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COLLEGE OF HEALTH SCIENCE

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WOMEN'S ATTITUDE, BARRIERS AND INTENTION TO USE LONG ACTING AND PERMANENT CONTRACEPTIVE METHODS AMONG SHORT TERM USERS, WOLAITA ZONE, SOUTHERN ETHIOPIA

BY: MENGISTU MESKELE (B.SC.)

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Women's Attitude, Barriers and Intention to Use Long Acting and Permanent Contraceptive Methods among Short Term Users, Wolaita Zone, Southern Ethiopia

By:

Mengistu Meskele (B.Sc.)

Approved by the examining board

Wakgari Deressa(Ph.D.)
Chairman Dep. graduate committee

Signature

Wubegzier Mekonnen(Ph.D.)
Advisor

Signature

Abiy seifu (MPH)
External examiner

Signature

Jemal Haidar (MD, MSc, DRM)

Internal examiner

Signature

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Acronyms

CBRH	Community Based Reproductive Health
CPR	Contraceptive Prevalence Rate
EDHS	Ethiopia Demographic and Health Survey
FMoH	Federal Minister of Health
FP	Family Planning
H.O	Health Officer
HEP	Health Extension Program
HSDP	Health Service Development Program
IEC	Information Education and Communication
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
LAPM	Long Acting and Permanent Contraceptive Method
MDGs	Millennium Development Goals
MoH	Minister of Health
MSIE	Mary Stopes International Ethiopia
SDPs	Service Delivery Points
SNNPR	Southern Nation, Nationalities and Peoples Region
SPSS	Statistical Package for Social Science
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund

ABSTRACT

Background: In Africa the use of long acting and permanent family planning methods (LAPMs) has not kept pace with that of short-acting methods, such as oral contraceptives and injectables. The utilization of contraceptive methods was dominated by short-term methods in Ethiopia as 21% of women used injectables, 3.4% used implants, 0.5% used female sterilization and 0.3% used intrauterine devices.

Objective: To assess the association of women's awareness, attitude and barriers with the intention to use LAPMs among short term users in Wolaita zone, Southern Ethiopia.

Methods: A cross-sectional study using both quantitative and qualitative methods was conducted in public health institutions of Wolaita zone from October 2012 to May 2013. Among six health institutions in the study three were chosen by systematic random sampling technique from rural while the other three reform town health centers were included. A total sample size of 416 was used for the quantitative study. Eleven in-depth interviews held to explore women's and provider's perceptions and opinions. Data were entered into EPI Info version 3.5.3 and it was also edited, cleaned, and analyzed using SPSS version 16.0. Moreover, bivariate and multivariate logistic regression model with crude and adjusted OR along with their 95% confidence interval were used.

Results: Among 411 women participated in the study, only 156(38%) had the intention to use LAPMs in the future. More than half 216 (52.6%) had a negative attitude to use these methods. Furthermore, 276 (67.2%) had myths and misconception about these methods. Women who had no myths and misconception on LAPM were (AOR= 1.71: 95% CI (1.08, 2.72) times more likely to use LAPMs compared with those who had myths and misconception. Moreover, the odds of women's intention to use LAPMs were (AOR=2. 10: 95% CI (1.11, 3.98) and AOR=2.80: 95% CI (1.15, 6.77) times higher among women who attained secondary and higher level of education compared with women with no education, respectively. Likewise, the women who had positive attitude were (AOR =2. 47: 95% CI (1.48, 4.11) times more likely to desire LAPMs compared with a woman who had a negative attitude on these methods.

Conclusion and recommendations: Most of the women had low intention to use LAPMs. Similarly, more than half of the participants had a negative attitude, myths & misconception on these methods. The government should focus on empowering women and increasing their educational level. There must be great emphasis on educating communities to change the attitude, myths and misconceptions.

Keywords: *LAPMs, intention, attitude, myths & misconceptions, Wolaita zone, Ethiopia*

1. INTRODUCTION

1.1 Background

Nowadays, more than 200 million women in the developing world want to avoid pregnancy but are not using a modern method of contraception (1). If all women who currently use contraceptives began using the most effective long acting and permanent methods (LAPMs) to meet their fertility intentions, the level of unintended births would decrease by an average of 27 percent (2). Moreover, if the obstacles to contraceptives overcome and the demand for family planning met, 54 million unintended pregnancies, more than 79,000 maternal deaths, and more than a million infant deaths could be averted each year(1)

The use of provider-dependent LAPMs of contraception including (intrauterine devices, hormonal implants, female sterilization, and vasectomy) has lagged behind in spite of their high effectiveness (3). Moreover, these methods are the most effective contraceptives, (between 3 and 60 times more effective than short acting methods during a year of typical use) and they require a little action by the client. Yet, despite these advantages, they are often difficult for clients to access and are not used as widely as other methods, particularly in Africa (4).

LAPMs also can fulfill a full range of women's and couples' needs. Until now in Sub-Saharan Africa, only 2.7 million women are currently using these methods (5). Over time, the practice of these methods has not kept step with those of short-acting contraceptive methods (6).

Ethiopia ranked the 12th and 2nd most populous country in the world and Africa respectively. The total population of the country is 87.1million according to 2012 population and economic development data sheet (7). The total fertility rate was 4.8 in 2011; but the modern contraceptive prevalence rate (CPR) among married Ethiopian women was 27%; the majority of them used short acting methods rather the most effective LAPMs (8).

Wolaita Zone represents one of the most densely populated parts of the country. According to the 2011 socioeconomic profile of Wolaita Zone, average population density (crude) for the Zone was about 374.8 persons per K². The highest and lowest population density was shown in Boloso Sore and Humbo Woreda; with 798 and 163 persons/ K² respectively. These show that there is high population pressure, and competition for natural resources. Thus, providing contraceptive methods particularly the most effective methods such as LAPMs is very important (9).

1.2 Statement of the Problem

Unintended pregnancies occur in the world because some 215 million women have an unmet need for contraception (4). In Africa use of LAPMs is very low, even among couples using family planning to limit family size. In thirteen countries in Africa, LAPMs accounted for an average of 17.1 % (range 2.2-37.8%) of the method mix of contraceptive users who did not want any more children. In only Burkina Faso, Kenya, Malawi and Tanzania do LAPMs account for more than 20% of the family planning method mix. Among contraceptive users who wanted to delay their next birth (spacers), on average only 3.3% (range 0.5-8.4%) were using LAPMs (5).

The awareness of LAPMs is much less than that of short-acting methods in Africa. Nineteen DHS studies conducted in the past five years, while awareness of any modern method averaged 89%, only 41% know of IUD, 34% know about implants, 51% know of female sterilization and 21% know about vasectomy. Among the different barriers, the system's policies, structures and organization of services and the providers' practices greatly influence client access to LAPMs (5).

In Ethiopia the utilization of contraceptive methods was totally dominated by the use of short-term methods such as pills and injectables (10). The most widely used methods are injectable (21%) followed by the implants (3.4%), pills (2.1%), and female sterilization (0.5%), IUD (0.3%), and male condom (0.2%). This indicates that among the method mix, prevalence of LAPMs is very low (8).

Moreover, in Ethiopia the discontinuation rate of short term contraceptives is higher than that of LAPMs. The 12-month contraceptive discontinuation rate for all methods is 37%. Among the major methods, the highest discontinuation rate is in the pill (70%), followed by the male condom (62 %). In contrast, implants have a discontinuation rate of just 5% (8). These levels of discontinuation for short-acting methods are highly inefficient and costly to programs, and represent very poor quality service for individuals and often lead to unplanned pregnancies and a bad image for family planning programs (5).

1.3 Rationale of the Study

Ethiopia relies more on short-term methods of contraception than LAPMs. The total fertility rate (TFR) of the country is still high (4.8). Thus, the country aimed to shift the method mix of contraceptives on LAPMs(11). The Minister of Health (MOH) reported that in Ethiopia lack of family planning method mix is among the challenges and implementation gaps of the Health Sector Development program (HSDP III). This gap is also true in Wolaita zone and the country envisages scaling up family planning program with focus on long-term options in HSDP IV (12). To my knowledge no study was conducted in Wolaita zone on women's awareness, attitude, barriers and intention to use LAPMs. Thus, this study will contribute to fill the information gap to scale up family planning program with focus on the most effective methods such as LAPMs options.

The result will also be used to alert the responsible authorities about the need to expand such services to increase contraceptive coverage by solving identified barriers to use of LAPMs. Therefore, it helps to reduce the number of unintended pregnancies by fulfilling family planning and reproductive health goals set in Millennium Development Goals (MDGs), HSDP and Health Extension Programs (HEP).

2. LITERATURE REVIEW

2.1. Method Mix of Contraceptives

Method mixes of contraceptives are different among countries. Female sterilization is the most widely used method of contraception worldwide, accounting for approximately 20% of all contraception followed by IUD which was used by 150 million women. Oral contraceptives and vasectomy were the third & the fourth most popular methods in the world (13). In contrary to this, a study conducted in Pakistan showed that traditional methods (withdrawal, rhythm method) was the commonest method of contraception (5.9%), followed by injectables (5.3%) and tubal ligation (5.1%). Moreover, 4.8% were using contraceptive pills, 3.6% condoms, 2.1% IUCD, and 3.8% were using contraceptives in combinations (14).

A study conducted in Rwanda showed that among current users, the method mix was dominated by injectables (61%), followed by pills (14%), implants (9%), male condoms (7%), and the Standard Days Method (SDM) (5%). In this country utilization of LAPMs other than implants was low (2.2% IUD and 1.4% female sterilization). On the other hand 19% were using a traditional method while 81% were not doing anything (15).

A study conducted at five regions (Amara, Harari, Oromia, SNNP, Tigray) and two administrative areas (Addis Ababa, Dire Dawa) showed that 51% reported use of modern FP (urban 61% , rural 49%), leading method chosen was injectables (37%) , 3% of FP users were using LAPMs, Unmet need 25% (16% and 27% in urban and rural areas, respectively), 52% aware of at least one long-term method(urban 77% rural: 47%) , 20% aware of at least one permanent method (urban 34%, rural 17% (16).

Similarly, another study conducted in East Hararge Zone showed that 178(37.6%) were using injectables, 37.6% were using pills, 23.3% were using implants, 1.1% were using an IUD, 0.4% were using condom. In general, 24.3% were using long term methods and 75.7% were using short term contraceptive methods. When we see method shift, only 127(26.8%) of the respondents have shifted from one family planning method to another and the reasons for method shift were 29.9% due to side effect, 24.4% need for a long term method, 18.1% inconvenience of previous method, 11.8% for the convenience of the new method, 5.5% lack of access to the previous method, 2.3% advised by provider, 0.78% influenced by partner, 7% mentioned other reasons (17).

A study conducted in Debre Birhan District, North Shoa Administrative Zone, Ethiopia showed that the modern contraceptive prevalence rate among married women was 46.9%. In this area out of the contraceptive users injectables comprised 62.9% while vasectomy was only about 0.8% (18).

Another study done in Tehuledere Woreda also showed that the majority of the clients were on short term family planning methods such as pills (72.9%) and injectables (41.3%) before they shifted to LAPMs. In this area close to 52.0% have undergone voluntary surgical contraception followed by Norplant (39.0%) and IUD (8.7%). This study indicated that these high achievement was due to CBRHA was their main source of information & 60% of model users were trying to encourage others (10).

Method mix in study conducted in Butajira District, South Central Ethiopia also showed that the method women ever used being totally dominated by short term contraceptives such as Depo-Provera (42.2%) followed by pills (24.7%). The least ever used modern method of contraceptive was female condoms (0.4%). Regarding LAPMs, 6.1% of married women used implants (19).

In conclusion female sterilization and IUCD are the most widely used methods in the world. On the other hand, most African countries as well as Ethiopia the utilization of LAPMs was very low despite the methods' effectiveness. As described above, in most studies contraceptive utilization in Ethiopia was dominated by short term methods particularly injectables.

2.2 Intention to Use Long-Acting and Permanent Family planning Methods

When we see women's intention and belief to use LAPMs, a study conducted in Pakistan showed that the methods females, most commonly reported that, they or their spouses intended to use were female sterilization (12%), condoms (11%) and rhythm (9%) in the next 12-months. On the other hand, males reported that condoms (15%), withdrawal (8%) and female sterilization (8%) were the methods they or their spouses intended to use in the next 12 months (20).

Another study conducted in Rwanda showed that the main reason cited for non-use among those who did not have any intention to use was because they believed they were not fecund or had reached menopause. Very few women 5% of non-intenders were fundamentally opposed to contraceptive use because of religion, and only 6% of non-intenders referred to husband or partner opposition (15).

The Ethiopia Demographic and Health Survey (EDHS) 2011 showed that more than half (56%) of currently married female nonusers intend to use family planning methods in the future, while (41%) were not to do so(8) . Similarly a study conducted in Ambo town showed that the overall magnitude of intention to use LAPMs in the future was (56.1%). Moreover, about half of the respondents supported use of LAPMs of contraceptives. Among the total respondents, (31.1%) of participants communicated about LAPMs with their husband or friends and (70.4%) of those who communicated with their partner or friends support the use of LAPMs (21).

2.3. Knowledge and Attitude Related Factors of LAPMs

Knowledge and attitude are also one of the important factors affecting women's intention to use LAPMs. A study conducted in central Tanzania indicated that when respondents were asked if they are aware of modern contraceptives, the overwhelming majority (98.8%) indicated to be aware of the methods and over (80%) knew at least three methods. The most commonly known methods were pills, followed by injectables, Norplant and IUD with (94.3%), (93.7%), (87.3%) and (51%) of respondents respectively (22).

Knowledge of family planning methods in Ethiopia is nearly universal; 97% of all women and 98% of all men aged 15–49 knew at least one modern method of family planning. Governmental health centers and health posts (occupied with HEWs) currently provide contraceptives to 82% of current users. The most commonly known methods were injectables (94.9%), male condoms (80.4%), and the pill (91.3%) (23). Moreover, the Ethiopia DHS 2011 showed that the awareness of women who aged 15-49 were (38.7%) for female sterilization, (11.2%) for male sterilization (26.3%) for IUD and (67.8%) for implants (8). On the other hand, study conducted in South Wollo zone showed that except for foaming tablets (70.0%), knowledge of modern family planning methods was over 90%. The majority (73.9%) of the respondents got their information on family planning from the CBRH program (10).

Regarding attitude on LAPMs, study conducted at Mekelle town in 2012 showed that (53.6%) of the married women had negative attitude towards practicing LAPMs. Almost (15.5%) and (26.8%) married women agreed that implant can result in irregular bleeding and cause severe pain during insertion and removal respectively. Nineteen point six percent agreed that IUCD prevents from doing normal activities and (34.4%) agreed that undergoing an operation for female sterilization was dangerous. Similarly, (39.1%) agreed undergoing an operation for female sterilization is unacceptable (24).

A study conducted in Butajira Southern Ethiopia showed that there was low (25%) knowledge/awareness on LAPM in the town. Among the LAPMS which contribute (5.2%) of contraceptive prevalence (18.7%), implant was known by most of the participants (20.5%) and the least known method was male sterilization (8.1%). More than 65.5% of the participants intended to use LAPMs sometime in the future (25). Similarly, another study conducted in this area also showed that knowledge of contraceptives were (74.4%), (13.1%), (8.2%) and (19%) for implant, loop, vasectomy and tuba ligation respectively(19).

2.4. Factors Affecting women's use of LAPMs

There are different factors affecting women's use of LAPMs. A study conducted in Pakistan showed that a woman's belief that the use of family planning was the husband's decision, fear that family planning could harm a woman's womb and women's belief that fertility was determined by God were associated with a lower intention to use the IUD. But facilities with competent staffs were significantly associated with women's intentions to use contraceptive methods. Similarly, women with secondary or matriculate education had higher intentions to use the IUD (20).

A study conducted in Dare Salam, Tanzania showed that stock outs of contraceptives continue to be deterrent factor for the choice of appropriate methods. In this study a fifth of respondents used oral contraceptive pills just because the injectables, implants and IUCDs were not available during the study period, others decided not to choose the alternative methods that were available (26).

Another Study conducted in Rwanda showed that factors statistically associated with not using a method were: being older, being less than six months postpartum, wanting a child within 12 months, hearing a family planning message in the media, distrusting contraception and acknowledging a set of barriers to contraceptive use. In this study lack of knowledge of contraceptive methods and access to services were not significantly associated with FP use. In contrast to this, having some education, more children, being sexually active in the past month, having a partner who supports FP, and attending a FP talk by a community health worker were found statistically associated with FP use (15).

Similarity, in a study conducted in Bale Zone, Goba town, South East Ethiopia showed that there was no statistically significant association between age of women, number of children alive, educational status, religion, income of the family and other variables; and utilization of LAPMs of contraceptives (27).

The study in Mojo town showed that there was statistical significance with family planning service utilization and those with higher parity, literate, approved use of family planning methods, discussed with husband or partner and those exposed to mass media (28).

Women desire of children is another factor which affects women's intention to use LAPMs. A woman who wanted no more children was much more likely to intend using contraceptive methods. A study conducted in Pakistan showed that intentions to use contraceptive methods were higher among women with four or more children (20). Similarly another study in the district Kohat in Pakistan showed that desire for more children, pressure from the husband and religious leaders were the main reasons for the non-users (14).

The Study conducted in Ghana showed that when providers asked about why their clients might not choose an IUD, 63% said that it was because of the rumors they have heard about the methods, (47%) reported hearing stories about IUDs being inserted could be traveling to other parts of the body, (22%) of providers said fear of insertion, or the fear of an infection and (17%) of providers also said that the clients feel shy and do not want to spread their legs for medical examination(29).

