

Perceptions and behaviour related to family planning in a rural area in the Oromia region, Ethiopia

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Abstract

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From 20th century, the rapid population growth in developing countries has been viewed as a big problem in the international society. The rapid population growth may increase poverty and environmental stress. Ethiopia is one of the countries that have faced this challenge and the present government is trying to reduce the total fertility rate.

The aim of this study was to investigate why there still are high fertility rates in rural Ethiopia. By the use of qualitative methods, the study sought to explore the variety of factors which may influence people's perceptions and behaviour regarding decision making related to family planning. We conducted nine interviews with the villagers, eight interviews with health workers and six focus group discussions with the villagers.

We found that there are changing perceptions as well as behavioural shifts in favour of contraceptive use and smaller family size, this because the concept of family planning seem to have been established among people.

Furthermore, the accessibility of contraceptives has been improved as different types of contraceptives are now provided free of charge at the health post in the village. On the other hand, our findings suggest there are multiple and specific obstacles working against family planning. We identified five factors which influenced reproductive perceptions and behaviour; the value of having children, religion, gender norms, side effects due to contraceptives, and information and services from health workers. The study also suggests these elements are intricately related with one another.

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Abbreviations

CIOMS Council for International Organizations of Medical Sciences

FGD Focus group discussion

IPPF International Planned Parenthood Federation

IUD Intrauterine device

NGO Non-governmental organization

PRB Population Reference Bureau

UNFPA United Nations Population Fund

USAID United States Agency for International Development

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1. Introduction

1.1. Background

1.1.1. Population growth and family planning

After the Second World War the population growth in developing countries reached historically unprecedented rates. Falling mortality due to medical discoveries and continued or even rising fertility turned this population growth into a second population explosion, the first population explosion took place when the industrial revolution started in England in the late 18th century (Bongaarts, 2009).

The rapid population growth has been identified as a problem by national governments and the international society (UNFPA, 2011a). This phenomenon, which causes for example shortage of cultivated land and unemployment, are claimed to cause increasing poverty (UNFPA, 2011b) and environmental stress (Collins, Sayer, & Whitmore, 1991).

However, the problem of population growth may not only be seen from an economical point of view. The high fertility rates, which account for the rapid population growth, have serious consequences for maternal and infant health. Short intervals pregnancy and many pregnancies and deliveries pose a large burden on maternal health. Inadequate periods to recover strength between each pregnancy, as well as many deliveries, all associated with different levels of risk, are factors that makes high fertility rates a threat to women's health. Moreover, infant health is also plagued by the short interval between births, because short birth interval is associated with increased risk of pre-term births, low birth weight and infant mortality (Bongaarts, 1987; Norton, 2005; Rutstein, 2005).

During the 1950's and 1960's, it has been important for national and

international societies to control populations. Since that period the population growth has been treated as a problem, and issues surrounding reproduction, that once were considered the most private to talk about, have become matters of intense public concern (Greenhalgh, 1995). Family planning is identified as the solution to control fertility rates against the rapid population growth. Subsequently, family planning has been expanded in developing countries by each national government, international organizations and non-governmental organizations (NGOs) (Greene, 2000). In the 1960's, the organizations related to provide family planning, for instance United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID), were established in response to the problem of the population growth. There has been an emphasis on increasing the use of contraceptives. These organizations, the international society and national governments have regarded long-term methods such as intrauterine device (IUD) as the most effective methods to achieve the demographic goal, which is to reduce fertility rates (Greene, 2000). Between the 1960's and the 1980's, declining fertility rate has been diffusing in developing countries, the exception being sub-Saharan Africa (Shapiro & Gebreselassie, 2008).

The role of family planning is important, not only to reduce fertility rates by providing contraceptives, but also to expand the understanding that all women have a right to control their fertility. The main activities of family planning programs are provision of contraceptives and education related to reproductive health, especially to women (Greene, 2000). General school education to women is also supposed to have an effect on fertility rates. Many studies show that educated women get married at a later age than non-educated women, and have better access to contraceptives than non-educated women (Alemayehu, Haider, & Habte, 2010; Bongaarts, 2010; Haile, 2004).

The main hypothesis in demographic studies, which are often based on economic rationalism, is that behaviour related to reproduction is decided by "calculations" conducted by individuals. These calculations are based on the costs and benefits of having children, and have had what Price and Hawkins

(2002) call “a positivist and empiricist research methodology” (Price & Hawkins, 2002). The major way of conducting such demographic research has been through large-scale sample studies. Anthropologists have criticized the demographical approach or viewpoint. Many anthropologists have insisted that reproductive behaviour or decisions made in relation to family planning is not only decided by economic factors, but also affected by socio-cultural factors such as fertility preferences or values related to having children. Further, political issues such as national population policy or reproductive health programs, are also influential matters. Subsequently, anthropologists emphasize that it is very important to understand what social, cultural or structural factors that may shape peoples thoughts and behaviours (Price & Hawkins, 2002). In recent years the idea that it is significant to understand the socio-cultural contexts in demographic studies has gradually expanded (Price & Hawkins, 2002).

Some studies have mentioned the importance of the role of men in reproductive health and their influence on the decision-making and behaviour related to reproduction (Dudgeon & Inhorn, 2004; Greene, 2000). As mentioned, many family planning programs have focused mainly on women. Even though men are increasingly being “involved” by reproductive health programmes, the view of men still seem to be that they are peripheral and problematic (Greene, 2000). Short and Kiros (2000) studied fertility preferences and demands for contraception in Ethiopia (Short & Kiros, 2002). The authors reported a gender difference between husbands and wives in fertility desires; husbands were more pronatalist than their wives (Greene, 2000; Short & Kiros, 2002). Lasee and Becker (1997) studied husband-wife communication related to family planning and the use of contraceptives in Kenya. The authors reported that “the wife’s perception of her husband’s approval of family planning” (Lasee & Becker, 1997) has a significant impact on the current contraceptive use. The result shows that men’s opinion and perception regarding reproduction have a strong impact on women’s perception and their subsequent behaviour. Therefore, it is important to study both gender’s perception related to reproductive, as well as the communication between wife and husband, in order to understand what factors shape their behaviour.

1.1.2. Background information about Ethiopia

Ethiopia has the second largest population in the African continent. A rapid population growth has taken place in Ethiopia, as in other developing countries. According to the policy report by Population Reference Bureau (PRB), the total fertility rate (2002-2004) in Ethiopia is 5.4 children per woman and the population increases with 2.6% every year, which means an increase by 2 million people every year (Ringheim, Teller, & Sines, 2009). The Oromia region, where this study was conducted, has the largest population in Ethiopia. Moreover the annual population growth in the Oromia region from 1994 to 2007 was 2.9%. The rate is higher than 1.7% in the Amhara region, where the second largest region is located (Federal Democratic Republic of Ethiopia Population Census Commission, 2008).

There is also a difference in the total fertility rate between urban areas and rural areas. For instance, the total fertility rate in Addis Ababa, which is the capital city of Ethiopia, is 1.4 children people per women. This is an extremely low rate as compared to the average in whole Ethiopia: 5.4 children per woman. However, the low rates in urban areas are an exception, because 84% of the population in Ethiopia lives in rural areas. One of the causes of the high fertility rates is said to be the high level of unmet needs (Ringheim et al., 2009). This means that more than 30% of Ethiopian women want to space their next birth or stop getting pregnant, but are not using contraceptives. Further, only 15% of married women who want to control their fertility, or do not want to get pregnant, use contraceptives (including both traditional and modern contraceptives) (Ringheim et al., 2009). It has been reported that the contraceptive prevalence in urban areas is 47% while in rural areas it is only 11% (Ringheim et al., 2009). Other reasons of high fertility rates are found to be related to the trend that men hesitate to use contraceptives, lack of knowledge or education about contraception use or family planning (Ringheim et al., 2009). The high infant mortality rate is also found to be one of the reasons for keeping high fertility rates (Eyayou, Berhane, & Zerihun, 2005). One study from Southern Ethiopia reported that having many children was seen as an insurance against high child mortality, that was highly prevalent in that area (Eyayou et al., 2005).

The Ethiopian government also considers the rapid population growth as a big problem. The government made “The National Population Policy” in 1993. The National Population Policy was formulated “in response to an imbalance between population growth, natural resources, and economic development, aggravated by spatial maldistribution, youthful age structure, high fertility, and the disadvantaged position of women in society”(Ringheim et al., 2009, p. 2). The rapid growth of the population brings exhaustion of all kinds of resources and the National Population Policy has set a goal of obtaining a balance between the population and the available resources. To reduce the total fertility rate, the first target is to increase the contraceptive prevalence rate among married women. One of the goals in the policy is increasing the contraceptive prevalence to 44% among married women by 2015 (Ringheim et al., 2009). The Ethiopian government also made other plans related to the population growth; the 2005-2010 Plan for Accelerated and Sustained Development to End Poverty. This plan is considered indispensable to reduce poverty because a reduced population growth may result in reducing “population pressure on the land, low incomes in rural areas, and youth unemployment in urban areas” (Ringheim et al., 2009, p. 1). Therefore, one of the goals is to reduce the total fertility rate which is “the average number of children that would be born alive to a woman during her lifetime if the age-specific fertility rates of a given year applied throughout her childbearing years” (IPPF, 2011). The aim is to decline the total fertility rate by 4 children per woman by 2010. The other goal is to encourage women to receive school education to raise the marriage age and to reduce the total fertility rate(Ringheim et al., 2009).

1.1.3. Previous studies on fertility in Ethiopia

Previous studies related to fertility in Ethiopia are predominated by the use of quantitative methods. For example, some of the often cited studies is analyzing the data from the “Demographic and Health Survey” and the “National Family and Fertility Survey”(Alemayehu et al., 2010; Bhargava, 2007; Dibaba, 2009; Hogan, Berhanu, & Hailemariam, 1999; Short & Kiros, 2002). There are few studies conducted by the use of qualitative methods, but two studies have explored the topic. Y. Berhane et al.(1999) studied the

perception of fertility regulation in a remote community in South Ethiopia with qualitative methods, using in-depth interviews (Y. Berhane, Mekonnen, Zerihun, & Asefa, 1999). The study described social and cultural factors informing us about their fertility preferences such as the marriage form, sexual norms and concept of family. The authors discuss the relationship between one of their traditional fertility regulations, postpartum sexual abstinence and the marriage form polygamy. The author claims that polygamy have contributed to the relatively few number of children per woman because husbands can settle out with another wife while one wife is in a prolonged period of postpartum sexual abstinence (Y. Berhane et al., 1999). On the other hand, polygamy may be one of the major causes for the increased population, and was reported as an important cause by all categories of informants (Y. Berhane et al., 1999). This contradiction is not clearly analyzed in the study. Further, it is difficult to understand the true meaning of important concepts described by interviewees, such as “family” or “marriage” because the study focused only on the interviewees’ answers and did not focus on the context and background of the community where the interviewees live.

Sahleysus (2005) studied attitudes toward family size preferences in urban areas in Ethiopia using qualitative methods; in-depth interview and focus group discussions (Sahleyesus, 2005). Most of the participants did not prefer large families. The author pointed to two reasons; economic hardship and the trend of enhancing child quality. The study suggests one interesting result; that it is the female residents that tend to prefer large number of children, and the male residents tend to prefer fewer (Sahleyesus, 2005). This is interesting because many previous studies have shown that men tend to be pronatalists compared to women, and that it may be one of the obstacles to use contraceptives. However, the author did not discuss this point. In order to explore why this phenomena occur, it might be necessary to study other parts of the participants’ social-cultural lives.

1.2. Research aims and rationale for the research

1.2.1. Rationale for the research

As shown in the background information, Ethiopia has a rapid population growth. The Ethiopian government and international organizations have tried to reduce the pace of growth by education in family planning and providing contraceptives. Despite these efforts, there is still a higher fertility rate than what is considered an ideal rate of 4.0 per woman. In rural areas, where the research place is located and approximately 84% of Ethiopians live, the population is growing at approximately 2.3% every year (Ringheim et al., 2009). However, existing studies on population growth have mainly been conducted by quantitative methods and there are very few qualitative studies in rural Ethiopia exploring people's point of view, and the reasons why the interventions have not worked and what kind of perception and experiences people have.

Based on the existing studies, we can argue that there is a knowledge gap related to this topic in this particular area. As mentioned, few studies on this topic have used qualitative methods, and there is no qualitative research from the rural Oromia regional state. Further, no previous studies, related to fertility, have adequately focused on the socio-cultural background, for example gender role, marriage form, religion, and occupation.

1.2.1 Research aims and sub-objectives

Based on previous studies related to family planning in Ethiopia, I found a lack of qualitative studies in rural Ethiopia, an area which has a much higher fertility rate compared to urban areas. Thus I decided to investigate why there are still high fertility rates in rural Ethiopia.

Some sub-objectives were set as a means to reach the main aim of the study. The sub-objectives were developed drawing upon the results and identified

knowledge gap in previous studies, and are as follows:

- To explore what having children means in different peoples' lives.
- To explore how people make decisions related to family planning (micro-level).
- To explore how a variety of cultural, social and structural factors influence such decisions.
- To explore what kind of contraceptives people know of and prefer to use.
- To explore what kind of needs, both met and unmet, people have in relation to family planning.

2. Theoretical framework

This study developed from the standpoint that there are few studies which explore why people in rural areas in Ethiopia keep their fertility high and why interventions by the government and international organizations have not worked well in rural Ethiopia. In the following, I will outline some theoretical perspectives in which this study draws upon, meaning that they are only serving as an inspiration for the study and are not applied as a complete framework as such.

2.1. The Health Belief Model

The Health Belief Model (HBM) is a model that attempts to explain and predict health behaviour (Becker, Drachman, & Kirscht, 1974) by focusing on individual beliefs, perceptions and attitudes. The HBM has been developed to encompass solutions to practical problems in public health services, and was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services (Rosenstock, 1974). Broadly spoken, the model illustrates that there will be some predisposing factors that together with certain enabling and supportive factors will lead people in different directions when they make choices related to how they are to treat their illness. Predisposing factors involve health beliefs and attitudes towards the illness, the related treatment, as well as the health services. The health beliefs people hold include general health beliefs such as how “health” in general is perceived and willingness to seek help based on a certain medical direction/treatment. It also includes more specific health beliefs such as perceived susceptibility to the disease, belief in the diagnosis, and perceived severity of the condition. (Rosenstock, 1974). The other main constructs that constitute the HBM is “perceived barriers”, which is an individual's assessment of the factors that discourage a certain health related behaviour, whereas “perceived benefits” is an individual's assessment of the factors that are seen as a positive consequence

of adopting a certain behaviour. At a later stage the HBM included certain modifying factors such as demographic variables (e.g. sex, age, ethnicity, occupation), socio-psychological variables (e.g. socio-economic status, coping strategies), and “cues to action” (e.g. information provided by powerful others, personal experiences) (Becker, 1990; Rosenstock, 1974). This means that perceptions and experiences of for example sociocultural factors or direct or indirect economic costs related to the behaviour are all influential. The combination of different factors will continuously be interpreted and evaluated and subsequently the “sum” of perceived negative and positive aspects of treatment lead people in different directions, making different choices related to their health.

This study presupposes beliefs/perceptions related to family planning and reproduction to be an important factor which affects contraceptive use. The Health Belief Models’ emphasis on health beliefs fits this presupposition in the sense that it draws attention to people’s beliefs which I regard as central in understanding behavioural varieties related to family planning.

