ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH

UTILIZATION OF LONG ACTING AND PERMANENT CONTRACEPTIVE METHODS AND ASSOCIATED FACTORS AMONG MARRIED WOMEN IN ADAMA TOWN, OROMIA REGION, CENTRAL ETHIOPIA: COMMUNITY BASED CROSS SECTIONAL STUDY.

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ABSTRACT

***Background*:** About 29% of couples in Ethiopia are not using any contraceptive methods to either space or limit childbirth. In addition long acting and permanent contraceptive method utilization is less than five percent.

Objective: Is to assess level of utilization of long acting and permanent contraceptive methods and associated factors among married women in Adama town.

Methodology: Community Based Cross Sectional Study complemented with Qualitative method was conducted in four kebeles of Adama town from April15-30, 2014. Multistage sampling technique was used to select participant for quantitative part where as purposive sampling was used for qualitative part of the study. Quantitative data was cleaned and entered using Epi info 3.5.3 and analyzed using statistical package for social science version 20.0. Open code version 3.6.2.0 was used to code qualitative data. Factors associated with utilization of long acting and permanent contraceptive method were identified using logistic regression model and content analysis was done for qualitative data.

***Result*:** Eighty seven percent of the respondents knew long acting and permanent contraceptive and 55% had positive attitude about it. Magnitude of long acting and permanent contraceptive method was 20.9% and the main reason for not using was fear of side effect (63.5%). Current use long acting and permanent contraceptive method was higher among women who have high knowledge (AOR=5.26, 95% CI=1.90-14.69) and positive attitude about the method (AOR=3.25, 95% CI=1.60-6.58). Participants need to have more children use this method less likely compared to those did not want to have more children. Those who gave birth to 3-4 used long acting and permanent contraceptive methods more likely than those who did not give birth. In qualitative part, discussants have expressed their concern of side effect though they had knowledge about this method.

Conclusion and recommendation: Current use of long acting and permanent contraceptive method in Adama town was low. The main reason for not using was fear of side effect. Main factors identified to affect use of this method were level of knowledge and attitude about long acting and permanent contraceptive methods. Targeted Information Education Communication Intervention should be intensified to improve utilization of this method.

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ACRONYMS AND ABBREVIATIONS

ACIPH	Addis Continental Institute of Public Health
BRDC	Birhan Research and Development Consultancy
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Agency
EDHS	Ethiopian Demographic Health Survey
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FP	Family Planning
HEW	Health Extension Workers
IDHS	Indonesia Demographic Health Survey
IUD	Intra Uterine Device
KAP	Knowledge, Attitude and Practice
LACMs	Long Acting Contraceptive Method
LAPCMs	Long Acting and Permanent Contraceptive Methods
MSI	Marie Stopes International
NPC	National Population Commission
OCs	Oral Contraceptives
PMs	Permanent Methods
SNNP	Southern Nation Nationality and Peoples
TFR	Total Fertility Rate
USAID	United State agency for International Development
WHO	World Health Organization

1. INTRODUCTION

1.1.Background

Family planning is a means by which individuals or couples space pregnancy and childbirth at intervals, mutually determined by both husband and wife in order to have desired number of children (1).

Four contraceptive methods are categorized as Long Acting and Permanent Contraceptive Methods: Intra Uterine Devices (IUDs or IUCDs), Implants, Tubal ligation, and Vasectomy. IUDs and Implants are long-acting temporary methods; when removed, return to fertility is prompt. Copper-containing IUDs, the ones generally available in African Ministry of Health (MOH) family planning programs, are effective for up to 12 years. Implants, depending on the type, last for up to 3–5 years. Tubal ligation and Vasectomy are permanent methods (2, 3).

LAPCMs have clear advantages over short-acting methods of contraception that benefit both clients and health systems (4). It increase the contraceptive method options that couples have, especially as their need evolve over time and is best choice for couples both to space and limit childbirth and is the best way to protect women and couples against unwanted pregnancies.

Over time, the use of Long acting and permanent contraceptive methods has not kept in pace with that of short-acting methods, such as oral contraceptives and injectables (5). Surveys from four Sub-Saharan countries show that the proportion of women currently using LAPCMs is significantly lower than the proportion using short-acting methods, which accounts for less than five percent (6). Like other Sub-Saharan countries, Long Acting and Permanent contraceptive Methods use have lowest rates in Ethiopia (4.2%) for which IUD, Implant and Female sterilization contribute 0.3%,3.4% and 0.5% respectively (7, 8).

The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has had tremendous lifesaving benefits (9). Despite this, approximately 25 percent of Sub-Saharan African couples and 25% of Ethiopian couples, who need to space or limit births, are not using any form of modern contraception (7, 8).

Therefore, the aim of this study was to assess utilization of LAPCMs and factors associated with it.

1.2. Statement of the problem

In many, Sub-Saharan African countries, Long Acting and Permanent Contraceptive Methods practice have lowest rates and is sometimes missing component of national family planning programs (10). In Ethiopia, the Contraceptive Prevalence Rate (CPR) at national level is 28.6%; where LAPMs contribute only 4.2%. Implant 3.4%, IUD 0.3% and female sterilization 0.5%. Unmet need for family planning is 25% and 30% for Ethiopia and Oromia Regional State respectively. Total fertility rate is 4.8 nationally and 5.6 in Oromia Region (8, 11).

Many potential clients lack information about LAPMs or have misconceptions about the methods (10). Even in countries where most people know about family planning, fewer people know of the IUD and vasectomy than know of other methods. Myths and misconceptions are also widespread for these methods (10).

The Federal Ministry of Health (FMoH) has been giving increased attention for expansion of long-acting and permanent contraceptive methods. To achieve this, ministry has practiced the task shift, which enabled the Health Extension Workers to provide Implanon at community level (12) and the scale-up of Intrauterine Contraceptive Devices was initiated in more than 100 district hospitals and permanent contraceptive method at selected health center and hospital (12). However, The CPR is highly dependent on short-term family planning methods with low utilization of LAPMs and unmet need for family planning is still high for spacing births (16%) and limiting (9%) (8).

Addressing the huge unmet need observed in the past decade is one area of critical intervention identified in the Health Sector Development Programme as well as in the reproductive health strategy of the country (12).

This low utilization of LAPCMs has its own impact for the nation to attain the millennium development goal regarding to universal access to reproductive health service, reduction of infant mortality and maternal mortality especially in oromia region where CPR is less than national level and Total Fertility Rate is above the national level. In addition to this there was no research conducted in this region regarding to utilization of LAPCMs rather different studies were conducted on demand of LAPCMs. Therefore, the main objective of this research is to assess utilization of LAPCMs and associated factors with it.

1.3. Significance of the study

The outcome of this study will help family planning programmes of Oromia Regional State to formulate viable programme options that will guide interventions at various levels to increase utilization of LAPCMs.

It enables Oromia Health Bureau and the Adama town Health Office to evaluate their progress in coverage of LAPCMs and to focus on alleviating factors affecting LAPCMs practice.

It will also help the Woreda Health Officers and health professionals at different levels to realize and conceptualize factors associated with utilization of LAPCMs specially reasons for non-users and intervene it.

2. OBJECTIVES

2.1. General objective

To assess Level of utilization of long acting and permanent contraceptive methods and associated factors among married women aged 15-49 years in Adama town, East Shawa Zone, Oromia Regional State, Ethiopia, April 2014.

2.1.1 Specific objectives

- To assess level of LAPCMs utilization among married women aged 15- 49 years in Adama town.
- To assess factors associated with the utilization of LAPCMs among married women aged 15- 49 years in Adama town.

3. LITERATURE REVIEW

3.1. Introduction

Programmes to promote family planning in developing countries began in 1960s, in response to large improvements in child survival, which in turn led to rapid population growth due to high fertility rate compared to developed country (13). It was during 1966, that FGAEs (Family guidance association of Ethiopia) pioneers modern FP service in Ethiopia. Following Ethiopia's adoption of a Population Policy in 1993, local and international institutions collaborated with the government in expanding FP programs and services (14).

Four contraceptive methods are categorized as long acting or permanent contraceptive methods; these are Intra Uterine Devices (IUDs), Implants, Tubal ligation, and Vasectomy. IUDs and implants are long-acting reversible methods; when removed, return to fertility is prompt. Copper-containing IUDs, the ones generally available in African family planning programs, are effective for at least 12 years. Implant, depending on the type, is effective for up to 3-5 years (3).

3.2. Utilization of modern contraceptives and LAPCMs

Worldwide the most widely used contraceptive method is sterilization and IUD which accounts for 34% and 26% of all contraceptive method (15). In china use of this method account for 41% and 36% for sterilization and IUD respectively (16).

Study done in Pakistan, revealed that**,** 48.2 % and 51.8 % of the respondents reported using hormonal methods and using non-hormonal methods respectively. The most preferred hormonal method was Norplant (41.0%) followed by injectables (36.0%) and pills (23.0%). Non-hormonal users were copper T (35.0%) and condoms (17.0%) followed tubal ligation (47.5 %) (7). However, the finding from Zimbabwe showed that**,** none of the respondents was using permanent method of contraception whilst condom was used by 17% of the respondents. The main long acting contraceptives, the Implant and intrauterine were used by 4% of the respondents (17). This wide gap is due to the evidence that, IUD use is much more common in Southeast Asia and condom use is most prevalent in Sub Saharan Africa, most likely in part because of the high levels of concern about HIV in that region (18).

However, Contraceptive Prevalence Rate of Ethiopia was 28.6% and that of Oromia was 24.6%. Contribution of LAPCMs is low compared to other modern contraceptive method to national

CPR, which accounts for less than five percent in Sub Saharan Africa and Ethiopia (8, 19). Survey on KAP of family planning held in four regions: Amhara, oromia, Tigray and SNNP revealed current use modern contraceptive method among respondent was 17 % in Tigray and 18% in Amhara region, 21 % in oromia and 14% in SNNP respectively (20).

Recent finding from study done in Tigray, Mekelle town showed that the level of long acting and permanent contraceptive methods utilization was 12.3%. The most preferred LAPCMs was Implants (87%) followed by IUCD (13%) and the prevalence of Implants and IUCD users was 10.6 and 1.5% respectively. There were no married women underwent female sterilization (21). Other studies in Ethiopia revealed low utilization of LAPCMs. For example, studies in Debra Markos and Adigrat showed that the use of LAPCMs was only 19.5% for each (22, 23).

Study done in Central Ethiopia, Butta jira district shows that majority of the respondents had ever used one of the contraceptive methods. The most favorite ones were Injectables (42.2%) followed by pills (24.7%) (24). Other similar study done in, Oromia Region, Bale Goba town showed that, 18% of the respondents had ever used LAPMs. The ever used LAPCMs were Norplant (12.8%), IUD (5.0%) and Tubal ligation (0.7%), which shows better practice in this area, compared to study done in Tigray (25).

3.3. Knowledge and attitude of married women about Long acting and permanent contraceptive method

In Uganda, study revealed that knowledge of contraceptive methods was almost universal; with 96.2% mentioning at least one method. The most known method was Injectables (85.2%), followed with oral pills, IUD, and male condoms but that of PMs was very low (26). This finding was similar with study in SNNP where 99% of married women knew at least one contraceptive method (27).

Cross-sectional study conducted in Pakistan, showed that, Majority of the women (68%) had knowledge of Tubal ligation as permanent method of contraception. Only 22% women had knowledge of Vasectomy as permanent method of contraception in men. Majority of the women received information about family planning from health professionals and family members (28).

In Ethiopia, study done in Mekelle town revealed that, 63.9% had heard about LAPMs in general, out of this, 80.7%, 55.3% and 39.8% had heard about implants, IUCD and Female sterilization, respectively. Only 15.6% of the married women heard about Vasectomy and 23.8% named more

than two contraceptive (21). In East Shawa, Batu Town revealed, majority (58.3%) had some general knowledge about LAPMs. The most known method was Implants (94%), followed by IUCD (49.6%) and the least known methods were Tubal legation and Vasectomy. Majority of them (90.9%) could mention at least two LAPMs (29).