Ethiopian Demographic and Health Survey 2011 (EDHS) also showed that just 28% of Ethiopian women were informed about possible side effects of contraceptive methods, 24% were informed about what to do if they experienced side effects, and 37% were informed about other available family planning methods (23). Moreover, study in Batu town showed that no facility has the material as well as trained staff to provide LAPMs (30).

The study conducted in the East Shoa Zone, Batu town also showed that among women who had general knowledge about LAPMs, (33.2%) heard myths and misconception. Around (24.6%) said that use of Norplant would affect their health negatively. Some women (5.2%) encountered that implants could move around freely in the body once inserted and could be lost on the day of removal (30). Similarly study conducted in Mojo Town showed that method related reasons like health concerns, fear of side effects, and lack of access/too far, too much cost and health care provider bias accounted for (32.4%) of non-utilizations of family planning services(28).

Another study conducted in Butajira District, South Central Ethiopia showed that barrier to contraception in the area included absence of preferred methods, religion, complaints related to providers and methods; and assumption of having proper diet and optimum workload when using family planning methods (19). Moreover, study conducted at Ambo town showed that attitude on LAPMs and total number of live children the women had were significantly associated with the intention to use LAPMs in the future (21). Furthermore, a study conducted in Debre Birhan District showed that the need for more children, husband approval of modern contraceptive use and husband wife communication about family planning methods and income were significantly associated with modern contraceptive utilization (18).

In conclusion there are different factors affecting women from using the most effective contraceptive methods such as LAPMs. Among these client characteristics, spousal communication, decision- making on family size and religion are the major ones. In addition to that provider bias, facility characteristics, myths and misconceptions are also among others.

Wolaita zone, being one of densely populated areas in the country with population pressure and variety of cultures; no study was so far conducted to show what barriers and misconceptions affecting women from using LAPMs. Thus, this study will help to identify factors affecting women's intention to use LAPMs and associated cultural or other barriers in the area to fill the information gaps for policy makers.

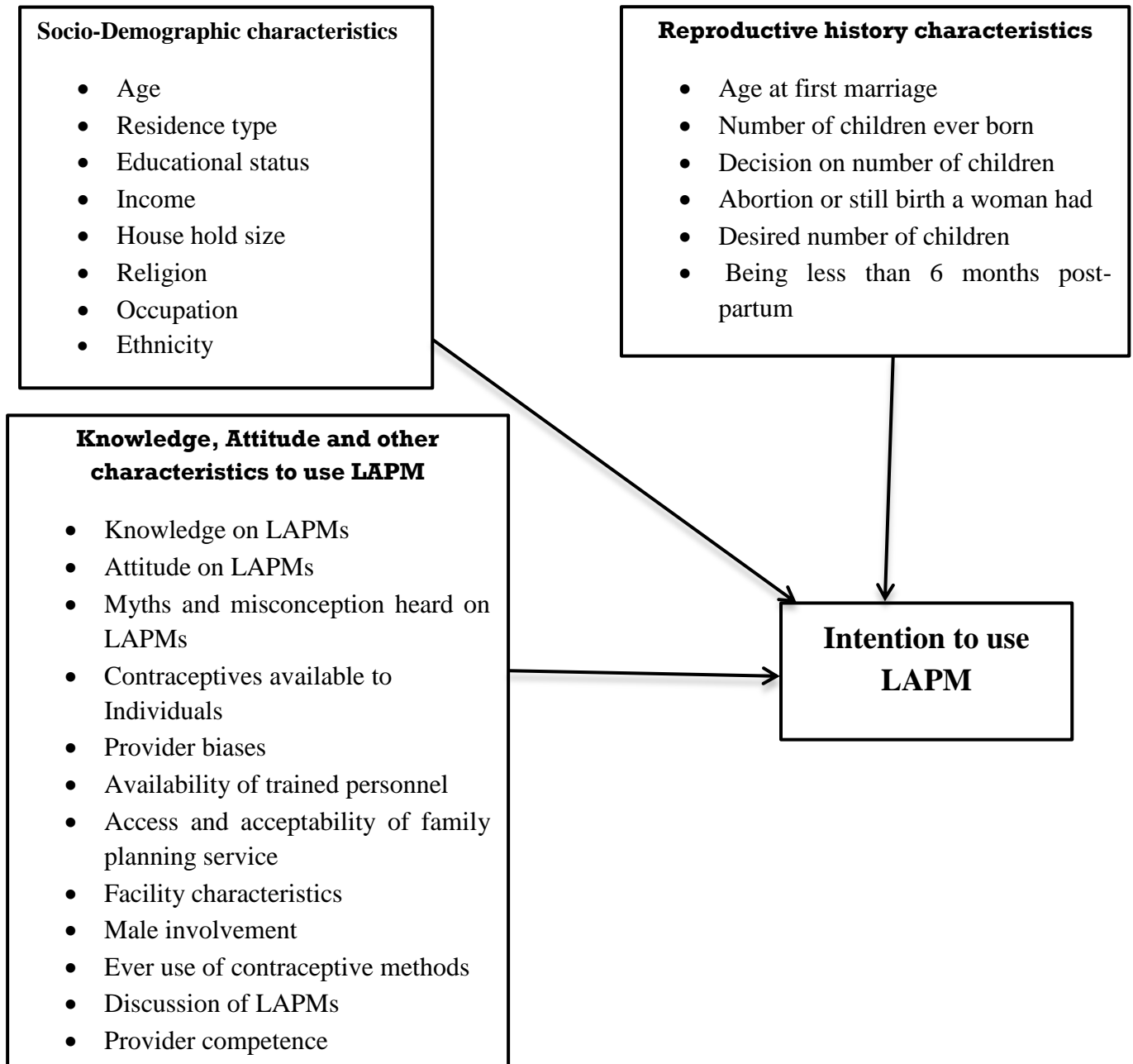


Figure 1: Conceptual frame work of women’s attitude, barriers and intention to use LAPM in Wolaita zone.

3. OBJECTIVES

3.1 Main Objectives

To assess women's attitude, barriers and intention to use long acting and permanent contraceptive methods among short term users in Wolaita zone, Southern Ethiopia

3.2 Specific Objectives

1. To assess the level of women's awareness and attitude to use LAPMs among short term family planning users in Wolaita zone, Southern Ethiopia.
2. To assess the level of women's intention and barriers to use LAPMs among short term family planning users in Wolaita zone, Southern Ethiopia.
3. To identify factors associated with women's intention to use LAPMs among short term family planning users.
4. To explore opinion and perceptions of short term family planning method users and their service providers on determinants of method mix (awareness, barriers, attitude and misconceptions) to use LAPMs.

4. METHODS AND MATERIALS

4.1 Study Area

This study was conducted in Wolaita zone. The capital, Sodo town, in Wolaita zone is about 360 km away to the south direction from Addis Ababa. Wolaita zone is one of the 13 zones in Southern Nations Nationalities and Peoples region in Ethiopia. Based on the most recent census (2007), the projected population of the zone was 1,750, 079 in July, 2012. By the year 2012 there were one government referral hospital; one non-government hospital, one private hospital, 70 health centers and 326 health posts providing health services for the community. There were 2 higher clinics, 8 medium clinics, 121 lower clinics and 42 pharmacies are among the private sectors serving the community according to the Zonal Health Department.

4.2 Study Design

Facility based cross-sectional study which employed quantitative and qualitative methods were used. Key informant in-depth interview were done among selected short term family planning user and service providers. The study was conducted between October 2012 and May 2013.

4.3 Source and Study Population

The source population was women aged between 15-49 years who were using short term family planning methods in Wolaita zone. Also providers, who were working on family planning service, were included. The study populations were all women in selected health centers in Wolaita zone who were using short term family planning methods at the time of the survey.

4.3.1 Inclusion criteria

- The women aged between 15-49 years who were using short term contraceptive methods in the selected health centers.
- Health professional stay more than 3 months on the same service delivery point working at FP clinic.

4.3.2 Exclusion criteria

- Long acting and permanent method users.
- A client who has hearing or other physical difficulty.
- Refusal to participate

- Health professionals not involved in direct care of FP, stay less than 3 months and refused to participate.

4.4 Sample Size

The required sample size for clients exit interview was determined by the single population proportion formula using the following assumptions:

$$n = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2} = \frac{(1.96)^2 0.561(1-0.561)}{(0.05)^2}$$

Desired precision: d = 5%

P = (56.1%) proportion of a client's intention to use LAPMs in the future at Ambo town.

Confidence level = 95%, which means α set at 0.05 and $Z_{\alpha/2} = 1.96$ (value of Z at $\alpha 0.05$ or critical value for normal distribution at 95% (C.I.)

Therefore, the calculated sample size was 378. Adding a 10 % non-response rate gave the required minimum sample size $n = 416$.

4.5 Sampling Procedure

A total of 6 health centers (three from urban and another three from rural areas) was selected for this study. The three rural health centers were randomly selected from the rural based health centers by systematic random sampling technique while the other three reform town health centers in Wolaita zone were included. Three health centers in these towns such as Sodo, Boditi and Areka were represented urban facilities. Samples were allocated to each health center based on the proportionate allocation to the size of their family planning clients' flow. All short term family planning users who were visiting selected health centers during the study period were interviewed until the allocated sample size to each facility were reached.

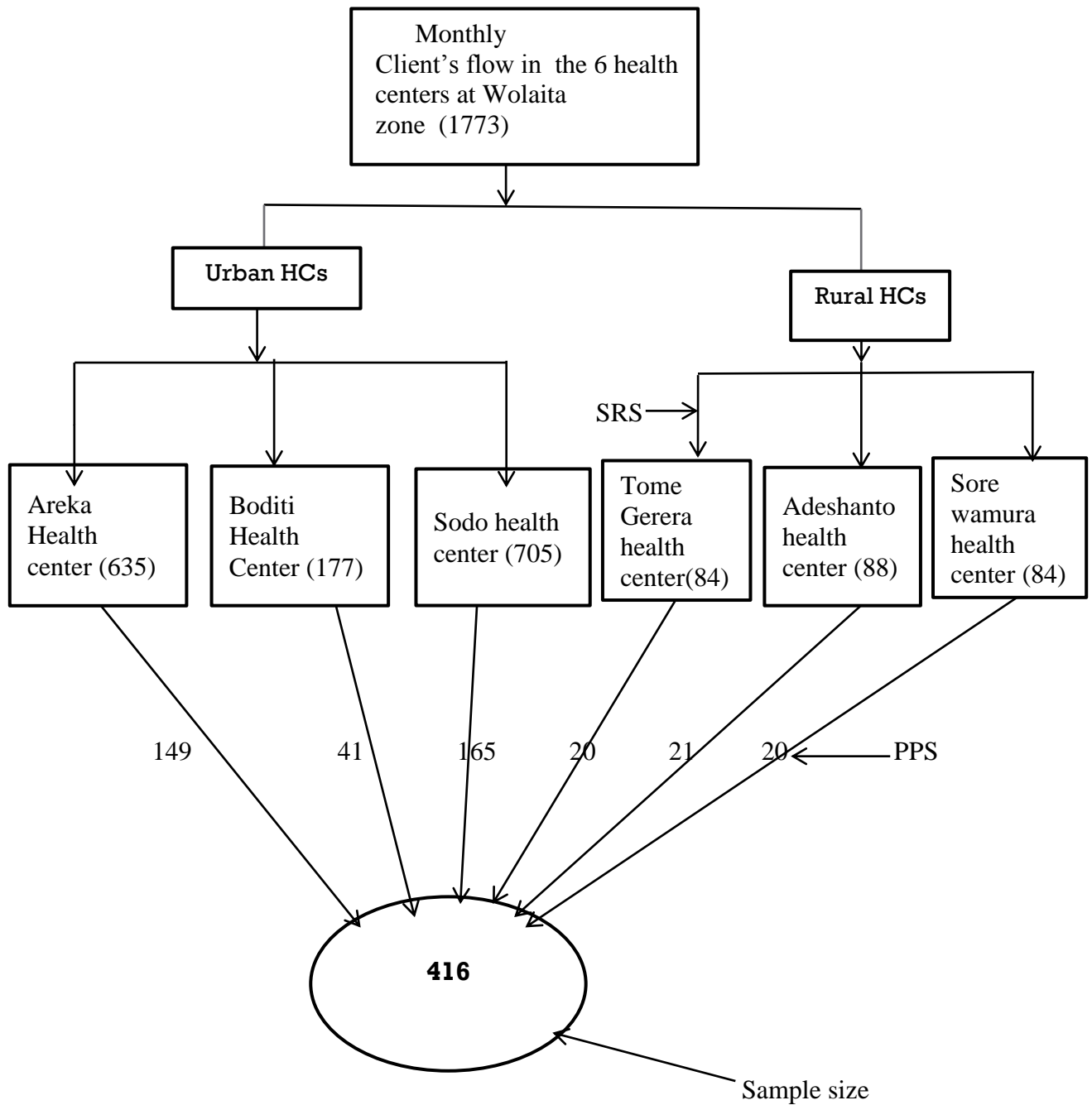


Figure2: Schematic presentation of the sampling procedure used in the study, Wolaita zone, Southern Ethiopia, 2013.

4.6. Data Collection

4.6.1 Quantitative Study

Structured questionnaire was developed by reviewing different literatures and the standard EDHS questionnaires. The questionnaire was prepared first in English and then translated to Amharic and back to English to check for consistency of translation. The interview was administered in Amharic language. Data was collected through interviewer administered questionnaires. Data collection was conducted by six health workers (Diploma holders) who were not working at that specific health facility to minimize interviewer bias. Also two other health professionals, one B.Sc. nurse and one health officer (B.SC.) supervised the six data collectors.

4.6.2 Qualitative Study

Key informant in-depth interview was used to gather greater depth of information to explore and understand opinions and perceptions of short term family planning users and their providers. It also helped to triangulate the finding of the quantitative study. Some of the important issues addressed were awareness, attitude towards LAPM, rumors and misconceptions, barriers to use LAPM, and factors that affect their intention to use these contraceptive methods. Five in depth-interviews with probing and open ended questions for each client from different health centers were done. Similarly, six professionals who were delivering family planning services, each from different health centers were interviewed by the principal investigator after getting verbal consent from them.

4.7 Variables

Dependent Variables: Intention to use LAPMs.

Independent Variables

Socio demographic and economic factors: - age, level of education, religion, marital status, income, house hold size and occupation

Reproductive health factors: -Age at first marriage, children ever born, decision on number of children and previous abortion or still births.

Other factors: -Knowledge on LAPM, attitude on LAPM, myths and misconception heard on LAPM

4.8 Operational Definitions

Long-acting and Permanent Methods of Contraception (LAPMs):- are defined as those methods that Provide pregnancy protection for more than one year per application.

Short term users: those clients who are using Depo Provera, Pills, condoms (male, female).

Intention to use LAPMs-women who were not using LAPMs but want to use these methods in the future

High knowledge: those who knew 7 -10 correct answers from ten knowledge questions.

Moderate knowledge: those who knew 4-6 correct answers from ten knowledge questions.

Low knowledge: those who knew 0-3 correct answers from ten knowledge questions.

Positive attitude: those who scored above the mean (4.6 correct answers) of ten attitude questions

Negative attitude: those who scored \leq the mean (4.6 correct answers) among ten attitude questions.

4.9 Data Entry, Cleaning and Analysis

The quantitative data were entered in EPI Info version 3.5.3. Then the data were edited, cleaned and analyzed by using SPSS version 16. Data cleaning was done in SPSS by running each variable frequency and cross tabulations to check missed values. Errors identified were corrected after revising orderly numbered questionnaires. Summary measures such as frequencies, tables, graphs and mean values were used. Knowledge score was computed based on the ten knowledge questions; so that “Yes” is coded as 1 and “No” as 0. The score is calculated by adding those who answered “Yes” to each of the ten questions. Then, terciles is used to divide it in to three equal parts as low, moderate and high knowledge. In the same way to measure frequencies of attitude those clients answered “Strongly disagree” and “Disagree” were recoded as “Disagree”, while those who answered “Strongly agree” and “Agree” were recoded as “Agree” but those who said “Not sure” were categorized as it is. Finally, for analysis purpose those who scored below the mean (4.6 correct answers) of ten attitude questions were recoded as “Negative attitude” whereas those who scored above this point were categorized as “Positive attitude”. Furthermore, bivariate and multivariate logistic regression model with crude and adjusted OR along with their 95% confidence interval were used to see the independent associations of each factors with intention to use LAPMs of family planning.

Qualitative Study: The data was audio taped, transcribed, translated and coded with Open Code version 3.6 and inductive content analysis was applied. The analysis was done using systematic coding, i.e., segment by segment based on the research questions. Finally the narrative qualitative information was organized and integrated according to emerging themes and concepts that used to answer the research questions.

4.10 Data Quality Management

Questionnaires were prepared first in English then translated to Amharic language for data collection. To check whether the translation was consistent with the English version the questionnaire were back translated to English by another language expert. Before the actual data collection, the questionnaire was Pre-tested on similar settings outside the study area. Two days training was given to Data collectors to be familiar with the objective and the methodology of the research. This training was given to standardize their interviewing technique and to ask questions in a consistent manner. The principal investigator was closely supervising the performance of the data collectors in the field and after field throughout out the data collection process. The questionnaires were checked by the supervisors on a daily basis for completeness. In the qualitative study data were recorded to capture all the information and note was taken to ensure the data quality. In-depth interview guide were developed and further probing questions were used to explore more information on the issue under caption.

