UTILIZATION OF MODERN FAMILY PLANNING METHODS AND FACTORS AFFECTING ITS USE AMONG MODEL AND NON MODEL FAMILY WOMEN OF REPRODUCTIVE AGE IN SHASHAMANE TOWN, OROMIYA REGION, SOUTH EAST ETHIOPIA

BY OMER HUSSEN (BSC IN PH)

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JIMMA, ETHIOPIA

JIMMA UNIVERSITY

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Abstract

Background: According to the 2007 census, Ethiopia's population is increasing by (2.6%) about two million each year and if this rate of growth continues, it is estimated that the population of the country will double every 27 years. Even though efforts are under way to expand reproductive health services including family planning, still (25%) of currently married women have an unmet need for family planning. In Oromiya region the unmet need for family planning is (30%) which is in line with high total fertility rate (5.6) and low modern family planning coverage (24.9%). After the government has introduced health extension program which focus on model family training, the outcome of this program in utilization of modern family planning is not assessed.

Objective:The study was aimed to assess utilization of modern family planning and factors affecting its use among model and non-model family women of reproductive age in Shashamane town.

Methods: A community based comparative cross-sectional study involving quantitative data collection was employed from February to March, 2013. Data were collected using a pre-tested structured questionnaire by diploma nurses from a sample of 672 (337 model and 335 non model family women) which was selected by simple random sampling. The collected data were entered to Epi Data and exported to SPSS version 20 for analysis. Descriptive statics, bivariate and multivariate analysis was performed .The results were presented in texts, tables and figures.

Results: Current modern family planning practice was 71.8% and 61.8% among model and non-model family women respectively. Model family women were 1.8 times more likely than nonmodel family women to utilize modern family planning method (AOR=1.77,95%CI=1.017,3.085).Among model family women independent predictors of modern family planning use were age (AOR=2.9, 95%CI=1.199, 6.947) and discussion with husband (AOR=4.4, 95%CI = 1.708, 11.076). Age range of26-34(AOR=3.3,95%CI=1.867,8.971), discussion with husband (AOR=2.8, 95%CI=1.479 ,5.454) ,approval of family planning use by relative(AOR=1.6 ,95 % CI=1.070 ,2.548)and husband (AOR= 4.2 ,95%CI=1.415, 12.497) were independent predictors of modern family planning method utilization among non-model family women.

Conclusion: There is relatively high level of modern family planning utilization in the study area, with differences between model and non-model family women. Model family women were better in utilization of modern family planning than non-model family women and factors affecting the utilization of modern family planning were different among model and non-model family women.

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Table of content

List of figures

List of Tables

Acronyms

CPHMS- College of public health and medical science

CPR - Contraceptive prevalence rate

EDHS - Ethiopia Demographic and Health Survey

EPI info - Epidemiological information

FMOH - Federal Ministry of Health

FP - Family planning

GOE - Government of Ethiopia

HEP - Health extension program

HIV/AIDS- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

IUCD - Intra uterine contraceptive device

MFP – Modern family planning

MFW - Model family women

NMFW -Non - model family women

ORHB - Oromiya Regional Health Bureau

RH - Reproductive Health

SPSS - Statistical Package for Social Science

STI - Sexually transmitted infection

TV- Television

TFR - Total fertility rate

UHEP- Urban health extension professionals

CHAPTER ONE –INTRODUCTION

1.1 Background

Reproductive Health (RH) is a key facet of human development. Improved RH outcomes lower fertility rates, improve pregnancy outcomes, and lower sexually-transmitted infections (STIs) -have broader individual, family, and societal benefits. But, even within countries with relatively good RH outcomes: access to family planning (FP), antenatal care, and delivery assistance among the poor and other vulnerable groups tend to be far worse than the national average [1].

Sexually-active women of reproductive age in developing countries experience high rates of unintended pregnancy. Nearly 90 percent of the estimated 208 million pregnancies in 2008 occurred in the developing world. Globally, 86 million pregnancies were unintended; of these, 41 million ended in abortions 33 million in unplanned birth and 11 million in miscarriage [2].

Family planning is a voluntary and informed decision by an individual or couple on the number of children to have and when to have them, by use of modern or natural methods. It can also be simply referred to as having children by choice and not by chance [13].

Access to safe and voluntary family planning counseling and services significantly reduces unintended pregnancies and abortions and saves women's lives. Countries where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises. Family planning is one of the most cost-effective, high-yield interventions that exist today. Countries that invest in family planning can reap immediate health benefits, investment savings in the health and education sectors, and social and environmental benefits that extend well beyond a single generation [3, 4].

In developing countries, almost 71 million married women were at risk for unwanted pregnancy and were not using FP in the 53 countries. Women in India accounted for the largest share by far of the world's unmet need, and nearly 31 million married women in that country alone were at risk of an unintended pregnancy. Although no country approaches India in this respect, other countries with high levels of unmet need include Brazil, Philippines, and Nigeria, Indonesia, Bangladesh and Ethiopia with 2.0–3.6 million married women living with an unmet need in each country [5].

Contraceptives prevent maternal death 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, such as the threat of abandonment. Contraceptives also allow women to delay motherhood, space births, and protect themselves from STI including Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) [6.] Each year modern contraceptive use prevents 188 million unintended pregnancies resulting in 150,000 fewer maternal deaths. By preventing high risk pregnancies, it is estimated that family planning currently prevents 215,000 maternal deaths each year, including those from unsafe abortion [7].

Voluntary family planning empowers women and men to decide when to have a child and to avoid unintended pregnancies and abortions. This results in healthier families, communities, and nations. In addition, some methods of family planning prevent both pregnancy and sexually transmitted infections, including Human Immunodeficiency Virus (HIV)[7].

Health extension program (HEP) assumes that health behavior can be enhanced in communities by creating model families that others will admire and emulate. Model family training is a community based health service delivery program whose educational approach is based on the diffusion model, which holds that community behavior is changed step by step: training early adopters' first, then moving to the next group that is ready to change. Those resistant to change would gradually be conditioned to change because of changes in their environment[10].

1.2 Statement of the Problem

In mid-2012, world population stood at 7.058 billion. Africa accounts 1.072 billion of world population of which, Ethiopia, the second populous country in Africa contributes 87 million people next to Nigeria, which is 170.1 million. The average total fertility rate (TFR) worldwide range from 1.6 children per woman in more developed countries to 4.4 children per woman in the least developed countries of which Africa contributes 4.7. But the African TFR ranges from 1.4 children per woman of Mauritius to 7.1 children per woman in Niger with 4.8 children per woman in Ethiopia .This puts Ethiopia among countries with highest total fertility rate in the world [11, 12].

According to the 2007 Ethiopian census, this country's population is currently increasing by 2.6% (about two million) each year and if this rate of growth continues, it is estimated that the population of the country will double every 27 years. Rapid population growth, low agricultural production and destruction of the environment are practices common to most of the sub-Saharan African countries, including Ethiopia, this situation in turn facilitates drought and hunger. Therefore, it is becoming very difficult for these countries to provide enough food, schools, jobs and health services including family planning for everyone in the existing population[4].

More than 200 million women wish to delay or plan for child bearing, but do not have access to the contraceptive methods that would allow them to make these decisions. Fully addressing the unmet need for contraceptives alone would prevent an additional 53 million unintended pregnancies each year and reduce maternal deaths due to unsafe abortion by 82 percent [7]. If unmet need for family planning were fully satisfied, additional 90,000 women's lives would be saved and 590,000 newborn deaths would be averted. Family planning and contraception empower women to achieve healthy outcomes for themselves and their children, advancing greater gender equity and dignity for women and families [14].

Even if, reproductive health services including family planning are available in Ethiopia, still 25% of currently married women have an unmet need for family planning (16 %) for spacing and 9 % for limiting.In Oromiya region the unmet need for family planning is 30 % (21% for spacing and 9 % for limiting) which is greater than the national average as well as other regions. The contraceptive prevalence rate (CPR) of the region is also found at 26.2% still less than the national (28.6%).

The national population policy of our country has set an objective to reduce number of children per women from 7.7 to 4.0 by the year 2015 and increase the contraceptive prevalence from 4% to 44 % by the same year. But, in Oromiya region TFR is found to be about 5.6 children per women, which is inline of the regional low contraceptive prevalence and higher than the National (4.8) next to Somalia (7.1) [12,15].

Therefore, to attain the already set objective of the national population policy it is important to assess factors affecting modern contraceptive utilization among segments (different categories) of population of the country in order to set strategies for policy makers and other responsible bodies. Currently, strenuous efforts are being made to increase the provision of all forms of modern family planning. The Government's innovative HEP strategy has an important role in accessing and availing modern family planning services to the majority of the community and expected to facilitate the expansion of family planning services, particularly in solving the geographical accessibility and filling gaps in almost all rural kebeles [8]. But, after the government has introduced health extension service program which mainly focus on model family training , there was no similar study on graduated model family in this particular area . Therefore, the aim of this study is to determine modern family planning utilization and factors affecting its use among model and non-model family women.

CHAPTER TWO -LITERATURE

More than half of all couples in the developing world are using family planning to delay, space, or limit future pregnancies, but still the need for family planning keeps increasing as the number of women of reproductive age continues to grow. Recent research is shedding light on how family planning increases survival, improves the health of millions of people, and helps achieve national goals [3]. The percent distribution of women using family planning methods varies by region, with a higher percentage (69%) of women using them in developed than in less developed regions (59%). Further, the percentages of women using contraceptives are as high as 71% in Latin America and the Caribbean and as low as 27% in Africa [16]. From the above reality it can be summarized that modern family planning use is not uniform and there are number of factors that influence utilization of the service.

2.1 Knowledge, information and utilization of family planning

It is believed that information education and communication about the importance of modern family planning use play an important role in raising contraceptive prevalence rate. However, different empirical evidences revealed that having knowledge about the method alone could not guarantee utilization of the service. A study done in Sudan indicated out of those who have good knowledge about contraceptive, (64.1%) are using family planning[17].In Nigeria, from (75.3%) who were awared of modern family planning, (42.9%) of them were currently using family planning [18]. Where as in Tanzania, more than half of the women (56.5%) had low level of knowledge and only (12.2 %) of women were using modern family planning at the time of the survey [19]. Another survey done in Ghana indicated that universal knowledge (97%) but, low family planning coverage and the main barriers not to use family planning were receiving family planning services from a provider of the opposite gender (58 %), the young age of the provider (42 %) [33].

In Ethiopia most of women get information about family planning through community event 36.7%, radio 33.7%, TV 18.1%, poster 8% and the least one was magazine 7.9% and knowledge of at least one method of contraception is nearly universal among both women and men but, still modern family planning utilization is low, 27% as national and 25%in Oromiya region [12] **.**

Study done in SNNP, Butajira showed that about 99% of women in district knew at least one method of contraception. Depo-Provera and pills were known by more than 97% of married women each followed by male condom and norplant's by about 82% and three-quarter of study participants, respectively [20].

Study done in Oromiya, Modjo town showed that knowledge and approval of family planning were high, 91.5% and 82.2% respectively. However, the actual practice of family planning methods was found to be 38.3%. Among the list of family planning methods, injectable was the most frequently used (55.45%) followed by pills (26.06%), condom (7.1%), IUD (5.21%) and norplant (0.95%) while the remaining 5.21% of respondents used other type of family planning methods and the most important barriers reported by non-users are fertility reasons, opposition of husbands, method related reasons and poor knowledge of method and sources, the problem of availability and accessibility of family planning services [21].

2.2 Education

From study conducted in rural Bangladesh the results of multivariate analyses revealed that women's education has a net effect on contraceptive use. Compared with women who had no formal education, the women with primary education and at least some secondary education were 15% and 31% more likely to use contraceptives [22]. Cross-sectional study conducted in Saudi 2008, revealed that utilization of contraception increased significantly with the increasing level of education. Women with the highest level of education used contraceptives more than twice (OR=2.7) than the non-educated ones [23]. Other study done in Nigeria Delta State revealed that contraceptive utilization of those with no formal education stood at 14.2%, while those with primary, secondary, and tertiary education were 29.5%, 32.7%, and 23.6%, respectively[18].

In Ethiopia the situation is not exceptional from the above-mentioned facts. study conducted in SNNP, Dawro Zone showed that for those women who educated to high school level and above contraceptives use were 2 times more than the illiterate ones [24]. Study in Butajira also indicated that women with primary and secondary level of education were about 1.32 (95% CI: 1.12, 1.56) and 1.99 (95% CI: 1.38, 2.88) times respectively more likely to use family planning compared to their uneducated counter-parts [20] .

