ADDIS ABABA UNIVERSITY
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Assessment of factors associated with non use of modern contraceptive methods among currently married women in reproductive age group in Kirkos sub-city, Addis Ababa city administration.

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LIST OF ACRONYMS:

AAU	Addis Ababa University
AOR	Adjusted Odds Ratio
CORHA	Consortium of Reproductive Health Associations
CPR	Contraceptive Prevalence Rate
CI	Confidence Interval
COR	Crude Odds Ratio
EDHS	Ethiopian Demographic Health Survey
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FP	Family Planning
IUCD	Intera Uterine Contraceptive Device
MCM	Modern Contraceptive Methods
NGO	Non Governmental Organization
OCPs	Oral Contraceptive Pills
OR	Odds Ratio
RH	Reproductive Health
SD	Standard Deviation
SRH	Sexual and Reproductive Health
SPSS	Statistical Package for Social Sciences
STDs	Sexual Transmitted Diseases
WFS	World Fertility Survey

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Abstract

Back ground- "Reproductive health ... [implies that people] have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family-planning of their choice ..." It is obvious that solutions are necessary to slow the rapid rate of population growth all over the world, in developing countries, as well as those in which people are not poverty stricken. One of the most popular solutions currently for decreasing the birth rate is to increase use of birth control and decrease nonuse rate.

Objectives: To assess factors associated with non use of modern contraceptive methods among currently married women of reproductive age group (18-49 years age).

Methods: Community based cross-sectional study was conducted in Kirkos sub-city, Addis Ababa city Administration from November 2009-June2010. Both quantitative and qualitative data collection method were used. Focus group discussion will be a qualitative method to complement the finding of the quantitative study. Data entry, data cleaning and analysis will be done by EPI INFO version 6 and analysis will be done using SPSS version 11 statistical package.

Results: Of the total respondents one hundred thirty three (16.1%) had ever used MCM and 272(32.8%) were never user of MCM. The current contraceptive prevalence was found to be 51.1%. Most women used Injectable and OCP. The main reasons for nonuse MCM were desire to have more children followed by medical problem. Of current non user 53.3% had intended to use MCM in the future. It was found that all women 828(99.9%) had information about MCM. The main source of information for MCM was health workers. In multivariate analysis, statistically significant association were found between MCM non use and respondent age, children ever born, educational status of respondents, husband educational status, occupation of respondent, source of information, and husband approval of MCM (PV < 0.05).

Concussion: Current CPR is relatively low in the sub-city; MCM should be distributed at community level especially those non clinical methods by using urban health extension workers.

1. Introduction

1.1 .Background

“Reproductive health ... [implies that people] have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family-planning of their choice ...”(1)

Ethiopia is the second most populous country in Sub-Saharan Africa next to Nigeria, having increased by almost four-fold in just half a century, from 19.2 million in 1950 to the current estimate of 74 million over the last 50 years.(2) The fertility level is one of the world’s highest, at about 5.4 children per woman. (3)At the current rate of growth the population is estimated to double in less than 25 years from now. The health statistics indicate that 673 mothers die in childbirth among every 100,000 live births, a frighteningly high figure by world standards and the lifetime risk of dying from pregnancy-related causes in Ethiopia is 1 in 27, which is higher than the global figure of1 in 92. (4)

1.2. Statement of the problem

Approximately 5 million married women are in need of family planning services (5)Unwanted or mistimed pregnancies are common and often lead women to concealed abortion, which results in serious health complications or even death. (5)According to DHS Ethiopia 2005, the national CPR for urban is estimated at 46.7 percent for any method and 42.2 percent for any modern method while for rural 10.9and 10.6 percent, respectively. Despite the availability of family planning services in governmental and private health facilities and access to health information in Addis Ababa (compared to the other part of the nation) the CPR of Addis Ababa seems relatively high, but it is still less than the total demand for family planning in the city (68.2%).

Therefore, the main aim of this study is to assess factors associated with non use of modern contraceptive methods among currently married women in reproductive age groups and to generate recent and reliable information on the current Contraceptive Prevalence rate (CPR) of kirkos sub-city. This study is justified since no recent FP survey has been conducted in Kirkos sub-city and other sub-city in Addis Ababa city administration. The findings of this study may provide important information for policy makers and health managers to improve the family planning services and coverage in the future, and also helps as a baseline survey for urban health extension program which is going to be launched by Addis Ababa health bureau in2009/2010 .(6)

2. Literature review

For several decades, researchers have sought to reveal the factors that influence women to adopt contraception. Area of residence, levels of schooling and socioeconomic status have been shown to identify women who are most likely to use or not to use contraceptive methods. For example, survey data from developing countries in Asia, Africa and Latin America have consistently shown that rural women with few economic resources and little schooling have especially low levels of contraceptive use. The resulting efforts to promote contraceptive use among these underserved women are based on the belief that fertility rates can be reduced by increasing both information about contraception and access to it.(7)

The associated factors of each of the outcomes are examined in terms of demographic (parity), socioeconomic, geographic and female autonomy factors. Socioeconomic factors include the respondent' s level of educational attainment, the educational attainment of her husband, and whether the respondent works in paid employment outside the home were also some of the factors that influence the non use of family planning service. (8)

The factors that may affect use or non use of modern methods of contraceptive have been studied and broadly grouped into seven categories these are:

1.1. Health service factors

In the area of health services the time spent to travel from the potential user to health facilities or family planning centers has been shown to be important. Administrative barriers were the second most commonly reported barrier to family planning services identified by urban poor women. Administrative barriers in this study referred to the perception that services are of poor quality and fear of using services due to reports of bad experiences of others. (7)

2. 2.Socio economic factors

2.2.1. Economical factors

There are some evidence that women who have been employed outside their home are more likely to use modern contraception than other women, a study which was conducted in Addis Ababa, Ethiopia in 1988 showed that government employees and employees of aid organization comprised the majority of modern contraceptive use, 33%and 27% respectively(8) Similar study which was conducted in Teguletna Bulga Awraja in1988 also showed that strong relation ship in

the monthly family income and modern contraceptive usage, the users had a proportionately higher monthly income ,whereas nonusers were more likely to be in the low income groups.[8-10]

2.2.2. Educational factors

Women's educational levels play a significant role in delaying the age of first marriage and creating better opportunities for employment. Moreover, it affects positively women's attitudes towards contraceptive use and puts them in a position to negotiate contraception adoption.

As the study which was conducted in Naogaon, Bangladesh and other similar study indicate ; the effect of the respondent's education on current contraceptive use is found to be the most important one. Women with secondary or higher education are found 79.7 percent more likely to use contraception as those who are illiterate. This indicates that women's education is the most important factor; it is followed in importance by women's participation in family planning decision-making. Both influence the current use rate of contraception positively.[11, 12]

A study which was conducted in Chiaps, Mexico and other similar study revealed that the lack of any schooling at all was independently associated with the likely hood of nonuse of modern contraception as illiterate women were 1.6 times as likely as those who attained secondary school to have never use modern contraception.[13]

2.2.3. Family structure

The presence of a mother-in-law may represent the presence of more traditional attitudes towards family planning use in the household. A mother-in-law may also represent familial pressure for larger families, particularly for sons. Women living in households with a mother-in-law present thus potentially face the dual burden of negative attitudes towards the use of family planning services from both the husband and the mother-in-law.[7]

2.3. Demographic factors

Age patterns of fertility differ considerably among regions, countries, and different groups with in countries. Modern contraceptive are more practiced by women in the middle reproductive years than by older or younger women. The world fertility survey (WFS) data showed that the level of current use of modern contraception reached a peak in the age groups of 30-39 in Asia countries and somewhat earlier in the Latin America and African countries, at age 25to 34 and 20-34 respectively. [14] Contraceptive use varied based on the women's age; it was 41.1% among women aged ≤20 and increased to 68.1% for those aged 21–35 and to 68.8% for those over 35. Similarly study conducted in Tehran, Iran indicated that, The estimated odds ratio of not using

contraceptive methods was 1.3 and 1.9 among women aged ≤20 and >35, respectively, in comparison with women aged 21–35 years old.[15] A study which was conducted in three South East Asia showed that Son preference remains widespread in all three countries. In general, desire for another child decreased and contraceptive use increased as the number of children and number of sons increased [16]

2.4. Reproductive factors

In populations where fertility regulation is not widespread, age at first marriage is highly correlated with fertility. In such populations, women who marry early tend to initiate childbearing early, have a longer lifetime exposure to pregnancy, and have a large completed family size, compared to those who marry late. The number of living children also appears to influence contraceptive use. According to studies based on WFS data, in many of the study countries, women who had no children living not tend to practice contraceptive. From zero low level of use prior to the first birth ,the percentage of users increased markedly tending to reach a peak in some countries when there were 3 or 4 children and tapering of there after. [13]Similar study in Tegultna Bulga Awraj indicate that a direct relation ship existed in gravidity and modern contraceptive use ($p<0.001$), that is modern contraceptive users had a significantly higher number of pregnancies (2 and more) whereas nonuser were more likely to have one or none. [10]

2.5. Awareness/knowledge of modern contraception and source of methods

Acquiring awareness and knowledge about family planning is an important step towards gaining access to and using a suitable contraceptive method in a timely and effective manner. Individuals who have adequate information about the available methods of contraception are better able to make choices about planning their families, whereas those who do not have awareness and knowledge of family planning less likely to use modern family planning methods.

According to EDHS 2005 report knowledge of contraception has remained high in Ethiopia over the past five years For example; knowledge of any modern method among currently married women was 85 percent in 2000 and 87 percent in 2005[3]

EDHS2005 also indicate that four-fifths of current users (80 percent) obtain methods from the public sector, 17 percent from the private medical sector, and 3 percent from other sources.

A study which was conducted in Teguletna Bulga Aweraja showed that there was statistically significance difference in modern contraceptive information sources between users and non users

(p=0.001).[10] A proportionately higher number of users received modern contraception information for the first time from health institution compared to non user.[3]

2.6. Attitudes towards family planning

Study done in East Africa has shown that an individual woman attitudes, beliefs or religion can also influences her contraceptive use directly or indirectly through her desire for children. More traditional beliefs can support the demand for large families and limit the up take of contraception, particularly non traditional method. Clearly, a variation in knowledge and attitudes could potentially create are variation in modern contraceptive use or not use. [17] Women living in households with a mother-in-law present thus potentially face the dual burden of negative attitudes towards the use of family planning services from both the husband and the mother-in-law.[7] The reason given to the use of family planning includes spacing of birth, prevention of unwanted pregnancy and limiting population. According to WFS data in Africa, spacing children was the most important reason for using family planning, while in Asia ending child bearing was the predominant reason. The percentage of Africa contraception uses who were spacing, rather than limiting births ranged from 59% in Lesotho to 90% in Nigeria and 89% in Zimbabwe. [18] Similarly a study which was conducted in Teguletna Bulga Awraja revealed that the reason for current user of modern contraceptive 53%were to prevent unwanted pregnancy(extramarital pregnancy)while 46% were using it for birth-spacing, only 1%was using modern contraceptive for prevention of STDs and no one were using for limiting.[10]

2.7. Husband approval (inter spousal communication)

The husband-wife discussion about family planning and a more equal status of women in family in terms of decision making about family planning are important for increasing the contraception use rate. A study which was conducted in six African countries showed that, in all 6 countries, women who reported frequent discussion of family planning with their partners were more likely to be using contraception than were women who reported they never discussed family planning.[12]. Similar study conducted in Jima town showed that MCM use was higher when the husband approved of FP than women with husband disapprove FP. [19]

According to the study conducted in Teguletna Bulga there was Statistically significant proportion of husband of current users approved modern contraception (98.7%) as compared to husband of non users(70.5%) ($P < 0.001$). Husband wife communication on family planning was significantly higher among users (40.9%) compared to non users (15.4%) ($P < 0.001$). [10]

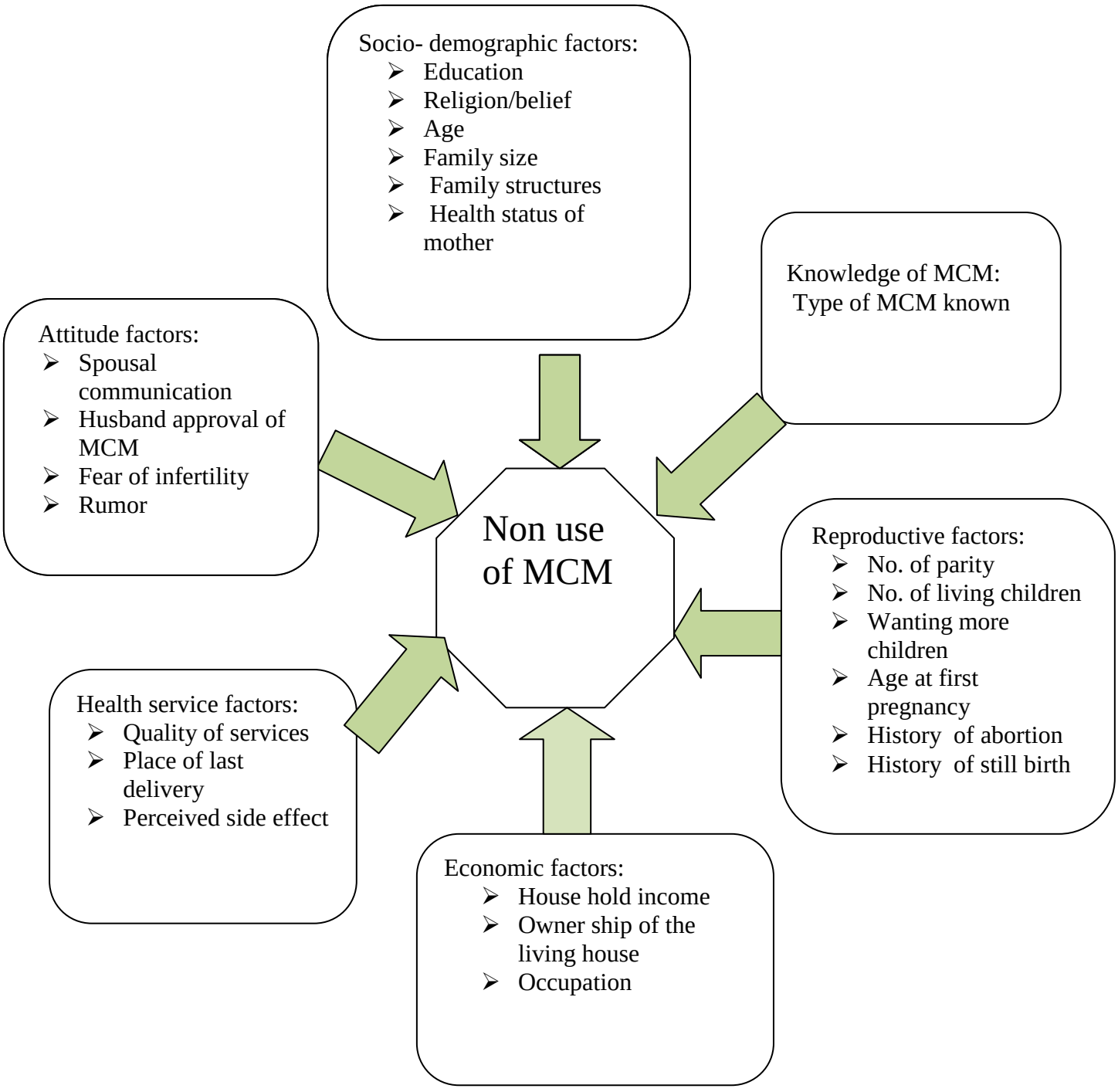

Figure 1: Conceptual frame work indicating associated factors of non use of MCM

3. OBJECTIVES OF THE STUDY

3.1. General Objective:

To assess the magnitude and factors associated with nonuse of modern contraceptive methods among currently married women in the reproductive age group (18-49 years age).

3.2. Specific objectives:

1. To determine the magnitude of modern contraceptive method nonuse among women of reproductive age group (18-49) in kirkos sub-city, Addis Ababa city administration.

2. To assess factors associated with non use of modern contraceptive practice among currently married women of reproductive age group (18-49) in the study area.