In Pakistan study revealed that, Majority 65% of them believe that contraception is prohibited by religion followed by 35% of them believe that it is permitted by religion. More than half i.e. 57% of the women thought that contraceptive use affects their health considerably (28). In east shawa Batu, respondents had mentioned their concern related side effect of LAPCMs as : weight gain, hypertension, anemia, infertility , bad smell of vagina, uterine mass, headache, discomfort during sexual inter course and disappearance of IUCD during removal (29). In Mekelle, Only 15.5% and 26.8% married women agreed that implant could result in irregular bleeding (15.5%) and cause severe pain during insertion and removal (26.8%). Others (29.7%) of the married women agreed that insertion of IUCD could result in shame while it inserted to cervix by health professional. In addition, majority 96% of the married women believe that, IUCD prevents from doing normal activities and 34.4% agreed that undergoing an operation for female sterilization was dangerous (21)

Qualitative descriptive research in Ghana showed that, participant, had misperceptions as IUD goes to other body part, cause infertility and interfere with sexual inter course. According to this study, 35% of care providers said their clients reported that, implant move through the body. Twenty five percent of them concerned that, duration is too long. Fifty percent agree of their clients reported that, if they use tubal ligation their husband will leave them (30).

3.4. Factors associated with the utilization of modern contraceptive method

In Nigeria, studies revealed that, access to contraceptive supplies and services continues to be a barrier to use, particularly in low-income areas. In addition to this, level of education, knowledge of family planning, confidential counseling, cultural beliefs, partner's opposition, spouse communication and source of information influence utilization of contraceptive method. (31-33).

Study conducted in Jimma Zone revealed: discussion of couples, spouse approval and history of previous child death, were known to affect FP utilization (34) . Other finding from study conducted in Hexosa, Arsi zone showed attitude and age are associated with contraception use (35). Highest abstinence, opposition of husbands, religious prohibition, fear of side effects,

number of children are pointed out as factors for nonuser of family planning by Abebe G and N. Regassa in Mojo town (36).

3.5. Factors associated with use of LAPCMs among married women

Researchers had cited a number of factors associated with use of long acting and permanent contraceptive method. Study conducted in Malaysia shows that, LAPMs use is surrounded by fear, misperception about modern contraceptive method like IUD that it had side effects on the healthy (37).

In Bangladesh, Low level of knowledge surrounding method specific side effects is worrisome, especially considering providers' current attitudes towards other FP issues. For example, about half of respondents feel that IUDs and implants have "too many or too adverse side effects," and about a third felt this way about Tubal ligation (38). A vast majority of providers feel that wives should not use a method if the husband does not agree with it and that husbands prefer OCs and condoms to long-acting methods. Similar to this in Nigeria study revealed that, 24.7% of married women were not using LAPCMs due fear of side effect (39).

Regarding to Tubal ligation, study conducted in Pakistan , showed that, age <30 years, illiteracy, duration of marriage <10 years, age of last child > 1 year, number of children < 3 and means of information like health worker and electronic media were known to affect utilization of sterilization (40). In Eastern Nigeria revealed that, high use of Norplant was seen among high parity women, age 30-34 years but when compared to IUD users Norplant users were significantly less educated in which less than one percent of Norplant users had tertiary education compared to 25% of IUD users (41). Similar to this, in Indonesia, women aged, 30-39, having 3-4 children, with educated husband were more likely to use long-term contraception (42).

In Ethiopia study conducted in Mekelle town showed that, level of knowledge, number of parity and age at marriage were positively associated with use of LAPMs among married women in which, women who had moderate knowledge were 6 times more likely to use LAPM as compared with those who had low knowledge. Mothers who had high knowledge were 8 times more likely to use LAPM as compared with those who had low knowledge. Mothers with two or more pregnancies were 3 times more likely to use LAPM as compared with those who had been pregnant only once (21).

Other study done in Ethiopia which indicates that married women with positive attitude about FP methods were more likely to use contraceptive method compared to their counterparts (43).

In addition to these factors, religion is one of the factors that affect utilization of modern contraceptive method. For example, Muslim married women had 30% lesser odds of using LAPCMs than their Christian counterparts (44). However, study done in Dembia district, North West Ethiopia revealed that, orthodox Christian was less likely to use contraceptive methods than others were (45).

Generally, articles, journals and different reports have been reviewed related to the topic or problem under study. Review was done on different topics: prevalence, knowledge, attitude, practice and associated factors with the use of modern family planning, long acting and permanent modern contraceptive method at global, regional and national level. According to this review, many literatures showed that married women had high knowledge towards LAPMs. However, they have less practice for LAPMs, which is less than five percent for Sub-Saharan African countries. Regarding to their attitude, married women had negative attitude towards LAPMs.

Utilization of LAPMs is low compared to other modern contraceptive methods in which different studies revealed CPR of less than ten percent in many Sub Saharan countries. Although there was an improvement of CPR in Ethiopia from year to year, utilization of LAPCMs remained low. This low utilization of LAPCMs in national CPR has its own impact for the nation to attain the millennium development goal regarding to universal access to reproductive health service, reduction of infant mortality and maternal mortality. In addition to this CPR in oromia region is less than national level and Total Fertility Rate is above the national level. Despite this research was not conducted in this region regarding to utilization of LAPCMs rather different studies were conducted on demand of LAPCMs.

3.6. Conceptual framework

A number of variables, independent variables, were used to examine factors influencing utilization of long acting and permanent contraceptive method.

The independent variables, which influence utilization of LAPCMs of the study population, were subdivided into socio demographic variables, reproductive history, and knowledge level, attitude status, fear of side effect, religious prohibition, spousal communication, myths and misperception

and media exposure. Independent variables were assumed to affect utilization of LAPCMs in the way they are ordered in the below conceptual framework.

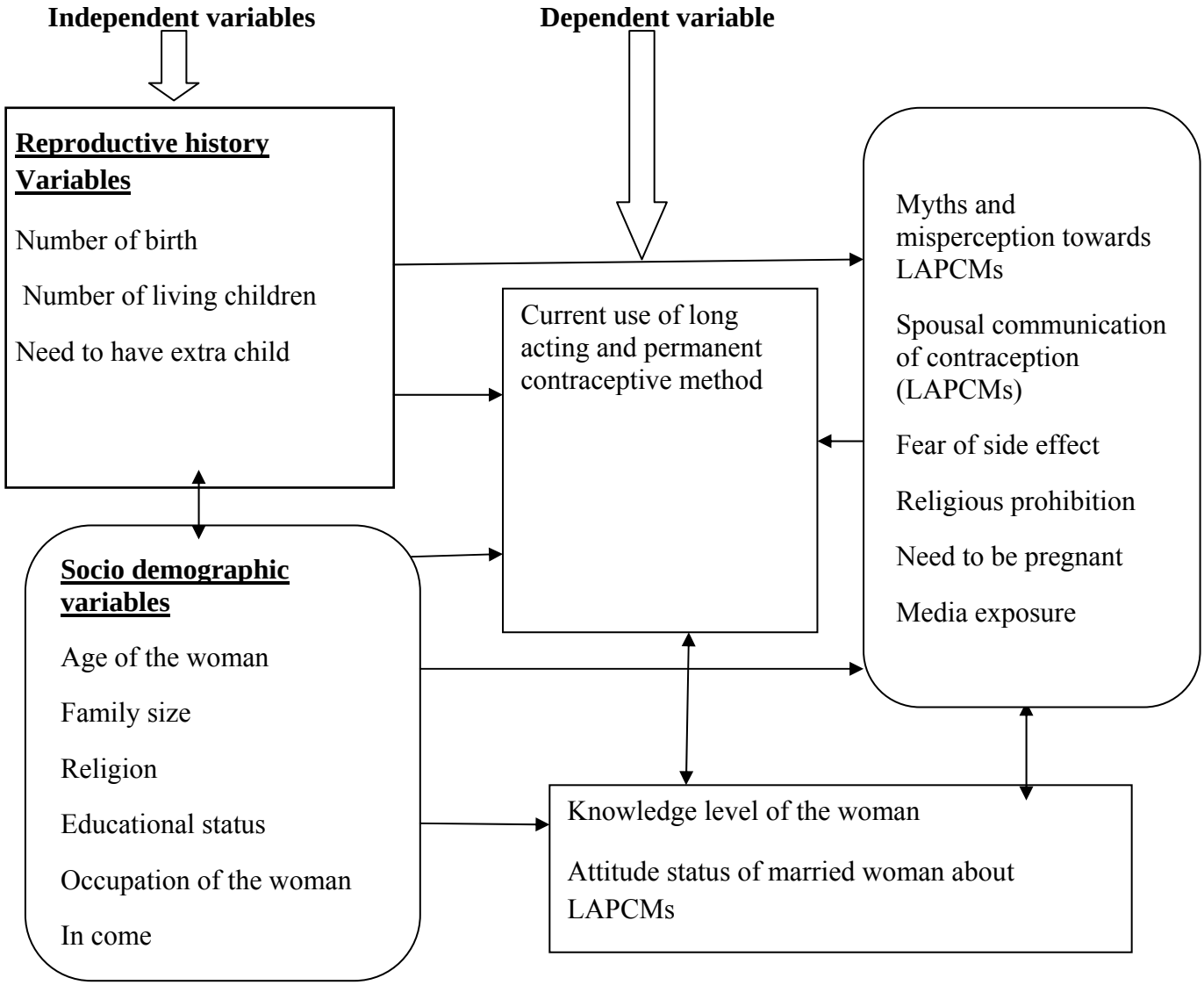

Figure 1: Conceptual framework for factors associated with utilization of LAPCMs

4. METHODOLOGY

4.1. Study area: This study was conducted in Adama town**.** It is located to the east of Addis Ababa at the distance of 99km. According to 2007 Census conducted by the Central Statistical Agency of Ethiopia (CSA), the city has a total population of 220,212. 60,174 households were counted in the city, which results in an average of 3.66 persons to a household, and 59,431 housing units (46). Adama town has one government hospital, three private hospitals; six government health centers, one private clinic, one maternal health clinic (Marie stops), one Adolescent and Youth SRH clinic (FGAE) and 72 drug shops. From this health institutions FP service is being delivered in all hospitals, health centers, FGAE and Marie Stops clinics (47).

4.2. Study period: The study was conducted from April 15 -30 2014.

4.3. Study design: Community based cross sectional survey complemented by qualitative FGDs was conducted to assess utilization of LAPCMs and associated factors among married women aged 15-49 in Adama town.

4.4. Source population: Source population was all married women aged 15-49 years in Adama town.

4.5. Study subject: Study subject was sampled married reproductive age (15-49) women from Adama town.

4.6. Sample size determination

Sample size was determined using the following assumptions to estimate sample size of single population proportion.

$$n_o = \frac{(Z\alpha/2)^2 P (1 - P)}{d^2}$$

Assumptions:

Desired precision (d) = 5%

Proportion of long acting and permanent contraceptive method clients from previous study done in Adigrat and Debre Markos town was 19.5% each (22, 23).

Confidence level = 95%, which means α set at 0.05 and Zα/2 = 1.96 (value of Z at α 0.05 or critical value for normal distribution at 95% CI (21).

Based on this formula desired sample size will be

$$n_o = \frac{(Z\alpha/2)^2 P (1 - P)}{d^2}$$

$$n_o = \frac{(1.96)^2 0.195(1 - 0.195)}{(0.05)^2}$$

$$= 241$$

By using design affect of two and multiply it by the above number '241', it gives us 482. Hence, the calculated sample size is 482. Adding a 10 % non-response rate gives the required minimum sample size (n) 530.

4.7. Sampling procedures

A multi-stage sampling technique was used to select the study participant by considering a design effect of two. The town has 14 kebeles. Out of this four kebele was selected using simple random sampling. Each kebele contributed the sample size proportion to size. Then picking a house on random for the initial household from each randomly selected kebele zones, the final households with married women was selected on systematic random sampling from the households. For selecting, the individual participant different sampling interval was used for each selected zones.

Eligible married woman from each selected household was interviewed and only one woman was interviewed for households having two or more married women on random to avoid intra-class correlation (21). In the absence of married women in sampled household, interviewer jumped to the next house.

For qualitative part: Four FGDs (Focus Group Discussion) were conducted in four kebeles until the saturation of information was reached. Purposive sampling strategy was used to select individuals for the study. The number of participants in each FGD was eight; homogeneity of group members was the main criteria for selection. Participants of the FGDs were permanent residents of the town (live in the town for more than 6 months) and their selection was by investigator in collaboration with health extension workers.

