

ADDIS ABABA UNIVERSITY  
COLLEGE OF DEVELOPMENT STUDIES  
CENTER FOR POPULATION STUDIES



MAGNITUDE AND FACTORS ASSOCIATED WITH UNINTENDED PREGNANCY  
AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE IN ADDIS ABABA,  
ETHIOPIA.

BY: HANAMARYAME GETENET

A THESIS SUBMITTED TO SCHOOL OF GRADUATE STUDIES IN PARTIAL  
FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE MASTER OF SCIENCE IN  
POPULATIONS STUDIES (REPRODUCTIVE HEALTH)

AUGUST, 2022  
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## DECLARATION

I, hereby declare that the thesis entitled “Magnitude and factors associated with unintended pregnancy among pregnant women attending antenatal care in Addis Ababa, Ethiopia” is my original work and has not been submitted earlier for the award of any academic degree or diploma. I also declare that no chapter of this thesis in the whole or part incorporated in this thesis from any earlier work done by others or me. The participant’s rights to anonymity, withdrawal from the study without prejudice.

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AUGUST, 2022

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## Approval Sheet

This is to certify that Ms. Hanamaryame Getenet has fulfilled the requirements prescribed for the MSc degree in the College of Development Studies, Addis Ababa University. The thesis entitled “Magnitude and factors associated with unintended pregnancy among pregnant women attending antenatal care in Addis Ababa, Ethiopia” was carried out under my supervision and evaluated and approved by examiners. No part of the thesis has been submitted for the award of any degree or diploma before this date. Ethical clearance was obtained from the Institutional Review Board (IRB) of the College of Development Studies, Addis Ababa University.

Signed by the Examining Board:

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2. Examiner: _____	_____	_____
3. Examiner: _____	_____	_____

Chief Department or Graduate Program Coordinator

Name	Signature	Date
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AUGUST, 2022

ADDIS ABABA, ETHIOPIA

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## ABSTRACT

*Unintended pregnancy is either unwanted or miss-timed at the time of conception and has a great impact on the health of fecund sexually active women in developing countries. This study aims to assess the magnitude and factors associated with unintended pregnancy among pregnant women attending antenatal care in Arada, Yeka sub cities, Addis Ababa. A facility based cross-sectional study was conducted from March to April 2022 at 6 selected public health centers. Using a pre-tested questionnaire 355 pregnant women were included this study. All collected data were cleaned, entered and analysed using SPSS version 28. Summary statistics was used to present the findings. Multicolinearity and model fit test were performed before the analysis. Bivariate and multivariate logistic regression analysis was done to test the association between the independent and outcome variables. P-value of <0.05 was considering as a cut-off point. Three hundred fifty five pregnant women with mean age 29.5 years included and 321(90.4%) were married. The prevalence of unintended pregnant was 65(18.3%) and majority of them 58(89.2%) experienced unintended pregnancy once until this study conducted. From the total unintended pregnancy 65 (18.3%), 37 (59.9%) were mistimed and 28 (43.1%) were unwanted. Significant determinant/factors of unintended pregnant were no or lower educational status, history of abortions, family planning accessibility and openly discussion with their partners/husbands. It is important that reproductive programs consider expanding their focus to the growing population of urban dwellers. This can be an interim strategy until the majority are empowered through better education and receive user friendly services.*

**Key words:** *unintended pregnancy, women, abortions, family planning*

## ACRONYMS AND ABBREVIATIONS

AOR	Adjusted Odds Ratio
ANC	Antenatal Care
CI	Confidence interval
EDHS	Ethiopia Demographic and Health Survey
HSDP	Health Sector Development Program
IEC	Information, Education and Communication
MMR	Maternal Mortality Rate
OR	Odds Ratio
SPSS	Statistical Package for Social Science
UP	Unintended Pregnancy
IPV	Intimate Partner Violence

## CHAPTER ONE: INTRODUCTION

### 1.1 Background

Unintended pregnancy is either unwanted or miss-timed at the time of conception and has a great impact on the health of fecund sexually active women in developing countries. An unintended pregnancy is a pregnancy that is either unwanted, such as the pregnancy occurred when no children or no more children were desired or the pregnancy is mistimed, such as the pregnancy occurred earlier than desired (CDC reproductive health, 2021).

The burden of unintentional child/pregnancy in Africa is also high. Fertility knowledge are deep routed in sociocultural context that affect the adoption programs reconsiderations. Diiferent studies indicated pregnancy termination rate were 16.27% in Africa. Women with unmet need for contraception and women in schooling age likely to terminate a pregnancy. Socio-economically disadvantaged women are likely terminate a pregnancy compared to the moderately and most socio-economically advantaged women. The underlying cause of poor adherence to the protocols of contraceptives or the reluctance of women to utilize contraceptives after experiencing sexual intercourse are some reasons for pregnant termination. Women in sub-Saharan Africa (SSA) have a higher risk of unintended pregnancies, most of which are unsafe with associated complications. Unmet need for contraception is highest in SSA and exceeds the global average. Increase met needs for contraception and also utilize mass media to encourage women to adhere to the prescription of contraceptives in order to reduce the incidence of unplanned pregnancies and unsafe abortions. (Adde et al, 2021; Iyand et al., 2020)

Studies shows women aged 15-19 years categories had higher unintended pregnancies. Substantially of maternal wellbeing by unveiling the prevalence and determinants of unintended pregnancy across the SSA region. Reported finding shows that the level awareness has increased substantially in most SSA countries. However, awareness still differs widely within and between SSA countries. (Ameyaw et al., 2019; Awopegba et al., 2021; Yah et al., 2020)

The pooled prevalence of unwanted and mistimed pregnancy was 12 & 17% respectively in Ethiopia. Unintended pregnancy is associated with a low level of education, poverty, multiparty, rural residence, extreme ages, being unmarried, lack of decision-making power, inaccessibility of health facilities, poor knowledge, and non-use of contraceptives. Pooled prevalence of unintended pregnancy in Ethiopia was high and among currently pregnant married young women were 31.1%. The communication strategies on fertility and contraceptive issues between couples through peer education is limited, and to encourage correct use of long-acting modern methods of family planning. Although high, the magnitude of unintended pregnancy in Ethiopia was lower compared to the global level. Some of the reasons for unintended pregnancy in Ethiopia are marital status, region, perceived distance to seek medical care, parity and history of contraceptive use. (Bekele & Fekadu, 2021; Merga et al., 2021; Nigussie et al., 2021).

Another study also concurs that age, level of education, marital status, exposure to radio and television, parity, and community literacy level reasons for unintended pregnancy. (Ahinkorah, 2021) and contraceptive ever use, discussion with partner, poor follow-up of counseling, fear of side effects, and un-satisfaction by the services given during the insertion rate of Implanon. (Mamecha et al., 2020).

## 1.2 Statement of the problem

The major reason for the increasing rate of unintended pregnancy followed by induced abortion and maternal mortality was the level of women autonomy and the gap on accessing and practicing contraceptive. Although high, the magnitude of unintended pregnancy in Ethiopia was lower compared to the global level. Marital status, region, perceived distance to seek medical care, parity and history of contraceptive use were found significant predictors of unintended pregnancy in Ethiopia (Bekele & Fekadu, 2021).

Unintended pregnancy among youth had spatial variation across the country. The distribution of unintended pregnancy among youth in Ethiopia was nonrandom. The overall prevalence of unintended pregnancy was 30% and the pooled prevalence of unintended pregnancy in Ethiopia was high. Inaccessibility of quality family Planning services can increase prevalence of unintended pregnancy and varies among rural, poor, unmarried, multiparous, less-educated, and adolescent women. (Bekele & Fekadu et al. 2021).

The level of repeat-induced abortion was found to be high in Ethiopia with high differences among urban residents, illiterate, multiple sexual partners, and early sexual initiation. The magnitude of unintended pregnancy during the COVID-19 pandemic among women attending antenatal care was found to be 47.17%. (Hunie Asratie, et. al 2021). Unintended pregnancy can result from contraceptive failure, non-use of contraceptive services, and, less commonly, rape. Abortion is a frequent consequence of

unintended pregnancy and, in the developing world, can result in serious, long-term negative health effects including infertility and maternal death. In 1920, Margaret Sanger said, "No women can call herself free who does not control her own body (Institute of Medicine Committee on Unintended, 1995; Klima, 1998; WHO, 2019). The prevalence of IPV during pregnancy in China is considerable and one of the highest reported in Asia, which suggests that issues of violence against women during pregnancy high. (Wang et al., 2017).

Little or no evidence for the effectiveness or cost-effectiveness of any of the interventions to reduce repeat pregnancy in young women. (Aslam et al., 2017). Research showed socioeconomic status, quality of care are the most important risk factors for unintended pregnancy. The prevalence of postnatal depression in Ethiopia was high. (Alipour, Kheirabadi, Kazemi, & Fooladi, 2018; Duko, Wolde, & Alemayehu, 2020; Hall, Benton, Copas, & Stephenson, 2017).

