Original article

Fertility regulation among women in rural communities around Jimma, Western Ethiopia

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Abstract: A cross-sectional study was conducted in April 1998 with the an objective to identify the awareness and practice of family planning among women living around Jimma Town. A pre-tested questionnaire was administered to a total of 863 women in reproductive age. Besides, a total of 11 Focus Group Discussion (FGD) sessions were held with a total of 101 women in eight panels. Findings showed that 41.7% of women respondents have heard about family planning, the main source being husbands and health facilities. The majority (93.8%) believed that "it is God that decides when to become pregnant and the number of children to bear". Current use of contraceptive among married women was found to be only 7.0% of which 65.0% use the pill. Age and educational status were found to have significant association with contraceptive non-use. Unlike many studies that concluded men's disapproval as reason for not using family planning services, it was found that men rather were sources of family planning information and the finding from FGD did also show that husbands remain neutral about their wives use of contraceptive. FGD outcomes are in congruence with survey results. God was found to be an ultimate decision-maker concerning their reproductive matters. Besides, it did clearly come out that discussants felt that they lacked sufficient information about family planning. It was concluded from this study that even in areas closer to major urban towns, awareness of women about reproductive services like family planning is far below from what is expected. Thus, it calls for enhancing collaborative effort to reach the wider majority of women. [*Ethiop. J. Health Dev.* 2000;14(2):117-125]

Introduction

Ethiopia is one of the populous countries in Africa. It stands third after Nigeria and Egypt. According to the 1994 estimate, the country's total population is over 57 million in 1997 with an annual growth rate of 3%. About 85% of the population lives in rural areas (1). The country is characterised by a young population. In 1997, for example, over 46% of Ethiopian population were below the age of 15 years. In its current trend, the country's population is expected to double in about 23 years. The 1990 nation wide population-based Family and Fertility Survey had revealed Total Fertility Rate to be 7.7. It also estimated the overall contraceptive prevalence rate to be 4.8 among currently married and non-pregnant women of reproductive age (2). In 1998, estimated TFR was 6.1 and contraceptive prevalence rate was 11% which has shown remarkable improvement within the last few years (3). Yet, these figures are very low as compared to many other African countries (3, 4).

Given such uncontrolled population growth and its impact on the socio-economic state of a country in general and maternal health of many women in particular, family planning is taken to be an important initiative (5). Specifically, the attention given to family planning world-wide to curb the ever expanding population, high maternal mortality rate as well as the economic and health care demands of the family and society is remarkable (6). The recent population policy of Ethiopia (7) has clearly targeted promoting social welfare by harmonizing the rate of population growth and the country's capacity for development and rational utilization of natural resources. In

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effect, the policy specified its goal to reduce TFR, which is currently 7.7 children/women to 4.0 and increase contraceptive prevalence rate from 4.0% to 44.0% by the year 2015. Nevertheless, the current status of family planning use, after five years of the policy, is still very low.

Access to services and availability of method mix are quite frequently important factors in family planning while they are seemingly not given due attention. The family planning service system in Ethiopia operates through government and private health institutions (hospitals, health centers health stations, pharmacies, private clinics, Community-Based Distributions (CBD), and social marketing outlets (8). The efforts and services however are weak and concentrated in urban areas. The maternal and child health/family planning (MCH/FP) program itself was introduced as a component of the national health care system only in 1980. Furthermore, access to health services in Ethiopia is extremely poor where health service coverage is estimated to be 38-47% (1,8). Consequently, access to family planning is extremely poor. Theoretically contraceptive method mix in Ethiopia is said to be broad. Nevertheless, in practical terms, the type of services available at facility level is largely poor. Although concrete studies are lacking in this area, a recent Contraceptives Requirement and Logistics Assessment study found that FGAE and, Marie Stops International (MSI) have 5-6 types of methods. Health facilities in rural Ethiopia are said to offer fewer services (9). The 1993 population policy does also acknowledge that existing delivery systems are limited in scope and that choice of family planning methods are limited. It had in fact called for an expansion of reproductive health service delivery currently available only through the limited formal health structure to clinical and community-based out-reach services. It did also recommend the involvement of NGO's in providing services, including the wider possible choice of contraceptives (7,8).