4.8. Inclusion and exclusion criteria

Married woman of reproductive age group (15-49); Women lived in the town for more than six months both for quantitative and qualitative study. Married men lived in the town for more than 6 months was included for FGDs. Those married women who were widowed, divorced, age less than 15 years, above 49 and those live in the town for less than 6 month were excluded from the survey.

4.9. Data collection and questionnaire

Structured interviewer administered questionnaire was used. Questionnaire was adopted from similar studies done in Mekelle and Adigrat town (21, 23). It was modified based on the situation of the study to collect information on utilization of long acting and permanent contraceptive method and associated factors from married women in Adama town. Questionnaire was prepared in English, translated in to Amharic language by native speakers of the languages and translated back to English by other person in order to check its consistency.

Questionnaire had socio demography, reproductive history, knowledge, attitude and practice of modern contraception sections. The questionnaire was also pretested before actual data collection among 28 respondents, five percent of the calculated minimum sample size (530), in kebele 8 of Adama town. It was needed to decide the number of data collectors, to know time needed for interview and to test the questions. This kebele was preferred for pretest because of the fact that it has more or less similar characteristics with the selected kebeles for the study.

Participants were interviewed, where they were free to express their idea freely. Moreover, in occasions when the sampled women was not be accessed for absence, up to two attempts was endeavored for interviewing to lessen the non-response rate.

During data collection, one supervisor was selected to supervise the data collectors. He was checking the completeness of questionnaire and data collectors approach during data collection. Five Health Extension Workers were selected as data collectors based on their ability in Afaan Oromoo and Amharic languages. They have been trained for one day on method of data collection by the principal investigator and they have been informed about how to approach the respondents, how to apply the designed data collection method, how to ask each of the questions; follow the instructions of the questionnaire and to keep the confidentiality of the respondents.

For qualitative part: Focus Group Discussion was used to explore ideas of male partners and married women on LAPCMs for triangulation with the quantitative study. During the FGDs, participants were informed about the purpose and process of the FGD to obtain the informed consent of each participant. Two persons were assigned for note taking and tape recording while the principal investigator was facilitating the discussion. Two FGD for male and two FGDs for women were conducted separately, consisting of eight participants each. Some of the issues raised on FGDs were the understanding of LACPMs and perception of LACMPs. Finally, the recorded discussions and notes were transcribed into English manually.

4.10. Variables

4.10.1. Independent variables

Socio demographic characteristics- Age, religion, family size, occupation, educational status, income and residence of the respondent.

Reproductive history- Number of living children, number of birth and need of extra children and other independent variables such as Knowledge of LAPCMs, attitude about LAPCMs, religious prohibition, fear of side effects, need to be pregnant, spousal approval and spousal communication about contraception.

4.10.2. Dependent variable

Current use of long acting and permanent contraceptive method among married women in Adama town.

4.11. Data processing and analysis

Collected quantitative data was cleaned and entered using Epi info version 3.5.3 and analyzed using SPSS version 20.0.

Respondent's attitude was measured as positive attitude and negative attitude. To do this ten attitude questions was considered in which those who answered as 'agree' got three point, 'not sure' two point and 'disagree' one point for each questions. Attitude questions were scored out of 30. Those who have scored above mean was grouped as positive attitude and mean or below mean will be grouped as negative attitude (21).

Married women's knowledge was measured by the total number of correct answers to 10 items on knowledge with a minimum score of '0' and maximum of '10'. Measure of the knowledge was categorized based on the percent of knowledge of the distinct characteristics of LAMCPs as "high" - those who knew 80% and above, "moderate" those who know 60 - 79% and "low" those who knew less than 60% (21)

Then, descriptive statistics and logistic regression (binary and multiple) analyses was used determine the effect of factor(s) on the outcome variable and to control possible confounders. P-value < 0.2 was considered to show statistical significance. Factors found to have a p-value <0.2 in the binary logistic regression was entered into the multivariate analysis to identify their independent effects. Odds ratio from logistic regression was used to identify their association with current use of long acting and permanent contraception.

For qualitative data: Data from the Focus Group Discussion was transcribed; in the language of the interview and translated in to English for analysis. Transcription was made word for word from the audio tapes. Correctness of transcription was checked for some part of the audio tapes. English transcripts were re-read to develop codes. The main developed themes were awareness/understanding of LAPCMs and myths and misperception related to LAPCMs. An "Open Code" computer program was used to organize coding. Then various codes were compared based on differences and similarities and sorted in categories. Finally, based on content analysis, the underlying meaning; that is the hidden content of the categories was formulated in to a theme. Finally, quotes that could explain the context of LAPCMs were identified and presented in the respondent's own word to give more insight into community's perceptions and beliefs (48).

4.12. Operational definition

Utilization of LAPCMs: Is practice or use of long acting and permanent contraceptive method.

Long acting and permanent contraceptive method: Four contraceptive methods are categorized as long acting and permanent: Intra Uterine Devices (IUDs or IUCDs), Implants, Female sterilization, and Vasectomy. IUDs and Implants are long-acting temporary methods; when removed, return to fertility is prompt. Copper-containing IUDs, the ones generally available in African Ministry of Health (MOH) family planning programs which is effective for up to 12 years. Implants, last for up to 3–5 years. On the other hand Tubal ligation and Vasectomy, are permanent methods (2).

Modern contraceptive method: This method includes Pills, Injectable, Condom and IUDs, Implant and Sterilization methods.

Married women: Are those married women in stable sexual union no matter whether the marriage was legal or not.

Reproductive age women: This includes women of aged 15-49 years.

Attitude of LAPCMs: Refers to one's own opinion, belief and perception about LAPCMs. In this study, attitude of the respondent was measured by attitude statements like: using Implant do not lead to abnormal bleeding, Implant and IUD do not move/escape in the body after insertion and using LAPCMs do not lead to abnormal bleeding. It was labeled as positive and negative attitude where those who have scored above mean of attitude questions was grouped as positive attitude and mean or below mean was grouped as negative attitude (21).

Knowledge of LAPCMs: Refers to one's own awareness and familiarity with LAPCMs. Ten knowledge questions were used to grade the knowledge of LAPCMs. It was graded as low knowledge; those who have answered less than 60% of knowledge question; Moderate knowledge: those who have answered 60%-79% of knowledge question; High knowledge: those who have answered above or 80% of knowledge question (21).

4.13. Data quality management

To maintain the quality of the data, structured interviewer administered questionnaire was used to collect information. Before the actual data collection, pre test had been conducted in kebele 8 of Adama town, which has similar characteristics with the study area. During data collection, data collectors were trained for one day and they have been informed about how to approach to the respondents, how to apply the designed data collection method, how to ask each of the questions, follow the instructions of the questionnaire and to keep the confidentiality of the respondents. One supervisor was assigned to check completeness of the questionnaire every night with principal investigator. During analysis, quantitative data was cleaned and entered using Epi info version 3.5.3 and analyzed using SPSS version 20.0.

For qualitative study, Focus Group Discussion was used to explore ideas of married men and women. Discussion was separated for male and female and there was one note taker, one tape recorder and one facilitator for each session. After discussion, notes have been read and

transcribed in to English for the purpose of analysis and Open code soft ware was used to facilitate coding.

4.14. Ethical consideration

Ethical clearance was obtained from Addis Ababa University, School of Public Health ethical committee. Permission for conducting the study was secured from the Oromia Regional Health bureau. Then official letter was written to Adama Health Bureau. Consent was obtained from all the study participants after they had briefed about the objectives and the aim of the research. Confidentiality of the information gathered was assured to the interviewee.

4.15. Dissemination of the result

Finally, report of this study will be presented for Addis Ababa University School of Public Health. The finding of the study will be also submitted to Oromia Health Bureau and Adama Health Office. In addition, it will be presented for the responsible body like program managers and health professionals in the region.

5. RESULTS

5.1. Socio demographic characteristics of the respondents

Five hundred twenty six married women were interviewed in quantitative part with the response rate of 99.25%. The mean age of the respondent was 29 years (±SD 6.31) majority of which belong to the age group 25-34 [297(56.5%)] and many of the participants were Oromo 220(41.8%) in ethnicity (data not shown in the table). More than half of the respondents were Orthodox 297 (56.5%) in religion. Most of the married women interviewed were educated (92.2%) where as by occupation 127 (51.5%) of the participant were housewife. The mean family size of the respondent was four (3.9 ±SD) majority of which have the family sizes of 2-3 (46.8%) (Table 1).

Table 1: Socio demographic characteristics of study participant, Adama town, April 2014

s.n	Socio demography	frequency	Percentage
1	Age		
	15-24	128	24.3
	25-34	297	56.5
	35-44	87	16.5
	>45	14	2.7
2	Religion		
	Orthodox	297	56.5
	Muslim	130	24.7
	Protestant	99	16.9
	Others*	10	1.9
4	Educational status		
	No education	49	9.3
	Only read and write	30	5.7
	Elementary(1-8)	161	30.6
	Secondary (9-10)	107	20.3
	Senior secondary (11-12)	66	12.5
	Diploma and above	113	21.5
5	Family size		
	2-3	246	46.8
	4-5	213	40.5
	>5	67	12.7

Others*: catholic and Adventist; others**: Wolayita, Silte and Hadiya

Four Focus Group Discussions were conducted in four kebeles. Two married women and two married men FGDs each of which contain eight individuals. In this FGDs, 16 married women and 16 married men was participated. The mean age of discussant was 30.75(±SD 7.23). Majority of the respondents were orthodox (66.7%) followed by protestant (25%) and Muslim (8.3%). Forty one point seven percent (41.7%) of discussant had one child followed by two children (33.3%), three children (16.7%) and 4 children (8.3%).

5.2. Reproductive history of the participants

Majority of the respondents gave birth to 1-2 (65.1%) and 293(67.4%) had living children of 1-2. Median number of birth was (± SD 2.0). Thirty four point seven percent (34.7%) of the respondents did not need to have more children and 54.3% of the participants need to have 1-2 more children. From all participant, 234(44.6%) want to have child in the next two years and 55.4% did not want to have child in the next two years. Four hundred seventy three (90.1%) of participants discussed modern contraceptive method with their husband and 80% of respondents decide jointly with their partner on the number of the child they need where as 17% of the respondents reported that, number children they want to have is decided by Allah (table-2)

Table 2: Reproductive history of study participant, Adama town, April 2014

s.no	Reproductive history	Frequency	Percentage
1	Ever gave birth (n=526)		
	yes	435	82.7
	No	91	17.3
2	Number of birth (n=435)		
	1-2	283	65.1
	3-4	117	26.9
	>4	35	8
3	Number of living children (n=435)		
	0	2	0.5
	1-2	293	67.4
	3-4	110	25.3
	>4	30	6.9
4	Additional number of child they need (n=435)		
	0	151	34.7
	1-2	236	54.3
	>2	48	11
6	Discussion about modern contraception (n=526)		
	Yes	474	90.1
	No	52	9.9

5.3. Comprehensive knowledge of the participants about long acting and permanent contraceptive method

From the total respondents 512(97.3%) have heard at least one modern contraceptive methods. Ninety three point six percent, 99.2%, 84.6%, 25.4% and 14.8% of respondent have heard Pill, Injectables, Implant, Tubal ligation and Vasectomy as contraceptive method respectively. The major source of information about modern contraceptive method was, health profession 453(88.5%) followed by mass media 423(82.6%).

Eighty seven percent (87%) of the respondents knew about long acting and permanent contraceptive methods**,** for which **TV** was the major source (98.4%). Majority of them knew

that, IUD prevents pregnancy for more than 10 years and 66.3% knew that, IUD has no effect on the sexual desire. About 69% and 72.1% knew that, pregnancy is possible immediately after removal of IUD and implant respectively. Eighty seven percent of them had awareness of LAPCMs, that, it prevent unwanted pregnancy; 284(63.7%) respondents had awareness LAPCMs, that, it prevents possible child and maternal death; space childbirth (69.5%); limit family size (91%) and others (1.8%) reported the advantage of this method as it contributes for the economic development of the nation. Concerning level of knowledge, 46.8% of participant had high knowledge, 24.5% had moderate knowledge and 28.7% had low knowledge (table 4).