Even though a variety of modifying factors have been added to the HBM, the model has however been criticized for focusing too much on individual factors compared to factors such as socio-economic and environmental factors. The strong focus on the individual’s part in the model has been suggested to encourage victim blaming and thrusting too much responsibility upon individuals (Roden, 2004). Due to the relatively strong focus on the individual, I will in this study also draw upon other perspectives, such as anthropology; a discipline which to a large extent focus on sociocultural and environmental factors. The characteristic of the anthropological perspective can be said to be “its holism”, and the advantage of the anthropological perspective is that it aims to encompass diversified and pluralistic understandings of a phenomena (Greenhalgh, 1995, p. 12) . Anthropological studies on fertility aim at “the creation of ‘whole demographies’ that contextualize reproductive behaviour not only in the social and economic terms of conventional demographic theory, but in political and cultural terms as well” (Greenhalgh, 1995, p. 12). Reproductive behaviour is understood as

intertwined within structures which mediate gender divisions within indigenous knowledge and health systems (Price & Hawkins, 2002).

Anthropological studies on fertility-related issues focus not only on the biological aspect of fertility but also on the social aspects of fertility. The social aspect of fertility indicates the way of “creation and perpetuation of families and kin groups, communities and nation-states” (Greenhalgh, 1995, p. 14). Therefore fertility’s “place has come to be surrounded by a thicket of confusing, conflicting, contested and vitally consequential moral values” (Greenhalgh, 1995, p. 14). Thus, an anthropological research on reproductive behaviour should focus on untangling the cultural process (Greenhalgh, 1995).

Blau (1960) early argued that social values and norms have influence on social conduct. He considered social values and norms as “common orientations toward social conduct that prevail in a society or group” (Blau, 1960, p. 179). The common values and norms cause two kinds of fears – fear of his or her conscience and fear of social sanctions. An individual’s behaviour can in other words be seen as influenced by the fears an individual feels. This viewpoint is applicable to the study since it emphasizes each person’s practices and perspectives, and how people’s perception about how the community views their actions affect their reproductive behaviour (Paek, Lee, Salmon, & Witte, 2008).

This study is also inspired by Price and Hawkins (2001) view on culture where they see culture as dynamic and “continually being constructed and negotiated in social interactions and everyday practice” (Price & Hawkins, 2002, p. 1328). In other words, we can say that there is a dynamic relationship between structures and agents, where contextual factors influence people’s perspective and behaviour, and where contextual factors are being constructed by the actions of individuals and groups.

3. Methodology

3.1. Study design

The object of this study was to explore a variety of factors which could influence people's perceptions and behaviour regarding decision-making processes in family planning. To be able to understand the views and behaviour among local people in this specific context, I utilized qualitative methods. As emphasized by Price and Hawkins, qualitative methods have the "potential to explore and probe more deeply into people's accounts of social life" (Price & Hawkins, 2002, p. 1327).

Price and Hawkins (2002), who study anthropology and development, claim that "sexual and reproductive behaviour must be understood within locally specific social, cultural, economic and political contexts"(Price & Hawkins, 2002, p. 1325). This means that perceptions and practices related to family planning and contraceptive uses cannot be reduced to a biomedical issue. Therefore, comprehensive understanding of cultural, environmental, and individual aspects are all significant when exploring factors influencing perceptions and practices. Price and Hawkins also emphasize "the need for a methodological approach in researching sexual and reproductive behaviour that enables a more rigorous engagement with the realities of the everyday lives of poor and marginalised people"(Price & Hawkins, 2002, p. 1328). One of the purposes of a qualitative methodological approach is to develop an "actor-centred" view, which tries to explore how different actors mould their strategies and dispose different social norms in specific situations (Price & Hawkins, 2002).

3.2. Study sites

The research was carried out in four places in Bale zone, Oromia regional state in Ethiopia: Salaam village and Jara town which were located in Gololcha district, and Robe and Goba which were the central cities in Bale Zone. A research assistant and I conducted the interviews with the villagers and health extension workers as well as the focus group discussions with the villagers in Salaam village. We conducted the interviews with health workers in Jara town, Robe and Goba. The research period was from August to October 2011.

3.3. Approaching the field and recruiting participants

At first, I had two reasons why I selected the village as research place. Firstly, Bale zone, where the village is located, has a higher total fertility rate (urban: 3.345, rural: 6.285) than the average in Oromia regional state (urban: 2.635, rural: 5.235) (Commission, 2010), which made it natural to investigate the reasons for a high fertility rate in this particular zone, comparing with other potential study sites. Second, the research assistant had extended family in the village, so in terms of increasing feasibility of the research, this was considered a big advantage for conducting the research smoothly and safely, and within a reasonable timeframe.

3.4. Research setting

For the duration of the study, the research assistant and I lived in one of the relatives' house in the village. Living in the research field made us able to understand and contextualize daily life within the sociocultural and

economic frames of the community. By living in the village we managed to obtain “background” information of the participants as a group as well as many of the individuals; such as where and how people lived; how the kids were taken care of, what the participants worked with and which religion they belonged to. During our stay in the village we had many "informal conversations", sometimes based on ongoing observations, which helped us to understand our topics even better.

By living in the research field, we obtained information which may not have been realized just through interviews or short explanations. By living in the field we got to know typical gestures, expressions, and the context that framed people’s everyday life. For example, we could see how daily tasks were divided by gender and how hard people worked every day. Living in the village gave us a deeper understanding of the context and meaning behind the utterances and perspectives provided us during and outside of our interviews and focus groups.

Moreover, living at the study site helped to establish a good relationship between me, the research assistant and the residents. By being present in the community on a daily basis people got to know both me and the research assistant, and by the time we conducted the interviews and the focus groups we were no longer strangers. We had managed to build trust and understanding for our fieldwork, which was a very valuable investment for conducting the research. Additionally, the research assistant and I have visited almost all of the households in one area of the village as the first step of the field work in the village. I managed to introduce myself and the research, recruit participants to the study and at the same time get background information of the community, such as people’s daily works, family relations, and social networks.

3.5. Presentation of research context

As mentioned earlier, the village where we conducted the field work is located in Gololcha district in Bale Zone. The district has a population of approximately 172,000 (Commission, 2010), and Jara town is the central town in the district. The village was approximately 4 km away from Jara town. There is no proper road for cars or carriages from the town to the village, and in the rainy season, the road became very muddy and slippery. When the villagers went to the town, they usually went there by foot or rode a mule if they owned one. There was no electricity or running water in the village, so the villagers used spring water and rainwater for domestic uses.

The village was divided into four areas and one area was, as mentioned, identified as our central research place. According to the results of the household visits, there were about 120 households and approximately 650 people living in our selected research area. The major occupation of villagers was agriculture and farming. Other occupations were merchants, civil servants, and teachers; however, there were significantly fewer people who worked within these areas compared to farming.

While staying in the village, we observed people's daily lives. Our host family usually woke up around 6:30 a.m. and after breakfast the male family members went to the fields to feed cattle, and they came back home between 6:00-7:00 p.m. The female family members worked with cooking, taking care of children, and other housekeeping tasks. During the farmer's busiest time in harvesting or cultivating, female family members also went to the fields and helped with farming. People were generally busy with this work every day. Additionally, people went to sell their products or buy groceries during the market day in the town. People seemed to value diligence in their daily work, and there was an established respect for wealthier people who accumulated smaller fortunes through hard work. We also recognized that all activities in their lives depended on their physical abilities and subsequently how important it was for them to keep their bodies strong and healthy.

From the house visiting, 2/3 defined themselves as Ethiopian Orthodox Christian and 1/3 as Muslims. There was one primary and lower secondary school with grades from 1-8. If a student wants to continue to study, they have to go to a school in Jara town.

3.5.1. The medical environment in the village

During the study I found that the “medical environment” of the village was having a significant impact on how people perceived and acted in relation to family planning and contraceptive use. For instance, the access to contraceptives and medical facilities directly influenced people’s knowledge and use of contraceptives. Subsequently, this environment was important to map and understand.

In the town which was the closest from the village, there was a governmental health centre as well as private clinics and pharmacies. According to health workers in the health centre, there were two health officers, 20 nurses, three laboratory technicians and 45 health extension workers (which are described later) for the entire district. There was no medical doctor in the district. Health extension workers were assigned to each village; however, all other health workers worked only in the health centre or private clinics in the town.

The village we were located in had a governmental health post which opened in 2009. Two health extension workers worked here and they provided antenatal care, vaccination services, contraceptives, and treatment of minor sicknesses. These health extension workers were therefore the most accessible and closest health worker for the people in the village. Health extension workers are community health workers who are assigned in each village (2 workers per 5,000 people) and their objective is providing primary healthcare in rural areas, for example, increasing awareness and knowledge related to health and hygiene by way of prevention. According to the professor who lectured candidates studying to be health extension workers, there were some main criteria for selection. First, the candidates must be

female. Second, they needed to pass the grade 10 in the national exam¹ with a score from 1.6 to 2.0. Third, they should be born and have grown up in the village where they would work, because they should know the culture and the language of that community. The professor said that they especially had to know the specific health problems and practices in their community. The district health office and health centre chose female candidates based on the following criteria: the candidates selected by each district must join the one-year education program; their training has been supported by the federal government; they had a curriculum which consisted of several subjects and topics, such as mathematics, English, epidemiology, statistics, hygiene, sanitation, nutrition, and family planning. This education program also included practical training. For example, the candidates were taught how to conduct consultations on family planning with couples, and about the provision of contraceptives. After the education program, they were each assigned a village.

A health extension worker's main activities were conducting home visits and giving lectures on issues related to health. Moreover, they also taught at the village officer meetings or by *afosha*². Because of their various activities outside the health post, the health extension workers in the village said that they only worked at the health post every Friday. If people needed more treatment than what the health extension workers could offer, they went to the health centre or private clinics in the town. We often heard complaints about the medical conditions in both the interviews, focus groups and informal conversations. During an informal conversation, one woman said:

"I have a pain in my leg. I cannot walk well. I know I have to go to the health centre. But I cannot because now the road is very muddy. I cannot stand walking the muddy road. I'm waiting for the rainy season to finish."

¹ The full mark of the exam is 4,00. Women who score 2.0 or 2.2 and men who score 2.4 can join the university.

² *Afosha* was the name of local reciprocal help organization and organized by each gender and location. There were several *afosha* groups in the village. A member of *afosha* had a right to be helped by other members in case of emergency, holding a funeral or going to the hospital. Most married people had their own *afosha* and they had monthly meetings in order to collect membership fees or report their activities.

As mentioned above, there were quite poor road conditions from the village to the town, and this made the accessibility of medical facilities very difficult, especially during the rainy season from April to October.

At the health post in the village, people could choose from four contraceptive methods free of charge: oral contraceptive pills, injectable contraceptives (injections/Depo), implants (Implanon), and condoms. Implants have been introduced recently at the health post and the health extension workers recommended the method because of the longer term prevention than other methods.

3.6. First step in the fieldwork

Before going to the village, the research assistant's grandmother, who knew the relatives in the village, asked them to take care of us during the research period in the village. Therefore, we were welcomed by the relatives when we reached there and could smoothly start our stay in the village.

First, we selected one area in the village (that was divided by four areas) due to our house being located there. This seemed advantageous for us because we could get to know potential participants easier, present ourselves and our study and make people familiar with our presence. Another reason was that due to the rainy season it was sometimes difficult to travel around, the village being quite large in circumference. We initiated the study by visiting almost all of the households in the selected area in order to present ourselves and our study, and to get an impression of the demographic profile of the community. For example, we took notes on the sizes of each household, number of children, their work/livelihood, size of the land, number of livestock and their religion. By visiting all these households, presenting ourselves and our study, we also aimed at recruiting participants for interviews and focus group discussions (FGDs).

Eventually we visited a total of 115 households, in an area which covered approximately 120 households. We were met with openness and friendliness and everyone seemed to understand the purpose of our study and accept our activities. I was introduced as a student who studied international community health and was interested in reproductive health issues within the cultural context of rural Ethiopia. Both the research assistant and I focused on showing respect and to have a positive attitude towards learning comprehensively about people's culture and lives.

3.7. Recruitment of participants of the residents in the village

Through the household visits, we recruited all participants both for the interviews and focus group discussions. The precise number of participants in the study was not decided beforehand, but in later stages in our research, and at a point where we believed we had reached a saturation point.

We did a purposeful sampling aiming at identifying a variety of relevant persons that could inform us about the topic from different perspectives (Patton, 2002). The advantage of purposeful sampling lies in selecting "information-rich cases" for the study. Purposeful sampling makes it possible to find participants that will be able to reflect on the topic (Patton, 2002), and the data may illuminate the aim of the study by providing relevant and sufficient information. Being inspired by Malterud (2001), the sampling in the study was done in a stepwise way, in order to answer the research question effectively (Malterud, 2001). In the process of visiting households we identified nine couples, consisting of women and men in the age range of 20-40 years who had a child /children. The characteristics of these participants are displayed in table 1. When we introduced ourselves and the research, all participants seemed interesting and curious about the study, and expressed positive attitudes about participating. Those that were included were chosen because they immediately responded positively to participate in the research and agreed to contribute with their perceptions and experiences related to family planning. After the participants had expressed their willingness to participate they were asked to give their

informed consent to participate.

We identified participants for focus group discussions by using the snowball method. We considered the composition of members in each group to be one of the most important factors to consider allowing for comfortable discussions about sensitive issues. In order to obtain various opinions about the topic, we initially selected participants with different attributes: mainly gender and religion. We selected three females (one Muslim, two Ethiopian Orthodox Christians), and three male participants (one Muslim and two Ethiopian Orthodox Christians), who were all older than 20 years of age. We then asked these six participants to invite from two to seven of their friends or relatives who they felt they could talk openly with, in order for each group to consist of four to eight people (Kitzinger, 1995). We made a schedule with those initially selected and asked them if they could choose the place where the focus group was to be held.

3.8. Research participants

The participants who took part in semi-structured interviews are detailed below: four couples and five female participants in the village, two health extension workers in the village, three staff members from private clinics, three workers in the health centre in the town, one health administrator in Robe, two staff members who worked at a NGO related to reproductive health in Robe, and one former lecturer from a health extension program in Goba.

3.8.1. Presentation of villagers recruited for interviewees

We selected nine couples to participate in the semi-structured interviews. We planned to have all interviews with both husbands and wives simultaneously, however, this was not feasible since only the wives stayed home and many husbands were busy with farming and not in their house before late in the evening. Consequently, we conducted interviews with four couples where the

husbands were available at early evening and with five female participants. The participants were composed of men and women who lived in the village. The age range was 20-40 years. Their job/occupation was within agriculture. All participants were married and had one child or more. The profiles of the participants are displayed below:

Table1. Profile of interviewees (villagers)

Couple	Age of wife:	Age of husband:	Religion:	Sex and number of children
A	30's	40's	Christian	3 boys, 2 girls
B	30's	40's	Muslim	3 boys, 6 girls
C	20's	20's	Muslim	1 boys, 2 girls
D	30's	30's	Christian	3 boys, 3 girls

Female participant:	Age:	Age of husband:	Religion:	Sex and number of children
E	20's	40's	Christian	3 boys, 2 girls
F	20's	30's	Christian	4 boys, 2 girls
G	20's	30's	Christian	1 boy
H	20's	20's	Muslim	1 boy, 1 girl
I	20's	20's	Muslim	3 boys

3.8.2 Presentation of health workers recruited for interviews

The participants among the health workers were chosen to participate in the semi-structured interviews because they seemed engaged in the topic, as well as being practically involved in family planning activities in the village. The information about these participants was based on informal conversations with the people in the village. The table shows that the participants had different positions and worked at different levels related to reproductive health in Bale zone. Below are the characteristics of each of the participants:

Table2. Profile of interviewees (health workers)

Position held:	Place of work:
2 health extension workers	Health post in the village
1 administration officer, 1 nurse, 1 midwife	Health centre in the town
3 nurses	Three different private clinics in the town
1 health administrator	Health bureau in Robe city
3 NGO staff members	Office in the health bureau in Robe city
1 ex-lecturer of a health extension program	Goba health science college in Goba city

3.8.3. Presentation of focus group participants

As mentioned earlier, the participants for the focus groups were recruited by snowball sampling. All participants were residents of the village. The characteristics of the participants are displayed below and the table shows that all groups were composed by people of the same sex. In terms of religion, except from one group, five groups were composed of people who had the same religion.

