

Awareness and determinants of family planning practice in Jimma, Ethiopia

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Background: The continuing growth of the world population has become an urgent global problem. Ethiopia, like most countries in sub-Saharan Africa, is experiencing rapid population growth. Currently, the country's population is growing at a rate of 3%, one of the highest rates in the world and if it continues unabated, the population will have doubled in 23 years, preventing any gain in the national development effort.

Aim: To determine the level and determinants of family planning awareness and practice in one Ethiopian town.

Methodology: A quantitative study using a descriptive survey design was conducted in Jimma University Hospital.

Discussion: The findings revealed that the knowledge and practice of modern contraception methods was low. Most women's contraceptive knowledge and practice was influenced by socio-cultural norms such as male/husband dominance and opposition to contraception, and low social status of women. A lack of formal education for women was identified as a key factor in preventing change in the patterns of contraceptive knowledge and use by women in this part of Ethiopia.

Conclusion: The support and encouragement for women and men to enter and complete formal education is essential in bringing about a cultural and social change in attitude towards the economic and social value of family planning. This study and others suggest that education can address the imbalance in decision making about contraception and the role of women in society generally.

Keywords: Culture, Family Planning, Quantitative Research, Survey Design, Womens' Reproductive Health

Introduction

The continuing growth of the world population has become an urgent global problem. Most of this growth is occurring in developing countries where the fertility rate is very high (Bandura 2002; Merrick 2002; Potts 2000; Ross & Winfrey 2002; WHR 2005). Ethiopia, like most countries in sub-Saharan Africa, is characterized by high fertility and rapid population growth. It stands third after Nigeria and Egypt in this respect (Fitaw et al. 2003). Currently, the country's population is growing at a rate of

3%, one of the highest rates in the world, and if it continues unabated, the population will have doubled in 23 years, preventing any gain in the national development effort (Berhane et al. 1999; DHS 2000; Kaba 2000). The country also has a young population. In 2000, for example, over 44% of the Ethiopian population were below the age of 15 years. With many years of reproductive life ahead, population growth is likely to continue at a rapid pace for some time.

Background

High fertility and rapid population growth have an impact on the overall socio-economic development of the country in general and maternal and child health in particular. Maternal and child mortality are two of the major health problems challenging

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healthcare organizations, especially in developing countries. The majority of maternal deaths are the direct result of complications encountered during pregnancy and arising from unsafe terminations (Gaym 2000; Merric 2002; Population Reports 1999). The World Health Report (WHR 2005) noted that unwanted, mistimed and unintended pregnancy is the most common cause of maternal mortality in developing countries. The Ethiopian demographic and health survey (DHS 2000) identified that one in four deaths among Ethiopian women in the period 1994–2000 was due to a pregnancy or pregnancy-related cause. One of the reasons for this is the lack of skilled healthcare personnel attending births. The WHR (2005) reported that in 2000 only 6% of births in Ethiopia were attended by an appropriately skilled person; however, there is also evidence to suggest that up to 100 000 maternal deaths could be avoided each year if women who did not want children used effective contraception (Marston & Cleland 2003).

Children with many siblings are less likely to enter and remain in school and more likely to have poor health and high mortality rates as compared with children who have fewer siblings (Asefa et al. 2000; Merrick 2002; Population Reports 1999). This problem in the developing world is disproportionately higher than in the developed one. For example, in Ethiopia, mortality rates under the age of 5 years for the 1996–2000 period were 166 per 1000 live births (WHR 2005). The issue of family planning clearly has implications for the planning and development of educational and healthcare policies and strategies.

Birth control is a priority in Ethiopia and many programmes to increase contraceptive practice have been implemented by the Ethiopian National Population Policy since 1993. However, the problem of high fertility and low contraceptive practice remains unresolved. The total fertility rate of the country for the year 2000 was found to be 5.9 children per woman and the contraceptive prevalence was only 8%. This is too low to affect the fertility levels significantly (DHS 2000; Fitaw et al. 2003), and the fertility rate of the country actually increased to 6.1 children per woman for the year 2003 (WHR 2005). High population growth prevents the long-term socio-economic development needed to alleviate poverty and to meet the immediate basic needs of the burgeoning population (Bandura 2002; Merrick 2002). Accurate and specific data about the reason behind the low contraceptive practice in the country should be available in order to develop an effective and relevant family planning strategy. Ethiopia is a large country divided into regions, each of which has its own culture and beliefs concerning fertility and contraceptive practice. Therefore, it is difficult to develop a family planning strategy that will work nationally unless each region is considered separately so that the key issues can be identified. Inadequate information about each region means that the planning and development of policies and

strategies may be inappropriate and therefore ineffective in bringing about an increase in family planning practice across all the regions. There is a need to identify the reasons for low contraceptive prevalence in different regions of the country in order to develop effective policies and strategies.