Table 3: knowledge of LAPCMs among study participant, Adama town, April 2014

s.n	Variables	Frequency	Percentage
1	Ever heard of modern contraceptive method (n=526)		
	Yes	512	97.3
	No	14	2.7
2	Type of contraceptive method known (n=512)		
	Pill	479	93.6
	Injectable	508	99.2
	Implant	433	84.6
	IUD	130	25.4
	Tubal ligation	76	14.8
	Vasectomy	368	71.9
	Condom	388	71.9
3	Source of information(n=512)		
	Friend, neighbor and relatives	137	26.8
	Husband	54	10.5
	Health professionals	453	88.5
	Mass media	423	82.6

*Each of the percentages does not add up to 100.00 because respondents could choose several responses, which could be spontaneous or prompted.

In qualitative study it was found, that majority of the discussants were aware of LAPCMs. Some of them mentioned that using long term methods avoid repeated visit of short-term methods and discontinuation due to memory lapse. However, they had misconception related to side effects like infertility, move through the body (Implant and IUD), decomposed and accumulated in the

body (Implant), bring about cancer (IUD), excessive bleeding (Implant), reduced sexual desire (Vasectomy and Tubal ligation).

On FGD participant said that, " I am not using these methods, but my friend said that, IUD and Implant has side effects like hypertension, excessive bleeding, heart problems and infertility". (Female, 45 years old, had 2Living children, Orthodox and Kebele 01). `

Other discussant said that, "I do not agree that female should use tubal ligation because if female under goes this procedure, the husband may need to have child with other woman and later lead to divorce. (Male, 42years old, had 3living children, Muslim and kebele 04).

Table 4 : knowledge level of study participant, Adama town, April 2014

	Knowledge variables (n=512)	**knowledge level**			
		True		False	
		Frequency	percent	frequency	Percent
1	IUD prevent pregnancy for >10 years	404	78.9	108	21.1
2	IUD is not good for women at risk of STI	246	48	266	52
3	IUD has no effect on sexual desire	349	68.2	163	31.8
4	Pregnancy is possible after removal of IUD	362	70.7	150	29.3
5	Implant prevent pregnancy for >5 years	423	82.6	89	17.4
6	Implant has no effect on sexual desire	409	79.9	103	20.1
7	Pregnancy is immediate after removal of implant	379	74	133	26
8	Vasectomy has no effect on sexual desire	205	40	307	60
9	Pregnancy is not possible after tubal ligation	312	60.9	200	39.1

5.4. Attitude of married women aged 15-49 years about LAPCMs in Adama town

Only 26% of the participant agreed that Implant do not bring about excessive bleeding. Fifty 59.6% of them perceived that insertion of IUD expose once own privacy and 82.3% perceived that IUD block ordinary activity. About 87% of the participant perceived that Implant move and escape in the body while most of them perceive that insertion and removal of Implant is pain full. Majority of the respondent belief that, it is health profession, who decide the method they use; while 51.8% perceived that it is spouse who can decide on the method choice. Concerning the respondent's general attitude status, 55.1% of the participant had positive attitude towards LAPCMs while the rest 44.9% had negative attitude (table 5).

On FGD participant said that, "my wife is using implant for which she is experiencing health problems like: loss of weight, head ache, irregular menstruation with excessive bleeding. As a result, she has asked the care providers to remove it but they refused her". (Male, 30 years old had 1 child, orthodox and kebele 04).

Other discussant said that, "I know my neighbor who was using IUD and up on removal she could not gave birth and finally became infertile. On the other hand, using long acting methods lead to expiration of fertility period if used at old age (since their time of service is too long). Vasectomy leads to reduced sexual desire, which in turn result in instability of the family". (Male, 40 years old, had 2 living children, orthodox, and kebele-12).

Table 5: Attitude of study participant about LAPCMs, Adama town, April 2014

s.n	**Perception statement(n=525)**	**Level of agreement**					
		Agree		Not sure		Disagree	
		frequency	Percent	frequency	percent	frequency	percent
1	Implant do not lead to bleeding	137	26.1	162	30.9	226	43
2	Insertion of IUD do not lead to lose of privacy	212	40.4	172	32.8	141	26.8
3	IUD do not move through the body	85	16.2	163	31	277	52.8
4	IUD do not prevent ordinary activity	93	17.7	134	25.5	298	56.8
5	IUD do not lead to excessive bleeding (n=524)	93	17.7	183	35	248	47.3
6	Operation of Tubal ligation is not dangerous	50	9.5	307	58.5	168	32
7	Insertion and removal of implant is painful	52	9.9	165	31.4	308	58.7
8	Implant do not move through the body	67	12.8	127	24.2	331	63
9	spouse cannot decide on wife's FPM choice	253	48.2	36	6.8	236	45
10	HP cannot decide on method choice of FP.	142	27	19	3.7	364	69.3

5.5. Utilization of Long acting and permanent contraceptive methods among married women aged 15-49 in Adama town

The ever use of modern contraceptive method in this study area was 87.1%. The most ever used method was Injectable (66.3%). Current modern contraceptive use was 59.9%. The most preferred method was Injectable 159(50.5%) and Implants 85(27%). The rest were using Pill 41(13%), IUD 24(7.6%), and Tubal ligation 1(0.3%). About 40.1% of the respondents were not using any modern contraceptive methods. Sixty three point five percent (63.5%) of them reported that, they were not using modern contraceptive method because of fear side effect (table 6, figure 2).

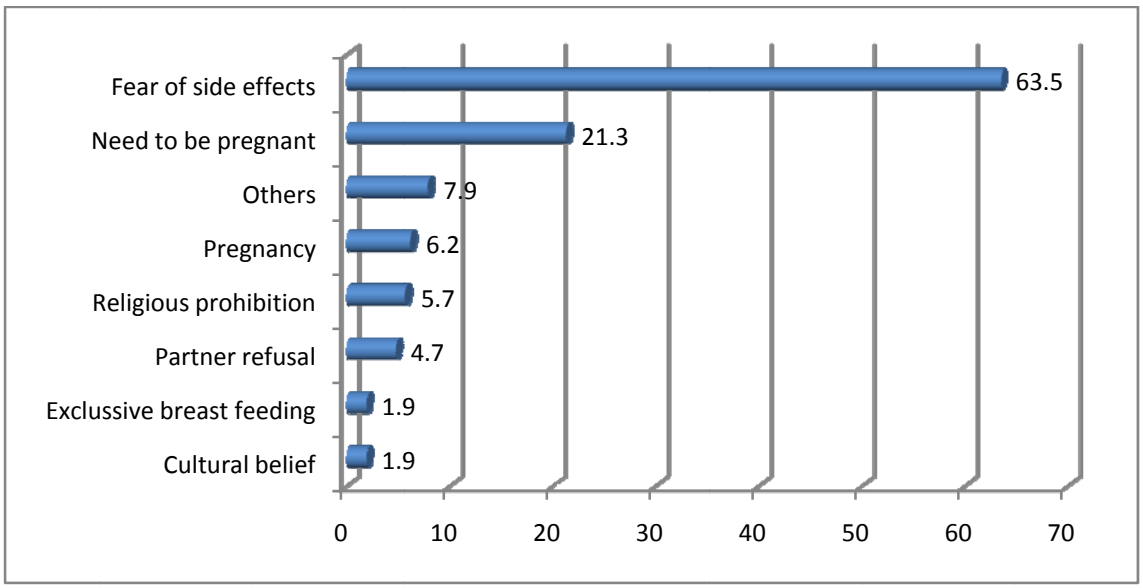

Figure 2 Reason for not using modern contraceptive method among study participants, Adama tow, April 2014

Over all prevalence of the LAPCMs was 20.9%. Majority of them use Implant (77.3%) and IUD (21.8%). The rest 0.9% used tubal ligation. Prevalence of Implant, IUD and Tubal ligation was 16.2%, 4.6% and 0.2% respectively. Health center was where majority of the users get the service (52.4%) while others get service from other government organization (16.2%), private clinic (19%) and others like Mariestops and FGAE (9.8%). One hundred eighty nine (41.3%) of all users have shifted one contraceptive to other method. Forty-eight participants (25.40%) shifted from Injectable to Implant, 22(11.64%) shifted Injectable to IUD and 12(9.0%) shifted from pill

to implant. The rest 12.66% of the participant shifted from short acting method to the other short acting method or from long acting to short acting method. This result revealed that many of the respondents were switching to long acting contraceptive methods.

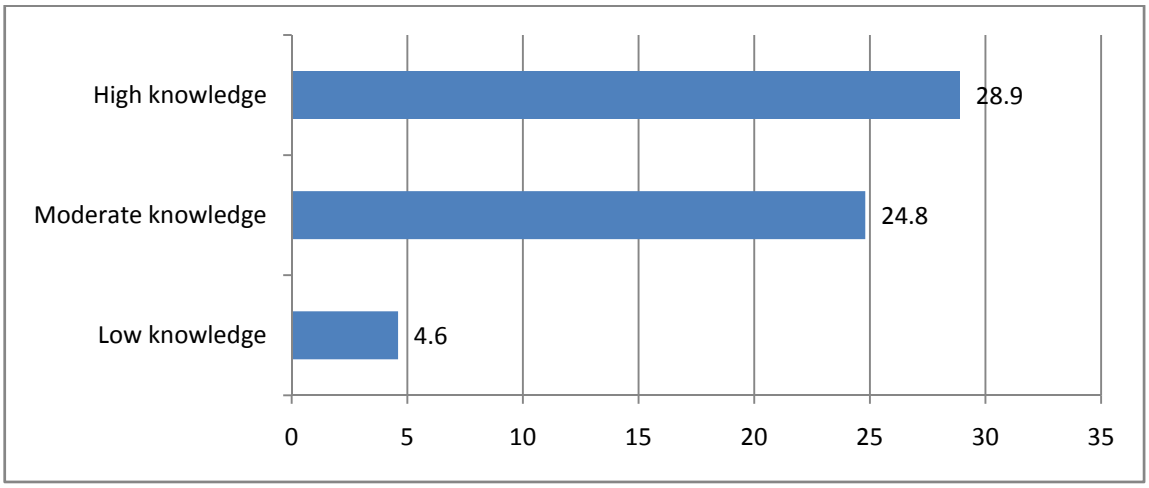

Figure 3: Current use of LAPCMs by knowledge level of study participant, Adama town, April 2014

There was low utilization of LAPCMs among married women who had no formal education (2%) and higher among diploma and above married women (28.3%). Current use of LAPCMs was also low among married women who did not give birth (4.4%). However, 37.6% and 25.7% of all married women in this study area who gave birth to 3-4 and >4 were using LAPCMs respectively.

On FGD participant said that, "it is good to use long acting method after having one or more children, because of infertility and accumulation of chemical of these methods in the body, which result in stunt and mentally retarded childbirth".

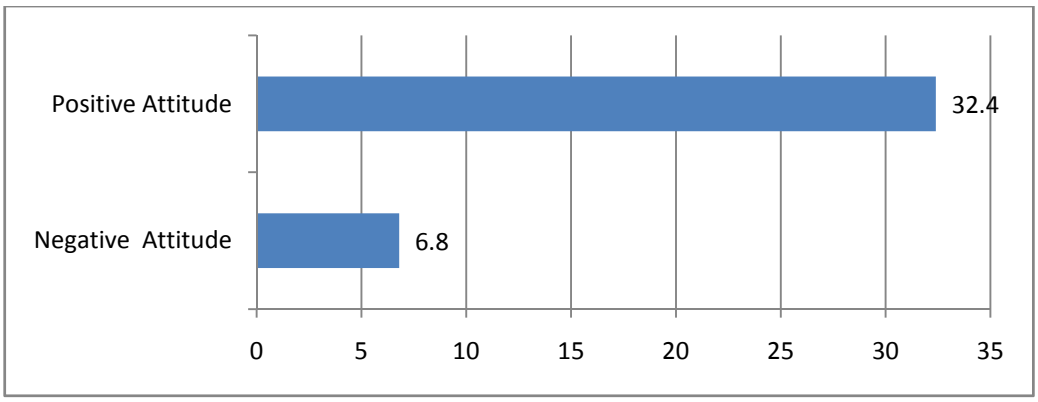

Figure 4: Current Use of LAPCMs by Attitude status of study participant, Adama town, April 2014

Current use of LAPCMs among those of low knowledge and negative attitude was, 4.6% and 6.8% respectively, but current use among those with high knowledge and positive attitude was found to be 28.9% and 32.4% respectively (figure 3 and 4).