4.11. Ethical Considerations

Ethical clearance was secured from the Research Ethics Committee of School of Public Health College of Health Science, Addis Ababa University. Then a written letter from the Graduate Coordinator of the Department was obtained and submitted to Wolaita Zone Health Department. Finally official permission was obtained from them. Informed verbal consent was obtained from individual participants. In order to assure confidentiality mothers name were not written on the questionnaire. All study participants were told about their participation would be on voluntary basis. The objectives of the study and the merits were communicated prior to asking the willingness to participate in the study. Privacy of clients was maintained. The study tried to increase the awareness of study participants by raising their knowledge, changing their attitude and misconception to use LAPM by providing appropriate information at the end of interview.

4.12. Disseminating the Results

The findings of this study will be disseminated to various stakeholders including AAU, Ministry of Health and SNNPR Regional Health Bureau and Zonal Health Department either through written report with or without formal presentations. At last this study results will be published in national or international journals. Moreover it will be presented at national and international conferences.

5. RESULTS

5.1. Socio-Demographic Characteristics

Out of 416 women approached, 411 women were included in this study, which makes the response rate to be 98.8%. Out of these women, 126 (30.9%) were from rural and 285 (69.3%) from urban areas.

Two hundred eight (50.6%) households had a family size of 1-4 persons and 203 (49.4%) households had a family size of greater than or equal to five persons in their families, with a mean household family size was 4.9 (± 1.9 SD) while the median household size was 4.

Two hundred two (49.14%) of the mothers were below the mean age (26.7 years). Three hundred ninety nine (97.1%) of women were married, more than half 254 (61.8%) were Protestant and 128 (31.1%) were orthodox Christians by religion. Almost a great majority 370 (90%) of women were Wolaita ethnicity; whereas the few others 41 (10) were the other ethnic origin. One hundred thirty five (32.8%) mothers did not attend formal education (no education); the rest attended formal or elementary school and above. With regards to the occupation status of the mothers, 184 (44.8 %) were housewives followed by 140 (34.1%) who were traders. One hundred seventy one (41.6%) of the respondents had low wealth index while 162(39.4%) and 78(19.0%) of women had moderate and high wealth indexes respectively (Table 1).

In the qualitative study a total of five key informant women who were using short term contraceptive methods and 6 family planning service providers with different socio-demographic backgrounds were participated in the interview. Three of the key informants were housewives by their occupation but the other two were merchant and civil servant.

Similarly two of the providers, who participated in the interview, were males and the rest four were females by sex. Moreover, three female providers were midwife nurses but one had B.Sc.in nursing. Among male providers one had B.Sc. in nursing while the rest were clinical nurses.

Table 1: Distribution of respondents by various socio- demographic characteristics in Wolaita zone, SNNPR, Ethiopia, April, 2013

Characteristics (n=411)	Frequency	Percent
Age		
15-24	126	30.7
25-34	249	60.6
35 and above	36	8.8
Residence type		
Rural	126	30.7
Urban	285	69.3
Religion		
Protestant	254	61.8
Orthodox	128	31.1
Others	29	7.1
Occupation		
House wife	184	44.8
Trader	140	34.1
Governmental/NGO worker	38	9.2
Daily laborer	25	6.1
Others	24	5.8
Educational status		
No education	135	32.8
Primary education	142	34.5
Secondary education	96	23.4
Higher education	38	9.2

Characteristics (n=411) continued	Frequency	Percent
House hold size		
1-4	208	50.6
5 and above	203	49.4
Wealth index		
Low (1-5)	171	41.6
Moderate (6-7)	162	39.4
High (8 and above)	78	19.0

5.2 Reproductive Health Characteristics

Among the study participants, more than half 207(50.4%) women had 3 and more total number of children in their household, while the rest had 0-2 children. The mean number of children ever born was 2.9 (\pm 2 SD) whereas the median number of children ever born was 3.

Almost half of women 208 (51.23%) were married between 12-17 years at time of the first marriage. The rest married when they were 18 years and above. Their mean and median age at first marriage were 17.6 (\pm 2.47 SD), and 17 respectively.

Seventy four (18%) respondents had encountered miscarriage, abortion, or ended in a stillbirth. Three fourth 55 (74.3%) women had one abortion in their lifetime; but the rest had two and more abortions. Most of decisions on the number of children a woman wants were made together with her partner 237 (57.7%); while 38 (9.2%) and 136 (33.1%) of decisions made by her husband and herself alone respectively (Table 2).

Table 2: Distribution of respondents by reproductive health characteristics, Wolaita zone, SNNPR, Ethiopia, 2013

Characteristics	Frequency	Percent
Age at first marriage (n=406)		
12-17	208	51.23
18 and above	198	48.8
Total number of children (n=411)		
0-2	204	49.6
3 and above	207	50.4
Abortion, still birth or miscarriage (n=411)		
Yes	74	18
No	337	82
Number of abortions (n=74)		
1	55	74.3
2 and above	19	25.7
Decide on the number of children (n=411)		
Husband	38	9.2
Myself	136	33.1
Together	237	57.1

5.3. Short Term Contraceptive User Women's awareness of LAPMs and its characteristics

Among 411 respondents who were asked whether they have ever heard LAPMs and its characteristics 116(28.2%), 37(9%), 222(54%), 361(87.8%) heard about female sterilization, male sterilization, IUCD and vasectomy respectively. Only around half 221 (53.8%) of participants heard that IUCD can prevent pregnancies for more than 10 years. Very few, 29% of women heard that after female sterilization pregnancy is not possible. Almost 349 (84.9%) of women heard that the implant can prevent pregnancies for 3-5 years. Very few 41 (10 %) of participants heard that

vasectomy has no interference with sexual intercourse. More than the fourth, 317 (77.1%) participants heard that implants require a minor surgical procedure during insertion and removal; but few 114(27.7 %) heard that IUCD is not appropriate for female at high risk of getting STIs.

When we see the composite Knowledge score 165 (40.1%) of women had low knowledge, 160 (38.9%) had moderate knowledge, and 86 (20.9%) had high knowledge (Table3). Regarding women's source of information on LAPM the majority of women (49.5%) got information from health institution, followed by friends (265.9%). (Fig. 3)

Table 3: Distribution of short term contraceptive user women's awareness on LAPMs and its characteristics in, Wolaita zone, SNNPR Ethiopia, April, 2013

Characteristics (n=411)	Frequency	Percent
Female sterilization	116	28.2
Male sterilization	37	9
IUD	222	54
Implants (Implanon/Jadelle/ Norplant)	361	87.8
IUCD can prevent pregnancies for more than 10 years	221	53.8
After female sterilization pregnancy is not possible	119	29
The implant can prevent pregnancies for 3-5 years.	349	84.9
Vasectomy has no interference with sexual intercourse	41	10
Implants require a minor surgical procedure during insertion & removal	317	77.1
IUCD is not appropriate for female at high risk of getting STIs	114	27.7
Knowledge score (Composite)		
Low knowledge (0-3 correct answers)	165	40.1
Moderate knowledge (4-6 correct answers)	160	38.9
High knowledge (7-10 correct answers)	86	20.9

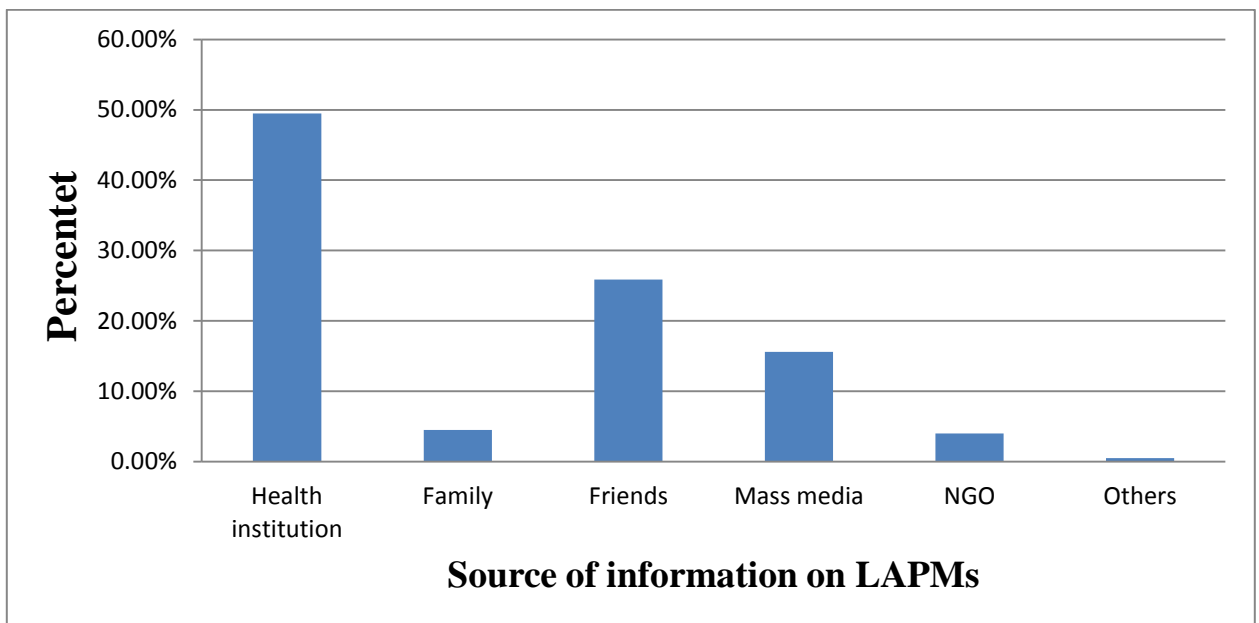


Figure3: Source of information on LAPMs in Wolaita zone, SNNPR, Ethiopia, 2013

5.3.1 Client's Awareness to Use Long Acting and Permanent Methods

Family planning clients had low awareness on the LAPMs. There were discussants who didn't hear IUCD & vasectomy. There is a belief that living in rural area is considered as a hindrance to use such methods as it cannot go with the type of workload which rural families had to undergo. Knowledge on loop was poor. Fear to use female sterilization and vasectomy were even rampant. Some clients said that even though they did not have enough knowledge on the methods; they also believed that HEWs strived to bring about change.

Service providers have also mentioned that there was no enough awareness on LAPM in these communities. According to providers view among the LAPMs women knew implant & IUCD but they did not know vasectomy & female sterilization.

The situation explained as: *“We have got health information from extension health workers. I am using Depo Provera. I have always 6-7 year interval between every birth by using Depo Provera. I have ever used implant but it was not comfortable for me. I heard loop but we are living in a rural area and we have a work load to use it. So that loop is not the best method for us to use. I have heard about female sterilization but not vasectomy. The reason why we are not using IUCD, we have no enough education; community has no knowledge on loop and vasectomy. I used implant but it has side effects. To use loop I am in a rural area, I have work load. I have fear to*

use IUCD, so that I don't want to use it. Our community does not know loop. Our people have no knowledge on female sterilization and vasectomy. I have also work load and I don't want to use it."

32 years old, married women

5.4 Attitude of Short Term Contraceptive Users women's to Use LAPMs in Wolaita Zone

More than half 216(52.6%) of the women had negative attitude; while the rest had a positive attitude. Two hundred eighty three (68.9%) of them agreed that using implants need proper diet; while 102(24.8%) agreed insertion and removal of implants is highly painful. More than a quarter 86(20.9%) agreed insertion of intrauterine contraceptive device interfere with privacy.

Less than a quarter 69 (16.8%) of women believed that using an IUCD restrict normal routine activities. Similarly, one quarter 109 (26.5%) women agreed that operation for female sterilization is dangerous.

One hundred thirty seven (33.3%) of women agreed that the implant may freely move other area from insertion site and cause severe pain, while 125(30.4%) agreed that it is not good to use LAPMs. Fifty seven (13.9%) of women agreed that discussing about LAPMs contraceptive methods with their husband or friend is not necessary. But 8 (1.9%) understood that using LAPMs would not prevent one from having the large family size. Ninety eight (23.8%) of women agreed that operation of women for female sterilization is unacceptable. (Table 4)

Table 4: Distribution of respondent's attitude to use long acting and permanent contraceptive methods in Wolaita zone, SNNPR Ethiopia, April, 2013

Characteristics (n=411)	Disagree	Not sure	Agree
	# (%)	# (%)	# (%)
Using implants needs proper diet	89 (21.7)	39 (9.5)	283 (68.9)
The insertion and removal of implants is highly painful	113 (27.5)	196 (44.7)	102 (24.8)
Insertion of IUCD causes loss of privacy	173 (42.1)	152(37)	86(20.9)
Using IUCD restricts normal routine activities	162(39.4)	180(43.8)	69(16.8)
Operation for female sterilization is dangerous	115 (28)	187 (45.5)	109 (26.5)
Implant freely move in the body& cause severe pain	197(47.9)	77(18.7)	137(33.3)
For me, it is not good to use LAPMs.	231(56.2)	55(13.4)	125(30.4)
Discussing LAPMs with husband (friend) are not necessary	334(81.3)	20(4.9)	57(13.9)
LAPM not preventing one from having large family size	356(86.6)	47(11.4)	8(1.9)
Operation for female sterilization is unacceptable.	153 (37.2)	160(38.9)	98(23.8)
Attitude score (Composite)			
Positive attitude: (Answered >4.6 correct answers)	195(47.4)		
Negative attitude: (Answered <4.6 correct answers)	216 (52.6)		

5.4.1. Attitude Related Barriers

Key informant clients believed that most of the community has a poor attitude towards LAPMs. Similarly, providers believed that the community had a negative attitude to use LAPMs. But very few clients and providers believe that community had good attitude.

The situation is described as: *“I have a negative attitude on LAPMs. Four years ago I have heard some rumors that one woman has developed mental problem after the implant inserted. After I heard the woman mental status was affected, I developed a bad attitude to use LAPMs .I need to know more about LAPMs. I need to know more if any person with good knowledge on LAPMs teaches me. I want to change my attitude if people with good knowledge on LAPMs explain to me the detail.”*

25 years old married client from urban health center

5.5 Women’s Intention Characteristics to Use LAPMs

Among the 50 (12.2%) of women who ever used LAPMs in Wolaita zone, all of them 50(100%) used implant. No one ever used other methods of LAPM in the study area. The majority of women 35(70%) used implant for a duration of 33.8 months and above. The mean duration of use was 33.8 (\pm 17.6 SD) months whereas the median use was 36 months.

Among the 411 women participated in the study, only 156 (38%) had the intention to use LAPMs in the future. An implant, which accounts 143 (91.7%), was the most leading LAPMs in the study area that most women intended to use in the future followed by IUCD 9(5.7%) and female sterilization5 (3.2%).

The reasons why the women not to practice LAPMs in the study area included 129 (35.4%) had fear of side effects, 31(8.6%) had medical problems, 28(7.8%) had fear of infertility, 38 (10.5%) had partner disapproval, 76 (21.1%) planned to get pregnant, 45 (12.5%) had lack of knowledge and 14(3.9%) had mentioned others. Moreover, 49(11.9%) of women did not get information about how to use the methods they ever used effectively from their providers (Table 5).

Table 5: Distribution of respondents by their intention to use long acting and permanent contraceptive methods in Wolaita zone, SNNPR, Ethiopia, April, 2013

Characteristics (n=411)	Frequency	Percent
Intention to use LAPM (n=411)		
Yes	156	38
No	255	62
Ever use LAPM (n=411)		
Yes	50	12.2
No	361	87.8
Duration of LAPM ever used (n=50)		
1-33.8 months	15	30
>33.8 months	35	70
Reason not practiced LAPM (n=361)		
Fear of side effects	129	35.4
Medical problems	31	8.6
Fear of infertility	28	7.8
Partner disapproves	38	10.5
To get pregnant	76	21.1
Lack of knowledge	45	12.5
Others	14	3.9
Provider explained how to use the method ever used effectively		
Yes	362	88.1
No	49	11.9

5.5.1 Women's reasons for not using LAPMs

Most women said that the fear to use the methods and lack of a balanced diet were the main reasons for not using LAPMs. But, some had different reasons for not using LAPMs like lack of

knowledge of the methods, some myths and misconceptions or rumors they heard, partner opposition, the shame to show their reproductive organ (vagina), side effects and belief that it may interfere with workload.

Similarly, the majority of the providers mentioned that myths and misconceptions or rumors, partner opposition, absence of information and lack of knowledge of the method were the major ones. But few believed that fear of side effects and lack of trained professionals was also barriers to use LAPMs. Yet again the majorities believed that religion related barriers were very few in their community; though, some few mentioned that it is also a barrier.

The situation described as: *“Emma..... I think rumors are the main reason for non-use of contraceptives. The reason why women in our community are not using implants is not clear for me. However, people are not using implant because they believed that it may cause burning of the whole body and weakens them. Likewise, some others say it sucks blood and move other system from inserted site and difficult for removal. I believe this is not the problem of implant but the rumors in our community. Moreover, some people believed that implant causes cancer and they enforce professionals for removal.”*

30 years old married women

Similarly, 23 years old midwife nurse described as: *“There are rumors certain individuals believed that in scripture of bible God said that “Be fruitful, and multiply, and replenish the Earth, and subdue it” In addition to that partner opposition is another barrier. Our husbands are saying that “give birth; I can take care for my children” government has no right on my issue. Women who have such barriers come to our health center without disclosing their utilization to their partner. Even some women with such barrier fear to take their appointment card at home and put it in our office. Some partners watch the insertion site of the implant. Some other women say, God said “Be fruitful and multiply, so that it is a sin for those who are delivering these contraceptive methods.”*

5.6 Barriers, Myths and Misconceptions on the LAPMs

Among study participants, 265 (64.5%) women believed that there are barriers to use LAPMs. Moreover, 276 (67.2%) of women heard myths and misconception on LAPMs.

There are different myths and misconception on the LAPMs in the study area. Among different myths and misconceptions 191(71%) of women heard that implant would cause hypertension, 162(58.7%) heard that the implant could move around freely in the body once inserted and could be lost at the day of removal, 187(67.8%) implant causes illness, 116(42%) IUCD Causes illness, 147(53.2%) implant causes anemia and 196(71%) implant cause weight gain.