Table3. Composition of focus groups

No.	Gender:	Religion:	Age: number of participants
FGD1	Female	Christian	20's:5, 30's:1
FGD2	Male	Muslim	20's:2, 30's:2, 60's:1
FGD3	Female	Muslim	20's:6
FGD4	Male	Christian & Muslim	20's:1, 30's:4, 40's:2
FGD5	Male	Christian	30's:5, 40's:3
FGD6	Female	Christian	20's:1, 30's:2, 40's:2, 50's:2, 60's:1

All the participants recruited for the focus groups, except two, were new participants. The two participants that did participate in both an interview and a focus group did that because they were incidentally invited by the initial participants who were asked to gather the member of focus groups.

3.9. The research assistant

I employed one male research assistant who fluently spoke English, Amharic (which was the official working language), and Oromic (the local language of the research participants). As for the educational background he had a Master's degree in psychology. I met the research assistant in Addis Ababa. Initially, I was thinking that the ideal research assistant should have a background within health and/or work in the public health sector. However, the way he referred to local people and the topic, expressing respect and concern, made me convinced of his ability to participate in the research. During the research process my first impression was confirmed. The way he managed to approach the participants, showing respect for their opinions and values, being curious without intimidating, was probably a much more important skill than being familiar with the topic. In general, his overall appearance and good communication skills clearly helped me build trust with the participants and the villagers as such. Moreover, the fact that he was fluent in English, Amharic and Oromic and had previous experience in conducting interviews as well as moderating focus group discussions was an extremely valuable asset. In order to understand the research's purpose and how I planned to conduct the research, a description of the study and a plan for the research process were discussed with the research assistant in detail before traveling to the village. We also discussed how to make the interview guides and we adjusted these while discussing different possibilities. I had made a first draft but we discussed the questions and the words to be used thoroughly in order to make the questions understandable and suitable for the participants. Regarding the focus groups, we exchanged views on the topics which were to be discussed and decided which topics were suitable for discussion.

The research assistant attended and organized/facilitated all of the interviews and the focus group discussions while I attended. After the interviews and the focus group discussions, the research assistant translated

the data recorded by IC recorder as well as notes taken during the interview and focus group discussions, from Oromic/Amharic to English.

3.10. Data Collection

I utilized multiple methods in order to collect the data in this study. As stated before, the research assistant and I conducted semi-structured interviews and focus group discussions. Furthermore, since the research assistant and I lived in the research setting we were also able to observe people's daily lives and patterns of interaction. By living in the village we were also able to closely connect with people and talk to them in various situations, rather than just in the interviews and focus groups.

3.10.1. Semi-structured interviews

Semi-structured interviews were conducted in order to examine subjects' experiences and individual opinions of family planning and contraceptive use. All the interviews were conducted by the research assistant and me. Semi-structured interviewing is based on the use of an interview guide, which is a written list of open-ended questions and topics that need to be covered, sometimes in a particular order (Bernard, 2002). Using an interview guide makes it possible to have some control of what you want from an interview, for example that certain topics are covered, but there is still space for the researcher and the participant to follow new leads (Bernard, 2002).

Another advantage of doing individual interviews is that the researcher can pay close attention to each participant. For instance, if a participant does not understand the meaning of the question or the researcher feel that he/she does not answer fully, the researcher can ask the question in a different way or probe him/her (Bernard, 2002). On the other hand, an individual interview is reactive in the way that the information given from a

participant depends on the relation between the researcher and the participant. The research assistant and I were aware of this and actively paid attention to this aspect by being careful in relation to how we spoke and how we behaved. In particular we observed the participants' body language and looked for signs that indicated whether or not they felt comfortable with the situation and the questions being posed. In the process of preparing for the interviews, the research assistant and I prepared a semi-structured interview guide. I developed an interview guide for couples based on topics identified from the literature and topics focused on in previous, similar studies. A second interview was conducted with both the villagers and the health extension workers in order to make us understand the answers of the first interview more clearly or more in-depth. Therefore the questions of the second interview were developed later in the research process, and were based on the answers from the first interviews with the participants. In the process of preparing for the interviews I explained and discussed in detail the intentions behind the questions. After the interviews, the research assistant and I discussed both the questions and answers in order to clearly understand what the participants' were asked and what they answered. The questions were open-ended and we added new topics during interviews, as the discussion evolved. All except one couple that had moved to another village during the research period participated in two interviews. We also conducted two interviews with the health extension workers in the village. The reason behind this was that both the villagers and the health extension workers gave us new ideas that we wanted to follow up in the first interviews, or we found that we needed additional information related to the answers they gave in the initial interview.

The interviews with the villagers were carried out in their houses because the participants preferred this location. The interviews lasted approximately 30 minutes and were recorded with an IC recorder. During the interviews, the research assistant did not translate into English or interpret to me, except when new topics or ideas came up. We did not have the time to translate while we did the interview because most of the participants were busy with their works and wanted the interview to be as fast and efficient as possible. Additionally, to facilitate a flow in the interview, as well as to

prevent misunderstandings due to a continuous interpretation between two languages (the main researcher not being totally fluent in English), we decided that this was the best approach. All the interviews were therefore conducted in Oromic. The research assistant and I usually translated the interviews from Oromic into English the same day as the interview was conducted, but sometimes within a few days. Even if we did not have the time to translate it directly after the interview, we immediately exchanged our views of the interview and the research assistant told me what the main information consisted of. Through the discussions and translations, we added new questions for the following interviews and made the interview guide for the second interview with that particular participant.

There were many challenges with the interview settings. It was very difficult to keep the area for the interview private, because, for example, many children who were very curious about our activities gathered around the house, guests came frequently during the interview, and the participants were also busy with their household chores. However, these “disturbances” also helped to make the atmosphere for the participants more relaxed. It created a less structured situation which seemed to encourage more comments, and it often felt more like a normal conversation. We also encouraged the participants to expand on a response because we thought it was important that their responses were open-ended and should not be controlled by our preconceived notions (Davies, 2008).

We also conducted semi-structured interviews with health workers, administrators, and NGO staff. To accommodate tight schedules and time limitations, all of the interviews were conducted once in their offices, which was a choice of the interviewees. These interviews lasted from 20 minutes to one hour and were also recorded with an IC recorder. Most of the interviews were conducted in Oromic, but one of the interviews with one of the administrators was conducted in Amharic, a language which the research assistant also spoke fluently.

3.10.2. Focus group discussion

Focus group discussions (FGD) is a good way to understand the perspectives of a community, because interpersonal communication is useful in highlighting cultural values or group norms (Kitzinger, 1995). As mentioned earlier we employed the snowball method to get the participants for the focus group discussions. We selected six group leaders and asked them to invite people who they thought could speak openly and comfortably about family planning. As a result, the participants seemed encouraged to discuss things with each other; ask each other questions, add comments on each other's opinions or experiences and share their own views and experiences. For the participants who may be reluctant to be interviewed alone or who may feel there is nothing to say, the group discussion process can be an easier, more suitable way to encourage more participation (Kitzinger, 1995).

Focus groups are meant to explore people's knowledge and experiences: what people think, how they think and why they think that way (Robinson, 1999). The method can also be used to investigate how people's opinions or views are constructed. In this way, focus groups are well-suited for research which focuses on the process of decision-making and opinions related to family planning. Although the topic may be seen as sensitive, we tried to challenge people's general and common opinions and experiences. For example, when we talked about the experiences of contraceptive use, we asked them what kind of contraceptives that was popular to use among the villagers. Through the discussions, we got the impression that most of the content related to family planning did not represent a taboo to talk about. The participants seemed comfortable and included their own individual experiences and opinions. The fact that the participants gave the impression of being comfortable can be related to the group composition; an inclusion strategy that seemed to work as intended.

We conducted six focus group discussions with both male and female villagers. By their choice, all discussions were held in one of the group participant's houses. The research assistant arranged the discussion with the topics we had prepared beforehand; however, we also made room for new topics during the discussions. The focus group discussions lasted 2-3 hours and were recorded with an IC recorder. I attended all discussions and

observed the participants' body language, expressions and the general atmosphere.

I sometimes gave indications to the research assistant to make sure that all respondents participated, to limit time used by some of the participants who seemed to dominate the discussion, and to include those who spoke less. Sometimes participants interrupted other participants to speak about their own opinions. We hypothesized that the reason why there was a difference between each participant's level of participation, was dependent on their own knowledge and their personalities, but it could also be due to how the discussion was exercised. Based on these types of observations we continuously tried to adjust the conversation and the topic in a way that made it easier for all participants to join the discussion.

The research assistant provided small summaries and comments to me during the discussions, so we could change to more suitable methods for the group or change topic. For example when participants brought up new ideas which we did not expect, or when we felt the way of our questioning was not coming across with the participants, we would have a small discussion before we went on. Subsequently, in many cases we conducted the discussion with much flexibility. All of the focus group discussions were carried out in Oromic. The translation of the first group discussion was conducted before we started the second group in order to examine whether our topics were suitable to discuss with the remaining participants. We also wanted to bring the knowledge gathered from each focus group into the next, and as such adjust each of the coming focus groups according to new topics or perspectives introduced by the participants. The only exception was after the second group discussion, where we could not finish the translation/discussion before the third discussion. This was due to the schedule based on the participants' requests which occasionally was very tight. However, we did exchange our views and experiences after each of the group discussions, and made sure that we made changes related to new topics coming up during the discussion, the participants' attitudes, and the familiarity with each topic or way of talking about it. We also made changes seeking to improve the more practical and technical aspects of the discussions, such as were to seat the

participants and how to moderate the discussion.

3.11. Data management and analysis

3.11.1. Transcription and translation

All of the interviews and focus group discussions were recorded with an IC recorder and transcribed verbatim. All interviews were conducted in Oromic or Amharic and later translated to English. Because of time limitations the research assistant simultaneously translated and transcribed the interviews and the focus group discussions. Through this process, in order to increase our understanding and limit sources of misunderstanding, we discussed the meaning of certain words and sentences used by the participants, as there might be different possible interpretations. Much time was used to confirm not only the linguistic meaning of the words/sentences but also the interpretation of them. Most of the transcription and translation was carried out in our residence in the village. I wrote translations down in notebooks and later typed them in a private laptop when we came back to Goba city.

3.11.2. The process of analysis

There are various ways of systematic analysis of qualitative data (Malterud, 2001). This study selected one style, in which “the researcher identifies units in the text, forming the basis for data-developed categories, which are used to reorganise the text so that its meaning can be clearly seen” (Malterud, 2001, p. 486).

The process of analysis followed the four steps as below: 1) reading the entire material; 2) identifying the meaning units; 3) transformation and summarizing the content of the meaning units; 4) integrating the insights in

the meaning units into a consistent description (Malterud, 1993).

Practically, after the typing was completed, I imported all the transcriptions to the NVivo qualitative analysis programme, in order to organize the data. First, I read all the transcripts several times in order to increase familiarity with all the data. Then, themes were noted and units of meanings were identified by coding the transcripts in NVivo. The codes were determined based on the contents of the data. Coding was conducted sentence by sentence. Some of the meaning units were revised and new ones were created. Examples of codes I created were; access to contraceptives, expected effectiveness of preventing pregnancy by contraceptives, side effects of each method, and requests to health workers. Then I combined these codes and created themes, such as cultural value of children, knowledge and experiences of each contraceptive method, attitudes towards contraception, and opinions about access to contraceptives and access to information. After the coding process I summarized units of meanings into a short text and found crucial quotes to reflect the meaning. Lastly, I integrated the insights from the summarized meaning units into generalized descriptions that reflected significant factors. This work was conducted by me but was based on the understanding created through the continuous discussion with the research assistant.

3.12. Reflexivity

A researcher's background and position affects the research topic both through the angle of investigation, the methods considered most appropriate for the study, the findings considered most adequate, as well as the presentation and communication of the results (Malterud, 2001). When assessing a study and its findings it is therefore important to address the researcher's perspectives and position.

3.12.1. Preconceptions

This research originally started from the observation that rapid population growth in developing countries is a large problem which can lead to many social and economic difficulties, such as poverty, high maternal mortality, and environmental stress. By studying previous studies on this topic I was influenced by the shared idea that high fertility rates, which are directly related to population growth, should be lowered. On the other hand, I have previously studied anthropology and experienced field work in rural Ethiopia. This particular background made me careful not to simply insist that “high fertility is a problem” because this position is typically from a “western” or “outsider’s” opinion. In other words, the word, “high” was also very ambiguous because it was not clear how much or for whom it is too high for. Subsequently, I have been very careful to fairly represent the opinions of the participants in regards to reproductive behaviour and perception based on the attitude towards “high” fertility rates. Through previous field work, I understood that some people could not realize their desired family planning because of many different barriers outside their control.

The research assistant also recognized that Ethiopia had high fertility rates, especially in rural areas and that it was a big problem. In order to share the attitude toward the research, I firstly told him that the research aim was to understand the people’s opinions and experiences, not to “educate” or “teach” people. Since the research assistant had knowledge of anthropology and research experiences in rural areas, the common understanding of the research aim and the attitude seemed to be built up easily.

3.12.2. Connection between me/research assistant and the participants

When the research started in the village, I was introduced as a master student studying international community health in Norway. We felt that people generally accepted us and our research topic. However, some of them wrongly assumed that I had training in medicine and specific medical knowledge, and asked for medical advice or for certain medicines; those who

were sick or had health problems came to us with these requests. It was difficult telling them that we could not help, because we understood the medical situation in the area; there were no doctor present, and we knew they seriously needed and expected our help.

During the research, another important factor which influenced the relationship between me and the people in the village was the presence of the research assistant. First in terms of language, since people preferred to communicate with me via the research assistant because I could not speak Oromic. This had both an advantage and a disadvantage. The advantage was that I was able to get more information from people, and in a faster speed, by utilizing the research assistant's language skills. Further, I felt more at ease to make contact with local villagers without being concerned about being understood through a second language. On the other hand, the disadvantage was that it was difficult to build a close relationship between me and the local people. When I asked simple questions in broken Oromic, they tended to wait for the research assistant to be present before answering.

Regarding our positions, the research assistant and I were strangers to the villagers. Although the research assistant's relatives lived in the village, it was his first time visiting. I believe that being strangers allowed villagers to speak more easily, openly and less cautiously. If we had been established members of the community, our participants would probably have hesitated to talk about their opinions or experiences related to reproduction. The topics, such as childbirth, children, contraceptives, and communication with partners, were considered as sensitive topics but also somehow neutral issues. Since the participants did not know us from previously they seemed more at ease to participate in the research.

Living in the village also influenced the relationship between the research team and the people living in the research area. We stayed with the research assistant's relatives during the research period. Although we were complete strangers, the homestay contributed to the villagers' sense of reliability in us because people saw that the relatives accepted us. If people thought poorly of

the relatives, our homestay might have given them a pre-conceived negative impression of us. However, through the entire period of research, we did not feel any negativity towards us as a result of the homestay. Rather, when people learned that we were staying at the relatives' house, we received positive reactions, and even affinity and relief.

