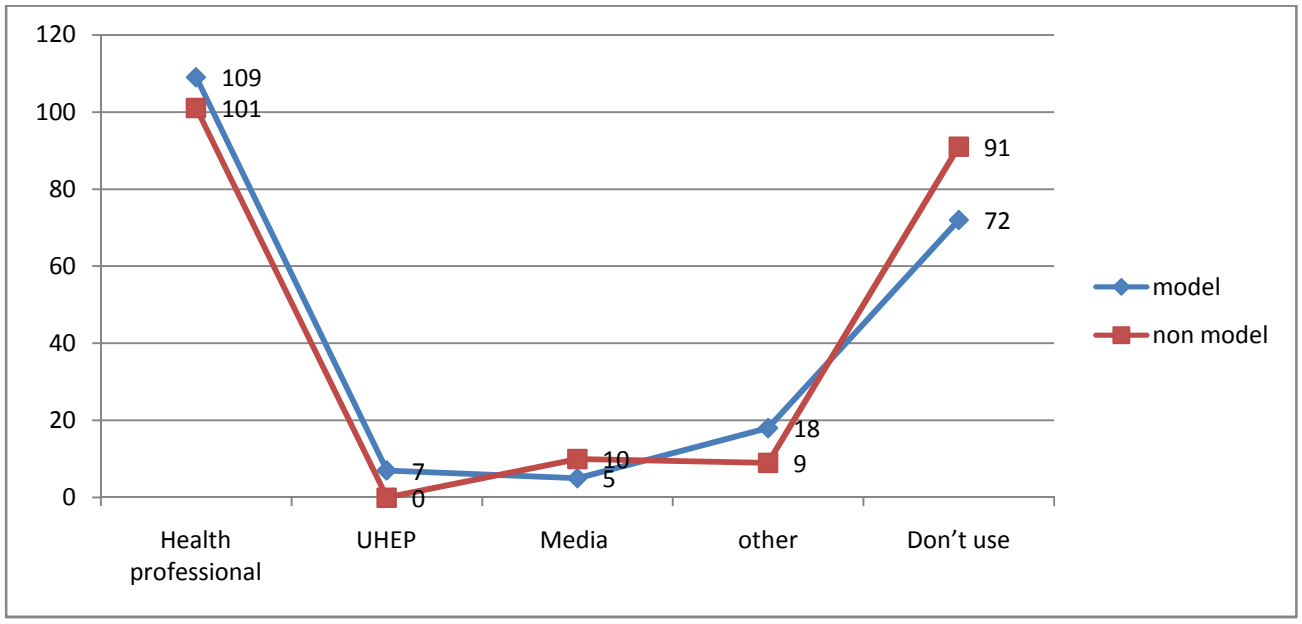
Table 1.6, Distribution of respondents by preferred informed choice for model and non model families in kirkos sub city ,may 2015

Variables	Model	Non model	Total no. (%)	X^2	P value
Got information/advise to choose methods					
Health professional	109(78.4%)	101(84.1%)	210(81.08%)	4.21	0.00021*
UHEP	7(5%)	0(0)	7(2.7%)		
Media	5(3.59)	10(8.33%)	15(5.79%)		
other	18(12.9%)	9(7.5%)	27(10.42%)		

* Indicate statistical significance

As indicated in figure 1.4, from those ever use one of contraceptive methods, large proportion of study population 210(81.08%) [109(78.4%)) and 101 (84.1%),) model and non model respectively] were they prefer to be informed by health professional.

Figure 1.4 , Distribution of respondents by information to choose those contraceptive methods for model and non model families in kirkos subcity May 2015



5.6. Marital status and FP use

As indicated below on table 1.6, off the total study participant, 422, off this 339(80.3%) [179(52.8%) and 160(47.2%) for model and non model respectively] were married, and the rest 70(16.5%) [24(34.28%) and 46(65.72%) for model and non model respectively] were unmarried.

Off the total married women.229 (88.4%) [124(89.2%) with OR=2.55and 105(87.5%) with OR=0.848 for model and non model family respectively] were use one cp methods. And the rest 110(67.4%) [55(76.3%) and 55(60.43%) for model and non model family respectively] they do not use any cp methods.

