ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

EXAMINATION OF CURRENT AND FUTURE DETERMINANT FACTORS OF MODERN CONTRACEPTIVE USE AMONG YOUTH IN ADDIS ABABA, EHIOPIA

INVESTIGATOR: ABILBA MARK MARTIN (MD)

ADVISORS: MULUGETA BETRE (Assoc.Prof-Dr)

MR. NIGUSSIE ASSEFA (Msc, MPH)

A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH FOR THE PARTIAL FULFILLMENT OF THE REQUIREMENTS OF MASTERS OF PUBLIC HEALTH IN REPRODUCTIVE AND FAMILY HEALTH

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Approved by Examining Board

Name of the Primary Advisor: Mulugeta Betre (Assoc.Prof.-Dr)

Date. _____Signature _____

Name of External Examiner:

Date._____Signature _____

Name of Internal Examiner: _____

Date._____ Signature _____

Acknowledgement

My ultimate appreciation goes to the Lord God Almighty, the giver of life and wisdom who gave me the opportunity to successfully complete this MPH training. I would like to thank my advisors, Mulugeta Betre (Assoc. Prof-Dr) and Mr. Nigussie Assefa (BSc, MPH) for their assistance and valuable comments in developing this research thesis. I cannot forget the scholarship body that funded my training and research, PAMAPS, whose secretariat is in Ibadan, Nigeria and the PAMAPS coordinators at Addis Ababa University (Prof. Damen H/Mariam, Adiam Nega and Berhan Tassew) who worked together to make all matters relating to my MPH training a huge success. I am deeply grateful and indebted to my beautiful wife (Hanna Kanzoni Abilba); my daughter (Faith Martin Abilba); my parents and siblings; and my in-laws for their support, while I was away from home to attend this MPH training

I would also like to express my deepest thanks and appreciations to all staff of Ghana Embassy in Addis Ababa, especially, the Ghana Ambassador to Ethiopia H.E.Ambassador (Mrs.) Amma A. Twum-Amoah. Brigadier General Asamoa Yeboa(Defence Advisor to the Embassy),Warrant officers, Christopher T. Tefuni and Forgive K. Badawusu who supported me to have a peaceful stay in Addis Ababa during my MPH training. Back home in Ghana, my sincere thanks go to Brigadier General Saka (Director General, Defence Medical Services and Dr Theresa Darkwa, who supported me to get my study leave for this program. Lastly my lecturers and friends especially Biruk Hailu, Melese Tabeka, Hanna Feleke, Abel Shita, and Mulugeta Ayelum, here at the School of Public Health of the College of Health Sciences of the Addis Ababa University for their support and encouragement in the development of this thesis. Lastly to my best friends in Kazanchis, Benjamin Geda,Eyasu Adani and Yared Mamo. God richly bless you all.

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Abbreviation

AOR- Adjusted Odds Ratio

ASFR-Age specific fertility rate

CI - Confidence Interval

CPR- Contraceptive Prevalence Rate

DMPA- Depo Medroxy-Progesterone Acetate

EDHS - Ethiopia Demographic and Health Survey

EC- Ethiopian Calendar

EFY- Ethiopian Fiscal Year

PI-Principal Investigator

FMOH- Federal Ministry of Health

FP- Family Planning

HBSC- Health Behaviors of School-Age Children

HSTP- Health Sector Transformation Plan

IUCD - Intra Uterine Contraceptive Device

IUD- Intra-Uterine Devises

LAM- Lactational Amenorrhea methods

LMICs-Low and Middle Income Countries

MCM-Modern Contraceptive method

mCPR- Modern Contraceptive Rate

SDG- Sustainable Development Goals

STIs - Sexual Transmitted Infections

WHO- World Health Organization

ABSTRACT

Background: Family planning and modern contraceptive use have relatively little attention to the roles that could be played among the youth regarding fertility regulation. Consequently, there is a shortage of information on modern contraceptive use as regards to knowledge, attitudes and practices among the youth alongside future intentions, and their fertility preferences in Addis Ababa.

Objective: To identify current modern contraceptive use, intention to use in the future and determinant factors among the youth population of 15 to 24 years in Addis Ababa

Methods: The study used a community-based cross-sectional quantitative survey conducted from July 2018 to June 2019 in Addis Ababa. A total of 552 youth within the ages of 15-24 years were included in the study through multi-stage random sampling technique. Data were collected through structured pre tested questionnaire. Data were entered into Epidata 4.4.3.1 and analyzed by using SPSS version 23 for windows. Descriptive statistics such as frequency, mean, median were used to summarize the results. Bivariate and multivariate logistic regression analyses were done. Quantitative data were summarized by using tables.

Results: Main source of information was the media, 407(82.9 %) which formed the highest. Out of 522 participants, Two hundred eighty eight (52.2%) are ever users, 249(45.1%) are current users, and 264(47.8%) are never users of modern contraceptives. In multiple logistic regression analysis, age, having a partner, discussion with partner or spouse, was significantly associated with current modern contraceptive use.

Conclusions: The study showed a high prevalence of knowledge of contraceptive methods among the youth, and high intention to use in the future. Age group 15 to 19 years had high level of modern contraceptive use. Generally current use of modern contraceptives methods is below fifty percent (45.1%) which is below the Government target goal in Addis Ababa. Family planning/modern contraceptives programs should focus on having partners, spousal discussion; encourage youth ages 19 to 24 years to use modern contraceptives and more media advocacy on modern contraceptive

Keywords: Modern contraceptives, Ages 15-19years, Discussion, Partner. Addis Ababa

1. INTRODUCTION

1.1. Background

In 2012, the global community launched the Family Planning 2020 (FP2020) initiative to reach 120 million new contraceptive users in developing countries by 2020(1).Family planning has a cross-sectoral intervention that can hasten progress across the 5 Sustainable Development Goals(SDG) themes: People, Planet, Prosperity, Peace, and Partnership(2). Family planning and contraceptive use has an impact on maternal, newborn, child, and youth. In 2012, the year for which the most recent data was available, approximately 85 million pregnancies, representing 40% of all pregnancies globally, were unintended(3).This data was reviewed in 2014 by World health Organization (WHO) where contraceptive use prevented 218 million unintended pregnancies in developing countries from 2012 to 2014 and, averting 55 million unplanned births, 138 million abortions (of which 40 million are unsafe), 25 million miscarriages and 118,000 maternal deaths(4).

SDGs 3.7 and 5.6 support ‘‘universal access to sexual and reproductive health-care services, including for family planning’’ and ‘‘universal access to sexual and reproductive health and reproductive rights,’’ respectively(2).

It therefore calls for SDG 3.7 and 5.6 investing in Family Planning: A key to achieving the Sustainable Development Goals to prevent unintended pregnancies thereby reducing the high youth birth rates in the world’s poorest countries(3).Unintended pregnancies lead to complications in pregnancy and childbirth death, high risk infants. Lower educational attainment and poverty also found in youth mother. Studies in both developed and developing countries show that contraceptive acceptance and usage differ significantly between the youth and the adult woman. This difference may be attributed to maturity, higher knowledge and experience among adults than among the youth. The youth, both married and unmarried, face the added obstacles of legal and cultural restrictions that limit their access to contraceptives and family planning(5).

Factors leading to poor access to the youth acquiring contraceptives include poor understanding of pregnancy risks, effects of contraceptives on health or fertility, opposition from partners, lack of knowledge of services, cost, shyness, community stigma about sexual

activity, and disapproving attitudes from providers .The youth sexual and reproductive health is affected by a country's cultural, religious, legal political and economic contexts; with social conservatism playing a hidden role-highlighted by religiosity, demand for male child, male dominance in couples acceptance to contraceptives, are all determining factors. In responding to these factors, health actions are needed at each level, from structural, through to community settings; which include schools and health services. There are a range of effective and scalable interventions; including comprehensive sex education and provision of youth-friendly sexual and reproductive health services. Notwithstanding, the evidence base for action still remains relatively weak(5, 6)

1.2 Statement of the Problem

In many lower-income countries, age- specific fertility rates (ASFR) for the youth ages of 15 to 24 years remain high. Tanzania, Nigeria, and Ethiopia are among the highest rates of youth fertility globally(7-9).The various demographic health surveys of these three countries recorded the following: for Tanzania 194, Nigeria185, and Ethiopia 113 births per 1000 girls, among the ages15– 24 years respectively. Equally, these countries also have some of the lowest rates in terms of use of modern contraception among the youth. In Nigeria, 98.8% of married and 50.3% unmarried sexually active youth girls do not use a modern contraceptive method. The equivalent figures, for married and unmarried youth girls in Ethiopia are 68.2% and 42.5% and in Tanzania 86.7% and 66.9% respectively(7-9).In Ethiopia, demographic survey (2016) showed that 13 percent of youth ages 15-19 years had begun childbearing: ten percent have had a live birth; and 2 percent were pregnant with their first child. The proportion of youth aged 15-19 who begun childbearing increased rapidly with age; from 2 percent among youth aged 15 years to 28 percent among youth aged 19 years(8).Youth giving birth to children is more common in rural than in urban areas The proportion of youth teenagers who have started childbearing decreases with increasing level of education: nearly 3 in 10 youth age 15-19 with no education (28 percent) have begun childbearing compared with 12 percent of teenagers who have attained primary education and 4 percent of those who have attained secondary education(8).Ethiopia's current population is 108 million ,with a projected growth rate of 2.5 percent per year(10). Almost a quarter of married women of reproductive age in Ethiopia have an unmet need for contraception(11).Adolescents and the youths are the

most victims of avoidable sexual and reproductive health (young people) problems; such as unwanted pregnancy, unsafe abortion, curtailment of career prospects and educational disadvantage, just to mention a few(12).

In spite of some of the positive determinants of modern contraceptive use, such as being wealthy, more educated, being employed, higher number of living children, monogamy ,media access, partner discussion, visitation by health worker at home etc. there is still low utilization of modern contraceptives among the youth(13) A study conducted in Hosanna town, southern Ethiopia by Tsedeke T, et al, demonstrated a high prevalence knowledge of contraceptives methods among the youth and adult population, but low utilization rate(14).

As a living reality, Ethiopia has made tremendous gains in access to modern contraceptive methods in recent years. The modern contraceptive prevalence rate (mCPR) has more than doubled since 2005, reaching 40% in 2014.Notwithstanding this progress, the mCPR remains far below the government's goal of 65% stipulated towards 2015.Unmet need still remains high among married women and much higher among rural low income young women(15).

In Addis Ababa, the nation's capital, both married and unmarried youth have a low rate of utilization of available contraceptives with mCPR of 56% which is below the government's target of 65% and for the age 15 to 24 years is 33.9%(8).The aim of this study, therefore, is to examine both current modern contraceptive use, its determinants and intention to use in the future among the population of 15 to 24 years in Addis Ababa.

1.3 Significance of the Study

A lot of research has been done in Ethiopia concerning contraceptives and its determinant factors especially by Getu Degu(16) but relatively scare information is known about the current determining factors affecting the low utilization of modern contraceptives and the intention to use in the future among the ages of 15 to 24 in Addis Ababa. The Federal Ministry of Health (FMOH) in the last Health Sector Transformation Plan (HSTP) has set a target to improve FP as measured by mCPR of 56% and to curb unmet need from 24% to 10%(11). These objectives have been set in line with the new global agenda for Sustainable Development Goals (SDGs) with the ambition of putting Ethiopia on track to meet the SDGs targets by 2030, where such ambitious plans might not get realized unless the younger

reproductive age group get rendered with quality services, including quality sexual and reproductive health care(6). After this study the new knowledge found will highlight determining factors affecting both current modern contraceptive and future use among the ages 15 to 24 years in Addis Ababa in particular.

It will also generate information that will help in formulation of evidence based decisions by program and policy makers to upgrade the current factors and future usage of contraceptives within the youth aged within 15 to 24 years. It can also add to the frontiers of knowledge concerning research. Finally the public, health institutions and the entire community may tap this knowledge to solving problems concerning this age group

2. LITERATURE REVIEW

2.1GlobalPopulation Overview, Sustainable Development Goals (SDGs), Family Planning and Youth Practices

Family planning saves lives every day, approximately 830 women die from causes related to pregnancy and childbirth. Nearly ninety nine percent (99%) of these maternal deaths are occurring in low-income countries. More than half of the deaths occur in sub-Saharan Africa, while one-third occurs in South Asia. In addition,5.995 million children in 2015 died who were under 5 years of age(17).

In 2015, world's population reached 7.3 billion(8, 18). Population growth remains high in the group of 48 countries designated by the United Nations and these involve the least developed countries (LDCs), of which 27 are in Africa. Ethiopia, the second most populous country in Africa, still has high fertility rate (4.6 children per woman) and fast population growth rate of 2,5 per year(8, 19). The current projections showed a continued increase in population which requires strategic interventions(8, 19). Ethiopia is among the top five most contributing countries to half of the world's population growth, stipulated between 2015–2050(18).

2.2 Family Planning: The key to sustainable development.

Family planning/contraceptives are widely approved as an important intervention towards achieving national and international goals as it has been proven to reduce maternal /child mortality and morbidity(8). It can prevent unwanted pregnancies and unsafe abortions

Family planning and contraceptives also have been found to promote gender equality as well as promote educational and economic empowerment of women(8, 19).Despite the enormous benefits of family planning services, the utilization of contraceptives still remain low in Sub-Saharan Africa(18-20).In Ethiopia, access of contraceptive service has been increasing due to the expansion of primary health care units (PHCU)(20). However, it is still very low as compared to the national and international targets set at different times(8).The 2016 Ethiopian Demographic and Health Survey (EDHS) Report showed that the utilization for all types and long term methods of contraceptive was 35.3 and 10.3% respectively(20). The most commonly used modern method is injectable, which is used by 31% of currently married women. However, only 5 and 3% of currently married women use implants and the pills

respectively(8, 21). This has resulted into high rates of unwanted pregnancies, unplanned deliveries and unsafe abortions resulting high maternal mortalities in the regions (8, 20, 22).

2.3Current modern contraceptives overview

.World health organization WHO, defined modern contraceptives as a method or procedure for pregnancy prevention and these include the following: female or male sterilization, oral contraceptive pill, intrauterine contraceptive device (IUCD), implants, Depo-Provera or interposing a barrier that prevents the ascension of the sperm into the upper female genital trace (e.g. condoms, diaphragm, cervical cap and spermicidal foams, jellies, creams and sponges) while traditional methods include periodic abstinence during the fertile period, coitus interrupts(withdrawal), using the naturally occurring periods of infertility e.g. during breast-feeding and postpartum amenorrhea(23). Dual protection method involves using a contraceptive method to achieve two goals at a time; prevention of pregnancy and also the transmission of sexual transmitted infections(STI) or human immune virus(HIV)(24).

2.4 Importance and significance of sexual and reproductive health among youth

Sexual and Reproductive health play an important role in the lives of the youth thereby promoting healthy development to meet needs, building competencies prevention and response to health problems among the youth. Some of the benefits derived from sexual and reproductive health include, counseling about the body and emotional changes in the youth, Life skill counseling on how to delay sex and avoid risky behaviors. Prevention of sexually transmitted infections (STIs). Family planning and counseling for sexually active youth. Screening, counseling and treatment for STIs. Post rape counseling and care. Pre-natal, post natal and delivery care for adolescent pregnancies. Voluntary Counseling and Testing (VCT) for HIV. Post abortion, emergency care and counseling

2.5 Factors influencing use of modern contraceptive among youth

The number of adolescence/youth using contraceptives is relatively low in Africa, following all effort by United Nations Fund for population Activities'(UNFPA) "campaigns" to reduce maternal morbidity and mortality through support and motivating the use of modern contraceptive methods(25). Some of the factors leading to low utilization are; Individual, Reproductive, Societal Expectation, Health Services and Cultural Factors.

2.5.1 Individual factors on modern contraceptive usage

Personal characteristics like age, marital status, educational level, religion, occupation, income, place of residence are important predictor of contraceptives utilization amongst the youth. In a study carried out in at Dabat, northwest Ethiopia, women in the age group of 21–30 years were 1.32times more likely to use modern contraceptives as compared to those less than or equal to 20 years(AOR = 1.32, 95%CI: 1.11, 1.58). However, women in the age group of 31–40 were 1.33 times more likely to use modern contraceptives as compared to those less than or equal to 20 years(AOR = 1.33, 95%CI: 1.07, 1.65). Women in the age group of 40 or more were 33% times less likely to use modern contraceptives as compared to those less than or equal to 20years(AOR =0.66, 95%CI: 0.51, 0.85) (26).

Women at primary educational level (AOR = 1.42, 95%CI: 1.22, 1.65) were 1.42 times more likely to use modern contraceptives as compared to women who are unable to read and write. Women with secondary and above educational level were 2.35 (AOR = 2.3 95%CI: 1.92, 2.88) times more likely to use modern contraceptives as compared to women who are unable to read and write. Urban women were 1.92 (AOR = 1.92, 95%CI: 1.67, 2.21) times more likely to use modern contraceptives as compared to their rural counterparts(26).In a study carried out in Yemen, age, marital status, parity, husband's education, husband's occupation, monthly family income, religion and woman's occupation were found to be associated with use of contraceptive. Conclusion showed that poverty, ignorance and illiteracy were the main limiting factors to the use of contraceptives in Yemen(27). The ability to purchase television, radio or cell phone influence knowledge about contraceptives and source of obtaining them; which contributed to its use or nonuse in the long run(26, 28, 29).

2.5.2 Health service related factors

Success requires that contraceptives are readily accessible at all-time; including a wide variety of affordable contraceptive methods and types. A need base multiple service-delivery channel, should ensure that clients know about the service, which is followed by evidence-based technical guidelines that will promote access and quality, geared towards client-centered services(26).

A population based study in Ethiopia showed that availability and accessibility to contraceptives influenced the use of contraceptives among users in Mojo town(30). In

Bangladesh, on availability of the commodities, long waiting time and behavior of service providers were the main reasons why women using Maternal Child Health(MCH)clinics did not use contraceptives(31).A study conducted in Burkina Faso, Ethiopia and Nigeria, by Hounton Set et al, revealed that the prevalence of modern contraception use among sexually active youth/ adolescents was 51.6% for four antenatal visits (ANC), 48.5% for childbearing adolescents who used postnatal care services, 43.3% for adolescents whose babies had completed diphtheria,tetanus,polio(DTP), 22.1% for adolescents who delivered in health facilities, and 37.6% for those who had a household visit by a family planning health worker. Additionally, 37.4%, for those who had visited a health facility in the past 12 months,37.5% for those who received information and counseling on family planning during a visit to a health facility(32) .