In this study, the awareness and determinants of family planning practice among women of childbearing age in Jimma town were examined. The social cognitive theory for social change was used as a theoretical framework because it helps to understand and explain how social and cultural norms, values, people's beliefs, behaviours, gender roles and social networks influence people's choices about family planning (Bandura 2001, 2002). According to Bandura (2002), one of the important components of social cognitive theory is efficacy belief. It plays an important role in the adoption of change and regulates human functioning through cognitive, motivational, affective and decisional processes. Bandura (2002, p. 213) states that

Among the mechanisms of self influence for change, none is more central or pervasive than beliefs in one's efficacy to exercise control over one's functioning and events that affect one's life. This core belief system is the foundation of human motivation and accomplishments. Unless people believe they can produce desired effects by their actions they have little incentive to act or to preserve in the face of difficulties whatever other factors serve as guides and motivators, they are rooted in the core belief that one has the power to effect changes by one's actions.

However, in many spheres of life, people do not live their lives independently. They depend on those who have power and resources, and they act according to the desires of the powerful (Bandura 2002; Hogan et al. 1999; Nagase et al. 2003). Furthermore, low socio-economic, occupational and educational status, and cultural and community norms affect behaviour through their influence on people's sense of control over their own lives (Bandura 2002; Hogan et al. 1999). This is particularly true in the use of contraception, which is subject to strong social and normative constraints. Therefore, assessment of the various socio-economic and cultural variables that contribute to low contraceptive practice is essential for promoting the use of contraception and lowering the birth rate.

The study

Aim

To determine the level of family planning awareness, practice and determinants among women of childbearing age who live in Jimma town, the capital city of Jimma Zone of Oromia administrative region of Ethiopia.

Methods

A quantitative approach using a descriptive survey design was chosen.

The instrument

A structured questionnaire was developed following an extensive literature review on the topic (Belay 2000; Kaba 2000; Mesfin 2002; Pasha et al. 2001). This helped to ensure validity and reliability of the questionnaire. The socio-demographic details recorded in the questionnaire included the age of women, educational status, occupation, religion, ethnic origin, marital status, monthly family income and number of children. Three aspects related to contraception were also explored in the questionnaire. The first was awareness, knowledge of modern contraceptive methods and sources of family planning methods. The second were levels and determinants of contraceptive practice. The third was spousal communication about family planning and family size. Respondents were asked to indicate their awareness of specific contraceptive methods, the benefits of family planning and the source of their information in relation to family planning. The practice and determinants of family planning practice for pregnant and non-pregnant women were assessed separately. Pregnant women who were using a contraceptive before the current pregnancy were asked the reason for its discontinued use. Those pregnant women who knew about contraceptives but were not using them before the current pregnancy were asked to indicate their reasons for not doing so, such as because they wanted children, they could not access the contraceptive, opposition from partner, religious belief and fear of side effects. Current contraceptive practice for non-pregnant women was assessed by reported current use of any modern contraceptive methods, and those who chose not to use contraceptives were asked to indicate why they did not.

In order to assess the importance of husbands'/partners' contribution to family planning practice, those women who were using a contraceptive at the time of the survey were asked whether they perceived that their husband/partner approved their current contraceptive practice or not. Also, all women were asked whether they had ever discussed family planning and preferred number of children with their husbands/partners. The respondents' contraception preference was assessed in terms of the number of children they want to have and whether or not their husband/partner concurred with their desired number of children.

Subjects

The participants were recruited using a convenience sampling technique. All married, unmarried, pregnant and non-pregnant women aged 18 years and more who came to Jimma University

Hospital, Maternal and Child health clinic during June 2004, and who had been residing in Jimma town for more than 1 month were included in the study. For those women who could not read or write, the data collectors provided assistance.