User friendly family planning programs to reduce unintended pregnancy and promoting partner involvement in pregnancy care less practiced and this contributed to high magnitude of delayed antenatal care in Ethiopia. (Tesfaye, Loxton, Chojenta, Semahegn, & Smith, 2017). There is also paucity of data for the risk factors and magnitude of unintended pregnancy due to social desirability in Ethiopia. So, the aim of this study was to assess magnitude and risk factors associated with unintended pregnancy at health facilities attending antenatal care.

### 1.3 Objectives

Therefore this study aims to assess the magnitude and factors associated with unintended pregnancy among pregnant women attending antenatal care in Arada, Yeka sub cities, Addis Ababa, Ethiopia. The specific objectives were assess the magnitude of

unintended pregnancy among pregnant women and determine factors associated with unintended pregnancy among pregnant women.

#### 1.4. Rationale of the study

Unintended pregnancy were under reported due to the fact that the legal, social desirability and cultural norms are not open to discuss on the sensitive issue of unintended pregnancies and abortion. The conceptual framework helped in identifying predictors of unintended pregnancy to inform the public health programme through determining the magnitude of unintended pregnancy among pregnant women as well as the factors associated with is very crucial in designing and implementing interventions and program reconsiderations that could be tailored to women needs. This study tried to assess prevalence unintended pregnancy and associated factors. Therefore, the result of this study will serve as a program informing information and intervention or program reconsiderations.

## CHAPTER TWO: REVIEW OF LITERATURE

### 2.1 Theoretical framework

There have been numerous theories pertaining to human health and wellbeing. Some of these theories focus on the impacts/consequences of illness/disease while others capitalize on the risk factors or determinants of health behavior. The most commonly cited theories of health behaviors include Anderson's Theory of Health Behavior or Behavioral Model (BM), Social Determinants of Health (SDH) and the social ecological model (SEM). These theories have been used to explain health behaviors (such as illness, pregnancy, maternal and child health care...etc.) of different groups of population.

**Anderson's behavioral model** is a kind of multilevel model that incorporates both individual and community level determinants of health. The model divides the major components or variables as: predisposing, enabling and need factors. The individual predisposing factors include a wide range of characteristics such as age and sex, education, occupation, and social relationships (e.g., family status), and mental factors in terms of health beliefs (e.g. health services). There are also contextual factors predisposing individuals to the use of health services (including social composition of communities perspectives). The enabling factors are related to finance and organizational factors (Anderson et al, 1995). On the other hand, the need factor is mainly differentiating between perceived need for health services (i.e., how people view and experience their own general health) and evaluated need (objective measurements of patients' health status and need for medical care). (Anderson et al. 2001).

**The Social Determinants of Health (SDH)** is commonly used to understand and appreciate differences in the health inequalities experienced by women (Bhawra et al,

2017). The SDH refer to the economic and social conditions that shape the health of individuals and communities (Raphael, 2016). The SDH includes a range of characteristics at both individual/household and community levels, including education, employment, food security, gender, geography, housing, and income (Raphael, 2016). The SDH approach also emphasizes understanding the social and economic factors that shape health behaviors and access to resources that influence health (Raphael, 2016). While some of the SDH variables are difficult to measure accurately, researchers around the world most often use this theory to explain health behaviors of individuals including high risk pregnancy and other maternal morbidities (Bhawra et al, 2017).

**The social ecological model (SEM)** (also known as the ecological model) is a theoretical framework that accounts for the multiple, reciprocal interactions between individual behaviors and the broader determinants of health (e.g., the SDH) (Stokols, 1996). The SEM recognizes there are numerous interacting spheres of influence that impact human behavior and health outcomes (including unwanted pregnancies) (Stokols, 1996). With respect to unwanted pregnancies, the SEM implies that individual health seeking behaviors must be situated and contextualized within people's broader environments. Although levels of influence vary according to the model, SEMs generally include considerations of individual (e.g., education and motivations), interpersonal (e.g., family, friends, and peers), physical environment (e.g., schools, home, and work sites), and macro-level (e.g., health policy, and social norms) variables (Story et al., 2008).

Each level of influence in the SEM is an important level of influence on pregnancy behaviours as well as a key point for health promotion more broadly. (Sallis & Owen, 2015). The SEM offers a framework to help researchers and health professionals to analyze and contextualize factors that influence health behaviours and to uncover a

deeper understanding of the relationships and interactions between factors (Willows et al., 2012). A fundamental strength of all SEMs is that their focus on multiple levels of influence expands the range of determinants considered and broadens options for interventions (Sallis & Owen, 2015). However, the SEM also has limitations as it does not necessarily specify the variables that are most influential at each level (Sallis & Owen, 2015; Story et al., 2008).

## **2.2 Eperical Review of literatures**

Unintended pregnancy is a worldwide problem affects women, their families, and society. Women and adolescents require access to age-appropriate and culturally sensitive reproductive health care services, including emergency contraception. Access to safe, legal abortion services is necessary to impact the staggering maternal mortality rates worldwide. Studies shows access to contraceptive services (including emergency contraception), safe and legal abortion services, and societal norms that empower women to make their own reproductive choices are prerequisites to solving this problem. A study conducted by the World Health Organization (WHO) in 36 countries also found that two-thirds of sexually active women who wished to delay or limit childbearing stopped using contraception for fear of side effects, health concerns and underestimation of the likelihood of conception. Though topic of preventing unintended pregnancies has long been treated gingerly because of personal sensitivities and public controversies, especially the abortions debate. (Klima, 1998; WHO, 2019 & Mamecha, Akalewold, & Deresse, 2020).

Different studies shows how socio demographics, attitudes, cultural routed and perceived behavioral relate affects the intention to have a child. In addition the effects of

the gender inequalities and correlations associated with key women's reproductive health, especially unintended pregnancy. (Ciritel, AA. Et al.,2019).

Reported findings showed that women's age, wealth index, place of residence, number of children, family size, the intention of contraceptive use, living with a partner, and first cohabitation age are essential determinants of unintended pregnancy. The study findings also underscore the need for significant improvement in the access to contraception methods and family planning information to reduce unintended pregnancies in the entire country. (Nyarko, 2019; Sarder, Islam, Maniruzzaman, Talukder, & Ahammed, 2021).

Social scientists have debated long how to measure pregnancy intentions and standard measure relies on mothers' retrospective reports of their intentions at the time of conception. Studies in 31 sub-Saharan African countries showed mothers less reporting deceased children resulted from unintended pregnancies. There is also challenges on the reliability of retrospective reports of pregnancy intentions in high- mortality settings and consequences of unintended pregnancies in different contexts. (Nyarko, 2019; Sarder, Islam, Maniruzzaman, Talukder, & Ahammed, 2021; Shahry, Kalhori, Esfandiyari, & Zamani-Alavijeh, 2016; Smith- Greenaway & Sennott, 2016).

The findings also showed magnitude of unplanned pregnancy was high and age, marital status, occupation, and history of unplanned pregnancy were factors for an unplanned pregnancy. Significant proportion of women had experienced an unintended pregnancy (Moges, Worku et al., 2020, & Merga et al.,2021).

Women in developing countries currently have an unmet need for modern contraceptive methods, which would prevent 54 million unintended pregnancies. In addition these unmet family planning need leads to 21 million unplanned births, 26 million abortions (of which 16 million would be unsafe) and 7 million miscarriages; 79,000 maternal deaths and 1.1 million infant deaths. Community education about family planning, improving women's decision-making power, giving emphasis on pregnancy-related complications with health-care provider support suggested to reduced unintended pregnancy (Hunie Asratie, 2021).

In Ethiopia, contraceptive prevalence rate is 29 percent. Whereas, unmet need for family planning services is 25%; from these 16 percent have a need for spacing, and 9 percent have a need for limiting as per 2016 (CSA, 2016).

In 2011, 48% of all pregnancies in the United States were unintended.(Brown SS, Eisenberg L, 1995 &Finer LB, Zolna MR, 2016.). In 1920, Magaret Sanger said, "No women can call herself free who does not control her own body." Although great strides have been made to improve the health and status of women since Ms. Sanger spoke those words, there remains much work to be done (Klima C. S., 1998). Publicly funded family planning services help women avoid pregnancies they do not want and plan pregnancies they do want. In 2014, these services helped women avoid two million unintended pregnancies. (Frost JJ, Frohwirth LF and Zolna MR, 2014)

Little change occurred in primary or secondary abstinence and significant number of women didn't use condom for pregnancy prevention. Even though promoting non-barrier contraceptive methods may inadvertently increase HIV risk, it reduce unwanted pregnancy; unwanted pregnancies were most common in Swaziland (39.54%) and least

common in Niger (0.74%). Unintended pregnancies are critical risks to achieving improved maternal health in respect optimal antenatal care coverage for women in Africa and could lead to pregnancy termination. In addition there is a need for regular integrated community-based outreach programs or community responsiveness of effective contraception and prevention of unintended pregnancy (Ali & Cleland, 2018; Amo-Adjei & Anamaale Tuoyire, 2016; Dickson, Adde, & Ahinkorah, 2018).

