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ASSESSMENTS OF THE DETERMINANTS OF MODERN CONTRACEPTIVE UTILIZATION AMONG CURRENTLY MARRIED WOMEN OF AGE BETWEEN 15-49YEARS IN HADYA ZONE MISHA DISTRICT, SNNPR, ETHIOPIA, 2014.

By: Zerfework Debebe(BSC)

Advisor: Erdaw Tachbele (MSC, PHD fellow)

A THESIS SUBMITTED TO GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY FOR THE PARTIAL FULFILLMENT OF DEGREE OF MASTERS OF SCIENCE IN MATERNITY NURSING AND REPRODUCTIVE HEALTH

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ADDIS ABABA, ETHIOPIA

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LIST OF ACRONYMS

AAU: Addis Ababa University

CI: Confidence Interval

CMR: Child Mortality rate

CPR: Contraceptive Prevalence rate

DHS: Demographic and Health Survey

FGAE: Family Guidance Association of Ethiopia

FP: Family Planning

HEW: Health Extension Worker

IEC: Information Education and Communication

IUCD: Intra Uterine Contraceptive Device

IMR: Infant Mortality Rate

MCH: Maternal and Child Health

MMR: Maternal Mortality Rate

MOH: Ministry Of Health

MC: Modern Contraceptive

OR: Odds Ratio

OCP: Oral Contraceptive Pill

RHB: Regional Health Bureau

RH: Reproductive Health

SNNPR: Southern Nation and Nationalities people's Region

SPSS: Statistical Package for Social Science

TV: Television

TFR: Total Fertility Rate

ZHD: Zonal Health Desk

ABSTRACT

Background: High fertility and rapid population growth have an impact on the overall socio- economic development of the country in general and maternal and child health in particular. Maternal and child mortality are two of the major health problems challenging health care organizations, especially in developing countries. The major role of family planning is reduction of maternal morbidity and mortality by reducing the number of unwanted pregnancies that might otherwise end in abortion.

Objective: To asses determinants of modern contraceptive utilization among currently married women of age between 15 to 49 years in Hadiya zone Misha woreda, SNNPR, Ethiopia

Methods: A community based cross-sectional survey was conducted from April 1-30/2014. Multistage Stratified sampling technique was employed for the study. Simple random sampling was used to select kebeles and households were selected by systematic sampling techniques. The collected data was entered and analyzed using SPSS version 16.0 statistical packages. Crude and adjusted odds ratios from bi-variant and multi-variant analyses were used to measure association between modern contraceptive use and independent variables. P-value less 0.05 and 95% confidence interval was used to identify potential associated factors.

Results: - In this study 591(98.8%) currently married women of reproductive age group were participated. Almost all of the women who participated in the study 576(97.5%) heard of about modern contraceptive (MC). The current contraceptive prevalence rate in the woreda was found to be 208(23.8%). Among background characteristics, those positively associated with MC utilization during multivariate logistic analysis were urban residents 1.967 times more likely to utilize MC than their counter part [AOR: 1.967 with 95% CI: (1.028, 3.763)]; Women of primary education were 5.139 times more likely to utilize MC compared to illiterate [AOR: 5.139 with 95% CI: (1.07, 21.885)] and having good knowledge of MC 3.685 times more likely to use compared to poor knowledge of MC [AOR: 3.685 with 95% CI: (2.396-5.670)].

Conclusions and Recommendations: It is concluded from this study that MC utilization is positively associated with urban residence, primary and secondary school achievement of women, having radio, family income of 381-520 birr, and good knowledge of contraceptive methods were significantly associated with contraceptive utilization. The fear of side effects was one of the major reasons for the discontinuation and non-use of contraception among the study participants. Based on these findings, empowering and encouraging women education, Improve household economic activities, further qualitative and analytic study were recommended.

1. INTRODUCTION

1.1 Background

High fertility and rapid population growth have an impact on the overall socio- economic development of the country in general and maternal and child health in particular. Maternal and child mortality are two of the major health problems challenging health care organizations, especially in developing countries. The majority of maternal deaths are the direct result of complications encountered during Pregnancy and unsafe abortion (1). The World Health Organization Report(WHO) noted that every minute, at least one woman dies from complications related to pregnancy or child birth that means 287,000 women a year, in addition, for every woman dies in child birth, five direct complications account for most of maternal death: hemorrhage, infection, unsafe abortion, eclampsia and obstructed labour(2).

Ethiopian currently (2012) serving for 56/100,000 maternal deaths a day on average. One of the reasons for this is the lack of skilled health care personnel attending births. The (EDHS 2011) identified that only 10% of births in Ethiopia where attended by an appropriately skilled person; however, there is also evidence suggest that up to 100,000 maternal death could be avoided each year if women who did not want children used effective contraception (3).

Family planning assists "families in achieving the number of children desired with appropriate spacing and timing, ensuring optimal growth and development of each family member" (4, 5). Failure to plan a pregnancy can adversely affect the health of the mother, the child and the families as a whole. Family planning can also protect women from high risk pregnancies, unsafe abortion, reproductive tract infection (RTI), sexually transmitted infection (STIs), including HIV/AIDS (4).The international conference on population and development (ICPD) defined voluntary family planning services as a fundamental human right as well as a couple' s right.

The world health organization (WHO) estimated in 2012 that 287,000 maternal deaths occurred in 2010; sub-Sahara Africa (56 %) and southern Asia (29 %) accounted for the global burden of maternal deaths (6).One of the targets of Ethiopian ministry of health, with respect to improving maternal and child health, is to increase contraceptive prevalence rate(CPR) from 32%to 60% by 2015. In order to achieve this target, the Ministry has given priority to the provision of family planning services in the community(7)

1.2 STETMENT OF THE PROBLEM

With 87 million people, Ethiopia is the second most populous nation in sub-Saharan Africa, with a continuing fast growing population of 2.7% per year (6).The maternal mortality ratio (MMR) is 676 per 100,000 aged 15 to 49,with an estimated 32% of all maternal death attributed to un safe abortions(7). A study conducted in Northwest Ethiopia in 2005 indicated that prevalence rate of spontaneous and induced abortions where estimated at 14.3% and 4.8% of all pregnancies respectively (8).Despite the recent increase in contraceptive use, in sub-Saharan Africa still characterized by high levels of fertility and a considerable unmet need for contraception (9).The total fertility rate in Ethiopia is 4.8 births per women and is considerably higher in the rural than the urban areas. Every day at least 1,600 women die worldwide from complication of pregnancy and child birth, 90% of which occurring in Asia and Sub Saharan Africa. The maternal mortality ratio (MMR), which is a measure of the obstetrics risk associated with each pregnancy, is estimated to be 400 per 100,000 live births globally, which is one in 92 deaths. It is high in sub-Saharan Africa 900 per 100,000 live births, lifetime risk of 1 in 22 comparing these with MMR of 9 and Lifetime risk of maternal death 1 in 7,300 for the developed country. This indicates that pregnancy in sub Saharan Africa is 100 times more likely to take life of a woman than pregnancy in developed country. Family planning is carried as one of the strategies for reducing the population growth rate as well as maternal mortality and child mortality (8, 9, and 10).

Throughout the world many women are taped in a dangerous cycle of repeated unwanted pregnancy and unsafe often illegal abortion. Although the importance of linking abortion care and F/p services seems obvious, two types of care rarely work together in developing world service delivery system (10).

Unsafe abortion is a critical public health problem in Ethiopia with a low modern contraceptive prevalence rate and a high fertility rate; untold number of Ethiopian women is faced with unwanted pregnancy. Unsafe abortion causes 50,000-100,000 deaths each year in some countries. Complication of unsafe abortion in majority of maternal deaths and in a few they are leading cause of death for a woman of reproductive age. The world health organization estimated that as many as 20 million abortions in each year are unsafe and 10 to 50% of women who undergo unsafe abortion need medical care for complication (10, 11, 12)

Family planning services are unique in providing the means for couples to space or limit their births, as well as to stabilize the world's population. They also have a role in the reduction of maternal morbidity and mortality by their ability in reducing the number of unwanted pregnancies that might otherwise end in abortion, the use of F/P service by women is an effective means of avoiding many of these fertility related health risk and it enables family to achieve their fertility goal (10, 13).

The rapid population growth, if uncontrolled by proper population policy, will exacerbate the existing unemployment problem, environmental degradation, food shortage and considerable pressure on the countries welfare system education and health service among others. In recognition of the need to address these issues the government of Ethiopia adopted a population policy in 1993, has objectives of reducing the total fertility rate, reducing morbidity and mortality of women as well as raising the contraceptive prevalence rate from 28.6% to a national coverage of 44% by the year 2015 (10).

Therefore, the aim of this study was to measure contraceptive prevalence and asses factors associated with usage like knowledge, attitude and practice and socio – demographic constraints which directly or in directly affect contraceptive use among women age 15-49 yrs in Hadiya Zone Misha worda

1.3. SIGNIFICANCE OF THE STUDY

High population growth prevents the long term socio-economic development needed to alleviate poverty and to meet the immediate basic needs of the burgeoning population (13). Accurate and specific data about the reason behind the low contraceptive practice in the country should be available in order to develop an effective and relevant family planning strategy. Ethiopia is a large country divided into regions, each of which has its own culture and believes concerning fertility and contraceptive practice. Therefore it is difficult to develop a family planning strategy that will work nationally unless each region is considered separately so that the key issues can be identified. In adequate information about each region means that the planning and development of policies and strategies may be inappropriate and therefore ineffective in bringing about an increase family planning practice across all the regions. There is a need to identify the reason for low contraceptive prevalence in different regions of the country in order to develop effective policies and strategies. (15)

Therefore this study, try to fill a gap in the identification of factors influencing use of modern contraceptive method utilization among currently married woman of age between 15 to 49 years, once the gap is identified it is easy for the professionals to fill the gap, improving family planning service utilization; in addition it contributes towards fertility control and important to reduce the maternal, infant and child mortality in the area this is the benefit for the community and that the study was help policy makers, program planning bodies and service providers to remove the obstacles and improve contraceptive prevalence rate in the Haddya zone Misha woreda, SNNPR, Ethiopia.

2. LITRATURE REVIEW

A study conducted in different regions of Ethiopia showed current use of any methods of contraception among all women of reproductive age was found more than four times higher in urban (47%) than in rural areas (11%). There is also substantial variation in current use in different regions of Ethiopia. It is highest in Urbanized areas like Addis Ababa (62.5%); Harrari(34.7%), Diredawa (33.9%), and 22.2%, 33.9%, 26.2%, 25.8% for Tigray, Amhara, Oromia and SNNPR respectively use all type of contraceptive. The level of modern contraceptive methods was 56.3% in Addis Ababa, 31.7% for Diredawa, 31.5% for Hararri, 33% for Amhara, 24.9% for Oromia and 24.7% for SNNPR (16).

2.1 Factors influencing utilization

2.1.1 Knowledge and Information

Having knowledge and information about modern contraceptive methods is one step ahead towards gaining access to and using suitable contraceptive methods in a timely and effective manner. In order to make choices about family planning individuals need to have adequate information about the available methods of contraception (17). Knowledge of contraceptive increases the use of it (18). Attitudes toward family planning depend on the safety and the feeling about specific contraception methods. Positive attitudes towards family planning encourage the use of it and vice versa. Contraceptive use, in developed countries, is determined by whether doctors are obliged to inform parents about an adolescent request for contraception service or not (19), adolescent's attitudes towards contraceptive methods, fear of side effects, and parents' support (20) and differences in societal attitudes towards adolescent sexual activity.

