AN ASSESSMENT OF KNOWLEDGE, ATTITUDES AND PRACTICES
OF FAMILY PLANNING METHODS AND SERVICES AMONG
CLIENTS IN AWASSA, ETHIOPIA

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENT FOR THE DEGREE OF MASTER OF EDUCATION OF
KENYATTA UNIVERSITY

1993

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DECLARATION

This Thesis is my original work and has not been presented for a degree in any other university.

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This Thesis has been submitted for examination with our approval as University Supervisors.

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DEDICATION

This work is dedicated to my daughter, Tsedna.
ACKNOWLEDGEMENTS

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<td>1. Pi ..........</td>
<td>Pills</td>
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<td>Injection</td>
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<tr>
<td>3. IUD ..........</td>
<td>IUCD - Intra-Uterine Contraceptive Device</td>
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<td>Foam/Tablet</td>
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This study was a survey of an assessment of knowledge, attitudes and practices of family planning methods and services among clients in Awassa town, Sidamo Province, Ethiopia. The study examined various demographic, social, cultural and economic variables. These include age, sex, current marital status, number of living children and desired number of children, educational attainment, occupational status and religious orientation of the respondents.

A sample of 135 family planning clients of both men and women of reproductive age was randomly selected for the study. However, only a few number of men were used in the study since most of the family planning clinics were dominated by women. The family planning clinics studied are Awassa Health Center, Awassa MCH Clinic, Sidamo Agriculture Enterprise Clinic, and Awassa Police Clinic. The sampling technique used for this study was systematic random sampling. Data were collected by means of an interview schedule. Descriptive statistics were used in data analysis thus tables of frequency distributions, percentages and histograms were used for data presentation.
According to the findings, respondents' knowledge of family planning methods was high while their knowledge of other places where family planning services could be obtained was very low. The study also indicated that the majority of the respondents were against the idea of discussing family planning matters with their children. Although the respondents who were involved in the study had used contraceptive methods for more than six months, most of them used contraceptives for child spacing rather than for limiting the number of births.

The study concludes that socio-economic factors have an effect on fertility patterns in that the lower the educational status of the respondents the higher the number of living children they have. It also concludes that age at marriage, number of living children, education and quality of family planning services are important factors for policy use. The results of the study could be used as a basis of planning for interventions which can increase family planning knowledge, develop favourable attitudes and promote use of efficient methods of contraceptives.
CHAPTER ONE

INTRODUCTION

1.1 Background to the Problem

History has shown that large families were being considered as the main asset of a nation's wealth and power. Mack and Pease (1973) indicated that children were seen as a source of security during the old age of their parents. Ancient societies have been governed by values which encouraged couples to have many children. Thus, it was a traditionally accepted norm to value a woman for her childbearing qualities. The agrarian societies had a tendency to have high birth rates usually accompanied by high death rates. Zawaki (1971) also stated that in tribal and preindustrial societies people would bear many children but most of these children would die at an early age. But nowadays due to the improvement of public health measures, it is noted that the overall death rates have been reduced at a faster pace than birth rates, (Udo, 1979).

Today, rapid population growth has become a global issue and recognized as a problem by many nations. In the words of Bushra (1976), it is indicated that unlike the past centuries, many nations experience rapid population growth which is accompanied by food shortages and poor quality of life that lead to hunger.
and even death. Therefore, many developing countries are not able to produce enough food to adequately feed their people thus food has become a critical issue. It has been observed that in the developing nations of the world, the explosive population growth is becoming a primary reason as to many obstacles to economic and social progress (Manisoff, 1973).

In the words of Goode (1979), the population of the developing countries is thus increasing faster than the economic growth of the society. Many African countries are experiencing high population growth where some of these societies are unable to feed and produce adequate foods for their people. According to Moss and Rathbone (1975), the level of fertility in this region remains higher than in any other part of the world. It was also indicated by the International Planned Parenthood Federation (1988) that contraceptive practices in Africa are actually lower than the rest of other developing world. Though there is change of circumstances and less farm plots, many societies in this region still give high value to frequent childbearing. As a matter of fact, the concept of considering children as security in their old age is still prevalent.

Ethiopia is one of those Sub-Saharan African countries which have unregulated population growth.
This country is situated in the horn of Africa and lies above the Equator. Geographically, it is bordered on the north by Red Sea, on the west and northwest by the Sudan, on the east and southeast by Somalia and on the south by Kenya (Appendix A). This nation has an area of about 450,000 square miles and it is divided into highlands of the north and the lowlands of the south, having an approximate elevation of 5,000 to 10,000 feet above the sea level (Schwab, 1985).

Economically, in the past decades Ethiopia was known for its agricultural potential, and about 80% of the population is concentrated in agricultural activities (Schwab, 1985). But due to natural calamities and man-made problems, structural obstacles were created which caused an economic backwardness of this nation. For many years, the country has been hit by drought and hence deteriorated in its economic capacity to feed its citizens. In addition, the civil wars in the country had also caused various destructions. It is also observed that there is little concern.

The population growth in Ethiopia has created difficulties in feeding the people and educating the children, and in addition, it has also caused maternal and child mortality. The International Conference for Reconstruction and Development (World Bank, 1989) expressed that poor countries in Africa such as
Ethiopia, Mali and Burkina Faso have the highest rates of deaths of young children who are below the age of five years. Though it is said that about one quarter of all children born die before they reach the age of five, it is also indicated that the mortality levels tend to decline earlier than fertility levels (World Bank, 1989).

Ethiopia is also one of those African countries which are considered populous nations. The Office of Population and Housing Census Commission of Ethiopia in 1984 estimated that Ethiopia’s population was about 42 million which is indicated as the third largest country in Africa (Kwast, Rochat and Kidanemariam, 1986). Lefort (1981) also stated that this nation has fertility growth rate of about 2.5%. Moreover, Ethiopia’s population growth leads to environmental degradation causing deforestation and soil erosion. The current population is about 52 million and as a result, there is an imbalance between the production capacity of the land and the size of the population to be fed. It is also observed that there is little concern over population control measures thus family planning has received little acceptance by the society.

To create positive attitudes on contraception acceptance in densely populated societies, it is necessary to promote widespread knowledge of family
planning principles and the delivery system. Since education forms an integral part of all family planning programmes, it should come first in a planned way in order to change people’s attitudes.

Bushra and Perl (1976) indicated that in various parts of the world educational resources in family planning are inadequate and are not evenly distributed. In the Ethiopian society, Daka (1986) stated that though the Family Guidance Association of Ethiopia’s efforts to disseminate information on family planning have been achieved to a certain extent, the Association’s various educational programmes have not as yet reached the majority of the population who have little or no education.

As in many parts of the country, Sidamo, which is in the northern area of the Southern Ethiopia Administrative Region is noted for its dense population (Southern Ethiopia Three-year Development Plan 1991-1993). In this manner Awassa, the capital city of Sidamo is not an exception. Though dependable statistics are still not available regarding the actual number of homeless children, a considerable number of them in this town are currently spending much of their lives on the streets just roaming about. They usually are engaged in begging, pick-pocketing and shoe-shining. The root cause of this problem is the result
of population growth where their families cannot afford to earn enough money to support them. Thus, Awassa and other urban areas of the country are seeking priority in family planning service and information (Southern Ethiopia, Three-year Development Plan 1991-1993). For the development and promotion of family planning services, the importance of educational programmes and transmission of information should be put into main consideration. Providing family planning education will enable people to make rational decisions concerning matters affecting their lives.

1.2 Statement of the Problem

As in other parts of the country, Awassa town shares the burden of rapid population growth and poor conditions of life. There is higher fertility rate particularly in persons with little or no formal education and in those women who tend to marry early and begin childbearing at a younger age. Hence, to cope with the low standard of living, low economic development and shortage of educational activities, it is important to reach the public with necessary information about family planning methods and services.

Generally, people are powerless to regulate their family sizes unless they are provided with adequate knowledge of contraceptive methods. They have to know
what they are, how they work and from where to obtain the services. The Centro Latinoamericano de Demografía (1971) states that knowledge of contraceptive methods is an essential pre-requisite to fertility reduction.

In this study, more emphasis has been placed on the user’s understanding of the benefit of family planning in relationship to their family needs. Hence, it is necessary that educational efforts have to go hand in hand with a contraceptive delivery system (Molnos, 1978). Furthermore, family planning should be an integrated phenomenon which encompasses all services such as contraceptive distribution, education, information, and clinical services. In fact, there are many people who do not have access to family planning information and services. Therefore, there is need for more research in this field. Thus, studies on family planning programmes should involve the scope of educational activities aimed at reaching the childbearing population. It was, therefore, anticipated that this study would provide relevant information on the need and use of family planning methods in Awassa.

1.3 Purpose of the Study

The purpose of this study was to find out knowledge of family planning methods and services and the clients’ attitude toward family planning methods.
The study also sought to establish the family planning practices of the clients.

1.4 Objectives of the Study

1. To establish the socio-economic profile of users of family planning services in Awassa.

2. To identify the social, cultural and religious factors that influence the use of family planning methods in Awassa.

3. To assess the clients' level of knowledge on family planning services and methods used in Awassa.

4. To determine the most commonly used contraceptive method(s) in Awassa.

5. To identify clients' attitude towards family planning services.

6. To investigate the existing constraints in providing family planning services.

1.5 Significance of the Study

The findings of this study will be of significant value in the following ways. The findings will:

1. be useful to family planning service providers and government or non-governmental organizations;

2. contribute to the improvement of the overall programme of family planning services to family
planning clients; and

3. help the author to draw recommendations so that policy-makers, government and non-governmental organizations may make more effort and collaboration in considering family planning as a timely and critical issue in the country.

1.6 Assumption of the Study

1. It was assumed that some form of family planning methods or services have been used by some Awassa women and men.

1.7 Limitation of the Study

1. This study only concentrated in Awassa area. Hence, the results cannot be generalized to the rest of Ethiopia. A larger sample would have required a longer period which would have inhibited the urgency of the study. However, a small sample enhanced the continuous nature of study in educational activities concerning family planning methods and services.

1.8 Definition of Terms

Family Planning: It is defined as the state of regulating births by spacing and limiting conception. Family Planning Association of Kenya
(1990) states that family planning is where a couple can make decisions on how many children to have and when to have them. Family planning includes contraceptive supplies, educational and necessary laboratory examinations.

Fertility: The Department of International Economic and Social Affairs Population Studies (1986) explained fertility as actual reproduction performance to live births.

Population Control: In the words of Manisoff (1973), population control deals with broad societal or governmental approaches to cope with problems that arise due to excessive growth in human numbers. It deals with social consequences of fertility growth and promotes family planning for the welfare of the family and the society.
CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

The literature for this study was reviewed under the following sub-headings:

2.1 Family Planning: Perspective and History.
2.2 Family Planning and Population Issues
2.3 Rapid Population Growth and Its Constraints on Health, Nutrition and Development
2.4 Contraceptive Methods
2.5 Factors Affecting Family Planning
2.6 Knowledge, Attitudes and Practices of Family Planning Clients.

2.1 Family Planning: Perspective and History

Family planning is a method of spacing and limiting births. It incorporates important measures and programmes to expand human right and freedom. Every individual has the right to get family planning information so that he/she can make proper choices of family sizes. Moreover, family planning serves as part of family life education and contributes to the socio-economic development of a society. Its major goal is to help mothers to achieve maximum health and well-
being between pregnancies. It has been recognized that child spacing and limitations of family sizes can be a good means for attaining planned parenthood. Thus it contributes to the health of the mother and child and to the welfare of the whole family in general (Law, 1973).

Sozi (1986) explains that family planning is not only a means of limiting and spacing births but also a tool for creating family happiness by promoting births which do not exist. This is especially necessary in Ethiopia and other parts of African countries where marriages often break up due to barrenness. In fact, family planning tackles the problem of infertility by enhancing guidance and counselling services and even to the extent of assisting those societies in the world which are in a state of decline. Thus, family planning should not only be assumed as birth control but also includes a broad sense of dealing with sub-fertility and marital difficulties.

Controlling fertility started since ancient times. Human history has shown the practice of traditional methods to control births and has been in existence for centuries. Gebrehiwot (1986) notes that mankind has been trying to discover effective birth control methods and it is shown in literatures of ancient nations of the world such as China, India, Egypt and Greek. He
further notes that since there was little or no migration during those past centuries, lowering the number of births was a means of solving the congestion.

Chaudury (1982) observes that the need to adjust the total number of births to complement the available resources has been very crucial. Though the world was believed to be underpopulated in the olden days, it has been also of concern to keep the number in check. Furthermore, Coser, Rhea, Steffan and Nock (1983) argued that though history shows that the practice of birth control methods was to regulate fertility, it has not been explained as to why people use them. Moreover, for whatever reasons history has shown that ancient people were regulating their fertility and thus people used to have fewer children when they were willing and able to do so.

Law (1973) notes that different methods were in practice to prevent conception in the past several centuries. But the idea of birth control to regulate the population growth came to the attention of governments of the world since the early 1800s according to Malthus. Thus, Malthus' theory has been concerned with the issue of population growth and resource distribution. Furthermore, Yimam (1986) indicates that contraceptive methods were introduced through family planning programmes and have been used
for about eighty years. In Ethiopia, family planning was started in 1966 by the Ethiopian Family Guidance Association. The Association was formed in collaboration with the International Family Planning Association and the Ethiopian Government (International Planned Parenthood Federation, IPPF, 1987). However, it was also observed that before two decades ago, the Ethiopian Government claimed that the country is not over-populated and in fact, it has uncultivated land which requires availability of labour force (FGAE, 1975).