Table 6: Utilization, reason for not using and service center of modern contraceptive methods of study participant, Adama town, April 2014

s.no	Variables	Frequency	Percentage
1	Current use of methods(n=315)		
	pill	41	13.0
	Injectables	159	50.5
	Implant	85	27.0
	IUD	24	7.6
	Tubal ligation	1	0.3
	Condom	5	1.6
3	Service center (n=315)		
	Health center	165	52.4
	Hospitals	51	16.2
	Private clinic	60	19.0
	Pharmacy	4	1.3
	HEW	3	1.0
	Relatives	1	0.3
	Others****	31	9.8

Others***: could not give birth, husband lives apart from women; others****: Mariestops and FGAE

5.6. Factors associated with utilization of Long acting and permanent contraceptive method among married women in Adama town

The results of bivariate analysis show that, some socio demographic characteristics, reproductive history, knowledge and attitude of the respondents were found to have association with current use of LAPCMs. Participant who had large family number use LAPCMs than those with small family size. Married women who had family of >5 use LAPCMs three times more likely compared to those who had family size of 2-3 (COR=2.61, 95% CI: 1.36-5.04,p value=0.004). Married women who had given birth to more than three children were found to use LAPCMs more likely than mothers who did not give birth. Participants who had high and moderate knowledge use LAPCMs 9 times (COR=8.60, 95% CI=3.80-19.45, p value=0.000) and seven times (COR=6.80, 95% CI: 2.86-16.17) more likely compared to those with low knowledge respectively. Respondents who had positive attitude use LAPCMs six times more likely compared to married women of negative attitude (COR=6.30, 95% CI= 3.55-11.18,p value=0.000). In addition to this, making discussion with partner about contraceptive method was positively associated with current use of LAPCMs. On the other hand, need to have more children was negatively associated with current use of LAPCMs. The above variables and other variables with the p value of less than 0.2 were taken to multivariate analysis to see their in dependent effect on current use of LAPCMs in Adama town.

The result of multivariate analysis revealed that, knowledge level was one of the predictors of current use of LAPCMs. Married women with high knowledge use LAPCMs 5 times more likely than those with low knowledge (AOR=5.26, 95%CI=1.90-14.69, p value= 0.002), and those with moderate knowledge use 3 times more likely compared to those with low knowledge (AOR=3.27, 95% CI=1.12-9.52, p=0.03). Attitude of the respondent was also known to predict the current use of LAPCMs in which those who had positive attitude about LAPCMs use the method 3 times more likely compared to those who had negative attitude AOR=3.25,95% CI=1.60-6.58, P=0.001).

In this model married women who gave birth to 3-4 children use LAPCMs 2 times more likely compared to those who had given birth to 1-2 (2.30,95% CI=1.14-4.63, p value=0.02). Participants need to have 1-2 more children had 67% lesser odds of using LAPCMs compared to participant who didn't need any more children (AOR=0.33, 95=0.16-0.66,p value=0.002).

Table 7: Multivariate and Bivariate analysis of selected variables affecting utilization of LAPCMs among married women aged 15-49 years, Adama town, April 2014

Variables	Total	Utilization of LAPCMs			
		Yes	No	COR,(95% CI), P-value	AOR,(95 CI), p-value
Age of the married women					
15-24	66	9(13.6)	57(86.4)	1.0(ref)	
25-34	269	64(23.8)	205(76.2)	2,(0.93-4.22),0.08	1.43,(0.57-3.60),0.45
35-44	87	33(37.9)	54(62.1)	3.87,(1.70-8.84),0.001	1.60,(0.51-5.00),0.42
>45	13	2(15.4)	11(84.6)	1.15,(0.22-6.07),0.87	1.13,(0.14-9.13),0.91
Occupation of women					
Housewife	235	53(22.6)	182(77.4)	1.0(ref)	
Gov't employee	76	26(34.2)	120(78.9)	1.79,(1.02-3.14),0.04	0.90,(0.42-1.94),0.79
Daily labourer	39	4(10.3)	35(89.7)	0.4(0.13-1.15),0.09	0.34,(0.10-1.16),0.08
Merchant	53	14(26.4)	39(73.6)	1.24,(0.62-2.44),0.5	0.84(0.36-1.94),0.68
Student	18	4(22.2)	14(77.8)	0.98,(0.3-3.10),0.97	0.76(0.18-3.18),0.70
NG0s	14	7(50)	7(50)	3.43,(1.15-10.22),0.03	4,(1.04-16.20),0.04
No of birth					
1-2	283	53(19.4)	230(80.6)	1.0(ref)	
3-4	117	44(37.6)	73(62.4)	2.5,(1.55-4.02),0.000	2.30,(1.14-4.63),0.02
>4	35	9(25.7)	26(74.3)	1.44,(0.64-3.24),0.38	1.43,(0.35-5.92),0.62
Knowledge level					
Low knowledge	123	7(5.7)	144(94.3)	1.0(ref)	
High knowledge	202	69(34.2)	133(65.8)	8.60,(3.8-19.45),0.000	5.26,(1.90-14.62),0.002
Moderate knowledge	110	32(29.1)	78(70.9)	6.80,(2.86-16.17),0.000	3.27(1.12-9.52),0.03
Attitude status					
Negative attitude	187	16(8.6)	171(91.4)	1.0(ref)	
Positive attitude	248	92(37.1)	156(62.9)	6.30,(3.55-11.18),0.000	3.25,(1.60-6.58),0.000
Number of child they wanted					
0	151	59(39.1)	92(60.9)	1.0(ref)	
1-2	236	40(16.9)	196(83.1)	0.32,(0.20-0.50),0.000	0.33,(0.16-0.66),0.002
>2	48	9(18.8)	39(81.2)	0.36,(0.16-0.80),0.01	0.50,(0.17-1.48),0.2

6. DISCUSSIONS

Magnitude of current use of LAPCMs in this study was 20.9%. This result was in line with studies in Adigrat and Debra Markos (19.5%) each (22, 23). The most preferred method was Implant (77.3%) followed by IUD (21.8%) and Tubal ligation (0.9%). The main reason cited by respondents not to use LAPCMs was fear of side effect (63.5%). This finding was greater than in Nigeria (24.7%) (39). One hundred fifty (150) participants did not need any more child but only 39.1% of the were using LAPCMs. This shows that, Contraceptive method providers should assess the reproductive intention of clients, inform all available methods and counsel them (23). Majority of the respondents knew about LAPCMs and significant amount of participant had positive attitude about LAPCMs.

Current use of modern contraceptive method was 59.9%. The most preferred method was Injectable (50.5%). This finding was less than that of Dawro zone (80.15%) and the most preferred method was Injectable (83.7%) (27). However, current use regarding to LAPCMs in Dawro was lower than finding of this study where only 4.6% them used Implant and none of them were using IUD and Tubal ligation. This shows that participants in this study area were switching to LAPCMs than in Dawro. Alternatively, this might be due to high knowledge and awareness (87.3%) of the participants towards LAPCMs in this study area.

Current use of IUD in this study area was 4.6%, which was lower than in Pakistan 30% and Nigeria (14.4%) (28, 49). This might be because of study participant in Adama perceived that IUD prevent ordinary activity(56%) , bring about excessive bleeding (47%) and escape/ move through the body (52%). Current use of implant was (16.2%) and sterilization (0.2%) which was greater than in Mekelle where prevalence of Implant was 10.6% and no user of sterilization. This might be due to low awareness of LAPCMs (63.9%) (21) in Mekelle compared to this study area (87%).

Current use of LAPCM was different among respondents' socio demographic and other characteristics. For example, current use of LAPCMs was higher among participants aged 25-34 and 35-44 years than participants aged 15-24 years. Similarly, current use was higher among participants gave birth to 3-4 than those gave birth to1-2. This finding was in line with study in Nigeria and Indonesia where married women of high parity and age 30-34 years use LACMs more likely compared to their counterparts (41, 42). This might be due to women aged 15-24

were at the beginning of childbearing age hence they had limited practice of LAPCMs due to fear of infertility.

Knowledge and awareness of modern contraceptive methods was almost universal in this study area, where 97.3% of the respondents knew at least one modern contraceptive method for which major source was health professions (88.5%) and mass media (82.6%). This finding was all most similar with finding of EDHS 2011(97.4%), study in Southern Ethiopia (99.4%) and South Central Ethiopia (99%) (8, 24, 27). Health profession was the major source of information (92.8%) (27). This provides a substantial reason why Health Workers should be trained at regular intervals in order to enhance service delivery to FP clients that visit health facilities for FP services and community at large. In addition, study in India and Southern Ethiopia showed women visited by FP workers used LAPCM more likely than their counterparts (42, 50). Nevertheless, media would still need to do much more work on continuous sensitization and awareness about contraception since an appreciable number of the respondents heard or knew about contraception in television, radio and print media in this study.

The finding of Study in Pakistan showed that 68% and 22% of them knew tubal ligation and vasectomy, which is greater than finding of this study (28). This difference might be due to high enforcement of permanent methods in many Asian countries.

Most of the participants had at least awareness about one advantage of LAPCMs (87%). This finding was greater than in Debra Markos (81.5%), Mekelle (63.9 %), Goba (66.9) and Batu town (58.3%) (21, 22, 25, 29). This deference could be due to difference in time of the study when LAPCMs is getting a large media coverage than ever and 95.3% of participants in this study area got information of LAPCMs through mass media. Alternatively, it might be due to geographical or regional variation.

Concerning the attitude of participants about LAPCMs, 63% and 52.8% of the participants agreed that implant and IUD move to other body part after insertion. This finding was greater than finding in Ghana, which showed that, participant had misperceptions like IUD goes to other body part, cause infertility, interfere with sexual inter course, duration is too long (25%) and lead family conflict (50%) (30). This difference might be due to increased funding and support for BCC campaigns that promote smaller family size, present benefits of LAPM, address misconceptions concerning the health consequences of long-acting methods in Ghana (51).

Most participants in Focus Group Discussion had noticeable awareness of LAPCMs but they had fear regarding to infertility, cancer, heart problem, bleeding, cancer and hypertension. This finding was similar with qualitative study in Pakistan and Nigeria where discussants have raised fear of IUD arising from myths and misperception they have heard (52, 53).

In multivariate analysis, knowledge level, attitude status, number of birth, number of wanted child and occupation of the women were found to predict current use of LAPCMs among respondents. Participant who had high knowledge and moderate knowledge used LAPCMs 5 and three times more likely compared to participant of low knowledge. Similarly study done in Mekelle revealed, participant of high knowledge had used LAPCMs eight times more likely compared to low knowledge level and those who had moderate knowledge used LAPCMs three times more likely compared to participant of low knowledge (21). In addition, finding in Uganda revealed, knowing duration of protection of IUD and Implant was positively associated with practice of LAPCMs (54) and EDHS 2011 showed even knowing at least one contraceptive method was perquisite for use of contraceptive method (8). This might be due to knowledge of contraceptive method helps women to know what and where to use and get the method.

Current use LAPCMs was higher among participants who had positive attitude about LAPCMs than those who had negative attitude. This finding was similar to the finding in Ethiopia where women with positive perceptions about contraceptive methods used contraceptive methods more likely (35, 43). In Malaysia practice of LAPMs was surrounded by fear and misperception about modern contraceptive method like IUD that it had harm full effects on the healthy (38). This might be due to, having positive attitude was prerequisite for using contraceptive method (8, 35).

Participants gave birth to 3-4 used LAPCMs more likely than participant who did not give birth. This finding was almost in line with finding in Mekelle where mothers who had more than two pregnancy use LAPCMs three times more likely than mothers who didn't experienced any pregnancy (21). This might be due to fear of infertility after removal of LACMs, which was supported by qualitative finding of this study where most of the discussants perceived that LACMs should be used by those who had at least one or two child. Because they perceived that woman could not be pregnant after removal of LACMs.

Participants need to have more children (1-2) had 67% lesser odds of using LAPCMs. This might be due to, significant amount of the respondents in this study did not know that pregnancy is

immediate after removal of IUD (31.2%) and Implant (27.9%). In addition to this qualitative part of this study revealed that discussants perceived that duration of service for LACMs is too long, which might lead to expiration of fertility period. This qualitative finding was in line with that of Ghana where 25% of them perceived that duration of service for LACMs were too long (51).

In addition to this participant of 'others' (nongovernmental organization employee) by occupation, used LAPCMs four times more likely compared to housewives. According to this study, this might be due to higher educational level (diploma and above) of those employed in NGO's (36.8%) where only 8.5% of house wives had educational level of diploma and above. In turn having higher educational level was related higher practice of modern contraceptive method (8).