The main objective of this particular study was to identify levels of family planning awareness and use among women of reproductive age group and males' perceived influence in rural communities of Jimma Zone. Awareness about family planning services, decision making responsibility, sources of information and services, men/husbands influence, desired number of children, etc., were the major variables focused on in this study.

Methods

The majority of Ethiopian population (85%) resides in the rural areas of the country (7). Demographic composition of the population shows that about 50% of the population are young owing to high fertility. Fertility regulation devices are not yet available as much as desired. The service is rendered mainly by the Ministry of Health through its MCH Department. However, there are family planning services offered by NGOs, FGAE being the pioneering organization to have started the service in Ethiopia in the 1960's.

Despite this fact that family planning as a service is offered to women of reproductive age, it is limited to potential users. This is due to limited health infrastructure and their urban bias. Even in urban centers the availability of services and awareness of potential members about their own reproductive health needs is critical.

This study was conducted in five peasant associations surrounding Jimma Town within 8-18kms radius. Selected kebeles[1] (Qunno from Dedo Wereda, and Bore, Qofe, Kechema, and Buyochala from Seka Chekorsa weredas) have similar characteristics in as far as access to health services (on average 8-15 kms) and distance from Jimma (8-25 kms) are concerned. The study sites are within the operational area of the Jimma Institute of Health Sciences[2]. Besides, the study sites are closer to health services. The total population of the selected kebeles was 5000 with an average household size of 5.8

people. The main economic activity is agriculture although petty trading is also practised. In all the kebleles there was no functional community level health care services.

Methods of data collection and analysis: A cross sectional survey was conducted in the month of April 1998. Five communities in two weredas of Jimma Zone were selected and households were selected by using systematic random sampling technique. A Pre-tested questionnaire was administered to a total of 863 women whose age ranged was 10-50 years. The lowest age limit was set based on local context where there are practices of early marriage at the age of as low as 10 years. They were asked questions pertaining to their reproductive history, problems they encountered and whether they know about birth control methods, use such services and where they get the services. In order to refine the information obtained from the survey, FGD was held with 101 women in two categories (women with children and those who do not yet have children). Discussion was thus made with 11 groups of panel each consisting of 8-10 group discussants selected from the respective kebeles. Ever married women and those who are not yet married were convened together. A checklist was developed to guide the discussion in such a way that it produced relevant information. Following data generation, analysis of survey data was made using UPSSPC software while data from FGD was analytically compiled on the basis of notes taken during the discussion. Points that were argued up on by participants and agreed up on in consensus were considered.

[1]The smallest politico-administrative unit

[2]the Jimma Institute of Health Sciences is a pioneering training institution in Ethiopia which deploys students to communities for practical learning by way of which the community's problems are diagnosed, prioritized and intervened.

Results

Demographic characteristics: the majority (92%) and (93.4%) of the women were Oromo and Muslims, respectively, (Table 1). Information generated on their educational status reveals that 90.0% are not able to read and write while 2.9% have got religious education (Qura'an). Eighty eight percent of the respondents are engaged in agricultural activity along with their husbands or as widows. Average age of respondents was 27.7 and average age at first marriage was calculated to be 16.8 years.

Table 1: **Basic demographic characteristics**

Characteristics	No.	%
Ethnicity		
Oromo	792	92
Kullo	19	2.2
Amahara	21	2.4
Kaffa	17	1.8
Others	14	1.6
Rligion		
Muslim	806	93.4
Orthodox	55	6.4
Other	2	0.2
Age in years		
14-19	137	15.9
20-25	229	26.5
26-31	155	18.0
32-37	136	15.8
38-43	133	15.4
44 and above	73	8.4
Educational status		
Could not reade and write	777	90
Primary schooling	58	6.7
Secondary schooling	3	0.3
Religious education/Qura'an	25	2.9
Current marital status		
Married	699	81
Separated	32	3.7
Widowed	28	3.2
Never marrid	104	12.1
Age at first marriage (years)		
10-14	128	16.9
15-19	525	69.2
20-24	92	12.1
25-29	14	1.8
Number of children ever born to the responding women		
Only 1	105	15.3
2-4	383	55.7
5-7	175	25.5
8-10	23	3.3
11 and above	1	0.1