Pilot

A pretest of the questionnaire was conducted with ten women who met the inclusion criteria and attended the maternal and child health clinic at Jimma University Hospital. The purpose of the pilot was to test the clarity and relevance of the questionnaire and to familiarize the data collectors with the instrument. The responses from the pilot study were checked for completeness and consistency by the principal investigator. The findings from the pilot study did not show potential problems. In order to avoid response biases, the participants in the pilot study were not included in the main survey. The main study was conducted during June 2004.

Validity and reliability

The questionnaire was first prepared in English and two medical practitioners assessed its content validity. It was translated by the principal investigator into Amharic, the official as well as the local language of Jimma town, and validated by another Ethiopian nurse researcher. Six postgraduate nursing students were recruited and trained for 2 days by the principal investigator on the method of data collection. The reliability of the instrument was tested using Cronbach's coefficient alpha, and the overall consistency of the instrument was found to be 0.61. Test-retest could not be carried out because of the difficulties associated with obtaining returns from postal questionnaires and because many of the women did not attend the clinic regularly or frequently.

Ethical considerations

Permission to conduct the study was obtained from Jimma University Hospital. The Faculty of Health Science, at The University of Dublin Trinity College, gave ethical approval. All participants' right to self-determination and autonomy were respected. They were given any information they needed, verbally and in writing. Participation was voluntary and they could withdraw from the study at any time without explanation and without penalty or loss of benefit. The anonymity of each participant was assured unless they needed assistance in filling out the questionnaire. In such cases, confidentiality was assured and no personal details were recorded or produced on any documentation related to the study.

Data analysis

Tabulation of data was made after completion of data collection. Before entering the data, the questionnaire was checked for com-

pleteness and consistency by the principal investigator. SPSS software version 11 (Pallant 2001) was used for statistical analysis. The chi-squared (χ^2) test was used to determine if there was a statistically significant association between variables. Comparisons and associations were considered statistically significant when *P*-value was less than 0.05.

Findings

A total of 260 women participated in the study. Of the respondents (148 non-pregnant and 66 pregnant women), 82.3% ($n = 214$) had heard about family planning. In total, 26.5% ($n = 69$) women knew of three or more modern contraceptive methods and 55.8% ($n = 145$) knew one or two. In total, 17.7% ($n = 46$) did not know about any methods of contraceptive. From those non-pregnant women who had heard about family planning, 48.6% ($n = 72$) were using a contraceptive at the time of the survey. Those non-pregnant women who knew about family planning but were not using modern contraceptive at the time of the survey (51.4%, $n = 76$) were asked why not. Pregnant women who were using modern contraceptives before the current pregnancy (59.1%, $n = 39$) were also asked the reasons for discontinued use. The most commonly cited reasons were fear of side effects, religious belief, opposition from partner and wanted more children.

The knowledge and current practice of modern contraceptive methods were analysed together with the socio-economic and demographic characteristics of the respondents to determine if there was a significant association between these variables. There was a significant association between the number of family planning methods known and women's education, occupation and monthly family income, while age and religion were not found to have a significant association with the number of family planning methods known by the participants (Table 1).

Current contraceptive practice was also found to be significantly associated with women's educational and occupational status (Table 2).

Current contraceptive practice was found to be strongly associated with spousal discussion about family planning ($\chi^2 = 23.477$, d.f. = 1, $P = 0.000$) (Table 3). There was also an association between husband/partner approval of current contraceptive practice and spousal discussion. Literate women were more likely to discuss family planning with their husbands than those who were illiterate ($\chi^2 = 39.722$, d.f. = 2, $P = 0.000$), and a higher family income was observed to promote spousal discussion on family planning ($\chi^2 = 10.537$, d.f. = 3, $P = 0.015$). Women's educational status and occupation had a positive association with spousal discussion about the preferred number of children ($\chi^2 = 19.841$, d.f. = 2, $P = 0.000$ and $\chi^2 = 8.166$, d.f. = 2, $P = 0.017$, respectively).