2.3 Culture and Religion

The roles of religion and culture as a fertility determinant have been a subject of considerable discussion in fertility literatures. Every social group has a characteristic culture, complex of belief, attitudes, values and social controls. The cultural and religious background of a given community has powerful effect on health seeking behavior in general and contraceptive use in particular. Study in urban slum of Bangladesh showed that Muslim women reported higher use rate of contraception than women of other religions, but the association was not found to be significant [25]. Whereas another study conducted in rural parts of Bangladesh revealed in comparison with Muslim women, non-Muslim women were 60% more likely to use contraceptives [22]. Survey conducted in Kenya's city slums indicated out of total users, 52 % were Protestants and 35 % Muslims while only 13 % were Catholics [26].Qualitative study in Nigeria, Kanuri family revealed that children were highly valued and desired irrespective of their gender as both sexes fill a very crucial gap in the social and cultural life of a Kanuri family. They also believe that couples with many children were respected; having many children was considered as insurance against the high child mortality prevalent in the area.[27]

According to the 2000 EDHS, significantly high proportion of females reported that in most cases religious leaders oppose the use of family planning and ethnicity and religion were the determinant factors to the use of contraception [28]. Also another study by Biniyam B et al revealed that Catholic followers are twice more likely to be MC decision makers as compared to the other religion. Being protestant or other religious group member was found to have less influence to be a decider as compared to Orthodox Christians of which 61.7% able to make decision on its use [29].

2.4 Reproductive health factors

Family planning methods may be used either for spacing or limiting births to avoid mistimed or unwanted pregnancies. A study done in Bangladesh revealed that women who had only daughter(s),women with at least one son and those with son(s) and daughter(s) were 43.0% and 61.2% respectively more likely to use any family planning method [25.]

Study conducted by Bezabih T in SNNP outlined that reason why women use modern contraceptives was responded by majority (75.6%) and 13.1% as child spacing and avoid unwanted pregnancy respectively. When Desire for additional children was asked, the majority of respondents (65.6%) and 31.2% replied that they have few children and have few and need more sons respectively. 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. 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. Again those currently using contraceptives said that they are using to space birth (80%) and limiting birth (20%) [24].

A study in Hosanna revealed that as the number of times women become pregnant increases, tendency to experience unintended pregnancy increases. The most frequently reported reasons for failure to avoid unintended pregnancy were contraceptive failure (31.3%) breast feeding as family planning (27.5%), husband disapproval (13.7%) and poor access to health services (3.8%) [30.]
Another study in Butajira showed that women's desire for children did not significantly decline with increasing size of surviving children. For instance about 70.8% of married women having four surviving children wanted another child. The odds of women with no experience of child death were 1.3 times more likely to use family planning compared to those who had dead children [20].

Study in Modjo town indicated that women who had 1 to 2 living children were 4.613 times more likely to use family planning services than women who had no living children and women who had 3 to 4 children were 3.638 times more likely to utilize family planning services than women who had no children while women who had five and more children were 7.382 times more likely to utilize family planning services than women who had no child [21].

2.5 Age

The utilization of modern family planning among different category of age is not similar. Study conducted in Bangladesh stated as women's current age was a significant predictor of contraceptive use. Compared to younger aged less than 25, the older women aged 35 or more were 62.8% less likely to use any contraception [22]. Another study in the same country at different period demonstrated that as age appeared as a strong significant predictor of contraceptive use. Compared with women aged less than 25 years, the women aged 25-34 and 35 or above were 2.11 and 1.64 times more likely to use contraceptives. The reduced odds ratio for the women aged 35 and above indicates decreasing need for contraceptives. The increased odds for women aged 25-34 is partly attributed to the fact that most of them had already achieved their desired family size and had taken the decision to stop childbearing or space the next childbirth. The women aged less than 25 years are relatively younger, newlywed, and have lower parity. As a result, they are reluctant to use contraceptive methods in the early years of their reproductive age [25]

A study done in Tanzania, showed that use of modern family planning methods was highest among women in the age 35 years and above and it justify as this could be attributed to the fact that the younger ones, though highly sexually active, desire to bear children and are not yet ready to use contraceptives but when another variables entered to the model the association between age of respondents and use of the modern family planning methods in not statistically significant [19]. Another study conducted in Sudan indicated that more of the older age group reported using modern family planning methods (55.6%) compared to the younger women (46.7%)[17],EDHS ,2011 revealed that Current contraceptive use is lower among young women and older women than among those at the intermediate age groups,5 % of all women age 15-19 report current use of any contraceptive method and this proportion increases until it peaks at 29 % in the 30-34 age group, after which it decreases steadily to 11 % among women age 45-49. A similar pattern is observed among currently married women[12] from the above fact we conclude that modern family planning utilization was vary among different age group in different setting.

2.6 Inter spousal Communication

Spouse discussion and agreement in the use of modern family planning methods are important psychological backing to women which might influence their final decision. Although, inter spousal communication could be considered as a reflection of culture, it can be affected by the level of knowledge and education status of the couples. Spousal communication is a result of power asymmetry between men and women, which is usually ascribed by the culture in which they are living in. Study in Rural Bangladesh on contraceptive use: socioeconomic correlates and method choices revealed that husband–wife interaction appeared to have significant effect on contraceptive use. The women who had discussed this issue with their husbands were 4.45 times more likely to use family planning methods compared with women who did not discuss this issue with their husbands [22] . A study in Tanzania also showed that about one fourth of women who reported to discuss with their partners about family planning issues used the methods as opposed to 3% of their colleagues who did not engage in such discussions. This relationship between spousal communication and use behavior of modern family planning methods was statistically significant (chi square = 29.35, $p < 0.0001$) [19] . Study in rural Bangladesh indicated that discussion between husband and wife about contraception is the most single influential factor in contraceptive use [19]. Another study conducted by Bezabih T stated that communication and decision about contraceptive utilization was seen and the odds of couple that made decision husband and wife together found to use contraceptives was 2 times more likely than those who did not [24].

Study done in Oromiya Arsi, Hetosa Woreda showed that the women who were willing to use long-term family planning methods were 2.5 times more likely to use family planning (OR = 2.472, 95%CI = 1.199–5.095) and the women who had more frequent discussion with their husbands/partners about family planning were 11 times more likely to use family planning than those who did not discuss about family planning (OR = 10.996, 95% CI = 4.196–28.817) [32].

For a woman to utilize modern family planning husband /partner approval or support to ward family planning is the main predictor variables. Study conducted in Kenya City Slum revealed that the most important determinant of the likely hood of Women in the slums using family planning services was partner's approval of family planning [26] .

Study in Pakistan showed that the strongest and most persistent determinant to a woman's forming an intention to use various family planning methods was her perception that her in-laws did not support family planning use [37]. Study in Zambia revealed those women's perceptions of their husband or partner's approval of family planning compared to women who did not perceive husband approval of family planning those who perceived approval were more likely to use modern methods [OR: 5.43, 95% CI: 2.30, 12.81) [39] .

Study in Zambia stated women approval of family planning family planning (women who approved of family planning were significantly more likely to be users of a modern method (OR: 5.87, 95% CI: 3.37–10.24).[39] Another study in SNNP, Butajira revealed that discussion about the use of family planning between married women and their partners was significantly associated with contraception use. Married women who had discussed about contraception with their partners were 2.2 (95% CI: 1.8, 2.7) times more likely to use the family planning compared to those who did not discussed about family planning. The odds of contraception was about 2.59 (95% CI: 2.11, 3.17) times higher among married women whose partners support the use of family planning compared to those whose partner didn't support[20] .

A study in Oromiya Modjo Town showed that women who discuss about family planning issues with their husband/partners were 9.644 times more likely to utilize family planning services than those women who never discussed such issues with their partners. and Women who approved of family planning method use were 6.023 more likely to use family planning services than those who disapproved and [21].

2.8 Significance of the study

It is well recognized that one of the potential challenges in the effort towards development in Ethiopia is the highest growth rate of the population. The country has a population policy (1993) aiming at balancing the pace of growth rate of the population with the corresponding socioeconomic development. Increasing the practice of modern family planning for fertility regulation is one of the most important strategies to meet the objectives in the population policy. In order to achieve the goal, Health service extension program is the basic implementation strategy in provision of basic health services to a significant number of urban/rural populations in countries like Ethiopia which needs close follow up. One of the packages of UHEPs is model family training, but the effect of model family training on utilization of reproductive health services including modern family planning is not yet evaluated as it is implemented recently. So, this study is intended to assess utilization of modern family planning and factors affecting its use among model and non-model family women which will help policy makers, health managers and other non-governmental organization to bridge the gap between service availability and utilization, to deliver primary health care to the community for the future and also as baseline for another researcher.

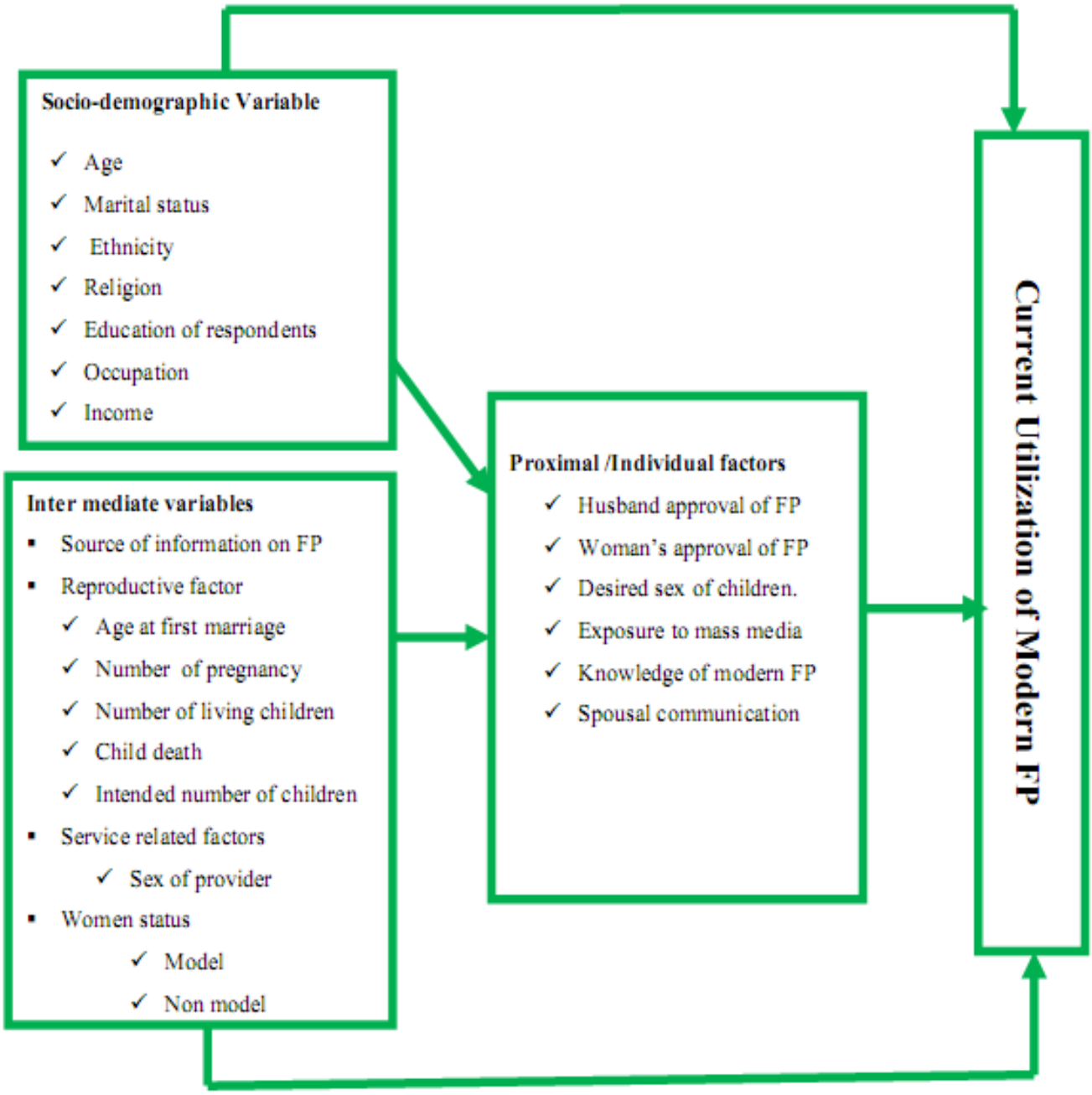

Figure 1- Conceptual frame work showing modern family planning utilization.

CHAPTER THREE - OBJECTIVES OF THE STUDY

3.1 General Objective

- To assess utilization of modern family planning method and factors affecting its use among model and non-model family women of reproductive age group in Shashamane town Oromiya, South East Ethiopia,2013.

3.2 Specific Objectives

- To determine the prevalence of modern family planning use among model and non-model family women.
- To compare modern family planning use rate among model and non-model family women.
- To determine factors associated with utilization of modern family planning service among model family women and non-model family women.

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CHAPTER FOUR - METHODS AND MATERIALS

4.1 Study area and period

The study was conducted in Shashamane town, which is 250 km from the capital city, Addis Ababa. Shashamane town is one of the Oromiya regional towns that has its own administrative structure. Administratively the town has eight kebeles.

According to national census of 2007, the projected population of the town for the year 2013 is 144,962 of which 26,528 are women of childbearing age and 22, 836 under five children. The town has basic service providing infrastructures like electric power supply, telephone, safe and clean water two bus and police station, seven branch banks, five insurance providing organizations and ten standard hotels. In terms of education there are ten colleges, six preparatory schools, ten high schools, forty-three elementary and thirty-eight KGs. The town has a particular feature in having five outlets which contributes for accompanying around twenty thousand vehicles per day. The public and private organizations which are involved in health care delivery are one referral and one district hospital, three health centers, thirty-two private (clinic and pharmacy) and six-NGOs [34] . The study was conducted from February 2013 to March 2013.

