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Viewpoints and Practices of Married Couples on Women's Fertility Control in Tiro Afeta Woreda, Jimma Zone, South West Ethiopia.

By

Raya Abafita

Advisors: Nega Jibat(chief advisor)

Dereje Wonde(co-advisor)

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Declaration, confirmation, approval and evaluation

Viewpoints and Practices of Married Couples on Women's Fertility Control in Tiro Afeta Wereda, Jimma Zone, South West Ethiopia.

Declaration

The undersigned, declare that this thesis is my original work, not presented for any degree in any universities, and that all the sources used for it are duly acknowledged.

Raya Abafita signature _____ date_____

Confirmation and Approval

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

Principal Advisor: Signature

Date

Name_____ _____ _____

Co-Advisor: signature Date

Name _____ _____ _____

External Examiner Signature Date

Name _____ _____ _____

Internal Examiner Signature Date

Name_____ _____ _____

Chair Person Signature Date

Name_____ _____ _____

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ABSTRACT

Rapid population growth has been a serious problem in developing countries. This creates shortage of cultivated land, unemployment, and speed up poverty. Ethiopia is one of the countries which have faced this problem. Now a day, Ethiopia has a total fertility rate of 4.6 children per women. Tiro Afeta district's current total fertility rate is 4.8 children per women, a bit higher than the national value. Since the coming to power of the present government, many attempts have been made to reduce fertility rate by introducing the Family Planning and Contraception services. The study, therefore, was intended to know the view points and practices of married couples on women's fertility control and how that is contributing to the usage of contraception in the district. Sixteen (16) interviews with married couples (8 each sex), 8 interviews with health service providers and 6 focus group discussions (three for husbands and thee for wives) in which 24 males and 23 females participants were carried out. Selection of key informants was purposive with the aim of obtaining knowledgeable, experienced and expressive individuals. This study site was chosen because it has higher fertility rate of 4.8 children per women that is greater than the national one. The study design of this research is phenomenological. Unstructured interview guides were used for the interviews. The structuration theory was used in explaining the findings of the study. The finding of the study reveals that there are six identified major obstacles hindering women from using fertility control. These include: husband's opposition to the use of the method, fear of side effects, misinformation, influence of religion, significance of child sex composition, gender norms and the importance of high fertility culture. The main factors contributing to this is less education on modern contraceptive methods and the inability of women to negotiate their husbands in order to adopt the methods effectively. Education was seen as the major factor to be considered in improving contraceptive usage in the district. The researcher recommends that contraceptive usage will improve if men are actively involved in family planning.

TABLE OF CONTENTS

List of Abbreviations

CSA Central Statistical Agency

ILO International Labor Organization

NGO Non-Governmental Organization

UNDP United Nations Development Programme

UN United Nations

WHO World Health Organization

SNNPR South Nations Nationalist and Peoples Regional State

CPR Contraceptive Prevalence Rate

TFR Total Fertility Rate

FC Fertility Control

FP Family Planning

HEW health extension workers

STD sexually transmitted disease

CHAPTER ONE: INTRODUCTION

1.1. Background of the study

The fast population growth has been recognized as a problem by national governments and the international society (UNFPA 2011a). This observable fact creates for example shortage of cultivated land and unemployment opportunity and this problem speed up poverty (UNFPA 2011b). Unregulated fertility, which contributes to such situations, impairs the economic development and political stability of the countries. Therefore, many countries consider limiting population growth as an important component of their overall developmental goal to improve living standards and the quality of life of the people (Almualem 2007). This strategy is now enhanced by the availability of effective modern contraceptive methods. The negative effects of high fertility rate are not only account for the rapid population growth but also have serious problems for maternal and infant health. Thus, using fertility control is well-known as the solution to control fertility rates against the rapid population growth (Ndayizigiye et al. 2014).Many unpredicted pregnancies and deliveries pose large burden on maternal health and associated with maternal mortality rates.

In less-developed countries, from 100 married women about 17 % would prefer to avoid pregnancy, but are not using any form of contraception (Kaggwa et al. 2008; Donna et al. 2010). According to Bongarts and sinding (2011) in West Africa 53% of pregnancies are unintended and its 33% give rise to abortion. The reasons for such huge number of unplanned pregnancies are in particular lack of access to a preferred contraceptive method or incorrect use of a method. In addition, some women are vulnerable to social pressure from their husbands or other family members on family planning issues and do not have the power to decide for themselves whether or when to become pregnant **(**Bongarts and sinding 2011).

Contraceptive use help couples and individuals to realize their basic right to decide freely and responsibly if, when and how many children to have (Ahmed and others 2012; Bhutta and others 2014; Rutstein and Winter 2015). Contraceptive use in the least developed

countries is small it is 40 per cent and was particularly low in Africa 33 per cent and 36% in Ethiopia (United Nations 2015).Currently, in Ethiopia family planning service is offered as free of charge in both governmental and NGO health stations, but Ethiopia is among countries with low contraceptive prevalence rate, with only 29 percent for all women and 36 percent for currently married women (Central Statistical Authority 2016). Likewise, ‘‘Majority of women uses modern methods than traditional methods. Thirty five percent of currently married women are using a modern method and one percent using a traditional method’’ (Central statistical Authority 2016:16). At present TiroAfeta district health office planned to offer modern fertility control for 19,425 from 32,588 married women and only 43% or approximately 8353 women used the method (Tiro Afeta Woreda health office report 2017).

As demographers clarify that family planning providers focus on women without considering the importance of participating male on women’s contraceptive usage, so that fertility rates and measures of contraceptive prevalence, unintended fertility, and unmet demand for contraception were all based on women reports (Aynekulu 2013). Men are responsible for the large proportion of ill reproductive health Suffered by their female partners. Also male involvement helps not only in accepting a contraceptive but also in its effective use and continuation. But men involvement in family planning at the study setting is rarely known.

However, it is recognized that programs that exclusively focus on either men or women may not be successful for the reason that the majority of sexual, contraceptive use and child bearing decision are made by husband and wives together (Aynekulu 2013).Thus, considering the severity of the problems associated with usage of fertility control in the district, this research is intended to provide a more detailed investigation on viewpoints and practices of married couple’s on women’s fertility control in TiroAfeta Woreda.

1.2. Statement of the problem

The government of Ethiopia has tried to reduce the pace of fertility by providing family planning and contraceptives with free of charge. Despite these efforts, there is still a higher fertility rate in Ethiopia and specifically in Tiro Afeta woreda where this study is conducted. At current levels, a woman from Ethiopia would bear an average of 4.6 children per women (CSA 2016). In area, where the research place is located approximately women would bear on average 4.8 children per women and this is greater than that of the national fertility rate (Tire Afeta woreda health office report 2017). Similarly before two years when I was working in rural area, I have seen couples who have a lot of children and exposed to economic problem to fulfill their children basic needs. Since then I have an intention to conduct my research on this area. Therefore, this study was conducted to provide the reason why the action taken has not worked and what are the obstacles that makes couples not utilize contraception.

Previous studies have identified several obstacles to the use of modern contraceptives. This includes; husbands' opposition to the use, misconceptions, insufficient knowledge and fear of side effects related to contraceptives, cultural barriers, gender power relations, socio-cultural expectations and contradictions, health service barriers, and dissatisfaction with sexual sensation when using them were the main obstacles to the use of contraceptives (Bongaarts and Bruce 1995; Casterline, *et al.*1997; Nagase *et al.*2003; Tucker 1986; Nalwadda *et al.* 2010). However, previous studies related to fertility in Ethiopia are predominated by the use of quantitative methods. For example, some of the often cited studies is analyzing the data from the "Demographic and Health Survey" and the "National Family and Fertility Survey" (Alemayehu *et al*. 2010; Bhargava 2007; Dibaba 2009; Hogan, Berhanu and Hailemariam 1999; Short and Kiros 2002). But large numbers of people live and governed by the norms and cultures of the society in which they live and problems of ambivalent to contraceptive is mostly related with cultural and social belief. As a result qualitative method is more advisable than quantitative method to conduct a study in detail to explore the view points and practices of couple's have on contraceptive use and the method helps to dig out and understand the views of couples. In addition to the aforementioned problem there are few studies conducted

by the use of qualitative methods, but the studies undertaken on the area of the topic are: Berhane *et al.* (1999) studied the perception of fertility regulation in South Ethiopia and described the social and cultural factors informing us about their fertility preferences in Bensa District, in SNNPR.

However the growing interest by the government to reduce fertility the government of Ethiopia offer family planning services for free in health stations but Ethiopia is among countries with low contraceptive prevalence rate (CSA 2011).In rural area, issues that affect contraceptive use are multifaceted and challenging. Different studies explained that socio-demographic, socio-cultural and socio-economic problems (Beekle and Mccabe 2006; Ibnouf *et al*. 2007; USAID Ethiopia 2010) frequently affected women's use of contraception.

It is widely argued that most researcher undertaken their research on reproductive health tended to focuses on women's report without addressing the importance of the role of men in reproductive health and decision making about fertility control utilization (Greene and barker 2011). Other studies mentioned the importance of the role of men participation in reproductive health and influence on the decision making about contraceptive use or not (Dudgeon and Inhorn 2004). But this research focuses on assessing both men's and women's views and practices simultaneously. Besides, no research conducted earlier on view points and practices of couples on women's fertility control issue. As a result this research is different from other research conducted so far. Yet these determinant factors and the reasons why married women distrust to use fertility control have not been studied in Tiro Afeta Woreda. Though having information on the issue of fertility regulation is pertinent it is often restricted and scarce (Beekle and Mccabe 2006; Nega 2008; Selam and Pasha 2009). To this end, the study was conducted with the aim of fulfilling the aforementioned gap by studding view points and practices of married couples on women's fertility control with particular emphasis on married couples in TiroAfeta Woreda.

1.3. Objectives of the study

1.3.1. The General objective

The general objective of this study is to examine the view points and practices of married couples on women's fertility control in TiroAfetaWoreda.

1.3.2. The specific objectives

The specific objective of this study includes:-

1. To scrutinize religious belief and cultural views of fertility that affect married women's practice of fertility control.
2. To describe the viewpoints of couples on the effectiveness of different contraceptive methods in fertility control.
3. To investigate common practices of couples that facilitates or hinders women's fertility control utilization.
4. To investigate how the involvement of male affects women's exercise of fertility control utilization.

1.4. Significance of the study

This study is expected to enhance awareness regarding the reasons why married women distrust to use fertility control method and issues that affect women's to utilize contraceptive. The study also aid concerned bodies to take the right actions in preventing the problem. The results of this study could bridge the existing research gaps in this area. It will also help professionals who work on the area of reproductive health to provide quality services and intervention. Furthermore, the outcomes will be used as a reference for those who are interested to conduct a research on the same topic. In addition, the findings of this research help as an input for planners and development workers who were discouraged by the lack of information regarding the issue under discussion for further plan and activity.

1.5. Limitation of the Study

This research compared to many other researches may have some possible limitations or biases. Some of them are: The selection of participant may have been biased because of selection was done purposely based on the criteria to address the objectives of the study. As a

result of this selection process the study may not provide a clear picture of the whole community in the study area and it lacks generalization. In my data collection process, since reproductive issue is sensitive area I also observed that some of the men and women in the area given “expected answers” or hidden some of their experiences and concerns from me.

Small numbers of women were also not willing to be interviewed for the first time because of the use of tape recorder. They were afraid that issues concerning their private lives will be heard on radio stations. I told the reason why I used tape recorder because of writing everything what they speak is impossible. Even though, I had to make appointments with most of my respondents before conducting the interviews some of the respondents were also busy with work and other meeting and had to schedule for other appointment dates. As a result the time allocated for the data collection period was extended. Finally, in focus group discussion few participants talked out of the topic and specially the problem of service given on heath center and raised other issues. During translating data from Afan oromo to English it may change the message because of some words cannot have literal meaning in English.

1.6. Delimitation of the study

The major intention of this thesis was exploring the viewpoints and practices of married couples on women’s fertility control. The study was conducted in Jimma Zone Tiro AfetaWoreda. The study participant includes married couple’s (women from age 15 to 49 and their husbands), health care service providers (physician who works in reproductive health) and health extension workers residing in the district were the specific purpose of this research. The research had given attention to investigate on the impact of the social, cultural, demographic and the tradition that affects contraceptive use of women. Furthermore the data collection was conducted from March 1 to March 30, 2017 and data analysis was from April 1 to April 30, 2017. The study was not included couples who live in cohabitation (alternative form of marriage). Because the society in which this study was conducted on, take men and women living together without legal marriage it perceived as sinful act.

1.7. Conceptual Definitions

A. Fertility control: "is the term used to refer to patterns of human behavior that have as their primary objective the prevention of unwanted pregnancies and births."(Crowell Collier And Macmillan 1968:382)

B. Contraceptive: -is defined as any method or practice used to prevent pregnancy (From Wikipedia, the free encyclopedia)**.**

C. Birth control: The term "birth control," coined by Margaret Sanger in 1914 (Lader 1955), is generally used as a synonym for contraception (Crowell Collier And Macmillan 1968).

D. **Family planning:** it is defined as birth spacing, preventing unwanted pregnancies or secure wanted pregnancy through the use of contraceptive methods (WHO 1995).

E. Couple: two people (i.e. male and female) who are married or closely associated romantically or sexually.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.1 Introduction

In this section there is a review of several authors work regarding the concept of fertility control and family planning. A number of research results and findings that are published and unpublished on the issue available would be investigated. A detailed review of available researches was conducted to enrich the research paper in the study area. Besides it contains theories that help to explain fertility control usage and an aid in the choice of the methodology and also in the analysis. This chapter highlights the trends in Contraceptive use and fertility rate, Gender Norms and Contraceptive Use, Male involvement in family planning, and The motivation for using fertility control, and Theories about the practice of fertility control.

2.2. Types of contraceptive

The types of modern contraceptive method available in the study area are: hormonal pills, the intra-uterine device (IUD), condoms, injectables, the implant (including Norplant), and emergency contraception. Rhythm (periodic abstinence) and breastfeeding methods are included in the traditional methods category.

2.3. Trends in Contraceptive Use and Fertility Rate

2.3.1. Trends in Contraceptive Use

Contraceptives are used by the majority of married or in-union women in almost all regions of the world**.** Contraceptive use helps couples and individuals realize their basic right to decide freely and responsibly if, when and how many children to have.

> *Contraceptive use and availability help to prevent unwanted pregnancies, space births and again help couples to plan for the number of children they wish to have. The use of contraception by a woman can improve her reproductive health as well as the health of her children because* she can space her births well (Ahmed and others 2012; Bhutta and others 2014; Rutstein and Winter 2015).

According to United Nations **(**UN**)** 2015:

> *Sixty four percent of married or in-union women of reproductive age worldwide were using some form of contraception. However, contraceptive use was much lower in the least developed countries particularly 33 per cent in Africa. The prevalence level of contraceptive use in Ethiopia is 36%* (United Nations 2015).

