ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

The Assessment of Determinants of family planning use and unmet need among women of reproductive age group with disabilities in Addis Ababa

By

Solen Abera

A THESIS TO BE SUBMITTED TO SCHOOL OF GRADUATE STUDIES IN ADDIS ABABA UNIVERSITY, FOR THE PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH.

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June 2016

DECLARATION

I, the under signed, declared that this is my original work, has never been presented in this or any other University, and that all the resources and materials used for the thesis, have been duly acknowledged.

Name of student: Solen Abera Nefa

Signature: _____

ADVISOR APPROVAL SHEET

This is to certify that the thesis entitled "the assessment of determinants of family planning use and unmet need among women of reproductive age group with disabilities in Addis Ababa" is submitted to school of graduate studies in Addis Ababa university, for the partial fulfillment of the requirements for the degree of master of public health and has been carried out by **Solen Abera Nefa** under my supervision. The student has fulfilled the thesis requirements and hence can submit the thesis to the school of public health

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EXAMINER'S APPROVAL SHEET

We, the undersigned, members of the board of examiners of the final open defense by Solen Abera Nefa, have read and evaluated her thesis entitled "the assessment of determinants of family planning use and unmet need among women of reproductive age group with disabilities in Addis Ababa". This is to certify that the thesis has been accepted in partial fulfillment of the requirements for the degree of master of public health in "reproductive health and family health".

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ACRONYMS

BCC	Behavioral Change Communication
CBD	Community Based Distribution
CBR	Community Based Rehabilitation
CBRHA	Community Based Reproductive Health Agents
CCBR	Comprehensive Community Based Rehabilitation
CPR	Contraceptive Prevalence Rate
CRPD	Convention on the Rights of Persons with Disability
DHS	Demographic and Health Survey
DKT	Das Kaufmannische Talent
DPOs	Disabled Person's Organizations
ECCD	Ethiopian Center for Disability and Development
ENAID	Ethiopian National Association on Intellectual Disability
ENDAN	Ethiopian National Disability Action Network
EWDNA	Ethiopian Women with Disabilities National Association
FPA	Family Planning Associations
HEW	Health Extension Workers
ICPD	International Conference on Population and Development
IEC	Information Education Communication
MDHS	Malawi Demographic and Health Survey
MoLSA	Ministry of Labour and Social Affairs
PWDs	Persons With Disabilities

RAPID	Rehabilitation And Preventive Initiative against Disability
SRH	Sexual and Reproductive Health
UNFPA	United Nation For Population Activities
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

ABSTRACT

Background: The 2007 Census of Ethiopia revealed 32630 of the 2739551 Addis Ababa population was persons with disability among which 7,835 are reproductive aged women. Persons with disabilities are the most marginalized groups concerning reproductive health services. Unmet need for family planning (FP) and Contraceptive Prevalence Rate (CPR) in Ethiopia was estimated at 25.3% and 29% in 2011 respectively. It may be difficult to achieve sustainable development goal without a focus on including people with disabilities.

Objectives: This study is designed to assess levels and determinants of family planning use and unmet need among women of reproductive age group with disabilities in Addis Ababa.

Method: Cross sectional study based on associations of persons with disabilities with stratified sampling was used to select 727 women's with disability. Data were collected using structured questionnaire by eight trained females who completed grade twelve; two of which communicate by speaking and sign language. Data were cleaned and analyzed using Epi data and Stata 12. Descriptive statistics, binary and multivariate logistic regression analyses was employed to identify factors associated with contraceptive use and unmet need for family planning. Cut-off point for the detection of significance is $p<0.05$.

Result: Current CPR among all reproductive age women and sexually active women with disability in Addis Ababa was 44.4% and 64.5% respectively. Unmet need of contraception was 20% among sexually active women with disabilities (10.6% for spacing and 9.4% for limiting) making percentage of demand satisfied 68.9%. Contraception was 6.8 (95% CI: 1.47, 31) times higher in women aged 30-34 compared to age group 45-49. Women whose partners attained primary education had about 3.1 (95% CI: 1.04, 9.5) times more likely to use FP compared with uneducated partners. Unemployed women were 0.8: (95% CI 0.3, 2.04) less likely to use FP methods compared with employed. Women discussing about contraception with partners were 3.3 (95% CI: 1.08, 10.34) times more likely to use FP. While unmet need is less likely among women aged 30-34, 0.05 (95% CI 0.04, 0.7) compared to age group 45-49. Besides women who discuss with their partner about contraception were less likely to have unmet need compared to counterparts 0.23 (95% CI 0.07, 0.7). Those women with number of living children above two are 3.3 (95% CI: 1.03, 10.7) times more likely to have unmet need compared to women with living children less or equal to two.

Conclusion and recommendation: Unmet need is found to be high among women with disabilities in Addis Ababa, therefore public and private sectors should promote targeting programs for women with disabilities and their partner for the uptake of the family planning services. Focus should be given to women with disabilities who are unemployed and those whose partners have never been into school.

INTRODUCTION

1.1 Background

Women that are not using contraception either because they are not interested to have any (more) child(ren) (for limiting) or that they want to wait for two or more years before having another child (for spacing) are considered to have an unmet need for family planning. The unmet need gives an estimate of the proportion of women who might potentially use contraception, if they have access to the methods. Women who are using contraceptives are said to have met need for family planning. The total demand for family planning is made up of the proportion of women with unmet need and women with met need for family planning.(1)

A number of international and local NGOs have been involved in the provision of family planning programs. Family Guidance Association of Ethiopia (FGAE) was the first institution to introduce a new intervention approach in Ethiopia, called community-based distribution (CBD), targeted towards expanding the service to a wider community through the involvement of community residents—who are not health professionals—in delivering contraceptive methods and services. CBD agents provide family planning information, distribute condoms and oral contraceptives, and make referrals for other clinical methods. A social marketing programme of contraceptive methods was also introduced in Ethiopia in 1990 by DKT (Das Kaufmannische Talent). Many agencies are providing technical and financial support to family planning programmes in Ethiopia. The United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) are the major donors of contraceptive methods in Ethiopia. (2)

UNFPA defines persons with disabilities as "…those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". The sexual and reproductive health needs of women with physical disabilities are similar to those of all women with regards to the need for; accurate information, accessible health services, supportive and knowledgeable health care providers. However, women with disabilities often encounter a number of obstacles that prevent or limit their access to such services. (3, 4)

The United Nations General Assembly adopted the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2006. CRPD is a particularly useful advocacy tool because Articles 23 & 25 provides explicit rights to sexuality and sexual health services for people with disabilities. International human rights documents, treaties, conventions and standards provide the platform from which the rights of disabled people to sexual and reproductive health can be realized. Some of the international consensus documents include the ICPD (international conference on population and development) Programme of Action, World Programme of Action Concerning Disabled Persons and the Standard Rules that states Persons with disabilities must have the same access as others to family-planning methods, as well as to information in accessible form on the sexual functioning of their bodies. (5)

As of April 2011, 99 of the 147 signatories had ratified the Convention on the Rights of Persons with Disabilities, the first human rights treaty of the 21st century. Countries that sign the convention are required to adopt national laws, and remove old ones, so that persons with disabilities will, for example, have equal rights to education, employment, and cultural life; to the right to own and inherit property; to not be discriminated against in marriage, etc.; to not be unwilling subjects in medical experiments. Although Ethiopia ratified the convention for the rights of persons with disabilities in 2007, an overall lack of inclusion, accessibility and persistent stigmas attached to disability make life challenging for people who are differently-abled. At the federal level, the Ministry of Labour and Social Affairs (MoLSA) is the main governmental organ responsible for the provision of social and vocational rehabilitation of people with disabilities. Operating within MoLSA is the Social Welfare Development Promotion Directorate which coordinates disability issues at the federal level as part of its wider mandate to deal with employment and social issues. Ethiopian center for disability and development (ECDD), an Ethiopian development NGO, is working collaboratively with other organizations to promote, facilitate and build disability inclusive development in Ethiopia. Currently the organization is partnering with the Packard Foundation (USA) and Ministry of Health to work with Family Planning and Reproductive Health (FP/RH) service-providing organizations to increase their awareness of the need to extend service delivery to persons with disabilities. (6, 7)

International Family Planning Association (FPA) policy states that "disabled people are sexual beings with sexual and emotional needs and desires. However, their sexuality is often ignored, stereotyped, viewed in a distorted way which may lead to the development of low expectations about sexual relationships and could affect their self-esteem. Acknowledgement of sexual identity is integral to an individual's wellbeing and is an important part of creating a sense of belonging, as well as upholding a basic human right". The policy of National Plan of action of persons with disabilities (2012-2021) also states that a mechanism shall be created by which persons with physical and mental disability will receive appropriate medical/ health services and supportive appliances and that all efforts shall be made to gradually remove all physical impediments and make residential areas, work, and other public places physically more accessible to persons with disabilities. (8, 9)

1.2 Statement of the problem

In the developing world 222 million women who want to plan their families and their lives have unmet need for modern contraception of which 50 million live in sub-Saharan Africa. The Guttmacher Institute estimated in a 2009 report that if all women who wanted to avoid pregnancy were using modern contraceptives, the number of unintended pregnancies in developing countries would fall from 75 million to 22 million annually. This would translate to 22 million fewer unplanned births, 15 million fewer unsafe abortions, and 90,000 fewer maternal deaths. A current projection for Ethiopia estimates 56 million pregnancies from 2005 to 2015, of which nearly 24 million would be unintended. (10, 11)

The total demand for family planning across regions ranges from 51 percent (Sub-Saharan Africa) to 80 percent (Latin America and the Caribbean). In Africa, only 45 percent of demand is satisfied, contrasting to 70–84 percent in the other regions. (1) According to family planning worldwide 2013 data sheet on average, the level of total unmet need for contraception in sub-Saharan Africa is 25 percent. In some countries this is even higher with one in three women having an unmet need (32 percent in Burundi and 37 percent in Togo). Ethiopia is one of the countries with a high level of unmet need. The 2011 Ethiopia Demographic and Health Survey (DHS) indicates that the unmet need for family planning among currently married Ethiopian women is 25 percent, with 16 percent having a need for spacing and 9 percent having a need for limiting. The met need for family planning is 42 percent as indicated in 2014 mini DHS. The unmet and met need together constitute the total demand for family planning, which is 54 percent at the national level. Total fertility rate is 4.8 where it is 60% higher than it would be if unwanted births were avoided. Non-use of contraception may be due to demand side reasons, including cultural or religious objections to contraception, objections from a spouse, and lack of knowledge or fear of side effects. (12, 13)

According to a report by World Health Organization (WHO) and the World Bank (WB), over a billion people or 15.6% of the world's population live with a significant disability. Approximately 300 million women around the world have mental and physical disabilities. Globally, Women with disabilities comprise 10 percent of all women and make up three-quarters of the disabled people

in low and middle income countries. Different studies estimate the number of Ethiopians living with disability. For instance, a study by Japan International Cooperation Agency estimates 7.6% (about 6.2 million) of the population lives with a disability. WHO and WB estimated that 17.6% (16 million) Ethiopians live with disability (WHO & WB, 2011). However, the national population census of 2007 puts prevalence rate of disability 1.17% (864,218) and from a total population of Addis Ababa (2,739,551) persons with disabilities are 32,630 among which 7,835 are reproductive age women. Although there is an observed discrepancy in statistical representation of persons with disabilities, they are still significant members of the society. (1, 5, 6, 13)

Persons with disabilities face many barriers to care and information about sexual and reproductive health (SRH). First is the frequent assumption that persons with disabilities are not sexually active and therefore do not need SRH services. Research shows, however, that persons with disabilities are as sexually active as persons without disabilities. Despite this, too often their sexuality has been ignored and their reproductive rights, denied. A qualitative study done in 2014 in Uganda found that People with physical disabilities (PWPDs) face health facility-related (service provider and facility-related challenges), economic and societal challenges in accessing SRH services. Women with disabilities are less likely to receive general information on sexual and reproductive health and are less likely to have access to family planning services. At worst, forced sterilization and forced abortion often have been imposed on persons with disabilities. (15, 16)

Furthermore, SRH services are often inaccessible to persons with disabilities for many reasons, including physical barriers, the lack of disability-related clinical services, and stigma and discrimination. In many situations barriers to health services include: lack of physical access, including transportation and/or proximity to clinics and, within clinics, lack of ramps, adapted examination tables, and the like; lack of information and communication materials (e.g. lack of materials in Braille, large print, simple language, and pictures; lack of sign language interpreter. This problems will have an impact on the family planning service utilization of differently abled women which in other words can affect the national development goal of the country in the long run. This study will help to know the current FP use and their unmet need of women with disabilities in Addis Ababa. Knowing the magnitude and factors helps to tackle the problems, help

women with disabilities to have equal access to health care and achieve development goal of the country (15, 17)

1.3 Rationale of the study

There is concerted effort from the Ethiopian government, non-governmental organizations and associations to improve family planning information and services in order to decrease the unmet need. Facility based programs, community based programs [(CBRHAs (Community Based Reproductive Health Agents), HEWs (health extension workers)] and social marketing are among those efforts. Ethiopia signed and ratified the convention on the Rights of Persons with Disabilities on March 30, 2007 and July 7, 2010 respectively and has the responsibility to uphold its contents. This study will help to know the current status of women with disability concerning family planning use and unmet need which will further help persons with disabilities to have "same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programs" as it is found in the article 25 of the convention. (2, 9, 5)

There are very few studies done on reproductive age women with disability specifically on family planning in Ethiopia. This study will provide more information than available for future researches and help program and policy makers to include persons with disabilities which will help the country to bridge the evidence gap to enable need-based appropriate family planning services for women with disability.

2 Literature review

2.1 Family planning use

2.1.1 The Levels of family planning service utilization

According to the analyses done globally incorporating 930 observations of contraceptive prevalence for 194 countries, contraceptive prevalence was estimated at 63 percent in 2011, though levels varied widely across major areas and sub-regions. At least two-thirds of married women of reproductive age were using contraceptives in North America (77%), Latin America and the Caribbean (73%), Europe (72%) and Asia (67%); however, only three in 10 African women (31%) were doing so. In sub Saharan Africa, contraceptive prevalence among women of reproductive age who are married or in a union varied between 4 percent in South Sudan and 67 percent in Réunion. One limitation of the study, is the focus on women who were married or in a union, though the researchers add that their methodology can be used to generate estimates and projections for all women. (18, 19)

A cross sectional community-based study conducted in 2010 to investigate the use of family planning in Kassala, Eastern Sudan showed that from a total of 613 women only 44.0% had previously or currently used one or more of the family planning methods. This study did not include unmarried women. (20) Demographic and Health Survey (2004-2005) data analysis done in Tanzania among married women showed that only 20% married women are using modern methods.(21) Similarly a study done in Senegal using a Survey data collected in 2011 among urban women aged 15–29 who were either currently married or unmarried but sexually active showed that Modern contraceptive prevalence was 20% among young married women and 27% among young sexually active unmarried women which showed that utilization of contraceptive is higher among unmarried women.(22)

Many studies regarding current prevalence of contraceptive use in Ethiopia have shown that the actual practice of family planning is low. A cross sectional study conducted in Butajira Demographic Surveillance Area among a total of 5746 married women showed that current contraceptive prevalence rate among married women was 25.4% (95% CI: 24.2, 26.5). (23)A similar study was conducted in 2010 among 809 reproductive age women who are living in randomly selected 9 kebeles of Arba Minch zuria woreda. The study revealed that from a total of 695 currently married women 32.7% use contraceptive at time of the survey (76% for spacing, 24% for limiting). **(**24)

Another cross-sectional community based study conducted in Dembia district, Northwest Ethiopia in 2004 showed that the CPR was 12.3%. The CPR in this study is lower compared to other studies which might be due to the inclusion of rular kebles in the study. In contrast a community based cross-sectional study conducted in 2010 among married women in Debre Birhan District revealed that modern contraceptive prevalence rate among currently married women was 46.9% which is almost double than the national CPR in 2011. This might be due to the availability and accessibility of health facility and family planning in the district and because the study was done among married women compared to the one done in Dembia district North West Ethiopia. (25, 26)

UNFPA defines persons with disabilities as "…those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".(3) Though it is widely believed that women with disabilities are neither sexually active nor capable for child bearing, majority of them are both sexually active and capable of pregnancy and childbirth and thus have reproductive health needs, including family planning. A cross-sectional study was conducted in 5 urban and peri-urban districts of Sierra Leone representing all 4 provinces of the country in 2009, they interviewed disabled respondents as well as a control group of 235 randomly selected non-disabled adults in the same households and in households in the same community with no disabled people living in them. The result showed that there were no significant differences in reporting use of contraception between disabled and non-disabled people; 67.3% of the non-disabled respondents and 71% of persons with disabilities reported that they did not use any form of contraception (p-0.733). This result is questionable due to small sample size which would result in low power to detect smaller differences between experiences of women with and without

disability also other studies have shown that women with disabilities face Physical, attitudinal and information barriers compared to abled persons that affects their contraceptive use. (27) Another study conducted in Malawi among 341 persons with disability in 2004 revealed that 28% of the respondents said they used family planning. This study included males which increased the result because of male condom use but still it's much lower than the national MDHS 2010 finding in which the CPR among all women using any method is 35%. (28)

A study conducted in Kampala Uganda in 2003 among 371 respondents of whom 197 were women, showed that current use of contraception was only 21% among women. (29)A local study was conducted By Ethiopian Center for Disability and Development (ECDD) in Collaboration with DKT Ethiopia in 2011 among 300 PWDs who were selected from the respective four disability based organizations. The study was carried out in four purposely selected major towns of Ethiopia; namely Hawassa, Bahir Dar, Mekelle and Addis Ababa to determine the overall use of SRH products and services by PWDs (with physical, visual, hearing and intellectual disability). The result showed that 26 (18.2%) female participants were currently using modern contraception. This study showed that contraceptive use is very low compared to the national value which implies that differently abled women are not using family planning as abled persons due to different reasons. (30) In this study females were only 143 (47.7%) and they were also sampled conveniently which affects the validity due to lack of representation so this study will try to fill this gaps. Most of the factors that affect contraceptive use which this study will try to address are partner's education, work status, parity, number of living children, desire to have children, discussion with partner, partners support, exposure to family planning message and knowledge about family planning.

