BASELINE REPORT

FAMILY PLANNING FOR RESILIENCE BUILDING - RESET PLUS PROJECT

Maria del Carmen Rodriguez

Independent Consultant

Acknowledgements

This baseline study represents an investigation of the family planning habits and its major determinants in the RESET PLUS Project areas. The present report presents major findings compiled from data collectors (ORBIT Consultancy) and includes an analysis guided by the gender approach. I would like to thank Habtamu Adane and his team from ORBIT for their commitment and their valuable work during data collection and data processing.

The survey process was promoted and overseen by AMREF Health Africa-Italy. I would like to thank Eleonora Silanus and Cristina Coletto for their considerable dedication support and guidance. Besides, I would like to extend my gratitude to AMREF Health Africa - Ethiopia team, particularly Dr. Kassahun Negash and Abebaye Getaneh.

This participatory research counted with the precious collaboration of RESET PLUS partners: AMREF Health Africa Ethiopia, CARE, Save the Children and WSA. I want to thank to all partners of the consortium for their time and their meaningful contributions.

Finally, it is to acknowledge that the conclusions and recommendations presented in this assessment do not imply the expression of any opinion from AMREF Health Africa or any other RESET PLUS project partner. Opinions have been produced freely by the author.

Addis Ababa, March 2019.

Executive summary

"Women we are not free to use FP"

The purpose of this baseline study is to determine baseline levels and document SRH-influencing behaviors, generate understanding of the attitudes related to Sexual and Reproductive Health, Family Planning, adolescents' and youth' views and experiences of sexuality and sexuality information and education, the range and quality of SRH services available to them in project areas; traditional practices that impact on SRH, the role of religious and traditional leaders and levels of male involvement.

The baseline study included a desk review of project document, a participatory process for development of baseline methodology in collaboration with project partners, data analysis and reporting of findings. The research is based on four quantitative and qualitative data collection methods: KAP survey distributed to 1.225 respondents in six cluster areas, Health Facility assessment done to 11 Health centres, Focus group discussion (15 groups) and Key Informant Interviews (25 interviews). The data collection of the study was performed by an independent firm, ORBIT Research & Consultancy during late December 2018 and early January 2019. The investigation included a number of methodological limitations related with the sensitivity of the research questions and the complexity and diversity of the areas of study that were neutralized by the multiplicity of research tools and applying triangulation of results when analysing the data.

Main findings

The baseline data indicated that women in the sample RESET Family planning intervention areas have an average of 4.4 children. Compared to the national average fertility rate, 4.6 children per women, almost in all clusters higher fertility rate was observed except in Waghmera cluster that have a relatively low fertility rate (3.2). Women in the study clusters are sexual active before men. The mean age at first sexual intercourse for women is 17 years old, compared to 19 years among men. However, about 56% of the respondents (53.26% of female and 60% of male) reported that a girl should never start having sex before 18 years old. In South Omo sexual debut is relatively earlier (16 years old for females and 17 years for males) that in other clusters, as well as the age for first birth with is 16 year for female and 17-year-old for male, comparatively younger than for the overall average which is 18 years old for females and 22 years for males. It is to highlight that the majority of the female adolescents (60%) gave birth after they marriage. The vast majority of the below 18 y.o. mothers, 82% of them, were illiterate. This signifies that in the project intervention areas, there is a strong correlation between educational status and age of first birth.

The contraceptive methods uptake in the surveyed areas is relatively low. Less than one third of the respondents in all the intervention clusters (27.2%) had ever used contraception. Among the different contraceptive methods, injectable (42%) were the most frequently used followed by implants (28 %) and pills (18%). Use or preference of each methods varies among clusters. In Wolitya, implants were used by the majority of respondents (45.16%) whereas implants use is almost null in South Omo. Injectable were the most preferred ones in South Omo, Bale and Waghenera. Women in Borena most frequently use pills. Contraceptive use is significantly associated with a number of variables. The likelihood of using contraceptives being educated is four times more as compared for those who are illiterate. Also, the probability of using contraceptives increase with the age as respondents from 20 to 29 y.o. showed four times more chances of using contraceptives than other age groups. Overall, the contraceptive knowledge (at least one method) among women in the intervention areas is relatively low (82%) compared to the national figure of 99%. The majority of the respondents (55%) in Waghmera know at least three methods of contraceptive methods unlike South Omo(13.5%) and Woliyata (21%). There are numerous misconceptions and mistaken ideas among the target population

concerning family planning associating the use of contraceptives with health problems in women and the born-to-be children.

Borena shows the highest unmet need (46%) followed by Bale (31%) which are by far higher than the Oromia regional figure of 15.7% (EDHS, 2016). Contraceptive use and future need of children and family size are correlated, particularly in Bale and Borena clusters. Respondents indicated that they started to use contraceptives after having their fourth child and precisely, the average family size in the project sites is 4.4. Among the sexually active population, only 15.7% of women and 14.7% of men reported having had experiences with other people than their regular partners (spouses). Borena and Bale seem to be the clusters with higher levels of infidelity.

Overall, 42% of female and 35% of male respondents have visited health facilities to receive FP services such as information, contraceptives and others. The utilization of health services is higher in Bale (58%) while the lowest rates of services utilization is found in South Omo (26%). More than 90% of the respondents informed that they prefer a public health facility (either a center or a post). Affordability and convenience were the most frequently mentioned reasons to visit a specific health facility across all the clusters. Among the main motive for visiting the health facility, contraceptive use was cited by the majority of female respondents (60%) above pregnancy check-ups (21.21%) and STDs (12.42%). The majority of male (91%) and female (81%) coincided in revealing that they were informed about contraceptive methods while visiting health facilities. Female respondents in South Omo feel the least comfortable at the health facilities and satisfied whereas in Wolayta, Bale and Borena the level of satisfaction is a bit higher but still comparatively low with percentages of satisfied respondents ranging from 20% to 30% only.

The most common type of contraceptive available is male condom and combined pills for women in all health facilities despite of the fact that those two are the least demanded methods by women respondents. Facilities appeared to have important problems related with stock-outs of a variety of contraceptives. The availability of contraceptive methods is better off in Waghemra cluster compared to the others. There is very limited availability of contraceptive methods in some surveyed facilities in clusters like South Omo where only one type of method (progestin-only injectable) was available at the time of the survey. Almost all surveyed facilities provided short term contraceptives. Some health centers also provided permanent contraceptives and abortion services. However, services are mostly not available at all times. The availability is mainly due to lack of supplies and lack of equipment and trained staff for the permanent contraceptives' delivery and abortion services. Also, availability of sufficient infrastructure and equipment is to be improved, particularly in some clusters like S. Omo, Bale and Borena. More than half of health facilities open at convenient hours to adolescents and have separate hours for young people assistance.

The vast majority of the respondents (92.46% of female and 83.5% of male) have positive attitudes towards family planning. However, married women are not free to use contraceptives without the permission of their husbands and un-married women are banned from using contraceptives since they are expected not to have sexual relationships outside marriage. Despite of the fact that more than half of the respondents (51% female and 56% male) reported that using FP should be a common decision between husband and wife, there is the general understanding that children are gift from God and if someone is to decide on the size of the family it should be the husbands. The majority of the women respondents (61.68%) and men (52.2%) reported that most husbands highly expect their wives not to use FP so they can have larger families. If married women dare to use contraceptives without their husbands' authorization, they take the risk of being expulsed from the family and isolated from the community. Not only men, but also communities have high expectations on the sexual behavior of women. Communities will punish unmarried women that use (or even just talk about) FP by isolating or expulsing them from the communities.

Conclusions and recommendations

The project should focus on groups of age and clusters were the uptake of contraceptives is lower. Besides, partners working in different clusters should adapt their advocacy and communications efforts to the particularities of each region. For instance, Waghemra, Borena and Wolaita should put more emphasis targeting adolescents and youth. Besides, partners should adapt their communications efforts to a highly un-educated and mis-informed population who has not been exposed to prior information on FP before or have been exposed only to biased ideas and prejudices on the use of FP. In this context, it is important for the project to work with religious and spiritual leaders as well as other informal leaders with enough power deciding on the morality of the communities. They should be trained and invited to participate in the project as allies, transferring accurate information on FP and contraceptives.

Besides, the project should invest in bridging the gap between people´s demands for FP and available services. On this regard, the project should coordinate efforts with the local health authorities to ensure enough and regular supply of most preferred methods in each cluster. Also, knowledge and capacities of staff may influence on the quality of the service provided. The project should continue supporting capacity building activities with all medical personnel. Health facilities supported by the project should comply with the minimum standards of water and sanitation. Partners should seek collaboration with larger government sanitation projects and other international agencies like UNICEF in order to ensure enough equipment of the facilities. Moreover, facilities should become more youth-friendly. The project should support health facilities in making services more accessible for youth and explore the possibility of connecting services with the schools through outreach activities.

Traditional and religious believes are strongly rooted in people´s minds and attitudes. Thus, awareness campaigns need to be framed under the Communications for Social Change approach that addresses the complex relations between people´s perceptions, attitudes and behaviours. In general, the use of FP is very much determined by the social norms that guide the sexual activity of the individuals (mainly women) in the community. Thus, the project shall address those social norms in a non-confrontational manner in order to ensure the success of the FP activities. Besides, project activities should acknowledge the power that the society has over women´s decisions and include actions targeting the whole community, not just at individual level. The aim at community level would be to transform the image societies have on the contraceptives as harmful for women and against religion.

Since sex is happening mainly in marriage (or long-time unions), communication campaigns and messages should target couples instead of individuals and the project should ensure enough availability of long-term types of contraceptives more adequate for stable couples. Only in Bale and Borena with higher levels of reported infidelity, the use of male condoms should be advocated for in order to avoid HIV and other STDs transmission.

Decision-making in the project areas is male-dominated, including decisions on the family size and the use of contraceptives. Because of this, traditional-type of communication strategies targeting only women may not be as effective as having men and couples as the main recipients of communication activities. On the other hand, it is essential that unmarried women have access to FP services and thus, specific actions should be taken by the project to protect their rights to access medical advice and contraceptives. Sensitization of the community will be necessary but also, strengthening of the role of HDAs and HEWs doing visits to houses will be needed.

Finally, early child bearing is common among female adolescents in the Project areas. Child bearing among adolescents is not related with early marriage but it is strongly related with their level of education (82% of the below 18 years mothers are illiterate in the project areas). It is essential that

training on sexuality and family planning is given in the earliest stages of adolescence (prior to the drop-out of the girls from the school) and sensitization activities involve both mothers and fathers of the children. It should be one of the highest priorities of the project to raise awareness and educate children and parents for the age of child bearing to be postponed beyond 18 y.o. Partners should build upon the sensitization work done at the schools and school clubs and expand/strengthen advocacy activities for the use of male condoms among adolescents during their early sexual relationships.

Table of Contents

1. INTRODUCTION 1

2. CONSULTANCY OBJECTIVES AND RESEARCH QUESTIONS 2

3. BASELINE METHODOLOGY 4

3.1. Design of the Study 4
3.2. Data Collection Methods 5
3.2.1. Desk review and secondary data gathering. 5
3.2.2. KAP Survey 5
3.2.3. Key Informant Interview (KII) 6
3.2.4. Focus Group Discussion (FGD) 6
3.2.5. Health Facility Assessment (HFA) 7
3.3. Sampling Methods 7
3.4. Methodological Challenges 8

4. FINDINGS 9

4.1. Socio-Demographic Characteristics of Respondents 9
4.1.1. Age of respondents 9
4.1.2. Marital status 9
4.1.3. Residence, Religious Affiliation and Primary Source of Income 10
4.1.4. Education 10
4.2. Fertility/Birth Story 11
4.3. Age of Sexual Debut and First Birth 11
4.4. Contraceptive use 13
4.4.1. Contraceptive Knowledge 16
4.4.2. Unmet need for contraception 19
4.5. Sexual Behaviour 20
4.6. Access and utilization of Family Planning Services 21
4.6.1. Main source of information on FP services 23
4.6.2. Reasons for not-visiting the Health facilities 24
4.7. FP services availability 25
4.7.1. Commodities availability 26
4.7.2. Availability of services 27
4.7.3. Availability of equipment and infrastructure 28
4.7.4. Availability of Youth-friendly services 28
4.8. Attitudes towards FP and Reproductive rights of women 29
4.8.1. Attitudes on suggesting the use of contraceptives 30
4.8.2. Attitudes on the use of contraceptives by the unmarried 30
4.9. Gender and Social Norms 32
4.9.1. Decision making on FP 32
4.9.2. Social norms and sexual agency 35
4.9.3. Expectations from the communities 37
4.9.4. Perceptions on GBV 38

5. CONCLUSIONS AND RECOMMENDATIONS 39

5.1. Use of contraceptives and FP Services 39
5.2. Service provision 40
5.3. Sexuality and Sexual Agency. 40
5.4. Gender roles and social norms 41
5.5. Interacting values, norms and other drivers 42
5.6. Adolescents and youth. 43

ANNEX 1. RESET PLUS LOGFRAME-BASELINE DATA I

ANNEX 2 LIST OF REFERENCES VII

ANNEX 3 DETAILED LIST OF KIIS AND FGDS ..... **VIII**

ANNEX 4. SAMPLE SIZE DETERMINATION AND SAMPLE DISTRIBUTION ..... **X**

ANNEX 5. OTHER TABLES ..... **XII**

ANNEX 6: DECISION MAKING WITHIN THE HOUSEHOLD ..... **XXI**

ANNEX 7. EQUIPMENT AVAILABILITY AT THE HFS ..... **XXV**

List of Tables

TABLE 1. RESET PLUS BASELINE ANALYSIS FRAMEWORK 2
TABLE 2: FIELD DATA COLLECTION TIMEFRAME AND ORBIT TEAM COMPOSITION 4
TABLE 3: SUMMARY OF DATA COLLECTION METHODS 5
TABLE 4. SUMMARY OF KAP SURVEY AREAS OF INQUIRY 6
TABLE 5: SUMMARY OF HEALTH FACILITIES ASSESSED 7
TABLE 6: SUMMARY OF AREAS COVERED BY THE STUDY 7
TABLE 7: AGE AND SEX DISTRIBUTION OF THE RESPONDENTS BY CLUSTER 9
TABLE 8: MARITAL STATUS OF THE RESPONDENTS DISAGGREGATED BY AGE AND SEX 10
TABLE 9: LEVEL OF EDUCATION ACROSS CLUSTERS BY SEX 11
TABLE 10: ADOLESCENTS (15-19 Y.O.) SEXUAL AND CHILD-BEARING EXPERIENCES 12
TABLE 11: CORRELATION BETWEEN EDUCATIONAL STATUS AND MEAN AGE OF CHILD BIRTH 13
TABLE 12: TABLE CONTRACEPTIVE USE BY AGE AND CLUSTER 15
TABLE 13: CONTRACEPTIVE USE IN RELATION TO OTHER DEMOGRAPHIC VARIABLES 15
TABLE 14: CONTRACEPTIVE KNOWLEDGE BY CLUSTER 17
TABLE 15: CONTRACEPTIVE KNOWLEDGE BY AGE 17
TABLE 16: ASSOCIATION BETWEEN CURRENT NUMBER OF CHILDREN WITH FUTURE NEED OF CHILDREN 20
TABLE 17: CORRELATION BETWEEN AGE AND CONDOM USE DURING RECENT SEX 21
TABLE 18: HEALTH FACILITY VISIT EXPERIENCE BY CLUSTER 21
TABLE 19: CORRELATION BETWEEN HEALTH FACILITY UTILIZATION AND AGE BY CLUSTER 22
TABLE 20: ESSENTIAL COMMODITIES AVAILABILITY AND STOCK OUT IN PROJECT INTERVENTION AREAS 26
TABLE 21: REPLACEMENT TIME OF ESSENTIAL COMMODITIES 27
TABLE 22: TYPE OF SERVICE IN PROJECT INTERVENTION AREAS 27
TABLE 23: ATTITUDES TOWARDS PREVENTION OF PREGNANCY BY CLUSTER 29
TABLE 24: IF UNMARRIED COUPLES WANT TO HAVE SEXUAL INTERCOURSE BEFORE MARRIAGE, THEY SHOULD USE CONDOMS 31
TABLE 25: DECISION-MAKING ON THE SIZE OF THE FAMILY 33
TABLE 26: IT IS OK FOR BOYS AND GIRLS TO HAVE SEX BEFORE MARRIAGE 35
TABLE 27: IT IS SOMETIMES JUSTIFIABLE FOR A MAN/BOY TO HIT HIS WIFE/GIRLFRIEND BY AGE 38
TABLE 28 EXAMPLES OF TAILORING PROJECT STRATEGIES 42
TABLE 29: KAP SURVEY SAMPLE SIZE. X
TABLE 30: SAMPLE DISTRIBUTION FOR THE KAP SURVEY ACROSS GENDER AND KEBELE X
TABLE 31: SUMMARY OF SAMPLE SIZE DISTRIBUTION BY TYPE OF DATA COLLECTION APPROACH XI
TABLE 32: MARITAL STATUS OF THE RESPONDENTS BY SEX AND CLUSTER XII
TABLE 33: RELIGION AFFILIATION XII
TABLE 34: SOURCE OF INCOME BY CLUSTER XII
TABLE 35: MAIN REASON FOR VISITING HEALTH FACILITY BY CLUSTER XIII
TABLE 36: MALE LEVEL OF SATISFACTION AND FREQUENCY OF ACCOMPANYING WIVES XIII
TABLE 37: A WOMAN CAN SUGGEST TO HER HUSBAND/BOYFRIEND THAT THEY USE CONTRACEPTIVE XIV
TABLE 38: A HUSBAND CAN SUGGEST TO HIS WIFE/GIRLFRIEND THAT THEY USE CONTRACEPTIVE XIV
TABLE 39: IF A WOMAN SUGGESTED USING CONTRACEPTIVE METHODS TO HER PARTNER, IT WOULD MEAN: XV
TABLE 40: IF A MAN SUGGESTED USING CONTRACEPTIVE METHODS TO HIS PARTNER, IT WOULD MEAN XV
TABLE 41: UNMARRIED WOMEN SHOULD NOT USE FP SERVICES XV
TABLE 42: COMMUNITY MEMBERS EXPECT UNMARRIED WOMEN NOT TO USE FAMILY PLANNING METHODS XVI
TABLE 43: IF UNMARRIED WOMEN USE FAMILY PLANNING SERVICE, THE COMMUNITY DISRESPECT HER XVI
TABLE 44: UNMARRIED WOMEN CEASE USING FAMILY PLANNING METHOD BECAUSE OF FEARING DISRESPECT FROM THE COMMUNITY XVI
TABLE 45: UNMARRIED WOMEN CAN USE FP METHOD IF THE COMMUNITY RECEIVE ADEQUATE HEALTH EDUCATION XVII

Table 46: Married women are not allowed to use FP method unless she get approval from her husband XVII
Table 47: Most husbands highly expect their wife not to use FP service so as to have large family size XVII
Table 48: If married women use family planning method without the consent of their husband conflict will raise even to end up with divorce XVIII
Table 49: Married woman will stop using family planning service if it raises conflict with their husbands XVIII
Table 50: what is the Ideal age a girl should get married? XVIII
Table 51: The ideal age a girl should give birth for the first time XIX
Table 52: It's all right for boys and girls to have sex with each other provided that they use methods to stop pregnancy XIX
Table 53: A man should never allow his wife to decide on the size of the family XIX
Table 54: It is sometimes justifiable for a man/boy to hit his wife/girlfriend XX
Table 55: Sometimes, a man or boy has to force a woman/girl to have sex if he loves her XX
Table 56: In your household who usually makes decisions about large household purchases XXI
Table 57: In your household who usually makes decisions about household purchases for daily needs XXI
Table 58: In your household who usually decides how to use money that the husband brings into the household. XXII
Table 59: In your household who usually decides how to use the money the wife brings into the household XXII
Table 60: In your household who usually decides to visit public spaces XXIII
Table 61: In your household who usually makes decisions about the health care of the women? XXIII

List of Figures

Figure 1: Phases of the study 4
Figure 2: Fertility Rate by cluster 11
Figure 3: Mean Age for Sexual Debut and First Birth by Cluster 12
Figure 4: Contraceptive use by type 13
Figure 5: Most frequently used contraceptive method used by cluster 14
Figure 6: Unmet need for contraception by cluster 19
Figure 7: Future need of children among women 19
Figure 8: Distribution of respondents by level of satisfaction while visiting health facility by cluster 24
Figure 9: Frequency on the provision of different types of contraceptives 26
Figure 10: Ideal age a girl should start having sex 36
Figure 11: Ideal age a girl should get married 36

List of Boxes

Box 1: Discussant testimony 12
Box 2: Discussants testimonies 16
Box 3: Women Association member testimony 17
Box 4: Female Discussant testimony 18
Box 5: Female Discussant testimony 18
Box 6: Female Discussant testimony 18
Box 7: Male Discussant testimony 18
Box 8: YSF expert testimony 18
Box 9: Female adolescent testimony 23
Box 10: Community Leader testimony 24
Box 11: YFS Expert testimony 25
Box 12: Health practitioner testimony 27
Box 13: Female member of a Women Association testimony 30
Box 14: Female adolescent testimony 31
Box 15: Community Leader testimony 31
Box 16: Female adolescent testimony 32
Box 17: Female member of a Women Association testimony 32
Box 18: Health Practitioner testimony 32
Box 19: Women Association member testimony 32
Box 20: Female testimony 33
Box 21: Discussant testimony 34

BOX 22: ADOLESCENT FEMALE TESTIMONY 34
BOX 23: DISCUSSANT TESTIMONY 34
BOX 24: COMMUNITY LEADER TESTIMONY 34
BOX 25: COMMUNITY LEADER TESTIMONY 37

ABBREVIATIONS AND ACRONYMS

CSA	Central Statistics Agency
EDHS	Ethiopia Demographic and Health Survey
EU	European Union
FP	Family Planning
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
GBV	Gender based Violence
GoE	Government of Ethiopia
HDA	Health Development Army
HEW	Health Extension Worker
HF	Health Facility
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practices
KII	Key Informant Interview
NGO	Non-Government Organization
SRH	Sexual Reproductive Health
STD	Sexual Transmittable Disease
UNICEF	United Nations Children's Fund

1. Introduction

The EU Project founded named "Family Planning for Resilience Building - RESET Plus"[1] started in the first months of 2018 with the aim of contributing to resilience building through consolidated Family Planning (FP) practices, gender equality and decreased demographic pressure in 5 EU RESET clusters.

The RESET PLUS Project builds on, and complements with RESET II Project (2017-2020) also founded by the EU. RESET II is based on the following objectives: greater economic and employment opportunities, strengthening resilience of most vulnerable communities, improved governance and conflict prevention within the EU Trust Fund. Within this larger frame, the focus of RESET Plus is improvement of the systems, from micro to macro levels and the interlinkage between sectors, while adding new areas of work: Family Planning. RESET Plus contributes directly to the achievement of improved access to wide range of contraceptives, increased gender equity among men and women as well as enhanced resilience and productive capacity of women's led organizations and groups.

Specific objectives of the Project are:

- SO1. Increased demand for family planning by 39% through awareness raising on demographic pressure and promotion attitudinal changes regarding family planning and gender equality, particularly among adolescents, youth, men and women in drought prone and chronically food insecure regions;
- SO2. Increased access to and provision of quality comprehensive Sexual Reproductive Health (SRH) services especially FP services by 28% among adolescents, youth and women through service delivery and outreach services, health systems strengthening (capacity building and technical support), monitoring and coordination, women's socio-economic empowerment and promotion of gender's equality

The total duration of the project 3.5 years starting from January 2018. The Project is run by a consortium consisting of five members organizations namely: Amref Health Africa in Ethiopia, Save the Children (in Ethiopia and Save the Children Netherlands), CARE (in Ethiopia and Austria) and Women Support Association (WSA) and leaded by Amref Health Africa in Italy.

The 5 clusters covered by the present action are the following: Wolayta and South Omo Zones in SNNP Region; Wag Himra Zones in Amahra Region; Bale and Borena Zones in Oromia Region. All target areas, though presenting differences are all highly drought prone and food insecure.

Within the frame of the project, Amref Health Africa Italy is leading the one of the cross-cutting activities of the project, the Baseline survey. The Baseline survey is an investigative exercise that has been coordinated by one international consultant with the support of a local team of consultants for the primary data collection. The scope of the research, methodology and tools have been prepared in a collaborative effort by all RESET PLUS partners who have contributed their ideas and inputs to the technical development of the survey. The present document reports on the main findings of the baseline research and propose a number of recommendations for the future design of RESET PLUS strategies and activities.