When women were asked whether they heard another myths and misconceptions, 32(34%) heard LAPMs to cause infertility, 3(3.2%) heard LAPMs burn the whole body, 6(6.4%) heard LAPMs change the skin (facial) color black and 3(3.2%) heard that using LAPMs interferes with a routine activity if one has work load. Again 15(16%) heard that LAPMs cause irregular menstrual bleeding, 4(4.3%) heard that LAPMs need a balanced diet, 9(9.6 %) heard LAPMs can cause weight loss and dizziness and 6.4% heard LAPMs dries (damages) vagina. Some other3(3.2 %) heard that using LAPMs leads to twin pregnancy, very few 1(1.1%) heard that after LAPMs insertion health professionals refuse to remove 3(3.2%) heard that using LAPMs make labor difficult and 9(9.6%) heard other misconceptions(Table 6).

Table 6: Distribution of myths and misconceptions respondents heard about long acting and permanent contraceptive methods in Wolaita zone, SNNPR, Ethiopia, April, 2013

Characteristics	Frequency	Percent
Women who think there are barriers to use LAPM (n=411)	265	64.5
Myths and misconception heard on LAPM (n=411)	276	67.2
The implant would cause hypertension (n=276)	191	71
Implant moves freely in the body& can be lost at time of removal (n=276)	162	58.7
Implant causes illness (n=276)	187	67.8
IUCD Causes illness (n=276)	116	42
Implant causes anemia (n=276)	147	53.2
IUCD causes anemia (n=276)	97	35.1
Implant cause weight gain (n=276)	196	71
LAPMs cause infertility (n=94)	32	34
LAPMs burn the whole body (n=94)	3	3.2
LAPMs change the skin (facial) color black (n=94)	6	6.4
It interfere with activities if one has work load (n=94)	3	3.2
LAPMs cause menstrual bleeding excess and irregular (n=94)	15	16
To use LAPMs one needs balanced diet (n=94)	4	4.3
LAPMs cause weight loss and dizziness (n=94)	9	9.6
LAPMs dries (damages) vagina (n=94)	6	6.4
Using LAPMs lead to twin pregnancy (n=94)	3	3.2
After LAPMs insertion health professionals refuse to remove (n=94)	1	1.1
Using LAPMs make labor difficult (n=94)	3	3.2
Others (n=94)	9	9.6

5.6.1 Myths and Misconceptions

Most of the key informant clients heard myths and misconceptions. Among the myths and misconceptions most clients believed that implant burns the whole body and moves freely to other body system from the insertion site. Some believed that implant causes weakness, itching and it is not suitable for a person who has work load. Others believe that it needs major operation and cause pain. Also very few believed that it causes cancer, mental problem. They also think that health professionals bulges the uterus outward at the time of loop insertion. They believed that LAPMs are only good for a woman who has abundant time to rest. Vasectomy is believed to make males impotent.

Similarly, providers heard from their clients that implants move to other body systems from insertion site, clients also assumed that it causes infertility and it would be a cause of cancer. Clients felt that IUCD moves to abdomen from its insertion site. They also heard that these methods are not good for those who have workload. Clients assumed that implants interfere with routine works. Providers have also heard that tubaligation causes severe illness, IUCD deters normal sexual pleasure. Moreover, they heard complaints about the fact that implants cause headache. After IUCD uterus cannot carry pregnancy and implant cause body burning. Providers summarized their observation by stating that clients associate any illness they encounter with the use of LAPMs. *A client stated as “Yes I have heard rumors. Most people believe it is freely moving inside the body flesh and to find it will be difficult at the time of removal Most people believe that implant may get out of insertion site when we carry objects (performing our task). Another myth I have heard is that at the time of insertion of loop health professionals take the uterus outward from its original site and replace it again they said. These rumors are spoken among those who have not used LAPMs. Other rumors on permanent methods I have heard is that after vasectomy male cannot perform sexual acts. They are just like castrated. I didn’t hear about rumors on tubal ligation. But I observed one man used vasectomy in our area. Some other rumors on implant I heard that most people think that to have implant it needs major operation and cause pain. Also they have fear to use it. Some other talks that implants cause dizziness and those who used three years say it cause itching.”*

30 years old married women

Additionally, 23 years old midwife nurse explained by saying *“Women say that implant moves to the abdomen, it is not found in the insertion site. It moves the other site from the insertion site. It interferes with routine work. If users of implant develop any headache or abdominal cramp they associate those illnesses with family planning methods.”*

5.6.2 Professional, Availability, Access and Facility Related Barriers

Most clients did not report family planning utilization barriers related to facility and availability of contraceptives. Few, however, mentioned that there is no more health education which was given previously. Most clients said that they are not getting detailed and proper counseling from their service providers. But few clients told that they are getting appropriate counseling.

Similarly, providers did not mention any barriers related to the availability of contraceptives, equipment, access and trained personnel for long acting methods; although there were no trained personnel at any health center for permanent methods. In contrary to that some researcher that there are supply problems while others reported on trained personnel shortages. Similarly some providers reported that clients received the family planning method of choice while other providers complained that clients could not get their preference.

Moreover, most providers said that clients were not getting detailed and proper counseling from them. But few providers told that they are providing appropriate counseling. *“Previously health providers were not good. Now community knows where the service is given in a health facility. They directly go to the card room and have a card without payment for FP service. Next to that they go to a FP room with happiness because they didn’t pay for the card. After that they disseminate this information to others and they also like to use. I don’t think the HEW teaches women deeply. If a woman refuses to use they do not try to convince her. CBRH were giving them better and deeper information. At this time no more health education as before. Some years ago there was family planning information given by audiovisual in public and more people use family planning. At this time no such kind of good health information given to the community. As a result women are giving many children now than before.*

30 years old married, CBRH agent

Consistently, the situation explained by the provider as: *“Health professionals are informing on possible side effects of family planning methods, however, due to more client flow we cannot deliver enough and detailed counseling to our clients. We are only giving the highlights of counseling.”*

28 years old midwife nurse

5.6.3. Availability of IEC, FP Guidelines, Strategic Manual, Evaluation and Monitoring on LAPMs

Most providers said that they have IEC materials to make awareness on LAPMs but few told they have family planning guidelines to give service based on it. Almost all health centers have no strategic manuals on family planning.

Concerning monitoring and evaluation from Woreda or zonal bodies with regards to LAPMs, there were no particular monitoring and evaluation of family planning methods. Most told that monitoring & evaluation was done along with other services.

The situation was described as: *“Yes, every three months there are monitoring & evaluation for all activities. We have a review meeting. But there are no particular monitoring and evaluation for LAPMs. IEC and family planning guidelines are available but we have no strategic manual”*

32 years old female BSc nurse

5.7 Enhancing Factors to Use LAPMs

Most participants believed that educating the community about family planning methods can enhance its utilization. Some others believed that arranging public meetings to all communities, educating the women with their partners, providing health information by audio visual aid, and preparing contraceptive options for husbands can enhance the utilization of LAPMs. Some said that observing model women who are using LAPMs can lead community to utilize LAPMs. The situation explained as: *“Educating women and their husbands together can help people to use LAPMs. If the woman has workloads, teaching her husband to take vasectomy is a good option.”*

32 years married women

5.8. Factors associated with women's intention to use LAPMs

Religion and wealth index were not significantly associated with the intention to use LAPMs (P-value >0.05). On the other hand, the intention to use LAPMs among short term contraceptive user women aged 25-34 was lower [COR=0.59: 95% CI (0.38, 0.91)] compared to those aged 15-24 years, while it was not significantly lower [0.57 (0.26, 1.23)] among those aged 35 and over compared to the same reference category. Table 7 also shows that the odds of women's intention to use LAPMs were 0.96 (0.57, 1.62), 2.69 (1.58, 4.64) and 4.07 (1.91, 8.67) times higher among women who attained primary, secondary and tertiary level of education, respectively. The odds of intention to use LAPMs among women who were members of households with 5 and above members were COR=0.58: 95% CI (0.39, 0.87) compared to those who had less than five members.

Total number of children and abortion or still birth a woman had were not found to be statistically associated with women's intention to use LAPMs. Women who decide on use of family planning together with their spouses were 2.93: 95% CI (1.29, 6.67) times more likely to use LAPMs compared to those whose husbands decide the use for them.

A woman who had a high knowledge score had COR=1.77: 95% CI (1.04, 3.02) higher intention to use LAPMs compared to those with low knowledge on LAPMs. Similarly, a woman who had Positive attitude towards family planning use were 2.31 (1.54, 3.47) times more likely to use LAPMs compared to those ladies who have negative attitude.

Moreover, women who had no myths and misconceptions on LAPMs were 1.57 (1.03, 2.39) times more likely to use LAPMs compared to those who had myths and misconceptions.

Socio-demographic and reproductive characteristics, awareness about family planning methods, attitudes and other factors which were significantly associated with the intention to use LAPMs in binary logistic regression model were entered in the multivariate regression to know their independent effect. Hence, women's educational level, their attitude to use LAPMs, whether they had myths and misconceptions on the methods was found to be significantly associated with intention to use LAPMs.

After controlling the confounders, the odds of women's intention to use LAPMs were (AOR=2.10: 95% CI (1.11, 3.98) and AOR=2.80: 95% CI (1.15, 6.77) times higher among women who attained secondary and higher level of education compared with women with no education, respectively. Similarly, women who had positive attitude were (AOR =2. 47: 95% CI (1.48, 4.11) times more likely to have intention to use LAPMs compared with a woman who had a negative attitude on LAPMs.

On the other hand, women who had no myths and misconception on LAPMs were (AOR= 1.71 (1.08, 2.72) times more likely to use LAPMs compared with those who had myths and misconception.

Table 7. Factors associated with women's intention to use LAPMs in Wolaita zone, SNNPR, Ethiopia, 2013

Characteristics (n=411)	Intention to use LAPMs		COR (95%CI)	AOR (95%CI)
	Yes, N (%)	No, N (%)		
Age				
15-24	59 (46.8)	67(53.2)	1.00	1.00
25-34	85(34.1)	164(65.9)	0.59 (0.38, 0.91)*	0.86(0.47, 1.53)
35 and above	12(33.3)	24(66.7)	0.57 (0.26, 1.23)	0.89(0.34, 2.31)
Household				
1-4	92(44.2)	116(55.8)	1.00	1.00
5 and above	64(31.5)	139(68.5)	0.58 (0.39, 0.87)*	0.81 (0.47, 1.41)
Educational status				
No education	40(29.6)	95(70.4)	1.00	1.00
Primary education	41(28.9)	101(71.1)	0.96 (0.57, 1.62)	0.85 (0.48, 1.48)
Secondary education	51(53.1)	45(46.9)	2.69 (1.58, 4.64)*	2.10(1.11, 3.98) **
Higher education	24(63.2)	14(36.8)	4.07 (1.91, 8.67)*	2.80 (1.15, 6.77) **
Decision on the number of children				
Husband	8(21.1)	30(78.9)	1.00	1.00
Myself	44(32.4)	92(67.6)	1.79 (0.76, 4.23)	1.53 (0.62, 3.80)
Together	104(43.9)	133(56.1)	2.93(1.29, 6.67)*	2.215 (0.93, 5.29)
Knowledge score				
Low knowledge	56(33.9)	109(66.1)	1.00	1.00
Moderate knowledge	59(36.9)	101(63.1)	1.37 (0.72, 1.79)	0.75 (0.43, 1.31)
High knowledge	41(47.2)	45(52.3)	1.77 (1.04, 3.02)*	0.74 (0.36, 1.52)
Attitude score (Composite)				
Negative attitude	62(28.7)	154(71.3)	1.00	1.00
Positive attitude	94(48.2)	101(51.8)	2.31 (1.54, 3.47)*	2.47 (1.48, 4.11) **
Heard myths and misconception				
Yes	95(34.4)	181(65.6)	1.00	1.00
No	61(45.2)	74(54.8)	1.57 (1.03, 2.39)*	1.71 (1.08, 2.72) **

*Statistically significance in COR: P-value<0.05, **statistically significance AOR: P-value<0.05

6. DISCUSSIONS

This study identified different factors affecting women's intention to use LAPMs in Wolaita Zone. Hence, women's intention to use LAPMs in Wolaita zone was low [156(38%)]. Moreover, most of the women 216 (52.6%) had a negative attitude to use LAPMs. Different determinants like women who attained secondary and higher educational level [AOR=2.10: 95% CI (1.11, 3.98)] and [AOR=2.80: 95% CI (1.15, 6.77)] compared with those who had no education respectively, their positive attitude to use LAPMs (AOR =2. 47: 95% CI (1.48, 4.11) compared to those with negative attitude and woman who had no myths and misconceptions (AOR= 1.71 (1.08, 2.72) compared to those who had myths and misconceptions were significantly associated with women's intention to use LAPMs.

In this study 38% of women have reported intention to use LAPMs in the future. This finding is less than study conducted in Ambo town, where 56.1% women had intention to use LAPMs (21). This difference could be due to the study settings. That means this study conducted both at urban and rural area where as study at Ambo was only in urban settings. In addition low intention to use LAPMs could be due to the existence of various myths and misconceptions as well as a negative attitude to use these methods.

Moreover, the LAPMs ever used and intended for use in the future by respondents is higher for Norplant. This finding is in line with the finding of EDHS 2011, in which more people used implants among LAPMs (8). The reasons could be the trainings given for Implanon insertion for health extension workers (11), variety of implants available for different duration of years (Implanon, Jadle, and Norplant), the service availability of these methods at every health center than that of permanent methods. Such training of midlevel professionals should be enhanced for permanent methods also. In contrary to this finding, women's intentions to use LAPMs are different from different parts of the world. The finding in the study at Pakistan showed that most women intend to use female sterilization. Similarly, female sterilization is the most widely used method of contraception worldwide, accounting for approximately (20%) of all contraception, followed by IUD (13, 20).

In this study, about 28.2%, 9%, 54% and 87.8% of women heard about female sterilization, male sterilization, IUCD and implants respectively. This finding is consistent with the findings of a

study conducted in Butajira, south central Ethiopia, in which knowledge on vasectomy was the lowest (8.2%) and implants the highest (74.4%). Moreover, this finding is consistent with DHS 2011, in which knowledge on vasectomy was lowest among LAPMs (11.2%) and highest on implant (67.8%). However, knowledge on IUCD (13.1%) and tubaligation (19%) in Butajira were much lower than this study finding. Similarly, in this finding women's knowledge on IUCD and implant are higher than those studies of Butajira and DHS 2011. This could be the fact that the government is scaling up the implant & IUCD training for HEWs and as a result these professionals are inserting Implanon to their clients and teaching the community about it (11,19,23).

In this study, more than half 216 (52.6%) of women had a negative attitude to use LAPMs. This finding is consistent with the study finding of Mekele town where 53.6% of the married women had a negative attitude towards the use of LAPMs (24). Similarly, this finding is in agreement with the findings of the key informant in-depth interviews. In the interview most of the informants believed that their community had a negative attitude to use LAPMs. This could be due to the existence of different myths and misconceptions in the community; which may lead the women to such a negative attitude to use LAPMs.

This study showed that the odds of women's intention to use LAPMs were (AOR=2.10: 95% CI (1.11, 3.98) and AOR=2.80: 95% CI (1.15, 6.77) times higher among women who attained secondary and higher level of education compared with women with no education, respectively. This study is consistent with the findings of other studies conducted in Rwanda, a population based study conducted in Pakistan and study in Mojo town (15, 20, 28). This could be due to those who were educated secondary & higher level can get more health information from different sources, like school, leaflet, newspaper, media and internet than those with no education. In contrast to this finding, a study conducted in Bale zone, Goba town showed that there was no statistical significance association between education and LAPMs use (27).

In this study religion and wealth index were not found to be statistically associated with women's intention to use LAPMs. This finding is in line with the study conducted in Bale town, Eastern Ethiopia and Rwanda (27, 15). This could be the influence of HEWs. They are participating on Implanon insertion & delivering health information on family planning methods and this could be changed the behavior of the community (11). Similarly, wealth index could not be associated with women's desire to use LAPMs due to the fact that contraceptive methods were provided to women free of any cost. However, income was statistically associated with family planning use in a study

conducted at Debre Birhan Town (18). In the same way, religion identified to play a significant role in decision to use contraception in the study of Pakistan (14). This could be the difference in the distribution of the types of religion and cultures among these countries.

After adjusting for all possible cofounders a woman who had positive attitude were (AOR =2. 47: 95% CI (1.48, 4.11) times more likely to desire LAPMs compared with a woman who had a negative attitude on these methods. This finding is consistent with a study in Ambo town (21). Similarly, the findings of key informant in-depth interviews on this issue were in agreement with these findings. This could be due to lack of adequate health information and counseling on long acting and permanent methods in the community as well as the various myths and misconceptions on the methods may led the community to negative attitude.

There are problems related to different barriers to use LAPMs in this study area. About 64.5% women were thinking that there are barriers to use LAPMs. Similarly 67.2% had different myths and misconception in this study area which is influencing the community from using LAPMs. This finding is consistent with study of Ghana in which 63% of clients said that it was because of the rumors why their clients might not choose an IUD and 47% heard IUD can travel other parts of the body from the insertion site. On the other way, this finding is higher than study conducted at the East Shoa Zone, Batu town where 33.2% heard myths and misconception. This difference could be due to the study setting, duration and variations in cultures (29, 30).