2.1.2 Determinants of family planning use

2.1.2.1 Socio demographic variables

There are multiple factors that correlate with met need for contraceptive. One significant factor is age, the practice of family planning is mostly associated with women aged 30-39 years(P = 0.001) for married women and with women aged 25-34 years (50%) for women who are sexually active as it was revealed in studies done in Qatar and Uganda respectively. (31, 32) Local studies

have also showed that age is significant factor for family planning utilization. In contrast a cross sectional community-based study conducted in 2010 in Kassala, Eastern Sudan showed that age was not significantly associated with family planning use [OR-0.9 (0.9-1.0) P= 0.6]. (20) similarly the cross-sectional community based study done among reproductive age women in Dembia district, northwest Ethiopia reveled in the multivariate analysis the age of the woman didn't show significant association with usage of contraceptives.(25)

Among studies done among women with disability the cross-sectional study conducted in Sierra Leone in 2009 showed that use of contraceptive was higher for the age group 30-39 [AOR-0.93 (0.40-2.16)] than the age group 40-49 AOR-0.57 (0.18-1.76).(27) Similarly a cross-sectional study carried out in rural Kabale district in South Western Uganda revealed that older women with disabilities had 1.09 times increased odds of utilizing family planning services (p=0.044).(32)The local study conducted by Ethiopian Center for Disability and Development (ECDD) in collaboration with DKT Ethiopia among persons with disabilities showed that those found in the age group 26-30 had the highest contraceptive use (28.6%) than the other age groups.(30)

The other important factor associated with family planning use is woman's education. The likelihood of using contraception is associated with women's educational attainment. The more schooling a woman has, the more likely she is to report use of contraceptive method. This is showed in studies done in Africa for example the trend analysis done in Ghana among sexually active women of reproductive age using data from the Ghana Demographic and Health Surveys (1988 – 2008) showed in the year 2008 contraceptive use among women with secondary and tertiary education was about 33.5% and 31.5%, respectively, relative to 17.4% among women with no education. (34) Same result was shown in studies done in Uganda, and Tanzania. Local cross sectional study done among Married women in Butajira Demographic Surveillance Area showed that women who attained primary and secondary plus level of education have about 1.3 (95% CI: 1.1, 1.6) and 2 (95% CI: 1.4, 2.9) times more risk to be in contraception also the odds of contraception is 1.3 (95% CI: 1.1, 1.6) and 1.5(1.1, 2.0) times more likely among women whose partners completed primary and secondary plus level of education.(23) This finding was supported by the cross sectional study done in Dembia district in North West Ethiopia.(25) Conversely the study done in Debre Brhan district found that educational status of the women is not statistically significant variable with the use of contraception method.(26)

Education of women is also important factor among women with disabilities as it was shown in the cross-sectional study carried out in South Western Uganda which showed that women who had attained secondary education and above had 6 times increased odds of utilizing family planning services (p=0.049). This shows that education is significant in seeking family planning services. (33) The same result is seen in the cross-sectional study conducted in Sierra Leone in 2009. (27)

Religion is the other significant factor that affects family planning use. There is no clear cut result to which religion is significantly associated with family planning use because different studies showed different result. Protestants are more likely to use family planning 32.4% in the data analysis done in Tanzania followed by Catholics 27.0% and lastly Muslims 23.0%. (21) While the local cross sectional study done in Dembia district North West Ethiopia showed that Followers of the Orthodox religion were less likely to use contraceptives. (25) In contract to the above studies the local study conducted By Ethiopian Center for Disability and Development (ECDD) in collaboration with DKT Ethiopia among women with disabilities showed that Orthodox believers are more likely to use family planning 22.1% followed by Muslims 10.5% and lastly were Protestants 5%. (30)In addition in the cross sectional community-based study conducted in 2010 in Kassala, Eastern Sudan, one of the reason for non-use of family planning among women who were not using contraceptive (56%) was, religious belief (28.2%). (20) The study conducted By Ethiopian Center for Disability and Development (ECDD) also supported this finding where, of the female disabled contraceptive non-users 4.2% of them cited religious factor as a reason. (30)

Marital status have been shown to determine the contraceptive use of women in different studies. The community based cross-sectional study conducted in 2010 in Debre Birhan (26)District showed that, those who were single (1.5%) and ever married but unmarried at the time of the study (0.02%) were less likely to be current user than those married at the time of the survey (32.7%). In contrast the cross-sectional study conducted in Sierra Leone in 2009, showed that unmarried disabled women were more likely to use contraceptives than married disabled women [AOR=0.82 (0.32-2.05)]. (26) This result is also supported by the local study done by ECDD among disabled women, where current use by unmarried persons is 45.5% while it is 44.8% for married. (30)`

Income and occupation of the women have also been identified as a determinant of family planning use. As expected most of the women who don't use family planning are found in the lowest income group. The prospective cross-sectional study done in Qatar among married women among

women showed that women who don't use family planning 116 (22.8) were in the highest income group while 146 (28.7) of the women were found in the lowest income group (P = 0.025).(31) Local community based cross-sectional study conducted in 2010 among married women aged 15–49 years in Debre Birhan District supported this finding showing that family monthly income was significant associated with the use of modern contraceptives.(26) in contrast to the above finding the study done in Sierra Leone in 2009 among disabled women showed that women's found in the Poorest wealth group used contraception [AOR=0.88 (0.27-2.87)] than those found in the Middle group [AOR=0.65 (0.19-2.12)].(27) Concerning occupation the local cross sectional study done in Dembia district in North West Ethiopia found that Government employed women were 3.4 times more likely to use contraceptives compared with housewives.(25) In contrast cross sectional study done in Butajira among married women showed that civil servants used contraceptives 6.2 times higher (95% CI:4.81,7.99) compared to those whose lively-hood was farming but the significance of the association disappeared when other factors were added in the model.(23)

2.1.2.2 Reproductive variables

Parity determines contraceptive use. High parity greater than 5 was found to be significant predictor of family planning service utilization [OR- 3.2 (1.5-6.7) P- 0.002] in the cross sectional community-based study in Kassala, Eastern Sudan. Similarly A cross-sectional study done in Mojo town, Oromiya region of Ethiopia among 551 women respondents revealed that women who had 1 to 2 living children were 4.613 times more likely to use family planning services than women who had no living children.(20) Desired number of children also affects family planning use as the study done in Uganda among sexually active women in 2011 showed that, Women who wanted a child within two years reported the lowest levels of contraceptive use [OR-2.86 (1.81-4.52)] Conversely, women who did not want any more children had the highest levels [OR-5.54 (2.84-10.83)]. (32) This finding is also supported by local studies where women who desire children after two years use contraceptive more than those who desire within two years. (26)

2.1.2.3 Client related variables

Studies showed that communication with partner increase the use of contraceptive compared with those women who did not communicate. The Demographic and Health Survey (2004-2005) analysis done in Tanzania showed that women who frequently discuss family planning with their partners are more likely to use family planning (41.0%) as compared to those who discuss once (27.2%) or who never discuss (4.3%). (21) The finding is also supported by the local community based cross sectional study conducted in 2010 in Arba Minch zuria woreda among reproductive age women. (24) The study revealed that women who had discussed about family with their partner in the last 6 months prior to the study were more likely to be current user of family planning than those did not (AOR = 0.259 (0.169 - 0.395). The cross sectional study done in Butajira among married women also found that women discussing about contraception with partners were 2.2 (95% CI: 1.8, 2.7) times more likely to use family planning. (23)

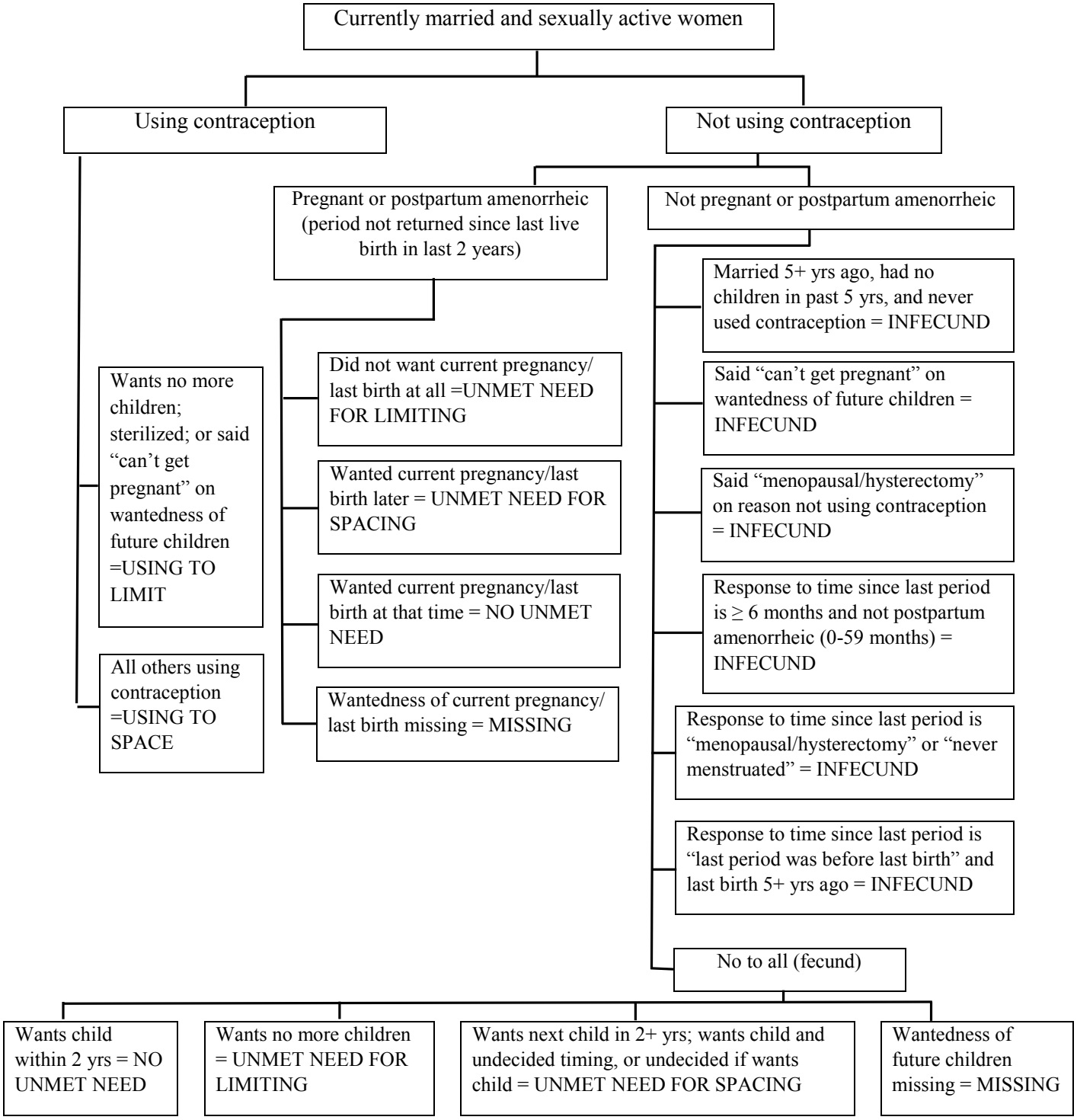
2.1.2.4 Communication variables

Women with no media exposure are about 56.7% less likely to use a method of family planning compared to those who have exposure according to the cross sectional study done in Mojo town, Oromiya region of Ethiopia among reproductive age women. (35)Supporting this finding the study conducted in Malawi among persons with disability found that 13% of respondents had difficulties accessing information on family planning because they did not have a radio and they were disabled. (28) Concerning knowledge data analyses performed on data from the Ghana Demographic and Health Surveys (1988 – 2008) showed that in both 2003 and 2008 women who had heard of contraceptive methods via television or radio were more likely to use contraceptives, also one of the reasons for not using contraceptives was not knowing about family planning (33.7%). (34) In the study conducted By Ethiopian Center for Disability and Development (ECDD) one of the reason given by respondents for non-use of family planning by women was Lack of knowledge (4.2%).(30) Conversely the study done in Debre Brhan district found that knowledge of the women is not statistically significant variable for contraceptive use(26)

2.2 Unmet need for family planning

2.2.1 Measure of the level of unmet need

Reproductive age woman (married or in union) is first asked whether she is using any method of contraception, whether for the purpose of limiting or spacing births. If she is using contraception, including traditional methods, she is considered to be a contraceptive user, and therefore does not have unmet need. Women who are not using contraception are then asked whether they are pregnant or amenorrheic. In the calculation of unmet need, pregnant or amenorrheic women whose pregnancy was mistimed or unwanted are added to the proportion with unmet need, even though they do not at the time of the survey have an immediate need for contraception given their pregnancy. Women who are not pregnant or amenorrheic and are infecund do not have unmet need, nor do women who want to become pregnant soon in less than 2 years according to the revised definition of unmet need for FP. (36) Although the measure of unmet need among unmarried women has not been in place for as long or used as frequently as that for married women, the measure of unmet need includes unmarried women who meet all of the criteria listed above, and who have had sexual intercourse in the past 12 month. (Figure 1)



Remark: this model is used for sexually active women with disabilities aged 18-49 years who are members of the disability associations included in this study

Figure 1 Framework to Estimate Total Unmet Need

2.2.2 The Level of unmet need for family planning

A systematic and comprehensive trend analysis was done at National, regional, and global level obtaining data from nationally representative surveys between 1990 and 2015, for women aged 15–49 years who were married or in a union. The estimates were based on 306 observations of unmet need for family planning from 111 countries or areas. The result showed that globally unmet need for family planning was 12·3% (10·9–13·9) in 2010, in other words, 146 million (130–166 million) women worldwide aged 15–49 years who were married or in a union had an unmet need for family planning. In eastern Africa the level of unmet need was 26·3 (24·5–28·2) in 2010. The study also projected that the absolute number of married women who either use contraception or who have an unmet need for family planning will grow from 900 million (876–922 million) in 2010 to 962 million (927–992 million) in 2015, and will increase in most developing countries. (18)

In 2010, about 23 percent of African women had an unmet need for family planning compared with 9 percent of Asian women and 10 percent of Latin American and Caribbean women. Similarly The World Bank 2010 estimated unmet need for family planning using recent DHS country reports (2000–2009). The result showed that across regions, unmet need ranged from 11 percent (Middle East and North Africa) to 26 percent (Sub-Saharan Africa); The total demand for family planning across regions ranged from 51 percent (Sub-Saharan Africa) to 80 percent (Latin America and the Caribbean). In Africa, only 45 percent of demand was satisfied, contrasting to 70–84 percent in the other regions. Unmet need was higher for limiting than spacing childbearing, in all regions except Sub-Saharan Africa, where unmet need for spacing was almost twice as high as for limiting(1)

Several studies have tried to show the magnitude of unmet need for family planning. According to this literature review the magnitude of the unmet need from studies conducted in Africa ranges from 9.6% from a study conducted using secondary data from a cross sectional survey that was conducted in Botswana among women respondents aged 15–49 years to maximum of 44.8% estimated using the westoff model, The study is community based, cross-sectional study carried out among married women in Kassala, Eastern Sudan in 2012.(37, 38) And in Ethiopia it ranges

from 17.4% from the Community based cross sectional study among 551 currently married women in Dangila town to 52.4%, from the study conducted in Butajira Demographic Surveillance Area among a total of 5746 married women using the same design.(23,39) concerning women with disabilities the Institution based cross-sectional study carried out in Bahir Dar among 337 women of reproductive age group with disabilities in 2013 showed that the level of unmet need for family planning is 24.3%. (40)The study used small sample size and it didn't include women with intellectual disabilities. Important variables associated with unmet need are also not addressed which this study will try to fill. Besides the current level of unmet need for family planning among women with disabilities in Addis Ababa is not known.

2.2.3 Determinants of unmet need for family planning

Unmet need for family planning is affected by many factors. A number of factors have also been identified as the major causes of unmet need for family planning: Age, Religion, Educational status of women and partner, occupation, income, knowledge, media exposure to family planning message, discussion with partner etc. Use of family planning is expected to be associated with demographic and socioeconomic factors.