Their marital history indicates that early marriage is still practised. Seventeen percent of the currently married respondents pointed out to have been married when below the age of fifteen. From the total of 863 women

respondents, 699 (81.0%) were currently married. Out of the ever married women, 687 (96.6%) have children. Two hundred ad thirty nine (34.8%) of these have two or less children, 333 (48.5%) have 3-5 children, and 111 (16.2%) have 6-9 children. On average there are 4.5 children ever borne to a mother and 104 (12.1%) of the respondents were never married (Table 1).

Fertility and family planning: Information about reproductive health in general and family planning in particular is inadequate among the study population. From the FGD, it appeared that the majority do not know when to get pregnant and how many children to have. These issues are always God's making as was clearly stipulated "if God wishes, every sexual contact results in pregnancy." Of the respondents, 360 (41.7%) claimed to have heard about what is termed locally as '*qusanno maati*' which is similar to family planning (Table 2). Of these, 279 (77.4%) pointed out to have heard about it as meant for spacing and/or stopping birth. While there are not formal sources of information locally (health personnel, school, religious institution), husbands and health facilities were mentioned to be sources of information about 'family planning' (Table 2). Results from FGD indicated that the type of information the majority claim to have is not that specific. Further inquiry on knowledge of any modern method of prevention of unwanted pregnancy revealed that only 273 (31.6%) knew one or more modern method of contraception.

Knowledge of contraceptives was limited to pills (67.3%), injectables (5.7%) and rhythm (27%). They claimed to have hearsays about the existence of other 'medicine' to regulate pregnancy which they could not specify. Respondents who have formal education and are relatively younger (14-37 years) claimed to know relatively better about family planning.

As it was strongly indicated during the FGDs, husbands' perceived role in family planning service utilization was found to be relatively neutral. Some participants of the FGD further indicated that husbands share information on family planning with their wives. This could be seen from the survey data where 14.9% of the respondents claim husbands to encourage them to use contraceptives and 38.3% of married women claim to have gotten information about family planning from husbands (Table 2).

Table 2: **Knowledge about family planning**

knowledge item	No.	%
Ever head of family planning		
Yes	360	41.7
No	503	58.3
Total	863	100.0
Know at least one method of modern contraceptives		
Yes	273	31.6
No	590	68.4
Total	863	100.0
Source of information		
husband	138	38.3
Community Health workers	133	36.9
Health facilities	64	17.8
School	15	4.2
Do not know	10	2.8

The survey result showed the current contraceptive prevalence rate among currently married and non-pregnant women to be nearly 7.0% (table 3). Age and educational status of the women were found to have an impact on contraceptive use. Those women who had some form of education and the younger ones were found to have had better knowledge and tend to use the services as well. The most common contraceptive method used by those who claimed to use is the pill (65%), injectables (4.4%) rhythm (23.3%) and both injectables and the pill by 5.3% (of those who ae using contraceptive). During the FGD, discussants were requested to enumerate the type of family planning methods that are known about and the majority failed to list beyond the pill. Some respondents hesitantly pointed out injectables as a family planning method. As substantiated by information gathered during the FGD, the reasons for not using contraceptives include the following: not knowing how to use them, wanting more

children, unavailability of the "Medicine", and fear of side effects (Table 3). Though 65% of current users reported to use pill, findings from the FGD show that taking the pill is believed to go with nutritious food and rest. Furthermore, it was reiterated that it brings about backache, occasional but regular headache and tiredness.