Alemu (1986), in commemorating the 20th Anniversary of the Family Guidance Association of Ethiopia, explained that marriage and the bearing of children ensure the survival of the next generation. But it is, however, stressed that the number of children born to a family should be regulated so that the general wellbeing of the family unit could be secured.

According to Gebrehiwot (1986), family planning is relatively new as an organized service providing activity in the African continent. It is obvious that the practice of child spacing was in existence even in the ancient times but it was more or less haphazardly practised in the traditional society.
Law (1973) further explains that the phrase 'family planning' was embarrassing about two decades ago. He observed that the subject was rarely raised for discussions and was even considered as if it was something irreverent.

A study conducted in Western Kenya by Khasiani and Mugenzi (1989) shows that family planning was considered a positive exercise by majority of the respondents and it is based on a principle which deals with the capacity of a couple to have the appropriate number of children. It depends on each couple's ability in looking for and fulfilling the need for education, health, food and clothing for the whole family. It is also believed that family planning allows couples to have enough time to perform other activities.

Haile (1990), did a study on fertility conditions in Gonder, Northwestern Ethiopia, and noted that family planning services are well-known in the study area but it is however, observed that contraceptive use was not widely practised by the people. In his survey, it shows that an estimated number of 3.6 per 1,000 women of child-bearing age were using contraceptives.
2.2 Family Planning and Population Issues

Ethiopia has not yet declared any population policy. But since recent years, it has supported and contributed to the development of family planning programmes in the country. In fact, during the past two decades, it was observed that the country’s third five-year plan had stressed on the necessity of having a growing population for developing the country’s minerals and other valuable resources (FGAE, 1975). It was further stressed that Ethiopia was reluctant to adopt population control policies and its laws supported the right to free reproduction. However, it is noted that though Ethiopia does not have a population policy, it does not impede the objectives and programmes of family planning. Moreover, in the Ethiopian society, family planning has never been openly discussed. It is, however, emphasized that the practice of voluntary child spacing is encouraged to a certain degree and comparatively only a very small number of people benefit from the family planning services.

Every couple has the right to make decisions on family planning acceptance and this has an overall effect on population growth of the society. As a matter of fact, the reduction in an overall population growth required the interaction of various factors and
mainly voluntary family planning measures (Hatcher, Stewart, Guest, Finkelstein and Godwin, 1976). Today, the demographic revolution in the world is perhaps the most crucial concern of many nations and necessitates the need to seek solutions for the rapid population growth rate. In the past centuries, bearing many children was strongly desired by traditional societies of the world while the modern world recognizes it as a major constraint that limits the socio-economic development. Now the problem appears as an acute issue and it particularly affects the poor developing nations. It is, however, believed that the necessity of promoting family planning programme is not questionable.

According to Khasiani and Mugenzi (1989), family planning is believed to contribute to the improvement of poor and populous nations by decreasing the number of births. Consequently, it would be possible to supply enough food, employment opportunities, good schools and health facilities. It should, therefore, be recognized that family planning is not a way of helping individual couples but also a way of helping a nation achieve its national goals. Hence, it can help the society by preventing over-population that can cause starvation and mass poverty in developing nations.
Yimam (1986) highlights the relationship between fertility rate and population growth. He states that Ethiopia and other developing countries should consider the problem of unemployment and the deterioration of living standards due to the increased rate of new-born babies. This has a consequence to an overall population growth in the nation and leads to shortages of food supplies, inadequacy of health care, education, housing and other necessities of life. It is further expressed that these problems have an impact on the socio-economic, educational and political stability of Ethiopian society. In fact, it is time to discuss such critical issues and form an appropriate policy that regulates population growth. In order to take effective measures, family planning services should be extended to every sector of the Ethiopian society. But, on the other hand, it should also be noted that mismanagement of public funds, unfair distribution of resources and other similar factors usually contribute to the deterioration of living standards of the society.

On whatever grounds, Ethiopia and many other countries of the world have been providing family planning services to their people. Gebrehiwot (1986) explains that family planning has been extending its services to benefit any society which needs its
services either on demographic grounds or as a component of health services or both. Furthermore, to equalize or minimize the gap between population growth and available resources, family planning is one of the best solutions.

Though the context of population issue has been debated for quite a long time, it is however accepted that family planning and population are closely related particularly in poor and populous nations. Certainly, the idea of regulating births was and still is a personal matter but it has been influenced by the society especially in such traditionally oriented areas. It is noted that in some societies having many children particularly males is believed to give them special respect and pride in life.

2.3 Rapid Population Growth and its Constraints on Health, Nutrition and Development

In the 20th Anniversary of the Family Guidance Association, Geberhiwot (1986) explains that Ethiopia and most African nations are usually concerned with the wellbeing of their citizens. Thus, to fulfill the need of their societies, it is however obvious to improve the health and nutritional status of the people. However, in backward nations, it is not possible to increase the level of living. Yitbark (1986) observes
that many people in Ethiopia, especially women and children live in poverty. In addition to both natural and man-made calamities, this country has poor socio-economic development and backward agricultural practices.

Lefort (1981) notes the problem of health measures in serving the ever-increasing number of people in Ethiopia. He further expresses that with the already existing social and political problems of this country, the fast growing population also contributes to deforestation and soil erosion which have led to breaking the balance between food production and the size of the population. Nevertheless, the nation's capacity is inadequate to feed its own people unless the birth rate is regulated.

The International Planned Parenthood Federation (IPPF, 1985) states that the need for birth spacing through family planning is necessary to maximize the health of mothers. Furthermore, limiting and spacing births are recognized as essential instruments for regulating population growth which directly or indirectly affects family life. It is noted that the rapid rate of population growth has an influential factor on every economic and social development of a nation. It involves overall integrated activities in aspects of housing, transport, employment, education,
migration, health services and agricultural production.

Centre for Disease Control (1983) expresses the effect of birth order and drought on the health and nutrition of children in poor nations of Africa which have rapid population growth. It further expresses the susceptibility of malnourished children to various malformations which cause stunted growth and mortality. It also explains about a study done in India which demonstrates the relationship between birth order and consumption of balanced diets of children; hence, the study shows a decline of consumption for the third, fourth and subsequent children born to a family. The problem of feeding children with appropriate diet is dependent on the number of siblings in the African families.

A synthesis of two authors, May ('1974) and Balderston (1981) explains the importance of spacing births to minimize child and maternal mortality. In expressing further, the mother cannot breastfeed her child properly when there is short birth interval. Hence, this has a consequence of premature weaning of infants and child malnutrition. Moreover, high fertility and poor nutrition lead to high infant mortality unless it is minimized and improved through parents' acceptance of contraceptives. Aspects of rapid fertility growth can affect the health and
nutritional status of both mother and the child to the extent of death and hindrance to mental and physical development.

2.4 Contraceptive Methods

Woodward (1983) notes two ways of population control which include mortality and reduction in births. Obviously, it is an inhuman act to control the number of people through some means of elimination. But humans have the ability to regulate fertility through natural or technological means so that the balance of nature can be maintained.

Thomas (1985) states the development of contraceptive technology in relation to its quality. He emphasizes the effectiveness of family planning services as somewhat dependent on the quality of contraceptive technology given to users. Furthermore, the technological innovation of contraceptives for controlling fertility contributes a great deal to the world society.

According to the 1981 report of the International Conference on Family Planning in the 1980s, most of the contraceptive methods that are used today were introduced in the 1960s, and about seventeen major categories of fertility control have been observed to exist today. It should, however, be noted that
contraceptive use varies from nation to nation depending on the availability of different types, number of acceptors and the level of awareness of the people. Furthermore, the report shows an estimated number of contraceptive users in the world to be about 270 million people. Some forms of birth control methods are utilized by about one-third in the developing countries and two-thirds in developed regions of the world.

Alemu (1986) and the Family Planning Association of Kenya (1990) classify family planning methods into four major types, such as:

(i) **Natural Family Planning and Traditional Methods:**

These include withdrawal of coitus interruptus, abstinence, douching, prolonged and frequent breast feeding, basal body temperatures (BBT), calendar and ovulation methods. Moreover, all methods vary in their use-effectiveness but more preferences indicated to intensive and prolonged breast feeding due to its overall benefits.
(ii) Medical Methods and Intra-Uterine Contraceptive Device (IUCD):
These are the oral pills, the injectable and the intra-uterine contraceptive devices or implants. These methods have been preferred by many women because of their safety in preventing pregnancy.

(iii) Barrier Methods: Consist of:
. Spermcides which are jellies, creams, foaming tablets and foams.
. Diaphragms and contraceptive sponges.
. Condoms: a method used by men to prevent unintended pregnancy and protection from sexually transmitted diseases.

(iv) Surgical Sterilization or Permanent Method of Family Planning:
There are surgical methods used which should be considered for both men and women. It is, however stated by Alemu (1986) that the tubal ligation method where sections of both fallopian tubes are removed and the ends tied for a permanent sterilization is commonly practised by many women in Ethiopia than other surgical methods.
2.5 Factors Affecting Family Planning:

Daka (1986) notes that F G A E has been offering services since its formation twenty years ago. However, the Association has faced various socio-cultural, political and religious problems to expand its services in all areas of the country. In addition, it is also observed that educational status and level of consciousness of the people has an impact on the acceptance of family planning services. Furthermore, in some cases it is the ignorance of the people which forms a stumbling block for family planning programmes to succeed.

In the Ethiopian society, as well as in many other African nations, a male child is favoured over a female child thus some couples who have only female children continue giving birth until they get male children. In such conditions, family planning acceptance can be at a lower level than is expected. Bevely, Cook and Judith (1977) explain that children may be considered as an asset to the parents during old age and as a matter of fact such a concept especially applies to male children. Traditionally, the status of women is very low while sons are considered important in carrying the family name.
Chaudury (1982) and Daka (1986) state that religious values are deeply embedded in individual's life and have been observed that in the Ethiopian society religion has a great role to play in the country's socio-cultural and traditional practices of family life. Moreover, the people who are not exposed to modern schools follow a biblical dictum which advocates "Multiply and replenish the earth." This statement is taken as a religious duty by many Christians and makes them to become reluctant to accept family planning.

Though the Church and the Mosque do not openly object to family planning, they say that parenthood is taken as a duty and the children are considered as "God's blessings" being provided to the world. In the Koran, it is also stated "Marry and generate". In the Protestant Church, family planning is favoured for the purpose of healthy family life while in the Roman Catholic Church contraceptive use has been condemned. The belief is based on the fact that controlling nature is against God's wish but on the other hand the Church recommends abstinence. Such a condition becomes a controversial issue among scholars. However, the stand of Catholics in Ethiopia seems that they have accepted contraceptives like any other families in the country.

Schwab (1985) highlights the effect of religion in
Thus, the educational status and the level of planning services and it is noted that literacy levels are higher in society do not understand the benefit of family planning, and the survey findings in Kenya by K.

Thus, it can be recognized that higher literacy levels of those people who were strongly religious have high infant mortality factors on fertility. Furthermore, the study indicates that those people who were strongly religious had higher levels of fertility rate than the fertility rate of those people who were not very religious.

According to a 1982 study (Hallet, 1990) on the rhythm method or periodic abstinence, not willing to accept contraceptive but approves only marriage contraceptive while the Roman Catholic Church is reluctant to accept changes, has shaped Ethiopian couples to be influence to a very large extent. The role of religion and tradition was shaped Ethiopian couples to be having a prevalent

Ethiopia which he expresses as having a prevalent
consciousness of clients have an influential factor on the acceptance and continuity of family planning.

Molnos (1978) notes that education normally involves new goals to achieve rather than seeking to have more children. It is observed that for leading a higher level of living, educated people are more likely to reduce desired family size. In fact, scholars say that women who have higher education have a tendency to reduce fertility in such ways as delaying marriage so that the time span to exposure to the possibility of conception can be limited. Furthermore, women's employment and higher level of communication between husbands and wives have also higher possibility for reducing fertility.

2.6 Knowledge, Attitudes and Practices of Family Planning Clients

Ebanks (1985) explains that family planning programmes have the main goal of dealing with complex aspects of human behaviour and regulating fertility. Hence, it becomes necessary to disseminate knowledge of family planning methods so that people could be willing to accept and benefit from the services. Moreover, in order for contraceptive methods to get better acceptance, widespread knowledge of family planning is crucial. Sources and locations of contraceptives and
their actual use should be explained properly to users. Thus, it would also be possible to persuade and change non-users into users of family planning services.

Yimam (1986) states that the system of delivering family planning programmes and the techniques of persuading the people could differ from country to country depending on the prevailing political, socio-cultural and economic factors. In the Ethiopian context, the phrase 'Family Planning' in relation to population control was wrongly labelled in the past decades. Since recent years, family planning has been associated with responsible parenthood, mother and child care and family wellbeing. It involves the principle of matching people's needs with the available resources of the country.

The 1981 Report of International Conference on Family Planning in the 1980s notes that in many developing countries, most family life decisions and fertility are made by men, but it is however observed that in many areas family planning services have been provided to women. Though the male methods of contraception tend to be ineffective, it is necessary to educate men about family planning and its contribution that enhances the family welfare. The report further expresses that many men do not like condoms. Nevertheless, they should be encouraged to
K. Ndeti and C. Ndeti (1977) did a study in Kenya and they also note that family planning educators usually concentrate on women and they do not pay much attention to men. In most cases men are forgotten when disseminating information on family planning services.