Women who had no myths and misconception on LAPMs were (AOR= 1.71 (1.08, 2.72) times more likely to use LAPMs compared with those who had myths and misconception. This might be few women educated at secondary and higher level. Much more different misconceptions found in this study area could be discussed here but lack of similar findings hinders to elaborate the discussion. Hence, further research should be done in different parts of the country to compare with these misconceptions.

Partner disapproval which accounts 38(10.5%) was also one of the reasons women for not practicing LAPMs. Similarly, women who decide on use of family planning together with their spouses were 2.22: 95% CI (0.93, 5.29) times more likely to use LAPMs compared to those whose spouse decided the use alone. This finding is in line with some other studies at Rwanda and Mojo (15, and 28). Similarly, the finding of the in-depth interviews also described the situation in agreement with this finding. This could be due to the women might have low status and low self-

determination as well as their husbands are the decision makers in the majority of household issue in the community.

Finally, findings from in-depth interviews showed that few health centers have family planning guidelines to referee the available standards. Almost all health centers had no strategic manuals on family planning. However, most health centers had trained personnel for long acting contraceptive methods (Implant and IUCD); though, there were no trained personnel and material at any health center for permanent methods. Moreover, no services on permanent methods (vasectomy & female sterilization) were given at all health centers. This finding is in line with the study of Batu town. This is a gap preventing women to choose full range of contraceptive methods as well as the bottleneck for contraceptive method mix (10, 30).

7. Strength and Limitation

7.1 Strength of the study

- ❖ The study used qualitative methods to triangulate the finding of quantitative results and elaborates issues not significantly explained in the quantitative data.
- ❖ This study is one of the few studies, which assess client's intention & their barriers to use LAPMs. Hence, the study identified the various barriers to the method mix of contraceptive methods particularly to the most effective LAPMs in this study area and may fill the information gaps on this issue.

7.2 Limitation of the study

- ❖ It is a cross sectional study; so as it is difficult to know which occurred first, the determinant/exposure or the outcome.
- ❖ Since the study was institutional based, that might undermine generalizing the result to the general population.
- ❖ Using only six health centers from a zone due to financial constraints is another limitation.
- ❖ Relatively low sample size was allocated for rural clients than that of urban inhabitants though equal number of health centers was allocated on both cases. This is due to the low client flow in rural health centers; which reduced by the probability proportional allocation with their sample size.
- ❖ Absence of enough literatures in Ethiopian situation hinders further discussion of the results.

8. Conclusion and Recommendations

8.1. Conclusion

In this study more than half of women had a negative attitude to use LAPMs. Moreover, women had low intention to use LAPMs in Wolaita zone. Among different determinants secondary and higher educational level, positive attitude to use the methods and those who had no myths and misconceptions were significantly associated with women's intention to use LAPMs.

Furthermore, the various myths and misconceptions, low awareness to use the methods, shortage of family planning guidelines and strategic manuals were barriers to use LAPMs.

Among different barriers to LAPMs use in Wolaita zone, myths & misconceptions were the main challenge to contraceptive use. For instance, women who believed that implant would cause hypertension, it could move around freely in the body once inserted and could be lost on the day of removal, implant and IUCD cause illness, implant causes anemia & weight gain were the major ones. Moreover, women who believed that LAPMs cause infertility, LAPMs burn the whole body, LAPMs change the skin (facial) color black and using LAPMs interference with a routine activity if one has work load, using IUCD dries (damages) vagina and LAPMs make labor difficult were another misconceptions in Wolaita zone.

Above and beyond, low awareness on vasectomy and female sterilization were also barriers to use LAPMs in the study area. Moreover, the availability of the methods and trained personnel on long acting methods (implant & IUCD) as well as access to facility was not the barriers to use LAPMs; though services provision and trained personnel on permanent methods (vasectomy & tubal ligation) were a challenge to a method mix in most health centers.

8.2. Recommendations

As this study shows, LAPMs utilization can be improved through empowering women & providing further education to them, increasing their awareness and attitude, improving method mix by training health professionals on surgical contraceptives and removing myths and misconceptions.

1. The government should focus on increasing women's educational level.
2. Health providers and other concerned bodies must put great emphasis on educating communities to increase client's awareness and attitude to use LAPMs. Moreover, taking great attention to bring the behavioral change of the community on myths and misconceptions from the community through health information is critical.
3. FMOH and regional health bureau as well as other NGOs working on family planning, should work to address provision of surgical contraceptives at every health center by training health professionals.
4. Zonal Health Desk and Woreda Health Officers: Should strengthen family planning guideline & strategic manuals in all health centers. Moreover, monitoring and evaluation of family planning activities in particular is very important.
5. Service providers should be strengthening couple's discussion on family planning methods in the communities is very crucial.
6. Researchers should conduct further study by using strong study designs at the community level in different parts of the country to identify what cultural, myths, misconceptions and other barriers hindering women from using LAPMs in different parts of the countries as well as private institutions, NGOs and manager's views should be assessed.

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10. Annexes

Annex 1: The English Version of Structured Questionnaires

Questionnaire on Women's attitude, barriers and intention to use long acting and permanent contraceptive methods among short term users, in the Wolaita zone.

How are you? My name is----- I represent a study team by a post graduate student in public health in Addis Ababa University who intends to do a research in SNNPR, Wolaita Zone, supervised by SPH/AAU instructors. We are studying women's attitude, barriers and intention to use long acting and permanent contraceptive methods and associated factors by asking clients who came for the service. You are randomly chosen to be interviewed by the research team. The information obtained from you and other respondents will help to enhance family planning service in district and beyond.

Your truth full answers for all of our questions about family planning service utilization will be very important to know the status of long acting and permanent contraceptive methods. In the interview we do not need to write your name. Your answers will be kept confidential. The interview shall be conducted in private situation. If you decide that you do not want to participate in the study, we can stop at any time you feel so .It will also not affect the services you receive at the clinic now or in the future. We appreciate if you try to answer all the questions. If you agree to be interviewed, we will go 20-25 minutes for us to complete the questionnaire. If you have any questions about the study you can ask. In case if you have any question you can contact the principal investigator Mr. Mengistu Meskele using his mobile phone **+251-913-17-79-96**.

Thank you. Next I will read a consent, which assures your interest to participate.

CONSENT FORM: The researcher explained the aim of the study with clear language that I can decide once I understand the objective of the study. I decided: **1. Agree to participate** **2. Not agree to participate** (stop here)

If the study subject agrees to participate in the study, start the interview.

Interviewer signature certifying that informed consent has been given verbally by the respondent.

Interviewer's name----- Signature-----Date-----

NB: 1. No need of enforcing the clients to be included in the study.

Name of health center _____ Questionnaires ID.-----Supervisor's name-----sig. -----

Section one. Socio-demographic and economic characteristics

No	Questions	Response	Skip
Q001	How old were you at your last birthday?	Age in completed years-----	
Q002	What is your current Marital status?	1. Single 4.Widowed 2. Married 5.Separeted 3. Divorced	
Q003	What is your usual place of residence type?	1.Urban 2.Rural	
Q004	What is the size of your house hold?	-----	
Q005	What is your religion?	1.Orthodox 2.Muslim 3.Protestant 4.Catholic 5.Traditional 88.Others,specify	
Q006	What is your ethnicity?	1.Wolaita 2.Amara 3.Dawuro 4.Gurage 5.Oromo 88. Others/specify-----	
Q007	Have you ever attended school?	Yes.1 No. 0	If no go to no.009
Q008	What is the highest level of Education (school you attended)?	-----	
Q009	Now I would like you to read this sentence to me. Show card to if respondent cannot read whole sentence, PROBE: Can you read any part of the sentence to me?	Cannot read at all Able to read only parts of sentence Able to read whole sentence No card with required language (specify language)----- Blind/visually impaired	

Q010	What is your Occupation?	1.Farmer 2. Trader 3.Potter 4. House wife 5. Government/NGO employee 6. Daily laborer 88.others,specify-----	
Q011	What is the total monthly income of your household? (From all sources and all members. Please ask income in kind and cash. If in kind use the current market price to convert it to cash income)	Enter the No. in birr _____	

Q012	Does your household have:		Yes	No	
	Q012.A Electricity?		1	0	
	Q012.B A watch/clock?	Electricity			
	Q012.C A radio?	A watch/clock	1	0	
	Q012. D A television?	A radio	1	0	
	Q012.E A mobile telephone?	Television	1	0	
	Q012.F Anon-mobile telephone?	mobile telephone	1	0	
	Q012.G A refrigerator?	non-mobile telephone	1	0	
	Q012.H A table?	Refrigerator	1	0	
	Q012.I A chair? `	Table	1	0	
	Q012.J A bed with Cotton/sponge/spring mattress?	Chair	1	0	
	Q012.K An electric mitad?	bed with cotton/sponge/spring mattress	1	0	
	Q012.L A kerosene	electric mitad	1	0	
		Kerosene	1	0	

No	Section two. Reproductive Health History Questions	Response	Skip
Q013	What was your age at time of first marriage?	-----	
Q014	How many children have you ever given births to?	-----	
Q015	How many of those are living with you?	-----	
Q016	How many are living elsewhere?	-----	
Q017	How many of your biological children are currently alive?	-----	
Q018	How many of your biological children are dead?	-----	
Q019	Total number of children ever born?	-----	
Q020	Have you ever had a pregnancy that was miscarried, aborted, or ended in a stillbirth?	1. Yes 0.No (if No, skip to 022)	If no go to 022
Q021	How many abortions do you have?	-----	
Q022	How many children you want to have?	Enter no-----	
Q023	Who decide on the no of children you want to have?	1. Myself 2. Husband 3. Together 88. Others, specify-----	

No	Section three. Knowledge Questions	Response	Skip
Q024	Do you know about Long Acting and Permanent Methods (methods used for many years or permanently just after having it once)	1.Yes 0.No (if answer is no go to Q No. 028)	If no go to 028
Q025	If yes to Q 024 what are the general uses of LAPMs? (Tick all mentioned) <i>(Multiple answers are possible)</i>	A. Helps for prevention of unwanted Pregnancies B. Prevention of possible maternal and child death and ill health. C. Limiting family size D. Child spacing E. Others-----	
Q026	If yes to Q 024 which LAPMs do you know? <i>(Multiple answers are possible)</i>	A. IUCD B. Implant C. Vasectomy D. Tubal Legation E. other	
Q027	What is your source of information? <i>(Multiple answers are possible)</i>	A. Health institution B. Family C. Friend D. Mass media (TV, Radio, etc.) E. NGO F. Others-----	
	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid Pregnancy. Have you ever heard of (METHOD)?		
Q028	Female sterilization PROBE: Women can have an operation to avoid having any more children	1. Yes 0. No	
Q029	Male sterilization PROBE: Men can have an operation to avoid having any more children.	1. Yes 0. No	
Q030	IUD PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse.	1. Yes 0. No	
Q031	Implants (Implanon/Jadelle/ Norplant) PROBE: Women can have one or more small rods placed in their upper arm by a doctor or	1. Yes 0. No	

	nurse which can prevent pregnancy for one or more years.			
Q032	IUCD can prevent pregnancies for more than 10 years	1.....Yes 0.....No		
Q033	After female sterilization pregnancy is not possible	1.....Yes 0.....No		
Q034	Implant can prevent pregnancies for 3-5 years.	1.....Yes 0.....No		
Q035	Vasectomy has no interference with sexual intercourse	1.....Yes 0.....No		
Q036	Implants require minor surgical procedure during insertion and removal	1.....Yes 0.....No		
Q037	IUCD is not appropriate for female at high risk of getting STIs	1.....Yes 0.....No		

Section four: Family planning information

No	Questions	Response	Skip
Q038	Do you currently have a regular sexual partner?	1. Yes 0. No	If no go # 42
Q039	If yes, does your partner support use family planning methods?	1. Yes 0. No	If no go #41
Q040	If yes, have you discussed use of family planning method with your partner?	1. Yes 0. No	
Q041	Whose preference was accepted during discussion on use of family planning method?	1. My choice 2. Partner's choice 3. Other's choice	
Q042	Which family planning method (s) did the provider whom you met last, discuss with you? (MULTIPLE RESPONSE IS POSSIBLE)	A. Female sterilization B. Male sterilization C. IUD D. Injectables E. Implants F. Pill G. Male condom	

		H. Female condom I. Diaphragm/foam/jelly J. Lactation Method K. Rhythm method L. Withdrawal M. Other modern method N. Other traditional method	
Q043	Did you get the method you want when you discussed with the provider?	1. Yes 0. No	If yes go no 045
Q044	If not, why do you think you did not get your preference (method named in 042)? <i>(Multiple response is possible)</i>	A. Chose not to accept a method at this time B. Preferred method was not appropriate another method (contraindications) C. Changed mind after listening to provider D. Not available at all E. Provider recommended F. Cost of method is not affordable G. Not available at clinic today. H. No appropriate provider available that day I. Don't know/ can't remember J. Other(specify)_____	
Q045	For the method you just decided to accept, did the provider:		
	A. Explain to you how to use the method effectively?	1. Yes 0. No	
	B. Describe potential side effects? C. Tell you what to do if you have experienced side effects? D. Give you information about other methods of family planning?	1.Yes 0.No 1.Yes 0.No 1. Yes 0. No	
Q046	Are you currently using any family planning method?	1.Yes 0. No 99.Don't know	If no go to 50

Q047	Which method(s) are you currently using?	A. Injectables B. Pill C. Male condom D. Female condom E. Diaphragm/foam/jelly. F. Lactation Method G. Rhythm method H. Withdrawal I. Other modern method J. Other traditional method	
Q048	Why do you prefer to be on the method you are currently using?	1. Side effect of the previous method 2. Spacing 3. Limiting 4. Better method use 88. Others-----	
Q049	Is the method you are currently using your choice?	1. Yes 0. No	

No	Section Five: Attitude Questions	Reponses	Skip
	Please tell me whether you strongly agree, agree, not sure, disagree or strongly disagree with each of the following statements		
Q050	Using implant need proper diet	1.Strongly agree 2.Agree 3. Not sure 4. Disagree 5.Strongly disagree	
Q051	The insertion and removal implant is highly painful.	1.Strongly agree 2.Agree 3. Not sure 4. Disagree 5.Strongly disagree	
Q052	Insertion of Intra uterine contraceptive device causes to lose privacy	1.Strongly agree 2.Agree 3. Not sure 4. Disagree 5.Strongly disagree	
Q053	Using Intra uterine contraceptive device restrict normal routine activities.	1.Strongly agree 2.Agree	

		3. Not sure 4. Disagree 5. Strongly disagree	
Q054	Operation for female sterilization is dangerous	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
Q055	For me, implant may freely move other area from insertion site and cause severe pain.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
Q056	For me, it is not good to use LAPMs.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
Q057	For me, discussing about LAPMs contraceptive methods with my husband or friend is not necessary.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
Q058	For me, using LAPM not preventing one from having large family size.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
Q059	For me, operation for female sterilization is unacceptable.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	

Section six: Intention Questions

No	Questions	Response	Skip
Q060	Have you ever used LAPMs contraceptive methods? (For those who have knowledge)	1. Yes 0. No (if answer is No, skip to 066)	066
Q061	Which of the LAPMs have you ever used?	1. Implants 2. IUCD	

		3.Female sterilization 4.Vasectomy(my husband)	
Q062	If yes to Q No. 060 when did You start?	Enter the starting year.....	
Q063	If yes to Q No 060 how long did you use it?	In months -----	
Q064	If yes to Q No. 060 where did you get the service?	1. Government Health institution 2. NGO 3. Private medical sector 88. Others, specify-----	
Q065	If you change the method (IUCD or implant), what is/could be the reason?	A. Fear of side effect B. Medical problem C. Fear of infertility D. Partner disapproves E. To get pregnant F. It is sinful G. Cultural taboo H. Others	
Q066	If you don't practice any of LAPMs what is / are the reasons?	A. Fear of side effect B. Medical problem C. Fear of infertility D. Partner disapproves E. To get pregnant F. It is sinful G. Cultural taboo H. Lack of knowledge I. Service unavailable J. I am single K. Others, specify-----	
Q067	Do you want to use LAPMs in the future?	1. Yes 2. No (if answer is no skip to 069) 3. I am not sure	If no go to 069
Q068	Which method do you intend to use in the future?	1. IUCD 2. Implant 3. Female sterilization 4. Vasectomy (for my husband)	
Q069	If you have no plan what could be the reason? (Multiple answers are possible.)	A. Fear of side effect B. Medical problem C. Fear of infertility D. Partner disapproves E. To get pregnant F. It is sinful G. Cultural taboo	

	H. Lack of knowledge I. Service unavailable J. I am single K. Others, specify-----	
--	---	--

	Section seven. Barriers to use LAPMs		Skip
Q070	Do you think are there any barriers to use LAPM?	1.Yes 0.No (If No skip to 072)	If No skip to 072
Q071	What are the barriers to use LAPM? (Multiple response possible)	A. I desire more children B. Lack of proper diet C. Absence of preferred methods D. Religion, E. Complaints related to providers F. I have work load to take LAPM G. Lack of trained personnel to provide the methods, H. Providers' bias me to choose other method. I. I have no knowledge J. Provider refusal at any time we want to discontinue the method. K. Others specify-----	
Q072	Are there myths and misconceptions you heard in communities like this on the use of family planning in general and long acting and permanent methods in particular?	1.Yes 0.No	Skip
	If yes to Q.072 for the following questions, I am going to read myths and misconceptions and answer "yes" or "no" whether you hear about it.		
Q073	Implant would cause hypertension	1. Yes 0. No	
Q074	Implant could move around freely in the body once inserted and could be lost at the day of removal	1. Yes 0. No	

Q075	Implant causes illness	1. Yes 0. No	
Q076	IUCD Causes illness	1. Yes 0. No	
Q077	Implant causes anemia	1. Yes 0. No	
Q078	IUCD causes anemia	1. Yes 0. No	
Q079	Implant cause weight gain	1. Yes 0. No	
Q080	If other myths& misconceptions	specify-----	

Thank you!