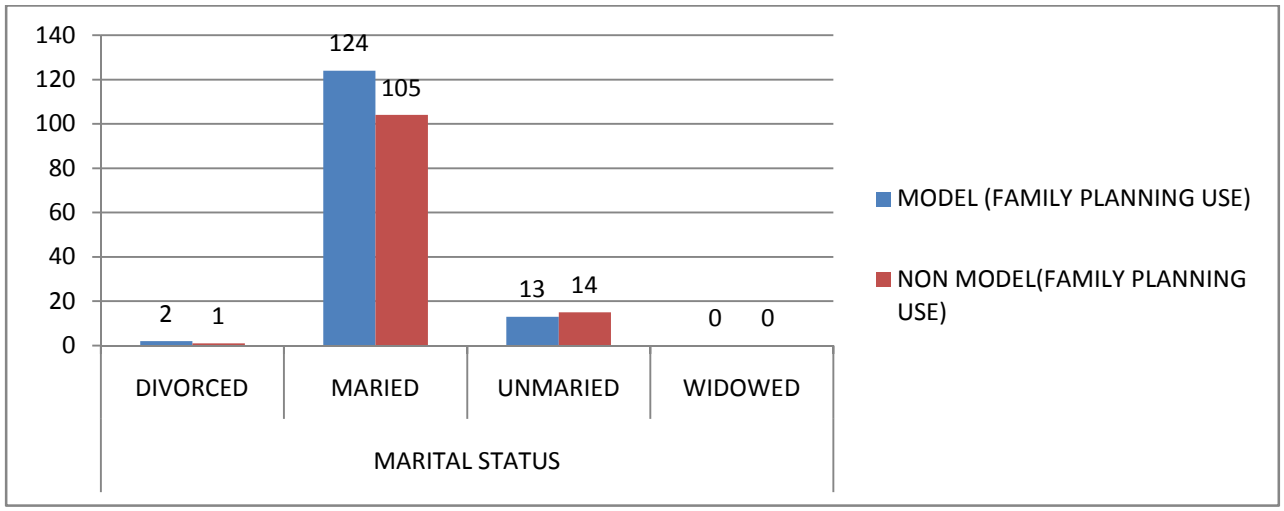
Off the total unmarried 27(10.4%) [13(9.35%) with OR=0.57 and 14(11.66%) wit OR=0.16 for model and non model family respectively] were use one cp methods. And the rest 43(26.38%) [11(15.2 with OR=0.57 and 32(35.16%) with OR=0.16 for model and non model family respectively] were not use any cp methods.

Table 1.7 Distribution of respondents by marital status and contraceptive use of study population in kirkos sub city ,may 2015

Marital status	Model Family			Non Model Family			Total	
	FP use	Don't use FP	OR	FP use	Don't use FP	OR	FP use	Don't use FP
Married	124(89.2%)	55(76.3%)	2.55	105(87.5%)	55(60.43%)	0.848	229(88.4%)	110(67.4%)
Unmarried	13(9.35%)	11(15.2%)	0.57	14(11.66%)	32(35.16%)	0.16	27(10.4%)	43(26.38%)
Divorced	2(1.43%)	4(5.5%)	0.25	1(0.83%)	3(3.29%)	0.17	3(0.1%)	7(0.4%)
Widowed	0(0)	2(2.7%)	NA	0(0)	1(1.09%)	NA	0(0)	3(0.1%)
Total	139	72		120	91		259	163

As indicated in figure 1.5, the current contraceptive use of the study population differs with marital status. The largest proportion of study population that have using contraceptive, largely accounted by married women for both model and non model ,124 and 104, respectively.

Figure 1.5, Distribution of respondents by marital status and contraceptive use of model and non model families in kirkos sub city ,may 2015



5.7. Literacy status and FP use

For model Families

As indicated below on table 1.8. Of 211 model families 198 (93.8%) were literate and 13(6.2%) were illiterates. from those that were literates 134 (67.7%) were using one FP methods with

OR=0.56[95% CI = (0.28,1.13)].And the rest 64(32.3%) were not using FP with OR=1.9[95% CI =(1.18,3.06)].