Table 1 Association between the number of family planning methods known and socio-economic and demographic characteristics of women in Jimma, Ethiopia (2004)

| Characteristics | Number of family planning methods known n (%) | | | χ^2 | P-value |
|-------------------------------------|---|------------|-----------|----------|---------------|
| | None | 1-2 | 3+ | | |
| Age group (year) | | | | | |
| 18-24 | 16 (17.8) | 54 (60.0) | 20 (22.2) | 3.126 | 0.926 (NS) |
| 25-30 | 16 (17.4) | 48 (52.2) | 28 (30.4) | | |
| 31-36 | 4 (12.1) | 20 (60.6) | 9 (27.3) | | |
| 37-42 | 7 (22.6) | 16 (51.6) | 8 (25.8) | | |
| 43-49 | 3 (21.4) | 7 (50.0) | 4 (28.6) | | |
| Total | 46 (17.7) | 145 (55.8) | 69 (26.5) | | |
| Religion | | | | | |
| Orthodox | 14 (14.7) | 49 (51.6) | 32 (33.7) | 7.198 | 0.303 (NS) |
| Protestant | 7 (19.4) | 21 (58.3) | 8 (22.2) | | |
| Muslim | 25 (19.5) | 75 (58.6) | 28 (21.9) | | |
| Other | - | - | 1 (100.0) | | |
| Total | 46 (17.7) | 145 (55.8) | 69 (26.5) | | |
| Monthly family income (Birr) | | | | | |
| ≤100 | 19 (28.4) | 34 (50.7) | 14 (20.9) | 14.176 | 0.028 |
| 101-200 | 10 (19.2) | 33 (63.5) | 9 (17.3) | | |
| 201-300 | 10 (17.2) | 31 (53.4) | 17 (29.3) | | |
| 300+ | 7 (8.4) | 47 (56.6) | 29 (34.9) | | |
| Total | 46 (17.7) | 145 (55.8) | 69 (26.5) | | |
| Educational level | | | | | |
| Illiterate | 28 (26.9) | 62 (59.6) | 14 (13.5) | 27.734 | 0.000 |
| Primary | 12 (16.0) | 44 (58.7) | 19 (25.3) | | |
| Secondary and above | 6 (7.4) | 39 (48.1) | 36 (44.4) | | |
| Total | 46 (17.7) | 145 (55.8) | 69 (26.5) | | |
| Occupation | | | | | |
| Housewife | 43 (21.4) | 122 (60.7) | 36 (17.9) | 38.219 | 0.000 |
| Civil servant | 3 (8.3) | 11 (30.6) | 22 (61.1) | | |
| Others | - | 12 (52.2) | 11 (47.8) | | |
| Total | 46 (17.7) | 145 (55.8) | 69 (26.5) | | |

NS, not significant.

Limitations of the study

Convenience sampling was used in this study because of the limited time for data collection and because it facilitates the collection of large amounts of data within a short period of time (Burns & Grove 2001; Parahoo 1997; Polit & Hungler 1999). However, biases may exist in this type of sampling technique that could affect the representativeness of the sample to the total population (Burns & Grove 2001; Polit & Hungler 1999). According to Burns & Grove (2001), the representativeness of the sample can be

Table 2 Association between socio-economic and demographic characteristics and current contraceptive practice of women in Jimma, Ethiopia (2004)