2.5.3 Societal expectations

Family members, in-laws have significantly influenced several women or adolescent couples reproductive intentions in both directions and this affect their contraceptives decision. Also some policies do not favor contraceptive uptake and utilization thereby influencing health facilities decision. Myths and misconception about contraceptives, their side effects are social missed information that has been reported in many African studies to influence their uptake. Other participants felt it socially imperative towards fertility, henceforth, been pressured by extended family to get pregnant so that people will not look down on them for being still young(33). In a study on barriers to modern contraceptive methods uptake among the youth in Kenya, showed that contraceptives use was influenced by other people (community, peers, family and partner) who directly or indirectly ask them not to used FP. Another qualitative study carried out in Kenya revealed that fear and concerns about contraceptives were a major barrier to it use in that community. This fear was based on myths and misconception that contraceptives can lead to infertility, cancer, birth defects and disruption of the normal body functions hindering / uptake and use among the youth(34).

2.5.4 Socio-cultural factors

Socio-cultural factors implicated into contraceptive use and utilization include discussion between spouses, male altitude towards contraceptive, partner/husband supports, and sex of children, cultural beliefs and religious beliefs. A PHD thesis study submitted by Getu D, in

Addis Ababa University revealed parity as one of the sociocultural determinant factors affecting modern contraceptive use in North western Ethiopia(16). As previously mentioned, following the study from Hounton Set al in Burkina Faso, Ethiopia and Nigeria, it was also found that, across the three countries there was a very low contraceptive prevalence in largely Islamic populations. Burkina Faso a predominantly animist region also had very low prevalence rates. Perceptions of risks and benefits attached to contraceptive use have influence in their use. Furthermore, studies have shown that spousal acceptance and communication contributes to acceptance of contraceptives(32).

2.5.5 Reproductive factors

This was observed for adolescence "not in union" and adolescence "in union" for the three countries: Burkina Faso, Ethiopia, and Nigeria(32).The relationship between modern contraception use and parity varied significantly by marital status. Using the latest demographic health studies (DHS) in each of the three countries, the prevalence of modern contraception use among sexually active adolescents with one child, who were not in union, were 65.3, 72.2, and 33.1% in Burkina Faso, Nigeria and Ethiopia; fifteen times the prevalence for those in union in these countries, respectively, Similarly, for adolescents with no child, prevalence of modern contraception use among adolescents not in union was 47.3, 56, and 41.3%, which was 7.7 times, 2.4times, and 411 times the prevalence for those in union in Burkina Faso, Ethiopia, and Nigeria, respectively. These differences across these countries are staggering and may point to a strong negative effect of marriage on the ability of adolescent girls to control their own fertility, irrespective of the level of modern contraceptive prevalence(35).Also observe in Dabat, northwest of Ethiopia, a woman having six or more living children was 1.39 (AOR = 1.39, 95%CI: 1.15, 1.68) times more likely to use modern contraceptive as compared to woman with less than three children(26).

2.5 Conceptual framework

The conceptual framework used for these study was Adopted from Gizaw and Regassa (2011),(30).It was modified after a review of different literatures. The framework in this study tried to explain the factors affecting uptake of contraceptive usage amongst the youth. These include individual, reproductive, societal expectation, health services and socio-cultural

factors. Different age groups have different contraception knowledge and needs. Women in their mid-twenties, who have had stable relationship, are more likely not to use modern contraceptive method / FP because it's a period for procreation in their life. On the other hand, women who have attended a higher educational level, have better awareness and information turn to be more likely to use FP methods compared to women with lower educational level. Couple's fertility desire, parity, sexual history (having a partner or not, age of onset of sexual activity) are predictors of contraceptive usage. Nonetheless, there some women who do not always have control on the uptake, utilization and discontinuation of a contraceptive method; it is either their husbands, influential people in their community or household (in-laws, family members, policy environment) who make these decisions. Also Myths and misconception about contraceptives/FP as well as fear of side effects influence their use, common in certain parts of Kenya

Socio-cultural values such as perceived need of many children as social security and searching for an heir (sex preference), denominates gender roles as well as could hinder the uptake of contraceptives. Also, discussion between partners (partner's approval or joint discussion for FP), male/female attitude towards FP and lack of support from spouse play a role in FP uptake and utilization. Furthermore, some cultural and religious beliefs may discourage women and their spouses/partners from using contraceptive methods. Socio economic factors like poverty or low income of mothers and their spouses may affect demand for FP/contraceptives which results in lack of transport fare and money for other costs. Lack of male involvement as well as lack of female empowerment in resources control could limit their capacity to utilize FP services hence low demand. One important factor that plays a critical role in contraceptives uptake and utilization is the service delivery point. Health care provider's attitudes and skills (judgmental, youth friendly service provision, health provider's knowledge, lack of effective communication and counseling skills, lack of skills), accessibility (opening hours, distance of the facility), availability (supplies stock out, presence of health personnel), affordability (direct and indirect cost) and acceptability of contraceptives/FP at the health facilities can negatively or positively affect its use. Also excess workload and less motivation leading to provision of low quality services hence missed opportunities hinder effective contraceptives/FP service delivery.

Political environment does affect uptake of contraceptives and family planning methods. An effective policy making and implementation process is the foundation of scalable and sustainable health programs including those that integrate family planning contraceptive usage.

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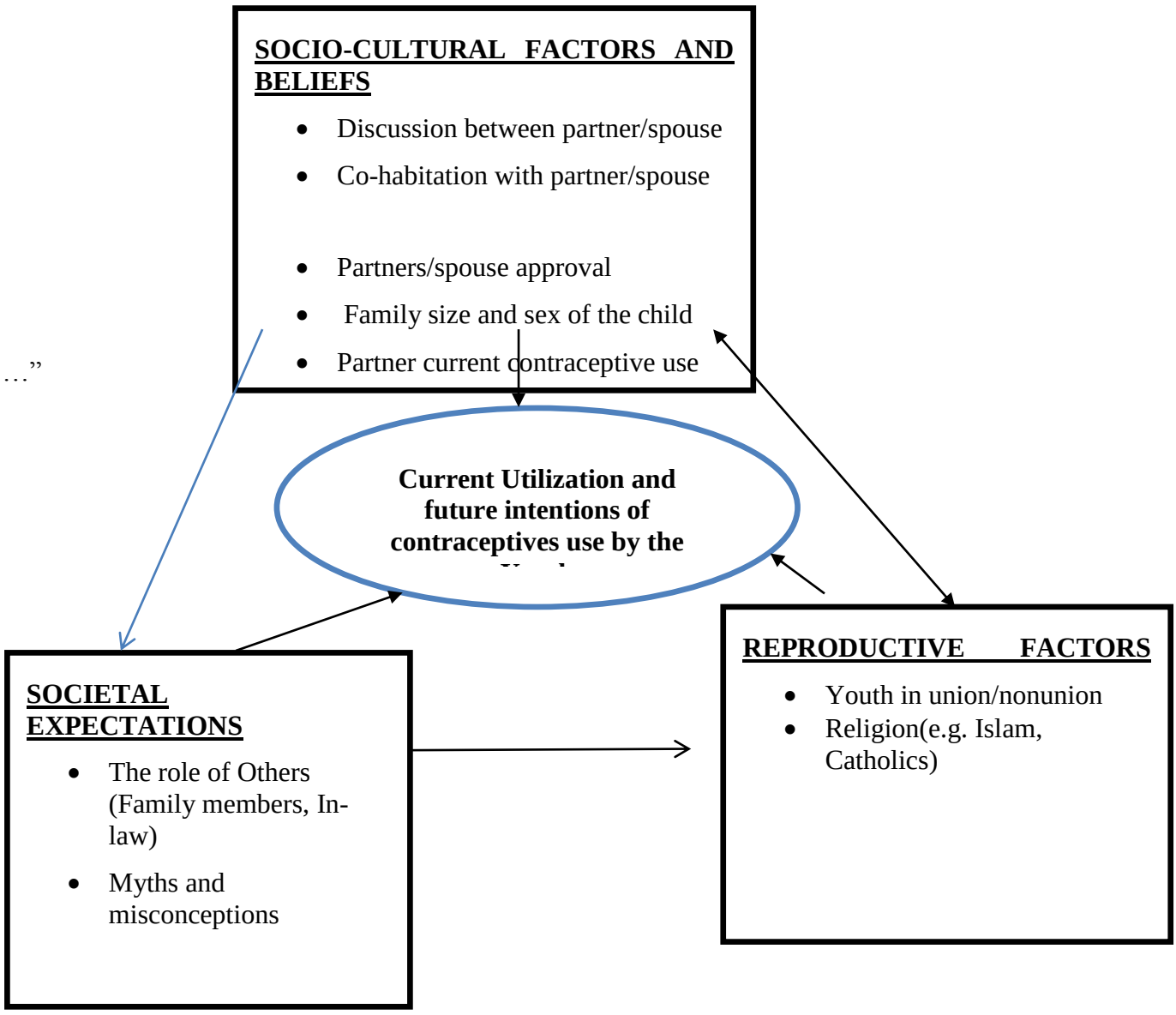


Figure 1: Conceptual relation of factors influencing uptake and utilization of contraceptives among youth with focus on socio-cultural factors and beliefs.

Source: Adopted from Gizaw and Regassa(2011) and modified after reviewed of different literatures (30)

- **Research question.**
- How much of the youth of age 15-24 years use modern contraceptives currently in Addis Ababa?
- How much of the youth of age 15-24 years have intention to use modern contraceptives in the future in Addis Ababa?

3. OBJECTIVES

3.1 General objective

- To identify current modern contraceptive use, intention to use in the future and determinant factors among the population of 15 to 24 years in Addis Ababa

3.2 Specific objectives

- To describe current modern contraceptives use among the age 15 to 24 years in Addis Ababa
- To identify the determinants of current modern contraceptives use in Addis Ababa among age 15 to 24
- To determine intention to use modern contraceptives in the future among the ages 15 to 24 years in Addis Ababa

4. METHODS AND MATERIALS

4.1 Study area and period

The study was carried out in Addis Ababa City, the Nation's Capital and one of the two city administrations of Ethiopia. It is the base of the African Union commission (AUC) and hosts the headquarters of the United Nations Economic Commission for Africa (UNECA) with larger bulk of embassies and numerous other continental and international organizations. It is the largest city in Ethiopia. As of 2012, its population is totally urban and all sides of the capital city are bordered by Oromiya Regional State, and covers an area of 540square kilometers (53,000 ha), with an annual population current growth rate of 3.8 and a total population projection of 3.38 million persons in 2007 census (approximately 1,452,663 males and 1,595,968 females) growing up to 4 million in 2018(36, 37).

The Nation's Capital, Addis Ababa, is made up of ten (10 sub cities, and 116 woredas. Currently, there are a total 52 hospitals in Addis Ababa of which 6 are government hospitals under Addis Ababa health bureau, 5 hospitals under federal ministry of health (FMOH), 3 hospitals under defense and police, 3 non-governmental organization(NGO) hospitals and 35 private hospitals. There are also 98 health centers and 800 different categories of clinic in the city(37). An estimated 80% of the population in Addis Ababa lives in poor and overcrowded districts with an estimated family size of 6 over 500000 households(38)

4.2 Study design and period

This is a community-based cross-sectional quantitative study which was conducted from July 2018 to June 2019.

4.3 Population

4.3.1 Source of population

All youth within Addis Ababa City Administration aged 15 -24 years where data were collected from May 9th to May 27th2019.

4.3.2 Study population

All youth who are Ethiopian citizens within the 15 -24years category in Addis Ababa City Administration within the randomly sampled five Sub cities

4.4 Eligibility Criteria

Youth, who are resident in Addis Ababa and are randomly selected in Addis Ababa City Administration and who will fulfill the inclusion criteria.

4.4.1 Inclusion criteria:

Youth both male and females aged 15-24 years who are fit and willing to participate in the study who are Ethiopian citizens and, also were able to give informed consent; during the study period.

4.4.2 Exclusion criteria:

Pregnant female youth or male youth whose spouse is currently pregnant (identified by history)

Youth with, mental health disorder, visual and hearing impairment are exempted from the interview, within the sampled household

The non-formal residential 15 – 24 years age group

4.4.3 Sample size determination

(a) For the first research objective, the sample size was estimated by using single population proportional formula with the margin of error (d) with 5% and the level of significance at 95% confidence interval (Z), a sample size 349 was derived by:

Using the single proportions given by: $\mathbf{n = \frac{Z^{2\times}\ (p\times\ q)}{d^2}}$ Where **n** = Sample size

Z = Z value corresponding to a 95% level of significance = 1.96

p = expected (assume) proportion of modern FP use among youth. EDHS 2016=35%

q = (1 - p) = (1-0.35) = 0.65 [where q is complementary probability]

d = absolute precision (5%) =0.05

Therefore, from the above sample size is:

n= $\underline{(1.96)^2 \text{ x } 0.35 \text{ x } 0.65}$

$(0.05)^2$=349

Assuming a 10 % non-response rate, design effect of 1.5 a total sample size for the study is 558 participants.

(b) For the second objective, the sample size was calculated on Epi-Info software using factors associated with modern contraceptive use by taking study findings from references (30, 39).(Table 1)

Table 1:Determination of sample size

Associated Factors	Expected Frequency among Unexposed	Ratio	OR	Sample Size	Non-Response Rate	Design Effect	Final Sample Size
Proportion of *MC use among uneducated women	22%	01:01	2	352	10%	1.5	581
Proportion of *MC use among women who have less than 2 children	34%	01:01	4.61	68	10%	1.5	112
Proportion of *MC utilization among rural married women (not living in urban)	23%	01:01	2.3	236	10%	1.5	389

**MC=modern contraceptive*

Finally, we took the maximum sample size calculated using education as determinant factor which was **581**

4.4.4 Sampling procedure

Addis Ababa has ten sub cities. The sampling procedure involved a multi-staged sampling technique. An assumption of 581 households with youth ages 15 to 24 years was included in the study to aim at 116 households in a sub city. The first stage sampling involved a simple random sampling, where five sub cities were selected (Bole, Yaka, Nifassilk, Arada and Addis Ketema). The second stage, each woreda in a sub city was considered as a stratum Three 3 woredas were selected by simple random sampling from each sub city(stratum), totaling fifteen (15) woredas within the five sub cities; with a target of thirty-eight (38) to thirty-nine (39) households in a woreda.According to UN Habitat, an estimation of over 500,000 households are within the 10 sub cities in Addis Ababa Administration, with an approximation of 50000 households in a sub city, making a woredas to have within 5000 to 4545 households(irrespective of slums and non-registered houses).The kth interval of seven(7^{th})was calculated from proportion of the sample size 581 and the estimated households in the woreda which is between 4545 to 5000.The third stage was a systematic random sampling with a kth interval of seven, (by simple random sampling with the first seven houses, a starting point was located to begin the household sampling). Finally, selection of youth, ages between 15 to 24years within the sampled households was done to obtain the sample size. A household within the communities had about one to six persons as a family size. On the other hand, households that were vacant of youth within the specified ages were immediately preceded clockwise to the next house for sampling. Further to this, houses that had two or more eligible youth within ages 15 to 24 years, simple random samplings was employed to select youth for inclusion in the study(Figure 2).

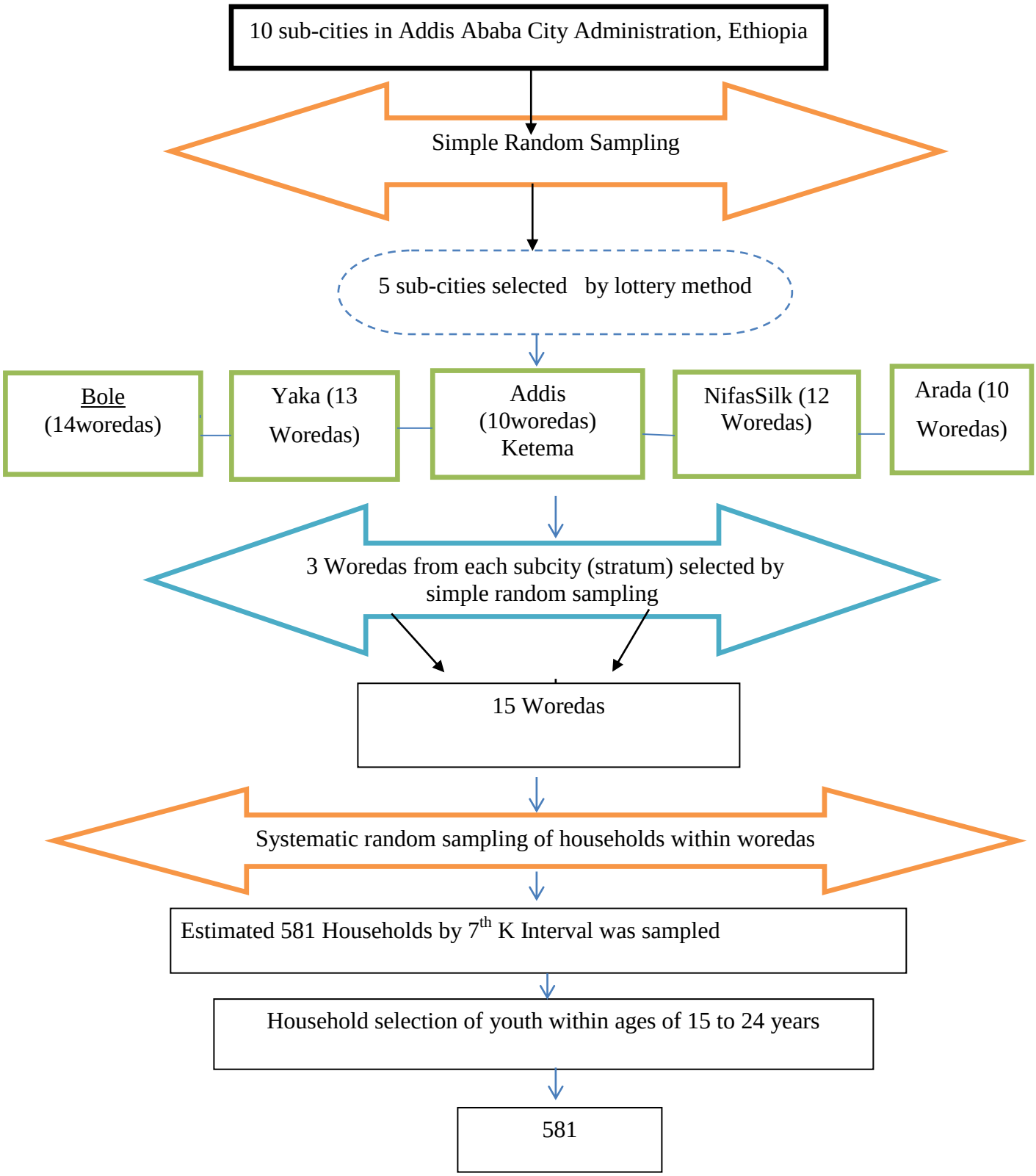


Figure 2: Schematic presentation of sampling procedure within youth in Addis Ababa sub cities

4.5 Measurement/Variables

4.5.1. Dependent Variables:

- The outcome variable in this study is utilization of current modern contraceptives& future intention
- Future intention for current users and non-current users

4.5.2. Independent variables:

- Socio-demographic characteristics: Age, sex, education, employment, marital status, residence, religion,
- Socio-cultural characteristics: partner/spouse approval towards contraceptive use, having a partner, partner's current use of contraceptive, family size, sex of the children, religion, tradition and cultural beliefs about contraceptives.
- The detailed content is presented in the Pretested Questionnaire (annex III)

4.6 Data collection tools and procedure.

Questionnaire was adapted from WHO guidelines on Health Behaviors of School-Age children (**HBSC)** 2013/2014 survey(40); and other relevant literatures. It was a well-designed, structured questionnaire which was administered by five data collectors, face to face interview and from house to house.

