UNMET NEED FOR FAMILY PLANNING & OCCURANCE OF UN INTENDED PREGNANCY AND CONTRIBUTING FACTORS AMONG WOMENS OF REPRODACTIVE AGE IN DARO LABU DISTRICT, OROMIA NATIONAL REGIONAL STATE.

By: Zekeriya Mohamed (BSC).

A Research paper Submitted to Jimma University; College of Public Health and Medical Sciences, Department of population and Family Health; In Partial Fulfillment for the Requirement of Masters of Public Health (MPH/RH)

Jimma, Ethiopia.

UNMET NEED FOR FAMILY PLANNING & OCCURANCE OF UN INTENDED PREGNANCY AND CONTRIBUTINGFACTORS AMONG WOMENS OF REPRODACTIVE AGE IN DARO LABU DISTRICT, OROMIA NATIONAL REGIONAL SATE

By: Zekeriya Mohamed (BSC).

Advisers:

1. **Professor Abebe Gebremariam.**
2. **Mr. Kalkidan Hassen.**

September, 2014

Jimma, Ethiopia

ABSTRACT

Background:-unmet need for family planning and unintended pregnancy is a serious health problem in developing country. From the stand point of women's reproductive health rights, unmet need for family planning and unintended pregnancy was considered as one of the indicators for violation of such rights and one of the several basic rationales for women empowerment. The status of unmet need for family planning and unintended pregnancy and associated factors was not explored in the study area. Therefore, the aims of this study was to provide information on the magnitude of unmet need for family planning and un-intended pregnancy and associated factors in the study area to fill literature gap and inform policy intervention.

Objective: to assess the prevalence of unmet need for family planning and occurrence of unintended pregnancy and associated factors among women in Daro Labu district.

Methods: - Multistage Cross-sectional study involving quantitative data collection method was carried out from may 1-5/2014.Sample of 532 of women in a reproductive age group participated in the study. Information was collected on: Age, parity, Educational status, Religions, socio-demographic characteristics, Ever use of contraceptive and on relevant explanatory variables on unmet need. This data was collected using a structured and pre-tested, close and open ended questionnaire and analyzed using SPSS for window a statistical soft ware's. Univariate, bivariate and multivariate analysis was carried out to see the association between independent and dependent variable.

Results From the total of 532 women's, 519 (97.5 %) responded to the questionnaire administered. Unmet need for family planning was 36.8% (26.4% for spacing and 10.4% for limiting). Eight two (47 %) perceived that their pregnancy was unintended 59 (34%) mistimed and 23(13%) unwanted). The independent variables associated with unmet needs for family planning at (P value<0.05) by both bivariate and multivariate analysis were: educational status, wealth, decision about contraceptive practice, knowledge of contraceptive method and exposure to media. Unintended pregnancy was also associated with educational status, parity and exposure to media (P<0.04).

Conclusion and recommendations:- In this study educational status, wealth, decision about contraceptive practice, knowledge of contraceptive method and exposure to media were identified as factors affecting **unmet need** for family planning. Similarly unintended pregnancy was associated with educational status, parity and exposure to media. As the issue of unmet need for family planning and Unintended pregnancy is a public health, gender and a population issue; effectively addressing these problems could help in multidimensional improvements and could pave the way to achieve MDGs. Therefore, Zonal and District health offices, , and other concerned body should take appropriate actions on the factors identified affecting unmet need and unintended pregnancy.

ACKNOWLEDGMENTS

Above all, I would like to thanks for Allah who gave me health. My heartfelt gratitude goes to my advisors, Professor Abebe G/Mariam and Mr. Kalkidan Hassen for their guidance, support and encouragement throughout the course of my work. Without them, this project wouldn't have been accomplished. I am also grateful for Jimma University, Collage of Public Health & Medical Sciences, Department of Population & Family Health, and staff for academic and technical support to excel my horizon of knowledge to become 'a real researcher.' My deepest gratitude also goes to IFHP (Integrated Family Health Program) for sponsoring my study. Deepest gratitude is also due to my beloved wife; Mrs Ayyantu shamshudin who encourage and support me throughout my work. Also, I would like to extend my appreciation to Mr. Kemal Kasim, and all my colleagues who support me during the course of this paper.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABREVATIONS AND ACRONYMS