Bruce (1990) notes that there are important elements to be recognized so that knowledge and information of family planning could be disseminated to clients. This includes the different types of contraceptives and their advantages and disadvantages, and the ability of making identifications of unsafe choices for the individual client. Necessary details to clients should be provided so that they can be confident enough on how to use the method preferred. It is further expressed that the relationship between clients and service providers has also an effect on the acceptance of family planning services.

Ebanks (1985) notes that mothers who are satisfied with the maternal health and child care services are more likely to accept family planning. It is, however, necessary for the women to have continuous contact with the clinics for the purpose of child care guidance and in the meantime it can also be a means of persuading the women to continue using contraceptives.
Mothers who usually visit the Maternal and Child Health Clinics have the opportunity to benefit from the educational activities about contraceptives. Since 1982, the Tunisian Fertility Study shows that women's level of educational experience is related to the decline of fertility. The study also notes that due to the efforts to improve programmes of family planning, it has been observed that about 99% of women knew of at least one modern method. It was also indicated that knowledge of sources of contraceptive methods is almost lower than knowledge of the methods (Population Reports, Series 1, 1985).

Ginn, Sebgo, Fenn and Bamba (1989) did a survey of women of reproductive age in Burkina Faso. This study shows that use of traditional method is very high in the society. As in any other developing country, the population in this nation has been growing so rapidly and the country has also faced problems of drought and destruction by locusts. It is also noted that family planning services are readily available to both men and women irrespective of marital status. The survey shows contraceptive acceptance varies according to religion, background experiences and educational level of the people. In addition, the result indicates Christian women and women who have urban life experience are more willing to use family planning services than Muslim
women and also women from rural background experiences.

Wawer, Goffikin, Ravano, Maiouka and Traore (1990) note that contraceptive prevalence survey in Niamey, Niger was conducted and shows that more than 75% of all women who are at the level of child-bearing age have some knowledge of at least one type of contraceptive method. Furthermore, it is observed that though general knowledge of contraceptives is high, the level of use by women remains low. This indicates that though women are the best sources of information of actual fertility, a thorough understanding of the social and cultural determinants of fertility requires that studies of men also be undertaken. In addition, low levels of acceptance also reflects a failure to design programmes and provide services in a manner appropriate to the needs of the people.

Summary

From the reviewed literature, it can be highlighted that in many Sub-Saharan African countries, knowledge of contraceptive methods is much higher particularly among women than contraceptive use. It is further noted that though men have the dominant role in the African households, many programmes of family planning do not include men and hence educational programmes have been predominantly directed towards
In regard to contraceptive acceptance, the literature review shows that socio-economic, religious and educational status are also determinants that contribute to fertility growth or fertility reduction. In Ethiopia as well as in some other African countries, much attention has not been given to effective family planning programmes. Thus, there is rapid population growth which is accompanied by poverty and characterized by disease, illiteracy and malnutrition. Therefore, it is noted that there is a critical and urgent need for family planning in most poor and populous nations so that family life could be improved. In this respect, Ethiopia is not an exception.
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents description of research design, study area, study population, selection of study sample, development of research instruments, data collection procedure and data analysis.

3.1 Description of Research Design

In this study, the researcher investigated clients' knowledge, attitudes and practices of family planning (FP) methods and services. The study was of descriptive nature and employed the survey method of data collection. The survey method was chosen because it was the most appropriate in achieving the stated objectives in that one is able to collect data from a large sample. The method of data collection was by means of pretested interview schedules administered by the researcher and a trained research assistant at the FP clinics in the study area. Data from interviews were analyzed and presented in descriptive form and in numerical tables.
3.2 Study Area

The investigation was carried out in the southern zone of Sidamo Province, in the town of Awassa which is the capital city of this province. The town has about five FP clinics and hence this study examined the present conditions of the services offered to the FP clients in regard to their knowledge, attitudes to and practices of modern contraceptives.

Initially, the study was to be undertaken in five clinics but due to various circumstances, the southern zone Military Clinic in Awassa was not offering FP services at the time of the survey. Thus, the study had to be carried out in only four of the FP clinics.

The researcher chose to undertake the study in Awassa due to the following reasons. Ethiopia is an opportune country for a study of fertility regulation because its average annual population growth from 1988-2000 is about 3.3% (World Bank, 1990). As a result, this is enforcing the circumstances to reduce population growth through voluntary means of using FP methods and services. A small-scale society within the natural context, Awassa town is also opportune. In fact, the Southern Ethiopia Co-ordinating Office (1991-1993) expressed that Awassa and other areas of the Southern Region have population growth rate of around 3% per year.
It is noted that the town has approximately 65,162 inhabitants with an expected target population of 13,684, out of which about 600 FP clients were using contraceptive methods from the FP clinics on continued basis (Awassa Health Center Statistical Chart, 1992). According to a 1987 study (Hailu, 1991) on Rural Family of Ethiopia, about 46% of the people in Awassa District were children below ten years of age. Thus, as a result of high fertility, Awassa District is characterized by a young population. Educational programmes on family planning in this area are also inadequate since the majority of the residents are not fully aware of contraceptive methods.

3.3 Study Population

The target population were all FP users in Awassa town. It included both men and women of child-bearing age, who were using modern contraceptives as well as natural/traditional birth control methods. The accessible population were FP clients of the four FP clinics in the town. The accessible population also constituted the sampling frame from which the sample had been drawn.
3.4 Selection of Study Sample

A sample of 135 FP clients of child bearing age of both men and women was derived from the sampling frame of about 605 (see Appendix B) who visited the four FP clinics (i.e. 22.3% from each clinic). Systematic random sampling was used and involved taking every nth unit of the clients from each clinic. In systematic random sampling, the larger population is divided by the desired sample size forming a sampling interval to select every nth unit. Moreover, the sample for this study was drawn by listing the population in an arbitrary order, using a random start. Thus, it was ensured that the family planning service clinics were proportionally represented in the sample.

The population was determined by dividing the intended figure of 135 by the total number of FP clients in the four FP clinics which was 605 and then multiplied by the number in each clinic.

3.5 Interview Schedule

This research instrument was designed on the basis of the objectives of the study. Library reading of literature related to the study was carried out initially to assist in the development of the
instrument. The Etono Fertility Survey by Ferguson (1989), also provided some relevant materials which assisted in the development of interview schedule.

The researcher used an interview schedule in order to get systematic responses to the questions related to knowledge, attitudes and practices from the clients of the FP clinics. This was an appropriate instrument to use since some of the respondents had little or no education which could enable them to answer questions for instance, in a self-administered questionnaire. The interview schedule consisted of structured questions and some unstructured ones. This type of instrument is noted for its flexibility because sensitive issues can be dealt with openly and information can be collected accurately.

Structured questions were used to elicit quantitative information. In this study, the unstructured items mainly yielded qualitative data which were needed to explain some attitudes and feelings of clients towards some of FP methods and services.

The interview schedule consisted of sections on demographic characteristics of the respondents such as age, sex, marital status, educational attainment, religious and occupational status. The section on knowledge elicited information on sources of FP
services/supplies and contraceptive method. The section on practice sought information on current contraceptive use, duration of use and problems encountered in using contraceptive methods. The section on attitude elicited information on reasons for the stated attitude related questions and/or statements.

3.6 Pretesting of the Instrument

Before the actual study, pretesting of the instrument was carried out with a sample of about 10 clients (i.e. 8 women and 2 men) who were not included in the study. After administering the instrument, the necessary adjustments in the order and wording of some questions were done two weeks prior to the actual fieldwork. For instance, "abstention", a practice for preventing pregnancy was not known in the area. To avoid confusion this term was disregarded and was considered to be under 'other.' Pretesting the instrument helps in enhancing the reliability and validity of the instrument in that one is able to refine vague questions, and also check whether the instrument measures the content that it is supposed to measure.
3.7 Data Collection Procedure

The instrument of the study was administered by the researcher in person with the help of one research assistant who was a graduate from a two-year diploma college, having a wide experience and qualification in teaching (Home Economics) and in communicating with people. Several hours of two working days were spent with the research assistant in introducing the survey and the technique of interviewing.

Permission was obtained from the offices of family planning clinics and the nursing sisters or service givers were fully briefed on the purpose of the study to ensure their cooperation. Simple Amharic language was used so that the interviewees could easily understand what was being asked since almost all of them were not English speakers. The researcher interviewed the respondents by translating the interview schedule into Amharic, an official language of Ethiopia. The researcher and her assistant conducted the interview schedule in a friendly atmosphere. They also ensured that all respondents were asked exactly the same set of questions in the same sequence.

Twelve working weeks, November 1992 - February 1993 were allocated for the entire survey. Monday to Friday, both in the mornings and in the afternoons were
interview days during the survey. Actually, the interview was conducted smoothly and with very high response rate except the problem of two field days that coincided with local markets. Thus, on Mondays and Thursdays, very few (i.e. about one to two) or even hardly any FP client used to visit the FP clinics compared to about three to four FP clients (i.e., new and/or continued FP clients) who were visiting the clinics on the other working days of the week. Furthermore, completed interview schedules had been checked for error and omissions immediately after interviewing so that the respondent could be consulted. The interview schedule appears in Appendix C.

3.8 Data Analysis

The data collected were organized, processed and analyzed. Descriptive statistics were mainly used to analyze the data. This involved measures of central tendency such as means, frequencies and percentages.

The findings were then presented in tables of frequency distributions, histograms and percentages. Standard statistical analysis was carried out using an SPSS PC (Statistical Package for Social Science) programme.
3.9 Measurement of Variables

1. Educational Level:
   This was measured by asking respondents how many years of formal schooling they had completed. Their level of schooling was categorized according to the Ethiopian school grade level system as: do not read and write, read and write, and formal schooling such as 1-6 years, 7-8 years, 9-12 years and above 12 years.

2. Number of Children:
   This was measured by asking respondents the number of living children they had at the time of interview.

3. Religion:
   Religious orientation of the respondents was measured by categorizing it into: orthodox, Catholic, Protestant, Islam, traditional or other.

4. Income:
   Income of the respondents was measured by asking them their monthly salary.
5. Continuing Family Planning Clients or Family Planning Users:
This was measured by the duration of time a man or a woman of reproductive age continues visiting the family planning clinics for the second time or more and using contraceptive methods at the time of the survey.

6. Contraceptive Methods Used:
This was measured by the different contraceptive methods used by family planning clients in Awassa. The methods were classified as medical and intrauterine contraceptive device, barrier methods, natural and traditional methods and surgical sterilization or permanent methods.

7. Family Planning Knowledge:
This was measured by counting the number of correct responses a respondent gets to the questions in the interview schedule and was categorized as: high, low or no knowledge.

8. Clients' Attitude:
This was measured by the opinions and feelings of clients about using family planning methods and services. Family planning service respondents
were given a list of statements and they had to respond using the scale: agree, disagree and undecided.

9. Clients' Practices:

This was measured by the length of time the respondents had used contraceptive methods either to avoid pregnancy, or space children.

Parameters for which information was collected included respondents' gender, age, educational status, marital status, occupation, marital status, and religion.

The purpose of the study focused on the demand for information that would influence respondents' decisions to use contraceptive methods. The study was designed to assess the reasons why people desire family planning services and how willing they are to accept contraceptive information. Although there are various sources of information, the study aimed to uncover the high correspondence of the demand for information and the willingness to accept contraceptive information. The study's findings can provide insights into the attitudes and preferences of females and males regarding contraceptive use. It is important to address the issue of modern contraceptive methods and include awareness campaigns to promote their use.
4.0 Introduction

This study deals with the socio-economic profile of family planning (FP) clients and their attitudes toward modern contraceptives and current use of some of the available methods.

Parameters for which information was collected included respondent's gender, age, educational status, marital status, occupational status and religion.

The purpose of this study focused on the current attitudes and actual practices of modern contraceptives by the clients in four FP clinics in Awassa town. There were three main groups of respondents: those who wish to delay the first pregnancy (singles); those seeking to space births (spacers); and those wishing to prevent additional childbearing (limiters).

Although women are the best source of information on actual fertility, a thorough understanding of the social and cultural determinants of fertility also requires that studies of men be undertaken (Oni, and McCarthy, 1991). Hence, in this study important considerations were also given to include men particularly those who were using modern contraceptive methods from the FP clinics.
4.1 Demographic and Socio-Economic Characteristics

4.1.1 Gender of Respondents

The survey consisted of a total of 135 respondents; 126 females and 9 males. The females formed 93.3% while the males formed 6.7% (Table 4.1).

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>Female</td>
<td>126</td>
<td>93.3</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In addition to female FP clients, the study also focused on males, a group that is generally overlooked due to perception that FP is a female issue. The significance of including both sex of the respondents in the study is that FP clinics have been considered a female domain. On the other hand, in such traditional communities like Awassa, the cultural attitudes towards women tend to depress their social status in the society. As a matter of fact, the women bear the impact of frequent pregnancies and other problems.
associated with maternity. However, men generally take FP as women's duty. It was, therefore, necessary to find out the sex distribution of the FP clients in the study area. Nevertheless, there were very few men who were benefiting from the services of FP clinic in Awassa Health Centre. All of them were included in the study while the women were randomly selected.

It is suggested that the role of men in family planning should not be ignored. Hence, FP educational and service programme expansion in order to include men in FP efforts has to be strengthened in such traditionally oriented Awassan communities.