Interviews were conducted in a serene place or room, to ensure confidentiality. After each interview, Amharic version was re translated back to English by data collectors, supervised by the professional language translator to ensure that the meaning of participant responses is not altered. Data was collected every day of the week according to the pre-planned schedule within the five sub cities.

4.7 Data quality assurance

Five data collectors and one supervisor (All BSc degree holders) were recruited who were fluent in the local language and training(Annex XII) for one week was given to them on the importance of research, techniques and skills on interviews, sampling, ethical issues, importance of participants' safety and interviewers, minimization of under reporting and maintaining confidentiality. Supervision was done in-process and feedback with discussions

were held at the end of each day to solve and clarify any issues raised during the day as regarding good data collection. The PI was present at the sites during the data collection period to oversee data collection process, checked all previously completed questionnaires for consistency and completeness(Annex XI).The supervisor also had ensured that all administered questionnaires were checked for errors and completeness such that necessary corrections were made on the field. All questionnaires with errors or missing variables which were noticed during data entry were rejected.

Before going into the detail data collection process, pre-test was made to check errors on the research design tool, and anticipated would-be problems within the real project. Pretesting was done a week prior to the commencement of the actual study among youth ages 15-24 in kirkos sub city (Kazanchis), which was excluded from the sampling frame for the study. Overall the pretesting was beneficial to the entire survey and data collection process as modification was made to questionnaire number 38 (insertion of response answer "me and my spouse") the modified versions of the questionnaire is attached (Annex V). A total of 30 questionnaires (5% of total sample size) were used for the pre-testing.

4.8. Data processing and analysis

Data were coded, cleaned and explored to identify outliers, missing values, with Epidata version 4.4.3.1. Data was thereafter exported to SPSS version 23 for final editing and analysis. Frequencies were generated for categorical variables and summary measures for continuous variables. Tables and graphs were used to present the data. Descriptive statistics showed the frequency and percentage of the characteristics. Cross tabulations (chi-square) were computed to examine relationships among the variables.

Initially, bivariate analysis was performed between current modern contraceptive use (dependent variable) and each of the potential factors associated with contraceptive use (independent variables), one at a time. These included socio-demographic factors and socio-cultural factors. Their odds ratios (OR) at 95% confidence intervals (CI) and p-values were obtained. The findings at this stage have identified important associations. Then multivariable analysis was performed using the logistic regression model. Factors that were significantly associated with FP use at bivariate analysis ($p < 0.05$, those with p-values < or = 0.2) and those not significant but with previous evidence from literature review indicating possible

association with FP use were considered in the logistic regression model. Confounding factors that are not the primary variables of interest but would possibly have an effect on the association of other primary variables of interest with contraceptive use such were also considered in the model to control for their effect. Their respective odds ratios (OR) which were found associated with these potential factors was reported as a measure of strength, together with the corresponding 95% confidence intervals.

4.9. Ethical considerations

A proposal initially was submitted to the Research and Ethics Committee of the School of Public Health, Addis Ababa University for the technical and ethical reviews and approval was granted. Permission letter for doing the research and collecting data was obtained from the Addis Ababa City Administration Health Bureau. Furthermore, during the data collection, written informed consent was obtained from each respondent who could read/write and verbal consent was obtained from respondents who could not read nor write ;foremost by first explaining the objectives of the study. To maintain anonymity identifiers like names were not taken in the questionnaire. All measure to maintain human rights including informed consent; the right to participate in the study, right to privacy and confidentiality and right to prevention from any type of harm was taken into consideration. All participants were informed that their participation is on voluntary bases and none was forced rock-solid for participation. It was clearly stated to the participants that the information they will provide whether orally or in writing will be for research purposes and strictly confidential. The data collectors have provided information to those in need and also health facilities referral for contraceptives/FP methods not available at the site.

4.10 Dissemination of the findings

The findings of the study would be communicated to the stakeholders through the following;

1. The final result study will be submitted to Addis Ababa University, School of Public Health and a copy will be made available in the library.

2. Feed-back to the Addis Ababa City Administration Health Bureau and the managers of the various health facilities.

3. Publication of the result in reputable journal.

4.11 Operational definitions

Sexually Active: A client who has had sexual intercourse at least once in the last, less than one month. A definition from Hubacher D and Trussell J document(41)

Current modern FP contraceptive user (1 item**)**: Any participant who reports using any form of modern FP contraceptive method at the time of interview.

Ever used modern FP contraceptive method (1 item): Any participant who said have used a modern FP **contraceptive** method before and whether is either using or not using at the time of interview.

Modern family planning utilization: This refers to use of any form of modern, family FP **contraceptive** method.

Future modern contraceptive use intent (1 item): Any participant who has used a modern contraceptive method but have the intent (desire) to use in the future

Never use modern contraceptive methods, but future intent (1 item): Any participant who has not used a modern contraceptive method but have the intent (desire) to use in the future

Youth: For the purpose of this study, this refers to ages between 15 to 24 years

Current and future modern contraceptive use intent (1 item): Any participant who said is a current modern contraceptive method user and intent to use in the future

Modern contraceptive method: Refers to contraceptives that are based on scientific knowledge of the process of conception such as pills, injectable (Depo-Provera), condoms, implants, intra uterine contraceptive devices, vasectomy, and bilateral tubal legation(23).

Contraceptive prevalence rate: Is the proportion of women of reproductive age who are using (Or whose partner is using) a modern FP method at a given point in time(8).

Approval of modern contraceptive methods: Any participant who is a current user or not but approves the use of modern contraceptive method.

Unmet contraceptive need: proportion of women of reproductive age who are sexually active, unwilling to get pregnant and not using any contraceptives method(19).

5. RESULTS

5.1 Socio-demographic Characteristics

The total respondents were 552 that gave a response rate of 95 %(n=581).One hundred eighty five (33.5%) youth were between the age of 15 to 19 years with a mean (SD) age of 20.7 ± 2.6 respectively. Males were 249 (45.1%) and females 303(54.9%) giving a sex ratio of 1: 1.2 male to female. One hundred and one (18.3%) of the respondents were married. High school level recorded the highest at 295(53.4%) in terms of level of education. Daily income of the youth families, were divided into five categories, from very poor to highest earned income in a day. Two hundred and ninety nine (54.2%) were orthodox Christians (Table 2).

Table 2.**Socio-demographic characteristics of the respondents [N=552] in five sub cities in Addis Ababa, Ethiopia, October 2019.**

Variables	Frequency	Percentage
Age Group(years)categorized^		
Mean+SD	20.7 ± 2.6	
15-19	185.0	33.5
20-24	367.0	66.5
Gender		
Male	249.0	45.1
Female	303.0	54.9
Marital Status		
Single	430.0	77.9
Married	101.0	18.3
Divorced	18.0	3.3
Widowed	3.0	0.5
Educational Level		
Never	6.0	1.1
Not Completed Elementary School	13.0	2.4
Completed Elementary School	66.0	12.0
High School	295.0	53.4
University Level	125.0	22.6
College Level	47.0	8.5
Occupation of respondents		
Unemployed	31.0	5.6
Self-employment	164.0	29.7
Unemployed Student	264.0	47.8
Employed	93.0	16.8
Daily Income of Family respondents **		
Greater than 280birr/day(Highest Level)>10usd	94.0	17.0
168-280 birr/day(Well doing)	248.0	44.9
84 - 167 birr/ day(Average)	173.0	31.3
28- 83birr/day(Poor)	31.0	5.6
Less than 28 birr/day(very Poor)<1usd	6.0	1.1
Religion		
Orthodox	299.0	54.2
Muslim	109.0	19.7
Protestant	112.0	20.3
Catholic	26.0	4.7
Others #	6.0	1.1

*Others #=traditional worshipers, **Adopted/modified from EDHS2011, ^ages 15 - 19 had valid percentages less than 10, giving a wide gap in confidence intervals. Ages were categorized from 15-19 and 20-24years to aid analysis.*

5.2 Ever heard of modern contraceptive methods

Out of a total of 552 participants, 351(63.6%) respondents have admitted to have had sexual intercourse. Further to this, above fifty percent 491(88.9%) of the participants responded yes to have ever heard of modern contraceptives and the source of information was from the media, 407(82.9%) which formed the highest. Second source of information was from peer youth groups 157(32.0%), and the least was from health facilities.ie 24(4.9%) (Table3)

Table 3. **Ever heard of modern contraceptives of respondents in five sub cities in Addis Ababa, Ethiopia, October 2019**.

Characteristic	Frequency	Percentage
Ever had Sex(n=552)		
Yes	351.0	63.6
No	201.0	36.4
Ever heard of modern contraceptives(n=552)		
Yes	491.0	88.9
No	61.0	11.1
Source of information on ever heard of modern contraceptives		
Media*(n=491)		
Yes	407.0	82.9
No	84.0	17.1
From Peer*(n=491)		
Yes	157.0	32.0
No	334.0	68.0
From husband/partner*(n=491)		
Yes	79.0	16.1
No	412.0	83.9
Seminars*(n=491)		
Yes	26.0	5.3
No	465.0	94.7
Health Facility*(n=491)		
Yes	24.0	4.9
No	467.0	95.1

5.3 Common known modern contraceptives methods

Out of a total of 552 participants,491 respondents confirmed knowledge of modern contraceptive method, giving the male condom a value of 374(76.2%), followed by the oral contraceptive pill commonly known as "OCP"370(75.4%).The injectable 197(40.1%), others i.e. norplant 2(0.4%)(Table 4).

Table 4.Common known contraceptives of respondents in five sub cities in Addis Ababa, Ethiopia, October 2019.

Characteristic	Frequency	Percentage
Know any contraceptive Method		
Pills*(n=491)		
Yes	370.0	75.4
No	121.0	24.6
Intrauterine Device*(n=491)		
Yes	143.0	29.1
No	348.0	70.9
Injectable*(n=491)		
Yes	197.0	40.1
No	294.0	59.9
Condom(Female)		
Yes	17.0	3.5
No	474.0	96.5
Condom(Male) *(n=491)		
Yes	374.0	76.2
No	117.0	23.8
Vasectomy*(n=491)		
Yes	77.0	15.7
No	414.0	84.3
Tubal Ligation*(n=491)		
Yes	70.0	14.3
No	421.0	85.7
Periodic Abstinence*(n=491)		
Yes	102.0	20.8
No	389.0	79.2

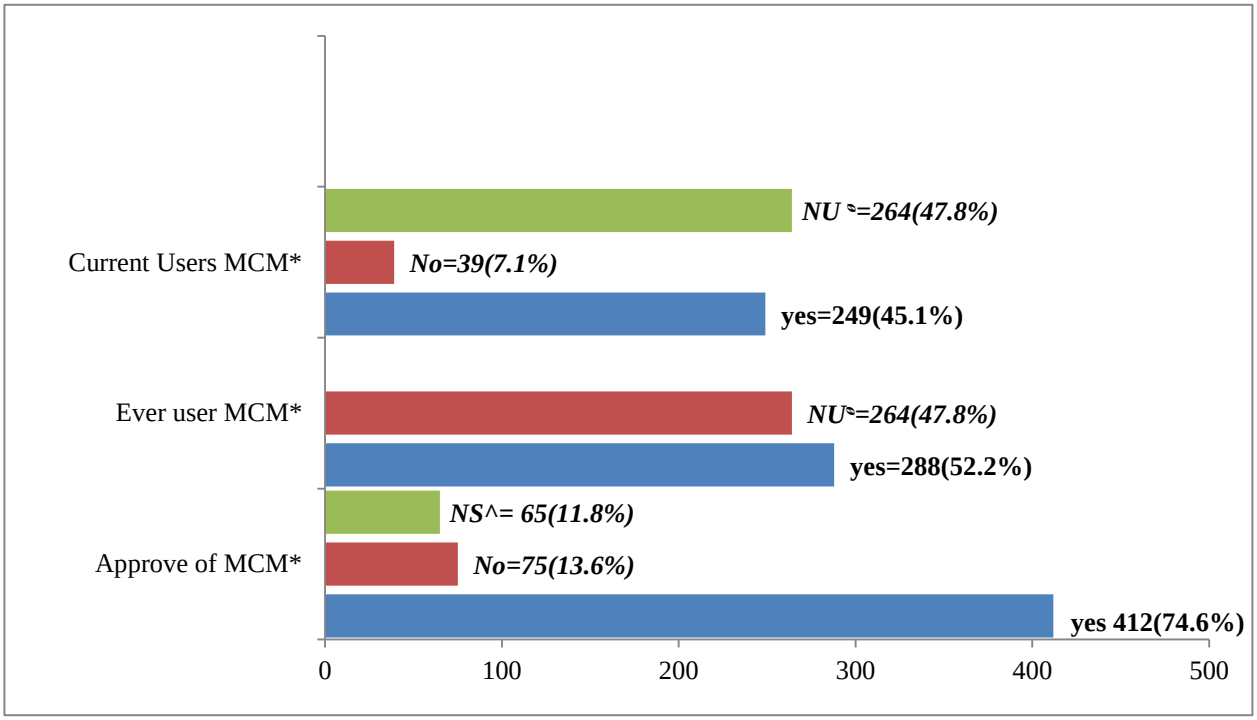
(Table 4 continu…)

Characteristic	Frequency	Percentage
Natural Methods *(n=491)		
Yes	17.0	3.5
No	474.0	96.5
Others#	2.0	0.4

**Multiple response Others #= Norplant*

5.4. Respondent approval, respondent ever use and respondent current use of modern contraceptives methods

Out of the total of five hundred and fifty two participants, 412(74.6%) of the respondents confirmed that they do approve the use of modern contraceptive and those who have ever used it before was 288 (52.20%) (figure3) Two hundred and forty nine (45.1%) of the respondents have confirmed that they are current users of modern contraceptives (Table 6). These are the currently used modern contraceptive methods: such that the highest being male condom, 114(45.8%), the pill, and 92(36.9%), the injectable, 39(15.7%) and the lowest is Norplant at a frequency of 1(0.2%)



**MCM=modern contrceptive methods, ^NS=Not sure, NUᵔ=never used MCM*Figure 3: Approve,ever,and current modern contraceptives use of respondents in five sub cities in Addis Ababa, Ethiopia, October 2019

5.5. Intention for future use (for current users and never-users)

Out of a total of two hundred and forty nine participants who are currently modern contraceptive users, 207(83.13%) responded to have intention for future use; and also out of a total of two hundred and sixty four participants who had never use modern contraceptives, 100(37.87%) of respondents confirmed to have intention for future use [henceforth, a total of 307(55.6%) for both current/never users responded for future intention out of 552 participants]. Thirty-nine of the respondents (7.0%) affirmed as non-current user out of the 552 participants (Figure 4, Table 5)

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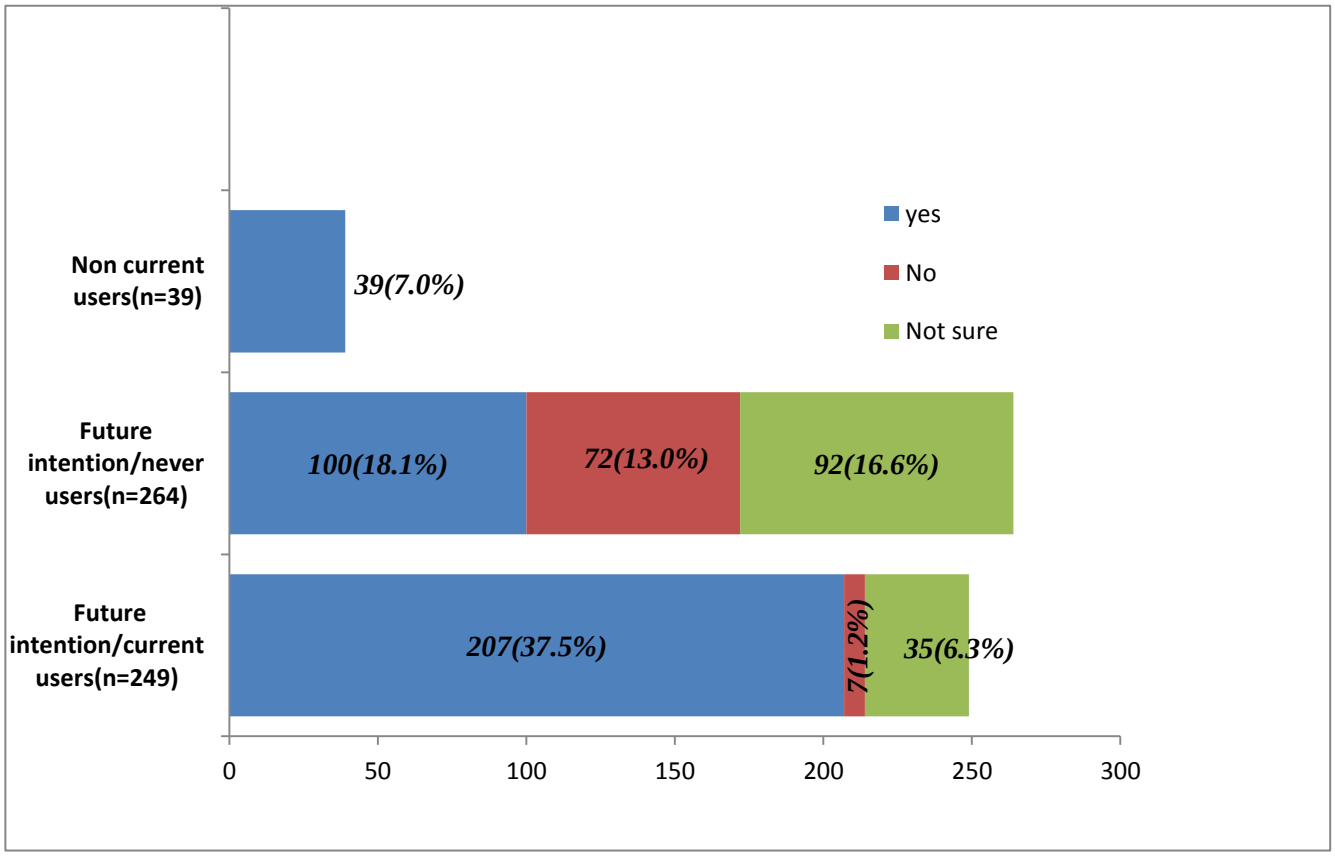

**MCM=modern contraceptives methods. Percentages derived out of the denominator N=552*

Figure 4: Intent future MCM for current users, never users of respondents in five sub cities in Addis Ababa, Ethiopia, October 2019

Table 5. Respondents future approval of modern contraceptive methods use in five sub cities in Addis Ababa, Ethiopia, October 2019.