4. Methods and Materials

4.1. Study area and period

This study was conducted in kirkos sub-city, Addis Ababa city administration from November 2009 to Jun 2010. Kirkos Sub-City is one of the ten sub-cities in Addis Ababa city administration and geographically located in the central part of Addis Ababa. The sub city has a total area of 1626 hectares and 11 kebele in it. It boarders with 5 sub-cities Arada in the north, Nefasilk lafto in the south, Ledeta sub- city in the west and Yeka and Bole sub - cities in the east. According to the Ethiopian population and housing census the 2009/2010 population projection of the sub-city is estimated to be 235,207of which 112,536(47.8%) and 122,671(52.2%) male and female respectively .The population density is around 258 person per hectare, The population structure of kirkos sub - city indicates that out of the total population 43.5% comprises of people under 15yrs of age, and 34.6% are in the reproductive age groups (15-49). There are two governmental hospitals, 3 health centers and one health post/clinic two private hospitals, 22 special clinics, 24 higher clinics 11 medium clinics and 34 small private clinics and making health service coverage of 51% and CPR 34.5% of the sub-city. The study was conducted from November 2009 to June 2010 in Kirkos sub-city, Addis Ababa city administration.

4.2. Study design

The study was used quantitative study method in the form of community based Cross sectional survey. Qualitative study methods employed to triangulate the quantitative method.

4.3. Study Population

The study population were all women in reproductive age group (18-49years) who are resides in the selected house holds of the four kebeles (kebele 01/19, 05/06/07, 02/03, and20/21) and who are currently married.

4.4. Sample size

The sample size was calculated using single population proportion

The formula used for calculating the sample is;

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

Where;

n=the desired sample size

p=proportion of contraceptive prevalence of Addis Ababa (EDHS2005)

Zα/2= critical value at 95% confidence level

d= the margin error between the sample and the population (5%)

Since there is no similar research conducted on contraceptive prevalence at sub-city level assuming that the contraceptive prevalence of Addis Ababa city administration is 45.2 % (non user 54.8%) (EDHS2005), 95% of confidence level and ,5% of tolerable error, design effect of 2 and 15% non response rate the total number of sample size required for this study was calculated to be 381 x 2=(762)+114=876 currently married women of reproductive age groups (18-49).

4.5. Sampling procedure

Kirkos sub-city was purposefully selected for this study for logistic and administrative reasons. Kirks sub-city is divided into 11 kebeles administration unit. Of these, 11 kebeles, four were selected by a simple random sampling method followed by the selection of households through systematic sampling methods. In each kebele, the starting household was selected by lottery method. The calculated sample allocated to the four kebeles proportionally to the size of each kebele (01/19, 05/06/07/, 02/03 and 20/21). Sample size distribution to selected kebeles was 177, 276, 222 and 201 households respectively. If there was more than one eligible respondent in a household, one was selected through a lottery method. If there was no an eligible woman in the selected household, the immediate next household was included in the survey. For those households in which eligible women were not found at home during interview, three further visits was made.

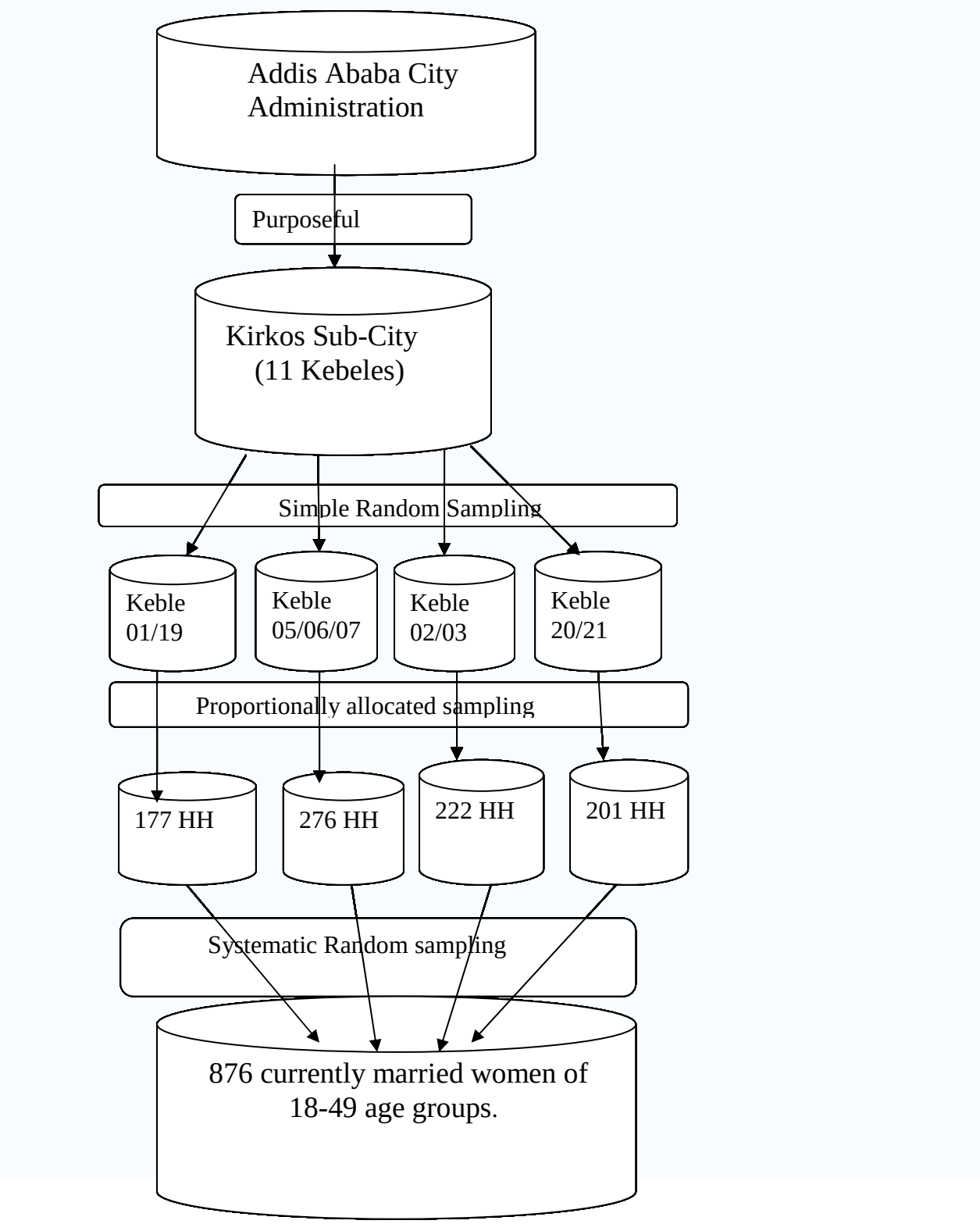

Figure2. Schematic presentation of the sampling procedure

Inclusion criteria: Currently married women in the reproductive age group (18-49 year) and (willing to participate in the study).

Exclusion Criteria: Women out side the age range 18-49year and currently not married.

4.6. Data collection procedure

Data were collected using the structured questionnaires. This was adopted from different literature developed for similar purpose by different authors. The questionnaire was reviewed to suit the local condition and was prepared with an aim to answer the main study questions of the research in English language and was translated into Amharic language and back to English by the principal investigator and other personnel fluent on both languages to prevent possible misunderstanding and misinterpretation. Ten female interviewers who are nurses and four health officer were recruited as data collector and supervisors respectively. Data collector were trained for three days on questionnaire, purpose of the study, on interviewing techniques, and importance of privacy, discipline, and approach to the interviews and confidentiality of the respondents. The questionnaire was containing mainly close ended questions, and it had had also few open ended questions. Before conducting the main study the questionnaire was pre-tested among 30 women 15-49 age group which was not included in the main study. Based on the result the questionnaire was modified as necessary. The supervisor and principal investigator were check filled questionnaires for their completeness everyday.

4.7. Variables in the study

Dependent variables included in the study was: Non use of Contraceptive

Independent variables included in this study were:

Socioeconomic variables: occupation, employment, monthly income, possession of private living house

Demographic and cultural variables: age, religion /belief, family size, ethnicity, family structure and education.

Knowledge of contraceptive methods: type of methods known

Attitude and practice of family planning; spousal communication, husband approval & MCM use

Service delivery: preference of the service delivery government, private, Pharmacy

Past and current reproductive history: parity, number of currently living children, age at first pregnancy, number of live births, place of most recent delivery number of still birth and number of abortion.

4.8. Operational definitions

Nonuser: A woman who are not using modern contraceptive method during the interview period

Current user: A woman who is using modern contraceptive method at the time of the study.

Ever user: A woman who has practiced modern contraceptive method sometime in the past and not using at the time of this study.

Intention to use modern contraceptive methods: -Number of respondents who are not currently using modern contraceptive methods during the survey, but intended to use MCM in the future.

Nuclear family: Those married women not living with their own or husband's mother or father.

Extended family: Those married women living with their own or husband's mother or father.

4.9. Data analysis

After data collection was completed, data entry and cleaning was done using EPI- Info version 6 and analysis was done using SPSS version 11 statistical packages. During analysis frequencies of the different variables were determined, cross- tabulations and chi-square test were used to compare frequencies. P- Value <0.05 indicated statistical significance; logistic regression analysis was carried out to assess the relative effect of selected variables on modern contraceptive nonuse.

4.10. Qualitative study

Two focus group discussions were held with currently married women of reproductive age groups from the selected kebeles. The number of participants in each focus group discussion was six to eight. Key informant interview was made with the sub-city health office responsible person.

For both qualitative studies, participants were purposefully selected. In FGDs homogeneity with in groups were considered. For both the key informant interview and FGD the participants were told about the purpose of the study and were asked for informed verbal consent, For both focus group discussion and the key informant interview guiding questions were used which is translate to Amharic and then the discussion was held with Amharic .Both the interview and the focus group discussions were moderated by the principal investigator. One facilitator and one note

taker who was trained participated in the qualitative data collection. A tape recorder was used to record the interviews and discussions. Participants' conversations were audio taped, transcribed verbatim and translated. Then the data were systematically coded segment by segment based on the research questions. Categories was formed and then based on the emerged relationships between the categories themes was developed and used to answer the research questions in conjunction with the data from the quantitative survey.

4.11. Data quality assurance

To ensure the external validity (generalizability) of the study, appropriate sample size and representative type of study units was selected and also for internal validity (accuracy and precision) of the study, maximum effort was made to minimize bias and errors using the following strategies: from the very beginning proper sampling method was used, Proper training of data collectors and supervisor were undertaken, pre-testing and standardizing of the questionnaires was made, the principal investigator and supervisor were made day to day site supervision during the whole period of data collection, at the end of each day the questionnaire was reviewed and checked for completeness, accuracy and consistency by supervisor and principal investigator and corrective discussion were carried out with all research team members, a reminding remark were given every morning in order to eliminate or minimizing errors and take corrective action timely, data was double entered using the Epi-Info version 6 soft ware package by the principal investigator and experienced data clerk. The data entered by two individuals were cross checked and corrected prior to analysis if there is any mismatch.

4.12. Ethical consideration

Ethical clearance was obtained from Addis Ababa University IRB, (the Faculty of Research and Publication Committee) before the start of fieldwork. Official letter of co-operation was written to Kirkos sub-city Administration from AAU/MF School of Public Health. After thoroughly discussing the ultimate purpose and method of the study, a written consent was sought from local authority and concerned government officials and also the purpose of study was discussed with respondents before the data collection; Participation was voluntary any one who was not willing to take part in the study have full right to do so and they can also withdraw from the study at any time. Finally an informed verbal consent was obtained from women to be interviewed .However, women was assured that neither the interviewer nor their parents would have access to their

responses, privacy and confidentiality was maintained throughout the process of this study. There was no any harm or benefit given to the participant in the survey.

4.13. Dissemination of the results

In addition to the partial fulfillment of MPH in AAUMF-SPH, the findings of this study would be submitted to policy makers, health managers and NGOs working on reproductive health in the study area. The findings would also be disseminated to different organizations for which it would have a contribution to improve family planning service. It is also believed this finding would also be used as baseline for urban health extension program that is going to be launched in Addis Ababa. The findings may also be submitted for possible publication in scientific journals.

5. Results

A total of 829 currently married women aged18-49 years were included in the study making a response rate of, 94.6%.While the remaining 47(5.4%) were non respondents.

Of the total respondent 424(51.1%), 133(16.1%) and 272 (32.8%) were current user, ever user and never user respectively.

The reasons for non responses to the survey questionnaire were; the selected house hold women were not able found in the home for three consecutive visits on different appointment days.

5.1. Socio-demographic characteristics of study population

Age distributions showed that majority of the respondents were in the age of 35 to 49 years with mean of 31±6.5 years .

The mean ever born children in the study population was 2.3± 1.4 the minimum and the maximum was zero and ten respectively.

Four hundred ninety one (59.2%) and 30.4% of the women had 1-2 children and 3 & above children respectively, while 10.4% women had no any children at all.

Amhara ethnicity constituted 448(54.0%) of the study population followed by Oromo, Gurage and Tigre & others 197 (23.8%), 99 (11.9%) and 85(10.3%) respectively.

Six hundred eighty seven of the respondents 687(82.9%) were fond to be followers of Orthodox Christianity while Muslim, Protestant and Catholic altogether accounts 142(17.1%).

Family structures showed that 787 (94.9%) the nuclear family and the remaining 42(5.1%) were extended family.

The mean family size of the respondent was 4.7±1.8 persons with minimum and maximum family size of 2 and14 persons respectively. Five hundred ninety eight (72.1%) of the respondent have 2-5 family size while the remaining 231(27.9%) have 6 and above family size.

Five hundred twenty five 525(63.3%) of the respondents were educated to the level of high school and above, while the remaining 196(23.6%) were educated to the level of elementary and 108(13.0%) of the respondent were illiterate or only able to read and write.

Regarding husband education 661(79.6%) of the respondents were educated to the level of high school and above, the remaining 122(14.7%) were educated to the level of elementary and 46(5.5%) were illiterate or only able to read and write. (Table-1)

Table1. Socio- demographic Characteristics among study population in, Kirkos Sub-city, Addis Ababa city administration, June, 2010.

Characteristics	Number	Percent
Age (in years)	**n=829**	
18-24	104	12.5
25-29	242	29.2
30-34	213	25.7
35 & Above	270	32.6
Mean ± SD	30 ± 6.5	
Ever born Children		
No children	86	10.4
1-2	491	59.2
3 & above	252	30.4
Mean ± SD	2.30 ± 1.363	
Ethnicity		
Amhara	448	54.0
Oromo	197	23.8
Gurage	99	11.9
Others (Tigre & Welayta)	85	10.3
Religion		
Orthodox	687	82.9
Muslim	87	10.5
Others (Protestant & Catholic)	55	6.6
Family Structure		
Nuclear family	787	94.9
Extended family	42	5.1
Total family Size		
2-5	598	72.1
6 & above	231	27.9
Mean ± SD	4.7± 1.8	
Education Status of Respondent		
Illiterate, only Reading & Writing	108	13.0
Elementary School (1-6)	196	23.6
High School (7-12) & Above	525	63.3
Husband Educational Status (n=829)		
Illiterate, only Reading & Writing	46	5.5
Elementary School (1-6)	122	14.7
High School (7-12) & Above	661	79.7

5.2. Socio economic characteristics

.Concerning occupation of the respondent 477 (57.5%) were house wives followed by 191(23.1%), 121(14.6%) and 40(4.8%) were business man/merchant & self employee, government/non government employee and others respectively. While occupation of the husband merchant & self employee were 457 (55.1%) followed by government / non government employee and others were 298 (35.9%) and 74 (9.0%) respectively.

Regarding family monthly income 500 (60.3%) of the respondents reported that they had less than 750 Eth. Birr while the remaining 137 (16.5%) and 191 (23%) had 751-1000 Eth. birr and greater than 1000 Eth. Birr respectively.

Four hundred twelve 412 (49.7%) of the respondents considered them selves as an average as compared to their neighbors, while the remaining 231(27.9%) and 186(22.4%) considered them selves as either very poor or poor and well to do or rich respectively.

Seven hundred seventeen 717 (86.5%) and 730 (88.1%) of the respondents had television and radio respectively, while the minority 315 (38.0%) had refrigerator. Concerning owner ship of the living house only 143 (17.2%) of the respondents had their own living house, while 686 (82.8%) of the respondents live in rented house. (Table-2)

Table 2 Socio economic characteristics of study population in kirkos sub-city, Addis Ababa city administration, June 2010.