Annex1.2. In-depth interview guide for clients

Good morning/afternoon.

My name is _____

I am a post graduate student in public health in Addis Ababa University and intend to do a research in SNNPR, Wolaita Zone for partial fulfillment of master's degree in public health supervised by SPH/AAU instructors. The information obtained from you and other respondents will help to enhance family planning service in district and beyond.

In the interview we do not need to write your name. Your answers will be kept confidential. The interview shall be conducted in private situation. If you decide that you do not want to participate in the study, we can stop at any time you feel so .It will also not affect the services you will receive at the clinic now or in the future. We appreciate if you try to answer all the questions. If you agree to be interviewed, we will go 35-40 minutes for us to complete the questionnaire. If you have any questions about the study you can ask.

Thank you. Next I will read a consent, which assures your interest to participate.

CONSENT FORM

The researcher explained the aim of the study with clear language that I can decide once I understand the objective of the study. I decided: 1.**Agree to participate** 2. **Not agree to participate** (stop here the interview)

Signature of Person administering consent _____ Date _____

Client's Signature _____ Date _____ ID no. -----

Age -----Occupation-----

Health center-----

Discussion topics

1. How do you understand about LAPM?
2. What do you / the community knows about long acting (IUCD, Implant) and Permanent (voluntary sterilization) contraception?
3. What are the reasons you/ the community don't use long acting (IUCD, Implant) and permanent (voluntary sterilization) contraception?
4. What are the barriers to use LAPM?
5. What myths and misconception you heard about LAPM? Can you tell if any?
6. Do you want to know more about long acting (IUCD, Implant) and Permanent (Voluntary sterilization) contraception? What could be the reason?
7. What can help people to use LAPM? Enhancing factors?
8. What is your opinion on having large family size?
9. Who should decide about family size? Why?
10. Are there any provider, facility and availability related issues prevent the community from using LAPM?
11. What is your attitude and communities perception concerning the use of LAPMs in this community?
12. Do you/community intend to use LAPMs in the future? Which method? Is there any additional issue up on LAPM?

Thank you!

Annex1.3:In-depth interviews guide for service providers

In-depth interviews questioners for Service providers and manager of health centers

How are you? My name is _____

I am a post graduate student in public health in Addis Ababa University and doing a research in SNNPR, Wolaita Zone for master's degree in public health supervised by SPH/AAU instructors. I am studying women's attitude, barriers and intention to use LAPM contraceptives among short term users. The information obtained from you and others respondents will help to enhance family planning service in district and beyond.

In the interview we do not need to write your name. Your answers will be kept confidential. The interview shall be conducted in private situation. If you decide that you do not want to participate in the study, we can stop at any time you feel so. We appreciate if you try to answer all the questions. If you agree to be interviewed, we will go 35-40 minutes for me to complete the questionnaires. If you have any questions about the study you can ask.

Thank you. Next I will read a consent, which assures your interest to participate.

CONSENT FORM

The researcher explained the aim of the study with clear language that I can decide once I understand the objective of the study. I decided: 1.**Agree to participate** 2. **Not agree to participate** (stop here the interview)

Signature of Person administering consent _____ Date _____

Service provider's/health center manager's Signature _____

Date _____

Age -----Occupation-----

Health center-----

Discussion Guides (Remember to ask many probing questions to have an in depth insight)

1. How do you perceive the population growth in your community?

2. What mechanisms should be put in place to control the fast growing population in this community?
3. How do you evaluate the attitude of your community towards use of family planning methods?
4. What are the barriers to use of modern family planning methods?
5. How about the use of long acting and permanent contraceptive methods?
6. What are the social, cultural and attitudinal and economic barriers to use LAPMs in this community?
7. What are service related barriers to use of LAPM in this community?
8. Are there any barriers to deliver LAPM in regarding supplies, equipment and trained staff and access in your health center?
9. What are health professional related attitude and barriers to deliver LAPM to his/her clients? For example during counseling and service provision?
10. What are religion related barriers to use of LAPM in this community?
11. Is LAPM available at all times in last 6 months? If no, what is the reason for unavailability in the last time?
12. Are all clients receiving their preferred method? If not why? What about provider determination in client's method selection?
13. What about provider delivery mechanism of giving accurate information about how to use the method and side effects?
14. What is women's awareness to use LAPM in your community?
15. What myths and misconception in your area preventing women from using LAPMs?
16. What is women's attitudinal barriers and intentional to use LAPM in your community?
17. Is there any follow up evaluation and monitoring from Woreda, zone, region and other stake holders in your health center about LAPM? When?
18. Are there any IEC materials, family planning guideline and strategy manual in your health center? Can you show me?

Thank you so much!

Annex 2: The Amharic Version of structured Questioneries

የአማርኛ ጥያቄ

በወላይታ ዞን የሚገኙ እናቶች ለረጅም ጊዜና በዘላቂነት የሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች ለመጠቀም ያላቸው ዝንባሌ፣ፍላጎትና አንቅፋቶች

ጤና ይስጥልን፤ ስሜ-----ይባላል። እኔ በአዲስ አበባ ዩኒቨርሲቲ የጤና አጠባበቅ ትምህርት ቤት የማስተርስ ድግሪ የሚያጠና ተማሪ ከአዲስ አበባ ዩኒቨርሲቲ መምህራን በመታገዝ በደቡብ ክልል ፣ ወላይታ ዞን ለረጅም ጊዜና በዘላቂነት ስለሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች ለማጥናት በተዋቀረው ቡድን ውስጥ አባል ነኝ። ጥናታችንም ጤና አገልግሎት ለማግኘት ወደ ጤና ተቋማት የመጡ ተገልጋዮችን በመጠየቅ የሚከናወን ነው። እርሶም በጥናት ቡድን አማካኝነት በዕጣ በዚህ መጠይቅ ተካተዋል። እርሶ የሚሰጡን መረጃ ከሌሎች መረጃ ምንጮች ጋር ተዳምሮ የቤተሰብ ምጣኔ አገልግሎት የሚሻሻልበትን ሁኔታ ለዚህ አከባቢና ለሌሎቹም ለማመቻቸት ታልም የተዘጋጀ ጥናት ነው። በሂደታችን ውስጥ በጥናቱ ላለመካፈል በማንኛውም ወቅት ከወሰኑ በማንኛውም ሰዓት መጠይቁን እናቆማለን። የቤተሰብ ምጣኔ አገልግሎቱን በተመለከተ ለምንጠይቆት ጥያቄዎች የሚሰጡን ትክክለኛና ቀና መልስ ስለረጅም ጊዜና በዘላቂነት ስለሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች በሚገባ ለማወቅ ወሳኝ ሚና አለው። በዚህ መጠይቅ ውስጥ ስሞትንና እርሶን ለመለየት የሚያገለግል ነገር አይፈቀድም። እርሶም የሚሰጡን ሚላሽ ሁሉ በሚስጥር ይያዛሉ። መጠይቁም የግል ምኞትን በጠበቀ ሁኔታ ይካሄዳሉ። በጥናቱ ውስጥ ላለመካፈል በሚወስኑበት ወሳኔ የተነሳ የሚደርስበት አንዳችም ሁኔታ የለም። የሚያገኙትንም የጤና አገልግሎት አሁንም ቢሆን ወደፊት አያስተጓጉልም። ነገር ግን ሁሉንም ጥያቄዎች እንዲመልሱልን እናበረታታለን። በጥያቄው ለመሳተፍ ፈቃደኛ ከሆኑ ከ20-25 ደቂቃ ውስጥ እናጠናቅቃለን። ግልፅ ያልሆነ ነገር ካለ ሊጠይቁን ይችላሉ። ማንኛውም ጥያቄ ካሎት የጥናቱ መሪ የሆኑትን አቶ መንግሥቱ መስቀሌን በስልክ ቁጥር +251-913-17-79-96 ማግኘት ይችላሉ።

አመሰግናለሁ በመቀጠል የስምምነት ቅጽ አነባለሁ፣ይህም በጥናቱ ለመሳተፍ ያለዎትን ፍላጎት ያረጋግጣል።

የስምምነት ቅጽ

ተመራማሪው የጥናቱን ዓላማ በሚገባ ግልጽ በሆነ ቋንቋ አስረድተውኛል። በዚህም መሠረት የጥናቱን ዓላማ ስለተረዳሁ ለመሳተፍ ወሳኝነጅን በሚከተለው መንገድ አረጋግጣለሁ። 1. አዎ እሳተፋለሁ። 2. አልሰማማም/ አልሳተፍም (አመስግነው በዚህ ያብቁ ።)

ተጠያቂው ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ

የመረጃ ሰብሳቢ ፊርማ ደንበኛው በቃል ስምምነት መስጠቱን ያረጋግኛል።

የመረጃ ሰብሳቢ ስም -----ፊርማ ----- ቀን -----

አስታውስ፡ ደንበኛው በግድ በጥናቱ እንድሳተፍ አያስገድዱ።

የጤና ድርጅቱ ስም : _____ የጥያቄ ቁጥር ----- ሱፌርሻይዘር ስም ----- ፊርማ -----

ክፍል አንድ

የማህበራዊና ዲሞክራሲያዊ ሁኔታዎች

ቁጥር	ጥያቄ	ሚላሽ	ይዘለሉ
Q001	የመጨረሻ ልደት ስያክብሩ እድሜዎ ስንት ነው? (በዓመት)	-----	
Q002	ያሁኑ የጋብቻ ሁኔታዎ?	1.ያላገባች 2.ያገባች 3.የተፋታች 4.ባሏ የሞተባት 5.ተለያይተዉ የሚኖሩ	
Q003	ቋሚ የመኖሪያ ቦታዎ የት ነዉ?	1.ከተማ 2.ገጠር	
Q004	የቤተሰብዎ ቁጥር ስንት ነዉ?	-----	
Q005	ሃይማኖትዎ ምንድነዉ?	1. ኦርቶዶክስ ክርስቲያን 2. እስላም 3.ፕሮቴስታንት 4 ካቶልክ 5 ባህላዊ 88. ሌላ (ይገለፅ)-----	
Q006	ብሔርዎ ምንድን ነዉ?	1. ወላይታ 2. አማራ 3.ዳዉሮ 4. ጉራጌ 5. አሮሞ 88. ሌላ -----	
Q007	መደበኛ ትምህርት ተከታትለዉ ያዉቃሉ?	1.አዎ 0.አይደለም	አይደለም ከሆነ ወደ ጥያቄ 009 ይሂዱ
Q008	ከፍተኛዉ የትምህርት ደረጃዎ ስንት ነዉ?	-----	
Q009	አሁን ይህንን ዓረፍተ ነገር አነብሎታለሁ::ተጠያቂዎቹ ሁሉን ዓረፍቱ ነገር ለማንበብ የማይችሉ ከሆነ ካርዱን ያሳዩአቸዉ:: ማረጋገጫ: ከተሰጡት ዓረፍተ ነገሮች ዉስጥ የተወሰኑትን ልያነቡልኝ ይችላሉ?	ምንም ማንበብ አይችሉም የተወሰኑትን ዓረፍተ ነገሮች ብቻ ማንበብ ይችላሉ ሁሉንም ዓረፍተ ነገሮች ማንበብ ይችላሉ	

		ለተፈለገው ቋንቋ ካርድ የለም (ቋንቋውን ይግለጹ)----- አይነ ስወር/ማየት የተሳናቸው		
Q010	ሥራዎ ምንድን ነው?	1. ገበሬ 2. ነጋዴ 3. ሸክላ ሠሪ 4. የቤት እመቤት 5. የመንግስት ሰራተኛ/መንግሥታዊ ያልሆነ ድርጅት ሠራተኛ 6. ቀን ሰራተኛ 88. ሌላ-----		
Q011	ጠቅላላ የቤተሰብዎ ወራዊ ገቢ ስንት ነው?(ከሁሉም የቤተሰብ አባላት የሚገኘውን ጠቅላላ የገቢ ምንጭ ጨምሮ :: እባክዎን ገቢያቸውን በዓይነትና በብር ይጠይቁ::ንብረቱ በዓይነት ከሆነ በወቅቱ ገቢያ መሠረት ወደ ብር ይቀይሩ::	የብሩን መጠን በቁጥር ያስገቡ -----		
Q012	በእርስዎ ቤተሰብ ውስጥ ከሚከተሉት የትኛው ይኖርዎታል?		አዎ	አይደለም
	ኤሌክትሪሲቲ?	1	0	
	Q012.A ኤሌክትሪሲቲ?			
	Q012.B የእጅ ሰዓት?	1	0	
	Q012.C ሬድዮ?	1	0	
	Q012.D ተሌቭዥን?	1	0	
	Q012.E የሞባይል ስልክ?	1	0	
	Q012.F ፍርጅ?	1	0	
	Q012.G ጤረጳዛ?	1	0	
	Q012.H ወንበር? `	1	0	
	Q012.I አልጋ ከጥጥ/ስፖንጅ/ስፐርንግ ፍራሽ?	1	0	

	Q012.J የኤሌክትሪክ ምጣድ?	አልጋ ከጥጥ/ስፖንጅ/ስፕሪንግ ፍራሽ?	1	0	
	Q012.K ከሮስን?	የኤሌክትሪክ ምጣድ	1	0	
		ከሮስን	1	0	

ክፍል ሁለት ስለተዋልዶ ጤና ታሪክ

No	ጥያቄ	መልስ	ይዘለሉ
Q013	የመጀመሪያ ጋብቻ ስፈጽሙ ዕድሜዎት ስንት ነበር?	-----	
Q014	ምን ያህል ልጆች ወልደዋል?	-----	
Q015	ከወለዱቸው ልጆች አሁን ከእርሶ ጋር ያሉት ስንት ናቸው?	-----	
Q016	ከወለዱቸው ልጆች ባሁኑ ጊዜ ሌላ ቦታ ያሉት ስንት ናቸው?	
Q017	እርሶ ከወለዱቸው ልጆች ባሁኑ ጊዜ በሕይወት ያሉት ስንት ናቸው?	-----	
Q018	እርሶ ከወለዱቸው ልጆች የሞቱት ስንት ናቸው?	-----	
Q019	በጠቅላላ ከእርሶ የተወለዱ ልጆች ስንት ናቸው?	
Q020	ካሁኑ በፊት እርግዝናዎ ወርጃ ኖሮት ወይም ሞቶ የተወለደ ልጅ አጋጥሞት ያወቃል?	1. አዎ 0. የለም (የለም ከሆነ ወደ 022 ይሂዱ)	የለም ከሆነ 022 ይሂዱ
Q021	ምን ያህል ወርጃ ተከስተዋል?	-----	
Q022	ምን ያህል ልጆች ወደፊት እንድኖሩ ይፈልጋሉ?	ቁጥር ያስገቡ -----	
Q023	የምትፈልጉትን ልጆች ብዛት የሚወስነው ማን ነው?	1. ራሴ 2. ባሌቤቴ 3. ሁለታችንም በጋራ 88. ሌላ ካለ ይገለጽ -----	

ክፍል አራተኛ ለረጅምና ቋሚ ቤተሰብ ምጣኔ እውቀት

No	ጥያቄ	መልስ	ይዘሉ
Q024	ለረጅም ጊዜና በዘላቂነት ስለሚያገለግለው ቤተሰብ ምጣኔ ያውቃሉ? (አንዴ ከተጠቀሙ ለረጅም ጊዜና በቋሚነት ለብዙ ዓመት ወይም በዘላቂነት ስለሚያገለግለው ቤተሰብ ምጣኔ)	1. አዎን 0. አላውቅም (መልሱ አላውቅም ከሆኑ ወደ ጥያቄ 028 ይሂዱ)	አላውቅም ከሆነ ወደ ጥያቄ 028
Q025	የጥያቄ ቁጥር 24 መልሱ አዎን ከሆኑ ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ የሚሰጠው ጠቅላላ ጥቅም ምን ምን ያውቃሉ? (የተጠቀሰውን ሁሉ ያክብቡ) (ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)	A. ያልተፈለገ እርግዝናን ይከላከላል B. ልክሰት ከሚችለውን የእናቶችና ሕጻናት ሞትና በሽታ ይከላከላል C. የቤተሰብ ቁጥርን በመወሰን D. ልጅን አራርቆ ለመወለድ E. ሌላ-----	
Q026	የጥያቄ ቁጥር 24 መልሱ አዎን ከሆነ ከረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ የትኛውን ያውቃሉ? (ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)	A. በማህፀን ውስጥ የሚቀመጥ(IUCD) B. በከንድ የሚቀበረውን የወልድ መከላከያ C. በቀዶ ጥገና የሚሰራ ዘላቂ (የወንድ) D. በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) E. ሌላ -----	
Q027	ለዚህ የቤተሰብ ምጣኔ የመረጃ ምንጭ ማን ነው? (ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)	A. የጤና ድርጅት B. ቤተሰብ C. ጓደኛ D. መገናኛ ብዙሃን (ቴሌቪዥን, ሬድዮ, ወዘተ.) E. መንግሥታዊ ያልሆነ ድርጅት F. ሌላ ይገለጽ-----	
	አሁን ከእርስዎ ጋር ስለቤተሰብ ምጣኔ ለመነጋገር ወደድኩ - ይህም ሁለቱ ጥንዶች እርግዝናን ለማዘግየት ወይም ለመከላከል የተለያዩ መንገዶችን /ዜደዎችን የሚጠቀሙበት ሁኔታ ነው:: ከዚህ በፊት የሚከተለውን ዘዴን ስምተው ኖሩዋል?		
Q028	በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት):ፈትሽ: ሴቶች ተጨማሪ ልጆች እንዳይኖሩ በቀዶ ጥገና እርግዝናን በዘላቂነት የመከላከል ዘዴአዎንአይደለም	
Q029	በቀዶ ጥገና የሚሰራ ዘላቂ (የወንድ) ፈትሽ: ወንድ ተጨማሪ ልጆች እንዳይኖሩ በቀዶ ጥገና	1.አዎን 0.አይደለም	