4.2 Study Design

A Community based comparative cross-sectional study involving quantitative methods of data collection was conducted.

4.3 Populations

4.3.1 Source population

All married women of reproductive age residing in Shashamane town.

4.3.2 Study population

Sampled married women of reproductive age residing in Shashamane town.

Inclusion- Exclusion criteria for both model family women and non-model family women

Inclusion

- Married women who were in the reproductive age group and living in Shashamane town.
- Who stayed at least six months in the study area.
- For model women those who graduated only before mid-year of 2011.

Exclusion:

Those who were critically ill and unable to communicate

4.3.3 Sample size determination and sampling procedure

The sample size was determined by using openEpi, version 2 modified 2007 with the following assumption:

Level of significance (α) =0.05,

Confidence level = 95%

Power =80%

P_1= 25% [proportion of modern FP user in non-model family women Oromiya region][12]

P_2 = 35% {with an assumption that the proportion in model women are greater by 10%}

The ratio of model to Non-model (n_1/n_2) =1 and considering, non-response rate of = 5%

$$n_1=341 \text{ and } n_2= 341$$

Total of **682** samples model and non-model family women

4.4 Sampling procedure

All eight kebeles found in the town were included in the study. Prior to the actual data collection, census was carried out to identify households with model and non-model family of married women of reproductive age in order to prepare sampling frame. After development of sampling frame, simple random sampling by using computer generator numbers was employed to pick study units. By applying simple random sampling Procedure, the house number/address of model and non-model family of married women has been specified from prior census result while location was identified in collaboration with kebele and katene leaders. The eligible identified married women of child bearing age were interviewed in each kebele till the number of sampled populations was completed. In some conditions if model or non-model family women of reproductive age are away from home, the interviewer revisited the household at least three times and if failed to get the respondents, it was considered as non- response.

4.5 Study Variables

4.5.1 Dependent Variable

- Current utilization of modern family planning

4.5.2 Independent Variables

- **Socio-demographic variables**
    - Age
    - Marital status
    - Ethnicity
    - Religion
    - Education status of respondents
    - Occupation of respondents
    - Income
- **Intermediate factors**
    - ✓ Source of information on FP
    - ✓ Reproductive factor
        - Age at first marriage
        - Number of pregnancy
        - Ever born children
        - Number of living children
        - Intended number of children
    - ✓ **Service related factors**
        - Sex of service provider
- **Proximal /Individual factors**
    - ✓ Exposure to mass media
    - ✓ Husband approval of family planning
    - ✓ Woman's approval of family planning
    - ✓ Desired sex of children.
    - ✓ Knowledge of modern family planning
    - ✓ Communication of family planning among partner.

4.6 Data collection instruments

Quantitative data were collected using a structured interviewer administered questionnaire that was prepared after reviewing similar literatures and modified to the local context [29]. The questionnaire was prepared in English and translated to the local language (Amharic) and then back translated to English by language expert to check for consistency. Amharic version was used for data collection.

4.7 Data Collection process

Four data collectors who were female ,diploma nurses, graduated from colleges, speak local language fluently and currently not engaged in other responsibility were recruited. One supervisor was recruited, who was senior BSc nurse from the town health office whose responsibility was checking whether the data collection instrument was correctly completed or not and supervising the data collectors and reporting problems encountered immediately to the principal investigator. Two days of training was given to data collectors and supervisor on the general data collection technique and tool used for the survey. The training included objective of the study, how to collect data and pretesting of the instruments. Repeated visit with appropriate time adjustment was made when study households were found to be closed or respondents were unavailable to minimize the non-response rate. If not found after three visit considered as non-respondent.

4.8 Data quality assurance

To assure the quality of the data, properly designed data collection instrument was developed after revising related literatures and adopting questionnaires used in other similar studies by considering local conditions. The English version of the questionnaire was translated to Amharic and back translated to English to check consistency by language expert who were familiar with languages. Before the actual data collection, the questionnaire was pre tested on 5% of similar populations which were not included in the survey and necessary modifications were made specifically on the understandability of specific item. Every day the collected data were reviewed and checked for completeness and consistency by supervisors and principal investigator. Discussions were made with the interviewers at the end of the day and in the morning corrective actions were taken timely to minimize errors committed during interview.

4.9 Operational definitions.

- **Child spacing-** refers to the minimum interval between two successive pregnancies, which is about two-five years.
- **Current users-**refers to women who were found using modern contraceptive method at the time of the survey.
- **Ever user-**these are women who were used modern family planning methods at some time in their life but not during the survey.
- **Family planning-** refers to the use of methods of fertility control that will help individuals (men and women) or couples to have the number of children they want when they want them in order to assure the well- being of the children and the parents.
- **Knowledge on modern family planning**: To measure knowledge on modern family planning nine knowledge questions were used to construct composite score. Each of the six questions was scored as follows:
    - Type of modern female contraceptive methods she knows? Response from non-to all the six will scored from 0-6 accordingly.
    - Which advantage of family planning does she know? Responses from none of them to all of the four advantages listed will be scored from 0-4 accordingly.
    - How many sources of contraceptive methods does she know? Responses from none of them to all of the seven sources of family planning listed will be scored from 0-7 accordingly.
    - Does she know presence of modern family planning methods for males? If yes, score = 1, if no, score = 0. And the two specific type for men also scored 0-2.
    - Does she know how long two consecutive children should be spaced? If response is correct score =1, if the response is not correct score meaning response other than 'three to five years) = 0. Based on the summation score, score above 70% were considered as having better knowledge on family planning [29]
- **Married women:** means ever married [currently married, divorced, widowed (official ending of marriage), and separated)].

- **Model family women**: are those who have been involved in other development work; accepted by the community as early adopters, and enjoy the credibility which comes from having adopted health practices including family planning and become role models. As role models, they help in diffusing health messages which leads to the adoption of improved health practices and behaviors by the community [35]. Model women's are satisfied users that can communicate the message to communities as well as their peers [4]. In this study model family women's are those involved in HEP package training, for ninety-six hours (complete), monitored by UHEP and their supervisors, finally certified by town health office, graduated before the mid-year 2011 and live in the study duration.
- **Modern family planning methods**- refers to methods of child spacing or birth control or limiting other than natural methods (abstinence, basal body temperature, cervical mucosa, and symptom-thermal and withdrawal methods).
- **Non- model women** -are women of reproductive age group who didn't take training on 16 packages but with the same socio demographic characteristics to that of model family women.
- **Non users**- refer to women who were found not using modern Family Planning method at the time of the survey.
- **Reproductive decision**: Refers to the intention of the individual to give birth to a child or use of contraceptives or thinking of possibility of giving birth.
- **TFR-** is the measure of children a women would have over her life time if she were to follow current age-specific fertility rates
- **Unintended pregnancy**-pregnancy that comes beyond the intention or need of the women for different reasons.

4.10 Data Processing and Analysis

The collected data were checked for completeness and consistencies, coded, entered to EpiData version 3.1and exported to Statistical Package for Social Sciences (SPSS) version 20.0 for analysis. The distributions of the data were explored and data cleaning were performed to identify outliers, errors and missing values. After categorizing and defining variables, descriptive analysis wer**e** computed to get summary values for each independent variable and their frequency and percentage was presented by table. Bivariate analysis was run for each independent variable with the outcome variable to see the association. Variables which remain statistically significant at p-value of less than 0.20 in bivariate analysis were entered to multivariate logistic regression to get final model. Odds ratio (OR) with 95% Confidence interval (CI) for each variable of interest was reported and P-value less than 0.05 was used as cut of point to declare significance. The findings were presented in text, figures and tables.

4.11 Ethical consideration

Ethical approval of the research proposal was obtained from the ethical review committee of Jimma University. A formal latter was written by the department of population and family health to Shashamane town health office. Co-operation letter was obtained from Oromiya regional health bureau to town health office to conduct the study. During recruitment, participants were given an explanation on the purpose of the study, confidentiality and anonymity of both the data and process. Hence, asked if they would like to participate or not. Upon approval oral informed consent was obtained to precede the interview, otherwise they were never probed or coerced to participate in the study.

4.12 Dissemination and utilization of results

The results of this study will be disseminated or communicated to Jimma University, Collage of public health and medical science, department of population and family health, Ministry of health , Oromiya regional health bureau, and Shashamane town health office, local institutions and other concerned bodies through reports and publication on an appropriate journal.

CHAPTER FIVE- RESULT

5.1 Socio-demographic characteristics

A total of 672 married women were interviewed giving a response rate of 98.5%. More than one third (37.1%) of the respondents in model family women fall in the age group of 26-34, while 147(43.9%) of non-model family women were in the age group of 15-25. The mean age of the respondents was 30.4 (SD ±7.1) years for model family women and 27.9 (SD ±6.4) years for non- model family women. Regarding marital status 266 (78.9%) of model family women and 290(86.6%) of none model family women were in a union and living together [Table-1].

Model and non-model family women were similar with their religious distribution, 137(40.7%) of model and 134 (40.0%) of non-model women were Orthodox. Out of six hundred seventy two married women interviewed, 209 (62.0%) of model family women and 220 (65.7%) of non-model family women were house wives. The educational status of women included in the survey showed that 59 (17.5%) of model family women and 77 (23.0%) non model family women were unable to read and write while only 43 (12.8%) and 20(6 %) of them had attended grade twelve and above respectively [Table-1].

The dominant ethnic group in both groups were Oromo accounted 160 (47.5%) for model family women and 124 (37%) for non-model family women. More than one third, (36.2%) of model family women and 129(38.5%) of non-model family women earn a monthly income of less than five hundred Birr [Table-1].

Table -1- Socio-demographic characteristics of married women, Shashamane Town, Oromiya, 2013

Characteristics	Model Family women (n=337)	Non-model Family women (n=335)	X^2	p- value
Age of respondents in years			**15.854**	**0.001**
15-25	102(30.3%)	147(43.9%)		
26-34	125(37.1%)	115(34.3%)		
=>35	110(32.6%)	73 (21.8%)		
Marital Status			**6.858**	**0.009**
In union	266(78.9)	290(86.6)		
Not in union	71(21.1)	45(13.4)		
Religion			**5.133**	**0.274**
Muslim	119(35.3%)	105(31.3%)		
Orthodox	137(40.7%)	134(40.0%)		
Protestant	68(20.2%)	88(26.3%)		
Catholic	10(3.0)	5(1.5%)		
Others*	3(0.9%)	3(2.4%0		
Occupation			**2.105**	**0.349**
Employed	39 (11.6%)	28(8.3%)		
House wife	209(62.0%)	220(65.7%)		
Merchant	89(26.4%)	87 (26.0%)		
Educational Status of mother			**21.812**	**0.001**
No formal education	77(22.8)	103(30.7)		
1-4 grade	49(14.5%)	36(10.7%)		
5-8 grade	101(30.0%)	80(23.9%)		
9-12	67(19.9%)	96(28.7%)		
Above grade 12	43(12.8%)	20(6.0%)		
Ethnicity			**17.453**	**0.002**
Oromo	160(47.5%)	124(37.0%)		
Amhara	57(16.9%)	73(21.8%)		
Gurage	33(9.8%)	39(11.6%)		
Wolayta	47(13.9%)	75(22.4%)		
Others**	40(11.9%)	24(7.2%)		
Monthly income in birr			**1.051**	**0.789**
≤500	122(36.2%)	129(38.5%)		
501-1000	94(27.9%)	82(24.5%)		
1001-1499	19(5.6%)	19(5.7%)		
≥1500	102(30.3%)	105(31.3%)		
Possession of TV/Radio			**14.238**	**0.001**
Yes	288(85.5)	247(73.7)		
No	49(14.5)	88(26.3)		

*Others -Wakefata and jova. **Others- Tigre, Silte, Hadiya and kambat

5.2-Reproductive characteristics

The mean age at first marriage was 18.75(±3.26) years for model family women and 18.85 (±3.07) years' for non-model family women. Among women who were currently in wedlock 312 (92.6%) of model family women and 305 (91%) of non-model family women had previous pregnancy at least once in their life time. From those who have had a previous pregnancy experience 57 (18.3%) of model family women and 41 (13.5%) of non-model family women encountered at least one child death [Table-2].When asked about which sex they prefer to have, 239(70.9%) of model family women and 241(71.9%) of non-model family women preferred to have male child to female [Table2].

5.3 Knowledge of Modern Family Planning

In this study the knowledge and approval of family planning were assessed and the finding of the survey showed that all model family women and 95% of non-model family women have heard about modern family planning methods and know at least one method [Table-2].

Women who heard about modern family planning were further asked to mention about source of information and it was found that health professionals were source of information for 225 (66.8%) of model family women and 192 (60.4%) of non-model family women. Nearly one third, (33.2%) of model family women and 126 (39.6%) of non-model family women mentioned mass media as a source of information for family planning.

Regarding the knowledge of specific modern family planning method 322 (95.5%) of model family women responded that they know injectable followed by oral pills 281(83.4%) and implant 195 (57.9%). While 287(90.3%) of non-model family women reported that they know injectable followed by pills 239 (75.2%) and implant 143 (45%) [Figure -2].