| Characteristics | Current contraceptive practice n (%) | | | χ^2 | P-value |
|--|--------------------------------------|------------|-------------|----------|---------|
| | Yes | No | Total | | |
| Age group (year) | | | | | |
| 18–24 | 26 (51.0) | 25 (49.0) | 51 (100.0) | 9.035 | 0.060 |
| 25–30 | 29 (60.4) | 19 (39.6) | 48 (100.0) | | |
| 31–36 | 9 (45.0) | 11 (55.0) | 20 (100.0) | | |
| 37–42 | 7 (33.3) | 14 (66.7) | 21 (100.0) | | |
| 43–49 | 1 (12.5) | 7 (87.5) | 8 (100.0) | | |
| Total | 72 (48.6) | 76 (51.4) | 148 (100.0) | | |
| Religion | | | | | |
| Orthodox | 28 (46.7) | 32 (53.3) | 60 (100.0) | 0.226 | 0.893 |
| Protestant | 10 (52.6) | 9 (47.4) | 19 (100.0) | | |
| Muslim | 34 (49.3) | 35 (50.7) | 69 (100.0) | | |
| Total | 72 (48.6) | 76 (51.4) | 148 (100.0) | | |
| Monthly family income (Birr) | | | | | |
| ≤100 | 13 (38.2) | 21 (61.8) | 34 (100.0) | 8.308 | 0.040 |
| 101–200 | 11 (33.3) | 22 (66.7) | 33 (100.0) | | |
| 201–300 | 19 (61.3) | 12 (38.7) | 31 (100.0) | | |
| 300+ | 29 (58.0) | 21 (42.0) | 50 (100.0) | | |
| Total | 72 (48.6) | 76 (51.4) | 148 (100.0) | | |
| Educational level | | | | | |
| Illiterate | 16 (31.4) | 35 (68.6) | 51 (100.0) | 11.571 | 0.003 |
| Primary | 24 (50.0) | 24 (50.0) | 48 (100.0) | | |
| Secondary and above | 32 (65.3) | 17 (34.7) | 49 (100.0) | | |
| Total | 72 (48.6) | 76 (51.4) | 148 (100.0) | | |
| Occupation | | | | | |
| Housewife | 44 (40.4) | 65 (59.6) | 109 (100.0) | 16.515 | 0.000 |
| Civil servant | 20 (87.0) | 3 (13.0) | 23 (100.0) | | |
| Others | 8 (50.0) | 8 (50.0) | 16 (100.0) | | |
| Total | 72 (48.6) | 76 (51.4) | 148 (100.0) | | |
| Number of family-planning methods known | | | | | |
| 1–2 | 40 (55.6) | 58 (76.3) | 98 (66.2) | 7.123 | 0.006 |
| 3+ | 32 (44.4) | 18 (23.7) | 50 (33.8) | | |
| Total | 72 (100.0) | 76 (100.0) | 148 (100.0) | | |

improved by controlling possible biases in the sample and by collecting data from a wide variety of populations. In this study, in order to enhance representativeness, data were collected over a 10-day period in the same setting and at the same time each day and by a limited number of trained data collectors.

Discussion

Family planning does more than enable women to limit family size. It enables women to have the number of children they want

Table 3 Association between discussion with husband about family planning by women vs. current contraceptive practice, educational level, occupation and monthly family income in Jimma, Ethiopia (2004)

| Characteristics | Have discussed family planning with their husbands n (%) | | | χ^2 | P-value |
|--|--|------------|-------------|----------|---------|
| | Yes | No | Total | | |
| Use modern contraceptive currently | | | | | |
| Yes | 55 (76.4) | 17 (23.6) | 72 (100.0) | 23.477 | 0.000 |
| No | 28 (36.8) | 48 (63.2) | 76 (100.0) | | |
| Total | 83 (56.1) | 65 (43.9) | 148 (100.0) | | |
| Partner approves current contraceptive practice | | | | | |
| Yes | 48 (96.0) | 2 (4.0) | 50 (100.0) | 34.893 | 0.000 |
| No | 7 (31.8) | 15 (68.2) | 22 (100.0) | | |
| Total | 55 (76.4) | 17 (23.6) | 72 (100.0) | | |
| Educational level | | | | | |
| Illiterate | 25 (24.0) | 79 (76.0) | 104 (100.0) | 39.722 | 0.000 |
| Primary | 41 (54.7) | 34 (45.3) | 75 (100.0) | | |
| Secondary and above | 56 (69.1) | 25 (30.9) | 81 (100.0) | | |
| Total | 122 (46.9) | 138 (53.1) | 260 (100.0) | | |
| Monthly family income (Birr) | | | | | |
| ≤100 | 27 (40.3) | 40 (59.7) | 67 (100.0) | 10.537 | 0.015 |
| 101–200 | 22 (42.3) | 30 (57.7) | 52 (100.0) | | |
| 201–300 | 22 (37.9) | 36 (62.1) | 58 (100.0) | | |
| 300+ | 51 (61.4) | 32 (38.6) | 83 (100.0) | | |
| Total | 122 (46.9) | 138 (53.1) | 260 (100.0) | | |
| Occupation | | | | | |
| Housewife | 87 (43.3) | 114 (56.7) | 201 (100.0) | 5.48 | 0.064 |
| Civil servant | 23 (63.9) | 13 (36.1) | 36 (100.0) | | |
| Others | 12 (52.2) | 11 (47.8) | 23 (100.0) | | |
| Total | 122 (46.9) | 138 (53.1) | 260 (100.0) | | |