A study conducted in Africa identified that high proportion of women (74.3%) who belonged to various clubs and associations that discussed health related topics were knowledgeable and contraceptive users, which indicated that information exchanges through discussion in such organization increase the increase the desire for modern contraceptives (21)

A study conducted in Addis Ababa indicated that 15% of the respondents had not heard of MC methods and 40% knew of only one such method implying that the IEC dissemination strategies were weak (22)

Another study conducted in southern Ethiopian in 1997 showed that 8.5% of urban and 64.3% of rural residents had no knowledge of MC, while 5.3% of urban and 11% of rural respondents knew only one type of modern contraceptive method (23)

A study conducted around Gonder town found that from women 15-49 yrs old and husbands 99% of the total respondents believed that F/P is important. From the female respondents 74.9% had information about family planning. Most of the total respondents had information about family planning 74.9% female and 77.4% of male respondents. About 72% of the female respondents, 36.6% of male respondents knew more than one method of F/P. condoms were known by 57.8% male respondents. Health professionals were the main information source (46.6%) followed by radio (21.5%). The overall modern contraceptive prevalence rate was 28.6% (35.5 from urban and 11% for rural respondents) (24).

2.1.2 Education

Increasing educational level has a positive effect on the use of contraceptives. Education gives young women autonomy to make informed choice about their reproductive health and to avoid un safe sex which realties un intended pregnancy (25) .Women with higher education standard of living are better as they appreciate the health and social advantages of protecting themselves by delaying pregnancy. Young women tend to postpone pregnancy until they have completed their education and they feel that they are socially economically secure (26). Education facilitates the acquisition of information about family planning; it increases husband-wife communication and increase couple's income potential, making a wide range of contraception methods affordable (27). Studies conducted in Ghana and Kenya found that married women with higher education were more likely to use contraceptives (28).

In a study conducted among women of reproductive age group in zimbabwe by the world Bank, modern contraceptive use and fertility regulation have significant association with increased education attainment, although at low level of education (less than 6 year) there was no clear association between and use of modern contraception. It was reported among women who have completed primary school (seven years of education) that the power full effect of education became apparent, similarly women who have completed secondary school and above were about twice as likely to use modern contraceptive method as women who didn't complete primary schooling (29).

In a study conducted in Uganda, modern contraceptive use higher was independently and positively associated with formal education. The study reported that in urban areas women with at list a secondary education had significantly higher odds of contraceptive use than non-educated women. The effect of education on use was even more striking in rural areas compare with women with no education, those with at least some primary schooling or higher had nearly five times the odds of contraceptives use and those with secondary or higher had almost ten times the odds of contraceptive use(30).

A study conducted in Asia in1993 identified significant variation in mean number of pregnancies, 6.2 among women of no schooling, 4.8 pregnancies among those with 1-7 years schooling, and 3.2 pregnancies among those with 8 years or above schooling (31).Other studies in part of the world have also shown a positive linear relationship between education and modern contraceptive use (32).

In Ethiopia the situation is not different from the above – mentioned facts, a study conducted in southern Ethiopia reported broad association of literacy with current and intended use of contraception (33). A study conducted in Gonder town showed that there was a positive trend of association in contraceptive use with increased educational status. The study showed that the relative percentages of contraceptive use increases from 33.7% - 41% among primary and secondary schooling and 52.5% among higher educated women (24)

A study conducted on urban youth in Ethiopia indicated that contraceptive use was 4.9% in those with no education, 13.1% in low education and 82% among higher education (34).

2.1.3 Quality of care

Situational analysis conducted in several African countries cites that the major reason for under utilization of service capacity was the lack of attention given to systems operating at institutional and local service sites (35).

In the area of health service, the time spent to travel from the potential user to the clinic or FP center (clinic) has been shown to be important. Cornelius and Novak demonstrated in five developing countries the effect of time to source up on use of modern contraceptives. A service quality study done in Latin America and the Caribbean indicated that the areas of quality that most often received more than 5% negative response from clients (termed negative

response cases) were waiting time (mentioned in 70% of the surveys with a mean dissatisfaction level of 20%), ease of reaching clinic (in 54%, with average dissatisfaction level of 12%) and price of services (in 47% of the surveys and 10% average dissatisfaction level) (42, 48).

A restricted access of contraceptive method has an impact on the individual's method choice and hence results in a lower level of contraceptive use. Accessibility of family planning expressed in terms of time, cost and location; hence contraceptive prevalence is higher in countries where access to all methods is uniformly high (36) .

In one study conducted in Jimma zone (Ethiopia) in 2003, virtually all components of quality of care could not be fully achieved by service delivery points. In this particular study the main identified deficiencies were unavailability of method mix, lack of providers special training, failure to explain about various methods available, lack of the national guideline of FP service and the like (37). The above researches showed that family planning programs focused heavily on contraceptive supply and paying insufficient attention to client needs and quality of care at large.

2.1.4 Cultures and Religions

The roles of religion and culture as a fertility determinant have been a subject of considerable discussion in fertility literatures. Every social group has a characteristic culture, complex of belief, attitudes, values and social controls. The cultural and religious background of a given community has powerful effect on health seeking behavior in general, and contraceptive use in particular. Globally, the strongest opposition was from the Catholic Church, which prohibits utilization of artificial contraception in the 1930s and Islamic religion followed it (30, 31). The Catholic and Orthodox Churches are known to be against family planning and abortion. In addition, the Muslim faith also opposes contraceptive use as children are considered to be gift from Allah. A study conducted in Ghana showed, however, that religion's effect on the current use of contraception was not significant because once women experiences higher education, her religion and ethnic background do not significantly affect current contraception use(28).

A study conducted in Bangladesh revealed that the percentage of current users of contraceptive methods among Muslims was significantly lower than their non-Muslim counterparts (30.2% and

36.3%, respectively) (32). A study conducted in Southern remote community in Ethiopia in 1999, reported that because of the male dominance in the culture, women would be forced to bear large number of children, and this was a major obstacle in the fertility regulation decisions by women According to the 2000 Ethiopian demographic and health survey (EDHS) Ethiopia report, significantly high proportion of females reported that in most cases religious leaders oppose the use of MC and ethnicity and religion were the determinant factors to the use of contraception (38).

Cultural features of various groups may, directly influence contraception through desired number of children or attitudes towards contraception methods (39, 28).

Ethiopian Christian women were less likely to use contraception as compared to those with other religions (18). But, current contraception use was significantly lower among Ghanaian Muslim women as compared to Christian women in general (40). In Kenya the Catholic religion followers are more likely to use family planning services as compared to Protestant and Muslim women (41).

The culture is transmitted through religion and through the education system. Currently there have been notable socio-cultural changes in sub-Saharan African region, but failure to increase contraceptive use has been observed. The role of religion as a fertility determinant has been the subject of considerable discussion, sub-Saharan Africa may well offer greater resistance to fertility decline than any other world region. The reasons are cultural and have much to do with a religious belief system that operates directly to sustain high fertility. But, that also has molded a society in such a way as to bring rewards for high fertility. Throughout sub-Saharan Africa, traditional religious beliefs and practices are embedded in lineage and descent systems that structure society and sustain high fertility. Two-thirds of all sub-Saharan Africans are now either Christian or Muslim, but most retain a belief in ancestral forces and in the concern of those spirits for fecundity and reproduction. High fertility (considerable number or surviving children) is associated with joy, the right life, divine approval and approbation by both living and dead ancestors. Conversely, low fertility is only too easily interpreted as evidence of sin and disapproval. Because reproduction and its context was the central pillar of African traditional religion, much disquiet surrounds fertility control practice that has not been long sanctioned. Innovative behavior is likely to be regarded as unnatural and, hence, sinful. It is also likely to have unpleasant squeal. These may take the usual form of divine or ancestral punishment such as

bareness, sickness, or child death. Much of the apprehension about FP in sub-Saharan Africa can be understood only in the context of attitudes toward infertility, sub fertility miscarriages and infant death. These phenomena are not clearly separated and are the major indicators of divine or ancestral disapproval or malevolence from humans or spirits. After seeking information from a wide range of anthropologists who had worked in East Africa, Molnos concluded: the paramount objective of having children was that there should always be a living descendant to remember and honor the departed. Children meant the continuation of the lineage and the perpetuation of the family name and spirit. A study in the Sudan stressed the importance of beliefs regarding the role of ancestors and God in the creation of children and high fertility as a barrier to contraceptive use. In Ethiopia, the study conducted among urban youth in 1990 showed that Christians were the highest (84.2%) ever users of contraceptives. In this country the impact of religion on family planning services may not be considered to be negative. However, very little is known about differences in attitudes toward the practice of contraception as a function of religious identity (21, 34, 42, 43, 44, 45,,and 47).

2.1.5 Availability of the method

A study conducted in Jimma zone (Ethiopia) in 2003 identified that significant proportion of clients were obliged to use methods other than their choices. The study showed that, 21.1% of clients were using oral contraceptive pill (OCP) without being their choice, and about 13.1% of the clients were not totally given the chance to choose the FP method. A tangible increase was evident by a study conducted in Bangladesh, which revealed that introducing household provision of injectibles in early 1977 helped raise CPR from 7% to 20%, the introduction of tubectomy services in 1978 helped to increase the prevalence by an additional 10%, and household insertion of IUDs in 1981 elevated the prevalence yet further, which showed that provision of different methods can enhance utilization of modern contraception (32).

2.1.6 Socio-economic factors

Economic status is one of the important factors of contraceptive use. There is some evidence that women who have been employed outside their home are more likely to use MC than other women. Study conducted in a Peruvian high land community revealed that more women who use MCs work full time than non-users (93% versus 58%). Similarly a study done in Bas, Zaire indicated that economic status was positively correlated with use of a modern method. Also a

number of studies done in different parts of the world, for instance, in 1993 in Lao people's Democratic Republic; multivariate analysis of factors affecting contraceptive use in Bangladesh, showed that the economically better of use modern contraceptive than the poor ones. Economic development affects fertility behavior. Employment in general and female employment in particular affects economic status of the family. Decreased fertility is mostly met with working women. According to a study by researchers in Egypt on the utilization of family planning methods among females in Kalyoubia Governorate, the majority of women utilizing FP methods were working and university educated (73.63% and 35.72%) respectively. The majority of women utilizing FP methods were wives of educated and working husbands. Level of education was found to be significant, current contraceptive users in a study on factors that determine utilization of MCs in east, central and southern Africa. A survey on socio-demographic factors in southwestern Ethiopia in 1993 revealed, using odds of contraceptive use among illiterate women as a reference, all groups of women with higher levels of education have a much chance of being a contraceptive user. The mean years of education for contraceptive users was, 5.7, is also higher than 4.9 years for non-users. In this study also women who are office workers tend to use contraceptives. More over women of higher family monthly incomes have a much higher increased chance of contraceptive use compared to women with low monthly incomes of less than 50 Birr or between 50 and 99 Birr per-month. Another study in SNNPR by Dennis p-Hogan et al stated that working women in rural areas more often desire to limit their births, and more often use or intend to use contraceptives than do women who do not work for pay (21 , 31 , 32 , 33 , 34, 49, 50, 51,52).

2.1.7 Demographic Determinants-

In this group, women's age, residence and marital status are important. Fertility rates differ by women's ages. These differences reflect reproductive preferences, the ability to act on these preferences, sexual behavior and fecundity. Age patterns of fertility differ considerably among regions, countries, and different groups within countries. In most countries fertility peaks among women aged 20 to 24. In nearly half of sub-Saharan African countries surveyed, WFS, however, this peak extends to age 29. In addition in sub-Saharan Africa women continue to have children at older ages than elsewhere. In this region, women over 40 contribute to an average 0.5 children, which can be explained by lack of availability and use 11 of contraceptive sterilization.