Induced abortion will never be totally eliminated, but decreasing the incidence is possible by removing the barriers to accessing abortion services.

In the developing world, providing safe abortion within existing legal constraints continues to be an international public health goal. unsafe abortion-related complications occur, adequate medical treatment should be available. Many challenges remain, however, as unsafe abortion continues to be an urgent global health concern.

Women and their husbands' age, the number of male offspring in family and marriage years were significantly associated and this showed unwanted pregnant women are more likely to be exposed to low level of perceived social support and self-efficacy (Shahry et al., 2016).

The prevalence of unintended pregnancy was 34.8% and unintended pregnancy was significantly correlated with women's age, marital status, gravidity and who made decisions on family planning (Nigussie et al., 2021). The prevalence of unintended pregnancy among the women is high (Teklu, Belina, Chemir, Tessema, & Yismaw, 2021). The level of education also plays a part in determining the rate of unintended pregnancy. Birth rates among women with low education are higher than those with secondary or tertiary education (Ameyaw et al., 2019) and partners who disagrees with

their number of family size also more likely to unintended pregnancy. Women with increased past history of unintended pregnancy have high probability of current unintended pregnancy (Aslam et al., 2017).

The research findings study showed that the proportion of women who experienced unintended pregnancy is considerably high. Parity, fertility preference, polygamy relation, women autonomy, and region were identified factors associated with unintended pregnancy. Policymakers at all levels, reproductive health experts, and concerned organizations should emphasize minimizing unintended pregnancy targeting the regional variation at large (Zelege et al., 2021). The conceptual framework developed based on the above mention theory and helps in guiding the tool preparations.

### 2.3 Conceptual framework

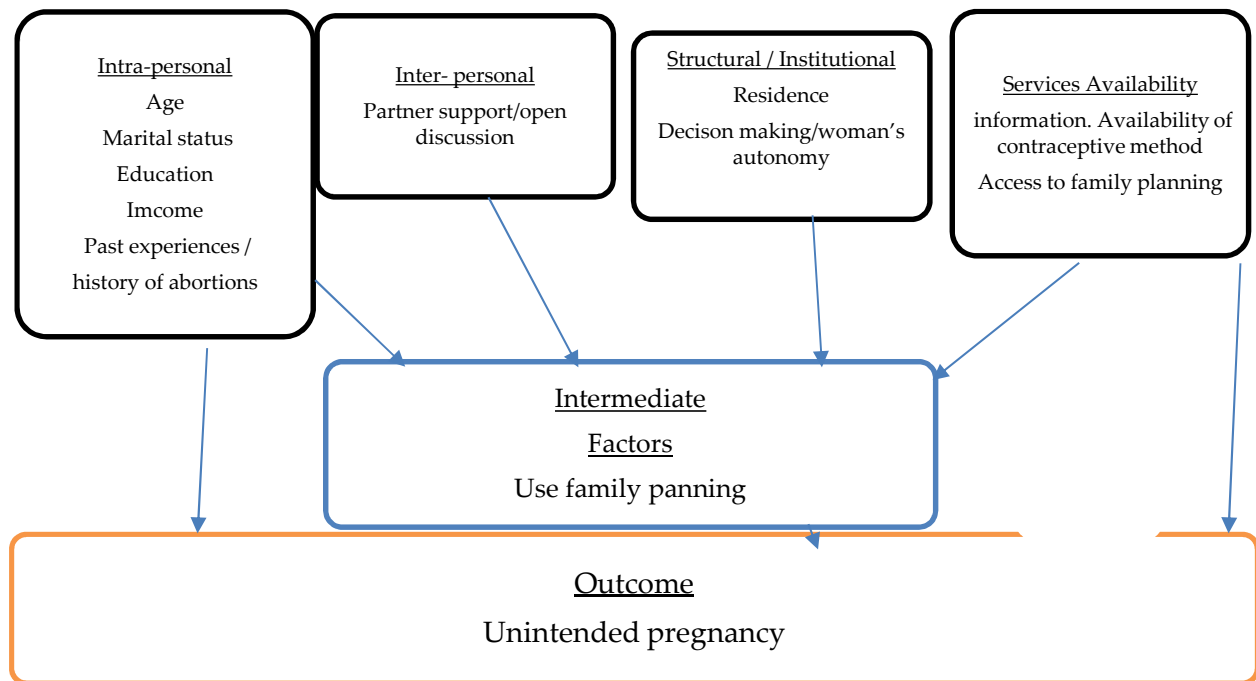


Figure 1 Conceptual framework for factors associated with unintended pregnancies adapt from literature reviews

## CHAPTER THREE: METHODOLOGY

### 3.1 Study Area

This study was conducted in public Health Centers at Yeka and Arada sub cities, Addis Ababa. Administratively, Addis Ababa is divided in to 11 sub cities with more than 5,006,000 populations. According to Addis Ababa health bureau there were 7 Federal, 6 regional, 38 private hospitals, and more than 850 private clinic. There is also a total of 97 public health centers are providing health care service for communities. According to Ethiopian Hospitals and Health center implementation guidelines, almost health centers give ANC and delivery service.

### 3.2 Study Design and period

A facility based cross-sectional study was conducted from March to April 2022 at 6 selected public health centers in Arada and Yeka sub cities, Addis Ababa.

### 3.3 Source population

All pregnant women who live in Arada and Yeka sub cites were the source population

#### 3.3.1 Study population

whose attending antenatal care (ANC) during data collection time were included in the study. Unable to communicate, Pregnant women who are seriously ill at the time of data collection and pregnant women who refuse to participate were excluded

### 3.4 Sample size determination

For the first objective it calculated by using single population proportion formula. The sample size of the study determined using the single population proportion based on the assumption that prevalence rate of unintended pregnancy was 30% (Kebede et al., 2021) and 95% confidence interval was used with a marginal error of 5% and by taking the non- response rate as 10% due to sensitivity of the issue. 
$$N = \frac{(Z_{\alpha/2})^2 pq}{d^2}$$

Where:  $n$  = sample size

$P$  = proportion of unintended pregnancy (30%)

$q = 1-p$ ,  $d$  = marginal error (5%)

$Z$  = is the standard normal value at 95% confidence level

= 322.69  $\approx$  323

= 10% of attrition rate was assumed

= the total sample size was three hundred fifty five 355

For the second objective the sample size was calculated by using an Open Epi software

Table 1 Calculated sample size by using Open Epi software for second objective.

Articles		Variables	Percent of unexposed with outcome	Odds ratio	Total sample
Name of authors	Year				
Kebede et al.)	2021	Unintended pregnancy	30%	0.3	168
Zelege	2021	post-partum depression	66.1%	2.84	188
Mekie	2021	unmet need for family planning	25.7	3.38	108
Mekie	2021	repeat-induced abortion	29.9%	3.8	88
Asmamaw Demis Bizuneh	2021	post-abortion family planning	67.86%	4.63	144

Since the calculated sample sizes in second cases are lower, the first calculated sample size (355) taken for both objectives.

### 3.5 Sampling procedures

All public health centers found in Arada and Yeka sub cities was served as the sampling frame, then by using lottery method, three public health center from each sub city was selected. Monthly total number of pregnant women visited health centers was guide the number of sample size allocation.

The proportion from each health center was calculated as:- Proportion of selected health center = Total number of women

$$\frac{\text{Attending ANC per month} \times \text{Sample size}}{\text{Total number of pregnancy in all selected health centers}}$$

Table 2 Proportion of respondents for each health centers calculated, 2021

Name of Health center	# of women attending ANC/month	Proportion of participants
Yeka woreda 2 HC	112	59
Yeka woreda 4 HC	50	41
Yeka woreda 9 HC	145	76
Arada woreda 71HC	98	59
Arada woreda 9 HC	87	50
Arada woreda 10 HC	104	70

Systematic random sampling technique was used to select the study participants using ANC registration book as a sampling frame, then interval of “K” was calculated. By divided the total number of women attending ANC per month to the allocated sample size for each health center. Finally every “K” interval the study participant was selected.

### 3.6 Study variables

#### 3.6.1 Dependent variables

Unintended pregnancy (Yes, No)

#### 3.6.2 Independent variables

Socio-demographics such as Age, Educational status, Occupation, Marital status, Previous pregnancy (parity), Past experiences / history of UP, Woman’s autonomy/decision making, Availability of information and contraceptive method mix, accessibility of FP

### 3.7 Terms of definition

Unintended pregnancy: - Is either unwanted or miss-timed at the time of conception

Mistimed pregnancy:-If a woman did not want to become pregnant at the time of conception, but did want to become pregnant in the future.