3.13. Ethical considerations

We firstly applied for ethical clearance to the Regional Committee for Medical Research Ethics in Norway; however, they regarded it as a project that did not need to be given a permission, this because the research was not considered as biomedical research. Therefore clearance was obtained from the Norwegian Social Science Data Services (NSD). In Ethiopia, we received the research permissions from the Institute of Ethiopian Studies at Addis Ababa University and each administrative area (zone, district and village).

3.13.1. Informed consent

All of the participants in the interviews and focus groups discussions were asked to give their informed consent to participate in the research. We gave the people living in the area information of the study by visiting households. Afterwards, potential participants for interviews or focus groups were informed in more detail, such as the expected risk of the study and the right to withdraw.

We planned to give this information both orally and in a written statement. However, I decided to give the information orally after discussion with the research assistant who was familiar with the local culture. The main reason is because most of the people in the village are likely illiterate or not familiar with written materials. Council for International Organizations of Medical Sciences (CIOMS) also states that "Informing the individual subject must

not be simply a ritual recitation of the contents of a written document. Rather, the investigator must convey the information, whether orally or in writing, in language that suits the individual's level of understanding" (CIOMS, 2002). This means that it is not necessary to provide written information in all cases, it depends on a participant's situation. The most important is that the participants truly understand the information they are given.

The second reason was that many of the participants could, according to the research assistant, become reluctant and even suspicious of participating in the research if we asked them to sign a piece of paper. Many would not understand the concept of informed consent or the necessity of a written explanation. Actually, this issue was a challenge in the first step of the research, as we felt the procedure made the participants feel uncomfortable and that being a participant was too much responsibility. Even though we gave an oral explanation in order to receive their informed consent, some participants asked us why this procedure was important and whether we were hiding something dangerous. As a response, we explained even further what the concept was and why we needed their consent before the interviews and focus group discussions could begin.

Although word of mouth was considered the most suitable way of recruiting participants for the research, there was a negative aspect to this strategy. It was difficult for the participants to remember all the information related to the research in order to make a decision on their own participation during the first visit. We had to provide the information continuously in order to overcome this problem. According to Richards and Schwartz, consent for research must be treated "as an on-going process", instead of treating it "as a once and for all event" (Richards & Schwartz, 2002, p. 137). If participants are given information several times to consider their participation, and have more than one chance to ask questions, I may be able to better inform potential candidates and likely receive more volunteers. Therefore, to inform and take time to answer questions from the participants at each interview or focus group discussion seemed to be the best way of securing voluntary participation. Giving explanations several times gave our participants the

time to consider whether they actually would take part in the research.

3.13.2. Relationship between the participants and me/the research assistant

If there is an unbalanced power relationship between the participants and the researcher/the research assistant, the imbalance may influence the number of participants recruited to the study. If participants feel that they have less power than the researcher/the research assistant, it may be difficult for the participants to decline to participate. Due to this we were actively aware of a potential power relationship when interacting with our participants.

In order to avoid or minimize power imbalance between us and the participants, and to secure voluntary participation, the research assistant and I considered it important to form a trustworthy and reliable relationship. On the other hand, we also realized that this strategy could have the opposite effect, by potentially making the participants feel forced or pushed to become involved in the research out of guilt, or a feeling of indebtedness or moral obligation. Though a trustworthy, reliable relationship was an essential factor in conducting our research, and we tried to be very clear that participation in our research was completely voluntary. Furthermore, we emphasized several times during the process that the participant had the right to withdraw at any time. Nevertheless, the participants who agreed to participate may have hesitated to say that they did not want to participate because they were afraid of the consequences, or would find it difficult to meet and interact with us in the village after having declined.

3.13.3. Benefits and risks

The expected benefit from participating in the study was that the information from interviews and discussions could help improve family planning programmes in that area. The expected risk of the study could be “identification of the participants by self or others” (Richards & Schwartz,

2002, p. 137). As mentioned by Richards, qualitative research may collect large amounts of information which are from many aspects of participants' lives and "contain multiple clues to the person's identity" (Richards & Schwartz, 2002, p. 137). Therefore, it is difficult to completely prevent identification by self or others even if the information is de-identified, because "it is not always easy to predict which data will lead to identification" (Richards & Schwartz, 2002, p. 137). We tried to reduce the probability of recognition by using participant numbers or position names instead of participants' actual names.

4. Findings

4.1. Value of children according to the participants

Having children had a significant meaning for all of the participants. They often said having children was “the medicine against death” and children were representatives of their parents. This chapter illustrates why people believe they need children and what kind of expectations parents in regard to their children.

4.1.1. Number of children

Almost all of the participants from FGDs mentioned that the level of respect parents received did not depend on the number of children they had. However, they said there were many merits of having many children, such as the parents being able to get various types of support from their children, and a family with many children has less risk of being physically attacked by another family than a family with a small number of children. Many also said that if a family was wealthy enough to have many children, it was considered good to have many children. However, several participants emphasized that having many children brought some families into poverty and that these families were not respected by others. Based on the interviews, most of the participants claimed that four to five children was the ideal number of children, but the number was decided by economic limitations or possibilities.

4.1.2. Sex composition of children

All participants from the interviews answered that they preferred to have both male and female children, and most of the participants thought it was

ideal to have more male children than female children. They also mentioned that it may be troublesome to have only male children, though, stating different reasons related to their type of marriage system and succession system. Firstly, when male children get married, they are still considered as the family member of their parents' house, the same as before their marriage, whereas females are considered a member of their husband's family when they marry. Many participants therefore claimed that female children could not truly be considered as "our children". As a result, male children were thought of as more important to the parents and the parents also expected their male children to take care of them when they became older. On the other hand, parents were also expected to give their male children their property, such as farmland and livestock, when they got married. This custom was another reason why participants preferred to have children of both sexes; the parents could not afford to give their property to their male children if they only had male children. Another reason why people desired children of both sexes was that their daily tasks were very rigidly divided by gender. If parents had children of both sexes, they could get different kinds of support. Some of the FGD-participants told they would choose to have more children if the male-female composition was not satisfactory, even if they felt the number of children was enough. One of the wives from the interview told:

"I want to have more male children than female ones. If the number of male children is less than female children, I will try to get male children. Even if the sex of children is a gift of God, I want to try until I get more male children." (Couple C's wife)

The importance of sex composition may encourage people to have more children than their ideal or desired number of children, or in some cases more than they can financially handle.

4.1.3. Interval between births

Half of the participants from the interviews said they so far had not planned when the children were born. Common reasons were that they believed the

timing was determined by God, and they did not know how to decide it by themselves. On the contrary, the participants who decided when to have children said that they decided the timing considering the prior child's development. There were only a few participants who used contraceptives in order to control birth intervals. Most of the participants who used contraceptives intended to have no children in the future. One of the wives from the interview said:

“We decided the time to have the second child. We planned to have him after the first child could walk and had become strong. Then I could dedicate myself to take care of the second one. It is good for both mother and children. But we did not use contraceptives. The time was decided by God.”(Couple C's wife)

This quote illustrates that even though some participants told that they decided in advance, the decision was first of all in the hands of God. This could be read as a statement indicating that even if they tried to plan timing and numbers of children, these decisions were mainly in the hands of God. In general, as illustrated in the quote, it was not common to use contraceptives in order to create the desired time between each childbirth. This attitude may lead to a delay in the point in time were people actively seek information related to contraceptive use. In fact, during discussions about contraceptive methods some participants said that they did not know anything about contraceptives because they wanted to have more children.

In spite of peoples understanding of the benefits of a longer interval between childbirths, many participants still conceived their children with shorter intervals than their ideal length. A wife explains why:

“I wanted to have babies with a longer interval. I had babies with two years interval. The child-rearing was very hard for me. But the two years interval was decided by us. Because children grow up very fast and they will support us (when they grow up).”(Female participant F)

This quote suggests that some parents would like to complete child-rearing at a younger age and thus receive support from their children earlier. This idea is connected to the livelihood of most villagers, where farming depends on their physical strength and abilities and the expectation of children to help with farm work (see 5.1.5.1.).

4.1.4. Marriage and the value of having children

Most of the participants mentioned that having children was the most important issue for married couples, and only when a couple has children they will be considered a serious and respected couple. One male participant from the focus group told how their status in the community changed after their children were born:

“If a husband cannot get a child, he cannot laugh and play with his friends who have children. If I don’t have a child, my name doesn’t change. My child changes my name. For example, my oldest child is called Tolaa. So, people respect me when they call me Abba (Father) Tolaa. Therefore I got respect because of my child. Having a child is having great respect.” (FGD 2)

The participants also said that children were essential for all couples to keep their marriage alive. In their opinions, couples should have their first child within one year after getting married. If they were unable to conceive a child in this period, there was a strong pressure on the wife from other members of the community, especially her husband’s family. If a couple was not able to conceive any child, there were solutions which the participants suggested, such as divorce, having a second wife, and adoption.

4.1.5. Expected role of children

4.1.5.1. Children as supporter of parents

All of the participants expected their children to support their parents, and mentioned having children meant getting support both at a younger age and later age in life. When the children were young, parents expected them to help with daily work, for example farming for male children, and fetching water for female children. The role of children in daily work was thus important, as more helping hands in the house and on the farm alleviated pressure from the parents. Some of the participants said that children brought solid economic improvement to their families. One wife from the interview said:

“I have children. So, I can let one child look after the cows and let another child go and sell crops. They help us.” (Couple C’s wife)

Parents received support from their children when they became older, too. This was especially the case for families who owned a farm, where the work is physically exhausting and taxing on the body. One husband explained:

“Why do we need children so much? First, they support us. When we get old or we get seriously sick, our children help us. Having children implies having support and services.” (Couple D’s husband)

For children who received higher education and better jobs, participants explained that pecuniary support was expected for the parents. Correlatively, children’s education seemed to be one of the more important issues to parents. Most of the participants from the interview hoped that they would be able to provide higher education for both their male and female children. The children who received higher education tended to move out from the village, however, participants considered the pecuniary support as important as labour forces.

4.1.5.2. Children as successors

The participants also mentioned the importance of children as successors. They said that if the parents passed away without having children, their property including the house, farmland, and livestock can easily be taken by others. Additionally, participants explained that children had an important role in keeping their father's name after his death. In this society, a person's name is comprised of their first name and then their father's name. Therefore, when the children are called by their names, the people also remember their father. A male participant from one of the focus groups said:

“Man is mortal. If a person dies without children it's the worst death. His name is also buried with his body. But if a person who has children dies, he is not considered as dead because of his children.” (FGD5)

As the above comment, many referred to their disappearance after their death by having no children and also mentioned the fear of being forgotten by others after their death if they did not have any children. Having children was one of the essential factors in being recognized as a respected person in the community. Further, children played important practical and symbolic roles as supporters and successors and this importance of the role deeply related to the fear of disappearance after the death.

4.2. Participants' knowledge and experiences with contraceptive methods

Knowledge and experiences with contraceptive methods influenced on people's perceptions on, and use of contraceptives. This chapter seeks to convey what kind of knowledge and experiences people had and how they perceived each contraceptive method.

4.2.1. Participants' knowledge related to contraceptive methods

According to the health extension workers, progestin (hormone) injections are the most commonly used contraceptive method in the village. Most of the health workers recommend these injections to those who visited clinics to receive contraception, this because the method had a longer effective period than birth control pills. The majority of the female participants that did use contraceptives received injections and seemed to have good knowledge about the use and effect of these injections. Some of those that had not used injections before talked about it as a contraceptive they were considering.

Based on the interviews with both health workers and regular people, the second common method of contraception seemed to be the birth control pill, which has been in use in this area for a while. Although some participants had sufficient knowledge of how to use the pill, a majority of the participants lacked knowledge on this topic or had misunderstood important issues. For example, one female participant from a focus group said that pills should be taken twice every day instead of once a day. When asked about the duration of one birth control pill's ability to prevent pregnancy, respondents had different opinions: one pill could prevent pregnancy for three months, six months, eight months, one year, or even three years. Overall, female participants tended to know more about this contraceptive than the male participants, and male participants were more often misinformed. For example, one male participant from one of the focus groups claimed there existed a birth control pill which had the same effect but was used by men. Other male participants believed that birth control pills had the effect of killing the foetus in the third month of pregnancy. Moreover, several male participants in the focus groups reported that they told women that the pills they swallowed did not dissolve in the body and it had bad effects on them and their foetus. Many shared ideas and stories related to how birth control pills accumulated in the body, as described by a male participant:

“The pills accumulated in her stomach. Then she got pregnant. She suffered from a pregnancy complication. She couldn't deliver the baby (in a normal

way). Then the family took her to a hospital. The pills she took were not dissolved. They were like stones. The pill didn't work, so she got pregnant. Then a doctor took out both the pills and the baby from her body by surgery. She had 4 children safely before she started to take pill. Then she started to take the pill and that made her unable to have the fifth baby safely. It may have happened due to other causes but a pill is generally harmful.” (FGD 4)

Many seemed to believe that the pill actually remained in the body, and this caused problems during delivery. The beliefs that the pill could be stored in the body made people fear it, also due to the risk of infertility. Therefore many participants preferred to use other contraceptive methods than the pill.

The health extension workers, on the other hand, believed that low usage of birth control pills was due to the fact that women had to come to get a new supply of birth control pills each month at the health post or another medical facility, which was inconvenient for most women. The health extension workers did not seem to be aware or understand patients' attitudes and fears related to this particular contraceptive method.

The third common method of pregnancy prevention used in the village is progestin implants. Implants were introduced in July 2011 at the health post in the village. Among the participants involved in the study, not all knew that the health post had started to provide implants. Nevertheless, of those who did know, a majority of them understood how implants are used, and some knew that implants could be removed if they wanted to get pregnant. However, there were huge differences in knowledge related to the effect of this contraceptive; some women believed they were protected only a few months while others thought they were protected up to twelve years. Findings from the focus groups indicate that the reason why some women hesitated using implants was due to a lack of information about this contraceptive, and thus many speculations about how implants affected women's health.

4.2.2. Participants opinions about the effectiveness of contraceptives

The majority of participants in the focus groups had the opinion that if a woman used a contraceptive in the right way, it was 100% effective against pregnancy. Therefore, they thought that if someone got pregnant while taking contraceptives, it was likely due to user failure or the failure of health workers. Participants cited common mistakes: for example, if they forgot to take the birth control pill every day or exceeded the prescribed dosage, or if they did not receive an injection on the exact day the health workers recommended. The failure of providers seemed to be related to distrust of private clinics. Some participants complained that health workers in private clinics injected women with only half dosage or water instead of medicine. They claimed that health workers in private clinics are more concerned with making money, and the participants told that they had never heard of this kind of accident happening to women who went to public medical facilities.

There were also participants who thought that contraceptives could not prevent pregnancy or that pregnancy prevention depended on certain conditions. Some participants mentioned that women had different blood types, and some blood types reject contraceptive medicines. Therefore these women could not be protected from pregnancy by contraceptives, even if they took it properly. Others said that birth control pills cannot prevent pregnancy when women feel a strong sexual desire. Some believed that pills cannot prevent pregnancy at all because of the belief that pills accumulated in the body. Regarding condoms, some male participants mentioned that condoms were breakable during sex, and thus the method was not trustworthy.