CI	Confidence Interval
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
FP	Family Planning
IFHP	Integrated Family Health Program
LDC	Less developed country
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	Non-Governmental Organization
SSA	Sub Saharan Africa
SPSS	Statistical Package for the Social Science
TFR	Total Fertility Rate

CHAPTER ONE: INTRODUCTION

1.1: Background

Women have an unmet need for contraception if they are married, in a consensual union, or never married and sexually active; are able to conceive; do not want to have a child soon or at all; and are not using any method of contraception, either modern or traditional. While unintended pregnancies are "pregnancies that are reported to have been either unwanted (i.e., they occurred when no children, or no more children, were desired) or mistimed (i.e., they occurred earlier than desired) (1). Globally, an estimated 137 million women have an unmet need for contraception. Demographers and health professionals refer to these women as having an "unmet need" for family planning. Unmet need as a concept dates to the 1960s, when researchers first demonstrated a gap in the developing world between women's fertility preferences and their use of contraception (2).Over the past 30 years, the use of modern family planning methods has increased dramatically in the developing world, leading to a fall in fertility rate. Yet, there are still significant levels of demand for family planning that are unmet (1). One hundred1 million women or 17 % married in Less developed country (LDC), would prefer to avoid a pregnancy, but are not using any form of family planning (3).According to the 2007 study by the Guttmacher Institute, using DHS from 53 countries (1995-2005), out of the estimated 108 million married women in developing counties that have an unmet need for contraception, 55% live in South and Southeast Asia, while 27% live in Sub-Saharan Africa. More than one in ten unmarried women has an unmet need in many Sub-Saharan countries (1). Adolescents indicate an unmet need for contraception that is more than twice as high as that of the general population (3). An estimated 358, 000 maternal deaths occurred worldwide in 2008, a 34% decline from the levels of 1990. Despite this decline, developing countries continued to account for 99% (355 000) of the deaths. Sub-Saharan Africa and South Asia accounted for 87% (313,000) of global maternal deaths (4). Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven interventions to ensure that every pregnancy is wanted by using modern contraceptive method (5). The careful planning of birth save lives and reduces a wide gap that exists on modern contraceptive use between poorer and wealthier women. The use of modern contraceptive is more common among wealthier women than poorer women in nearly all countries and the gap is particularly pronounced in the poorest countries (6). In SSA, the need is predominantly for spacing (delaying) births rather than for limiting. Ethiopia is the second

most populous country in Africa; with a population of more than 85 million and annual population growth rate of 2.7 %.(8). The majority of Ethiopian women (76%) prefers to space or limit the number of children they would have and a potential need for family planning. If all currently married women who say they want to space or limit the number of children were to use family planning the contraceptive prevalence rate in Ethiopia would increase from 15% to 49%.Currently only 31% of the demand for family planning is being met (7).The present distribution of births (including current pregnancy), by fertility planning status, in the five years preceding the survey, according to birth order and mother's age at birth, nearly three births of every four (72 percent) were wanted at the time, 20 percent were wanted but later, and 9 percent were unwanted. The proportion of births wanted at the time of conception, generally declines with both increasing birth order and mother's age. According to the 2011 Ethiopia Demographic and Health Survey (EDHS), the TFR (total fertility rate) was 4.8 children per woman in 2011 which was declined from 6.4 in 1990 to 5.9 in 2000 and further to 5.4 in 2005and 4.8 in 2011.According to 2011 EDHS ,twenty-five percent of currently married women have an unmet need for family planning services in Ethiopia;16 percent have a need for spacing, and 9 percent have a need for limiting(18).The maternal mortality and morbidity is the major public health problem of the country, which is one components of MDG. But the main cause of maternal mortality and morbidity is unintended pregnancy which is one consequences of unmet need for family planning and associated factors (1).The same finding confirmed similar problems in Oromiya National Regional state (8).

.