[1] Hereby within addressed as Project or RESET Plus

2. Consultancy objectives and research questions

The main outcome of the baseline is the development of background papers and documentation on family planning, gender and resilience that will represent the common working framework for the intervention among the consortium partners.

According to the consultancy Terms of Reference, the objective for the baseline is:

> "To determine baseline levels and document Sexual and Reproductive Health (SRH)-influencing behaviors, generate understanding of the attitudes related to Sexual and Reproductive Health, Family Planning (FP), adolescents' and youth' views and experiences of sexuality and sexuality information and education, the range and quality of SRH services available to them in project areas; traditional practices that impact on SRH, the role of religious and traditional leaders and levels of male involvement"

Accordingly, the baseline research was built upon two main objectives:

- On the one hand, the baseline survey determines the baseline levels and completes the Log-frame of the project. On this regard, the baseline survey collects the data that feeds the indicators of the project (both impact and process indicators) and sets up the starting point for the project monitoring and evaluation activities.
- On the other hand, the baseline gathers more context-specific information on the SRH-influencing behaviors and attitudes towards FP and SRH of project beneficiaries. It also generates a more adapted and broad understanding of the adolescents' and youth' views and experiences of sexuality and sexuality information and education. It collects first-hand information on the range and quality of SRH services available in project areas and what are the roles that community leaders and traditional structures play in the adoption of FP and SRH practices. To this end, the baseline survey expands the research questions to these aspects that are not fully contemplated on the log frame of the project. The findings will be presented by cluster and thus, they will be used by partners when defining project activities and intervention strategies.

As per project-document, the baseline study covers six specific objectives and a number of research questions presented in following Table 1:

TABLE 1. RESET PLUS BASELINE ANALYSIS FRAMEWORK

Specific Objective	Research Question
1. To determine baseline levels and document SRH and FP behaviors	What are SRH and FP related behaviors among the project´s target groups? What are the main determinants (education, cultural, economic, etc.) of these behaviors? What is the level of knowledge on FP and SRH of men and women Have they ever been exposed/reached by any sensitization campaign or awareness raising messages?
2. To generate understanding of the attitudes related to SRH and FP	What are the attitudes among men on FP and SRH? What are the attitudes among women on FP and SRH? What are the attitudes among youth and adolescents (boys and girls) on FP and SRH?
3. To understand what are adolescents and youth views and experiences of	What is the knowledge of contraceptives among adolescents and youth (boys and girls)?

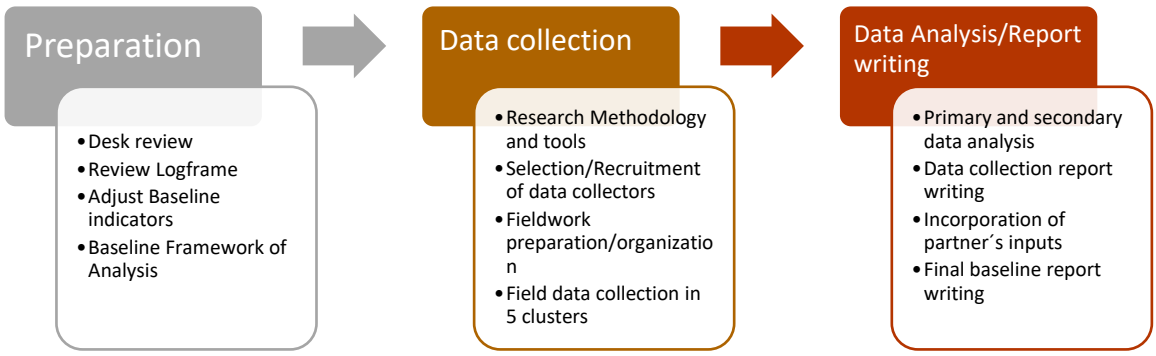
sexuality, sexuality information and education	What is the sexual behavior of adolescents and youth (boys and girls) on the target areas? What is the access of adolescents and youth (boys and girls) to FP information and sexuality education? What are the attitudes among youth and adolescents (boys and girls) on sexuality?
4. To assess the range and quality of SRH and FP services available in the project areas	How many health facilities at the project target areas provide with quality FP services? What type of services/materials/contraceptives are available at the facilities? What are the capacities and knowledge of the health facilities staff on SRH and FP? What is the quality/accessibility of the facilities for adolescents and youth?
5. To determine what are the traditional practices and gender norms that impact on the access of women and girls to SRH and FP services.	What gender and social norms determine men and women attitudes towards FP, sexual behavior and sexuality? What gender and social norms determine youth and adolescents (boys and girls) attitudes towards FP, sexual behavior and sexuality? What are the social expectations and traditional practices that determine the sexual behaviors and the FP-seeking behavior of men and women/boys and girls?
6. To determine what is the role of the community in facilitating/ limiting the access of women, girls and boys to SRH and FP services.	What is the role of the community in facilitating/ limiting the access of women, girls and boys to SRH and FP services. What is the role of community leaders/religious leaders/idris in facilitating/limiting women and girls' access to FP and SRH? What is the role of the education community, particularly peer educators in facilitating the access to FP services and knowledge on sexuality for adolescents and youth?
Other Project-related objectives	How much RESET II partners promote and facilitate FP as a component of resilience building? Is there integration of activities related with nutrition within FP services?

3. Baseline methodology

3.1. Design of the Study

A participatory approach inspired the design of the baseline methodology. All consortium partners collaborated in all phases of the study.

FIGURE 1: PHASES OF THE STUDY



1. Data collection preparation, including:
    a. Desk review of the most relevant project documents, context information and most recent data on FP and SRH in Ethiopia.
    b. An identification of the most relevant indicators to be measured through the baseline data collection based on the Project´s Log frame and partners' needs in terms of context-based information. This phase included the revision of the Project´s Log Frame by all partners and the adjustment of some project indicators (See Annex 1).
2. Baseline data collection coordination, including:
    c. Development of a methodology plan, data collection tools and a common analysis framework to all partners.
    d. Selection and contract of data-collection company. The selected company, ORBIT Research and Consultancy was selected after a competitive process leaded by AMPREF-Ethiopia. ORBIT was given the task of collecting primary data based on methods and tools developed by international consultant and partners.
    e. Data collection in the field with the support of consortium partners. ORBIT conducted the field data collection from December 25th 2018 TO January 18TH 2019 as detailed in Table 2 below.

TABLE 2: FIELD DATA COLLECTION TIMEFRAME AND ORBIT TEAM COMPOSITION

Cluster	Date	Profile of Supervisors	Profile of Data Collectors
Wolaita	December 25-December 30/18	1 Supervisor (MPH)	10 (6 female &4 male)
South Omo	January1- January 9/2019	1 Supervisor (MPH)	6 (4 female and 2 male)
Waghemra	December 30-January 7	1 Supervisor (PhD)	7 (4 female and 3 male)
Borena	December30/18-January 6/2019	1 Supervisor (Assistant Prof)	10 (6 female and 4 male)
Bale	January11-January 18/2019	1 Supervisor (Assistant Prof)	6 (4 female and 2 male)

3. Baseline reporting, including:
    f. Data Analysis. Both descriptive and inferential analysis techniques were used to scrutinize the variables under study. Triangulation of data was used as the main tool

for analysis, utilizing both triangulation of sources and triangulation of methods. Content analysis techniques were used to examine the qualitative data whereas descriptive and inferential statistics methods including crosstab, tables, graphs and regression[2] were used for the quantitative data analysis.

g. Report writing. ORBIT wrote a data collection report including detail of all findings in all indicators and variables studied[3]. International consultant, based on the above-mentioned report and secondary data collected prepared the present report.
h. Incorporation of partner´s feedbacks and inputs on final report. A first version of the present report was shared with partners for their feedback. Comments and inputs from partners were included and modifications inserted in the final report.

3.2. Data Collection Methods

The study combined both quantitative and qualitative methods. The quantitative approach employed a cross-sectional design using the Knowledge, Attitudes and Practices survey (KAP Survey) and Health Facility Assessment (HFA). Two qualitative methods supported and enriched the findings from the Key Informant Interviews (KII) and Focus Group Discussion (FGD).

TABLE 3: SUMMARY OF DATA COLLECTION METHODS

	QUANTITATIVE TYPE	**QUALITATIVE TYPE**
PRIMARY SOURCES	KAP Survey Health Facility Assessment	Key Informant Interviews Focus Group Discussion (
SECONDARY SOURCES	Desk review	Desk review

3.2.1. Desk review and secondary data gathering.

Desk review of both project documents and most recent studies on the field of Family Planning and Sexual Reproductive Health was carried out prior to the methodology development in order to gain knowledge on both the academic and practice context of the object of study.

Data feeding Indicators at impact level were documented through the latest Demographic and Health Survey (EDHS, 2016) and other regional reports (See Annex 2. List of References)

3.2.2. KAP Survey

The tool was used to assess the family planning and SRH attitudes, knowledge and practices of RESET PLUS target area beneficiaries (men and women from 15 to 49 y.o), with the aim of informing the baseline of the Project. Because of the nature and sensitivity of the type of questions asked, individual interviews with men and women took place – instead of proposing a household questionnaire. The questionnaire was adapted from UNICEF´s Multiple Indicator Cluster Surveys (MICS) and WHO

[2] Using STATA for Windows, software version 15.1.
[3] ORBIT Data collection Report has fed the presented finding in this report and is available to readers under request to RESET PLUS consortium members

Illustrative Questionnaire for interviews-surveys with young people and enriched with contributions from partners.

TABLE 4. SUMMARY OF KAP SURVEY AREAS OF INQUIRY

	QUESTIONNAIRE FOR INDIVIDUAL WOMEN	**QUESTIONNAIRE FOR INDIVIDUAL MEN**
General questions from standardized questionnaires	1. Woman´s Information Panel (name, date and time of interview) 2. Woman´s background (age, education) 3. Fertility/Birth Story (number of births, desire for last birth) 4. Contraception (use of contraception presently or in the past ONLY!) 5. Unmet need 6. Marriage/Union 7. Sexual Behavior (recent sexual activity)	1. Man´s Information Panel (name, date and time of interview) 2. Man´s background (age, education) 3. Fertility 4. Marriage/Union 5. Sexual Behavior (recent sexual activity)
Supplemental questions	8. Access and use of FP services 9. Attitudes towards FP and gender-sensitive decision making on family size and women´s reproductive rights 10. Sexuality, gender and norms	6. Access and use of FP services 7. Attitudes towards FP and gender-sensitive decision making on family size and women´s reproductive rights 8. Sexuality, gender and norms

The tool was translated into the local languages (Amharic and Afan Oromo) and pilot testing of the tool was carried out by trained data collectors who have acquaintance with the local culture and well versed with the local languages. The data was collected using Open Data Collect/ODK or KOBO, where a structured questionnaire with pre-coded answers was uploaded.

3.2.3. Key Informant Interview (KII)

Semi-structured interviews happened with key informants at the different clusters in order to capture the ideas and opinions of community representatives and RESET program stakeholders. The list of key informants was selected in each cluster in consultation with partner´s teams at the field (See detail of key informants on Annex 3) Purposive sampling technique was applied to identify individuals involved as key informants. A guide was developed also in coordination with partners.

3.2.4. Focus Group Discussion (FGD)

Focus group discussions were held with homogenous groups of the relevant potential project beneficiaries residing in the targeted communities, which among others include school club members (adolescents), HDAs, women associations´ members or HEWs. The information gathered enriched the results from KAP Survey providing with very valuable in-depth inputs to better frame and understand quantitative findings. Convenience sampling was used with the help of partner´s teams at the field to identify participants from different groups of the project beneficiaries. A total of 15 FGDs were undertaken from all the clusters (See detail of FG discussants on Annex 3). All FGDs were recorded using a tape recorder and then transcribed by the lead researcher and the supervisors who are well versed with local languages.

3.2.5. Health Facility Assessment (HFA)

The Health Facility assessment was used to determine the readiness of the facility to deliver FP and SR health related services. Additionally, the check-list gathered information on the equipment and commodities, condition of the facility, materials, supervision, information and management systems, and protocols and guidelines.

An adaptation from the Facility Audit presented at MEASURE Evaluation (2016) was developed and tailored to the specific needs of the present study. The check-list was used by baseline surveyors at the different clusters during their visits to Health facilities together with a short interview with the provider, and an observation of FP consultation. In total, 11 Health facilities were assessed distributed through the five clusters.

TABLE 5: SUMMARY OF HEALTH FACILITIES ASSESSED

	Amhara	**Oromia**	**SNNPR**	**TOTAL**
Health Center	2	0	4	6
Health Post	0	5	0	5

3.3. Sampling Methods

The baseline study covered the targeted locations by RESET PLUS Project as described in Table 6 below:

TABLE 6: SUMMARY OF AREAS COVERED BY THE STUDY

Southern Nations, Nationalities and Peoples (SNNP) Regional State		**Amhara Regional State**	**Oromia Regional State**		**TOTAL** **3 Regions**
Wolaita Zone	South Omo Zone	Waghimra Zone	Bale Zone	Borena Zone	**5 Zones (clusters)**
Damot Pulasa, Dugna Fango, Boloso Sore and Kindokoysha	Hammer, Dasenech, and Nyangatom	Abergele, Dehana, Gazgibla, Sehala, Sekota and Ziquala	Rayitu, Dawe, Kachen, GuraDamole, Barbere and Meda Wollab	Dilo, Arero, Moyale, Miyo, Dhas and Dire	**24 Woredas**

The sample size for the KAP Survey was calculated based on single population proportion formula and considering key variables: expected proportion, level of significance, and desired precision. Four key outcome indicators of the project were used to propose the sample size related with the use of contraceptives, demand for family planning and knowledge on FP[4].

Multistage stage cluster sampling technique was employed, where districts were the primary sampling unit, and Kebeles were selected randomly from the selected district.

[4] See Annex 4 on Sample size determination and sample distribution

As for the qualitative tools, purposively selected key actors, health facilities and groups participated in the study following the principle of saturation for the calculation of the number of groups and interviews.[5]

3.4. Methodological Challenges

Through the preparation and development of the baseline study, a number of challenges were faced and overcome:

- The indicators on the original Log-frame of the project were to be amended in order to avoid duplication and facilitate measuring. To this end, prior to the development of the baseline methodology, partners collaborated in the revision of the Log-frame indicators.
- Because of the size of the consortium and the participatory nature of the study, the time for the preparatory phase lasted more than it was initially planned. Besides, because of security issues in some locations (particularly in Borena and Bale), the field work suffered some delays.
- According to ORBIT data collection report, although great care was taken in the recruitment and training of data collectors, individual differences on respondents were observed due to the sensitivity of the topic of study and the capacity of surveyors to stablish enough rapport and trust with informants. Besides, data collectors reported finding some difficulties in keeping the privacy of informants during interviews influencing on individuals' responses to some private questions. In general, the sensitivity of the topics discussed and cultural taboos around them, limited respondents´ capacities to openly and sincerely discuss and express their perceptions.
- Neither the Health centres nor the local health authorities collaborated in providing with HMIs data on number of consultations and profile of the patients assisted on those centres.
- The sampling strategy, to a certain extent, has contributed to the source of potential bias. Even if the study team employed a standard sample size determination technique, the result generated from relatively small sample in some study Kebeles may exaggerate certain knowledge and attitude related issues.
- The report writer and data analyst did not participate in the field data collection and thus, findings' interpretations do not count with first-hand observations important on these types of studies. Besides, contents of transcripts from qualitative tools in English have been summarized and thus, data analysis has been partial.

The above-mentioned limitations were neutralized through the sufficient representativeness of the sample studied and the use of triangulation methods for data analysis. Besides, the variety of indicators and variables used has provided with a colourful set of findings that offer rich information not only to inform the project´s log frame but to guide further actions of partners in an evidenced-based way.

[5] For more detailed information on the methodological aspects of the survey, please see ORBIT Report.

4. Findings

4.1. Socio-Demographic Characteristics of Respondents

A total of 1225 respondents participated in the KAP Survey. Besides, qualitative data from 15 FGD and 25 Key informants and quantitative data from 11 health facilities were also collected to augment the KAP survey tool. The total sample size of those who participated in the KAP survey using Mobil applications (ODK and Kobo) represent 103% of the target sample size (n=1190) of which 783 (64%) were women and 442 (36%) were men[6].

4.1.1. Age of respondents

The age of the respondents ranged from 15 to 49 years. Female respondents ages 15-19 accounted for 36.4% of the total sample, while age ranges 20-29 and 30-49 represented 42% and 22 %, respectively. As for male, 30% represented the age range 15-19, 40% the age range 20-29 and 28% the range 30-49. The mean age of female respondents was 24 ± years and 25.7 ± years for male (see Table 7 for disaggregated data by cluster).

TABLE 7: AGE AND SEX DISTRIBUTION OF THE RESPONDENTS BY CLUSTER

Age	Bale		Borena		South Omo		Waghemra		Wolaita		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
15-19	65	27	45	19	37	34	42	20	96	36	285	136
%	54.17	38.57	22.73	26.76	46.25	51.52	21.32	18.52	51.06	28.35	36.4	30.77
20-29	35	25	88	26	33	15	118	65	51	49	325	180
%	29.17	35.71	44.44	36.62	41.25	22.73	59.90	60.19	27.13	38.58	41.51	40.72
30-49	20	18	65	26	10	17	37	23	41	42	173	126
%	16.67	25.71	32.83	36.62	12.5	25.76	18.78	21.3	21.81	33.07	22.09	28.51
Total	120	70	198	71	80	66	197	108	188	127	783	442
%	100	100	100	100	100	100	100	100	100	100	100	100
	Obs		**Mean**		**Std.Dev**		**Min**		**Max**			
Female	783		24.023		7.827		15		49			
Male	442		25.708		8.506		15		49			

4.1.2. Marital status

More than half (53.7%) of the study participants (55.6% of female and 50.5% of male) were married or live with partners as if married, while 42.45% of the respondents (38.8% of female and 48.86% of male) were single. Only 5.6% of female and 0.7% of males presented themselves as separated or divorced, being Waghemra the zone encountering more divorced respondents (12.7% of females and 2.8% of males)[7].

Taking a closer look at the situation of adolescents (15 to 19 y.o.), the majority of them (75.8% female and 87.5% male) were single. Still, a significant proportion of them, 23.5% of girls and 12.5% of boys were married before the age of 19 (See table 8 below) Compared to the latest national

[6] See Annex 4 on Sample size determination and sample distribution
[7] See Annex 5 on Detailed tables on Socio-Demographic Characteristics

sociodemographic data (EDHS 2011), where 50% of girls were reported to be married by age 18, child marriage in the project intervention areas is not acute but still significant, especially in clusters like Borena, South Omo and Bale to a lesser extent.

TABLE 8: MARITAL STATUS OF THE RESPONDENTS DISAGGREGATED BY AGE AND SEX

Age categories	Marital status							
	Married		Single		Separated/Divorce		Total	
	F	M	F	M	F	M	F	M
15-19	67	17	216	119	2	0	285	136
%	15.40	7.62	71.05	55.09	4.55	0.00	36.40	30.77
20-29	221	88	86	90	18	2	325	180
%	50.80	39.46	28.29	41.67	40.91	66.67	41.51	40.72
30-49	147	118	2	7	24	1	173	126
%	33.79	52.91	0.66	3.24	54.55	33.33	22.09	28.51
Total	435	223	304	216	44	3	783	442

4.1.3. Residence, Religious Affiliation and Primary Source of Income

Almost all respondents to this survey were living in rural areas (97.32% female and 95.02% males). Only 2.17% percent of females and 2.94% of males lived at semi-urban areas at the time of the survey.

The majority of the respondents (56%) professed the Christian faith (28.32% Christian-Orthodox and 27.59% Christian-Protestant), while the rest were Muslims (24.16%) and other faiths (19.91%). There are important variations by location: majority of the respondents from Waghemera and Wolaita were Christians whereas in Bale cluster majority of respondents were Muslims. In South Omo and Borena clusters, majority of the respondents reported other faiths: in Borena respondents self-reported as Wakefeta, while in South Omo respondents mentioned that they don't profess any conventional religion[8].

The livelihoods of the vast majority of the respondents (85.37%) were primarily based on subsistence agriculture, of which more than half (58% of male and 48% of female respondents) reported "land cultivation" and 33.87% (31% of male and 36% of female) reported "animal husbandry" as their primary source of income. There are also significant differences between clusters, being Borena and South Omo pastoralists areas with 90.14% and 87.88% of respondents respectively identifying the pastoralist job as their main source of income[9].

4.1.4. Education

Within the project sites, 39.42% of the total respondents (44.44% of women and 30.5% of men) are illiterate, 36.24% (33.6% of female and 41% of men) have completed primary education, 19.10% (13.3% of female and 19.2% of men) have completed lower secondary education and only 5.22% of the study participants (5.1% of female and 5.4% of men) have completed higher education. The situation is especially worrisome for women in clusters like South Omo and Borena, where 96.2% and 71.7% of female respondents respectively are illiterate (See Table 9 below). As described in following sections, the low education among women correlates with the knowledge and use of contraceptives.

[8] See Annex 5 on Detailed tables on Socio-Demographic Characteristics

[9] See Annex 5 for more details

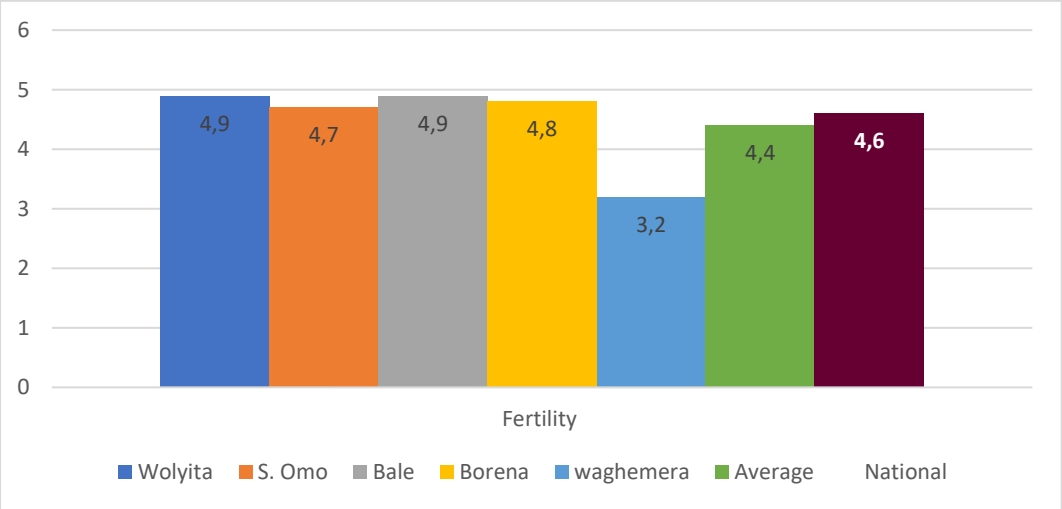
TABLE 9: LEVEL OF EDUCATION ACROSS CLUSTERS BY SEX

Level of education	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Illiterate	21	12	142	31	77	52	66	22	42	18	348	135
%	17.5	17.1	71.7	43.7	96.2	78.8	33.5	20.4	22.3	14.2	44.4	30.5
Primary (1-8)	85	41	49	39	3	14	31	30	95	57	263	181
%	70.8	58.6	24.8	54.9	3.8	21.2	15.7	27.8	50.5	44.9	33.6	41.0
Lower 2^0_(9-10)	10	14	4	0	0	0	49	30	41	41	104	85
%	8.3	20.0	2.0	0.0	0.00	0.0	24.9	27.8	21.8	32.3	13.3	19.2
Upper 2^0/prep	2	3	1	0	0	0	20	10	5	4	28	17
%	1.7	4.3	0.5	0.0	0.0	0.0	10.2	9.2	2.7	3.1	3.6	3.9
Higher	2	0	2	1	0	0	31	16	5	7	40	24
%	1.7	0.0	1.0	1.4	0.00	0.0	15.7	14.8	2.7	5.5	5.1	5.4

4.2. Fertility/Birth Story

The baseline data indicated that women in the sample RESET Family planning intervention areas have an average of 4.4 children. Compared to the national average fertility rate, 4.6 children per women (EDHS, 2016), almost in all clusters higher fertility rate was observed except in Waghmera cluster that have a relatively low fertility rate (3.2). As depicted in the graph below, variations in the fertility rates across clusters were observed, where the highest fertility rate were seen in Wolaita and Bale Clusters.