For Non model Families

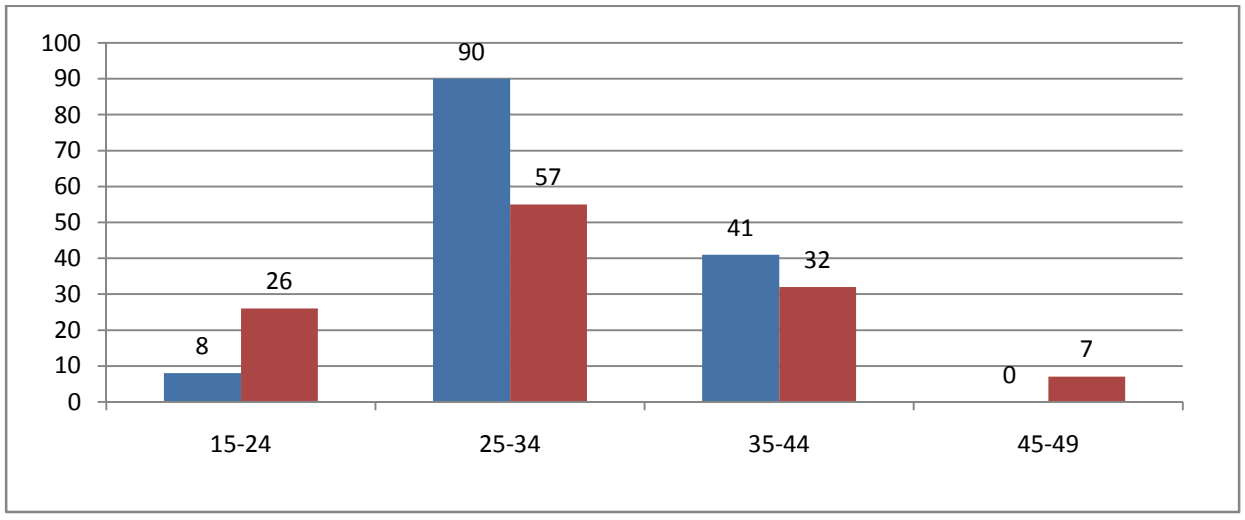
Of 211 study participant 201 (95.2%) were literate and 10(4.8%) were illiterates. From those that were literates 113 (56.2%) were using one CP methods with OR=1.223[95% CI = (0.8,1.86)].And the rest 88(43.8%) were not using CP with OR=0.68 [95% CI =(0.26,1.78)].

Table 1.8 frequency distribution on Family planning use versus literacy status of study population, in kirkos sub city may. 2015

Study participant	Model family (number (%)	OR(95%CI)	Non model family (number (%)	OR(95%CI)	Total (number (%)
Literates and use one of cp methods	134 (67. 7%)	0.56(0.28,1.13)	113 (56.2%)	1.24(0.8,1.9)	247(62.79%)
Literates and do not use cp methods	64(32.3%)	1.9(1.18,3.06)	88(43.8%)	0.68=(0.26,1.78)	152(37.21%)

As indicated below on figure 1.6, the current contraceptive use of the study population differs with age group. The largest proportion of study population that have using contraceptive, largely accounted by women that are found in age group of 25 - 34 for both model and non model ,90 and 57,respectively.

Figure 1.6, , Distribution of respondents by age group and Current Contraceptive use of study population in kirkos subcity May 2015.



5.9. Association of contraceptive ever use among model and non model families and selected social, demographic and personal characteristics

As indicated in detail in Table 10.1 age and model status had statistically significant association with use of cp. Accordingly high proportion of study population that have using contraceptive, largely accounted by women that are found in age group of 25 – 34 , 147 (for both model and non model ,90 and 57 respectively). There was a statistically significant association between literacy and ever use of cp. Accordingly high proportion of study population that have using contraceptive, largely accounted by married women. While, religious status did not showed association with ever use of cp. There was a statistically significant association between literacy and ever use of cp.

Table 1.9. Chi-square test for the association between ever uses of contraceptive and selected socioeconomic, demographic and personal characteristics of study population in kirkos subcity May 2015

Variables	Ever use of contraceptive		X^2	P value
	Yes Number (percents)	No Number (percents)		
Age group				
15-24	33	16		
25-34	147	55		
34-44	72	66	4.778	0.00001*
45-49	7	26		
Marital status				
Married	229	110		
Unmarried	27	43	3	0.028*
Divorced	3	7		
Widowed	0	3		
Religion				
Orthodox	226	141		
Muslim	18	11	3	0.076
Catholic	3	0		
Protestant	12	11		
Literacy				
Literates	247	152	4.362	0.031*
Illiterates	12	11		
Job				
Employed	133	80	4	0.002*
House wife	79	52		
Merchant	24	3		
Self employed	23	26		
Number of children				
Don't have	48	53		
One child	63	27	4	0.0005*
Two children	79	28		
Three children	28	26		
More than three children	31	29		

* Indicate statistical significance

Table1.10. multiple logistic regressions for ever use of contraceptives and selected characteristics of study population in kirkos sub city May 2015