Unwanted pregnancy:-If a woman did not want to become pregnant at conception or at any time in the future.

Parity: - The number of times a women has given birth.

Women autonomy: the ability to decide independently about type of contraceptive use, self- health care, and their income management.

### 3.8 Data Collection Instrument and procedure

Data was collected by interviewer administered structured questionnaire, composed of socio demographic variables and reproductive history of pregnant women including awareness and practice of family planning and unintended pregnancy as well as birth and induced abortions. five BSc nurses and three Health officers of female data collectors was recruited considering women's preference in the community. They were received two days intensive training. The training was given on how to ask and fill the question, selection criteria of ANC attending pregnant women, and how to approach the mothers before the actual data collection days.

### 3.9 Data quality control

The questionnaire was initially prepared in English and translated in to local language and again back translated to English by another expert to check for its consistencies. And the questionnaire was pre-tested prior to data collection in pregnant women who are attending ANC outside the study area. In Gulele health center 5% of the sample and modifications are done accordingly. At the end of each data collection day, the principal investigator and Supervisors also was checked the completeness of filled questionnaires.

### 3.10 Data Management and Analysis

All collected data was checked for completeness and coded and entered in SPSS version 28 statistical package software to analyze the data. Summary statistics such as, percentage and frequency was computed, table and figure presentations used. The bivariate analysis was done to test the association between the independent and outcome variables. All explanatory variables associated with the outcome variable in bivariate analysis was included into multivariate logistic regression, to determine the independent predictor of unintended pregnancy. P-value of  $<0.05$  was considered as a cut-off point.

### 3.11 Ethical Consideration

Ethical clearance was obtained from ethical committee of AAU and letter of permission was also obtained from Addis Ababa Health Bureau. The principal investigator was communicated these sites. Consent form was provided for respondents to read for those who can read and the interviewer was read the paper for those respondents who cannot read. Finally, the respondent was asked the agreement to participant in the study. Confidentiality was maintained by omitting their names and personal identifiers, it was not revealed to anyone except the principal investigator. Privacy was maintained by arranging a quiet place for interviewer and study participant to protect them exposing other parties. Study participants have the right to participate on the study or not and they can withdraw any time of they wish.

### 3.12 Dissemination of results

The final report of the study was submitted to the Addis Ababa University center of population studies. Hard copy will be given to public health centers included in this study. The research finding will also disseminated in publication.

## CHAPTER FOUR: RESULTS

### 4.1 Socio demographic characteristics of respondents

Three hundred fifty five pregnant women were included in this study with response rate of 100%, 176 were from Yeka sub city and 179 were from Arada sub city health centres. The mean age of respondents were 29.5 years with 17 and 47 years minimum and maximum ages respectively. Almost 94% of the study participants were living in urban. Among study participants (90.4%) were married and the mean age of respondents at marriage was 23.6% with minimum and maximum was 17 and 33 years respectively. Significant amount of the pregnant women (13.0%) participated in this study had no education and 27.3% attain primary school while 14.0% of their husband had no education and 23.4% attain primary school. Twenty seven percent of households had less or equal to 300 ETB per month and almost seventeen percent of the household had more than 7000 ETB per month. The minimum and maximum income of the respondents was 1000 ETB and 12000 ETB respectively.

*Table 3 Socio-demographic characteristics of pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.*

Variable	Percent (%)	
Marital status	Married or living together	90.4
	Divorced or separated	4.2
	Widowed	0.6
	Never married /never lived together	4.8
Religion status	Orthodox	52.7
	Muslim	22.0
	Catholics	10.1
	Protestant	15.2
Educational status	No education	13.0
	Primary Education	27.3
	Secondary education	25.6
	Diploma and above	32.7
	Others	1.4
Educational status for husband	No education	14.0
	Primary Education	23.4
	Secondary education	28.0
	Diploma and above	33.3
	Others	1.2
Household monthly income	≤ 3000	27.0
	3001-4500	23.9
	4501-7000	32.1
	≥7001	16.9

On the other hand, as the reported finding shows, majority of the respondents (52.1%) were between 26-34 years and significant amount of the study participants were work in professional (29.3%), clerical (36.3%) and their counterpart/husbands work in clerical (37.7%), professional (22.6%) and skill manual (8.8%).

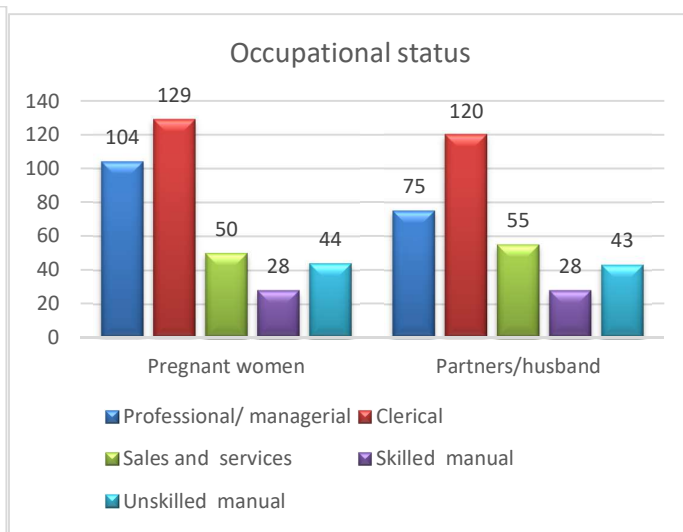
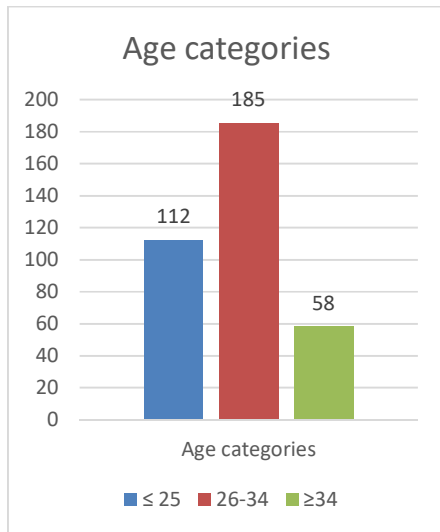


Figure 2 Age category of pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia

Figure 3 Occupational status of pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia

#### 4.2 Reproductive health status of pregnant women

Pregnant women included in this study were ranging from 1 to 9 months since their conception time (see table 4) and have children's ranging 1 and maximum 6 children's with mean 2 children's. Majority (46.5%) of women had two and more pregnancy history including the current pregnant. And (76.4%) of the pregnant women thought they had got pregnant at the right time.

Table 4 Reproductive health status of pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

Variable		Percent (%)
Months since pregnant	≤ 4	29.3
	5-6	23.9
	7-8	34.6
	≥9	12.1
Pregnant before the current pregnancy	yes	46.5
	no	53.5
Number of pregnant including current one	2	39.4
	3	32.1
	≥4	28.5
Want to get pregnant at the time	yes	76.4
	no	23.6
How many live children do you have that were born to you?( Enter number)	1	46.7
	2	27.0
	3	26.3

Among 355 pregnant women, 165 women had pregnancy before the current and among these women, (27.3%) had a history of abortions. Based on the respondents response the abortion history, (53.3%) were induced and (46.7%) were spontaneous.

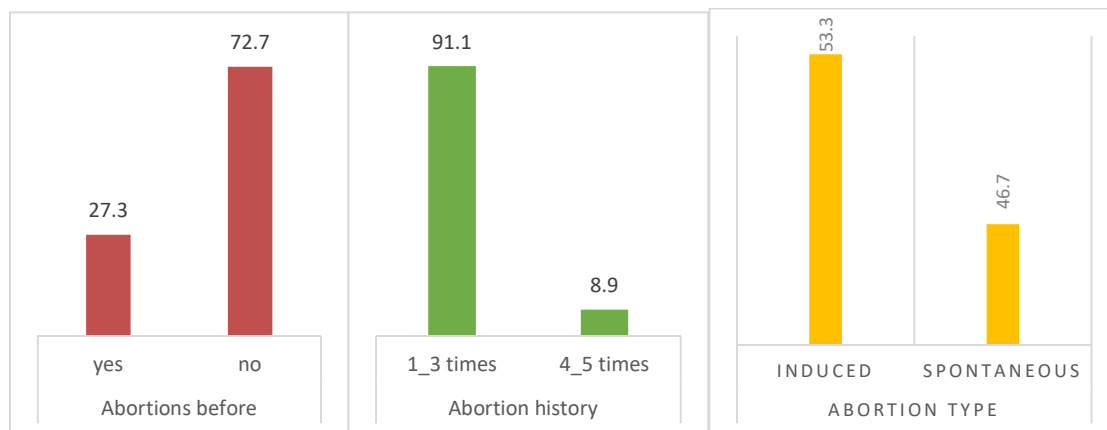


Figure 4 Percentage of abortion history among pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

### 4.3 Prevalence of unintended pregnancy among pregnant women

The reported finding shows the prevalence of unintended pregnant was 18.3%, majority of them (89.2%) experienced unintended pregnancy once until this study conducted. From the total unintended pregnancy (18.3%), (10.4%) were mistimed and (7.9%) were unwanted (see figure 5 & table 5). More than 56% of them tried to stop the pregnancy; 18.5% failed to managed and 38.5% successfully stop the pregnancy to continue.