2.3.2. Trend in fertility rate

"Fertility control," as the term is used to refer to patterns of human behavior that have as their primary objective the prevention of unwanted pregnancies and births. Individuals and couples adopt these patterns in accordance with their cultural values, reinforced by formal or informal social pressures"(Crowell Collier And Macmillan 1968:382).Avoiding unwanted pregnancies and births achieved through the use of contraceptive methods.

According to Central Statistical Agency 2014 fertility report, in between 2005 and 2014, substantial declines in fertility have taken place in both **rural areas (**from 7.0 to 4.6) and **urban areas (**from 5.2 to 2.3) of Ethiopia.

Similarly the TFR has declined from 5.5 children per woman in 2000, to 5.4 children per woman in 2005, to 4.8 children per woman in 2011, and to 4.6 children per woman in 2016. If fertility were to remain constant at current levels, a woman from Ethiopia would bear an average of 4.6 children in her lifetime (CSA 2016).

2.4. Gender Norms and Contraceptive Use

It is widely argued that research on reproductive health has tended to focus on women without addressing the role of male in contributing to gender inequities, and in putting men and their partners at risk (e.g. Greene and Barker 2011). Other studies have mentioned the importance of the role of men in reproductive health and their influence on the decision-making and behavior related to reproduction (Dudgeon and Inhorn 2004; Greene 2000).

Even though men are increasingly being "involved" by reproductive health programmes, the

view of men still seem to be that they are peripheral and problematic (Greene 2000).

In many relationships, decision-making around family planning and contraception may not include, or may include to a greater or lesser extent, child-bearing girls and women themselves. Men play a greater role in highly gender-stratified populations (Mishra et al. 2014). Family (e.g. mothers-in-law) and community members (e.g. elders) may also play a role in decision-making.

A key reason for not using contraception is opposition by a male partner (e.g. Nalwadda, Mirembe, Byamugisha, and Faxelid 2010). Participants in studies in Tanzania (Schuler et al. 2011) and Uganda (Nalwadda et. al. 2010) said that using contraception in secret or against the wishes of the husbands could lead to violence or divorce of the woman. Therefore patriarchal gender norms influence many aspects of family planning and contraception use including: fertility rates; timing of marriage and childbearing; family size; sex preference and composition of children; age of marriage (child marriage); contraception use; etc (Schuler, Rottach, and Mukiri 2011; Campbell, Prata, and Potts 2013).

2.5. Early marriage and contraceptive use

Muralidharan et al.2014. Find that early marriage prevalence is 'strongly linked to low contraceptive use, high fertility rates, unwanted pregnancies, and unsafe abortions', among other factors. "In many settings, particularly in Asia and sub-Saharan Africa, there are societal and family expectations for women to become pregnant and give birth soon after marriage and cohabitation" (Daniel et al. 2008 and Herbert S. 2015:3). This is particularly the case in contexts ''where women's gender identities and social status are tied to motherhood, such as in sub-Saharan Africa. The use of modern contraceptives is low in this region, especially among married youth'' (Hindin and Fatusi 2009:59).

However, Amin and Bajracharya (2011) find that "When marriage is early, contraceptive uptake might be higher as a function of the number of factors including the absence of expectations to bear children right away when marriage takes place potentially during a time when girls are sub fecund" (p.19).

2.6. Male involvement in family planning

According to research conducted in Tigray by Adera et al 2015 explained that women who currently use contraceptive method tend comparatively more younger, educated, with large family, and those who perceive their husbands' approval and support to use contraception. On this region it is also the level of awareness of modern family planning methods by men was quite high but contraceptive usage is low in this study.

This study implies that high level of knowledge alone was not sufficient to promote a high level of use. As a result the cultural barrier in itself without any other external influence will demotivate men from getting involved in family planning program (Adera et al. 2015). The majority of the Men had never been involved themselves in FP with their wife and this may be attributed to negative perceptions recorded among them. A technical report by United Nations Population Fund stated that most reproductive health/family planning service delivery systems are almost entirely oriented to women and provide little or no information about male contraceptive methods. On a larger scale, recognition is growing that steps to economic development, including efforts to reduce poverty, are hindered by persistently large average family size (Birdsall et al. 2001).

2.7. The variety of Barriers

"The combined effect of several inhibiting factors barring women from easy access to fertility regulation may be subtle yet so influential that even those couples with a strong desire to space or limit their family size may not be able to achieve their goals"(Campbell et al. 2006:88).

2.7.1. Geography and Method Choice

Mahmood and Ringheim (1996), using 1990–91 Demographic and Health Survey (DHS) data, conclude that contraceptive use or nonuse correlates most closely with a woman's knowledge of sources of supplies. A number of studies have shown a close correlation between the travel time from a woman's home to any health clinic and the likelihood that she will use a contraceptive (Rodríguez 1978; Chamratrithirong and Kamnuasilpa 1984; Ross et

al. 1989; Bertrand et al. 2001). In Bangladesh, couples were two and a half times less likely to practice contraception if acquiring a method required traveling for 30 minutes or more to a clinic (Levin et al. 2000).

2.7.2. Cultural Beliefs and Sentiments

Casterline et al. (2001) suggested that fertility regulation is a function of the motivation to avoid pregnancy and the cost of fertility regulation. Biddlecom et al. (1996) also suggested that the cost of contraception encompasses much more than accessibility to family planning services and that it includes all factors (social, psychological, and cultural) that may act as barriers to contraceptive practice among men and women. Casterline et al. (2001) noted that socio-cultural and religious disapprovals of contraception repeatedly emerge as important obstacles to the use of a contraceptive method. Wall (1998) identified a combination of these factors that obstruct contraceptive knowledge, adoption, and use among Hausa women in northern Nigeria. He asserted that few Hausa women have any knowledge of birth control and they consider family planning as the moral agnate of murder. This is because birth is an antidote for bereavement in the cultural idioms of this Islamic society and children are considered a divine benefaction. Children are the desired outcome of any Hausa, marriage, and giving birth is traditionally viewed as the greatest fulfillment of being a woman (Wall 1998). Such cultural beliefs and sentiments may render the adoption and use of contraceptive methods difficult in many sub-Saharan African communities.

2.7.3. Lack of knowledge

Lack of knowledge is clearly a significant barrier to fertility regulation. In their analysis of the single question posed in the Demographic and Health Survey about "contraceptive knowledge," Bongaarts and Bruce (1995) found that in 13 countries, one-fourth of all women surveyed indicated lack of knowledge as a reason for not practicing family planning "Combined knowledge index" from the available DHS questions, which included questions about recognition of contraceptive methods, knowledge of sources for obtaining them, and knowledge of their side effects.

They concluded that ‘‘the principal reasons for nonuse are lack of knowledge, fear of side effects, social and familial disapproval” (Bongaarts and Bruce 1995:57).

2.7.4. Fear of Side Effects Misconception and Stereotype

Most of the male participants who did not use contraception were against contraception as they were misinformed about side effects and feared it would harm their wives. As participants believed family planning to be a woman’s job, men rarely sought information from reputable sources on family planning. Similarly the women participants seemed to have comparable misconceptions and fears about contraceptive (Schuler et al. 2011).Negative stereotypes, Social stigma, misconceptions and fear limit uptake of contraception.

The World Bank’s 2015 World Development Report suggests therefore that ‘‘fertility transitions may be better viewed as a norm-driven process than as the aggregate outcome of autonomous decisions’’ (2015:54).

In Uganda, contradictory messages about whether to use contraceptives from partners, parents, teachers, cultural leaders and health workers were identified as key obstacles to uptake (Nalwadda et al. 2010).Research in Tanzania by Schuler at al. (2011), found that sexual jealousy discouraged contraceptive use, as men worried that women’s use of contraception might allow them to be promiscuous and unfaithful without fear of conceiving. In Uganda, focus groups with young people found that they believed and were afraid that Contraceptives could harm their fertility (Nalwaddaet al.2010).

In both Bangladesh and India, adolescent women in urban settings demonstrated higher use of (modern) contraception than adolescents in rural settings. The authors suggest this is perhaps indicative of greater health facilities and concentration of mass media in urban areas, resulting in greater awareness and access (Rahman 2010; Moore et al. 2009).

2.7.5. Provider Bias

In Zambia, young people seeking emergency contraception (EC) from clinics found providers to be unwelcoming and judgmental (Bullock 1997; Ahmed et al. 1998). Health workers are

sometimes poorly trained in counseling men about safer sexual practices and male methods, and may communicate negative rumors about them (Adera et al. 2015).Many men, as well, would like to find ways to control the size of their families, but lack effective options. In 2001, in the Afghan refugee camps in northern Pakistan, family planning providers asked each woman coming to the service whether she had her husband's permission to practice contraception. The same women could obtain family planning methods in the bazaar without such interference, and surveys show that 6 percent of the refugee women went to the local market for their injectable contraceptive, whereas only 4 percent used the family planning service (Tomeczuk 2000).This shows that the women cannot discuss about contraceptive with their husband, the reason that the husband cannot permit to take it. Therefore the women use contraception in secret.

2.7.6. Cultural values and norms

In a peer-reviewed journal article Mayaki and Kouabenan (2015) examine the variables likely to influence family planning practices in Niger through questionnaire analysis of 200 married females (aged 21-50). Their findings suggest that ‘‘subjective norms have a direct effect on contraceptive use among women with no formal schooling, living in either rural or urban settings. For women with some formal schooling, it was their attitude towards family planning that had a direct effect on family planning practices’’ (p.249). They suggest that targeted family planning messages should be based on cultural values and norms (Mayaki and Kouabenan 2015).Similarly, theory of behavioral beliefs refer to an individual's attitude towards a given behavior. Normative beliefs (subjective norms) represent people's perception of the pressure exerted by others in their environment, especially by significant others whose beliefs one cares about, that is, what each person holds to be the expectations of his or her reference group (Mayaki and Kouabenan 2015: 250) .

Therefore community-level fertility norms are important determinants of contraception use specifically, the number of children desired by others in the community affects use of contraception by women (Wang et al. 2013).

2.7.7. Socioeconomic factors

Commonly, women's decisions to practice contraception are considered to be influenced by culture and religious traditions. We suspect, however, that culture may influence women's family planning options more than their preferences, because culture often manifests itself through providers' biases or medical barriers to use. Where the status of women is low, social barriers to accessing family planning methods can be more formidable than financial costs.

In the Punjab, Pakistan, Casterline and his colleagues (2001) made various perceived costs of practicing contraception and of the motivation to do so. They found that two main obstacles to using a contraceptive were: (1) the woman's perception that such use would conflict with her husband's preferences and attitudes toward family planning and (2) her perception of the social or cultural costs of using a method. Another study from Pakistan (Stephenson and Hennink 2004) also found psychosocial barriers to be the most important self-reported obstacle to the practice of family planning among the urban poor, whereas physical and economic barriers were reported much less frequently. The psychosocial barriers were defined as religious interpretations and value systems that limit the mobility and decision making abilities of women, who were dominated by the men and older women (especially mothers- in-law) in the family.

Family planning services in Ethiopia are considerably affected by several socioeconomic factors such as, religion and tradition, the position of women on decision making in the society, cultural values and others. Women's position in the family, economic affairs and public life can affect their access to family planning services (Tolassa 2004).

Family planning use is affected by factors operating at the levels of the individual, family, friendship group, peer group, neighborhoods, community, institutional (including health care providers), and the policy environment. Effective programme's assess the barriers at each of these levels to identify which interventions are needed in a given context, and to 'identify the group or social network within which a relevant norm is enforced (World Bank 2015).These factors need to be modified; appropriate family planning service targets need to be couple centered.

2.8. The motivation for using fertility control

The intrinsic motivation for birth planning was driven by a mix of the following perceived benefits: Birth spacing was perceived as a way to allow enough time to breastfeed and/or wean a baby. Benefits for the mother included adequate time to recover and regain her beauty, as well as balance child care responsibilities. Perceived all-family benefits included reduced financial strain, hence 1) increased potential to attain life goals, e.g., pursuit of further education, securing financial stability, and 2) better spousal relations linked to restoration of female beauty and the absence of frequent financial demands associated with closely-spaced births (Campbell et al. 2006).

2.9. Theoretical perspective

2.9.1. The structuration theory

The basic concepts spelt out in Anthony Giddens structuration theory include the concepts of structure, action, social rules and duality of structure. Structures are sets of rules or constraints and resources (capacities or possibilities) which exist only as memory traces, the organic basis of human knowledge ability and as instantiated in action (Giddens 1984). Giddens (1984) explains the structuration theory simply: As how individuals born intosocieties are entrapped with social structures, which both constrain and enable them. Individuals (human agency) in one way or the other also influence the structures of the society to their benefit. The structures in the society as used in this study can be physical or social.

The physical structures that can influence women's choice of and use of contraception include available family planning in an area constructed by the government or a Non-Governmental Organizations, pharmaceutical shops where contraceptives are sold. The social structures on the other hand include influences from spouses and other family members especially those from the extended families. Socially, friends can also influence the decision by women to use contraceptives. This theory can however be applied to the study in the sense that contraceptive usage by women can be influenced by their personal reasons as well as by existing structures and institutions in the society. Therefore, to help in the analysis of the study and aid in the choice of the methodology the researcher used structuration theory.

CHAPTER 3: RESAERCH METHODS

3.1. Study area and population

The Study was conducted in Tiro AfetaWoreda which is located at South Western part of Ethiopia in the Oromiya regional state at a distance of 310 km from Addis Ababa and 70 km from Jimma. TiroAfeta Woreda is one of the 21 Jimma Zone District. It has twenty five Kebeles. According to the Ethiopian Population and Housing Census of 2007 reported a total population of TiroAfeta woreda is 131,536, of whom 65,341 were men and 66,195 were women; 5,309 or 4.04% of its population were urban dwellers. 92.44%, of the inhabitants were Muslim, while 5.99% of the population Orthodox and 2.49% were Protestant. The ethnic composition was 93.71% Oromo and 5.27%Yem; all other ethnic groups made up 1.02% of the population. The following map shows Tiro Afeta District.