7. LIMITATION AND STRENGTH OF THE STUDY

Strength of the study

Mixed study design was used, which helps to triangulate the quantitative findings with qualitative findings.

Limitation of the study

The study did not include the idea of health professionals concerning the reason why clients prefer short-term methods to LAPCMs.

Knowledge and attitude of male partner about LAPCMs and its influence was not studied in this study

Cross-sectional study was used which cannot establish temporal relationship.

8. CONCLUSION

Based on the finding of the study it is concluded that level of utilization of LAPCMs was low (20.9%) and the main reason to this were fear of side effect. High knowledge level, moderate knowledge and positive attitude about LAPCMs; parity of (3-4) and being NGO employee in occupation were positively associated with current use of LAPCMs. Whereas more wanted children (1-2) was negatively associated with current use of LAPCMs. Significant amount of participant had low knowledge level particularly for tubal ligation and vasectomy and more than half of the participants had positive attitude towards LAPCMs practice.

On qualitative part, discussant had awareness of LAPCMs but they relied on myths and misperception from their friends and neighbors. There was a strongly expressed fear side effects like bleeding changes, infertility, heart problems and cancer.

9. RECOMMENDATION

Federal Ministry of Health, Regional Health Bearoue and other stakeholders should continue the promotion of LAPCMs. Especially, emphasis should be given for permanent methods of which the use is close to zero.

Adama Health Bearoue should continue to work on reduction of myths and misperceptions prevailing in the community through provision of health information concerning these factors. In addition to this, the Bearoue should continue to work on community mobilization in collaboration with Community Health Workers Army beside HEWs in order to increase community's awareness and change their attitude regarding to LAPCMs.

HEW and other FP service providers should counsel FP clients and community as whole about LAPCMs especially concerning misperceptions prevailing in the community that affect utilization of LAPCMs. In addition to this, they have to assess the reproductive intention of the FP client, inform all the method available and counsel them.

Furthermore, further study should be conducted to investigate perception, attitude and other factors associated with the utilization of LAPCMs among male partners, ever-married women and service providers. In addition to this further study should be conducted to assess the service quality of LAPCMs among FP worker, clients and Health institutions.

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ANNEX-1: Data collection tool (questionnaire): English version

Addis Ababa University College of Health Science, School of Public Health

Survey questionnaire on utilization of long acting and permanent contraceptive method and associated factors among married women in Adama town

Questionnaire ID: …….. Kebele no: ……..

I. Participants' information sheet

Greeting: good morning /afternoon

My name is ……I am working on behalf of research team(project), which is conducted by Addis Ababa University. I would like to ask few questions, which take around 30 minute about knowledge, perception and practice of long acting and permanent contraceptive methods among married women in reproductive age. Genuine response that you are going to give is very important to identify problem related to long acting and permanent contraceptive methods, and design programs of family planning service in this town and in general to our country.

Title of the study: Utilization of long acting and permanent modern contraceptive method and associated factors among married women in Adama town

Background of the study: Despite the growing use of modern contraception, which gives couples the ability to choose the number and spacing of their children and tremendous lifesaving benefits, approximately 25 percent of sub-Saharan African couples and 25% of Ethiopian couples who want to space or limit births are not using any form of contraception

Objective of the study: To assess long acting and permanent modern contraceptive method utilization and associated factors among married women in Adama town

Benefit of the study: Participant will not gain any direct benefit for being participated. The result can be used as base line for further studies that can be done in the town to identify problems associated with utilization modern contraceptive method in the town as well as in the country.

Risk of the study: The study has no risk for participants and interview will be private to make safe participants from any fear.

Right of participants: Participating and not participating is the full right of the participants and they can stop participating in the study at any time. They can skip any question, which they want to and can ask question, which is not clear for them

Confidentiality: Any information forwarded will be kept private. Her name will not be specified

Informed consent: I have read this form or it has been read to me in language I comprehend and understand all conditions stated above. Are you willing to participate in this study?

1. No (say thank you) 2. yes (continue your interview)

Name of principal investigator: Markos Desalegn

Address: cell phone: +251915439372; email: markosdesalegn@gmail.com

Name of institution: Addis Ababa University College of Health Science Research Ethics Committee

Address: Addis Ababa, Ethiopia

Tel no: 251-11-553873

Signature of interviewer certifying that the informed consent has been accepted by the participant the ----------date /----/------/2014

Date of interview /…../…../2014

Result of interview: 1. Completed 2. Respondent not available

3. Refused 4. Partially completed

Checked by supervisor, name ----------signature----------date---------

Structured English version questionnaire

Part I: socio demographic characteristics of the participants

Q.No	Questions	Choices	Remark
101	How old are you?(age in years)	**Insert**…….(completed year)	
102	What is your ethnicity?	Oromo Amhara Tigre Guraghe **Other(specify**)---------	
103	What is your religion?	Orthodox Muslim Protestant **Other (specify**---------	

104	What is the highest level of school you have completed?	Illiterate Read and write Elementary [1-4] Junior secondary [5-8] Secondary[9-10] Senior secondary[10-12] Diploma and above	
105	What is your spouse's maximum level of education?	Illiterate Read and write Elementary [1-8] Secondary[9-10] Senior secondary[10-12] Diploma and above	
106	Family size of the respondent	**Insert No**……..(numbers)	
107	What is your occupation?	House wife Government employee daily labourer Merchant Student **88. Other (specify)**----------	
108	What is your partner's occupation?	Government employee daily labourer Merchant Student **88. Other (specify)**----------	
109	What is your monthly income?	Insert birr in cash----------	

Part II. Reproductive history of the participants

Q.No	Questions	Choices	remark
110	Have you ever given birth?	Yes No	
111	How many births you gave?	**Insert No […..]**	
112	How many of them are alive?	**Insert No […..]**	
113	How many more children do you want?	**Insert No […..]**	
114	Do you want to have a child within two years (soon)	Yes No	
115	Do you discuss with your partner on contraceptive methods?	Yes No	

116	Who decide /will decide on number of children you want to have?	1. Husband 2.Wife 3. Both 4.God 88.Other specify----------	

Part III. Knowledge of modern contraceptive method of the respondents

Q.NO	Questions	choices	Remark
117	Have you ever heard about modern contraceptive method	Yes No	
118	what type of modern contraceptive do you know(circle all methods mentioned spontaneously or promoted	Pills 6. vasectomy Injectables 7. condom Implant 99. I don't know ⟶ IUD 5. tubal ligation	126
119	From where did you get information on modern contraceptive?	1.Friends, neighbors/relatives 2.Husband 3.Health professionals 4.Mass media 88.Other specify----------	
120	Do you know about LAPCMs (methods used for many years or permanently just after having it once)	yes no ⟶	Q126
121	Have you ever had exposure to LAPCMs message through mass media within the last 12 months?	yes no ⟶	124
122	If yes what was the type of media	Television 2. Radio 3, print media	
123	If 'yes' to Q. 121 which one (circle all mentioned)	Implant 3. Tubal ligation IUD 4. Vasectomy Other specify----	
124	What general uses of LAPMs do you know? Circle all mentioned spontaneously or prompted)	1. Helps for prevention of un wanted pregnancy 2. Prevention of possible maternal and child death 3. Limiting family size 4. Child spacing 88. Others(specify) ----------	

125	What do to know about LAPCMs?	1. True	2. False	99. I don't know	

	1. IUCD can prevent pregnancies for more than 10 years 2. IUCD is not appropriate for female at high risk of getting STIs 3. IUCD has no interference with sexual intercourse or desire 4. IUCD is immediately reversible(become pregnant quickly when removed) 5. Implant can prevent pregnancies for 5 years 6. Implant has no interference with sexual intercourse 7.Implants is immediately reversible(becomes pregnant quickly when removed) 8.Vasectomy has no interference with sexual intercourse 9.After female sterilization pregnancy is not possible 10.Female sterilization has effect on sexual performance				

Part IV. Participants' beliefs and perceptions on modern contraception

s.n	Statements of perception on LAPCMs	Choices	Remark
126	Using implant do not cause irregular bleeding	Agree Not sure Disagree	
127	Insertion of Intra uterine contraceptive device do not lead to lose privacy	Agree Not sure Disagree	
128	For me IUD don't move through the body after insertion	Agree Not sure Disagree	
129	Using Intra uterine contraceptive device do not restrict normal activities	Agree Not sure Disagree	
130	For me There is no bleeding side effect from using IUD	Agree Not sure Disagree	
131	For me Operation during tubal ligation is not dangerous	Agree Not sure	

		Disagree	
132	For me insertion and removal of implant is not highly pain full	Agree Not sure Disagree	
133	For me Implant don't move through the body after insertion	Agree Not sure Disagree	
134	For me it is women herself who decide to use contraception	Agree Not sure Disagree	
135	For me it is not health provider who decide the method I am going to use	Agree Not sure Disagree	

Part V. Practice of modern contraceptives

136	Have you ever used modern contraceptive method?	Yes No →	142
137	If yes for Q137, what was the method?	1. Pills 5 .Tubal ligation 2. Injectables 6. Vasectomy 3.Implant 4.IUD 7.Condo	
138	For how long did you use it (not for female and male sterilization)	Enter [……] month or years	
139	Have you ever shifted one contraceptive method to other?	Yes No →	143
140	If yes for Q 143 from which contraceptive to which contraceptive(recent one)	From[----------] To[----------]	
141	why did you shift from one method to another	1.For inconveniency of previous method 2.For convenience of new method 3.Due to lack of access to the previous method 4.Due to side effect 5. Need for long acting contraceptive method 6.Provider advice me 7.Partner influenced me 88. Other specify	

142	If 'No' for Q. 136, why?	1.Lack of knowledge 5.Partner disapproves 2.Lack of access 6.Fear of side effect 3. To get pregnant 7. religious prohibition 4.Fear of infertility 8.Cultural taboo 88.Others specify	
143	Are you using modern contraceptive method now?	Yes → No	145
144	Why?	1.I am pregnant 2.I want to be pregnant 3.Iam on exclusive breast feeding 4. I fear side effect 5.Religious prohibition 6.Provider make me not use 7. I can't get access to it easily/is not available 8. My husband don't allow me 9. cultural taboo 88.Others specify	
145	which method you are using now	1. Pills 5.Tubal ligation 2. Injectables 6.Vasectomy 3. Implant 4. IUD 7.Condom	
146	From do you get the method you are using?	1.Health center 6.Friends 2. hospitals 7.Relatives 3.Private clinic 88.Others specify 4.Pharmacy 5.Health extension worker	
147	If Q.145 (1, 2,3,4,5 or 6) Does partner approve you taking of the method.	Yes No	

Thank you

Focus group discussion (FGD) for married women and married men

Guideline for focus group discussion

Hello participants, good morning /afternoon

My name is ----------and my colleague here with me is called ----------.we are team from Addis Ababa University. This discussion is going to be conducted for assessing the status of family planning utilization, specifically long acting and permanent contraceptives. We hope that the discussion we would have with you is very useful to improve the quality and accessibility of long acting (implant and IUD) and permanent (voluntary male and female sterilization) in this area and the whole country. For this discussion, I will raise some point for discussion concerning long acting and permanent contraceptives attitude and related factors with the practice of long acting and permanent contraceptive method. Before that, I would like to thank for your voluntary participation.

Instruction:

1. Your presence is very important
2. We are interested in all of your ideas and suggestions
3. There are no wrong and right answers
4. All ideas ; both positive and negative to the point of discussion are welcomed
5. Please feel free to disagree with one another. We would like to have many points of view.

We would like to ask your permission to audiotape your comments and opinions so that we would not miss any of your ideas while to take notes. I want assure you that your ideas are confidential and used for research purpose only. I want our session to be group discussion so that you need to wait for me to call on you. We have many points to rise. Please stop me incase if you want to add something more

It is not important to have side conversations because it interferes with individual's full participation in the group discussion and Posses challenges for recoding the discussion

Discussion topics for the FGD

Date of focus group discussion: __/___/2014_____

Location of focus group discussion:_____ _____

Name of note taker:_____ _____ _____

Name of investigator: _____ _____ _____

Name of tape recorder: _____ _____ _____

Information of the of participants

Code of the respondents	Age	sex	Religion	No Living children	kebele
P1					
P2					
P3					
P4					
P5					
P6					
P7					
P8					

1. Warm up question

a. Current issue on family planning

b. Advantage and disadvantage of many child birth

2. What do you understand by LAPCMs (probe for issue related to each methods: IUD, implant and sterilization)

a. What do you think are advantages/benefit of LAPCMs

b. Who do you think are using LAPCMs? In addition, why do they use it?

c. Who do you think are not using LAPCMs? Why not they use it?