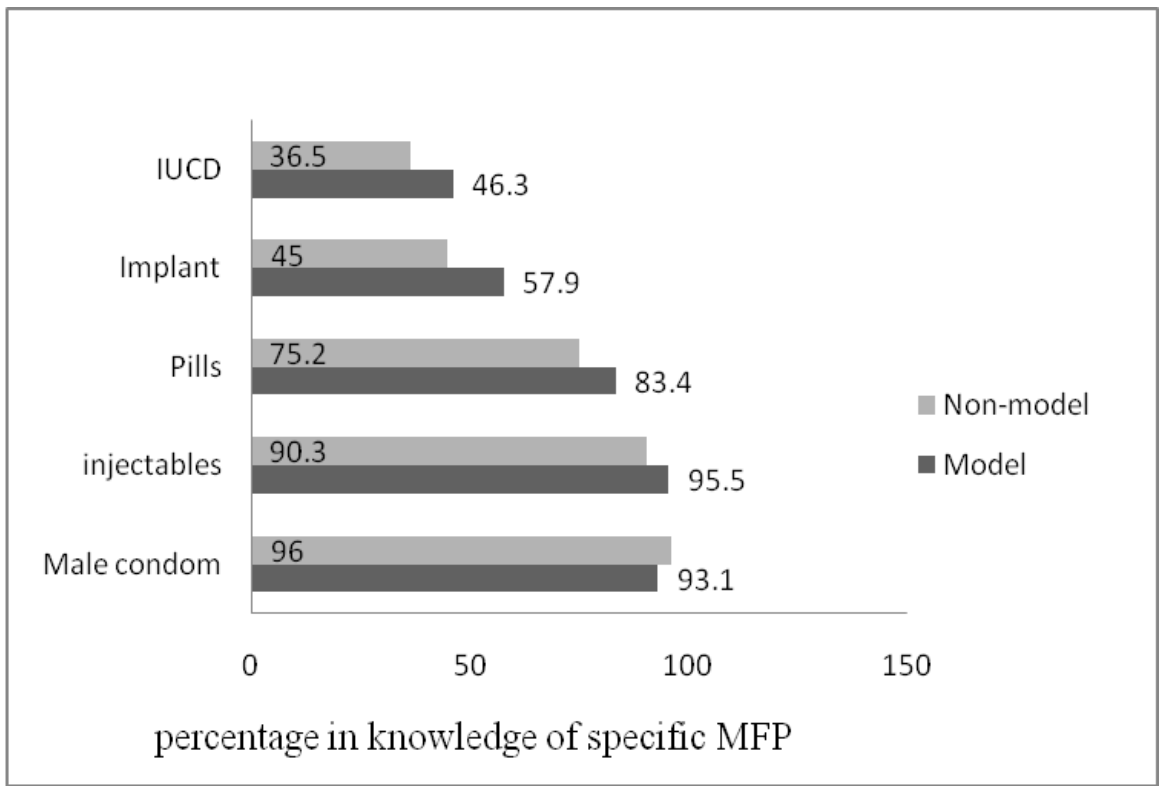

Figure- 2 Knowledge of specific modern family planning method among model family women and non-model family women in Shashamane town, Oromiya region 2013.

When asked about presence of modern family planning for male, more than two third (64.1%) of model family women and 152 (47.8%) of non-model family women reported that they know the presence of modern family planning for men. With regard to the recommended inter-pregnancy interval, more than three quarter (76.0%) of model family women and two third (61.8%) of non-model family women reported that it should be two to five years [Table-2].

Table -2-Reproductive characteristics and knowledge of family planning among model and non-model family women Shashamane town, Oromiya 2013

Characteristics	Non model women (n & %)	Model family women (n & %)	X^2	p- value
Age at first marriage	**n= 327**	**n=327**	**0.501**	**0.479**
<18	176(53.8)	185(56.6)		
>=18	151(46.2)	142(43.4)		
Any pregnancy before			**0.528**	**0.467**
Yes	305(91.0)	312(92.6)		
No	30(9.0)	25(7.4)		
Ever born children			**6.08**	**0.009**
1-5	277(91.1)	264(84.6)		
>5	27(8.9)	48(15.4)		
A live children			**0.246**	**0.620**
1-4	286(91.7)	281(92.7)	0.620	0.365
.>5	26(8.3)	22(7.3)		
Ever encountered child death	**n=304**	**n=312**	**2.632**	**0.105**
Yes	41(13.5)	57(18.3)		
No	263(86.5)	255(81.7)		
Intended number of children			**0.033**	**0.857**
1-4	212(63.3)	211(62.6)		
>4	123(36.7)	126(37.4)		
Sex preference			**0.086**	**0.770**
Female	94(28.1)	98(29.1)		
Male	241(71.9)	239(70.9)		
Pregnancy interval	**n=325**	**n=337**	**21.077**	**0.001**
Less than 2 years	61(18.2)	30(8.9)		
From 2- 5 years	201(61.8)	256(76.0)		
>5 years	73(21.8)	51(15.1)		
Ever heard MFP			**17.545**	**0.001**
Yes	318(95.0)	337 (100.0)		
No	17 (5.0)	0(0.0)		
Source of information			**2.886**	**0.089**
Mass media	126(39.6)	112(33.2)		
Health professional	192(60.4)	225(66.8)		
Do you know any FP for men?			**17.650**	**0.001**
Yes	152 (47.8)	216 (64.1)		
No	166 (52.2)	121(35.9)		

The overall knowledge about modern family planning methods was assessed after asking 9 knowledge measuring questions. Accordingly, 209 (62.0%) of model family women and 125(39.3%) of non-model family women were regarded as knowledgeable [Fig-2].

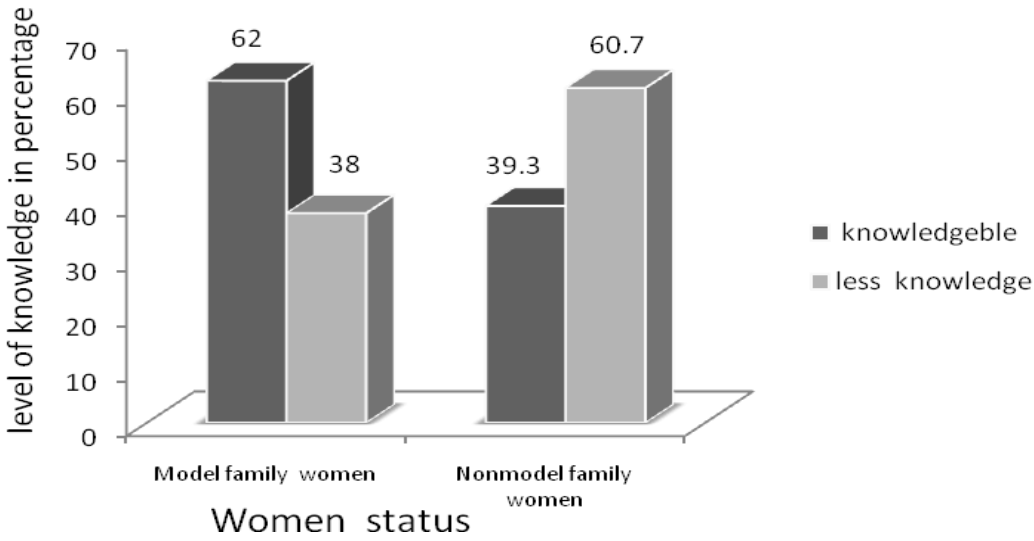

Figure 3-knowledge about modern Family Planning among model and non-model family women Shashamane Town, Oromiya 2013.

5.4-Modern family planning approval and utilization.

Majority, (96.0%) of model family women and 304 (93.3%) of non-model family women approves the use of modern family planning methods. When asked about their perceptions whether husband approves the method adoption or not 245 (92.1%) of model family women and 225 (81.8%) of non-model family women believed that their husband approves method adoption[Table -3].

For non-users , the main reason for not use modern family planning methods include, desire to have more children (74.6% of model 11.7% of non-model), fear of side effects (8.4% of model and 12.5% of non-model) and religious prohibition (3.2% of model and 15.6%)[Table -3].

Table -3- Approval and practice of model and non-model family women towards modern family planning Shashamane Town, Oromiya, 2013.

Characteristics	Model family women (n&%)	Non model family women(n&%)	X2	P value
Do you approve use of FP**	**n=337**	**n= 318**	**2.533**	**0.111**
Approve use of MFP *	316 (93.77)	304 (95.6)		
Disapprove use of MFP	21 (6.23)	14 (4.4)		
Ever discussed with partner about MFP	**n=266**	**n=290**	**11.917**	**0.001**
Yes	246 (92.5)	240 (82.8)		
No	20 (7.5)	50(17.2)		
Do your husband approve use of FP			**12.550**	**0.000**
Approve use of MFP	245 (92.6)	225(81.8)		
Disapprove use of MFP	21(7.9)	50(18.2)		
Do your relatives approve use of FP	**n=329**	**n=326**	**6.218**	**0.013**
Approve use of MFP	215(65.3)	182(55.8)		
Disapprove use of MFP	114(34.7)	144 (44.2)		
Reason to use this method?	**n=242**	**n=207**	**1.129**	**0.569**
To limit	47 (18.9)	39 (18.9)		
To space	200 (80.3)	163 (79.1)		
Others /prevent STI/HIV	2 (0.8)	4(1.9)		
Reason not to use MFP by non-user			**139.907**	**0.001**
Fear of side effect	8 (8.4)	16(12.5)		
Religious	3(3.2)	20(15.6)`		
Desired for children	**71 (74.6)**	**15(11.7)**		
No husband with them	13(13.7)	77 (60.2)		
Sex of service provider preferred			**9.029**	**0.011**
Female	143(43.9)	166(51.1)		
Male	19(5.8)	31(9.5)		
Both	164(50.3)	128(39.4)		

*MFP- modern family planning ** FP- Family planning

Current modern family planning utilization was 242 (71.8%) among model family women and 207(61.8%) among non- model family women [Fig-3].

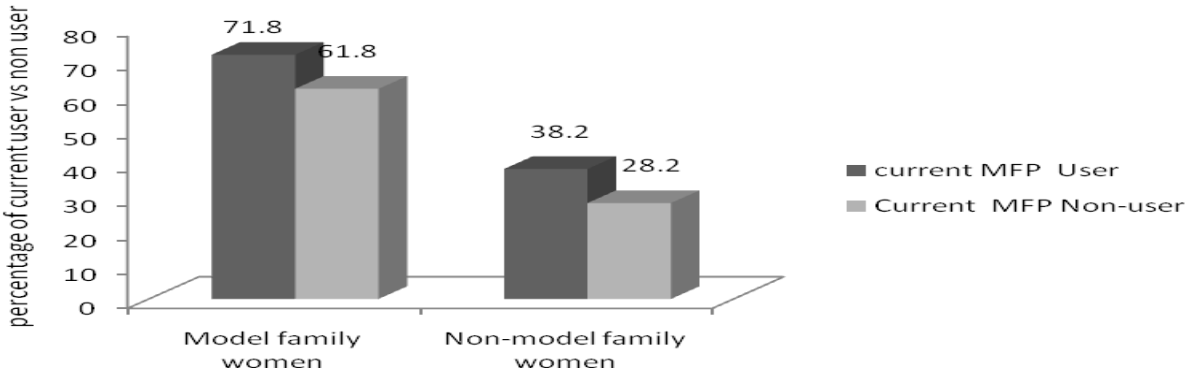

Figure 4-Modern family planning use by women status Shashamane town, Oromiya, 2013.

From a total of 249 model family women who were current users 142 (57%) of them used injectable followed by 64 (25.7%) implants while three individuals 3(1.2%) used tubal ligation. Among non-model women 142 (68.9%) used injectable followed by 30 (14.6%) implants. For permanent methods and IUD less than 5% were reported from both model and non-model family women [Fig-5].

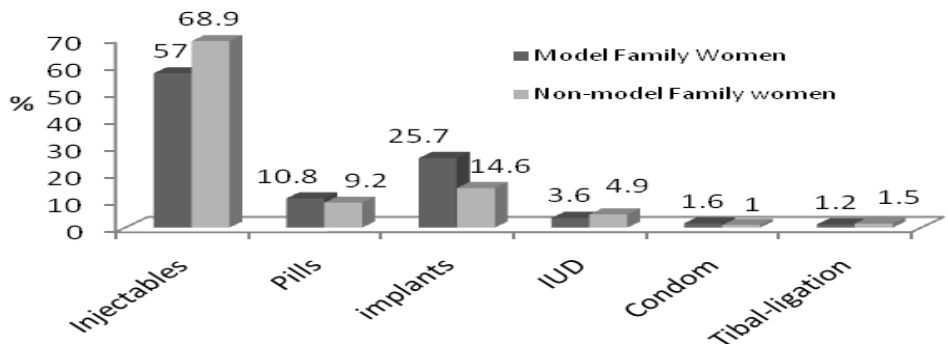

Figure 5- Specific modern family planning in use among model and non-model family women Shashamane town, Oromiya 2013.

More than three forth (80.3%) of model family women and 163 (79.1%) of non-model family women used the method for spacing, while 18.9% of both women used it for limiting. Regarding the sex of the health providers they prefer, 143(43.9%) of model family women and 166 (51.1%) of non-model family women preferred male provider while 164 (50.3%) and 128(39.4%) of model and non-model family women preferred both providers respectively [Table -3].