Variables	Ever use of contraceptive		OR [95%CI] Crude	OR [95%CI] Adjusted
	Yes Number (percents)	No Number (percents)		
Age group				
15-24	33	16	1	1
25-34	147	55	2.6[0.35,8.09]	2.6[0.35,8.09]
34-44	72	66	8.07[2.14,10.65]	8.07[2.14,10.65]*
45-49	7	26	1.61[0.41,3.05]	1.61[0.41,3.05
Marital status				
Married	229	110	1	1
Unmarried	27	43	2.3[0.361,25.3]	2.28[1.532,12.65]*
Divorced	3	7	0.29[0.21,2.85]	3.08[1.64,4.32]
Widowed	0	3	0	0
Literacy				
Literates	247	152	1	1
Illiterates	12	11	3.35[1.05,10.64]	1.926[0.508,7.303]
Number of children				
Don't have	48	53	0.752[0.54,1.03]	0.42 [0.162,1.19]*
One child	63	27	0.286[0.08,0.976]	3.17[0.86,11.61]
Two children	79	28	0.348[0.14,0.83]	0.51[0.19,1.37]
Three children	28	26	0.5[0.16,1.56]	0.88[0.34,2.3]
More than three children	31	29	1	1

* Indicant significance when OR does not cross one

6. Discussions

Knowledge of family planning is a prerequisite to obtaining access to and using a suitable contraceptive method in a timely and effective manner. In this study 96.6% of total study population (100% and 93.36% for model and non model family women respectively) have heard /informed about contraceptive, i.e. all models have knowledge about contraceptive than non model families. Of these 65.9% of model and 57.8% non model family spontaneously named at least one cp.Similarly 65.9% of model and 57.8% non model family correctly identify at least one cp from the list of item.

The study has also indicated that radio, health professional/institution, TV, UHEP and other; were frequently reported as a source of information. While, the majority of respondent reported they prefer to hear more about cp from radio, UHEP and health professional/institution, if they are given choices, there choice mainly depends on reliability of the sources. In other word the source information were largely accounted by radio 280 (66.35%), by UHEP were 53(12.55%) (Which is for model families only) and by health professional/institution 52(12.24%) .In addition there are no non model family women that have been informed by UHEP about cp rather they have heard more from radio and health professional, 71.8% and 18.48%, respectively.

Current use of contraceptive methods is one of the indicators most frequently used to assess the success of family planning programmes. In our study, of the total of study population who have heard /got information from different sources, 51.7% were ever-use of one contraceptive methods, 65.9% and 60.9% for model and non model family women respectively. And the rest 48.3% of the study population were don't use any kinds of cp.

According to DHS 2011, Twenty-two percent of women with no education report current use of any method, compared with 68 percent of women with more than secondary education. Similarly, current use of any contraceptive method increases with wealth, from 13 percent of women in the lowest quintile to52 percent of women in the highest quintile (8).

Similarly in our study, off 422 study participant 399 (94.5%),198(49.6%) and 201(50.3%) for model and non model family were literates respectively. Of the total 399 study population that were literates, 247(61.9%) were use one cp methods, 134(54.2%) and 113(45.7%) for model and non model families respectively .and the rest of study population, 152(38.09%), 64(42.1%) and 88(57.9%) for model and non model family even if they were literates the do not use any cp methods respectively.

Current contraceptive use is lower among young women and among older women (some of whom are no longer fecund) than among those at the intermediate age groups. For example, 5 percent of all women age 15-19 report current use of any contraceptive method. This proportion increases

until it peaks at 29 percent in the 30-34 age group, after which it decreases steadily to 11 percent among women age 45-49. A similar pattern is observed among currently married women (8).

Accordingly high proportion of study population that have using contraceptive, largely accounted by women that are found in age group of 25 – 34 , 147 (for both model and non model ,90 and 57 respectively).

According to DHS 2011, 29 percent of currently married women report use of a contraceptive method, with 27percent using a modern method. The same pattern is observed among all women and unmarried sexually active women. The most common modern method used by each group of women is injectables, currently used by 14 percent of all women, 21 percent of currently married women, and32 percent of unmarried sexually active women. (8)

Similarly in our study also, large proportion of married women.229 (88.4%) [124(89.2%) with OR=2.55and 105(87.5%) with OR=0.848 for model and non model family respectively] were use one cp methods. And the rest 110(67.4%) [55(76.3%) and 55(60.43%) for model and non model family respectively] they do not use any cp methods.

In contrary in our study in case of unmarried women the figure is different from what was reported in DHS 2011, Off the total unmarried women 27(10.4%) [13(9.35%) with OR=0.57 and 14(11.66%) wit OR=0.16 for model and non model family respectively] were use one cp methods. And the rest 43(26.38%) [11(15.2 with OR=0.57 and 32(35.16%) with OR=0.16 for model and non model family respectively] were not use any cp methods.