Two more methods of contraception, breast feeding and the calendar rhythm method, were also discussed. There were different opinions about breastfeeding as a natural form of contraception, opinions which drew on personal experience or from hearing about other's experiences. Some people believed that breastfeeding is effective against pregnancy, while others thought that breastfeeding did not prevent pregnancy at all because they

themselves had become pregnant, or knew other women that got pregnant during breastfeeding. One group of participants said that getting pregnant during breastfeeding depended on the condition of the women and/or the babies. They believed that pregnancies in this period occurred due to a woman's predisposition, or depended on how much breast milk women produced. However, the majority of participants considered breastfeeding as an ineffective form of contraception. In general few participants thought breastfeeding was an alternative method to modern contraceptives.

The calendar rhythm method was also mentioned as one of the methods for natural birth control. While some participants had knowledge and opinions about this method, others did not know about this method at all. The health personnel at the health centre in the town told that this type of contraception method was effective if the people used it correctly. One of the interviewed health personnel in the health centre explains how she presented this method:

“(We explain) there are two types of periods decided by the menstrual cycle. One is the fertile period where women get pregnant easily and the other is the infertile period where women do not get pregnant easily. If a woman has a 28 days stable menstrual cycle, first divide 28 by 2. It is 14 days. Then subtract 5 days from the first 14 days and 5 days plus the latter 14 days. So, from the 9th day to the 14th day is identified as a fertile period. Other days are safe. So, we advise people to use condom or to be abstinent from having sex during the fertile period. Additionally we also explain that the method cannot prevent pregnancy perfectly because the menstrual cycle can be irregular sometimes. Then the method does not work”.

The health personnel emphasized that they taught the method to the “educated” people who seemed to understand the method, but did not teach the method to those they considered uneducated. However, we found that there were various opinions about fertile and infertile periods among the participants. For what was considered the fertile period, methods of counting varied drastically: for example, within 10 days after menstruation, within 15

days from starting menstruation, immediately after menstruation, three days before and after menstruation, within nine days from starting menstruation, after 18th days from starting menstruation, and within one week after finishing menstruation.

The effectiveness of the calendar rhythm method was disputed in the focus groups. Some suspected that this method was not reliable, and did not believe it prevented pregnancy. Others said it was not applicable to all women because of husband's lack of tolerance of sexual abstinence. Some were confident that the method prevented pregnancy as long as one did not have sex in the unsafe periods. One male participant from one of the focus groups told about his wife's unexpected pregnancy due to the calendar rhythm method:

"I asked health care workers and they told me that if a woman has sex within nine days after menstruation starts, she will become pregnant, Then I separated my bed from my wife's for nine days and I added two days more myself. So we had sex after 11 days from her menstruation came. But she got pregnant. I don't believe that calendar method works". (FGD4)

The staffs who worked with reproductive health in an NGO were asked about their opinion on the calendar rhythm method. One staff member said:

"The method is not a preferable contraception because it has a high failure rate. We recommend using other contraceptive methods because there are many uneducated people in our community. The method is not proper for uneducated people. Therefore we provide contraceptive medicines and education programmes for them. But, we do not prohibit health personnel to teach the people the method. We do not recommend it. We encourage people to use other methods, especially long term methods."

The health personnel considered the method to be useful if used by educated people considered to have ability to understand the method. Uneducated

people were not considered to be capable of understanding the method. The health personnel did not seem to consider the communication going on among people, and which included communication between both educated and uneducated people. Limited access to information from the health personnel seemed to produce misinformation among people and allowed for fewer chances to receive accurate information. As a result, the level of knowledge about different contraceptive methods varied greatly from person to person. Although the NGO staff thought the method was not fully reliable as contraception, the health personnel in the health centre did not seem to emphasize the fact that the method was not preferable when they taught people. Even if practicing the method may be better than doing nothing, the data indicate that this approach may serve as an obstacle to use modern contraceptives, which would be more effective if they were used properly.

4.2.3. Participants' knowledge and experiences with side effects

Whenever the participants talked about contraceptives, they always referred to side effects caused by contraceptives. The participants had various opinions, knowledge and experiences related to side effects, and openly exchanged information with others.

Many female respondents from both the focus groups and interviews told about side effects associated with progestin injections. Participants believed a variety of health problems were caused by these injections, such as menstrual irregularity, increasing menstrual bleeding, bodily pain, high blood pressure, and weakness/fatigue. Injections were popular and the preferred form of contraceptive among participants, however, many women told that they had suffered from side effects. Most of the women believed that there was no better way to prevent pregnancy than injections, so they continued to receive injections despite experiencing side effects. Another reason that the method was preferred was that it was considered an easier method for women than birth control pill which must be taken every day. Additionally, many believed that side effects from injections were milder than the side effect from birth control pills. A female participant from one of

the focus groups explained that for her all contraceptives were potentially harmful, but that she has no other choice than to use them:

“We don’t have any alternatives. We want to limit the number of our children, even if the medicine is harmful to our health.” (FGD1)

Although some female participants reported never to have suffered from any side effects, other participants claimed to have suffered severe side effects. One of the wives from the interview told about her experience:

“I used contraceptives 8 years ago. It was injectable contraceptives. I used it for 9 months. Then I quitted and got a baby. I never started to use it again. The reason why I quitted after 9 months use is that it harmed my health. [...] I became sick due to the injection. It made my stomach hot and burn. After I had food, my stomach got hot for 1 hour. Moreover, I couldn’t resist sunlight. That’s why I quitted it.” (Female participant F)

As illustrated in this quote, side effects from contraceptives could be a factor which induced people to discontinue contraceptive use. With regards to birth control pills, most of the participants emphasized the deleterious effect of these pills and considered pills to have more serious side effects than any other contraceptive methods. There were various symptoms considered as consequences of taking pills such as stomach aches, balance problems, black spots on the face, increased menstrual bleeding, menstrual irregularities, and high blood pressure. During the interviews, answers were based on both participant’s own experiences as well as rumors. One of wives among the interviewed couples told about her experience with the use of the pill:

“I have used pills. I found that the pills harmed my health. Therefore I quitted it. First the pills burnt my stomach. Then my menstruation became longer and the amount of bleeding also increased. Moreover, the pills made me exhausted, especially when I stood in a hot place.” (Couple D’s wife)

Many of the participants believed pills made women's body weak and exhausted, as illustrated in the quote. Some of the participants explained that the pills "burnt" their bodies and related this to some of the symptoms they categorized as side effects. Stomach ache and black spots on the face was for example interpreted as a result of the pills having burnt the stomach and the face.

Some participants spoke about complications in everyday life as a result of the side effects. They said that women who took the pills could not work beside a fire in a kitchen due to the weakness caused by the side effect of the pills. Some of the participants explained this was due to the pill sucking blood from the body. Since working besides fire is seen as a task that is also draining energy, using the pill was considered a big problem since cooking is being one of the main female tasks. Such perceived drastic side effects made women to discontinue taking pills or to change to another method. Furthermore, some of the participants who had not tried to use pills became more reluctant to use them hearing about such experiences from others.

Two side effects from implants, which participants mentioned, were weakness in the arm and menstrual irregularity. Some had been so troubled with their arm that they had the implant removed. However, compared to side effects reported from the use of pills and injections, fewer side effects were reported from the use of implants.

Additionally, some respondents believed that the use of condoms carried side effects. They tended to believe that if condoms were broken before being used or during sex, parts of the broken condoms would remain in the women's body, and subsequently harmed the women's health. A male participant in the focus group told:

"When we chew khat (Catha edulis) and drink arake (local spirits), we (men) become powerful. That's why condoms are broken." (FGD4)

The explanation why condoms were broken was connected with the powerfulness of men and implied that condoms were not a reliable method to prevent pregnancy because the effectiveness depended on users' condition.

The findings indicate that information and rumors about the side effects influenced those who had never used contraceptives. One of the wives in the interviews said that she hesitated to start to use contraceptives because she heard many women get serious health problems due to contraceptives. A male participant being interviewed said that they would start using a contraceptive if they found a form of contraception which did not harm his wife's health.

The participants gave two main or basic reasons why they believed side effects occurred at all: differences in blood types, and the users' diet and workload. Some explained that side effects were related to different blood types, and some types of blood did not match injections in particular. A male participant from one of the focus groups explained:

“Some blood types may fail to be mixed with injections. That’s why it affects health. So, women should check whether the medicine can be mixed easily with their blood ...or not before taking the medicine.”(FGD5)

The second reason was related to the type of food and the type of work people living in poverty were exposed to, an association referred to by most of the participants. The respondents said that women who took contraceptive medicines should eat “good food” and avoid “hard work”. “Good food” meant food rich in protein, such as meat, eggs, milk and butter. This type of food is also the most costly food. Many complained that they could not afford this type of food every day and it was difficult to find someone to help the wives. One of the interviewed husbands explained:

“When we heard about contraceptives from health workers, they said these medicines had side effects. We have to take enough amount of food, and it

should be protein-rich. Therefore women who take contraceptives must eat meat and eggs; otherwise they may suffer from side effects. I also heard some died because of the side effect. [...] I want them (health workers) to provide a contraceptive method which does not have any side effect. I need a contraceptive medicine which does not require us to eat meat and eggs in order to use it.” (Couple C’s husband)

As a result of this belief, some participants hesitated to start using contraceptives because of their “poor” living standard. Although most of them believed contraceptives were effective in preventing pregnancy, they also believed that the people who took contraceptives should have access to protein-rich foods and be able to rest more than others. As a result of these perceptions, many were reluctant to use contraceptives because they feared serious health problems.

4.2.4. Health workers perspectives on side effects

When interviewing health workers about side effects of contraceptives, three major findings became evident: 1) health workers had different opinions on the issue than their patients, 2) health workers underestimated the fears of side effects and the social influences attached to them, and 3) there was a difference in opinion on side effects amongst health workers. The majority of health workers recognized the side effects and took time to explain possible side effects to their patients when administering the contraceptives. However, the health extension workers in the village and health workers in one private clinic simply told patients that the contraceptives had no side effects at all. One health extension worker in the village explained:

“I believe there is no side effect. That (contraceptives have side effects) is a wrong perception among the people. People tend to associate their problem with contraceptive use. For example if a woman takes Depo (injection) and catches other diseases not related to contraceptives, then people think that the disease comes from the medicine. So, it’s a wrong understanding. And they spread this idea among others in the community. They said; I got sick

after I took the medicine!”

The health extension workers considered all side effects to be based on people’s misunderstanding of how to use contraceptives, and that many wrongfully thought that the contraceptives caused their health problems. Therefore, they did not inform the patients about side effects when starting to use contraceptives. However, lack of information about side effects seemed to make people distrust the health workers. A female participant from one of the focus groups explains:

“They didn’t tell us the side effect of the contraceptive medicines. They simply call us and tell us to use contraceptive methods. Then we take it without information on the side effects.” (FGD1)

Furthermore, some health workers did not view side effects as seriously as the participants did. An NGO staff member who coordinated various health programs in Bale zone said:

“All medicines have side effects, however, if people are afraid of it and do not use it, much more serious problems may occur. People in our society are very poor and in an economically vulnerable position. But, our total fertility rate is around six to seven. Family planning can reduce maternal mortality rate, too. Delivery is attended by many risks. In Bale zone, it is very popular to have more than five children [...] It is easy to estimate how many mothers died of complication from pregnancy and delivery. Is there another method to reduce the fertility rate and mortality rate without using contraceptives? The risk of side effects is smaller than the risk of having many children.”

Many of the participants recognized that having many children might bring the burden on the health of the mother and children and the house economy, as the NGO staff member mentioned above. However, there was a difference in attitude in regards to side effects between the participants and the providers of family planning. The providers did not consider the villagers

view of the value of health, and the importance of remaining strong and healthy in the daily life so as to manage all the competing tasks.

Among health workers, there were different opinions about the relation between contraceptive use and food/hard work. Some health workers thought there was a correlation and they advised people to consume protein-rich foods and not to work hard. On the other hand, some health workers said there was no relation and the people could eat any foods which were available for them. The difference in opinions and information provided seemed to cause confusion and potentially make patients even more hesitant in using contraceptives.

Many of the participants talked about their personal experiences suffering from various side effects, and some of them stopped using the contraceptive without first consulting health workers. Those who did consult with health workers received curatives like pills to make the menstruation come more regularly or they were advised to change method. Those that did consult health workers tended to continue using contraceptives use compared to those who did not. However, a few participants said that when they discussed their health problems, health workers advised those who suffered from side effects to quit the medicine and get pregnant. The findings in general illustrate how different types of advice from health workers to a large extent affect the continuation or discontinuation of contraceptives.

4.3. Factors influencing attitudes and behaviour related to family planning

The following sections will in more detail describe how attitudes and behaviour towards family planning differed as well as changed due to a variety of interacting factors such as differences in experiences, differences in how contraceptives were viewed; partly based on the receptiveness related to religious as well as social norms. As illustrated below, most of the

participants were often ambivalent or insecure when they took decisions related to family planning; this because their perceptions was somehow contradictory and conflicting due to many different factors influencing their choices.

4.3.1. General attitudes towards contraception

Many of the participants talked about the experiences of contraceptive use and the side effects in a general way, expressing the public or community opinion. Most of the participants said that the attitude towards contraceptive use in the community had changed. Although contraceptives were unpopular when they first arrived, most participants said that the people in the community gradually had accepted use of contraceptives. They also claimed that their “culture” in general did not prohibit contraceptive use. However, some female participants reported that they were still met with some opposition to contraceptive use, and claimed that women in general did not talk about their own contraceptive use, but took it secretly. A few of the female participants said that sometimes their husband’s family and relatives insulted them for using contraceptives. However, the majority of participants said the attitude towards women who use contraceptives had been improving, because many seem to have recognized the importance of family planning from an economic point of view. A male participant from one of the focus groups explains his view:

“In previous period, people begged God to give them many children. But now, it becomes difficult to live a life with many children because of shortage of farmland and children’s education. For example, I have five children and my friend has one child. I buy five pair of shoes for my children but he buys one. So that’s why people are motivated to use contraceptives.” (FGD 5)

The quote illustrates how economic burdens seem to influence people’s perceptions related to family planning. Arguments related to economy were one of the most often raised arguments in favour for family planning. A female participant from one of the focus groups told how people perceived the

importance of family planning:

“We see women who use contraceptives to limit the number of children, and also to improve their lives. So we learn from each other and it motivates us to use contraceptives. If a family has too many children, it is impossible to improve the life and to meet the needs of the children.” (FGD 6)

This participant had observed positive changes due to family planning and recognized the benefit of family planning in the household economy. The participant also suggested that the community members had learned and inspired each other due to the visible and practical effects of family planning. Additionally, some participants mentioned that contraceptives often were used by “educated” people who “understood” the advantage of family planning. The fact that those who possessed more knowledge than others used contraceptives seemed to have a positive influence on people’s perceptions of contraceptives.

In general, the findings indicate that negative attitudes towards contraceptives and those who use contraceptives have been decreasing, and that there is a movement in the direction of contraceptives being accepted as a method for family planning.

4.3.2. The influence of religion

Although most of the participants recognized the positive change and the increasing tolerance related to the use of contraceptives, we also found that many of the same participants expressed ambivalence when religion was brought up as a theme. Religion, as opposed to peoples “culture” or the “community attitude”, brought a different perspective into the discussion and was obviously framing people’s perceptions; making people ambivalent and insecure whether it in fact was right or wrong to use contraceptives. When the participants talked about contraception from a devotees’ position, they tended to express negative attitudes and the importance of following

religious interpretations.