Characteristics	Number	Percent
Main Occupation of Respondent	**n=829**	
House wives	477	57.5
Government/non government employee	121	14.6
Businessman/Merchant & self employee	191	23.1
Others (Daily laborer &student)	40	4.8
Main Occupation of Husband		
Government/non government employee	298	35.9
Businessman/Merchant **&** Self employee	457	55.1
Others (Daily laborer, no job)	74	9.0
Possession of Television		
Yes	717	86.5
No	112	13.5
Possession of Radio		
Yes	730	88.1
No	99	11.9
Possession of Refrigerator		
Yes	315	38.0
No	514	62.0
Family monthly income		
< 500 Birr	233	28.1
500-750 Birr	268	32.3
751-1000Birr	137	16.5
>1000 Birr	191	23.1
Family Economic Status Compared to Neighbors		
Very poor and poor	231	27.9
Average	412	49.7
Well to do and rich	186	22.4
Ownership of the living house (n=829)		
Belongs to self	143	17.2
Rented	686	82.84

5.3. Reproductive characteristics

Seven hundred and twenty six 92.6% of the respondents reported that they have ever had pregnancy prior to the survey. The mean number of pregnancy was 2.5 ± 1.5 and the minimum and maximum number of pregnancy were one and ten respectively. Six hundred ninety four (90.4%) of the respondents reported that the pregnancy was wanted and the remaining 74 (9.6%) as unwanted.

The mean and median age at first pregnancy was 21.7 ± 3.8 and 21 years respectively, with minimum and maximum age of 15 and 36 years respectively.

Concerning place of last delivery, 661 (90%) and 74 (10%) of the respondents reported that they had given birth in the health facilities and at their home respectively.

The average number of living children was 2.3 ± 1.4 with a range of 0-10 children.

Six hundred fifteen (74.2%) had 1-3 children the remaining 126 (15.2%) had 4 & above children and 88 (10.6) had no living children.

Three hundred eighty six (50.3%) of the respondents were wanted any more (children) .The mean number of wanting children was 1.19 ± 0.4. Of those who wanted children 351 (91.1%) of the respondents wanted 1-2 more (children), while the remaining 35(8.9%) wanted 3 & above more (children).The reason given for wanting more (children) were; two hundred sixty (67.4%) and 123 (31.9%) were needs more son (daughter) and have only few children respectively.

Women who had history of still birth were 45 (5.9%). Women who had history of abortion were 117(15.2%). The mean number of abortion was 1.36±0.5 with a range of 1-3 abortions. Seventy seven (91.1%) had only one abortion and 4(8.9%) had 2 & above abortions.

Table3. Past reproductive history among currently married women aged 18-49 years in Kirkos Sub-city, Addis Ababa city administration, June 2010

Characteristics	Number	Percent
Ever pregnant	**n=829**	
Yes	768	92.6
No	61	7.4
Number of pregnancy	**n=768**	
1-3	600	78.2
4 & above	168	21.8
Mean ± SD	**2.5 ±1.5**	
Were all pregnancies wanted?		
Yes	694	90.4
No	74	9.6
Age at first pregnancy (years)		
15-19	271	35.3
20-29	471	61.3
30 & Above	26	3.4
Mean ± SD	**21.7± 3.8**	
Place of last delivery	**n=743**	
Health facility	669	90.0
Home	74	10.0
Number of live birth		
1-3	615	82.8
4 & above	128	17.2
Mean ± SD	**2.3 ± 1.4**	
Number of living children	**n=829**	
None	88	10.6
1-3	615	74.2
4 & above	126	15.2
Mean ± SD	**2.29 ± 1.36**	
Do you want any more children	**n=768**	
Yes	386	50.3
No	382	49.7
Total number of wanted Children	**n=386**	
1-2	351	91.1
3 & Above	35	8.9
Reason for wanting more children		
Have only few children	123	31.9
Need more son (daughter)	260	67.4
Child/Children died	3	0.7
Ever experienced still birth?	**n=768**	
Yes	45	5.9
No	723	94.1
Ever experienced abortion?		
Yes	117	15.2
No	651	84.8
Number of abortion	**n=117**	
1	77	65.8
2 & Above	40	34.2

5.4. Knowledge of MCM

All women 828 (99.9%) had ever heard about MCM. The most frequently mentioned source of information for MCM were; health workers 537 (64.9%) followed by mass media 186 (22.5% and friends & others 105 (12.7%).

OCP 816 (98.6%), IUDs 529 (63.9%), Injectable 748 (90.3%), Norplant 459(55.4%), spermicidal 26 (3.1%), condom 226 (27.3%) female sterilization 38 (4.6%) and male sterilization 16 (1.9%) were MCMs mentioned by women in the study population.

The most frequently mentioned advantage of MCM by study population were; Eight hundred ninety (98.9%) prevention of unwanted pregnancy followed by 793 (98.5%) child spacing and 568 (68.6%) to limit family size. Prevention of STDs and menstrual regulation were the less frequently mentioned of advantage of MCM with frequency of 109 (13.2%) and 15 (1.8%) respectively.

All women in the study population 828 (99.9%) were knew source of MCM. The most frequently mentioned source of MCM was health center with frequency of 738 (89.1%) whereas hospital, health post/clinic, FGAE clinic and pharmacy altogether constituted 90 (10.9%) as source of getting MCM. (Table-4)

Table 4 Modern contraceptive knowledge /awareness among study population in Kirkos Sub-city, Addis Ababa city administration, June 2010

Characteristics	Number	Percent
Ever heard of MC	**n=829**	
Yes	828	99.9
No	1	0.1
Source of information on MCM for the first time	**n=828**	
Health workers	537	64.9
Mass media (Radio, Television & News paper)	186	22.4
Friends& others	105	12.7
Types of MCM known *	**(n=828)**	
OCP	816	98.6
IUDs	529	63.9
Injectable	748	90.3
Implant/Norplant	459	55.4
Spermicidal	26	3.1
Condom	226	27.3
Female sterilization	38	4.6
Male sterilization	16	1.9
Main place to get MCM		
Health center	738	89.1
Hospital	25	3.0
Others (FGAE clinic, HP/clinic, private clinic& pharmacy)	65	7.9

***** Multiple responses

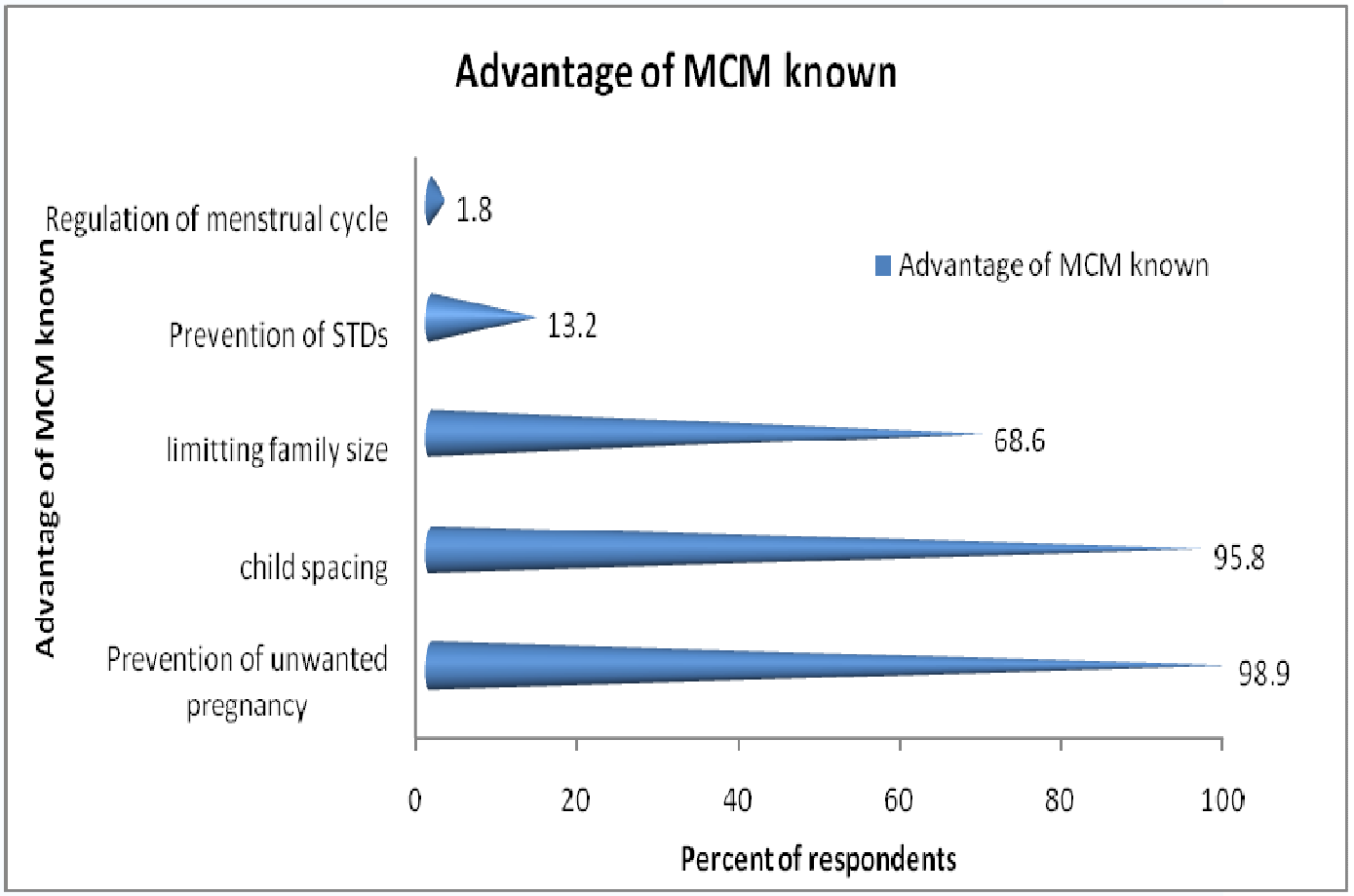

Figure 3 Advantage of MCM known by study population, June 2010 (multiple responses)

5.5. Practice of modern contraceptive methods

Among currently married women in Kirkos sub-city 424 (51.1%) were current user of MCM. Of the total study population 272 (32.8%) and 133 (16.0%) were ever user and never user of MCM respectively.

Among ever user of MCMs, OCP 178 (65.4%), Injectable 184 (67.6%), IUDs 20 (7.4%), spermicidal 1(0.4%) and condom 2(0.7%) were the type of MCMs used by the study population.

Main reasons given by ever user for the discontinuation of using MCM were; 139 (51.1%) desire to have more children, 118 (43.4%) medical problems and others 5(5.5%) (Like fear of side effect & using natural methods).

Among the total current users of MCM, 65 (15.3%) OCP, 274 (64.6%) Injectable, 38 (7.8%) IUDs, 33(7.8%) Norplant/implant, 6 (1.4%) and 8 (1.9%) were using female sterilization method. Surprisingly no women were reporting male sterilization method at the time of the survey.

Among current user of MCMs, two hundred twenty (51.9%) were using for child spacing, followed by 200 (47.3%) to limit family size and 4 (0.9%) for other purpose.

Source of MCM for current users were 29 (6.8%) private clinic, 21 (6.2%) government hospital, 324 (76.4%) health center, 22 (5.2%) FGAE clinic and 23 (5.4%) were from pharmacy.

According to respondents, the most preferred source to get MCM was health center with frequency of 354 (83.5%).

Out of 405 (48.9%) of current non user 216 (53.3%) had intended to use MCM in the future of which 81 (37.5%) for child spacing and 135 (62.5%) to limit family size.

Two hundred and six (48.6%) of current user of MCM reported that they travel 30-60 minutes from their home to get MCM, 122 (28.8%) and 96 (22.6%) were travel less than 30 minutes and greater than 60 minutes to get MCM respectively.(Table 5)

Table 5 MCM practices among study population in Kirkos sub-city, Addis Ababa city administration, June 2010.

Characteristics	Number	Percent
Are you currently using MCM	**n=829**	
Yes	424	51.1
No	405	48.9
Are you ever used MCM	**n=405**	
Yes	272	67.2
No	133	38.8
Type of ever used MCM*	**n=272**	
OCP	178	65.4
Injectable	184	67.6
IUDs	20	7.4
Implant/Norplant	5	1.8
Others (Spermicidal & Condom)	3	1.1
Intention to use MCM among current non user	**n=405**	
Yes	216	53.3
No	189	46.7
Purpose of intended to use (n=216)		
Child spacing	81	37.5
Limiting family size	135	62.5
Types of MCM currently Using	**n=424**	
OCP	65	15.3
Injectable	274	64.6
IUDs	38	9.0
Norplant/Implant	33	7.8
Others (Condom & Female sterilization)	14	3.3
Purpose of currently using MCM	**n=424**	
Child spacing	220	51.9
Limiting family size	200	47.2
Others	4	.9
Time taken to travel to the source MCM (minutes)		
< 30	122	28.8
30-60	206	48.6
>60	96	22.6