FIGURE 2: FERTILITY RATE BY CLUSTER



4.3. Age of Sexual Debut and First Birth

Findings indicate that women in the study clusters are sexual activity before men. The mean age at first sexual intercourse for women is 17 years old, compared to 19 years among men. The result was found to be consistent with national data from EDHS (2016) where first sexual intercourse for women is 16.6 years and 21.2 years for male.

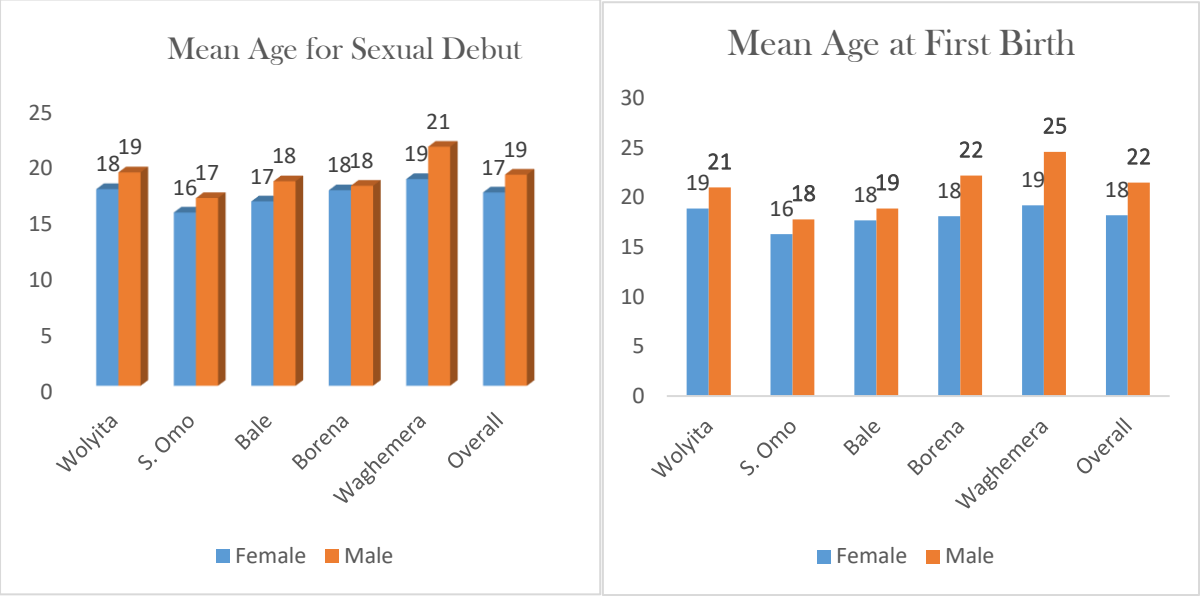
Cluster-wise analysis indicates that in South Omo sexual debut is relatively earlier (16 years old for females and 17 years for males) that in other clusters, while in Waghemera women sexual debut mean age is 19 and 21 for man (See Figure 3 below). However, discussants in the majority of clusters (both female and male adolescents) ensure that adolescents have their sexual debut much earlier

Box 1: Discussant testimony

> *Female adolescents in our community start sexual relations from 14 to18 years while male start from 13-17 years.* Adolescent Female discussant, FGD Damot Pulsa, Wolaita

Likewise, findings show the existence of a clear age variation between women and men to have their first child. The average age for women respondents having their first baby was 18 years old, while 22 years for men. Alike the sexual debut, sample respondents from South Omo were found to give birth at younger age (16 year for female, 17-year-old for male) compared to other clusters.

FIGURE 3: MEAN AGE FOR SEXUAL DEBUT AND FIRST BIRTH BY CLUSTER



Among all adolescent respondents (285 female and 136 male), 26% of female and 27% of male have ever had sexual experience. Among them, about 11% of girls (15 – 19), gave birth before the age of 19 years old, which is slightly lower than the national teenage child-bearing percentage of 13 % (EDHS, 2016).

TABLE 10: ADOLESCENTS (15-19 Y.O.) SEXUAL AND CHILD-BEARING EXPERIENCES

Indicator		Female (15-19)	Male (15-19)
Ever had sex	No	210	99
	%	73.68	72.79
	Yes	75	37
	%	26.32	27.21
Child-bearing	No	254	134
	%	89.12	98.53
	Yes	31	2
	%	10.88	1.47
	No	268	-

Current pregnancy	%	94.04	
	Yes	17	-
	%	5.96	
Total		285	136

It is to highlight that the majority of the female adolescents (60%) gave birth after they marriage. Interestingly, in the clusters surveyed there is a strong association between early marriage and early child bearing.

Among women respondents, about half of them (50.8%) have given birth. Of which a considerable proportion of them (41.5%) gave birth before the age of 18 years old. Even more disturbing is the fact that the vast majority of the below 18 y.o. mothers, 82% of them were illiterate. This signifies that in the project intervention areas, there is a strong correlation between educational status and age of first birth.

TABLE 11: CORRELATION BETWEEN EDUCATIONAL STATUS AND MEAN AGE OF CHILD BIRTH

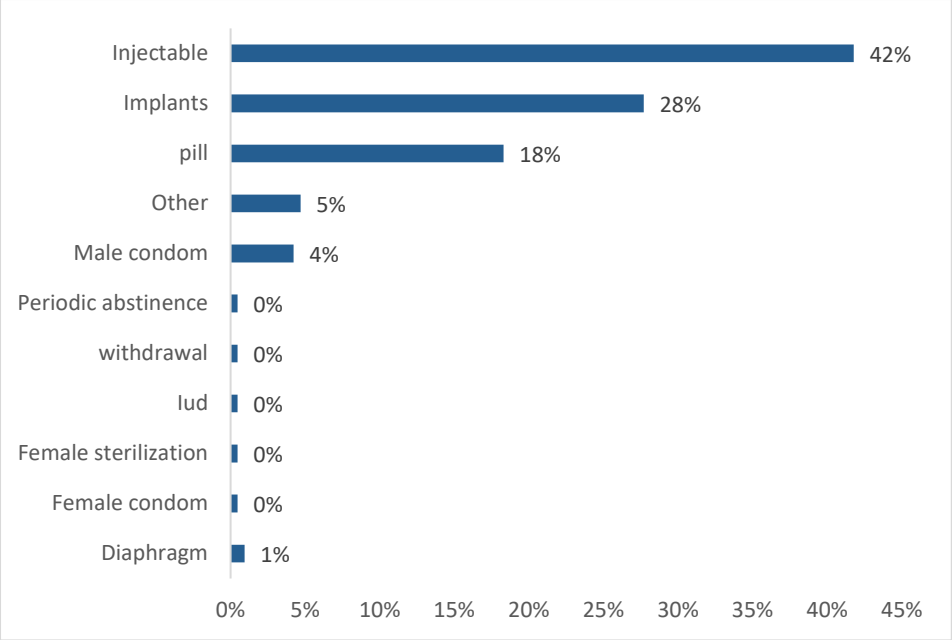
Educational status	**Age of Birth**		
	<18 years	**>=18**	**Total**
Illiterate	135 (81.8)	141(51.1)	276
Literate	30 (24.6)	92(75.4)	122
Total	165(41.5)	233(58.5)	398
Pearson chi2 = 20.6 P= 0.000			

4.4. Contraceptive use

The contraceptive methods uptake in the surveyed areas is relatively low. Less than one third of the respondents in all the intervention clusters, 213 (27.2%) had ever used contraception[10]. Among the different contraceptive methods, injectable (42%) were the most frequently used followed by implants (28 %), pills (18%) and the remaining (12%) accounts all other family planning methods.

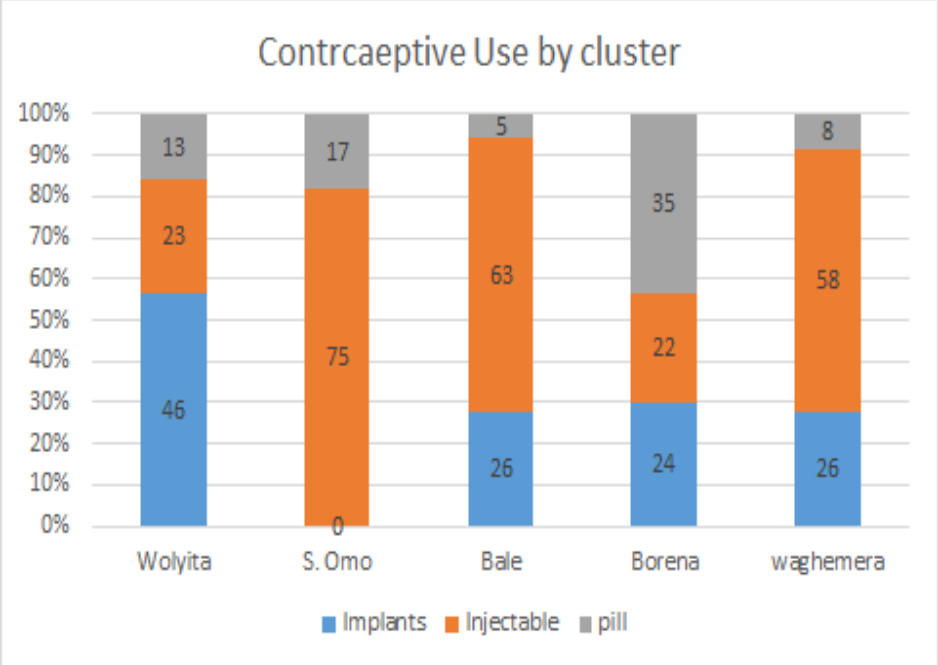
FIGURE 4: CONTRACEPTIVE USE BY TYPE

[10] Respondents answered positively of the following question from the KAP Survey: "Have you ever done something or used any method to delay or avoid getting pregnant?"



Use or preference of each methods varies among clusters. In Wolitya, implants were used by the majority of respondents (45.16%) whereas implants use is almost null in South Omo. Injectable were the most preferred ones in South Omo, Bale and Waghenera. Women in Borena most frequently use pills.

FIGURE 5: MOST FREQUENTLY USED CONTRACEPTIVE METHOD USED BY CLUSTER



The age group showing higher use of contraceptives is the one from 20 to 29 y.o. in all clusters but specifically in Waghemra, the percentage of use is higher (70%). Among the adolescents'

group (15-19) the higher use is registered in Bale, with 31.58% and the lower use is seen in Waghemra (3.9 %) followed by Borena and Wolaita with 6.45% of use respectively.

TABLE 12: TABLE CONTRACEPTIVE USE BY AGE AND CLUSTER

Age	Bale		Borena		South Omo		waghemra		wolaita	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
15-19	6	59	2	94	3	34	3	39	2	94
%	31.58	58.42	6.45	59.87	25.00	50.00	3.90	32.50	6.45	59.87
20-29	9	26	19	32	8	25	54	64	19	32
%	47.37	25.74	61.29	20.38	66.67	36.76	70.13	53.33	61.29	20.38
30-49	4	16	10	31	1	9	20	17	10	31
	21.05	15.84	32.26	19.75	8.33	13.24	25.97	14.17	32.26	19.75

Results of the regression analysis shows that contraceptive use is significantly associated with a number of variables including age, level of education, knowledge of contraceptives, type of religion, family size and level of satisfaction during health facility visit (see Table 13 below).

The likelihood of using contraceptives being educated is four times more as compared for those who are illiterate. Also, the probability of using contraceptives increase with the age as respondents from 20 to 29 y.o. showed four times more chances of using contraceptives than other age groups. Similarly, for those women who know at least three methods of family planning, the likelihood of using contraceptive methods is three times higher compared to those who know less than three methods. Having four and more children would likely increase the possibility of using contraceptive methods by three times as compared to those who have less than four children.

TABLE 13: CONTRACEPTIVE USE IN RELATION TO OTHER DEMOGRAPHIC VARIABLES

Determinants	Family planning use among women respondents				
	Options	AOR	95% CIs		p-value
Age	15-19 (ref)	1.0	.	.	.
	20-29	3.9	0.74	21.1	0.107*
	30-49	1.7	0.28	10.7	0.550
Marital status	Married	2.2	0.28	17.8	0.450
	Single (ref)	1.0	.	.	.
	Separated	0.43	0.527	-0.69	0.491
Occupation	Farmer(ref)	1.000	.	.	.
	no job	1.06	0.44	2.6	0.887
	Student	2.6	0.38	17.5	0.337
	employee	0.77	0.06	9.5	0.837
	own business	0.72	0.2	2.5	0.604
	daily laborer	0.59	0.12	2.9	0.528
Educational status	Illiterate(reference	1.0	.	.	.

	Educated	3.930	1.4	10.9	0.008***
	Christian orthodox	5.5	1.04	28.9	0.045**
	Christian protestant	7.5	1.4	40.5	0.018**
	Muslim	2.1	0.60	7.8	0.246
Religion	Others(ref)	1.0	.	.	.
Family Planning knowledge	Know at least 3 method	3.1	1.4	6.6	0.003***
	Do not or know less than3 method (ref)	1.0	.	.	.
Number of children	Less than 4 children (ref)	1.0	.	.	.
	More than 4 children	2.9	1.3	6.7	0.012**
Level of satisfaction	Not satisfied(ref)	1.0	.	.	.
	Regular/somewhat	7.5	1.5	37.4	0.013**
	Very satisfied	2.1	0.41	10.6	0.379
Cluster	Wolayita	0.061	0.006	0.54	0.012**
	South Omo(ref)	1.0	.	.	.
	Bale	0.063	0.008	0.48	0.008***
	Borena	0.639	0.15	2.7	0.539
	Waghemra	1.486	0.16	13.9	0.729

Legends: COR= Crude Odds ratio; AOR= Adjusted Odds Ratio; *** p<0.00; ** p<0.01; * p<0.05;

Another associated factor is religion, as the groups of the self-declared Christian protestants and Christian orthodox respondents show a probability of 7.5 and 5.5 times higher of using contraceptives than other religious groups. Consistently, discussants from FGD in South Omo (with majority of animists) and in Borena (majority Muslims) shared that it is their belief that using contraceptive is interfering with the will of God. They stressed that birth and death should be left to God. Cognizant to this, some people consider getting family planning services like committing a sin; sin of killing the human life.

Box 2: Discussants testimonies

"If I found my wife using contraceptive, I consider her as a killer. We must leave everything to God. I will basically file divorce if she tends to continue utilizing the contraceptive." Male discussant, Kindo Koyesh Kebele, South Omo

"In Muslim family, both husband and wife cannot decide on family size. It is Allah's gift and trying to control birth is seen as sin. But there is exception where some families use FP to control family size" Female discussant, Arero, Borena.

Finally, the level of satisfaction with the services received at the health facilities may be another predictor in the use of contraceptives as satisfied respondents in the survey presented 7.5 times more probabilities of using contraceptives than those not satisfied.

4.4.1. Contraceptive Knowledge

Overall, the contraceptive knowledge (at least one method) among women in the intervention areas is relatively low (82%) compared to the national figure of 99% (EDHS, 2016). Only about one third of the repondents (34%) know at least three methods of contraceptive. Analysing by clusters, majority of the respondents (55%) in Waghmera know at least three methods of contraceptive methods unlike South Omo(13.5%) and Woliyata (21%).

Discussants from South Omo cluster indicated the lack of sufficient trainings on contraceptives to make informed decision. They stressed that the trainings, if any, are basically general that wouldn't help the sexually active people to select the type of contraceptive that might suit them.

Box 3: Women Association member testimony

"We don't have enough trainings about the pros and cons of each type of contraceptives. If government or NGOs give us trainings, they usually give us a general type of training which wouldn't enable us to make a choice from the available contraceptives." [Dassenech Women Association Member discussant, South Omo]

The most frequently mentioned contraceptive method are injetables (54.6%) in the first place, followed by implants (41%) and Pills (45%).

TABLE 14: CONTRACEPTIVE KNOWLEDGE BY CLUSTER

Contraceptive knowledge		bale	Borena	South_omo	Waghemra	Wolaita	Total
Knowing at least 3 methods		30 (25%)	78(39.4%)	11(13.5%)	109(55%)	39(20.7)	267(34%)
	yes						
	No	90 (75%)	120(60%)	69(86.5%)	88((45%)	149(79.3%)	516(66%)
Contraceptive knowledge by type							
Injectable		53	86	40	167	97	443
		44.17	43.43	50.00	84.77	51.60	56.58
		25	70	7	156	61	319
Implants		20.83	35.35	8.75	79.19	32.45	40.74
Pills		55	130	18	69	77	349
		45.83	65.66	22.50	35.03	40.96	44.57
		42	85	7	68	41	243
Male condom		35.00	42.93	8.75	34.52	21.81	31.03
IUD		0	1	7	27	12	47
		0.00	0.51	8.75	13.71	6.38	6.00
Female condom		3	4	1	1	4	13
		2.50	2.02	1.25	0.51	2.13	1.66
Do not know any		23	34	35	16	31	139
		19.17	17.17	43.75	8.12	16.49	17.75

When analysing the level of knowledge by age, results show that a higher proportion of respondents among the age group of 20 to 29 y.o. have better knowledge of contraceptives as depicted in Table 15 below:

TABLE 15: CONTRACEPTIVE KNOWLEDGE BY AGE

Age categories	Known at least three Contraceptive Methods		
	Yes	No	Total
15-19	77	208	285
%	27%	73%	100%
20-29	137	188	325

%	42%	58%	100%
30-49	53	120	173
%	31%	69%	100%
Total	**267**	**516**	**783**

Qualitative findings reveal that there are numerous misconceptions and mistaken ideas among the target population concerning family planning, which is consistent with the low knowledge on contraception displayed above. In line with this, FGD discussants mentioned that contraceptives in some cases would tend to increase family size rather than limiting family size mentioning cases where women would give birth to twins while ceasing utilizing contraceptives.

Box 4: Female Discussant testimony

"Using contraceptives is a source of twin birth. It creates pressure on a family. I considered some women in my community giving birth to twin children while stopping using contraceptives." [FGD,Damo Pulsa Suke, Wolaita]

In Waghemra cluster it was found that there is the general misperception that contraceptive use increases women´s appetite and food intake, which is not convenient in drought-prone areas where they suffer food shortages through the year.

Box 5: Female Discussant testimony

Women, including me, failed to seriously take contraceptives because we think it increases our food intake. The area is drought prone where cannot afford to eat as much as we want. FGD. Kerjul, Waghemra

Other misconceptions are related with the negative health impact on the mothers or future babies. Some discussants in South Omo noted that using contraceptives makes the users unproductive and weak or even worse, long term contraceptives will make women infertile.

Box 6: Female Discussant testimony

"People in this area think it is impossible to have any more children after taking contraceptives, mainly the long-term ones. As a result, we tend to use, if there is the will, the short-term ones." [Female discussant from Dassenech, South Omo cluster]

Box 7: Male Discussant testimony

I don't allow my wife to use contraceptive, particularly injectables, as it makes her get tired and unproductive [FGD, Netsanet Melkam, Waghemra

It is also perceived that using contraceptives decreases women´s sexual desire and increases their mood swings. This lack of sexual desire is perceived by husbands as lack of sexual interest and a clear sign of infidelity.

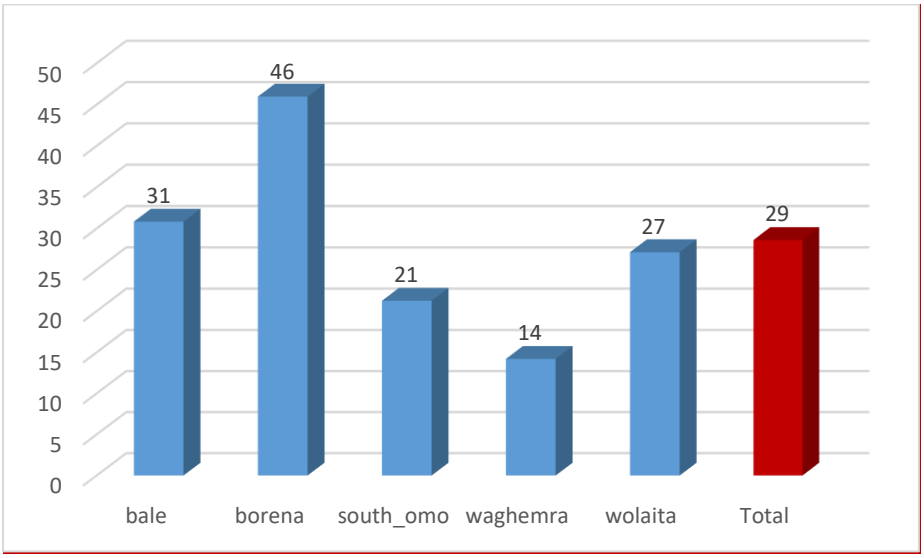
Box 8: YSF expert testimony

"I usually hear complaints of discomfort that contraceptives create on woman utilizing contraceptives. Users of combined injectable contraceptives claim that it makes them feel tired, bring mood swings, and in some cases low libido; and make their husbands to complain of being unfaithful to them or have extra marital affairs. As a result, I noted some stop using contraceptives. KII, Asketema, Waghemra

4.4.2. Unmet need for contraception

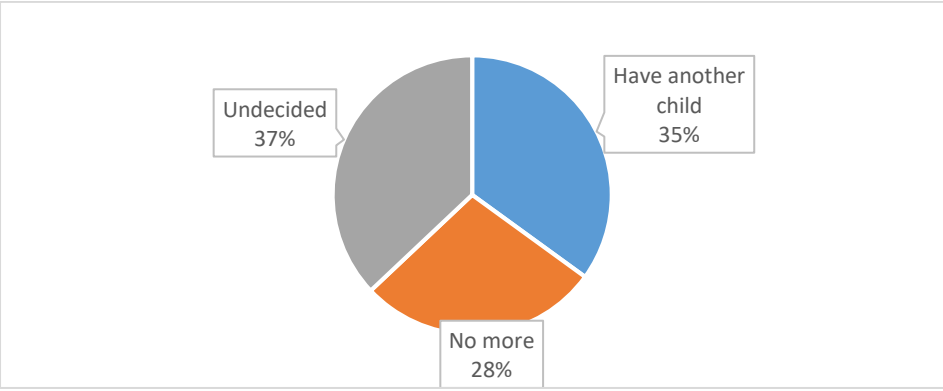
The overall unmet need for family planning is 29% of the total respondents which is slightly higher than the national unmet need coverage of 22% (EDHS, 2016). Further analysis indicated that Borena shows the highest unmet need (46%) followed by Bale (31%) which are by far higher than the Oromia regional figure of 15.7% (EDHS, 2016). Whereas, Waghemera (14%) shows lower levels of unmet need than the Amhara regional figure of 29.9%; and South Omo (21%) data is similar to the SNNP regional percentage of 22.6% (EDHS, 2016).

FIGURE 6: UNMET NEED FOR CONTRACEPTION BY CLUSTER



Furthermore, results indicate that of all the women (89) who were pregnant at the time of the survey, 83% of them reported that they want their pregnancy while the remaining 17% said they didn't want the current pregnancy. Additionally, out of the total female respondents, only 28% said they did not want to have future children while the major portion of the participants (37%) indicated that they are still undecided.

FIGURE 7: FUTURE NEED OF CHILDREN AMONG WOMEN



Besides, contraceptive use and future need of children and family size are correlated. Respondents indicated that they started to use contraceptives after having their fourth child and precisely, the average family size in the project sites is 4.4. However, this correlation differs by cluster. In Bale and Borena, the relationship the actual number of children and the desire (lack of it) of having more children is more significant than for other clusters.

TABLE 16: ASSOCIATION BETWEEN CURRENT NUMBER OF CHILDREN WITH FUTURE NEED OF CHILDREN

Cluster	Number of children	future need of children				Chi2	P Value
		Have another	no more	Undecided	Total	16.99	0.001
Bale	Below average (4)	16	0	1	17		
		66.67	0.00	50.00	41.s		
	Above average (4)	8	15	1	24		
		33.33	100	50	58.5		
	Total	24	15	2	41		
		100.00	100.00	100.00	100.00		
Borena	Below average (4)	37	18	3	58	12.13	0.002
		52.86	24.66	33.3	38.2		
	Above average (4)	33	55	6	94		
		47.14	75.34	66.7	61.8		
	Total	70	73	9	152		
		100.	100.00	100	100		
South Omo	Below average (4)	11	3	3	17	1.17	0.56
		37.93	21.43	33.3	32.7		
	Above average (4)	18	11	6	35		
		62.07	78.57	66.7	67.3		
	Total	29	14	9	52		
		100.00	100.00	100	100		
Waghmera	Below average (4)	28	15	5	48	3.86	0.146
		62.2	57.7	33.3	55.8		
	Above average (4)	17	11	10	38		
		37.9	42.3	66.7	44.2		
	Total	45	26	15	86		
		100	100	100	100		
Wolaita	Below average (4)	4	5	6	15	4.0128	0.131
		23.5	14.3	40.	22.4		
	Above average (4)	13	30	9	52		
		76.5	85.7	60	77.6		
	Total	17	35	15	67		
		100.00		100.00	100		

4.5. Sexual Behaviour

A similar percentage of male and female respondents declared that they ever had a sexual intercourse (59.39% of females and 59.28% of males). Among this 59% of sexually active population, only 15.7% of women and 14.7% of men reported having had experiences with other people than their regular partners (spouses). Borena and Bale seem to be the clusters with higher levels of infidelity with 33.33% of women and 14.89% of men declaring having sex with other people than the partner in Borena and 28.95% and 30.43% respectively in Bale. Whereas in the rest of the clusters the figures of infidelity are almost anecdotal.