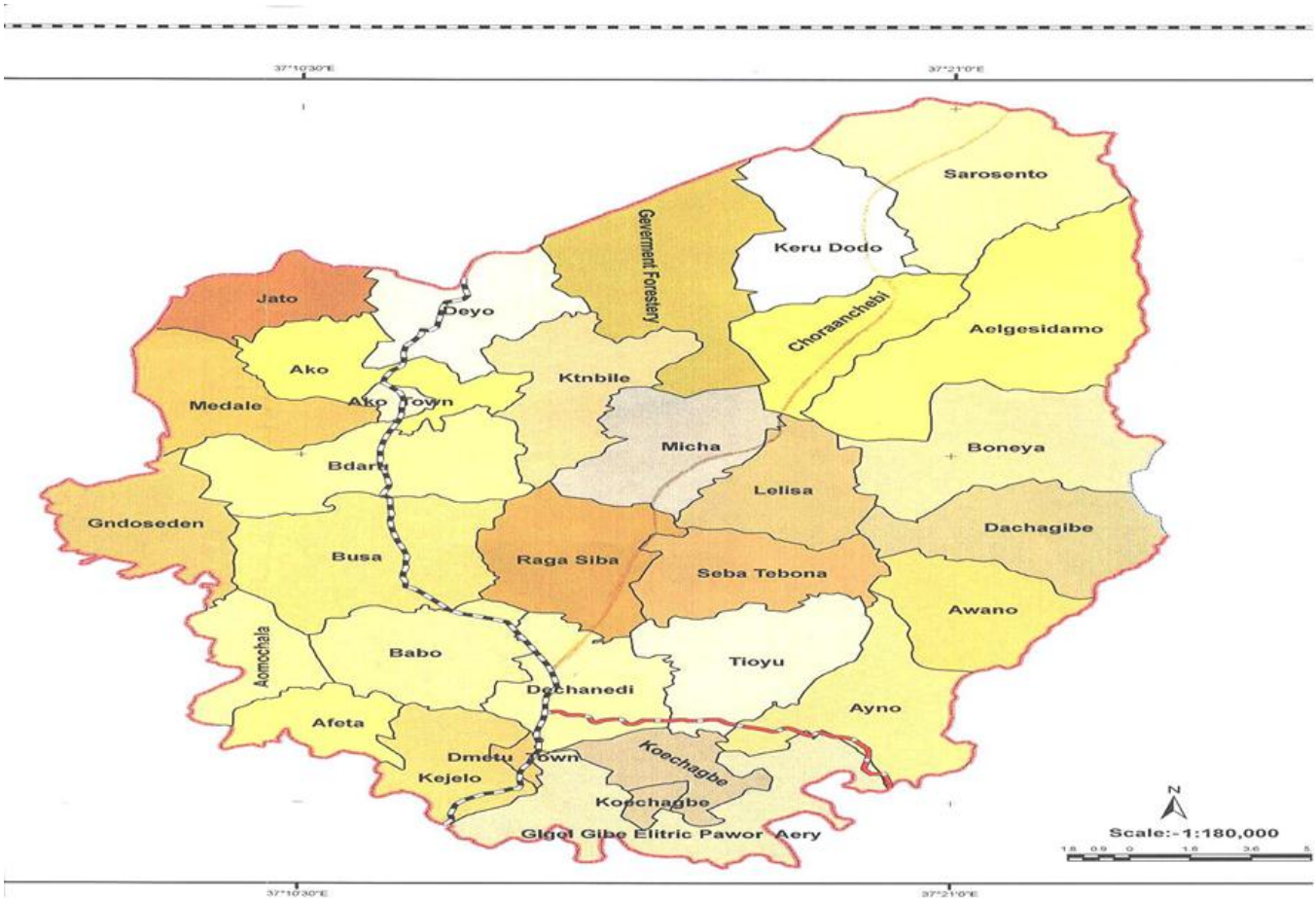

Figure 1 Map of Tiro Afeta Woreda

Source: Tiro Afeta Wereda health office report 2017

The study population consists of married couples (husbands and wives) who are married and lived for more than one year in the study area and the wives were 15-49 years (the reproductive age group), health care service providers and health extension workers.

3.2. Sampling

The study employed purposive sampling to get people who could provide the required information. In purposive sampling, a researcher can reach a targeted sample quickly. This method saves time, money and effort. Also it is flexible and meets multiple needs and interests, enabled us to hear different opinions on the study subject. In addition, it enables researchers to select a sample based on the purpose of the study and knowledge of a population. Since the participant selected was based on their relevance, expressiveness and an assumption to provide the necessary information and it have an advantage of reducing the possibility of non-response. In a qualitative study, the sample size is relatively small as the purpose of the study is to make more an in-depth analysis of the topic and not to study a representative sample of the population. Generally I conducted six focus group discussions with married couples (thee group participant from husbands and three from wives) which contains 24 males and 23 females carried out in a separated place. Sixteen in-depth interview with married couples (eight each) and eight key informant interviews, 5 from five health center (health care service providers) by taking one respondent from each health center and 3 from health extension workers. Key informants were purposively selected based on their perceived knowledge and experiences of working in the area of reproductive health unit. This is because it is assumed that experienced professionals can provide relatively more detailed information about the issue at hand.

The major selection criteria of the participants were:-

Wives within age of 15-49 years along with their husbands, and couples who lived together for one year and above and willingness to participate was another factor of sample selection in all interview procedures. Based on the given criteria, Participants in both FGD and in-depth interview was selected purposively by the help of health development army team leader because of the sensitivity of the issue.

3.3. Research Design

The study used phenomenological research design. Because of it enables to explore social phenomenon. This design was also believed to assist studying the view point and practice of couples on women's fertility control usage. The researcher employed narrative and descriptive analytical approach. Based on the nature of the topic qualitative method is best suited for this research. Because applying qualitative research gives a stronger consideration to the feelings, experiences, beliefs and attitudes that individuals have about the topic under study (Gatrell 2002). Also Minichiello *et al.* (1995) assert that qualitative methods include approaches that seek to reveal the thoughts, perceptions and feelings experienced by informants. Moreover qualitative research is preferred to collect data about human life realities, experiences, behavior, emotion and feeling, cultural and religious phenomena in social interaction (Straus and Carbin 1998). The approach seeks to interpret the meaning people make of their lives in natural setting rather than describing statistical associations between variables. To this effect, qualitative research would have been undertaken.

Data collection was conducted from March 1 to March 30, 2017 and data analysis was from April 1 to April 30, 2017. During data collection, a tape recorder was used and notes of the responses of the participants were taken.

3.4. Data Collection Methods

The study was carried out through applying various qualitative data collection methods and analysis. The data collection methods triangulated in this study include focus group discussions, in-depth interviews, key informant interview and document review analysis related to family planning issue available at woreda health center. All interviews and FGDs were conducted in Afan Oromo and translated into English after transcription. All FGDs and IDIs were conducted in the presence of the researcher because of data quality and the role of the researcher was taking notes, recording the interviews and discussions, probing and elaborating guiding topics as it was necessary to do so**.**

3.4.1. Interviews

Unstructured individual in-depth interviews were conducted with married couples. This method was chosen because it is suitable for obtaining individual experiences, opinions, feelings and addressing sensitive topics like reproductive issue. And this type of research method guarantees a high response rate and makes it easier to explain questions to informants (Neuman 1994). A total of sixteen interviews (16) were conducted with married couples (with eight husband and eight wives from various household to get a variety of information) to answer objective two, three, and four. The interviewees were friendly approached only after they showed willingness to participate in the interview. The main themes that were covered by the interview discussion guides include knowledge of contraception, experience regarding fertility control utilization, sexual normsbeliefs regarding fertility control and family planning, socio cultural factors related to contraceptive use and health care service providers in promoting family planning. The participants include married couples and health care service providers. The objective of interviewing health professionals is to obtain their expert opinions and perceptions regarding fertility control methods. One in-depth interview was accomplished each day. Finally, all the interviews were conducted by the researcher.

3.4.2. Focus Group Discussions (FGD)

Participants in the FGD include married couple's (wife's and their husband's) in separate sessions. This method was selected because of its advantage in acquiring deeper understanding and gathering detailed information from the target groups about the influence of culture, religion and group norms influencing people's perceptions and practices of contraceptives. The discussions are organized in an environment in which discussants are free to express their views. For example, husbands' FGD took place on garden under big trees whereas wives were gathered in front of health post. Finally, the researcher conducted six FGDs (three for wives and three for husbands) and each group consisted of eight participants except it was seven in one group. Men and women discussion groups were undertaken separately because sex (or gender) is very important factor in this particular study. Basically all FGDs were conducted to answer objective one, three and four of the study. The discussion guide was prepared in English and translated into Afan Oromo then transcribed and translated in to English for the purpose of analysis.

3.4.3. Key informant interviews with professional

In order to get information (data) on past events and scenarios and even on the current reality in related to the perception and experiences of service providers, on the side effect of contraception, the way they advised husbands, and service given for the couples were looked during data collection. Five health care service providers from five health centers (one from each) who worked on the reproductive health unit and three health extension workers were purposively recruited and interviewed.

The objective of interviewing health professionals is to obtain their expert opinions and perceptions regarding the issue at hand. The interviews with key informants, that is, with the health care providers were held at their respective offices or work settings.

3.4.4. Document Review

In order to gain additional information and conceptualize the prevailing problem, various secondary data regarding the issue were reviewed. This includes different relevant published and unpublished documents, reports and statistical records of health offices on contraceptive services are assessed to analyze the trend and frequency of fertility control utilization.

3.5. Source of data

Primary data was obtained from in-depth interview, key informant interview and focus group discussion with married couples and health care service providers. Secondary data was acquired from published and unpublished documents and Tiro Afeta Woreda health office annual plans and reports. Secondary data served as for triangulating information obtained from primary sources.

3.6. Data Processing and Analysis

Primary and secondary data collected from the field were recorded and transcribed word for word. All interviews were conducted in Afan Oromo and later translated in to English. Because of researcher's interest to give emphasis to carry out a single activity work at a time and inconveniences of simultaneously collecting and analyzing the information, the researcher translated and transcribed all the interviews and the focus group discussion after data collection was completed. I wrote translations down in notebooks and later typed them in laptop when I came back to Jimma town.

Information obtained from focus group discussions and interviews were transcribed, categorized, and analyzed manually using thematic analysis and narrations. In order to organize the data first, I read all the transcripts repeatedly in order to increase familiarity with the data. Then, themes were formed and components of meanings were identified by coding the transcripts. The codes were determined based on the contents of the data. Coding was conducted using phrases or sentences. Examples of codes I created were side effects of contraceptive method, male involvement in contraception, effectiveness to prevent pregnancy, norm and health workers opinion on side effects of fertility control. Next, I combined these codes and created themes in line with the research questions or objectives. Data collected from secondary sources were used as reference and to explain some of the results obtained through primary data gathering.

3.7. Validity and reliability of data

This section looks at mainly how valid and reliable the study can be or about the trustworthiness of the study. According to Hammersley (as cited in Silverman 2000) reliability has to do with the extent of repeatability or consistency of finding by different observers or by the same observer but on different occasions. In view of the sensitive nature of this study, and the fact that it look in to people's private lives, some respondents may have given "wrong", or distorted or expected answers to some of the sensitive questions. In other words, it concerns whether informants will change their responses during an interview or whether they would give varied answers to different interviewers. Newman (2000) asserts that when sensitive questions are asked respondents may attempt to present a positive picture

of themselves to researchers instead of giving the “right answers”. In some instances, some women may have lied about the types of contraceptive method they are using and how they felt happy with their selection of contraception. It may not beeasy for one to argue that a research instrument will yield the same results when used and interpreted by different researchers at different periods. This is because other researchers will interpret the information given by a research instrument based on their set objectives. So it is hoped that other researchers will come up with similar interpretations of the results if they are addressing similar objectives as in this study. So long as qualitative research involves researcher and participants’ interaction and highly depends on the researchers’ skills of creating rapport with study participants, documentation and analysis skills, complete similarities between two different studies should not be expected.

Thus, the establishment of reliability in qualitative research involves reporting and proper documentation of the research process but not necessarily obtaining the same results (Opare-Henaku, 2006). This study therefore adequately documented the procedures employed to facilitate consistency, accuracy, evaluation and repeatability or replicationif other factors mentioned above do not affect the processes and findings.

One research is valid when the findings of the study that co-relates to those theoretical issues set earlier in the literature review. Therefore, the findings of the present study directly related to the theoretical explanations. Creswell (2003) points out that validity assesses if the findings are accurate from the view of the researcher, the participant, or the readers of the description. As a result, the existing study used different methods of data collection: focus group discussion, individual interview, and key informant interviews. This also helped the researcher to achieve a round understanding of couple’s viewpoints and practices on women’s fertility control in Tiro Afeta Woreda.

3.8. Ethical considerations

I obtained ethical clearance from Jimma University Sociology department. I also obtained permission to conduct the study from the health office of the zone, district and village authorities. Individual’s verbal consent was sought and obtained from the study participants

prior to their participation in the FGDs and in-depth interviews. Because in written consent the participants become reluctant and even suspicious of participating and feel uncomfortable. Also most of the participants may not be able to read and write. Therefore, explanations on the consent would be read and administered by the researcher to the couples; and respondents showed their agreement with hand. All information was kept confidential, with names excluded from the recorded materials to avoid giving away the identity of the participants.

3.9. Access to the Field and Recruitment of Participants

First of all, I submitted supportive letter to jimma zone health office from Jimma University. Then I briefly explained my research proposal to the concerned bodies of the organizations. The higher officials were very happy and welcomed me. They gave me permission letter and informed the appropriate staffs in order to facilitate and cooperate with my research. Then I talked to concerned departments and staffs for interviews and accessing documents. Before starting data collection I began a preliminary field visit to the research sites for three days to get a better understanding of the actual study background in Tiro Afeta woreda. Then I build good rapport with the health office workers. After that I arranged appointments with them for discussion and I introduced myself as M.A student studying sociology and Family Studies to all study participants and explained the purpose of the study, the processes, and confidentiality issues. The selection of the participant was performed purposively based on proximity, fulfilling criteria of selection and convenience to collect the data in short period of time. Following purposive selection of the informants and discussants, interviews were undertaken with each at their private home based on their preference.

Information from interviewees is gathered through taking notes and tape recording. Informed consent was secured verbally from every interviewee for different reasons. If they requested for written consent, the participants may become reluctant and even suspicious of participating or feel uncomfortable. Also many participants cannot be able to read and write as they are illiterate. Finally, most of in-depth interviews lasted from thirty to forty five minutes and one FGD approximately took one and half to two hours. The data gathered from the field was written down manually and translated from Afan Oromo to English.

Experience acquired and challenges encountered in the field

Challenges encountered

Even though I appointed the participants before I started the discussion in FGD, participants not come on time, even they may also absent. Therefore collecting participants in one area was tricky.

Few women participants afraid to tell their experience because of the researcher is male. But I convinced them saying that their individual person privacy cannot transfer to third party and my aim is only for academic purpose and preparing graduation paper.

The other challenge encountered during data collection was the difficulty of making the interview and discussion area private. For example, interruption of children sounds of generator during interview.

When I interviewed the case study, few women participants expected me as physician and a higher governmental representative who studied about the side effects of contraception and in the middle of the discussion they said that inform this problem to the government. Therefore I had to take my time to explain further the purpose of my research to the respondents because they had some misunderstanding about the study. I had to convince them that my study is purely academic but that it will possibly help the government and family planning experts to address the family planning needs of the community.