1.2: Problem Statement

Each year worldwide, more than 20 million women experience ill health as a result of pregnancy, most of them ends with disability and death due to pregnancy and delivery related complication (9). It is assumed that most women with unintended pregnancy do not continue the pregnancy to the full term and try to terminate it, often by a traditional and harm full method, leading to serious health consequences (9). It is estimated that within the next 15 years, unmet needs for family planning will grow by 40% worldwide (9). Family planning is an economically sound investment. However, it has been losing ground as an international development priority. There is a gap between need and available resources and also the funding is decreasing (10). Ethiopia is one of the third populous countries from Africa. With the highest annual population growth rate of 2.9%, high maternal mortality rate of 871\100, 1000 live birth and high infant mortality rate of 97/1000 live birth(4). The population increased over the decades, from 42.6 million in 1984 to 53.5 million in1994.There was slight decline in a population growth rate over a decade from 3.1% in 1984 to 2.9 in 1994(11).In recognition of the need to address this issue; the government of Ethiopia adopted the population policy in 1993. The prime objective of the policy is to harmonize the rate of population growth with socioeconomic development. The policy also aims at reducing the total fertility rate from 7.7 children per women in 1995 to 4 children per women in 2015 and an increase contraceptive prevalence rate from 4% in 1995 to 44% in 2015(11). In similar fashion, achieving this policy is another agenda of meeting Millennium Development Goal of country. Despite decades of the government effort to reduce total fertility rate through increasing contraceptive prevalence rate, the policy was not fully achieved. What have to be clear is that reducing the unmet need for family planning services and occurrence of unintended pregnancy can help Ethiopia significantly to reduce the costs of meeting the Millennium Development Goal (2). However, little empirical findings have been undertaken on the unmet need for family planning and occurrence of unintended pregnancy as well as contributing factors in Ethiopia including the study area. For instance, the unmet need for contraception is highest in the Oromiya region (30%) and lowest in Addis Ababa (11%). (8), but the status of unmet need for unmarried women and associated factors are not clearly known in our country. Maternal and child mortality and morbidity is the major public health problem of the country including the study area. The main cause for maternal mortality is un intended pregnancy which is one consequences of unmet need for family planning (8). Since there was no previous study done on this topic around the study area, the status of unmet need

and un intended pregnancy and associated factors was totally unknown (12).The aim of this study is to assess the prevalence of unmet need for family planning and unintended pregnancy and contributing factors in the district. Therefore, my assessment on this topic provided the magnitude of unmet need for family planning and unintended pregnancy and contributing factors in the district, which can be used as a base line data for the study area for farther study.

CHAPTER TWO: LITERATURE REVIEW

For this research, a theoretical and conceptual framework of unmet need and unintended pregnancy, contraceptive knowledge, attitude and, practice, prevalence of unmet need and unintended pregnancy, reasons for unmet need and unintended pregnancy and their consequences were reviewed.

2.1: Definition of Unmet Need and Unintended Pregnancy

Unmet need is defined as the percentage of women who are currently not using any method of contraception and want no more child (limiting) or delay child bearing (spacing) (13).Other literature also define unmet need as:-number of women in need of contraceptive services and supplies to space or limit births or the population of women who are exposed to risk of pregnancy but not using contraception (14).Many unmarried adolescents are also sexually active and are at high risk of contracting unwanted pregnancy and other reproductive health problems. While they are more likely to use contraception than married teens, they too have substantial unmet need for contraceptive services. As a result, many adolescents with unwanted pregnancies resort to unsafe abortion (2).While Unintended pregnancy is defined as the situation when a pregnancy comes sooner than desired or when woman doesn't have any intention of having a baby (15). From the standpoint of women's reproductive health rights, unmet need was considered as one of the indicators for violation of such rights and one of the several basic rationales for women empowerment (14).

2.2: Prevalence of Unmet Need and Unintended Pregnancy

Unmet need and unintended pregnancy is no longer the problem of only low or middle income country. Studies conducted in UK found that, half of all the pregnancies in UK were unintended, of which 22% were aborted (19).Recent reports published by American national health statistics analyzing the intended and unintended pregnancy from 1982 to 2010 found that, about 37% of birth in the unites state were unintended at the time of conception (20). In developing countries, millions of women have unmet need. As estimated by population reports in 1996, about 100 million in developing country have unmet need (20).WHO has estimated that nearly 222million women in developing world would like to delay or stop child bearing but do not have access to any method of contraception (21). 170 million women have no access to safe and effective methods of family planning in developing countries. 1/3 of population growth is due to unplanned pregnancies. Of the 210 million pregnancies occurring each year, nearly 80 million are unintended. Each year, modern contraceptives help