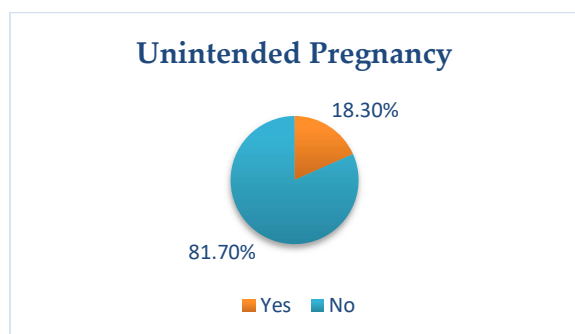


Figure 5 Unintended pregnancy status of pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

Table 5 Unintended pregnancy status of pregnant women ( $n=355$ ), Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

Variable	Percent	
Unintended pregnancy (mistimed or unwanted)	Mistimed	10.4
	Unwanted	7.9
Number of unintended pregnancy	1	89.2
	$\geq 2$	9.8
Actions taken for unintended pregnancy	nothing, unintended pregnancy continue	43.1
	attempt to stop pregnancy but failed	18.5
	Attempted to stop pregnancy and succeeded	38.5

Respondents mentioned schooling time, financial, raped, and separated/divorced and no support were the main reason for the unintended pregnancy (see figure 5)

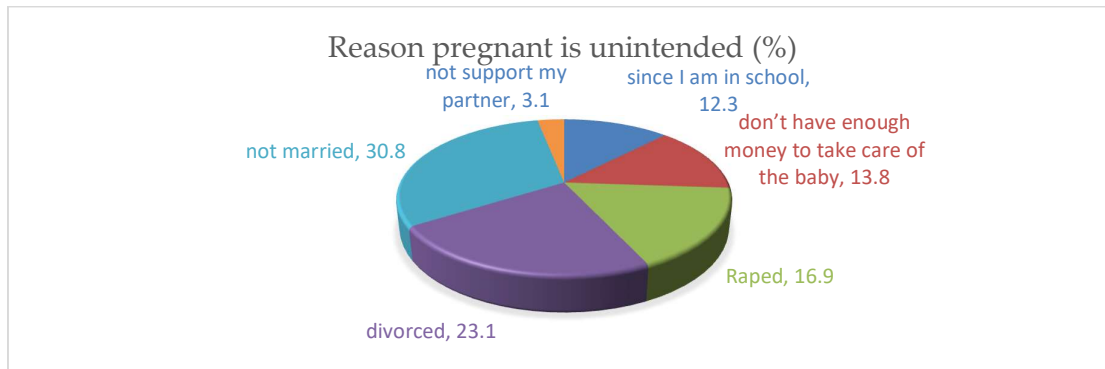


Figure 6 Reasons for pregnant to be Unintended, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

#### 4.4 Awareness on modern family planning and utilizations status of pregnant

Majority of the study participant (95.2%) had information on family planning to avoid or delay pregnancy. Family, friends, mass media and health workers are the sources of information for pregnant women. Significant number of study participants 67.3% know modern type of family planning have been using modern family planning, among these users majority were using pills 58.8%, injectable 41.7%, IUCDs 30.4% and emergency contraceptives 30.9%. (see table 6)

Table 6 Respondents awareness on modern family planning and utilizations status of pregnant women, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

Variable		Percent (%)
Heard methods for couple to delay or avoid a pregnancy	yes	95.2
	No	4.8
Heard from	family	13.4
	friend	23.3
	Mass media	23.6
	health worker	30.0
	other	9.6
Method know (multiple answers)	Pills	74.3%
	Condoms	47.8%
	Injectable	66.8%
	IUCDs	63.6%
	Implants	52.2%
	Calendars	49.3%
	emergency contraceptive	55.8%
	Others	7.9%
Used any type of contraceptives	yes	67.3
	No	32.7
methods used (multiple answers)	Pills	57.8%
	Condoms	22.2%
	Injectable	41.7%
	IUCDs	30.4%
	Implants	26.1%
	Calendars	28.3%
	emergency contraceptive	30.9%
	Others	20.4%
Knowledge how to prevent unintended pregnancy for unprotected sex	yes	56.4
	No	45.6

Significant proportion of women 39.4% make decision by themselves for utilizations of family planning, 17.2% women make decisions with their partners/husbands and 9.6% of the respondents said her partner/usband decided for family planning utilizations. See figure 7

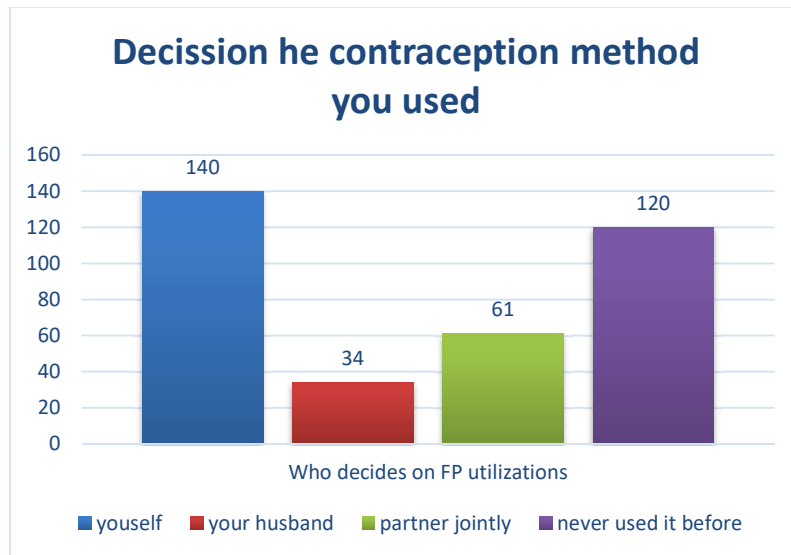


Figure 7 Who makes decision on family planning utilizations, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

Women were also asked how to spend the money earned and significant proportion of women 52.7%% make decision by themselves to spent it for what they needed, 31.0%% women make decisions with their partners/husbands and 15.8% of the respondents said her partner/husband decided for for the money to spent. See table 7

Table 7 Who makes decision on family planning utilizations, Yeka and Arada Sub City, May 2022, Addis Ababa, Ethiopia.

Variable	Percent	
Decision maker on money women earn	yousef	52.7
	husband/partner	15.8
	partners jointly	31.0
	others	.6
	Total	100.0

#### 4.5 Multivariate analysis

The multivariate analysis was done by considering the conceptual framework to assess the relative effect of predictors on the outcome variable (unintended pregnancy).

As the cross-tabulation percentage shows, among women who had no education 47.8% of them had history of unintended pregnancy and 68.9% of women who had history of abortion had unintended pregnancy. Among women who had accessible family planning, only 12.2% of women had unintended pregnancy and women who experienced open discussion, only 10.6% unintended pregnancy. Multicollinearity teste using variance inflation factor (VIF). The value for VIF test were 1. 2 for all independent variable which indicates there is no correlation between a given predictor variable and any other predictor variables in the model.

The model goodness test was performed using Hosmer and Lemeshow Test and it show the model is good (chi-square=8.819 & significance=0.358) to proceed the analysis. Multivariate analysis of this study revealed that accessibility of family planning, history of abortions and openly discussion with partners/husband found statistically significant and predictors of unintended pregnancy.

The likelihood of unintended pregnancy is lower by 78% for those who had previous history of abortion [AOR=0.22(0.075-0.664)]. The likelihood of unintended pregnancy is lower by 94% for those pregnant women who had access to family planning services [AOR= 0.06(0.014-0.269)]. The likelihood of unintended pregnancy amongst women who had open discussion with their husband/partner about family planning is lower by 80% [AOR= 0.2(0.073-0.567)].

Table 8 Multivariate analysis to observe the relative effect of determinants for unintended pregnant women, Yeka and Arada Sub City, May 2022 Addis Ababa.