Experience acquired

I acquired the method of working in the field and how to interview and communicate with rural community**.** I have got the experience of solving problems and working in cooperation.

CHAPTER FOUR: FINDINGS AND DISCUSSION

4. Findings

4.1. Introduction

This section of the study provides analyses of the responses received from interviews, focus group discussion and key person conducted in the field. The main intention of this study was sought to look at the view points and practices of married couples on women's fertility control. The perceptions and experience of couples about contraceptive usage will probably determine their willingness to use the various types of modern /natural methods of contraception. Here also a summary of the findings that the study came across is presented. This is followed by a conclusion; finally there will be some recommendations on how best to improve contraceptive usage in Tiro Afeta Woreda.

4.2. Participants knowledge and experiences with modern contraceptive methods

The kind of knowledge and experiences the community had and how they view each contraceptive method influenced on couples perceptions and use of contraceptive. All the participants heard about family planning issue. Most of the male and female respondents were aware of many of the modern method. They have got this information from health workers, participating in kebele meeting and listening from media promotion. The study participants in the district most commonly use injection method of contraception. The reason is that most of the health workers recommend injections to those who visited clinics to receive contraception, because of the method had a longer effective period and easily understandable or manageable than pills. Both husband and wife participants know the duration of injections to prevent pregnancy. They said that it helps or prevents for three months.

The other method of pregnancy prevention used in the village is implant. Most of the male participants didn't know how implants are used and some knew that implants could be removed if they wanted to get pregnant. There were differences in knowledge related to the

effect of this contraceptive as some men and women believe that they were protected only for one year while others thought they were protected up to three, five and more years. Some women hesitated using implants due to a lack of information about this contraceptive and fear of side effects.

The other method of modern contraceptive which has been in use to control fertility in this area is the birth control pills. Women participants had sufficient knowledge of how to use the pill. When asked about the duration of one birth control pills ability to prevent pregnancy, female respondents said that it prevents for one month and the pills should be taken once daily. As opposed to this, male participants didn't have information and knowledge of how to use because of their perspective taking pills is a women's duty.36 years male FGD participant reflected his understanding about pills saying "birth control pills used for three months". The above quote depicts that female participants likely know more about this contraceptive than the male participants. They have got this information and knowledge from HEWs, participating in different meeting provided by women's and children affairs office at kebele and from media promotion program.

When asked about condom use and its effectiveness to prevent pregnancy, male and female participants in the study afraid to talk about it because using condoms is perceived as sinful act and have the opinion of condom used for unmarried couples (not used for married). Moreover, majority of farmer couples who participated in the interview have information about condom but they relate condom to preventing STDS especially HIV/AIDS only. One of 55 years old male interview participant reported that "I am not using condom because of having marriage and condom helps to prevent STDs for the unmarried one" this quote shows that they didn't have awareness that condoms serve as preventive against unwanted pregnancy. Young couples around 20-23 age have information about it.

But one participant said that, *"*If I use condom during sexual intercourse to prevent pregnancy, I am afraid of my wife and she may not live with me."(IDI, male, 44 years)

A twenty three years male informant narrated that, “Once while I was using with condom, the condom broken down easily on my body since then I am afraid to use it.” Therefore, condoms are breakable during sex, and thus the method is not trustworthy.”

4.3. **Participants knowledge and experience of natural method of contraception**

We also discussed about breast feeding and the calendar rhythm method with model farmers and employed couples. And the majority of couples were categorized under natural method of birth control. Different ideas were raised and debated concerning the effectiveness of both breast feeding and the calendar rhythm method to prevent pregnancy. Few educated and model farmers have information and knowledge about natural (traditional) method of birth control. They believe that breastfeeding and menstrual cycle counting is effective against pregnancy, while others thought that breastfeeding and menstrual cycle counting do not prevent pregnancy at all. Some participants reported that they themselves had become pregnant, or they know other women who got pregnant during breastfeeding. Educated couples and civil servant had knowledge and information of this method as alternative to preventive to unwanted pregnancy and others do not. They said that this method needs menstrual stability and knowledge about menstrual cycle. However, either the husband or the wife may lack of tolerance from sexual abstinence during save period. Couples give different opinion about fertile or risky and infertile or save period.

A twenty five years female informant said that, “If a woman has a 28 days stable menstrual cycle, first divide 28 by 2. It is 14 days. Then subtract 3 days from the first 14 days and add 3 days plus the latter 14 days. So, from the 11th day to the 17th day is identified as a fertile period. Other days are safe.’’

The other 30 years informant said that, “If a woman has a 28 days stable menstrual cycle, first divide 28 by 2. It is 14 days. Then subtract 5 days from the first 14 days and add 5 days to the latter 14 days. So, from the 9th day to the 19th day is identified as a fertile period.”

This shows that different participants have different awareness’s about the length of safe period using the menstrual cycle. Consequently, the level of knowledge about use of contraceptive methods varies greatly from person to person. It appears that effectiveness of this method varies from person to person based on their understanding level which in turn will affect their

utilization. Three informants who have reported the less effectiveness of this method based on their own experiences.

One woman explained this like:-

*"*This year I have a child and begun to use breast feeding to prevent unwanted pregnancy but unexpectedly I become pregnant. Therefore the method is not effective to prevent pregnancy." (FGD, female, 30 years)

Grade nine male participant explained similar experience as, *"*My wife used the calendar rhythm method for a year, and we discuss and follow the safe and unsafe periods. Unexpectedly, she had got pregnant. Therefore, the calendar method did not be effective." (Male, IDI, 25 years)

As shown above breast feeding cannot prevent pregnancy for all women. Calendar method is only applicable to those women whose menstrual cycle is stable. As consequence of their experiences, it appears that effectiveness of breast feeding and calendar rhythm methods are an effective fertility control method to prevent pregnancy. Another two male interviewees expressed their failure experiences of using this method. The first narrates it as, "We used the natural (i.e. calendar method) method of birth control to prevent unwanted pregnancy based because we heard from users that the modern contraceptive methods have side effects. But it is difficult to identify the save and unsafe period." (IDI, male 40 years)

The other participant adds that:

> *Before using the natural method, my wife has experience of using injection and birth control pills. These affects her health (i.e. it produces black spot in her face) during she was using it. As a result, we chose to use the natural breastfeeding and calendar method believing that those methods cannot have any negative impact on her health. But its effectiveness is susceptible*. (IDI, male, 30 years)

The above statement shows that people afraid of using modern methods of contraception because of their side effects and based on information they obtain from users and non-users.

On the other hand we also discussed about breast feeding and the calendar rhythm method with uneducated farmers. Almost all illiterate farmers did not have any information, experience and knowledge whether breastfeeding and the calendar rhythm can be used as an alternative fertility control methods. As mentioned here with, the very reason for failure to use the natural/traditional methods for birth control is lack of information. Yet, both husbands and wife reported that in the earlier people used to use the roots of plant or shrubs (herbal medicine) for preventing unwanted pregnancies.

I asked the health extension workers how they thought and why the entire participant didn't tell their experience on this issue. They said that, "We taught the method to the educated people who seemed to understand the method but we did not teach the method to those we considered uneducated. Because of the natural method of fertility control is not suitable for uneducated people.''

Similarly, the expert who works on reproductive health in the woreda responded that:

> *The method is not a preferable fertility control technique because it has a problem. We recommend using other contraceptive methods because there are many uneducated people in our community and the method is not suitable for them. Therefore, we offer other contraceptive and education programmes for them. But, we do not prohibit health personnel to teach people about the method. We just encourage people to use other methods, especially long term ones.*

One can understand the following key points from above discussions. First, it appears that there is growing interest and need of using contraceptives in the rural communities. Second, couples are not passively receive reproductive services provided to them rather they question, test and re-test, discuss about pros and cons, make decisions and revise the decisions when necessary. Third, utilization of contraceptive methods are shaped and influenced by personal factors, the socioeconomic and demographic contexts of certain community. Fourth, males (husbands) have remarkable involvement in fertility control in collaborating with their wives. Fifth, all aforementioned points have implication on service provision, effectiveness of different methods and people's future utilization of the service in general.

4.4. Participant experience with side effects of modern contraceptives

When male and female respondent are initiated to talk about contraceptives, they always like to speak about their side effects. Many women from the focus groups and in-depth interviews told about the side effects associated with injections. According to them, injection creates menstrual irregularity, increasing menstrual bleeding, high blood pressure, bodily pain, and weakness of arm and fatigue. They also relate the perspective of using injection with sterility. Even though many women told that they have suffered from side effects but injections are accepted and the preferred form of contraceptive among many of them. Because of they believe that injections cause less side effects than the other methods and is considered as an easier method for use.

A male participant recalled that,

*"*My wife used to use injection but as health professional told her that using injection dried out breast milk from her child, she has changed into birth control pills since then." (FGD, male, 27 years)

The implication is that the way health care providers communicate with their clients and the terms they use in counseling interaction which in turn may lead to undesired action.

Another adult man shared his wife's experience of using contraceptive methods provided through injection and the consequent delay in return when they decided to have a child as,

"Last year, my wife used injection to space birth but this year she stopped using the method because we want to have child but still we couldn't get the chance of fertility." (FGD, male, 45 years)

I have asked health care service provider a question that why a woman who used injection for a certain time could not become pregnant when discontinued to use the method? The response was that even though a women stops using contraception after using injection for long time, there may be a chance to wait for longer or delay to get pregnant.

This shows that side effects of using modern contraceptives could be a barrier against the methods or to discontinue the use. Participants in the study have identified other side effects of different contraceptive methods based on their diversified sources of knowledge. For instance, a woman told the negative side of injection methods based on the information she shared from her

friend that, *"*Using injection in some women decreasing menstrual bleeding or prevent bleeding which results in high blood pressure and moreover injection brings infertilityand I have got this information in discussion about contraception with one of my friend." (FGD, female 25 years)

Message from the quotation tells us that information obtained from friends are trusted even without cross-checking reliability of the information by consulting health care providers including HEWs are relatively easily accessible in the village. In other words, there are alternative information sources for women about the effects of contraceptives which in turn affect their utilization of the services provided to them.

In a similar fashion, even advices from the health care provider in supporting them to choose a method suits their condition could be differently understood and used as factor of totally rejecting some methods than others.

Yet, others have suspicion about using the contraceptive methods based on others' experiences with negative effects on the lives of the users. In this line, a woman narrates that*, "*Some people grow very fat and others become very thin after using the Norplant. Some women experience excessive bleeding as a result of using the injection method. A women near my house experienced irregular menstruation after taking the injection." *(*FGD, female, 36 years)

This shows that participants discuses about experiences of other women in their locality, women share information and experiences about contraceptive use and may use such information for decision making for themselves. On the way, personal factors may be overlooked in choosing appropriate methods because of lack of technical knowledge and personal differences in a setting of less educated communities.

Participants explained some side effects from using implants too which include: weakness in the arm, fatigue and menstrual irregularity. Removing implants by operation based on its perceived mentioned effects mentioned earlier is practiced in the rural communities of the Tiro Afeta which has become trouble to other users and health care providers.

Actual practices of women in the study area show that they are responding to those listed side effects of the implants by removing it. A woman voices like*, "*I used implants to prevent

pregnancy but it affected my health because it created back pain. As a result, I removed it by the help of the health care providers .But I am not using any contraception now; I need to have children.*''* (IDI, female, 29 years)

Similar sentiments are raised by a woman whose idea is presented in the following quotation.

> *A woman in my neighborhood had implants inserted into her hands by health extension workers. However, her hands cannot work anything since then and she ends up paralyzed. After this event, she went to health center and repeatedly asked to remove it from her hands but the health workers responded it will not be removed before the planned time ends. Then she went to private clinic in Serbo and removed it from her hands after which she has got remedy for her hand.*(FGD, female 36*)*

Males participate in in-depth interview also raised the same case as the negative outcome of the implants.

Two practical case analyses with 20 and 25 years women who use implants have reported similar problem of using implant which is summarized as follows. They have used implants for three years but that finally results in a serious problem on their health that forced them to go to Dimtu health center to remove the object from their bodies by the help of the health care providers. Unfortunately, implants are hidden in their bodies from access to be identified by the health care providers with naked eyes. Hence, it required diagnosis with x-ray technology for which they had to go further to Jimma University Specialized Hospital for treatment and discharge of the implants by more qualified professionals and with better health facilities.

Therefore I have asked both women encountering this experience for their decision in response to the referral ordered. And their response is just to stop using this method not only because of its side effects on their physical health but it also causes excessive and prolonged bleeding which in turn keeps them away from practicing “selat” and “fasting” Islamic religious commandments. Such excessive bleeding is also complained against by male participants for disturbing patterns of sexual relations.

I have also observed both couples and interviewed both husbands when they were waiting for car to go to Jimma with their wives for the treatment. They commented that the medicine has advantage to control fertility but it also creates excessive bleeding, physical fatigue and failure to move hands. As a result, they decided to discontinue using the method at all.

This news is very popular in the locality with likely implications of leading women turn their back to the method in general and generally suspects other contraceptive methods alike. So, people fear against using contraception because it creates social, economic and religious side effects on users is beyond labeled as perceived and ignorance rather based on actual experiences of women using the technology. Health care providers have also witnessed the happening of the two cases and asserted that it is normal condition but occurs in few women.

Other women who are not currently using contraceptives but interest to start remain in dilemma hearing different rumors about the side effects. It is obtained from women's FGD that a lot of women afraid to use fertility control even if they want to limit the number of children they want to have. Some of the women taking rumor of the side effects others believe if the inserted object (implants) cannot be removed from the hands as a chance or if the woman dies with remaining it in her hands, she will not inherit haven because of the foreign object that God has not created that man created against God's will of human fertility.

One male FGD participant said that:

> *Fertility control brings trouble for women and our families. For example, if an implant is inserted into a woman's arm and then she is told not to do hard work such as farming, fetching water and cooking, how that woman will survive when she is supposed to earn her food through farming? Therefore, it is better for that women should not use family planning methods because it will make our lives trouble.*(FGD, males, 40 years)

The above result indicated that information and rumors about the side effects influenced those who had never used any pregnancy prevention services. One of the woman in the interviews

reported that she failed to start contraceptive use because she heard many women who get health problems due to using fertility control.

4.5. Viewpoints of Health workers on side effects

The nurses/health officers who work on reproductive health and health extension workers interviewed for this study agreed on the side effects that contraceptives have on users. Implants and pills are particularly focused on by the health workers. According to professional witnesses given by the experts:

*"*Implant produces excessive bleeding, menstrual disturbance, loss in weight and develop anemia and birth control pills create headache, fever, burns the stomach and menstrual irregularity on users." The health workers noted that "the users administer the method we tell them along with the advantages and disadvantages or side effects of each contraceptive method and then we give them by their own choice.*"*

They also reported that they give advice for husbands too about family planning and effects of different contraception methods by making the wives to call the husbands when the women come to health facilities for treatment and checkup we including the advantage of family planning and small family size.