2.2.3.1 Socio demographic variables

One important demographic variable is age as expected and it was shown in the community based, cross-sectional study done among married women of reproductive age group (15-49 years) in India that unmet need varied significantly with age ($p < 0.05$) and was highest among younger aged women (≤ 19 years age group) (33.7%). (41) local Institution based cross-sectional study was carried out in Bahir Dar among 337 women of reproductive age group with disabilities which showed that age group of 25 - 29 had 80% less likely to have unmet need than women above 35 years old. (40) Conversely a descriptive cross sectional study done among 356 women attending the antenatal clinic in Nnamdi Azikiwe University Teaching Hospital, Nigeria and the community-based cross sectional study among 812 married women in Kassala, Eastern Sudan (2012) showed that there is no significant association between age and unmet need for family planning. (38, 42)

Religion was also the other important factor as the study conducted using secondary data from a cross sectional survey in Botswana among women respondents aged 15–49 years showed that unmet need for FP was lowest among Christians (8.9%) and highest among non-Christians (12.7%).(37) But cross-sectional studies done among married women of reproductive age group (15-49 years) in India, in Nnamdi Azikiwe University Teaching Hospital, Nigeria among women attending the antenatal clinic and local study conducted in Enemay district, North West Ethiopia among married reproductive age women showed that there is no significant association between unmet need and religion.(41, 42, 43)

The other important factor associated with family planning use is women's and their partner's education. The community-based cross sectional study among 812 married women in Kassala, Eastern Sudan (2012) showed that women education less than secondary level (OR=7.8; CI=5.6-10.9; P=0.00) and husband education less than secondary level (OR=1.9; CI=1.3-2.6, P = 0.00) were associated with unmet need for family planning.(38) Similarly a local study conducted in Enemay district, North West Ethiopia among 770 married reproductive age women showed that women and their partners with educational level of secondary and above (AOR=0.201; 95%CI: 0.13-0.213) and (AOR=0.231, 95%CI: 0.144-0.295) respectively were also less likely to have unmet need for FP when compared with those with no formal education. (43) The previously mentioned study done in Bahir Dar among women with disability also showed that women with disability who have no education were 11 times more likely to have unmet need than those who have secondary education but the cross sectional study done in Nnamdi Azikiwe University Teaching Hospital, Nigeria among women attending the antenatal clinic showed that there is no significant association between unmet need and educational status of women. (40, 42)

The community-based cross sectional study among 812 married women in Kassala, Eastern Sudan showed that women's occupation; housewife's (OR=4.3; CI=2.5-7.2; P=0.00) were associated with the total unmet need. (38)Similarly the previously mentioned study done in Dangila, Awi zone revealed that women who were housewives/farmers were about 7 [OR = 6.81 (1.91–24.29)] times more likely to have unmet need compared to employed women. Opposite to this finding the Bahir Dar study done among women with disability showed that there is no significant association between unmet need and occupation. (39,40) Women's economic income also has been shown to

affect unmet need for FP. Community based, cross-sectional study conducted in Kishanganj, India among 330 Married women aged 15-49 years showed families with a monthly per capita income of less than thousand rupees. ($P < 0.05$) had a higher unmet need. (41) But again the local study done among women in disability in Bahir Dar showed no significant association between income and unmet need for FP. (40)

2.2.3.2 Reproductive variables

Parity is the other determinant for unmet need, unmet need increases as women's parity increase which is supported by different studies. A study conducted using secondary data from a cross sectional survey in Botswana. (37) Showed that having zero parity (OR=0.454; CI 0.225 to 0.915; p=0.027) were protective factor against unmet need for FP. Similarly the above study done in Nigeria among women attending the antenatal clinic showed that Parity significantly affected the incidence of unmet need for family planning (x^2=47.33; p=0.00). (42) Cross sectional study carried out in urban slum area of south India among married women aged 15-49 in 2009 showed that unmet need for family planning is highest (54.47%) among women having more than 2 children as compared to women having 2 or less children (26.11%). (44) Conversely the study done in Eastern Sudan showed no significant association. The local study done among women in disability in Bahir Dar showed that women who desire to have more than 3 children have more likely to have unmet need than those who need to have 1 - 2 children. (40)

2.2.3.3 Client related variables

Men play a paramount role in determining health care needs of women. Since men are decision makers and in control of all the resources, they decide when and where women should seek health care. Thus partner support plays an essential role on women's family planning usage. Cross sectional study conducted in Enemay district showed that women whose partner had non-supportive attitude for family planning use [OR = 3.34 (1.26–8.90)] were more likely to have unmet need. Similarly the cross sectional study conducted in Dangla revealed that married women whose partners do not support the use of FP methods were 3.73 times more likely to have unmet need for FP services compared to those whose partners support FP use (AOR=3.73, 95%CI: 1.293-4.770) (39, 43).

2.2.3.4 Communication variables

Another important factor in the utilization of family planning is media exposure to family planning messages the study done in Botswana showed that women who did not listen to a radio and who did not watch television in the past week had the highest unmet need for FP, 15.7% and 14.1%, respectively (37). Although the scarcity of available literatures concerning the research objective restricted the review, this study will try to assess the above factors associated with contraceptive use and unmet need of women with disabilities found in Addis Ababa visualizing the barriers from different dimensions.

2.3 Research questions

After reviewing the existing body of knowledge on the research issues under caption, the following research questions were formulated

What is the magnitude of family planning use among women of reproductive age group with disabilities in Addis Ababa?

What is the magnitude of unmet need for family planning among women of reproductive age group with disabilities in Addis Ababa?

What are the determinants of family planning use and unmet need among women of reproductive age group with disabilities in Addis Ababa?

2.4 Conceptual frame work

The independent variables, which influence the contraceptive use and unmet need for family planning, are subdivided into four sets. The first two are the underlying factors that are indexed by some important demographic and socioeconomic variables. The third and fourth group of independent variables are the proximate determinants that are indexed by client characteristics and health facility related characteristics. For this particular study, two dependent dichotomous variables are considered (unmet need and met need). Demographic and socioeconomic factors are assumed to be the underlying determinants of the met/unmet need for family planning. That is, the effect of the underlying factors is expected to reach the ultimate dependent variable, unmet/met need through the assumed proximate variables, namely, client characteristics and health facility related characteristics.

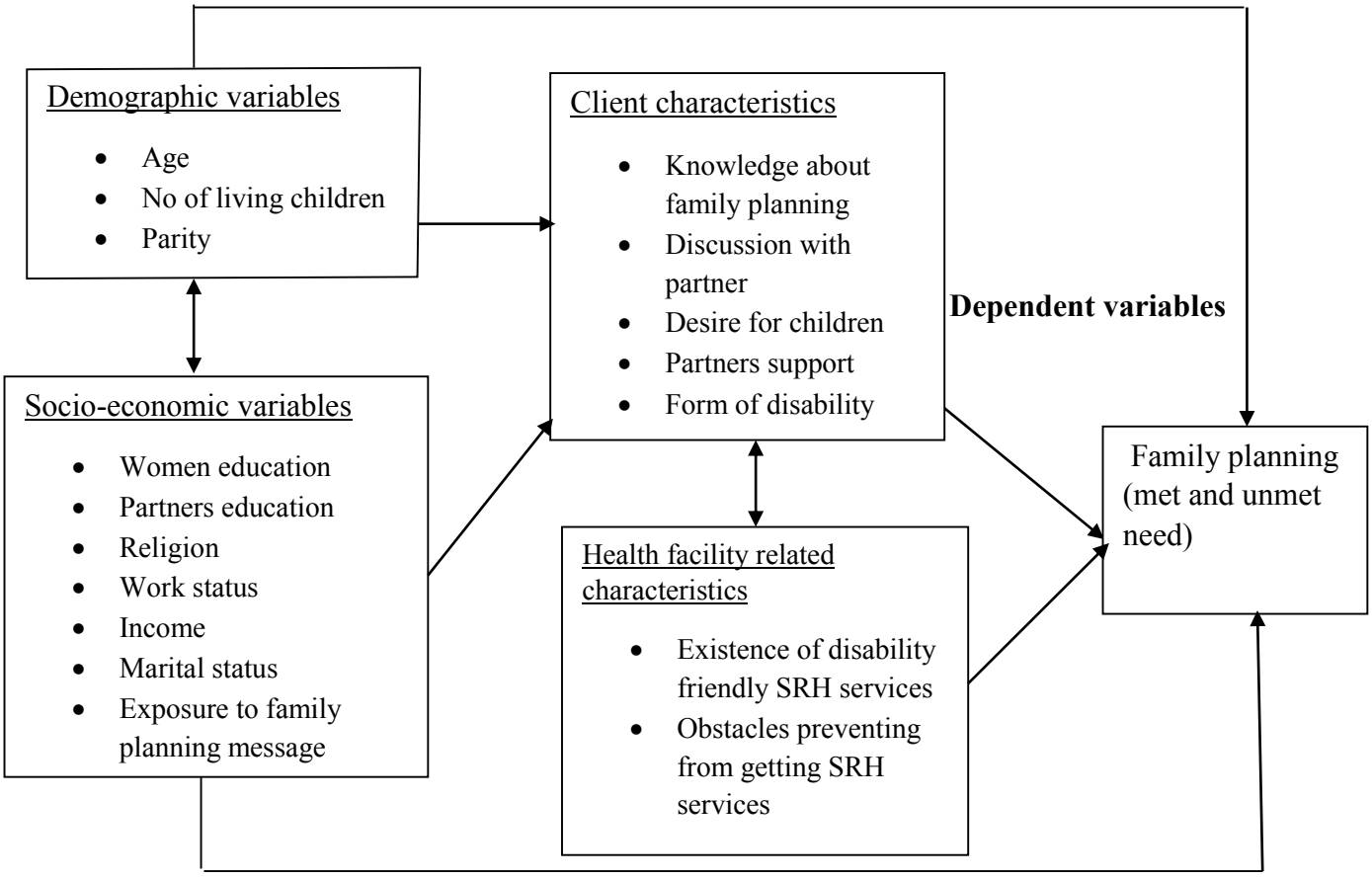


Figure 2 Conceptual framework of unmet need family planning adapted from Korra, Antenane.2002.

3 OBJECTIVES

3.1 General objectives

To measure levels and identify determinants of family planning use and unmet need among sexually active women with disabilities in Addis Ababa, Ethiopia 2016

3.2 Specific objectives:

To measure the current family planning use, unmet need for contraception and demand of family planning among sexually active women with disabilities in Addis Ababa Ethiopia 2016

To identify factors associated with the current family planning use among sexually active women with disabilities in Addis Ababa Ethiopia 2016

To identify factors associated with the unmet need of contraception among sexually active women with disabilities in Addis Ababa Ethiopia 2016

4 METHODOLOGY

4.1 Study design

Institution based cross sectional study was used. The institutions used were Ethiopian national association of intellectual disabilities (ENAID) and Ethiopian women with disabilities national association (EWDNA).

4.2 Study area

Addis Ababa is the capital city of Ethiopia, according to 2007 census with a total population of 2, 739,551. In Addis Ababa there are 32,630 persons with disability among which 7,835 are reproductive age women. Personnel of government bureaus and development organizations are often unaware of disability issues and lack knowledge and skill on how to include persons with disability in their service, programs and projects. (44)

Under Ministry of Labour and Social Affair the Rehabilitation Affairs Department at central level is in charge of providing rehabilitation services for persons with disabilities. Besides, there are many organizations and agencies involved in rehabilitation services for persons with disabilities (PWD's). In the country the plight of the disabled and prevention of disability is addressed to be a multi-sectorial approach involving many branches of several Ministries and organizations such as, Ministry of Health, Ministry of Education and other NGO's. The services they render include education of visually, aurally and mentally disabled children, provision of medical care, vocational training programs, employment opportunities, reunification, shelters, food, appliances, subsides etc. Currently the services mentioned above are provided in piecemeal approaches based on the aims and objectives of the organizations establishment. Most stakeholders regarded the health sector as laggard in taking the steps towards devising clear policies and strategies and also implementing the few that it has in document. The MoH has not made any significant leap in making health service accessible to disabled persons both in terms of primary and special care. The focus of the health sector as indicated in the HSDP is promotion of preventive approach. In

this regard, efforts worth mentioning are program on prevention of blindness, treatment & detection on leprosy, immunization, pre and postnatal care and disease control. (44, 45)

Persons with disability (PWD) Organizations are associations established by PWDs which are directly working on disability issues. The Federation and member associations are engaged in advocating for cessation of social discrimination and promoting the rights of PWDs. Their activities include advocacy and awareness raising, initiating research and information gathering activities, offering capacity building as well as economic empowerment and integration of persons with disabilities. One of the federation's intervention area is HIV/AIDs/health. Other organizations focusing directly on disability issues include the – Ethiopian National Disability Action Network (ENDAN), The Ethiopian Women with Disabilities National Association(EWDNA), The Ethiopian Centre for Disability and Development (ECDD), Handicap International, Rehabilitation and Preventive Initiative against Disability (RAPID), SALU Self-Help Blind and Handicap Association, Addis Ababa Prosthetics-Orthotics Centre and Cheshire Services Ethiopia. These organizations are among those actively engaged in the implementation of comprehensive community based rehabilitation (CBR) activities. (46)

Ethiopian center for disability and development (ECCD) is Ethiopian development NGO working with other organizations to include persons with disability in government service delivery and non-governmental development programs. One of the developmental priorities of their strategic plan (2013-2017) is inclusive family planning and reproductive health (FP/RH) services. (7)

4.3 Source population

Reproductive age women with physical, sensory or intellectual disabilities living in Addis Ababa.

4.4 Study population

Reproductive age women who are members of Ethiopian national association of intellectual disabilities (ENAID) and Ethiopian women with disabilities national association(EWDNA) and who are selected to be included in the study.

4.5 Inclusion and exclusion criteria

4.5.1 Inclusion criteria

Members of the associations aged 18 up to 49 years and who are participating in the associations.

4.5.2 Exclusion criteria

Members who are not willing to participate

Intellectually disabled women who have no one to care for them.

Members who are seriously ill.

4.6 Sample size

A sample size of 727 was determined using the formula for single population proportion based on the assumptions: from previous prevalence data, P for met need is 0.18 (30) and p for unmet need for family planning is 0.24 (40) Moreover, a margin of error of 4%, a confidence level of 95% assumed (Z α/2=1.96), and a design effect of 1.5 sample size becomes 540 for met need and 648 for unmet need. Adding 2% infecundity rate sample size for met need and unmet need becomes 551 and 661 respectively and with 10% contingency for non-response final sample size becomes 606 for met need and 727 for unmet need. The highest sample size which is 727 for unmet need was used.

$$n = DE^{*}\frac{(Z\ \alpha/2)^2\ p\ (1-q)}{d^2}$$

$$n = 1.5^{*}\frac{(1.96)^2\ 0.18(0.82)}{0.04^2} = 540$$

$$n = 1.5^{*}\frac{(1.96)^2\ 0.24(0.75)}{0.04^2} = 648$$

4.7 Sampling procedure

Disability type Stratified simple random sampling was used to select the study participants. First total sample size was allocated to each disability stratum using population proportional to size allocation formula. Then, the allocated samples to each stratum was selected using simple random sampling from sampling frames that were developed from list of the members obtained from the associations.

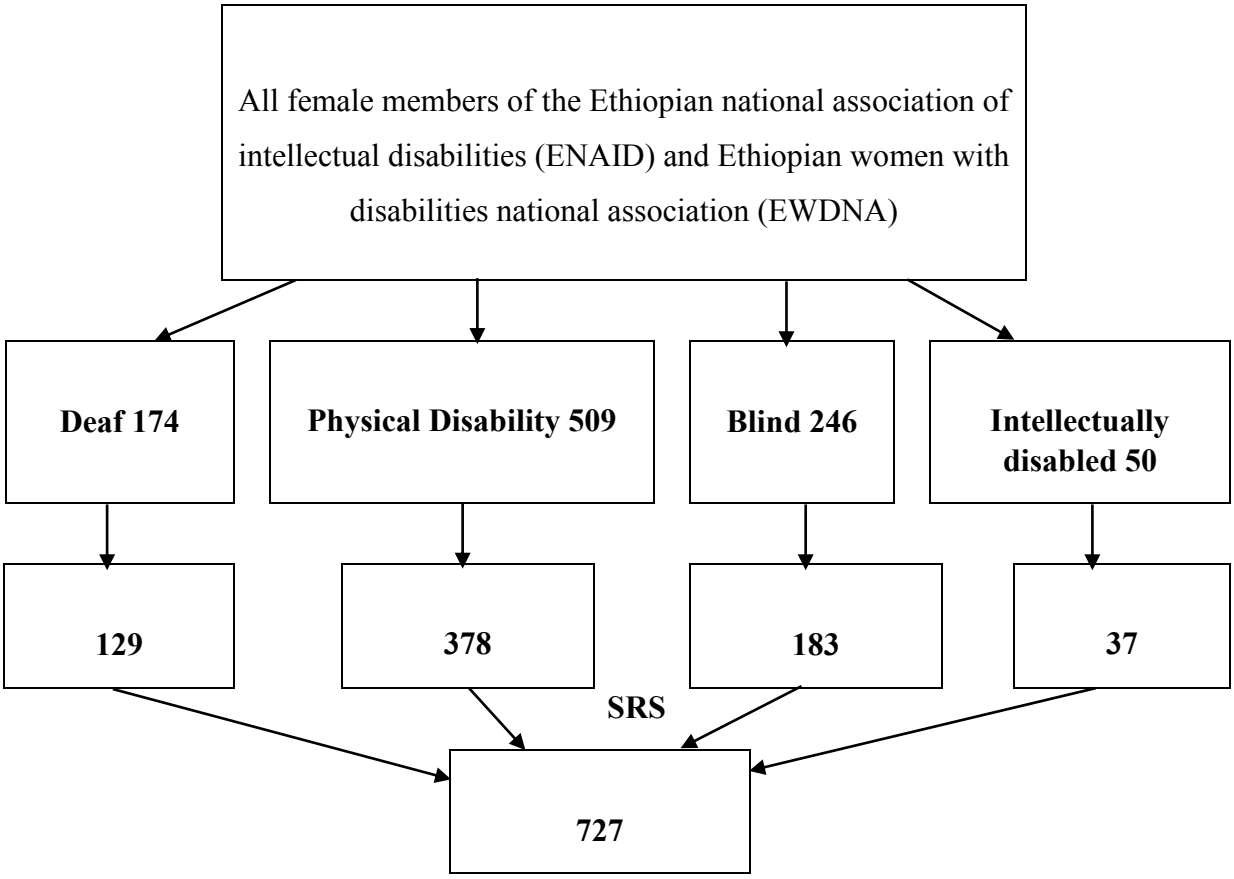


Figure 3 Schematic presentation of sampling procedure

4.8 Variables

4.8.1 Dependent variable

Met need and unmet need for family planning

4.8.2 Independent variables

The main independent variables that are considered in this study include

- Socio demographic variables

Age, Women Education, Partner education, religion, marital status, income, work status,

- Reproductive variables

Parity, number of living children, desire to have children,

- Communication related variables

Exposure to family planning message,

- Client and facility related variables

Discussion with partner, partners support, form of disability, existence of disability friendly SRH services, obstacles preventing from getting SRH services, knowledge about family planning,.