4.1.2 Age of Respondents

In this study, the age of the respondents ranged from 19 to 40 years. The frequencies are presented in Table 4.2.
TABLE 4.2: Distribution of the Sample Population by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-20</td>
<td>19</td>
<td>14.0</td>
</tr>
<tr>
<td>21-25</td>
<td>41</td>
<td>30.4</td>
</tr>
<tr>
<td>26-30</td>
<td>43</td>
<td>31.9</td>
</tr>
<tr>
<td>31-35</td>
<td>26</td>
<td>19.3</td>
</tr>
<tr>
<td>36-40</td>
<td>6</td>
<td>4.4</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Minimum ages were 19 years in females and 26 years in males. The average ages for female and male respondents in this study were 26.6 and 30.8 years respectively. The information in table 4.2 shows that only a small percentage (4.4%) of the respondents were in the oldest age group (36-40 years) while majority (62.3%) of the respondents were between 21 and 30 years. The age of the respondents was considered important as it reflects on the acceptance of contraceptives. The results are also presented in the histogram below.
4.1.3 Age at Marriage

Early marriage was not uncommon and it has been practised to some extent in Awassa area. The minimum age for marriage reported was 9 years for women and 23 years for men. However, the maximum age was 28 years for both men and women. Excluding unmarried ones,
62.2% out of 127 of the respondents got married between the ages of 14 to 18 years while 15.7% got married at an age between 9 to 13 years. Some others who constituted 22.1% of the respondents got married between the ages of 19 to 28 years. Table 4.3 presents the results. In such communities where girls marry and begin childbearing early, they are likely to have more children and therefore would have large family sizes.

### TABLE 4.3: Distribution of Respondents' Age at Marriage

<table>
<thead>
<tr>
<th>Age at Marriage</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-13</td>
<td>20</td>
<td>15.7</td>
</tr>
<tr>
<td>14-18</td>
<td>79</td>
<td>62.2</td>
</tr>
<tr>
<td>19-23</td>
<td>18</td>
<td>14.2</td>
</tr>
<tr>
<td>24-28</td>
<td>10</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>127</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*The total number excludes those who were unmarried (singles).

In various studies of FP, particularly in developing countries like Ethiopia, results show that marriage is universal and it begins at an early age. Furthermore, studies conducted in Ethiopia in 1984...
reported that thirty-two per cent of the population in the age group 15-19 were married (People's Democratic Republic of Ethiopia, Central Statistical Authority, 1990).

In the past, it was a tradition in many parts of the country for girls to be married at a very early age. Furthermore, delayed marriage of females was not considered as socially good. As a result of social and religious beliefs, parents used to marry off their daughters at a young age. The social value of early marriage was being considered as a safeguard of the parents' honour. Today, such tradition is considered as negatively affecting the status of women in contemporary society. It is also negative in terms of large family size and other related phenomena which result into adverse economic implications. In addition to table 4.3 a histogram presentation is also given below.
4.1.4 Current Marital Status

In this study, the terms "living together" and "married" are combined and referred to as currently married."
TABLE 4.4: Distribution of Respondents by Current Marital Status

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>8</td>
<td>5.9</td>
</tr>
<tr>
<td>Currently Married</td>
<td>114</td>
<td>84.4</td>
</tr>
<tr>
<td>Divorced</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>4</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The information presented in table 4.4 reveals that a great number of the respondents (83.7%) were married. Of the sampled population, only a small number (5.9%) of the respondents who were of childbearing age are not married. Those who were divorced and widowed constituted only 10.4% of the total respondents.

Some years ago, FP clinics in Ethiopia required marriage certificate to provide services to the needy individuals. However, this might have contributed to an increased number of illegal abortions performed by untrained practitioners and in unhygienic conditions. Although there was no evidence that could show the number of illegal abortions, it was reported by the Southern Ethiopia, Co-ordinating Office, Three Year
Plan (1991-1993) that illegal abortions and unplanned pregnancies were high in Awassa and in some other towns in the Sidamo Province. Further, in the Ethiopian society, abortion has been considered illegal and it is regulated by Article 528-535 of the Penal Code. The law allows abortion only if it is necessary to save the pregnant woman from losing her life or from damage to her health, that is, only on a medical ground. Besides this, no other ground is permitted.

Such a condition could be harmful when lack of means to prevent conception leads to resort to illegal abortion, where the risks to health and even to life could be extremely high. However, the measure that was taken since recently in allowing individuals to get FP services irrespective of their marital status is very crucial for the unmarried citizens.

The people of Awassa town are predominantly Christians and religion plays a critical role in their lives. Even though all denominations oppose sex outside marriage, and pre-marital contraception as well, there are still individuals who do not adhere to the religious beliefs and to the cultural practices of the society. Consequently, the findings of this study indicate that there were unmarried respondents from both male and female groups who were using contraceptive methods from the FP clinics.
4.1.5 Number of Living Children and Desire for More Children

Table 4.5 shows the number of living children the respondents had at the time of the study.

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>8</td>
<td>5.9</td>
</tr>
<tr>
<td>1-2</td>
<td>66</td>
<td>48.9</td>
</tr>
<tr>
<td>3-4</td>
<td>33</td>
<td>24.4</td>
</tr>
<tr>
<td>5-6</td>
<td>21</td>
<td>15.6</td>
</tr>
<tr>
<td>7 and over</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

More than half (73.3%) of the respondents had 1 to 4 children while small number of them (20.8%) had 5 to 7 or more children at the time of the interview. Even though the 5.9% of the respondents who were singles happened to have no children at the time of the survey, this does not, however, necessarily mean that fertility is always limited to marriage.
<table>
<thead>
<tr>
<th>Age of Respondents who had Children</th>
<th>No of Respondents</th>
<th>Mean No of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-20</td>
<td>17</td>
<td>13.4</td>
</tr>
<tr>
<td>21-25</td>
<td>38</td>
<td>30.9</td>
</tr>
<tr>
<td>26-30</td>
<td>41</td>
<td>32.3</td>
</tr>
<tr>
<td>31-35</td>
<td>25</td>
<td>19.7</td>
</tr>
<tr>
<td>36-40</td>
<td>6</td>
<td>4.7</td>
</tr>
<tr>
<td>Total</td>
<td>127</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*The total number is in exclusive of an unmarried respondents who did not have children.

Table 4.6 presents that out of the currently married, divorced and widowed respondents, more than one fourth (32.3%) of them were between 26-30 years old and had mean number of 3.2 living children. Those whose ages ranged from 16-20 years constituted 13.4% and had mean number of 1.4 living children. The oldest age group whose age ranged between 36-40 years constituted 4.7% and had mean number of 6.8 living children. The study thus shows that only a small percentage of the respondents were in the oldest age
The majority of the respondents were using contraceptive methods and that this group had the highest number of children. Use of contraceptive methods is more common after having about two surviving children. Nearly more than half of the respondents who were using birth control methods, as the data reveal, were those who had more than three children.

Respondents who already had children were asked "Would you like to have more children"? and were expected to respond "Yes" or "No". If they answered "Yes", they were asked questions relating to the number of children they desire to have. Of the 127 respondents who already had children, 76 (59.6%) of them expressed their desire to have more children while 51 (40.2%) of the respondents did not want more children (Table 4.7).

<table>
<thead>
<tr>
<th>TABLE 4.7: Desire for More Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to have more Children</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*This refers to the total number of those respondents who desire more children.
From this finding, it can be concluded that the majority of the respondents were using contraceptive methods to space their next child rather than to limit. Information from the study shows that the highest demand for more children lies between the age of 21-30 years. After the age of 36 years, the desire for more children falls to a very low level. The evidence from the survey indicates that there is a strong will for limiting pregnancies once a woman is in her mid-thirties.

For those respondents who desired to have more children a question was asked as to how many they intended to have. Among the 76 respondents, 65.7% of them wanted between 1 to 4 children while only 1.3% of the respondents mentioned between 5 to 6 children. Others who constituted 21.0% of them expressed the wish for many more children. On the other hand, 11.8% of the respondents said that they desire more children but they did not know the number they would like to have. The results are presented in Table 4.8.
**TABLE 4.8:** Distribution of Respondents by Desired Number of Children

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>#1N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>28</td>
<td>36.8</td>
</tr>
<tr>
<td>3-4</td>
<td>22</td>
<td>28.9</td>
</tr>
<tr>
<td>5-6</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>As many as possible</td>
<td>3</td>
<td>3.9</td>
</tr>
<tr>
<td>As many as God gives</td>
<td>13</td>
<td>17.1</td>
</tr>
<tr>
<td>I don't know</td>
<td>9</td>
<td>11.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>76</td>
<td><em>100.0</em></td>
</tr>
</tbody>
</table>

*1 The total number refers to those respondents who reported the desired number of children.

* The total percentage is rounded up to one decimal point.

Some reasons were given as to why they desired to have more children. About three-fourth of the respondents indicated preference for male or female children and/or just seeking additional children to what they already have. On the other hand, few of them, 17.1% cited side effects from contraceptive pills while only 9.2% reported that the spouse objects or the religion forbids as the case for having more children (Table 4.9).
<table>
<thead>
<tr>
<th>Reasons</th>
<th>*N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side effects</td>
<td>13</td>
<td>17.1</td>
</tr>
<tr>
<td>Spouse objects</td>
<td>3</td>
<td>3.9</td>
</tr>
<tr>
<td>Religion forbids</td>
<td>4</td>
<td>5.3</td>
</tr>
<tr>
<td>Preference of male/female</td>
<td>56</td>
<td>73.7</td>
</tr>
<tr>
<td>children</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>76</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*The total number refers to those respondents who gave their reasons as to why they desire more children.

The sex distribution of offsprings was an important and more often emphasized factor. Thus no respondent with only boys or with only girls was willing to limit childbearing and had expressed desire to continue reproducing even when they already have more than the desired number of children. This implies that family planning users still adhere to the socio-cultural influences of their communities and that children are considered as a labour force and as a security and prestige to their families. Therefore, it is important to realize that successful contraceptive delivery service efforts should be accompanied by FP educational activities in relation to the issues of
family size and family life conditions. This is one fact that FP service by itself is unlikely to have great impact on contraceptive behaviour of the user.

4.1.6 Educational Status

The distribution of the respondents by level of education is shown in Figure 3. Vast majority of the respondents (82.0%) were literate while only 17% reported no formal education at all. Of the literate group some 27.4% in fact had tertiary level education. Respondents who completed seven to twelve years of formal schooling constituted 35.5% while those who went beyond this level were only 19%. All male respondents (6.7%) were literate and had attained higher levels of education especially senior high school and above. Table 4.10 presents the results.
<table>
<thead>
<tr>
<th>Years of Schooling</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Education - None</td>
<td>24</td>
<td>17.8</td>
</tr>
<tr>
<td>Traditional/Adult Literacy</td>
<td>10</td>
<td>7.4</td>
</tr>
<tr>
<td>1-6 Elementary School</td>
<td>27</td>
<td>20.0</td>
</tr>
<tr>
<td>7-8 Junior High School</td>
<td>13</td>
<td>9.6</td>
</tr>
<tr>
<td>9-12 High School</td>
<td>35</td>
<td>25.9</td>
</tr>
<tr>
<td>12 + Certificate/Diploma</td>
<td>24</td>
<td>17.8</td>
</tr>
<tr>
<td>12 + 4 years of College and above</td>
<td>2</td>
<td>1.5</td>
</tr>
</tbody>
</table>

| Total                                      | 135 | 100.0|

In addition to table 4.10, results are also presented in the histogram below.
Based on the assumption that the level of academic attainment affects fertility conditions, the study then presents the mean number of children according to the educational background of the respondents. It was found out that respondents with no formal education had
4.8 mean number of children and those who completed adult literacy and junior high school had 3.1 mean number of children. The other group who completed high school and above had 2.1 mean number of children. However, these results are similar to earlier findings from other studies done in the country. As de Jong (1989) reported from the studies he did in Addis Ababa, Ethiopia, women with lower levels of formal education had on average, higher fertility rate than those women with high levels of educational attainment.

Obviously, education for all is the key to an improved quality of life. For women, it improves their status beyond childbearing. According to Sadik (1990), women with elementary level of education tend to marry almost four years later than those who did not have education. The women's Bureau (1991) also argued that women's education level has been found to be related to family size. Thus, most educated people have usually smaller family sizes than those with no formal education.

Learned women have responsibilities and knowledge that enable them make various choices. Thus, the level of educational attainment has an impact on contraceptive use and on the health of the family and on its chosen size in general.
4.1.7 Occupational Status

Degree of occupational involvement was also crucial in determining the kind of career the respondents were engaged in. The table below shows the results.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed/Housewives</td>
<td>66</td>
<td>48.9</td>
</tr>
<tr>
<td>Professional (teacher etc.)</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>White Collar Job (Clerk, Secretary)</td>
<td>14</td>
<td>10.4</td>
</tr>
<tr>
<td>Skilled labour (driver, mechanic)</td>
<td>4</td>
<td>3.0</td>
</tr>
<tr>
<td>Unskilled labour (bartender, etc.)</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>Business</td>
<td>12</td>
<td>8.9</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>135</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*The total percentage is rounded off to one decimal point.

The occupational status of respondents indicates that 48.9% of the total population were housewives and/or unemployed group, dependent on their husbands' or families' income. This group had a mean number of 3.3 children.
Those respondents who were engaged in administrative and clerical work constituted 10.4% and had monthly salary ranging from 100 to 500 birr and above. Their educational level ranged from junior high school to 12 plus certificate and/or diploma. It was indicated that these respondents had mean number of 2.7 children.

The other respondents who were engaged in teaching in elementary school, high school or college level constituted 11.9% and had monthly salary ranging from 301 to 500 birr and above. This group had a better educational level than the other respondents and had mean number of 1.6 children.