Characteristic	Frequency	Percentage
Approve the use of modern contraceptives(n=552)		
Yes	412.0	74.6
No	75.0	13.6
Not sure	65.0	11.8
Ever used modern contraceptives(n=552)		
Ever use	288.0	52.2
Never use	264.0	47.8
Method ever used #MCM		
Approve among ever use: pill(*n=288)		
Yes	171.0	59.4
No	117.0	40.6
Approve among ever use: intrauterine device(*n=288)		
Yes	12.0	4.2
No	276.0	95.8
Approve among ever use: injectable(*n=288)		
Yes	42.0	14.6
No	246.0	85.4
Approve among ever use: condom (female) (*n=288)		
Yes	5.0	1.7
No	283.0	98.3
Approve among ever use: condom(male) (*n=288)		
Yes	163.0	56.6
No	125	43.4
Approve among ever use: vasectomy(*n=288)		
Yes	2.0	0.7
No	286.0	99.3
Approve among ever use: tubal ligation(*n=288)		
Yes	4.0	1.4
No	284.0	98.6
Approve among ever use: others		
Abstinence	1.0	0.2
Norplant	1.0	0.2

Table 6 Respondents current use, never use, and future intention of modern contraceptive methods use in five sub cities in Addis Ababa, Ethiopia, October 2019

Characteristic	Frequency	Percentage
Current modern contraceptives use now (n=288)		
Current users(only)	249.0	86.5
Non-current users(only)	39.0	13.5
Current users with intention for future use(n=249)		
Yes	207.0	83.1
No	7.0	2.8
Not sure	35.0	14.0
Never Use ^MCM but Intention for future use(n=264)		
Yes	100.0	37.8
No	72.0	27.3
Not sure	92.0	34.8
Currently used modern contraceptive methods		
Pill(*n=249)		
Yes	92.0	36.9
No	157.0	63.1
Intrauterine Device(*n=249)		
Yes	17.0	6.8
No	232.0	93.2
Injectable(*n=249)		
Yes	39.0	15.7
No	210.0	84.3
Condom(Female(*n=249))		
Yes	0	0.0
No	249	100
Condom(Male) (*n=249)		
Yes	114.0	45.8
No	135.0	54.2
Tubal Ligation(*n=249)		
Yes	2.0	0.8
No	247.0	99.2
Others (*n=249)		
Norplant		
Yes	1.0	0.2
No	248.0	99.8

**multiple response ^MCM=modern contraceptive methods*

5.6. Factors affecting approval, ever and current modern contraceptives use among respondents

Through cross tabulation with observed frequencies/percentages, 131(96.30%) respondents out of 288 participants affirmed yes to have discussed to each other in the past on the use of modern contraceptive at a p-value of 0.001(which was significant).Out of 288 participants, 182(91.20%) of respondent confirmed to have partners and are currently using MCM at a p-value of 0.001.Further to this, 201(87%) of respondents support and approve the use of MCM at a p-value of 0.021. close relatives etc. do not have effect on the use on MCM(Table 7).

Table 7.Factors affecting approval, ever and current modern contraceptives use on respondents in five sub cities in Addis Ababa, Ethiopia October 2019

Factors	Modern contraceptive method use currently		Chi-sq.x^2	p-value
	Yes	No		
Discussion with partner in the past about modern contraceptives(n=288)				
	131	5	22.55	0.001*
	96.30%	3.7%		
Ever informed partner of using contraceptives in family planning(n=288)				
	116	7	16.01	0.001
	94.30%	5.70%		
Does your partner/spouse approve of family planning methods(n=288)				
	201	28	7.68	0.021*
	87.80%	12.20%		
Close relatives support you of the use of modern contraceptive methods(n=288)				
	117	15	2.45	0.293
	88.60%	11.4%		
Traditional /cultural believes against the use of family planning(n=288)				
	109	20	0.77	0.680
	84.50%	15.5%		

(Table 6 continu..)

Society supports modern family planning methods(n=288)				
	176	28	0.02	0.989
	86.30%	13.70%		
Have children in the future? (n=288)				
	224	36	0.24	0.886
	86.20%	13.80%		
Having a partner(n=288)				
	182	17	13.74	0.001*
	91.50%	8.50%		
Not having a male child prevent you from using family planning method(n=288)				
	20	0	3.529	0.171
	100.00%	0.0%		

**=significant<0.05, MCM=modern contraceptives methods, % =Observed values*

5.7 Relative views on influence of socio-cultural factors on use of contraceptive methods

Five response answers were designed on a likert scale which were strongly agree to strongly disagree with "not sure" in the middle. These response answers were coded 1 for "strongly agree" to 5 as "strongly disagree". Likert Items questions were designed on socio-cultural factors influencing family planning and modern contraceptive use. Out of 522 participants 231(41.8%) respondents s agree with Fp/contraceptives use jointly with partner influence with a mean of 2.25. Fp/contraceptives use 268(48.6%) influenced by partner approval with a mean of 2.30 respondents agree. FP/contraceptive use 225(40.8%) influenced by friends/relatives approval disagree with a mean of 3.47 (Table 8)

Table 8. Relative views on influence of socio-cultural factors on contraceptive methods use on respondents in five sub cities in Addis Ababa, Ethiopia. October 2019

Views	Strongly agree n(%)	Agree somewhat n(%)	Not sure n(%)	Disagree somewhat n(%)	Strongly disagree n(%)	Means on likert scale
*Fp/contra use influence by cultural beliefs	124(22.5)	216(39.1)	123(22.0)	72(13.0)	17(3.1)	2.35
*Fp/contra use influence by religion	134(24.3)	167(30.3)	125(22.0)	96(17.4)	30(5.4)	2.49
Fp/contra influenced by friends/relative approval	9(1.6)	64(11.6)	197(35.0)	225(40.8)	57(10.3)	3.47
*Fp/contra influenced by village talk/Rumors	21(3.8)	104((18.8)	243(44.0)	156(28.3)	28(5.1)	3.12
*Fp/contra influenced by partner approval	108(19.6)	268(48.6)	82(14.9)	91(16.5)	3(0.5)	2.30
*Fp/contra jointly with partner influences	141(25.5)	231(41.8)	80(14.5)	100(18.1)	0(0.0)	2.25

**Fp/contra= Family planning /contraceptives*

5.8. Analysis of socio-cultural factors determining current use of modern contraceptive within the youth ages 15 to 24 in Addis Ababa, Ethiopia, October 2019.

Table 9 showed binary and multi logistic regression analysis with socio-cultural variables. In binary logistic analysis, youth who are (i)having a partner, (ii) discussion of modern contraceptives, (iii)current partner/spouse use,(iv) partner approval were significantly associated with current modern contraceptive use. In a univariate analysis, those who are having partners had a significant use of modern contraceptives as compared to singles COR= 3.5 (1.75, 7.02) as they were 4 times higher odds to use modern contraceptive. Likewise those who did not discuss contraceptive methods with spouses or partners were 86.0% lower odds to use modern contraceptives as to discussers COR=0.14(0.04, 0.51). Partner approval also played a role, as those who did not approve their partners/spouse in family planning use were

80.0% lower odds to use modern contraceptives COR=0.20(0.04,0.94) as to those who approved of MCM. Non-current partner/spouse user were 77.0% lower odds to use modern contraceptives COR=0.23(0.07, 0.73) as compared to current partner/spouse users.

Religious denomination, orthodox were 72% lower in odds to use modern contraceptives to protestants, catholic and non-believers in God COR=0.28(0.09,0.84),likewise muslems were 75% lower odds to use modern contraceptives as compared to protestant, catholic and non-believers in God COR=0.25(0.06,0.95). Ever inform partner of using modern contraceptives, traditional /cultural believes and, society supports of modern family planning methods, having children in the future, education, and occupation did not have associations with current modern contraceptive use (Table 9).

Factors with variables which were statistically significant within binary logistic regression, and following adjusting odds, were entered into multivariable logistic regression analysis to establish the determinants of modern contraceptive use.

In multiple logistic regression analysis, age category having a partner, discussion with partner and religion were significantly associated with current modern contraceptive (Table 9).Age category of 15-19 years were AOR=5.93(1.20,29.20) 6 times higher odds to use modern contraceptives as compared to ages 20-24years. Having partner or spouse was also associated as compared to singles AOR=12.8(1.62, 100.9). Those who had partners were 13 times higher odds to use modern contraceptive as compared to singles. Discussing modern contraceptives with partner and spouses had an association. Non discussers of modern contraceptives AOR=0.18(0.04, 0.85) were 82.0% lower odds to use modern contraceptives as compared to discussers. Orthodox Christians were AOR=0.26(0.08,0.85) were 74% less likely to use modern contraceptives than protestants, catholic and the non-believers.Muslems were 89% less likely to use modern contraceptives than protestants and catholic.

On the other hand, partner's approval, support from close relatives, and occupation did not have significant association with the model (table 9)

Table 9 Binary and multivariable logistic analysis of socio-cultural factors determining current use of modern contraceptive within the youth ages 15 to 24 in Addis Ababa, Ethiopia, October 2019

	Current modern contraceptive use			
Variables	**Yes (%)**	**No (%)**	**Crude OR(95%CI)**	**Adjusted 0R(95%CI)**
Having a partner				
Yes	182(91.5)	17(8.5)	**[α]3.51(1.75, 7.02)**	***12.8(1.62,100.9)**
No	67(75.3)	22(24.7)	**1**	**1**
Current Partner use[R]				
Yes	116(95.1)	6(4.9)	**1**	
No	37(82.2)	8(17.8))	**[α]0.23(0.07, 0.73)**	
I don't remember	29(90.6)	3(9.4)	0.50(0.11,2.12)	
Discussion with partner				
Yes	131(96.3)	5(3.7)	**1**	**1**
No	23(79.3)	6(20.7)	**[α]0.14(0.04, 0.51)**	***0.18(0.04,0.85)**
Partner approval				
Yes	201(87.8)	28(12.2)	1.16(0.47,2.84)	
No	5(55.6)	4(44.4))	**[α]0.20(0.04,0.94)**	
Not sure	43(86.0)	7(14.0)	**1**	
Close relatives support you[R]				
Yes	117(88.6)	15(11.4)	**1**	
No	16(76.2)	5(23.8)	**[€]0.41(0.13, 1.28)**	
Not sure	116(85.9)	19(14.1)	0.78(0.37,1.61)	
Ever Inform Partner				
Yes	116(94.3)	7(5.7)	**[€]2.76(0.65,11.66)**	
No	48(87.3)	7(12.7)	1.14(0.26,4.90)	
I don't remember	18(85.7)	3(14.3)	**1**	
Tradition/cultural beliefs against the				

use of Fp**				
Yes	109(84.5)	20(15.5)	0.74(0.34,1.65)	
No	60(88.2)	8(11.8)	1.03(0.39,2.72)	
Not sure	80(87.9)	11(12.1)	**1**	
Society supports Fp**				
Yes	176(86.3)	28(13.7)	0.93(0.38,2.27)	
No	26(86.7)	4(13.3)	0.96(0.25,3.61)	
Not sure	47(87.0)	7(13.0)	**1**	
Age category years				
Yes (15-19)	43(95.6)	2(4.4)	**[α]3.86(0.89, 16.6)**	***5.93(1.20,29.20)**
No (20-24)	206(84.8)	37(15,2)	**1**	**1**
Marital status©				
Single	167(86.5)	26(13.5)	1.01(0.49,2.08)	
Married/devoiced/widowed	13(13.7)	82(86.3)	1	
Education Level^				
High school below	139(86.9)	21(13.1)	1.08(0.55,2.13)	
College/university	110(85.9)	18(14.1)	**1**	
Occupation of Respondent				
Unemployed	19(90.5)	2(9.5)	1.13(0.22,5.79)	
Own business/self employed	87(87)	13(13)	0.79(0.31,2.03)	
Unemployed Student	76(82.6)	16(17.4)	0.56(0.22,1.40)	
Employed	67(89.3)	8(10.7)	**1**	
Religion				
Orthodox	150(83.8)	29(16.2)	**[α]0.28(0.09,0.84)**	***0.26(0.08,0.85)**
Muslim	27(81.8)	6(18.2)	**[α]0.25(0.06,0.95)**	***0.11(0.02,0.61)**
others∞	60(95.2)	3(4.8)	**1**	**1**

**significant at multivariate analysis p<0.05, [α] significant at bivariate analysis p<0.05, [ε] variable eligible for multivariate analysis at p≤ 2,*
***Fp=Family planning OR=odd ratio, [∞] catholic, protestant, non-believers, CI confident Interval*
[R]=coding Ref to last p>0.2 ^ merge education into high school below and College/university level to aid analysis
© merged into single and married/divorced/widowed

6. DISCUSSION

This study was conducted to identify current modern contraceptive use, future intentions and the determinants amongst youth in Addis Ababa. From the multivariate logistic regression analysis for this sample size, the adjusted ORs for all selected explanatory factors showed, statistically significant associations with modern contraceptive use except for youth' education, partner approval ,current partner use ,cultural/traditional beliefs, and desire for male child. The strongest adjusted association observed in modern contraceptive use was significantly with the age category of 15 to 19 years, as they were 6 times higher odds to use modern contraceptives than age 20 to 24 years. The youth ages between 15 to 19 years still lie in the developmental years, (schooling, dependent on parents, unemployment) therefore care is taking by this age group not to get pregnant as one of the main reason, illustrated by the high use of the male condom and the female pill in this study. To confirm this, a study was done in Germany; during the reunification of east and western(era of 1990)where the barrier methods especially the condom recorded a prevalence rate of 10.4% and the pill recorded 75% ,as compared to Addis Ababa, 45% and 36% for the same ages of 15 -24 years. These differences could be due to the unstable environment at the time of the reunification of Germany where the country was in violence and war, with low availability of the male condom and high use of the oral pill ,as the pill was easily accessible(42). Inversely, a similar study in Tigray recorded the pill prevalence rate at 4.5% and the male condom at 0. 9%, this was far below the prevalence rate in Addis Ababa for the same ages 15-24 years. In Tigray, the commonest use of modern contraceptives was the injectable (long acting) and the lowest was the pill and the male condom (short-acting). The reason for respondents in Tigray was that ,the long acting contraceptives, were cheap, highly effective and one need less visits to health institutions as compared to the pill and the condom where one has to use every time, more often and more compliance needed (43).Another study done on modern contraceptive use was among married women of reproductive age in Misha Woreda Hadiya Zone, South Ethiopia, where the commonest modern contraceptive use was also the injectable(long acting) at a prevalence rate of 50% for ages 30 -34 and rather low 2.8% for ages 15-24 years showing both geographical and age variations in long acting contraceptives(44); also a confirmation from 2011 EDHS.Partner discussion also played a role in the association of modern contraceptive use, following the multivariate regression. Partner/spouses, who are

living together, most likely, would be engaged in discussions about the benefits of modern contraceptives use, especially the harmful effect of STIs, HIV, unwanted pregnancy, unemployment, creating the tendency to use family planning (FP) during their co habitation. A study done in Debremarkos in Ethiopia revealed that youth mothers who had FP discussions with their husband or spouse were more likely to use family planning than their counterparts. This indicates that partner discussion involving family planning could be a factor in increasing the number of family planning users(45).In addition, improvement in modern contraceptive methods will be achieved by involving both young men and women in family planning programs. A similar association was observed in a study carried out in Kenya, where greater approval and more frequent discussions among youth couples enhanced modern contraceptive use by women(34). Consistent with the results of previous studies in Uganda, showed that high levels of partner discussions of modern contraceptives/family planning methods led to a significantly association with current use of contraception(46).

On the part of respondents currently having partners, the model showed strong association with the use of modern contraceptives, as this group had 13 times higher odds to use modern contraceptives more than those who do not have partners. In this regards, the role of men in decision making has been instrumental in traditional patrilineal societies and has contributed to high use of modern contraceptives, with Ethiopia not being an exception. Men decide almost every aspect of life including reproductive health service choices. A study done by Terefe A, and Larson CP, in different parts of Ethiopia showed significant association of men who involved themselves in family planning methods led to encouraging high use of modern contraceptive methods(47).To add to this, women in a union (married or consensual union) were more likely to be using a contraceptive method than singles. When a woman is married or living with a partner under the same roof, the partner's opinion and decision on contraceptive use become influential and highly beneficial to both of them.