4.9 Data collection instrument and procedure

4.9.1 Data collection instrument

Data were collected by adapting Ethiopian Demographic and Health Survey questionnaire that was then translated in to Amharic, The Amharic version was used for data collection. The main components of the questionnaire are: socio demographic characteristics, knowledge of the respondents towards family planning methods, Fertility related characteristics and health facility related characteristics

4.9.2 Data collectors and collection procedures

Data were collected using eight twelve grade complete females. Two of the collectors were females who can communicate by speaking and sign language to collect data from the deaf. The

interviewers were trained for two days before the actual data collection on interviewing approach and data recording. Lecturing, mock interview and actual field practice was used to train data collectors. The interviewing was done under close supervision. Interviewer administered questionnaire was used for data collection. To collect data from the deaf the two females who can speak sign language were used and from the blind, since the questionnaire is interview administered their blindness will not affect the process. To collect data from intellectually disabled women, their family members or their guardians was interviewed. Study participants were interviewed while they come to their respective associations for coffee ceremony and women's day. Women who are government and private employees were interviewed at their respective work places according to their address from the association. There was also a phone call for parents or guardians of intellectually disabled women and women with physical disability who were not coming to the associations and who are not employed, to make sure if they are able to come to the institution and to make an appointment for the interview. For those parents who are unable to come data collectors went to their home using their address.

4.10 Operational definitions

The definitions are based on Central statistical agency, the 2007 population and housing census of Ethiopia.

Blind: - persons who totally lost their vision

Deaf: - persons who are not able to hear from both ears

Disability in hands: -loss of one hand or both hands, paralysis of one hand or both hands or any other disability in one hand or both hands.

Disability in legs: -loss of one leg or both legs, paralysis of one leg or both legs or any other disability in one leg or both legs.

Intellectual disability: - A person who has difficulties in learning, whose social interaction is below expected and backward having low capacity of understanding, training with difficulties in helping themselves in attending their day to day activities or learning due to undeveloped brain.

Sexually active women: - women who have been sexually active within the last 30 days plus currently married women (13)

Unmet need for family planning: - Sexually active women who say they are not using contraception and who say either that they do not want any more children or that they want to wait two or more years before having another child. (13)

Met need: - All reproductive age women who are currently using family planning method. (13)

Demand satisfied for family planning: - Percentage of all reproductive age women currently using family planning divided by the percentage of women using family planning plus the percentage of women with unmet need for family planning. (13)

4.11 Data Quality Management

The data collection questionnaire was first prepared in English and then translated into Amharic and back to English for checking language consistency by a different person with an excellent Amharic and English speaking skill. To ensure data quality, pre-test was conducted in associations not included in the study to assess the clarity of the questions, their sensitiveness as well as understanding of the data collectors. Discussion was held based on the result of the pre-test and accordingly, some amendments were made. There was also demonstration and practical session on interviewing women's with each type of disability that were included in the study. A two days training was given to the supervisors and the data collectors on the procedure. The data was checked for completeness, accuracy, clarity, and consistency by the supervisors and the investigator on daily basis. Any error or ambiguity and incompleteness was corrected accordingly and shared with data collectors.

4.12 Data processing and Analysis

Data was checked for completeness and coded and entered in the computer using EPI data software. Then the data were exported to STATA version 12 program for analysis. Descriptive statistics which involved frequency and percentage for the dependent and independent variables was used. Continuous variables were expressed as mean ± standard deviation. For skewed variables, median ± interquartile range was reported. Categorical variables were expressed as number (percentage, %). Unmet need for family planning was computed using variables recommended in the revised model from DHS analytical studies 2012 which includes 1-married/in union or sexually active (Y, N) 2-current contraceptive use (Y, N) 3-pregnant or amenorrheic (Y, N) 4-pregnancy timed or wanted(Y, N) 5-fecundity (Y, N) 6-want child now (Y, N) 7-want a child before 2 years(Y, N). Chi-square test was used to evaluate the differences in the distribution of categorical variables for study groups. Multivariable logistic regression model was fitted to predict the association between contraceptive use and unmet need with their determinants. First, bivariate analysis was done to identify candidate variables for multivariable logistic regression. Second, to identify predictors of contraceptive use and unmet need having a $p < 0.2$ were entered in the multivariable logistic regression model. At this step, interaction between different independent variables was checked and collinearity diagnostics was done by checking the variance inflation factor. All statistical analysis was set at 5% level of significance (i.e. $p < 0.05$. The results were reported using Odds Ratio and 95% CI. Appropriate tables and graphs were used to present findings.

4.13 Ethical consideration

The proposal was reviewed by ethical review committee of School of Public Health in Addis Ababa University. The study started after verbal consent was obtained. Verbal consent was taken from each selected participant or guardians of those with intellectual disabilities to confirm willingness. Honest explanation of the survey purpose, description of the benefits and an offer to answer all inquiries was made to the respondents. It was explained that answering the interview questions will have no harm on the participants and that their participation will help to create awareness concerning the issue. It was also explained that their participation will help the government to plan accessible and disability friendly health service. Also affirmation that they are free to withdraw consent and to discontinue participation without any form of prejudice was made. Privacy and confidentiality of collected information was ensured by using anonymous data collection tools and private rooms throughout the process.

4.14 Dissemination plan

After approval from Addis Ababa University, the findings of the study will be disseminated to all relevant stakeholders including the disability associations. Copies of the research will be given to Addis Ababa University, Collage of Health Sciences, and the School of Public Health. Further effort will be made to publish in peer- reviewed international journals

5 RESULT

5.1 Respondents Characteristics

From sample size of 726 the response rate was 96.5% (701). Out of 701 respondents, majority of the respondents were in the 25-29 years age group 54.64% (n=181) with the mean age of 29.7 (± 7.6 SD) years. About 27.39% (n=192) are currently married/union. Among those who are not currently married or in union (n=509), 47.15% (240) have started sexual intercourse of which 30.42% (n=73) were sexually active. Mean age at first sex was 18 (±4.6). About 26.82% (n=188) of women and 23.44% (n=45) of partners of those who are married/union never been enrolled into a formal education. (Table 1) In the forms of disabilities those who are physically disabled accounted for 50.93% and those who are blind were 25.4% while deaf and mentally disabled women were 18.4 and 5.3 respectively. (Table 2)

Most of the respondents were unemployed represented by 24.25% (n=170) while 20.40% (n=143) were students and 19.83 (n=139) were handicrafts. Most partners are employed represented by 110 (57.3%). Respondents who were Orthodox followers accounted 74.75% (n=524), followed by 14.55% (n=102) who were Protestants and the rest were Muslims 9.56% (n=67) or others represented by and 1.14% (n=8). About 24.25% (n=170) of the respondents were categorized as having low house hold income (less than 600) and 26.82% (n=188) as moderate (601-1000) while 48.93% (n=343) were categorized as having high house hold income (more than 1000). In addition 268(51%) of respondents don't read newspaper at all while 426(74.5%) and 444(63.34%). Most of the respondents represented by 138(71.9%) discuses with their partner while 132 (68.75%) partners support their wife. (Table 1)

Table 1: Frequency distribution of reproductive age women with disability by their background characteristics in Addis Ababa, 2016

Background characteristics	Frequency	Percent
Age (n=701)		
15-19	49	6.99
20-24	153	21.83
25-29	181	25.82
30-34	109	15.55
35-39	113	16.12
40-44	60	8.56
45-49	36	5.14
Women education (n=701)		
No education	188	26.82
Primary	173	24.68
Secondary	231	32.95
Higher	109	15.55
Partner education (n=192)		
No education	45	23.44
Primary	46	23.96
Secondary	68	35.42
Higher	33	17.19
Occupation (n=701)		
Unemployed	170	24.25
Employed	160	22.82
Student	143	20.4
Handicraft	139	19.83
Merchant	70	9.99
Other	19	2.71
Religion (n=701)		
Orthodox	524	74.75
Protestant	102	14.55
Muslim	67	9.56
Others	8	1.14
Marital status (n=701)		
Currently married	192	27.39
Currently unmarried	509	72.61
HH income (n=701)		
Low (less than 600)	170	24.25
Moderate (601-1000)	188	26.82
High (more than 1001)	343	48.93
Discussion with partner (n=192)		
Yes	138	71.88
No	54	28.13
Partner support (n=192)		
Yes	132	68.75
No	60	31.25

More than half of the respondents 61.6.1% (n=432) have given birth of which 73.7% have 0-2 living children and only 26.3% (n=70) had more than 2 living children. Only 15% (n=40) of the respondents had experienced child loss or death while the rest 84.9% (n=226) had never experienced any as shown in Table 2. Majority (63%) of the women reported having the desire to have children in their lifetime and 26.83% desired no or no more children while the remaining 10.12% didn't decide at all. (Table 2).

The knowledge level of the respondents on both modern and traditional contraceptives, a total of 11 methods was explored to capture their knowledge. A maximum of 33 knowledge items were used. These items covered knowledge within the scope on contraceptives types, instruction to use them and the right place to get them. Their scores were recorded and analyzed after grouping them for each contraceptive type. Table 2 below revealed that half of the respondents, 351(50.07%) have low knowledge of contraceptive. While 434(61.9%) respondents think that the existing reproductive health services are disability friendly the rest 201(28.67%) respondents do not think that the services are disability friendly and 66(9.42%) of them are unsure. (Table 2)

Table 2: Distribution of reproductive age women with disability by fertility, family planning use and health facility related characteristics, Addis Ababa, Ethiopia, 2016

Reproductive health characteristics	frequency	percent
Started sex (n=509):		
Yes	240	47.15
No	269	52.85
Have ever given birth (n=432)		
Yes	267	61.81
No	165	38.19
Parity (n=266)		
2 and less children	183	68.80
Above 2 children	83	31.20
Number of living children (n=266)		
2 and less children	196	73.68
Above 2 children	70	26.32
Have experienced child death (n=266)		
yes	40	15.04
No	226	84.96
Desire to have a child (n=682)		
Want/Want more	430	63.05
No/No more	183	26.83
Don't know	69	10.12
Current family planning use (n=432)		
yes	192	44.44
no	240	55.56
Family planning ever use (n=432)		
yes	337	78
no	95	22
Knowledge (n=701)		
Low knowledge	351	50.07
High knowledge	350	49.93
Think that existing SRH services are disability friendly (n=701)		
Yes	434	61.91
No	201	28.67
Unsure	66	9.42
Type of disability (n=701)		
Physically disabled	357	50.93
Blind	178	25.39
Deaf	129	18.40
Mentally disabled	37	5.28

Proportion of contraceptive use

The respondents were asked whether they are currently using family planning methods or not (Table 2). Nearly 44.4% (n=192) of all reproductive age women and 64.5% (n=171) of sexually active women (currently married/in union and sexually active) with disabilities are currently using contraceptive. While 78% (n=337) of all reproductive age women with disability have ever practiced one form of family planning methods, 22% (n=95) of them have never practiced family planning methods in their life. The most frequently used contraceptive method is injectable 35.42% (n=68) followed by implants 24.48% (n=47) whereas the least ever used family planning method were female sterilization 4.12% (n=8) and emergency contraceptives 4.12% (n=8). (Figure 1)

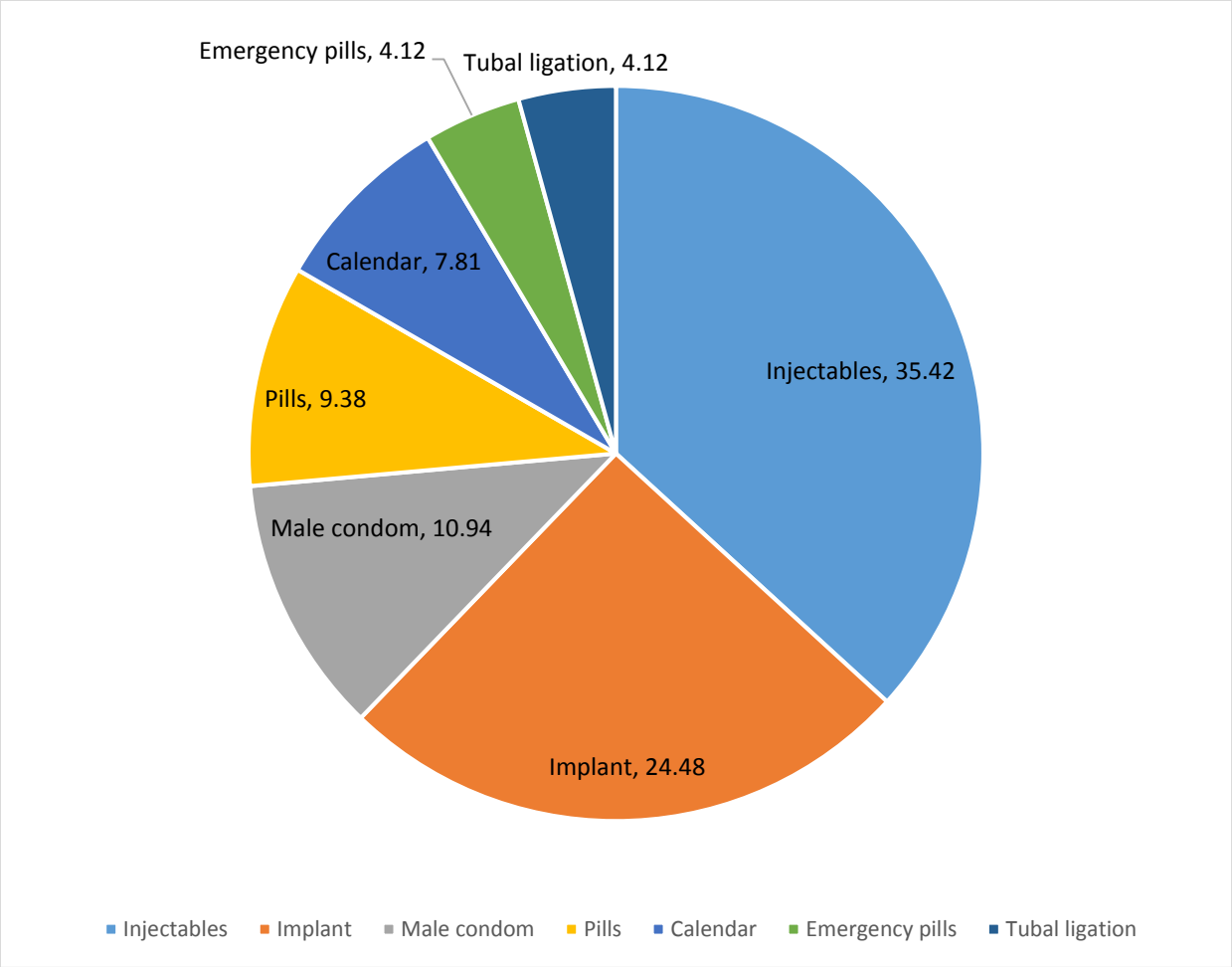


Figure 4 Current family planning use by type among reproductive age women with disabilities living in Addis Ababa, Ethiopia 2016

Study participants were asked for why they are not currently using family planning. From the multiple reasons they have given the highest was fertility related reason with 344 frequency from which the leading response being not having sex with 253 frequency followed by infrequent sex (30) and saying that they cannot get pregnant (21). The next reason with the highest frequency was not being married followed by method related reasons with 21 frequency of which side effects/health concern took the lead with 15 frequency. Not using contraception due to opposition to use had 16 frequency of which partner opposition took the lead followed by religious prohibition (Table 3) The least reason given was lack of knowledge (n=1). (Figure 5)