The people living in the area were either Ethiopian Orthodox Christians or Muslims. Most of the participants, who consisted of both Ethiopian Orthodox Christians and Muslims, thought their religion actually prohibited birth control, or that contraceptive use was accepted but seen in a negative way by religious leaders and religious interpretation of the Bible or the Koran. The most common reason mentioned by many participants was that children were gifts from God and people must receive everything God give them. A participant from one of the focus group explained:

“It’s obvious that God will punish us for using contraceptives because children are the gift of God and the work of God. Using contraceptives means we interfere with the work of God, violate his work. Contraceptives are the work of the government. God does not accept it.” (FGD 4)

The participants claiming this view thought that if one was taking contraceptives they were committing a sin. One of the participants from one of the focus groups told that she quit taking contraceptives when she began attending religious teachings. She said she begged God to prevent pregnancy and claimed that God had stopped it so far.

Like the Ethiopian Orthodox Christians, the majority of the Muslim participants said that even if people in the “community” increasingly allowed the use of contraceptives, their religion did not allow it. They stated that God was the one who decided everything from conception to death, and subsequently wrong to interfere in these processes with birth control methods. A participant from one of the focus groups plainly stated:

“Sharia encourages having many children. It orders us to have many children.” (FGD 2)

Due to this type of interpretation, a few Muslim participants reported that

they closely followed the writings in the Koran and thus never used contraceptives. Even if there were only a few participants that told that they never considered using contraceptives due to religious reasons, religion still seemed to produce an atmosphere of ambivalence and frustration and made it difficult for people to initiate and continue the use of contraceptives. In most cases, participants initiated and continued to use contraceptives because they knew that it could improve their economic situation, despite recognizing it as a sin; some participants actually verbalizing the felt frustration between the felt need of following religious rules and the difficult economic situation they would face if they have too many children. Many participants therefore tried to juggle the contradiction between economics and religion, by for example using contraceptives secretly. Some participants said they felt the need to consult their religious leader because they did not know whether using contraceptives were acceptable or not, seen in the light of the economic problems they faced due to having many children. One male Muslim participant who reluctantly admitted that he accepted the use of contraceptives referred to his experience approaching a religious leader: when he asked about contraception, the religious leader just told him that it was not good if he had too many children and could not meet their needs, without actually verbalising anything related to contraceptive use.

There were also different interpretations among the participants who believed in the same religion. Some of the participants being Ethiopian Orthodox Christian said that their religion and the Bible did not mention contraception and contraceptive use, but they still thought that birth control was a sin and not desired by God. On the other hand, some of the participants in one of the focus groups eagerly discussed the positive acceptance of contraceptive use by the Ethiopian Orthodox Church. One of the participants argued on the basis of economics claiming that the religion does not prohibit the use of contraceptives:

“Our religion (Ethiopian Orthodox Church) encourages contraceptives because the religion doesn’t want us and our children to suffer. So the religion doesn’t prohibit it.” (FGD 6)

The participants who thought their religion actually accepted and encouraged contraceptive use were, however, fewer than those who thought that contraceptive use was prohibited or seen as a sin by their religion.

Among the Muslim participants, there were some who claimed that Islam addressed both contraceptives and abortion, and reported that they were living in agreement with what was written in religious texts on the topic, as stated by one of the participants:

“Sharia does not prohibit contraceptive use. It prohibits abortion.” (FGD 3)

A participant in the same group supported this idea, and continued arguing that Islam supported contraceptives based on the idea that it was necessary and therefore accepted, to prevent poverty:

“If a person doesn’t have enough wealth they should not have many children. The children may suffer from poverty after they come to this world. Sharia supports this idea (limiting the number of children).” (FGD 3)

Based on these findings, we can see how religion strongly influenced the attitudes of those who considered using contraceptives. Some of those that did decide to use contraceptives still felt fear of being punished by God, to be accused by others, or they felt a frustration caused by a contradiction between religious rules and their practices. Another issue was that the religious texts were interpreted differently, and in order to deal with this contradiction, some of the participants sought advice among the religious leaders and actively tried to interpret religious texts. No matter what decisions that were taken, religious beliefs affected individual attitudes and decision-making processes in a way that complicated the decisions being made. The community under study is a small and intimate community and most people know one another. Religious peer influence and fear of disapproval among peers due to decisions based on wrong interpretations were factors that influence how people talked about and related to

contraceptives. However, the ambivalent relationship – caused by a conflicting interest between religious beliefs and socio-economic needs – first of all seemed to cause a conflict within the individual.

4.3.3. Influence of gender relations

When the participants talked about practice of contraception, they often referred to the relationship with their spouses and the general gender norms. Typically, the majority of both female and male participants agreed that deciding to use contraceptives was a discussion solely between husband and wife. Although some of them had not been taught about family planning, they all spoke with their partners because they all seem to think that family planning was important. All the participants that had used contraceptives said that they started to use contraceptives after discussing it with their partner. They claimed they had never hesitated to speak openly about family planning and contraceptive use with their partners because these issues were very important for both husband and wife.

There were, however, those who said that if they wanted to use contraceptives, the husband needed to be involved in the issue in some way, whether it was to give permission or to assist in various ways. There were for example some female participants telling that their husband helped them to read what the health worker wrote and remember when the next appointment was. When couples could not reach an agreement, we found that these discussions usually ended in wives following their husbands' decisions. Most of the participants said the decision should be made through discussion and some female participants insisted that a wife was the one who decided whether she used contraceptives or not. However, the influence of the husband on decision-making in family matters was evident, and there often seemed to be a power imbalance between husband and wife. A female participant from one of the focus groups said:

“If he (a husband) chooses to have many children and he thinks that he can meet the needs of many children, his wife do not have any chance to refuse it.

She has to continue to give birth to babies.” (FGD 3)

One of the husbands from the interview explained why the husband was the one who made final decisions in the family:

“I am a leader of my family. I have a responsibility to provide them with everything they need, for example, food, clothes and education fee.” (Couple C’s husband)

The participants from the focus groups also mentioned the role of the husband in the family as the reason why they have the right to make a decision. Moreover, most of the female participants from the focus groups stated that they accepted this imbalance and claimed that there was no option of dissenting from their husbands’ decisions. The female participants from one of the focus groups (FGD 3) referred to their religious norms as an explanation for this imbalance; “good wives” should follow their husband’s decisions.

In the cases where participants talked about husbands refusing to use contraceptives, this refusal included both female and male contraceptives. Some women knew of others who had initiated contraceptive use secretly because their husband did not allow them to use contraceptives. Some male participants told that women who took contraceptives in secret ended up telling their husbands the truth after they got serious health problems due to side effects of the contraceptives. These male participants seemed not to reflect on the reason why these women had to use contraceptives secretly.

Conversely, there were husbands who imposed contraceptive use on their wives because the husbands preferred to have less number of children than the wives wanted. Even if the wives did not want to take contraceptives, the female participants said the wives could not refuse because women had less power than men to make decisions in general. Some of the female participants, who had suffered from side effects caused by contraceptives,

said that women should endure and continue to use it because they believed there was no other way to avoid poverty.

Surprisingly, an opinion that were stated in several of the interviews was that women should be more responsible than men and learn more about family planning and contraceptives, despite the fact that decision-making in the family was explained as the man's role. However, we also found that there was a norm implying that women did not need to attend the meetings conducted by the village, which is one of the opportunities to get information from health workers. If women attended such meetings frequently, the surroundings considered them lazy. The norm seemed to be related to a gender norm implying that wives' work place was at home and that they should stay home and work hard. Several female participants claimed that they hesitated to attend the meetings because they were afraid of being labelled as an idler by other community members. Many male participants, nevertheless, believed that women should learn more about contraceptives because they were the ones who used it, suffered from the side effects, and took care of the children. Some male participants from the focus groups claimed their indifference about the use of contraceptives. One male participant stated:

“It's the women who use contraceptives and who have knowledge about it. We never ask women detail information of contraceptives. Therefore we don't have any knowledge.” (FGD 5)

However, some male participants claimed that women were reluctant to learn about family planning and contraceptives. One male participant from one of the focus group claimed:

“Health extension workers try to gather women and teach them. But women run away from them. [...] But they should learn it.” (FGD 4)

Some of the male participants claiming that women should attend meeting

and be more responsible in the family planning seemed to be unwilling to take responsibility for these types of decisions, and wanted to shift this responsibility over to women. Further, these male participants did not seem to be concerned about whether or not leaving these types of decisions to women would change the power balance between husband and wife. The findings indicate that there are two likely reasons why several male participants consider reproductive issues as a female responsibility; that contraceptives for females were more popular to use among the villagers compared to male contraceptives. Second, many of the education programmes related to family planning were primarily targeted towards women.

5. Discussion

On the basis of the findings obtained from this research, we argue that there are several factors that influence the perception of family planning and reproductive behaviour. These factors, and how they may interlink, are described and discussed in this chapter.

5.1. The importance of having children

Having children was an essential issue for the married people that we interviewed, and one of the most important reasons was the perceived value of children to the family and community.

From a socioeconomic perspective, which is commonly used in demographic studies, reproducing is considered a result of calculating economic costs and benefits, and high fertility rates are the result of perceiving “labour and old age security” as benefits which outweigh the costs (Ezeh, Mberu, & Emina, 2009). In our study we did find that the importance of having children was strongly related to economics, such as having children as an eventual means of getting support when they got older and obtaining opportunities to improve their living condition. The advantages of having children were deeply related to the average person’s lifestyle, which is heavily dependent on manual labour. However, contrary to this, the participants also experience the economic burdens of reproducing and the various benefits of family planning and contraceptive use. A similar situation is reported from a case study in Uganda, where changes in the perception of the value of children – based on perceived changes related to costs and benefits – influenced reproductive behaviour (Nalwadda, Mirembe, Byamugisha, & Faxelid, 2010). The changing value of children make people re-consider whether or not to have many children, since many now seem to experience that having a large family can also bring economic burdens, such as education fees.

Caldwell, who is a demographer and have conducted studies in the field of fertility transition proposed a theory called “intergenerational wealth flows” (Caldwell, 1976). The theory present a direct link between family structure and fertility (Kaplan & Bock, 2001) and focus on micro-level changes in family organization (Greenhalgh, 1995). Caldwell’s theory describes high fertility as rational for societies in which parents mainly receive benefits from their children (called “upward flows”), and that low fertility is rational for societies in which children mainly receive benefits from the parents (“downward flows”) (Kaplan & Bock, 2001). The findings in our study indicate that people increasingly have started to acknowledge the importance of education, and subsequently the benefit of a small number of children. In other words, changes in how people view education, has made people look differently upon the number of children due to the costs that educating children actually imply.

The wealth flows theory only evaluates the economic aspects of having children. According to the theory, in order to lower fertility rates, it is essential to change the social structures. In reference to this theory, Kaplan and Bock (2001) claim that education can influence the rate of fertility in three ways: 1) by disrupting the traditional value system which people share in the community and training children to seek individual goals, 2) by reducing a child’s ability to contribute to the household economy, and 3) by increasing the costs of raising children (Kaplan & Bock, 2001). However, even if our study found that educating children do have a downward flow of wealth from parents to children, it also seemed to create a new and expected upward flow of wealth in the form of monetary support from children who become wage-earners after their education. We therefore found that the theory does not fully apply to our findings: the flow of wealth between parents and children having both upward and downward directions.

Most of the participants described economic burdens related to having children, even in the Bale zone where the village is located, which has a higher fertility rate compared to average rates in Ethiopia. However, these costs were balanced and compared to the potential benefits that parents and the family as such could have from children being educated and becoming

wage earners. Another finding that does not fit with the proposed wealth flow theory is that the value of reproducing has not only a strong economic value but it also has a cultural value to people. For example, children are expected to become successors. The importance of the successor role was related to fears of property being stolen or taken away by others, and fears of being totally forgotten after people died. Preferences in regards to birth spacing and gender composition of children are also constructed by the existing sociocultural system, such as the marital system, inherent customs, gender norms or people's needs related to their agricultural livelihood. The different preferences show that the cultural value of reproducing is thus a very important factor in this society. In other words reproduction is far more than a biological issue; such as concrete pregnancy and delivery related factors. The findings of this study indicate that perceptions and behaviour are results of socially-constructed and dynamic processes, and where social, cultural and economic costs and benefits interplay and may change over time. Greenhalgh (1995), an anthropologist contributing in understanding how to situate fertility, claims that people transform their biological fertility into their social lives and see reproductive behaviour as a sociocultural process focusing on the continuity of families or groups, as well as a biological issue (Greenhalgh, 1995). In other words, perceived advantages and risks of having children are not only related to biological factors (e.g. risks related to pregnancy and giving birth), but also to economic factors (e.g. economic burdens of childrearing, economic support from educated children) and sociocultural factors (e.g. the importance of children's labour, fear of being forgotten after death). As illustrated in the HBM, perceived risks and benefits are different and might change as a result of people's background and how people interpret the current situation in which they are in, and whether having more children are seen as an asset or not at that particular moment in that particular context (Becker, 1990).

5.2. Religion

This study shows that another factor that affects reproductive behaviour is religion. The participants in our study were either Muslims or Ethiopian Orthodox Christians, and in general they saw children as gifts from God, and many claimed that people must receive all what God gives them. Moreover, many thought that God decided the number of children and the timing of pregnancies, and that controlling this by using contraceptives was regarded as a sin. Therefore, some participants used contraceptives secretly or without really talking about it, because they were afraid of religious punishment by God or community members. The study therefore suggests that religion has a direct impact on contraceptive use, and that religion tend to create an anti-contraceptive atmosphere or at least cause frustration and ambivalence among potential users. A study that explored reasons for low contraceptive use among young people in Uganda reported a similar situation (Nalwadda et al., 2010). The churches in the area were highly pronatal and the messages given from these churches were perceived as key obstacles to the use of contraceptives and contradictory to what partners, parents, teachers, cultural leaders and health workers were saying. The position of the churches on this issue therefore seemed to put young people in a dilemma (Nalwadda et al., 2010), creating the same type of ambivalence and frustrations as seen in our study.

Also in our study, we found that the anti-contraceptive atmosphere set by religious leaders went against the wider community's views and general acceptance of using contraceptives. The general acceptance was related to the economic problems associated with the upbringing of many children. However, religion also has a significant position in people's daily life and there are close peer relationships based on religion. Therefore, a potential punishment from God and criticism from religious peers due to the use of contraceptives may be perceived as a barrier and make people hesitate to use contraceptives. Even though the risk in terms of economic burden is evident, the influence of religion can be stronger or more important among some, and make it more difficult to decide whether or not to use contraceptives. If the decision of using contraceptives was somehow accepted on a personal level,

but people were afraid of being punished or judged by religious peers or family members, the solution could be to use contraceptives secretly. Even though some participants seemed clear about the decision of using contraceptives, it was obvious that among the majority religious thoughts caused a certain level of ambivalence.

We also found, however, that some participants, despite being religious, interpreted the use of contraceptives in a different way. Sarkar (2008), who studies reproductive biology, have found that the use of contraceptives is approved by some Muslims because the Islamic faith underline that children have a right to education and future security; this entails that the number of children in a family may have to be limited, and birth control subsequently allowed (Sarkar, 2008). This is similar to some of the views among participants in our study, and the finding therefore suggests that it could be important to focus on the diversity within a religion, and that there are many interpretations. Different ways of understanding promotes the possibility for health workers or others to use that as a gateway to overcome some of the current religious barrier against the use of contraceptives. Subsequently, family planning providers, such as health extension workers, need to understand how people are influenced by religious interpretations in order to promote contraceptive use effectively. Involving religious leaders in family planning programmes, such as facilitating open discussions between providers and religious leaders, may help reduce some of the perceived barriers to contraceptive use.