Religion showed an association with modern contraceptives use as orthodox Christians and Muslims had lower odds as compared to the protestant, catholic and the non-believers. Prevalence rates for protestant, catholic and non-believers was 95.2% and for orthodox Christians 83.8% and Muslim at 81,8%.This is consistent with a study in Bahir Dar done by Damot W,et al. in 2014 where orthodox Christian had CPR of 63.1% , Muslim 36.1% and

protestant, catholic 68.1%(48).This is explained due to religiosity which was identified as one of the factors which determine modern contraceptive use. Compared with religious youth women, less religious were about 5.56 times more likely to use modern contraceptives (95%CI: 1.4, 21.3) in Orthodox Christian youth women and 5 times more likely to use modern contraceptives (95% CI: 1.9,14.8) in Muslim youth women and much higher in the protestant. On this regard, a study conducted on the influence of religiosity on contraceptive use among Roman Catholic reproductive age women in the United States in 2007, showed that, Low Church attending women were 38% more likely to use contraceptive than high church attendants(49).Also in line with a joint study involving Burkina Faso, Nigerian and Ethiopia, by Hounton S,et al. Muslims in Islamic state in Burkina Faso and Nigeria has low utilization of modern contraceptives as compared to orthodox Christians and protestants, catholic(32).This reason was due to low levels of educations and the Muslim youth more often rely on the traditional method of family planning and prolonged breast feeding, which is often times unreliable leading to unwanted pregnancies. Further supporting our study is in Bengul in Bangladesh where Islamic conservatism encourages low use of modern contraceptives(50).

Contrary, in line to this study, findings from the study in Misha woreda Hadiya Zone, religion did not affect modern contraceptive utilization and this might be due religious variation(51). Educational level in this study showed low association, in promoting the utilization of modern contraceptives. This could be due to the fact that, the highest medium of promoting contraceptive use in the youth of Addis Ababa was the media/peers and least from health facilities; which is the opposite in a study in Misha Woreda Hadiya Zone,south Ethiopia, where education was found as one of the important determinant factors where women educated up to high school level and above were four times more likely to use modern contraceptives as compared to illiterates(44). This agrees with studies done in Kenya, Rwanda, Uganda and Tanzania. Literacy helps in increasing contraceptive knowledge, change attitude towards use and contraceptive use itself. Education increases women's access to information of different sources. Education also help women to get better jobs to be better of economically ,changes their outlook of fertility and imparts them sense of trust in scientific explanations and use of technology(52).

6.1 Strength and Limitation

6.1.1Strengths of the study

1) A random sampling to represent the community

2) There was a high response rate (95%)

3) Maximum quality data application procedures, which assures internal validity of this study

6.1.2 Limitation of the study

1). Reponses to questions related to' practices in the past (such as ever use of

contraceptive method or responses by males about the contraceptive practice of their spouse/partner) could be subject to recall bias.

2) Perceived desirability of responses rather than actual knowledge or practices could as well introduce response bias.

4) The main outcome, measurement modern contraceptive use, was sensitive information, which was self-reported and could be subject to reporting bias.

5) Adequate assessment as to how the technique or procedure of application of the male condom and pill were not assess; subjected to application bias.

6) Limitations of Likert scale. Whether consider categorical variables as ordinal or interval is an issue unsolved. Also midpoints of responses such as strongly agree, agree and neutral cannot be quantified

7. CONCLUSION AND RECOMMENDATION

7.1 Conclusion

This study revealed below fifty percent current use of modern contraceptive among the youth age group 15 to 24 years. Respondent ever use of modern contraceptives was above 50% and never uses was below 50%.Media and peers promoted modern contraceptives use more than educational level and health facilities. Having partners, spousal discussion, and religion and age category of 15- 24 years had influence in utilization of modern contraceptives. The youth had intention to use modern contraceptives in the future but did not specify which method of choice intended for future use, which could be investigated in further studies. Mode of application of barriers method, the pill, injectable, noplant could also be investigated in further studies,

7.2. Recommendation

Media: As a high source of channel for health promotion should highlight more contraceptives use within the communities through education. Media promotion on more modern contraceptives use, application, especially on peer education, spousal discussion within the communities.

Health personnel: Should embark on house to house visitation, organize health talks/seminars, contraceptives should be readily available at low cost, easily accessible, non-stigmatization. User friendly of contraceptives and health staff to youth should be cordial. Since the youth ages 15 to 19 years had a high use and desire for modern contraceptives, more of the commodity should be readily available. Moreover, existing "Reproductive Health Clubs" in the communities could be the venue for disseminating similar information

Governmental NGO and policy makers: Sex education, reproductive health issues, youth clubs should be encourage, in communities for disseminating modern contraceptives importance

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8. Reference

1. Family Planning 2020. Accelerating progress, strategy for 2016–2020[intenet]. United Nations Foundation 1750,NewYork: United Nations; 2015 [cited 2015 November 2018]. Available from: http://www. familyplanning2020. org/.
2. Starbird E, Norton M, Marcus R. Investing in family planning:key to achieving sustainable developing goals. Global Health: Science and Practice. 2016;4(2):192-210.
3. Sedgh G, Singh S, Hussain R. Intended and unintended pregnancies worldwide in 2012 and recent trends. Studies in Family Planning. 2014;45(3):301-14.
4. World Health Organization. Family planning enables people to make informed choices about their sexual and reproductive health[Internet]. Avenue Appia 20, CH-1211 Geneva 27, Switzerland: World Health Organization; 2014 [November 2019]. Available from: www.who.int/reproductivehealth.
5. Chandra-Mouli V, Parameshwar PS, Parry M, Lane C, Hainsworth G, Wong S, et al. A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it. Reproductive Health. 2017;14(1):p.85.
6. World Health Organization. Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation. Geneva: World Health Organization; 2017.
7. DHS. Nigeria Demographic and Health Survey 2013 [Internet]. [cited 2013 November 2018]. Available from: http:// dhsprogram.com/publications/publication- fr293- dhs-final-reports.cfm.
8. CSA, ICF M. Ethiopia Demographic and Health Survey 2016[Internet]. [cited 2016 November 2018]. Available from: https:// dhsprogram.com/publications/publication-FR328-DHS-Final-Reports.cfm.
9. DHS. Tanzania Demographic and Health Survey 2015-16 [Internet]. [cited 2016 November 2018]. Available from: https:// dhsprogram.com/publications/publication-FR321-DHS-Final-Reports. cfm.
10. World Bank Document, . Ethipia's progress[Internet].Washington DC: World Bank 2017 [cited November 2017 November 2019]. Available from: http://data.worldbank.org/country/ethiopia.
11. Report.EC.FP PMA2020. Ethiopia Country Report. NewYork: United Nations; 2018-19 [cited 2019 November 2019]. Available from: http://www.pma2020.org/sites/default/files/indicators-table-CPR_mCPR_UnmetNeed
12. Korra A , Haile M. Sexual behaviour and level of awareness on reproductive health among youth. Ethipian Journal of Health Development. 1999;13(2):107-13.
13. CSA, ICF M. Ethiopia Demographic and Health Survey 2011[Internet]. [cited 2011 November 2018]. Available from: https:// dhsprogram. com/publications/publication-FR328- DHS- Final-Reports. cfm.

14. Tuloro T, Deressa W, Ali A, Davey G. The role of men in contraceptive use and fertility preference in Hossana Town, southern Ethiopia. Ethiopian Journal of Health Development. 2006;20(3):p.5.

15. United Nations. World Population Prospects: The 2015 Revision, Key Findings and Advance Tables. New York: Department of Economic and Social Affairs, Population Division; 2015 p. 1–8.

16. Getu Degu Alene. Examination of the Levels and determinant factors of fertility and contraceptive use in Northwest Ethiopia:With special reference to the application of the Bongaarts' model: A thesis submitted to the school of Graduate Studies of Addis Ababa University in partial fulfillment of the requirements for the degree of Doctor of Philosophy (PhD); 2009.

17. World Health Organization. Children: reducing mortality: fact sheet[Internet]. Geneva: World Health Organization; ; 2016 [updated 2016 Jan cited 2016 May 15 November 2018]. Available from: http://www.who.int/.

18. United Nations. World Population Prospects: The 2017 Revision, Key Findings and Advance Tables. New York: Department of Economic and Social Affairs; ; 2017. p. 1–14.

19. Ayele W, Tesfaye H, Gebreyes R, Gebreselassie T. Trends and determinants of unmet need for family planning and programme options, Ethiopia. Federal Ministry of Health of Ethiopia and ICF International. 2013.

20. United Nations. Trends in Contraceptive use worldwide. New York: Department of Economic and Social Affairs ,Population Division; 2015. p. 31-5.

21. United Nations. Trends in Contraceptive Use Worldwide 2015. New York:Department of Economic and Social Affairs. Population Division New york; 2015. p. 1–31.

22. Stephen K, Biddlecom A, Kantorova V, editors. Adolescent Fertility Since the International Conference on Population and Development (ICPD) in Cairo.Proceedings,1990-2010 World Population Prospects 2013; Cairo. NewYork:Department of Economic and Social Affairs Population Division; 2013.

23. Addis Ababa. Community-based family planning, including long-acting contraceptive services at selected health centers and their health posts in four regions of Ethiopia:The Last Ten Kilometers Project (L10K):a situational analysis. JSI Research & Training Institute, Inc. 2015.

24. CSA, ICF M. Ethiopia Demographic and Health Survey 2014[Internet]. 2014. [cited 2014 November 2018]. Available from: https:// dhsprogram. com/ publications/ publication-FR328-DHS-Final-Reports. cfm.

25. Eliason S, Baiden F, Quansah-Asare G, Graham-Hayfron Y, Bonsu D, Phillips J, et al. Factors influencing the intention of women in rural Ghana to adopt postpartum family planning. Reproductive Health. 2013;10(1):p.34.

26. Alemayehu GA, Fekadu A, Yitayal M, Kebede Y, Abebe SM, Ayele TA, et al. Prevalence and determinants of contraceptive utilization among married women at Dabat Health and Demographic Surveillance System site, northwest Ethiopia. BMC Women's Health. 2018;18(1):p.118.

27. Almualm YKA, Khamis Y. Knowledge, attitude and practice of husbands towards modern family planning in Mukalla, Yemen: Thesis submitted in fulfillment of the requirements for the degree of Master of Science (Family Health) 2007, University of Sains, Malaysia; 2007.

28. Singh S, Darroch JE, Ashford LS, Vlassoff M. Adding It Up: The costs and Benefits of Investing in family Planning and maternal and new born health. New York: Guttmacher Institute and United Nations Population Fund: 2009.

29. UNFPA. Family planning and poverty reduction benefits for families and nations. FACTSHEET NewYork: United Nations; 2010. [Noember 2018]. Available from: http://www.unfpa.org/rh/planning/mediakit/docs/new_docs/sheet4english.pdf.

30. Gizaw A, Regassa N. Family planning service utilization in Mojo town, Ethiopia: A population based study. Journal of Geography and Regional Planning. 2011;4(6):355-63.

31. Zainab B, Sharmin S, Islam MN, . Factors affecting utilization of MCH services in Bangladesh. The Journal of Family Welfare. 2011; 47(1):p.1385.

32. Hounton S, Barros AJ, Amouzou A, Shiferaw S, Maïga A, Akinyemi A, et al. Patterns and trends of contraceptive use among sexually active adolescents in Burkina Faso, Ethiopia, and Nigeria: evidence from cross-sectional studies. Global Health Action. 2015;8(1):297-37.

33. Harrington, Elizabeth K, Newmann, Sara J, et al. Fertility intentions and interest in integrated family planning services among women living with HIV in Nyanza Province, Kenya: a qualitative study. Infectious Diseases in Obstetrics and Gynecology. 2012.

34. Ochako R, Mbondo M, Aloo S, Kaimenyi S, Thompson R, Temmerman M, et al. Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. BMC Public Health. 2015;15(1):p.118.

35. Darroch, Jacqueline E, Woog, Vanessa, Bankole, Akinrinola, et al. Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents. Guttmacher Institute. 2016.

36. World Bank. Addis Ababa, Ethiopian enhancing urban resilience. Washington DC: World Bank; 2015. p. 1-46.

37. Addis Ababa City Government. Population of subcities[Internet]. Addis Ababa: Addis Ababa City Administration; 2019 [Novemeber 2019]. Available from: http://www.addisababa.gov.et/web/guest/facilities-and-infrastructure.

38. United Nations Human Settlements Programme (UN-HABITAT). Situation analysis of informal settlements in Addis Ababa, cities without slums sub-regional programme for Eastern and Southern Africa, Addis Ababa Slum. Nairobi: United Nations; 2007.

39. Mekonnen W, Worku A Determinants of low family planning use and high unmet need in Butajira District, South Central Ethiopia. ReprodHealth 8: 37. 2011.

40. WHO. Health Behaviour in school -age children:HBSC 2013/2014 survey. Geneva: WHO; 2014

41. Hubacher D, Trussell J. A definition of modern contraceptive methods. Contraception. 2015;92(5):420-1.

42. Oddens B.J, Vissera A.P, Vemerb H.M, Everaerdc W. Contraceptive use and attitudes in reunified Germany. European Journal of Obstetrics & Gynecology and Reproductive Biology. 1994;57(1994):201-8.

43. Alemayehu M, Aster K, Alem D, Hailay G, Tesfalem H, Henock Yy, et al. Rural women are more likely to use long acting contraceptive in Tigray region,Northern Ethiopia: a comparative community-based cross sectional study. BMC Women's Health. 2015;15(5):p.71.

44. Hamdalla T, Abinet A, Markos T, et al. Prevalence and associated factors of modern contraceptive utilization among married women in reproductive age group in Misha Woreda Hadiya Zone, South Ethiopia. Journal of Women's Health Care. 2017;6(3):p.6.

45. Gizachew AB, Tatek AZ, Teresa KB, Alemayehu M, Belachew T, Tilahune. Demand for long acting and permanent contraceptive methods and associated factors among married women of reproductive age group in Debre Markos Town, North West Ethiopia. BMC Women's Health. 2014:14-46.

46. Sileo KM, Wanyenze RK, Lule H, Kiene SM. Determinants of family planning service uptake and use of contraceptives among postpartum women in rural Uganda. International Journal of public health(Int J). 2015;60(8):987–97.

47. Terefe A, Larson CP. Modern Contraception use in Ethiopia: Does involving husbands make a difference? Am J public Health. 1993;83(11):1567-71.

48. Damot W, Alemtsehay M, Mastewal N, Tarekegn M. Modern Contraceptive Use among orthodox christian and muslim women of Reproductive Age Group in Bahir Dar City, North West Ethiopia: Comparative Cross Sectional Study. Open Journal of Epidemiology, . 2014;1(4):235-42.

49. Victor A, . Religion and Contraception in Mozambique: A Multidimensional Analysis Center for Population Dynamics Arizona State University[Internet] Arizon: Arizona State University; 2014 [cited 2014 November 2019]. Available from: https://auca.kg/uploads/Migration.../Victor_Agadjanian_CV.pdf.

50. Kamal N. The influence of husbands on contraceptive use by Bangladeshi women. Health Policy and Planning. 2000;15(1):43-51.

51. Olugbenga Bello AI, Abodunrin OL. Contraceptive practices among women in rural communities in Nigeria. . Global Journal of Medical research. 2011;1(2):1-8.

52. Wenjuan W, Wang S. How family planning supply and the service environment affect contraceptive use. Findings from four East African countries DHS Analytic studies 2012:p: 26.

9. Annexes

Annex I: Information sheet in English

Addis Ababa University

School of Public Health

Study on "***Examination of Current and Future Modern Contraceptive Use and the Determinants among Youth in Addis Ababa, Ethiopia*****"**

Greeting, first of all I would like to thank you for your time.

Good morning /Good afternoon, I am…… working as data collector in this study.

Dear respondents here are lists of questions with different sections, which are designed for research work to be conducted in partial fulfillment of master Degree in public health by Mark.M.Abilba in collaboration with Addis Ababa University, School of Public Health. The main purpose of the study is "*Examination Of Current And Future Modern Contraceptive Use and the Determinants Among Youth In Addis Ababa,"* We are inviting the youth between the ages of 15 to 24 years to contribute for the study. You have been selected at random among respondents within households in this woreda. The study will not cause any harm to you except giving the information.

I will ask you some questions about yourself. The interview will take about 15 minutes. There are no anticipated problems but in case some questions make you feel uncomfortable; you are free to express your discomfort or decide not to respond. If you choose not to participate or withdraw from the interview at any point, you are obliged to do so at your own will.

There are no direct benefits for you for choosing to participate in this interview. However, you will be helping program managers and others in future to develop better family planning/modern contraceptives services so as to improve the quality of life of the youth in Addis Ababa. Also any question you love to ask about Family Planning and modern contraceptives, feel free to ask.

Your name will not be recorded and all the information you give will be kept strictly confidential, which will be used only for the purpose of this study.

At this time, do you want to ask me anything about the study? If you have any questions at any time even after the interview, feel free to ask.

Contacts for Additional Information

Any questions or any further clarifications concerning the study can be directed to:

Contact of the principal investigator:

Dr. MARK.M.ABILBA (MD)

Phone no.: 0947315854 Email: **drabilba@gmail.com**

Advisors

1. **Mulugeta Betre(Assoc.Prof-Dr) Phone no 0920812800**
2. **Mr. Nigussie Asefa(MPH) Phone no 0912142509**

Do you agree to be a respondent in this study? _____ 1= yes 2=No

If yes, I will continue and

If no, I will skip to the next participant after writing the reasons of not responding _____

Date: -------/MM/------/DD/----------/YY/

Signature of client ----------

Name of the data collector ---------- Signature of data collector ----------

Questionnaires ID number_____

The result of collected data

A) Completed

B) Not completed

C) Partially completed .D) Refused.