A prospective study between 1995 and 1998 in Rakai district Uganda found women practicing family planning for prevention were predominantly in the age 20-39 years and were married. In all countries surveyed since 1990, the TFR is lower in urban areas from a difference Just 0.1 child per woman in Mauritius to 3.4 children in Uganda. Urban residents usually have more interest in FP, because of their more access to MCs. Significantly higher proportion of married women were currently using MCs (31.6%) compared with single women (19.6%), according to a study in east, central and southern Africa, in 1996. from this study it was also possible to notice lowest contraceptive use among teenagers (15-19 Years) with prevalence of 16.5%, and use rate almost doubled for women in age category, 20-34 years (31.3%) and those who were 35 or more (31.7%). Ethiopian DHS data of 2000 also revealed that current use varies by women's age and is lowest among currently married age 15-19 and highest among women age 35-39. From this data currently married women in urban areas are nine times more likely to use a modern method (54, 52, 21, 38, 47, and 32)

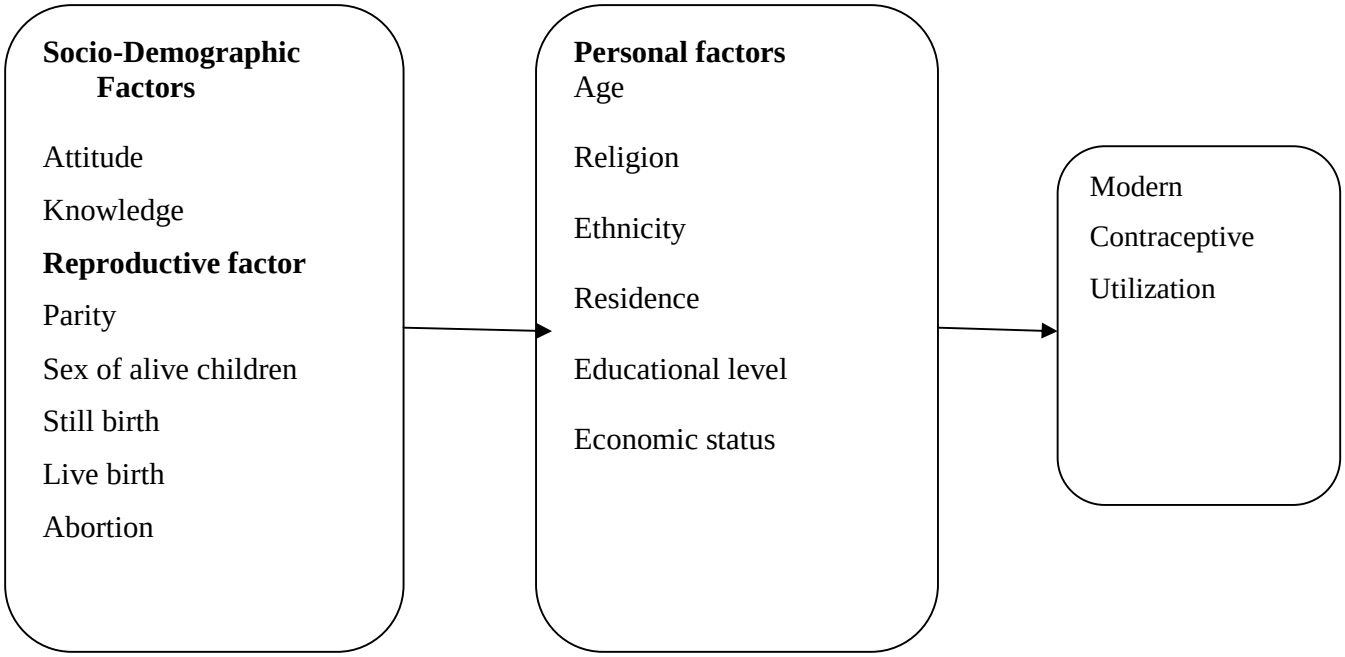
2.1.8. Reproductive factors-

FP methods may be used either for spacing or limiting births to avoid mistimed or unwanted pregnancies. Hence a prospective study in Rakai district Uganda, out lined contraceptive use was higher among women who desired fewer children, among those who wished to space or terminate child bearing and among women with previous experience of unwanted births or abortion. In another survey in east, central and southern Africa, among women who had no children, 16.5% indicated that they had used some form of MCs. Of those who had between 1 and 4 children 32.4% said they had used contraception. And among those who had 5 or more children, 31.7% stated they had used contraception. A bivariate analysis from Bangladeshi study brought forth that those who do not desire additional children are more likely to be current users than those who desire additional children. In this study multivariate analysis 12 showed that the prevalence of current Contraceptive use varies with the sex composition of living children. Couples who have only daughters are less receptive to the idea of FP and contraceptive use than their counterparts who have at least one son in addition to daughters. The 2000 Ethiopia DHS reported that younger women report first use of contraception at lower parities than older women. Contraceptive use among women with no living children, for instance, is more than seven times for those age 20-24 than among those age 35-39 years, suggesting a shift toward the early use of contraception and the desire to delay childbearing among the Ethiopian.

A survey in southwestern Ethiopia in 1993 showed that the mean number of pregnancies, live births and living children for registered contraceptive users were 4.3,4.0 and 3.3 compared to 3.1, 2.7 and 2.2 for non-users. The difference is statistically significant ($P<0.001$). In this study a substantial increase in contraceptive use was noticed with increase in number of living children. According to a survey done in Sidama zone in 2003, among reproductive characteristics, only history of childbirth, desired number of children and number of living children were positively associated with current contraceptive use. In addition to the desire, current alive male children were also positively associated with current contraceptive use (55, 21, 32, 38, 52, and 53)

From the above studies conducted in different parts of Ethiopia shows that there is high knowledge and low practice of contraception is present. Factors like Educational status; income, age, knowledge, Attitude, Religion and number of children of a woman are highly associated with usage. Unmet need in Ethiopia is very high. So this study was measure the modern contraceptive prevalence rate and determinants associated with usage in SNNPR Hadiya Zone Misha woreda.

CONCEPTUAL FRAME WORK



Source: developed from various similar literature reviews

Fig: 1. Conceptual frame work of factors affecting modern contraceptive methods uses

3. OBJECTIVES

3.1 GENERAL OBJECTIVE

To assess the determinants of modern contraceptive utilization among currently married women of age between 15 to 49years in Hadiya Zone, Misha Woreda, SNNPR, Ethiopia.

3.2 SPECIFIC OBJECTIVES

1. To determine the prevalence of modern contraceptive methods utilization among the study participants in Misha Woreda, Hadiya Zone.

2. To assess the socio economic, demographic, and reproductive factors influencing the use of modern contraception use in Misha Woreda, Hadiya Zone

3. To assess the knowledge, attitude and decision making towards modern contraception use among the study participants in Misha Woreda Hadiya Zone

4. Material and Methods

4.1 Study Design

A community based cross-sectional study was conducted with quantitative data collection technique to carry out assessment of the determinants of modern contraceptive utilization in SNNPR Hadiya Zone Misha woreda.

4.2 Study Area and period

This study was conducted in Hadiya Zone, Misha Woreda's community as of April 1-30/2014. Misha Woreda is found in SNNPR, Hadiya administrative Zone at the south of the country. It is located 248km far away from Addis Ababa; 186km from the regional capital city, Hawassa and 18km from Hosanna. It is one of the eleven Woreda's of Hadiya Zone. The Woreda has 33 rural and 2 urban kebeles with a total populations of 151,121 as projected from the 2007 Ethiopian census, from these 76,361 are females and 74,850 are males, and women of reproductive health age group are 34,757. It is bounded by Gurage and Siltie Zone in the north, Gibe Woreda in the west, Lemo Woreda in the east and Gomebora Woreda in the south. It has purely about 90% Dega agro ecological zone. More than 95% of the population is engaged in agriculture. There are 42 health institutions in the woreda, of which 35 are health posts and 7 are health centers.

4.3 Population

4.3.1 Source population

Women of reproductive age group (15-49) who reside in Misha woreda during the study period.

4.3.2 The study population

Currently married women of childbearing age (15-49) residing in Misha woreda during the study period.

4.4 Sampling unit

List of households in seven selected kebele's of Misha woreda during the study period.

4.5 Study unit

Women aged 15-49 years, currently married and living in the sampled households was taken as a study unit

4.6 Inclusion Criteria

Women who are in the reproductive age group, currently married and permanent resident (at least 6 months) of the selected kebeles

4.7 Exclusion Criteria

Women who were critically ill that cannot respond for the questionaries' during study period.

4.8 Sample size and sampling technique

4.8.1 Sample size determination

The sample size (n) required for the study was calculated using the formula to estimate a single population proportion by considering the following assumptions.

Zα/2 = critical value for normal distribution at 95% confidence level which equals to 1.96 (Z value at alpha=0.05).

P= (24.7%) prevalence based on the EDHS 2011, the SNNPR prevalence of modern contraceptive use (**13)**.

d= margin of error of 0.05 with 95% confidence level.

D= 2(design effect)

$$n = \frac{(Z\alpha/2)2\ p\ (1-p)}{d2}$$

$$\mathbf{n} = \frac{(1.96)2\ (0.247)\ (1-0.247)}{(0.05)2} = \mathbf{285}$$

2 design effect and 10% non response rate

Total sample size = **598**

4.8.2 Sampling procedure

Stratified multistage sampling technique was employed for the study. The totals of 35 kebeles found in the selected woreda were stratified in to urban and rural kebeles settings using naturally existing strata. There were 2 urban kebeles and 33 rural kebeles. The total number of kebeles included in the study was determined by using proportional allocation to size. Hence, one urban and six rural kebeles were randomly selected by using lottery method. Households from each kebele were selected again by systematic random sampling with a sampling interval of 12 intervals. The first household was selected by spinning the pen at the center of the kebele and going clock wise direction was used to proceed the next household with the interval. In case of

the houses closed or the mothers do not present at the time of data collection, three revisits were made and till does not present considered as none response. For a household, women married where more than one; one woman will be selected by using lottery method.