An examination for different personal factors of a woman who wants to use a certain contraceptive is quite important besides respecting the choices of the service users. Hence, professionals have some degree of discretion in guiding the user in selecting the proper type of contraception. That is, the type of contraception to be used by a user is not entirely the exclusive decision of the user. Rather, professional advises are quite important in the process of fixing the type of contraceptive to be used. Otherwise, overlooking necessary examinations of patient personal conditions before administering any method may cause some problems to the user. Service providers have reported their unique experiences while administrating different contraceptive methods.

An experience of a HEW is narrated as "Last year I have inserted implant in women's hand and then by the time she stood to go, she fell down on the ground. I have given her soft drink

"Mirinda" after which she stood up and told me that she had not anything to eat before coming here.*"*

Woreda health office expert was asked to elaborate what happened to the women and he told the reason as "If you give implant to anemia patient, it can result in falling down of the woman. Therefore, a physician is expected to provide physical examination and medical eligibility criteria before giving the services to the needy." However, from the overall practices of HEWs working at the community level have difficulty of getting contraceptive user women to produce such examination results because of different attitudinal, economic and social factors. This indicates even though conducting medical eligibility and physical examination before administering contraception is a requirement, it is possibly by passed by the HEWs who are at the forefront line of providing the services or related advices. Yet it is might be difficult to judge as if this is mistake of the HEWs given there are other factors beyond their control.

Other health center based health care provider shares his experience saying:

> *When I worked in a place called Akko, I have practically seen three women who used implants and their hand become paralyzed. Even though they were repeatedly treated at heath center, their health could not be improved. With the cause was wrong way of inserting the implant by the health extension workers because of lack of concentration when they give the services.*(A nurse at health center who is working in reproductive health unit).

According to this and other experts, implants are supposed to be given intradermal (between skin and flesh). If it is done otherwise it might cause health problems by affecting nerves. To what extent, HEWs are technically capable of doing this thing might be answered by expertise in the area.

4. 5.1. Suggestions of health care service providers on how to increase contraceptive use.

It appears that health care providers also share the concern of couple's related contraceptive use such as fear of the side effects, health experiences and some rumors reported by the

couples about contraception. In rural communities, there are a lot of negative perceptions and rumors towards using different contraceptive methods with particular emphasis on implants. Among others, the health care providers (nurses, health officers and HEWs) share the idea or the concern that:

Implant paralyzes the body, it cause sterilization, prohibits from entering *in to* paradise if a woman dies with the object in her body. Moreover, removing implants is viewed as operation which results in negative attitude towards using implants. The health care providers believe that this actually prevents most women from taking it.

Therefore, the experts suggest, if the government wanted many people to utilize this method, it is pertinent to change implant in to **injection or liquid form** so that it would become user friendly.

4.6. Participants belief /perception about the effectiveness of different contraceptive method

Husband and wives participated in both focus group and in-depth interview had the belief that if a woman uses modern contraceptive in the right way, it was perfectly effective against pregnancy. They reported also that if someone got pregnant while taking contraceptives, it was likely due to user failure. For example, when women forget to take the pills daily they may become pregnant. One male participant forwarded contradicting idea saying that everything will happen with God will (judgment) and one cannot have capability to control its fertility, except Allah. Male discussant narrated that, *"*My wife used modern contraception for two years. When she stops using the method after two years she gave birth to twins. This shows that even if we take the medicine to prevent pregnancy everything, pregnancy will happen as God's will." *(*FGD, male, 36 years)

On the other hand how other couples appreciate the benefits of modern methods and also the risk involved in using certain types of contraceptive. A woman informant witnessed importance of using modern contraception as, *"*Modern contraceptives are convenient if we use them correctly and can work effectively. I have the experience of using the injectable contraception." (IDI, female 25 years)

Similar reflections from grade ten women of similar age, reads as

> *Modern methods are paramount since they are administered by health workers. In the earlier, I used the three years injection but now I have taken IUCD that serves for ten years and above. The Intra Uterine Device is very effective and has no side effects since it does not react with any hormones in the body. (*IDI, female, 25 years*)*

Considering pills, most of the participants explained the harmful effects of pills and considered pills to have more serious side effects than any other methods. During interview, couples explained various indicators and consequences of taking pills. This includes: stomach aches, balance problems (locally referred to as "jonjeessu"), causes black spots on their face, increased menstrual bleeding and menstrual irregularities. Informants emphasized that they fear the side-effects caused by contraceptives to use them.

As a woman explained her experience that:
"I used to use birth control pills last year which resulted in excessive and irregular bleeding. But now I have stopped to use it. Because of this repeated and irregular bleeding prevented me from "selat". There are other women who never use the method for the same reason." (FGD, female, 30 years)

Female participants have believed that using pills needs quality food (good life situation) otherwise the women who use pills couldn't work close to fire and the degree of its side effect depends on user's diet. Male participants have similar perception about the special and extra food requirements for contraceptive user women citing information they obtained from health workers. Health workers told them that the contraceptives have side effects that necessitate women to take enough amount protein-rich food. Therefore, women who take contraceptives must eat meat and eggs; otherwise they may suffer from side effects. A male informant expressed his worries as *"*Even if I am poor, I am expected to provide protein rich food for my wife. How is this possible?*"* (FGD, male, 36 years)

Other male respondent told similar sentiments saying that "We are farmers who don't have capability to give quality diet for our wives and her job is cooking around fire; so, if she stopped working with fire how we can sustain our life*?"* (FGD, male, 55 years)

Similar sense of doubt about women's contraceptive use (particularly the Pills) along husbands is asserted as, "Women who take contraception especially pills are expected to eat high-quality food but we are poor and unable to give this type of food to our wife. Therefore, rural people cannot afford to use contraception because using fertility control medicine needs protein food*." (*IDI, male 44)

The beliefs that the pill needs quality meal and women who uses pills unable to cook food with fire made people fear to use the method. Therefore several participants favored to use other contraceptive methods than the pill.

Others also complain that women who took the pills could not work near a fire in a kitchen due to the weakness caused by taking the pills. Some of the respondents explained this was due to the pill sucking blood from the body. Since working beside fire is seen as a women's task, using the pill was considered a big problem since cooking is being one of the major female tasks. Such perceived and practical side effects of using fertility control made women to resist taking contraception. This includes, of the information that taking pills needs quality food, fear to become sterile, paralyze the arm and weaken the body and the social stigma attached to using contraception which all results in low usage of contraception in the study area.

Participants also have the views that birth control has bad effects on women's physical appearances and health with potential influence of reducing their attractiveness. A male interview has presented this idea stating that "Pills produce black spot on women's face during usage therefore, it is better not to use it." (IDI, male, 30 years*)*

Other than fearing the side effects of using contraception, perception of having many children is equally important reason to avoid contraceptive use at all. A female interview reflected her interest of having many children in her saying *"*I have one child and I am not using fertility control because I need to have more and more children."(IDI, female, 25 years) Within this notion of having interest for many children, sex preference or interest to balance between number of sons and daughters of parents is also a powerful driving force behind avoiding any attempt of fertility control. A couple with five daughters are still running after more sons hence

have no plan for using family planning methods. The wife expressed her stand as, "I have five daughters but no sons; I am not using fertility control because I need to have sons so that I will try until to get sons." *(*FGD, female, 35 years) The husband also repeated same idea and stand point confirming that the decision was jointly made by both of them.

Social pressure, family influence in particular, is another equally important driving force against contraceptive use even if a woman has personal interest or inclination to use. In a society whereby life is characterized by more of collective interests than personal inclinations, personal decision might not be effective even on personal matters let alone family issues that in one way or another involves the significant others. A woman who has interest to use contraception but unable to do so because of influence from others told the story presented below.

> *I want to use fertility control method for my health but I am afraid my mother-in-law expects me to give birth for more children to her son and she says child is a gift given from God. In contrary, my family supports if I use the method. I suspect that if I stopped to give birth, my husband's family may force him to marry another additional wife. (*FGD, female, 30 years*)*

As to what are the reason/s why this side effect occurs attribute it to both personal differences and experiences. A participant gave her opinion emphasizing on biological differences saying, "Different people experienced differently and differences in blood type it is a cause for this side effects*."* (IDI, female, 25 years)

Few participants also have the opinion that repeated use of contraception may cause side effect on users. The above quote shows that the main reasons why participants believe that side effects are due to differences in blood types, users' diet and repeated using of contraceptive medicine. Beside of this, although most of them believe contraceptives are effective in preventing pregnancy, they also believe that the people who take the contraceptives should have access to protein-rich foods. As a result of these perceptions, many were reluctant to use contraceptives because of their poor living standard and they feared serious health problems.

4.7. Socio cultural factors that affect the practice of contraceptive utilization

4.7.1. The influence of religion on adopting modern contraception

As female FGDs and IDI participant responded that in Muslim religion to inherit in to paradise it is important to participate in "selat" and "fasting." This needs to become clean and free from blood. But after woman started to use most of modern contraception the normal flow of menstruation totally changed. Thirty six years women narrated that, "normally menstrual bleeding lasts for 4-6 days, but after using contraception, in most women menstrual bleeding is extended up to 14 days and even more. This prohibits Muslim women from "selat" and "fasting" (Islamic rituals).As a result; a lot of women afraid to use contraception because of its prolonged menstrual bleeds which results in withdrawal from praying." As other informants reported, it is strictly forbidden for women practicing and following any praying with blood. Three Orthodox Christianity "fasting" followers also shared this idea. Therefore, due to this problem, a lot of women discontinue using modern contraceptive methods.

There are also different interpretations and contradictory thoughts among the participants when it comes to fertility control and contraceptive use though all belong to same religion. Some of the participants believe that Islamic religion does not prohibit contraceptive use religion but abortion. Others say that using contraception is forbidden because it is interferes into God's work.

According to the later view, God will punish those who use contraceptives because children are the work and the gift of God. It appears that these two contradictory viewpoints have resulted in some degree of confusions among the people. The uncertainty further increases by religious leader's interpretation of contraceptive use. In this regard, religious leaders advise their followers to use for a different reason than the very objective of family planning, contraceptive use and then fertility control which are limiting the number of children. This very scientific and political reason of spacing or limiting number of children is not acceptable. Rather, it is only possible if the motive of contraceptive use is for the sake of the woman. A male interviewee reported the advice he received from religious leader as, *"*If it is from thinking for your wife, it is possible to use birth control. If your aim is for reducing the number of children based on the idea that you have many children, it is impossible to use contraceptive." (FGD, male, 44 years*)*

The notion of interfering in to the work of God comes here when the intention is to reduce the number of children born to the family which is considered as violating against God himself. Both males and females who oppose contraceptive use believe that God creates children whereas human beings created contraceptives against the will of God.

Two Christian female respondents have shown similar sentiments that and do not use fertility control based on the message from the Bible that order people to replicate themselves. One of the two questions like, *"*Don't think you yourself are on the hands of God, God thinks more than you for the child whom you give birth to." (FGD, female, 30 years*)*

This last point may give us hint that there might not be fundamental differences between Muslims and Christians on acceptability of the contraceptive use even if some degree of differences might be there. Given, the people living in the study area are mostly Muslims and a few Christians, Christians' viewpoints and practices incase differ from other Christian dominant areas. However, most of the participants, both Orthodox Christians and Muslims, thought their religion actually prohibited birth control, or that contraceptive use is accepted but seen in a negative way by religious interpretations. The reason mentioned by many respondents was that children were gifts from God and people must receive everything God given them. This indicates that religion still seemed to produce feeling of opposition and frustration and made it difficult for people to initiate and continue the use of contraceptives. The majority of respondents motivated and continued to use contraceptives because they knew that it could improve their economic situation, although recognizing it as a sin.

As a final point, participants who believe their religion actually accepts contraceptive use were fewer in number than those who thought that contraceptive use is prohibited or seen as a sin or "haram" by their religion. Whatever any decisions were made, religious beliefs affected individual attitudes and decision-making processes in a way that complicated the decisions being made to use contraceptive.

4.7.2. Participant Sex preferences

Even though all participants reported that they like to have both sons and daughters, most of them want to have more sons than daughters. They provide different reasons for the preference.

Firstly, a son remains a permanent member of the family even after he gets married whereas the daughter shifts her family membership to her husbands' group. Many participants declare that daughter cannot truly be considered as their children. As a result, sons are perceived as more essential to the parents and the parents expect their sons to take care of them when they become older. Sex preference along with reasons for it summarized as follows for an interviewee.

"I want to have more sons because the number we have only one son and three daughters, I will try to get sons. Even if the sex of children is a gift of God, I want to try until I get more sons*."* *(*FGD, female, 30 years)

Commitment of husband and wives to have sons even if they already have many daughters is underlined by couples with five daughters but agree to have more children till sons would be obtained. The couples have agreed that they should not use fertility control.

Parents' expectation of property inheritance, particularly land and livestock, to sons upon their marriage is among the important factors to prefer sons over daughters. The reason why people prefer sons than daughters' was that their daily tasks were very strongly divided based on sex and gender. Therefore, if parents have children of both sexes, they can get various types of support or services from them.

On the other hand, the participants of male FGD give as their still speak in favor of sons thinking them as guards of the family against external attack and insurance in the later life for the parents in which daughters are assumed to have little roles to play because of change in their family membership to their husbands.

Participant expresses the differences as

> *Even though children's sex is decided by the will of God but I prefer sons because daughters are members of their husband's family when they marry and cannot support me during old age and sons share the property from family as well protect the family and its resources from enemy." (*FGD, male, 30*) The other one also adds "I prefer to have male children. Because male replicate my species and females replicate her husband's family after they marry.*(FGD, male, 40 years*)*

The above quotations showed that the importance attached to both male and female children (sex composition) may encourage people to have more children than their ideal or desired number of children, or even in some cases more than they can financially handle. Searching for sons in particular increases the tendency of having more and more children which by default reduces people's chance and interest of using fertility control methods.

4.7.3. Participants Perception about Fertility and Infertility

What does it mean to have children?

Couples have different opinion about the effects of having or not having children are on their lives. Generally, having children had an important meaning for all of the participants and positively regarded. Children are seen as representatives or substitutes of their father and mother. Most of the participants expected their children to support their parents at older age so having children means getting future support. That is, having children has not only social implications but also economic benefits as they will be expected as insurance for the latter time. Having children strongly related to economics, such as an eventual means of getting support when they got older and obtaining opportunities to improve their living condition. For the question why do you need to have children? The participants think thatChildren support them when they get older or when they get seriously sick. They also think of children as a source of pleasure, strengthen the couple's relation and helps for continuity of lineage.