From the sampled population, those who were either skilled or unskilled and engaged in business were 15.1% while others who were employees of textile factory, housekeepers, office messengers and house maids constituted 11.9%.

The study sought to identify the monthly salary of respondents. Of the total sample, 66 (48.9%) of female respondents were not earning income while 21 (15.6%) were earning below 100 birr. Those who were earning between 100 to 400 birr were 32 (23.7%), and others who were earning above 400 birr were 16 (11.8%) of the total respondents.

The results indicate that almost half (48.9%) of
the sampled population were unemployed/housewives. This finding particularly applies to female respondents because all male respondents were earning above 400 birr. It is also important to note that most people in Ethiopia do not hold several jobs thus it is not common to run a small business or do farming besides the job once an individual is working for pay. This means that employed people are totally dependent only on their salary and housewives are also mostly dependent on their husbands' income.

Since the level of educational attainment and occupational involvement are closely related to different patterns of voluntary fertility regulation, it was useful to examine the different ways in which a respondent earned a living. Furthermore, when the teachers and the professionals are considered logically, this group of respondents have broader exposure to many aspects of life outside the community in which they work. As a matter of fact, when considering the backgrounds, interests, career and lifestyle, this group is more likely to be familiar with contraceptive methods.

4.1.8 Religious Orientation

Awassa town consists of about 95.1% Christians (i.e. Orthodox 76.4%, Protestants 14.4%, Catholics
4.3%) and only 3.4% Muslims, 1.0% traditional, 0.3% others and 0.2% not stated (PDRE, Central Statistical Authority, 1990). However, there was no FP client from the Islamic religion who visited the FP clinics at least at the time of this research.

TABLE 4.12: Distribution of Respondents by Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodox</td>
<td>105</td>
<td>77.8</td>
</tr>
<tr>
<td>Catholic</td>
<td>6</td>
<td>4.4</td>
</tr>
<tr>
<td>Protestant</td>
<td>23</td>
<td>17.0</td>
</tr>
<tr>
<td>Traditional</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>*100.0</td>
</tr>
</tbody>
</table>

*The percentage is rounded off to one decimal point

Almost all of the respondents were Christians. The majority (77.8%) of them belonged to the Ethiopian Orthodox church followed by Protestants (17.0%) and Catholics (4.4%) of the sampled population. The traditional religious belief constituted 0.7% and it is not common within the town but it is somewhat practised in the nearby rural areas of Awassa. The results from the survey indicate that Christians are more likely to be using FP methods and services than those of other
religious groups or those with no religious affiliation. It is, therefore, felt that religious beliefs and traditions play an important part in determining the fertility patterns of individuals in Muslim communities. At present, there is no organized religious opposition to the implementation of FP in the Awassa community. Nevertheless, religion has its own contribution to family life in that bringing up children is a sign of a religious and holy life. Thus, religious people are usually reluctant to limit the number of children because in the marriage ceremony the blessings include the call to have as many children as God gives.

4.2 Respondents' Knowledge of Family Planning

To determine the level of contraceptive knowledge possessed by the respondents, it was desirable to establish whether the respondents had heard about or were aware of the different types of FP methods.

4.2.1 Type of Contraceptive Methods Known

Since knowledge of contraceptive methods is a pre-requisite for use, all the respondents were asked to name the method(s) they know that can be used to prevent pregnancy. To some extent probing was done and the interviewer recorded all methods mentioned.
All the respondents (100%) had the knowledge of the oral pills. Other contraceptive methods such as injection (93.3%), IUCD (91.9%) and condom (96.3%) were also popularly known. It is important to note that condoms are familiar to the sampled population as a means of disease prevention and as a means of family planning method. As it is shown below (Figure 4) respondents who were familiar with diaphragm (for females), vasectomy and withdrawal (for men) constituted 51.1%; 43.7% and 40.0% respectively. Insignificant number (0.7%) of the respondents mentioned breast feeding as a birth control method. The period after birth in which a woman is infertile because of the hormonal effects of breast feeding is a fertility determinant which is of a major importance to some women.
Of the ten contraceptive methods given, 15.6% of the respondents mentioned two to four; 36.3% of them knew five to seven and the majority (48.1%) of the respondents mentioned eight to ten types of contraceptive methods.
The above findings imply that all of the survey respondents knew of at least two birth control methods. Knowledge in this sense simply implies the respondents' awareness with regard to child spacing or limiting family size.

4.2.2 Knowledge About the Frequency of Taking Contraceptive Pills

Respondents were also asked about the frequency of taking contraceptive pills. The results show that majority of the respondents (97.8%) were aware of how the pill is used. Table 4.13 shows the results.

<table>
<thead>
<tr>
<th>Frequency of Taking Contraceptive Pills</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every day</td>
<td>132</td>
<td>97.8</td>
</tr>
<tr>
<td>I don't know</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

This finding of very high awareness about the use of contraceptive pills is consistent with other family planning studies (Mugenda, 1991).
4.2.3 Knowledge About IUCD

The respondents were asked to agree or to disagree with the statement of "IUCD can be inserted to a womb by a trained doctor/nurse". On this statement, 75.6% of the respondents agreed, 1.5% disagreed and 23.0% of the respondents reported that they did not know. The table below presents the results.

<table>
<thead>
<tr>
<th>IUCD Should be Inserted by a Trained One</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>102</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>%</td>
<td>75.6</td>
<td>1.4</td>
<td>23.0</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

4.2.4 Knowledge About Condoms

The respondents were asked about the advantages of using condoms. The majority of the respondents knew of at least two advantages. Out of the 135 respondents, 125 (92.6%) mentioned that condoms prevent pregnancy, while 124 (91.9%) reported that condoms also prevent
aids. Some others who indicated that using condoms does not have side effects were 54 (40.0%) and those who said they prevent venereal diseases were 9 (6.7%). Those who reported that they don’t know were 5 (3.7%). However, it should be noted that this explanation pertains to the number of answers a respondent gave and this is why the number of respondents given here are more than the actual sample size (Table 4.15).

TABLE 4.15: Knowledge of Condoms as Reported by Respondents

<table>
<thead>
<tr>
<th>Advantages of Using Condoms</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No side effects</td>
<td>54</td>
<td>40.0</td>
</tr>
<tr>
<td>Prevent pregnancy</td>
<td>125</td>
<td>92.6</td>
</tr>
<tr>
<td>Prevent aids</td>
<td>124</td>
<td>91.9</td>
</tr>
<tr>
<td>Prevent venereal diseases</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
<td>3.7</td>
</tr>
</tbody>
</table>

*Multiple, responses were allowed

In summary then, the knowledge imparted to the respondents indicated that basic knowledge of birth control methods particularly the pill, injection, IUCD and condoms is very high. However, more education on
methods such as, foam/tablet rhythm/natural, diaphragm, breast feeding, withdrawal and vasectomy is required.

4.2.5 Sources of Family Planning Information

In identifying the main source of FP information, about half (50.4%) of the respondents indicated clinics or hospitals. As a matter of fact, health staff, mainly nurses and Family Guidance Association of Ethiopia (FGAE) field workers are the main promoters of FP in the clinics and hospitals. On the other hand, 22.1% of the respondents got FP information from neighbours/friends; 6.7% from newspapers; 5.2% from radio; 4.4% from husband/wife; 3.7% from school and 1.3% from work place/posters. The table below presents the results.
### TABLE 4.16: Distribution of Respondents' According to Source of Family Planning Information

<table>
<thead>
<tr>
<th>Sources of FP Information</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Media</td>
<td>7</td>
<td>5.2</td>
</tr>
<tr>
<td>Print Media</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>Neighbours/friends</td>
<td>38</td>
<td>28.1</td>
</tr>
<tr>
<td>Family: Husband/wife</td>
<td>6</td>
<td>4.4</td>
</tr>
<tr>
<td>Work Place/Posters</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Clinics/hospitals</td>
<td>68</td>
<td>50.4</td>
</tr>
<tr>
<td>School</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The results on the above table are represented in the histogram below.
In the study area, FP programmes are integrated in maternal and child health and basic health care programmes. Thus FP is offered at clinics and health posts that also provide other health services. In
fact, the above findings imply that clinics or hospitals are playing a very important role in information dissemination to individuals about FP. Many of the respondents were first informed about FP at clinics because it is at the clinics where most facilities and personnel are found. In addition, it is also important to note that the information is mostly received when a woman attends an ante natal clinic or takes her baby to the clinic for immunization.

Results from Table 4.16 imply that husband/wife, school and work places supplied information to a minority of adopters. Similarly, the audience for mass media, particularly in developing countries like Ethiopia, are too limited. The mass media could not be fully relied upon in FP information dissemination due to the restriction of motivating and persuading the audience through mass media. However, it should also be noted that though the mass media have some limitations, they are relatively more useful in creating awareness about FP.

Furthermore, various research activities indicated that inter-personal channels are mostly effective in persuading individuals to form favourable attitudes of FP acceptance. As a matter of fact, FP information which is disseminated through face-to-face interaction by FGAE field workers or nurses in the clinics are much
more accepted by the people.

4.2.6 Knowledge of Places for Obtaining Contraceptive Supplies/Services

An attempt was made to investigate respondents' knowledge of other places which provide contraceptive methods and/or offer FP services rather than the clinics they were visiting. Table 4.17 presents the results.

<table>
<thead>
<tr>
<th>Knowledge of Contraceptive Supplies/Services</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>39</td>
<td>28.9</td>
</tr>
<tr>
<td>No</td>
<td>96</td>
<td>71.1</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It can be observed from Table 4.17 that though there are about four FP clinics in Awassa town, very few (28.9%) of the respondents knew the other FP clinics in addition to the particular clinic they go to for FP services. Thus, the majority (71.1%) did not know other FP clinics in the town. At the time of the
research, it was noted that knowledge of FP sources and/or supplies were inadequately reported by the respondents. However, in order for childbearing population to adopt and continue to use FP methods, they need to be fully aware of where they can obtain contraceptive methods and services. This study agreed with other findings (Ross, Rich and Molzan, 1989) in that most people of reproductive age in developing countries have limited knowledge as to where to get services. Furthermore, it is suggested that a programme must give individuals specific details as to where to get services and supplies.

4.3 Contraceptive Practices

In reference to Table 4.17, excluding the unmarried respondents, majority of the sampled population were using contraceptive methods to space births rather than to limit childbearing.

During the survey, it was also found out that except for insignificant number of the respondents who came to the FP clinics for checkup/side effects or for switching FP methods, almost all of the respondents who were interviewed came to the FP clinics for resupply.

4.3.1 Current Use of Contraceptives

In this study, out of the total of 135 FP
clients, 110 (81.3\%) were using pills, 15 (11.1\%) injectables, 9 (6.7\%) condoms and 1 (0.7\%) IUCD. As indicated, the pill was preferred by the majority of acceptors and was also received most often on the first visit. At the time of the research, it was also noted that the IUCD was not a popular method in all four FP clinics. Table 4.18 show the results.

TABLE 4.18: Distribution of Respondents by Type of Contraceptives Used

<table>
<thead>
<tr>
<th>Contraceptive Methods</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>110</td>
<td>81.5</td>
</tr>
<tr>
<td>Injection</td>
<td>15</td>
<td>11.1</td>
</tr>
<tr>
<td>IUCD</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Condom</td>
<td>9</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The researcher tried to obtain more information about the insignificant number of IUCD users from the Awassa branch of FGAE. According to some of the staff of the Awassa FGAE office, IUCD was not favoured by almost all FP clients due to the rumours that it was not effective in preventing pregnancies and that it also caused side effects. The women did not prefer to
use IUCD after the news that some of the IUCD users got pregnant while they were using this particular method. Since then, this type of contraceptive method has not been favoured by almost all FP clients.

Compared to contraceptive pill users, the injectables were not used by majority of the respondents. The main reason given was that FP clinics in Awassa town were not offering the injectables because they were not available until around July 1992.

During the survey, it was observed that switching contraceptive methods became somewhat common since the injectables were introduced to the clinics. At the time of the interview, the majority of the injectable users were using pills before they switched to injectables within less than eight months period. A respondent is considered to have switched method if there is no time lag between the discontinuation of the old method and the adoption of the new one. The injectables are considered convenient to some women because they do not have to be taken everyday like the oral pills. Since the injectables provide an invisible protection, they are especially favoured by some women in a situation where their husbands are seriously opposed to contraceptive methods.

From the discussion with the FP clients, there were positive and negative attitudes expressed towards
contraceptive methods. Men's methods such as condoms and withdrawal were considered to be either ineffective or inconvenient. When vasectomy method (for men) was mentioned, it was considered not appropriate since it has been impractical to apply in such communities. Moreover, traditional beliefs imply that FP is considered as women's issues and hence men are not willing to accept birth control methods particularly the one which is a permanent method. This and other socio-cultural reasons made them unpopular with men which actually contributed to the transfer of contraceptive responsibilities to women. Consequently, (except an insignificant number of males) a very large number of FP clients were females. On the other hand, the contraceptive methods for women were also associated with negative and positive attitudes. However, except for the pill which was associated with negative effects, there were also positive attitudes in regard to ease of management, efficiency and regular supplies, less side effects which promoted favourable attitudes and use of contraceptive methods by clients.

4.3.2 Problems Encountered in Using the Current Contraceptive Methods

More than three-quarters (82.2%) of the respondents did not report any problems related to
their current use of contraceptive methods while less than a quarter (17.8%) of the respondents experienced problems mostly related to side effects due to taking contraceptive pills. Tables 4.19 and 4.20 present the results.