Table 3: **current contraceptive use among married women**

use characteristics	No	%
Currently using contraceptives (N = 863)		
Yes	60	6.9
No	803	93.1
Reasons for not using (N = 863)		
Want more children	145	18.1
Fear of side-effects	312	38.9
Do not know how to use	225	28.0
'Medicine not available'	121	15.0
Type of family planning services used (N = 60)		
Pill	39	65
Injectable	3	4.4
Rhythm	14	23.3
Both pills and rhythm	4	5.3
Total	60	100.0

Although contraceptive use rate is relatively limited, there appeared a strong desire for more information on family planning and availing the service within their community. It was gathered from FGD that 'current changes in economic and social life demands high in-put for the up-bringing of children'. It was pointed out that nowadays families are socially expected to send children to school, which requires parents to buy them the necessary items, and this is said to be a new development. Though this has not yet taken root and practised, it would be an important development in the process of planning family size in rural settings.

Knowledge of family planning services was found to have positive association with women's age and educational status, while religion was not found to have strong association. Similarly, use of contraceptives was found to have strong association with women's educational status, while age and religion were not strongly associatied with contraceptive service use (Table 4 and 5).

Table 4: **Association between knowledge of avoiding pregnancy and contraceptive practice with religion, age and educational status**

Characteristics	Total	Know how to avoid pregnancy			
		Yes	%	x^2	P = value
Religion					
Muslim	806	256	31.8		
Orthodox	55	17	30.9	0.14	0.7042 (NS)
Age					
14-19	137	36	26.3		
20-25	229	89	38.9		
26-31	155	68	43.9	20.92	0.0008
32-37	136	47	34.6		
38-43	133	30	22.6		
44+	73	18	24.7		
Education					
Illiterate	777	231	29.7		
Elementary	58	26	44.8	127.78	0.00001
Secondary	3	3	100.0		
Other (religious)	25	13	52.0		

Table 5: **Association between contraceptive practice and religion, age and educational status.**

Characteristics	Total (N=861)	Current use of contraceptives		x^2	P=value
		Yes	%		
Religion					
Muslim	806	56	6.9		
Orthodox	55	4	7.3	0.02	0.898 (NS)
Age					
14-19	137	8	5.8		
20-25	229	22	9.6		
26-31	155	13	8.4	2.76	0.598
32-37	136	8	5.9		
38-43	133	9	6.7		
44+	73	--	0.0		
Education					
Illiterate	777	45	5.8		
Elementary	58	8	13.8	14.51	0.0007
Secondary	3	1	33.3		
Other (religious)	25	6	24.0		

Discussion

The current concern of women's health advocates have shifted from women's liberation in the 60's to critiquing contraceptive technologies which had in-fact targeted women irrespective of their interest. Provision of relevant information so that women can control problems related to sexuality and fertility have been considered a remedy to properly address the family planning and reproductive health problems of the majority of women. Contrary to this fact, this study has revealed limited knowledge of women about contraceptives and family planning.

Yet, the usual assumptions of interest in large families in many developing countries (10), do not seem to hold true in this study. "True, children were considered as wealth in those days when life was not as difficult as it is now. At the moment the cost of meeting new standards such as educating children, buying them necessary items and clothes are beyond our capacity". This is one of an important point noted during FGD sessions despite the agreement of the majority about fertility issues being a domain of 'God'; there is a desire for more information about family planning services. A recent study in SNNPR did also reveale similar fact where severe shortage of and access to cultivable land has improved the attitude towards family planning (11).

Indepth inquiry of methods known to women, how services are used, the underlying notion of fertility, etc show that their knowledge is based on hearsay. This is reflected in the survey data where knowledge of at least one method of modern contraceptives is limited to 31.6%. Community and family survey of 1997 in the southern regions of the country have revealed that knowledge of any family planning method was reported by 32.8% of the respondents (12). A similar study by Family Health International has revealed that 45% of the respondents from selected rural areas of the southern regions were shown to have knowledge of at least one method of modern family planning method (13). In view of the closeness of the study sites to Jimma Town and in light of the Jimma Institute of Health Science's intensive community-based activities in the surrounding villages, knowledge about family planning should have been remarkably different from rural studies in the south.