Checked by Supervisor: Name……..Sign…….Phone no……

Annex II: Information sheet in amharic

1.**የ መ ረ ጃ መ ስ ጫ ቅ ጽ**

አ ዲ ስ አ በ ባ ዩ ኒ ቨ ር ሲ ቲ

የ ህ ብ ረ ተ ሰ ብ ጤ ና ት ም ህ ር ት ቤ ት

የ ም ር ም ር ዕ ስ ፡ የ ዘ መ ና ዊ ቤ ተ ሰ ብ ዕ ቅ ድ ዘ ዴ አ ሁ ን ከ ማ ጠ ቀ ም ጋ ር እ ና ወ ደ ፊ ት ለ ማ ጠ ቀ ም ከ ሚ ፈ ለ ጉ አ ፍ ላ ወ ጣ ቶ ች ጋ ር የ ተ ያ ያ ዙ ም ክ ን ያ ቶ ች በ አ ዲ ስ አ በ ባ ኢ ት ዮ ጵ ያ

ሰ ላ ም፤ በ ቅ ድ ሚ ያ ለ ሚ ጠ ሻ ጊ ዜ ከ ልብ አ መ ሰ ግ ና ለ ሁ ፡ ስ ሜ ---------- ይ ባ ላ ል፤ በ ዚ ህ ጥ ና ት ላ ይ ም የ ሚ ጃ ሰ ብ ሳ ቢ ባ ል ሞ ያ ሆ ኜ የ ም ሰ ራ ይ ሆ ና ል ፡ ፡

ከ ዚ ህ በ ታ ች የ ተ ለ ያ ዩ የ ጥ ያ ቄ ክ ፍ ሎ ች ን የ ያ ዙ ጥ ያ ቄ ዎ ች የ ሚ ኙ ሲ ሆ ን ጥ ያ ቄ ዎ ቹ ም ከ ላ ይ በ ተ ቀ ማ ጠ ው ና በ ቤ ተ ሰ ብ ዕ ቅ ድ ዙ ሪ ያ ባ ተ ኮ ረ ው የ ም ር ም ር ዕ ስ ዙ ሪ ያ የ ሚ ጠ ተ ጥ ኑ ሲ ሆ ን ም ር ም ሩ ም በ ዶ/ር ሚ ር ክ አ ቢ ል ባ መ ሪ ነ ት የ ሚ ከ ና ወ ን ይ ሆ ና ል ፡ ፡ እ ር ስ ዎ ም በ ዚ ጥ ና ት ወ ስ ጥ እ ን ዲ ሳ ተ ፉ እ ድ ሜ ዎ ከ 15 እ ስ ከ 24 ድ ረ ስ በ መ ሆ ኑ ና በ ዚ ህ ወ ረ ዳ ወ ስ ጥ በ እ ጣ የ ተ መ ረ ጡ ሲ ሆ ን ም ር ም ሩ ም በ እ ር ሶ ፍ ቃ ድ ላ ይ የ ሚ ሳ ረ ት ይ ሆ ና ል ፡ ፡ ይ ህ ም ር ም ር ም ከ እ ር ሶ ጥ ቂ ት ጥ ያ ቄ ዎ ች ን በ ማ ጠ የ ቅ መ ረ ጃ ከ መ ሳ ብ ሰ ብ ወ ጪ ም ን ም አ ይ ነ ት ጉ ዳ ት የ ሞ ያ ስ ከ ት ል ብ ዎ ት መ ሆ ኑ ን ለ ሚ ረ ጋ ገ ጥ እ ፈ ል ጋ ለ ሁ ፡ ፡

በ ቅ ድ ሚ ያ ስ ለ እ ራ ስ ዎ አ ን ዳ ን ድ ጥ ያ ቄ ዎ ች ን የ ም ጠ ይ ቅ ዎ ት ሲ ሆ ን ፤ ይ ህ ም በ አ ማ ካ ይ እ ስ ከ 15 ደ ቂ ቃ ለ ፈ ጅ ቡ ን ይ ች ላ ል ፡ ፡ ብ ዙ ም ች ግ ሮ ች ይ ከ ሰ ታ ሉ ብ ለ ን ባ ና ስ ብ ም አ ን ዳ ን ድ ጥ ያ ቄ ዎ ች ም ና ል ባ ት ም ኞ ት ከ ነ ሳ ዎ ት በ ነ ጻ ነ ት ማ ን ወ ቅ አ ል ያ ም አ ለ መ ሞ ላ ስ ይ ች ላ ሉ ፡ ፡ በ ተ ጨ ማ ሪ ም በ የ ት ኛ ዉ ም ጊ ዜ ላ ለ መ ሳ ተ ፍ ም ይ ሁ ን ሜ ቋ ረ ጥ የ ሚ ፈ ል ጉ ከ ሆ ነ ያ ለ ም ን ም ጫ ፍ ላ ጎ ት ዎ የ ሚ ከ በ ር ይ ሆ ና ል ፡ ፡

በ ዚ ህ ጥ ና ት ላ ይ በ መ ሳ ተ ፍ ዎ በ ቀ ጥ ታ የ ሚ ገ ኙ ት ጥ ቅ ም ባ ይ ኖ ር ም ከ ወ ጣ ቶ ች ጋ ር የ ተ ያ ያ ዘ የ ቤ ተ ሰ ብ ዕ ቅ ድ አ ገ ል ግ ሎ ት ዙ ሪ ያ ለ ሚ ሰ ሩ አ ካ ላ ት ም ይ ሁ ን ተ ቃ ማ ች ከ ም ር ም ሩ የ ሚ ኘ ዉ ዉ ጤ ት መ ል ካ ም አ ስ ተ ዋ ጽ አ የ ሚ ኖ ረ ው ይ ሆ ና ል ፡ ፡ በ ተ ጨ ማ ሪ ም ስ ለ ዘ መ ና ዊ ቤ ተ ሰ ብ እ ቅ ድ ዘ ዴ ዎ ች ና ተ ያ ያ ዥ ጉ ዳ ዮ ች ማ ኛ ዉ ን ም ማ ወ ቅ የ ሚ ፈ ል ጉ ት ነ ገ ር ካ ለ በ ማ ኛ ዉ ም ወ ቅ ት መ ጠ የ ቅ የ ሚ ቻ ሉ ይ ሆ ና ል ፡ ፡

በ ዚ ህ ጥ ና ት ላ ይ ሲ ሳ ተ ፉ በ የ ት ኛ ዉ ም ሁ ኔ ታ የ እ ር ስ ዎ ን ስ ም የ ማ ን ጠ ቅ ስ ሲ ሆ ን ፤ የ ሚ ኘ ዉ ን ም መ ረ ጃ ሚ ጠ ራ ዉ ኒ ቱ የ ተ ጠ በ ቀ ና ለ ዚ ህ ም ር ም ር አ ላ ማ ብ ቻ የ ሚ ዉ ል ይ ሆ ና ል ፡ ፡

ጥ ያ ቄ ካ ለ ዎ ት አ ሁ ን ም ይ ሁ ን ፣ በ መ ረ ጃ ዉ አ ሰ ባ ሰ ብ ሂ ደ ት አ ል ያ ም ከ ዚ ያ በ ኃ ላ የ ማ ን ሳ ት መ ሉ መ ዉ ጣ ት ያ ለ ዎ ት መ ሆ ኑ ን እ ገ ል ጻ ለ ሁ ፡ ፡

<u>ለ በ ለ ጠ መ ረ ጃ</u>

ስለጥናቱ ያለህን/ሽን ጥየቄም ሆነ መበረርየ ከፈለግከ/ሽ ከዝህበተች በለዉ አድረሻ ልታገኘን/ኝን ትችላለ/ትችያለሽ፡፡

ዶ/ር ሚኪ አበልባ፡ ስልክ ቁጥር ፡ 0947315854 ኢሜይል፡ drabilba@gmail.com

አማክሪዎች፡ -

1. ሞኒግታ በትረ (ተባባሪ ፕሮፌሰር - ዶ/ር) ስልክ ቁጥር 0920812800

2. አቶ ንጉሴ አስፋ ስልክ ቁጥር 0912142509

ለተፈለገዉ መረጃ ፍቀደኘ ነህ/ነሽ ……..? 1. አዎ 2. አይደለሁም

መልስህ/ሽ አዎ ከሆነ እቀጥለለዉ፡፡

መልስህ/ሽ አየደለሁም ከሆነ ፤ምክንያቱን በመግለፅ ወደ ሚቀጥለዉ ተሳታፊ አልፋለዉ፡----------
---

ቀን----------

የተሰተፊዉ ፊርማ----------

የመረጃ ሰብሳቢዉ ስም----------ፍርማ----------

የማጠይቁ መላያ ቁጥር----------

የመረጃ አሰባሰብ ዉጤት

A. ሞኑ ለሞኑ ተሞልቷል

B. በከፊሉ ተሞልቷል

C. ሞኑ ለሞኑ አልተሞላም

D. እምቢ አለ

የተቆጣጣሪዉ፡ ስም----------ፊርማ----------ስልክ ቁ.ጥ----------

Annex III: Consent form and questionnaire in English

This consent form has been read and explained to me and I have understood, and my questions have been addressed. I therefore willingly agree to take part in the study.

1, Yes; continue to the consent form

2, NO; skip to the next participant

Participant signature/ finger print _____

Name of household _____

Interviewer name _____ signature _____

Date of interview _____Time started _____time finished _____

Supervisor name _____ signature _____

8.3 Questionnaire in English

ID. No._____ Date of Interview_____Site of service delivery_____

A. SOCIO - DEMOGRAPHIC DATA

Questions	**Coding category**	**Skip to Q no indicated**
1. How old were you at your last birthday? **1.1** What is your date of birth?	_____years (age in complete years) ___ day/_____month/_____year	
2. Sex of respondents.	1. Male 2. Female	
3. What is your marital status?	1. Single 2. Married. 3. Divorced 4. Widowed 99. Others (Specify)……	
4. What is the level of formal education?	1. Never 2. Not completed Elementary school 3. Completed Elementary school 4. High school level 5. University level 6. College level 99. Others (specify)……..	
5. What is your occupation?	1. Unemployed 2. Own Business 3. Farmer 4. Student 5. Employed 6. Retired 99. Others (specify) ……	

6. What is your spouse/partner's occupation?	1. Unemployed 2. Own Business 3. Farmer 4. Student 5. Employed 6. Retired 99. Others (specify)……..	
7. What is your religion?	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 99. Others (specify)……..	
8.specific daily income of family	1..HighestLevel>10usd/day(>280birr/day) 2.Well-doing:6-10usd/day(168-280 birr/day) 3.Average:3-5.96usd(84-167birr/day) 4. Poor1-2.96usd/day(28-83birr/day) 5. Very Poor<1usd/day,(28birr a day)	
9. How often do you attend religious services?	1. Every day 2. At least once in a week 3. At least once in a month 4. At least once in a year 5. Never	

B: CONTRACEPTIVE METHODS KNOWLEDGE AND USE

1. Knowledge about contraceptives

Questions	**Coding category**	**Skip to Q No indicated**
10. Have you ever had sexual intercourse?	1. Yes 2. No	
11. Have you ever heard of modern contraceptives?	1. Yes 2. No	**if No, skip to Q 15**
12. Where did you get information	1. Media	

about modern contraceptives? (Remark: more than one answer is possible)	2. From peer 3. From husband/partner 4. Seminar/training 5. Health facility 99.Other(specific)----------	
13. What are the reasons of using modern contraceptives? (Remark: more than one answer is possible)	1. To space pregnancy 2. To limit pregnancy 3. To avoid unwanted pregnancy. 99. Others(specific)----------	
14. Which types of contraceptive method do you know? (Remark: more than one answer is possible)	1. Pills 2. Intrauterine device 3. Injectable 4. Condom (female) 5. Condom (male) 6. Vasectomy 7. Tubal ligation 8. Periodic abstinence 9. Prolonged breast feeding 10. Natural methods 99. Others (specify)……	
15. Do you approve the use of contraceptives?	1. Yes 2. No 3I don't know	
16. Have you ever used modern contraceptives?	1. Yes 2. No	**Skip if No to Q 20**

17. Which modern contraceptives method did ever use? (Remark: more than one answer is possible)	1. Pills 2. Intrauterine device 3. Injectable 4. Condom (female) 5. Condom (male) 6. Vasectomy 7. Tubal ligation 99. Others (specify)……..	
18. Are you currently using any contraceptives?	1. Yes 2. No	**If No, skip to Q 20**
19. What type of modern contraceptives methods are you using? (Remark: more than one answer is possible)	1. Pills 2. Intrauterine device 3. Injectable 4. Condom (female) 5. Condom (male) 6. Vasectomy 7. Tubal ligation 99. Others (specify)……..	**After Q 19,skip to 21**
Questions	**Coding category**	**Skip**
21 Have health care providers ever discussed about modern contraceptives with you?	1. Yes 2. No 33. I don't remember	
22. Do you want to use modern contraceptives in the future? (For those currently using contraceptive methods)	1. Yes 2. No 3.I don't know	
23. Do you want to use modern contraceptive in future? (For those who never used contraceptive methods)	1. Yes 2. No 3.I don't know	

24. Do you think that there are any advantages with the use of modern contraceptives?	1. Yes 2. **No** 3. I don't know	**If No, skip to Q.26**
25. What would be the reasons for you to use modern contraceptives methods? (Remark: more than one answer is possible)	1. Child spacing 2. No need for more children 3. Delay due to employment. 4. Delay due to school 5. Fear of infecting my unborn child. 6. My family member advise me to use it 7. peer advice 99. Others (specify)……	

B .SOCIO-CULTURAL FACTORS INFLUENCING THE USE OF MORDERN CONTRACEPTIVES

Questions.	**Coding category**	**Skip to Q No indicated**
A. Communication between spouses about family planning.		
26. Have you a spouse/partner?	1. Yes 2. No.	If, No skip to Q33
27. Does your partner use contraceptive methods currently? Any or modern	1. Yes 2. No. 33. I don't remember	
28. Have you ever discussed about modern contraceptives with your spouse/partner in the past?	1. Yes. 2. No. 33.I don't remember	If, No skip to Q30
29. How many times in the last 6 months?	1. Never. 2. Once. 3. Twice. 4. Three times. 5. More than three times	If yes to Q28 continue Q29

30. Why you did not discussed about modern contraceptives with your spouse/partner?	1. She/he does not approve 2. It is against cultural norms 99. Others (specify)……	If yes to Q28 skip to Q31
31. Have you ever informed your spouse/partner that you use contraceptives in family planning?	1. Yes. 2. No 33. I don't remember	
32. If you want to use contraceptives methods, who makes decision on utilization of modern family contraceptive planning methods?	1. Husband/friends. 2. Wife/friends. 3. Husband and wife /**friends** jointly. 4. Mother or father of husband 99. Others (specify)……	
B. Attitude and support towards family planning/contraceptive use.		
33. Does your spouse/partner approve you using family planning methods?	1. Yes 2. No 3. I don't know	
34. Do your close relatives (mother, father, father-in-law or mother-in-law, sister or brothers of your partner) support if you want to use contraceptive methods?	1.Yes 2. No. 3. I don't know	
C. Family size and sex preference.		
35. Do you have any children?	1. Yes 2. No	If No skip to Q38
36. How many children do you have?	_____children	
37. How many boy(s) and girl(s)?	1. Boy(s)_____ 2. Girl(s)_____	
38. Who decides on the number of children you have?	1. Spouse/partner. 2. Myself.	

	3. Family members/Close relatives. 4. Parents 5.Me and my spouse 99.Others (specify)……	
39. Do you think not having a male child prevent you from using family modern planning methods? (Remark: This should have to be asked when she/he has no male child)	1. Yes. 2. No. 3.. I don't know	
40. Do you think your traditional /cultural believe are against use of modern family planning?	1. Yes. 2. No. 3. I don't know	
41. Does your society you are living in support use of family modern planning methods?	1. Yes. 2. No. 3. I don't know	
42. Would you like to have children in the future?	1. Yes 2. No 3, I don't know	

AA42. ***Please indicate the most appropriate response***

	Strongly Agree	Agree somewhat	Neutral	Disagree somewhat	Strongly Disagree
1. FP/Cont use is influenced by cultural belief.	O	O	O	O	O
2. FP/Cont use is influenced by religious belief.	O	O	O	O	O
3. Deciding a FP/ Cont method is influenced by friends/ relative approval	O	O	O	O	O
4. FP/ Cont methods use is influenced by village talk/rumors.	O	O	O	O	O
5. FP/ Cont use is influenced by partner approval	O	O	O	O	O
6. Choosing FP/ Cont method jointly with your partners influences your FP usage.	O	O	O	O	O

THANKS VERY MUCH FOR PARTICIPATING.