Characteristics		Unintended pregnancy		B	S.E	95% CI_AOR	P-value
		yes	No				
Educational status	No education	47.8%	52.2%	-0.467	0.657	0.6(0.182-2.158)	0.459
	Primary Education	10.2%	89.8%	-0.836	0.780	2.3(0.688-7.743)	0.176
	Secondary educa	10.9%	89.1%	-0.250	0.631	1.3(0.293-5.634)	0.740
	Diploma & above	19.3%	80.7%			1	
Marital status	Married	18.4%	81.6%	-0.995	0.976	0.37(0.55-2.505)	0.308
	Non-married	17.6%	82.4%			1	
Had abortions	yes	68.9%	31.1%	-1.503	0.558	<b>0.22(0.075-0.664)*</b>	<b>0.007</b>
	no	28.3%	71.7%			1	
Family planning accessibility	yes	12.2%	87.8%	-2.786	0.752	<b>0.06(0.014-0.269)*</b>	<b>0.000</b>
	no	49.2%	50.8%			1	
Open discussion	yes	10.6%	89.4%	-0.591	0.522	<b>0.2(0.073-0.567)*</b>	<b>0.002</b>
	no	24.3%	75.7%			1	
Age categories	≤25	17.0%	83.0%	-0.571	0.571	0.6(0.134-2.390)	0.438
	26-34	18.4%	81.6%	-0.227	0.227	0.8(0.220-2.890)	0.729
	>34	20.7%	79.3%			1	
Monthly income	≤ 3000	16.7%	83.3%	-0.411	0.411	0.663(0.137-3.211)	0.609
	3001-4500	24.7%	75.3%	-0.800	0.800	0.449(0.093-2.177)	0.320
	4501-7000	15.8%	84.2%	-0.326	0.326	0.722(0.173-3.007)	0.654
	≥7001	16.7%	83.3%			1	
Decision making FP	Myself	31.4%	68.6%			1	
	My husband	20.6%	79.4%	-0.781	0.561	0.458(0.095-2.200)	0.330
	Jointly	23.0%	77.0%	-0.034	0.856	1.035(0.345-3.104)	0.952

## CHAPTER FIVE: DISCUSSION

This study has examined the magnitude and predictors of unintended pregnancies among pregnant women attending antenatal care in Arada, Yeka sub cities, Addis Ababa. The study was based on a representative sample of 355 pregnant women drawn randomly from selected health facilities. It is understood from the analysis that almost one-fifth of pregnant women (18.3%; 95%CI: 1.78-1.86) had unintended pregnancy and 45.9% of women had two or more gravidity.

Significant study participants had abortions history which is directly related to unintended pregnancy. This finding concurs with a study conducted in Ethiopia (Nigussie et al., 2021). The prevalence is lower than a recent study conducted in selected districts in Oromia region, which reported that 31.1% of currently pregnant married women in the study area had unintended pregnancy (Merga et al, 2021). Bekele & Fekadu (2021), reported that about 30% of married women had unintended pregnancy.

Unwanted and mistimed pregnancy were lower as compared to a meta-analysis conducted in Ethiopia based on 250 studies computed a pooled prevalence of unwanted and mistimed pregnancy as 12 & 17%, respectively (Kindie et al, 2021). The differences in the reported figures could arise from difference in the study set up (such as socio demographic and cultural differences) or variations in scope (such as sample size) or both.

The study found three variables predicting unintended pregnancy in the study population. These are: having abortion experience, family planning accessibility and experience of open discussion on reproductive health issues. The other five variables in the model did not become significant.

The multivariate analysis showed that having history of abortion is a predictor of lower unintended pregnancy among the study population and . This finding also compliment with WHO and other studies (Institute of Medicine Committee on Unintended, 1995; Klima, 1998; WHO, 2019).

The analysis witnessed statistically significance positive association between family planning accessibility and the likelihood of unintended pregnancy. A meta-analysis conducted in Ethiopia based on 250 studies showed that women who travelled more than an hour to reach the health facilities for receiving services (including FP) were more likely to experience unintended pregnancy(Kindie et al, 2021). The study further reiterated that women who had never been visited by health or family planning workers were more likely to report unintended pregnancy. Gebremariam et al(2019) also confirmed that those who did not have access to the services were more likely to experience unintended pregnancy. The finding is also consistent with other similar studies conducted around the world, including Ethiopia (e.g Bekele & Fekadu, 2021; Kebede et al., 2021; Kebede et al, 2021; Nyarko, 2019; Sarder et al, 2021; Alipour et al, 2018; Duko et al, 2020; Hall et al, 2017).In most instances, accessibility of family planning services are constrained by lack of knowledge and unfavourable attitudes (Abebe and Nigatu, 2011) A community-based study in the Oromia region showed that low contraceptive knowledge was strongly associated with unintended pregnancy even after controlling for the accessibility of family planning clinics (Teshome et a, 2014; Abebe and Nigatu 2011).

Another statistically significant predictor was open discussion about contraceptives. It is noted that women who had open discussion about family planning were less likely to have unintended pregnant compared to those who didn't have open discussion about family planning with their husband/partners. This reported finding is similar with previous studies conducted in Ethiopia (Tesfaye et al, 2017 & Cirtel et al.,2019). Given the fact that most women in Ethiopia are less educated and are living

a patriarchal society, their autonomy and participation in decision making on their own health could be limited. This in turn limits the possibilities of open discussion with their husband, health workers and other members of the community.

## CHAPTER SIX: STRENGTH AND LIMITATIONS OF THE STUDY

### 6.1 Strength of the study

- ✓ This study tried maximum effort to be understood the importance of this study to avoid recall bias and social desirability. Therefore, the result of this study will serve as a program informing information and intervention or program reconsiderations for the public health facilities.
- ✓ Given studies on the subject are limited, the present study could be very useful in increasing our understanding of the magnitude of the problem and the risk factors associated with it. The findings could be useful for program planning, management and evaluation

### 6.2. Limitations of the study

- Finally, this study is not without limitations. First, the study was based on cross-sectional data which entails collection of information at a specific point of time in the lives of the respondents. This implies that the findings cannot implicate cause-effect relationship between the independent variables and the outcome variable of interest. Secondly, the retrospective measure of women's pregnancy intention and other characteristics could increase the probability of recall bias and miss reporting of events during data collection which could affect the analysis and interpretation of the findings.
- This study includes only urban areas, thereby providing measure of unintended pregnancy at large level to make conclusions is limited.

## CHAPTER SEVEN: CONCLUSION AND RECOMMNDATIONS

### 7.1 CONCLUSION

The results of the study have shown that the prevalence of unintended pregnancy is fairly high among the study population. While many individual and community variables interact to influence the likelihood of unintended pregnancy, the present study found three key predictors of the outcome variable in the study area: History of abortion, accessibility to family planning services and discussion on reproductive health issues. Unintended pregnancy and abortions is still a public health problem and fairly high in the study areas. Increasing accessibility of family planning and openly discussion with husband/partners were the important predictors to reduce unintended pregnancy.

### 7.2 Recommendations

Based on the key findings, the concerned local authorities should make sure that FP resources are available with quantity and quality, strengthening the follow up system. For those who had abortions, it is important to emphasize the importance of burden of health consequences and increase counseling services to reach majority for reducing abortions and unintended pregnancies. Use of Behavioral Change Communication (BCC) could help change the attitudes and beliefs of men and women and promote open discussions and inter- spousal communication on key reproductive health issues. Finally, further research is warranted on the socio-cultural context of women that influences women's empowerment and family planning use to establish an in-depth understanding and equity in society

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## I Appendics English Version Questioners

### Informed consent statement

#### Addis Ababa University, Center for populations study

A Questionnaire for the Study of Determinants of unintended pregnancy among pregnant women attending ANC Addis Ababa, Ethiopia, 2022

Good morning/afternoon, my name is \_\_\_\_\_ and I represent (name of the health facility). We are conducting a study within Addis Ababa with Addis Ababa University. We would appreciate your participation in this survey very much. I would like to ask you questions about some important issues in relation to unintended pregnancy. This information will help us to plan services that address the special needs of your community.

The information you provide on the basis of your experiences, will help to make policies and programs related unintended pregnancy. Whatever information you provide will be kept strictly confidential and will not be shown to other individuals. Participation in this survey is voluntary, If you prefer not to respond to all questions or to some of the questions it is your right and your decision will not affect in any way the services you are receiving at the hospital/clinic and you don't have to answer any question if you don't, and you can stop the interview at any time. However, we hope that you will actively participate in this survey since your views are important.

The interview will take only about 30 minutes of your time.

At this time, do you want to ask me anything about the survey?

May I begin the interview now? (Circle)

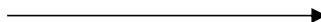
1 = Yes 2 = No (End the interview)

Name & Signature of interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Name & Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Respondents ID number .....Health center.....