A relatively higher proportion of female respondents (66.7%) from age groups of 20-29 years old used condom during their recent sex experience although the relation is not significant. However, the correlation between age and condom use is found to be significant on males and specifically among male adolescents between 15 and 19 y.o. (43.75%).

TABLE 17: CORRELATION BETWEEN AGE AND CONDOM USE DURING RECENT SEX

Age categories		**Condom use during recent sex**		
		No	Yes	Total
Female	15-19	60	8	68
		17.96	16.67	17.80
	20-29	171	32	203
		51.20	66.7	53.14
	30-49	103	8	111
		30.84	16.7	29.06
	Total	334	48	382
		100.00	100.00	100.00
		Pearson chi2 = 4.8 P= 0.09		
Male	15-19	12	21	33
		6.25	**43.75**	13.75
	20-29	82	18	100
		42.71	37.50	41.67
	30-49	98	9	107
		51.04	18.75	44.58
	Total	192	48	240
		100.00	100.00	100.00
		Pearson chi2 = 4.8 P= 0.000		

4.6. Access and utilization of Family Planning Services

Overall, 42% of female and 35% of male respondents have visited health facilities to receive FP services such as information, contraceptives and others. The utilization of health services is higher in Bale (58%) while the lowest rates of services utilization is found in South Omo (26%) for female respondents. Similar pattern of utilization was observed for male respondents.

Asked about the type of health facility they visited, more than 90% of the respondents replied that they visited a public health facility (either a centre or a post). Affordability and convenience were the most frequently mentioned reasons to visit a specific health facility across all the clusters. Respondents also seem to prefer governmental health facilities since the access to private facilities are limited in the intervention areas.

TABLE 18: HEALTH FACILITY VISIT EXPERIENCE BY CLUSTER

Sex	**Clusters**	**Bale**	**Borena**	**South Omo**	**Waghemra**	**Wolaita**	Total
Ever visited the health facility to receive services or information on contraception, pregnancy							
Female	Yes	70	82	21	95	62	330
		58.33%	41.41	26.25	48.22	32.98	42.15
	No	50	116	59	102	126	453
		41.67%	58.59	73.75	51.78	67.02	57.85

	Total	120	198	80	197	188	783
		100	100	100	100	100	100
Male	Yes	41	50	9	22	31	153
		58.57%	70.42	13.64	20.37	24.41	34.62
	No	29	21	57	86	96	289
		41.43%	29.58	86.36	79.63	75.59	65.38
	Total	70	71	66	108	127	442
		100	100	100	100	100	100
Type of facility visited							
Female	health center	57	68	21	91	60	297
		81.43%	82.93	100.00	95.79	96.77	90.00
	Hospital	13	13	0	3	2	31
		18.57%	15.85	0.00	3.16	3.23	9.39
Male	health center	36	46	9	19	27	137
		87.80%	92.00	100.00	86.36	87.10	89.54
	Hospital	4	2	0	3	3	12
		9.76%	4.00	0.00	13.64	9.68	7.84
Why you chose this facility							
Female	It was the most affordable option	35	49	15	45	26	170
		50.00	59.76	71.43	47.37	41.94	51.52
	Convenient in terms of distance	27	18	17	61	48	171
		38.57	21.95	80.95	64.21	77.42	51.82
	I trust more people there	22	3	0	9	7	41
		31.43	3.66	0.00	9.47	11.29	12.42
	I like how they treat me	12	22	1	3	11	49
		17.14	26.83	4.76	3.16	17.74	14.85
Male	It was the most affordable option	26	45	7	10	17	105
		63.41	90.0	77.78	45.45	54.84	68.63
	Convenient in terms of distance	15	21	6	18	23	83
		36.59	42.0	66.67	81.82	74.19	54.25
	I trust more people there	1	2	0	3	1	7
		2.44	4.00	0.00	13.64	3.23	4.58
	I like how they treat me	4	2	0	0	2	8
		9.76	4.00	0.00	0.00	6.45	5.23

As presented in Table 19 below, women from the age group from 20 to 29 y.o. are more prone to use health facilities in all clusters but in South Omo where the correlation between age and use of health facilities is not found significant. As for the male respondents, adult age group (30-49) are more likely to visit health facility in Wolaita and South Omon clusters. Whereas age group 20-29 y.o. male respondents are more likely to visit health facility in Bale cluster. No significant association was found of these two variables in Borena nor in Waghemra clusters.

TABLE 19: CORRELATION BETWEEN HEALTH FACILITY UTILIZATION AND AGE BY CLUSTER

Sex	**Age**	**Bale**		**Borena**		**South Omo**		**waghemra**		**wolaita**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Female	15-19	23	42	9	36	7	30	9	33	9	87
		32.9	84.0	10.98	31.03	33.3	50.8	9.5	32.3	14.5	69
	20-29	30	5	45	43	12	21	62	56	28	23
		42.9	10.0	54.88	37.07	57.1	35.6	65.3	54.9	45.2	18.2

	30-49	17 24.3	3 6.0	28 34.1	37 31.90	2 9.5	8 13.6	24 25.3	13 12.7	25 40.3	16 12.7
	Total	70 100	50 100	82 100	116 100	21 100	59 100	95 100	102 100	62 100	126 100
		Chi2=30.7 P<0.001		Chi2=12 P = 0.002		Chi2=2.9725 P= 0.250		Chi2=17 P<0.001		Chi2=49.8 P<0.001	
Male	15-19	7 17.1	20 69	11 22.	8 38.1	1 111	33 57.9	1 4.5	19 22.1	1 3.2	35 36.5
	20-29	19 46.3	6 20.7	19 38	7 33.3	2 22.2	13 22.8	16 72.7	49 57	10 32.3	39 40.6
	30-49	15 36.6	3 10.3	20 40	6 28.6	6 66.7	11 19.3	5 22.7	18 20.9	20 64.5	22 22.9
	Total	41 100	29 100	50 100	21 100	9 100	57 100	22 100	86 100	31 100	96 100
		Chi2=19.5362 P<0.001		Chi2=2.04 P = 0.359		Chi2=10.07 P= 004		Chi2=3.66 P=0.153		Chi2=21.81 P<0.001	

Among the main motive for visiting the health facility, contraceptive use was cited by the majority of female respondents (60%) above pregnancy check-ups (21.21%) and STD (12.42%). Contraception is also the major reason for visiting Health facilities for male respondents (40%) followed by STD (37.91%)[11]

4.6.1. Main source of information on FP services

When asked about the main source of information for FP services, Health Extension Workers (HEWs) are named by the majority of female (35%) and male (42%) respondents. However, there are some variabilities depending on the locations. In Waghemera, health development armies/women associations were the main source of information (69%) followed by neighbors (65.8%), radio (53%) and health facility (33.9%).

Overall, the majority of male (91%) and female (81%) coincided in revealing that they were informed about contraceptive methods while visiting health facilities. There are also variabilities between clusters with Waghemra and Borena doing better than the other locations. Results from qualitative data analysis reinforces this idea that FP is seen as a sensitive topic that is discussed face to face and in private.

Box 9: Female adolescent testimony

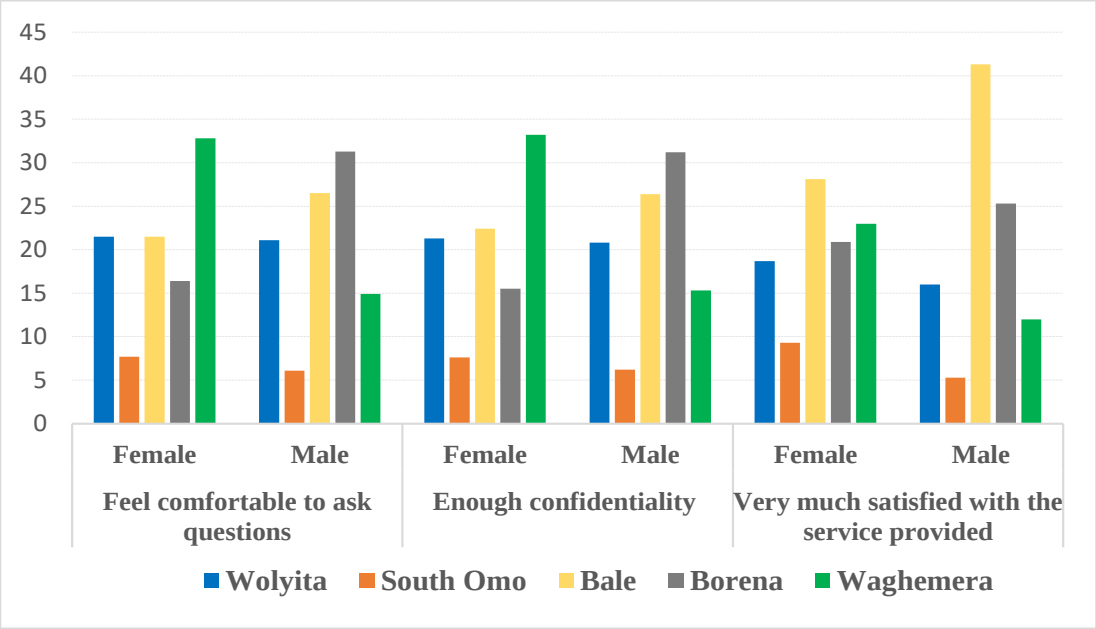
So far, we don't have the habit of discussing with family about contraceptives. We just restrict/ ashamed to talk with family/ the discussion between friends. The community is still not free to discuss

[11] See more details in Annex 5

about contraceptives. There is even condemnation of the un/married woman for taking contraception. This make most of them to use family planning services in secret. FG discussant. Asktema. Waghemra

Respondents were also asked about their experience during their visit to the health facilities. As seen at the figure below, female respondents from Waghemera are in general more satisfied with the services provided, the confidentiality and they feel more comfortable asking questions that females in other clusters. Female respondents in South Omo feel the least comfortable and satisfied whereas in Wolayta, Bale and Borena the level of satisfaction is a bit higher but still comparatively low with percentages of satisfied respondents ranging from 20% to 30% only.

FIGURE 8: DISTRIBUTION OF RESPONDENTS BY LEVEL OF SATISFACTION WHILE VISITING HEALTH FACILITY BY CLUSTER



Married men were asked whether they accompanied their wife during FP visit, and 37% responded positively. The distribution was highest (28%) at Waghemra cluster and lowest (6%) at South Omo. The majority of married men mentioned that the main reason for not accompanying their wives was the feeling of shame[12].

4.6.2. Reasons for not-visiting the Health facilities

- **Distance from the HF**. Results from FGDs and KIIs show that respondents consider the long distance to reach the health facility as the main reason for them to refrain from accesing the health centers/health posts. Participants explained how long distances from their houses make women reluctant of visiting the HFs since they know they need to be on time or meet the opening schedule otherwise their efforts traveling all the way to the center will be useless.

Box 10: Community Leader testimony

[12] See more details in Annex 5

"Sometimes I considered women from remote rural areas face difficulties reaching the inflexible working time at the health facilities. The fixed time for provision contraceptives deters a woman from using family planning services at the time they reach the health facilities." [Male Community Leader, Netsanet Melekam Keble, Waghemra Cluster]

- **Poor services provided at the HF**. This is a difficulty mentioned by the HF workers themselves. They explained that the trainings organized by governmental or non-governmental organizations have been some what general, infrequent and given only few workers. As a result, they said they couldn't execute tasks that require specific skill. This limit the health workers to provide the visitors as per their demands. The limited training opportunities coupled with turnover of staff who took the training aggravates the problem.

Box 11: YFS Expert testimony

"I usually face difficulties telling the pros and cons of different contraceptives to people visiting the health center to widen their choices as I have never been given trainings specific to each type of contraceptive." [Male YFS Expert, Asketema Kebele, Waghemra Cluster]

- **Limited number of staffs with expertise at the HF**. Lack of sufficient staff in the health facilities was also found to influence the access of women to health facilities. The respondents mentioned that if there is a time when the designated staff is absent from the health facility, the possibility of the facility to give family planning services is almost null, nobody would be able to replace the expert. For instance, most health facilities usually have just one YFS expert.
- **Infrequent presence of HEWs at certain Health Posts**. Some respondents reported also that HEWs are more often that expected not present at their working posts. For instance, during the survey time the surveying team realized that some of the health posts in Borena (Haralo health post and Fuldowa health post) were closed. Similarly, a health post at Mylomin, Waghemra zone was closed during our facility visit.

4.7. FP services availability

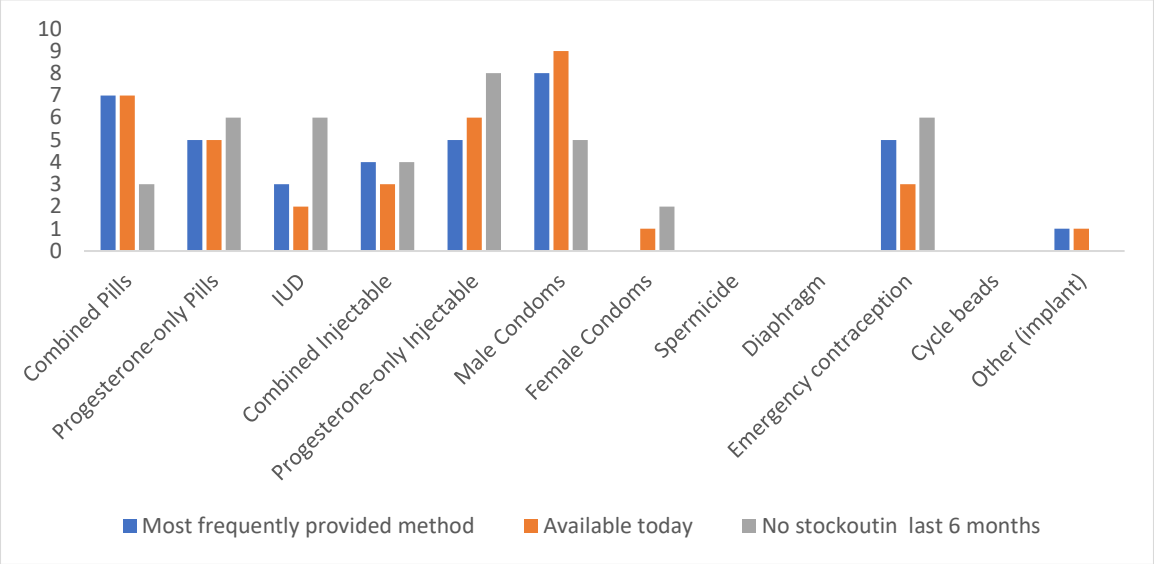
The assessment of the FP services available, has been done through the Health facility Assessment used in 11 health facilities distributed through the area of study. In all areas surveyed it was expressed by Health practitioners that other than the government-funded centers and posts there are very few other private health facilities nor the contraceptives are distributed/sold anywhere else than the health facilities. Public health facilities do not engage with any type of relationship with these private clinics.

Some of the centers surveyed reported that they receive intermittent support from NGOs and private foundations like the Dasenech Omorade Health Center (S. Omo) receiving assistance from the Clinton Center, providing training to the staff and some supplies.

4.7.1. Commodities availability

The most common type of contraceptive available is male condom and combined pills for women in all health facilities (see figure 9 below) despite of the fact that those two are the least demanded methods by women respondents(see section 4.4. on contraceptive use).

FIGURE 9: FREQUENCY ON THE PROVISION OF DIFFERENT TYPES OF CONTRACEPTIVES



Overall, many of the surveyed facilities have a relatively high availability of at least one contraceptive method. However, facilities appeared to have important problems related with stock-outs of a variety of contraceptives. The availability of contraceptive methods is better off in Waghemra cluster compared to the others. There is very limited availability of contraceptive methods in some surveyed facilities in clusters like South Omo where only one type of method (progestin-only injectable) was available at the time of the survey.

TABLE 20: ESSENTIAL COMMODITIES AVAILABILITY AND STOCK OUT IN PROJECT INTERVENTION AREAS

Cluster	Bale (n=2)			Borena (n=3)			South Omo (n=2)			Waghemra(n=2)			Wolaita (n=2)		
Type of contraceptive	Most frequently provided method	Available today	No stockoutin last 6 months	Most frequently provided method	Availabl e today	No stockout in last 6 months	Most frequentl y provided method	Available today	No stockouti n last 6 months	Most frequ ently provi ded meth od	Availa ble today	No stockou tin last 6 months	Most frequ ently provid ed metho d	Availa ble today	No stocko utin last 6 month s
Combined Pills	1	1	0	2	2	2	0	0	1	2	2	1	2	2	0
Progesterone-only Pills	1	2	0	1	1	3	0	0	0	2	1	2	1	1	1
IUD	1	0	2	1	0	2	0	0	0	0	1	2	1	1	0
Combined Injectable	0	1	0	2	1	1	0	0	0	1	1	2	1	0	1
Progesterone-only Injectable	0	1	2	0	0	2	2	2	2	1	1	2	1	2	0
Male Condoms	2	2	0	2	3	1	0	0	0	2	2	2	2	2	2
Female Condoms	0	0	2	0	0	3		0	0	0	1	2		0	2
Spermicide															
Diaphragm			2		3			0			2				1
Emergency contraception	1	0	1	0	0	3	1	0	0	2	2	2	1	1	0
Cycle beads			2			3			0			2			1
Other (implant)	0		2	0		3	0	0	2	1	1	1	0		2

The replacement time for stock out of essential commodities varies among 11 health facilities. Five of health facilities replaced within one week or less while the other five replaced in one month or less. Only one health facility reported that replacement took about six months for contraceptives. It was observed that the replacement time of commodities didn't show significant difference between health centers and health posts.

TABLE 21: REPLACEMENT TIME OF ESSENTIAL COMMODITIES

Time of replacement	Oromia		SNNP		Amhara	
	Bale	Borena	South Omo	Wolyita	Waghemera	Total
One month or less	0	2	1	1	1	5
One week or less	2	1	0	1	1	5
Six months or less	0	0	1	0	0	1
Total	2	3	2	2	2	11

4.7.2. Availability of services

Almost all surveyed facilities provided short term contraceptives. Some health centers also provided permanent contraceptives and abortion services. However, as shown in the table 7 below, services are mostly not available at all times. The availability is mainly due to lack of supplies and lack of equipment and trained staff for the permanent contraceptives' delivery and abortion services.

Box 12: Health practitioner testimony

The short-term FP products are available in a sufficient quantity. But there no long-term FP in our health because there is no staff member is trained on how to provide it. KII. Health practitioner. Kerjul Health Post. Bale

TABLE 22: TYPE OF SERVICE IN PROJECT INTERVENTION AREAS

Type of Service	Provided Yes	Available at ALL times in the last 6 months Yes	reason not available last time
Short-term contraceptives	10	6	Supplies not available=4 Equipment not available=1
LARCS	9	6	Supplies not available=3 Equipment not available=1 Trained staff not available=1
Permanent contraceptives	0	3	Supplies not available=4 Equipment not available=3
Abortion services	1	1	Supplies not available=6 Equipment not available=4

Among the eleven health facilities, seven health facilities had most recent version of written guidelines and protocols for delivering family planning (national guidelines). However, one facility in Bale, two in South Omo and one in Wolaita clusters did not have any guidelines and protocols. Even for those using the national guidelines, it has been admitted by health practitioners that practitioners don't have the same understanding of the manual, meaning, some practitioners do not sufficiently follow the manual. Also, the high frequency of staff turnover is been identified as one mayor challenge.

Client records were kept in a secured area in many of health facilities. All Health facilities report through the government HMIS system. However, the system does not fully gather information on the profile of patients and thus, disaggregated data for further analysis is not available[13]

Community sensitization is done in most of the cases through the Health Extension Workers (HEWs) and Health Development Armies (HDAs). They do family visits at people´s houses and provide with information and advice on FP. Some Health Centers like the one in Meda Wolabu (Bale) organize groups of discussion with women. They meet once a month and talk about FP issues among others. However, these groups are suitable for women who do not live too far from the Health facilities.

4.7.3. Availability of equipment and infrastructure

According to the inventory assessment, it can be said that health facilities are to improve their basic equipment and infrastructures[14]. As an example, four of the surveyed facilities in South Omo and Waghmera cluster have no waiting area.

Regarding the availability of clean water, South Omo health facilities used unprotected water well, one of health facilities in Bale used surface water and one of the health facilities in Borena has no water sources at all.

4.7.4. Availability of Youth-friendly services

More than half of health facilities open at convenient hours to adolescents and have separate hours for young people assistance. This is the case of the Meda Wolabu (Bale), where they allocate specific times for women and youth to be assisted. 50% of the surveyed facilities provided all services at free of costs to adolescents and half of the surveyed facilities provided only certain services at free of cost.

[13] Data collectors did not have access to HMIS data from health facilities nor from local health authorities.
[14] For the detailed list of equipment available at health facilities, please see Annex 7

Apparently, youth are better informed about sexuality and FP at the school. Through the school clubs, adolescent boys and girls receive information sessions about the basic concepts of biology, FP and prevention of STDs. In some clusters, like in Bale, the girls' school clubs are very active and engaging in a number of activities for community sensitization.

4.8. Attitudes towards FP and Reproductive rights of women

The vast majority of the respondents (92.46% of female and 83.5% of male) have positive[15] attitude towards family planning. The preferred reason to this positive attitude is the believe that FP is good for the family economy (71.5% of females and 62.7% of males), followed by the idea that FP is good for the health of the mother (47.6% of females and 14.3% of males).It is to highlight that there are significant differences on the attitudes towards FP between men and women, being the latter more positive than the men.

However, among respondents there is still a good proportion of men (16.5%) and a lower proportion of women (7.5%) who believes that preventing a pregnancy is not good for the family. The majority of these negative responses are found in South Omo (40.9% male and 25.5% female), Bale (34.3% male and 27.1%female) and Wolaita to a lesser extend (34.3% male and 27.1%female). On the other side, almost 100 percent of both female and male respondents from Wagehemera and female respondents from Borena cluster were in favor of family planning methods for the wellbeing of the family. (See details in table 23 below)

TABLE 23: ATTITUDES TOWARDS PREVENTION OF PREGNANCY BY CLUSTER

	Study clusters											
	Wolita		**S.Omo**		**Bale**		**Borena**		**Waghemra**		**Total**	
Pregnancy prevention	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Yes, it is good for the family economy	123	68	24	18	67	34	156	62	190	95	560	277
%	65.4	53.5	30.0	27.3	55.8	48.6	78.8	87	96.5	88	71.5	62.7
Yes, it is good for the health of mother	79	27	30	9	63	10	137	5	64	12	373	63
%	42	21.3	37.5	13.6	52.5	14.3	69.2	7.0	32.5	11.1	47.6	14.3
It is good because of other reasons	33	15	21	12	18	2	2	0	2	0	76	29
%	17.5	11.8	26.2	18.2	15.0	2.9	1.01	0.0	1.01	0.0	9.7	6.6
No, preventing a pregnancy is not good for the family	13	17	18	27	26	24	1	4	1	1	59	73
%	6.9	13.4	25.5	40.9	21.7	34.3	0.51	5.6	0.51	0.9	7.5	16.5

[15] It includes all respondents who reported that prevention of pregnancy is good for the health of mothers, for the family economy and good for other reasons.

4.8.1. Attitudes on suggesting the use of contraceptives

When talking about who should take the lead and propose the use of contraceptives within a couple, the majority of male (27.8% completely agree and 43% slightly agree) and female respondents (25.5% completely agree and 41.3% slightly agree) with the idea of being the women the ones suggestion the use of contraceptives to their husbands. This trend is true for the majority of the clusters except for South Omo (37.5% of female and 33% of male strongly disagree) and Bale (48.33% of female and 40% of male strongly disagree)[16]

Likewise, respondents have a similar attitude regarding their husband's role in suggesting the use of contraceptive though the degree of their level of agreement varies per cluster. The majority of the respondents (71% of female and 66% of male) agreed that a husband can suggest to his partner that they use contraceptive, while less than a fifth of the respondents (13% female and 19% male) strongly disagree with it[17]

When asked about the motivation of a woman suggesting her partner to use contraceptives, about 26% of female and male respondents agreed that it would mean she is concerned about feeding her children and an equal amount 26% and 27% of female and male respondents respectively reported that the woman should be concerned about her own health.