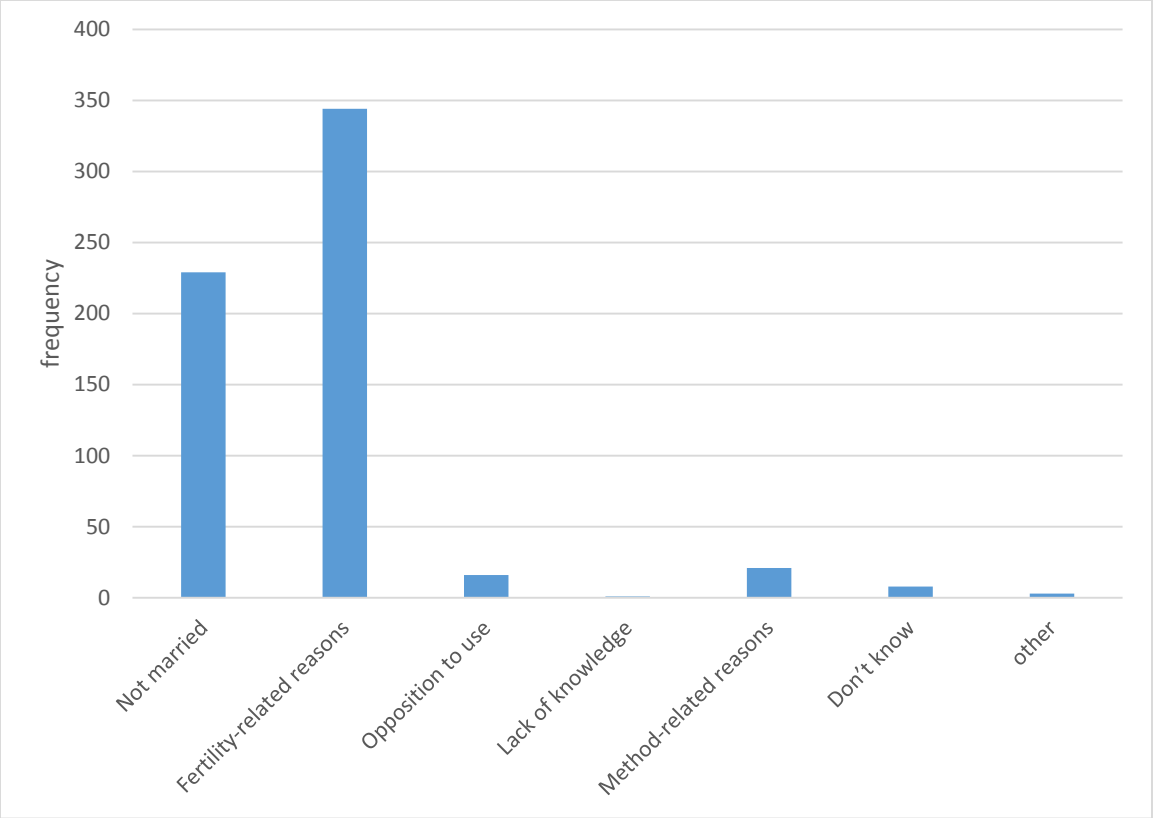


Figure 5 Reported reasons for non-using of family planning (multiple response) among reproductive age women with disabilities living in Addis Ababa, Ethiopia 2016

Table 3: Distribution of reproductive age women with disability by reported reasons for non-utilization of family planning services (multiple responses), Addis Ababa, Ethiopia 2016

Reasons	Frequency	Percentage (%)
Not married	**229**	**56.82**
Fertility related reasons	**344**	
Not having sex	253	62.78
Infrequent sex	30	7.48
Menopausal/hysterectomy	2	0.50
Can't get pregnant	21	5.21
Not menstruated since last birth	2	0.50
Breast feeding	0	
Up to God/fatalistic	36	
Opposition to use	**16**	
Respondent opposed	0	
Husband/partner opposed	9	2.23
Others opposed	2	0.50
Religious prohibition	5	1.24
Lack of knowledge	**1**	
Knows no method	1	0.25
Knows no source	0	
Method related reasons	**21**	
Side effects/health concerns	15	3.72
Lack of access/too far	2	0.50
Costs too much	0	
Preferred method not available	1	0.25
No method available	0	
Inconvenient to use	2	0.50
Interferes with body's normal process	1	0.25
Don't know	**8**	**1.99**
others	**3**	**0.74**

Respondents who said that the existing reproductive health services are not disability friendly were asked further for their reason. Among the perceived reasons poor physical access was repeatedly give reason with 137 frequency which was followed by poor experience of health workers with 91 frequency. The least reason given was lack of privacy with 18 frequency.

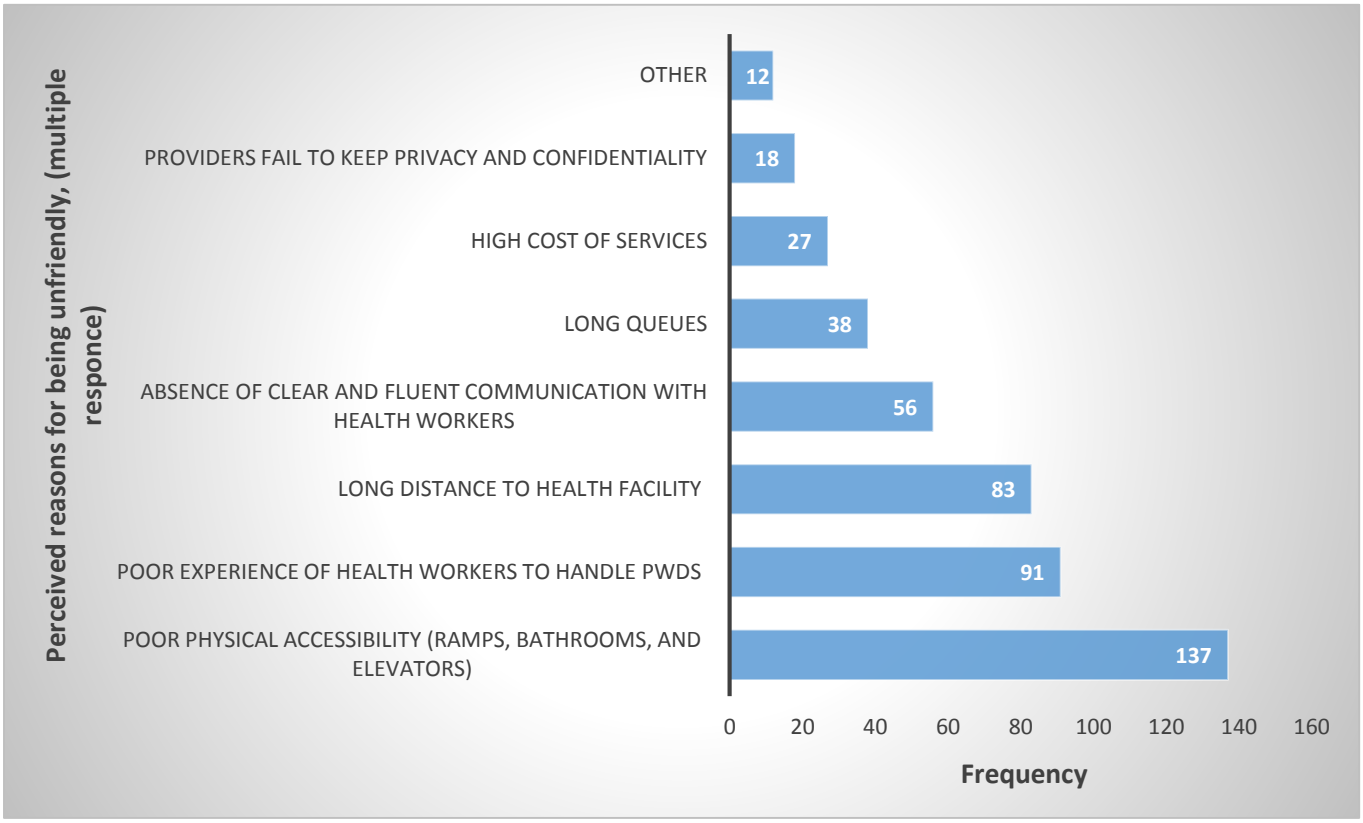


Figure 6. Perceived reasons by reproductive age women with disabilities for the reproductive health services to be disability unfriendly Addis Ababa, Ethiopia 2016

5.2 Proportion of unmet need

Out of the total 701 sample size only 192(27.4%) where currently married and from 240 respondents who have started sex only 73(30.42) respondents were sexually active with in the past 30 days. From this 265 respondent's, 28 respondents representing 10.6% had total unmet need for spacing pregnancy while 25 respondents representing 9.4% had unmet need for limiting child bearing. The total unmet need rate was therefore 20% (n=53) making the demand satisfied 68.9 %.(Figure 7)

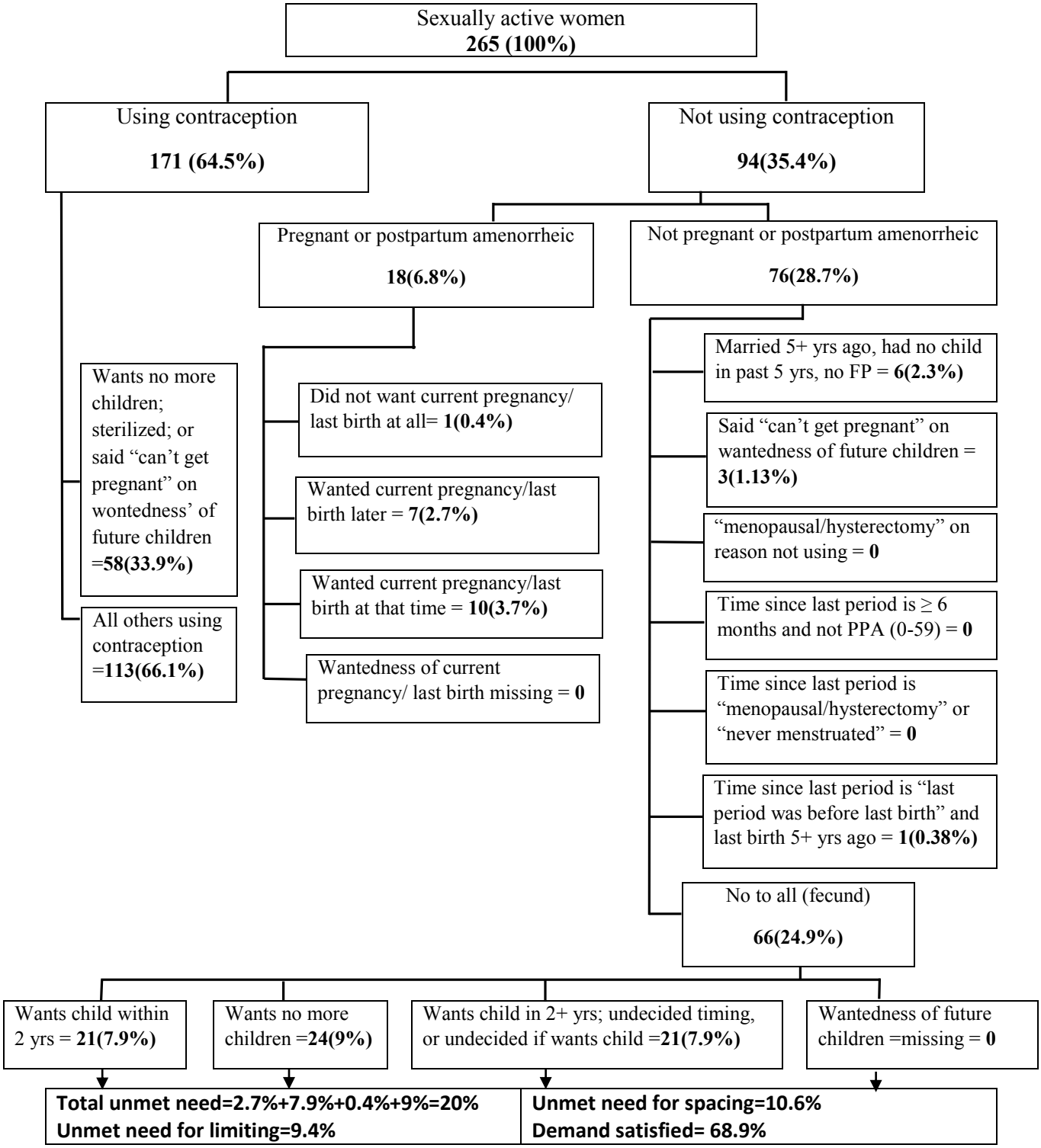


Figure 7: prevalence of unmet need for family planning among reproductive age women with disability in Addis Ababa, 2016

5.3 Determinants of family planning use among reproductive age women with disability in Addis Ababa

In the study, various explanatory variables were subjected to a regression model to determine whether they have any significant association with the dependent variable, current family planning use.

Table 4 below showed that the proportion of contraceptive use has relatively same value until the age group 30-34, after which it decreased steadily to 24.2 percent among women aged 45-49.

On the other hand the multivariate model results indicated that women with disabilities in the age group 30-34 were AOR=6.8 (95% CI 1.47, 31) times more likely to use family planning compared to women in the age group of 45-49 years. The probability of women to use family planning methods were AOR=3.1: 95%CI (1.04, 9.5) times higher among those whose partners attained primary level of education compared with those with no formal education. Women with disabilities who were unemployed are AOR=0.8: 95%CI (0.3, 2.04) less likely to use family planning methods compared with those who were employed.

The study also indicated that the odds of family planning use was AOR=3.3: 95%CI (1.08,10.34) times higher among those women with disabilities who had discussion with their partners on the use of family planning methods compared with those who did not have such a discussion.

Table 4 Factors associated with family Planning use among reproductive age women with disability living in Addis Ababa, Ethiopia 2016

Variables		Family planning use		COR(95%CI)	AOR(95%CI)
		Yes	No		
Age:	<=24	5 (54.55)	30(45.45)	3.7 (1.4, 9.5)	3 (0.4,22.8)
	25-29	23 (42.73)	63 (57.3)	2.3 (0.9, 5.6)	2.4 (0.5,10.1)
	30-34	47 (54.43)	36(45.57)	3.7 (01.5, 9.2)	**6.8 (1.47,31)**
	35-39	43(40.43)	56(59.57)	2.1 (0.8, 5.2)	4 (0.9,16.6)
	40-44	38(40.00)	30(60.00)	2 (0.8, 5.5)	4.4(0.85, 22.7)
	45-49	8(24.24)	25(75.76)	1.00	1.00
Women educ. :	No edu.	47(35.34)	86(64.66)	1.00	1.00
	Primary	56(48.28)	60(51.7)	1.7 (1.02, 2.8)	1.14 (0.45,3)
	Secondary	55(44)	70(56)	1.44 (0.87,2.4)	0.9 (0.32, 2.6)
	Higher	34(58.6)	24(41.4)	2.6 (1.4, 4.9)	1.4 (0.38,4.7)
Partner edu. :	No edu.	19(42.22)	26(57.8)	1.00	1.00
	Primary	32(69.57)	14(30.43)	3.1(1.3, 7.4)	**3.1 (1.04,9.5)**
	Secondary	45(66.2)	23(33.8)	2.7 (1.2, 5.8)	2.6 (0.91,7.4)
	Higher	24(72.73)	9(27.3)	3.6 (1.4, 9.6)	2.4 (0.6, 9.6)
Occupation:	Employed	59(51.3)	19(38.78)	1.00	1.00
	Unemployed	53(40.7)	77(59.23)	0.6 (0.4, 1.1)	0.8 (0.3,2.04)
	Student	30(61.22)	51(68.9)	1.5 (0.23, 0.8)	0.9 (0.2,4.3)
	Handicraft	23(31.08)	56(48.7)	0.43 (0.23,0.8)	**0.3 (0.09,0.87)**
	Merchant	22(44)	28(56)	0.74 (0.4,1.45)	1.3 (0.42,4.23)
	Other	5(35.7)	9(64.3)	0.53 (0.16,1.6)	1.2 (0.09,15.8)
HH income:	Low(<600)	34(34.3)	65(65.66)	1.00	1.00
	Moderate (601-1000)	45(36)	80(64)	1(0.62, 1.87)	0.6(0.18,1.8)
	High (> 1001)	113(54.33)	95(45.7)	2.3(1.4, 3.7)	0.7(0.25,2)
Discussion with partner:	No	23(42.6)	31(57.4)	1.00	1.00
	Yes	97(70.3)	41(29.7)	3.2(1.6, 6.1)	**3.3(1.08,10.34)**
Partner support:	No	31(49.21)	32(50.8)	1.00	1.00
	Yes	89(68.9)	40(31)	2.3(1.24,4.3)	0.8 (0.3,2.6)
Knowledge:	Low	81(39.32)	125(60.7)	1.00	1.00
	High	111(49.12)	115(50.9)	1.5(1.01,2.2)	0.7(0.35,1.63)

5.4 Determinants of unmet need for family planning among reproductive age women with disability in Addis Ababa, Ethiopia 2016

Table 5 Factors associated with unmet need among sexually active women with disability in Addis Ababa, Ethiopia 2016

Variables	Unmet need				COR(95%CI)	AOR(95%CI
	Yes			No		
	Limiting	Spacing	Total			
Age: <=24	2(8)	2(7.14)	4(11.11)	32(88.9)	0.2(0.05, 0.93)	1.9(0.14,28.3)
25-29	4(16)	16(57.1)	20 (27)	54(72.97)	0.7(0.24, 1.9)	0.3(0.03,2)
30-34	2(8)	1(3.57)	3(5.77)	49(94.23)	0.1(0.02,0.5)	**0.05(0.04,0.7)**
35-39	5(20)	7(25)	12(21.43)	44(78.57)	0.5(0.16,1.5)	0.3(0.05,2.1)
40-44	5(20)	2(7.14)	7(25.93)	20(74.07)	0.6(0.2,2.2)	0.2(0.02,1.7)
45-49	7(28)	0	7(35)	13(65)	1.00	1.00
Women Edu:						
No	18(72)	6(21.43)	24(30.38)	55(69.62)	1.00	1.00
Primary	4(16)	11(39.3)	15(18.75)	65(81.25)	0.5(0.25, 1.1)	0.3(0.08,1.28)
Secondary	3(12)	7(25)	10(15.4)	55(84.62)	0.4(0.18,0.9)	0.4(0.08,1.93)
Higher	0	4(14.3)	4(9.76)	37(90.24)	0.2(0.07,0.7)	0.4(0.03,4.9)
Discussion with partner:						
No	9(52.94)	10(47.6)	19(35.19)	35(64.81)	1.00	1.00
Yes	8(47.06)	11(52.4)	19(13.77)	119(86.2)	0.3(0.14,0.6)	**0.2(0.07,0.7)**
No.of living children: <=2	15(65.2)	6(46.15)	21(16.4)	107(83.6)	1.00	1.00
>2	8(34.78)	7(53.85)	15(30.6)	34(69.4)	2.5(1.17,5.4)	**3.4(1.09,10.8)**
Desire to have child: Want/want more	0	20(95.2)	20(13.7)	126(86.3)	1.00	1.00
No/no more	22(91.6)	1(4.76)	23(28.4)	58(71.6)	2.5(1.27,4.9)	0.3(0.8,9.2)
Don't know	2(8.33)	0	2(9.5)	19(90.5)	0.6(0.14,3.0)	0.1(0.01,1.8)
Knowledge:						
Low	17(68)	16(57.1)	33(27.05)	89(72.95)	1.00	1.00
High	8(32)	12(42.8)	20(13.99)	123(86)	0.43(0.24,0.8)	1.6(0.5,5.05)

The proportion of unmet need is low in the age group 30-34, after which it started to increase steadily to 35 percent among women aged 45-49. The table below showed that unmet need for spacing is highest among women aged 25-29 (57.14%) while for limiting it was highest among women aged 45-49 (28%). (Table 5)

In addition to this, the multivariate model results showed that women with disabilities aged 30-34 were 0.05 (95% CI 0.04, 0.7) times less likely to have unmet need compared to women in the age group of 45-49 years. The study also indicated that the odds of having unmet need was AOR=0.23: 95%CI (0.07,0.7) times lower among those women with disabilities who had discussion with their partners on the use of family planning methods compared with those who did not have such a discussion. In addition those women with number of living children above 2 are 3.3 (95% CI: 1.03, 10.7) times more likely to have unmet need compared to women with living children less or equal to 2. (Table 5)

6 Discussion

6.1 Levels of family planning use and unmet need

In this study 44.4% (n=192) of all reproductive age women with disabilities and 64.5% (n=171) of sexually active women (currently married/in union and sexually active) with disabilities are currently using contraceptive. This result is comparable with the study done in Debre Brehan in 2010 which have shown that use of modern contraceptive is 46.9% which is almost similar to the national CPR in 2014 (42%). (26) Although the population used for the current study and this study are different the similarity between the proportions of CPR might be due to availability and accessibility of health facility and family planning services in both cities. In addition this finding supports the cross-sectional study conducted in 5 urban and peri-urban districts of Sierra Leone which showed that there were no significant differences in reporting use of contraception between disabled and non-disabled people.