Annex IV: Consent form and questionnaire in amharic

8.2. የፊቀደኝነት መግለጫ ቅጽ

ይህ የፈቀደኝነት መግለጫ ቅጽ ተነቦልኛል፤ ተብራርቶልኛል፤ እኔም ተረድቼዋለዉ እንዲሁም ጥያቄዎቼ ተመልሰወልኛል፡ ፡ ስለዚህ በጥናቱ ላይ በገዛ ፍቃዴ ለመሳተፍ ወስኛለዉ፡ ፡

1. አዎ ወደ ፍቃደኝነት መግለጫ ቅጽ እቀጠላለሁ

2. የለም ወደ ሚቁጥለዉ ተሳታፊ ይሂዱ

የተሳታፊ ፊርማ/የጣት አሻራ----------

የቤተሰብ ስም----------

የቃለመጠይቅ አድራጊ ስም---------- ፊርማ----------

የቃለመጠይቅ ቀን----------/ቀን/----------/ወረ/----------/ዓ.ም/ የተጀመረበት ጊዜ----------የተጠናቀቀበት ጊዜ----------

የሱፐረቪይዘር ስም---------- ፊረማ----------

8.3 ጥያቄዎች በአማረኛ

ሚሊያቁ ጥር_____ የቃለ ማጠይቅ ቀን_____

የአገልግሎት ማቅረብያ ቦታ _____

ሀ. የማህ

በራዊ – ዲሞግራፊክ ሚጃ

ጥያቄ	**መልስ**	**ወደ ተመለከተዉ የጥያቄ ቁጥር ሚሸፍ**
1. እድሜዎት ስንት ነዉ? 1.1 የልደት ቀን?	_____አመት ___ቀን/_____ወር/_____ዓም	
2. ጸታ?	1. ወንድ 2. ሴት	
3. የጋብቻ ሁኔታ?	1. ያላገባ/ች 2. ያገባ/ች 3. አግብቶ የፈታ/ች 4. ባል የሞተባት/ሚስት የሞተበት 99. ሌላ ካለ (ይግለጹ)……	
4. የትምህርት ደረጃ?	1. ምንም ያልተማረ/ች 2. 1ኛ ደረጃ ያላጠቀቀ/ች 3. 1ኛ ደረጃ ያጠቀቀ/ች 4. ሁለተኛ ደረጃ ያጠቀቀ/ች 5. ዩኒቨርሲቲ/ ከሌጅ ያጠቀቀ/ች 99. ሌላ ካለ (ግለፅ/ፂ)……	
5. የስራ ሁኔታ?	1. ስራ የሌለዉ/ የቤት እማቤት 2. የግል ስራ 3. የግብርና ባለሞያ 4. ተማሪ 5. የመንግስት/የግለሰብ ተቀጣሪ 6. ጡረተኛ 99. ሌላ ካለ (ይግለጹ)……	

6. የትዳር አጋርዎ የስራ ሀኔታ?	1. ስራ የሌለው 2. ተማሪ 3. የመንግስት/ የግለሰብ ተቀጣሪ 4. ነጋዴ 5. የግብርና ባለሙያ 99. ሌላ ካለ (ይግለጹ).....	
7. ሀይማኖት?	1. አርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 99. ሌላ ካለ (ይግለጹ).....	
8. የቤተሰብየ ለትገቢ	1. እጅግ በጣም ከፍተኛ ደረጃ (>280 ብር) 2. ጥሩ 6-10 USD (168-280 ብር) 3.መካከለኛ 3-5.96 USD(84-167በር) 4. ደሃ1-2.96 (28-83 ብር) 5. በጣም ደሃ (<28 ብር)	
9. የእምነት/አምልኮ ስርዓቶች ላይ ምንያህል ትሳተፋለህ/ሽ?	1. በየቀኑ 2. ቢያንስ በሳምንት 1 ጊዜ 3. ቢያንስ በወር 1 ጊዜ 4. ቢያንስ በዓመት 1 ጊዜ 5. ተሳትፎ አላወቅም	

ለ. በእርግዝና መከላከያ ዘዴዎች እወቀት እና አጠቃቀም ዙሪያ

1. ስለ እርግዝና መከላከያ ዘዴዎች የተሳታፊዎች እወቀት

ጥያቄዎች	ምላሾች	ወደ ተመላከተዉ የጥያቄ ቁጥር ሚለፍ
10.የግብረስጋ ግኑኝነት አድረገህ/ሽ ተወቅለህ/ሽ?	1. አዎ 2. የለም	

11.ስለዘመናዊ እርግዝና መከላከያ ዘዴዎች ሰምተህ/ሽ ተወቃለህ/ሽ?	1. አዎ 2. አላወቅም	መልሱ አላወቅም ከሆነ ወደጥያቄ15 ይሂዱ
12.ስለ ዘመናዊ የእርግዝና መከላከያዎች ሚጃወን ከየትአገህ/ሽ? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. ከማናኛ ብዙሃን 2. ከአቻ እኩያ 3. ከትዳር አጋሬ/ ከገደኛ 4. በስልጠና/ ወይይት 5. ከጠፍ ተቋማት 99. ሌላ (ይገለጽ)……	
13. የዘመናዊ እርግዝና መከላከያ ዘዴዎችን የምትጠቀምበት/ የምትጠቀሚት ምክንየት ምንድረነወ? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. አራርቆ ለመውለድ 2. እርግዝናን ለመግታን 3. ያልተፈለገ እርግዝናን ለመከላከል 99. ሌላካለ (ይግለጹ)……	
14.የትኛዉን ዘመናዊ የእርግዝና መከላከያ ዘዴ አይነት ታቃለህ/ታቅያለሽ? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. ኪኒን / እንክብል 2. በሚዘን ወስጥ የሚቀመጥ መሳረያ 3. በሞፈሬ የሚጥ 4. ኮንዶም (የሴት) 5. ኮንዶም (የወንድ) 6. ዘላቂ የወንዶች መከላከያ ዘዴ (ሚስቋጠር) 7.ዘላቂ የሴቶችመከላከያ ዘዴ (ሚስቋጠር) 8. በእርግዝና አጋላጭ ቀናት ከወሲብ በመታቀብ 9. በተከታታይና ረጅም ጊዜ ጡት በማጥባት 10. የተፈጥሮ ዘዴዎች 99. ሌላ (ይግለጹ)…….	
15.የእርግዝና መከላከያ ዘዴዎችን ማጠቀም ትደግፋለህ/ሽ?	1. አዎ 2. አልደግፍም 3. አላወቅም	

16. ከዚህ ቀደም ዘመናዊ የእርግዝና መከላከያ ዘዴ ተጠቅመህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም	መልሶ አላውቅም ከሆነ ወደ ጥያቄ 20 ይሂዱ
17. የትኛውን እርግዝና መከላከያ ዘዴ ተጠቅመህ/ሽ ተወቅለህ/ሽ? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. ኪኒን / እንክብል 2. በማህፀን ውስጥ የሚቀመጥ መሳሪያ 3. በመርፌ የሚሰጥ 4. ኮንዶም (የሴት) 5. ኮንዶም (የወንድ) 6. ዘላቂ የወንዶችመከላከያ ዘዴ (ሚስቋጠር) 7.ዘላቂ የሴቶችመከላከያ ዘዴ (ሚስቋጠር) 99. ልላ (ይግለጹ)…….	
18. በአሁኑ ወቅት የእርግዝና መከላከያ ዘዴ ትጠቀማለህ/ትጠቀምያለሽ?	1. አዎ 2. የለም	መልሶ የለም ከሆነ ወደ ጥያቄ 20 ይሂዱ
19. የትኛውን እርግዝና መከላከያ ዘዴ እየተጠቀምክ/ሽ ትገኛለህ/ሽ? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. ኪኒን / እንክብል 2. በማህፀን ውስጥ የሚቀመጥ መሳርያ 3. በመርፌ የሚሰጥ 4. ኮንዶም (የሴት) 5. ኮንዶም (የወንድ) 6. ዘላቂ የወንዶች መከላከያ ዘዴ (ሚስቋጠር) 7.ዘላቂ የሴቶች መከላከያ ዘዴ (ሚስቋጠር) 99. ልላ (ይግለጹ)……..	ከጥያቄ 19 በኋላ ወደ ጥያቄ 21 ይሂዱ
20.ዘመናዊ የእርግዝና መከላከያን የሚጠቀምበት/ የሚጠቀሚት ምክንያት ምንድነ ው? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. የትዳር አጋሬ/ነወደኛዬ ስለሚይፈቅድ/ስለሚፈቅድ 2. የሃይማኖት አስተምህሮቴ ስለሚይፈቅድ 3. የነንዮሽ ጉዳቶች አሉትብዬ ስለማምን	

	4. እንደ ካንሰረ፡ መካንነት፡ ብዙ የደም መፈሰስ የመሳሰሉ ብዙ ችግሮችን የስከትላል የሜል ወሬ ስላለ 5. የቤትሰብ አባላቶች እንደ ሌሎች ሰዎች ልጆች፤ ልጆች እንደኖሩኝ ስለሚፋልጉ 6. ለትዳረ አጋሬ/ነ ወደኛዬ ታማኝ እንዳልሆን ስለምያደረግ (ምማዘረን ስለሚፀበረታታ) 7. ግንዛቤ ስለሌለኝ 8. የግብረ ስጋ ግኑኝነት ስለማለደረግ 99. ሌላ ካለ (ይግለጹ) …….	
21. የጠፍ ባለሞያዎች ከእረሰዎ ጋር ስለ ዘመናዊ የእርግዝና መከላከያ ዘዴዎች ወይይት አድረጎ ያወቃሉ?	1. አዎ 2. የለም 33. አላስታወስም	
22. ለወደፍቱ ዘመናዊ የእረግዝና መከላከየ ዘዴዎችን ማጠቀም ይፈልገሉ? (በአሁን ወቅት የእርድዝና መከላከያ ዘዴዎችን አየተጠቀመላሉ)	1.አዎአለኝ 2. የለኝም 3. አላወቅም 99. ሌላ (ይግለጹ) …….	
23. ለወደፊቱ ዘመናዊ የእርግዝና መከላከያ ዘዴዎችን ማጠቀም ትፈልጋለህ/ሽ? (ከዝህ በፊት ማንኛዉንም የእርግዝና መከላከያ ዘዴ ፈፅሞ ለልተጠቀመ/ መች)	1.አዎአለኝ 2. የለኝም 3. አላወቅም	
24. የእርግዝና መከላከያ ዘዴዎችን ማጠቀም ጥቅም አለው ብለህ/ሽ ታስበለህ/ሽ?	1. አዎ 2. የለም 3. አላወቅም	መልሶ የለም ከሆነ ወደ ጥያቄ 26 ይሂዱ
25. ዘመናዊ የእርግዝና መከላከያ ዘዴዎችን ለማጠቀም ምክንያቶችህ/ሽ ምንምን ናቸው ? (ከአንድ በላይ መልስ መስጠት ትችላለህ/ትችያለሽ)	1. አራርቆ መዉለድ ስለምፈልግ 2. ተጨማሪ ልጆችን መዉለድ ስለሚያስፋልገኝ 3. በስራ ምክንያት መቆየት ስለምፈልግ 4. በትምህርት ምክንያት መቆየት ስለምፈልግ 5. ያልተወለደ ህጻን በበሽታ	

	እንዳይያዝ ስለምፍራ 6. የቤተሰቤ አባል እንድጠቀም ስለማረኝ/ችን 7. የጎረቤቴ/ አቻ ምክረ 99. ሌላ ካለ (ይግለጹ)	

ሐ. ዘመናዊ የእርግዝና መከላከያን በማጠቃም ላይ ተጽእኖ ያላቸው ማህበራዊ/ ባህላዊ ምክንያቶች

ጥያቄዎች	ምላሾች	ወደተመለከተዉ የጥያቄ ቁጥር ሚለፍ
ሀ. ስለ ቤተሰብ ምጣኔ በባልና በሚስት መካከል የሚደረግ ወይይት		
26. የተቃራኒ ፆታ አጋረ/ ጎረቤኛ አለህ/ሽ?	1. አዎ 2. የለም	መልሱ የለም ከሆነ #33 ወደ ዝለል
27. የትዳር አጋርህ/ሽ (ጓደኛህ/ሽ) በአሁኑ ወቅት የእርግዝና መከላከያ ዘዴ ይጠቀማል/ ትጠቀማለች?	1. አዎ 2. የለም 33. አላስታወስም	
28. ከዚህ ቀደም ከትዳር አጋርህ/ሽ (ጓደኛህ/ሽ) ጋር ስለ ዘመናዊ የእርግዝና መከላከያ ዘዴ ተወያይተህ/ሽተወቃለህ/ሽ?	1. አዎ 2. የለም 33. አላስታወስም	መልሱ የለም ከሆነ ወደ #30 ዝለል
29. ባላፉት ስድስት ወራት ምን ያህል ጊዜ ተወያይተዋል?	1. ምንም 2. አንድጊዜ 3. ሀለትጊዜ 4. ሶስትጊዜ 5. ከሶስት ጊዜ በላይ	ጥያቄ 28 አወ ከሆነ ወደ ጥያቄ 29 ይቀጥሉ
30. ለምድን ነው ከትዳር አጋርህ/ሽ (ጓደኛህ/ሽ) ጋር ስለ ዘመናዊ የእርግዝና መከላከያ ዘዴ የማትወያይው?	1. ፍቃደኛ ስልሆነ (ች) 2. ከባህላችን ስለሚይፍቅድ 99 ሌላ ካለ (ይግለጹ) ------	ጥያቄ 28 አወ ከሆነ ወደ ጥያቄ 31 ይቀጥሉ
31. ከዚህ በፍት ዘመናዊ የእርግዝና መከላከያ እንደምትጠቀም/ሚ ለትዳር አጋርህ/ሽ (ጓደኛህ/ሽ) አሳወቀህ/ሽ ተወቀለህ/ሽ?	1.አዎ 2. የለም 33. አላስታወስም	
32. የእርግዝና መከላከያ ዘዴዎችን ለማጠቃም በትፈልግ/ጊ፤ ዘመናዊ እርድዝና መከላከያ ዘዴ አጠቃቀም ላይ ወሳኔ የሚጠው ማ ው?	1.ባል/ጓደኛ 2.ሚስት/ ጓደኛ 3. ባልና ሚስት በጋራ/ጓደኛሞች	

	4. የባል እናት ወይም አባት 99. ሌላ (ይግለፁ) ……	
ለ.ስለ ቤተሰብ ምጣኔ ወይም የእርግዝና መከላከያ አጠቃቀም ያለ አመለካከት እና ድጋፍ		
33. የትዳር አጋርህ/ሽ (ጓደኛህ/ሽ) የቤተሰብ ምጣኔ ዘዴ እንዲጠቀሙትፈቅደለህ/ሽ?	1. አዎ 2.የለም 3. አላወቅም	
34. የቅርብ ዘመዶችህ/ሽ (እናት አባት አማት የትዳር አጋርዎ እህት ወይም ወንድሞች) የወሊድ መከላከያ ዘዴ ይፈልጋሉ?	1. አዎ 2.የለም 3. አላወቅም	
ሐ. የቤተሰብ ጣጠን እና የጾታ ምርጫ		
35. ልጆች አለዎት?	1. አዎ 2. የለኝም	መልሱ የለም ከሆነ #38 ወደ ዝለል
36. ስንት ልጆች አለዎት?	በቁጥር_____	
37. ስንት ወንድ/ዶችሴት/ቶች?	1. ወንድ/ዶች_____ 2. ሴት/ቶች_____	
38.ሊኖርህ/ሽ የምትችል/ይ የልጅ ብዘት የሚመስነ ዉ ማነ ው?	1. የትዳር አጋሬ/ጓደኛዬ 2. እራሴ 3. የቤተሰብ አባላት/ የቅርብ ዘመዶች 4. ወላጆች 5.me and my spouse 99. ሌላ (ይግለፁ) ……	
39. ወንድ ልጅ አለመመለደህ/ሽ ዘመዛዊ የቤተሰብ ምጣኔ እንዳትጠቀም/ሚ ከልከለኛል ብለህ/ሽ ታስበለህ/ ታስብየለሽ?	1. አዎ 2. የለም	
40. ባህላዊ እምነት፤ዘመናዊ የቤተሰብ ምጣኔ ዘዴን ይቃረናል ብለህ/ሽ ታስባለህ/ሽ?	1. አዎ 2. የለም	
41.የምትኖረበት/ የምትኖሪበት ማህበረሰብ የቤተሰብ ምጣኔን ይደግፋል?	1. አዎ 2. የለም	

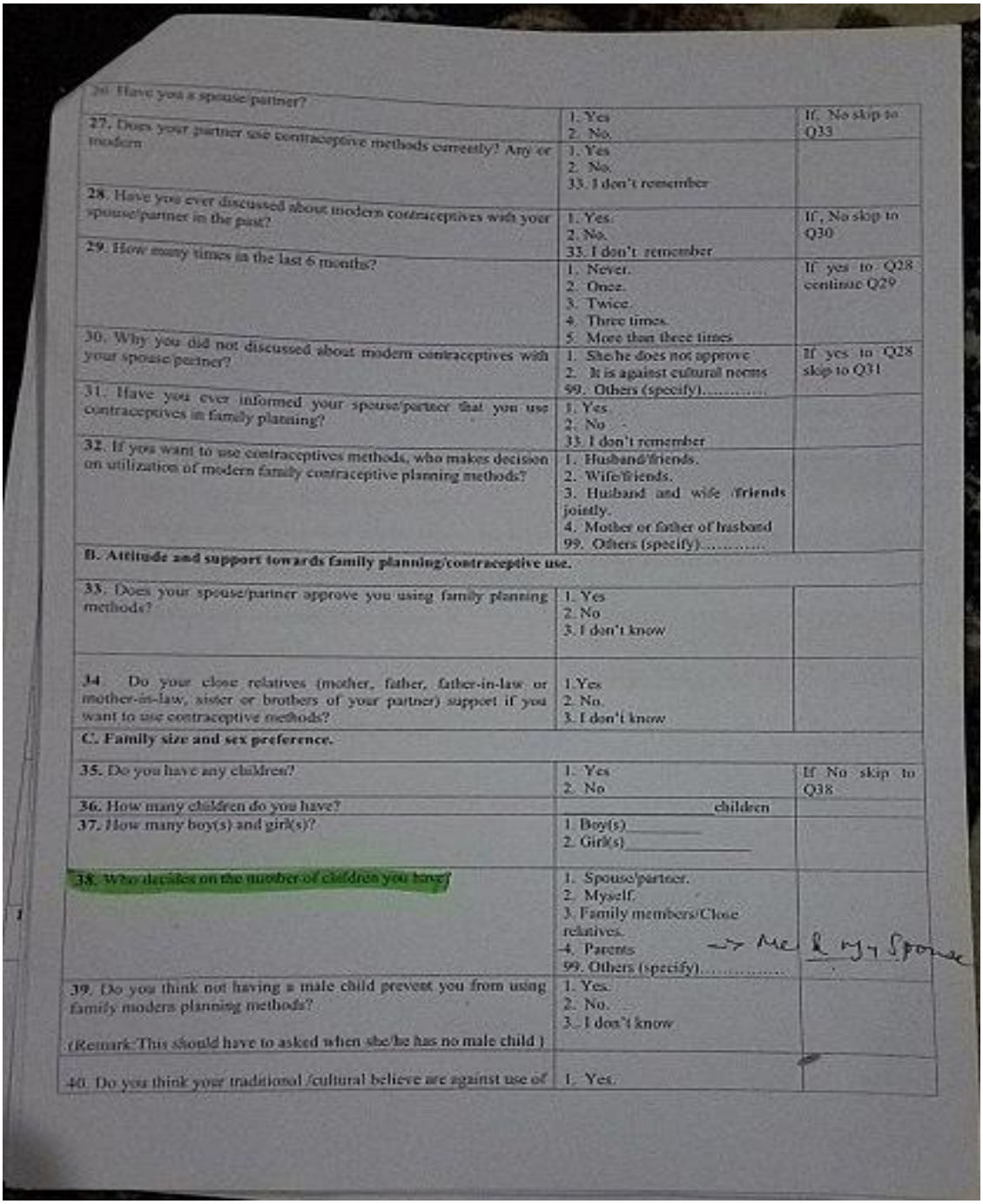
42. ወደፊት ልጅ እንዲኖረህ/ሽ ትፈልጋለህ/ሽ?	1. አዎ 2. የለም	