Similarly with DHS 2011, the most common modern method used by each group of women is injectables 98(37.06%) [57(41%) for model and 41(32.5%) for non model [with X^2= 3.46 and p value=0.0001]. followed by long-term, 68(26.25%) [23(16.5%) and 45(62.5%) for model and non model families respectively] and pills 40(15.44%)[26(18.7%) and 14(19.44%) for model and non model family respectively, with p value =0.0001.

Informed choice is an important principle in the delivery of family planning services. As an aspect of informed choice, it is required that all family planning providers inform users about Potential side effects of the method and what they should do if they encounter such side effects. This information assists the user in coping with side effects and thus decreases discontinuation of temporary methods.

From those ever use contraceptive methods, large proportion study population 210(81.08%) [109(78.4%)) and 101 (84.1%),) model and non model respectively] were they prefer to be informed about contraceptive methods were by health professional and followed by other (like Friend , husband..) were 27(10.42%) [18(12.9%) and 9(7.5%) for model and non model families respectively] , media (Radio and TV) were 15(5.79%) [5(3.59) and10 (8.33%) for model and non model families respectively] and finally and the lest referred choice of study population were UHEP with 7 (2.7%) [7(5%) and 0 (0) for model and non model families respectively] with X^2 =4.21, pvalue =0.000021.

7. Strengths and limitations of the Study

7.1 Strengths

Since data collector and supervisor have program connection this reduces information bias .The use of standardized questionnaire from different literatures.

Employment of probability sampling technique to select both model and non model respondents, achievement of high response rate, making house- to-house visit model and non model to achieve fairly representative samples are also part of the strength.

7.2 Limitation

Difficult to establish causal relationship and also since most mean age of study participant were ≥34 it have Recall bias (age at menarche).

8. Conclusion

More model families were heard about cp than their counterpart non model families and the major source of information for both families were Radio and followed by UHEP and health professionals with respective orders.

Even though the study has showmen that UHEP have brought some little contribution as the first sources of information about FP practice especially for model families next to Radio, large proportion of study population were they prefer to be informed about contraceptive methods were by health professional followed by, Other (like friend, husband and the like) , media and finally the lest referred choice of study population about cp were by UHEP, which accounts only 2.7% of study population. From this we can say that UHEP were not the right preferable source of information for the community, so that enhancing them to choose and use cp methods as compare to other source of information like media and health institution/professional.

Generally the contribution of UHEP on FP utilization can be measured by considering the provision of the program in all aspects of FP service utilization like let the community to inform about the service and then to be as the major preferable informed choice for them. By this measurement the UHEP programs lacks the aspects expected to be done, as we have mentioned earlier.

9. RECOMMENDATIONS

FMOH should see the implementation strategies of UHEP on providing and upgrading family planning service because most model family got information and advice on method choice about family planning were from Heath institution/health professional and media respectively, rather than UHEP.

Community-based family planning services need to be expanded and strengthened in urban so as to disseminate information, education, and counseling on family planning and provide services to the needy, especially to the unreached and underserved populations.

Annex A: Information Sheet to get Permission for the Research

This sheet is to be read for the participants of the study. Good morning/afternoon, my name is ---------- and I am one of the data collectors for the study being conducted by Addis Ababa University, College of Health Sciences, School of Public Health on the assessment of the role of health extension workers in improving utilization of family planning services in kirkos sub city. You are selected scientifically to be participant of this study if you give me consent after you have understood the following information sheet:

Title of the study: Assessment on family planning use among model and non model family women of urban health extension program in kirkos sub-city administration

Background

The Ethiopian government designed the Urban Health extension Program based on the life style and settlement of the urban community, and by taking the existing major health problems and the structure of health services into consideration. This program is mainly preventive and planned to provide health services, which enable the promotion and prevention of diseases, equitably to the urban community (FMOH manual).

Objective

To assess on family planning service utilization among model and non model family women of urban health extension program in kirkos sub-city administration..

Benefit of the study:

-The participant will not get any direct benefit for being participant

- The result can be used as a baseline for further studies that can be done in this wareda.
- The result will be used to design method to improve utilization.
- The result will be disseminated to kirkos sub city Health Office.

Harm of the study: the study has no any harm except that participant will spend up to 30 minutes in the interview.

Rights of the participant:

-participation has full right

- Not participate
- The participant can stop participating in the study at any time

- The participant can skip question which she does not want to respond
- During the interview, the participant can ask questions which are not clear

Confidentiality: - the secrecy of any information forwarded will be maintained

Persons to contact:

This research project will be reviewed and approved by the institutional review board of Addis Ababa University. If you want to know more information you can contact the Committee through the address below. If you have any question you may contact the following individuals.