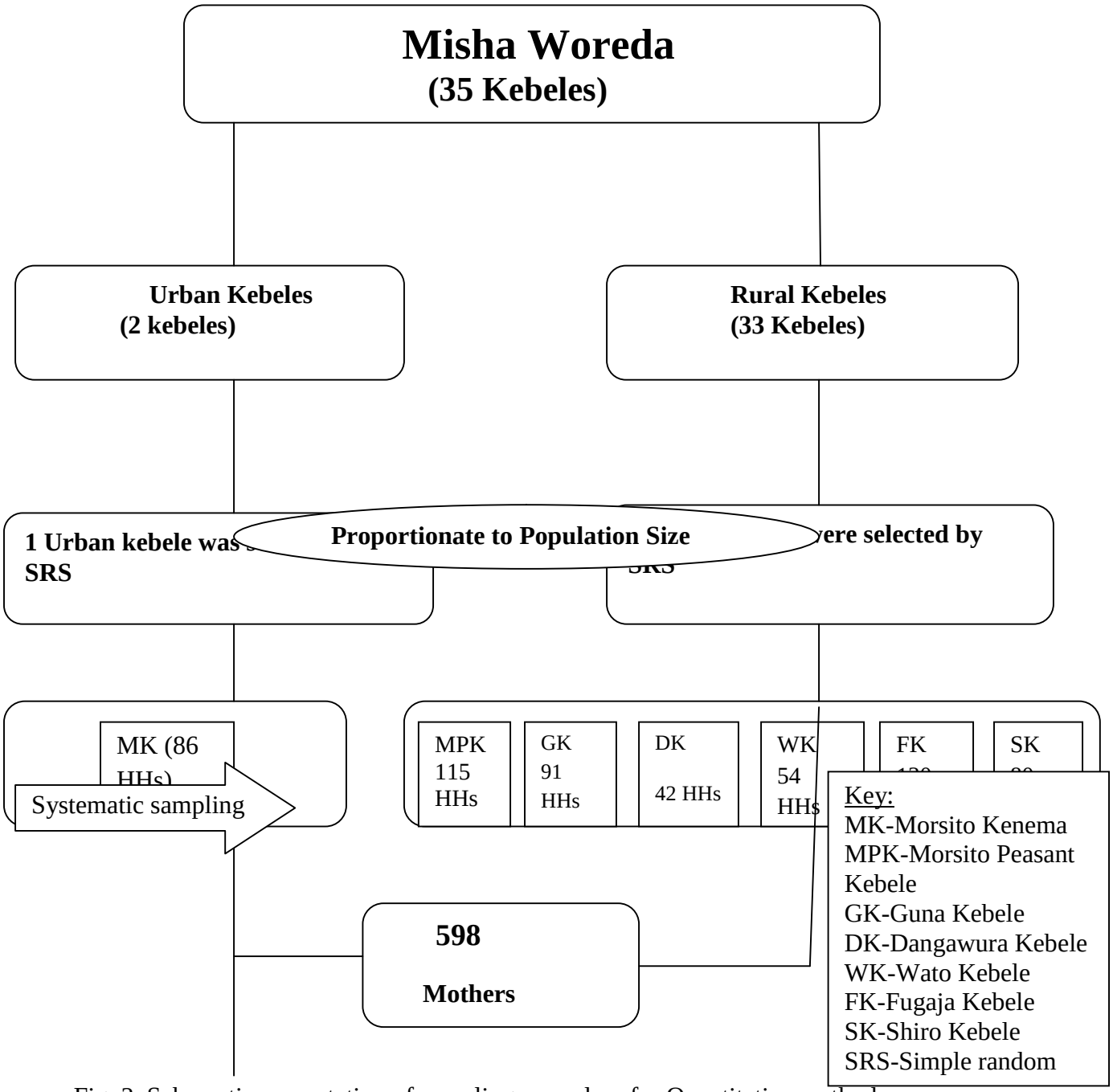


Fig: 2. Schematic presentation of sampling procedure for Quantitative method

4.9. Study variables

4.9.1. Independent variables

Clients/service acceptors

1. Age
2. Parity
3. Still birth
4. Sex of alive children
5. Abortion
6. Religion
7. Residence
8. Educational level
9. Economic status
10. Decision making
11. Ethnicity

4.9.2. Dependent variable

Attitude towards to MC

Knowledge of MC

Modern contraceptive use

4. 10. Data collection procedures

Structured interviewer administered questionnaire was used to collect the data which is adapted from relevant literatures and modified to local. The questionnaire was first prepared in English and translated to Amharic and back translation to English was made to check for consistency by language teachers. Five interviewers that have completed high school Education and who know the local language very well were recruited as interviewers and two-health personnel were assigned as supervisors.

Data collectors were trained for three days on questions included in the questionnaire, on interviewing techniques, purpose of the study, and importance of privacy, discipline and approach to the interviewees and confidentiality of the respondents. Before conducting the main study, pretest was carried out in similar population rather than study population. Based on the result, data collectors were reoriented and the questionnaire was modified as necessary.

4.11 Operational Definition

Contraceptive prevalence rate: women who received a contraceptive method for one continuous year and above.

Current contraceptive user: - a woman using any one of the modern methods currently

Ever-contraceptive user: - a woman who have ever used any of the modern method **Good knowledge of modern contraceptive**: - after scoring knowledge questions those respondents who respond above or equal to average mean value were considered had good knowledge for contraceptive methods.

Poor knowledge of modern contraceptive: - after scoring knowledge questions those respondents who respond below average mean value were considered had poor knowledge for contraceptive methods.

Modern contraceptives (MCs): - Modern contraceptive methods which include oral contraceptive pills, injectables, condoms, implants IUDS diaphragm vaginal foam and male and female sterilization.

Favorable attitude: - Those respondents who responded above the mean value for cumulative eleven attitudinal statements.

Unfavorable attitude: - Those respondents who responded the mean and below mean value for cumulative eleven attitudinal statements.

Availability of services: - services of family planning available when the respondent says yes.

Currently married: - a women who lives with husband's at this time.

4.12 Data Quality Assurance

The quality of data was maintained by using properly designed and pre-tested questionnaire; proper training of the interviewers and supervisors on data collection techniques and procedures. Every day, 10% of the computed questionnaires were reviewed and checked for completeness and relevance by the supervisors and principal investigator and the necessary feedback offered to data collectors in the next morning before the actual procedure.

4.13 Data processing and analysis

The collected data was entered and analyzed by SPSS version 16 statistical package was used for analysis purpose. Data was cleaned before and after data entry. Frequency tables and graphs were used for descriptive analysis. Crude and adjusted odds ratios from bivariate and multi-variate logistic regression were used to measure association between modern contraceptive use and independent variables. Furthermore, 95% CI and p-value of 0.05 were used to assess the degree of statistical significance.

4.14 Ethical

Ethical clearance was obtained from Department of Nursing and midwifery ethical clearance Committee of AAU. A formal letter, from AAU, was submitted to zonal health department, Misha woreda health office and concerned bodies to obtain their co-operation. Then permission and support letter was written to each respective Kebele. The purpose of the study was explained to the study participants. At the time of data collection, a verbal consent was taken from the participants to confirm whether they are willing to participate. Those not willing to participate were given the right to do so. Confidentiality of responses was also be ensured throughout the research process.

4.15 Communication of the result

The final report will be presented as partial fulfillment of the degree of Masters of Science to Department of Nursing and midwifery, school of allied health science, Addis Ababa University, and a copy of it will be offered to FMOH Family health department, to SNNPR regional health Bureau, Hadiya Zone Health Department and Dissemination through publication (local or international journals), presentation on annual Scientific meeting, conferences, etc.

5. Result

Demographic and socio-economic characteristics

In this study 591 currently married women of reproductive age group were participated and producing 98.8% response rate. Urban residents were 84(14.2%) and 507(85.8%) were rural residents. The Mean age of the women was 5.1± 31.6 years. Mainly, 461(78.0%) of the respondents were Hadiya by ethnicity. Majority of the respondents 441(74.6%) were protestant religious followers. Educational status of the women, 257(43.5%) were primary school and followed by 203(34.3%) were illiterate. The main occupation of the women is housewife which is 534(90.4%). Majority of the respondents 442(74.8%) have more than 5 children. Possession of television and radio were 19(3.2%) and 365(61.8%) respectively. Family income of the respondents is less than 380 birr were 218(36.9%) and followed by more than 521 were 169(28.6%). (Table 1)

Table: 1. Demographic and socio-economic characteristics of currently married women in the reproductive age group, Misha woreda, 2014 [n=591]

Characteristics	Frequency	Percent (%)
Residence		
Urban	84	14.2
Rural	507	85.8
Mother's age		
15-19	7	1.2
20-24	31	5.2
25-29	187	31.6
30-34	202	34.2
35-39	129	21.8
+40	35	5.9
Ethnicity		
Hadiya	461	78.0
Gurage	94	15.9
Kambata	24	4.1
Others	12	2.0
Religion		
Protestant	441	74.6
Orthodox	135	22.8
Others	15	2.5
Educational status		
Illiterate	203	34.3
Primary school	257	43.5
Secondary school	114	19.3
Above secondary	17	2.9
Occupation		
Housewife	534	90.4
Gov. employee	18	3.0
Merchant	29	4.9
Others	10	1.7
Experience child death in the last 12 months		

Yes	44	7.4
No	547	92.6
Family size		
1-4	149	25.2
>=5	442	74.8
Possession of TV		
Yes	19	3.2
No	572	96.8
Possession of Radio		
Yes	365	61.8
No	226	38.2
Family income		
<=380	218	36.9
381-400	85	14.4
401-520	119	20.1
>=521	169	28.6

Reproductive characteristics

Almost all of the study subjects 588(99.5%) had been pregnant at least once and among this pregnancy 87(14.8%) were unwanted pregnancy. Regarding the history of induced abortion, 89(15.1%) had experienced induced abortion. The mean age at first pregnancy was 2.16±20.05 years. Nearly ten percent of the women had the history of still birth. (Table 2)

Table: 2. Reproductive characteristics of currently married women in the reproductive age group, SNNPR, Misha woreda, 2014.

Characteristics	Frequency	Percent (%)
Ever been pregnant (n=591)		
Yes	588	99.5
No	3	.5
Were all pregnancy wanted (n=588)		
Yes	501	85.2
No	87	14.8
Ever experienced induced abortion (n=588)		
Yes	89	15.1
No	499	84.9
Age at first delivery (n=591)		
15-20	373	63.4
21-25	213	36.2
>=26	5	.8
Have any still birth (n=591)		
Yes	55	9.4
No	533	90.6

Attitudes towards MC

Regarding attitude towards modern contraceptive, 532 (90.0%) and 468(79.2%) not agree that too many children improves income and guarantee to generation continuity respectively. About ninety percent of the women disagree and strongly disagree for high infant mortality compensated by too many births. Those who believe using MC methods as sin were 53(9%) and those who believe using MC was dangerous for women were 143(24.2%). (Table3).

Table 3: Attitudes towards modern contraceptive use among currently married women of reproductive age group, SNNPR, Misha Woreda, 2014 {n=591}

Characteristics	Frequency	Percent (%)
Too many children improves income		
Strongly disagree	76	12.9
Disagree	456	77.2
Neutral	19	3.2
Agree	37	6.3
Strongly agree	3	.5
Too many children guarantee to generational continuity		
Strongly disagree	42	7.1
Disagree	426	72.1
Neutral	14	2.4
Agree	99	16.8
Strongly agree	10	1.7
High infant/child mortality be compensated by too much birth		
Strongly disagree	64	10.8
Disagree	470	79.5
Neutral	19	3.2
Agree	35	5.9
Strongly agree	3	.5
It is sin to practice MC methods		
Strongly disagree	46	7.8
Disagree	468	79.2
Neutral	24	4.1
Agree	49	8.3
Strongly agree	4	.7
MC has side effects dangerous to a mother		
Strongly disagree	16	2.7
Disagree	392	66.3
Neutral	40	6.8
Agree	129	21.8
Strongly agree	14	2.4
Child spacing protect the health of mothers and children		
Strongly disagree	4	.7
Disagree	10	1.7
Neutral	7	1.2
Agree	432	73.1

Strongly agree	138	23.4
Contraceptive use cause infertility in women		
Strongly disagree	46	7.8
Disagree	476	80.5
Neutral	48	8.1
Agree	19	3.2
Strongly agree	2	.3

Knowledge of MC

Almost all of the women who participated in the study 576(97.5%) heard of about modern contraceptive. The main source of information for modern contraceptive was health facilities which was 539(96.3%) and followed by their friends which was 167(29.0%). Among those who heard MC, mainly recalled methods were injectable and pills which was 546(92.6%) and 527(89.2%) respectively. Concerning importance of contraceptive methods use, 493(83.4%) said for child spacing and followed 403(68.2%) said helps to prevent unwanted pregnancy. (Table 4 and Fig 2)