Data on awareness show that about 42% of the respondents claimed to have heard about family planning. It was revealed that 38.3% of the respondents heard about it from their husbands. Findings from a study on men's knowledge, attitude, and practice of family planning in North Gondar (14) also revealed that over 60% of the 832 responding men approved their wives' use of family planning service, while 43.6% reported to have discussed about contraceptives with their wives. The study by Family Health International (13) did also reveal that 73.2% of rural husbands know about their wives contraceptive use and 62% approved it. This shows the relative improvement in men's involvement in family planning. From this study, contraceptive prevalence among currently married and non-pregnant women was found to be 7.0%. A study in rural Dalle revealed contraceptive use rate to be 2.6% (15) and the Family Health International's study in selected rural setting in the southern region (13) also found contraceptive use rate to be 4.6%. As can be seen, the contraceptive use rate here is higher in comparison. However, in light of the broad-based family planning services available in the town, both from the FGAE branch office, health facilities in closer distances and moreover presumed influence of the Jimma Institute of Health Sciences, contraceptive prevalence rate is not convincingly high.

It is also important to note that knowledge on how to avoid pregnancy has significant difference with women's age ($p=0.0008$) and their educational state ($p=0.00001$). Notwithstanding this, religion was not found to have strong association with knowledge on how to avoid pregnancy. Contraceptive use was found to have strong association with women's educational status ($p=0.00071$). Age and religion, however did not show strong association ($p=0.5980$ and $p=0.8980$ respectively). A study by Tesfayi (16) also revealed that knowledge and practice of family planning to be determined by educational status of women.

Studies about the socio-economic and demographic factors that determine contraceptive non-use in Ethiopia concluded that the major constraints, among others, are religious prohibitions (17). However, though religion is in general implicated as a factor playing important role in prohibiting contraceptive use, Focus Group discussions in this study did also revealed that Qura'an does not directly inhibit the use of birth control. It was rather pointed out to prohibit frequent delivery, which is believed to be a harm to both the women and children.

Unlike studies that unanimously witnessed male disapproval as sources of resistance to family planning services, outcomes from FGD showd that men are sources of information and are either neutral or encourage their wives' use of contraceptives. The fact that the study areas are fairly closer to JIHS's operation area might have brought such changes. Yet, there were some women (from in-depth discussions) who still admit husband's disapproval about wives use of contraceptives. Fear of side effects was repeatedly mentioned to be a major source of resistance. Participating women were found to share common points about consequences of the pill. It is mentioned to bring about distension, heartburn, backache, and headache. Besides, it was repeatedly pointed out that it goes with nutritious food and avoiding labourious tasks, which is not practical in the context of what life demands from them. Concepts of side effects are shown in other studies to preclude current use of contraceptives (18, 19). Lack of information and knowledge about contraception itself and about one's own reproductive dynamics was rather an important factor affecting the interest in seeking contraceptive services. Although it did not come out strongly in the FGDs, non-availability of the desired method mix itself appeared to be an important factor that affects contraceptive use. A study by Antenane (20) has also shown poor method mix to be a factor for non-use of contraceptives.

From this study, it is generally concluded that knowledge about reproductive health in general and contraceptive use in particular is grossly deficient. One needs to be critical about arguements concerning knowledge about family planning. Does knowledge about family planning mean that women are 'well' informed about different aspects (types of services along with their merit, where to obtain them, how to use, etc). Sometimes, self-report of knowing seems to be taken as a point of departure than critically assessing what exactly is known. According to Lisa Bohmer (21), there is a clear gap between being able to name various contraceptive methods and being able to get access to them and actually use them effectively. Hence, knowledge should be substantiated with more concrete information. Perhaps attempts to improve family planning services, thereby improving the health and wellbeing of women, should be geared towards creating proper and sufficient awareness about family planning. Furthermore, the service provision should be organized in such a way that it is accessible and acceptable to the wider majority of potential users in the rural communities. Enhancing the role of men in family planning would also help in improving the use of the service. This study attests the vital role of husbands as source of family planning information. Thus, efforts should be made to encourage male involvement in the whole process of improving family planning services in particular and reproductive health in general. Although relevant studies among Muslim communities of rural areas in Ethiopia is limited, in this study it was found that Islam does not prohibit family planning use. This needs to be further substantiated with other community-based studies.

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