A study participant mentioned the function of having children as, *"*If I don't have a child after marriage my name doesn't change. My child changes my name. For example, my oldest child is called Biyya. So, people respect me when they call me Abba Biyya (Biyya's Father). So, I have got respect because of my child. Having a child is having great respect.*"* (FGD, male, 55 years)

This implies that having children is a means of securing respect from the community. Because of this socially meaningful reason, husbands in the district have interest to have children exceeding the ideal size. Furthermore, participants described that children had an important role in keeping their father's name after his death. It is fairly possible to accept that children by only their existence will have a social meaning for their parents and there is mutual relationship between

parents and their children. Regardless of their age and economic benefit they bring for the parents, parents tend to render high value for children just for their existence as early as from their time of birth. They sense of proud, source of acceptance and expected to be economic insurance for their parents. So, the actual relationship between children and their parents is maintained throughout the life course and the symbolic relations even extend beyond life after death.

There is a general view in the study community that if a person dies without children it's the worst death. His name is also hidden with his body. But if a person dies having children, he is not considered as dead because of his children. That is, the people's sense of continuity is closely related with having children; otherwise, the generation link stops somewhere if someone remains infertile. Such interpretation derives its meaning and relevance so long as they are highly valued by a cultural group. It is felt that this is among the top concerns in people's lives in Tiro Afeta which might be same among people in similar contexts.

The above statement show that how couples want to live after their death and not having children ends up in disappearing from history.

4.7.4. Perception on Infertility and premarital sex

Both premarital sex and infertility are unacceptable as participant explained. An infertile woman is seen as unfortunate or evil not only for herself but also for others surrounding her. Study participants revealed that, if a woman is unable to bear a child (reproduce), she doesn't get respect from her husband's family and neighbor. People do not show her their children because they believe that she may kill them with her evil eyes. It is assumed that a woman becomes infertile because of a negative power that dwells in her which can also hurt others. So, if a woman prefers not to give birth to a child in that community, she is easily stereotyped and stigmatized by the same logic which also tends to extend itself to attempt of reducing number of children. As a result, women refrain from using a family planning even if some changes are observed both in people's view and practices.

One interviewee shared an experience of a woman who was infertile. He narrated the scenario saying,

> *My brother's wife could not get a child. People in the neighborhood challenged him for living with her while she cannot give birth to a child. They frequently asked him what she did for him if she doesn't bear a child. Is she a donkey? And will she carry you? These were among the questions forwarded to him. The people put pressure on him to divorce her and conclude another marriage. As the pressure continued, they indeed up in divorce last year.*(FGD, Male 38 years)

Ideas raised in this quotation reveal that fertility is at the centre of women's lives on as primary criteria for her respect, right of marriage and social acceptance. The reproductive role is more valued than her productive role as the comparison of the woman's analogy to donkey while she fails to give birth to a child reveals. It shows that the social norms and expectations of having children after marriage and the stigma attached to infertility makes women afraid to use birth control method. Norms of motherhood are powerful in defining women's master status the violation of which causes tough social sanctions.

Sexual purity before marriage is also an emphasized social norm and its violation that is, having sexual contact before marriage is thought as a sinful act with likely chance of being stigmatized if the practice is publicized.

Historically, premarital sex used to be attributed as cause of lack of rain (drought if it occurs in a certain community even by a single person. Consequently, upon identification of the person, the people take the deviant individual to waterside and wash her body with different stem of plants and trees in order to purify her and get remedy for the lack of rain.

This shows that the traditional sexual norm of the society in the study area is that both male and female should practice sex only after marriage. Practicing it before marriage may result in strong social sanction up on the actors. Equally important is investigation of the actual sexual practice of unmarried people and community's response if the rule is violated. This is beyond the scope of this study but the researcher strongly suggests further studies that primarily focus on people's practices in relation to premarital sexuality.

4.8. Involvement of male on women's fertility control utilization

4.8.1. Couples Discussion and decision making about fertility control usage

As to who initiated, conversation there was disagreement. In both husbands' and wives' FGDs, there was a general agreement that the wife mostly initiates discussion. They believed that the wives feel more responsible and be concerned for her and her child's health. They believe that the burden of day to day child care, taking them to the health center, even the increasing living cost causes the mother to initiate discussion related to the issue. Moreover, the wife fear too frequent pregnancies and hence raises the issue of family planning. One of the male participants in the study speaks that

*"*My wife doesn't want to have many children and she brings the issue of family planning and birth spacing in to my consideration or attention*." (FGD, male, 30 years)*

In contrary, a wife expressed her husband's reluctant condition about fertility control as *"*My husband doesn't worry about the number of children we have because the problem of frequentpregnancies and the burden of day to day child care affect my health more than him." (FGD, female, 36 years)

Male participants admit that men's role in initiating the discussion is rare except for those who are educated husband. They believed that the husband has much more responsibilities than the wife as the head of the family including economic provisions. They agree that discussion about family planning is mostly initiated; otherwise husbands' participation in the discussion at may not be realized if they are waited for to do so. Here, we can easily understand how the traditional dichotomized gender-based role division in which men and women respectively assigned to roles of productive and reproductive categories operates. Critical observation of conditions of the study participants regardless of sex reflect that they generally tend to observe the rules. Yet, some tendencies of looking things differently is also observed among both sexes. For instance, there are males and females who pose some challenges to the existing norms of having many children and considering fertility issue as role of women alone. A male interviewee expressed his experience asserting that, *"*Since I and my wife are government employees, we know our income and it is mandatory to balance the number of children with our own income. Therefore, I always

initiate birth spacing and family planning issue, she accepts what I suggest without any contradiction." *(*IDI, male, 28 years*)*

Here, we notice how changes in economic conditions will have its influence on views and practices of people about family planning and fertility control. It is also evident that men's involvement in reproductive health can make a difference so long as men are either the sole or at least joint decision makers on matters of fertility control. The researcher calls attention of other researchers for comprehensive investigation on topics related to men involvement in these areas of interest.

The women felt that the husband, being the dominant person in the family, is the major decision maker and the wife has to obey with what he likes even if she isn't happy with his idea. They deemed that decisions on family matters including fertility control are largely made by the husband. They felt that this is the effect of their culture. The employed women also feel same whether the wife has occupation or not, it doesn't make any difference on this issue so long as the final say is up to the husband even if she does not agree with the decision.

In response to the question who decides whether to use or not to use contraception for a woman a participant emphasized that

*"*You can't influence a lot to get him accept what you like. You have to fulfill what he wants. Even if you have a job, you are a wife. You don't have power like him in the family because the cultural values and religious doctrine encourage a wife should accept her husband's interest." (FGD, female, 35 years)Being a bread winner is also additional and more practical advantage for husbands to get their decisions accepted by their wives. As husbands are already in a dominant position by virtue of their economic statuses, it was difficult for women to persuade husbands in discussions.

One woman commented, "Men are the decision-makers in the households, including on the number of children to have and FP use or not use*."* (FGD, females, 35 years)

On the other hand, another woman who has a different view from the conventional norms argues that *"*I tell my husband the number of children I want to have as well as the spacing between the children. We prepare ourselves before we add another child*." (*IDI, female, 25 years)

Housewives also reported the secret use of contraception as a means to exercise the interest of fertility control. This is another mechanism of challenging the status quo using secrecy as a tool of agency. Yet other women are against this practice fearing that it leads to marital dispute upon disclosure the result of which might be worse than having more children.

For the question what is going to be your reaction if your wife is found using any contraceptive type without your knowledge? A study participant concluded that "Secret use of contraception by wives creates conflict and even it brings divorce." (FGD, male participant) The other added that "If my wife uses contraception secretly and I become aware of it, I suspect that she wanted to practice infidelity so I call her relative and make her leave my home." (IDI, male, 44 years)

From the family point of view, secrete use of contraceptive can be considered as a family problem in itself so long as it does not involve consents of both parties. Yet, the practice might be considered individual business from the perspectives of human (woman) rights' proponents.

Nearly all study participants in principle agree with the importance of discussion among couples towards joint discussion on the matter though practices largely do not support the views. Along the favorable attitude for importance of couples' discussion, men have reservation that the role of husbands as head of the family should not be compromised which implicitly requires the husband makes decision and the wife accepts it with little resistance. It also implies that the couples have to exercise discussions towards joint discussion as much as possible clearing misunderstandings that may prevail between them due to lack of discussion. The problem, however, is if disagreement on the point occurs, that of husband remains valid and effective. The participants also pointed that fear of conflict and possibly consequent separation and religious doctrines are among the important barriers to husband-wife discussion on sexual and reproductive health matters.

4.9. Opportunity for using fertility control

Participants can have information about family planning, but what motivates them to practice fertility control is not simply awareness, or general approval, as was seen in both the focus group discussion and in-depth interview. There seemed to be positive attitude towards family planning among the groups. They tended to approve fertility control for its economic and health benefits for both birth spacing and limiting. Participants know the advantage of fertility control and small number of children saying that Contraception is good for the

mother and children's health. Too frequent pregnancies affect women physical condition. The children can't grow healthy. When they are sick, they have to take to the health center and these days the cost of health care for the children is becoming heavy.In fact participants associate contraceptive usage with the health of the mother & children, and with the family's benefit as a whole. All the participants who approve and use contraception tended to realize the high cost of child rearing. For the question what motivates you in promoting fertility control usage? One respondent expresses her view that:

*"*Now life is getting more and more expensive. Child rearing is becoming very challenging. It is difficult to have many children like before. Our husbands have also realized this." (FGD, female, 35 years)

Similar idea rises from male participant saying:

> *Living remuneration is rising, children's clothing, schooling, and health care. As children's age get increases, their need also increases. The land is getting small and we fail to fulfill their need. As a result, we discuss how we can limit our family size according to our living standard*(FGD, male, 36 years*).*

*"*At present both husband and wives are changing. The wife has learnt the benefits of having a small family size. Those who have a few children improve themselves and live better life than a large family size. Therefore we don't spend all their time caring for children*." (*FGD, female, 30 years*)*

The above quotation reveals that, rather than deep transformation of their beliefs and values, Scarcity of resources urging the respondents to want a fewer family size. The high cost of child rearing seemed to urge couples to practice fertility control. The economic pressure and health benefits could be an important point to promote family planning among men and women. The economic and health benefit to get from small family size result couples a chance to utilize contraceptive.

4.10. Discussion

4.10.1. Couples Knowledge and experience about modern contraceptives

The study finding shows that respondents participated in both FGD and in-depth interview have heard about family planning. Most of the respondents were aware of family planning programmes. Husbands have lower awareness about how contraception used especially in related to implants. Male participants didn't know how implants and birth control pills are used and conversely some knew that implants could be removed if they wanted to get pregnant. Because of their perspective taking birth control pills is a women's duty. But women, educated individuals and the youth have sufficient knowledge of how to use contraception. This shows that Knowledge of family planning is different from individual to individual. Obviously, having wide knowledge does not necessarily mean that such persons have adequate exposure to the use of contraceptives because other decision-making influences possibly will determine it. Even though the participants perceived that Injectables, implants, Pills, IUCD and Condoms respectively were the modern methods identified by the respondents. Therefore wives and husbands participated in the interview knew and name at least one modern method of contraception.

Health extension workers, media advocacy programs and different meeting provided by kebele and woreda are the major source of information known and listed by couples. Most of the time husbands received indirect information from their wife who had relatively a higher opportunity to visit clinics and were informed about by health workers.

The study finding clearly shows that injectables found to be the most known and commonly utilized pregnancy prevention method used by wives followed by implants and birth control pills. Even though there is a difference in knowledge of contraception from person to person couples explained the importance of Modern contraceptives and problems encountered during implementation process.

Modern contraceptives are convenient if we use them correctly and can work effectively. I have the experience of using the Inject able contraception *(*FGD, female 30 years).

“I used implants to prevent pregnancy but using affects my health it created back pain and excessive bleeding. As a result I removed it by the help of the physician”(IDI, female, 29 years).

The above statement shows that for some women using contraception can create any side effects in other women it has a chance to produce sever problems.

The Knowledge and experience in using condom as a contraceptive method was not known among uneducated wives and husbands. This may be due to the advocacy task of intervention programs aimed at prevention of STD\HIV leads to both men and women associate condom with STD\HIV protection only. Couples may have not been aware of condom as a male and alternative contraception method. As a result couples hesitated to use the method. A similar situation is reported by Bongaarts and Bruce (1995) found that lack of identification of the different contraceptive methods, and knowledge of their side effects is the reason for not using fertility control.

4.10.2. Perceptions of Couples about modern and traditional contraceptive methods

Educated study participants had knowledge about modern and traditional methods of contraception. Most of the respondents informed that they preferred to use the modern methods compared to the natural/traditional method. Because of they think that modern methods are highly efficient, it is easily accessible (modern methods are available to the women located near their resident), convenient to use and also have better understanding of their usage.

On the other hand few women reported that they preferred to use the natural/traditional method because of the perspective that modern methods have many side effects and their religion also does not encourage using modern contraceptive. Generally, for the question why do you choose to use modern contraceptive methods? Women responded that they consider how accessible, how effective to control fertility, and the length of time that the method can prevent any unwanted pregnancy.

4.10.3. Perception of contraceptive Side effects

The study finding clearly shows that fears of side effects linked to the use of contraceptives disallowed women from using fertility control. Most of the husbands have the belief that using contraception weaken the arm and paralyze the hand, increased menstrual bleeding and makes women infertile. Related research in Tanzania by Schuler at al. (2011), described that Most of the male participants who did not use modern contraception or oppose contraception as they were misinformed about side effects and feared it would harm their wives.

The study finding revealed that many rumor related to side effects caused by contraceptive use, regardless of whether couple had ever used contraceptives or not. Almost all of the female participants associated intake of medicines, such as contraceptives, as something that required "good food" (protein food) "far from fire" and a lot of rest, otherwise the overall health of the women body would be damaged. The strong belief in this association in reality introduced an indirect economic barrier for people in using contraceptives even if contraceptives were provided free of payment; they had to provide money to buy good food to be able to take contraceptives. Since some of the health workers shared the same description and these beliefs were reinforced in the interview with the health workers. There were health workers recommending rest and protein-rich foods in order to use contraceptive methods. Subsequently, some of the participants stop to use contraceptives because they could not afford to eat protein-rich food. Similar study undertaken In Uganda by Nalwadda et al. 2010, taking ambiguous information whether to use contraceptives or not from partners, parents, cultural leaders and health workers were identified as key obstacles to the uptake of modern contraception (Nalwadda et al. 2010).