Table 4: Knowledge of contraceptive among currently married women of reproductive age group, SNNPR, Misha Woreda, 2014

Characteristics	Frequency	Percent (%)
Ever heard of modern contraception (n=591)		
Yes	576	97.5
No	15	2.5
Source of information (n=576)		
Health facilities	539	96.3
Mass media	82	14.2
Friends	167	29.0
Contraceptive methods known (n=576)		
Pills	527	89.2
Injectable	546	92.6
Implants	249	49.7
IUCD	358	57.2
Condom	123	20.8

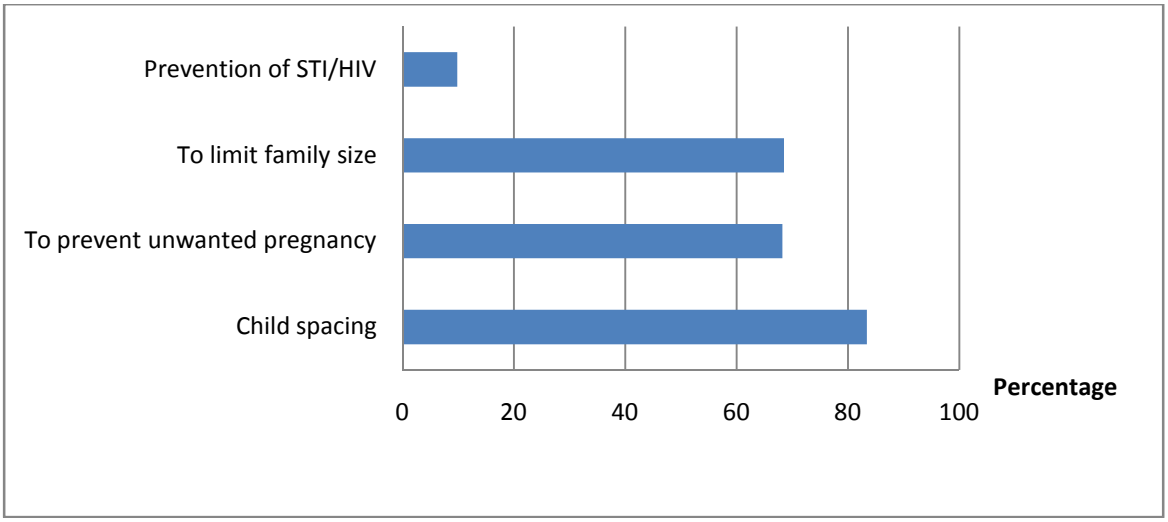


Fig 3 Importance of contraceptive method responded by women of reproductive age group, SNNPR, Misha woreda, 2014

Practice of modern contraceptive

Concerning the use of MC methods, 370(62.6%) of the study women ever practiced MC methods. Among those currently using the methods were 208(35.2%) of the respondents. The more frequently used MC method by the respondents was injectable where 139 (66.8%) of the study participants. The prevalence (using more than 1years) of MC in the study area was 141(23.8%). The main reasons to default the use of MC were medical problems and fear of side effect which was 86(48.3%) and 45(25.3%) respectively as reported by those who defaulted from MC method use. Majority of the respondent walks less than 30 minutes to get MC method service. (Table 5 and Fig 2)

Table 5: Practice of contraceptive use among currently married women of reproductive age group, Misha Woreda, 2014

Characteristics	Frequency	Percent (%)
Ever use of Contraceptive		
Yes	370	62.6
No	221	37.4
Current use of any MC		
Yes	208	35.2
No	383	64.8
MC Method used (n=208)		
Pills	50	24.0
Injectable	139	66.8
Implant/Jaddle	19	9.1
Duration of contraceptive use (n=591)		
Grater or equal to 1 years	141	23.8
Less than 1Years	67	11.3
Are you using the method you choose (n=208)		
Yes	203	97.6
No	5	2.4
Reason for not using MC (n=383)		
Fear of side effects	219	57.2
Desire to have more children	76	19.8
Rumors they are not good	72	18.8
Others	16	4.2
Is MC culturally accepted (n=591)		
Yes	508	86.0
No	83	14.0
Distance from health facility (n=591)		
Less than 30'	440	74.5
Greater than 30'	151	25.5

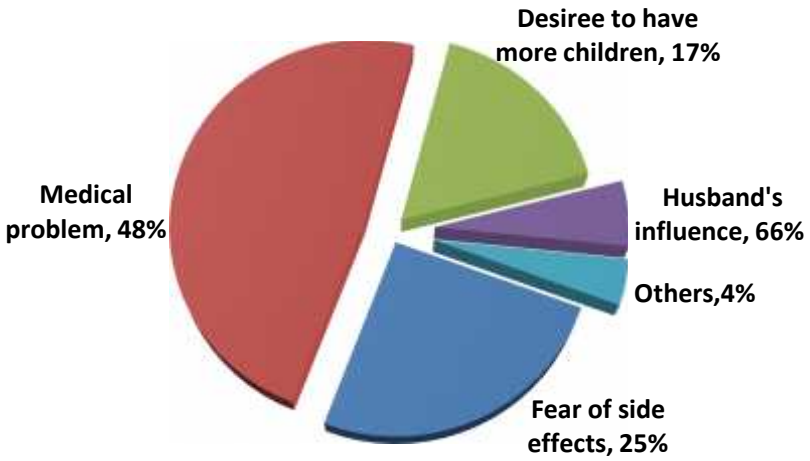


Fig: 4. Reason to discontinue contraceptive methods responded by women of reproductive age group, SNNPR, Misha Woreda, 2014

Bivariate analysis

Among demographic and socio-economic characteristics, those variables significantly associated with modern contraceptive utilization at p-value 0.05 during bivariate logistic analysis were place of residence, women age, educational status of women, occupation of women, and possession of radio and television. Urban residents are 1.733 time more likely to utilize MC [OR: 1.733 with 95% CI: (1.087-2.765)], women age 25-34 categories were 55% less likely to utilize MC compared to age less than 25 years [OR: 0.452 with 95% CI (0.216-.946). As women education increase the probability of utilizing MC methods increase. Government employees were 4.987 times more likely use MC compared to housewife [OR: 4.987 with 95% CI: (1.751-14.205)]. Possession television and radio also have increased utilization of MC [OR: 2.617; 95% CI: (1.036-6.613) and OR: 4.704; 95% CI: (3.117-7.097 respectively]. Regarding knowledge of MC, those who have good knowledge of MC were 5.541 more likely to use MC [OR: 5.541 with 95% CI: (3.802-8.075)] (Table 6).

Table 6: Bivariate analysis of demographic and socio-economic characteristics of currently married women in the reproductive age group, Misha woreda, 2014 [n=591]

Characteristics	User of MC	Not User of MC	Crude OR (95% CI)
Residence			
Urban	39	45	1.733(1.087-2.765)*
Rural	169	338	1
Mother's age			
≤24	12	26	1
25-29	65	122	0.866(0.410-1.89)
30-34	102	100	0.452(0.216-.946)*
35+	29	135	2.149(0.972-4.748)
Ethnicity			
Hadiya	159	302	1
Gurage	34	60	0.929(0.585-1.475)
Others	15	21	0.737(0.370-1.469)
Religion			
Protestant	151	290	1
Orthodox	52	83	0.831(0.558-1.238)
Others	5	10	1.041(0.350-3.102)
Educational status			
Illiterate	28	175	1
Primary school	102	155	20.3(6.182-66.738)*
Secondary school	65	49	4.939(4.939-15.569)*
Above secondary	13	4	2.450(0.753-7.976)
Occupation			
Housewife	183	351	1
Gov. employee	13	5	4.987(1.751-14.205)*
Others	12	27	0.171(0.50-0.588)*
Experience child death in the last 12 months			
Yes	16	28	1
No	192	355	1.057(0.558-2.001)

Table 6: Bivariate analysis of demographic and socio-economic characteristics of currently married women in the reproductive age group, Misha woreda, 2014 [n=591]……continued

Family size			
1-4	52	97	1
>=5	156	286	0.983(0.666-1.451)
Possession of TV			
Yes	11	8	1
No	197	375	2.617(1.036-6.613)*
Possession of Radio			
Yes	172	193	4.704(3.117-7.097)*
No	36	190	1
Family income			
≤380 birr	29	189	1
381-400 birr	18	67	1.751(0.913-3.357)
401-520 birr	50	69	2.614(1.629-4.281)*
≥521 birr	111	58	2.697(1.429-5.090)*
Were all pregnancy wanted (n=588)			
Yes	501	85.2	1
No	87	14.8	1.339(0.817-2.193)
Ever experienced induced abortion (n=588)			
Yes	89	15.1	1
No	499	84.9	0.813(0.502-1.319)
Age at first marriage (n=591)			
15-20	373	63.4	1
21-25	213	36.2	1.186(0.831-1.691)
>=26	5	.8	0.581(0.36-9.355)
Have any still birth (n=591)			
Yes	55	9.4	1
No	533	90.6	0.801(0.440-1.458)
Knowledge of MC (n=591)			
Good knowledge of MC	55	245	5.541(3.802-8.075)*
Poor knowledge of MC	153	123	1
Attitudes towards MC (n=591)			
Favorable attitude towards MC	6	22	1
Unfavorable attitude towards MC	202	361	0.487(0.194-1.222)

MC= modern contraceptive **OR**= odds ratio * p-value< 0.05

Multivariate analysis

During multivariable logistic regression, urban residents were 1.967 times more likely to utilize MC than their counter part [AOR: 1.967 with 95% CI: (1.028, 3.763)]. Women of primary education were 5.139 times more likely to utilize MC compared to illiterate [AOR: 5.139 with 95% CI: (1.07, 21.885)]. Possession of having radio is significantly associated with MC utilization that 2.187 more likely than counterpart [AOR: 2.817 with 95% CI: (1.705-4.655)] [AOR: 2.036 with 95% CI: (1.506-8.188)]. The respondent's family income 381- 400 birr were 9.834 times more likely to utilize MC compared to family income less than 380 birr[AOR: 9.834 with 95% CI (5.451-17.739)]. The probability of using MC was 3.685 more for those who have good knowledge of MC compared to poor knowledge of MC [AOR: 3.685 with 95% CI: (2.396-5.670)]. (Table 7).

Table 7: Multivariable analysis of factors associated with contraceptive utilization among currently married women in the reproductive age group, SNNPR, Misha woreda, 2014

Characteristics	User of MC	Not User of MC	Crude OR (95% CI)	Adjusted OR (95%CI)
Residence				
Urban	39	45	1.733(1.087-2.765)*	1.967(1.028-3.763)*
Rural	169	338	1	1
Educational status (n=591)				
Illiterate	28	175	1	1
Primary school	102	155	20.3(6.182-66.738)*	5.139(1.071-11.885)*
Secondary school	65	49	4.939(4.939-15.569)*	2.036(1.506-8.188)*
Above secondary	13	4	2.450(0.753-7.976)	1.568(0.380-6.478)
Possession of Radio (n=591				
Yes	172	193	4.704(3.117-7.097)*	2.817(1.705-4.655)**
No	36	190	1	1
Family income (n=591)				
Less than 380 birr	29	189	1	1
381-400 birr	18	67	1.751(0.913-3.357)	9.834(5.451-17.739)**
401-520 birr	50	69	2.614(1.629-4.281)*	5.204(2.543-10.647)**
Greater/equal 521 birr	111	58	2.697(1.429-5.090)*	1.728(0.967-3.085)
Knowledge of MC (n=576)				
Good knowledge of MC	55	245	5.541(3.802-8.075)*	3.685(2.396-5.670)**
Poor knowledge of MC	153	123	1	1

MC= Modern Contraceptive OR = Odds Ratio * p-value <0.05 ** p-value<0.001

6. Discussion

This study showed that prevalence of modern contraceptive use was 23.8% which is in line with EDHS 2011 for SNNPR which is 24.7% and lower than Harreri (31.5%) and Oromia (24.9%). This difference may be due to socio-demographic and socio-economic difference.