Although this study included sexually active women with disabilities still the CPR (64.5%) is similar with the mini EDHS 2014 CPR for Addis Ababa done among married women which is 64.1%. The CPR in this study is much higher than the study conducted By Ethiopian Center for Disability and Development (ECDD) in Collaboration with DKT Ethiopia in 2011 which revealed that Twenty six (18.2%) female participants were currently using modern contraception. This discrepancy might be due to the sample size the study used in which females were only 143 (47.7%) and they were also sampled conveniently moreover, the study included only modern contraceptives. Also the fact that the study was conducted 5 years ago should not be overlooked, which could bring the idea that access to family planning methods among women with disabilities is increasing through time. In addition the study included three cities other than Addis Ababa and the regional CPR of this cities is lower than Addis Ababa which might have decreased the CPR of the ECDD study. (13, 27, 30)

On the other hand this study found that unmet need is 20% among sexually active women with disability (currently married/in union and sexually active) which is comparable to the national unmet need (25%) of EDHS 2011 but almost twice the regional unmet need of Addis Ababa (10.6%).This shows that as studies pointed out there are still barriers for utilization of family

planning services among women with disability.(27-30, 33) The study done in Bahir Dar among 337 women of reproductive age group with disabilities in 2013 showed that the level of unmet need for family planning is 24.3% which is almost similar to unmet need of this study (20%). Although this study calculated unmet need in a different way from the current study, unmet need of the current study might have become slightly lower than Bahir Dar unmet need among reproductive age women with disabilities due to the fact that Addis Ababa is the capital city with more availability and accessibility of health facility than Bahir Dar and also the regional DHS unmet need is lower for Addis Ababa than other regions. In addition, access and awareness on family planning methods among women with disabilities might have increased through the past three years found between the Bahir Dar study and the current study (13, 40)

6.2 Factors associated with family planning use

This study have showed that women with disabilities in the age group 30-34 were AOR=6.8 (95% CI 1.47, 31) times more likely to use family planning compared to women in the age group of 45-49 years. This finding is in line with studies done in Qatar and Uganda where contraceptive use was associated with women aged 30-39 years (P = 0.001) for married women and with women aged 25-34 years for women who are sexually active respectively.(31, 32) The local study done in Arba Minch also showed that women in the age group 25 - 29 years were about 3 times more likely to be current user than those in the age group 15 - 19 years [AOR = 3.047 (1.387 - 6.693)]. (24) There is 5 year difference between the age group for this study and the current study, which might be due to somewhat late initiation of sexual intercourse and family planning need among women in Addis Ababa. Studies done among women with disabilities also showed same finding as the current study for example the cross-sectional study conducted in Sierra Leone in 2009 showed that use of contraceptive was higher for the age group 30-39 [AOR-0.93 (0.40-2.16)] than the age group 40-49 AOR-0.57 (0.18-1.76).(27) The local study conducted by Ethiopian Center for Disability and Development (ECDD) in collaboration with DKT Ethiopia among persons with disabilities showed that those found in the age group 26-30 had the highest contraceptive use (28.6%) than the other age groups. There is 5 year difference between the studies which might be due to the addition of other cities on the ECDD study. (27, 30) Although age affects contraceptive utilization the finding of the current study shows that some of the national policies which state that

persons with disability should have access to age-appropriate information and reproductive and family planning education are not being implemented fully.

The other important associated factor with contraceptive use that this study resulted is partner education. Disabled women whose partners attained primary [AOR-3.1 (95% CI 1.04-9.5) P-0.04], secondary [AOR-2.6 (95% CI 0.91-7.4)] and higher [AOR-2.4 (95% CI 0.6- 9.6)] education are more likely to use contraception compared to women whose partner is not educated. Although the studies done among women with disability did not include husband education as a variable, studies done among non-disabled person's supports this finding. The cross sectional study done among Married women in Butajira Demographic Surveillance Area which showed that the odds of contraception is 1.3 (1.1- 1.6) and 1.5 (1.1- 2.0) times more likely among women whose partners completed primary and secondary plus level of education. The cross sectional study done in Dembia district in North West Ethiopia also revealed the same result. The current study have showed that women's education is not significantly associated with contraceptive use. Despite the fact that Addis Ababa is the capital city where women are more educated and empowered the current study finding showed association of partner's educational status with contraceptive use instead of disabled women's educational status. This might be due to dependence of women with disability on their partner's decision to use family planning, also frequency of illiterate women with disability was more than their respective illiterate partner. (23, 25)

As expected, in this study women who are employed are more likely to use contraception. The odds of using contraception is 1.25 (0.3-2.04) and 3.3 (0.09-0.87) higher among employed and handicrafts respectively compared to unemployed. The study in Dembia also resulted supportive finding where government employed women are 3.4 times more likely to use contraceptives compared with housewives [AOR-3.40(1.71-6.71) P-0.001]. (25) In addition to the finding of the current study, the cross-sectional study conducted in Sierra Leone in 2009 showed that disabled people who were working had less access to public facilities than non-disabled working people. This shows that employed women are more likely to have better access for information about FP since they have the opportunity to get printed materials and can get trainings on contraception or support through their respective work place. Moreover due to the fact that women with disability have fewer opportunities for education, job training and employment, at the end of the day they tend to be poorer which will affect their family planning utilization.

The current study also showed that women who discuss with their partner about family planning are more likely to use contraceptive than those who did not [AOR-3.3 (1.08-10.34) P-0.03]. This finding is also supported by the local community based cross sectional study conducted in 2010 in Arba Minch zuria woreda among reproductive age women. (24) The study revealed that women who had discussed about family with their partner in the last 6 months prior to the study were more likely to be current user of family planning than those did not (AOR = 0.259 (0.169 - 0.395). The cross sectional study done in Butajira among married women also found that women discussing about contraception with partners were 2.2 (95% CI: 1.8, 2.7) times more likely to use family planning which is in line with the current study finding. In addition to the current study finding on partner's education which was discussed above, it shows that men play major role in deciding utilization of family planning use. This has an implication that the current activities which are being implemented as it is found on the national plan of action of persons with disabilities (2012-2021), in order to assure inclusive family planning services to women with disabilities are not involving male. (23)

6.3 Factors associated with unmet need

This study showed that sexually active women (currently married/in union and sexually active) with disabilities aged 30-34 have less likelihood of unmet need compared to age group 45-49 [OR=0.05; (0.04-0.7) p=0.02.] similarly the cross sectional survey done in Botswana among women respondents aged 15–49 years showed that being aged 25–34 years was protective factors against unmet need for FP when compared to age group of 35-39 (OR=0.567; CI 0.390 - 0.824; p=0.003) . (37) Conversely the cross-sectional study carried out in urban slum area of India Among married women aged 15-49 years showed that unmet need is maximum in the age group 20-24 (37.96%) years and was higher in age group below 30.this discrepancy might be due to the focus of the study only on slum areas which could be due to insufficient knowledge of young women about contraceptives and less opportunity to participate actively in decision making.(44) But the local cross-sectional study carried out in Bahir Dar among 337 women of reproductive age group with disabilities supported the current study showing that age group 25 - 29 had 80% less likelihood to have unmet need than women above 35 years old. In general this study and the current finding shows that younger age is protective factor for unmet need for FP. This shows that although

giving emphasis to younger age group is important, training's and other efforts that have been made to make family planning services accessible to women with disabilities are not all age inclusive. (40)

Other factor that this study revealed to have association with unmet need is number of living children, where women who have above two children had the highest unmet need (30.6%) with the likelihood of 3.3 compared to those who have two and less children [AOR=3.3 (1.03-10.7) P=0.04]. Studies done among non-disabled women also supports this finding for example, the community based, cross-sectional study conducted in India in 2012 where unmet need was significantly higher among the respondents with more than two living children than those with two or less living children (30.5% vs. 20.3%; p = 0.04). Another study in same country also showed same result. It appears that women disabilities, with less than two living children do not wish to stop or limit childbearing. (41, 44)

In this study sexually active women with disabilities who had never discussed about family planning with their partner had the highest unmet need for family planning compared with women who discussed, 35.19% and 13.77%, respectively (OR=0.23**;** (0.07-0.7) P=0.01). The cross sectional survey done in Botswana also found that there is an increased likelihood of unmet need for FP among those married women who never discussed about FP with their partner than those who discuss more often [OR=1.598; CI 0.955 to 1.923; p=0.025). This shows as discussed in contraceptive use males play major role in decision making on family planning utilization of women with disabilities but the current efforts which are being made to assure inclusive family planning services to women with disabilities are not involving male. (37)

Strength and limitations of the study

Since this study is a cross sectional study cause and effect relationship could not be evaluated and one of the limitation of the study is that it did not include men as study participants and interviewing parents of women with intellectual disability. Using large sample size and including intellectual disability can be mentioned as the strength of the study. The findings are also essential for the government and organization working on disability in Addis Ababa and shows direction for future researchers on where to focus concerning family planning and disability.

Conclusion

This study showed that CPR (64.5%) is high among sexually active women with disability in Addis Ababa (currently married/in union and sexually active). Unmet need among sexually active women (20%) is also found to be high. In addition demand satisfied became, 68.9% which is also high. Variables that are found to have association with contraceptive use are women's age, partner education, women's occupation and discussion with partner. Women's age, number of living children and discussion with partner are the variables associated with unmet need for FP. The main reasons mentioned for not using contraceptives at the time of interview were not having sex, not having frequent sex, believing that it is up to god and saying that they cannot get pregnant.

7 Recommendation

Persons with disability (PWD) Organizations and other NGOs should strengthen trainings and workshops on family planning and should make sure that they are husband inclusive so that disabled women's role in decision making about family planning issues can be increased. The trainings and supports given should also include all age groups in order to decrease the unmet need among older age groups and also emphasis should be given to unemployed women.

Federal ministry of health should make services disability friendly by making the buildings physically accessible, training professionals, preparing appropriate information, communication and education (IEC)/ behavioral communication change (BCC) materials and recruiting sign language interpreters.

Existing programs with some adaptations such as including males and all age groups, can meet the SRH needs of most PWDs. PWDs also need to be consulted, and the needs of PWDs should be addressed in all programs at all levels.

Further researches should be done including male participants with large sample size and more emphasis should be given to rural areas.

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QUESTIONER (ENGLISH VERSION)

INFORMATION SHEET

Hello, my name is _____ and I belong to a research team for master's thesis project in Addis Ababa University, College of health science, school of public health. We are conducting a research among women with disabilities about family planning use and willingness to stop or delay childbearing but are not using any method of contraception in Addis Ababa. The information we collect will inform the public on major RH related problems among people with disabilities. Moreover, it will help the government on evidence based planning and designing of friendly family planning service for women with disabilities. The study usually takes 15 minutes.

All of the answers you give will be confidential and will not be shared with anyone other than members of our team. You have the right to refuse participation in this study, but we hope you will agree to answer the questions since your views are important.

If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time without any consequences to the services you receive from this or any other health facility now or in the future.

If you have any questions you can ask me now or you may contact Solen Abera on 0913394466 or using the email address solicoolab@gmail.com.

Do you have any question?

CONSENT FORM

The above information regarding my participation in the study is clear to me. The objectives of the study were clearly mentioned using the language I can understand. Besides, I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will still get the same medical care whether I decide to leave the study or not and my decision will not change the care I will receive from medical centers.

Name of the Participant…….... Date……

Signature/ Thumb print……

Investigator's statement

I, the undersigned, have explained to the volunteer in a language she understands, procedures to be followed in the study and the benefits involved.

Name of the interviewer……

Date……

Interviewer signature……

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 ↓ CONTINUE

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 ↓ END

SECTION ONE- BACKGROUND INFORMATION OF THE RESPONDENTS

No	QUESTIONS AND FILTERS	CODING CATAGORIES	SKIP
101	In what month and year were you born?	MONTH . . . . . ☐☐ DON'T KNOW MONTH. . . . . 99 YEAR . . . . . ☐☐☐☐ DON'T KNOW YEAR. 9999	
102	How old were you at your last birth day? COMPARE WITH 101 AND CORRECT IF NOT CONSISTENT	AGE IN COMPLETED YEARS . . . . . ☐☐ DON'T KNOW. 99	
103	Can you read and write in any language you speak?	YES . . . . . 1 NO. 2	106
104	What is the highest grade/number of years you completed?	GRADE/NUMBER OF YEARS. . . . . ☐☐ INFORMAL . . . . . ☐☐	
105	Do you read a newspaper or magazine at least once a week, less than once a week or not at all?	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL. 3	
106	Do you listen to the radio at least once a week, less than once a week or not at all?	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL. 3	
107	Do you watch television at least once a week, less than once a week or not at all?	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL. 3	
108	What is your religion?	ORTHODOX. . . . . 1 CATHOLIC. . . . . 2 PROTESTANT. . . . . 3 MOSLEM . . . . . 4 OTHER . . . . . 5 _____ SPECIFY	
109	What is your occupation?	NO OCCUPATION . . . . . 1 GOVERNMENT EMPLOYEE . . . . . 2 PRIVATE EMPLOYEE . . . . . 3 MERCHANT. . . . . 4 STUDENT. . . . . 5 DAILY LABORER. . . . . 6 HANDICRAFT. . . . . 7 OTHER 8	

		SPECIFY	
110	How much is your household's monthly income?	_____ RECORD	
111	Do you own the house you are currently living in?	YES . . . . . .1 NO. 2	
112	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED. . . . . 1 YES, LIVING WITH A MAN. . . . . 2 NO, NOT IN UNION 3	119
113	Now I would like to ask about your (husband/partner). In what month and year did you start living with him?	MONTH . . . . . ☐☐ DON'T KNOW MONTH. . . . . 99 YEAR . . . . . ☐☐☐☐ DON'T KNOW YEAR. 9999	
114	Can your husband/partner read and write in any language that he speaks?	YES . . . . . .1 NO. 2	116
115	What is the highest grade/number of years that he completed?	GRADE/NUMBER OF YEARS. . . . . ☐☐ INFORMAL . . . . . ☐☐	
116	What is your husband/partner current occupation?	NO OCCUPATION . . . . . 1 GOVERNMENT EMPLOYEE . . . . . 2 PRIVATE EMPLOYEE . . . . . .3 MERCHANT. . . . . .4 STUDENT. . . . . 5 DAILY LABORER. . . . . 6 HANDICRAFT. . . . . 7 OTHER . . . . . 8 _____ SPECIFY	
117	Have you ever discussed about family planning with your partner?	YES . . . . . .1 NO. 2	
118	Did your husband or partner support use of family planning methods?	YES . . . . . .1 NO. 2	120 120
119	Have you started sexual intercourse yet?	YES . . . . . .1 NO. 2	 223
120	What was your age when you had sexual intercourse for the first time?	_____ RECORD	201 (md)
121	When was the last time you had sexual intercourse? IF LESS THAN 12 MONTHS, ANSWER MUST BE RECORDED IN DAYS, WEEKS OR MONTHS. IF 12 MONTHS (ONE YEAR) OR MORE, ANSWER MUST BE RECORDED IN YEARS.	DAYS AGO . . . . . .1 ☐☐ WEEKS AGO. . . . . 2 ☐☐ MONTHS AGO . . . . . .3 ☐☐ YEARS AGO . . . . . 4 ☐☐	