On the other hand, about 18.52% of female and 18% of male respondents mentioned that if a woman suggests using contraceptives to her partner, it would mean she doesn´t trust her husband, of which majority of them were found in Borena cluster (42.9% and 50.7%). Only less than 4% of the total respondents (4.1 of female and 2.7% of male) were found to have the perception that it would mean she is not committed to her family[18].

Box 13: Female member of a Women Association testimony

The use of family planning methods helps women and children health and helps mothers to regain their strength between pregnancies" FGD. Kindo Koyshe, Wolaita Cluster

Likewise, majority of the respondents (57.6% of female and 55.4% of male) reported that if a man suggested using contraceptive methods to his partner it would mean he is concerned about feeding his children and concerned about his wife health condition. Among the intervention areas, relatively higher proportion of the respondents from Borena cluster (53.5% of male and 32.8% of female) stated that if a man suggested using contraceptive methods to his partner, it would mean he doesn't trust her[19].

4.8.2. Attitudes on the use of contraceptives by the unmarried

Regarding condom utilization, about 49% (18.65% completely agree and 30.27% slightly agree) of female and 56% (27.8% completely agree and 28.5% slightly agree) of male respondents believe that unmarried couples should use condoms whenever they want to have sexual intercourse before marriage, while 31% of female and 29% of male respondents disagree with it. This might be one of the factors that influence the low condom utilization (17% female and 20% male) in the project

[16] See more details in Annex 5
[17] See more details in Annex 5
[18] See more details in Annex 5
[19] See more details in Annex 5

intervention areas as discussed in the contraceptive use section above. Cluster-wise, among the total respondents who agree with it, the majority of them were found in Waghemera and Borena clusters.

Box 14: Female adolescent testimony

I took combined injectables with the training I got in the school. I usually considered myself fortunate. I could have been pregnant from my brother in law. He raped me in his house while my sister was out for shopping. FGD. Asktema. Waghemra.

On the other hand, a considerable percentage of the respondents (10.34% female and 9% male) strongly believe that unmarried couples should never have sex before marriage, a relatively higher proportion (37% of female) of the respondent are from Bale cluster.

Box 15: Community Leader testimony

It is not allowed for unmarried women to have sex according to Bale culture. Therefore, she should not use FP. If she is found using it, the community disrespects her. It is considered as she is against the culture. She may be excluded from social activities. No one marries her. KII. Meda Wolabu. Bale

TABLE 24: IF UNMARRIED COUPLES WANT TO HAVE SEXUAL INTERCOURSE BEFORE MARRIAGE, THEY SHOULD USE CONDOMS

	Bale		**Borena**		**South_Omo**		**Waghemra**		**Wolaita**		**Total**	
	F	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Completely agree	5	19	73	54	14	8	14	17	40	25	146	123
%	4.2	27.1	36.9	76.1	17.5	12.1	7.1	15.7	21.3	19.7	18.7	27.8
Don't know/not sure	14	3	12	3	28	14	6	0	20	5	80	25
%	11.7	4.3	6.1	4.2	35.0	21.2	3.1	0.0	10.6	3.9	10.2	5.7
Slightly agree	8	10	42	6	10	8	138	64	39	38	237	126
%	6.7	14.3	21.2	8.3	12.5	12.1	70.3	59.3	20.7	29.9	30.3	28.5
Slightly disagree	7	1	21	1	1	4	14	16	20	18	63	40
%	5.8	1.4	10.6	1.4	1.3	6.1	7.1	14.8	10.6	14.2	8.1	9.1
Strongly disagree	42	34	40	0	21	23	22	3	51	29	176	89
%	35.0	48.6	20.2	0.0	26.3	34.9	11.2	2.9	27.1	22.8	22.5	20.1
They should never have sex if they are not married	44	3	10	7	6	9	3	8	18	12	81	39
%	36.7	4.3	5.1	9.9	7.5	13.6	1.5	7.4	9.6	9.5	10.3	8.8
Total	**120**	70	**198**	71	**80**	66	**197**	108	**188**	127	**783**	442

Results of the study regarding the perception of the respondents whether unmarried women should use condoms or not revealed that almost half of female respondents (49.3%) and more than half of male respondents (54.8%) believe that they should use family planning service. Whereas a lower

proportion of respondents (27% female and 40% male) consider that unmarried women should not use family planning service, the majority of whom are found in Wolaita and Borena clusters[20].

Box 16: Female adolescent testimony

Borena community call anyone who do sex before marriage as 'caphana' in Afan Oromo to mean the one who beaches culture. The punishment is that those boys/girls cannot marry someone else except the person with whom he/she practices sexual intercourse. FGD Adolescents Arero, Borena

Box 17: Female member of a Women Association testimony

In our community, a woman who get pregnant outside of marriage is embarrassing for both partners as well as for their family. Even though I don't encourage sexual intercourse before marriage, I prefer my children use family planning service, if they have a secret sexual partners, as I don't want to see my children to get pregnant before marriage. FGD in Tsisika Kebele, Waghemra

4.9. Gender and Social Norms[21]

4.9.1. Decision making on FP

When asked about who should decide the size of the family, more than half of the respondents (51% female and 56% Male) reported that it should be a common decision between husband and wife. However, 20.18% of female and 26% of male respondents believe that the main person deciding on the size of the family should be the husband. Interestingly, a considerable proportion of the respondents (22.2% female and 13.6% male) consider that children are a gift of God, so the number of children the family will have is only in the hands of God. Only 15.2% of women in Borena and 14.4% of men in Bale considered that it should be the wife to decide on the family size.

Box 18: Health Practitioner testimony

Married women continue using FP provided that she gets approval from husbands. If not, they continue using it secretly. Unmarried/divorced/widowed continues using it secretly. They go to the nearest town to get FP products/services. KII. Meda Wolabu. Bale.

There are significant variations per cluster. In South Omo, the majority of the respondents (68.8% of females and 51.5% of males) believe that it should be the husband deciding. Whereas in Waghemra, an overwhelming majority (82.7% of females and 73.2% of males) consider that it should be a common decision.

Box 19: Women Association member testimony

[20] See more details in Annex 5

[21] There are many definitions of social norms but all of them emphasize the importance of shared expectations or informal rules among a group of people (reference group) as how to people should behave (Marcus & Harper, 2015) In this sense, the present report use the concept of ´Social Norms´ when referring to norms as the informal rules governing behaviors (in this case, the use of FP) and specifically, ´Gender Norms´ as the informal rules and shared social expectations that distinguish expected behaviors on the basis of gender.

"Women's contraceptive uptake decision depends mainly on husbands' preference. It is almost impossible for a woman to make family planning decision freely" [Dassenech Women Association Member discussant, South Omo]

TABLE 25: DECISION-MAKING ON THE SIZE OF THE FAMILY

	Wolita		S.Omo		Bale		Borena		Waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
It is only in the hands of God	15	11	5	12	65	15	81	15	8	7	174	60
%	8	8.7	6.3	18.2	54.2	21.4	40.9	21.1	4.1	6.5	22.2	13.6
It_is_the_man_who_should decide	57	33	55	34	19	25	7	3	20	21	158	116
%	30.3	26	68.8	51.5	15.8	35.7	3.5	4.2	10.2	19.4	20.2	26.3
It_is_the_woman who should decide	13	3	1	1	2	10	30	3	6	1	52	18
%	6.9	2.4	1.3	1.5	1.7	14.3	15.2	4.2	3.1	0.9	6.6	4.1
It_should_be_a_ common decision	103	80	19	19	34	20	80	50	163	79	399	248
%	54.8	63	23.8	28.8	28.3	28.6	40.4	70.4	82.7	73.2	51	56.1
Total	188	127	80	66	120	70	198	71	197	108	783	442

When looking at the subject deeply, findings show that 66% of female and 70% of male participant agreed that married women in their community are not allowed to use family planning methods unless they get approval from their husbands. Among them, the vast majority of respondents are from South Omo (59.1% of male and 66.3% female) and Borena (91.6% of male and 62.1% female)[22]

Box 20: Female testimony

Many married women in our community who wanted to delay/avoid pregnancy are not using family planning service because their husband disapproval. FDG, Wolaita Cluster

Although respondents are not so firmly positioned, the previous result is confirmed by respondents when asked if a man should never allow his wife to decide on the size of the family. In total, 40.2% of women and 31.2% of men believe a man should never allow his partner to decide on the size of the family. Particularly, women from South Omo (48.8%) and Borena (56.6%) are in favor of this statement and surprisingly, more strongly positioned than their male counterparts in the same clusters.[23]

In line with previous findings, the majority of the women respondents (61.68%) and men (52.2%) reported that most husbands highly expect their wives not to use FP so they can have larger families. Only the male respondents from Waghemra show a strong percentage (75%) of disagreement with this expectation[24] In Waghemra, discussants testimonies confirm the fact that the main reason for husbands expecting their wives not to use contraceptives is to show their power over women.

[22] See more details in Annex 5
[23] See more details in Annex 5
[24] See more details in Annex 5

Box 21: Discussant testimony

If she gives birth, the husband thinks, she is under his control and will not undermine him. Otherwise, she may tempt to go with others. FGD Wolen, Waghemra

Consistently, the majority of the respondents (75% of female and 71% of male) agreed that a woman using family planning method without the consent of their husband will have conflict in their marriage eventually leading to divorce.[25]

Box 22: Adolescent female testimony

Married women are not entirely free to take FP. They need to get approval from their husbands, or it should need to be a common decision. If the woman uses contraceptive without the knowledge of the husband, it may be risky for her marriage. If the husband discovers that his wife is taking contraception without his consent, that may be a cause of disagreements in the family and ending up the marriage., FGD Damot Pulsa, Wolaita.

Similarly, 67% of female and 60% of male reported that married woman will stop using family planning service if it raises conflict with their husbands[26]

Box 23: Discussant testimony

There was a woman got implants to be used for five years without the consent of her husband (in clandestine). After some time, her husband discovered her act and forced her to stop using it; otherwise he vowed to file divorce. Finally, she promised him to quit it. She stopped that one and tried a short term one in hole-and-corner again. He came to know that again and made a divorce with her. Unfortunately, she was pregnant because she had some sex debut after stopped the long term one but before starting the short-term contraceptive. FGD Zarota Kebele, Waghemra.

Qualitative findings show that there are also cases where disputes arise between husbands and women association leaders / or health extension workers for consulting their wives to use contraceptives. Husbands consider them as bad that tend to make women bad, unfaithful and infertile.

Box 24: Community Leader testimony

When we advise women to use contraceptives, some husbands usually approach us to give us warnings; claiming that we are making their wives infertile, and unfaithful. We are like men after these husbands. KII, Kerjul, Bale

Despite of the results presented above indicating that men have stronger decision power than women, it is interesting to see how an important number of respondents consider women as the ultimate responsible for the intake of contraception. Both male (38%) and female (37.1%) respondents agree with the idea that it´s mainly women´s responsibility to ensure contraception is used regularly. Interestingly, a similar proportion of respondents agreed that a man should never allow their wives to decide on the size of the family. This finding is to be analyzed from the gender perspective that

[25] See more details in Annex 5
[26] See more details in Annex 5

explains how patriarchal social norms allocate most of decision-making power on men whereas most of responsibilities (particularly the domestic ones) fall on the women´s shoulders.

It is also important to highlight that findings regarding the decision-making on FP are in correspondence with those related with decision-making within the household. Full account on findings on decision-making at household level is presented in Annex 6.

4.9.2. Social norms and sexual agency

Findings show that majority of the study participants (82.6% male and 79.1% female) didn't support young people to have sexual intercourse before marriage. Similar results are found in all clusters except for Borena, where the majority of women (58.6%) believe it´s ok for boys and girls to have sex before marriage (see table 26 below).

TABLE 26: IT IS OK FOR BOYS AND GIRLS TO HAVE SEX BEFORE MARRIAGE

MSGN1	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely Agree	12	1	7	86	2	3	3	3	2	3	26	96
%	17.1	0.8	9.9	43.4	3.0	3.8	2.8	1.5	1.6	1.6	5.9	12.3
Slightly agree	8	5	6	30	4	9	14	3	10	9	42	56
%	11.4	4.2	8.5	15.2	6.1	11.3	13	1.5	7.9	4.8	9.5	7.2
Don't know/not sure	0	1	0	2	4	4	0	0	5	5	9	12
%	0.0	0.8	0.0	1.0	6.1	5.0	0.0	0.0	3.9	2.7	2.0	1.5
Slightly disagree	0	8	10	22	16	6	43	51	36	47	105	134
%	0.0	6.7	14.1	11.1	24.2	7.5	39.8	25.9	28.4	25.0	23.8	17.2
Strongly disagree	50	105	48	58	40	58	48	140	74	124	260	485
%	71.4	87.5	67.6	29.3	60.6	72.5	44.4	71.1	58.3	66.0	58.8	61.9
Total	70	120	71	198	66	80	108	197	127	188	442	783
%												

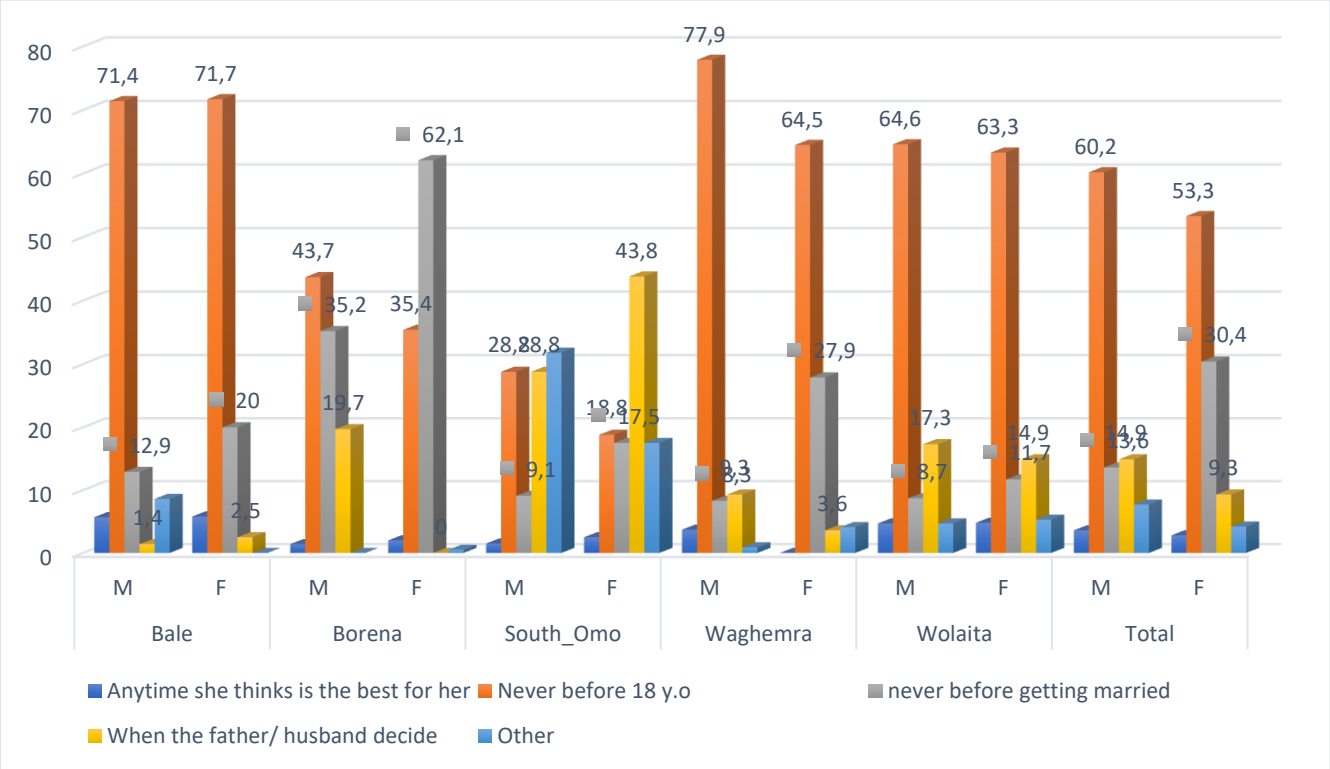
However, when asked if it would be OK for adolescents to have sex provided that they use contraceptives, respondents do not confront the idea as strongly. Actually, a higher proportion of both male (51.8%) and female (54.7%) respondents agree with adolescents couples having sex as long as they use protection. This is the case for all clusters except for Bale, where a total of 90% of women and 74.3% of men disagree with the idea of adolescents having sex even if they use contraceptives[27].

Despite of the significant number of girls in the project areas having their sexual debut and their first child earlier than 18 y.o., about 56% of the respondents (53.26% of female and 60% of male) reported that a girl should never start having sex before they are 18. As results of the study indicated, a considerable proportion of female respondents (30.4%) also believe that a girl should never start having sex before getting married. Compared to other study clusters, majority of the respondents from Bale, Wolaita and Waghemera believe that a girl should never start having sex before 18 years old. Whereas respondents from South Omo believe that girls should start having sex when the father/husband decides. Consistently with the tradition mentioned before, in Borena the majority of women believe that a girl should never have sexual relationships before getting married (see Figure 10 below)

[27] See more details in Annex 5

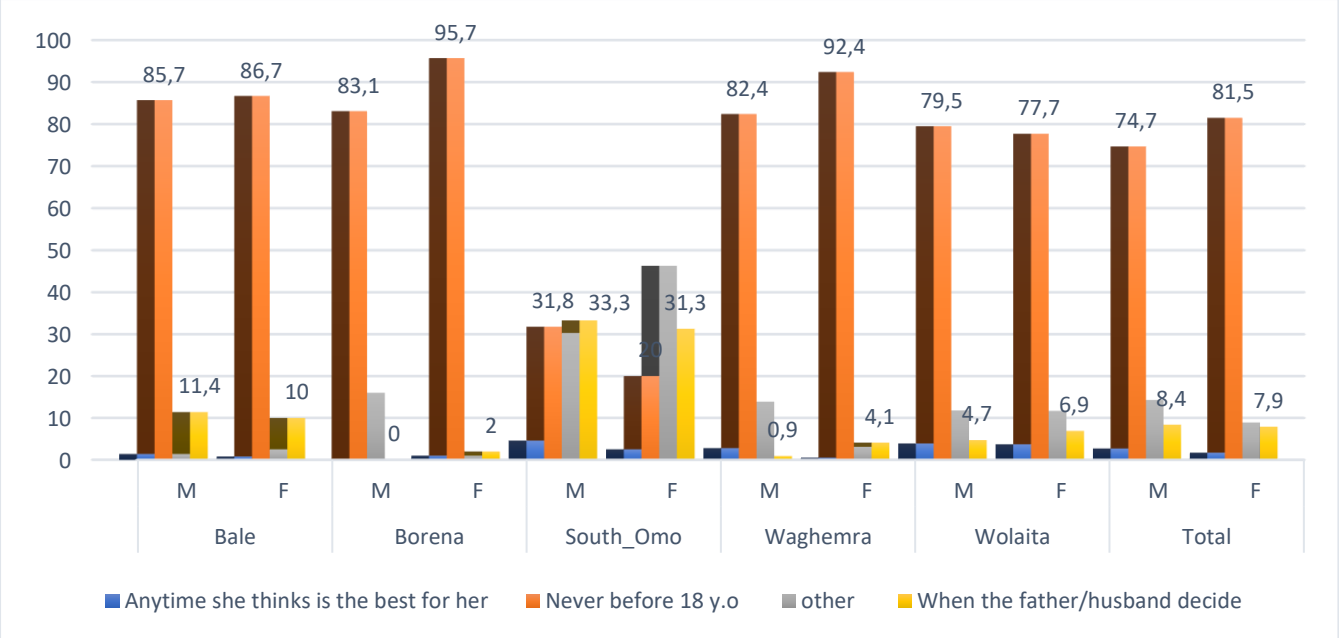
Only a meager of the respondents (2.81% female and 3.6% male) have the perception that a girl can start having sex anytime she thinks is the best for her. This implies that the vast majority of the respondents doesn't accept girls to start having sexual relationships anytime they think is the best for them or young girls have a very limited right to exercise their own sexual agency.

FIGURE 10: IDEAL AGE A GIRL SHOULD START HAVING SEX



Correspondingly, the most common believe among respondents (74.7% males and 81.5% females) is that girls shouldn't get married before they are 18 years old (See figure xx below). Only in South Omo, there is a clear preference for girls to be married just when the father or husband decides. This result is aligned with previous ones in South Omo indicating an even poorer sexual agency for girls in this cluster.

FIGURE 11: IDEAL AGE A GIRL SHOULD GET MARRIED



Regarding the perception of respondents on the ideal age a girl should give birth for the first time, majority of the study participants (71.52% of female and 64% of male respondents) had the perception that a girl should never give birth before 18 years old, whereas 14% of female and 6% of male respondents had the perception that a girl can give birth anytime she thinks is the best for her[28]

4.9.3. Expectations from the communities

More than half of the respondents (51.6% of women and 50% of male) reported that community members expect unmarried women not to use family planning methods, as having sexual relationship with someone before marriage is considered as embarrassing and unfaithful act. Particularly, the vast majority (93%) of the respondents from Borena Cluster reported that community members expect unmarried women not to use family planning methods before marriage[29].

Similarly, majority of the respondents (57.6% of female and 48% of Male)[30] also reported that if unmarried women use family planning service the community disrespect her. Only a third of women respondents (34.6%) and 46.5% of male respondents disagreed with it[31].

Box 25: Community Leader testimony

It is not allowed for unmarried women to have sex according to Bale culture. Therefore, she should not use FP. If she is found using it, the community disrespects her. It is considered as she is against the culture. She may be excluded from social activities. No one marries her. KII. Meda Wolabu. Bale

Consistently, according to the majority of the respondents (59.65% of female and 45.7% of male), unmarried women in their community cease using family planning methods because of fearing

[28] See more details in Annex 5
[29] See more details in Annex 5
[30] The figure includes those who replied Completely agree and Slightly agree
[31] See more details in Annex 5

disrespect from the community. This is true especially in Borena (46% of female and 57.8% of male), Bale (40% of female and 35.7% of male) and Wolaita (32.5% of female and 24.4% of male)[32]

Finally, asked whether unmarried women can use family planning methods if the community receive adequate health education, majority of the respondents (65.39% of female and 72.6% of male) have shown optimistic attitude towards the potential contribution of it, while a quarter of the respondents (25.67% of female and 21% of male) disagreed with its potential benefit[33.]

Despite of the cluster-wise differences, in general, men tend to be less fearful of the community expectations while women assign tougher judgement to the communities, maybe because they are suffering the community-pressure more than men do (see findings on gender and social norms below)

4.9.4. Perceptions on GBV

The KAP Survey included some questions on the perception of respondents regarding Gender based Violence (GBV). The majority of the respondents (75.86% of female and 74.43% of male) believe that it is not justifiable for a man/boy to hit his wife/girlfriend. However, a significant proportion of women (20.6%) and men (22.2%) think that it is sometimes justifiable for men to hit their partner (see table xx below) This result is worrisome since the justification of violence is mainly done by young respondents.

TABLE 27: IT IS SOMETIMES JUSTIFIABLE FOR A MAN/BOY TO HIT HIS WIFE/GIRLFRIEND BY AGE

Age Category	Completely Agree		Don't Know		Slightly Agree		Slightly disagree		Strongly disagree		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
15-19	25	8	11	4	27	26	70	44	152	54	285	136
	29.8	19.1	73.3	57.1	34.6	46.4	38.5	31.4	35.9	27.6	36.4	30.8
20-29	35	19	3	3	28	17	76	56	183	85	325	180
	41.7	45.2	20.0	42.9	35.9	30.4	41.8	40.0	43.2	43.3	41.5	40.8
30-55	24	15	1	0	23	13	36	40	89	57	173	125
	28.6	35.7	6.7	0.0	29.5	23.2	19.9	28.6	21.0	29.1	22.1	28.4
Total	84	42	15	7	78	56	182	140	424	196	783	441

Cluster-wise, South Omo stands out among other clusters as compounding the majority of the respondents who somehow justify physical violence against women. Both women (41.3%) and men (33.4%) agree with the statement presented above[34]

Concerning sexual violence, the acceptance of forced sex between couples is less common. Actually, there is a general disapproval of the statement affirming that sometimes a man/boy has to force a woman/girl to have sex if he loves her. As such, 77.4% of women and 76.3% of men disagree with forced sex by partners. However, there are exceptions in clusters like South Omo and Borena, where 31.3% of women and 30.3% of men in the first and 44.4% of women and 52.2% of men in the latter believe that it´s ok to force girls/women in the name of love[35]

[32] See more details in Annex 5
[33] See more details in Annex 5
[34] See more details in Annex 5
[35] See more details in Annex 5

5. Conclusions and Recommendations

5.1. Use of contraceptives and FP Services

The contraceptives uptake in the intervention clusters is low. **Only 27.2% of the respondents have ever used contraception**. The use and preference of contraceptives varies by clusters but in general, injectables, implants and pills are the three most preferred methods.