To identify factors associated with utilization of modern family planning bivariate analysis was done using logistic regression and variables significantly associated at($p<0.20$) were entered into multivariate analyses using stepwise methods of logistic regression. Model goodness of fit was assessed using hosmers-lemshow test, while sample adequacy was checked by chi-square test. Accordingly the variables: Woman status (model vs non-model), age, marital status, occupation ,possession of Radio/TV, average monthly income , age at first marriage , previous history of child death, knowledge, discussion, woman's approval ,husband's and, relative approval of Family Planning use were found to be significantly associated ($p<0.20$) and entered into multivariate analyses using stepwise methods of logistic regression model to determine factors independently associated with modern family planning use[Table-4].

However: religion, ethnicity, educational status of women, numbers of ever born children, alive and intended numbers of children, were not significantly associated ($p > 0.20$).

Table-4-Socio-demographic,reproductive, knowledge, approval and practice variables showing association in bivariate analysis among married women, Shashamane town, Oromiya, 2013

Variables	Current user(n&%)	Non-users (n& %)	COR (95 % CI)	p-value
Women status				
Model women	242(71.8)	95(28.2)	1.575(1.139,2.178)	0.006*
Non-model women	207(61.8)	128(38.2)	1.00*	
Age				
15-25	171(68.7)	78(31.3)	1.901(1.281,2.823)	0.001*
26-34	180(75.0)	60(25.0)	2.602(1.723,3.929)	0.001*
≥35	98(53.6)	85(46.4)	1.00*	
Marital Status				
In union	412(74.1)	144(25.9)	6.109(3.958,9.430)	0.001*
Not in union	37(31.9)	79(68.1)	1.00*	
Occupation				
Employed	45(67.2)	22(32.8)	1.319(0.729,2.386)	0.360
House wife	297(69.2)	132(30.8)	1.451(1.007,2.091)	0.046*
Merchant	107(60.8)	69(39.2)	1.00*	
Do you Have Radio /TV?				
Yes	371(69.3)	164(30.7)	1.711(1.164,2.514)	0.006*
No	78 (56.9)	59 (43.1)	1.00*	
Monthly income				
≤500	152(60.6)	99 (39.4)	1.00*	
501-1000	130(73.9)	46 (26.1)	1.841(1.208,2.804)	0.004*
1001-1499	25(65.8)	13 (34.2)	1.253(0.612,2.564)	0.538
≥1500	142 (68.6)	65 (31.4)	1.423(0.966,2.097)	0.075*
Age at first marriage				
<18 year	259(71.3%)	102(28.2%)	1.504(1.082,2.091)	0.015
>=18 year	184(62.8%)	109(37.2%)	1.00*	
Child death				
yes	60(61.2%)	38(38.8%)	1.00*	
No	370(71%)	148(28.6%)	1.583(1.011,2.480)	0.045
Knowledge of MFP				
Knowledgeable	251(75.1%)	83(24.9%)	1.929(1.380,2.695)	0.001
Less knowledge	196(61.1%)	125(38.9%)	1.00*	

Women approval of MFP				
Approve	434(70.0%)	186(30.0%)	5.091(2.444,10.607)	0.001
Disapprove	11(31.4%)	24(68.6%)	1.00*	
Husband approval of MFP Use				
Approve	375(79.8%)	95(20.2%)	4.060(2.421,6.808)	0.001
Disapprove	35(49.3%)	36(50.7%0	1.00*	
Ever discussed with husband				
Yes	387(79.6%)	99(20.4%)	7.036(4.11,12.03)	0.01
No	25(35.7%)	45(64.3%)	1.00*	

* P –value less than 0.20 1.00* - Reference category

When binary logistic regression run independently to model and non- model family women the variables :age, marital status, possession of TV/Radio, average monthly income, age at first marriage, any pregnancy before, knowledge, women approval, husband approval, relative approval and ever discussion were found to be statistically significant at(p value < 0.20) for both settings and in addition sex preference and sex of service provider were found to be significant for non- model family women[Table-5].

However, religion, ethnicity, educational status, numbers of ever born, alive and intended numbers of children were not found to be significantly associated (p>0.20) in both settings.

Table- 5- Comparison of socio demographic, knowledge and reproductive history of current user and non-user among model and non-model family women of Shashamane Town, Oromiya, 2013.

Characteristics	Non model family women		COR (95% CI)	Model family women		COR (95% CI)
	Current user (n & %)	Non-user (n & %)		Current user (n & %)	Non-user (n & %)	
Age						
15-25	95(64.6)	52(35.4)	2.214(1.250,3.922)*	76(74.5)	26(25.5)	2.024(1.127,3.634)*
26-34	79(**68.7**)	36(31.3)	2.660(1.450,4.878)	101(**80.8**)	24(19.2)	2.913(1.623,5.231)*
≥35	33(45.2)	40(54.8)	1.00*	65(59.1)	45(40.9)	1.00*
Marital Status						
In union	198(**68.3**)	92(31.7)	8.609(3.981,18.614)*	214(**80.5**)	52(19.5)	6.320(3.595,11.111)*
Not in union	9(20.0)	36(80.0)	1.00*	28(39.4)	43(60.6)	
Education						
Illiterate	47(61.0)	30(39.0)	0.993(0.550,1.793)	41(69.5)	18(30.5)	0.816(0.406,1.639)
Read & write	18(69.2)	8(30.8)	1.426(0.572,3.552)	13(72.2)	5(27.8)	0.931(0.305,2.893)
Grade1-8	71(61.2)	45(38.8)	1.001(0.590,1.696)	107(71.3)	43(28.7)	0.891(0.513,1.548)
Gra9& above	71(61.2)	45(38.8)	1.00*	81(73.6)	29(26.4)	1.00*
Possession of TV/Radio						
Yes	158(**64.0**)	89(36.0)	1.413(0.862,2.316)*	213(**74.4**)	75(26.0)	1.959(1.046,3.668)*
No	49(55.7)	39(44.3)	1.00*	29(59.2)	20(40.8)	1.00*
Monthly income						
≤500	72(55.8)	57(44.2)	2.625(1.413,4.878)*	80(65.6)	42(34.4)	1.303(0.728,2.332)
501-1000	63(**76.8**)	19(23.2)	1.357(0.502,3.670)	67(**71.7**)	27(28.7)	1.138(0.403,3.208)
1001-1499	12(63.2)	7(36.8)	1.056(0.628,1.775)	13(68.4)	6(31.6)	2.152(1.164,3.982)*
≥1500	60(57.1)	45(42.9)	1.00*	82(80.4)	20(19.6)	1.00*
Age at first marriage						
< 18	119(**67.6**)	57(32.4)	1.578(1.005,2.477)*	140(**75.7**)	45(24.3)	1.397(0.856,2.278)*
>=18	86(57.0)	65(43.0)	1.00*	98(69.0)	44(31.0)	1.00*
Any Pregnancy before						
Yes	201(65.9)	104(34.1)	7.731(3.064,19.504)*	230(73.7)	82(26.3)	3.039(1.333,6.928)*
No	6(20.0)	24(80.0)	1.00*	12(48.0)	13(52.0)	1.00*
Ever born children						
1-4	152(68.5)	70(31.5)	1.145(0.505,2.599)	135(74.6)	46(25.4)	1.679(0.873,3.230)
≥5	48(58.5)	34(41.5)	1.00*	95(72.5)	36(27.5)	1.00*
Alive children						
1-4	185(65.8)	96(34.2)	1.101(0.446,2.717)	213(74.5)	73(25.5)	1.545(0.660,3.616)
≥5	14(63.6)	8(36.4)	1.00*	17(65.4)	9(34.6)	1.00*
Sex preferences						
Female	50(53.2)	44(46.8)	0.608(0.375,0.987)*	76(77.6)	22(22.4)	1.519(0.878,2.629)
Male	157(65.1)	84(34.9)	1.00*	166(69.5)	73(30.5)	1.00*
Sex of provider						
Female	100(60.2)	66(39.8)	0.616(0.376,1.008)*	109(76.2)	34(23.8)	1.327(0.796,2.212)
Male	15(48.4)	16(51.6)	0.381(0.171,0.850)*	14(73.7)	5(26.3)	1.159(0.395,3.395)
Both	91(71.1)	37(28.9)	1.00*	116(70.7)	48(29.3)	1.00*

Intended No. of children						
1-4	126(59.4)	86(40.6)	0.760(0.478,1.207)	157(74.4)	54(25.6)	1.402(0.864,2.276)
≥5	81(65.9)	42(34.1)	1.00*	85(67.5)	41(32.5)	1.00*
Knowledge of MFP						
Knowledgeable	92**(73.6)**	33(26.4)	1.974(1.209,3.222)	159**(76.1)**	50(23.9)	1.724(1.064,2.793)*
Less knowledgeable	113(58.5)	80(41.5)	1.00*	83(64.8)	45(35.2)	1.00*
Women approval of MFP						
Approve	198**(65.1**)	106(34.6)	3.269(1.329,8.041)	236**(74.4)**	80(25.3)	9.833(2.640,36.623)*
Disapprove	8(36.4)	14(63.6)	1.00*	3(23.1.0)	10(76.9)	1.00*
Husband approval of MFP						
Approve	171**(76.0)**	54(24.0)	3.167(1.68,5.965)*	204**(83.3)**	41(16.7)	5.473(2.182,13.730)*
Disapprove	25(50.0)	25(50.0)	1.00*	10(47.6)	11 (52.4)	1.00*
Relative approval of MFP						
Approve	142 **(78.0)**	40 (22.0)	4.437(2.744,7.177)*	172**(80.0)**	43(20.0)	2.806(1.701, 4.630)*
Disapprove	64 (44.4)	80 (55.6)	1.00*	67(58.8)	47 (41.2)	1.00*
Ever discussed MFP use with partner						
Yes	179**(74.6)**	61 (25.4)	4.788(2.523,9.087)*	202(84.2)	38(15.8)	6.202(2.663,14.433)*
No	19(38.0)	31 (62.0)	1.00*	12 (46.2)	14 (53.8)	1.00*

* P –value <0.20 1.00* - Reference category

From the variables that were entered to multivariate: marital status, occupation, possessions of Radio/TV ,average monthly income, age at first marriage, previous child death ,knowledge, husband and relative approval of modern family planning were not found to be significantly associated (p >0.05). The rest variables: woman's status, age, women approval of Family Planning use and discussion among spousal about family planning methods were found to be statistically significant(p <0.05)[Table-6].

Model family women were 1.77 times more likely to utilize modern family planning compared to their counter parts (AOR=1.771, 95%CI=1.017, 3.085). Regarding the age of women, as the age of women increases the likelihood of utilizing modern family planning is increasing. Women in the age range of 15-25 were two times (AOR = 2.003, 95%CI=1.289, 3.818) and the age range of 26-34 were about three times more likely to utilize modern family planning (AOR= 3.906, 95%CI =.1.901, 8.025) compared to women in the age of greater than 35 years. Married women who approved family planning use were about four times more likely to utilize modern family planning than women who disapprove modern family planning(AOR= 4.206, 95%CI= 1.415, 12.497) [Table-6].

Concerning discussion of women and husband communication, women who ever discussed about family planning with their husbands utilized modern family planning three times more likely compared to women who never discussed with their partner about family planning(AOR =3.327, 95%CI = 1.546, 7.163) [Table-6].

Table-6- Factors associated with modern family planning utilization among married women of reproductive age Shashamane town, Oromiya, 2013.

Variables	Users (N&%)	Non-users (N & %)	COR (95 % CI)	A OR (95 % CI)	p-value
Women status					
Model women	242(71.8)	95(28.2)	1.575(1.139,2.178)	**1.771(1.017,3.085)***	0.044
Non model women	207(61.8)	128(38.2)	1.00*	1.00*	
Age (years)					
15-25	171(68.7)	78(31.3)	1.901(1.281,2.823)	**2.003(1.289,3.818)***	0.031
26-34	60(25.0)	180(75.5)	2.602(1.723,3.929)	**3.906.(1.901,8.025)***	0.001
≥35	85(46.4)	98(53.6)	1.00*	1.00*	
Women approval of MFP use					
Approve	434(70.0)	186(30.0)	5.091(2.444,10.607)	**4.206(1.415,12.497)***	0.01
Disapprove	11(31.4)	24(68.6)	1.00*	1.00*	
Ever discussed with husband					
Yes	387(79.6)	99(20.4)	7.036(4.11,12.03)	**3.327(1.546,7.163)***	0.002
No	25(35.7)	45(64.3)	1.00*	1.00*	

* P –value < 0.05 1.00* - Reference category

Factors associated with modern family planning utilization among model family women

When analyzed independently for model family women; marital status, possession of Radio/TV, average monthly income, age at first marriage, any pregnancy, knowledge, woman's approval, husband approval and relative approval were not found to be significantly associated with modern family planning (P >0.05) while age of model family women and ever discussion about family planning with partner were found to be significantly associated (at P<0.05).

Model family women in the age range of 26-34 were about 2.886 more likely to utilize modern family planning compared to women in the age of greater than 35 years (AOR= 2.886,95%CI = 1.199,6.947).