SECTION TWO-FERTILITY RELATED CHARACTERISTICS OF RESPONDENTS

No	QUESTIONS AND FILTERS	CODING CATAGORIES	SKIP
201	Did you give birth to a live born child?	YES . . . . . .1 NO. 2	 205
202	How many total live born children do you have?	MALE. . . . . ☐ FEMALE. . . . . ☐ TOTAL . . . . . ☐	
203	How many of this children are currently alive?	MALE. . . . . ☐ FEMALE. . . . . ☐ TOTAL . . . . . ☐	
204	How many of this children are dead?	MALE. . . . . ☐ FEMALE. . . . . ☐ TOTAL . . . . . ☐	
205	Are you currently pregnant?	YES . . . . . .1 NO. . . . . .2 UNSURE. 3	 208 208
206	When you got pregnant, did you want to get pregnant at that time?	YES . . . . . .1 NO. 2	209
207	Did you want to have a baby later (after minimum of two years) or did you not want any (more) children?	LATER (AFTER MINIMUM OF TWO YEARS). . . . . 1 NO MORE 2	209 209
208	When did your last menstrual period start? _____ (DATE, IF GIVEN)	DAYS AGO . . . . . .1 ☐☐ WEEKS AGO . . . . . 2 ☐☐ MONTHS AGO . . . . . 3 ☐☐ YEARS AGO. . . . . 4 ☐☐ IN MENOPAUSE/ HAD HYSTERECTOMY . . . . . 5 BEFORE LAST BIRTH . . . . . .6 NEVER MENSTRUATED. 7	
209	CHECK 205: NOT PREGNANT OR UNSURE ☐ (↓) PREGNANT ☐ (→)		214
210	Are you currently doing something or using any family planning method to delay or avoid getting pregnant?	YES . . . . . .1 NO. 2	 214
211	What is the family planning method that you are using?	_____ RECORD	
212	Who chose this method for you?	MY SELF. . . . . .1 MY HUSBAND. . . . . .2 MY FRIEND. . . . . 3 MY NEIGHBOR . . . . . .4 THE PROVIDER. 5	

		OTHER _____ 6	
213	Did you discuss with the health provider before choosing the method?	YES . . . . . .1 NO. 2	
214	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	YES . . . . . .1 NO. 2	
215	What was the name given to your last baby?	_____	
216	In what month and year was your last baby born? PROBE: When is his/her birthday?	MONTH. . . . . ☐☐ YEAR. . . . . ☐☐☐☐	
217	CHECK 216: Birth in 2010 or later ☐ → 218 ; birth before 2010 ☐ → 220		
218	When you got pregnant with your last baby, did you want to get pregnant at that time?	YES . . . . . .1 NO. 2	219
219	Did you want to have a baby later on (AFTER MINIMUM OF TWO YEARS), or did you not want any (more) children?	LATER (AFTER MINIMUM OF TWO YEARS). . . . . .1 NO MORE 2	
220	Has your menstrual period returned since the birth of your last baby?	YES . . . . . .1 NO. 2	
221	CHECK 205: PREGNANT ☐ → 222 ; NOT PREGNANT OR UNSURE ☐ → 223		
222	Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?	HAVE ANOTHER CHILD. . . . . 1 NO MORE/NONE. . . . . 2 UNDECIDED/DON'T KNOW 3	225 225 225
223	Now I have some questions about the future. Would you like to have child, or would you prefer not to have any children?	HAVE ANOTHER CHILD . . . . . .1 NO MORE/NONE . . . . . .2 SAYS SHE CANT GET PREGNANT. . . . . .3 UNDECIDED/DON'T KNOW 4	
224	How long would you like to wait from now before the birth of (a/another) child?	MONTHS . . . . . .1 ☐☐ YEARS. . . . . .2 ☐☐ NOW. . . . . 3 NO MORE/NONE. . . . . 4 SAYS SHE CAN'T GET PREGNANT . . . . . 5 AFTER MARRIAGE . . . . . 6 DON'T KNOW . . . . . .7 OTHER _____ 8 (SPECIFY)	
225	CHECK 205: NOT PREGNANT OR UNSURE ☐ → 301 ; PREGNANT ☐ → 301		

226	CHECK 210: USING A CONTRACEPTIVE METHOD? NOT CURRENTLY USING ☐ →	CURRENTLY USING ☐ →	301
227	CHECK 224: NO MORE/NONE ☐ →	24 OR MORE MONTHS OR 02 OR MORE YEARS ☐ →	00-23 MONTHS OR 00-02 YEAR ☐ → 301
228	CHECK 227: WANTS TO HAVE A/ANOTHER CHILD ☐ → You have said that you do not want (a/another) child soon. Can you tell me why you are not using a method to prevent pregnancy? Any other reason? WANTS NO MORE/NONE ☐ → You have said that you do not want any (more) children. Can you tell me why you are not using a method to prevent pregnancy? Any other reason? RECORD ALL REASONS MENTIONED	NOT MARRIED . . . . . 1 FERTILITY-RELATED REASONS NOT HAVING SEX . . . . . 2 INFREQUENT SEX . . . . . .3 MENOPAUSAL/HYSTERECTOMY. . . . . .4 CAN'T GET PREGNANT . . . . . .5 NOT MENSTRUATED SINCE LAST BIRTH . . . . . .6 BREASTFEEDING . . . . . 7 UP TO GOD/FATALISTIC . . . . . 8 OPPOSITION TO USE RESPONDENT OPPOSED . . . . . .9 HUSBAND/PARTNER OPPOSED . . . . . 10 OTHERS OPPOSED . . . . . .11 RELIGIOUS PROHIBITION . . . . . .12 LACK OF KNOWLEDGE KNOWS NO METHOD . . . . . .13 KNOWS NO SOURCE . . . . . .14 METHOD-RELATED REASONS SIDE EFFECTS/HEALTH CONCERNS . . . . . 15 LACK OF ACCESS/TOO FAR . . . . . 16 COSTS TOO MUCH . . . . . 17 PREFERRED METHOD NOT AVAILABLE. . . . . .18 NO METHOD AVAILABLE . . . . . .19 INCONVENIENT TO USE . . . . . 20 INTERFERES WITH BODY'S NORMAL PROCESSES .21 DON'T KNOW . . . . . 22 OTHER _____ 23 (SPECIFY)	

SECTION THREE- KNOWLEDGE OF RESPONDENTS ABOUT FAMILY PLANNING METHODS

Now I am going to ask you questions about ways to prevent pregnancy. The first set of questions are about your knowledge of family planning methods. These are not questions about your current use of family planning methods.

CODES FOR Q303 (DO NOT READ OUT LOUD)

1. Health center
2. Private health clinic
3. Supermarket / market
4. Friends / relatives
5. Pharmacy
6. Don't Know
7. Other (specify) _____

Method	Q301 Have you ever heard about _____ ?	Q302 Have you ever been thought or instructed on how to use it?	Q303 Where would you usually go to get it?
A. The pill (oral contraceptives) - prevents the release of egg from the ovaries which is taken every day at the same time.	YES 1→Q302A NO 2→B	YES 1→Q303A NO 2→Q303	_____ →B
B. IUD(loop) –it's a small flexible family planning method inserted in the uterus that's prevents fertilization	YES 1→Q302B NO 2→C	YES 1→Q303B NO 2→Q303	_____ →C
C. Male condom-method that covers erected pines which is worn before sex that prevents pregnancy and STDs	YES 1→Q302C NO 2→D	YES 1→Q303C NO 2→Q303	_____ →D
D. Female condom-it's a method produced from plastic which is inserted inside the vagina before sexual intercourse	YES 1→Q302D NO 2→E	YES 1→Q303D NO 2→Q303	_____ →E
E. Implants-have a size of match stick inserted under the arm skin that prevents fertilization by controlling the female hormone?	YES 1→Q302E NO 2→F	YES 1→Q303E NO 2→Q303	_____ →F
F. Injectable-it's a method given on arm or thigh every three month that prevents release of egg from ovaries.	YES 1→Q302F NO 2→G	YES 1→Q303F NO 2→Q303	_____ →G
G. Emergency hormonal contraception-is a method used when a women forgets to take her pills/injectable when she has an unprotected sex including rape	YES 1→Q302G NO 2→H	YES 1→Q303G NO 2→Q303	_____ → H
H. Tubal ligation-its tying the fallopian tube that prevents fertilization using simple surgery	YES 1→Q302H NO 2→I	YES 1→Q303H NO 2→Q303	_____ → I
I. Vasectomy-it's a method used to prevent the passing of sperm through vas difference using simple surgery	YES 1→Q302I NO 2→J	YES 1→Q303I NO 2→Q303	_____ → J
J. Rhythm/calendar/counting days- it's a method based on women's ovulation period to avoid occurrence of unwanted pregnancy	YES 1→Q302J NO 2→K	YES 1→k NO 2→k	
K. Withdrawal(coitus interruptus)-it's a way of preventing the entrance of the male semen in to the women's vagina by the removal of the male penis	YES 1→Q302K NO 2→L	YES 1→L NO 2→L	
L. Other contraceptive method (SPECIFY)	YES 1→Q302L NO 2→401	YES 1→Q303L NO 2→Q303L	_____ →401

SECTION FOUR- FACILITY REALTED CHARACTERSTICS

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Do you agree that existing sexual and reproductive health services are disability friendly?	AGREE. . . . . 1 DISAGREE. . . . . 2 UNSURE. 3	END
402	What is your reason? (MULTIPLE ANSWER IS POSSIBLE)	POOR PHYSICAL ACCESSIBLITY (RAMPS, BATHROOMS, AND ELEVATORS) . . . . . 1 LONG DISTANCE TO HEALTH FACILITY . . . . . 2 HIGH COST OF SERVICES. . . . . 3 ABSENCE OF CLEAR AND FLUENT COMMUNICATION WITH HEALTH WORKERS. . . . . 4 POOR EXPERIENCE OF HEALTH WORKERS TO HANDLE PWDS . . . . . 5 PROVIDERS FAIL TO KEEP PRIVACY AND CONFIDENTIALITY. . . . . 6 LONG QUEUES. . . . . 7 OTHER. . . . . 8 _____ SPECIFY	
403	What are the main obstacles that prevent disabled from getting Sexual and reproductive Health services in health institutions?	POOR PHYSICAL ACCESSIBLITY (RAMPS, BATHROOMS, AND ELEVATORS) . . . . . 1 LONG DISTANCE TO HEALTH FACILITY . . . . . 2 HIGH COST OF SERVICES. . . . . 3 ABSENCE OF CLEAR AND FLUENT COMMUNICATION WITH HEALTH WORKERS. . . . . 4 POOR EXPERIENCE OF HEALTH WORKERS TO HANDLE PWDS . . . . . 5 PROVIDERS FAIL TO KEEP PRIVACY AND CONFIDENTIALITY. . . . . 6 LONG QUEUES. . . . . 7 DON'T KNOW 8	

ANNEX 2

QUESTIONNAIRE (AMHARIC VERSION)

የመረጃ ቅጽ

ጤና ይስጥልኝ ስሜ ---------- ይባላል፡፡ የመጣሁት ከአ/አ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና ት/ቤት ነዉ፡፡ አ/አ በሚኖሩ አካል ጉዳተኛ ሴቶች የቤተሰብ እቅድ መጠቀምን በተመለከተ እና ልጅ መውለድ ማቆም ወይም ማዘግየት እየፈለጉ የቤተሰብ እቅድ የማይጠቀሙ አካል ጉዳተኛ ሴቶችን በተመለከተ ጥናት እያደረግን ነው፡፡ የጥናቱ ውጤት አካል ጉዳተኛ ሴቶች ስላሉባቸው መሰረታዊ የሆኑ ከስነ ተዋልዶ ጤና ጋር የተያያዙ ችግሮች በተመለከተ ግንዘቤ ለመፍጠር እና መንግስት ለአካል ጉዳተኞች ተስማሚና ምቹ በሆነ መልኩ የጤና አገልግሎት መስጠት እንዲችል ይረዳል፡፡ አሁን ምናደርገው ቃለ ምልልስ 15 ደቂቃ ይወስዳል፡፡

እርስዎ የሚሰጡት ማንኛውም መረጃ በሚስጥር የሚያዝ ሲሆን መረጃዎ ስምዎን በማይገልጽ ሁኔታ ተቀነባብሮ ጥቅም ላይ ይውላል፡፡ ከጥናቱ አባላት በስተቀር ማንም ሶስተኛ ወገን የእርስዎን መረጃ ማግኘት አይችልም፡፡በዚህ ጥናት ያለመሳተፍ ወይም በማንኛውም ግዜ ተሳትፎዎን የማቁዋረጥ ሙሉ መብት አለዎት፡፡ ሆኖም ግን ከርስዎ የምናገኘው መረጃ ለጥናቱ በጣም ጠቃሚ ስለሆነ በጥናቱ እንዲሳተፉና መረጃዎን እንዲሰጡን እናበረታተለን፡፡

መመለስ የማይፈልጉትን ማንኛውንም ጥያቄ ከጠየኩዎት ይንገሩኝ እና ወደቀጣዩ ጥያቄ እንሸጋገራለን ወይም በፈለጉት ሰአት ቃለምልልሱን ማቆም ይችላሉ፡፡ይህን ሲያደርጉ ግን አሁንም ሆነ ወደፊት ከዚህም ሆነ ከየትኛውም የተቋም በሚያገኙት አገልግሎት ላይ ተጽእኖ ይኖረዋል ብለው አይስጉ፡፡

ጥናቱን በተመለከተ ማንኛውም ጥያቄ ካለዎት አሁን ሊጠይቁኝ ይችላሉ፡፡ ተጨማሪ መረጃ ቢያስፈልግዎ በስልክ ቁጥር 0913 394466 ወይም በ email solicoolab@gmail.com ሶለን አበራን ማግኘት ይችላሉ፡፡

ጥያቄ አለዎት?

የስምምነት ቅጽ

የተጠያቂ ቃል

የኔን በዚ ጥናት መሳተፍ በተመለከተ ከላይ የቀረበልኝ መረጃ ግልጽ ሆኖልኛል፡፡ የጥናቱ አላማ በምረዳው ቋንቋ ተገልጾልኛል፡፡ ከዚህም በተጨማሪ ጥያቄ እንድጠይቅ አጋጣሚ የተሰጠኝ ከመሆኑም በላይ ጥያቄዎቼ በተገቢው መንገድ መልስ አገኝተዋል፡፡የኔ በዚ ጥናት መሳተፍ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ነው፡፡እኔ የምሰጠው መረጃ በሚስጥር እንደሚያዝና በፈለኩት ሰአት ቃለምልልሱን ማቆም እንደምችል ገብቶኛል፡፡ የኔ በዚ ጥናት መሳተፍም ሆነ አለመሳተፍ ከዚህም ሆነ ከሌላ ተቋም በማገኘው አገልግሎት ላይ ምንም ተጽዕኖ እንደማይኖረው ተገንዝቤያለሁ፡፡

የተሳታፊ ያአካል ጉዳት አይነት ……...

ፊርማ / ምልክት ……

የጠያቂ ቃል

እኔ ከዚ በታች ስሜ የተጠቀሰው ለፈቃደኛ ተሳታፊዋ በምትረዳው ቋንቋ በጥናቱ ውስጥ ያሉትን ስርዐቶች እና ደንቦች እንዲሁም ጥቅሞቹን አስረድቻለሁ፡፡

የጠያቂ ስም……

ቀን……

ፊርማ……

ተጠያቂዋ ለመሳተፍ ፈቃደኛ ሆናለች . . . . . 1 ↓ ቀጥይ	ተጠያቂዋ ለመሳተፍ ፈቃደኛ አልሆነችም . . . . . 2 ↓ አቁሚ

ክፍል አንድ - የመልስ ሰጪ የዲሞግራፊ ሁኔታ

ተ/ቁ	ጥያቄ እና ማጣሪያ	ኮድ ማድረግያ ምድብ	እለፍ
101	የተወለዱበት ወር እና አመት መቼ ነዉ?	ወር . . . . . ወሩን አላውቅም. . . . . .99 አመት . . . . . አመቱን አላውቅም. 9999	
102	የመጨረሻውን የልደት ቀንዎን ሲያከብሩ ስንት አመት ሆንዎት ነበር? ከ፲፬ ጋር ይመሳከር፡፡ ካልተጣጣሙ ይስተካከል፡፡	እድሜ በሙሉ አመት. . . . . .. አላውቀውም. 99	
103	በሚናገሩት በማንኛውም ቋንቋ ማንበብና መጻፍ ይችላሉ?	አዎ. . . . . .1 የለም. 2	106
104	ከፍተኛው ያጠናቀቁት የከፍል ደረጃ ስንት ነዉ?	ከፍል/አመት. . . . . መደበኛ ያልሆነ	
105	ጋዜጣ ወይም መፅሄት የሚያነቡት ቢያንስ በሳምንት አንድ ግዜ ወይም በሳምንት ከአንዴ በታች ወይስ ምንም አያነቡም?	ቢያንስ በሳምንት አንዴ . . . . . .1 በሳምንት ከአንዴ በታች. . . . . 2 ምንም አላነብም. 3	
106	ሬድዮ የሚሰሙት ቢያንስ በሳምንት አንዴ ወይም በሳምንት ከአንድ ግዜ በታች ወይስ ምንም አይሰሙም?	ቢያንስ በሳምንት አንዴ . . . . . .1 በሳምንት ከአንዴ በታች. . . . . 2 ምንም አላነብም. 3	
107	ቴሌቪዥን የሚያዩት ቢያንስ በሳምንት አንዴ ወይም በሳምንት ከአንድ ግዜ በታች ወይስ ምንም አያዩም?	ቢያንስ በሳምንት አንዴ . . . . . .1 በሳምንት ከአንዴ በታች. . . . . 2 ምንም አላነብም. 3	
108	ሃይማኖትዎ ምንድን ነዉ?	አርቶዶክስ . . . . . .1 ካቶሊክ . . . . . . 2 ፕሮቴስታንት. . . . . 3 ሙስሊም . . . . . 4 ሌላ . . . . . 5 ይገለጽ _____	
109	ስራዎ ምንድን ነዉ?	ስራ የለኝም. . . . . .1 የመንግስስት ሰራተኛ . . . . . 2 የግል ስራ ሰራተኛ. . . . . .3 ነጋዴ . . . . . 4 ተማሪ. . . . . 5 የቀን ሰራተኛ .. . . . . .6 የእጅ ሙያ ሰራተኛ . . . . . 7 ሌላ . . . . . 8 ይገለጽ _____	