There are also differences by clusters on the frequency of use of different age groups. Among adolescents, the higher use is registered in Bale, with 31.58% and the lower use is seen in Waghemra (3.9 %) followed by Borena and Wolaita with 6.45% of use respectively. **The age group were the use of contraception is higher is of respondents between 20 to 29 y.o**. Because of that, it is recommended that RESET PLUS project consider them as allies and involve both men and women on this age group to support communication activities and other advocacy actions. Besides, consortium partners working in Waghemra, Borena and Wolaita should put more emphasis targeting adolescents and youth.

The likelihood of using contraceptives being educated is four times more as compared for those who are illiterate. This fact is also related with the access to knowledge on contraceptives since for those women who know at least three methods of family planning, the likelihood of using contraceptive methods is three times higher. **There is a clear correlation between education, knowledge on FP and use of contraceptives**. Because of this, partners should adapt their communications efforts to a highly uneducated and mis-informed population who has not been exposed to prior information on FP before or have been exposed only to biased ideas and prejudices on the use of contraception.

Clusters with lower rates of knowledge on contraception like South Omo and Wolaita should definitely invest more resources on information sharing campaigns -targeting poorly educated people- and awareness raising activities among adolescents and youth. Communications materials and messages should be adapted and based on images more than written messages.

Religious believes and misconceptions on contraceptives are common in the project intervention areas. Especially among communities where the most practiced religion is more rigid with women sexual roles (like in South Omo and Borena). Fallacies related with contraception increasing the appetite and laziness of women or increasing the probabilities of becoming sterile or conceiving twins are rampant in all clusters. Above all, the idea that children are gifts from God and we, humans, should not interfere with the divine desire is most frequent. In this context, it is important for the project to work with religious and spiritual leaders as well as other informal leaders with enough power deciding on the morality of the communities. They should be trained and invited to participate in the project as allies, transferring accurate information on FP and contraceptives.

In Oromia region clusters, **Bale and Borena, the unmet need for contraception is extremely high,** even higher than the regional average. Besides, in these two clusters, the association between the number of current children and the desire of stop having children is higher than in any other clusters. It seems that in Bale and Borena the only possible reason for a woman to start having contraceptives is if she has given birth to at least 4 children already. Partners working in these clusters should better explore the reasons behind this finding and design their interventions placing the focus on the relationship between number of children and resilience.

In the majority of the clusters the most frequent source of information on FP is the HEWs or the HDAs, neighbours and the health facility to a lesser extent. This indicates that **people is used to the "mouth to ear" type of communications**. Partners should be aware that mass-media may not be of the

preference of beneficiaries or simply they may have restricted access. Nevertheless, the project should strengthen the current channels of communication and further empower the role of outreach workers (HDAs and HEWs)

The level of satisfaction with the services received at the health facilities is another predictor in the use of contraceptives (satisfied respondents in the survey presented 7.5 times more probabilities of using contraceptives). Consistently with this finding, project activities should invest in the enhancement of quality type of FP services (see recommendations below).

5.2. Service provision

The ratio of utilization of health facilities is still low in RESET PLUS areas of intervention. Despite of the regional differences, availability and accessibility are identified as the main reasons influencing the access to the services.

The two most available type of contraceptives (male condoms and pills) at the surveyed health facilities are two of the least desired contraceptives as expressed by women respondents. Overall, many of the surveyed facilities have a relatively high availability of at least one contraceptive method. However, facilities appeared to have important problems related with stock-outs of a variety of contraceptives, including injectables and implants, the two most preferred types of contraceptives in the surveyed clusters. Thus, the project should coordinate efforts with the local health authorities to ensure enough and regular supply of most preferred methods in each cluster.

Besides, **services are not available at all times**. This may be one of the reasons why the satisfaction levels of the respondents are relatively low. It is not by chance that respondents from Waghemera show, in general, higher levels of satisfaction, where health facilities display higher availability of contraceptives than others. Also, availability of staff (regular presence at the HFs), knowledge and capacities of staff may influence on the quality of the service provided. The project should continue supporting capacity building activities with all medical personnel.

At least four out of eleven health facilities surveyed had **no appropriate water system in place**. Health facilities supported by the project should comply with the minimum standards of water and sanitation. Partners should seek collaboration with larger government sanitation projects and other international agencies like UNICEF in order to ensure enough equipment of the facilities.

Adolescents and youth are less prone to use health facilities than other age groups. Results from health facility assessment show that, despite of the fact that centers reported having specific working hours for youth, there is still room for improvement providing better youth-friendly services and making the facilities more accessible to youth. As expressed by adolescents themselves, they prefer to talk about sexuality and FP with other peers and within the context of school or school clubs. However, they have also mentioned that they would like to expand their knowledge on the issue. Thus, there is an opportunity for the project to support health facilities in making services more accessible for youth and explore the possibility of connecting services with the schools through outreach activities.

5.3. Sexuality and Sexual Agency.

The vast majority of the respondents (92.46% of female and 83.5% of male) have positive attitudes towards family planning. There is good understanding that FP support the economy of the family and improve women´s health. This discourse contrast with the low proportion of contraceptives uptake and with the high ratio of children per women. A plausible explanation to this apparent contradiction can be found on the social norms and cultural believes that explain how a high number of children are

necessary for the survival of the family ("children are gifts from God"). As much as it is recognizable by respondents that raising a large number of children is expensive, yet, traditional and religious believes are strongly rooted in people´s minds and attitudes. Thus, awareness campaigns need to be framed under the **Communications for Social Change approach** that addresses the complex relations between people´s perceptions, attitudes and behaviours. Only by producing changes at the first two levels, people will be ready to take up new habits like using contraceptives in a regular basis.

Women on the project areas are not free to decide about their bodies and FP. As described in the findings, married women need the approval from their husbands to use contraceptives or they may use them secretly. Unmarried women are banned from using any contraceptive since women are not allowed to have any sexual intercourse outside the family. The use of FP is very much determined by the social norms that guide the sexual activity of the individuals in the community. Thus, the project shall address those social norms in a non-confrontational manner in order to ensure the success of the FP activities.

The community plays an important role on women´s sexuality and FP decisions. Women may stop or refrain themselves from contraceptive use fearing the reaction of the community. Project activities should acknowledge the power that the society has over women´s decisions and include actions targeting the whole community, not just at individual level. The aim at community level would be to transform the image societies have on the contraceptives as harmful for women and against religion. FP needs to stop being a social taboo and communities shall start open up conversations on it.

Among the sexually active population quested, only 15.7% of women and 14.7% of men reported having had experiences with other people than their regular partners (spouses) and most of it is contributed by Oromia clusters as described below. This finding has important implications for partners. Since **sex is happening mainly in marriage (or long-time unions),** communications campaigns and messages should target couples instead of individuals and the project should ensure enough availability of long-term types of contraceptives more adequate for stable couples.

Borena and Bale clusters show a peculiarity. They seem to be the clusters **with higher levels of infidelity** with 33.33% of women and 14.89% of men declaring having sex with other people in Borena and 28.95% and 30.43% respectively in Bale (while in the rest of the clusters the figures of infidelity are almost anecdotal). It may be related with other cultural and social aspects that exceeded the scope of this study but it may be worthy for partners to continue investigating on the determinant factors on these types of behaviours. On this clusters, the use of male condoms should be advocated for in order to avoid HIV and other STDs transmission.

5.4. Gender roles and social norms

Decision-making in the project areas is male-dominated, including decisions on the family size and the use of contraceptives. Because of this, traditional-type of communication strategies targeting only women may not be as effective as having men and couples as the main recipients of communication activities. On top of this, since married women facing prohibition from their husbands and unmarried women being socially condemned take important risks trying to access contraceptives, women should not be taken responsible for the use of contraceptives in this project. Moreover, as seen in section 4.9.1 above, women have no power (or very limited) to decide over the use of contraception. By doing so they expose themselves to be accused of adultery and being expulsed from the family and community. Thus, targeting only women could expose them even more and increase the risk for them to be rejected, isolated or even abused.

Unmarried women are banned from using and FP service as they are not supposed to be sexually active. However, single women (adolescent girls), divorced or widowed are especially vulnerable and

in need of protection from unwanted pregnancies, HIV and other STDs. They are also more exposed to (sexual) violence. It is essential that unmarried women have access to FP services and thus, specific actions should be taken by the project to protect the right of these women to access medical advice and contraceptives. Sensitization of the community will be necessary but also, strengthening of the role of HDAs and HEWs doing visits to houses will be needed.

South Omo shows most radically how girls and women are expected to have no decision-making power or any agency over their bodies. The majority of the respondents in this cluster agree with fathers and husbands to decide over the girls and even justify the violence against the women. Partners working on this cluster should increase the efforts in campaigning for the rights of women and prevention of HTP such us early marriage among others.

5.5. Interacting values, norms and other drivers

The low use of contraceptives by women in the project are is the manifestation of a number of underpinning factors including social norms and gender norms but also cultural values, traditional ideologies and believes, economic factors and level of education among others. The present study has identified a number of factors relevant for the context where the project is being implemented that can be summarized as follows:

- ✓ Social expectations (norms) concerning the appropriate circumstances for a woman to use contraceptives (being married, having at least 4 children already, being able to continue working hard and getting the approval from their husbands)
- ✓ Cultural and/or religious values emphasizing the importance of large-size families, which encourages the view of women as mothers and women playing a reproductive role only. Thus, women´s bodies are more a public domain where husbands, relatives, community members and religious leaders decide.
- ✓ Gender ideologies and roles that assign the majority of the domestic work to girls and women which can, in turn, impede their opportunities for study (see gender gap in education presented in table 9 above)
- ✓ Contraceptive bias or misperceptions on what are the effects (amd side-effects) of contraceptives. These lead people to believe that contraceptives are dangerous to the health of the women and future children.
- ✓ Gender norms and values that limit women' voices and decision-making power over their health and their families.
- ✓ Economic and resources availability such as means of transportation to reach the health facilities or money to afford the health visit.
- ✓ Limited educational/information leading parents and husbands to conclude that getting started on an adult life through marriage and motherhood is preferable than risking a pregnancy outside the marriage.

It is important to highlight that these factors are interlinked and interact among them. In this sense, it is important that strategies developed by the project are tailored to the different levels of interdependence and adapted to the regional/local contexts (see proposed table 28 below)

TABLE 28 EXAMPLES OF TAILORING PROJECT STRATEGIES

Drivers	Change Strategy	Example

Social expectations (norms) concerning the appropriate circumstances for a woman to use contraceptives	Change attitudes through raising awareness of problems associated with current practices. Co-ordinate abandonment of old norm and adoption of new norm, through participatory dialogue	Co-ordinated efforts to get everyone in the communities accepting small-size families as a way of resilience building Engage men in the process
Contraceptive bias or misperceptions on what are the effects (amd side-effects) of contraceptives	Provide new information that challenges beliefs. If this is insufficient to motivate change, market new social norm	Information campaigns and community level education/ dialogue with community/religious leaders and the educational community
Cultural and/or religious values emphasizing the importance of large-size families	Stress the ways in which new norm is consistent with cultural values, or ways new norm can be adopted in ways that leave other values intact.	Campaigning not against religion or traditions but pro-resilience building (pro-life)

5.6. Adolescents and youth.

The age for sexual debut in the project areas (17 for women and 19 for men) and the mean age for first birth (18 for women and 22 for men) is worryingly low although is correspondent with national figures. In clusters like South Omo and Bale figures are alerting since the mean age for girls to have their sexual debut and child bearing is 16 y.o. in the first case and 17 y.o. in the latter.

Early child bearing is common among female adolescents in the Project areas (11% of adolescent girls interviewed were mothers before the age of 19 years old and 41.5% of all interviewed women reported having had their first child before the age of 18). Child bearing among adolescents is not related with early marriage but it is strongly related with their level of education (82% of the below 18 years mothers are illiterate in the project areas). It is essential that training on sexuality and family planning is given in the earliest stages of adolescence (prior to the drop-out of the girls from the school) and sensitization activities involve both mothers and fathers of the children. It should be one of the highest priorities of the project to raise awareness and educate children and parents for the age of child bearing to be postponed beyond 18 y.o.

A relative high proportion of male adolescents (43.75%) reported having used a condom during a recent sexual experience. Besides, some school teachers reported that it was part of their informative sessions on sexuality to the adolescents, the promotion of male condom. These experiences should be carefully analysed and partners should build upon the sensitization work done at the schools and school clubs and expand/strengthen advocacy activities for the use of male condoms among adolescents during their early sexual relationships.

As mentioned earlier, **the school is the preferred setting for adolescents to be informed about sexuality and FP**. Also, in most of the clusters there are existing good practices and recent experiences the project should build upon and leverage through the clusters. Activities should involve parents and expand activities to all educational community.

Annex 1. RESET PLUS LOGFRAME-BASELINE DATA

RESULTS CHAIN	Project Indicators	BASELINE DATA	SOURCE OF VERIFICATION
Contribute to resilience building through decreased demographic pressure by means of increasing demand and providing quality service on consolidated Family Planning (FP) practices in 5 EU RESET clusters.	Indicator 0.1. Decrease in total Fertility Rate (impact)	Fertility Rate: Oromia: 5.4 SNNPR: 4.4 Amhara: 3.7	EDHS 2016
	Indicator 0.2. Decrease of adolescent pregnancy rate (aged 15-19 years) (impact)	Teenage Pregnancy rate: Oromia:17% SNNPR:11% Amhara:8%	EDHS 2016
	Indicator 0.3. Key stakeholders and cluster partners promote family planning as a key component for increased resilience	Baseline quantified as 0	KIIs
	Indicator 0.4. Increased the nutritional status of children under 5 y.o.	Under-aged 5 children Stunted: Oromia:37% SNNPR:39% Amhara:46%	EDHS 2016
S01: Increased demand for family planning by 39% through awareness raising on demographic pressure and attitudinal changes particularly among women, men and youth in drought prone and chronically food insecure regions	Indicator 1.1: Contraceptive Prevalence Rate among women married or in union and unmarried and sexually active (15-49 y.o.) increased by 15%	Contraceptive Prevalence Rate: Total:27% Bale:16% Borena:37.4% South Omo:15% Wolaita: 16.5% Waghemra:39.1%	KAP Survey

	Indicator 1.2: Number and Proportion of men that accepts/support wife/partner's decision to use FP	Number of men who supported wife's decision to use FP: Bale: 48/70=69% Borena: 44 /71=62% South Omo:6/66=9% Wolaita: 70/127=55% Waghemra: 90/108=83%	KAP Survey
SO2: Increased access to and provision of quality comprehensive SRH services by 28% particularly for women and adolescent girls	Indicator 2.1. Number of health facilities counting with health professionals capable of providing with Long active FP services	No. of HF counting with long active FP services: Bale: 1 from 2HF, Borena: 3 from 3HF South Omo:2 from 2HF Wolaita: 2 from 2HF Waghemra: 2 from 2HF	Health Facility Assessment
	Indicator 2.2: Unmet need for family planning decreased by 10%	Unmet need for FP: Total:29% Bale: 31%, Borena:46% South Omo:21% Waghemra:14% Wolaita:27%,	KAP Survey
	Indicator 2.3: % of increase in utilization of adolescent and youth friendly SRH services from the baseline by 15%	Not possible to access the HMIS during the data collection. The consortium members are advised to get the information from the zonal bureaus.	
	Indicator 2.4. Increased the level of satisfaction of beneficiaries on FP services provided at the health facilities	Level of satisfaction: Total:(42.1%F,49%M) Bale:(55.7%F, 75.6%M) Borena:(35.4%F,38%M) South Omo:(61.9%F,44.4%M Waghemra:(33.7%F, 40.9%) Wolaita:(41.9%F, 38.7%M)	KAP Survey

Op 1.1 Increased awareness on the impact of demographic pressure on food security and livelihoods and the importance of SRH, especially FP among community members in 5 EU RESET Clusters	Indicator 1.1.1. % of increase of women of reproductive age who know about at least three methods of family planning by 35%	Knowledge of at least three FP methods: Total:34% Bale: 25% Borena: 39.4% South Omo: 13.7% Waghemra: 55.3% Wolaita: 20.7%	KAP Survey
	Indicator 1.1.2: Number of adolescents and adults sensitized through project awareness raising activities	<u>Through radio</u> Bale: 59% Borena: 33.8% South Omo: 0% Waghemra: 61% Wolaita: 42% Total 43% <u>Through IEC</u> Bale: 19.2% Borena: 11.1% South Omo: 0% Waghemra: 16.8% Wolaita: 7.4% Total 11.8% <u>Through campaign</u> Bale: 20% Borena: 19.2% South Omo: 2.5% Waghemra: 1% Wolaita: 0.5% Total 8.6% <u>Through community meeting</u> Bale: 36.7% Borena: 52.5% South Omo: 18.7% Waghemra: 11.7% Wolaita: 30.3% Total 31%	KAP Survey

	Indicator 1.1.3: # of community leaders participating in gender equity promotion among targeted communities	Baseline quantified as 0	
	Indicator 1.1.4: # of Health Development Armies (HDAs) trained and promoting SRH/FP at household level and link with the HEP	Most of the HDAs lack basic information regarding FP, Baseline quantified as 0	FGDs
Op 1.2 Percentage of women, youth and adolescent boys and girls empowered to make informed SRH & FP decisions.	Indicator 1.2.1: # of members of in school and out school clubs engaged in SRH/FP promotion after training	Baseline quantified as 0	FGDs
	Indicator 1.2.2:% of beneficiaries who report Gender-equitable attitudes toward women's and girls' sexual agency	% of respondents reporting positive attitudes towards FP: Total:64.3% Wolaita:91.6% South Omo:37.78% Bale:48.6% Borena:39.4% Waghemra: 98.15%	KAP Survey
	Indicator 1.2.3: Number of beneficiaries participating in FP services counselled on nutrition	Ratio of respondents participating in FP services counselled in nutrition: Total(66%F,59%M) Bale: (71%F,85%M) Borena:(78%F, 44%M) South Omo:(62%F,56%M) Waghemra(50%F, 32%M) Wolaita(69%F,71%M)	KAP Survey

Op 2.1. Improved quality SRH/FP services, delivered to women, adolescents and youth in 63 health facilities	Indicator 2.1.1: No of health facilities that integrate and offer FP/SRH service in its different units	Total 6/11 Bale: 2/2 Borena:3/3 South Omo:0/2 Waghemra 1/2 Wolaita 0/2	KAP Survey
	Indicator 2.1.2: No. of FP/SRH service users in different units (disaggrgated by sex and age)	Unable to get FP service user data from HMIS, project partners may obtain from HMIS in their respective implementation area	
	Indicator 2.1.3 # of people benefited from outreach activities	Baseline quantified as 0	
Op.2.2 Strengthened/established multi-sector coordination for better acesss to quality SRH/FP services	Indicator 2.2.1**:** # of meetings facilitated by the action to increase harmonisation and sharing of knowledge among stakeholders in the 5 cluster areas	Baseline quantified as 0	
	Indicator 2.2.3: # government officials and reset II partners sensitized and committed to support SRH/FP mainstreaming	Baseline quantified as 0	KIIs
	Indicator 2.2.4: number facilities with public-private partnership created or reinforced	Baseline quantified as 0	HFAs

Annex 2 List of References

- Adolescent and youth Strategies 2016-2022
- Alemayehu, M., Lemma, H., Abrha, K., Adama, Y., Fisseha, G., Yebyo, H., Medhanyie, A. A. (2016). Family planning use and associated factors among pastoralist community of afar region, eastern Ethiopia. *BMC Women's Health*, *16*, 39. http://doi.org/10.1186/s12905-016-0321-7
- Central Statistical Agency (CSA) [Ethiopia] and ICF. (2016). Ethiopia Demographic and Health Survey 2016: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF
- Kidest Getu Melese, Mignote Hailu Gebrie, Martha Berta Badi, and Wubalem Fekadu Mersha, "Unintended Pregnancy in Ethiopia: Community Based Cross-Sectional Study," Obstetrics and Gynecology International, vol. 2016, Article ID 4374791, 5 pages, 2016
- Marcus, R and Harper, C (2015) Social norms, gender norms and adolescent girls: a brief guide. ODI, London, September 2015.
- National Health Sector Transformation Plan (HSTP)
- ORBIT (March 2019) RESET PLUS Baseline Report (unpublished document)
- POPULATION REFERENCE BUREAU (AUGUST 2015) POLICY BRIEF: BUILDING RESILIENCE THROUGH FAMILY PLANNING: A TRANSFORMATIVE APPROACH FOR WOMEN, FAMILIES, AND COMMUNITIES. www.prb.org
- Population council: A More Resilient World: The Role of Population and Family Planning in Sustainable Development
- Reproductive Health strategy for 2016-2022
- RESET PLUS Project Proposal. Annex 3 of Project Proposal: Log frame
- RESET PLUS Beneficiaries PP Presentation
- RESET PLUS PP introductory presentation
- Rovin et al. Linking Population, Fertility, and Family Planning with Adaptation to Climate Change: Perspectives from Ethiopia. African Journal of Reproductive Health, 2013; 17(3): 15-29.
- Tilahun T, Coene G, Luchters S, Kassahun W, Leye E, et al. (2013) Family Planning Knowledge, Attitude and Practice among Married Couples in Jimma Zone, Ethiopia. PLoS ONE 8(4): e61335
- UN population projection 2017
- Vouking, M. Z., Evina, C. D., & Tadenfok, C. N. (2014). Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests. *The Pan African Medical Journal*, *19*, 349. http://doi.org/10.11604/pamj.2014.19.349.5090

Annex 3 Detailed list of KIIs and FGDs

Cluster	KII		FGD	
	Discussants	**Sex**	**Informants**	**Sex**
Wolaita	✓ DamotePulsaSuke health center head	Male	✓ KindoKoyshe School Male adolescents	Male
	✓ DamotePulssaSuke Heath center expert	Male	✓ Kindokoyshe School Female Adolescents	Female
	✓ DamotePulssata School director	Male	✓ DamotePulsaHelinaKorke School female	Female
	✓ KindoKoyshehanaza Health center head	Male	✓ DamotPulsaSuke Women Association	Female
	✓ KindoKoysheHanza Health center Expert	Male	✓ KindoKoyshe women association	Female
	✓ KindoKoyshe Religious leaders	Male		
	✓ KindoKoyshe Secondary school director	Male		
South Omo	✓ Dassench Hado Health Center head	Male	✓ Dassenech Women Association	Female
	✓ Dassench hado health Center Expert	Male	✓ Dassench hado school girls	Female
	✓ Dassench hado religious leader	Male	✓ Dassenchhado school boys	Male
	✓ Dassench omorade health center	Male		
	✓ RESET Plus Focal Person	Male		
Waghemra	✓ Tsisika Health office head	Male	✓ Mylomin HDA	Female
	✓ Tsisika YFS expert	Male	✓ Tsisika HDA	Female
	✓ Waghemra RESET Plus Personnel	Male	✓ NetsanetMelkam HDA	Female
	✓ Woleh Religious leader	Male	✓ Asketema HAD	Female
	✓ Asketema Health center head	Male		
	✓ Asketema Health office head	Male		
	✓ Asketema YFS expert	Male		

	✓ NestanetMelkam Community Leader	Male		
Borena	✓ Harallo Primary School director	Female	✓ Renji: Aba GedaBoruMadha Students	Male
	✓ Dida Mega Clan Leader	Male	✓ Renji: Aba GedaBoruMadha Students	Female
	✓ Renji Health Post head	Female	✓ Renji: Women Association	Female
	✓ Fuldowa Health Extension Worker	Female	✓ Male Group: Kerjul School	Female
	✓ Harallo Health Post head	Female	✓ G/Melka Women Association	Female
Bale	✓ RESET Plus Local Person	Male	✓ Meda Welabu Kerjul School	Female
	✓ G/MelkaChira Community Leader	Male	✓ Women Association in Genale	Female
	✓ G/MelkaChira Religious Leader	Male		
	✓ Kerjul Elementary school head	Male		
	✓ Kerjul Health Post health extension worker	Female		

ANNEX 4. Sample Size determination and sample distribution

TABLE 29: KAP SURVEY SAMPLE SIZE.