women to prevent 215,000 pregnancy-related deaths (including 66,000 from unsafe abortions), 2.7 million infant deaths and the loss of 60 million years of healthy life. 1 in 5 married women of childbearing age have an unmet need for contraception in Africa. 17% of married women of reproductive age use a modern contraceptive in Sub-Saharan Africa. 39% of pregnancies in Africa are unintended. For every 100,000 births, 640 women die of complications related to pregnancy and childbirth in Africa. 760,000 lives would be saved annually in Africa if women's family planning needs and maternal and newborn health care needs were met. Unintended pregnancies would drop by 77% in Africa if women's family planning needs and maternal and newborn health care needs were met.16 million women 15-19 years old give birth each year. Adolescent women account for 16% of all births in Sub-Saharan Africa. 15% of unmarried adolescent women in Sub-Saharan Africa are sexually active and want to prevent pregnancy (22). In Ethiopia Unmet need for rural areas was 35% while for the urban it is 25% (17). A Study conducted in Ethiopia about unintended pregnancy among married women in southern Ethiopia found that among 713 respondents, about 43% had their resent pregnancies unintended (23). Another cross sectional study conducted in Ethiopia among the patients seeking abortion service in Adigrat zonal hospital Tigray Region Ethiopia revealed that nearly 70% of the pregnancies were unintended (23).Women living in the Oromiya region (30%) and women in the lowest wealth quintiles (31%) are most likely to have unmet need for family planning(8).

2.3: Reasons for unmet need and unintended pregnancy

There are various reasons which are responsible for unmet needs for family planning. According to World Health Organization (WHO), the reasons are:- Limited choice of family planning methods , Limited access to contraception mainly among young people, poor people or unmarried people, Fear or experience of having side-effects, Cultural or religious opposition, Poor quality of available family planning services and Gender based barriers (26).Even if the desired numbers of children for women have decreased compared to past generations, poverty, lack of access to effective contraceptive protection and profound inequalities between men and women in many countries limit women's ability to plan their pregnancies. Rather than the personal preference of the women the differing patterns of contraceptive use reflects political and economic decisions made by governments to emphasize certain methods, the attitudes of medical professionals, cost, the limited range of methods offered in some countries or an uneven availability of contraceptive supplies

(27).Other literatures also classify the reasons for unmet need and unintended pregnancy as follow:-

Demographic Factor

Various studies have identified different demographic variables as they influence the use of contraceptives and unmet need. These variables include: age, number of children surviving and desired number of children. (26). A study conducted by Tizazu based on service statistics from Yirgalem family project, revealed that contraceptive use was lowest among women aged between 15—19 years and among those approaching the end of childbearing period (27). The need for family planning is positively related to the number of surviving children (28).

Difficulties with access to Methods and Quality of Services

In the DHS of 44 countries the percentage of women who cited lack of access as the main reason for not using contraception is higher among women who have never used contraceptive methods than among those who have tried contraception (28). Even if distance to any service site may not be important to unmet need, lack of access to people's preferred method and quality of service can be a formidable obstacle. In addition to lack of preferred methods various other costs limit family planning (28). Poor quality services or the expectation of poor services keep some women from using family planning services. Some have been poorly treated at family planning clinics or have had problems with the services (29). Studies conducted in different parts of Ethiopia showed that, some of the main reasons for not practicing contraception are inaccessibility and unavailability of contraception methods (30).

Health concerns and side effects

In many countries concerns about health and contraceptive side effects cause much unmet need. These concerns come from a variety of sources, including women's own experiences in using contraception, experience of friends and the rumors that often result as these experiences are told and retold throughout the communities (28). Many women have discontinued contraceptive use, not because they wanted to become pregnant, but because they experienced side effects and health problems attributed to contraceptive (28).