Religion also had an influence on gender norms. Muslim female participants tended to say that according to their religion “wives should follow their husbands’ opinion”, and we may say that religious norms support an unbalanced gender relationship. Heaton, an educator in sociology (2011), has studied the influence of religion on fertility among different religions. He claims that religion is linked with other social characteristics and proximate determinants, such as level of education, type of residence, marriage age, contraceptive use and divorce (Heaton, 2011). In other words, single factors such as “gender norms” and “religious norms” can be related to and shape each other. Further, what influences people’s perception and behaviour

related to reproductive behaviour can be influenced by different “modifying” factors, such as level of education, and must be viewed holistically.

5.3. Gender norms

The findings indicate that different gender norms influence contraceptive use in various ways. Some studies emphasize the importance of influence from male partners and that in order to get a man’s acceptance of contraceptive use there is a need of better communication between partners (A. Berhane, Biadgilign, Amberbir, Morankar, & Deribe, 2011; Ko et al., 2010). However, we found that when a couple could not reach an agreement related to contraceptive use, the husband’s decision tended to be prioritized because of a gender-based power imbalance. A case study regarding gender norms and decision-making in Tanzania reports a similar situation in which almost all men and women discussed family planning, but a gender inequality was still present in the execution of decisions with family planning; the final decision maker being male (Schuler, Rottach, & Mukiri, 2011). These findings suggest that communication between couples does not imply an equal status between husband and wife.

Moreover, men are in many cases found to be more pronatalistic than women, which is considered an obstacle to contraceptive use (Greene, 2000). In such cases the power imbalance between genders will to a large extent prevent women from using contraceptives. However, a power imbalance between genders can also cause other trends. In a study from Tanzania, Schuler et.al (2011) reported that men forced their wives to use contraceptives (Schuler et al., 2011). This may occur when the idea of family planning is becoming increasingly accepted. These two different examples/approaches are apparently contradictive; however, they are both a product of a common gender-imbalanced relationship as well as a tendency of a change of views on the acceptance of contraceptives. Our findings also showed that there were examples of husbands that made their wives use contraceptives, even if the

wives did not want to use it, but where the gender-imbalanced relationship made it difficult for these wives to refuse.

Based on our findings, there seem to be a tendency that men increasingly seem to entrust the responsibility of taking contraceptives to women. This attitude may be influenced by the prevalence of female contraceptive methods and female-centred educational programmes. A strong focus on the woman's role from the health workers and the educational programs may have affected the male participants' views and a potential negative attitude related to family planning (A. Berhane et al., 2011; Dudgeon & Inhorn, 2004; Greene, 2000). This study also found that gender norms influenced the opportunity to get information on family planning and contraceptives. These gender norms, implying that women should stay at home and work, hindered women from attending the meetings conducted by the village officers. There were also examples of social sanctions such as people talking negatively about the women who attended the meetings. The existing gender norms must be considered by family planning providers, such as health extension workers, in order to find a more functional way of distributing information.

5.4. The perception of side effects

The study clearly shows that fears of side effects related to the use of contraceptives prevented people from using them. The interviews revealed the many rumours related to side effects caused by contraceptive use, regardless of whether people had ever used contraceptives or not.

The impact of side effects caused by contraceptive use has been discussed in previous studies in different countries. Studies from countries as different as Uganda and USA have described that side effects do influence a person's choice of contraceptive methods, contribute to poor adherence, and represent a barrier to the use of contraceptives (Gilliam, Warden, Goldstein, & Tapia,

2004; Nalwadda et al., 2010). Our findings showed that the difference in experienced side effects may depend on various factors, such as the access to treatments or advice from medical staff, shared experiences and knowledge related to contraceptives, and the overall value of health and illness.

There appeared to be a gap between how side effects were perceived by lay people and how it was perceived by health workers. The general population were greatly concerned about side effects, while most health workers, even though recognizing side effects, considered the burden caused by the contraceptives as negligible. The high concern about side effects among people seems to be related to the importance of maintaining their overall health. When the participants talked about the fear of side effects, they expressed their concern that they might not be able to carry on their daily work due to a deterioration of their health. There is a clear division of labour between husband and wife, and if women could not work due to suffering from side effects, they could not support their family in many areas. On the contrary, health workers emphasized the health-related risks of childbirth and the burden of child-rearing, based on their medical knowledge. This difference in perception may be caused by different ways of understanding health and illness or a different interpretation of which factors that are beneficial and which factors that are actual barriers (Rosenstock, 1974). Health workers and the general population have different educational backgrounds and may view the concept of risk differently, as well as what actually constitutes risk. Kleinman (1980) conceptualizes illness and disease as socially constructed “explanatory models” which represent patterns of thoughts that provide answers to questions regarding etiology, symptoms, cause, prognosis and treatment. In other words, the health care system as such includes people’s beliefs and their behaviours, and these particular beliefs and behaviour are to a great extent governed by cultural interpretations (Kleinman, 1980). Health workers and the lay people may use different “explanatory models” when relating to and interpreting the symptoms from the body after starting to use medications such as contraceptives. While most health workers may interpret symptoms from a biomedical explanatory model only, lay people may use other types of explanatory models where a variety of symptoms may be seen as side-effects,

and where health and the body as such is viewed in a broader way. However, we also found that some of the health workers actually did share (parts of) the same “explanatory model” as lay people, and the difference in opinions, and the inconsistent information given by health workers could cause confusion, exacerbate misconceptions and rumours, and increase fears related to the use of contraceptives. For example, lay people, and some of the health workers, used the same explanatory model when explaining about the causes of side effects due to contraceptives. They referred to their poor living standards which required them to work hard and consume foods low in protein. Almost all of the participants among the lay people associated intake of medicines, such as contraceptives, as something that required “good food” (protein food) and a lot of rest, otherwise the body or the overall health would be damaged. The strong belief in this association actually introduced an indirect economic barrier for people in using contraceptives; even if the public health facilities provide contraceptives free of charge, they had to provide money to buy good (expensive) food to be able to take contraceptives. Since some of the health workers shared the same explanatory model these beliefs were reinforced in the meeting with the health workers. There were examples of health workers recommending rest and protein-rich foods in order to use contraceptive methods. Subsequently, some of the participants hesitated to use contraceptives because they could not afford to eat protein-rich food such as eggs, meat and milk, nor could they hire someone who could help with the daily work.

A similar response to medication and medication adherence is reported in a case of tuberculosis patients in Addis Ababa. Sagbakken et al. (2008a) reported that the tuberculosis patients in Addis Ababa hesitated to take the prescribed medicine because they could not afford to eat protein-rich foods daily (Sagbakken, Frich, & Bjune, 2008a). Sagbakken et al. (2008b) reported that health workers informed tuberculosis patients on the importance of consuming protein-rich foods and to avoid physical activity as hard manual work, and even sex (Sagbakken, Frich, & Bjune, 2008b). These findings suggests that culture specific understanding of illness and disease; causes and risk factors, inhibits Ethiopian people from taking medicine. The idea that protein-rich food creates some sort of resistance against medicines may

be related to the fact that people believe many disease (and their risk factors) are caused by poverty related factors such as poor housing, poor food, and hard work. Subsequently, symptoms of illness, such as side-effects, are signs that say something about the body not being able to handle the medication, and that one need good food (protein rich as meat, milk and eggs) that will address the underlying cause of the symptoms (Sagbakken et al., 2008b). The fact that both lay people and health workers to some extent share these beliefs, reinforces patients perceptions, and this “cost” becomes even more important to attend to. Kleinman claims that the beliefs and behaviour that constitute different perceptions and behaviors are influenced by particular social institutions and interaction settings (e.g. clinics), social roles, interpersonal relationships (e.g. health worker-patient relationships, social network relationships), economic and political constraints (accessibility, availability) and a number of other factors. Illnesses and their variety of responses, such as side-effects, form different components of the health care system, and are systematically interconnected (Kleinman, 1980). All contraceptives are provided free of charge in this context, and subsequently accessibility and availability of contraceptives are increased. However, people’s decisions, and as such peoples “cues to action”, are made based on a balance with many other relevant factors, such as indirect costs related to a perceived requirement of using contraceptives (good food, rest), as well as the perceived influence on the body and the overall health in a holistic, long term perspective. These costs are (often) reinforced trough social network relationships and also to some extent in the meeting with health workers. Within this rather complicated picture the perceptions of costs and benefits related to have children, as well as the “costs” in terms of religious repercussions, all play a role.

5.5. Information and services from health workers

Partly touched upon already, information and services from health workers is another major factor that influences family planning and reproductive

behaviour. Snow et al. studied women's preferences towards contraceptives in seven different countries, and describe how services and providers seemed to be significant determinants of women's preferences for contraceptive attributes (Snow et al., 1997). Their findings showed that providing sufficient, adjusted and convincing information often encourage those who are hesitant to use contraceptives. In addition to offering recipients sufficient information, proper treatment and advice appeased those who were suffering from side effects, and kept them from discontinuing contraceptive use. However, in our study receiving proper services and information was sometimes a difficulty, which could be directly related to the discontinuation of contraceptive use and distrust of contraceptives as well as in health workers.

In general, we found that the community's perception of contraceptive use has gradually changed and become more tolerant, probably partly due to information and education provided by family planning programs and health workers. The positive attitude towards contraception was also supported by the image that educated people seemed willing to use it. If a response on a certain issue becomes increasingly prevalent in the community, and role models such as those being highly educated adhere to the idea, it is likely that the perceived "costs" of the behaviour will be less and the perceived benefits may increase. According to Blau, people might not adapt a behaviour if they fear that they are not following social values and norms, and that there will be social sanctions, such as reproach from family members and community members (Blau, 1960). Therefore, we suggests that what seem to be a positive change in the community in general, is one of the factors which encourage people to use contraceptives.

On the other hand, we found that despite the community being more tolerant towards contraceptives and despite health workers often providing information, a negative image can still be created depending on the way information is given. Almost all of the research participants among the lay people were for example reluctant to use condoms because of the information they had gotten through HIV education programs. By including condoms as a part of HIV education, people associated condoms with HIV prevention,

and considered them as a method of pregnancy prevention for single people and people with several sexual partners. Sarkar (2008), in a review of studies related to barriers of condom use, reported that negative associations due to comprehensive advertisements of AIDS educational programmes in the media hamper people from using condoms (Sarkar, 2008). This shows that the way of giving information has a strong influence in creating images, and the importance of considering an element, such as contraceptives, in a wider perspective including marital norms, socio-economic issues, and fear or stigma related to diseases like HIV.

In general, our study found that participants thought they did not have enough opportunities to get information related to family planning and contraceptive use. On the other hand, participants were also reluctant to attend meetings about family planning; either due to expectations based on gender norms or because people found it difficult to simply set aside time to participate in activities outside of their daily work. Subsequently, although most of the participants considered that the opportunities to get adjusted information was not enough, people often chose not to attend the meetings or lectures that were held in the community. This seemingly ambiguous behaviour can be seen as a result of a cost-benefit analysis; people considering the costs related to attending these meetings being higher than the benefit. The costs or barriers associated with the attendance to such meetings were partly economic since they would have to use labour hours to participate. Another cost was the social restriction caused by the gender norm implying that women should stay at home, and not attend meetings in the public sphere. The possible benefit was the useful information from health workers. In order to let people make the most of these opportunities, it is important to reduce the perceived costs/barriers and increase the perceived benefits, for example by organizing such meetings in collaboration with people so as to adjust to relevant time schedules or to find others ways of providing the information that people need to know.

The findings show that the opportunities to receive adequate and adjusted information were sometimes also limited by choices made by the health workers. For example, teaching patients the calendar method was reduced to

only include “educated” people selected by health workers. We found that most of the participants had received misleading information about the method, which resulted in unwanted pregnancies. This situation may be a result of health workers underestimating the influence of communication amongst the general population; including communication between people with different level of education.

The importance of communication also appeared in the exchange of information related to the side effects of using contraceptives. The information which these rumours were based on derived from people’s own or someone else’s experiences. According to many participants, the rumours exchanged by members of the community seemed to have more influence on behaviour than information provided by health workers. For example, many explained how they believed contraceptives had side effects based on their own experiences or based on information from family or peers, even if health workers had explained there was no side effect due to contraceptives. In a study on Latinos in the United States Gilliam et al. (2004) reported that people tended to rely on “informal sources”, for example family and friends, for contraceptive information (Gilliam et al., 2004). Locally-exchanged information or “informal sources”, had larger influence on their perception and decision-making compared to “formal sources”, or explanation given by governmental agents (Gilliam et al., 2004). The research findings in our study indicate that information is circumscribed by sociocultural factors and values, and the difficulties of receiving adequate information seem to be a factor which influences a person’s perception of risk (Rosenstock, 1974). Moreover, unwanted pregnancies which occurred while using contraceptives lead to many misconceptions, and may also lead to distrust of health workers as well as of contraceptive methods. In the study of Latinos in the United States, there were many cases of misinformation caused by poor communication between provider and patient (Gilliam et al., 2004). Similar to our study, we found that this case also suggest that misconceptions and misinformation due to poor communication may have caused people to distrust both providers and contraceptives (Gilliam et al., 2004).

5.6. Strengths and limitations

We took several measures to increase the validity of study, such as using several data collection methods and continuous discussions between the researcher and the research assistant during the field work.

The study design has some limitations. We used focus groups as one of the main methods, and it is difficult to say whether the perspectives we have presented are representative for the community as such. The composition of the group (consisting of peoples knowing each other) may have served as a factor facilitating openness and involvement, but it may also have served to limit the amount of perspectives. However, we also conducted interviews with the villagers and health extension workers at two points in time, giving us a possibility to also speak with single individuals not being influenced by peers in a group. We believe that the fact that we conducted 2 interviews increased the validity of the data.

Triangulation is one of the ways of increasing the validity of qualitative research (Mays & Pope, 2000) by using different or multiple sources of data (time, space, person), different methods (observations, in-depth interviews, focus groups, analyze documents), different researchers, and different theories (single versus multiple perspectives of analysis). During the research, we used semi-structured interviews, focus group discussions (FGDs) and resided in the community during the research period. Although each method has different weaknesses and strengths, Mays and Pope argues that weakness in one method can be compensated by strengths in another (Mays & Pope, 2000). By using several sources of data and several sources of methods for data collection we were able to map out and understand more fully the dynamics and complexity of human behaviour. By triangulating with data sources and methods we were able to get a more detailed and nuanced picture of the factors influencing people's perceptions and behaviour, at the same time as we were able to identify similarities and congruencies. By using different theoretical perspectives, we were able to analyse the topic from different angles.

The quality of data collection and analyses depends on the ability and experience of the researcher. I did not speak the language which the participants spoke and worked with a research assistant all throughout the research project. Although the research assistant helped a lot in order to conduct the research smoothly, his presence exaggerated me as a stranger and kept a distance between the villagers and me. Moreover, all interviews' and FGDs' transcriptions were interpreted, transcribed and translated by the researcher. We used English as a common language, however either of us is a native speaker. I had a clear consciousness related to the limitations of my own language skills and we often faced difficulties in translating or expressing what we wanted to describe throughout the research process. We might have lost participants' particular expression or nuances which could have been the key to understand the meaning of their statements in a deeper or more accurate way. On the other hand, the fact that the research assistant and I conducted the interviews and FGDs together can also be seen as a way of increasing the validity of the data; in order to understand the contextual meaning of what the participants said, it was important and valuable to discuss each interview with the research assistant afterwards, who knew the local language and the local context. In this way the data that are presented is the result of a challenged and negotiated version of the data that we collected.