	እርግዝናን በዘላቂነት የመከላከል ዘዴ		
Q030	በማህፀን ውስጥ የሚቀመጥ፡ ፈትሽ፡ ሴቶች በማህፀን ውስጥ በዶክተር ወይም በነርስ አማካይነት የሚያስቀምጡት ክር መሰል ነገር።	1 አዎን 0 አይደለም	
Q031	በክንድ ውስጥ የሚቀበር (አምጥላኖን/ጃድል/ኖርጥላንት) ፈትሽ፡ ሴቶች ተጨማሪ ልጆች እንዳይኖሩ በክንድ ውስጥ አንድ ወይም ከዛ በላይ ትናንሽ ክብሪት እንጨት መሰል በዶክተር ወይም በነርስ እርግዝናን ለአንድ ዓመትና ከዛ በላይ የሚከላከሉበት ዘዴ.	1 አዎን 0 አይደለም	
Q032	በማህፀን ውስጥ የሚቀመጥ(IUCD)፤ እርግዝናን ከአሥር ዓመት በላይ ልክላከል ይችላል።	1 አዎን 0 አይደለም	
Q033	በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት)፤ ከተሠራላት በኋላ ዳግመኛ እርግዝና ልክሰት አይችልም።	1 አዎን 0 አይደለም	
Q034	በክንድ ውስጥ የሚቀበር መከላከያ ዘዴ እርግዝናን ለአምስት ዓመት ልክላከል ይችላል።	1 አዎን 0 አይደለም	
Q035	በቀዶ ጥገና የሚሰራ ዘላቂ (የወንድ) የመከላከያ ዘዴ የግብረ ሥጋ ግንኙነትን አያስተጓጉልም።	1 አዎን 0 አይደለም	
Q036	በክንድ ውስጥ የሚቀበር መከላከያ ዘዴ ለማስገባትና ለማስወጣት መለስተኛ የቀዶ ጥገና ይፈልጋል።	1 አዎን 0 አይደለም	
Q037	በማህፀን ውስጥ የሚቀመጥ(IUCD) በአባለ ዘር በሽታ የመጋለጥ አደጋ ላይ ላሉ ሴቶች ምቹ አይደለም።	1 አዎን 0 አይደለም	

ክፍል ሦስት፡ ስለቤተሰብ ምጣኔ መረጃ

	ጥያቄ	ምላሽ	ይዘላሉ
Q038	ባሁኑ ጊዜ ባሌበት አሎት?	1. አዎን 0. አይደለም	አይደለም ከሆነ ወደ # 42 ይሂዱ

Q039	ጥያቄ 038 አዎን ከሆነ፣ ባለቤትዎ የቤተሰብ ምጣኔ አገልግሎት አጠቃቀምን ይደግፋል?	1. አዎን 0. አይደለም	አይደለም ከሆነ ወደ # 41 ይሂዱ
Q040	ጥያቄ 038 አዎን ከሆነ ፤ የወሊድ መቆጣጠሪያ ጥቅም ከባለቤትዎ ጋር ተማክረዋል?	1. አዎን 0. አይደለም	
Q041	የቤተሰብ ምጣኔ አገልግሎት አጠቃቀምን በሚትወያዩበት ጊዜ የማን ምርጫ ተቀባይነት አገኘ?	1. የራሴ ምርጫ 2. የባለቤቴ ምርጫ 3. የሌሎች ምርጫ	
Q042	የጤና ባለሙያው የትኛውን አይነት የወሊድ መቆጣጠሪያ ዘዴ አወያዩት? <i>(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)</i>	A. በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) B. በቀዶ ጥገና የሚሰራ ዘላቂ (ወንድ) C. በማህፀን ውስጥ የሚቀመጥ D. በመርፌ የሚሰጥ E. በክንድ ውስጥ የሚቀበር F. የሚዋጥ ፒል G. የወንድ ኮንዶም H. የሴት ኮንዶም I. አረፋማ እንክብል. J. በማጥባት እርግዝናን መከላከል. K. የቆጠራ ዘዴ L. ግንኙነት ማቆም M. ሌላ ዘመናዊ ዘዴ N. ሌላ ባህላዊ ዘዴዎች	
Q043	ከአገልግሎት ሰጪ ጋር በተወያዩበት ጊዜ የፈለጉትን ዘዴ ወስደዋል?	1. አዎን 0. አይደለም	አዎን ከሆነ ወደ 045 ይሂዱ
Q044	አይደለም ከሆነ፣ ምርጫዎን ያላገኙበት ምክንያት ምንድን ነው (በጥያቄ ቁጥር 042 የተገለጸውን)? <i>(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)</i>	A. በዚህ ጊዜ ዘዴውን ለመቀበል ስላልመረጥኩ B. የመረጥኩት ዘዴ ምቹ ስላልነበረ C. የጤና ባለሙያውን ሰምቼ ሀሳቤን ስለቀየርኩ D. በጤና ድርጅቱ ፈጽሞ ስለሌለ E. ጤና ባለሙያው ዘዴውን እንድትወስድ ስለገፋፋኝ F. ዋጋው ስለከበደኝ G. በጤና ድርጅቱ ውስጥ ዛሬ ስለሌለ H. ሊሰጠኝ የሚችል ባለሙያ ስለሌለ I. አላወቅም J. ሌላ_____	

Q045	<p>አገልግሎት ሰጪው ለመውሰድ ስለወሰነዎት ዘዴ፤</p> <p>A. አጠቃቀሙን ነገሮት?</p> <p>B. የጎንዮሽ ጉዳት እንዳለው ነገሮት?</p> <p>C. ችግር ቢያጋጥም ምን ማድረግ እንዳለቦት ነገሮት?</p> <p>D. ስለሌላ የቤተሰብ ምጣኔ አገልግሎት መረጃ ነገሮት?</p>	<p>1. አዎን 0. አይደለም</p> <p>1. አዎን 0. አይደለም</p> <p>1. አዎን 0. አይደለም</p> <p>1. አዎን 0. አይደለም</p>	
Q046	ባሁኑ ጊዜ የወሊድ መከላከያ ዘዴ የትኛውንም ቢሆን እየተጠቀሙ ነዎት?	<p>1. አዎን</p> <p>2. አይደለም</p> <p>99. አላውቅም</p>	አይደለም ከሆነ ወደ 50 ይሂዱ
Q047	የትኛውን ዘዴ (ዘዴዎች) ነው ባሁኑ ጊዜ የሚጠቀሙት?	<p>A. በመርፌ የሚሰጥ</p> <p>B. የሚዋጥ ፒል</p> <p>C. የወንድ ኮንዶም</p> <p>D. የሴት ኮንዶም</p> <p>E. አረፋማ እንክብል</p> <p>F. በማጥባት እርግዝናን መከላከል</p> <p>G. የቆጠራ ዘዴ</p> <p>H. ግንኙነት ማቆም</p> <p>I. ሌላ ዘመናዊ ዘዴ</p> <p>J. ሌላ ባህላዊ ዘዴዎች</p> <p>.</p>	
Q048	ባሁኑ ጊዜ የሚጠቀሙበትን ዘዴ ለምን መረጡ?	<p>1. ከበሬቱ ዘዴ ጎንዮሽ ጉዳት የተነሳ</p> <p>2. ልጅ ለማራራቅ</p> <p>3. ለመወሰን</p> <p>4. የተሻለ ዘዴን ለመጠቀም</p> <p>88. ሌላ-----</p>	
Q049	ባሁኑ ሰዓት እየተጠቀሙበት ያለው ዘዴ የእርስዎ ምርጫ ነው?	<p>1. አዎን</p> <p>2. አይደለም</p>	

ክፍል አምስት። የዝንባሌ ጥያቄ

ተራ ቁጥር	ጥያቄ	ምላሽ	ይዘላሉ
	<p>እባክዎን የሚከተለውን ጥያቄዎች በጣም እስማማለሁ፤ እስማማለሁ፤ እርግጠኛ አይደለሁም፤ አልስማማም፤ በጣም አልስማማም ብለው ይመልሱ።</p>		
Q050	<p>በክንድ የሚቀበረውን የወሊድ መከላከያ ለመጠቀም የተመጣጠነ ምግብ ያስፈለጋል።</p>	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም 	
Q051	<p>በማህፀን ውስጥ የሚቀመጥ የቤተሰብ ምጣኔ ዘዴን ማስገባትና ማወጣት በጣም ያሳምማል።</p>	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም 	
Q052	<p>በማህፀን ውስጥ የሚቀመጥ የቤተሰብ ምጣኔ ዘዴን ማስገባትና ማወጣት ገመናን ያሳጣል/ ያጋልጣል/።</p>	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም 	
Q053	<p>በማህፀን ውስጥ የሚቀመጥ የቤተሰብ ምጣኔ ዘዴ ቀን ተቀን ሥራ በአግባቡ እንዳንሠራ ያስተጓጉላል።</p>	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም 	
Q054	<p>በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) የቤተሰብ ምጣኔ ዘዴ አደገኛ ነው።</p>	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም 	
Q055	<p>በክንድ የሚቀበረውን የወሊድ መከላከያ መጠቀም ከገባበት የሰውነት ክፍል ወደ ሌላ የሰውነት ክፍል በመሄድ ሕመም ያስከትላል።</p>	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 	

		3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም	
Q056	ለረጅም ጊዜና በዘላቂነት የሚያገለገለውን የወሊድ መከላከያ መጠቀም ጥሩ አይደለም።	1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም	
Q057	ለረጅም ጊዜና በዘላቂነት የሚያገለገለውን የወሊድ መከላከያ ዘዴ ከባለቤቴና ከጓደኞቼ ጋር መወያየት አስፈላጊ አይደለም።	1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም	
Q058	ለረጅም ጊዜና በዘላቂነት የሚያገለገለውን የወሊድ መከላከያ መጠቀም የቤተሰብ ቁጥር እንዳይበዛ አያግድም።	1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም	
Q059	በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) ዘዴ መጠቀም ተቀባይነት የሌውም።	1. በጣም እስማማለሁ 2. እስማማለሁ 3. እርግጠኛ አይደለሁም 4. አልስማማም 5. በጣም አልስማማም	

ክፍል ስድስት ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ ለመጠቀም ያለው ፍላጎት

ተራ ቁጥር	ጥያቄ	ምላሽ	ይዘለሉ
Q060	ከዚህ በፊት ለረጅም ጊዜና በቋሚነት የሚያገለግለው ቤተሰብ ምጣኔ ተጠቅመው ያውቃሉ? (ስለዚህ ዘዴ እውቀት ያላቸውን ይጠይቁ።)	1 አዎን 0. አይደለም መልሱ አይደለም ከሆነ ወደ 066 ይሂዱ	መልሱ አይደለም ከሆነ ወደ ጥያቄ 066 ይሂዱ
Q061	ከዚህ በፊት የትኛውን የረጅም ጊዜና በቋሚነት የሚያገለግለው ቤተሰብ ምጣኔ ዘዴ ተጠቅመዋል ?	1. በክንድ የሚቀበረውን 2. በማህፀን የሚቀበረውን 3. በቀዶ ጥገና የሚሰራ ዘላቂ (ሴት) 4. በቀዶ ጥገና የሚሰራ ዘላቂ (ወንድ) ለባለቤቴ	
Q062	የጥያቄ ቁጥር 060 አዎን ከሆነ መቼ ነበር መጠቀም የጀመሩት?	የጀመሩበትን ዓመት-----	

Q063	የጥያቄ ቁጥር 060 አዎን ከሆነ ምን ያክል ጊዜ ነው የተጠቀሙት?	-----	
Q064	የጥያቄ ቁጥር 060 አዎን ከሆነ ከየት ነበር አገልግሎትን ያገኙት?	1. ከመንግሥት ጤና ድርጅት 2. መንግስታዊ ያልሆኑ ድርጅት 3. ከግል ሕክምና ማዕከል 4. ሌላ ይገለጽ-----	
Q065	ያንን ዘዴ ወደ ሌላ ቀይረዋል ከሆነ ምክንያቱ ምንድነው? (በክንድ የሚቀበረውንና በማህፀን የሚቀበረውን የወሊድ መከላከያ ለተጠቀሙት)	A. የጎንዮሽ ጉዳት በመፍራት B. ከጤና ችግር የተነሳ C. መካኒካት በመፍራት D. ባሌቤቴ በመቃወም E. ለማርገዝ F. ኃጢአት ስለሆነ G. ከባሕል ተጽዕኖ H. ሌላ ይገለጽ-----	
Q066	ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ አገልግሎትን የማይጠቀሙ ከሆነ ምክንያቱ ምንድነው?	A. የጎንዮሽ ጉዳት በመፍራት B. ከጤና ችግር የተነሳ C. መካኒካት በመፍራት D. ባሌቤቴ በመቃወም E. ለማርገዝ F. ኃጢአት ስለሆነ G. ከባሕል ተጽዕኖ H. እውቀት ስለሌለኝ I. አገልግሎቱ ስለሌለ J. ስላላገባሁ K. ሌላ ይገለጽ-----	
Q067	ወደፊት ለረጅም ጊዜና በቋሚነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎትን ለመጠቀም ይፈልጋሉ?	1. አዎን 2. አይደለም(አይደለም ከሆነ ወደ 069 ይሂዱ) 3. እርግጠኛ አይደለሁም	አይደለም ከሆነ ወደ 069 ይሂዱ
Q068	የትኛውን ዘዴ ለመለጠቅም ያስባሉ?	1. በማህፀን የሚቀበረው 2. በክንድ የሚቀበረውን የወሊድ መከላከያ 3. በቀዶ ጥገና የሚሠራ ዘላቂ(የሴት) 4. በቀዶ ጥገና የሚሠራ ዘላቂ(የወንድ)	
Q069	ለመጠቀም ዕቅድ ከሌለዎት ምክንያቱ ምንድን ነው ?	A. የጎንዮሽ ጉዳት በመፍራት B. ከጤና ችግር የተነሳ C. መካኒካት በመፍራት D. ባሌቤቴ በመቃወም E. ለማርገዝ F. ኃጢአት ስለሆነ	

		G. ከባሕል ተጽዕኖ H. እውቀት ስለሌለኝ I. አገልግሎቱ ስለሌለ J. ስላላገባሁ K. ሌላ ይገለጽ-----	
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ክፍል ሰባት: ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ እንቅፋቶች

			ይዘላሉ
Q070	ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ ለመጠቀም እንቅፋት ይኖራል ብለው ያስባሉ?	1. አዎን 0. የለም (የሌም ከሆነ ወደ 072 ይህዱ)	የለም ከሆነ 072
Q071	ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ ለመጠቀም እንቅፋቶች ምንድን ናቸው? (ብዙ አማራጭ መልስ ከተሰጠ ያክብቡ)	A. ብዙ ልጆች መፈለግ B. የተመጣጠነ ምግብ አለመኖር C. እኔ የምመርጠው የወሊድ መቆጣጠሪያ አለመኖር D. ሐይማኖት E. ከአገልግሎት ሰጪ የሚመጣ ጭቅጭቅ F. የሥራ ጫና ስላለብኝ ነው G. የሰለጠነ የጤና ባለሙያ አለመኖር H. አገልግሎት ሰጪው ሌላን ዘዴ እንድመርጥ ገፋፋኝ I. እውቀት ስለሌለኝ ነው J. ዘዴውን ለማቋረጥ በሚንፈልግበት ጊዜ አገልግሎት ሰጪው እሺ ስለማይል ነው K. ሌላ ካለ ይገለጽ-----	
Q072	በማኅበረሰባችን ውስጥ ስለቤተሰብ ምጣኔ በጠቅላላ ለረጅም ጊዜና በቋሚነት ስለሚያገለግለው ቤተሰብ ምጣኔ በተለይ አልባሉታና የተሳሳተ አመለካከት ስለመኖሩ ስምተዋል?	1. አዎ 0. አይደለም (መጠይቁን በዚህ ያብቁ::)	

	የጥያቄ ቁጥር.072 አዎን ከሆነ ለሚከተሉት ጥያቄዎች እኔ የማይበደውን አልባሉታና የተሳሳተ አመለካከት ሰምተዉ ከሆነ “አዎን ” ካልሰሙ “አይደለም ” ብለዉ ይመልሱ።		
Q073	በክንድ የሚቀበረዉ ዘዴ ደም ግፊትን ያመጣል።	1. አዎን	0. አይደለም
Q074	በክንድ የሚቀበረዉ ዘዴ ከገባ በኋላ በሰውነት ውስጥ በነፃነት በመዟዟር ይጠፋና በሚያወጡበት ጊዜ አይገኝም።	1. አዎን	0. አይደለም
Q075	በክንድ የሚቀበረዉ ዘዴ በሽታን ያመጣል።	1. አዎን	0. አይደለም
Q076	በማህፀን የሚቀበረዉ ዘዴ በሽታን ያመጣል።	1. አዎን	0. አይደለም
Q077	በክንድ የሚቀበረዉ ዘዴ የደም ማነስን በሽታን ያመጣል።	1. አዎን	0. አይደለም
Q078	በማህፀን የሚቀበረዉ ዘዴ የደም ማነስን በሽታን ያመጣል።	1. አዎን	0. አይደለም
Q079	በክንድ የሚቀበረዉ ዘዴ የክብደት መጨመርን ያመጣል።	1. አዎን	0. አይደለም
Q080	ሌላ አልባሉታና የተሳሳተ አመለካከት ካለ	ይገለጹ-----	

ስለሰጡን ምላሽ በጣም አመሰግናለሁ!