Investigator:

Yonas Assefa: Addis Ababa University, College of Health Sciences, School of Public Health, Department of General Master of public health**,** Tel -0913317291**,** Email: - yonastu@gmail.com

Advisors: Dr. Mesfin Addissie (MD, MPH, Associate Professor,): Addis Ababa University, College of Health Sciences, School of Public Health dean.

Annex B: Amharic information sheet

ለሚጠናዉ ጥናት ማብራሪያ መስጫ ቅፅ

መግቢያ ፤ ይህ የመረጃ ቅፅ የሚዘጋጀዉ ለሚጠናዉ ጥናት አስፈላጊ ማብራሪያ ለመስጠት ነዉ።። የጥናቱ ዋና አላማ ምርምሩ በከተማው የከተማ ጤና ኤክስቴንሽን ፕግራም በጤተሰብ ምጣኔ መጨመር ላይ ያለው ተፅእኖ ምን ይመስላል የሚለውን ለማጥናት ነዉ።።

የጥናት ዋና ተመራማሪ፤ አቶ ዮናስ አሰፋ

የጥናቱ አማካሪዎች፤ዶ/ር መስፍን አዲሴ (ተባባሪ ፕሮፌሰር)

ለጥናቱ የገንዘብ ፤ በግል

ተመራማሪዉ ትምህርቱን የተከታተለበት ዩኒቨርሲቲ፤አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ፣የህብረተሰብ ጤና አጠባበቅ ስልጠና ተቋም።።

ይህን የመረጃ ቅፅ ያተዘጋጀዉ ከላይ ስሙ የተጠቀሰዉ ተመራማሪ ሲሆን የጥናቱ ዋና አላማም ምርምሩ በሚካሄድበት በአዲስ አበባ ከተማ አስተዳደር በቂርቆስ ክ/ከተማ ጤና ጽ/ቤት የከተማ ጤና ኤክስቴንሽን ፕግራም በጤተሰብ ምጣኔ አጠቃቀም ላይ ያመጣው ለውጥ ለማጥናት ነዉ።።

የጥናቱ ዓላማ:

በአዲስ አበባ ከተማ አስተዳደር በቂርቆስ ክ/ከተማ ጤና ጽ/ቤት የከተማ ጤና ኤክስቴንሽን ፕግራም በጤተሰብ ምጣኔ አጠቃቀም ላይ ያመጣው ለውጥ ለማጥናት ነዉ።። ጥናቱ በዋናነት የተቀረፀዉ የአካባቢዉን ነባራዊ ሁኔታ በማገናዘብ ጤና ኤክስቴንሽን ፕርግራም በጤተሰብ ምጣኔ አገልግሎት ላይ ለውጥ እንዴት ማምጣት

እንደሚቻል እና መሻሻል የሚገባቸዉን የፓሬግራም አተገባበር በማጤት እንዲስተካከሉ ከሚመለከታቸዉ የጤና አመራሮች እና ሌሎች ባለድረግሻ አካላት ጋር በመሆን አዋጭ የሆነ የትግበራ መርሃ ግብር ለመቅረፅ እና ተፈፃሚነት እንዲኖረዉ ለማድረግ ነዉ።

ከጥናቱ የሚገኘዉ ዉጤት በየደረጃዉ ለሚመለከታቸዉ አካላት በማድረስ ለችግሩ መፍትሄ የሚሆን የትግበራ እቅድ ዝግጅት እንዲያደርጉ በመረጃ የተደገፈ ሙያዊ አስተያየት በመስጠት የከተማ ጤና ኤክስቴንሽን ፕሮግራም በቤተሰብ ምጣኔ ስገልግሎት ሳደ ስሙ እንዲያመጡ ስማድረግ ነዉ።

በጥናቱ መሳተፍ ስለሚያስገኘዉ ጠቀሜታ

በጥናቱ እርሰዎ በመሳተፉ አሁን የሚገኝ/የሚሰጥ ጥቅም እንደሌለ ልግልፅለዎት እወዳለሁ ነገር ግን ይህ ጥናት ተጠንቶ ካለቀ በኋላ የተገኘዉን መረጃ መሰረት አድርጎ የሚመለከታቸዉ አካለት እንዲያዉቁት በማድረግ አስፈላጊ የሆነ ችግሩን የሚፈታ የእቅድ እና የአተገባበር እስትራቴጂ ዝግጅት እንዲደረግ ሙያዊ ድጋፍ ለማድረግ ዝግጁ መሆናችን እንገልፃለን።