Model family women in Shashamane town who ever discussed about modern family planning methods with their partner were 4.350 times more likely to utilize modern family planning compared to women who never discussed about family planning with their husbands (AOR =4.350,95%CI = 1.708,11.076)[Table- 7].

Table -7- Factors associated with modern family planning utilization among model family women Shashamane Town, Oromiya, 2013

Characteristics	Current user (n & %)	Non-user (n and %)	COR	AOR (95% CI)	P-Value
Age					
15-25	76(74.5)	26(25.5)	2.024(1.127,3.634)	1.042(0.473,2.114)	0.995
26-34	101(80.8)	24(19.2)	2.913(1.623,5.231)	**2.886(1.199,6.947)***	0.018
≥35	65(59.1)	45(40.9)	1.00*	1.00*	
Ever discussed with husband					
Yes	202(84.2)	38(15.8)	6.202(2.666,14.433)	**4.350(1.708,11.076)***	0.001
No	12 (46.2)	14 (53.8)	1.00*		

p –value less than 0.05 1.00 Reference category

Factors associated with modern family planning utilization among non-model family women

Non-model family women in the age range of 26-34 were about three times more likely to utilize modern family planning compared to non-model women whose age greater than 35 years (AOR = 3.339,95%CI = 1.867,5.971) (P=0.001). Non model family women who ever discussed about family planning with their husbands were about 2.84 times more likely utilized modern family planning compared to those who never discussed with their husband's about family planning(AOR =2.840, 95%CI=1.479, 5.454). Non model family women who were knowledgeable of family planning were about two times more likely to utilize modern family planning than those who were less knowledgeable (AOR=1.691, 95%CI=1.079,2.650)[Table-8].

Non-model family women who perceive their husbands approve of family planning use were more likely to utilize modern family planning compared to those who perceive their husbands disapprove family planning use (AOR = 1.978, 95%CI =1.062, 3.684). Regarding relative approval of family planning, non-model family women who perceive their relatives approve family planning use were 1.6 times more likely to utilize modern family planning compared to non-model family women who perceive their relatives disapprove family planning(AOR=1.602, 95%CI = 1.070, 2.548)[Table-8].

Table- 8- Factors associated with modern family planning method among non-model family women Shashamane town, Oromiya, 2013.

Characteristics	Current user (n& %)	Non-user (n&%)	COR	AOR (95% CI)	P Value
Age					
15-25	95(64.6)	52(35.4)	2.214(1.250,3.922)	1.496(0.898,2.493)	0.122
26-34	79(**68.7**)	36(31.3)	2.660(1.450,4.878)	**3.339(1.867,5.971) ***	0.001
≥35	33(45.2)	40(54.8)	1.00*	1.00*	
Ever discussed with husband					
Yes	179**(**74.6**)**	61 (25.4)	4.788(2.523,9.087)	**2.840(1.479,5.454)**	0.002
No	19(38.0)	31 (62.0)	1.00*	1.00**	
Knowledge					
Knowledgeable	92(73.6)	33(26.4)	1.974(1.209,3.222)	**1.691(1.079,2.650)***	0.022
Less knowledgeable	113(58.5)	80(41.5)	1.00*	1.00*	
Relatives approval of MFP use					
Approves	142 **(78.0)**	40 (22.0)	4.437(2.744,7.177)	**1.602(1.070,2.548)***	0.047
disapproves	64 (44.4)	80 (55.6)	1	1.00*	
Husband approval of MFP					
Approves	171**(76.0)**	54(24.0)	3.167(1.68,5.965)	**1.978(1.062, 3.684)***	0.032
disapproves	25(50.0)	25(50.0)	1.00*	1.00*	

p –value less than < 0.050 1.00 Reference category

CHAPTER SIX - DISCUSSION

This study assessed factors that influence Modern Family Planning utilization among model and non-model family women in Shashamane town. The study showed that knowledge of modern family planning method is high among women in Shashamane town, 100% among model family women and 95% for non-model family women who have heard and mention at least one method. This figure is higher than the results from the Ethiopian 2011 EDHS [12]. The possible reason could be the recent introduction of urban health extension program in the town, 66.5% of model family women & 59.1% of non-model family women have got information about modern family planning from health professionals.

Majority, 96% of model family women knew injectable compared to 90% of non-model family women. This figure was lower among non-model family women when compared to study in Butajira which found knowledge of 99% [20]. Similarly, higher proportion of model family women mentioned long term family planning methods such as implants (57.9%) and IUD (46.3%) compared to non-model family women (45% implant and 36% IUD). This figure is still less than the results from EDHS 2011 for implants [12] and study in Mekele, (80.0%) and (55.3%) [36] for implants and IUD among non-model family women.

The result of this study showed that model family women were found to be more likely to use modern family planning than non-model family women. Modern family planning utilization was 71.8% among model family women and 61.8% among non-model family women. This is higher than the finding from Bangladesh (53.2%), Butajira (46.9%), EDHS 2011(49.5%) and Modjo Town, (38.3%) [25, 20, 12, 21]. The increase in modern family planning use in recent years could be attributed to the expanding health service coverage and the recent introduction of urban health extension program, in the town which make this service available to women. Since model family women can get comprehensive knowledge on reproductive health specifically on modern family planning during the package training by urban health extension professionals, they will be better in identifying the miss conception, rumors and side effects related to contraceptive which are obstacles for using modern family planning for women.

In our study, 57% of model family women and 68.9% of non-model family women use injectable where as 25.7% of model family women and 14.5% of non-model family women were using implants. In many studies the most commonly used method were injectable in Butajira (74.2%), Modjo (55.5 %), and Dawro (77.4%) [20,21,29]. The reason why implants higher among model family women may be due to their comprehensive knowledge on long acting family planning than non-model family women. In addition, urban health extension professional has got training on insertion of implants, so that they can provide easily for those who are in need and ready to use the methods.

In this study age appeared as predictor of modern family planning use for both model and non-model family women. Compared with women aged 15-25 years, women aged 26- 34 years were more likely to use modern family planning. The increased odds for women aged 26- 34 years may attribute to the fact that most of them had already achieved their desired family size and had taken the decision to stop childbearing or space the next childbirth compared to women aged less than 25 years that were relatively younger, newlywed, and had lower parity. As a result, they are not hasty to use modern family planning methods in the early years of their reproductive age. The other possible explanation could be that since 77% of model family women and 69% of non-model family women had formal schooling, they might have used traditional method of family planning. This finding is in line with the study in rural and urban Bangladesh [22, 25] which revealed more women in this age range utilized modern family planning than earlier age, 15-25 years.

Knowledge of family planning is also associated with modern family planning utilization. In this a study non model family women who were knowledgeable of modern family planning were more likely to utilize modern family planning than those who were less knowledgeable. It is believed that information education and communication about the importance of modern family planning use play an important role in raising the contraceptive prevalence rate. However, different empirical evidences revealed that having knowledge about modern contraceptive alone could not guarantee utilization of the service. This is similar with the study conducted in Sudan, Kenya, Tanzania, Mekele town, and in SNNPR Dawro, zone [17, 26, 19, 36, 29].

In our study women who ever discussed about family planning with their husbands were more likely to utilize modern family planning than women who never discussed with their husband. Husband and wife discussion and agreement on the use of modern family planning methods are important psychological backing to women which might influence their final decision [17]. Men's support or opposition to their partners' practice of family planning has a strong impact on using the methods in many parts of the world. This is may be due to the reason that as a woman gain more autonomy, they are better able to claim their rights as individuals including the right to act and protect their own reproductive health. This is consistent with the study conducted in Tanzania Shinyanga District, Tanzania Mpwapwa District, Bangladesh, Ghana [19, 42, 22, 38]. Several studies from Ethiopia [20,21,32,41] also revealed that women who discuss about family planning issues with their husbands were more likely to utilize family planning services than those women who never discussed such issues with their partners.

Woman who approved of family planning use were more likely to utilize modern family planning methods when compared to women who disapprove family planning use. This is to be expected because respondents who approve of family planning are more likely to ensure that their favorable attitude is translated into high use of family planning. This is consistent with the studies conducted in Pakistan, Ghana and Modjo town oromiya region [40, 38, 21].

Non model family women whose husbands approve family planning method use were more likely to utilize modern family planning compared to those whose husbands disapprove. This is may be due to the reasons that as a woman attain the school the more they freely discuss issue and convince their husbands and also aware of their reproductive right and gender equality including the right to get information, to use safe and appropriate modern family planning method . This is in line with studies conducted in Pakistan, Zambia, Tanzania Mpwapwa District, Kenya and Butajira, [37, 39, 26, 42, 20, 41] which supported that women who perceived that their partner's /husband's approve family planning use were more likely to use modern family planning methods.

Since the study was a community based comparative type hence, used to identify differences in the two settings. The large sample size, appropriate probability sampling methods which may helped to improve the validity of the study were considered as strength of our study.

Limitation of the study may be due to some social desirability (not to list some methods like condom, average monthly income)and subjectivity because the respondents may desired to provide socially acceptable response. The other possible limitation was since model family women and non-model family women were living in the same town difficult to exclude mutually one another.

CHAPTER SEVEN - CONCLUSION AND RECOMMENDATION

7.1 Conclusion

- ✓ The major sources of information on modern family planning were health professionals for both women especially for model family women.
- ✓ Knowledge of modern family planning was found higher among model family women than non-model family women.
- ✓ The utilization of modern family planning is higher in model family women than non-model family women in Shashamane town.
- ✓ The most commonly used modern family planning method was injectable in both groups however, the utilization of implant were higher among model family women.
- ✓ In this study age range of 26-34, being model family women, woman's approval and discussion with husband about family planning were the factor associated with modern family planning utilization.
- ✓ For model family women, factors associated with modern family planning were age and discussion with partner while for non-model women: age, discussion, knowledge, relative and husband's approval of family planning.
- ✓ For non-user the main reason not to use or intended to use were fear of side effect and fertility reason were the predominant once.

7.2 Recommendation

Program level

- ✓ Since majority of model family women have better knowledge on modern family planning, as well as in utilization, model family training package should be continued and strongly supported by ministry of health, regional health bureau and town health office and NGO's.
- ✓ Since husband approval of family planning use has paramount in utilization of modern family planning men's involvement in reproductive health service decision making particularly family planning should be promoted and due get attention by ministry of health, regional health bureau and town health office

- ✓ Training on modern family planning counseling and provision as well as supportive supervision to urban heath extension professionals, health workers at health center/hospital from town health office, non-government organization's working in the area should be given attention.
- ✓ Information and education about modern family planning methods by different local FM radio should be continued in order to change the miss conception about possible side effects and aware its benefits to their family, community and country.

Facility level

- ✓ Couple communication and discussion about family planning should be stressed and promoted by urban heath extension professionals and health workers at health facility during clinic based family planning counseling sessions.
- ✓ In order to avert reasons for non-users related to side effects at facility level appropriate information on available modern family planning methods, counseling on their possible side effects and benefits is paramount.

For researchers

- ✓ Since model family training is in early stage in this study the desired behavior may not achieved so, further studies with strong design are necessary to identify other potential factors associated with the use of modern family planning methods among model and non-model family women in Shashamane town.

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Annexes

Annex 1- English Questionnaires

Introduction

Structured questionnaire for quantitative study

Greeting: my name is_____I came from Jimma University Collage of Public Health and Medical Science and I am working with Mr. Omer Hussen. He is doing a research on modern family planning use and factors affecting its utilization among model and non-model family women as partial fulfillment for Master's Degree in Public Health/Reproductive Health. You have been randomly selected to participate in this study. We would like to ask you a few questions about your life, children, and modern Family planning methods use. This interview will probably take a while. If you do not have time to do the interview right now, we can arrange to come back at a later time. You can refuse to answer any questions or series of questions if you are uncomfortable. This will help us to identify some of the barriers to use available reproductive health services in general and family planning in particular based on your answer to our question. No identification related to you will be stated on the questionnaire. Confidentiality of your responses will be kept. We appreciate your help in responding to this survey questions.

Do you have any questions? Can I proceed with the Questions?

Yes_____ (Thank and continue)

No _____ (Thank and stop)

Kebele _____ ketene_____ Date of interview_____

Women status: (1) Model (2) non model

Time started_____Time finished _____

Name and Signature of interviewer _____

Part -I Socio demographic characteristics

S.No	Question	Response	Instruction
101	Age of the respondent	------years old	
102	Religion	1. Muslim 2. Orthodox 3. Protestant 4. Catholic 5.others specify	
103	Marital status	1. Married 2. Unmarried 3. Divorced 4. widowed 5. Separated	
104	Ethnicity	1. Oromo 2. Amhara 3. Gurage 4.wolayta 5. others specify _____	
105	Occupation	1. Government employee 4. Student 2. Housewife 5. NGO Worker 3. Merchant 6.	