**TABLE 4.19: Distribution of Respondents According to Whether or not There are Problems Due to Taking Contraceptive Methods**

<table>
<thead>
<tr>
<th>Whether or Not Have Problems</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24</td>
<td>17.8</td>
</tr>
<tr>
<td>No</td>
<td>111</td>
<td>82.2</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Of the twenty four (17.5%) respondents who experienced various health problems, majority of the female group reported severe headaches, heavy bleeding and/or spotting between periods, high blood pressure, abdominal pains, gastritis and/or skin discolouration. It was reported that some of these respondents had more than two of these health problems. The other client (0.7%) who mentioned about torn condom was from the male respondents. Hence, when comparing with the other contraceptive methods the pill was associated with
negative effects such as the ones mentioned above. The table below shows the results.

**TABLE 4.20: Health and Other Problems as Reported by the Respondents Due to Taking Contraceptive Methods**

<table>
<thead>
<tr>
<th>Health and Other Problems</th>
<th>*N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>24</td>
<td>100.0</td>
</tr>
<tr>
<td>Heavy bleeding during monthly periods</td>
<td>6</td>
<td>25.0</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>4</td>
<td>16.6</td>
</tr>
<tr>
<td>Gastrities/stomach pain</td>
<td>11</td>
<td>45.8</td>
</tr>
<tr>
<td>Skin discoloration</td>
<td>7</td>
<td>29.2</td>
</tr>
<tr>
<td>Torn condom</td>
<td>1</td>
<td>4.2</td>
</tr>
</tbody>
</table>

*Multiple responses were allowed.

It is, therefore, felt that when providing information on contraceptive methods, it is necessary to bear in mind that service providers should not deliver FP information just by listing the various methods. Instead, they have to explain possible side-effects, modes of use and contra-indications. Such information will enable users to make their own decisions about contraceptives in terms of comfort and safety. Actually, when choices are offered to FP clients they can use the methods more effectively. In
such conditions, it is also possible to minimize the number of discontinued cases. According to informal discussions made with the clinic nurses, it was found that quite a number of FP clients discontinued their visits to the FP clinics. However, due to financial problems and therefore lack of an adequate follow-up, there were no reliable data which could show the number of discontinued cases from the clinics.

Many women of childbearing age are fearful about contraceptive side-effects and the reactions they experience from partners, families or friends to contraceptive use. Thus, it is vital to make programmes for proper counselling at service delivery points so that individuals can get satisfaction from the FP methods and services.

4.3.3 Duration of Contraceptive Methods Use

This study also sought to identify the length of time the respondents had been using the current contraceptive methods (Table 4.21)
TABLE 4.21: Distribution of Respondents by Lengths of Time the FP Methods were used

<table>
<thead>
<tr>
<th>Duration</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 months</td>
<td>39</td>
<td>28.9</td>
</tr>
<tr>
<td>6 months - 11 months</td>
<td>20</td>
<td>14.8</td>
</tr>
<tr>
<td>1 year - 2 years</td>
<td>31</td>
<td>23.0</td>
</tr>
<tr>
<td>More than 2 years</td>
<td>45</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Out of the 135 respondents, 45 (33.3%) of them were using the current contraceptive method for more than two years; others 51 (37.8%) of the respondents had been using it from six months to two years and 39 (28.9%) of them had been using it from three to six months (most of the injectable users belong to this particular period of time).

At the time of the research, the respondents were asked their reasons for attending the FP clinics. A great number (94.1%) of them came for fresh supply, some (5.0%) came for check-up, few (1.5%) of them came for switching contraceptives and an insignificant number (0.7%) of them came for treatment due to side effects.
4.4 Attitudes Toward Family Planning

Regardless of their education or socio-economic status, majority of the respondents who were using contraceptive methods had favourable feelings toward FP. Tables 4.22, 4.23, 4.24, 4.25 show the results.

4.4.1 Husband or Wife's Approval to Family Planning

Excluding those who were singles the respondents in the sample were asked whether they discussed FP with their husbands or wives. It was found that 92.1% of the respondents had discussed it. It was also reported that only few (7.9%) had not discussed with their spouses (Table 4.22).

<table>
<thead>
<tr>
<th>Ever Discussed FP</th>
<th>*N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>105</td>
<td>92.1</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Total 114 100.0

*The total number refers to currently married respondents.

Lack of free discussion on sex between husband and wife can greatly jeopardize FP acceptance. For fear of
being misunderstood, some men and/or women refrain from discussing sex openly with their partners and thus they end up with frequent childbearing or with unwanted pregnancies.

Majority of the respondents believe that the decision about FP should be made jointly by both husband and wife. Among those who discussed 92.4% reported that their spouses had positive responses to FP while 7.6% of the respondents said that their spouses did not approve it (Table 4.23).

TABLE 4.23: Approval of Spouse as Reported by the Respondents

<table>
<thead>
<tr>
<th>Spouse Approved</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>97</td>
<td>92.4</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>7.6</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100.0</td>
</tr>
</tbody>
</table>

One important information derived from these findings is that vast majority of the respondents indicated that the attitude of their respective spouses toward FP methods and services is supportive.

To the question which was asked: "If your spouse does not approve FP what reason does he/she give"? The
response given was just preference for having large family sizes.

4.4.2 Satisfaction in Using contraceptive Methods

Respondents were asked "How satisfied are you with the contraceptive methods"? They gave their responses according to the table below.

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>116</td>
<td>85.9</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Undecided</td>
<td>14</td>
<td>10.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Out of the total sampled population, 85.9% of them expressed their satisfaction to the type of contraceptive methods they were using. On the other hand, very few (3.7%) of them were dissatisfied and others who constituted 10.4% were not sure of what to say about it.
4.4.3 **Satisfaction Toward Obtaining Contraceptive Supplies and Clinic Services**

Out of the total of 135, only 1 (0.7%) respondent reported to have difficulties in obtaining contraceptive supplies from the clinics. A great number of the respondents (96.3%) had expressed their positive responses to the services offered in FP clinics. None of the respondents mentioned their dissatisfaction. However, 3.7% did not express their opinion on this issue (Table 4.25).

TABLE 4.25: **Satisfaction to Contraceptive Supplies and Clinic Services as Reported by the Respondents**

<table>
<thead>
<tr>
<th>Respondents Satisfaction</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>130</td>
<td>96.3</td>
</tr>
<tr>
<td>Undecided</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.4.4 **Family Planning clinic Hours**

An attempt to ascertain the impression on such aspects as suitability of clinic hours and length of waiting time in FP clinics was made and this shows that nearly all the respondents (97.0%) had expressed their agreement toward the suitability of the FP clinic hours.
while very few (3.0%) did not agree with the hours of FP clinics. Their responses were based on the fact that it was impractical for them to visit the FP clinics during working hours. In fact, 1.5% of the respondents preferred the services to be offered on weekends (Saturdays/Sundays), while some others who also constituted 1.5% suggested provision of the services in the evenings.

From personal observation, however, it was reported that there were some complaints about hours of FP clinics. The integrated maternal and child health (MCH) and FP clinics were receiving FP clients only during the early morning hours 8-9 a.m. and the early afternoon hours 1-2 p.m. Visiting time was set for the purpose of meeting both MCH and FP users at the same time. This was planned for convenience of conducting a short lesson about FP for about few minutes before the actual service begins. Those who went to the clinics after 9 a.m. or 2 p.m. were not allowed to get services. In fact, some of the FP clients were seen complaining about it. Therefore, it is believed that this type of information can improve programme effectiveness if it is taken seriously and the programme is modified in regard to this issue.

In this study, an attempt was also made to establish whether the length of waiting time at the
clinic is of concern to clients. It was found out that of the total respondents, 127 (94.1%) felt that it was not a bother to them while 8 (5.9%) believed that waiting time at the clinics was too long.

Though vast majority of the respondents said clinic services and clinic hours fulfilled their expectations, it was observed that there were inadequate spaces and seats for the FP users in the reception areas of the FP clinics. In such conditions, it was not possible to say that services could be delivered in clean and tidy situations.
### Attitudes Toward Various Circumstances of Family Planning

The respondents' attitude toward family planning was measured using three scales such as agree, disagree and undecided (table 4.26).

#### Table 4.26 Distribution of Respondents According to Their Attitudes Towards Family Planning

<table>
<thead>
<tr>
<th>Circumstances</th>
<th>Agree</th>
<th>Disagree</th>
<th>Undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no need for discussion on FP issues between husband and wife</td>
<td>12</td>
<td>123</td>
<td>-</td>
</tr>
<tr>
<td>Bearing as many children as possible means better family life</td>
<td>8</td>
<td>124</td>
<td>3</td>
</tr>
<tr>
<td>FP should be more beneficial to men than to women</td>
<td>2</td>
<td>128</td>
<td>5</td>
</tr>
<tr>
<td>Increasing the number of FP clinics can be useful to the society</td>
<td>119</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>The practice of FP interferes with the work of God</td>
<td>21</td>
<td>105</td>
<td>9</td>
</tr>
<tr>
<td>FP practice is not appropriate for married people</td>
<td>9</td>
<td>126</td>
<td>-</td>
</tr>
<tr>
<td>FP contributes to better health of mothers</td>
<td>120</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>FP is harmful to the health of the users</td>
<td>14</td>
<td>110</td>
<td>11</td>
</tr>
<tr>
<td>FP should be compulsory to both men and women</td>
<td>126</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>FP contributes to better education of children</td>
<td>124</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>FP services should be for women only</td>
<td>13</td>
<td>119</td>
<td>3</td>
</tr>
<tr>
<td>FP is a western concept and does not apply to our culture</td>
<td>8</td>
<td>125</td>
<td>2</td>
</tr>
<tr>
<td>FP encourages prostitution</td>
<td>5</td>
<td>118</td>
<td>12</td>
</tr>
<tr>
<td>It is good to share your knowledge on FP with others</td>
<td>125</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Parents should not discuss FP matters with their children</td>
<td>70</td>
<td>58</td>
<td>7</td>
</tr>
</tbody>
</table>
Discussion on FP matters between husband and wife is instrumental in the decision to control fertility. The findings of this study support the idea of discussing FP issues between husband and wife. As shown in Table 4.26 majority (91.1%) of the respondents believed that FP should be discussed among the couples while minority (8.9%) of the respondents were against the idea of discussing it. However, it should be noted that male attitudes affect women's decisions on contraception. Thus FP is obviously the responsibility of both husband and wife.

Controlling fertility clearly enhances a woman's opportunities for education, employment and other activities other than her role as mother. The activities outside the home may provide additional income that may be used to improve the quality of family life. A statement based on this idea was given to the respondents and surprisingly, almost all of them (91.9%) expressed their belief that a smaller number of children could lead to a better family life. Only very few (5.9%) of the respondents reported their disagreement on the idea of bearing many children while others (2.2%) neither agreed nor disagreed with opinions about FP methods.

The response to the statement, "FP contributes to better health of mothers" was that 88.9% agreed, 6.7%
disagreed and 4.4% were undecided. On the other hand, similar responses were also given to the following statement: "FP contributes to better education of children." Among the 135 sampled population, 124 (92.9%) of them supported the idea in that parents should have fewer children so that each child could have better education and care. However, to some people, having many children seems to be the best hope. In support to this idea, there were 11 (8.1%) respondents who had not yet been convinced about the contribution that FP could make to better education of children.

Considering the importance of FP methods to both men and women, statements were given at the time of the interviews such as: "FP should be more beneficial to men than to women" and "FP services should be for women only". Results on the former statement were that 1.5% agreed, 94.8% disagreed and 3.7% were undecided. The latter statement also showed similar responses in that, of the 135 respondents, 13 (9.6%) expressed their agreement on the given statements, 119 (88.1%) did not support the idea and 3 (2.2%) did not want to agree or disagree on the issue. Actually, majority (93.3%) of the respondents expressed their beliefs in that FP should be compulsory to both men and women; while few (6.7%) of the respondents were on the negative side of
Majority (92.6%) of the respondents were willing to share their knowledge on FP issues with others while only very few (5.2%) of them were not willing and still others (2.2%) of them were undecided. As a result, it was felt that influencing others to use birth control methods is indicative of a behavioural commitment to FP. In relation to sharing FP knowledge with others, Bogue (1970) argued that willingness to influence can be considered as an expression of positive birth control sentiments. Though the findings of the study show that a great number of the respondents expressed their interest to share their FP knowledge with others, it was also reported that there was poor communication between youth and parents about sex related matters. FP is the parents’ responsibility and yet, nearly more than half (51.9%) of the respondents said parents should not discuss FP matters with their children. On the other hand, there were also others (43.0%) who disagreed with the given statement. Instead, they expressed their willingness to discuss with their children while insignificant number (5.2%) of the respondents did not say whether it is appropriate or not to discuss with their children.
As in some other African societies, sex related subjects in the Ethiopian context have been considered as private and personal and therefore not for open discussions. Moreover, the traditional norm of the society has been based on the fact that discussing about birth control methods is considered as a way of promoting immorality to the youth. In a situation where there is poor communication between parents and children about sexuality of young children, particularly girls, the latter are usually forced to consult married friends about FP instead of asking their family members. Thus, friends seem to be the closest advisors on reproductive issues. However, in such circumstances, there can be so much misunderstanding because there may not be adequate knowledge of all the issues involved. As a matter of fact, changing the traditional attitudes of the parents in regard to their communication with their children about sexuality and contraceptive methods must be given special emphasis in programmes of FP educational sector.
4.5 Existing Constraints in Providing Family Planning Services

Based on the informal discussion with some of the clinic nurses, FGAE field workers and researcher's observation, the following problems were reported during the survey.