and subsequently reduces the incidence of maternal and infant mortality. However, more than 100 million women in the developing world have unmet needs for family planning (Population Reports 1999, 2001; Ross & Winfrey 2002). The provision of accurate and relevant information concerning the various types of modern contraceptive methods that exist, their benefits and low side effects has been considered an important strategy to address the family planning needs of most women and the subsequent decrease in fertility rates. In spite of this, the extent of knowledge about family planning in this study was limited to 82.3% ($n = 214$) respondents. However, this finding is higher when compared with research carried out by Kaba (2000) among women in rural communities around Jimma, when only 41.7% ($n = 360$) of respondents claimed that they had heard about family planning. This difference might be explained by the fact that the current study was carried out in Jimma town, where women may have bet-

ter access to information and health services than those who live in rural communities.

The overall assessment of awareness and knowledge of modern contraceptive showed that there is a knowledge deficit. However, this study demonstrated a significant association between the number of family planning methods known and current contraceptive practices. To be able to make choices between the different types of contraceptive methods, women must first be aware of the methods that exist, their benefits and the side effects of each (Population Reports 1999; WHR 2005). This highlights the importance of the quality of family planning services and their educational role. The study also attempted to look into the practice and determinants of family planning practice for pregnant and non-pregnant women. A wide disparity was observed in the knowledge and practice of modern contraceptives. Although 84.6% ($n = 148$) of the non-pregnant respondents knew about family planning, only 48.6% ($n = 72$) were using modern contraceptives at the time of the survey. Similarly, 77.6% ($n = 66$) of pregnant women knew about family planning, but only 59.1% ($n = 39$) were using contraception before the current pregnancy. The most commonly cited reasons for not using modern contraceptives were the desire for more children, fear of side effects, opposition from partner and religious beliefs. Studies in other parts of Ethiopia and other countries identified similar reasons to those found by this study (Belay 2000; Fitaw et al. 2003; Nagase et al. 2003; Wyatt et al. 2000). Analysis of the overall knowledge and determinants of family planning practice in this study revealed that knowledge and accessibility of the service might not be enough for the acceptance of contraceptive. Hogan et al. (1999) and Bandura (2002) also noted that in developing countries where women are bound by dated traditions and normative constraints, knowledge of family planning is not the only decisive factor for the adoption of contraceptive practice and the accompanying reduction in fertility rate. In order to be effective, government policies and strategies in relation to family planning practice need to confront and address the socio-cultural norms and gender imbalances in education, decision making, occupational levels and income (Bandura 2002).

The importance of improving the educational and economic opportunities, bargaining power and independence of women is often emphasized in fertility reduction and family planning programmes (Bandura 2002; Sharan & Valente 2002). Numerous studies indicate that women's educational and occupational status and decision-making power are positively associated with contraceptive use (Bandura 2002; Hogan et al. 1999; Sharan & Valente 2002). The findings from this study also demonstrated a significant association between the number of family planning methods known and women's education, occupation and monthly family income. Literate women were much more likely

to know more than one method of contraceptive than those who were illiterate. Also, women who were government employees and worked outside the home were more likely to be knowledgeable about modern contraceptive methods than their housewife counterparts. Women's educational and occupational status was found to be associated with current contraceptive practice. Kaba (2000) documented similar results. Hogan et al. (1999) showed that in the Southern Nations, Nationalities and People's Region of Ethiopia women's literacy and autonomy were the most important factors for the adoption of contraceptive and the accompanying reduction in fertility rates. However, as in most developing countries, women in Ethiopia are limited mainly to household responsibilities such as child rearing and feeding the family. They may have no say in decisions on whether to use contraception, when to have a child or how many children she should have.

According to the social cognitive theory, raising the status of women in decision making, social and educational levels helps them to develop a sense of efficacy belief that enables them to exercise better control over their lives (Bandura 2002; Bhat 1998; Hogan et al. 1999; Mesfin 2002; Sharan & Valente 2002). Hogan et al. (1999) and Bandura (2002) also noted that women who have good status in terms of education, occupation and monthly family income have a high efficacy belief and control in household decisions including reproductive matters. Moreover, such women are innovators for change. It is therefore important for government policy makers and programme implementers in developing countries such as Ethiopia to give special attention to supporting and encouraging formal education for females.