According to Sagbakken et al., 2008b study finding reveals that sign of illness, such as side-effects are indication that say something about the body not being able to handle contraceptive medicine, and that one required good food (protein rich as meat, milk and eggs) are the major reason for women not practicing modern method (Sagbakken et al., 2008b). The fact that both couple and health workers to some extent share these beliefs and reinforce participant's perceptions and these conditions becomes even more important to attend to. Accessibility and availability of contraceptives are increased. However, people's decisions

and peoples indication to action are made based on indirect costs related to a perceived requirement of using contraceptives (good food, rest), as well as the perceived influence on the body(side effects) and the overall health becomes long term perspective. These costs are often reinforced trough social network relationships and also in the interview with health workers. The perceptions of money to buy protein rich food and benefits related to have children, as well as the costs in terms of religious belief; all play a role to promote fertility control in the study area.

4.10.4. Influence of Religion

There is conflicting idea in between people who follow the same religion. InMuslimreligion some people says that the religion cannot prohibit using contraception but it forbid abortion. Most of the participant said thatGod will punish those who use contraceptives because of children are the work of God and the gift given from God to human beings. This contradictory thought make the individual confused. Similarly Casterline et al. (2001) emphasize that socio-cultural and religious disapprovals of contraception repeatedly emerge as important obstacles to the use of a contraceptive method. In a different way Sarkar (2008),who studies about reproduction, have found that the use of contraceptives is approved by some Muslims because the Islamic belief underline that children have a right to education, this entails that the number of children in a family may have to be limited, and birth control subsequently allowed (Sarkar, 2008).

4.10.5. Sexual norms

The study findings show that the tradition strictly forbids premarital sexual affairs. According to most of the respondent reported that earlier, girls identified having pre-marital sex or giving birth before marriage face the risk of being outcasts from the community. They do not get any assistance from the family and the community at large. Changes in the pattern of sexual practice are occurring among the youth. Irresponsible sexual affairs are increasing. The breakdown of the traditional sexual norms is believed to result in unwanted pregnancy and contribute to the increasing fertility rate. Besides, expose the productive generation to sexually transmitted diseases.

4.10.6. The influence of Gendered Norm

The study finding suggests that the patriarchal gender norms influence contraceptive use in various ways. The studies emphasize that the husband is the dominant person in the family issue including fertility control and the major decision maker and the wife has to obey with what he likes even if she isn't happy with his idea. This shows that the norms that place lesser value on women and this enable inequality between men and women. However, we found that when a couple could not reach an agreement related to contraceptive use, the husband's decision tended to be prioritized because of a gender-based power imbalance. According to Gender and Development (GAD) theoretical approaches explains that the inequalities that exist between men and women on their reproductive roles and societal norm that gives smaller value to women and gives decision power to men in any issue. Similar study undertaken in Tanzania show that almost all husband and wives discussed about family planning, but a gender inequality was still present in the implementation of decisions with fertility control; the final decision maker become male (Schuler, Rottach and Mukiri 2011; Prata and Potts 2013). Therefore, power imbalance between men and women will prevent women from using contraceptives. Female informants reported also that, "because of the male dominance in the culture, women would be forced to bear large numbers of children."(FGD, female, 36 years) This is reported to be a major obstacle in the fertility control decisions by women. A key reason for woman not using contraception is opposition by a male partner. (e.g. Nalwadda, Mirembe, Byamugisha & Faxelid, 2010)

The study clearly shows that men mostly seem to give the responsibility of taking contraceptives to women. It doesn't give attention on it. Because of the society perceived reproductive issue is taken as women's job and health workers strongly focus on women and this affects the participation of male in contraceptive use negatively. Family planning services that have selectively hold women rather than focusing on both male and female and giving much emphasis on women reinforced the idea that reproduction and family welfare are women's responsibilities (Schuler et al. 2011).

Both husband and wives FGD discussed about **Secret use** of contraception are a method for using contraception. All of the participants concluded that secret using of contraception

against the wish of the husbands it creates conflict and separation. Similar studies conducted in Tanzania (Schuler, et al., 2011) and Uganda (Nalwadda, et. al., 2010) emphasize that using contraception in secret or against the wishes of the husbands could lead to violence or divorce of the woman.

4.10.7. Socio-economic influences on using contraceptive methods

During a focus group discussion I confirmed that few women had decided not to use contraception because of experienced or perceived side effects of the methods. This revealed that they don't use FP methods because "it gives health problems" and "we are afraid to use it" because using modern contraception "causes sterility." This study is similar with the findings reported by Hoque 2007 birth control pills creates irregular bleeding and other side effects in addition to the social stigma and fear related to the use of the methods could be the reason for nonuse the method to few women. Modern contraceptives use has been documented to cause temporal infertility due to delay ovulation as a result of hormone imbalance (Kayembe et.al, 2003; Hoque, 2007). Religious enculturation on the use of contraception such that claimed by women in the district is preserved in the doctrine that God plan for humans is to multiply and that he think about all human being and therefore, it is sinful if one attempts to stop fertility. This shows that socio-cultural and religious disapprovals of contraception repeatedly appear as important obstacles to the use of a contraceptive method.

The number of children influences the use of FP method among women because of the obvious load (burden) to feed and to fulfill the children need. This was confirmed by the focus group discussion when a 30 year woman and supported by others that "the number of children affects the mother's health and also if one have many children one cannot get sufficient money for oneself thus one cannot buy so many clothes like other women who do not have many children do."

4.10.8. Fertility Preference

The study clearly shows that couples who lacked male child said that they want additional child while those who lacked female child said that they want additional child and not utilize

fertility control. This indicates that searching the required sex (significance of sex composition) force people not to use fertility control.

4.10.9. The Fertility Culture: perceptions and the need to regulate

Respondents were asked to offer explanations why people want to have children. The reason given by most was “to see one’s eyes through one’s own eyes” directly translated in to English. Both male and female respondents underlined the importance of “having an image of their own”, “children support during old age.” it is “eternal or divine support” to the life after earth.

The social believe that having children support for life after earth motivates the people for not adopting contraception. Research conducted in northern Nigeria by Wall (1998) emphasize that birth is a remedy for bereavement in the cultural idioms of this Islamic society and children are considered a divine benefaction. Children are the desired outcome of any Hausa, marriage, and giving birth is traditionally viewed as the greatest fulfillment of being a woman (Wall 1998).

The two major reasons mentioned for having children were linked to the ideas of children “to see an image of their own through children” responded by few participants and most participant have the idea that “as a source of support during old age”.

“The reason to have children is because they will support me in many ways, they will feed me, they will defend for me and if I can and if I educate them” (FGD, male, 40 years)

The implication from the above interviewee represents the outlook of many others, is that one needs to have children regardless of her/his ability to support (security)them later in their life. This view sees children as a source of wealth. Caldwell's theory of wealth flows (Caldwell 1982) it supports on the assumption that parents are motivated to have high number of children for economic benefit. Similar studies conducted by Becker (1960) clearly shows that families chose a fertility level in order to maximize their wellbeing which is represented by budget constraints which balances household expenditure with income. The value of having children has not only a strong economic but it also has a cultural value to people. Fears related to being totally forgotten after people died. Therefore socio cultural costs affect contraceptive use of many women negatively.

4.11. Husband-Wife Discussion and decision making

Most of the couples (both wives and husbands) said that we discussed about birth spacing and limiting or family planning issue. They disagreed in their report of as to who initiated discussion. Husbands were found more likely to say that they had initiated the discussion where as wives reported themselves as the initiators.

This was also reflected in the focus group discussion men initiate the discussion because of the perception that the husband feels responsible for economic provision of the family. Women initiate the discussion In terms of his and her child's health it is the wife who feels responsible thus takes the initiative to discuss about family planning with her partner. But some of the men from the government employee group supported the women's report by saying that it is mostly the wife who initiates discussion. According to the views of both male and female the women's generally initiates discussion they explained that, because day to day care of children, taking them to clinic, even the increasing living cost largely affects the women than the men. So this push to express her thought. It is the wife who at this time states her fear of too frequent pregnancies and raises the issue of family planning. In the focus group discussion, from the participant's point of view, it was learnt that the initiator of discussion is the women who mostly feels responsible.

Both male and female respondent participated in FGD reported that the decisions to use or not to use contraception viewed as the husband, has the major decision maker in reproductive and other family issu**e** and the wives is obeying the decision intended for. They deemed that decisions on family matters including fertility control are largely made by the husband. As Women, Culture and Development (WCD) approach argues that for one to consider the distinct cultures of individual regions as one studies gender relations between men and women. There may also be some social values, customs, norms and other institutional arrangements in individual societies that may influence contraceptive use. The worker women mentioned that "whether the wife has occupation or not, doesn't make any difference-the final say is up to the husband. Men play a greater role in highly gender-stratified populations"(Mishra et al., 2014). Contraceptive usage by women in many societies can be influenced by man and sometimes family members from the extended family like grand-

parents, uncles and aunties mostly have some influence on a couple's reproductive life and may also play a role in decision-making. One female FGD participant reported her interest to use contraceptive but if she stopped to give birth, she afraid of her husband's family (i.e. grand-parents) they may forced him to marry another additional wife. As a result she frightened to start the medicine. Relating this to the structuration theory used in this study, the extended family members serve as the social structure and the women serve as the agent. Agents are just as much influenced by the actions of others. According to the theory the social structure can influence the choice and women's contraceptive use includes influences from spouses and other family members. Cleveland (1986) however reports on how some family members of rural inhabitants can influence the sexual lives of married people and hence their fertility levels.

4.12. Motivation for using fertility control

For the question what motivates you in promoting fertility control usage? As was seen in both focus group discussion and in-depth interview the couples reported that what motivates them to practice fertility control is not awareness, or just general approval. Things most participant initiated practice to use fertility control is that child rearing; feeding and educating them were more expensive and hard to fulfill the children's need than the previous time. Similarly three women participants underlined this saying "if life cost goes progressively as the present situation; most of the couples start to use fertility control unwillingly." This shows that they tended to approve fertility control for its economic (the family's benefit as a whole) and health (health of mothers and children) benefits for both birth spacing and limiting. Campbell et al.2006 emphasizes that the intrinsic motivation for birth spacing was driven by perceived all family benefits included reduced financial strain, hence 1) increased potential to attain life goals, e.g. securing financial stability, and 2) better spousal relations linked to return of female beauty and the absence of frequent financial demands associated with closely-spaced births are the main drive which open a door for using family planning.

To sum up**,** the findings that emerged from the analysis it depicts that there are major obstacles that hinders women from using fertility control. Those factors which influenced reproductive perceptions and practice are: husband's opposition to the use of the method, fear of side effects and related rumor, misinformation, and influence of religion and religious leader doctrine,

significance of sex composition especially the need to acquire sons, gender norms and the culture of having high fertility. The main factors contributing to this is less education on modern methods and the inability of women to negotiate their husbands in order to adopt the methods effectively. Male involvement helps not only in accepting a contraceptive but also in its effective use and continuation. But men involvement in family planning at the study setting is rarely known. It is most likely that contraceptive usage will improve if men are actively involved in family planning.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

Rapid Population growth is a serious problem for the development of a society and the country. A very vital tool used for reducing fertility rate is using contraception. The most commonly known modern and natural method of contraception mentioned by the participants includes injection, implant, pills and IUCD and breast feeding and rhythm method of contraception method. Couples who involved in the interview and participated on the discussion found that shifting their outlook in favor of small family size and to exercise using fertility control.

The study finding reveals that knowledge about contraceptive is almost universal to the couples. Married couples who use contraceptives whether natural or modern is however low in the study area. The less use of contraception in Tiro Afeta Woreda was really affected by socio cultural specific obstacles that influence on the adoption of the method include: husband's opposition to the use of the method, fear of side effects, misinformation, and influence of religion, significance of sex composition, gender norms and the culture of having high fertility. Husbands usually make decisions about fertility and family issue, due to the patriarchal societal power imbalance between men and women. Moreover, strong social and religious norms and contradicting information from friends, relatives and health workers negatively affect adoption of family planning in relation to providing service and counseling patients or contraceptive users. Commodity supply from the region to the district has been irregular in the study area. This study suggests that all of these elements are complicated related with one another, consequently couple's perceptions and experience towards contraception are affected by complex issues and people make choices to continue and discontinue based on several and conflicting factors. Paying attention to all other considerations that should be taken into account to improve contraceptive utilization ,health workers, scholars, the government, the contraceptive users themselves (men and women) and family planning experts need to put in place (acknowledge) measures, aimed at increasing modern contraceptive method in the District.

5.2. Recommendations

- Woreda administration office and Woreda health office expected to provide in collaboration program strategies for male involvement both in uptake and in advocacy, especially to promote partner discussion and decision making about choosing a method or change to another method.

- The governmental and nongovernmental institution to facilitate education program for the community. Misinformation is the reason for nonuse of fertility control method.

- The media, likely to invite participation program of religious leader in administering, discussion and advocacy about the advantage of small family size. Because the way religious leader guide or pass message disallowed women from using fertility control method.

- District health office likely to give training for extension workers and physician who worked in reproductive health about insertion and removing of implants. The finding clearly shows that error created during providing service is the other reason for nonuse.

- Health workers recommended that it is important, the government is prone to prepare implants in to injection or liquid form because of perceived societal believe in related to the solid implants, the community said that " if a woman died with implants with in her hand she doesn't enter in to paradise." This is also the main reason for not adopting the method.

- As the sample size is relatively small the study lacks generalization because of the nature of qualitative research. Thus, future researcher needs to focus on; mixed methods of both quantitative and qualitative study with a large sample size will help for generalizations to be made.

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Appendix A: List of Tables

Table 1-3 shows profiles of participants recruited for the interview and discussion

Table1. Profiles of husbands and wives participated on in-depth interview

Couples	Age of wives	Age of husbands	Religion	Number of Children		
				Boys	Girls	Total
A	35	40	Muslim	4	3	7
B	43	55	Muslim	3	3	6
C	23	25	Orthodox Christian	3	2	5
D	25	30	Muslim	1	2	3
E	28	32	Orthodox Christian	2	2	4
F	35	44	Muslim	-	5	5
G	25	44	Muslim	2	4	6
H	40	44	Muslim	4	1	5

Table.2. composition of FGD participants recruited for discussion

Number	**Gender**	**Number in each FGD**	**Age of participants**	**Religion**
FGD 1	Female	8	25s-2,35s-3,30s-2, 36s-1,	Orthodox Christian and Muslim
FGD 2	Male	8	40s-2,44s-3,38s-2, 46s-1	Muslim
FGD 3	Female	7	30s-4,25s-2,35-1	Muslim
FGD 4	Female	8	25s-3,35s-3,30s-2,	Orthodox Christian and Muslim
FGD 5	Male	8	45s-3,46s-2 38s-2,55s-1	Muslim
FGD 6	Male	8	40s-2,44s-3,40s-2,30s-1	Muslim

Table.3. Profiles of health workers participated in the study

Sex and Positions of the participants	**Place of work**
One male health officer(HO)	Health center in the town
2 male and 2 female nurses	Health center in the town
Three health extension workers	Health post in the village

Appendix B: Interview guide for couples: English Version

Jimma University College of Social Sciences and Humanities Department of Sociology MA Program in Sociology and Family Studies

Part one: information on Socio Demographic Characteristics

1- Age _____ Sex: M ____F____

2. Religion A. Muslim ____ B. Orthodox____ C. Protestant ___ D. Others _____

3. Ethnicity

A. oromo____ B.Amhara_____ C.Yam_____

D. Others (specify)_____

4. Educational status

A. Unable to read and write_____

B. Able to read and write but no formal education_____

C. Literate (write the highest educational level achieved)_____

5. Occupation

A. Farmer___B. Merchant____C. Governmental employee___

D. Others (specify)_____

6. How long have you lived in this kebele's? Year____ month_____

7. At what age did you get married? _____

8. How long is it since you got married (in years)?_____

9. How many children do you have together?_____

10. Do you have the desire to add other children on the future?_____

11. How many persons live in your house (family size)?_____

12. How much is your daily income?_____

Part two: information on Practice and perception related to contraceptive use

1. Have you ever used contraceptive methods?

2. Did you think that contraceptive prevent pregnancy? How?

3. Which method did you use?

4. Which types of contraceptive methods do you prefer to use frequently? 1^{st} ,2^{nd},3^{rd}

5. Why do you use the method frequently?

6. Have you ever been discussed contraceptive use and family planning with your wife/husband?

7. What was the result of the discussion about contraceptive use?

8. The reason why continue or discontinue of contraceptive usage? What the major obstacles in related to fertility regulation usage by women?