Urban residents were more likely to use modern contraceptive than rural resident among currently married women of reproductive age group. This finding is similar to EDHS 2011. Most popular methods of modern contraceptive methods used by currently married women were injectable (66.8%) and followed by pills (24.0%). This study result is in line with other similar studies in different area (15, 16, and 33). Among currently married women of reproductive age group those who had completed primary education were 5.139 times and secondary education 2.036 times more likely to use modern contraceptive. This finding is in line with other similar study in Oman, Brazil, Thailand and Ghana (25,26,27 and 28) where increased education level has positive effect on use of modern contraceptive that gives young women autonomy to make informed choice about reproductive health and to avoid un safe sex (25). Also similar study conducted in Ethiopia showed increased education has positive effect on MC uses (33, 34).

Economic status is one of important factors of utilization of contraceptive use. In this study those who had monthly family income of 381-400 birr and 401-520 birr was positively associated with modern contraceptive utilization but income of more than 521 was not showed clear association. This positive association finding is also supported by different similar studies in SNNPR (52) thus higher income has much more probability of using MCs and other studies outside of the country (50).

The cultural and religious background of a given community has powerful effect on health seeking behavior in general, and contraceptive use in particular. Globally, the strongest opposition was from the Catholic Church, which prohibits utilization of artificial contraception and Islamic religion followed it (30, 31). But in this study religious and cultural characteristics were not statistically significant difference. This inconsistency may due to attribute to the small number of Catholic and Muslim religion followers in the study area.

Possession of having radio is highly significantly associated with MC utilization that 2.187 more likely than counterpart. This may be those who have radio may have more access to family

planning messages which in turn may lead to utilization of modern contraceptive methods. Also radio was the third source of information for family planning information.

EDHS 2006 and Gordon et a 2011 result showing that having knowledge and information about modern contraceptive methods is one step ahead towards gaining access to and using suitable contraceptive methods in a timely and effective manner (17, 18). Similarly in this study those who have good knowledge of contraceptive method were 3.865 times more likely to use MCs. This may be attributed to having knowledge of contraceptive methods is an enabling factor to use the methods.

7. Strength of the study and Limitation of the study

Strength of the study

This study is entirely community based study that can show the real associated factors of utilization of contraceptive methods.

Limitation of the study

The study design is cross sectional study design that the inherent nature of the study design that does not show cause and effect relationship between dependent and independent variables.

8. Conclusions

This study was conducted among currently married women in child bearing age group of Misha woreda to assess prevalence & factors which affect modern contraceptive utilization. Regarding modern contraceptive prevalence rate, although the finding is comparable with national and regional averages; the current figure for contraceptive prevalence rate is still low when compared to the national target of MDGs. Factors which are positively associated with modern contraceptive utilization were urban residence, primary and secondary school achievement of women, having radio, family income of 381-400 birr and 401-520 birr, and good knowledge of contraceptive methods were significantly associated with contraceptive utilization. The fear of side effects was one of the major reasons for the discontinuation and non-use of contraception among the study participants;

9. **Recommendations**

Based on findings of this study, to enhance contraceptive use by married women of reproductive age in a study population it is recommended that:

1. At health facilities level potential side effects of contraceptives and how to overcome them should be emphasized into family planning education and counseling.

2. Empowering and encouraging women education is also very important

3. Improve household economic activities through broadening micro finance institutions, rural banks and intensifying other developmental activities

4. Further qualitative and analytic study shall be under taken to get the actual predictor of MC utilization and influence of traditional and religion on contraceptive utilization.

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ANNEXES

ANNEX-I: RESPONDENTS INFORMATION SHEET ENGLISH VERSION

ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES ALLIED SCHOOL OF HEALTH SCIENCES DEPARTMENT OF NURSING AND MIDWIFERRY

Here, I the undersigned, at Addis Ababa University School of Graduate Studies Program, currently undertaking research on a topic entitled Assessment of the Determinants of modern contraceptive utilization among currently married women of age between 15 to 49 years at Hadiya Zone, Southern Ethiopia. For this study, you will be selected as a participant and before getting permission of your participation, you need to know all necessary information related to the study.

Purpose of the study:-The purpose of the study is to Assess Determinants of modern contraceptive utilization among currently married women of age between 15 to 49 years at Hadiya Zone, Southern Ethiopia.

Participants to be included:-Women in the age of 15 to 49.

Risks of the study: The study will be carried out by asking you the already prepared and structured questions. The procedure doesn't bear any physical or psychological trauma. Furthermore, you will not be forced to respond to the information you do not know.

Benefits of the study: For your participation in the study no payment will be granted or has no any special privilege to you. On the other hand, participating in the study and giving your information to questions asked will have great input in efforts at reducing maternal deaths.

Confidentiality: All information you give will be kept confidential and won't be accessible to any third party. Your name won't be registered on the original question sheet so that you will not be identified.

Consent: Your participation in the study will be totally based on your willingness. You have the right not to participate from the beginning, or stop any time after starting participation. You will not be forced to respond to the information you do not know.

Finally, I would like to acknowledge you for your either responses after listening me.

Name of PI Zerfewerk Debebe Tel: 0911857018Email: zerfedebebe@gmail.com Sign & Date__

IRB Contact Address: Tel: 0115538734 E-mail: aaumfirb@yahoo.com 32

ANNEX-II: RESPONDENTS INFORMATION SHEET AMHARIC VERSION

በጥናቱ ተሳታፊዎች የሚጃ ቅጽ (ከእንግልዝኛዉየተተረጎመ)

በአድስ አበባ የኒቨርሲቲ ጠፍ ሳይንስ ኮለጅ በድህረ ምረቃ ትምህርት ፕሮግራምየነርሲንግና ሚድ ዋይፈሪ ትምህርት ክፍል፡፡

ከዚህ በታች እንደተመለከተዉ በአድስ አበባ የኒቨርሲቲ በድህረ ምረቃ ትምህርት ፕሮግራምነርሲንግና ሚድ ዋይፈሪ ትምህርት ክፍል "በአሁኑ ወቅት የእናቶችን የበተሰብ ምጣኔ አገልግሎት አጠቃቀምን የሚዳስስ ነዉ" በዚኒርዕስ በጎዲያ ዞን ሜቬ ወረዳ ጥናት እያካሄድኩነዉ፡፡

የዚህ ጥናት ተሳታፊ በመሆን እርስዎ ተጋብዘዋል፡፡ በጥናቱ ላይ ለመሳተፍ ፍቃደኝነትዎ ከመጠየቁ በፍት ጥናቱን በተመለከተ አስፈላጊ የሆኑ መረጃዎችን ማግኘት ያ ስፈልግዎታል፡፡ስለሆነ ም በጥናቱ ላይ ለመሳተፍም ሆነ ላለመሳተፍ መጀመሪያ ማወቅ የምገባዎትን መረጃ እንደምከተለዉ እናቀርብልዎታለን፡፡

1.የጥናቱ አላማ፡ የምርምሩ አላማየእናቶችን የበተሰብ ምጣኔ አገልግሎት አጠቃቀምን የሚዳስስ ነዉ፡

2.በጥናቱ የሚካተቱ ተሳታፊዎች፡ ማንኛዉም ከ 15-49 አድሚ ያላት እናትና ለመረጃዉፍቃደኛ የሆነች፡፡

3. ከጥናቱ ጋር የተያያዘ ጉዳት፡ ጥናቱ የምካሄደዉ ቀደም ለዚህ ጥናት የተዘጋጀዉን ጥያቀ በመጠየቅ ነዉ፡ ሆኖም በጥናቱ ተሳታፊዎች አካል ላይም ሆነ አእምሮ ላይ ፈፅሞ ጉዳት የለዉም፡ ያልገባዎትን መረጃ ለመጠለስ አይገደዱም፡

4. ጥቅም፡ በጥናቱ በመሳተፍዎ የምከፈልዎት ከፍያ ወይም የተለየ ጥቅም የለዉም፡ በለላ በኩል በጥናትዎ መሳተፍዎና ለምጠየቁት ጥያቀዎች ተገቢዉን መረጃ መስጠትዎ የእናቶችን ሞት ለመቀነስ ለምደረገዉስራ ከፍተኛ እገዛ ይኖረዋል፡፡

5. ምስጥር የመጠበቅ ሁኔታ፡ እርስዎ የምስጠት መረጃ በምስጥር የጠበቃል፡፡ ለሶስተኛ ሰዉ ተላልፎ አይሰጥም ወይም አይጋለጥም፡ ማንነትዎ እንዳይታወቅ ስምዎ በዋናዉኮፒ አይመዘገብም፡

6. ፍቃደኝነትዎን በተመለከተ፡ በጥናቱ ላይ መሳተፍዎ መላ በመላ የምመሳረተዉበራስዎ ፍላጎትና ፍቃደኝነት ላይ ነዉ፡ ከመጀመሪያዉበጥናቱ ላይ መሳተፍም ሆነ ላለመሳተፍ ይችላለ፡፡ ካልተስማሙት በመህል የሜጠረጥ መበትዎ መላ በመላ የተጠበቀ ነዉ፡ ያልገባዎትን መረጃ ለመመለስ አይገደዱም፡

7.ጥያቀዉየምመስደዉግዜ በአማካይ 40 ደቅቃ ብቻ ነዉ፡ በሚቬፈሻምስላዳመጠኝ ከልብአመሰግናለሁ፡

አጥኚዉ ስም፡ -ዘርፈወርቅ ደበበ ስልክ፡ 0911857018 ኢሜይል፡ zerfedebebe@gmail.com

ፊርማእና ቀን _____

የ IRB አድራሻ፡ Tel: 0115538734/0913273829 ኢ-መይል: aaumfirb@yahoo.com 33

ANNEX: III CONCENT SHEET ENGLISH VERSION

INFORMED CONSENT

Hello. My name is _____ (data collector) and I am Temporarily working as a researcher at Addis Ababa University (A.A.U). We are conducting a research on Assessment of the Determinants of modern contraceptive utilization among currently married women of age between 15 to 49 years at Hadiya Zone, Southern Ethiopia. The information we collect will help the local governor to plan health services. Your household was selected for the survey. This interview usually takes about 40 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of this research team. You don't have to be paid in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

Do you have any questions?

May I begin the interview now?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED: Name & Sign_____.