*** Multiple responses**

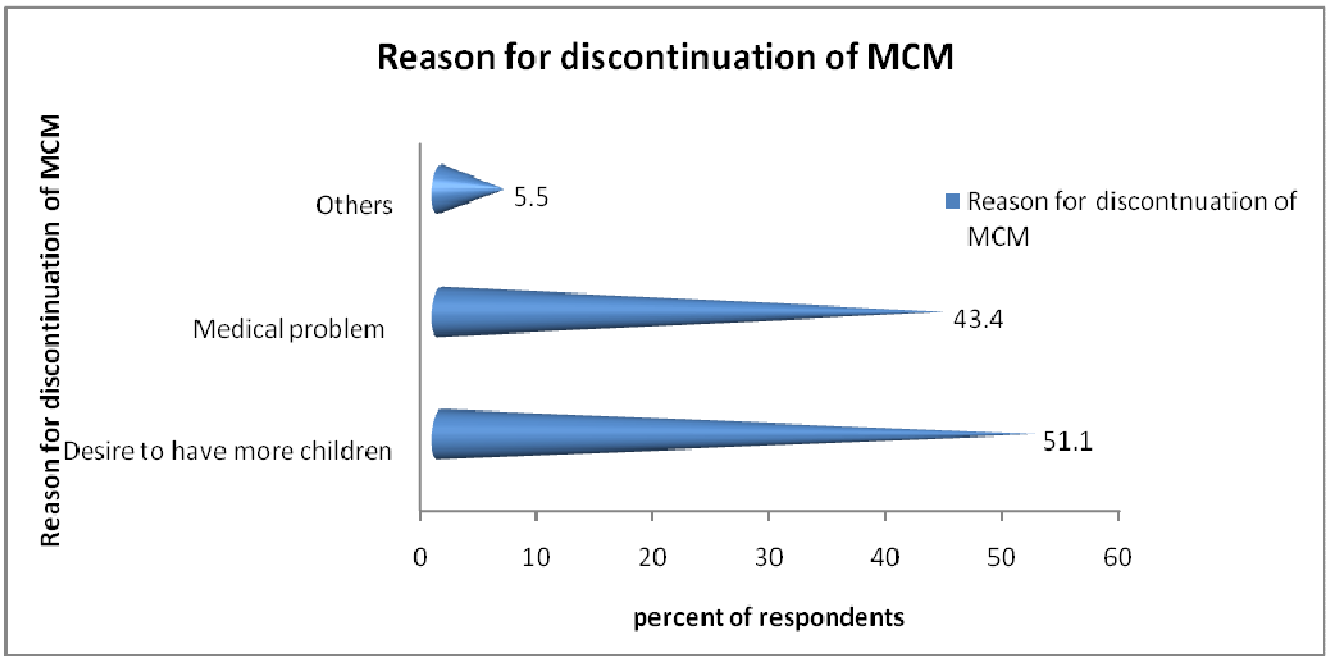

Figure 4 Reason for discontinuation of MCM among the study population, June 2010

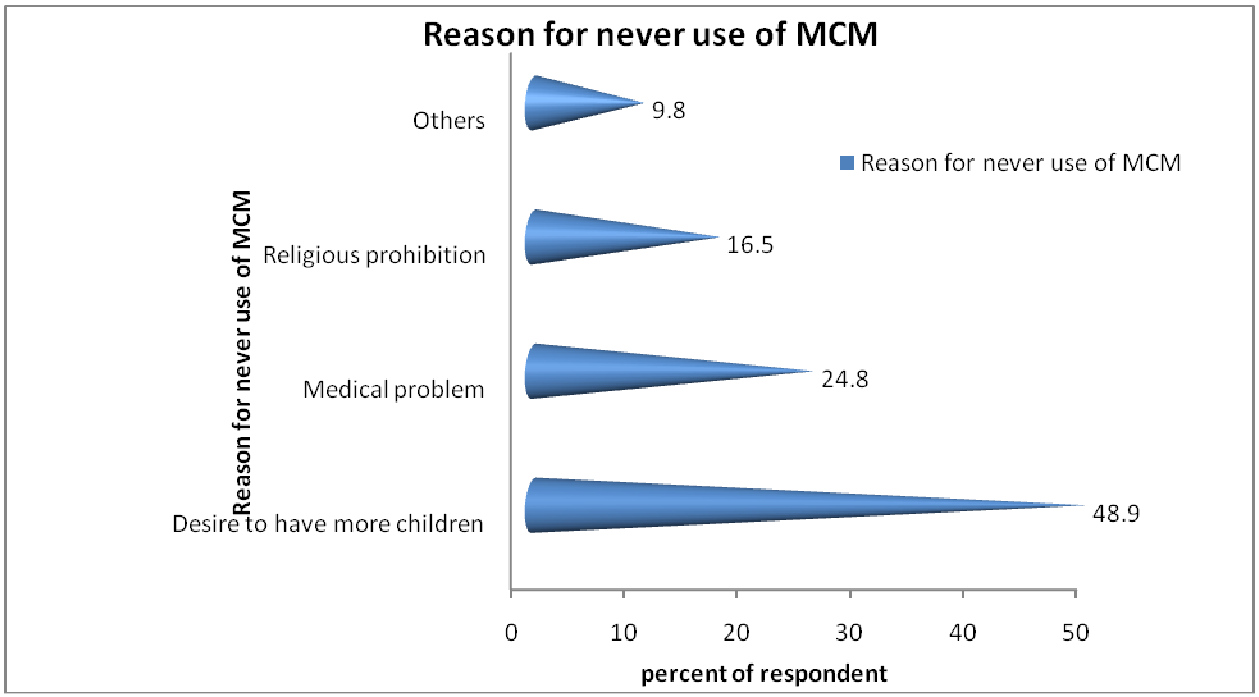

Figure 5 Reason for never use of MCM in the study population, June 2010

Source of MCM for currently using and preferred source

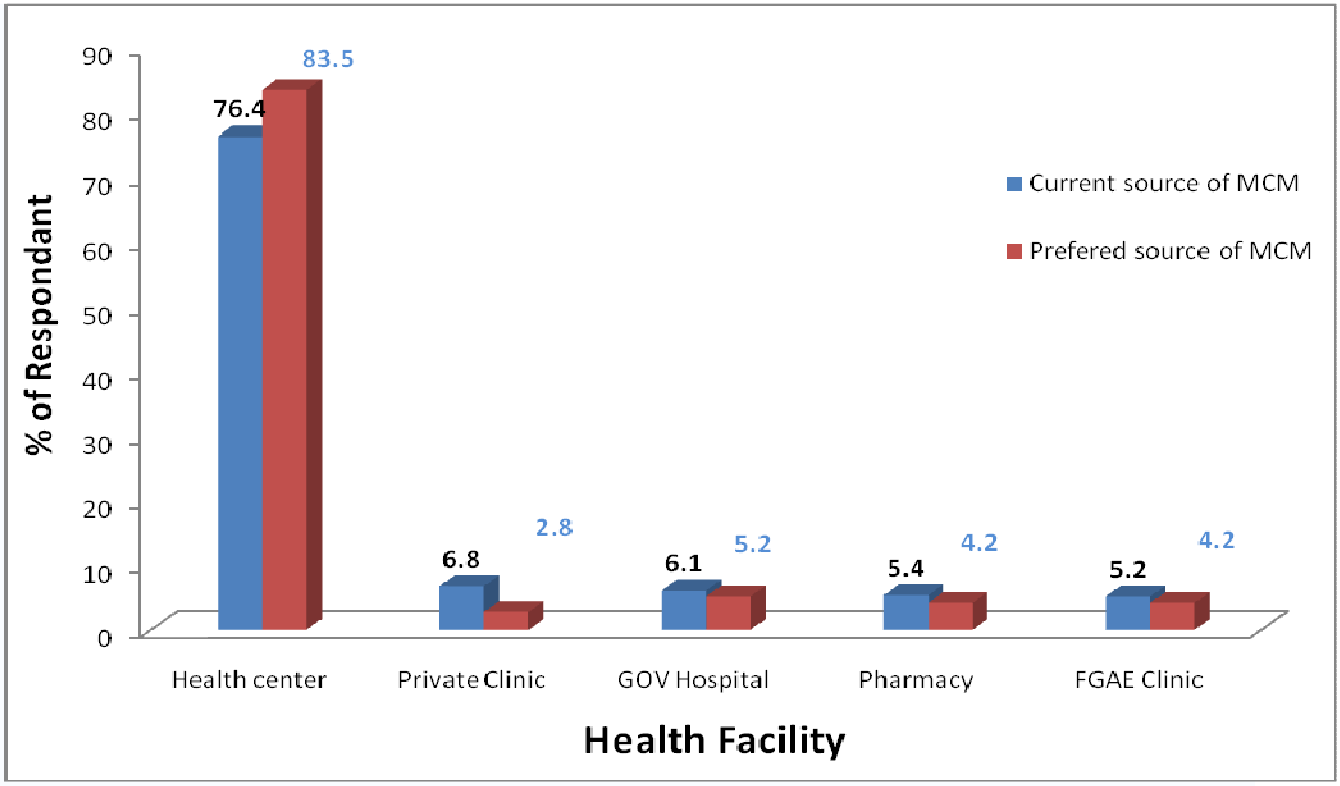

Figure 6 Shows source of MCM for currently using and preferred source among study population, June, 2010

5.6. Attitudes towards MCM

Regarding attitudes towards MCM respondents were asked to respond on four positive and two negative structured attitude questions with three choices agree, disagree and neutral. Four hundred twenty three (51.5%) MCM users and 399 (48.5%) of non users agree that children will have better opportunity for education if parents practices FP, 422 (51.3%) of MCM users and 400 (48.7%) of non users were agree that FP will improve one's standard of living, 419 (51.5%) of MCM users and 394 (48.5%) of non users were agree that FP helps mothers to regain strength before her next baby, 419 (51.3)of MCM users and 398 (48.7%)of non users agree that child spacing helps to protect the health of mothers and children, 394 (53.5%) of MCM users and 342 (46.5%) of MCM non users disagree that FP causes loss of confidence between husband and wife and 316 (55.5%) of MCM users and 253 (44.5%) of MCM non users were disagree that using MCM may causes infertility.(Table 6)

Table 6 Attitude towards modern contraceptives among study population in kirkos sub-city, Addis Ababa city administration, June 2010

Attitude factors	Agree n (%)	Disagree n (%)	Neutral n (%)
Children will have better opportunity			
MCM users	423(51.5)	1(100)	0(0)
MCM non users	399(48.5)	0(0)	5(100)
MC Improve standard of living			
MCM users	422(51.3)	1(100)	1(16.7)
MCM non users	400(48.7)	0(0)	5(83.5)
FP helps mothers to regain strength before next pregnancy			
MCM users	419(51.5)	4(57.1)	1(11.1)
MCM non users	394(48.5)	3(42.9)	8(88.9)
Child spacing protect health of children and mother			
MCM users	419(51.3)	4(66.7)	1(16.7)
MCM non users	398(48.7)	2(33.3)	5(83.3)
FP can cause loose confidence b/n couples			
MCM users	25(35.2)	394(53.5)	5(22.7)
MCM non users	46(64.8)	342(46.5)	17(77.3)
Using MCM can cause infertility			
MCM users	58(39.5)	316(55.5)	50(44.2)
MCM non users	89(60.5)	253(44.5)	63(55.8)

5.7. Socio- economic & demographic characteristics associated with MCM non use, among the study population

Cross tabulation and Logistic regression analysis was carried out to determine the association between socio-demographic factors with MCM non-use among participants. In the bi-bariate analysis the common socio-economic & demographic characteristics such as family structures, religion, husband occupation and perceived economic status had no statistically significant association with current non use of MCM.

Age group where high MCM non use was observed above median age (30 years) with frequency of 254 (52.6%), when this occurrence compared with respondent of below median age group, it was found to be significantly associated with[OR(95%CI) =1.432 (1.085,1.891)].

Respondent who have had 1-2 and 3 & above children were less likely to be MCM non user with frequency of 212 (43.2%) and 123(48.8%) respectively, taking respondents with no child as referent category, it was statistically associated with [OR (95%CI) = 0.174 (0.098, 0.308) and 0.218(0.120, 0.396) respectively.]

Having family size of 6 & above was significantly associated with current MCM non use as compared to 2-5 family size with [OR(95%CI) =1.440 (1.06, 1.954).]

Respondents with education status of high school and beyond as compared to illiterate and only able to read & write were less likely to be current MCM non user with [OR(95%CI)= 0.36 (0.23, 0.459).] Considering illiterate and only able to read and write as a referent category, husband with educational status of elementary and high school & beyond were less likely to be current MCM non user with[OR(95%CI) 0.149 (0.055, 0.402) and 0.100(0.39, 0.255) respectively.]

It was found that occupation of respondent government/non government employee with frequency of 69 (57.0%) with [OR (95%CI) 1.550 (1.037, 2.315) were significantly associated with current MCM nonuse. (Table 7)

Table-7 Socio economic & demographic characteristics associated with MCM non use among study population in Kirkos sub-city, Addis Ababa city administration, June 2010

variables	MCM use status Nonuser	user	COR 95%CI
Respondent age (years)	**n %**	**n (%)**	
<30	151(43.6)	195(56.4)	1.00
≥30	254(52.6)	229(47.4)	**1.43(1.09, 1.89)** **
Children ever born			
None	70(81.4)	16(18.6)	1.00
1-2	212(43.2)	279(56.8)	**0.17(0.10, 0.31)** ***
3 & above	123(48.8)	129(51.2)	**0.218(0.12, 0.40)** ***
Religion			
Orthodox	338(49.2)	349(50.8)	1.00
Muslim	40(46.0)	47(54.0)	0.88(.56, 1.38)
Protestant& Catholic	27(49.1)	28(50.9)	1.00(0.57, 1.73)
Family structures			
Nuclear family	380(48.3)	407(51.7)	1.00
Extended family	25(59.5)	17(40.5)	1.58(0.84, 2.96)
Family size			
2-5	277(46.3)	321(53.7)	1.00
6 & above	128(55.4)	103(44.6)	**1.44(1.06, 1.95)***
Education status			
Illiterate & only read and write	72(66.7)	36(33.3)	1.00
1-6	115(58.7)	81(41.3)	0.71(0.44, 1.160)
7-12 & above	218(41.5)	307(58.5)	**0.36(0.23, 0.46**) ***
Husband education			
Illiterate & only read and write	41(89.1)	5(10.9)	1.00
1-6	67(54.9)	55(45.1)	**0.15(0.06, .40)** ***
7-12 & above	297(44.9)	364(55.1)	**0.100(0.04, .26)** ***
Occupation of respondent			
House wives	220(46.1)	257(53.9)	1.00
Government /non Gov. employee	69(57.0)	52(43.0)	**1.55 (1.04, 2.32)***
Merchant & self employee	92(48.2)	99(51.8)	1.086 (0.78, 1.52)
Others	24(60.0)	16(40.0)	1.75 (0.91, 3.38)
Husband occupation			
Government/non Gov. Employee	145(48.7)	153(51.3)	1.00
Merchant & self employee	220(48.1)	237(51.9)	0.98 (0.73, 1.31)
Others	37(52.1)	34(47.9)	1.148 (0.68, 1.93)
Perceived economic status			
Very poor & poor	115(49.8)	116(50.2)	1.00
Average	207(50.2)	205(49.8)	1.02 (0.74, 1.41)
Well to do & rich	83(44.6)	103(55.4)	0.81 (0.55, 1.20)

Reproductive characteristics like, age at first pregnancy and number of abortion were not found to have statistically significant association with non use of MCM.

Ever not been pregnant with frequency of 46(75.4%) was found to have statistically significant association with non use of MCM with [OR (95%CI) 3.494 (1.918, 6.64).]

Respondents who ever had 1-3 and 4 & above pregnancies with frequency of 263(43.8%) and 96(57.1%) respectively, as compared to with those women who had not ever pregnant were found to be less likely of MCM non user with [OR (95%CI) 0.254 (0.139, 0.460) and 0.435 (0.225, 0.840) respectively.]

Home delivery during the last pregnancy when compared with institutional delivery were found to be significantly associated with current MCM non use with [OR (95%CI) 2.160 (1.318, 3.540).]

Respondent who had 1-3 and 4 & above alive children with frequency of 260 (42.3%) and 74(58.7%) respectively, when compared these with respondent who had no alive children with [OR (95%CI) 0.175 (0.101, 0.305) and 0.341 (0.180, 0.644) respectively were less likely of current MCM non user.

Those respondents who had no history of abortion with frequency of 290 (44.5%) were less likely to be current MCM non user with [OR (95%CI) 0.559 (0.375, 0.833).] (Table8).

Table-8 Relation ship between reproductive characteristics and MCM non use among study population in Kirkos sub-city, Addis Ababa city administration, June 2010

variables	MCM use status Nonuser	user	COR 95%CI
Ever been pregnant	**n %**	**n %**	
Yes	359(46.7)	409(53.3)	1.00
No	46(75.4)	15(24.6)	**3.49 (1.92, 6.36)** ***
Number of pregnancy			
None	46(75.4)	15(24.6)	1.00
1-3	263(43.8)	337(56.2)	**0.25 (0.14, 0.47)** ***
4 & above	96(57.1)	72(42.9)	**0.435 (0.23, 0.84)** ***
Place of last delivery			
Health facility	289(43.2)	380(56.8)	1.00
Home	46(62.2)	28(37.8)	**2.16 (1.32, 3.54)** **
Number of living children			
None	71(80.7)	17(19.3)	1.00
1-3	260(42.3)	355(57.7)	**0.18 (0.10, 0 .31)** ***
4 & above	74(58.7)	52(41.3)	**0.34(0.18, 0.64)** **
Ever experienced abortion			
Yes	69(59.0)	48(41.0)	1.00
No	290(44.5)	361(56.5)	**0.56 (0.38, 0.83)** **
Number of abortion			
One	45(58.4)	32(41.6)	1.00
Two & above	24(60.0)	16(40.0)	1.07 (0.49, 2.32)

= significant** *= moderately significant** ***** =highly significant**

As source of information for MCM, mass media with frequency of 114 (61.3%) was found to be significantly associated with current MCM non use when compared to health workers with [OR (95% CI) 1.974 (1.404, 2.775).]

Those respondents who were not discussing family planning issues with their husband were fond to be significantly associated with current MCM non use as compared their counterparts [OR (95% CI) 5.561 (3.384, 9.141).]

Decision made by husbands about family planning in the family was found to be significantly associated with current MCM non use as compared to decision made by respondent [OR(95% CI) 2.27 (3.384, 9.141).]