Key indicators	Expected proportion (Benchmark)	Level of significance	Desired precision d	Design effect (DE)	Non response (%)	Estimated Total sample size	Target Audience
Contraceptive utilization rate in the country (EDHS, 2016)	35%	95%	0.05	2	5%	734	Female
Demand for family planning among women of reproductive (EDHS, 2016)	**40.5%**	**95%**	**0.05**	**2**	**5%**	**778**	**Female**
Comprehensive Knowledge (mEDHS,2014)	24%	95%	0.05	2	5%	589	Both Sex
Men who are familiar with the concepts and benefits of family planning(berhane A, 2017, Almayehu B 2012)	**85%**	**95**	**0.05**	**2**	**5%**	**412**	**Male**

TABLE 30: SAMPLE DISTRIBUTION FOR THE KAP SURVEY ACROSS GENDER AND KEBELE

AMHARA REGIONAL STATE: WAGHEMRA ZONE (22%)						
	Population			**Sample**		
Wereda	Male	Female	Total	Male	Female	Total
Sekota Zuriya	***3785***	***3987***	***7772***	***32***	***54***	***86***
Gazgiblla	**5295**	**5512**	**10807**	40	67	107
Ziquala	***4911***	***5129***	***10040***	***36***	***76***	***112***
Sub Total	***13991***	***14628***	***28619***	***108***	***197***	***305***
SNNP Region: Wolaita Zone (32%)						
Wereda	**Population**			**Sample**		
	Male	Female	Total	Male	Female	Total
Damot Pulssa			***20188***	***78***	***115***	***193***
Kindo Koyish			***15494***	***49***	***73***	***122***
Total			***35682***	***127***	***188***	***315***
SNNP: South Omo Zone (7%)						
	Population			**Sample**		
Wereda	**Male**	**Female**	**Total**	**Male**	**Female**	Total
Dassenech	***3101***	***3201***	***6302***	33	34	67
Hammer	***4276***	***4416***	***8692***	33	46	69
Total	***7377***	***7617***	***14994***	***66***	***80***	***146***

Oromia Region: Bale Zone (17%)						
	Population			Sample		
Wereda	**Male**	**Female**	**Total**	**Male**	**Female**	Total
Meda Welabu	***8429***	***8774***	***17203***	***49***	97	***152***
GuraDamole	***2461***	***2562***	***5023***	21	***23***	***45***
Total	*10890*	*11336*	*22226*	*70*	*120*	*190*
Oromia Region: Borena Zone (22%)						
	Population			**Sample**		
Wereda	**Male**	**Female**	**Total**	**Male**	**Female**	Total
Arero	***6369***	***4932***	***11301***	***39***	124	***161***
Dire	***2461***	***2562***	***5023***	32	***74***	***106***
Total	***10133***	***8638***	***18771***	***71***	***198***	***269***
Grand Total				***442***	***783***	***1225***

NB: 1. the sample size for South Omo is adjusted (from 87 to 146) considering the consortium members concern and comment

TABLE 31: SUMMARY OF SAMPLE SIZE DISTRIBUTION BY TYPE OF DATA COLLECTION APPROACH

Region and sample cluster	Sample size for the quantitative study	Sample size for Health facility assessment	1Sample size for KII	Sample size of FGDs
SNNP-Wolita	315	2	5	3
NNP-South Omoo	146	2	5	3
Amhara-Waghemera	305	2	5	3
Bale	190	2	5	3
Borena	269	3	5	3
Total	**1225**	**12**	**25**	**15**

ANNEX 5. Other tables

TABLE 32: MARITAL STATUS OF THE RESPONDENTS BY SEX AND CLUSTER

Sex	Marital Status	Bale	Borena	South Omo	Waghemra	Wolaita	Total
Female	Married/Live with	67	159	57	78	74	435
	%	55.8	80.3	71.3	39.6	39.4	55.6
	Single	47	30	23	94	110	304
	%	39.2	15.2	28.6	47.7	58.5	38.8
	Divorced	6	9	0	25	4	44
	%	5.0	4.6	0.0	12.7	2.1	5.6
	Total	120	198	80	197	188	783
	%	100	100	100	100	100	100
Male	Married/Live with	38	56	28	48	53	223
	%	54.3	78.9	42.4	44.4	41.7	50.5
	Single	32	15	38	57	74	216
	%	45.7	21.1	57.6	52.8	58.3	48.9
	Divorced	0	0	0	3	0	3
	%	0.0	0.0	0.0	2.8	0.0	0.7
	Total	70	71	66	108	127	442
	%	100	100	100	100	100	100

TABLE 33: RELIGION AFFILIATION

Religion	Bale		Borena		South Omo		Waghemra		Wolaita		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Christian Orthodox	2	1	9	0	2	1	193	104	22	13	228	119
%	1.7	1.4	4.6	0.0	2.5	1.5	98.0	96.3	11.7	10.2	29.1	26.9
Christian Protestant	1	1	42	15	0	3	0	1	161	114	204	134
%	0.8	1.4	21.2	21.1	0.0	4.6	0.0	0.9	85.6	89.8	26.1	30.3
Muslim	117	68	77	27	0	0	4	3	0	0	198	98
%	97.5	97.2	38.9	38.0	0.0	0.0	2.0	2.8	0.0	0.0	25.3	22.2
Other	0	0	70	29	78	62	0	0	5	0	153	91
%	0.0	0.0	35.3	40.9	97.5	93.9	0.0	0.0	2.7	0.0	19.5	20.6
Total	**120**	**70**	**198**	**71**	**80**	**66**	**197**	**108**	**188**	**127**	**783**	**442**
%	100	100	100	100	100	100	100	100	100	100	100	100

TABLE 34: SOURCE OF INCOME BY CLUSTER

Sex	Household Income	Bale	Borena	South Omo	waghemra	wolaita	Total
	Cultivation	50	35	26	47	100	258
	%	71.43	49.30	39.39	43.52	78.74	58.37

Male	Paid/labor job	4	3	1	19	15	42
	%	5.71	4.23	1.52	17.59	11.81	9.50
	Pastoralist	6	64	58	2	7	137
	%	8.57	90.14	87.88	1.85	5.51	31.00
	Small business	7	0	0	29	12	48
	%	10.00	0.00	0.00	26.85	9.45	10.86
Female	Cultivation	58	68	21	91	135	373
	%	48.33	34.34	26.25	46.19	71.81	47.64
	Paid/labor job	11	7	0	45	17	80
	%	9.17	3.54	0.00	22.84	9.04	10.22
	Pastoralist	34	165	77	0	2	278
	%	28.33	83.33	96.25	0.00	1.06	35.50
	Small business	33	3	2	43	29	110
	%	27.50	1.52	2.50	21.83	15.43	14.05

TABLE 35: MAIN REASON FOR VISITING HEALTH FACILITY BY CLUSTER

Sex	Clusters	Bale	Borena	South Omo	Waghemra	Wolaita	Total
Main reason for visiting the facility							
Female	Contraception	23	49	14	74	39	199
		32.86	59.76	66.67	77.89	62.90	60.30
	STD	7	26	0	3	5	41
		10.00	31.71	0.00	3.16	8.06	12.42
	Pregnancy check ups	38	10	5	10	7	70
		54.29	12.20	23.81	10.53	11.29	21.21
	Other	4	4	2	19	10	39
Male	Contraception	34	26	7	5	7	79
		82.93	52	77.78	22.73	22.58	51.63
	STD	9	27	2	7	13	58
		21.95	54	22.22	31.82	41.94	37.91
	Other	1	10	1	10	12	34
		2.44	20	11.11	45.45	38.71	22.22

TABLE 36: MALE LEVEL OF SATISFACTION AND FREQUENCY OF ACCOMPANYING WIVES

Sex	Clusters	Bale	Borena	South Omo	Waghemra	Wolaita	Total
Level of satisfaction with the service provided							
Female	Very much satisfied	39	29	13	32	26	139
		55.71	35.37	61.90	33.68	41.94	42.12
	Regular	26	41	8	57	36	168
		37.14	50.00	38.10	60.00	58.06	50.91
	Not satisfied	5	11	0	5	0	21
		7.14	13.41	0.00	5.26	0.00	6.36
	Very unsatisfied	0	1	0	1	0	2
		0.00	1.22	0.00	1.05	0.00	0.61
	Total	70	82	21	95	62	330
		100.00	100.00	100.00	100.00	100.00	100.00

Male	Very much satisfied	31	19	4	9	12	75
		75.61	38.00	44.44	40.91	38.71	49.02
	Regular	10	26	5	11	19	71
		24.39	52.00	55.56	50.00	61.29	46.41
	Not satisfied	0	5	0	2	0	7
		0.00	10.00	0.00	9.09	0.00	4.58
	Total	41	50	9	22	31	153
		100.00	100.00	100.00	100.00	100.00	100.00
Accompany Wife							
Male	Yes	32	34	9	45	42	162
		45.71	47.89	13.64	41.67	33.07	36.65
	No	38	37	57	63	85	280
		54.29	52.11	86.36	58.33	66.93	63.35
	Total	70	71	66	108	127	442
		100.00	100.00	100.00	100.00	100.00	100.00

TABLE 37: A WOMAN CAN SUGGEST TO HER HUSBAND/BOYFRIEND THAT THEY USE CONTRACEPTIVE

	Bale		**Borena**		**South_Omo**		**Waghemra**		**Wolaita**		**Total**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Completely Agree	20	21	23	104	22	14	17	19	41	42	123	200
%	28.6	17.5	32.4	52.5	33.3	17.50	15.7	9.6	32.3	22.3	27.8	25.5
Don't know/not sure	2	10	2	4	11	23	0	4	7	25	22	66
%	2.9	8.33	2.8	2.0	16.7	28.8	0.0	2.0	5.5	13.3	5.0	8.4
Slightly Agree	16	19	35	56	5	7	76	153	58	88	190	323
%	22.9	15.8	49.3	28.3	7.6	8.8	70.4	77.7	45.7	46.8	43.0	41.3
Slightly disagree	4	12	9	4	6	6	13	14	9	15	41	51
%	5.7	10.00	12.7	2.0	9.1	7.5	12.0	7.1	7.1	8.0	9.3	6.5
Strongly disagree	28	58	2	30	22	30	2	7	12	18	66	143
%	40	48.33	2.8	15.2	33.3	37.5	1.9	3.6	9.5	9.6	14.9	18.3
Total	70	**120**	71	**198**	66	**80**	108	**197**	127	**188**	442	**783**

TABLE 38: A HUSBAND CAN SUGGEST TO HIS WIFE/GIRLFRIEND THAT THEY USE CONTRACEPTIVE

	Bale		**Borena**		**South_omo**		**waghemra**		**wolaita**		**Total**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Completely agree	21	31	29	109	11	34	18	13	25	54	104	241
	30	25.8	40.9	55.0	16.7	42.5	16.7	6.6	19.69	28.7	23.5	30.8
Don't know/not sure	4	10	2	2	10	22	0	4	8	23	24	61
	5.7	8.3	2.8	1.0	15.2	27.5	0.0	2.1	6.3	12.3	5.4	7.9
Slightly agree	9	15	31	57	6	10	81	156	61	79	188	317
	12.9	12.5	43.7	28.9	9.1	12.5	75.0	79.2	48.0	42.1	42.5	40.5
Slightly disagree	5	13	8	14	8	3	8	14	14	15	43	59
	7.1	10.8	11.3	7.1	12.2	3.8	7.4	7.1	11.02	7.9	9.7	7.5
Strongly disagree	31	51	1	16	31	11	1	10	19	17	83	105
	44.3	42.5	1.41	8.1	47	13.7	0.9	5.1	15	9.1	18.8	13.4
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 39: IF A WOMAN SUGGESTED USING CONTRACEPTIVE METHODS TO HER PARTNER, IT WOULD MEAN:

	Wolita		S.Omo		Bale		Borena		waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Doesn't trust her partner	17	14	4	1	24	12	85	36	15	17	145	80
%	9.0	11.0	5.0	1.5	20	17.1	42.9	50.7	7.6	15.7	18.5	18.1
Unfaithful to her/his partner	0	3	0	1	4	2	1	0	4	1	9	7
%	0.0	2.4	0.0	1.5	3.3	2.9	0.5	0.0	2.0	0.9	1.15	1.6
Concerned about feeding the children	65	40	13	13	3	2	9	5	114	55	204	115
	34.6	31.5	16.3	19.7	2.5	2.9	4.6	7.0	57.9	50.9	26.1	26.0
Concerned about her health %	51	39	17	11	40	11	62	27	26	31	196	119
	27.1	30.7	21.3	16.7	33.3	15.7	31.3	38.0	13.2	28.7	25.0	26.9
Not a good (decent wife/husband) %	18	6	6	6	37	29	14	0	11	2	86	43
	9.6	4.7	7.5	9.1	30.8	41.4	7.1	0.0	5.6	1.9	11	9.7
Not a good wife/husband %	14	14	16	22	5	9	14	0	14	0	63	45
	7.5	11.0	20.0	33.3	4.2	12.7	7.1	0.0	7.1	0.0	8.1	10.2
Not committed to her/his family	6	5	0	1	6	5	8	1	12	0	32	12
%	3.2	3.9	0.0	1.5	5.0	7.1	4.0	1.4	6.1	0.0	4.1	2.7
Others	17	6	24	11	1	0	5	2	1	2	48	21
%	9.0	4.7	30.0	16.7	0.8	0.0	2.5	2.8	0.5	1.9	6.13	4.8
Total	**188**	**127**	**80**	**66**	**120**	**70**	**198**	**71**	**197**	**108**	**783**	**442**

TABLE 40: IF A MAN SUGGESTED USING CONTRACEPTIVE METHODS TO HIS PARTNER, IT WOULD MEAN

MATT5B	Wolita		S.Omo		Bale		Borena		waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
He_doesn´t_trust_her	14	9	2	2	23	13	65	38	13	9	117	71
%	7.5	7.1	2.5	3.0	19.2	18.6	32.8	53.5	6.6	8.3	14.9	16.1
He_is_being_unfaithful	2	4	2	5	2	1	8	0	2	2	16	12
%	1.1	3.2	2.5	7.6	1.8	1.4	4.0	0.0	1.0	1.9	2.0	2.71
Concerned about feeding the children	86	51	28	18	4	2	16	4	123	71	257	146
%	45.7	40.2	35.0	27.3	3.3	2.9	8.1	5.6	62.4	65.7	32.8	33.0
Concerned_about her health	42	32	19	14	39	6	71	26	23	21	194	99
	22.3	25.2	23.8	21.2	32.5	8.6	35.9	36.6	11.7	19.4	24.8	22.4
He_is_not_a_good (decent man)	11	7	0	3	26	33	15	0	6	2	58	45
	5.9	5.5	0.0	4.6	21.7	47.1	7.6	0.0	3.6	1.9	7.4	10.2
Not_a_good_husband	11	10	5	13	21	7	8	0	14	0	59	30
	5.9	7.9	6.3	19.7	17.5	10.0	4.0	0.0	7.1	0.0	7.5	6.8
He_is_not_committed to his family	4	5	0	0	4	8	8	3	15	0	31	16
	2.1	3.9	0.00	0.0	3.3	11.4	4.0	4.2	7.6	0.0	4.0	3.6
others	18	9	24	11	1	0	7	0	1	3	51	23
%	9.6	7.1	30.0	16.7	0.8	0.0	3.5	0.0	0.5	2.8	6.5	5.2
Total	188	127	80	66	120	70	198	71	197	108	783	442

TABLE 41: UNMARRIED WOMEN SHOULD NOT USE FP SERVICES

	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	25	10	20	83	20	25	6	25	36	38	107	181
%	35.7	8	28.2	42	30.3	31	5.6	13	28.4	20	24.2	23
Don't know/not sure	2	41	1	21	9	30	1	3	9	50	22	145
%	2.9	34	1.4	11	13.6	38	0.9	2	7.1	27	5.0	19

Slightly agree	1	10	11	5	3	2	29	25	27	29	71	71
%	1.4	8	15.5	3	4.6	3	26.9	13	21.3	15	16.1	9
Slightly disagree	7	13	14	28	14	7	31	73	37	43	103	164
%	10.0	11	19.7	14	21.2	9	28.7	37	29.1	23	23.3	21
Strongly disagree	35	46	25	61	20	16	41	71	18	28	139	222
%	50.0	38	35.2	31	30.3	20	38	36	14.2	15	31.5	28
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 42: COMMUNITY MEMBERS EXPECT UNMARRIED WOMEN NOT TO USE FAMILY PLANNING METHODS

	Bale		**Borena**		**South_Omo**		**Waghemra**		**Wolaita**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	29	48	46	68	25	31	8	7	38	57	146	211
%	41.4	40.0	64.8	34.3	37.9	38.8	7.4	3.6	29.9	30.3	33.0	27
Don't know/not sure	2	9	1	2	9	23	1	8	10	20	23	62
%	2.9	7.5	1.4	1.0	13.6	28.8	0.9	4.0	7.8	10.6	5.2	7.9
Slightly agree	5	19	20	45	7	4	16	81	27	44	75	193
%	7.19	15.8	28.2	22.7	10.6	5.0	14.8	41.1	21.3	23.4	17	24.7
Slightly disagree	4	10	1	23	15	9	46	68	39	43	105	153
%	5.71	8.3	1.4	11.6	22.7	11.3	42.6	34.5	30.7	22.9	23.8	19.5
Strongly disagree	30	34	3	60	10	13	37	33	13	24	93	164
%	42.9	28.3	4.2	30.3	15.2	16.3	34.3	16.8	10.2	12.8	21.0	21
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 43: IF UNMARRIED WOMEN USE FAMILY PLANNING SERVICE, THE COMMUNITY DISRESPECT HER

	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	29	46	54	98	24	26	10	8	37	59	154	237
%	41.4	38.3	76.1	49.5	36.4	32.5	9.3	4.1	29.1	31.4	34.8	30.3
Don't know	4	8	1	2	9	23	0	9	9	19	23	61
%	5.7	6.7	1.4	1.0	13.6	28.8	0.0	4.6	7.1	10.1	5.2	7.79
Slightly agree	6	28	14	44	5	6	6	99	28	37	59	214
%	8.6	23.3	19.7	22.2	7.6	7.5	5.6	50.3	22.1	19.7	13.4	27.3
Slightly disagree	6	7	1	24	17	8	69	62	42	51	135	152
%	8.6	5.8	1.4	12.1	25.8	10.0	63.9	31.5	33.1	27.1	30.5	19.4
Strongly disagree	25	31	1	30	11	17	23	19	11	22	71	119
%	35.7	25.8	1.4	15.2	16.7	21.3	21.3	9.6	8.6	117	16.1	15.2
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 44: UNMARRIED WOMEN CEASE USING FAMILY PLANNING METHOD BECAUSE OF FEARING DISRESPECT FROM THE COMMUNITY

MATT14	**Bale**		**Borena**		**South_Omo**		**Waghemra**		**Wolaita**		**Total**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Completely agree	25	48	41	91	23	28	5	6	31	61	125	234
%	35.7	40.0	57.8	46.0	34.9	35.0	4.6	3.1	24.4	32.5	28.3	29.9
Don't know/not sure	4	8	1	0	10	23	0	9	10	18	25	58
%	5.7	6.7	1.4	0.0	15.2	28.8	0.0	4.6	7.9	9.6	5.7	7.4
Slightly agree	6	24	23	45	4	5	14	113	30	46	77	233
%	8.6	20.0	32.4	22.7	6.1	6.3	13.0	57.4	23.6	24.5	17.4	29.8
Slightly disagree	9	12	5	23	16	7	69	56	40	41	139	139

%	12.9	10.0	7.0	11.6	24.2	8.8	63.9	28.4	31.5	21.8	31.2	17.6
Strongly disagree	26	28	1	39	13	17	20	13	16	22	76	119
%	37.1	23.3	1.4	19.7	19.7	21.3	18.5	6.6	12.6	11.7	17.2	15.2
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 45: UNMARRIED WOMEN CAN USE FP METHOD IF THE COMMUNITY RECEIVE ADEQUATE HEALTH EDUCATION

MATT15	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	12	26	49	77	20	28	23	15	37	63	141	209
%	17.1	21.7	69.0	38.9	30.3	35.0	21.3	7.6	29.1	33.5	31.9	26.7
Don't know/not sure	5	7	0	0	12	23	0	13	11	27	28	70
%	7.1	5.8	0.0	0.0	18.2	28.8	0.0	6.6	8.7	14.4	6.3	8.9
Slightly agree	10	36	20	43	12	21	79	136	59	67	180	303
%	14.3	30.0	28.2	21.7	18.2	26.3	73.2	69.0	46.5	35.6	40.7	38.7
Slightly disagree	10	12	0	31	14	7	6	29	16	21	46	100
%	14.3	10.0	0.0	15.7	21.2	8.8	5.6	14.7	12.6	11.2	10.4	12.8
Strongly disagree	33	39	2	47	8	1	0	4	4	10	47	101
%	47.1	32.5	2.8	23.7	12.1	1.25	0.0	2.0	3.2	5.3	10.6	12.9
Total	***70***	***120***	***71***	***198***	***66***	***80***	***108***	***197***	***127***	***188***	***442***	***783***

TABLE 46: MARRIED WOMEN ARE NOT ALLOWED TO USE FP METHOD UNLESS SHE GET APPROVAL FROM HER HUSBAND

MATT16	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	36	41	33	68	27	41	38	11	40	65	174	226
%	51.4	34.2	46.5	34.3	40.9	51.3	35.2	5.6	31.5	34.6	39.4	28.9
Don't know/not sure	5	6	0	1	12	21	2	4	10	19	29	51
%	7.1	5.0	0.0	0.5	18.2	26.3	1.9	2.0	7.9	10.1	6.6	6.51
Slightly agree	10	37	32	55	12	12	47	137	35	51	136	292
%	14.3	30.8	45.1	27.8	18.2	15.0	43.5	69.5	27.6	27.1	30.8	37.3
Slightly disagree	10	14	4	27	13	4	17	32	31	34	75	111
%	14.3	11.7	5.6	13.6	19.7	5.0	15.7	16.2	24.4	18.1	17.0	14.2
Strongly disagree	9	22	2	47	2	2	4	13	11	19	28	103
%	12.9	18.3	2.8	23.7	3.0	2.5	3.70	6.7	8.7	10.1	6.3	13.2
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 47: MOST HUSBANDS HIGHLY EXPECT THEIR WIFE NOT TO USE FP SERVICE SO AS TO HAVE LARGE FAMILY SIZE

	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	42	39	22	66	23	34	9	23	31	47	127	209
%	60.0	32.5	31.0	33.3	34.9	42.5	8.3	11.7	24.4	25.0	28.7	26.7
Don't know/not sure	9	11	1	1	10	22	1	2	9	21	30	57
%	12.9	9.2	1.4	0.5	15.2	27.5	0.9	1.0	7.09	11.2	6.8	7.3
Slightly agree	6	29	38	51	10	8	17	125	33	61	104	274
%	8.6	24.2	53.5	25.8	15.2	10.0	15.7	63.5	26	32.4	23.5	35
Slightly disagree	4	21	9	33	16	10	70	31	47	45	146	140

%	5.7	17.5	12.7	16.8	24.2	12.5	64.8	15.7	37.0	23.9	33.0	17.9
Strongly disagree	9	20	1	47	7	6	11	16	7	14	35	103
%	12.9	16.7	1.4	23.7	10.6	7.5	10.2	8.1	5.51	7.5	7.9	13.2
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 48: IF MARRIED WOMEN USE FAMILY PLANNING METHOD WITHOUT THE CONSENT OF THEIR HUSBAND CONFLICT WILL RAISE EVEN TO END UP WITH DIVORCE

	Bale		**Borena**		**South_Omo**		**Waghemra**		**Wolaita**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	37	53	38	105	27	39	18	13	45	76	165	286
%	52.9	44.2	53.5	53.0	40.9	48.8	16.7	6.6	35.4	40.4	37.3	36.5
Don't know/not sure	6	6	0	1	9	21	2	3	9	19	26	50
%	8.6	5.0	0.0	0.5	13.6	26.3	1.8	1.5	7.0	10.1	5.9	6.4
Slightly agree	10	31	27	44	12	15	56	147	44	65	149	302
%	14.3	25.8	38.0	22.2	18.2	18.6	51.8	74.6	34.7	34.6	33.7	38.6
Slightly disagree	6	15	5	21	14	4	29	23	25	25	79	88
%	8.6	12.5	7.1	10.6	21.2	5.0	26.8	11.7	19.7	13.3	17.8	11.2
Strongly disagree	11	15	1	27	4	1	3	11	4	3	23	57
%	15.7	12.5	1.4	13.7	6.1	1.3	2.9	5.6	3.2	1.6	5.2	7.3
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 49: MARRIED WOMAN WILL STOP USING FAMILY PLANNING SERVICE IF IT RAISES CONFLICT WITH THEIR HUSBANDS

	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Completely agree	34	45	38	109	26	37	13	10	45	70	156	271
%	48.6	37.5	53.5	55.1	39.4	46.3	12.0	5.1	35.4	37.2	35.3	34.6
Don't know/not sure	6	6	0	2	9	21	1	4	9	22	25	55
%	8.6	5.0	0.0	1.0	13.6	26.3	0.9	2.0	7.0	11.7	5.7	7.0
Slightly agree	15	39	32	34	14	16	15	121	33	47	109	257
%	21.4	32.5	45.1	17.2	21.2	20.0	13.9	61.4	26	25.0	24.7	32.8
Slightly disagree	7	11	0	30	8	5	70	49	36	47	121	142
%	10.0	9.2	0.0	15.2	12.1	6.3	64.8	24.9	28.4	25.0	27.3	18.1
Strongly disagree	8	19	1	23	9	1	9	13	4	2	31	58
%	11.4	15.8	1.4	11.6	13.6	1.3	8.3	6.6	3.2	1.1	7.0	7.4
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 50: WHAT IS THE IDEAL AGE A GIRL SHOULD GET MARRIED?