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED…….. . . 2 END HERE

ANNEX-IV: CONSENT SHEET, AMHARIC VERSION

የተሳትፎ ፈቃደኝነት ሚረጋገጫ

ጤና ይስጤልኝ:: ስመ_____(ሚጃ ሰብሳቢ) ይባላል:: የምሰራዉ በአድስ አበባ ዩኒቨርሲቲ በጤና ሳይንስ ኮሌጅ በሚገኝ የምርምር ቡድን በግዜያዊነት ነዉ:: የምናጠናዉ ጥናት የእናቶችን የበተሰብ ምጣኔ አገልግሎት አጠቃቀምን የሚዳስስ ነዉ:: እኛ የምንሰበስበዉ ሚጃ በአከባብዎ ያለዉ የጤና አገልግሎት ድርጅት የተለያዩ የጤና አገልግሎት ፅቅድ ለማዉጣት እንዲችል ይጠቅማል፡፡ ቤትዎ ለጥናቱ ተመርጧል፡፡ አጠቃላይ የምፈጀው ሰዓት 40 ደቅቃ ያህል ነዉ፡ እርስዎ የምሰጡት ሚጃ ከምርምር ቡድን ወጪ ከማንም ጋር የማንጋራ መሆኑን እየገፅኩ ምስጠሪዎ በማለ እንደተጠበቀ መሆኑን አረጋግጣለሁ፡፡ በዚህ ጥናት እርስዎ ምንም ዓይነት ክፍያ የሎዎትም፣ ይሁን እንጂ አማለካከትዎ መልካም ስለሆነ በጥሩ

ሁኔታ ሚልስ እንደምትሰጪ አምና ለሁ፡ ፡ ምና ልባት የ ሚይፈልጉትን ጥያቀ የ ጠየ ኩ ከሆነ አስቀድመው ይንገሩኝ እና ወደ ቀጣይ ጥያቀ እሻገራ ሆሁ ወይም ማከይቁን ማለ በ ማለ ማስቆም ይችላሉ፡ ፡

ያልገባዎት ነገር ካለ?

ማከይቁን አሁን መጀመር እችላለሁ?

የ ጠያ ቂዉ ፊር ማ ፡ _____

ቀን _____

ተጠያ ቂዋ እና ት ተስ ማምታለች ስ ም እና ፍር ማ

_____

ተጠያ ቂዋ እና ት አልተስ ማሙችም: ስ ም እና ፍር ማ_____2 (ማከይቁን እዚሁ ያብቁ)

ANNEX V: DATA COLLECTION TOOL

PART ONE: - SOCIO - DEMOGRAPHIC ASSESSMENT

Number	Questions	Responses	Code	Skip
101	How long did you live/st y here?	_____mm/ yy		
102	What is your age? Enter no	_____years		
103	What is your ethnicity?	1. Hadiya 2. Gurage 3. Amhara 4. Kambata 5.Silte (77). Other, specify----------		
104	What is your family size?	1.male----- 2 Female------ 3.total---------		
105	What is your Religion?	1. Protestant 2. Orthodox 3. Muslim 4. Catholic (77). Other, specify		
106	Educational status of respondent	1. Illiterate 2. Can read and write 3. Primary school 4. Secondary school 5. Above secondary		

107	What is your main occupation?	1. Housewife 2. Gov. employee 3. Student 4. Farmer 5. Daily laborer 6. Merchant (77). Other, specify. ……		
108	Did you experience infant/child death in the past 12 months?	1. Yes 2. No (99) No response		

PART TWO SOCIO-ECONOMIC STATUS ASSESMENT				
201	Do you have Television?	1. Yes 2. No (99) No response		
202	Do you have Radio?	1.Yes 2.No		
203	What is Your monthly income (in birr)?	----------Birr		
204	Compared to your neighbors where do you classify the family's economic status?	1. Very poor 2. Poor 3. Average 4. Well to do 5. Rich		

PART THREE: - REPRODUCTIVE HISTORY

Number	Question	Response	Code	Skip
301	Did you have any pregnancy before?	1. Yes 2. No ⟶ (99) No response		401
302	If yes, how many pregnancy?	Enter number…….		
303	Were all pregnancies wanted?	1. Yes 2. No (99) No response		
304	How many live births did you have?	1. Enter the number ------ (99) No response		
305	How many live children do you have now?	1 Male --- 2.Female--- 3 Total… (99) No response		
306	Did you have any still births?	1. Yes 2. No (99) No response		
307	Have you ever experienced induced Abortion?	1. Yes 2. No (99) No response		
308	What was your age at first pregnancy?	1. Enter the number------		
309	Desired number o children	----------		

PART FOUR: - SOCIO-PSYCHOLOGICAL FACTORS				
401	How many children do you want?	1. Males …… 2. Females------ 3 Total……		
402	Will having too many children help improve the income of the family?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree		
403	Will having too many children guarantee generational continuity?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree		
404	Should high infant/child mortality be compensated by too much birth?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree		
405	Is it a sin to practice MC methods? (Not religiously allowed)	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree		
406	MC has side effects; will it be dangerous to a mother?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree		
407	Does child spacing help protect the health of mothers and children?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree		

SOCIO-PSYCHOLOGICAL FACTORS ……..				
408	Will family planning practice cause a loss of confidence between couples?	1. Strongly disagree 2.Disagree 3. Neutral		

		4. Agree 5. Strongly agree		
409	Does contraceptive use decrease sexual satisfaction?	1. Strongly disagree 2. Disagree 3.Neutral 4.Agree 5. Strongly agree		
410	Does contraceptive use cause infertility in women?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Stronglyagree		
411	Does FP help a mother to regain her Strength before her next baby?	1. Strongly disagree 2.Disagree 3. Neutral 4. Agree 5. Strongly agree		
412	Should men share the responsibility of family planning use?	1. Strongly disagree 2.Disagree 3. Neutral 4.Agree 5.Strongly agree		

PART FIVE: - KNOWLEDGE ASSESSMENT

501	Have you ever heard of modern Contraception?	1. Yes 2. No ⟶ (99) No response		601
502	From where/whom did you first get the information?	1.Health facility 2.Massmedia 3. Partner (77) Other specify… (99) No response		
503	Which method of MC do you know? (More than one answer is possible!)	1. Pills 2. Inject able 3. Implant 4.Condom 5. IUDs (77). Other, specify… (99) No response		
504	What are the important reasons that a woman should use MC?	1. Prevention of unwanted Pregnancy		

	(More than one answer is possible!)	2. Child spacing 3. Prevention of STI/HIV 4. To limit family size (99) No response		

PART SIX: - ATTITUDE, PRACTICE AND OTHER QUESTIONS ON THE USE OF MODERN CONTRACEPTION

601	Have you ever used any MC?	1. Yes 2. No → 607 (99) No response		
602	Are you currently using any MC?	1.Yes → 604 2.No (99) No response		
603	If yes q601 and no for q602, what was the reason to default?	1. Fear of side effects 2. Husband's influence 3. desire to have more children 4. religious prohibition 5. medical problem 6. preferred method not available 7.Others influence (77)Other specify-		
604	If yes, which method are you using?	Mention the method-------		
605	For how long did you take this method?	---------months/-------years		
606	Are you using the method you choose?	1.Yes 2. No (99) No response		
607	Why are you not using contraceptive? (for nonusers)	1.I Want more children 2 Fear of side effects 3. Husband's influence 4. Religious prohibition 5.Others influence 6. Rumors they are not good 7. Unavailable in the nearby (77). Other, specify----------. (99) No response		
608	Is it culturally acceptable to practice MC in your community?	1. Yes → 610 2. No (99) No response		
609	If no, what is the reason	1.Unacceptable in my culture 2.Considered as sin 3.Rumors		

		(77).Others, specify…		
610	Do religious fathers approve MC use?	1. Yes 2.No (99) No response		
611	In your opinion, what is the most important reason/s for a woman for not using MC methods?	1. Husband dominance 2.Religious prohibition 3. Sex preference 4. Side effects of methods 5. Rumors they are not good 6.unavailable in the nearby (77) Other, specify.……		
612	Whom do you think should make a decision to use family planning?	1. Jointly 2. Husband 3. Wife (77) Other, specify		
613	What do you tell us regarding communication about MC with your husband?	1. Had ever discussed 2. Had discussed in the past 12 months 3. Discuss usually 4. Have an intention to Discuss		
614	How long did it take for you to go to the nearby health facility to get FP service (on foot)?	_____Minuets/Hrs		
615	What are the major weaknesses you have observed so far?	1. Lack of contraceptive supplies 2. Shortage of skilled man power 3. Poor client handling 4. Poor follow up 5. Drugs are expensive. 6. I have not observed problem 7. I don't know (77). Others ----------		

005: Enumerator's ID number ----------
006: Date of interview in Ethiopian calendar------
007: Approved by Supervisor Name----------
Signature---------
Date----------

ዘመናዊ የቤተሰብ ምጣኔ/የወሊድ መከላከያ ዘዴዎችን በተመለከተ ሕብረተሰቡ ያለውን አመለካከትና የአጠቃቀም ሁኔታ ፤ ለማጥናት የተዘጋጀ መጠይቅ

መግቢያ፡ -

ስሜ ..... ይባላል፡፡ የአዲስ አበባ ዩኒቨርሲቲ እያካሄደ ባለው ሳይንሳዊ ጥናት ውስጥ የጥናት ቡድኑ አባል በመሆን በመስራት ላይ እገኛለሁ፡፡ ዕድሜያቸው በመውለድ ክልል ውስጥ ለሚገኙ ሴቶች ስለ ዘመናዊ የወሊድ መከላከያ ዘዴዎች መጠይቅ እናቀርባለን፡፡

የመጠይቁም ዓላማ በዘመናዊ የወሊድ መቆጣጠሪያ አጠቃቀም ዙሪያ ያሉ ዋና ዋና እንቅፋቶች ምን ምን እንደሆኑ ለይቶ ለማወቅ ነው፡፡ እርሶንም ለመመለስ ቀላል የሆኑ የተወሰኑ ጥያቄዎችን እጠይቅዎታለሁ፡፡ ስምዎን በዚህ መጠይቅ ላይ አላሰፍረውም እንዲሁም የሚሰጡት መልስ ከእርሶ ጋር ምንም ግንኙት አይኖረውም፡፡ ከማቀርብልዎት ጥያቄ ለመመለስ የማይፈልጉት ካለ አይገደዱም በተጨማሪም አጠቃላይ መጠይቁን በፈለጉት ጊዜ የማቋረጥ መብት አለዎት፡፡ ሆኖም የሚሰጡት እውነተኛ መልስ በዘመናዊ የወሊድ መቆጣጠሪያ አጠቃቀም ዙሪያ ያሉ ዋና ዋና እንቅፋቶችን ለማወቅና የህብረተሰቡን የቤተሰብ ምጣኔ አገልግሎት የበለጠ ለማሻሻል ትልቅ ጠቀሜታ እንዳለው ላረጋግጥልዎት እወዳለሁ፡፡ በመጨረሻም ለሚሰጡት መልስ በቅድሚያ እያመሰገንኩ በአጠቃላይ መጠይቁ ከ30 ደቂቃ በላይ እንደማይወስድ እገልጽሎታለሁ፡፡

001፡ - የመጠይቁ ቁጥር .....
002፡ - የጥንዶች ቁጥር .....
003፡ - በዚህ ጥናት ለመሳተፍ ፍቃደኛ ነዎት? 1) አዎ 2) አይደለሁም
004፡ - ትክክለኛውን ምርጫ አክብቡ
(1) ዘመናዊ የወሊድ መከላከያ ተጠቃሚ
(2) የማይጠቀሙ
005፡ - የተሳታፊዋ መኖሪያ አካባቢ ዞን ..... ወረዳ .....
ቀበሌ ..... 1) ከተማ 2) ገጠር
የቤት ቁጥር .....