9. How is religious leader interpreting using fertility control?

10. Does it have an impact on you?

11. Are you current use of contraceptive? Why?

12. What do you think will happen if she/he uses or not using fertility control?

13. What will happen if you use fertility control in secret without the wish of your husband's?

Information On male involvement in contraceptive use

1. Have you heard about family planning?

2. Which types of FC method you heard?

3. From where do you get information about family planning?

4. Which types of modern fertility control you know?

5. Would you like to control the size of your family? _____why?

6. Which types of fertility regulation method used? _____why you prefer?

7. Have you ever been discussed, involved on contraceptive use with your wife? In what ways?

8. Has your wife been using any contraceptive type in the last two years?

9. Is your wife currently using any of the types? Please give reasons.

10. What has been your influence on your wife's usage of contraception?

11. What is going to be your reaction if your wife should use any contraceptive type?

Without first informing you?

12. What in your opinion can husbands do to improve contraceptive use among their wives?

Information on opportunities that facilitate for using fertility control

1. What is birth spacing or to have smaller family size means?

2. What is its advantage for the mothers, child and for the couples?

3. What motivate you for using fertility control?

Part three: The socio cultural factors related to contraceptive use

1. What kind of idea about family planning and contraceptive methods do your parents have?
2. How many children do they want you to have?
3. What kind of opinion related to having many children do your parents have?
4. Are there any people who have influenced/pressured you to have many children?
5. Do you follow their interest about the number of your children? (Why?)
6. Do you use or encourage your wife/husband to use contraceptive methods and family planning?
7. How many children you want to have and when to have children? (With whom?)
8. Is it easy to communicate about family planning with your husband/wife? how?
9. Who decide the number of children?
10. Why the person decided?
11. Have you ever discussed contraceptive use or family planning/ number of children you have with anyone else? (How/ why/ when)
11. How the culture sees participation of male in family planning?
13. What is the social perspective on women's contraceptive use? Or how did the community perceived a woman who uses fertility control?
14. Do you want to use family planning methods in the future?

Cultural value of having children

1. Why you want to have children? (What is the expected role from children?)
2. What does having children mean in your life?
3. What do you feel about having many children?
4. Who decided when to have children? When do you plan to have the next child?
5. What is expected from a woman after marriage?
6. What is the attitude toward not having children at all?
7. What will came from the society if a women an able to reproduce? to his husband from the society? What is your Perceptions of Large family size and small family?
8. How many children you want to have (the desire) and son preferred? Male or female? Why?

9. The age at first marriage for male and for female is how much? The reason behind first **age o**f marriage is what?

10. Which types of traditional contraception methods to prevent pregnancy do couples widely practice?

11. How did the community look premarital sex, what is the traditional sexual norms? What will happen if a woman committed the action?

Accessibility

1. From where do you get the source of supply? Do you know the area of where the service given?

2. Where did you receive information and/or counseling about the contraceptive methods you use/used?

3. Can you explain how the service provider demonstrated to you how to use the method?

4. Can you suggest some reasons why other women may not use different types of contraception?

5. How many hour your home far from clinic?

Part four: For health workers

1. How many workers work at the facility?

2. What kind of services do you provide? (example education programmes and contraceptives)

3. Which contraceptive method do you recommend? Why?

4. What are some of the concerns raised by women and men about the use of the Various contraceptive types?

5. What are the outlook of men and women about the use of the various contraceptive types?

6. Why were most of modern contraceptive user experiences negative side effects when we ask married couple?

7. What kind of explanation do you give the people who want to use contraceptives?

8. What kind of criteria for who can use contraceptive medicines do you have?

9. What kind of problem or obstacle do you face through educational programmes?

10. How do you give counseling service for family planning users?

11. Are you counsel the husband?

12. How many of you have got training on counseling?

13. What is best to improve contraceptive use in the Woreda?

Appendix C. Interview guide: Afan Oromo Version

Qajeelfama gaafannoo Odeeffannon Ittin Sassaabamu

Yuuniversiitii Jimmaatti Dame Saayinsii Hawaasaa Muummee Soosholooji Sadarkaa Barnoota Maastarii Gosa Barnoota Soosholoojii Fi Qo'annoo Maatii.

Tajaajila ittisa da'umsaa haadholii irratti ilaalchaaf gocha Haatii manaa fi abbaan manaa qaban.

1. Malawwan ulfa ittiin ittisan fayyadamtee beektaa?_____

2. Mala kam fayyadamtee beektaa?_____

3. Mala isa kam yeroo baay'ee fayyadamtaa? 1ffa,_____2ffa,_____3ffa_____

4. Maaliif toofticha yeroo hedduuf fayyadamtee?

5. Kanaan dura mala itti fayyadama too'annoo da'umsaa kanaa fi qusannaa maatii haadhamanaa ykn abbaamanaa kee wojjin mari'attee beektaa? _____

6.Bu'aan marii kanarraa argatte maalii?_____

7. Sababiin fayyadamuu ykn fayyadamuu dhabuu kanaa maali? _____

8.Gufuuwwan dubartoonni mala kana akka hinfayyadamnee godhu maalinnii?_____

9. Abbootiin amantaa fayyadamuu qoricha too'annoo ittisa ulfa hin barbaachiifnee kana akkamitti ilaaluu?

10. Ilaalchi jaraa kun dhiibbaa sirratti uume qabaa? Karaa kamiin?_____

11. Mala da'umsa ittiin ofirraa ittisan fayyadamaa jirtaa? Maaliif?_____

12. Osoo mala too'annoo /ittisa da'umsaa fayyadamuu baattee maaltu uumama jettee yaaddaa?

13. Fedhii abbamanaa keetiin ala osoo mala da'umsa ittisuu fayyadamtee maaltuu umama

jettaa?

Odeeffannoo dhiironni mala tajaajila ittisa da'umasaa fayyadamuu irratti qaban

1. Waa'ee qusannaa maatii odeeffannoo qabdaa?_____maal qabdaa_____

2. Odeeffannoo kana eessaa argattee?_____

3.Malaulfa ittisuu ammayyaawaa isa kamiin beektaa?_____

4. Lakkoofsa maatii horattuu too'achuu ni barbaaddaa? Maaliif?_____

5. Mala too'annoo da'umsaaisa kamiin gargaaramtaa? Maaliif filattee?_____

6. Haadhamanaa keewoliin waa'ee ittisa da'umsaa mari'attee beektaa? Haala kamiin?

7. Mala fayyadamuu ittisa da'umsaa fi qusannaa maatii worrikee akka fayyadamtu ni deegartaa?_____

8. Woggoota lamaan darbaniif haati manaa kee tajaajila ittisad a'umsaa fayyadamteettii?_____

9. Yeroo ammaa gosa tajaajila ittisa da'umsaa kamiin fayyadamtii? Sababni isaahoo?_____

10. Dhiibban ati fayyadamuu tajaajila mala ittisa da'umsaa worra keetiif gootu maalii?_____

11. Osoo worri kan kee mala tajaajila ittisa da'umsaa si dhoksuun fayyadamtee maal gootaa?_____

12 .Akka yaada keetiitti dubartoonni tajaajila mala ittisa da'umsaa hedduminaan akka fayyadamanuuf abbaan manaa maal gochuu qaba jettee yaaddaa?_____

Carraawwan mala ittisa da'umsaa akka fayyadamnuuf nu kakaasan

1. Wal irraa fageessanii da'uun maalii? Ykn maatii xiqqaa horachuun (qabaachuun)maalii?__

2. Faayidaan kanaa haadhaaf, ilmoof, akkasumas haadha manaaf abbaa manaaf maali?_____

3. Mala too'annoo da'umsaa kana akka fayyadamtuuf maaltu si kakaasee?_____

Kutaa 3ffaaAadaa hawasa mala tajaajila ittisa da'umsaa fayyadamuu woliin wal qabatan.

1. Maatiin kee yaada akkamii qusannaa maatii fi mala ittisa da'umsaa fayyadamuu irratti qabuu?_____
2. Maatiin kee ilmoo meeqa akkati horattu barbaadu?_____
3. Maatiin kee ijoollee hedduu horrachuu irratti ilaalcha akkamii qabuu?_____
4. Dhiibbaan nama biraarraa akkati maatii/ilmoo hedduu qabaattu sigodhu jiraa?_____
5. Ilaalcha jarri ilmoo hedduu horachuu irratti qaban ni deeggartaa? Maaliifii?_____
6. Ilmoo meeqa horachuu barbaaddaa? Yoom? Eenyuuwoliin?_____
7. Waa'ee qusannaa maatii abbamanaa /haadhamanaa woliin dubbachuun salphaadha jettee yaaddaa? Akkamittii?_____
8. Baay'na ilmoo horattuu eenyutu murteessaa?_____
9. Maaliif isheen/inni murteessee?_____
10. Namoota biraa wojjin waa'ee qusannaa maatii, mala fayyadamuu ittisa da'umsaa ,/baay'ina ijoollee horattuu mari'attee beektaa? Bu'aa maalii argattee?_____
11. Hirmaannaa dhiirri qusannaa maatiiirratti qabu aadaadhaan akkamitti ilaalamaa?_____
12. Mala ittisa da'umsaa fayyadamuu dubartootaa irratti hawaasni ilaalcha akkamii qabaa? Ykn dubartoota mala ittisa da'umsaa fayyadaman hawaasn iakkamitti ilaalaa? _____
13. Garafuula duraatti mala qusannoo maatii fayyaqdamuu feetaa/barbaaddaa? Maaliif?_____

Ilmoo qabaachuun ykn dhabuun aadaan akkamitti ilaalamaa

1.Maaliif ilmoo(dhala) argachuu barbaaddee? Ilmoo horatte kanarraa ga'ee maali eegdaa?_____

2.jireenya kee keessatti ilmoo qabaachuu jechuun maal jechuu dhaa?_____

3.Ilmoo baay'ee yoo horatte maaltu ta'a jettee yaaddaa?_____

4.Yoom akka ilmoo horattu eenyutu murteessaa? Ilmoo itti aanu argachuuf yoomitti karoorsitee?_____

5.Heeruma dubartootaatin booda maaltu irraa eegamaa?_____

6.Ilaalchi dhabiinsa ilmoo irratti jiru wolii galaan maalii?_____

7. Yoo dubartoonnidhala dhabde ilaalcha akkamiitu hawaasa biraa ka'aa? Gara abbamanaa ishiitiihoo?_____

8.Ilaalchi ati maati xiqqaa fi maatii bal'aa irratti qabdu maalii?_____

8.Ilmoo meeqa horachuu barbaaddaa? Dhiira ---- dubaraa-----? Maaliifii?_____

9. Dhiirri woggaa meeqatti fuudhaa? Dubarri meeqatti heerumtii?Sababiin isaa maalii?_____

10. Mala ittisa da'umsaa **aadaa** keessaa maatiiwwan (couples) yeroo hedduu isa kamiin fayyadamuu?_____

11.Wol qunnamtii saalaa gaa'ilaan duraa hawaasni akkamitti ilaalaa? Safuun duraan waa'ee kanaa irratti hawaasa keessa jiru maalii?_____

12.Yoo dubartoonni gocha kana raawwatani argaman kara hawaasaaan maaltu irratti uumamaa?_____

Waliin ga'iinsa(accesebility)

1.Odeeffannoo /barnoota /gorsa tajaajila mala ittisa da'umsaa fayyadamtu eessaa argattee?_____

2.Akkaataa qaamoleen tajaajila kana kennan ykn tooftaa jarri siif ibsan himuu dandeessaa?

3.Naannoo tajaajilichi itti kennamu nibeektaa?_____

4.Mana keerraa hagam fagaataa?_____

5.Sababa dubartoonni biro mala tajaajila ittisa da'umsaa garaagaraa hin fayyadamnee himuu dandeessaa?

Kutaa 4ffaa gaaffannoo Ogeessa fayyaaf

1. Ogeessota meeqatu mala qusannaa maatii irratti ramadamanii hojjatuu?_____

2. Gargaarsa akkamii kennituu?_____

3. Mala ittisa da'umsa isa kam akka fayyadaman gorsituu? Maaliif?_____.

4. Ilaalchi dhiironnii fi dubartoonni fayyadamuu mala ittisa da'umsaa garaagaraa irratti qaban hoo maalii?

5. Qabxiilee dhiiraa fi dubartoota biraa itti fayyadama mala ittisa da'umsaa garaagaraa irratti kaasan ibsuu ni dandeessaa?_____.

6. Fayyadamtoonni mala ittisa da'umsaa ammayyaa baay'ee ala gaafannu maaliif miidhaa isaa kaasuu?

7. Namoota mala ittisa da'umsaa fayyadamuu barbaadaniif gorsa akkamii kennitaafii?_____

8. Ulaagaaleenfayyadamtoota qoricha mala ittisa da'umsaatiif ati keessu maalii?_____

9. Yeroo barumsa kana dabarsitu rakkoolee/ gufuu akkamiitu simudatee?_____

10.Namoota qusannoo maatii fayyadamanan akkamitti gorsitaa?_____

11. Abbaa manaa nigorsitaa?_____ Akkamitti ?_____

12.Ogeessa meeqatuleenjii akkaataa gorsa haadholii fudhatee?_____

13. Mala ittisa da'umsaa ittifufiinsaan dubartonni akka fayyadamanuuf akka Aanichaatti maaltu godhamuu qaba jettee yaaddaa?_____