Opposition from Husbands

Many women do not use contraception because their husbands are opposed (31). In seven Sub-Saharan African countries, contraceptive use among women whose husbands disapprove of family planning averages only one- third as much as among women whose husbands approve of it (26). In Kenya, among women who had stopped using contraceptive for reasons other than having another child, 12% stopped because their husbands wanted another child, or forced them to discontinue for another reason (32). Lack of support from extended families and community leaders also prevents some women from using contraception (29). According to (DHS 2011) Demographic and Health Survey of Ethiopia, opposition from husbands was one of the reasons for not using contraception (17)

Little perceived risk of pregnancy

When a woman believes that she is unlikely to become pregnant, she is unlikely to be interested in contraception (29). Women with unmet need for limiting birth are much more likely than potential spacers to think that they face little risk of pregnancy (29).Because most women with unmet need for limiting are older

2.4: Significance of the Study

The study can provided important information to the government, NGOs and donors who are interested in working towards unmet need for family planning and occurrence of unintended pregnancy and associated factors among reproductive age women in the study area. Furthermore, this study can help to fill the literature gap by providing information to the existing body of knowledge in order to improve the potentials of women's family planning service utilization in the study area. Since there was no previous study done on this topic around the study area, it can be used as a base line data for the study area for farther study.

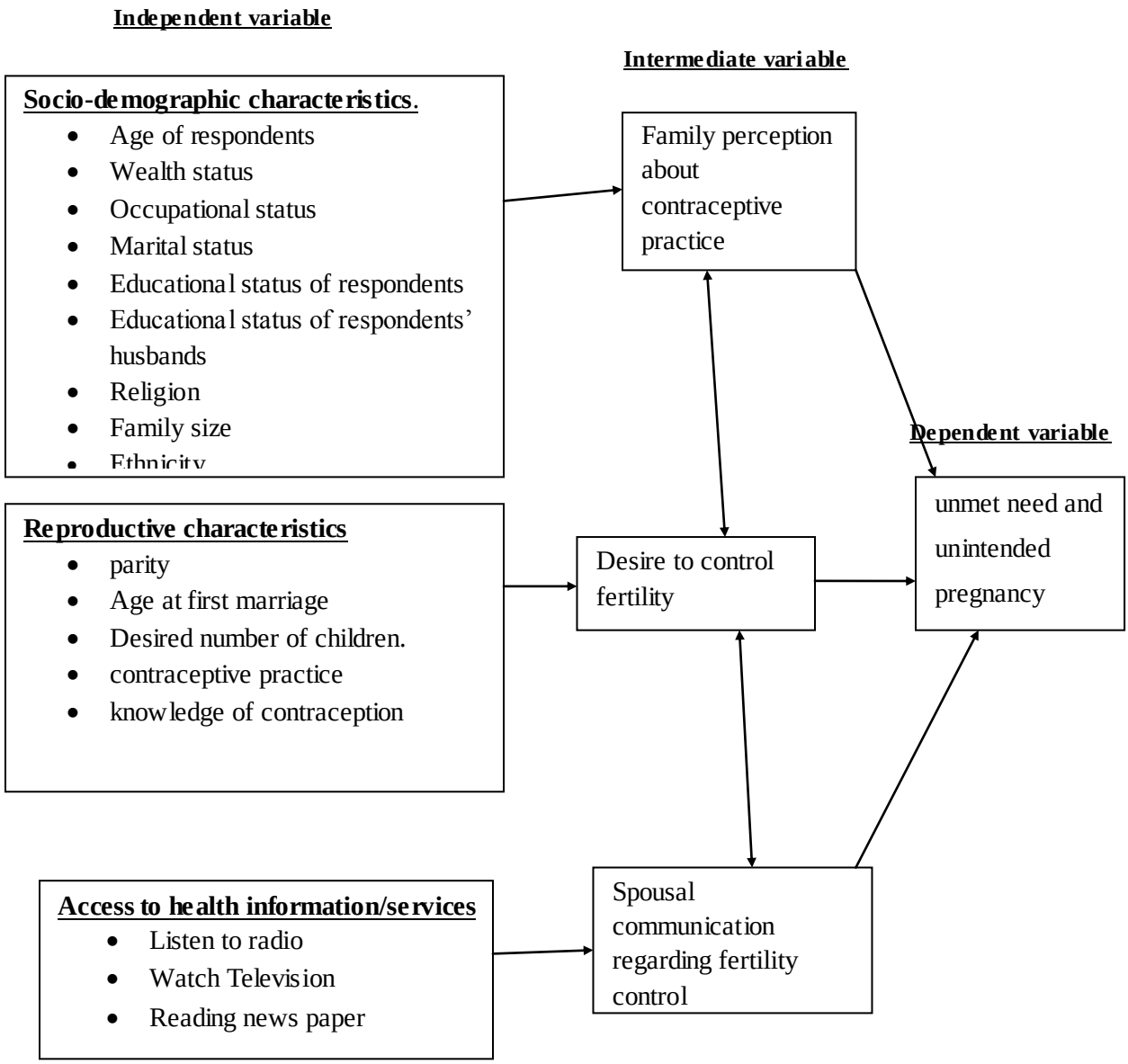

Fig 1: Conceptual Framework for determination of unmet need for family planning and un intended pregnancy among reproductive age women in Daro Labu district from may 1-5/ 2014