በጥናቱ መሳተፍ ሊፈጥረዉ የሚችለዉ ተፅኖ/ምቾት ስለመኖሩ

በጥናቱ እርሰዎ በመሳተፈዎ/ፉ ምንም ዓይነት ችግር እንደማያመጣ ለመጠቀስ እወዳለሁ፣ ምን አልባት የማቀርብልዎትን ጥያቄዎች ለመመለስ የተወሰነ ሰዓት ልወስድብዎች እችላለሁ፤ በጥያቄዎቹ የሚሰጡኝን ማንኛዉንም ዓይነት መረጃ ለማንም የማይደርስ መሆኑን እና ሚስጥራዊነቱ የተጠበቀ መሆኑን ልገልፅልዎት እወዳለሁ።

ማንኛዉን ዓይነት ጥያቄ በፈለጉ ጊዜ ለመጠየቅ እንዲያግዘዎት የሚረዳ አድራሻ፤

ይህ ጥናት ሳይናሳዊነቱ እና ለህብረተሰቡ የሚጠቅም መሆኑን በአዲስ አበባ ዩኒቨርሲቲ የሚገኝ የጥናት እና ምርምር ደህንነት ፈቃድ ሰጪ ኮሚቴ የሚታይ እና የሚፀድቅ መሆኑን በመግለፅ ማንያዉንም አይነት ጥያቄ ለኮሚቴዉ ማቅረብ ከፈለጉ ከዚህ በታች በተጠቀሱት አድራሻዎች መጠቀም የሚችሉ መሆኑን እንገልፃለን።

የጥናቱ ተመራማሪ

አቶ ዮናስ ስስፋ : አዲስ አበባ ዩኒበርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና አጠባበቅ ትምህርት ተቋም የማህበረሰብ ጤና ትምህርት ክፍል ስልክ - 0913317291, ኢሜል አድራስ: - yonastu@gmail.com.

የትናቱ አማካሪ: ዶ/ር መስፍን ስዲሴ (ተባባሪ ፕሮፌሰር): አዲስ አበባ ዩኒበርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና አጠባበቅ ትምህርት!!!

Annex C: Consent form

Consent form

I --------have well understood the study information sheet read above. And now I am in a position -------- to participate in the study by giving information. To be voluntary sign below and conduct interview not to be voluntary---------- go to the next house hold

Signature of the interviewer **----------**

(Signature of the interviewer certifies that informed consent has been given verbally by the respondent)

Questionnaire identification number _____

Name of the Interviewer _____ Signature _____date _____

Name of the supervisor _____ Signature _____ date _____

Address of the investigator:

Mob = 0913317291

Email = yonastu@gmail.com

For further question/ information use the address of the IRB School of public health:

Addis Ababa University, School of public health

Phone number=

Email=

Annex D: Amharic consent form

የፍቃድ መጠየቂያ ቅፅ

እኔ---------- የጥናቱ መግለጫ ተነቦልኝ/አንብቤና ተገንዝቤ
የትናቱ ተሳታፊ ለመሆን ፍቃደኛ ሁኛለሁ ፈርመሽ መጠይቁን ሙይ
ፍቃደኛ አልሆንኩም ወደ ሚትቀጥለው ቤት እለፍ
(የመረጃ ሰብሳቢው ፊርማ መኖር ግለሰቡ የጥናቱ ተሳታፊ ለመሆን ፍቃደኛ መሆኑን ያመለክታል)
የመጠይቅ መለያ ቁጥር----------

የመረጃ ሰብሳቢው ስም----------ፊርማ----------ቀን----------

የተቆጣጣሪው ስም----------ፊርማ----------ቀን----------

የተመራማሪው አድራሻ

ሞባይል፡- 0913317291

ኢሜል፡- yonastu@gmail.com

ለበለጠ መረጃ የሚከተለውን የተቋሙን ገምጋሚ ቦርድ አድራሻ ይጠይቁ
አዲስ አበባ ኒቨርሲቲ የማህበረሰብ ጤና ትምህርት ቤት፡፡
ስልክ፡-
ኢሜል፡-

Annex E: Declaration

I, the undersigned, Public Health student declare that this thesis is my original work in partial fulfilment of the requirement for the degree of Master of Public Health.

Name: Yonas Assefa

Signature: _____

Place of submission: School of public Health, College of Health Sciences, Addis Ababa University.

Date of Submission: May 20015

This thesis work has been submitted for examination with my/ our approval as university advisor(s).

Advisors

Name	Signature
_____	_____
_____	_____

Annex F: Assurance of Investigator

The undersigned agrees to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as pre terms and conditions of the research and publications office of Addis Ababa University.