		Others, Specify __	
106	Educational Status of mother	1 .illiterate 2. Read and write only 3. Grade_____	
107	Educational Status of husband	1 .illiterate 2. Read and write only 3. Grade_____	
108	What is your monthly income?	----------ETB?	
109	How do you rate your family economic status/living standard as compared to your neighbors	1 Better off 2. Middle 3. Poor 4. Very poor	
110	Do you have TV/Radio?	1. Yes 2. No	

Part –II- Woman's desired and achieved fertility level/reproductive factors

S.	Question	Responses	Instruction
201	At what age did you get married to your husband?	.....years old	
202	Have you had any pregnancy before?	1. Yes 2. No ----------	208 If No.Q.205
203	How many children ever born to you?	..... (enter number)	
204	How many of them are alive?	1. Male ____ 2. Female____ 1. Both sex ____	

205	Have you ever encountered child death?	1.yes 2.no	
206	Have you experienced unintended	1. Yes 2. N o ----------	208
207	How many of your pregnancies were unintended?	----------(enter numbers)	
208	How many children do you want to have?	1. Male ____ 2 Female____ 3 Both sex ____	
209	Which sex do you prefer to have?	1. Male 2. Female 3 Don't mind	
210	Do you think your partner wants the same number of children that you want, or does he want more or fewer than you want?	1. Same Number 2. More Children 3. Less children 4. Don't Know	

Part III. Woman's Knowledge on Modern Family Planning

S. No	Question	Responses	Instruction
301	Have you ever heard of Modern FP methods?	1. Yes 2. No	If no Skip to Q. 305
302	From where /whom you have heard	1. Mass media(Radio, Television) 2. Husband 3. Peer 4. Health professionals 5. Others [specify].....	
303	Which type of FEMALE contraceptive methods do you know? /multiple response is allowed and read from the list and mark all that apply/	1. Pills 2. Intrauterine device (IUCD) 3. Injectable (Depo-Provera) 4. Norplant (buried under skin) 5. Spermicidal/ Diaphragm, Foam 6. Tubal ligation/female sterilization 7. Others [specify]_____	
304	Do you know if there is any family planning method for men?	1. Yes 2. N o	
305	If yes to Q.305 which type of MALE contraceptive methods do you know?	1. Condom 2. Vasectomy/male sterilization 3. Others specify_____	
306	Which advantages of FP do you know? /multiple response allowed mark all that apply/	1. To Limit family size 2. To avoid unwanted pregnancy 3. To Space child birth 4. For the mothers / child health 5. I don't know 6. Others (specify)----------	
307	Between two consecutive children, how many years of intervals do you think is good? (How long they should be spaced)	1. Less than one year 2. One to two years 3. Two to five years 4. I don't know 5. Others (specify)----------	

308	Do you know where to get Modern FP	1. Yes 2. No---------	If No. Q 401
309	Which one do you know/mark all that apply/	1. Health center 6. Pvt. clinic 2. Health post 7. at home/ CBD 3. Pharmacy 8. Others 4. Hospital 5. Social markets	

Part IV. Woman's Practice of Family Planning

S. No	Question	Responses	Instruction
401	What do you feel about using **MODERN** FP methods?	1. Supports modern family planning method use 2. Oppose contraceptive modern family planning method use 3. Don't mind	
402	Have you ever discussed about family Planning with your partner?	1. Yes 2. No	If no Skip to to Q.404
403	How frequent in the last 6 month?	1. None 2. Once 3. Twice 4. Three times 5. More than three times	
404	What do you think is your husband's attitude towards FP use?	1. Supports FP method use 2. Oppose FP method use 3. Don't mind 4. Don't know	
405	What do you think is your closer relatives (mother, father, father or mother of your partner) attitude	1. Supports FP method use 2. Oppose FP method use 3. Don't mind 4. Don't know	
406	Have you **ever used** FP methods?	1. Yes 2. No	If no Skip to Q.408

407	Which FP method did you used?	1. Pills 2. Intrauterine device (IUCD) 3. Injectables (Depo-Provera) 4. Norplant (buried under skin) 5. Condom 6. Spermicidal/Diaphragms/jelly 7. Tubal ligation/female sterilization 8. Vasectomy/male sterilization 9. Others [specify_____	
408	Are you using any FP methods currently?	1. Yes 2. No 3. NOT APPLICABLE{infertile, recently gave birth}	If **no** Skip to Q.416
409	Which type of FP methods are you using?	1. Pills 2. Intrauterine device (IUCD) 3. Injectables (Depo-Provera) 4. Implant (buried under skin) 5. Condom 6. Spermicidal/ Diaphragms/Jelly 7. Tubal ligation/female 8. Vasectomy/male sterilization 9. Others [specify----------	
410	Why do you use this method?	1. To Limit the number of 2. To Space pregnancy	
411	Where did you get it?	1. Health center 2. Health post 3. Pharmacy 4. Hospital 5. Social markets 6. Private clinics 7. At home from CBD and outreach service agents 8. Others,	
412	Have you get different option to select the FP method you are interested?[Method mix]	1 .Yes 2 .No	

413	Is the current method your choice?	1 .Yes 2 .No	
414	Have you ever switched from using one FP methods to another?	1. Yes 2. No	If no Skip to 416
415	For the most recent switch, what is the main reason you switched methods?	1. Side effects from previous method 2. Forgot to take previous method 3. Previous method inconvenient 4. Wanted a longer term method 5. Afraid to be discovered by 6. Husband/partner didn't like the method 7. Method failed 8. Provider persuaded me to 10. Method no longer available/supply problem 11. Others , (specify)----------	
416	Does your husband/partner know that You are currently using Modern FP?	1. Yes ----------if yes 2. 2. No ----------	Skip to Q.418
417	If no to Q. 416 why is that?	----------	
418	Have you ever used modern FP without the knowledge of your husband/partner?	1. Yes 2. N o	
419	What would happen if you have used FP without the knowledge of your husband?	1 . Divorce me immediately 2. Bits me 3. Stops coming to me 4. Others, specify_	
420	Would you like your husband to use FP?	1. Yes 2. N o 3 . Did not think about that	
421	By whom do you prefer to get FP services?	1.Female provider 2.Male provider 3. Both	

422	**[FOR NON USERS]** What is your main reason not to use/ intend to use modern FP method?	1. Fear of side effect 2. Husband opposition 3. Lack of knowledge 4. Religious prohibition 5. Opposition from relatives 6. Desired No. of children not achieved 7. Decreases sexual pleasure 8. Others, specify	
423	Have you ever-encountered opposition from Your partner for using /intending to use FP?	1. Yes 2. No 3. I never used or intended to use	
424	Have you ever-encountered opposition from your close relatives (mother, father, father or mother of your partner) for using/intending to use FP ?	1. Yes 2. No 3. I never used or intended to use	
425	Why did that person make you stop using the Method of FP?	1 wanted me to have more children 2. worried about my health 3. Religious opposition FP 4. Others Specify----------	
426	Do you think Modern FP has Side Effect?	1.Yes ---------- 2. No.	426
427	If yes to Q.422, what are the side effects?	----------	

Annex2. Amharic Questionnaires

ዘመናዊ የቤተሰብ ዕቅድ አገልግሎት ዘዴዎችን በተመለከተ ህብረተሰቡ ያለውን አመለካከትና የአጠቃቀም ሁኔታ ለማጥናት የተዘጋጀ መጠይቅ።

<u>መግቢያ</u>

ስሜ----------ይባላል፡፡ የጅማ ዩኒቨርሲቲ እያካሄደ ባለው ሳይንሳዊ ጥናት ውስጥ የጥናት ቡድኑ አባል በመሆን በመስራት ለይ እገኛለሁ፡፡ ዕድሜያቸው በመውለድ ከልል ውስጥ ለሚገኙ ሴቶች ስለ ዘመናው የቤተሰብ ዕቅድ አገልግሎት ዘዴዎች መጠይቅ እናቀርባለን፡፡የምጠይቁ አላማ በዘመናው የቤተሰብ ዕቅድ አገልግሎት ዘዴዎች አጠቃቀም ዙርያ ያሉ ዋና ዋና ዕንቅፋቶች ምነ ምን እነደሆኑ ለይቶ ለማወቅ ነው፡፡ እርሶንም ለመመለስ ቀላል የሆኑ የተወሰኑ ጥቄዎችን እጠይቅዎታለሁ፡፡ ስምዎን በዚህ መጠይቅ ላይ አለሰፍረውም እነዲሁም የሚሰጡት መልስ ከእረሶ ጋር ምንም ግንኙነት አይኖረውም። ከማቀርብለዎት ጥያቄ ለመመለስ የማይፈልጉት ካለ አይገደዱም በተጨማሪም አጠቃላይ መጠይቁን በፈለጉት ጊዝ የማቋረጥ መብት አልዎት። ሂኖም የምሰጡት እውነተኛ መልስ በዘመናዊ የቤተሰብ ዕቅድ አገልግሎት ዘዴዎች አጠቃቀም ዙርያ ያሉ ዋናዋና እንቅፋቶችን ለማወቅ እና የህብረተሰቡን የቤተሰብ ዕቅድ አገልግሎት የበለጠ ለማሻሻል ትልቅ ጠቀሜታ እነዳለው ላረጋግጥልዎት እወዳለው። በመጨረሻም ለምሰጡት መልስ በቅድሚያ እያመሰገንኩ በአጠቃላይ መጠይቁ ከ 20-30 ደቂቃ በላይ እነደማይወስድ እገልፅሎታለው።

ወደ መጠይቁ ከመግባቴ በፊት ጥያቄ አልዎት? ቃለመጠይቁን መቀጠል እችላለው?

አዎ----------

አይደለም----------

ቀበሌ_____ ዞን ----------የቤት ቁጥር----------

ኮድ **(1) ሞዴል ቤተሰብ** **(2) ሞዴል ያል ሆኑ ቤተሰብ**

ቀለመጠይቁ የተደረገበት ቀን_____

ቀለመጠይቁ የተጀመረበት ሰኣት---------- ቀለመጠይቁ የተጠናቀቀበት ሰኣት----------

መረጀውን የሰበሰበ ሰው ስምና ፍረማ_____

ክፍል -አንድ፡ የማህበራዊና ስነ-ህዝብ መጠይቅ /socio-demographic /

ተ.ቁ	ጥያቄ	መልስ	ተዕዛዝ [ወደ ——– ሂድ]
101	ዕደሜዎ ስንት ነው?	_____ዐመት	
102	የትኛው ሀይማኖት ተከታይ ነዎት?	1. ሙስልም 2. አርቶዶክስ 3. ፕሮቴስታነት 4. ካቶልክ 5.ሌላ ይገለፅ_____	
103	የጋብቻሁኔታስ?	1. ያገባች 2. ያላገባች 3. የፈታች 4. የሞተባት 5.የተለያዩ	
104	የትኛው ቢሄረሰብ አባል ነዎት?	1. ኦሮሞ 2. አማራ 3.ጉራጌ 4.ዎላይታ 5. ሌላይገለፅ_____	
105	ዋና ስራዎ ምነድነው?	ነ . የመንግስት ሰራተኛ 2. የቤት አመቤት(ያልተቀጠረች/ደሞዝ የለላት 3. ነጋዴ 4. ተማሪ 5. የመንግስታዊ ያልሆነ ድርጊት ሰራተኛ 6 . ሌላ ይገለፅ.....	
106	የትምህርት ደረጃዎ?	ነ .ማንበብና መጻፍ የማይችሉ 2. ማንበብን መጻፍ ብቻ የሚችሉ 3._____ከፍል የተማረ	
107	የባለቤተትዎ የትምህረት ደረጃ?	ነ . ማንበብን ና መጻፍ የማይችሉ 2.ማንበብን መጻፍ ብቻ የሚችሉ 3. _____ከፍል የተማረ	
108	የቤተ ሰብዎ ወርሃዊ ገቢ ስነት ነው?	----------የኢትዮጵያን ብር	
109	የኑሮ ሁኔታን ከጎረቤትዎ ጋር ስያነፃፅሩ እርስዎ የትይመደባሉ?	ነ. የተሻለ 2. መካከለኛ 3. ዝቅተኛ 4. በጣም ዝቅተኛ	
110	ቴሌቪዥን/ሬድዮን አሎት?	ነ. አዎ 2. የለም	

ክፍል-ሁለት ፡ የሴቶች ፍላጎት እና የደረሱበት የዉልድ መጠን።/woman's Desired and achieved fertility level/

ተ.ቁ	ጥያቄ	መልስ	ወደ—ሂድ
201	ለመጀመርያ ስያገቡ እድሜዎት ስንት ነበር?	---------- ዕመት	
202	ከዝህ ቀደም አርግዛው ያውቃሉ?	፡ አዎ 2. የ ለ ም - - - - - - - - - - - - -	ወደ 208
203	202 አዎ ከሆነ ስነት ልጆች ወልደዋል?	_____(በቁጥር ይቀመጥ)	
204	ከተወለዱት ልጆች ስነቶቹ በህይወት አሉ?	፡ . ወነድ _____ 2. ሴት_____ 3. ሁለቱምዖታ	
205	ከዝህ በፍት ልጅ ሞቶብዎት የውቃል?	1 አዎ ከሆነ ስነት ይገለፅ_____ 2 የ ለ ም	
206	ያልታሰበ /ያልታቀደ/ እርግዝና አጋጥምዎት የውቁል?	1. አዎ 2 . የ ለ ም - - - - - - - - - - - -	ወደ 208
207	206 መልሱ አዎ ከሆነ ለስነት ጊዜ?	(----------ቁጥር)	
208	በህየዎት ዘመኖ ስነት ልጆች አነድኖሮት ይፈልጋሉ ?	፡ ወነድ-------- 2. ሴት---- 3. ሁለቱንም	
209	የትኛው ዖታ እነድኖርዎት ይመርጣሉ?	፡ ወንድ----- 2. ሴት_____ 3 የትኛውም ቢሆን አያሳስበኝም	
210	የትዳር አጋርዎ እርሶ የምፈልጉትን ያህል /በለይ/ያነሰ/ የልጆች ብዛት ይፈልጋል ብሎ ያስባሉ ?	1. ተመሳሳይ 2. ብዙ ልጆች/ከኔ በለይ 3. ጥቅት/ከኔ በታች 4. አላውቅም	