- The FP clinics lacked adequate funds for follow-up programmes. Thus, it was not possible to know the number of discontinued cases.

- Some of the clinic (i.e. MCH and Health Center) nurses complained of lack of adequate space and lack of necessary facilities. There was no adequate privacy for the FP clients to ask questions and to discuss with the clinical nurses.

- The FP clinics lacked well-maintained toilets, running water and general comforts.

- The FGAE field workers expressed their complaints in that although they have been working as FP educators, they have not attended any programmes that concern inservice training. Obviously, inservice is a very necessary activity in any profession and FP educators are no exception.
Despite some problems mentioned above, it was, however, reported that there was a high demand for FP methods and services in the FP clinics. It is, therefore, important to consider education for high quality service delivery systems in the clinics.

The purpose of this study was to examine attitudes of Family Planning (FP) service and services in relation to attitudes and practices of FP clients reported that there was a high demand for FP clinics. The study was set up on the premise that previous FP related services in Ethiopia were well concentrated around the capital city of the country. Addis Ababa. However, the high values in Addis Ababa which is not similar to eastern population, have been measured. The study widened because the values are required for the future understanding of FP principles in relation to FP family needs.

The main hypotheses were that certain factors such as social, economic and cultural factors that influence fertility and practices of FP are to be examined. In addition, factors such as culture, include sex, number of children and exposure to.
CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The purpose of this study was to examine knowledge of Family Planning (FP) methods and services in relation to attitudes and practices of FP clients in Awassa town. The study was set off on the premise that previous FP related studies in Ethiopia were mostly concentrated around the capital city of the country, Addis Ababa. Communities like those in Awassa town, which is noted for its dense population, have been somewhat neglected. Therefore, the study widened the research area and put more emphasis on the clients' understanding of FP principles in relation to their family needs.

The main assumptions were that certain characteristics such as socio-economic and cultural factors affect knowledge, attitudes and practices (KAP) of FP clients. In addition, such factors include sex, age, religion, number of children and exposure to source of FP information.
5.1 Summary of Preceding Chapters

Chapter one of this study, which is mainly an introductory chapter, stated the issue of population growth and the concern it created globally, in the African nations, as well as in the Ethiopian context. The researcher briefly discussed the value of large family sizes in traditional perspectives. The impact of large family sizes on the general well-being of the family, particularly in the societies of developing nations such as Ethiopia were explained. The chapter also briefly outlined the problem of rapid population growth and the condition of FP educational activities in the study area. Further, explanations were also given on significance, objectives, assumptions, limitations and important terms used in the study.

Chapter two of the study contained the literature review under different sub-headings. An attempt was also made to classify FP methods into four major types such as: natural FP and traditional methods; medical methods and intra-uterine contraceptive device; barrier methods; and surgical sterilization or permanent method of FP. The chapter identified certain factors such as economic, culture, religion and social factors influencing the use of contraceptive methods. Various studies conducted by different scholars in relation to KAP gave valuable grounds to the study. It was briefly
stated that FP educators mostly concentrate on women and thus men are forgotten when disseminating information on FP methods and services.

The methodology for collecting data was described in Chapter Three. From a population of about 605 FP clients a sample size of 135, which is about 22% from each of the four FP clinics in Awassa town, was used for the study. In section 3.1 description of research design was given briefly and in section 3.2 a detailed discussion of the study area was presented. The study area was chosen because, as in many areas of the country, Awassa town is also noted for its high fertility. It was reported that its fertility growth is 3.0% per year. However, Awassa district is noted for its young population of about 45.5%, children below ten years of age. Sections 3.3 and 3.4 focused on study population and discussed how the study sample was selected. It presented the sample size drawn and the sampling method. An interview schedule was used for collecting data for the study. In the interview schedule designed, necessary adjustments were made after pretesting the instrument. Section 3.7 discussed the procedures taken in order to administer the instrument. Then section 3.8 explained the method of data analysis. The data were presented using frequencies and percentages. Section 3.9 gave brief
explanation on measuring the variables used for the study.

5.2 Summary of Findings

This section looked at the research objectives formulated for this study in respect of findings presented in Chapter Four. The findings of the study focused on the demographic and socio-economic characteristics, knowledge of contraceptive methods, practices and attitudes of respondents towards FP.

5.2.1 Socio-economic Profile of the Respondents

Objectives one and two were to establish the socio-economic profile of users of family planning services and to identify the social, cultural and religious factors that influence the use of family planning methods in Awassa. A great majority (93.3%) of the respondents who were using FP methods and services were females while men constituted only 6.7% of the total respondents. Culturally, FP related subjects are considered as women's issues thus, in the study area, FP clinics were dominated by women. Men who are the decision-makers in the Ethiopian households were not considered seriously as responsible individuals regarding birth control uses. Moreover, the findings show that men respondents were older than
women respondents in that their average age reported was 30.8 years in men and 26.2 years in women. Considering both males and females who were involved in the study only 4.4% of the total respondents were between 36-40 years of age. In addition to the current age of the respondents, age at marriage and current marital status were also analyzed. There was an insignificant number (5.9%) who were singles (unmarried). Those who reported married, divorced or widowed (94.1%) however, married between 9 to 18 years of age. As a result, early marriage was reported very high in the study area. Thus, the social pressures to marry girls off while they are very young has been applied in practice in the communities. An attempt was also made to investigate the mean number of children according to the age group of the respondents. It showed that the higher the age of the respondent the more the number of living children he/she had at the time of the survey. Further, those who were 16 - 20 years old had an average number of 1.4 children while those who were 36 - 40 years old had average number of 6.8 children. The age group between 21 and 35 years had the average number of 3.2 children. The fact that the number of living children reported at the time of the survey was not high, can be explained by the following factors.
First, the number presented here refers to living children only. The number of child deaths (child mortality) was not recorded. Second, 43.3% of the respondents were between 16 to 25 years old. This shows that there are many years remaining for producing more children. Third, 76% of the respondents who had children reported that they desired to have more children in the near future. In fact, except 36.8% who desired one to two children, the rest, who constituted 63.0% of the respondents, desired more than 3 children, as many as God gives and/or as many as possible. Though there is no open opposition from the Ethiopian churches to fertility regulation, religious orientation plays important role on the beliefs and the cultural practices of the society. It was also recorded that, of all respondents interviewed, no member of the Muslim community used FP methods from the clinics. As it was indicated in Chapter Four, Muslim constituted 3.4% of the total population in the town. As in other African countries, the traditional beliefs of putting value on high fertility is still prevalent in the study area. Nevertheless, the findings of the study revealed that those who desired more children favoured both male and female children. Those who had male children desired to have female children and vice-versa.

Almost half (48.9%) of the respondents were
unemployed/housewives while 15.6% were earning below 100 birr (U.S$1 = 5.00 Ethiopian Birr). Considering this group of respondents they add up to more than half (64.5%) of the total sampled population. All male respondents were employed and earning above 400 birr. Further, it should also be noted that although almost half of the respondents were unemployed/housewives, the vast majority (82.0%) of them were literate. Only 17% of the women respondents were illiterate. Surprisingly, the majority of the respondents completed from 9 years to 12 years of schooling. When considering the educational attainment and the occupational status of the respondents, it was found that the majority of those who had high school education had no jobs. As a result, such idleness greatly contributed to frequent childbearing.

5.2.2 Knowledge of Family Planning Methods and Services

The third objective was to assess the clients' level of knowledge about family planning methods and supplies in Awassa. The respondents' rate of FP knowledge were generally very high. Of the total ten FP methods probed during the interview 48.1% of the respondents knew eight to ten types of FP methods. The
rate of knowledge of specific method was greatest for the pill, followed by condom, injection and IUCD. Moreover, these four methods were recognized by the largest number of the respondents. In addition, majority of them knew the correct answers to the questions given such as frequency of taking contraceptive pills, IUCD insertion and advantages of condoms. On the other hand, few respondents had never heard of any of the male methods such as withdrawal and vasectomy. Also they had not heard female methods such as rhythm/natural and diaphragm.

In most cases, it was observed that illiterate respondents were just as likely to recognize contraceptive methods as those who were literate. However, with such high rate of FP methods' awareness, it was concluded that the more methods the respondents' knew the better they were able to choose appropriate methods.

The above picture changed to a great extent when knowledge of contraceptive supplies was sought. Table 4.17 revealed that the majority (71.1%) of the respondents did not know the other three FP clinics in the town other than the clinics they were visiting. Further, knowledge of FP supplies was reported very low in the study area.

In relation to knowledge of the main source of FP
information, an attempt was made to identify from which of the given sources of information had contributed the most. As it was indicated in section 4.2.5 about half (50.4%) of the respondents mentioned clinics/hospitals followed by neighbours/friends 28.1%. Majority of the respondents had got FP information when they attended clinics for ante natal and for their babies immunization purposes. However, from the findings, it is clear that face-to-face interaction in the clinics were the best means for persuading respondents to accept FP methods and services in the study area.

5.2.3 Use of Contraceptives

The fourth objective was to determine the most commonly used contraceptive method(s) in Awassa. This objective explains the actual use of contraceptive methods from the results given in section 6.0. Concerning the current use of contraceptive methods during the survey, 81.3% of the respondents were using oral pills. Thus, it was identified that the pill was the most favoured method while only 0.7% of the respondents preferred IUCD. Due to rumours, IUCD was not favoured by a vast majority of the respondents in all four of the FP clinics in the study area. It was also found that injection, which was introduced to the FP clinics around July 1992 quickly gained popularity.
In fact, it was observed that users were switching from pills to injectables during the survey.

Although oral pills were the most commonly used contraceptive methods in the town, it was also reported that 17.5% of the respondents had complaints in using this method due to side effects. In fact, some of them experienced more than two kinds of health problems. On the other hand, except 0.7% who mentioned the problem of torn condom the rest who constituted 6.7% of male respondents did not report negative effects of using condom. In general, both male and female contraceptive methods were associated with both negative and positive effects. However, except IUCD and in exclusive of some pill users complaints’, there were positive attitudes of FP methods, with regard to their effectiveness, regular supplies and less side effects. Moreover, the respondents were regular users of FP and it was reported that more than half (56.3%) of them had been using the method from one year to two years. Actually, respondents’ purpose of using contraceptive was both for limiting and spacing births.

5.2.4 Attitudes' Toward Family Planning

The fifth objective was to identify client's attitude towards family planning services. Considerable attention has been given in this study to
the opinions of the respondents on adoption of FP and related topics such as husband or wife's approval to FP, satisfaction toward obtaining contraceptive supplies/toward clinic services and FP clinic hours and other related questions. Contraceptive and fertility behaviour can be affected by attitudes of both husband and wife. Several investigators have confirmed the importance of communication in FP behavior. However, the findings in section 4.4.1 revealed that vast majority 92.1% of the respondents had discussed FP issues with their spouses. Those who discussed, 92.4% reported that their spouses had approved FP methods. Hence the attitude of spouses regarding the practice of the methods was supportive. It was also found out that 96.3% of the respondents had favourable attitudes towards obtaining contraceptive supplies from the clinics. In addition, the majority of the respondents (94.1%) had expressed their satisfaction with the clinic hours. On the other hand, 5.9% of the respondents believed that waiting time in the clinics was too long. However, although the respondents had favourable attitude toward the overall FP clinic services, there were no adequate spaces and other necessary facilities that could promote good quality services.

The findings reported in section 4.4.5 show that in
almost all FP related issues given during the survey, vast majority of the respondents had positive attitudes regardless of their socio-economic factors. Nevertheless, the idea of discussing FP issues between parents and youth was only supported by 43.0% of the respondents. Thus, nearly more than half (51.9%) of the respondents were against the idea. This however, shows that there was poor communication between youth and parents on matters of FP. In order to develop a favourable atmosphere regarding communication between youth and parents about FP, it is important to impress on parents the necessity of playing the role of sex education to their children.

5.2.5 Constraints in Providing Family Planning Services

The sixth objective was to investigate the existing constraints in providing family planning services. As to the quality of services available, the large majority of the respondents were satisfied with the services provided. But on the other hand some complaints about the lack of adequate space, necessary facilities, lack of inservice training were reported. In short, services were not delivered in clean and tidy conditions. Moreover, these complaints point to the need of fulfilling facilities and expanding programmes so that the more caring and personalized service could
5.3 Conclusions

In this section, the conclusions and recommendations drawn from the findings of the study are given.

The aim of this study has been to contribute to the understanding of the processes of KAP of FP methods and services of the FP clients in Awassa town. Given the apparent complexity of the problem, data collection and analysis were carried out using the socio-economic profile of the respondents. The investigation focused on the socio-cultural practices and the contribution it makes to patterns of fertility.

The age at marriage was reported as early as nine years for women. Various scholars have discussed that girls who got married at a very young age usually experience long child-bearing periods and hence contribute to the problem of population growth. In such communities where women marry and bear children early, the women's exercise of their right to an education or to limit childbearing may not be possible as the social, economic and cultural pressures that steer them into an early marriage have an
effect in the first place. Although the average number of children the respondents had at the time of the survey did not seem to be very high, it was however confirmed that majority of them expressed their desired for more children. Thus when considering the age of the respondents and their desired number of additional children, it can be concluded that they will have high number of children in the near future. As a matter of fact, a great number of them were using FP methods for spacing births rather than for limiting childbearing. Further, family size and reproduction in general is still not considered an area of serious importance.