The odds of MCM non use were twenty one times higher among women whose husbands disapprove MCM [OR (95% CI) 21.05(9.10, 48.65).] (Table 9)

Table 9 Relation ship between information and MCM non use among study population in Kirkos sub-city, Addis Ababa city administration, June 2010

	MCM use status		
variables	**Nonuser**	**user**	**COR 95%CI**
Source of information about MCM	**n (%)**	**n (%)**	
Health workers	239 (44.5)	298 (55.5)	1.00
Mass media	114 (61.3)	72 (38.7)	**1.974(1.404, 2.775)** ***
Friends & others	51 (48.6)	54 (51.4)	1.178 (0.775, 1.790)
Couple discuss about FP			
Yes	314 (43.8)	403 (56.2)	1.00
No	91 (81.3)	21 (18.8)	**5.561 (3.384, 9.141)** ***
Decision on FP made by			
Me	105 (49.8)	106 (50.2)	1.00
My husband	63 (69.2)	28 (30.8)	**2.271 (1.349, 3.821)** **
Both of us	237 (45.0)	290 (55.0)	0.825 (.599, 1.136)
Husband approval of MCM			
Approve	311 (42.7)	418 (57.3)	1.00
Disapprove	94 (94.0)	6 (6.0)	21.046 (9.103, 48.654) ***

= significant** *= moderately significant** ***** **=highly significant**

5.8. Result of multiple logistic regression analysis:

By putting those predictors that had significant association with current MCM non use in the biviarte analysis and avoiding the redundant ones multiple logistic regression analysis was done to see the relative effect of the predictors on the out come variable. Accordingly respondent age, children ever born, educational status of respondent, husband educational status, occupation of respondent, source of information, and husband approval of MCM were analyzed. As a result respondent age, which was significant before, showed significant association with MCM non use yet in multiple logistic regression; compared to women aged below median age those women >30 years were significantly more likely to be non users of MCM with [AOR (95% CI) 1.782 (1.247, 2.547)]

Children ever born also remained statistically significant with MCM non use; As compared to those who had no children women who have had 1-2 and 3 and above children were significantly less likely to be non user of MCM with the [AOR (95% CI) 0.152 (0.081,0.283) and 0.114 (0.056,0.231) respectively.]

Women who were educated to the level of high school and beyond also remain statistically significant with MCM non use; As compared to those women who are illiterate and only able to read and write, women who were educated to the level of high school and beyond were significantly less likely to be non user of MCM with the [AOR (95% CI) 0.125 (0.307, 0.966).]

Similarly husband education remained significantly associated with MCM non use in the logistic model.

Women whose husbands were educated to elementary and high school and beyond were significantly less likely to be non users of MCM as compared to illiterate and can only read and write, [AOR(95% CI) 0.124 (0.042, 0.366) and 0.125 (0.044,0.359) respectively.]

Respondent occupation also remained significantly associated with MCM non use; those women who were government and non government employee were significantly more likely to be non user of MCM as compared to those who were house wives with [AOR (95% CI) 1.845 CI (1.170, 2.909).] Source information about MCM also significantly associated with MCM nonuse; Those women who had heard information about family planning from mass media for the first time had significantly higher proportion of not using MCM as compared to those who have had information from health workers for the first time with [AOR(95% CI) 1.728 (1.172, 2.548).]

Husband approval of MCM still remains highly significant with MCM non use in multiple logistic regressions. Women whose husband not approved MCM have significantly higher odds of not using MCM; which was AOR (95% CI) 17.3 (7.311, 40.935)**]** (Table 10)

Table 10 Results of multiple logistic regression analysis for possible explanatory variables of MCM non use among study population in kirkos sub-city, June 2010.

Variables	Current non use of MCM		
	Nonuser	user	AOR (95%CI)
Respondent age (median 30Years)	**n (%)**	**n (%)**	
Below median	151 (43.6)	195 (56.4)	1.00
Above median	254 (52.6)	229 (47.4)	**1.78 (1.25, 2.55)** **
Children ever born			
None	70 (81.4)	16 (18.6)	1.00
1-2	212 (43.2)	279 (56.8)	**0.15 (0.08, 0.28)*****
3 & above	123 (48.8)	129 (51.2)	**0.12 (0.06, 0.23)** ***
Educational status of respondent			
Illiterate and read & write only	72 (66.7)	36 (33.3)	1.00
Elementary school (1-6)	115 (58.7)	81(41.3)	0.95 (0.52, 1.73)
High school &above	218 (41.5)	307 (58.7)	**0.55 (0.31, 0.97)***
Husband educational status			
Illiterate and read & write only	41 (89.1)	5 (10.9)	1.00
Elementary school (1-6)	67 (54.9)	55 (45.1)	**0.12 (0.04, 0.37)** ***
High school &above	297 (44.9)	364 (55.1)	**0.13 (0.04, 0.36)** ***
Respondent occupation			
House wives	220 (46.1)	257 (53.9)	1.00
Government/non gov. employee	69 (57.0)	52 (43.0)	**1.85 (1.17, 2.91)** **
Merchant & self employee	92 (48.2)	99 (51.8)	0.87 (0.59, 1.29)
Others	24 (60.0)	16 (40.0)	0.98 (0.44, 2.18)
Source of information			
Health workers	239 (44.5)	298 (55.5)	1.00
Mass media	114 (61.3)	72 (38.7)	**1.73 (1.172, 2.55)** **
Friends & others	51 (48.6)	54 (51.4)	0.801 (0.48, 1.33)
Husband approve MCM			
Approve	311(42.7)	418(57.3)	1.00
Disapprove	94(94.0)	6(6.0)	**17.3 (7.31, 40.94)** ***

*=significant **=moderately significant ***=highly significant

5.9. Qualitative study result

Two sessions of focus group discussions were held with currently married women of 18-49 years age group in kirkos sub city to complement the quantitative findings. Each group consists of 8 members which add up to a total of 16 members. Their mean age was 30.8 years.

Based on the semi-structured discussion guide relevant information was obtained. The findings of FGDs are summarized according to the following themes;

Knowledge about family planning

All of the participants explained that they knew what family planning is. They also reported that they have heard of family planning from different sources. The most frequently mentioned source of information was; health workers followed by mass media (like television, radio & news paper), friends, neighbor and community meetings.

Perception on tradition of having a large family

Unanimously participants agreed that having a large family size traditionally was not supported. Majority agreed that having large family currently very troublesome to both the parents as well as for the children, because children needs have to have good nutrition, appropriate schooling, well dressing and good health.

They also added *"If some one has large family which is impossible to fulfill the basic needs of all the family members as the result the chance of the children became street children. Those who need large family traditionally were with poor knowledge abut family planning, they need to be told deeply abut family planning and need to change their bad perception."*

One middle age women also said that *"nowadays having large family size is a problem for the family as well as the country."*

Concerning the right number of children, majority of respondents agreed that those who have good income it is wise to have up to four children whereas where there is less income two children could be enough.

Generally majority of the respondents agreed that a person should limit his family size based on his ability or economic status.

Knowledge about modern contraceptive methods

All discussions were towards OCP, Injectable, implant/ Norplant, IUDs, condom, female sterilization and male sterilization. Most of the participants also mentioned type of MCM they

knew. OCP, Injectable, Norplant, IUDs and condom were among the most frequently mentioned MCM. Female and male sterilization were the less frequently mentioned MCM.

The most frequently mentioned source information were; health workers, mass media (like television, radio and news paper), friends and neighbor. Majority of the respondents agreed that MCM has lots of advantages like; prevention of unwanted pregnancy, child spacing, limit family size, prevention of STDs and menstrual regulation.

Reason for not using MCM

Majority of the participants mentioned several reasons why women in their area were not using MCM. The most frequently mentioned and agreed up on were health problem (like hypertension, heart disease and gastritis), side effect of the methods, religion prohibition, and rumors like infertility (if taken for along time.)

Towards this one young lady said *"most of women in our sub-city know about MCM but some of them did not use it because of some rumors. I remember once my neighbor told me that she was using OCP for seven years by that time she needed to be pregnant, she stopped it. But she could not get pregnant. Currently, she is advising others not to take MCM for longer time by saying that if you take MCM for longer time, you may remain with only one child like me or not at all, if you do not have before. So, such a rumor may be a cause for a woman not to use MCM. Therefore health workers should work hard and give explanation for the client on such type of rumors during appointment time to prevent discontinuation of using MCM.''*

Another middle aged participant said" *most of the time health workers did not tell us about the side effect of MCM, even they did not ask us whether we are comfortable or not with the methods we are taking previously when we visit them for the second time . Most mothers did not go back to the health facility to take the method if they develop minor side effect, because they did not told about side effect and what to do if the symptoms have developed. She concludes by saying that it is better if the health workers explain briefly and clearly about the side effect and what to do when it happens especially for the new clients."*

Majority of the respondent agreed that Orthodox Christianity did not allow using MCM, especially for those who are married by church ceremony such as "Teklil"

Responsibility to take MCM and decision towards FP

Most discussants agreed that both the husband and wives should together decide about family planning and also both should responsible to take MCM. Adding on this a participant said

"as we see practically, husbands are not using MCM, almost most of the time taking MCM is considered as duties of women's, but it should be the responsibility of both to take MCM, for example if a family decide to limit family size there is an equal method for both male and female that is surgical method but the male pushes the female to use it rather than using for him self ,she conclude by saying that husbands must share the responsibility and practice of using MCM which are available for them."

Men's attitude towards FP/MCM

Almost all participants agreed that men in their area approve family planning. One middle aged participant said

"Currently having many children is a headache for parents. Children need lots of things, yet you could not satisfy their needs too. Satisfying their needs is the responsibility of both. Husbands do not need to suffer with many children, so my husband always reminds me to take MCM; I think all the husbands in our area do this."

Religion towards modern contraceptive methods

A great majority of the participant agreed that Orthodox Christianity doesn't allow using MCM, adding on that one participant said *" children are a gift of God and the church advice not to use MCM especially for those who married by church ceremony ('Teklil')"* Another participant argues that "*religion doesn't enforce us; I never heard that religion who said don't use MCM and give birth, it is up to me to use or not to use MCM generally religion has no opposition of MCM."*

Suggestion to minimize non use of MCM

All participants agreed up on the point that the first step towards the improvement of MCM use is that training should be given for the health workers especially for those who have been working in family planning clinic in order to tell to the clients what to do when the side effect and other problem happen while taking MCM. The client's needs not only to be given MCM and said goodbye, but also needs to be told about the side effect of the methods and should be told what to do if she is not comfortable with the method taken before. So to do all this it should be worked hard on health workers as able to convince the clients not to discontinue the method.

They also suggested that, those women who started to use MCM should not discontinue using MCM due to the side effect or health problem and if not comfortable with the method taken before, rather they should go to the health facilities and discuss the problem with the health workers and change another method which will be favorable for them and the health workers also should give attention to the clients.

5.10. In-depth interview

An in-depth interview carried out with key informant of kirkos sub-city health office responsible person to assess service availability, accessibility, affordability, acceptability, problem faced during service provision and reason for low contraceptive prevalence.

The key informant reported that family planning services are available, accessible, affordable and also acceptable in the sub-city. The available methods are; OCP, Injectable, Norplant, IUDs, condom and also there is referral linkage for surgical methods, all MCM given to the clients free of charge, moreover the methods are acceptable by most of the community, but still there are some mothers who argue that with rumors like using MCM needs good diet and taking MCM is not good for those who are daily laborer (labor-intensive).

Concerning resource and methods availability, as the methods are supported by engender health in addition to health bureau the methods are available through out the year; there is no shortage of the methods at all. Even if there are skilled health workers high staffs turn over was the problem. Giving training only can not change the behavior of the health workers sometimes there are some health workers who are trained about family planning and may not properly council the clients which may affect the quality of the services , they should properly told the method available, side effects and make them to have informed choice of the methods, this is one gap which can makes the quality of the service poor and results lower modern contraceptive utilization rate and higher discontinuation rate.

For the question “Why do people in your community do not use MCM?” posed to the key informant, the respondent started by saying that I think yet we did not go to the community, but the community comes to us, this might be one factor that can be mentioned as a reason. Currently, an urban health extension worker starts to work in all our sub-city, so that we can reach the community and solve this problem. The other reason could be male participation on family planning also less and discussion with the family on family planning issues also not adapted that much, religion and health problem were some of the reason mentioned for not using MCM.

The reason given for low prevalence of MCM by key informant was in addition to the reason mentioned above it might be because of different source of MCM; for example those who took the methods from private clinic, pharmacy and NGOs might not be reported, sometimes the recording and reporting systems in our health facilities might be weak, and health workers may

not properly council the client. The health workers should told the method available, side effect and make them to come back if clients faced problem while taking the methods, so that to prevent method discontinuation and increase prevalence rate.

Concerning attitude of the community towards FP the key informant reported that majority of the community approve MCM, but the participation of the male towards MCM were yet less, in order to reach high contraceptive prevalence the participation of males are crucial. Being living in Addis Ababa still there are women who use MCM behind closed doors of their husband.

What do you think should be done to decrease the contraceptive non use rate?

Key informant also suggested that; using urban health extension workers and selecting those who are model parents and make them to teach the community in their living area is the first action to be taken to decrease the contraceptive non use rate. The health workers should have a sense of service provider and community server. It should be worked hard on religious leaders and community organization like “Idir”. Recording and reporting should be strengthening in the healthy facilities.

6. Discussion

This study has provided an estimate of the prevalence of MCM used and identified factors associated with MCM non use among currently married women of aged 18-49 years in kirkos sub-city Addis Ababa city administration.

Older women above median age were more likely to be non user of MCM as compared to younger women [AOR (95% CI) 1.8 (1.247, 2.547).] Different study conducted in different parts of the world shows different results. Study which was conducted in Tehran showed that women whose age was above 35 years were more likely to use the methods than those who were less than 35years. [14,15). The possible justification for the difference could be geographical variation that older women in Addis Ababa did not consider them selves to be at risk of pregnancy, because they did not have sex regularly, were experienced post partum amenorrhea, believed them selves to be in fecund or were in menopause.

The result of this study revealed that the prevalence of MCM among currently married women in Kirkos sub-city was 51.1%, which was slightly higher than EDHS 2005 report for Addis Ababa (45.2%) and higher than Dredawa and Harari, but lower than Awassa which was 68.8%.(3, 20). The possible justification for the difference with Awassa town could be aligned with the quality of the services provision.

However, family planning services are available and accessible in different parts of the sub-city, such as; in governmental health facilities, in private clinic, pharmacy and FGAE clinic, and also affordable (free of charge in all governmental health facilities), the result of the study revealed that contraception nonuse rate was relatively high; it has been shown that 48.9% of currently married women in kirkos sub-city still did not use any form of MCM. This indicates that there is much need for strengthening education, information and counseling services for family planning. Among those women who were not using the methods during the survey period, 48% of them yet not intended to use MCM in the future. This should be an area of further study with better study design to be undertaken to gain further insight into reasons for non use of MCM.

As one would expect, the number of ever born children strongly influenced women's MCM utilization. Women who had one or two ever born children were less likely to be non user of MCM than those women who had no ever born children [AOR (95% CI) 0.15 (0.08, 0.28)] and women who had 3 and above ever born children were less likely to be non user of MCM. The finding was also in line with study findings reported from Jima and other countries. [13, 15, 19, 21-23)

Educational status of respondents and husband for the high school and beyond were high (63.3% and 79.7%) respectively, which was almost similar with EDHS 2005 and study conducted in Awassa town. [3, 20]

Women who were illiterate and with non formal education were less likely to use MCM (36%)than those who were elementary and high school and beyond (41.3% and 58.5%) respectively. This finding was also supported by previous studies done in Amhara, Oromia, SNNPR and Tigray regions of Ethiopia, and East Africa; Tunisia, Kenya, Malawi and some where other places. [5, 15, 17, 24, 25]

As expected the multivariate analysis showed that strong association existed between education and MCM non use. For example; women with high school and beyond level were less likely to be non user of MCM as compared to those who were illiterate and with no formal education. [AOR (95% CI) 0.55 (0.307, 0.966)] . Study conducted in Sub-Saharan Africa and else where, with the exception of Ghanaian, showed that women with secondary education or higher were less likely to be non user of MCM than those women were not educated. [12, 13, 24-26]

The effect of education on contraceptive use also explained in the interaction with the status of discussing FP with partners. Women with high school education and discuses FP with their partners have a high probability of using MCM than those with no education and do not discuss with their partners. This findings support evidence obtained from different international literature that empowering effects of high school education to discus FP with their partners, increasing knowledge of fertility process and positive attitudes towards use of MCM. [13, 27]

The odds of MCM non use among women whose husbands had elementary and high school and beyond levels of education were significantly lower than they were among women with husbands were illiterate and had no formal education [AOR(95% CI)0.042 (0.042, 0.366) and 0.044 (0.044, 0.359)] respectively. Similar studies conducted in Mali and else where also indicated this [15, 17, 22, 24, 28, 29].

Husband's education had significant role in decreasing the risk of not using MCM. Husbands with better education were more concerned of higher living status and also more aware of the outcome of having large family. Moreover this study showed that the effect of husband's education on MCM non use was larger than that of his wife's education; this finding was also supported by the finding of FGD and in depth interview.