3. Do you think that you or community prefer short-term modern contraceptive to long term and permanent contraceptive methods? Probe for

a. Why do they prefer it

b. Values, beliefs, religious and traditional factors attached to it

c. Perceived side effect of LAPCMs

4. Is there any idea you want to add on our discussion on LAPCMs and related issues?

Thank you!

ANNEX-2: Amharic version questionnaire

አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ ፐብሊክ ሄልዝ ትምህርት ቤት የሰርቬ ጥያቄ ስለ የረጅምና ቋሚ የወሊድ መቆጣጠሪያ ዘደዎች አጠቃቀምና ተያያዥ ምክንያቶች (በአዳማ ከተማ)

የሰርቬ code ---------- ቀበሌ ----------

የተጠያቂው ኢንፎረማቲነ ሽት

ስም ---------- እባላለሁ እኔ የምሰራው አዲስ አበባ ዩኒቨርሲቲ ምርምር ቡድንጋ በመተባበር ነው ። የኔ ጥያቄ የሚፈጀው 30 ደቂቃ ብቻ ስሆን፣በዚህም ስለ ረጀምና ቋሚ የሆነው የወሊድ መቆጣጠሪያ እውቀት፣ አመለካከት፣ አጠቃቀም እና በዚህ ተያያዥ የሆኑ ምክንያቶች ይካተታል።የርሶ ምላሽም ለከተማውና ለሀገሪቱ የወሊድ መቆጣጠሪያ እና አጠቃቀም ደረጃን ከፍ ለማድረግ የጎላ ፋይዳ አለ።ለዚህ አጠያየቅ የተመረጣቹት እንደ እጣ ነውና የሚቀጥለው ኮንሴንት ከተስማማቹው መሳተፍ ይችላሉ።

የጥናቱ ርዕስ፤ ስለ ረጅም ጊዜና ቋሚ የስነ ወሊድ መቆጣጠሪያ ዘዴና የተያያዝ ምክንያቶች

ኢንፎርምድ ኮንሴንት: እኔ ከላይ የጠቀስትን አምብቢያለሁ፣ በምገባኝ ቋንቋም ተነቦልኛል።

በዚህ ጥናት ውስጥ ለማሳተፍ ፍቃደኛ ኖት

1. አዎ 2. አይደለም

የተመራማሪው ስም፤ ማርቆስ ደሳለኝ

አድራሻ ስልክ ቁጥር 251915439372

የድርጅቱ ስም፤ አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ ሪሰርች ኮሚቴ

የጠያቂው ስም..... ፊርማ.....

የኢንተርቪው ውጤት

1. አልቋል/ተጠናቋል 2. ተጠያቂው አልተገኘም
2. ፍቃደኛ አልነበረም 3. የተወሰነ ፓርት ተጠናቋል።

የሱፐርቫይዘር ስም..... ፊርማ.....

ክፍል ፤. የተሳታፊው የማህበራዊ ስነ ህዝባዊ ባህሪ

ተ.ቁ	ጥያቄ	ምርጫ	አስተያየት
101	እድመዎ ስንት ነው (በዓት)	በሙሉ ዓመት ፃፉ.....	
102	ብሔርዎ ምንድ ነው	ኦሮሞ 3. ትግራይ 88. ሌላ /ይጠቀሱ/..... አማራ 4. ጉራጌ	
103	የምን ሀይማኖት ተከታይ ኖት	ኦርቶዶክስ 3. ፕሮቴስታንት ሙስሊም 88. ሌላ (ይጥቀሱ).....	

104	የደረሱት የትምህርትደረጃዎ ምን ያህል ነው	ምንም ያልተማሩ 4. መለስተኛ 2 ደረጃ (5-8) ማንበብና መጻፍ የሚችሉ 5. ሁለተኛ ደረጃ (9-10) አንደኛ ደረጃ (1-4) 6. ከፍተኛ 2 ደረጃ (10-12) 7. ድጅሎማና ከዛበላይ	
105	ባለቤትዎ የደረሱት የትምህር ደረጃ ምን ያህል ነው	1. ምንም ያልተማሩ 4. መለስተኛ 2 ደረጃ (5-8) 2.ማንበብና መጻፍ የሚችሉ 5. ሁለተኛ ደረጃ (9-10) 3.አንደኛ ደረጃ (1-4) 6. ከፍተኛ 2 ደረጃ (10-12) 7. ድጅሎማና ከዛበላይ	
106	የቤተሰቦዎ ቁጥር ምን ያህል ነው ?	በቁጥር ፃፉ(.....)	
107	ስራዎ ምንድ ነው	የቤት እመቤት 4. ነጋዴ የመንግስት ተቀጣሪ 5. ተማሪ የቀን ሰራተኛ 88. ሌላ (ይጥቀሱ)	
108	ባለቤትዎ ስራዎ ምንድ ነው	1. የመንግስት ተቀጣሪ 3. ነጋዴ 88. ሌላ (ይጥቀሱ)..... 2. የቀን ሰራተኛ 4. ተማሪ	
109	የወር ገቢዎ ስንት ነው	ቁጥር ይጻፉ.....	

<u>ክፍል ሁለት የተሳታፊው የስነተዋልዶ ታሪክ</u>

ተ.ቁ	ጥያቄ	ምርጫ	አስተያየት
110	ወልደው ያውቃሉ	አዎ አይደለም	
111	ስንት ልጅ ወልደዋል	..... ቁጥር	
112	በህይወት ያሉት ስንት ልጆች ናቸው	..... ቁጥር	
113	ምን ያህል ተጨማሪ ልጅ ይፈልጋሉ	..... ቁጥር	
114	በሁለት አመት ውስጥ ልጅ እንደኖርዎት ይፈልጋሉ (አሁን)	አዎ አይደለም	
115	ከባለቤትዎ ጋር ስላ ወሊድ መከላከያ ወይይት ያደርጋሉ	አዎ አይደለም	
116	የልጆችዎን ቁጥር ብዛት ማንነው የሚወስነው	ባል ሚስት ሁለቱም ፊጣሪ ሌላ ይጥቀስ.....	

<u>ክፍል ሶስት ስለ ዘመናዊ ወሊድ መቆጣጠሪያ የተሰታፊዉ እውቀት</u>

117	ስለ ዘመናዊ ወሊድ መቆጣጠሪያ ስምተው ያውቃሉ	አዎ አይደለም	
118	118 አዎ ከሆነ የትኛውን ወሊድ መቆጣጠሪያ ያውቃሉ የጠቀሱትን ወይም ያስታወሱትን ያክብቡ	ፒልሲ የመርፌ 6. የወንዱ የዘር ቱቦ ማቋጠር ክንድ ላይ የሚቀበር 7. ኮንዶም 4. ሉፕ የማህፀን ማቋጠር 99. አለቅም	ካላወቀች ወደ 126

119	ስለ ዘመናዊ ወሊድ መቆጣጠሪያ መረጃ ከየት አገኙ	ከጓደኛ, ጎረቤት, ዘመድ 3. ከጤና በላሙያ 88. ሌላ ይጥቀስ..... ከባለቤትዎ 4. ከብዙሃን መገናኛ			
120	ስለ ረጅም ጊዜ የሚያገለግሉና ቋሚ ወሊድ መከላከያ ዘዴዎች (ለረጅም አመታትና በቋሚነት) የሚያገለግሉ ያውቃሉ	አዎ አይደለም			አይደለም ከሆነ ወደ 126
121	ባለፈው 12 ወር ውስጥ ስለ ረጅም ጊዜ የሚሰራ እናዘላቂ ስለሆነ የወለድ መከላከያ ዘዴዎች በብዙሃን መገናኛ መልዕክት ደርስዎታል	አዎ አይደለም			
122	121 አዎ ከሆነ በየትኛው የብዙሃን መገናኛ	ቴሌቪዥን 2. ሬዲዮ 3. በህትመት (ይግለጹ).....			
123	121 አዎ ከሆነ የትኛዎችን (የጠቀሱትን አከብብ	ከንድ ላይ የሚቀበር 3. የሴት የማህፀን ማቋጠር ሉፕ 4. የወለድ የዘር ፍሬ ቱቦን ማቋጠር 88. ሌላ (ይጥቀስ).....			
124	121 አዎ ከሆነ የረጅምና ዘላቂ አገልግሎት የወሊድ መቆጣጠሪያ ዘደዎችን ጥቅል ጥቅም ዘርዝር የተጠቀሱትን ወይንም ያስታወሱትን ሁሉ ያክብቡ	ያልቴፈለገ እርግዝናና ለመከላከል ይረዳል የህፃናትን የእናቶችን ጤና ለመጠበቅ የቤትሰብ ቁጥርን ለመወሰን ልጆችን ለማራራቅ ሌላ ይጥቀስ.....			
125	ስለ ረጅም ጊዜና ዘላቂ የወለድ መቆጣጠሪያዎች ምን ያውቃሉ የሚከተሉት ዓረፍት ነገሮች ስለ ረጅም ጊዜ እናዘላቂ ስለሆኑ የወለድ መቆጣጠሪያ ዘዴዎች ሲሆኑ፣ ትክክል የሆኑትን እውነት፣ ትክክል ያልሆኑትን ደግሞ ሀሰት ይላሉ(ቁጡሩን ይከበቡ) ሉፕ ከ10 አመት በላይ ለሆኑ ጊዜ እርገዚናን ይከላከለል ሉፕ ለአባላዚር በሽታ ተጋላጭ ለሆኑ ሴቶች ጥሩ አይደለም ሉፕ የግብረስጋ ግንኙነት ወይም ፍላጎት ላይ ተጽኖ አይኖርም ሉፕ ከወጣ በኋላ ወዲያውኑ እርጉዝ መሆን ይቻላል ቆዳ ውስጥ የሚቀበረው የወሊድ መቆጣጠሪያ ለ5 ዓመት እርግዝና ይከላከል ቆዳ ውስጥ የሚቀበር የወለድ መቆጣጠሪያ የግብረ ስጋ ግንኙነት ላይ ተጽኖ የለውም ኢምፕላኖን ከወጣ በኋላ ወዲያውኑ ማረገዝ ይቻላል የወንዱ የዘርትበን ማቋጠር የግብረስጋ ግንኙነት ላይ ተጽኖ የለውም የሴት የማህፀን ከተቋረጠ በኋላ ማርገዝ አይቻልም የግብር ስጋግንኙነት ላይ ተጽኖ	ኢዉነት	2.ሀሰት	99. አለቅም	

	የለውም				

ክፍል 4 በዘመናዊ የወሊድ መቆጣጠሪያ ላይ የተሳታፊው (የመላሹ)አመለካከት እና ግንዛቤ

ተ.ቁ	ስለ ዘመናዊ የወሊድ መቆጣጠሪያ **እምነትና** ግንዛቤ	ምርጫ	***አስተያየት***
126	እንደ እኔ ኢምፕላንትን መጠቀም የተዘባደም መፍሰስ አያስከትልም	እስማማለው እርግጠኛ አይደለም አልስማማም	
127	እንደ እኔ ሉፕ በሚገባበት ወቅት የግል ሁኔታና ሚስጥርን ያጋልጣል	እስማማለው እርግጠኛ አይደለም አልስማማም	
128	እንደ እኔ ሉፕ ከተቀበረ በኋላ የሰዉ አካል ዉስት አይዘመትም	እስማማለው እርግጠኛ አይደለም አልስማማም	
129	እንደ እኔ ሉፕ መጠቀም የተለመዱ እንቅስቃሴዎችን ማድረግን አይገድብም	እስማማለው እርግጠኛ አይደለም አልስማማም	
130	እንደ እኔ ሉፕን መጠቀም የተዘባደም መፍሰስ አያስከትልም	እስማማለው እርግጠኛ አይደለም አልስማማም	
131	እንደ እኔ የሴትን የማህፀን ለመቋጠር የሚደረግ ኦፕራሲዮን ጉዳት ይኖርም	እስማማለው እርግጠኛ አይደለም አልስማማም	
132	ኢምፕላንት ሲገባና ሲወጣ የተጋነኔ ህመም ይኖርም	እስማማለው እርግጠኛ አይደለም አልስማማም	
133	እንደ እኔ እምፕላንት ከገባ በኋላ የሰዉ አካል ዉስት አይዘመትም	እስማማለው እርግጠኛ አይደለም አልስማማም	
134	እንደ እኔ ባሎች ሴቶች የወሊድ መቆጣጠሪያ መጠቀም እንደሚችሉ/ማይችሉ/ ለመወሰን አይችሉም	እስማማለው እርግጠኛ አይደለም አልስማማም	
135	እንደ እኔ የትኛውን የወሊድ መቆጣጠሪያ ዘዴ መጠቀም እንዳለብኝ የወሚስን የጤና ባለሙያ ነው	እስማማለው እርግጠኛ አይደለም አልስማማም	

<u>ክፍል 5 የዘመናዊ የወሊድ መቆጣጠሪያ ዘዴ አጠቃቀም ተግባር</u>

136	ዘመናዊ የወሊድ መቆጣጠሪያ ተጠቅመው ያውቃሉ	አዎ አይደለም	አይደለም ከሆነ ወደ 142
137	137 አዎ ከሆነ የትኛውን ዘዴ ተጠቀሙ	ፒልሲ 5. መሀጸን ማቋጠር መረፌ 6. የወንዱ የዘር ቱቦ ማቋጠር ኢምፕላንት 7. ኮንዶም ሉፕ	
138	ለምን ያህል ጊዜ ተጠቀሙት (መሀጸን ማቋጠር የወለድ ዘር	በወር ወይም በዓመት.....	