It was found that socio-economic factors have an effect on fertility patterns. Moreover, the findings of the study revealed that the lower the educational status of the respondents the higher the number of living children they had. Thus better educated individuals were more likely to use FP methods and had smaller number of children than the less educated.

Even though the rate of the respondents'
knowledge of FP methods was very high, their knowledge of other places where to obtain FP supplies/services was reported very low.

The rate of communication between parents and youths regarding sexuality and FP methods was found to be very low.

Less attention however, was given to the quality of the services that were offered in the FP clinics.

In short, from the above points it can be concluded that there was inadequacy of systematic educational programmes in FP that could assist individuals internalise the knowledge gained and use it as a tool for change.

5.4 Recommendations

In view of the findings, the following recommendations were made:

Focus should be made on strengthening the integration of FP services in the clinics, factories, colleges, different training institutions and other sectors.

There is a critical need for inservice training of the nurses and FGAE field workers in the field of population and family planning.
• Improve the quality of services since quality of care is increasingly being recognized as an important determinant of contraceptive method acceptance and continuation.

• Communication between parents and youth regarding FP should be strengthened through education. In addition, the move to include men in FP efforts had to be strengthened.

• Consideration should be given to motivate people to their fertility, in that FP educational activities should also focus on the limiting of family sizes.

• Raising the legal age at marriage is a very important step. Moreover, it is recommended that the government should introduce social measures which would have the effect of raising the age at marriage. This particularly implies to young females, by increasing the opportunities to further their education and to obtain employment. Thus, legislation against child marriage should be enforced.
5.3 Suggestions for Further Research

Based on the findings and recommendations, the following are some of the suggestions for further research:

. This study was limited only to four FP clinics in Awassa town thus similar studies are needed for other towns in Ethiopia.

. Research is needed on the mechanisms through which socio-economic factors such as education and income influence fertility behavior.
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Appendix A: Map of Ethiopia: Showing Study Area, Awassa
Appendix B: The Sampling Frame and Selected Sample

<table>
<thead>
<tr>
<th>Family Planning Clinics in Awassa</th>
<th>Total No. of Clients</th>
<th>Sample of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Awassa Health Centre</td>
<td>254</td>
<td>57</td>
</tr>
<tr>
<td>2. Awassa MCH Clinic</td>
<td>264</td>
<td>59</td>
</tr>
<tr>
<td>3. Sidamo Agriculture Enterprise</td>
<td>68</td>
<td>15</td>
</tr>
<tr>
<td>4. Awassa Police Clinic</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>605</td>
<td>135</td>
</tr>
</tbody>
</table>

* (Source: From the list of Awassa Family Planning Office, showing clients of 1990 - 1991).
Appendix C: Interview Schedule

1. Clinic ___________ Date _______ Case No. ______
   Location: Kebele _______ Higher ______
   Put a tick "✓" to indicate the response in each of the following:

2. Respondents' Gender (sex)
   _______ 1) Male
   _______ 2) Female

3. What is your age? ________ years

4. Can you read?
   _______ 1) Yes
   _______ 2) A little
   _______ 3) No

5. Can you write?
   _______ 1) Yes
   _______ 2) A little
   _______ 3) No

6. What is the highest level of education that you have attained?
   _______ 1) In traditional or adult literacy programme system
   _______ 2) 1 - 6 (Elementary school)
   _______ 3) 7 - 8 (Junior high school)
   _______ 4) 9 -12 (High school)
   _______ 5) 12 + Certificate/diploma
   _______ 6) 12 + 4 years of college and above
7. What is your marital status?
   ________ 1) Single
   ________ 2) Married
   ________ 3) Separated
   ________ 4) Divorced
   ________ 5) Widowed

8. If 'married' indicate age at marriage _____ years

9. How many living children do you have?
   Male ________
   Female ________
   Total ________

10.a) Would you like to have more children?
     ________ 1) Yes
     ________ 2) No

10.b) If 'Yes' how many? ________
     ________ 1) As many as possible
     ________ 2) As many as 'God' gives
     ________ 3) I don't know
     ________ 4) Not applicable

10.c) If 'Yes' why do you want to have more children?
     ________ 1) Fear of side effects due to contraceptives
     ________ 2) Spouse objects to contraceptive methods
     ________ 3) Religion forbids limitation of children
     ________ 4) Other (specify)
11. Which religion do you belong to?
   __________ 1) Orthodox
   __________ 2) Catholic
   __________ 3) Protestant
   __________ 4) Islam
   __________ 5) 7th Day Adventist
   __________ 6) Traditional
   __________ 7) Other (specify)

12. What is your occupation?
   __________ 1) Unemployed/housewife
   __________ 2) Farmer/peasant
   __________ 3) Professional (teacher etc.)
   __________ 4) White collar (clerk, secretary)
   __________ 5) Skilled labour (driver, mechanic)
   __________ 6) Unskilled labour (Bartender etc.)
   __________ 7) Business (shopkeeper etc.)
   __________ 8) Other (specify)

13. What is your monthly salary? (If private business estimate monthly income) 5.00 Ethiopian Birr is equal to US $ 1.00
   __________ 1) Less than 100 birr
   __________ 2) 100 - 200 birr
   __________ 3) 201 - 300 birr
   __________ 4) 301 - 400 birr
   __________ 5) 401 - 500 birr
   __________ 6) Above 500 birr
14.a) Indicate the method(s) you know that can be used to prevent pregnancy (Tick all those mentioned, probe but do not name the methods)

1) Pill
2) Injection
3) IUD
4) Foam/tab
5) Rhythm/Natural
6) Condom
7) Withdrawal
8) Tubal ligation
9) Vasectomy
10) Diaphragm
11) Other (specify)

14.b) Total number of methods mentioned

15. Which method(s) are you using currently? Refer to No. 14.a)

16. For how long have you used the method?

1) Less than 6 months
2) 6 months to 11 months
3) 1 year to 2 years
4) More than 2 years

17.a) Do you have any problem in using the current birth control method(s)?

1) Yes
2) No
17. b) If 'Yes' specify/explain

18. How satisfied are you with the contraceptive method(s)?

_______ 1) Satisfied
_______ 2) Dissatisfied
_______ 3) Undecided

19. a) Do you know of any specific source of contraceptive supplies or services? (Other than the particular clinic)?

_______ 1) Yes
_______ 2) No

19. b) If 'Yes' which of the sources do you know?

20. Can you tell me how often a woman should take the contraceptive pill in order to avoid pregnancy?

_______ 1) Every day
_______ 2) Once a week
_______ 3) Once a month
_______ 4) I don't know

21. An IUCD can be put in the womb only by a trained doctor/nurse

_______ 1) Agree
_______ 2) Disagree
_______ 3) Don't know
22. What are the advantages of using condom? (do not prompt)

_____ 1) Prevent pregnancy
_____ 2) No side effects
_____ 3) Prevent aids
_____ 4) I don't know
_____ 5) Other (specify)

23. How did you come to know/learn about family planning? (put a tick "✓" on one of the most source of family planning information)

_____ 1) Electronic media (Radio, T.V. etc)
_____ 2) Print media (Newspapers etc)
_____ 3) Neighbour/Friends
_____ 4) Family: husband/wife
_____ 5) Work place/posters etc.
_____ 6) Clinics/hospitals
_____ 7) Other (specify)

24.a) Have you ever discussed family planning with your husband/wife?

_____ 1) Yes
_____ 0) No

24.b) If the response is 'Yes' does he/she approve family planning?

_____ 1) Yes
_____ 0) No
25. If your spouse does not approve family planning what reason does he/she give? 

26. Are you satisfied with the services you have obtained in this clinic?

1) Satisfied
2) Dissatisfied
3) Undecided

27.a) Do you ever have difficulties in getting contraceptive supplies/services?

1) Yes
2) No

27.b) If 'Yes' explain

28.a) Are clinic hours suitable to you?

1) Yes
2) No

28.b) If the response is 'No' what hours do you prefer?

29. Does the length of waiting time in the clinic always bother you?

1) Yes
2) No

30. Why did you come to the clinic today?

1) For check up
2) Resupply
3) Side effects
4) Other (specify)
31. Attitudes Towards Family Planning

(put "✓" against the response given)

<table>
<thead>
<tr>
<th>Agree</th>
<th>Un-decided</th>
<th>Dis-agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) There is no need for discussion on family planning issues between husband and wife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Bearing as many children as possible means better family life</td>
<td></td>
<td></td>
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<tr>
<td>c) Family planning should be more beneficial to men than to women</td>
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<td></td>
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<tr>
<td>d) Increasing the number of family planning clinics can be useful to the society</td>
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<td></td>
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<tr>
<td>e) The practice of family planning interferes with the &quot;work&quot; of God</td>
<td></td>
<td></td>
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<tr>
<td>f) Family planning practice is not appropriate for married people</td>
<td></td>
<td></td>
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<tr>
<td>g) Family planning contributes to better health of mothers</td>
<td></td>
<td></td>
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<tr>
<td>h) Family planning is harmful to the health of the users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Family planning should be compulsory to both men and women</td>
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<td></td>
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<tr>
<td>j) Family planning contributes to better education of children</td>
<td></td>
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<tr>
<td>k) Family planning services should be for women only</td>
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<tr>
<td>l) Family planning is a Western concept and does not apply to our culture</td>
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<tr>
<td>m) Family planning encourages prostitution</td>
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<tr>
<td>n) It is good to share your knowledge on family planning with others</td>
<td></td>
<td></td>
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<tr>
<td>o) Parents should not discuss family planning matters with their children</td>
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3/ ቢለፈም ወንወጥ
4/ ወንወጥ ወንወጥ

11. የሆኔ እንወጥ ያስቀር በተለቀም የሚገኝ ያልሆን፣ ምን እንወጥ?

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7/ ከሆኔ እንወጥ

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(አወንятся ይህ ይህ ወንወጥ ያስቀር ያልሆን፣ ምን እንወጥ፣)

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18. የካለት የምስጆ ከማት ሁኔታ ያሳካ የሚያስነድ ያሆኔ?  
   1/ ያትርት
t   2/ ከወን ሰነ ይህ ያለኝ
   3/ ጥን በዓይነት ያቀረበው

19. ያ/ ከርጭር ከስማማት ከአጠል ሁኔታ የካለት የምስጆ ያስካፋጆ ከአጠል ሁኔታ ከአጠል ያሆኔ?  
   1/ ያትርት
t   2/ ከወን ሰነ ይህ ያለኝ
   3/ ጥን በዓይነት ያቀረበው

20. የጆጆ ከተርጭር ከስማማት የካለት የምስጆ ከአጠል ሁኔታ ያስካፋጆ ከአጠል ያሆኔ?  
   1/ ያትርት
t   2/ ከወን ሰነ ይህ ያለኝ
   3/ ጥን በዓይነት ያቀረበው
   4/ ከወን ሰነ ይህ ያለኝ

21. ከምወን የሚን ያስማማት የካለት የምስጆ ከአጠል ሁኔታ ከአጠል ያሆኔ?  
   1/ ከወን ሰነ ይህ ያለኝ
   2/ ከወን ሰነ ይህ ያለኝ
   3/ ጥን በዓይነት ያቀረበው
   4/ ከወን ሰነ ይህ ያለኝ
   5/ ከወን ሰነ ይህ ያለኝ

22. የምወን የሚን ያስማማት የካለት ያስካፋጆ ከአጠል ሁኔታ ከአጠል ያሆኔ?  
   1/ ሰበር እስ ያምስጆ ከአጠል ሁኔታ ከአጠል ያሆኔ
t   2/ ሰበር እስ ያምስጆ ከአጠል ሁኔታ ከአጠል ያሆኔ
   3/ ከወን ሰነ ይህ ያለኝ
   4/ ከወን ሰነ ይህ ያለኝ
   5/ ከወን ሰነ ይህ ያለኝ

23. ከአስክስ ያሆን ከአጠል ሁኔታ ያስካፋጆ ከአጠል ሁኔታ ከአጠል ያሆኔ?  
   1/ ሰበር እስ ያምስጆ ከአጠል ሁኔታ ከአጠል ያሆኔ
t   2/ ሰበር እስ ያምስጆ ከአጠል ሁኔታ ከአጠል ያሆኔ
   3/ ከወን ሰነ ይህ ያለኝ
   4/ ከወን ሰነ ይህ ያለኝ
   5/ ከወን ሰነ ይህ ያለኝ
   6/ ከወን ሰነ ይህ ያለኝ
   7/ ከወን ሰነ ይህ ያለኝ
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| 24. | U/ 
|     | kütunis y c c nathana pu'4 ;o jh ;o qutbuna ? |
|     | 1/ yu
|     | 2/ shala
|     | 3/ ;o qutbuna. |
| 25. | kütunis 
|     | nathana pu'4 wathla qutbuna ? |
|     | 1/ yu
|     | 2/ qutbuna |

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| 26. | Huyu 
|     | nathana pu'4 wathla qutbuna ? |
|     | 1/ shala
|     | 2/ sara
|     | 3/ ;o qutbuna |
| 27. | U/ 
|     | nathana pu'4 wathla wathla ? |
|     | 1/ yu
|     | 0/ nathana pu'4
|     | 3/ ;o qutbuna |

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| 28. | nathana pu'4 
|     | wathla ? |
|     | 1/ yu
|     | 3/ ;o qutbuna |

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| 29. | Huyu 
|     | wathla ? |
|     | 1/ yu
|     | 2/ sara |

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| 30. | Huyu 
|     | wathla ? |
|     | 1/ yu
|     | 2/ nathana pu'4 wathla
|     | 3/ ;o qutbuna
|     | 4/ ?ulia / nathana pu'4