The current study showed that husband approval of MCM had strong associations with MCM non use; those women whose husbands disapprove MCM were more likely to be non user of MCM. Husband approval of MCM was found to be an important predictor of MCM use, this was consistent with study conducted in Sri Lanka, where the female literacy is high; women whose husband's disapprove family planning were more likely to be non user of MCM as compared to those who had husband's approval.[36] Moreover in this study husband's education and approval of MCM were found important for decreasing MCM non use; therefore male and female education as well as husband's involvement in MCM practice found important in decreasing MCM non use, as also underlined in focus group discussion. Husband's have strong influence on MCM use decision making. Similar studies conducted in Jima town and else where also inline with this findings. [23, 30-33]

Our findings differ some what from those of several studies that have showed working out side home (employed) to decrease MCM non use. Study which was conducted in India and some where else revealed that women who were employed were using contraception more than those who were not employed. [17, 24, 29, 34]

On the contrary our study revealed that employed women were almost 2 times more likely to be non user of MCM as compared house wives. In contrast with our study, another study conducted in Mali and else where showed that women who worked out side home were less likely to be non user of MCM than who did not.[24, 29, 34] Study which was conducted in Chiaps, Mexico also showed that women who were not working outside home were 2.1 times as likely as not to use MCM than those who were working out side home.[13]

The possible speculation for the inconsistency of strong association between employment and non use of MCM could be due to geographical variation. Late marriage and late pregnancy may be common in Addis Ababa which is more likely to be non user of MCM. Those who were employed women could be educated and might have late marriage and late pregnancy which could result to have few years to attain their desire family size. Where as those who were house wives could have early marriage and attain their desire number of children earlier and use MCM. The other possible explanation could be those who work out side home may be more educated than house wives and likely to use some sort of traditional methods (such as; calendar methods).

Among those women who were ever user of MCM, health problem next to wanting more children were reason cited for discontinuation of the methods by 43.3% of the women. This also

supported by focus group discussion, many women agreed that they stopped using MCM because of health problem, such as hypertension, gastritis; they add that rumors like using MCM for longer time can cause infertility also causes for discontinuation of the methods. Study which was conducted in Awassa, Indonesia and elsewhere also showed that reason for discontinuation were health problem next to fertility related. [5, 20, 23, 34, 35]

The discontinuation of MCM generally may occur due to poor counseling and informed choices received from health workers. If health workers provide clients with full information of methods available, make them to choose the favorable methods for them and advice the clients to come back if they faced any problem after initiation of MCM, the discontinuation of method would decrease. This was also supported by focus group discussion and an in-depth interview.

Most frequently mentioned reasons for never use of MCM were desire to have children, medical problem and religious prohibition. Medical problem and religious prohibition were also supported by FGD especially religious prohibition was more discussed by participants; a great majority agreed that Orthodox Christianity doesn't allow the followers to use MCM, especially for those who were married by church ceremony 'Teklil'. Another participant argued that *"religion doesn't enforce us, I never heard that religion that says don't use MCM and give birth. It is up to me to use or not to use MCM she conclude by saying that generally religion has no opposition of MCM."* Religious opposition to use of MCM was mentioned in all the three tools used in the current study: quantitative, FGD and in depth interview, indicating the dominance of the idea. So that this also a potential area for further research. .

7. Strength and limitation of the study

7.1. Strength of the study

- ✓ In this study qualitative and quantitative methods were used to collect data and that improve the research outcomes as qualitative study complement (triangulate) the quantitative study.
- ✓ The study subjects were selected using random sampling technique, which help to avoid selection bias.
- ✓ Since there is no similar study conducted in the sub-city, it contributes as a base line survey for currently implemented urban health extension workers.
- ✓ Well structured questionnaire and check lists used.

7.2. Limitation of the study

- ➢ The study included only married women.
- ➢ Because of the cross-sectional nature of our study, we were unable to determine the cause and effect relationship from this study.

8. Conclusion

1. Age was one of the factors to influence MCM utilization, women with the age group above the median age were found more likely to be non user of the methods.

2. Modern contraceptive prevalence rate for currently married women in kirkos sub-city was relatively low (51.1%). Family planning services were available, accessible and affordable (free of charge) in all governmental health facilities found in Kirkos sub-city, however quality of the services is under question mark.

3. Women with educational level of high school and beyond were less likely to be non user of MCM than illiterate and only able to read and write.

4. Husband approval of MCM was found to be strongly associated with MCM utilization.

Lack of any schooling of husband's, at all was associated with the likely hood of non use of MCM, those women with illiterate and only able to read and write husbands were more likely to be non user of MCM as those with elementary and high school and beyond husbands.

5. Health problem second to wanting more children were reasons for the discontinuation of the methods among women who have ever used contraception. Reasons mentioned by never user not to practicing the methods were found to be wanting more (children) followed by health problem and religious prohibition.

6. Respondent occupation also strongly associated with MCM non use, those women who were governmental and no governmental employee were more likely to be non user of MCM as those who were house wives.

9. Recommendations

Based on the findings of this study, the following recommendations were made:

1. Urban health extension workers have to work hard by reaching the community and distributing MCM especially those non clinical methods and also bring change on some rumors on FP.
2. Client should provided with complete information about the method available including the side effects and have informed choice which can lead to decrease MCM discontinuation rate and increase MCM utilization.
3. Universal education is crucial for decreasing MCM nonuse rate and increasing MCM utilization.
4. Husband involvement not only in approval of MCM, but also participating in MCM utilization should be promoted to decrease MCM non use rate as they are the one who decide on fertility regulation.
5. It should be worked hard on religious leader to bring change upon religious prohibition on MCM utilization. Also intensive health education at various levels and at various places including community meeting, health institutions, schools, through the peer group and the media should be carried out.
6. Further exploratory study shall be under taken to find the real association between occupation of respondent, influence of religion on MCM utilization and also quality of family planning service in the area which could also affect MCM utilization.

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11. Annexes

11.1. Annex I Structured English questionnaire

Informed Consent Sheet

1. Study Information sheet

Addis Ababa University, Medical Faculty Department of Community Health.

Survey questionnaire to assess factors associated with non use of modern contraceptive among currently married women of reproductive age group (18-49).in Kirkos sub-city, Addis Ababa city Administration.

Introduction

Hello! Madam

My name is ---------- I am working in research team, which is conducted by Addis Ababa University. We are interviewing currently married women in the reproductive age group (18-49age) about factors associated with non use modern contraceptive, the general knowledge, practice and attitude to wards family planning. I am going to ask you some questions that are not difficult to answer. The study result may help the health managers and policy makers in the city and those NGOs who are worked on reproductive health in the city. There is no any problem that you will face by participating in this survey .We keep your confidentiality and your name will not be written in this form and will never be used in connection with any of the information you tell me. You do not have to answer any question that you do not want to answer and you may end this interview at any time you want to. However, your honest answers to these questions will help us in identifying factors associated with non use of modern contraceptive. We would appreciate your help in responding to this survey questions, you are expected to stay with me for about 30 minutes. If you have any question you can contact the principal investigator Dejene Mulatu by phone number 0911883812,

Email dejene_mulatu@yahoo.com. Or the IRB Chair person Professor Yeweyenharg Felke by phone number 0115-53-87-34

2. Consent form

I, the selected participant, heard the information in the consent sheet and understood what is required from me and what will happen to me if I take part in the study. I understand that all the information regarding me, like name and all answers given by me must not be transferred to the third party. I can also understand that I can withdraw from the study at any time without giving a reason and without me or my families' routine service utilization being affected for my refusal. Now please tell me if you agree to participate in the interview.

The Participant:

1. Agreed ☐

2. Did not agree ☐ → End the interview and thank the respondent.

Interviewer Agreement

I certify that I have taken verbal consent from the respondent that she has agreed to participate in study and I have confirmed the agreement is correct.

Interviewer Name: _____ Signature_____

|_____|_____|-_____.

Date

Supervisor Name: _____ Signature_____

|_____|_____|_____

Date

Currently married women (18-49 years) who are family planning user, ever user otherwise never user, are asked. You should circle the right answer among the multiple choices or write the code.

IDENTIFICATION

N0.	QUESTIONS	RESPONSE	CODE
001	Questionnaire number	☐☐☐☐	
002	Identification number of interviewer	☐☐	
003	House hold number	Kebele _____ No. _____	
004	Result code	1. Complete 2. Incomplete 3. Respondent not available 4. Other, specify _____	
005	Would you tell me please about Your contraceptive practice? Are you:	**(Tick only one answer)** 1. ☐ Current user 2. ☐ Non-user 3. ☐ Ever-user	

PART – ONE SOCIO-DEMOGRAPHIC ASSESSMENT

NO	Questions	Responses	**code**	**skip**
101	Respondent age	----------in year		
102	Number of children ever born to you	1. Male_____ 2. Female_____ 3. Total_____		
103	Ethnicity?	1.Amhara 2.Oromo 3.Tigre 4.Gurage 5.Other_____		
104	Religion	1.Orthodox 2.Islam 3.Protestant 4.Catholic 5.Others specify_____		
105	Family structure	1.Nuclear (husband, wife &children) 2.Extended(including Mather-in law & father in-law)		
106	Family size?	1.Male____2.Female_____ 3.total_____		
107	Educational status of respondent	1.Illiterate 2. Reading & writing 3 Elementary school (1-6) 4.Highschool (7-12) 5.Diploma and above		
108	What is your husband Educational level?	1.Illiterate 2.Reading and writing 3.Primary school (1-6) 4. High school(7-12) 5. Diploma and above		

109	What is your main occupation?	1.House Wife 2.Gov./Non Gov. employee 3.Buisnessman /Merchant 4.Self employee 5. Student 6. Daily laborer 7 Other, specify _____		
110	What is your husband occupation?	1 Gov./N on Gov.employee 2.Business man /Merchant 3.Self employee 4.Daily laborer 5.No job 6.Other, specify ----------		

PART-TWO SOCIO-ECONOMIC STATUS

201	Do you have radio and/or television? Refrigerator?	TV 1.Yes 2.No Radio 1.Yes 2.No Refrigerator 1.Yes 2.No	Code	Skip
202	What is your monthly income in Birr?	1. <500 birr 2. 500- 750bir 3.751-1000birr 4. 500&above 5. No response		
203	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		
204	Ownership of the living house (is the living house yours own?)	1. Yes 2. No		

PART-THREE REPRODUCTIVE HISTORY

301	Did you have any pregnancy before?	1. Yes _____ 2. No _____		**G0 to**
302	If yes how many Pregnancies have you had?	Express in No----------		
303	Were all pregnancies wanted?	1 Yes 2.No 3.No response		
304	What was your age at first pregnancy? (Age in year)	1._____year 2.I do not remember		
305	Place of last delivery	1.Medical facility		

		2.Home		
306	How many live births have you had? Express in no.	1. _____ 2. No response		
307	What is the sex composition of your living children? Express in no	1. Male _____ 2. Female _____ 3. Total _____		
308	Do you want any more children?	1. Yes 2. No		
309	If yes, How many? Express in no	1. Male _____ 2. Female _____ 3. Total _____		
310	Why did you want more children?	1. Have only few children 2. Need more sons 3.Child/children died 4. Other specify_____ 88. no response		
311	Did you have stillbirth?	1. Yes 2. No		
312	If yes how many times? Express in no	1. _____ 88. No response		
313	Have you ever-experienced abortion?	1. Yes _____ 2. No _____		
314	If yes, How many times? Express in no.	1. _____ 88. No response		
315	What was the reason for abortion?	1.Spontenous 88.no response 2.Induced		

PART-FOUR MODERN CONTRACETION KNOWLEDGE/AWARENESS

401	Have you ever heard of modern contraception?	1. Yes 2. No	**Code**	**Skip**
402	If yes ,what are Source of information for F/P for the first time	1.Health Worker 2.Redio 3. News Papers 4. TV 5. Friends 6. Other specify_____		

403	What type of modern contraceptive methods do you know? (Read and thick all mentioned) Method 1. Pill 2. IUDs 3. Injectables 4. Implants/Norplant 5. Spermicidal 6. Condom 7. Female sterilization 8. Male sterilization	Yes No 1____ 2____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ___ ____ ____		
404	Which advantage of modern contraceptive form do you know? **Tick all mentioned.(Please don't read out the list)**	1.Preventionof unwanted pregnancy 2. Child spacing 3.To limit family size 4.Prevention of STDs 5.Regulation of menstrual cycle 6. Others, specify_____		
405	Where is the main place that you or other women are able to get modern contraceptives?	1.Hospital 2.Health center 3. Health post/Clinic 4.FGAEclinic 5.Privet clinic 6. Other		

PART FIVE PRACTICES OF MODERN CONCTRCEPTIVES

501	Are you currently using any modern contraceptive methods?	1. Yes 2. No 88. No Response		**If yes go to 508**
502	If no to qes.501, have you ever used any modern contraceptive methods?	1.Yes 2.No		
503	If yes, what methods did you use? (tick all mentioned)	1.Pill 2.Injectable 3.IUDS 4. Implant 5.Spermicidal 6.Condom		

504	The main reason to stop the method/s (**only one answer**)	1. Fear of side effects 2. Fear of infertility 3 Desire to have more children 4. Religious prohibition 5. Medical problem 6.preferred method not available 7. Rumors 8. Spouse disapproved 9. Lack of knowledge 10.others,specify _____		
505	If never used any modern contraceptive, what was the main reason? **(only one answer)**	1. Fear of side effects 2. Fear of infertility 3. Desire to have (more) children 4. Religious prohibition 5. Medical problem 6.preferred method not available 7. Rumors 8. Spouse disapproved 9. Lack of knowledge 10.others,specify _____		
506	Do you have intention to use modern contraception in the future? **(For:- ever user and never use only)**	1 yes 2. no		
507	If yes, for what purpose you are intended to use?	1.For spacing 2.For limiting 3.Others specify_____		
508	If yes, to qes 501 what method of modern contraception are you currently using? **(Tick only one answer)**	1.Pill 2.Injectable 3.IUDS 4. Implant 5.Spermicidal 6.Condom 7.Female sterilization 8.Male sterilization		
509	Why do you practice modern contraceptive methods at present? **(Tick only one answer)**	Reason 1 For child spacing 2.For birth limiting 3.Others specify_____		

510	Where did/ do you get from modern contraceptive method you use currently? **(Tick only one answer)**	1. From private clinic 2. From government hospital 3. From health center 4. From health post/Clinic 5. From FGAE clinic 6. From pharmacy		
511	From where do you prefer to get this contraception?	1. From private clinic 2. From government Hosp. 3. From health center 4. From Clinic 5. From FGAE 6. From pharmacy		
512	Time taken to travel to the source of contraceptive method	1. lessthan 30 minutes 2. 30-60 minutes 3. Greater than 60 minutes 4. Idon't know 88. No response		

PART-SIX ATTITUDES TOWARDS MODERN CONTRACEPTIVES

601	Children will have better opportunities for education, If their parents practice FP.	1. Agree 2. Disagree 3. Neutral		
602	FP will help improve one's standard of living	1. Agree 2. Disagree 3. Neutral		
603	FP helps a mother to regain strength before her next baby.	1. Agree 2. Disagree 3. Neutral		
604	Child spacing helps protect the health of children and mothers.	1. Agree 2. Disagree 3. Neutral		
605	FP causes a loss of confidence between a husband and a wife.	1. Agree 2. Disagree 3. Neutral		
606	Contraceptive use may cause infertility in a women	1. Agree 2. Disagree 3. Neutral		

607	Do you discuss about FP with your husband?	1. Yes 2. No		
608	Who usually makes decision about FP in the family?	1. Me 2. My husband 3. Both of us 4. Our parents 5. Others, specify _____		
609	Does your husband approve MCMs?	1.Yes 2.No		

The end! Thank You for your participation!

Interviewer
Name _____
Signature _____
Date _____/ _____/ _____
D m Y

Supervisor
_____
_____
_____

11.2. Annex II. - Focus group discussion guide, 2009.

GREETINGS!
A. Introduction

1. We thank you all for coming to this session.

2. Your presence is very important.

3. My name is Mr. x. and my colleague here with me is called _____we are a team from kirkos sub-city health office.

B. Purpose

1. We will be discussing your reactions to why contraceptive use is low in your community/ why majority of the women in your community are not using modern contraceptives.