Name of the student: Yonas Assefa

Date: May 20015 Signature: _____

Approval of the advisor (s)

Advisors

	Name	Signature	Date
1.	_____	_____	_____
2.	_____	_____	_____

Annex 2

Questionnaire

General instructions: on this questionnaire there is no need to write the name or the Addresses of the respondent. Therefore, there is no means to identify who filled the questionnaire. Though some of the questions touch personal life and secret, we kindly request you to give the true and right answer. The purpose of this study is to assessments of family planning utilization among model and non model family women enrolled in urban health extension program in kirkos sub city .

Code no_____

I. Socio-demographic information			
1.01	Sex of respondents	1.Female 2. Male	remark
1.02	What is your age now? (Based on last birth day) .	_____ Years	
1.03	What is your marital status?	1. Un married 2. Married 3. Divorced 4. Widowed 5. Others Specify----------	
1.04	How many children did you have?	1.one 2.two 3.three 4.more than three	
1.06	What is your religion? 1.	1. Orthodox 2. Catholic 3. Protestant 4. Muslim 5. Others specify----------	
1.07	What is your educational status?	1. literate 2. Illiterate	
1.08	If the answer is yes literate (1) What is the level of your	1.Reads and Writes 2. Completed Elementary 3. Completed Secondary 4. 12 Completed 5 .Diploma	

	education?	6 . First degree and above 7. Do not know	
1.09	What is your job?	1.not working/ house wife 2.merchant 3. employed 4.self-employed	
1.10	Did have any income that you get	1.yes 2.no	

ii. Model family status

2.01	Are you model family now?	1.yes 2.no	
2.02	If answer is yes for above qn.2.01 did you have graduated ?	1.yes 2.no	
2.03	If the answer is yes for above qn. 2.02 Did you have fulfilled all criteria of graduation?	1.yes 2.no	
2.04	If the answer is MCH fo qn.2.03 which one that you failed to fulfil	1.FP 2.EPI 3.other specify	

iii. contraceptive Knowledge

3.01	Have you hear of modern contraceptive ?	1.yes 2.no	
3.02	Please name all contraceptive method you know	1_____ 2._____ 3._____ 4.;_____	

3.03	Which of the following have heard to be contraceptive?	Condom 2. Pills 3. Injectable 4.IUD 5. Norplant 6.Female sterilization 7.Male sterilization 8.Natural method	
iv. Source of information			
4.01	From whom that you heard about FP before?	1.radio 2.TV 3. From Health professional in health institution 4.Urban health extension 5. other specify	
V. Contraceptive use			
5.1	Have you ever used contraceptive methods?	1.yes 2.no	
5.02	Did you and your partner discussed about contraceptive methods?	1. . Yes 2. . No 3. . Don not remember	
5.03	Did you or your partner use contraceptive method?	1. . Yes 2. . No	
5.04	Which types of method did used ?	1. Condom 2. Pills 3. Injectable 4. Withdrawal 5. Safe period 6.**longterm** 6. Others / specify _____	
5.05	From whom that you have got advise to choose those methods?	1.From Health professional in health institution 2.From UHEP 3.From media/tv,radio….. 4.other----------	
vi For non model families			
6.01	Did you know about Urban health extension program?	1.yes 2.no	
6.02	Why you did not have been	1.Becouse the UHEP not	

	a model family?	told me 2. Because am not interested to be a part 3.other specify----------	
6.03	If the answer is 2 for qn4.02 why?	1. Because am not get new things 2. Because am not interested 3. Other specify	
6.04	Did you have any idea to get this service	1.yes 2.no	
vii. contraceptive Knowledge			
7/01	Have you hear of modern contraceptive ?	1.yes 2.no	
	Please name all contraceptive method you know	1_____ 2._____ 3._____ 4.;_____	
7.02	Which of the following have heard to be contraceptive?	Condom 2. Pills 3. Injectable 4.IUD 5. Norplant 6.Female sterilization 7.Male sterilization 8.Natural method	
viii.Source of information			
8.01	From whom that you heard about FP before?	1.radio 2.TV 3.Urban health extension 3. From Health professional in health institution 4 other specify	
8.02	Have you ever used contraceptive methods?	1.yes 2.no	
8.03	Did you and your partner discussed about contraceptive methods?	1. . Yes 2. . No 3. . Don not remember	
viiii.Contraceptive use			
9.01	Did you or your partner use contraceptive method?	1. . Yes 2. . No	
9.02	Which types of method did	1. Condom	

	used ?	2. Pills 3. Injectable 4. Withdrawal 5. Safe period 6. Others / specify _____	
9.03	From whom that you have got advise to choose those methods?	1.From Health professional in health institution 2.From UHEP 3.From media/tv,radio….. 4.other----------	

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