Source: - Adopted from a published article

CHAPTER THREE: OBJECTIVE

3.1:General Objective

- To assess the prevalence of unmet need for family planning and occurrence of unintended pregnancy and associated factors among women in a reproductive age in Daro Labu district

3.2: Specific objective

- To determine the prevalence of unmet need for family planning.
- To determine the prevalence of unintended pregnancy.
- To determine the associated factors of unmet need for family planning and unintended pregnancy.

Research question

1. What are the factors influencing the unmet needs for family planning and unintended pregnancy?
2. What are the prevalence of unmet needs for family planning and unintended pregnancy?

CHAPTER FOUR: RESEARCH METHODOLOGY

4.1:Study area

The study was conducted in Daro Labu district, West Hararghe zone of Oromiya National Regional State. The capital town of the district, Mechara is located at about 434 km south east of Addis Ababa, the capital city of Ethiopia. Daro Labu district is bordered with Anchar and Habro district to the north, Hawi Gudina district to the south, Arsi zone to the west and Boke and Habro district to the East .The district have 40 kebele, (37 rural and 3 urban). The estimated total population of the district is 180,641 (88,514 male and 92,127 female) in the year 2013 as projected from CSA, census in 2007. 39,741 in a reproductive age group 15-49 years. 7,225 are estimated to be pregnant and 34,741 are married. The districts have 6 health center and 37 health post. The total health coverage of the district is about 80% and the family planning service coverage is 28%.

4.2: Study period.

The study was conducted from May,1-5/2014.

4.3: Study Design

A community based cross- sectional study.

4.4: Source and study population

4.4.1: Source population

The source populations for this study were all women in a reproductive age group of Daro Labu district residing in households during the study period.

4.4.2: The study population

The study population was representative sample of women in reproductive age group, selected from source population.

4.5: Sampling procedure and sample size determination.

4.5.1: Sample size determination.

Sample size was determined by using the formula for single population proportion with the following assumption: Thirty percent prevalence of unmet need for family planning among reproductive age women was taken from other study [EDHS 2011], with confidence interval of 95%, margin of error 5% and non response rate of 10%. Based on this assumption: - n= (z2α/2pq)/d2. Where n = number of sample size, Z = Z score at 95% confidence interval, Z=1.96, α=0.05, P= proportion of reproductive age women with unmet need for FP =0.30, q= 1-p, = 1- 0.3 = 0.70, d= margin of error = 0.05, n= $(1.96)^2$) x (0.30x0.70))/0.0025 =323. n= 323+10% non response rate n=323+32.3=**355.** For design effect=355x1.5=**532**

I was used design effect 1.5 because, I have seen from other published literature.

Therefore, final sample size**=n=<u>532.</u>**

Inclusion and exclusion criteria

Inclusion criteria:-reproductive age women [15-49] who are living in the study area, sexually active and voluntary to participate.

Exclusion criteria:- in fecund women, women who are not sexually active and not voluntary to participate.