መ. እባክዎ እጅግ የተሸለዉን ተገቢ ሜልሰይ ጠቁሙ

	በጣምእስማሜለሁ	እስማሜለሁ	ሃሳብአልሰጥም	አልስማሜም	በጣምአልስማማም
1. የቤተሰብ ምጣኔ/ የወልድ መከላከያ አጠቃቀም በባህላዊ እምነት ተጽእኖ ይደረግበታል፤	○	○	○	○	○
2. የቤተሰብ ምጣኔ/ የወሊድ መከላከያ አጠቃቀም በሃይማኖታዊ እምነት ተጽእኖ የደረግበታል፤	○	○	○	○	○
3. የቤተሰብ ምጣኔ /የወልድ መከላከያ ዘዴን በሚመለከት የሚሰጠ ዉሳኔ በጓደኞች/ በዘመድ ፍቃደኝነት ላይ የተመሰረተ ነዉ፤	○	○	○	○	○
4. የሞሪያአካባቢ ወሬ በቤተሰብ ምጣኔ/ እረግዝና መከላከያ ዘይዎችን በማጠቀም ላይ፤	○	○	○	○	○
5. የትዳርአጋር ፍቀደኝነት በቤተሰብ ምጣኔ/ እረግዝና መከላከያ አጠቃቀምላይተፅእኖአለዉ፤	○	○	○	○	○
6. የቤተሰብ ምጣኔ/ የወሊድ መከላከያ ዘይን ከትዳርአጋርጋርበጋራመሰን በእረስዎ የቤተሰብ ምጣኔ ዘዴ አጠቃቀምላይተፅእኖአለዉ፤	○	○	○	○	○

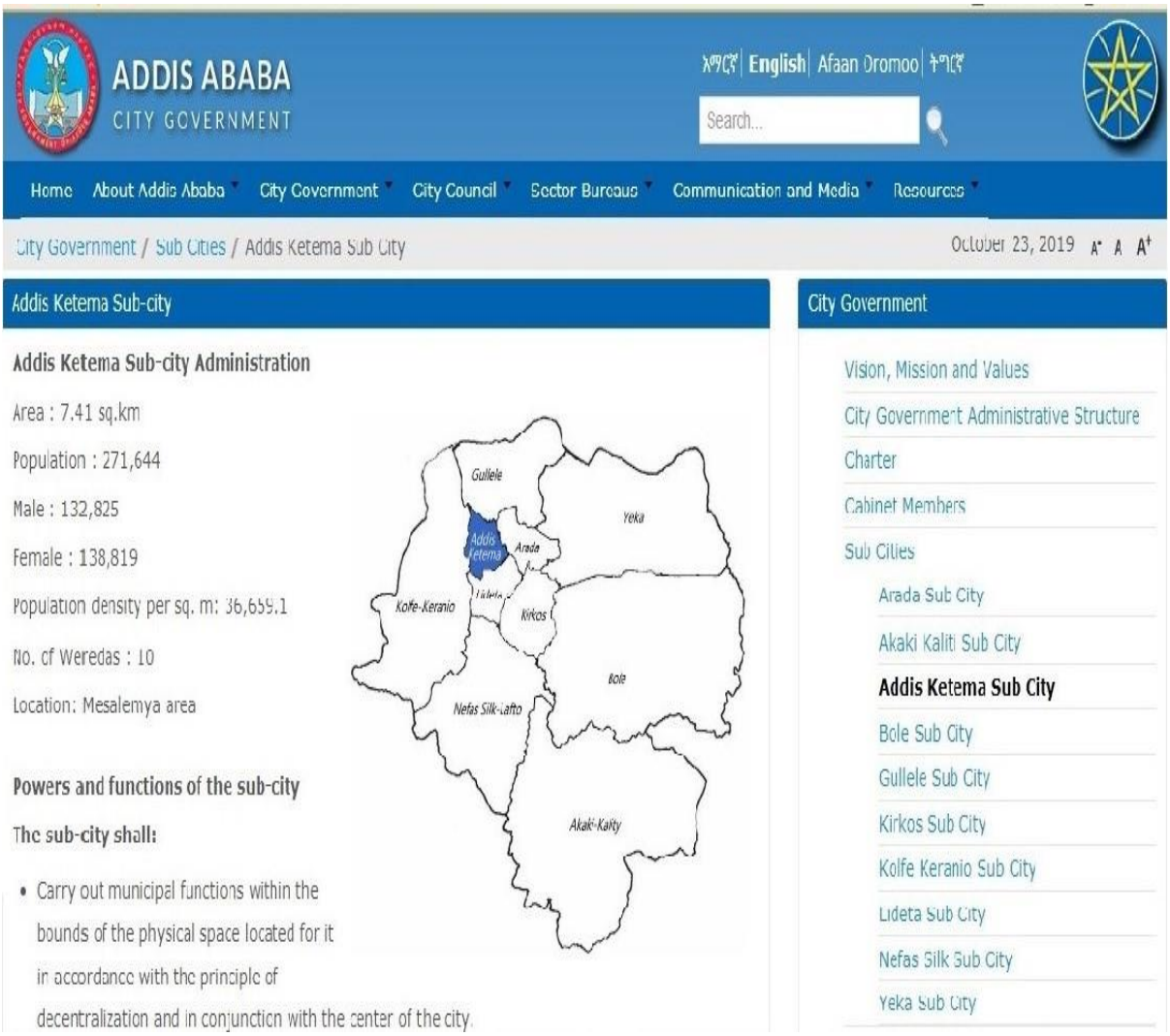
ስለተሳትፎዎ በጣምአመሰግናለዉ፤

Annex V: Modification to Question 38



26. Have you a spouse/partner?	1. Yes 2. No.	If No skip to Q33
27. Does your partner use contraceptive methods currently? Any or modern	1. Yes 2. No. 33. I don't remember	
28. Have you ever discussed about modern contraceptives with your spouse/partner in the past?	1. Yes. 2. No. 33. I don't remember	If , No skip to Q30
29. How many times in the last 6 months?	1. Never. 2. Once. 3. Twice. 4. Three times. 5. More than three times	If yes to Q28 continue Q29
30. Why you did not discussed about modern contraceptives with your spouse/partner?	1. She/he does not approve 2. It is against cultural norms 99. Others (specify).....	If yes to Q28 skip to Q31
31. Have you ever informed your spouse/partner that you use contraceptives in family planning?	1. Yes 2. No 33. I don't remember	
32. If you want to use contraceptives methods, who makes decision on utilization of modern family contraceptive planning methods?	1. Husband/friends. 2. Wife/friends. 3. Husband and wife /friends jointly. 4. Mother or father of husband 99. Others (specify).....	
B. Attitude and support towards family planning/contraceptive use.		
33. Does your spouse/partner approve you using family planning methods?	1. Yes 2. No 3. I don't know	
34. Do your close relatives (mother, father, father-in-law or mother-in-law, sister or brothers of your partner) support if you want to use contraceptive methods?	1.Yes 2. No. 3. I don't know	
C. Family size and sex preference.		
35. Do you have any children?	1. Yes 2. No	If No skip to Q38
36. How many children do you have?	children	
37. How many boy(s) and girl(s)?	1. Boy(s)_____ 2. Girl(s)_____	
38. Who decides on the number of children you have?	1. Spouse/partner. 2. Myself. 3. Family members/Close relatives. 4. Parents -> Me & my Spouse 99. Others (specify).....	
39. Do you think not having a male child prevent you from using family modern planning methods? (Remark:This should have to asked when she/he has no male child)	1. Yes. 2. No. 3. I don't know	
40. Do you think your traditional /cultural believe are against use of	1. Yes.	

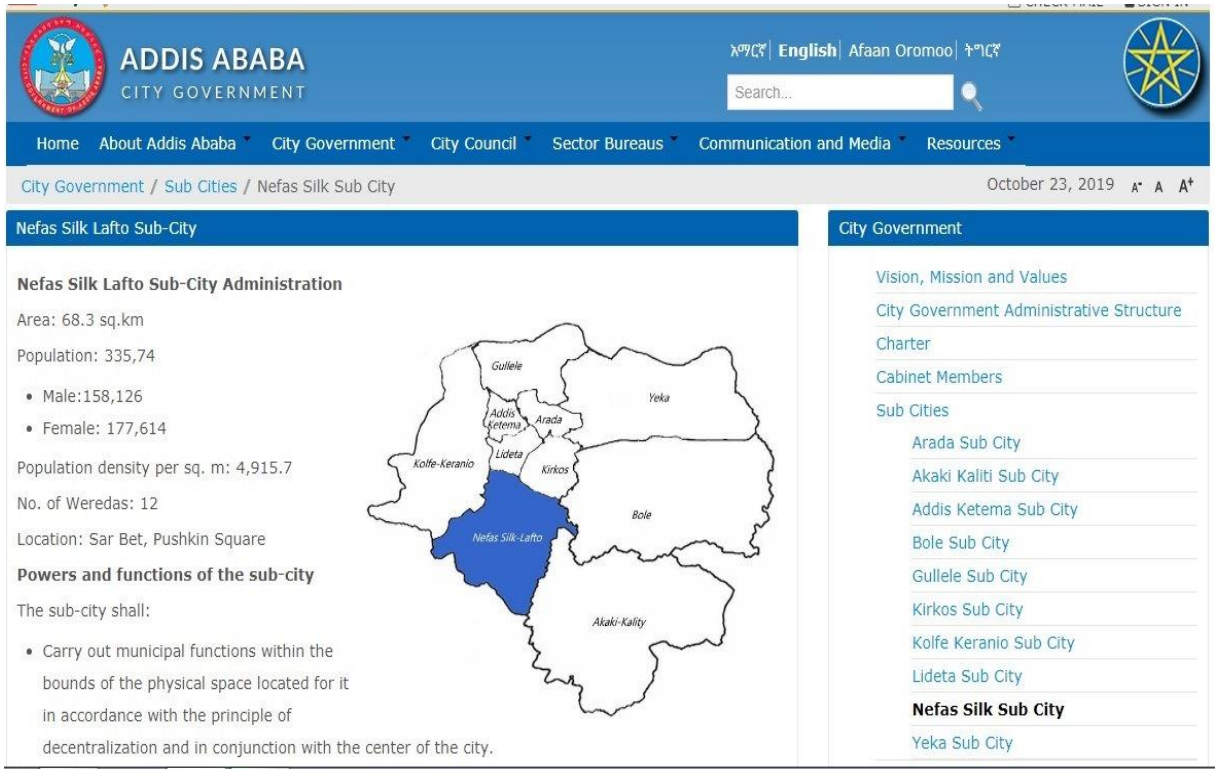
Annex VI: Addis ketema geographical profile



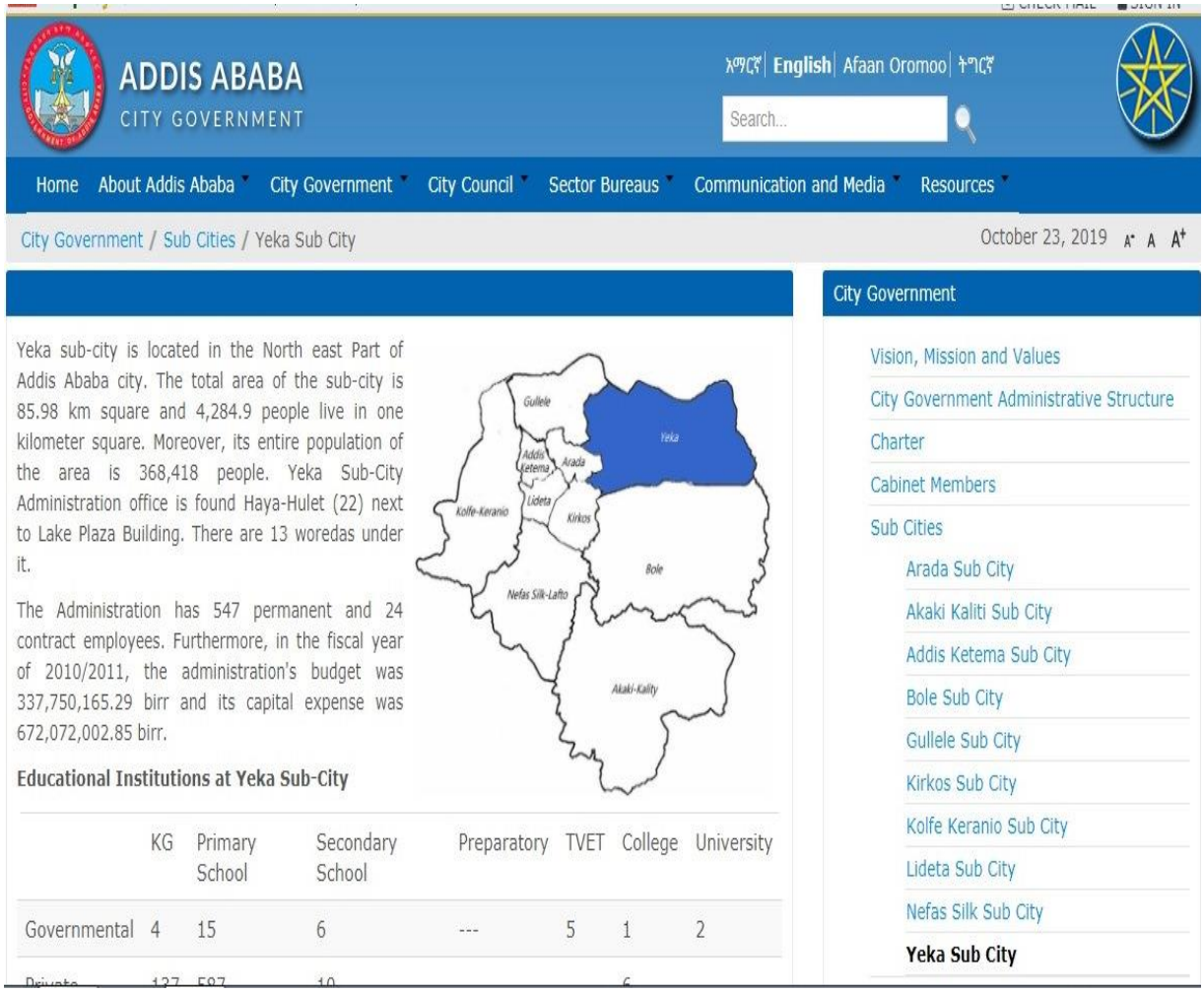
Annex VII: Arada geographical profile

Annex VIII: Bole geographical profile

Annex IX: Nifas Silk geographical profile



Annex X: Yaka geographical profile



ADDIS ABABA
CITY GOVERNMENT

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City Government / Sub Cities / Yeka Sub City

October 23, 2019 A- A A+

Yeka sub-city is located in the North east Part of Addis Ababa city. The total area of the sub-city is 85.98 km square and 4,284.9 people live in one kilometer square. Moreover, its entire population of the area is 368,418 people. Yeka Sub-City Administration office is found Haya-Hulet (22) next to Lake Plaza Building. There are 13 woredas under it.

The Administration has 547 permanent and 24 contract employees. Furthermore, in the fiscal year of 2010/2011, the administration's budget was 337,750,165.29 birr and its capital expense was 672,072,002.85 birr.

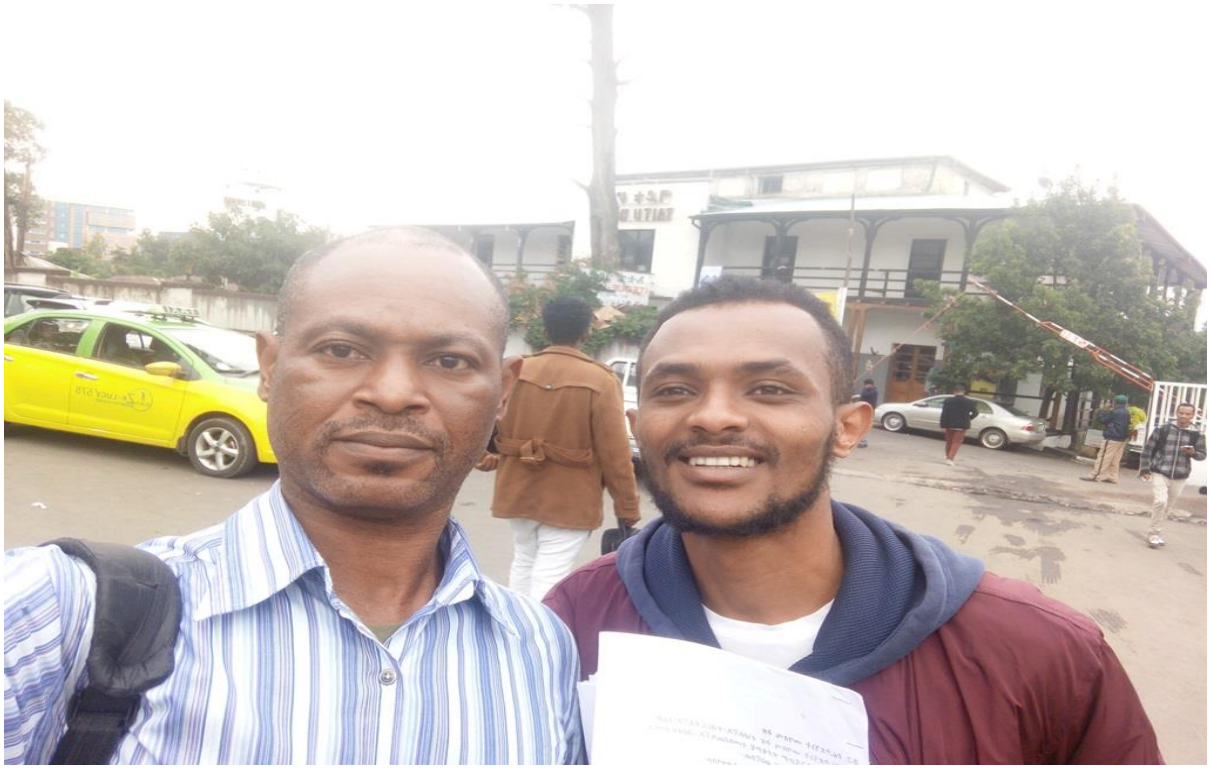
Educational Institutions at Yeka Sub-City

	KG	Primary School	Secondary School	Preparatory	TVET	College	University
Governmental	4	15	6	---	5	1	2
Private	137	587	10			6	

City Government

- Vision, Mission and Values
- City Government Administrative Structure
- Charter
- Cabinet Members
- Sub Cities
  - Arada Sub City
  - Akaki Kaliti Sub City
  - Addis Ketema Sub City
  - Bole Sub City
  - Gullele Sub City
  - Kirkos Sub City
  - Kolfe Keranio Sub City
  - Lideta Sub City
  - Nefas Silk Sub City
  - **Yeka Sub City**

Annex XI: Illustration Data collection in process in one of the sub cities (Arada Piasa)



Annex XII: Illustration of the Data collectors training session