Section I: Socio-demographic characteristics of pregnant women attending ANC at health

code	Questions	Responses	skip	Remark
101	How old are you? (Enter age in years)	-----		
102	What is your marital status?	1.Married or living together 2. Divorced or Separated 3. Widowed 6. Never married or never lived together		
103	If Q No 102 is married, what was the your age during getting married?	-----		
104	What is the highest grade you completed?	-----		
105	What is the highest grade your husband completed?	-----		
106	Where do you live	Urban Rural  108		
107	If urban Q.No. 104.Duration of urban residence( Enter in years)	-----		
108	What is your Religion?	Orthodox Muslim Catholics Protestant Other		
109	What is your occupation? That is, what kind of work do you mainly do?			
110	What is your (husband's/partner's) occupation? That is, what kind of work does he mainly do?			
111	How much is your/as family/ monthly income?	..... In Birr		

centre.

**Section II. Reproductive History of Pregnant women attending ANC clinic**

Code	Questions	Responses	Skip	
201	How many months pregnant are you now?	.....Months		
202	Have you ever been pregnant before the current pregnancy	Yes No →	209	
203	If YES Q.No. 202. How many times have you ever been pregnant including this one? (Enter number)	-----		
204	If YES Q.No. 202, when you got pregnant, did you want to get pregnant at that time?	Yes No		
205	If YES Q.No. 202, how many live children do you have that were born to you?( Enter number)	_____		
206	If YES Q.No. 202, have you had abortions before?	1.Yes 2.No      If No →	209	
207	If YES Q No 206, how many times (Enter number)			
208	If YES Q No 206, was the abortion induced or spontaneous?	1.Induced 2.Spontaneous 3. Other.....		
209	Have you had previously unintended pregnancy?	1 Yes 2.No      IF No → 3 Not Sure	213	
210	If YES Q. No. 209, when did the last unintended pregnancy?	-----		
211	If YES Q. No. 209, how many times you have had previously unintended pregnancy? (Enter number)	-----		
212	If YES Q. No. 209, what did you do during unintended pregnancy had?	Nothing, unintended pregnancy continue Attempt to stop pregnancy but failed Attempted to stop		

		pregnancy & succeeded		
213	Right before you became pregnant including your current pregnancy, did you yourself want to have a child at any time in the future?	1.Yes 2.No 3. not sure If your answer for Q213 is No → 215		
214	If YES Q. No 213 do you think that you become pregnant at the right time?	1.Yes 2.No		
215	If NO Q. No.213. Right before you became pregnant this time, did you think not to have any child /children/ in the future?	1.Yes 2.No		

### Section III: Contraceptive history of Pregnant women attending ANC clinic

Code	Questions	Responses	skip	
301	Have you ever heard about methods that a couple use to delay or avoid a pregnancy?	1.Yes 2.No		
302	If yes Q. No.301, where do you heard?	Family Friends Mas media 4 Health care provider 5. Other.....		
303	Which one do you know?(Circle all that you know)	1.pills 2.Condoms 3.Injectables 4.IUCD 5.Implants 6.Calendar 7.Emergency contraceptive		

		8. Other		
304	Have you ever used any type of contraceptives?	1.Yes 2.No                      If NO                      →	311	
305	If yes Q. No 304, which among these methods have you used?	1. Pills 2. condoms 3. Injectables 4. IUCD 5. Implants 6. Natural method 7. Emergency contraceptives 8. Other (mention).....		
306	Have you been using appropriately the specified /used method accordingly to the instruction provided?	Yes No Not sure		
307	Where do you think to get the above MFPMs?	1.Hospital 2.Health center 3.FGAE 4.Pharmacy 6.Other specify		
308	Are these MFPMs accessible?	1.Yes 2.No		
309	Is the current pregnancy as per your planned to get pregnant?	1.Yes 2.No		
310	If NO Q. No. 309 why is it unintended?	1. Since I am in school 2. Don't have enough money to take care of the baby 3. Raped 4. Divorced 5. Not married 6. Short gap on between previous pregnancy 7. Not support my partner		

		8.I don't like pregnancy at all 9. Other (mention)		
311	If NO Q. No. 304, why are you not using contraceptives?	1.Too young to attend FP clinics 2.No awareness on contraceptives 3.Contraceptives not available 4. Religious of moral reasons 5.Method failure 6.Fear of side effect 7.Forget it 8.Other (mention)-----		
312	Do you Know how to prevent unintended pregnancy following unprotected sex?	1Yes 2.No		
213	If YES Q No.312 what method can be used?	1.Emergency contraceptive pills 2.IUCD 3. other		
314	Who usually makes decisions about your reproductive health care?	1yourself 2.your husband/partner 3.you and Your husband/partner jointly 4.other		
315	Who decides the contraception method you used? before current pregnancy	1.youself 2.your husband/partner 3.you and Your husband/partner jointly 4.other		
316	Who usually decides how the money you earn will be used?	1.youself 2.your husband/partner Jointly 3.other		
317	Do you have openly discussion about family planning with your partner?	1.Yes 2.No		

# Appendix II: Amharic Version Questioners

በአዲስ አበባ ዩኒቨርሲቲ የሕዝብ ጥናት ማዕከል

የሚስጥር አጠባበቅ ስምምነት

መግቢያ ስህተት አልታወቀም እርግዥና ምክንያቶቻችንን ለማወቅ ለሚቀረግ ጥናት ለጥናቱ

ተሳታፊዎች የተዘጋጅ ማብራሪያና

የስምምነት ቅጽ ጤና ይስጥልኝ

እኔ ----- እባላህሁ።

የአዲስ አበባ ዩኒቨርሲቲ እያካሄድ ባህሪ ሳይንሳዊ ጥናት ውስጥ የጥናት ቡድን አባል ነኝ ከአዲስ አበባ ዩኒቨርሲቲ ጋር በመሆን ስህአልታወቅ እርግዥና ዋና ምክንያቶችን ለማወቅ በአዲስ አበባ ውስጥ በሚገኙ የመንግስት ጤና ጣብያዎች ላይ ጥናት እያካሄድን ነው።

በዚህ ጥናት እንዲሳተፍ በትህትና እጠይቃለሁ በመሆኑም ስህአልታወቅ እርግዥና ጋር የሚያያዙ ጠቃሚ መረጃዎችን አጠይቆታለሁ።ይህ ክርስታል ልምድ በመነሳት የሚሰጡን መረጃ ህወቀፊት ስህአልታወቅ እርግዥና ሆኖቻችን ህህበረተሰቡ የሚሰጠውን የጤና አገልግሎት ለማሻሻልና የመፍትሄ መንገዶችን እንዲቀይሱ ይረዳል። እርስዎ የሚሰጡን መረጃ ያህን እርስዎ ስምምነት ምንም አይነት መረጃ ሆሎላ ሰው የማይተላለፍ /የማይሰጥ/ መሆኑን አረጋግጣለሁ።በጥናቱ ላይ የሚሳተፍት በፍላጎትዎ ሲሆን በሙሉም ሆነ በከፊል ያህን መሳተፍ መብትዎ የተጠበቀ ነው። ጥናቱ ላይ ያህን መሳተፍ ወሳኔዎ የተከበረ ከመሆኑም በላይ የጤና አገልግሎት አጠቃቀምዎት ላይ ምንም ዓይነት ችግር አይከሰትም ። የማያውቁትን አሳይተው ይቻላል እንዲሁም በማንኛውም ሰዓት መጠይቁን ማቆም ይችላሉ። ነገር ግን እርስዎ የሚሰጡት ሃሳብ በጥናቱ ላይ በእጅጉ ጠቃሚ ነው።

ቃላት መጠይቁ 20 ቀን ያህል ይወስዳል።

እስካሁን በተነጋገርናቸው ጉዳዮች ላይ ያልገባዎትና ግልፅ ያህን ነገር ካህ መጠየቅ ይችላሉ በጥናቱ ላይ ለመሳተፍ ተስማምተዋል?