2. I am interested in all your ideas, comments and suggestions.

3. There are no wrong or right answers.

4. All comments, both positive and negative to the point of discussion are welcomed.

5. Please feel free to disagree with one another. We would like to have many points of view.

We will audiotape all your comments and opinions so that we could not miss any of your ideas while trying to take notes. And I assure you that all your comments are confidential, used for research purpose only. I want our session to be a group discussion, so you need not wait for me to call on you. Please speak one at a time, so that the tape-recorder can pick up every of your suggestions and comments. We have a lot of points to cover, so I may change the subject or move ahead. Please stop me incase if you want to add some thing more.

Each participant is asked to introduce herself and tell us something about you.

Semi-structured questionnaire for F G D for currently married women in reproductive age group.

1. How do you understand about family planning in general?

Probe-would you explain further

-would you give me an example

-Is there any thing else

2. What do you suggest about the tradition of having large family size? What do you think is the best family size?

Probe-would you explain further

-would you give me an example

-Is there any thing else

3 .Do you know abut modern contraceptive methods and what kinds of modern

Contraceptive do you know?

Probe-would you explain further

-would you give me an example

-Is there any thing else

4. Where do you get the information which related to family planning?

5. What is the attitude of the community regarding family planning? Approve

Disapprove

Probe-would you explain further

-would you give me an example

-Is there any thing else

6. What are the reasons for not using modern contraceptive methods?

Accessibility

Availability of different kinds of methods

Acceptability

Fear of side effects

Cultural and religious opposition

Lack of adequate information about family planning

Spousal opposition

Desire to have more children

7. Do you think that either any problem (any difference) to use modern contraceptive being formal or consensual union?

Probe-would you explain further

-would you give me an example

-Is there any thing else

8. How do you think, who should decide about family size and who should take responsibility practicing modern contraceptive methods?

9. Discuss about men's opinion towards family planning

Approve

Disapprove

Probe-would you explain further

-would you give me an example

-Is there any thing else

10. Does religion or belief in your community some thing to do with the use of modern contraceptive?

Probe-would you explain further

-would you give me an example

-Is there any thing else

11. What do you think should be done to improve contraceptive use in your community?

Closing

Thank you so much for coming to this session. Your time is very much appreciated and your insight have been very helpful

11.3. Annex III In-depth interview for Health Worker (responsible person at sub-city health office)

1. Family planning Service-Available

-Accessible

-Affordable

-Acceptable

2. What problem do you face while providing the service?

Explain in terms of resource availability, skill (training), Method available

3. Why do people in your community not using modern contraceptives?

Tips, # of sons, # of living children, husband influence, important others influence

4. Why do think is contraceptive non use rate is high in this sub-city?

Poor method mix

-Knowledge factor

-Attitude

-Socio-cultural Culture and religion matter

-Demographic

-Socio-economic Too much cost

5. Attitude of the community to ward family planning

Approve

Disapprove

6. What do you think should be done to decrease the contraceptive non use rate (improve contraceptive use) in your institutions?

The end! Thank you!

11.4. Annex IV Structured Amharic questionnaire

አዲስ አበባ ዩንቨርስቲ ፋኩልቲ የሕብረተሰብ ጤና ክብካቤ ክፍል

ሀ. የጥናቱ መረጃ ቅፅ (Study Information Sheet)

ቃለ መጠይቁ ከመካሄዱ በፊት የተሳታፊዎችን ፍቃደኝነት መጠየቂያ ቅፅ ዘመናዊ የቤተሰብ ምጣኔ/ የወሊድ መከላከያ ዘዴዎችን በተመለከተ በመውለድ እድሜ ክልል ላሉና ባለትዳር የሆኑ ሴቶች ዘመናዊ የወሊድ መከላከያ እንዳይጠቀሙ ያደርጋቸውን ሁኔታዎች ለማወቅ የተዘጋጀ ጥናት ነው::

መግቢያ

ጤና ይስጥልኝ እንደምን ዋሉ?

ስሜ ---------- ይባላል ከአዲስ አበባ ዩኒቨርሲቲ እየካሄደ ባለው ሳይንሳዊ ጥናት ውስጥ የጥናቱ ቡድን አባል በመሆን በመስራት ላይ እገኛለሁ:: እድሜአቸው በመወለድ እድሜ ክልል ውስጥ ለሚገኙና ባለትዳር ለሆኑ ሴቶች መጠይቅ እናቀርባለን:: የመጠይቁም አላማ ዘመናዊ የወሊድ መከላከያ እንዳይጠቀሙ ያደርጉአቸውን ምክንያት፣ ስለቤተሰብ ምጣኔ አጠቃላይ እውቀተኛውን፣ ልምዳቸውንና ስለዘመናዊ የወሊድ መከላከያ ያላቸውን አመለካከት በተመለከተ ለይቶ ለማወቅ ነው:: እርሱንም ለመመለስ የማያስቸግሮትን ቀለል ያሉ የተወሰኑ ጥያዎችን እጠይቅዎታለሁ:: የዚህ ጥናት ውጤትም ለሕግ አውጪዎች፣ ጤና ላይ ለሚሠሩ ለኃላፊዎች በስነተዋልዶ ጤና ላይ ለሚሰሩ መንግስታዊ ላልሆኑ ድርጅቶች ይረዳል::

በዚህ ጥናት ላይ በመሳተፍ ምንም የሚያጋጥሞት ችግር የለም:: ስምዎን በዚህ መጠይቅ ላይ አላሰፍረውም የሚሰጧቸው መረጃዎች ሙሉ በሙሉ ሚስጥራቸው በከፍተኛ ደረጃ የተጠበቀ ስለመሆኑ ልናረጋግጥልዎ እንወዳለን:: ከማቀርብሎት ጥያቄ ለመመለስ የማይፈልገት ካለ አይገደዱም በተጨማሪም አጠቃላይ መጠይቁን በፈለጉ ጊዜ የማቋረጥ መብት አልዎት ሆኖም የሚሰጡት እውነተኛ መልስ በመውለድ እድሜ ክልል ውስጥ ላሉና ባለትዳር ሴቶች ዘመናዊ የወሊድ መከላከያ እንዳይጠቀሙ ያደርጉአቸውን ሁኔታዎች ለማወቅና የቤተሰብ ምጣኔ አገልግሎትን የበለጠ ለማሻሻል ትልቅ ጠቀሜታ እንዳለው ላረጋግጥሎዎት እወዳለሁ::

በመጨረሻም ለሚሰጡት መልስ በቅድሚያ እያመሰገንኩ አጠቃላይ መጠይቁ ከ30 ደቂቃ በላይ ስለማይወስድብን ለ30 ደቂቃ አብረን እንቆያለን::

ስለ ጥናቱ ጥያቄ ከሎት ከዚህ በታች በተጠቀሰዉ አድራሻ ዋና ተመራማሪዉን ማግኘት ይቻላል ስም ደጀኔ ሙላቱ ስልክ ቁጥር 0911883812 መደም ዶ/ር የመደንሃረግ ፈስቀ ስልክ ቁጥር 0115-53-87-34

ለ. የፍቃደኝነት ማረጋገጫ ቅፅ

እኔ በጥናቱ ላይ እድሳተፍ የተጠየቅኩ ከዚህ በላይ በጥናቱ መረጃ ቅጽ ላይ የተቀመጠውን ነገር ባግባቡ በመረዳት ከኔ የሚጠበቀውን ሁሉ አውቄአለው፡፡ ከዚህም ሌላ በጥናቱ ላይ ተሳታፊ ብሆን እኔ የምሰጣቸው መረጃዎች ለሶስተኛ አካል ተላልፎ እንደማይታወቁና የግለሰብ ስም እንደማይካተት ተረድቻለው በተጨማሪም ጥናቱን የማልፈልገው ከሆነ በማንኛውም ሰአት ያለምንም ምክንያት ማቆም እንደምችልና በማቆሜም እኔ ወይም ቤተሰቦቼ ከድርጅቱ በሚያገኘ ት አገልግሎት ላይ ምንም አይነት ተጽእኖ እንደማይኖረው ተረድቻለው

በቃለ መጠይቁ ለመሳተፍ ፍቃደኛ ነዎት ?

በጥናቱ ለመሳተፍ

1.ተስማምተዋል ☐

2.አልተስማሙም ☐ ⟶ **አመስግነህ/ሽ ጨርስ/ሽ**

<u>የቃለ መጠየቅ አድራጊው/ዋ ስምምነት</u>

ተሳታፊዋ በጥናቱ ላይ ለመሳተፍ ፍቃደኝነትን የሚገልፅ ስምምነትን በቃል መልክ መውሰዱንና ስምምነቱም ተክክለኛ መሆኑን እገልፃለሁኝ፡፡

<u>የቃለ መጠይቅ አድራጊው/ዋ</u>

ስም----------

ፊርማ----------

ቀን-----/-------/--------

<u>የሱፐርቫይዘር</u>

ስም----------

ፊርማ----------

ቀን-----/-----/------

ይህ መጠይቅ እድሜያቸው ከ18-49 ዓመት መካከል ላሉና ለገቡ ሴቶች ከዚህ በፊት የወሊድ መከላከያ ዘዴን ላልተጠቀሙ ለተጠቀሙና እየተጠቀሙ ላሉ የቀረበ ነው። ከተሰጠው አማራጭ ምልክት ትክክለኛው መልስ ይክበቡ/ይሞላ/

መለያ

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ
1	የመጠይቁ ቁጥር	☐ ☐ ☐	
2	የጠያቂው መለያ ኮድ ቁጥር	☐	
3	የቤተሰብ መለያ ቁጥር	ቀበሌ ---------- የቤት ቁጥር ----------	
4	የውጤት መለያ	1. ያለቀ 2. ያላለቀ 3.ተጠያቂዋ አልተገኙም 4. ሌላ ይገለጽ----------	
5	እርሶ ዘመናዊ የወሊድ መቆጣጠሪያ(**አንድ መልስ ብቻ**)	1. አሁን አየተጠቀሙ ነው 2. ተጠቅመው አያውቁም 3. ተጠቅመው ያውቃሉ	

<u>ክፍል አንድ ማህበራዊና ስነ ሕዝብ መጠይቅ</u>

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ	ወደ እለፍ
101	እድሜዎ ስንት ነው?	----------በዓመት		
102	የወለዱአቸው ልጆች ብዛት	1. ወንድ --------2.ሴት ----------ድምር ------		
103	የየትኛው ብሔረሰብ አባል ነዎት?	1. አማራ 2. ኦሮሞ 3. ትግሬ 4. ጉራጌ 5. ሌላ----------		
104	የየትኛው ሃይማኖት ተከታይ ነዎት ?	1. ኦርቶዶክስ 2. እስልምና 3.ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ----------		
105	የቤተሰብ አወቃቀር/አኗኗር/	1. ቤተሰብ ብቻ (ባል ሚስትና ልጆች ብቻ) 2. ከቤተሰብ ዘመድ ጋር/እናት አባት /		
106	የቤተሰብዎ ብዛት ስንት ነው?	1. ወንድ ---------2.ሴት---------ድምር ---------		
107	የትምህርት ደረጃዎ ?	1. ያልተማረች 2.ማንበብና መጻፍ 3. አንደኛ ደረጃ/1-6 4.ሁለተኛ ደረጃ/7-12/ 5. ዲፕሎማና ከዚያ በላይ		
108	የባለቤትዎ የት/ት ደረጃስ?	1. ያልተማረ 2. ማንበብና መጻፍ 3. አንደኛ ደረጃ/1-6 4. ሁለተኛ ደረጃ/7-12/ 5. ዲፕሎማና ከዚያ በላይ		
109	ዋና ስራዎ ምንድን ነው?	1. የቤት እመቤት 2. የመንግስት/መንግስታዊ ያልሆነ ድርጅት ሠራተኛ 3. ነጋዴ 4. የግል ሠራተኛ 5. ተማሪ 6. የቀን ሠራተኛ 7. ሌላ ይጠቀስ---------		
110	የባለቤት ዋና ሥራ ምንድን	1.የመንግስት/መንግስታዊ ያልሆነ ድርጅ ሠራተኛ		

	ነው ?	2. ነጋዴ 3. የግል ሠራተኛ 4. የቀን ሠራተኛ 5. ሥራየለውም 6. ሌላ ይገለጽ----------		

ክፍል ሁለት የኢኮኖሚ ሁኔታን የሚዳስስ ጥያቄ

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ	ወደ እለፍ
201	ቴሌቪዥን፣ራድዮ ወይም እና ፍሪጅ አለሎት?	ቴሌቪዥን 1/አዎ 2/የለኝም ራዲዮ 1/ አዎ 2/የለኝም ፍሪጅ 1/አዎ 2//የለኝም		
202	አማካይ የቤተሰቦ የወር ገቢዎ በብር ስንት ነው?	1. ከ500 ብር በታች 2. ከ500-750ብር 3. 751-1000 ብር 4. ከ1000 ብር በላይ 5. መልስ የለም		
203	ከጐረቤትዎ ጋር ራስዎን ሲያነፃጽሩ የቤተሰቦ የኑሮ ደረጃ ከየትኛው ይመድባል ?	1. በጣም ደሃ 2. ደሃ 3. መካከለኛ 4. ደህና 5. ሀብታም 6. መልስ የለም		
204	የመኖሪያ ቤትዎ የእራሰዎ የግልዎ ነው ?	1.አዎ 2.አይደለም		

ክፍል ሶስት የስነ ተዋልዶ ታሪክን የሚዳስስ መጠይቅ

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ	ወደ እለፍ
301	ከዚህ በፊት አርግዘው ያውቃሉ?	1.አዎ 2.አርግዤ፤ አላውቅም		አላውቅም ወደ401
302	መልስዎ አዎ ከሆነ ስንት ግዜ?	በቁጥር ይግለጹ----------		
303	ሁሉንም ፈልገው ነበር ያረገዙአቸው?	1.አዎ 2.አይደለም		
304	መጀመሪያ ሲያረግዙ እድሜዎ ስንት ነበር?	1.---------- ዓመት 2. አላስታውስም		
305	የመጨረሻ ልጅዎን የት ነው የወለዱት?	1. ጤና ተቋም ውስጥ 2. ቤት ውስጥ		
306	በሕይወት የወለዷቸው ልጆች ስንት ናቸው? **በቁጥር ይገለጽ**	1.---------- 2.መልስ የለም		
307	የወለዷቸው አሁን በህይወት ያሉ ልጆች በየታ	1.ወንድ---- 2.ሴት----- 3.ድምር-------		
308	ሌላ ተጨማሪ ልጆች እንዲኖርዎት ይፈልጋሉ?	1. አዎ 2. አይ		አይ ወደ 312
309	አዎ ከሆነ ስንት? በቁጥር ይገለጽ	1. ወንድ----- 2. ሴት----- 3. ድምር-----		
310	ተጨማሪ ልጅየፈለጉት ለምንድን ነው?	1. ጥቂት ልጆች ስላሉኝ 2. ወንድ(ሴት) ልጅ ስለምፈልግ 3. ልጅ ስለሞተብኝ 4. ሌላ ይገለጽ---------- ----------		

		----- 5. መልስ የለም		
311	ሞቶ የተወለደ ልጅ ነበረዎት?	1.አዎ 2.የለኝም 3.መልስ የለም		የለኝም 314
312	አዎ ከሆነ ስንት ጊዜ? በቁጥር ይገለጽ	1.---------- 2.መልስ የለም		
313	ከዚህ በፊት አስወርዶት ያውቃል ?	1.አዎ 2.አይ		አይ ወደ401
314	አዎ ከሆነ ስንት ጊዜ? በቁጥር ይገለጽ	1.---------- 2.መልስ የለም		
315	የውርጃው ምክንያት ምን ነበር?	1.በድንገት 2.ፈልጌ 3.መልስ የለም		