Spousal discussion about family planning and contraceptive practice has been found to be crucial for the wider acceptance of contraceptive practice and lessening partners' fertility intention in developing countries (DeRose et al. 2004; Mesfin 2002; Nagase et al. 2003; Sharan & Valente 2002). This study also indicated that the percentage of women who used modern contraceptives was higher among those who had discussed family planning with their husbands than among those who had not. The Demographic and Health Survey data from many African countries (Botswana, Kenya, Senegal, Burundi and Togo) also indicated that women who discussed family planning with their spouses were more likely to use contraceptives (DeRose et al. 2004; Sharan & Valente 2002; Toure 1996). A study by Mesfin (2002) in the Tigray region of Ethiopia also showed that contraceptive use was higher among those who had discussed family planning with their husband than among those who had never done so. Spousal discussion about matters related to reproduction and family planning is viewed as being successful to the extent that it directly increases the use of contraception and favourable attitudes towards contraception among couples (Sharan & Valente 2002; Toure 1996). This study also demonstrated a positive association between husband/part-

ner approvals of current contraceptive practice and spousal discussion.

Spousal discussion about family planning opens the door for couples to talk about the number of children to have and the importance of using contraceptives. Through discussion a couple can come to a mutual decision on whether or not to use contraception to plan when to have children and how many to have (DeRose et al. 2004; Sharan & Valente 2002). This is particularly challenging in countries like Ethiopia where overt spousal discussion of sexual matters is discouraged and husband's opposition is the major obstacle to contraceptive practice. Therefore, it is important to implement different intervention programmes that involve men and encourage couples to discuss about family planning. For example, a study on the effects of a radio drama serial in Nepal on spousal communication and family planning adoption indicated that listening to this programme increased communication among couples who had not already been discussing family planning (Sharan & Valente 2002).

In this study, spousal discussion about family planning and the number of children they want to have demonstrated a significant association with certain socio-demographic characteristics of the women. Literate women and those who have better educational achievement were more likely to discuss family planning with their husbands than those who were illiterate. Women's monthly family income was also observed to promote discussion about family planning. Similarly, women's educational and occupational status was found to have a positive association with women's discussion with their husband about the number of children they want to have. Literate and civil-servant women were more likely to discuss the number of children with their husbands than those who were illiterate and housewives. Mesfin (2002) documented similar findings, and Hogan et al. (1999) also found that women who are educated and working in cash-generating activities are economically self-sufficient and more likely to acquire greater confidence and personal control in marital relationships including the discussion of family size and contraceptive use.

Conclusion

The findings from this study may not be generalized to the total population because of the sampling limitations. Nevertheless, they are supported by other research and carry implications for policy development and the future design and formulation of family planning programmes. The factors that influence contraceptive awareness and practice are multifaceted and challenging. It is evident from this study that most women's knowledge and use of contraception is affected by socio-cultural norms and their educational and social status in the family and community.

Current contraceptive practice was found to have a positive association with the number of family-planning methods known; therefore, family planning programmes should incorporate educational campaigns aimed at increasing women's knowledge of contraception. This may help them to know and choose a contraceptive method that may be more appropriate to individual health and living conditions. The fear of side effects was one of the major reasons for the discontinuation and non-use of contraception among the study participants; therefore, the potential side effects of contraceptives and how to overcome them should be incorporated into family planning education and counselling. These messages should be reinforced by using different communication channels, including the media that are available and accessible to most women and men.

It appears from this study that a lack of formal education for women limits their ability to make informed and independent choices about family planning and indeed many other aspects of their lives. Based on the social cognitive theory, it is possible that the formal education of women in this part of the world could result in a significant cultural and social shift in attitude towards the economic and social value of family planning. Through the medium of formal education, the status, bargaining power and independence and decision making of women can be improved. This study did not examine the education status of men that used family planning strategies; however, formal education for men may also result in increased acceptance of the role of women in family planning and society in general. Education is needed to bring about change that retains the uniqueness and strengths of a culture while at the same time providing a medium through which both men and women can contribute to the economic, cultural and social development of their country.

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