ክፍል -ሶስት፡ የሴቶች ስለ ዘመናዊ የቤተሰብ ዕቅድ አገልግሎት ዕውቀት የምዳስስ መጠይቅ/knowledge on Modern FP /

ተ.ቁ	ጥየቄ	ምለሽ	ወደ___ ሃዱ
301	ስለ ዘመናዊ የቤተሰብ ዕቅድ ዘዴዎች ከዝህ በፊት ሰምተው	3. አዎ 2. የ ለ ም - - - - - - - - - - -	ወደ ጥ. 305
302	የ301 መልስዎ አዎ ከ ሆነ ከየት/ከማን መጀመርያ	፡ ከመገናኛ ብዙሃን(ሬድዮን, ቴሌቭዥን) 2 ከባለቤቶ 3 ከአቻ/Peer 4 ከ ጤና ባለሙያ 5. ሌላ [ይገለ---------	
	የትኞቹን የሴት የቤተሰብ ዕቅድ ዘዴዎች ያውቃሉ? ብዙ ምላሽ ል ኖርስለምችል ከዝረዘሩ ያንብቡለት/የተመለሰውነ ሁሉ ያክብቡ/	፡ ፕለስ/እንክብል 2 መህፀን የምቀመጥ (IUCD) 3 በመርፌ የምሰጥ (Depo) 4 ቆዳስር/ክነድ/ የምቀመጥ (እምፕላንት) 6 የመህፀንቱቦ መቋጠር/female 7 ሌላ [ይገለፅ]----------	
304	ስለወንዶች የቤተሰብእቅድ ዘዴ ሰምተው ያውቃሉ?	፡ አዎ 2. የ ለ ም	

305	የ 304 መልሱ አዎ ከሆነ የትኛውን ዘዴ ያውቃሉ?	1 ኮነዶም 2 የወንድ አባለ ዘር ፍሬ ቱቦ መቁጠር 3 ..... ሌላ	
	የትኛውን የቤተሰብ እቅድ አገልግሎተ ጠቀሜታ/ፋይዳ ያውቃሉ? /multiple response allowed mark	1 የቤተሰብ ቁጥር መወሰን 2 ያልተፈለጋ እረግዝናን መከላከል 3 ልጅ ለማራራቅ 4 ለ እናት/ለልጅጤንነት 5 አላውቅም 6---------- ሌላ [ይገለፅ]----------	
307	በሁለት ተከታታይ ልጆች መሃከል ሳይ ወልዱ ለምን ያህል ብያራርቁ ጥሩ ነው ብለው ያስባሉ?	1 ከአንድ አመት በታች 2 ከአንድ እስከ ሁለት አመት 3 ከሁለት እስከ አምስተ አመት 4 አላውቅም 5. ሌላ ካለ ይገለፅ----------	
308	ዘመናዊ የቤተሰብ ዕቅድ አገልግሎት ከየት እንደ ምያገኙ	1. አዎ 2. አ ይ ደ ለ ም	
309	የትኛውን ያውቃሉ? /mark all that apply/	1 ጤናጣብያ 2 ጤናኬላ 3. ፋርማሲ 4.ሆስፕታል 5 ከመህበረዊ ገበያ/ሱቅ/Social 6 ከግል ክልኒክ 7 ቤትለቤት ስርጭት/ CBD/ Outreach	

ክፍል -አራት : የሴቶች የቤተሰብእቅድ አገልግሎት አመለካከት እና ተግባር አጠቃቀምን የምዳስስ/attitude & practice/መጠይቅ

ተ.ቁ	ጥያቄ	ምላሽ	ወደ— ሂድ
401	ስለ ዘመናዊ የቤሰብ እቅድ አገልግሎት መጠቀም ምን ይሰሞታል? ወይም እነዴት ይመለከቱታል?	1. ዘመናዊ የቤሰብ እቅድ አገልግሎት መጠቀሙን እ የግፋለጡ 2. ዘመናዊ የቤሰብ እቅድ አገልግሎት መጠቀሙን እ ቀጠማለጡ 3. Don't mind (ምንም አልጨነቅም)	
402	ስለ ቤተሰብ እቅድ አገልግሎተ ከባለቤቶ ጋር ተወያይቶ ያውቃሉ?	1 አዎ 2 2. የ ለ ም - - - - - - - - - - - - - - -	404
403	ባለፉት ስድሰት ወራቶት ውሰጥ ምን ያህል ግዜ?	1. ኣነድም 2. ኣነድ ግዜ ብቻ 3. ሁለት ግዜ 4. ሦስት ግዜ 5. ከሦስት ግዜ በላይ	
404	የትዳር አጋሮት ስለ የቤተሰብ ዕቅድ ምን አይነት አመለካከት አለው ብልው ያስባሉ	1. ዘመናዊ የቤተ ሰብ ዕቅድ አገልግሎት መጠቀሙን ይደግፋል 2. ዘመናዊ የቤተ ሰብ ዕቅድ አገልግሎት መጠቀሙን ይቃወማል	

405	የቅረብ ዘመድዎ ስለ የቤሰብ እቅድ አገልግሎት ምን አመለካከትአለው ብለው ያስባሉ (እናት, አባት, የባለ ቤትዎ እናት/ አባት,)?	1. ዘመናዊ የቤተሰብ ዕቅድ መጠቀሙን ይደግፋሉ 2. ዘመናዊ የቤተሰብ ዕቅድ መጠቀሙን ይቃወማሉ	
406	ከዝህ በፊት የቤሰብ እቅድ አገልግሎት ተጠቅመው ያውቃሉ?	3. አዎ 2. .አ ይ ደ ለ ም - - - - - - - - - - -	408
407	የ406 አዎ ከ ሆነ የትኛው ዘዴ?	1. ፒልስ/ እንክብል 2. በመህፀን ስጥ የምቀመጥ (ኣዩስዲ)/IUCD 3. ባለመርፌ (Depo-Provera) 4. ቆዳስረ የምቀመጥ 5. ኮንዶም 6. አረፋማ ክኒኒ 7. የመህፀን መቋጠር /female sterilize 8. የወነድ ዘር ፍሬ መቋጠር /male 9. ሌላ [ይገለፅ]_____	
408	**በአሁኑ ግዜ** የቤተሰብዕቅድ አገልግሎት እየተጠቀሙ ይገኛሉ?	1. አዎ 2 . የ ለ ም - 3 አይመለከተኝም{infertile, recently gave birth}	421
409	ጥያቄ 408 አዎ ከ ሆነ የትኛውን የቤተሰብዕቅድ አገልግሎት ዘዴ?	1. ፒልስ(ክንኒ?) 2.በመህፀን ስጥ የምቀመጥ (ኣዩስዲ)/IUCD 3. ባለመርፌ (Depo-Provera) 4. ቆዳስረ የምቀመጥ 5.ኮንዶም 6. አረፋማ ክኒኒ 7 .የመህፀን መቋጠር /female steriliza 8 የወነድ ዘር ፍሬ መቋጠር /male 9 ሌላ [ይገለፅ]	
410	ይሄንን የቤሰብ እቅድ አገልግሎት ለምን ይጠቀማሉ?	1. አርግዝናን ለማቆም/ለመገደብ 2. አራርቆ ለመውለድ 3. ሌላ [የገለፅ]----------	
411	ይሄንን የቤሰብ እቅድ አገልግሎት ከዬት ነው የምያገኙት?	1. ከጤናጣብያ 2. ከጤና ኬላ 3. ከፋርማሲ 4. ከሆስፕታል 5. ከማህበራዊ ገበያ /Social markets/ 6. ከግል ክልንክ 7..ከቤት በመህበረሰብ አቀፍ ክፍፍል /CBD 8 ሌላ ካለ ይገለፅ----------	

412	የቤሰብ እቅድ አገልግሎት ለመጠቀም በቂ አማራጭ አለ ብሎ ያስባሉ?	1. አዎ 2. 2. አይደለም	
413	አሁን የመረጡትን/የፈለጉትን የቤሰብ እቅድ አገልግሎት ነው በመጠቀም ላይ ያሉት?	1. አዎ 2. . ይደለም	
414	ከ አነድ የቤሰብ እቅድ አገልግሎት ወደ ሌላ ለውጥ ያውቃሉ?	1. አዎ 2. አይደለም ----------	416
415	በቅረብ ወደ ሌላ እነዲለውጡ የደረገው ምክንያቱ ምነድነው?	1. የጎንዮሽ ጉዳት/ ተጽእኖ/Side effect/ 2. መርሳት 3. የበፊቱ ዘዴ 4. የረጅም ግዜ ስለፈለኩኝ 5. ባለቤቴ ያውቅብኛል ብዬ 6. ባለቤቴ ስላል ወደደ 7. የበፊቱ ስላልሰራልኝ 8. የጤና ባለሙያ ስላሳመነኝ 9.. የፈለኩት ዘዴስለሌሌ 10 ሌላ ይጠቀስ----------	
416	ባለቤቶዎ ዘመናዊ የወሊድ መከላከያ እነደምጠቀሙ ያውቃል?	1 አዎ 2 . የ ለ ም _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	418
417	ካላወቀ ምክንያቱ ምነድነው?	---------- ይገለጽ	
418	ከባለቤትዎ አውቅና ውጪ ዘመናዊ የቤተሰብ ዕቅድ ተጠቅመዎ	1. አዎ 2. የ ለ ም	
419	ከባለቤትዎ አውቅና ውጪ የቤተሰብ ዕቅድ ቢጠቀሙ ምን የፈጠራል ብሎ የስባሉ?	1. ወዲያዉኑ ይታኛል 2. ይመታኛል 3 . ወደ ቤት መምጣቱን ያቆማል 4. ሌላ ካለ ይገለፅ_____	
420	ባለቤትዎ የቤተሰብ እቅድ እነዲጠቀም ይፈልጋሉ?	1. አዎ 2. የ ለ ም	
421	የቤተሰብ እቅድ አገልግሎትን በማን ብሰጣቸው ይመርጣሉ?	1 በሴት 2 በ ወ ን ድ 3. በ ሁለቱም	
422	**[ለማይጠቀሙት ብቻ]** ዘመናዊ የቤተሰብ አቅድ አገልግሎት እነዳይጠቀሙ/ለመጠቀም አንደያስቡ ያደረገው ነገር ምነድነው?	1 የጎንዮሽ ጉዳቱን/ተፅዕኖ በመፍራት 2 ቤቴ ስለምቃወም 3 አውቀቱ ስለሌለኝ 4 ሀይማኖት ስለምከለክለኝ 5 ጎደኞቼ ስለምቃወሙኝ 6 የምፍልጉትን ያህል ልጅ ስላለደረስኩ 7 የወሲብ ፍላጎት ስለምቀንስ 8 ሌላ ይተቀስ----------	
423	ከ ትዳር አጋርዎት የቤተሰብ አቅድ አገልግሎት እነዳይጠቀሙ/ለመጠቀም አንደያስቡ ተቃውሞ ደረሰርሶበት ያውቃል?	1 . አዎ 2. አይደለም 3 . ተጠቅሜ/ለመጠቀም አስቤ አላውቅም	
424	ከቅርብ ዘመድ / ጓደኛ [እናት፣አባት፣የባለቤትሽ አባት/እናትስ እነዳይጠቀሙ/ለመጠቀም አንደያስቡ ተቃውሞ ደረሰርሶበት ያውቃል?	1. አዎ 2. አይደለም 3. ተጠቅሜ/ለመጠቀም አስቤ አላውቅም	

425	እነዚህ ሰዎች ለምን የቤተሰብ እቅዲን እንደይጠቀሙ ያደርጋሉ ብሎ ያስባሉ?	፡ . ብዙ ልጆች እነዲኖረኝ ስለምፈልጉ 2. ለጤናዬ ሰላሰቡልኝ 3 . በሃይማኖት ስለምከላከል 4. ሌላ ካለ ይጠቀስ____	
426	ዘመናዊ የቤተሰብ አቅድ አገልግሎት መጠቀም የጎንዮሽ ጉዳትን/ተፅዕኖ አለው ብሎ የስባሉ?	1. አዎ 2. የለም	
427	426. አዎ ከሆነ ምን አይነት ጉዳቶች?	ይጠቀስ----------	

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in this or any other University, and all sources of materials used for this thesis have been fully acknowledged.

Name: _____

Date_____Signature _____

Place: Jimma University

Date of submission_____

This thesis has been submitted for examination with approval as University Advisor

Name of First Advisor_____

Date_____ Signature _____

Name of Second Advisor_____

Date _____ Signature _____