110	የቤተሰብዎ የወር ገቢ ምን ያህል ነውን?	መዝግቢ _____	
111	አሁን የሚኖሩበት ቤት የራስዎ ነውን?	አዎ. . . . . 1 የለም. 2	
112	አሁን ያሉበት የጋብቻ ሁኔታ ምንድን ነው?	ትዳር ውስጥ ነኝ. . . . . 1 ከአንድ ወንድ ጋር እየኖርኩ ነው. . . . . 2 አላገባሁም ከወንድ ጋርም አልኖርም. 3	119
113	አሁን ስለ ባለቤትዎ /አጋርዎ ልጠይቅዎት ነው፡፡ ከመቼ(ወር----------አመት--------) ጀምሮ ነው አብራችሁ መኖር የጀመራችሁት?	ወር . . . . . [ ][ ] ወሩን አላውቅም. . . . . 99 አመት . . . . . [ ][ ][ ][ ] አመቱን አላውቅም. 9999	
114	ባለቤትዎ በሚናገሩት በማንኛውም ቋንቋ ማንበብ ወይም መጻፍ ይችላሉ?	አዎ. . . . . 1 የለም 2	116
115	ባለቤትዎ ያጠናቀቁት ከፍተኛው ያጠናቀቁት የክፍል ደረጃ ስንት ነዉ?	ክፍል/አመት. . . . . [ ][ ] መደበኛ ያልሆነ . . . . . [ ][ ]	
116	የባለቤትዎ /አጋርዎ የስራ ሁኔታ ምንድን ነው?	ስራ የለውም. . . . . 1 የመንግስሰት ሰራተኛ . . . . . 2 የግል ስራ ሰራተኛ. . . . . 3 ነጋዴ . . . . . 4 ተማሪ. . . . . 5 የቀን ሰራተኛ .. . . . . 6 የእጅ ሙያ ሰራተኛ . . . . . 7 ሌላ . . . . . 8 ይገለጽ _____	
117	ከባለቤትዎ ጋር ስለ ቤተሰብ አቅድ ተወያይታችሁ ታውቃላችሁን?	አዎ. . . . . 1 የለም 2	
118	ባለቤትዎ/ የትዳር አጋርዎ የቤተቴሰብ እቅድ መጠቀምን ይደግፋሉን;	አዎ. . . . . 1 የለም 2	120 120
119	የግብረ ስጋ ግንኙነት መፈጸም ጀምረዋልን?	አዎ. . . . . 1 የለም 2	201
120	ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ሲፈጽሙ የስንት አመት ልጅ ነበሩ?	መዝግቢ _____	ላገቡ (201)
121	ለመጨረሻ ጊዜ የግብረ ግንኙነት የፈጸሙት መቼ ነበር? (ከአመት በታች ከሆነ በቀን፣በሳምንት፣ ወይም ወራት መመዝገብ አለበት፡፡ ከአመት በላይ ከሆነ በአመታት መመዝገብ አለበት፡፡)	ከቀናት በፊት. . . . . 1 [ ][ ] ከሳምንታት በፊት . . . . . 2 [ ][ ] ከወራት በፊት. . . . . 3 [ ][ ] ከአመታት በፊት. . . . . 4 [ ][ ]	

ክፍል ሁለት - የመልስ ሰጪ ከወሊድ ጋር የተያያዙ ሁኔታዎች

ተ/ቁ	ጥያቄ እና ማጣርያ	ኮድ ማድረጊያ ምድብ	እለፍ
201	በህይወት ያለ ልጅ ወልደው ያውቃሉን?	አዎ . . . . . 1 የለም 2	 205
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203	በህይወት ከወለዱዋቸው ልጆች መካከል አሁን በህይወት የሚገኙ ስንት ናቸው?	ወንድ. . . . . [ ] ሴት. . . . . [ ] ድምር . . . . . [ ]	
204	በህይወት ከወለዱዋቸው ልጆች መካከል አሁን በህይወት የሌሉ ስንት ናቸው?	ወንድ. . . . . [ ] ሴት. . . . . [ ] ድምር . . . . . [ ]	
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226	ከጥያቄ 210 ጋር አመሳክሪ: የእርግዝና መከላከያ ዘዴ እተጠቀሙ ነው? አሁን እየተጠቀምኩ አይደለም:: አሁን እየተጠቀምኩ ነዉ::	301
227	ከጥያቄ 224 ጋር አመሳክሪ: ልጅ/ሌላ እንዲኖራት አትፈልግም 24 ወራት እና ከዛ በላይ ወይም 2 አመትና ከዛ በላይ 00-23 ወራት ወይም 00-02 አመት	301
228	ጥያቄ 227ን አመሳክሪ: ልጅ/ሌላ ልጅ እንዲኖራት ትፈልጋለች በቅርቡ ማለትም በሚመጣው ሁለት አመት ውስጥ ልጅ /ሌላ ልጅ እንዲኖርዎት እንደማይፈልጉ ተናግረዋል:: የእርግዝና መከላከያ ዘዴ እየተጠቀሙ ያልሆነው ለምን እንደሆነ ሊነግሩኝ ይችላሉ? ሌላ ምክንያት አለዎት? ልጅ/ሌላ ልጅ እንዲኖራት አትፈልግም ልጅ/ሌላ ልጅ እንዲኖርዎት እንደሚይፈልጉ ተናግረዋል:: የእርግዝና መከላከያ ዘዴ እየተጠቀሙ ያልሆነው ለምን እንደሆነ ሊነግሩኝ ይችላሉ? ሌላ ምክንያት አለዎት? የተገለፀትን ምክንያቶች ሁሉ መዝግቢ	አላገባችም . . . . . A ከወሊድ ጋር የተያየዙ ምክንያቶች የፆታ ግንኙነት እየፈጸሙች አየይደለም . . . . . B የፆታ ግንኙነት አዘወትራ አትፈጽምም . . . . . C አርጣለች /ማፀህኗ በቀዶ ጥገና ወጥቷል . . . . . D ማርገዝ አትችልም . . . . . E የመጨረሻ ልጇን ከወለደች ጀምሮ የወር አበባዋ አልመጣም. . . .F እያጠባች ነዉ. . . . . G የፈጣሪ ፈቃድ ነዉ ብላ ታሰባለች . .. . H ከተቃውሞ ጋር በተያያዘ ምክንያት መላሻ ተቃውማለች . . . . . I ባለቤቷ/ጓደኛው ተቃውሟት . . . . . J ሌሎች ተቃውመዋት . . . . . K ዕምነቷ ይከላከላታል . . . . . .L የእውቀት /ግንዛቤ እጥረት ምንም ዘዴ አታውቅም. . . . . M ምንም ምንጭ አታውቅም . . . . . .N ከዘዴው ጋር የተያያዙ ምክያንቶች የጤና/የጎንዮሽ ጉዳቶች ያስጨንቋታል. . . . . .O ማግኘት አትችልም/በጣም ሩቅ ነዉ. . . . . P በጣም ወድ ነዉ. . . . . .Q የመረጠችው ዘዴ አይገኝም. . . . . R ምንም ዜዴ አላገኘችም . . . . . .S ላጠቃቀም ምቹ አይደለም . . . . . T ከሰውነት የተለመደ አሰራር ጋር ይጋጫል . .. . .U አታወቅም. . . . . Z ሌላ _____ X	

ክፍል ሶስት- የእርግዝና መከላከያ ዘዴን በተመለከተ የመልስ ሰጪ እውቀት

አሁን እርግዝናን መከላከል ስለሚቻልባቸው መንገዶች ጥያቄ እጠይቅዎታለሁ፡፡ እነኚህ ጥያቄዎች ስለቤተሰብ እቅድ መንገዶች ያለዎትን እውቀት ለማወቅ እንጂ አሁን እየተጠቀሙ እንደሆነና እንዳልሆነ ለማወቅ አይደለም፡፡

ለጥያቄ ቁጥር 303 የተዘጋጀ ኮድ **(ድምፅሽን ከፍ አድርገሽ አታንብቢ)**

1. ጤና ጣብያ
2. የግል ክሊኒክ
3. ገበያ
4. ጓደኛ/ዘመድ
5. ፋርማሲ
6. ሌላ (ጥቀሺ) _____
7. አላውቅም

የእርግዝና መከላከያ ዘዴ	Q301 ስለ _____ ሰምተው ያውቃሉ ?	Q302 ስለ _____ አጠቀቃቀም ማብራሪያ አግኝተው ያውቃሉ ?	Q303 _____ ለማግኘት በዋናነት ወዴት ነዉ የሚሄዱት?
M. እንክብል (የሚዋጡ)-በየቀኑ ተመሳሳይ በሆነ ሰአት የሚወሰድ እና እንቁላል ከእንቁላል እጢ እንዳይለቀቅ በማድረግ እርግዝናን የመከላከያ ዘዴ ነው	አው,ቃለው 1→Q302A አላውቅም 2→B	አው,ቃለው 1→Q303A አላውቅም 2→Q303	_____ →B
N. በማህፀን ውስጥ የሚቀመጥ (ሉፕ)-አነስተኛ እና ተጣጣፊ በማህጸን ውስጥ የሚቀመጥ የእርግዝና መከላከያ ዘዴ ሲሆን የወንድ የዘር ፍሬ ከእንቁላል ጋር ዕንዳይገናኝ በማገድ እርግዝናን ይከላከላል	አው,ቃለው 1→Q302B አላውቅም 2→C	አው,ቃለው 1→Q303B አላውቅም 2→Q303	_____ →C
O. የወንድ ኮንዶም-የቆመ የወንድ ብልትን የሚሸፍንና ከማብረ ስጋ ግንኙነት በፊት የሚጠለቅ ቀጭን ላቴክስ ከተባለ ጎማ መሰል ቁስ የተሰራ የእርግዝና እና የአባላዘር በሽታ መከላከያ ዘዴ ነው	አው,ቃለው 1→Q302C አላውቅም 2→D	አው,ቃለው 1→Q303C አላውቅም 2→Q303	____ →D
P. የሴት ኮንዶም-ከማብረ ስጋ ግንኙነት በፊት የሴቷ ብልት ውስጥ የሚገባ ከፐላስቲክ የተሰራ የእርግዝና መከላከያ ዘዴ ነው	አው,ቃለው1→Q302D አላውቅም 2→E	አው,ቃለው1→Q303D አላውቅም 2→Q303	_____ →E
Q. በክንድ ቆዳ ስር የሚቀበር(ኢምፕላንት)-የክብሪት እንጨት የሚያክል በክንድ ቆዳ ስር የሚቀበር የእርግዝና መከላከያ ሲሆን በሴትዋ ቅመም(ሆርሞን) ላ ተጽእኖ በማድረግ ውህደት እንዳይፈጠር ያደርጋል	አው,ቃለው1→Q302E አላውቅም 2→F	አው,ቃለው1→Q303E አላውቅም 2→Q303	_____ →F
R. መርፌ-በላይኛው ክንድ ወይም ቢታፋ በየሶስት ወሩ የሚሰጥ እንቁላል ከእንቁላል እጢ እንዳይወጣ የሚያደረግ እርግዝናን የመከላከያ ዘዴ	አው,ቃለው1→Q302F አላውቅም 2→G	አው,ቃለው1→Q303F አላውቅም 2→Q303	_____ →G
S. የድንገተኛ እርግዝና መከላከያ-አንዲት ሴት ኪኒን/መርፌ መወጋት ስትረሳ ወይም መደፈርን ጨምሮ ያለ መከላከያ ጥንቃቄ የጎደለው የግብረ ስጋ ግንኙነት ስታደርግ የሚወሰድ ኪኒን ነው	አው,ቃለው1→Q302G አላውቅም 2→H	አው,ቃለው1→Q303G አላውቅም 2→Q303	_____ →H
T. የእንቁላል ማስተላለፊያ ቱቦን ማስቋጠር (ቲዩባል ሊጌሽን)-የሴትዋን የእንቁላል ማስተላለፊያ ቱቦ ከወንድ የዘር ፍሬ ጋር እንዳይገናኝ የሚያደርግ በቀላል የቀዶ ጥገና የሚሰራ የእርግዝና መከላከያ ዘደ ነው	አው,ቃለው1→Q302H አላውቅም 2→I	አው,ቃለው1→Q303H አላውቅም 2→Q303	_____ →I
U. የወንድ የዘር ማስተላለፊያ ቱቦን መቋጠር-የወንድ የዘር ህዋስ(ስፐርም) ጉዞን ለመግታት የሚደረግ ቀላል ቀዶ ጥገና ነው	አው,ቃለው1→Q302I አላውቅም 2→J	አው,ቃለው1→Q303I አላውቅም 2→Q303	_____ →J
V. በካላንደር ተጠቅሞ ቀን በመቁጠር-የወር አበባ ቀንን መሰረት በማድረግ እንቁላል ወደማህጸን ጉዞ ከመጀመሩ በፊት ወይም የማህጸን ግድግዳ ከፈረሰ በኋላ ቀን በመቁጠር የታሰበበት የግብረስጋ ግንኙነት በማድረግ እርግዝናን የመከላከያ ዘዴ ነው	አው,ቃለው1→Q302J አላውቅም 2→k	አው,ቃለው1→k አላውቅም 2→k	
W. ማቋረጥ (ኮይተስ ኢንተራፕተስ)- በግብረ ስጋ ግንኙነት ወቅት ግንኙነቱን በማቋረጥ የወንድ ዘር ወደ ሴትዋ ብልት እንዳይገባ የሚደረግ እርግዝናን የመከላከያ ዘዴ ነው	አው,ቃለው1→Q302k አላውቅም 2→L	አው,ቃለው1→L አላውቅም 2→L	
X. ሌላ የእርግዝና መከላከያ ዘዴ (ይገለጽ) _____	አው,ቃለው1→Q302L አላውቅም 2→401	አው,ቃለው1→Q303L አላውቅም 2→Q303	_____ →401

ክፍል አራት- ከተቋም ጋር የተያያዙ የመልስ ሰጪ ሁኔታዎች

ተ/ቁ	ጥያቄዎች እና ማጣሪያ	ኮድ ማድረግያ ምድብ	እለፍ
401	አሁን ያሉት የስነ ተዋልዶ አገልግሎቶች ለአካል ጉዳተኞች በሚስማማ እና ምቹ በሆነ መልኩ የሚቀርቡ ናቸው ብለው ያስባሉ?	አዎ . . . . . 1 አላሰብም. . . . . 2 እርግጠኛ አይደለሁም. 3	አቁሚ
402	የስነ ተዋልዶ አገልግሎቶች ለአካል ጉዳተኞች የሚስማሙና እና ምቹ ያልሆኑበት ምክንያት ምን ምን ናቸው? (ከአንድ በላይ መልስ ይቻላል)	ለአካላዊ እንቅስቃሴዎች አይደሉም (ደረጃዎቹ፣ ሽንት ቤቱ፣ ሊፍቱ). . . . . 1 ወደ ህክምና ቦታ እስከደርስ መንገዱ ረዥም ነው. . . . . .2 አገልግሎቱ ውድ ነዉ. . . . . .3 ከጤና ባለሞያዎች ጋር ግልፅ በሆነ መልኩ የመግባባት ችግር. . . . . 4 የጤና ባለሞያዎቹ የአካል ጉዳት ያለብንን ሰዎች የመያዝና የማስተናገድ ልምድ የላቸውም. . . . . 5 ባለሞያዎቹ ሚስጥር አይጠብቁም ብቻችንንም አያስተናግዱንም. . . . . .6 አገልግሎቱን አማግኘታችን በፈት ረዥም ሰልፍ. . . . . .. 7 ሌላ. . . . . .8 ይገለጽ _____	
403	የአካል ጉዳተኞች ከጤና ተቋማት የፆታ እና የስነተዋልደ አገልግሎቶችን እንዳያገኙ የሚያግዷቸው ነገሮች ምንድን ናቸው? (ከአንድ በላይ መልስ ይቻላል)	ለአካላዊ እንቅስቃሴዎች አይደሉም (ደረጃዎቹ፣ ሽንት ቤቱ፣ ሊፍቱ). . . . . 1 ወደ ህክምና ቦታ እስከደርስ መንገዱ ረዥም ነው. . . . . .2 አገልግሎቱ ውድ ነዉ. . . . . .3 ከጤና ባለሞያዎች ጋር ግልፅ በሆነ መልኩ የመግባባት ችግር. . . . . 4 የጤና ባለሞያዎቹ የአካል ጉዳት ያለብንን ሰዎች የመያዝና የማስተናገድ ልምድ የላቸውም. . . . . 5 ባለሞያዎቹ ሚስጥር አይጠብቁም ብቻችንንም አያስተናግዱንም. . . . . .6 አገልግሎቱን አማግኘታችን በፈት ረዥም ሰልፍ. . . . . .. 7 አላውቅም 8	