Annex2.1: Amharic in-depth interview with clients

Annex 2.1 ከአገልግሎት ተጠቃሚ እናቶች ጋር የሚካሄድ ጠለቅ ያለ መጠይቅ

ጤና ይስጥልን፤ ስሜ-----ይባላል። እኔ በአዲስ አበባ ዩኒቨርሲቲ የጤና አጠባበቅ ትምህርት ቤት ተማሪ ስሆን ከአዲስ አበባ ዩኒቨርሲቲ መምህራን በመታገዝ በደቡብ ክልል ፣ ወላይታ ዞን ለረጅም ጊዜና በዘላቂነት ስለሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች ላይ ጥናት እያጠናወድ እገኛለሁ።። እርሶ የሚሰጡን መረጃ ከሌሎች መረጃ ምንጮች ጋር ተዳምሮ የቤተሰብ ምጣኔ አገልግሎት የሚሻሻልበትን ሁኔታ ለዚህ አካባቢና ለሌሎቹም ለማመቻቸት ታልም የተዘጋጀ ጥናት ነው።በዚህ መጠይቅ ውስጥ ስምትንና እርሶን ለመለየት የሚያገለግል ነገር አይጻፍም። እርስዎ የሚሰጡን ሚላሽ ሁሉ በሚስጥር ይያዛሉ።መጠይቁም የግል ምችትን በጠበቀ ሁኔታ ይካሄዳል።በጥናቱ ውስጥ ላለመካፈል በሚወስኑበት ውሳኔ የተነሳ የሚደርስበት አንዳችም ሁኔታ የለም። የሚያገኙትንም የጤና አገልግሎት አሁንም ቢሆን ወደፊት አያስተጓጉልም።ነገር ግን ሁሉንም ጥያቄዎች እንዲመልሱልን እናበረታታለን።በጥያቄዎ ለመሳተፍ ፈቃደኛ ከሆኑ ከ35- 40 ደቂቃ ውስጥ አጠናቅቃለሁ።ግልፅ ያልሆነ ነገር ካለ ሊጠይቁን ይችላሉ።

አመሰግናለሁ በመቀጠል የስምምነት ቅጽ አነባለሁ።ይህም በጥናቱ ለመሳተፍ ያለዎትን ፍላጎት ያረጋግጣል።

የስምምነት ቅጽ

ተመራማሪው የጥናቱን ዓላማ በሚገባና ግልጽ በሆነ ቋንቋ አስረድተውኛል።በዚህም መሠረት የጥናቱን ዓላማ ስለተረዳሁ ለመሳተፍ ወሳኝነቴን በሚከተለው መንገድ አረጋግጣለሁ።

1. አዎ እሳተፋለሁ
2. አልስማማም/ አልሳተፍም(አመሰግነው መጠይቁን ያብቁ።)

የጥያቄ አቅራቢው ፊርማ -----ቀን _____

የደንበኛው ፊርማ _____ ቀን _____ መለያ ቁጥር: _____

ዕድሜ -----ሥራ-----

የጤና ጣቢያ ስም-----

የመወያያ ርዕሶች

1. ስለረጅምና በቋሚነት ስለሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት እንዴት ይረዳሉ?
2. እርሶ በማህፀን የሚቀበረውን/በክንድ ስለሚቀበረውና በፈቃደኝነት ላይ ስለተመሠረተና በቀዶ ጥገና የሚሠራ (የሴት) የቤተሰብ ምጣኔ አገልግሎቶች ምን ያወቃሉ?

3. እርሶ ወይም ኅብረተሰቡ ለረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት (አዩድ፣በክንድ ስለሚቀበረውንና በቀዶ ጥገና የሚሠራ (የሴት) ዘዴ የቤተሰብ ምጣኔ አገልግሎቶችን የማይጠቀሙበት ምክንያት ምንድን ነው?
4. ለረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም እንቅፋቶች ምንድን ናቸው?
5. ስለረጅምና በቋሚነት ስለሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት የሰሙት አልባሎታ ወይም የተሳሳተ አመለካከት አለ? ካሌ ይንገሩን?
6. ስለረጅምና በቋሚነት ስለሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት ማለትም ስለ አዩድ፣በክንድ ስለሚቀበረውንና በፈቃደኝነት ላይ ስለተመሠረተው ቀዶ ጥገና የሚሠራ የሴት የቤተሰብ ምጣኔ አገልግሎቶችን ብዙ ማወቅ ይፈልጋሉ? ምክንያቱስ ምንድን ነው?
7. ስለረጅምና በቋሚነት ስለሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት ኅብረተሰቡ እንድጠቀም ምን ልያበረታታ ይችላል?
8. ብዙ ቤተሰብ ወይም ልጆች መኖሩ ላይ ያሎት አስተያየት ምንድነው?
9. የቤተሰብዎን መጠን የሚወስነው ማን ነው? ለምን?
10. ስለረጅምና በቋሚነት ስለሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት ኅብረተሰቡ እንዳይጠቀሙ የአገልግሎት ሰጪ፣የተቋም ወይም አገልግሎቱ መኖር ጋር የተያያዘ ነገር ካሌ?
11. ረጅምና በቋሚነት ስለሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም ለእርሶ ወይም ለኅብረተሰቡ ያለው ዝንባሌና አመለካከት ምንድነው?
12. እርሶ ረጅምና በቋሚነት የሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት ወደፊት ለመጠቀም ያስባሉ? የትኛውን ዘዴ? ረጅምና በቋሚነት የሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት ተጨማሪ ነገር ካሌ?

ስለተሳትፎዎት በጣም አመሰግናለሁ!

Annex2.2: Amharic in-depth interview with providers

ከአገልግሎት ሰጪዎች ጋር የሚደረግ ጠለቅ ያለ ቃላት መጠይቅ

በወላይታ ዞን የሚገኙ እናቶች ለረጅም ጊዜና በዘላቂነት የሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች ለመጠቀም ያላቸው ዝንባሌ፣ፍላጎትና አንቅፋቶች

ጤና ይስጥልን፤ ስሜ-----ይባላል። እኔ በአዲስ አበባ ዩኒቨርሲቲ የጤና አጠባበቅ ትምህርት ቤት የማስተርስ ድግሪ ተማሪ ስሆን ከአዲስ አበባ ዩኒቨርሲቲ መምህራን በመታገዝ በደቡብ ክልል ፣ ወላይታ ዞን የእናቶችን ለረጅም ጊዜና በዘላቂነት ስለሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎችን ለመጠቀም ያላቸውን ዝንባሌ፣እንቅፋትና ፍላጎት በማጥናት ላይ እገኛለሁ። ፡ እርሶ የሚሰጡን መረጃ ከሌሎች መረጃ ምንጮች ጋር ተዳምሮ የቤተሰብ ምጣኔ አገልግሎት የሚሻሻልበትን ሁኔታ ለዚህ አካባቢና ለሌሎችም ለማመቻቸት ታልሞ የተዘጋጀ ጥናት ነው።በሂደታችን ውስጥ በጥናቱ ላለመካፈል በማንኛውም ወቅት ከወሰኑ በማንኛውም ሰዓት መጠይቁን እናቆማለን።በዚህ መጠይቅ ውስጥ ስሞትንና እርሶን ለመለየት የሚያገለግል ነገር አይገኝም። እርስዎ የሚሰጡን ሚላሽ ሁሉ በሚስጥር ይያዛሉ።መጠይቁም የግል ምቹትን በጠበቀ ሁኔታ ይካሄዳሉ።ነገር ግን ሁሉንም ጥያቄዎች እንዲመልሱልን እናበረታታለን።በጥያቄዉ ለመሳተፍ ፈቃደኛ ከሆኑ ከ35-40 ደቂቃ ውስጥ እናጠናቅቃለን።ግልፅ ያልሆነ ነገር ካለ ሊጠይቁን ይችላሉ።

አመሰግናለሁ በመቀጠል የስምምነት ቅጽ አነባለሁ።ይህም በጥናቱ ለመሳተፍ ያለዎትን ፍላጎት ያረጋግጣል።

የስምምነት ቅጽ

ተመራማሪው የጥናቱን ዓላማ በሚገባ ግልጽ በሆነ ቋንቋ አስረድተውኛል።በዚህም መሠረት የጥናቱን ዓላማ ስለተረዳሁ ለመሳተፍ ወሳኝጌን በሚከተለው መንገድ አረጋግጣለሁ። 1.አዎ እሳተፋለሁ። 2. አልስማማም/ አልሳተፍም (አመስግነው በዚህ ያብቁ ።)

ተጠያቂዉ ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ

የመረጃ ሰብሳቢ ስም -----ፊርማ _____ ቀን -----

የጤና ባለሙያ/የጤና ጣቢያ ኃላፊ ፊርማ----- ቀን-----

ዕድሜ-----ሥራ-----

የጤና ድርጅቱ ስም : _____

የመወያያ ጥያቄዎች

1. በኅብርተሰብዎ ላይ ያለውን የህዝብ ብዛት(ዕድገት) እንዴት ያያሉ/ይገነዘባሉ?
2. በዚህ ኅብርተሰብ ውስጥ በፍጥነት እያደገ ያለውን የህዝብ ብዛት ለመቆጣጠር ምን መላ መደረግ አለበት?
3. ህብርተሰብዎ የቤተሰብ ምጣኔ ለመጠቀም ያለውን ዝንባሌ እንዴት ይገመግማሉ?
4. ዘመናዊ የቤተሰብ ዕቅድ አገልግሎት ለመጠቀም እንቅፋቶቹ ምንድን ናቸው?
5. የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ጥቅም እንዴት ነው?
6. በዚህ ኅብርተሰብ ውስጥ የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም ማህበራዊ፣ባህላዊ፣የዝንባሌ እና እኮኖሚያዊ እንቅፋቶች ምንድን ናቸው?
7. በዚህ ኅብርተሰብ ውስጥ የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም አገልግሎት አሰጣጥ ጋር የተያያዙ እንቅፋቶች ምንድን ናቸው?
8. የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመስጠት የአቅርቦት፣የመሣሪያ፣ የሠለጠነ ባለሙያ እና ከቦታ ርቀት ጋር የተያያዘ እንቅፋቶች ካሉ?
9. የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመስጠት ከጤና ባለሙያተኞች ጋር የተያያዙ ዝንባሌና እንቅፋቶች ምንድን ናቸው? ለምሳሌ የምክር አገልግሎት አሰጣጥና የቤተሰብ ምጣኔ አገልግሎት አሰጣጥ?
10. በዚህ ኅብርተሰብ ውስጥ የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም ከሃይማኖት ጋር የተያያዙ እንቅፋቶች ምንድን ናቸው?
11. ባለፉት ስድስት ወራት በሙሉ የረጅም ጊዜና በዘላቂነት የሚያገለግለው የቤተሰብ ምጣኔ አገልግሎት መድኃኒቶች በዚህ ጤና ጣቢያ ነበሩ? ከሌሉ ምክንያቶቹ ምንድን ናቸው?
12. ሁሉም ደንበኞች የመረጡትን ዘዴ ይጠቀማሉ? ካልሆነ ምክንያቱ ምንድን ነው? በደንበኞች ምርጫ ላይ የጤና ባለሙያተኞች ወሳኝ እንዴት ነው?
13. የጤና ባለሙያተኞች ዘዴውን እንዴት መጠቀም እንዳለባቸውና ስለ ጎንዮሽ ጉዳት ላይ ትክክለኛ መረጃ የመስጠት ሁኔታ እንዴት ነው?

14. በዚህ ኅብረተሰብ ውስጥ ሴቶች የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም ያላቸው ዕውቀት (ግንዛቤ) እንዴት ነው ?
15. በዚህ ኅብረተሰብ ውስጥ ሴቶች የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት እንዳይጠቀሙ የሚከለክል አልባሉታ እና የተሳሳተ አመለካከቶች ምንድን ናቸው?
16. በዚህ ኅብረተሰብ ውስጥ ሴቶች የረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም ያላቸው ዝንባሌ፣እንቅፋቶችና ፍላጎት እንዴት ነው?
17. በዚህ ጤና ጣቢያ ከወረዳ፣ከዞን፣ወይም ከክልል ስለ ረጅም ጊዜና በዘላቂነት የሚያገለግለውን የቤተሰብ ምጣኔ አገልግሎት የክትትል ግምገማ ተካሂዶበት ያወቃል? መቼ?
18. በዚህ ጤና ጣቢያ ውስጥ የመረጃ ቁሳቁሶች(IEC materials)፣ስለቤተሰብ ምጣኔ የተጻፈ መጽሐፍ(family planning guide line)፣እና ስትራቴጂ ማኑዋሎች(strategy manual) አሉ? ልያሳዩኝ ይችላሉ?

በጣም አመሰግናለሁ!

Annex3: knowledge score

No	Knowledge questions, whether women had heard the method &its characteristics	Score
1	Female sterilization PROBE: Women can have an operation to avoid having any more children	Yes =1 No =0
2	Male sterilization PROBE: Men can have an operation to avoid having any more children.	Yes =1 No =0
3	IUD PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse.	Yes =1 No =0
4	Implants (Implanon/Jadelle/ Norplant) PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	Yes =1 No =0
5	IUCD can prevent pregnancies for more than 10 years	Yes =1 No =0
6	After female sterilization pregnancy is not possible	Yes =1 No =0
7	Implant can prevent pregnancies for 3-5 years.	Yes =1 No =0
8	Vasectomy has no interference with sexual intercourse	Yes =1 No =0
9	Implants require minor surgical procedure during insertion and removal	Yes =1 No =0
10	IUCD is not appropriate for female at high risk of getting STIs	Yes =1 No =0

Annex4: Attitude score

Attitude score			
1	Using implant need proper diet	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
2	The insertion and removal implant is highly painful.	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
3	Insertion of Intra uterine contraceptive device causes to lose privacy	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
4	Using Intra uterine contraceptive device restrict normal routine activities.	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
5	Operation for female sterilization is dangerous	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
6	For me, implant may freely move other area from insertion site and cause severe pain.	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
7	For me, it is not good to use LAPMs.	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
8	For me, discussing about LAPMs contraceptive methods with my husband or friend is not necessary	1.Strongly agree	0
		2.Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1

9	For me, using LAPM not preventing one from having large family size.	1.Strongly agree	0
		2. Agree	0
10	For me, operation for female sterilization is unacceptable.	3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1
		1.Strongly agree	0
		2. Agree	0
		3. Not sure	0
		4. Disagree	1
		5.Strongly disagree	1

Table 8 .The theme, categories and codes as identified from the qualitative study, Wolaita zone,SNNPR, Ethiopia,2013.

Theme: Women’s awareness, attitude, myths, misconception and other different barriers to use LAPMS in Wolaita zone.				
Categories	Awareness to use LAPM	Reason women/community doesn’t use LAPM	Myths and misconceptions	Professional, availability, access and facility related barriers
Code	<ul style="list-style-type: none"> •Didn’t hear IUCD& vasectomy •Don’t know other than implant •Fear to use IUCD •Fear to use female sterilization &vasectomy •HEW are source of information •No enough education on loop •No knowledge on loop •Not hear vasectomy •Asking removal because of side effects. •I know implant •I know implant &female sterilization •HEWs brought great change 	<ul style="list-style-type: none"> •Fear to use the method •Work load •Lack of method •Myths& misconceptions •Lack of balanced diet •Problem on insertion and removal •Shame to show reproductive organ •Partner opposition •No more information •Lack of knowledge •Lack of trained professional •Fear of side effects •Religion opposition 	<ul style="list-style-type: none"> •Implant burns the whole body •Implant freely moves to other area from insertion site •Development of mental problem •Good for who has rest •Implant causes cancer •Implant causes dizziness •Implant causes itching •Implant causes weakness •IUCD interfere with sexual intercourse •Implant needs major operation •LAPM not suitable for who has work load •Bring uterus outward at time of IUCD insertion •It causes cancer •IUCD causes infertility •Uterus cannot carry pregnancy •Tuba ligation causes illness •LAPM cause pain •LAPM cause head ache •It moves to abdomen •It interferes with routine work •Associate LAPM with other illness. 	<ul style="list-style-type: none"> •Good counseling •No problem with availability •No problem with providers •No enough health education •No deeper education •Trained personnel available No vasectomy & female sterilization •No access problem •No proper counseling •All methods are available •Client receives their preferred methods •No equipment problem • Client not receives their preferred methods. •Supply problem •No supply problem

Theme: Continued...			
Categories	Attitude related barriers	IEC, FP guidelines, strategic manuals, M&E	Enhancing factors to use LAPMs
Code	<ul style="list-style-type: none"> •Poor attitude (4) •Good attitude (1) •Poor attitude (4) •Good attitude (2) 	<ul style="list-style-type: none"> •Has FP guideline •Has IEC •Has M&E •Has strategic manual •No FP guideline •No IEC •No M&E •No strategic manual 	<ul style="list-style-type: none"> •Observing model users of LAPMs •Educating women at public meeting •Providing health information by audio visual •Preparing contraceptive option for husbands •Regular training

Annex5: Map of Wolaita zone



Annex 6: Letters for declaration

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

Name: **Mengistu Meskele Koyira**

Signature: _____

Date: _____

Place: *Addis Ababa University, Ethiopia*

Date of submission: June, 2013

This thesis has been submitted for examination with my approval as University advisor.

Name: **Wubegzier Mekonnen (B.SC., MSc, PhD)**

Signature: _____

Date: _____