	ቱቦን ማቋጠር አያካትትም)		
139	ከአንድ ወሊድ መቆጣጠሪያ ወደ ሌላ ቀይረው ያውቃሉ፤	አዎ አይደለም	አይደለም ከሆነ ወደ 143
140	140 አዎ ከሆነ ከምንና ወዴት ቀየሩ	ከ..... ወደ.....	
141	ለ140 አዎ ከሆነ ለምን ቀየራችሁ	1.የመጀመሪያው ስላልተመቸኝ ስለፈለኩ 5. የረጅም ጊዜ መቆጣጠሪያ 2.አዲሱ ስለተመቸኝ 6. ባለሙያ ምክር 3.የመጀመሪያው ማግኘት ባለመቻሌ 7. ባለቤቴ ተጽኖ 4.ተጓዳኝ ጎዳት ምክንያት 88. ሌላ ግልጽ.....	
142	137 አይደለም ከሆነ ለምን	እውቀት ማነስ 5. ባለቤቴ ስላልተቀበለው ማግኘት አለመቻል 6. ተጓዳኝ ጉዳትን በመፈራት ለማርገዝ 7. መጠቀም አጽአት ነው መሀነት ማፍራት 8. በባህል የተወገዘበ መነው 88. ሌላ ግለጽ.....	
143	ዘመናዊ የወሊድ መቆጣጠሪያ አሁን እየተጠቀሙ ነው	አዎ አይደለም	አዎ ከሆነ ወደ 145
144	አይደለም ከሆነ ለምን	1.እርጉዝነኝ 6. የባለሙያው ተጽኖ 2.ማርገዝ እፈልጋለው 7. ማግኘት አልቸልኩም 3.ጡትን ብቻ መሰጥበት ላይ ነኝ 8. ባለቤቴ ስላልተቀበለው 4.ተጓዳኝ ጉዳቶችን ፈርቼ 9. በባህል የተወገዘበ 5.ሀይማኖቴ ይከለክለኛል 88. ሌላ ግለጽ.....	
145	የትኛውን ዘዴ ነው አሁን እየተጠቀሙ ያሉት	1.ፕልስ 2.መረፊ 3.ኢምፕላንት 4.ሉፕ 5.ማህፀን ማቋጠር 6.የወንድ የዘር ትቦን ማስቋጠር 7.ኮንዶም	
146	የሚጠቀቡትን መቆጣጠሪያ ከየት አገኙ	1.ጤና ጣቢያ 2.መንግስት ድርጅት 3.የግል ክሊኒክ 4.መድህኒት ቤት 5.ከረዳት የጤና ባለሙያዎች 6. ከጓደኛ 7. ከዘመድ 88. ሌላ ይግለጹ	
147	ባለቤትዎ መጠቀምዎን ፈቅደዎል	አዎ አይደለም	

አመሰግናለው

መጠያቄን ጨርሻለው

ማንኛውም ጥያቄ ካሎት ይጠይቁ.

<u>የውይይት ጥያቄ/ፎከስ ግሩፕ ዲሰከሰሽን/</u>

የውይይት ቀን _____

የውውይቱ ቦታ _____

የጸሀፊው ስም _____

የጠያቂው ስም _____

የቀጅው ስም _____

<u>የተሳታፊው መረጃ</u>

1. የመዝናኛ ጥያቄ/መግብያ ጥያቄ

    ሀ. ወቅታዊ የቤተሰብ መቆጣጠሪያ ዘዴ ሁነታዎች

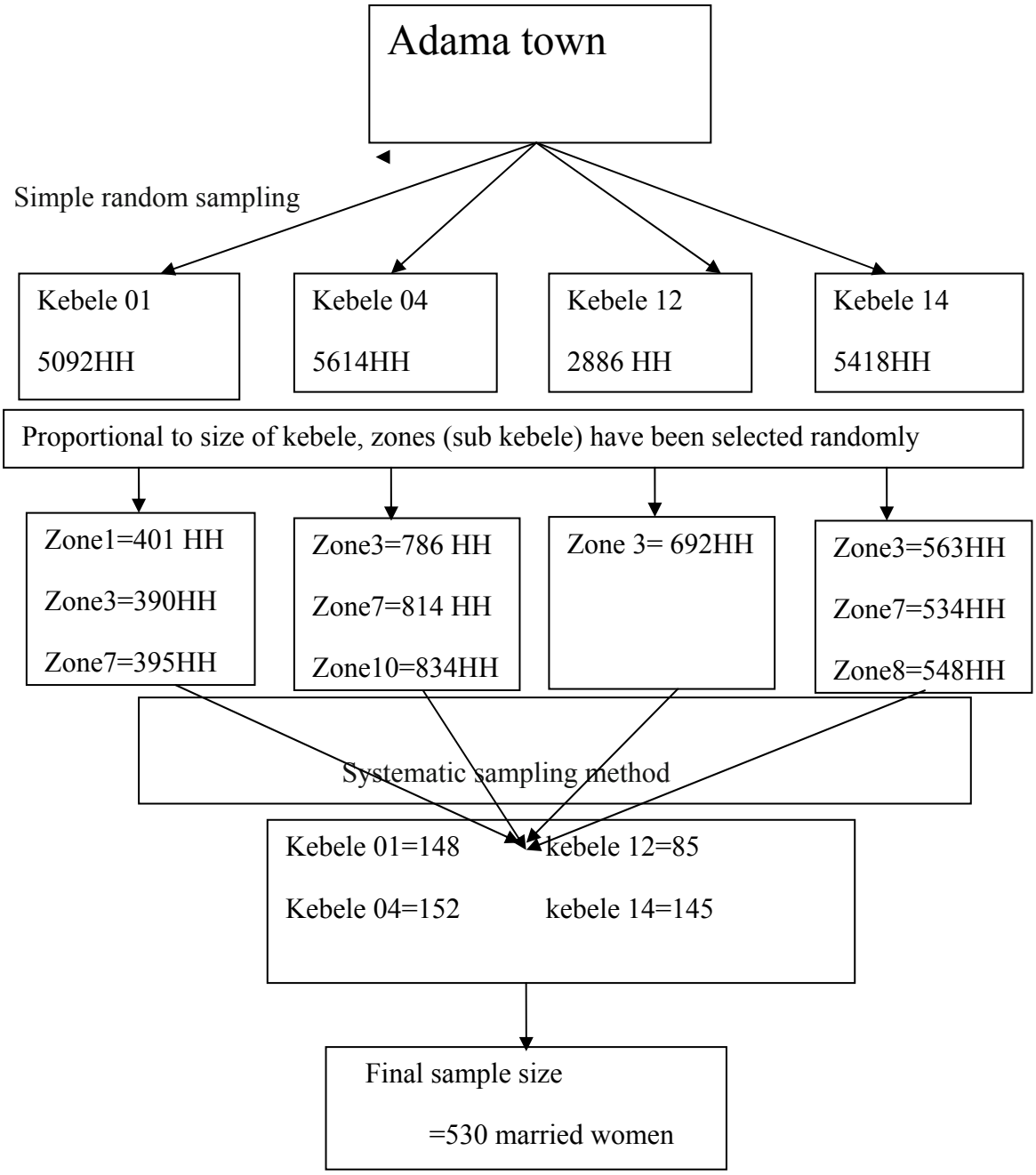
    ለ. የብዙ መውለድ ጥቅም ና ጎዳት

2. ስለ ረጅም ጊዜና ዘላቂ የወሊድ መቆጣጠሪያዎች ምን ታቃለህ/ሽ
   ሀ. ስለ ጠቀሜታችሁ ምን ታስባለሁ/ሽ
   ለ. እነማናቸዉ እየተጠቀሙት ያሉት ብለህ/ብለሽ ታስባለሁ/ሽ ፤ ለምንድነው የምጠቀሙት?
   ሐ. እነማናቸው የማይጠቀሙበት? ለምንድ ነው የማይጠቀሙት?
3. እንደተም ሆነ ሀብረተሰቡ የአጭር ጊዜ የወሊድ መቆጣጠሪያ ዘዴ ከረጅም ጊዜና ዘላቂ የወሊድ መቆጣጠሪያዎች ትምህርጣለህ/ሽ/ይመርጣሉ?

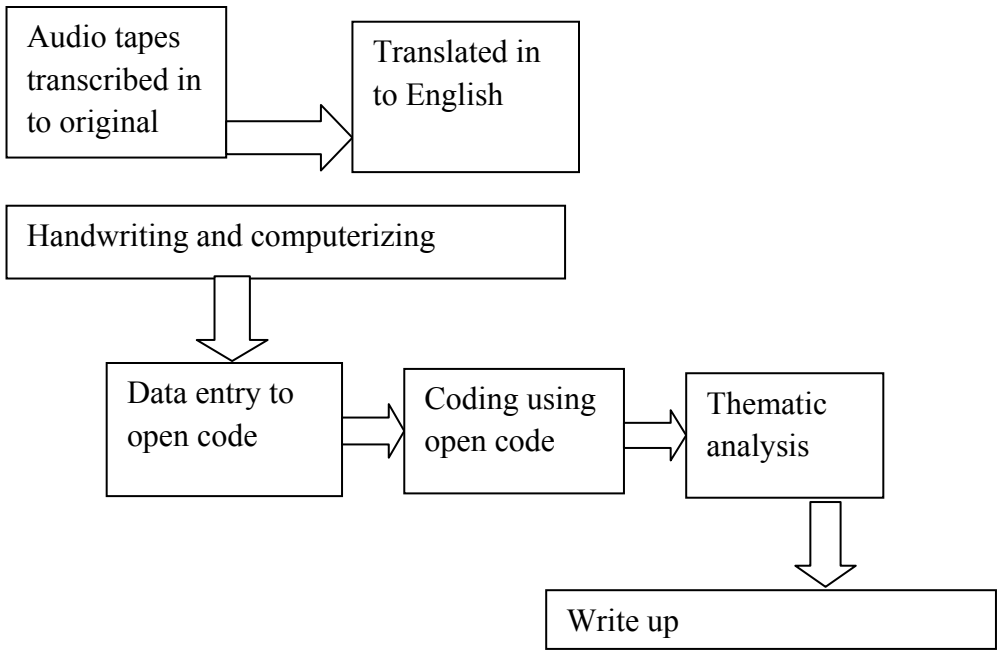
    አዎ ከሆነ ለምን

4. ከውይይታችን ሌላ የምጨምሩት አለህ/ሽ?

<u>እናመሰግናለን!!</u>



ANNEX 3: diagrammatic representation of sampling procedure in Adama town



ANNEX 4- Diagrammatic re presentation of qualitative data processing steps

Source: Academy for Educational Development (AED) and Net Mark, July 2000 (reference no, (48)