1 አዎ----- 2 አይ----- (ፈቃድ ካህሁን ወሳኔዎቻችንን አክብረን በማመስገን

ወቅት ቀጣይ ተጠያቂ)

የተስማሙ ከሆነ ቃላት መጠይቁን ቀጥይ

ቃላት መጠይቁን ያቀረግኩ ስም-----ፊርማ-----ቀን-----

የተቆጣጠረው ስም-----ፊርማ-----ቀን-----

የተጠያቂው ኮድ ቁጥር-----

የጤና ተቃራኒ ስም-----

**ክፍል 1 ማህበራዊና ስነ ህዝባዊ መረጃዎች**

ክፍል	ጥያቄ	አማራጭ	ይላፍ	አስተያየት
101	እድሜዎ ስንት ነው?	-----		
102	አሁን ያሉበት የጋብቻ ሁኔታ?	1. በጋብቻ ላይ ወይም አብሮ መኖር 2. ከባልዎ የተፋታች ወይም ወይም የተለያዩ 3. የሞተባት 4. አግብተው የማያወቁ ወይም አብረው ኑረው የማያወቁ		
103	አግብተው ከሆነ በስንት ዓመታት ከገቡ?	-----		
104	ከፍተኛው የትምህርት ደረጃዎት ምን ይህል ነው?	-----		
105	የትዳር አጋርዎ/ባለቤትዎ ከፍተኛው የትምህርት ደረጃ ምን ይህል ነው?	-----		
106	የሚኖሩት ቦታ የት ነው?	ከተማ		
	?	2. ገጠር	መልስዎ ገጠር ከሆነ → 108	
107	ጥያቄ ቁ 106 መልስዎ ከተማ ውስጥ ከሆነ መኖር ከጀመሩ ምን ይህል አመት ሆነዎት?	-----		
108	ሃይማኖትዎ ምንድን ነው?	1. ኦርቶዶክስ 2. እስላም 3. ካቶሊክ 4. ጥቅል ተቃራኒ		
109	ስራዎት ምንድን ነው? በአብዛኛው ምን ትስራ ይላሉ?	-----		
110	ስራዎት ምንድን ነው? በአብዛኛው ምን ይሰራሉ?	-----		
111	የቤተሰቡ ወራዊ ገቢ ሥንት ነው?	----- ብር		

**ክፍል 2. የተጠያቂዎ የስነ ተዋልዶ ታሪክ መጠይቅ**

201	የስንት ወር ነፍሰ ጡር ነሽ?	-----		
202	ከዚህ እርግዝናዎ በፊት አርግዘው ያውቃሉ?	1. አዎ 2. አላውቅም	መልስዎ አላውቅም ከሆነ → 209	
203	ጥያቄ ቁ 202 መልስዎ አዎ ከሆነ ከአሁኑ እርግዝናዎ ጋር ስንት ጊዜ አርግዘው ያውቃሉ?	-----		
204	ጥያቄ ቁ 202 መልስዎ አዎ ከሆነ፣ የታቀደ እርግዝና ነበር ወይ	1. አዎ 2. አይደለም		
205	ጥያቄ ቁ 202 መልስዎ አዎ ከሆነ ከርስዎ ከሚዎለዱ ልጆች ውስጥ በሂዎት ያሉት ስንት ናቸው?	-----		

206	ጥያቄ ቁ 202 መልስ አዎ ከሆነ ከዚህ በፊት ውርጃ	1. አዎ 2. የለኝም መልስ የለኝም ከሆነ	209
207	ለጥያቄ ቁ. 206 መልስ አዎ ከሆነ ስንት ጊዜ ውርጃ	_____	
208	ጥያቄ ቁ 206 መልስ አዎ ከሆነ ውርጃዉ/ፀንሰ ማቀረጥ የተከናወነው	1. ፈልጌ ነው ያስወረድኩት 2. በራሱ ጊዜ ነው ያስወረደኝ 3. ሌላይ ገለጽ.....	
209	ከዚህ እርግዝናዎ በፊት ሳያቅዱ አርግዘው	1. አዎ 2. አላውቅም መልስ አላውቅም ከሆነ	213
210	አዎ ከሆነ ከጥ.ቁ.209 መቼ ነበር ሳያቅዱት	_____	
211	ስንት ያልታወቀ እርግዝናዎች አጋጥሞዉት ያውቃል?	_____	
212	ከዚህ በፊት ሳያቅዱ ለተከሰቱት እርግዝናዎች ምንድነው?	ምንም ወለድኩት እርግዝናውን ለማጠረጥ ሞክርኩ ግን አልተሳካም	
213	ልክ ይህ እርግዝና ከመከሰቱ በፊት ለመውለድ	1. አዎ 2. አይ መልስ አይ ከሆነ	215
214	ለጥያቄ ቁ. 213 መልስ አዎ ከሆነ የአሁኑ እርግዝናዎ ልክ በፈለጉት ጊዜ ነው ያረገዙት?	1. አዎ 2. አይ	
214	መልስ አይ ከሆነ የአሁኑን እርግዝና ከማርገዝ በፊት ልጅ/ሌላ ልጅ ላለመውለድ አስበው ነበር?	1. አዎ 2. አይ	
<b>ክፍል 3. የዘመናዊ የርግዝና መከላከያ ዘዴዎች ግንዛቤ/ዕውቀት መጠየቂያ</b>			
301	ባለትዳሮች ላለማርገዝ የእርግዝና የሚጠቀሙበት መከላከያ መንገዶች	1. አዎ 2. አይ የእርግዝና የሚጠቀሙበት የእርግዝና መንገዶች ሰምተው	
302	ለጥያቄ ቁ. 301 መልስ አዎ ከሆነ ከየት ሰሙት	ከቤተሰብ ከጓደኛ ከብዙኋን መገናኛ	
303	ለጥያቄ ቁ. 301 መልስ አዎ ከሆነ ከሚከተሉት መከላከያ የትኞችን የእርግዝና መከላከያ መንገዶች ያውቃሉ? (የሚያውቁትን ያክብቡ)	ኪነን ኮንዶም መርፌ በማጎፀን ውስጥ የሚቀመጥ /ሉፕ በክንድ ቆዳ ስር የሚቀበር	
304	ለጥያቄ ቁ. 301 መልስ አዎ ከሆነ የእርግዝና መከላከያ ዘዴ	1. አዎ 2. አይ መልስ አይ ከሆነ	311

305	ጥ. ቁ 305 መልስዎ አዎ ከሆነ የትኛውን የእርግዝና መከላከያ ዘዴ ይጠቀሙ ነበር?	ኪነን ኮንዶም መርፌ በማጎፀን ውስጥ የሚቀመጥ /ሉፕ በክንድ ቆዳ ስር የሚቀበር የጭረት ጭረት ጭረት /ካሊግራፍ/	
306	ለጥያቄ ቁ. 304 መልስ አዎ ከሆነ ይህን እርግዝና በሚያረግቡበት ጊዜ የእርግዝና	አዎ አይ እርግጠኛ አይደለሁም	
307	ጥ. ቁ 305 መልስዎ አዎ ከሆነ የትኛውን የእርግዝና መከላከያ ዘዴ አገኙት?	ሆስፒታል ጤና ጣቢያ የቤተሰብ መምሪያ	
308	ለጥያቄ ቁ. 303 የተዘረዘሩት የእርግዝና መከላከያ መንገዶች በቀላሉ ያገኛሉ ወይ?	1.አዎ 2.አይ	
309	ይህን እርግዝና አቅደው ነው የፀነሱት?	አዎ አይ መልስዎ አይ ከሆነ	310
310	ጥ.ቁ 309 መልስዎ ከሆነ ለምን ያልታወቀ እርግዝና ሆነ?	አይ በትምህርት ላይ ስላለሁ ልጅ የማሳድግበት በቂ ገቢ ሥላላለኝ ተደፍሬ ስለተከሰተ ከባለቤቴ ጋር ስለተለያየን ትዳር ላይ አይደለሁም የተቀራረበ እርግዝና ስለሆነ	
311	ለጥያቄ ቁ. 304 መልስዎ አይ ከሆነ ለምን መከላከያ አልተጠቀሙም?	ገና ልጅ ስለሆነኩ ሥላ እርግዝና መከላከያ እወቀት ስላለኝ የርግዝና መከላከያ ሰላላገኝሁ ሃይማኖቴና ባህሌ ስለማይፈቅድ እየተጠቀምኩ ነው የተከሰተ	
312	በድንገት ወይም ያለመከላከያ ዘዴ በተፈጽመ ወሲባዊ ግንኙነት የሚፈጠር ያልታወቀ እርግዝና መከላከል እንደሚቻል	1.አዎ 2.አይ	
314	ለጥ.ቁ.312 መልስ አዎ ከሆነ ምን አይነት በመጠቀም መከላከል ይቻላል?	ድንገተኛ የእርግዝና መከላከያ ኪነን በማጎፀን ውስጥ የሚቀመጥ /ሉፕ/ ሌላ (ይገለጽ)... 2.	

314	በጤናዎን ሁኔታ /እንክብካቤ/ ላይ ውሳኔ የሚሰጠው ማን ነው?	እኔ ባለቤቴ እኔና ባለቤቴ በጋራ በመሆን ሌላ (ይገለጽ)	
315	ተ.ቁ 304 መልስዎ ዎ ከሆነ ከዚህ እርግዝና በፊት የሚጠቀሙትን የእርግዝና መከላከያ ዘዴ ይመለከቱ	እኔ ባለቤቴ እኔና ባለቤቴ በጋራ በመሆን ሌላ (ይገለጽ)	
31 5	እርስዎ በሚያስገቡት (በሚያገኙት) ገንዘብ ላይ ውሳኔ የሚሰጠው ማን ነው?	እኔ ባለቤቴ እኔና ባለቤቴ በጋራ በመሆን ሌላ (ይገለጽ)	
31 6	ስለእርግዝና መከላከያ መንገዶች ከባለቤትዎ ጋር ተወያይተው ያውቃሉ?	አዎ አይ	
አመሰግናለሁ			