The choice of living in the research site was also rational for and beneficial to the research. By living in the research site we were able to more fully understand people's perceptions and behaviour. It made it possible for us to obtain contextual background information and helped us build a relationship between the researcher, the research assistant and the villagers. These efforts made it possible for us to integrate different topics into their everyday lives and more deeply understand the data in hand. Our hope is that this research provides a new angle to a field which is heavily occupied by quantitative studies.

6. Conclusions

6.1. Conclusions

This study was conducted in order to explore why there still exist high fertility rates in rural Ethiopia, and to understand what governs people's perceptions and behaviour related to family planning.

Among the people in the village, we found that there are changing perceptions and behavioural shifts in favour of contraceptive use and a smaller family size. The concept of family planning has been established and most of the participants had knowledge about contraceptives. Furthermore, the accessibility of contraceptives has been improved as four types of contraceptives are now provided for free at the health post in the village.

On the other hand, our findings suggest there are multiple and culture-specific obstacles working against family planning. The many misconceptions, rumours and fears are precipitous, and it is evident that husbands usually make decisions about fertility and family, due to a societal gender imbalance. Moreover, strong social and religious norms and contradicting information from health workers negatively affect family planning. This study suggests that all these elements are intricately related with one another, subsequently, people's perceptions and behaviour are affected by complex issues and people make choices based on numerous and conflicting factors. In order to understand people's perceptions and behaviour, it is necessary to view family planning and contraceptives as one piece in a larger picture containing of many puzzle bites. Health workers and family planning programs needs to acknowledge this and design activities that have a more holistic approach; including and integrating factors such as socio-cultural values, interpersonal relationships, and structural barriers.

6.2. Recommendations

The research mainly dealt with villagers' perspectives and experiences. Other groups of people that have significant influence on decisions made by people in regards to reproductive health, such as health workers, NGO staff, and religious leaders, were not focused on, as only a few health workers were included. Further studies should examine perspectives of the health providers more thoroughly, and include the perspectives of NGO staff and religious leaders. These groups of participants can provide new perspectives and help us understand the concept of family planning even more holistically.

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Appendix

Appendix A Interview guide for villagers

The preference related to their children

(Example of possible questions)

- How many children do you want to have? (why?)
- How many male children do you want? (why?)
- How many female children do you want? (why?)
- Up to which level of education do you want/encourage your children to learn?
- Is that for both male and female children or for male or female only?
- When do you expect your children to marry?
- How old is the ideal time of marriage for your children?
- Why do you want your children to marry at this age?
- How did you decide when to have the first child, the second child etc.?
- Why do you decide to have such interval of time between children's birth?
- How do you control/maintain the interval of pregnancy?

Knowledge of family planning/ contraceptives

(Example of possible questions)

- Do you know/have any concept and idea about contraceptive method and family planning?
- Have you ever heard about family planning?
- What do you know about contraceptive method and family planning?
- What kind of family planning/contraceptive methods do you know?
- From whom did you hear/learn about family planning and contraceptive methods?

- Do you think that family planning and birth control is important or relevant?

Experiences and perception related to contraceptive use

(Example of possible questions)

- Which contraceptive methods or family planning methods do you prefer to use?
- Why do you choose prefer to use these contraceptive methods or family planning methods?
- Have you ever used contraceptive methods?
- Which method did you use?
- Which one is used most frequently?
- Why do you use the method frequently?

Influence from others on their contraceptive use

(Example of possible questions)

- What kind of idea about family planning and contraceptive methods do your parents have?
- How many children do they want you to have?
- What kind of opinion related to having many children do your parents have?
- Are there any people who have influenced/pressured you to have many children?
- Do you follow their interest about the number of your children? (why?)
- Do you use or encourage your wife/husband to use contraceptive methods and family planning?
- Have you ever been discussed contraceptive use and family planning with your wife/husband?
- What was the result of the discussion?

- Have you ever planned about how many children you want to have and when to have children? (With whom?)
- Is it easy to communicate about family planning with your husband/wife?
- Who decide the number of children?
- Why the person decided?
- Have you ever discussed contraceptive use or family planning/ number of children you have with anyone else? (how/ why/ when)

Medical environment

(Example of possible questions)

- Is there any clinic or health care centre in your area that serves you on family planning and contraceptive methods? (where?)
- Is the service provided by the health care centre and the worker sufficient or satisfactory to you?
- Is there any things missed or lacked in these health care service centres
- Are the health care workers volunteer and well-motivated to serve you?
- Are they always present in their office?
- Please mention some improvements that you need to be made on the health care services in your local area.

Cultural value of having children

(Example of possible questions)

- What does having children mean in your life?
- What do you think about having many children?
- Is it important to have children? (Why? How?)

Appendix B Interview guide for health workers

For the health extension workers, health workers in Jara

(Example of possible questions)

- How many workers work at the facility?
- What kind of services do you provide?
(ex. education programmes and contraceptives)
- Which contraceptive method do you recommend? (why?)
- What kind of opinion about side effects from contraceptives do you have?
- What do you think the relation between the side effects and the patients' living standard?
- What kind of explanation do you give the people who want to use contraceptives?
- What kind of check list do you have before you give the people contraceptives?
- What kind of criteria for who can use contraceptive medicines do you have?
- What kind of problem or obstacle do you face through educational programmes?

For the NGO's staff in Robe

(Example of possible questions)

- What kind of programmes and activities do you have?
- What kind of relationship with other organizations do you have?
- Why does Bale zone keep higher fertility?
- What do you think the challenges in the area?
- Do you feel the changes among the people through your activities?
(what kind of?)
- What do you think the role of men in reproductive health?
- What do you think the side effects due to contraceptives?

For the lecturer in Goba

(Example of possible questions)

- Please tell us about the education programme for health extension worker candidates.
- Did you provide practical training for them or only lectures? (what kind of practice?)
- How did you teach them about the side effects due to contraceptives?
- Do you have updating programmes for health extension workers? (what kind of?)

Appendix C

INFORMATION SHEET

Regarding participation in the research project:

My name is Aiko Ieda, and I am an anthropologist and a master student at the University of Oslo. At the moment I am doing research for my master degree in 'International Community Health'. I am asking you to participate in this research, which seeks to explore the variety of factors which may influence people's perceptions and behaviour regarding decision making related to family planning. Therefore, it is essential to listen directly your opinion and experiences by interview and focus group discussion. I would like to ask you questions about your background, your reproductive history and about what you have opinion related to family planning. The aim is to use this information to increase the focus on perception and experience related to family planning among the people in rural Oromia region.

By accepting to participate in semi-structured interview, you accept to be interviewed about your opinion and experience related to reproduction.

By accepting to participate in focus group discussion, you accept to be discussed topics related to reproduction to other member of the group.

As our conversation may focus on private matters, you should not feel pressured to discuss issues that you want to keep private. If you do not wish to use an IC recorder, you can refuse this, and I will take notes instead. The tape recordings will be deleted at the completion of the project, which is within 10 months.

The potential advantage can be that the information from the interviews and discussions could be improved family planning programme. The potential disadvantage can be identification of you by yourself or others. You will be anonymized and I never write down names or other information which could easily be identified at a later stage, however, there may still be possibility to be identified because interview and focus group discussion collect large amount of information which are from many aspects of your life and contain multiple clues to your identity.

The information that is registered about you will only be used in accordance with the purpose of the study as described above. All the information will be processed without name, ID number or other directly recognisable type of information.

Only authorised project personnel will have access to the list of names and be able to identify you.

As far as possible, an attempt shall be made to publish the results in such a manner that the participants' identities are not disclosed to identify you in the results of the study when these are published.

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. If you wish to participate, sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent.

The project is approved by Norwegian Social Science Data Services. I am an independent researcher and doing this out of my own interest. I do not work for any organization and I am not paid by anyone to do this research.

If you have any questions or requests about the research and your part in it, I encourage you to ask me at any time before, throughout or after the interview.

If you have any questions or would like to receive further information about the project, please contact me by email at aiko.ieda@studmed.uio.no or my supervisor, associate professor Mette Sagbakken, at mette.sagbakken@medisin.uio.no

Appendix D

Request for participation in a research project

“Experience and perception related to family planning in rural area in Oromia region Ethiopia”

Background and purpose

This is a request for you to participate in this research study that intends to investigate why there still are high fertility rates in rural Ethiopia. By the use of qualitative methods, the study seeks to explore the variety of factors which may influence people’s perceptions and behavior regarding decision making related to family planning. Therefore, it is essential to listen directly your opinion and experiences by interview and focus group discussion.

What does the study entail?

By accepting to participate in semi-structured interview, you accept to be interviewed about your opinion and experience related to reproduction.

By accepting to participate in focus group discussion, you accept to be discussed topics related to reproduction to other member of the group.

Potential advantages and disadvantages

The potential advantage can be that the information from the interviews and discussions could be improved family planning programme. The potential disadvantage can be identification of you by yourself or others. You will be anonymized and I never write down names or other information which could easily be identified at a later stage, however, there may still be possibility to be identified because interview and focus group discussion collect large amount of information which are from many aspects of your life and contain multiple clues to your identity.

What will happen to the information about you?

The information that is registered about you will only be used in accordance with the purpose of the study as described above. All the information will be processed without name, ID number or other directly recognisable type of information.

Only authorised project personnel will have access to the list of names and be able to identify you.

As far as possible, an attempt shall be made to publish the results in such a manner that the participants' identities are not disclosed to identify you in the results of the study when these are published.

Voluntary participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. If you wish to participate, sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent. If you later on wish to withdraw your consent or have questions concerning the study, you can contact me directly and email: aiko.ieda@studmed.uio.no.

Consent for participation in the study

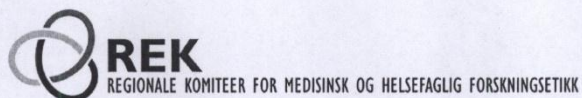
I am willing to participate in the study.

(Signed by the project participant, date)

I confirm that I have given information about the study.

(Signed, role in the study, date)

Appendix E



Region: Saksbehandler: Telefon:
REK sør-øst A Jørgen Hardang 22845516

Vår dato: Vår referanse:
19.07.2011 2011/1111
Deres dato: Deres referanse:

Mette Sagbakken
University of Oslo

2011/1111a Experiences and perceptions related to family planning in a rural area in the Oromia region, Ethiopia

Project Manager: Associate Professor PhD Mette Sagbakken, University of Oslo

The Committee reviewed the application during its meeting on 9 June 2011. The project was assessed in accordance to the Norwegian Research Ethics Act of 30 June 2006 and Act on medical and health research (the Health Research Act) of 20 June 2008 for the regional committees for medical and health research ethics.

The committee considers that the study protocol, *Experiences and perceptions related to family planning in a rural area in the Oromia region, Ethiopia*, lies outside the remit of the Act on medical and health research. The project can be implemented without the approval by the Regional Committee for Medical Research Ethics.

Yours Sincerely

Gunnar Nicolaysen
Chair of the Regional Committee for
Medical Research Ethics of Southern Norway
(P.P.)

Jørgen Hardang
Secretary

Copy to : University of Oslo: universitetsdirektor@uio.no

Besøksadresse:
Gullhaug torg 4A
0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: <http://helseforskning.etikkom.no>

Vi ber om at alle henvendelser sendes inn via vår saksportal eller på e-post. Vennligst oppgi vårt referansenummer i korrespondansen.

Appendix F

Norsk samfunnsvitenskapelig datatjeneste AS NORWEGIAN SOCIAL SCIENCE DATA SERVICES



Harald Hårfagres gate 29
N-5007 Bergen
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Mette Sagbakken
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Postboks 1130 Blindern
0318 OSLO

Vår dato: 05.09.2011

Vår ref: 27632 / 3 / KH

Deres dato:

Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 21.07.2011. Meldingen gjelder prosjektet:

27632	<i>Experience and Perception related to Family Planning in Rural Area in Oromia Region, Ethiopia</i>
Behandlingsansvarlig	<i>Universitetet i Oslo, ved institusjonens øverste leder</i>
Daglig ansvarlig	<i>Mette Sagbakken</i>
Student	<i>Aiko Leda</i>

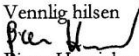
Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 31.07.2012, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Bjørn Hennrichsen


Kjersti Håvardstun

Kontaktperson: Kjersti Håvardstun tlf: 55 58 29 53
Vedlegg: Prosjektvurdering
Kopi: Aiko Leda, Platousgate 27 A, 0190 OSLO

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
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Appendix G

አዲስ አበባ ዩኒቨርሲቲ
ADDIS ABABA UNIVERSITY



የኢትዮጵያ ጥናትና ምርምር ተቋም
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ቀን: ነሐሴ 10/2003
Date: _____
ቁጥር: ኢፕምተ/361/11/03
Ref.No. _____

ስ ማ መ ስ ከ ተ ው ሁ ሱ

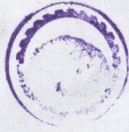
ሚስ. አይኮ የዳ (Ms. Aiko leda) የጃፓን ተወሳጅ የሆኑት በአዲስ አበባ ዩኒቨርሲቲ የኢትዮጵያ ጥናትና ምርምር ተቋም ጉብኝ ምዘር መሆናቸውን በቅድሚያ አንገልጻለን።

ተጠቃሻ በሾሮሚያ ክልል ባሴ ዞን አየተዘዋወሩ “Experience and perception family planning in rural areas of Oromia region, Ethiopia” በሚል ርእስ ላይ ጥናት አያካሂዱ መሆናቸውን አላገለጽን፤ ጥናታቸው የተሳካ እንዲሆን ጉዳዩ በቀጥታም ሆነ በተዘዋወሩ የሚመለከታቸው መንግሥታዊና ህዝባዊ ድርጅቶች ሁሉ የሚፈልጉትን መረጃ በመስጠት አስፈላጊው ትብብርና ድጋፍ አንድደረግላቸው እየጠየቅን ስሚደረግላቸው ትብብር በቅድሚያ አናመሰግናለን።

ከሰላምታ ጋር

ገብሩ ታረቀ (ፕሮፌሰር ሲሙራቲስ) ተዳዶር
የኢትዮጵያ ጥ/ምርምር ተቋም ዲሬክቶር

Appendix H



Mootummaa Naannoo Oromiyaa
Bulchiinsa Godina Baalee
Wajjira Bulchiinsa Aanaa Goloolchaa
ሰርዲናሪ ከላዊ መንግሥት ሰላላ ሆኖ
ግድግዳ ላይ አስተዳደር ጽ/ቤት

Lett D-4/202/06

Guyyaa 30/12/2003

Bulchiinsaa Ganda Salaa tiif

Bulchiinsaa Ganda Dobil tiif

Bulchiinsaa Ganda Dinsaa tiif

Dhihaati:- Degaarsaa Hojii akka Gootaan isiin beeksiifina Ilaala.

Dhallaata Biyyaa Japaan kan ta'aan Addee Ms.Aikoo Leeda Yunivarstii

Finfineettii Hayyuu Dhabbataa Qorannoo fi gu'aamaa kan ta'aan

Muxannoo Qusannaa Mastii gandoota baadiyyaa isaaluuf waan dhuufaaniif

yeroo hojiif ganda keessaan dhufaan degaarsaa hojii akka gootaniif isix

igtiin beeksiifina.



"Nagaa wajjin"

Istaayee Dammisee
ተስፋ ደግሎ

Duraa Iba'aa Bulchiinsa
Aanaa Goloolchaa

ግድግዳ ላይ አስተዳደር ጽ/ቤት