ክፍል አራት ስለ ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴ ግንዛቤን በተመለከተ

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ	ወደ እለፍ
401	ስለዘመናዊ የወሊድ መከላከያ ዘዴ ሰምተው ያውቃሉ?	1. አዎ 2. ሰምቼ አላውቅም 3. ለመመለስ ፍቃደኛ አይደለሁም		ሰምቼ አላውቅም 505
402	መልስ አዎ ከሆነ ለመጀሪያ ጊዜ ከማን/ከየት ነው የሰሙት ?	1.ከጤና ባለሙያ 2.ራዲዬ 3.ጋዜጣ 4.ቴሌቭዥን 5.ከጓደኛ 6.ሌላ ይገለጽ-----		
403	የትኞቹን ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴዎችን ያውቃሉ ? /የተጠቀሱትን ሁሉ ይክበቡ/ 1.በአፍ የሚዋጥ ክኒን 2.በማህፀንየሚቀመጥ 3.በመርፌ የሚሰጥ 4.በክንድ የሚቀበር 5.አረፋማ ክኒን 6.ኮንዶም 7.የሴት ማህፀን አሸንዳ ማስቆረጥ 8.የወንድ ዘር መተላለፊያቧንባንማስቆረጥ	1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም 1. አዎ አውቃለሁ 2.አይ አላውቅም		
404	ከዘመናዊ የወሊድ መቆጣጠሪያ ዘዴ ምን ዓይነት ጥቅም እንደሚገኝ ያውቃሉ? /የተጠቀሱትን ሁሉ ይክበቡ/	1. ያልተፈለገ እርግዝና ለመከላከል 2. አራርቆ ለመውለድ 3. የቤተሰብ ቁጥርን ለመወሰን 4. የአበለዘርን በሽታን ለመከላለል 5. የወር አበባን ለማሰተከከል 6. ሌላ ይገለጽ----------		
405	እርስዎም ሆኑ ሌሎች ዘመናዊ የወሊድ መቆጣጠሪያን በዋናነት ከየት ነው የሚያገኙት?	1. ሆስፒታል 2. ጤና ጣቢያ 3. ጤና ኬላ/ ክሊኒክ 4. ከቤተሰብ መምሪያ ክሊኒክ 5. ከግል ክሊኒክ 6. ከፋርማሲ		

ክፍል አምስት ዘመናዊ የወሊድ መቆጣጠሪያ አጠቃቀም በተመለከተ

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ	ወደ እለፍ

501	እርሶ አሁን ዘመናዊ የወሊድ መከላከያ እየተጠቀሙ ነው?	1.አዎ 2.አይደለም 3.መልስ የለም		አዎ ከሆነ ወደ 508
502	**የ501** ጥያቄ መልስ **አይደለም** ከሆነ ከዚህ በፊት ዘመናዊ የወሊድ መቆጣጠሪያ ተጠቅመው ያውቃሉ?	1.አዎ 2.አይ		አይ ከሆነ ወደ 505
503	ተጠቅመው የሚያውቁ ከሆነ የትኛውን ነው የተጠቀሙት? **/የተጠቀሱትን ሁሉ ምልክት አድርግ/**	1. የሚዋጥ ክኒን 2. በመርፌ የሚሰጥ 3. በማህፀን የሚቀመጥ 4. በክንድ የሚቀበር 5. አረፋማ ክኒን 6. ኮንዶም		
504	ዘመናዊ የወሊድ መከላከያ ዘዴ መጠቀም ያቆሙበት **ዋነኛ** ምክንያት ምንድን ነው? **/ሰንድ መልስ ብቻ/**	1. መከላከያው ችግር ያስከትላል በሚል ፍራቻ 2. መካን እንዳያደርገኝ ፍራቻ 3. ተጨማሪ (ልጆች) እንዲኖሩኝ ስለምፈልግ 4. ሀይማኖቴ ስለማይፈቅድ 5. በጤና ምክንያት 6. የምፈልገው የመከላከያ አይነት ባለመኖሩ 7. አሉባልታ ወሬዎች 8. ባለቤቴ እንድጠቀም ስለማይፈልግ 9. እውቀቱ ስለሌለኝ 10. ሌላ ይገለጽ----------		
505	ዘመናዊ የወሊድ መከላከያ ዘዴ ተጠቅመው የማያውቁ ከሆነ ላለመጠቀሞ **ዋነኛ** ምክንያትዎ ምንድን ነው ? **/ሰንድ መልስ ብቻ/**	1. መከላከያው ችግር ያስከትላል በሚል ፍራቻ 2. መካን እንዳያደርገኝ ፍራቻ 3. ተጨማሪ (ልጆች) እንዲኖሩኝ ስለምፈልግ 4. ሀይማኖቴ ስለማይፈቅድ 5. በጤና ምክንያት 6. የምፈልገው የመከላከያ አይነት ባለመኖሩ 7. አሉባልታ ወሬዎች 8. ባለቤቴ እንድጠቀም ስለማይፈልግ 9. እውቀቱ ስለሌለኝ 10. ሌላ ይገለጽ----------		
506	ወደፊት ዘመናዊ የወሊድ መከላከያ ዘዴን ለመጠቀም ይፈለጋሉ ? **/ባሁኑ ሰዓት ለማይጠቀሙት ሁሉ/**	1. አዎ 2. አይ		
507	**ለ506 አዎ** ከሆነ መልስዎ ለምን ዓላማ ነው መጠቀም የሚፈልጉት?	1. አራርቆ ለመውለድ 2. የቤተሰብን ቁጥር ለመወሰን 3. ሌላ ይገለጽ----------		
508	**ለ501** ጥያቄ **አዎ** ከሆነ ምን ዓይነት የወሊድ መከላከያ ነው	1. የሚዋጥ ክኒን 2. በመርፌ የሚሰጥ 3. በማህፀን የሚቀመጥ 4. በክንድ		

	አሁን እየተጠቀሙ የሉት ?(ከአንድ በላይ ብቻ)	የሚቀበር 5. አረፋማ ክኒን 6. ኮንዶም 7. የሴት ማህፀን አሸንዳ ማስቆረጥ 8.የወንድ የዘር ፍሬ መተላለፊያ ቧንቧን ማስቆረጥ		
509	ለምን አላማ ነው አሁን እየተጠቀሙ ያሉት?	1. ልጅን አራርቆ ለመውለድ 2. የቤተሰብን ቁጥር ለመወሰን 3. ሌላ ይገለጽ ----------		
510	አሁን እየተጠቀሙያሉትን ዘመናዊ የወሊድ መከላከያ ከየት ነው የሚያገኙት?(ከአንዱ በላይ ብቻ)	1. ከግል ክሊኒክ 2. ከመንግስት ሆስፒታል 3. ጤና ጣቢያ 4. ጤና ኬላ/ክሊኒክ 5. ከቤተሰብ መምሪያ ክሊኒክ 6. ከፋርማሲ		
511	ይህንን የወሊድ መከላከያ ከየት ቢያገኙ ይመርጣሉ?(ከአንዱ በላይ ብቻ)	1. ከግል ክሊኒክ 2. ከመንግስት ሆስፒታል 3. ጤና ጣቢያ 4. ጤና ኬላ/ክሊኒክ 5. ከቤተሰብ መምሪያ ክሊኒክ 6. ከፋርማሲ		
512	የወሊድ መከላከያን በአሁኑ ጊዜ እየተጠቀሙ ከሆነ ከቦተው ለማምጣት ምን ያህል ጊዜ ይፈጅቦታል?	1. ከ30 ደቂቃ በታች 2. ከ30-60ደቂቃ 3. ከ60 ደቂቃ በላይ		

ክፍል ስድስት ስለ ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴ ዝንባሌን በተመለከተ

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ	ወደ እለፍ
601	ወላጆች ዘመናዊ የቤተሰብ መከላከያ ዘዴ ቢጠቀሙ ልጆች የተሻለ የትምህርት እድል ይኖራቸዋል?	1. እስማማለሁ 2. አልስማማም 3. ገለልተኛ		
602	ዘመናዊ የወሊድ መከላከያ ዘዴ የኑሮ ደረጃን ለማሻሻል ይረዳል?	1. እስማማለሁ 2.አልስማማም 3. ገለልተኛ		
603	የቤተሰብ ምጣኔን መጠቀም እናት የሚቀጥለውን ልጅ ከመውለዷ በፊት ጥንካሬዋ እንዲመለስላት ይረዳታል?	1. እስማማለሁ 2. አልስማማም 3. ገለልተኛ		
604	አራርቆ መውለድ ለእናትና ለሕፃኑ ጤንነት ጠቃሚ ነው?	1. እስማማለሁ 2. አልስማማም 3. ገለልተኛ		
605	የቤተሰብ ምጣኔ አገልግሎት በተጓደኞች መካከል አለመተማመንን ይፈጥራል?	1. እስማማለሁ 2. አልስማማም 3. ገለልተኛ		

606	ዘመናዊ የወሊድ መከላከያ መጠቀም መካንነትን ያስከትላል?	1. እስማማለሁ 2. አልስማማም 3. ገለልተኛ		
607	ስለ ቤተሰብ ምጣኔ ከባለቤቷ ጋር ይወያያሉ?	1. አዎ 2. አይ		
608	በቤተሰብ ውስጥ ስለ ቤተሰብ ምጣኔ ሁልጊዜ ውሳኔ የሚሰጠው ማን ነው?	1. እኔ 2. ባለቤቴ 3. ሁለታችን 4. ቤተሰቦቻችን		
609	ባለቤቶ ዘመናዊ የወሊድ መከላከያን ይደግፋሉ?	1. አዎ 2. አይ		

የመጠይቁ መጨረሻ **በጣም አመሰግነዎታለሁ !**

የመረጃ ሰብሳቢው **የተቆጣጣሪው**

ስም----------
ፊርማ----------

ቀን --------/----------/----------
ቀን ወር ዓ/ም

ስም----------
ፊርማ----------

ቀን -------/---------/----------
ቀን ወር ዓ/ም

<u>ሠላምታ</u> - እንደምን ዋላችሁ::
<u>የቡድን ውይይት መመሪያ</u>:-

ሀ. <u>መግቢያ</u>

1. ወደዚህ ውይይት በመምጣታችሁ ሁላችሁንም እናመሰግናለን::
2. የእናንተ እዚህ መኖር በጣም ጠቃሚ ነው::
3. እኔ አቶ ---------- እባላለሁ:: አብሮኝ ያለው ጓደኛዬ ---------- ይባላል:: እኛ ከቂርቆስ ክ/ከተማ ጤና ጽ/ቤት የመጠን ቡድን ነን::

ለ. <u>አላማ</u>

1. እኛ ከእናንተ ጋር ዘመናዊ የወሊድ መከላከያ አጠቃቀም በህብረተሰቡ ዘንድ ለምን አነስተኛ እንደሆን ወይም አብዛኛዎቹ ሴቶች ለምን ዘመናዊ የወሊድ መከላከ ያ እንደማይጠቀሙ እንወያያለን::
2. በምትሰጡኝ አስተያየት ሃሳብ እርማት ደስተኛ ነኝ::
3. ትክክል ወይም ትክክል አይደለም የሚባል መልስ የለም::
4. ሁሉንም አስተያየት/እርማት አዎንታዊ ሆኑ አሉታዊ እንቀበላለን::
5. በሃሳብ ባለመስማማታችሁ ምንም አትጨነቁ::

የእናንተን ሃሳብና አመለካከት በቴኘ እንቀርፃለን ምክንያቱም ስንፅፍ የእናንተን ሃሳብና አስተያየት እንዳንስት ስንል ነው:: የምትሰጡን መረጃዎች በሙሉ ምስጥራቸው በከፍተኛ ደረጃ የተጠበቀ ለመሆኑ ልናረጋግጥላችሁ እንወዳለን:: የምንጠቀምባቸውም ለጥናቱ አላማ ብቻ ነው:: ጊዜአችን የጋራ ውይይት እንደሆን እፈልጋለሁ ስለዚህ እኔ እንድቀስቅሳችሁ መጠበቅ የለባችሁም::

የሁላችሁንም ሃሳብና አስተያየት በድምፅ መቅረጫው ለመቅረፅ እንዲቻል በአንድ ጊዜ አንድ ሰው ብቻ ይናገር:: ብዙ ርዕሶችን መሸፈን ስላአለብን ምንአልባት ወደፊት ቀድሜ ከሄድኩ የምትጨምሩት ነገር ካለ አስቁሙኝ::

እየአንዳንዱ ተሳታፊ ስሙን አስተዋውቆን ስለእራሱ አንዳንድ ነገሮችን ይንገረን::

<u>በወሊድ ክልል ላሉና ለባትዳር ሴቶች የቡድን ውይይት መጠይቆች</u>

1. በአጠቃላይ የቤተሰብ ምጣኔ እንዴት ትረዱታላችሁ?

2. በባህል ቡዙ ቤተሰብ / ልጆች/ እንዲኖሩን ስለመፈለግ ምን አስተያየት አላችሁ? ትክክለኛው የቤተሰብ /ልጆች/ መጠን ስንት ነው ትላላችሁ?
3. ስለ ዘመናዊ የወሊድ መከላከያ ዘዴ ታውቃላችሁ? ምን አይነት ዘመናዊ የወሊድ መከላከያ ታውቃላችሁ?
4. የቤተሰብ ምጣኔን በተመለከተ መረጃ ከየት ነው የምታገኙት?
5. ስለ ቤተሰብ ምጣኔ የህብረተሰቡ አመለካከት ምን ይመስላል?
6. ዘመናዊ የወሊድ መከላከያ ያለመጠቀም ምክንያቶቹ ምንድ ናቸው ትላላችሁ?
   - ተደራሽነት
   - የተለያዩ አይነት ዘዴዎች አለመኖር
   - የጐንዮሽ ጠንቅን መፍራት
   - ባህላዊና የእምነት አለመፍቀድ
   - የመረጃ እጥረት
   - የትዳር ጓደኛ/ባለቤት ተቃውሞ
   - ቡዙ ልጆች እንዲኖሩ የመፈለግ
7. ዘመናዊ የወሊድ መከላከያ ለመጠቀም የጋብቻው ህጋዊ ወይም በስምምነት መሆኑ ችግር ነው ብላችሁ ታስባላችሁ? እንዴት? አስረዱ::
8. የቤተሰብን መጠን ማን መወሰን አለበት እንዲሁም ዘመናዊ የወሊድ መከላከያን የመጠቀም ኃላፊነቱ የማነው?
9. ወንዶች ለቤተሰብ ምጣኔ ያላቸውን አመለካከት ተወያዩ
10. በህብረተሰቡ ውስጥ ያለው እምነት ስለ ዘመናዊ የወሊድ መከላከያ የሚያደርጓቸው ነገሮች አሉ?
11. ዘመናዊ የወሊድ መከላከያን አጠቃቀም ለማሻሻል ምን መደረግ አለበት ብላችሁ ታስባላችሁ?

<u>መዝጊያ:-</u> በመጨረሻም ስለዘመናዊ የወሊድ መከላከያ እና ያልጠቀስቸው ነገሮች ካሉና ጠቀሚ ናቸው ብላችሁ የምትሉት ካለ መጨመር ትችላላችሁ::

ወደዚህ ክፍለጊዜ በመምጣታችሁና ስለአደረጋችሁት ውይይት በጣም እናመሰግናለን::

<u>ለክ/ከተማው ጤና ጽ/ቤት የሚቀርብ ሠፋ ያለ ቃለ - መጠይቅ</u>

1. የቤተሰብ ምጣኔ አገልግሎት

- ተደረሽነት
- ተመጣጣኝ ዋጋ
- ተቀባይነት

2. አገልግሎትን ስትሰጡ የአጋጠማችሁ ችግር አለ?
- ሁሉም ዘዴዎቹ አሉ
- ክህሎት / ስልጠና /
- ንብረት

3. ለምንድነው ህብረተሰቡ የፈለገውን ያህል የዘመናዊ ዘዴ ተጠቃሚ ያልሆነው?
- የወንዶች ልጆች ቁጥር
- በህይወት ያሉ ልጆች ቁጥር
- የባለቤት ተፅኖ
- የሌሎች ተፅኖ

4. ለምንድነው ዘመናዊ የወሊድ መከላከያ የማይጠቀሙ ሴቶች ቁጥር ከፍተኛ የሆነው በክ/ከተማችሁ ውስጥ?
5. የህብረሰቡ ለቤተሰብ ምጣኔ ያለው አመለካከት እንዴት ነው?
6. በክ/ከተማችሁ ውስጥ ዘመናዊ የወሊድ መከላከያ የማይጠቀሙ ሴቶች ቁጥር ለመቀነስ ምን መደረግ አለበት ብለው ያስባሉ?

አመሰግናለሁ::

Declaration

I, the undersigned, declare that this thesis is my original work in partial fulfillment of the requirement for the Degree of Masters of Public Health and has not been presented for a degree in this or any other university. All source of materials used for this thesis have been duly acknowledged.

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Date of submission: _____

This thesis has been submitted for examination with our approval as the university Advisor

Name of the advisor Signature

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