ተ.ቁ	ክፍ አንድ፡- የማህበራዊና የስነ-ህዝብ መጠይቅ ( ) አ ዱ በመክበብ አሳዩ		ኮድ	ወደ ... እ ፍ
101	የቤተሰብ- ብዛት ስንት ነው?	1) ወንድ.... 2) ሴት.... 3)ድምር ...		
102 :	የወለዱአቸው ልጆች ብዛት ስንት ነው?	1) ወንድ.... 2) ሴት.... 3)ድምር ...		
103	አድሜዎ ስንት ነው?.....			
104	የየትኛው ብሄረሰብ አባል ነዎት?	1) ሃዲያ 2)ከምባታ 3)አማራ 4)ኦሮሞ 5) ሌላ		
105	የየትኛው ሀይማኖት ተከታይ ነዎት?	1) እስልምና 2) ኦርቶዶክስ 3) ፕሮቴስታንት 4) ካቶሊክ 5) ሌላ ...		

106	የትምህርት ደረጃዎ?	1)ያልተማረ 2)ማንበብና መጻፍ የምትችል 3) አንደኛ ደረጃ 4) ሁለተኛ ደረጃ 5) ከዚያ በላይ		
107	ዋናው ስራዎ ምንድነው?	1) የቤት እመቤት 2) የመንግስትሰራተኛ 3) ተማሪ 4) ገበሬ 5) የቀን ሰራተኛ 6) ሌላ		
108	ባለፈው 12 ወራት ውስጥ ልጅ ሞቶቦታል	1) አዎ 2) አልሞተብኝም 99) መልስ		

ተ.ቁ	ክፍል ሁለት:- የኢኮኖሚ ሁኔታን የሚዳስስ መጠይቅ ( )		ኮድ	
201	ቴሌቪዥን እና/ ወይም ሬዲዮ አለዎት?	ቴሌቪዥን 1) አዎ 2) የለኝም ሬዲዮ 1) አዎ 2) የለኝም		
202	አማካይ የወር ገቢዎ ስንት ነው? /በብር/	1) ከ100 በታች 2) 100-200 3) 201-300 4) ከ301-400 5) ከ401-500 6) ከ500 በላይ		
203	ከጎረቤትዎ ጋር ሲያነጻጽሩ የእርሶን የኑሮ ደረጃ ከ ትኛው ይመድባሉ?	1) በጣም ደሀ 2) ደሀ 3) መካከለኛ 4) ደህና 5) ሐብታም 99) መልስ የለም		
204	ስንት የቤት እንስሶች አሎት? /በግብርና ለሚተዳደሩ/	1) ምንም የለም 2) አን 3) ሁለት 4) ሦስት 5) አራትና ከዚያ በላይ		

ተ.ቁ	ክፍል ሶስት:- የስነ ተዋልዶ ታሪክን የሚዳስስ መጠይቅ ( )		ኮድ
301	ከዚህ ቀደም አርግዘው ያውቃሉ?	1) አዎ 2) አይደለም 99) መልስ የለም 88) አላውቅም	
302	መልሱ አዎ ከሆነ ስንት ጊዜ ?	.....	
303	ሁሉንም ፈልገው ነበር ያረገዙአቸው?	1) አዎ 2) አይደለም 99) መልስ የለም	
304	በህይወት የተወለዱት ስንቶቹ ነበሩ?	..... 99) መልስ የለም	
305	አሁን በህይወት ያሉት ስንት ናቸው?	1) ወንድ ... 2) ሴት .... 3)ድምር ... 99) መልስ የለም	
306	ሞቶ የተወለደ ልጅ ነበረዎት?	1) አዎ 2) የለኝም 99) መልስ የለም	
307	ከዚህ ቀደም ውርጃ ያውቆታል?	1) አዎ (ስንት....) 2) አያውቀኝም 99) መልስ የለም	

308	በመጀመሪያ እርግዝና ጊዜ እድሜዎ ስንት ነው?	..... 99) መልስ የለም	

ተ.ቁ	ክፍል አራት፡- ማህበራዊና ስነ ልቦናዊ ሁኔታን የሚዳስስ መጠይቅ ( )		ኮድ
401	ስንት ልጆች እንዲኖሮት ይፈልጋሉ?	1) ወንድ... 2) ሴት.... 3) ድምር	
402	ብዙ ልጅ ማፍራት የቤተሰቡን ገቢ የበለጠ ያሻሽላል?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4)እስማማለሁ 5) በጣም እስማማለሀ	
403	ብዙ ልጅ መውለድ ለቤተሰቡ የዘር ሀረግ መቀጠል ዋስትና ነው?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
404	ከፍተኛ የህጻናትን ሞት ብዙ በመውለድ ማካካስ ይቻላል?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
405	ዘመናዊ የወሊድ መቆጣጠሪያ መጠቀም አጢአት ነው?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
406	ዘመናዊ የወሊድ መቆጣጠሪያዎች የጐን ጉዳቶች ስላሏቸው በእናቶች ላይ የጤና ችግር ያስከትላሉ?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
407	አራርቆ መውልድ ለእናትና ለሕጻኑ ጤንነት ጠቃሚ ነው?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
408	የቤተሰብ ምጣኔ አገልግሎት መጠቀም በተጓዳኞች መካከል አለመተማመንን ይፈጥራል?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
409	የወሊድ መቆጣጠሪያ የወሲብ እርካታን ይቀንሳል?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
410	የወሊድ መቆጣጠሪያ መሀንነትን ያስከትላል?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
411	የቤተሰብ ምጣኔን መጠቀም ከሚቀጥለው ወሊድ በፊት የእናት ጥንካሬ እንዲመለስ ይረዳል?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	
412	ወንዶች የቤተሰብ ምጣኔ አላፊነትን መጋራት አለባቸው?	1) በጣም አልስማማም 2) አልስማማም 3) ገለልተኛ 4) እስማማለሁ 5) በጣም እስማማለሁ	

ተ.ቁ	ክፍል አምስት፡- ስለ ቤተሰብ ምጣኔ ያለን እውቀት የሚዳስስ መጠይቅ (Knowledge assessment)		ኮድ
501	ስለዘመናዊ የወሊድ መከላከያ ከዚህ በፊት ሰምተወ ኑያውቃሉ?	1) አዎ 2) አልሰማሁም 99) መልስ የለም	
502	የ501 መልስዎ አዎ ከሆነ ከየት/ከማን ነበር መጀመሪያ የሠሙት?	1) ከጤና ድርጅት 2) ከመገናኛ ብዙሀን 3) ከጓደኛ 77) ሌላ ይጠቅስ ---------- 99) መልስ የለም 88) አላውቅም	
503	የትኞቹን የወሊድ መከላከያ ዘዴዎች ያውቃሉ?	1) ፒልስ 2) መርፌ የሚሰጥ 3) በክንድ የሚቀበር 4) በኮንዶም 5) ማህጸን ውስጥ በሚቀመጥ (ሉፕ) 77) ሌላ ----------፣---------	
504	የወሊድ መከላከያ መጠቀም ዋና ዋና ጠቀሜታው ምንድን ነው?	1) ያልተፈለገ እርግዝናን መከላከል 2) ልጅ ለማራራቅ 3) ኤች አይ ቪ መከላከል 4) የቤተሰብ ቁጥር መወሰን 5) ለመድሃኒት 77) ሌላ ይጠቅስ ----------፣---------- 88) አላውቅም	

ተ.ቁ	ክፍል ስድስት፡- ስለ ዘመናዊ የወሊድ መከላከል ዘዴ ያለ አመለካከትንና የተግባር አጠቃቀምን የሚዳስስ መጠይቅ (Utilization)		ኮድ
601	አሁን እየተጠቀሙ ያሉት የወሊድ መከላከያ ዘዴ ምንድን ነው?	1) ፒልስ 2) መርፌ የሚሰጥ 3) በክንድ የሚቀበር 4) ሉፕ 5) በኮንዶም 77) ሌላ ----------	
602	የመረጡትን /የፈለጉትን የወሊድ መከላከያ ዘዴ ነው በመጠቀም ላይ ያሉት?	1) አዎ 2) አይደለም 99) መልስ የለም	
603	መልሱ አይደለም ከሆነ ምን ነበር ምክንያቱ?	1) የፈለኩት ባለመኖሩ 2) እንድመርጥ ባለመጠየቄ 77) ሌላ ይጠቀስ ----------	
604	ከዚህ ቀደም ዘመናዊ የወሊድ መከላከያ ተጠቅመው ያውቃሉ?	1) አዎ (ለምን ያህል ጊዜ ----------) 2) አላውቅም 99) መልስ የለም	
605	መልሱ አዎ ከሆነ ያቋረጡበት ምክንያት ምንድነው?	1) ስላልተስማማኝ 2) የባል ተጽእኖ 3) የልጅ ጸታ ምርጫ 77) ሌላ ይጠቀስ ----------	
606	የቤተሰብ ምጣኔ ጥንዶች አላፊነት እንዲሰማቸው ያደርጋል?	1) አዎ 2) አያደረግም 99) መልስ የለም 88) አላውቅም	
607	ዘመናዊ የወሊድ መከላከያ መጠቀም በባህላችሁ ተቀባይነት አለው?	1) አዎ 2) የለውም 99) መልስ የለም 88) አላውቅም	
608	መልሱ የለውም ከሆነ ምክንያቱ ምንድነው?	99) መልስ የለም 1) ምክንያት ይጠቀስ	
60	በሃይማኖት አባቶች ዘንድ ዘመናዊ የወሊድ መከላከያ ተቀባይነት	1) አዎ 2) የለውም 99) መልስ የለውም 88) አላውቅም	

9	አለው ወይ?		
610	በእርሶ አመለካከት ሴቶች ዘመናዊ የወሊድ መከላከያ እንዳይጠቀሙ ምክንያቱ ምንድነው?	1) የባል ተጽእኖ 2) ሃይማኖት 3) የልጅ ጸታ ምርጫ 4) የሚያስከትለው የጤና ችግር 5) የቦታ ርቀት 77) ሌላ ----------	
611	ስለ ዘመናዊ የወሊድ መቆጣጠሪያ መወሰን ያለበት ማን ነው?	1) በጋራ 2) ባል 3) ሚስት 77) ሌላ ጥቀስ -------	
612	ስለ ዘመናዊ የወሊድ መቆጣጠሪያ ከትዳር አጋርዎ ጋር ይወያያሉ?	1) በፊት ተወያይተን እናውቃለን 2) ባለፉት 12 ወራቶች ተወያይተናል 3) በየጊዜው እንወያያለን 4) አስበናል:: 77) ሌላ ---------- 99) መልስ የለም	
613	ባቅራቢያዎ ወዳለ የጤና ተቋም በመሄድ የቤተሰብ ምጣኔ አገልግሎት ተጠቃሚ ለመሆን ምን ያህል ጊዜ ይፈጅብዎታል? /በእግር ጉዞ/	1) ---------- ደቂቃዎች/ ሰዓት 2) ---------- ኪ.ሜትር	
614	በአገልግሎት አሰጣጡ ላይ እስከአሁን የታዘቡትን ችግር ይግለጹ::	1) የወሊድ መቆጣጠሪያ መድሀኒቶች እጥረት 2) የሰለጠነ የጤና ባለሞያ እጥረት 3) የደንበኞች መስተንግዶና አቀባበል ችግር 4) የሀላፊዎች ክትትልና ግምገማ ማነስ 5) የመድሀኒቶች ዋጋ መወደድ 6) ሌሎች ችግሮች ካሉ ይግለጹ	

006: - የመረጃ ሰብሳቢው መለያ ቁጥር ----------
007: - መጠይቁ የተሞላበት ቀን (በኢትዮጵያ አቆጣጠር) ----------
008: - የተቆጣጣሪው ማረጋገጫ ስም ----------
ፊርማ ----------
ቀን ----------

አመሠግናለሁ::