MATT9	**Bale**		**Borena**		**South_Omo**		**Waghemra**		**Wolaita**		**Total**	
	M	F	M	F	M	F	M	F	M	F	M	F
Anytime she thinks is the best for her	1	1	0	2	3	2	3	1	5	7	12	13
%	1.4	0.8	0.0	1.0	4.6	2.5	2.8	0.5	3.9	3.7	2.7	1.7
Never before 18 y.o	60	104	59	190	21	16	89	182	101	146	330	638
%	85.7	86.7	83.1	95.7	31.8	20.0	82.4	92.4	79.5	77.7	74.7	81.5
other	1	3	12	2	20	37	15	6	15	22	63	70

%	1.4	2.5	16.0	1.0	30.3	46.3	13.9	3.1	11.8	11.7	14.3	8.9
When the father/husband decide	8	12	0	4	22	25	1	8	6	13	37	62
%	11.4	10.0	0.0	2.0	33.3	31.3	0.9	4.1	4.7	6.9	8.4	7.9
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 51: THE IDEAL AGE A GIRL SHOULD GIVE BIRTH FOR THE FIRST TIME

MATT10	Bale		Borena		South_Omo		Waghemra		Wolaita		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Anytime she thinks is the best for her	0	6	0	6	4	3	5	68	17	27	26	110
%	0.0	5	0.0	3.0	6.1	3.8	4.6	34.5	13.4	14.4	5.9	14.1
Never before 18 y.o	59	97	36	186	27	27	71	111	89	139	282	560
%	84.3	80.8	50.7	93.9	40.9	33.8	65.7	56.4	70.1	73.9	63.8	71.5
other	2	13	11	0	15	27	31	12	18	12	77	64
%	2.9	10.8	15.5	0.0	22.7	33.8	28.7	6.1	14.2	6.4	17.4	8.2
When the father/husband decide	9	4	24	6	20	23	1	6	3	10	57	49
%	12.7	3.3	33.8	3.0	30.3	28.6	0.9	3.1	2.4	5.3	12.9	6.3
Total	70	120	71	198	66	80	108	197	127	188	442	783

TABLE 52: IT'S ALL RIGHT FOR BOYS AND GIRLS TO HAVE SEX WITH EACH OTHER PROVIDED THAT THEY USE METHODS TO STOP PREGNANCY

MSGN5	Wolaita		South Omo		Bale		Borena		Waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Completely Agree	28	12	21	8	4	9	84	17	2	5	139	51
	14.9	9.5	26.3	12.1	3.3	12.9	42.4	23.9	1.0	4.6	17.8	11.5
Slightly Agree	79	48	14	12	7	9	54	40	134	69	288	178
	42.0	37.8	17.5	18.2	5.8	12.9	27.3	56.3	68.0	63.9	36.9	40.3
Don't Know/Not Sure	19	7	20	14	1	0	3	0	7	0	50	21
	10.1	5.5	25.0	21.2	0.8	0.0	1.5	0.0	3.6	0.0	6.4	4.8
Slightly Disagree	25	37	5	13	20	11	31	12	23	16	104	89
	13.3	29.1	6.3	19.7	16.7	15.7	15.7	16.9	11.9	14.8	13.3	20.1
Strongly Disagree	37	23	20	19	88	41	26	2	31	18	202	103
	19.7	18.1	25.0	28.8	73.3	58.6	13.1	2.8	15.7	16.7	25.8	23.3
Total	188	127	80	66	120	70	198	71	197	108	783	442

TABLE 53: A MAN SHOULD NEVER ALLOW HIS WIFE TO DECIDE ON THE SIZE OF THE FAMILY

	wolita		South Omo		Bale		Borena		waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Completely agree	38	15	23	23	30	29	69	16	0	0	160	83
%	20.2	11.8	28.8	34.9	25.0	41.4	34.9	22.5	0.0	0.0	20.4	18.8
Slightly agree	26	17	16	3	8	6	43	27	62	2	155	55
%	13.8	13.4	20.00	4.6	6.7	8.57	21.7	38.0	31.5	1.9	19.8	12.4
Don't know/not sure	14	4	13	15	7	1	4	0	8	0	46	20
%	7.5	3.2	16.3	22.7	5.8	1.4	2.0	0.00	4.1	0.0	5.9	4.5
Slightly disagree	70	59	10	13	32	11	36	14	88	50	236	147
%	37.2	46.5	12.5	19.7	26.7	15.7	18.2	19.7	44.7	46.3	30.1	33.3
Strongly disagree	40	32	18	12	43	23	46	14	39	56	186	137
%	21.3	25.2	22.5	18.2	35.8	32.9	23.23	19.7	19.8	51.9	23.8	31.0
Total	188	127	80	66	120	70	198	71	197	108	783	442

TABLE 54: IT IS SOMETIMES JUSTIFIABLE FOR A MAN/BOY TO HIT HIS WIFE/GIRLFRIEND

MSGN4	Wolaita		South Omo		Bale		Borena		waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
completely agree	17	8	25	17	0	12	46	8	1	3	89	48
	9.0	6.30	31.3	25.8	0.0	17.1	23.2	11.3	0.5	2.8	11.4	10.9
slightly agree	10	15	8	5	9	1	51	30	9	6	87	57
	5.3	11.8	10.0	7.6	7.5	1.4	25.8	42.3	4.6	5.6	11.1	12.9
Don't/not sure	4	3	6	3	0	2	3	0	0	0	13	8
	2.1	2.4	7.5	4.6	0.0	2.9	1.5	0.0	0.0	0.0	1.7	1.8
slightly disagree	52	39	9	20	18	13	38	31	61	46	178	149
	27.7	30.7	11.3	3030	15.0	18.6	19.2	43.7	31.0	42.6	22.7	33.7
strongly disagree	105	62	32	21	93	42	60	2	126	53	416	180
	55.9	48.8	40.0	31.8	77.5	60.0	30.3	2.8	64.0	49.0	53.1	40.7
Total	188	127	80	66	120	70	198	71	197	108	783	442

TABLE 55: SOMETIMES, A MAN OR BOY HAS TO FORCE A WOMAN/GIRL TO HAVE SEX IF HE LOVES HER

MSGN3	Wolaita		South Omo		Bale		Borena		Waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
completely agree	11	6	24	16	1	10	46	7	2	3	84	42
%	5.9	9.5	30.0	24.2	0.8	14.3	23.2	9.9	1.0	2.8	10.7	9.5
slightly agree	26	21	1	4	2	0	42	30	7	1	78	56
%	13.8	16.5	1.3	6.1	1.7	0.0	21.2	42.3	3.6	0.9	10.0	12.7
don't know	5	4	6	3	1	0	1	0	2	0	15	7
%	2.7	3.2	7.5	4.6	0.8	0.0	0.5	0.0	1.0	0.0	1.9	1.6
slightly disagree	48	45	18	24	18	11	32	14	66	46	182	140
%	25.5	35.4	22.5	36.4	15.0	15.7	16.2	19.7	33.5	42.6	23.2	31.7
strongly disagree	98	51	31	19	98	49	77	20	120	58	424	197
%	52.1	40.2	38.8	28.8	81.7	70.0	38.9	28.2	60.9	53.7	54.2	44.6
Total	188	127	80	66	120	70	198	71	197	108	783	442

Annex 6: Decision Making within the household

The objective of this section is to give an account of decision making within the household. It considers decision regarding household purchases, how to use the money brought to the household, visiting public places and health care of women.

Decisions regarding large household purchases in the sample zones were considered to be made commonly by husband and wife. About half (49.8%) of female and 35.5% of male sample respondents said the decision should be made by both husband and wife although the case in South Omo somewhat different. Female respondents (60%) from South Omo contend that the husband is the sole player in making decisions regarding large household purchases. Alike female respondents in South Omo, male respondents in all project intervention areas have perception that wife should not make the decision about large household purchase. Moreover, in South Omo, more than half of male respondent believed that father/ father in law should make decisions regarding for both large and small household purchase, which is not the case in other intervention clusters (See tables xx and xx below).

TABLE 56: IN YOUR HOUSEHOLD WHO USUALLY MAKES DECISIONS ABOUT LARGE HOUSEHOLD PURCHASES

MSGN9	wolita		South Omo		Bale		Borena		waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Both you and your partner	63	42	8	4	93	44	122	32	104	35	390	157
	33.5	33.1	10.0	6.1	77.5	62.9	61.6	45.1	52.8	32.4	49.8	35.5
Father/Father In Law	72	42	21	37	13	11	3	5	18	16	127	111
	38.3	33.1	26.3	56.1	10.8	15.7	1.5	7.0	9.1	14.8	16.2	25.1
Mother/Mother In-Law	6	2	1	0	11	5	0	0	1	2	19	9
	3.2	1.6	1.3	0.0	9.2	7.1	0.0	0.0	0.5	1.9	2.4	2.0
Other	5	0	0	0	1	1	10	4	0	0	16	5
	2.7	0.0	0.0	0.0	0.8	1.4	5.1	5.6	0.0	0.0	2.0	1.1
You_(Respondent)	8	40	2	23	2	6	37	29	20	55	69	153
	4.3	31.5	2.5	34.9	1.7	8.6	18.7	40.9	10.6	50.9	8.8	34.6
Your Husband/Wife	34	1	48	2	0	3	26	1	54	0	162	7
	18.1	0.8	60.0	3.0	0.0	4.3	13.1	1.4	27.4	0.0	20.7	1.6
Total	188	127	80	66	120	70	198	71	197	108	783	442
	100	100	100	100	100	100	100	100	100	100	100	100

Decisions about household purchases for daily needs is indicated mainly to be taken by the wives in all the sample clusters. About 44.5% of female respondents and 48% male respondents contend that decisions about household purchases for daily needs are taken by the women. A considerable number of respondents (35.38% female and 22.85% male) consider the decision to be common while higher proportion of respondents in Bale (47.50% female and 52.86% male respondents) consider the decision to be common.

A closer analysis of the result indicates that, females are more engaged in small and daily needs of household purchase while men are taking the upper hand of in large-household purchase decision. These disparities on decision-making power between men and women are present in all clusters despite of variabilities.

TABLE 57: IN YOUR HOUSEHOLD WHO USUALLY MAKES DECISIONS ABOUT HOUSEHOLD PURCHASES FOR DAILY NEEDS

	Wolaita		South Omo		Bale		Borena		Waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
Both you & your wife	44	31	9	3	57	37	68	7	99	23	277	101
%	23.4	24.4	11.3	4.6	47.5	52.9	34.3	9.9	50.3	21.3	35.4	22.9

father/father in-law	19	10	16	27	3	5	2	1	3	1	43	44
%	10.1	7.9	20.0	40.9	2.5	7.1	1.0	1.4	1.5	0.9	5.5	10.0
mother/mother in-law	58	36	6	12	20	12	2	5	14	15	100	80
%	30.9	28.4	7.5	18.2	16.7	17.1	1.0	7.0	7.1	13.9	12.8	18.1
other	4	0	0	0	0	1	10	4	0	0	14	5
%	2.1	0.0	0.0	0.0	0.0	1.4	5.1	5.6	0.0	0.0	1.8	1.1
you_(respondent)	48	8	11	18	40	7	87	5	73	3	259	41
%	25.5	6.3	13.8	27.3	33.3	10.0	43.9	7.0	37.1	2.8	33.1	9.3
your husband/wife	15	42	38	6	0	8	29	49	8	66	90	171
%	8.0	33.1	47.5	9.1	0.0	11.4	14.7	69.0	4.1	61.1	11.5	38.7
Total	188	127	80	66	120	70	198	71	197	108	783	442
	100	100	100	100	100	100	100	100	100	100	100	100

A critical examination of utilization of the money bring into the household, reveals that both the husband and the wife have a big stake in taking decisions about utilization of the money brought into the household except for South Omo where 52.5% of female reported that decision about the money the husband brought to the household is made by the husband.

TABLE 58: IN YOUR HOUSEHOLD WHO USUALLY DECIDES HOW TO USE MONEY THAT THE HUSBAND BRINGS INTO THE HOUSEHOLD

MSGN11	**Wolaita**		**South Omo**		**Bale**		**Borena**		**Waghemra**		**Total**	
	F	M	F	M	F	M	F	M	F	M	F	M
You & your partner	74	50	12	4	84	43	125	23	153	62	448	182
%	39.4	39.4	15.0	6.1	70.0	61.4	63.1	32.4	77.7	57.4	57.2	41.2
father/father in-law	56	27	22	39	7	5	4	0	11	2	100	73
%	29.8	21.3	27.5	59.1	5.8	7.1	2.0	0.0	5.6	1.9	12.8	16.5
mother/mother in-law	14	8	1	0	16	10	1	0	2	0	34	18
%	7.5	6.3	1.3	0.0	13.3	14.3	0.5	0.0	1.0	0.0	4.3	4.1
other	5	3	1	0	0	1	10	7	0	0	16	11
%	2.7	2.4	1.3	0.0	0.0	1.4	5.1	9.9	0.0	0.0	2.0	2.5
you_(respondent)	21	34	2	21	10	10	29	37	26	40	88	142
%	11.2	26.8	2.5	31.8	8.3	14.3	14.7	52.1	13.2	37.0	11.2	32.1
your husband/wife	18	5	42	2	3	1	29	4	5	4	97	16
%	9.6	3.9	52.5	3.0	2.5	1.4	14.7	5.6	2.5	3.7	12.4	3.6
Total	188	127	80	66	120	70	198	71	197	108	783	442

Decisions about utilization of the money the wife brings into the household is taken commonly by the husband and wife in the sample areas except for South Omo. For South Omo, decision regarding utilization of money the wife brings into the household is made by the husband. Fifty-five percent of female respondents and 54.55% of male respondents said the decision is made by husbands.

TABLE 59: IN YOUR HOUSEHOLD WHO USUALLY DECIDES HOW TO USE THE MONEY THE WIFE BRINGS INTO THE HOUSEHOLD

	Wolaita		**South Omo**		**Bale**		**Borena**		**waghemra**		**Total**	
	F	M	F	M	F	M	F	M	F	M	F	M
Both you & your wife	80	56	11	6	85	45	117	27	159	70	452	204
	42.6	44.1	13.8	9.1	70.8	64.3	59.1	38.0	80.7	64.8	57.7	46.2
father/father in-law	52	27	19	36	4	4	4	0	11	2	90	69
	27.7	21.3	23.8	54.6	3.3	5.7	2.0	0.0	5.6	1.9	11.5	15.6
mother/mother in-law	12	10	3	3	19	9	0	0	2	14	36	36

	6.4	7.9	3.8	4.6	15.8	12.9	0.0	0.0	1.0	13.0	4.6	8.1
other	2	3	0	1	0	1	11	12	0	0	13	17
	1.1	2.4	0.0	1.5	0.0	1.4	5.6	16.9	0.0	0.0	1.7	3.9
you_(respondent)	12	21	3	18	10	9	40	26	18	14	83	88
	6.4	16.5	3.8	27.3	8.3	12.9	20.2	36.6	9.1	13.0	10.6	19.9
your husband/wife	30	10	44	2	2	2	26	6	7	8	109	28
	16.0	7.9	55.0	3.0	1.7	2.9	13.1	8.4	3.6	7.4	13.9	6.3
Total	188	127	80	66	120	70	198	71	197	108	783	442

As show in the table below, overall 56% of female and 41% of male respondents think both husband and wife make decisions about visiting public places. But in South Omo, majority of male respondents (59%) reported that decision regarding visiting public places is mainly made by Father/Father in law, whereas female respondents (58.75%) reported that the decision is made by the husband.

TABLE 60: IN YOUR HOUSEHOLD WHO USUALLY DECIDES TO VISIT PUBLIC SPACES

	Wolaita		South Omo		Bale		Borena		waghemra		Total	
	F	M	F	M	F	M	F	M	F	M	F	M
You & your wife	77	49	11	4	85	45	114	31	154	53	441	182
	41.0	38.6	13.8	6.1	70.8	64.3	57.6	43.7	78.17	49.1	56.3	41.2
father/father in-law	56	33	22	39	13	9	5	7	14	15	110	103
	29.8	26.0	27.5	59.1	10.8	12.8	2.5	9.9	7.11	13.9	14.1	23.3
mother/mother in-law	11	8	0	0	10	8	0	0	0	1	21	17
	5.9	6.3	0.0	0.0	8.3	11.4	0.0	0.0	0.0	0.9	2.7	3.9
other	5	0	0	0	1	1	11	5	0	0	17	6
	2.7	0.0	0.0	0.0	0.8	1.4	5.6	7.04	0.0	0.0	2.2	1.4
you_(respondent)	14	30	0	22	2	6	23	28	20	38	59	124
	7.5	23.6	0.0	33.3	1.7	8.6	11.6	39.4	10.2	35.2	7.5	28.1
your husband/wife	25	7	47	1	9	1	45	0	9	1	135	10
	13.3	5.5	58.8	1.5	7.5	1.4	22.7	0.0	4.6	0.9	17.2	2.3
Total	188	127	80	66	120	70	198	71	197	108	783	442

Most sample respondents (56.32% of female and 49.55% of male) considered decision-making regarding the health care of the women should be a common decision that would engage both the husband and the wife. Among the study clusters, the vast majority of respondents of Waghemer (82% of female and 73%of male) believed that the decision regarding health care of women should be shared responsibility. But in case of South Omo, more than half of male and female respondents assume the decision regarding the health care of the women is made by the husband.

TABLE 61: IN YOUR HOUSEHOLD WHO USUALLY MAKES DECISIONS ABOUT THE HEALTH CARE OF THE WOMEN?

MSGN15	**Wolaita**		**South Omo**		**Bale**		**Borena**		**waghemra**		**Total**	
	F	M	F	M	F	M	F	M	F	M	F	M
Both you & your wife	78	57	11	4	86	37	104	42	162	79	441	219
%	41.5	44.9	13.8	6.1	71.7	52.9	52.5	59.2	82.2	73.2	56.3	49.5
father/father in-law	18	16	19	35	4	4	1	3	7	3	49	61
%	9.6	12.6	23.8	53.0	3.3	5.7	0.5	4.2	3.6	2.8	6.3	13.8
mother/mother in-law	50	22	3	4	19	11	2	0	5	8	79	45
%	26.6	17.3	3.8	6.1	15.8	15.7	1.0	0.0	2.5	7.4	10.1	10.2
other	4	0	0	0	0	1	12	8	0	0	16	9

%	2.1	0.0	0.0	0.0	0.0	1.4	6.1	11.3	0.0	0.0	2.0	2.0
you_(respondent)	22	16	8	21	4	6	60	11	20	12	114	66
%	11.7	12.6	10.0	31.8	3.3	8.6	30.3	15.5	10.2	11.1	14.6	14.9
your husband/wife	16	16	39	2	7	11	19	7	3	6	84	42
%	8.5	12.6	48.8	3.0	5.8	15.7	9.6	9.9	1.5	5.6	10.7	9.5
Total	188	127	80	66	120	70	198	71	197	108	783	442

Annex 7. Equipment availability at the HFs

Legend	Equipment available in all health facilities Equipment available at least in one HF Requirement not available in all HF							
Bale (n=2)	Types of equipment and availability	Borena (n=3)	Types of equipment and availability	South Omo (n=2)	Types of equipment and availability	Wolaita (n=2)	Types of equipment and availability	Waghemra (n=2)
	Flashlight		Sterile needles and syringes		Working lamp		Flashlight	
	Blood Pressure gauge		Sterile gloves		Scale		Working lamp	
	Sterile needles and syringes		Scale		Blood Pressure gauge		Scale	
	Uterine sound		Stethoscope		Thermometer		Blood Pressure gauge	
	Thermometer		Scissors		Stethoscope		Thermometer	
	Stethoscope		Specula		Scissors		Stethoscope	
	Scissors		Sponge holding forceps		Sterile needles and syringes		Scissors	
	Alligator forceps		Artery forceps		Specula		Sterile needles and syringes	
	Dressing forceps		Dressing forceps		Tenacula		Specula	
	Tissue forceps		Tissue forceps		Uterine sound		Uterine sound	
	Mosquito forceps		Sutures		Alligator forceps		Sponge holding forceps	
	Iodine		Iodine		Sponge holding forceps		Artery forceps	
	Sterile gloves		Antiseptic		Artery forceps		Dressing forceps	
	Disposal containers for contaminated waste/supplies		Disposal containers for contaminated waste/supplies		Dressing forceps		Tissue forceps	
	Sharps containers for used sharps		Sharps containers for used sharps		Tissue forceps		Scalpels	
	Working lamp		Examination table capable of Trendelenburg		Mosquito forceps		Sutures	
	Scale		Flashlight		Sutures		Needle holder	
	Specula		Working lamp		Needle holder		Sterilizers	
	Tenacula		Blood Pressure gauge		Sterilizers		Iodine	
	Sponge holding forceps		Thermometer		Antiseptic		Antiseptic	
	Artery forceps		Tenacula		Chlorine solution		Sterile gloves	
	Intestinal forceps		Uterine sound		Examination couch or table		Disposal containers for contaminated waste/supplies	
	Babcock forceps		Alligator forceps		Iodine		Sharps containers for used sharps	
	Nsv ringed forceps		Mosquito forceps		Sterile gloves		Plastic buckets or containers for decontamination	
	Scalpels		Intestinal forceps		Disposal containers for contaminated waste/supplies		Clean instrument container	
	Sutures		Babcock forceps		Sharps containers for used sharps		Instrument trays	

	Needle holder		Nsv ringed forceps		Plastic buckets or containers for decontamination		Swab containers with sterile swabs or gauze	
	Retractor		Scalpels		Clean instrument container		Examination couch or table	
	Tubal hook		Needle holder		Instrument trays		Procedure area for IUD, injectables or implants.	
	Sharp trocars		Retractor		Swab containers with sterile swabs or gauze		Tenacula	
	Sterilizers		Tubal hook		Examination table capable of Trendelenburg		Alligator forceps	
	Xylocaine or lignocaine		Sharp trocars		Procedure area for IUD, injectables or implants.		Intestinal forceps	
	Antiseptic		Sterilizers		Flashlight		Retractor	
	Chlorine solution		Xylocaine or lignocaine		Intestinal forceps		Sharp trocars	
	Plastic buckets or containers for decontamination		Chlorine solution		Babcock forceps		Xylocaine or lignocaine	
	Clean instrument container		Plastic buckets or containers for decontamination		Nsv ringed forceps		Chlorine solution	
	Instrument trays		Clean instrument container		Scalpels		Mosquito forceps	
	Swab containers with sterile swabs or gauze		Instrument trays		Retractor		Babcock forceps	
	Examination couch or table		Swab containers with sterile swabs or gauze		Tubal hook		Nsv ringed forceps	
	Examination table capable of Trendelenburg		Examination couch or table		Sharp trocars		Tubal hook	
	Operation theater		Operation theater		Xylocaine or lignocaine		Examination table capable of Trendelenburg	
	Recovery room		Recovery room		Operation theater		Operation theater	
	Procedure area for IUD, injectables or implants.		Procedure area for IUD, injectables or implants.		Recovery room		Recovery room	