4. 5.2: Sampling procedure

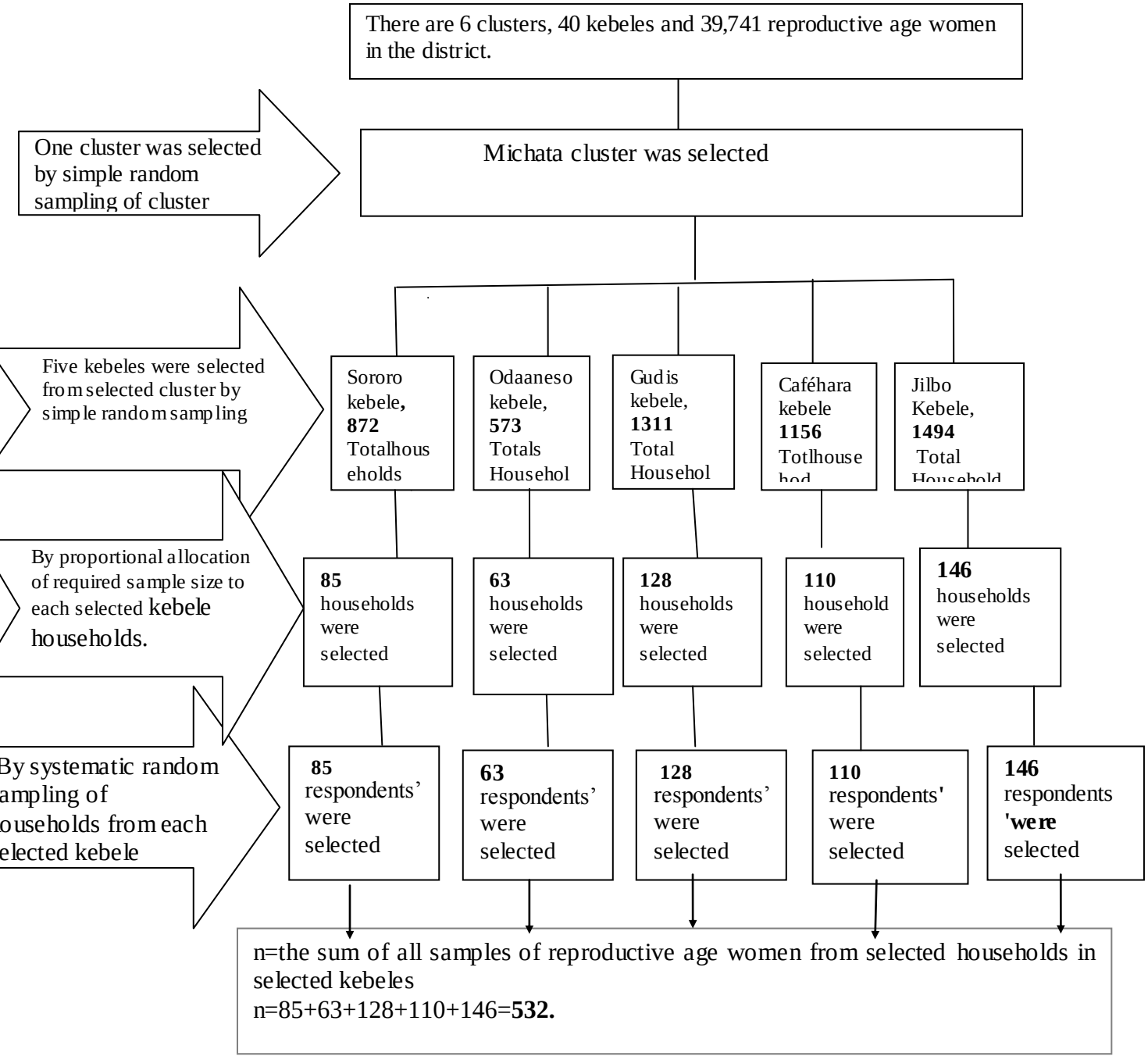

Figure 2: Schematic representation of the sampling procedure for the assessment of unmet needs for family planning and unintended pregnancy among reproductive age women in Daro Labu District, from May,1-5/2014.

Multistage Simple random and systematic random sampling technique was employed to reach study unit. In the district there are 6 cluster, 40 kebeles and 39,741 reproductive age women. To get calculated sample size, multi stage sampling technique was employed. First for the purpose of logistic facility, one cluster was randomly selected by simple random sampling technique. From the selected cluster, five rural kebeles were randomly selected by simple random sampling. Then for each of five selected kebeles, the list of total number of household was prepared. By considering proportional allocation of total required sample size to each five selected kebeles, the number of households that would be taken from each selected kebeles was determined. Then, by applying systematic random sampling technique, the list of households that would be investigated was prepared for each selected kebele. That means the total number of households in each selected kebele was divided by the sample size required from it and class interval was identified. Depending on this sequence, by skipping the interval the list of households to be investigated was prepared for each five selected kebeles before starting data collection. During Data collection one reproductive age women was interviewed per each selected household's regardless of marital status. Where there were more than two women in the selected households, one among them was selected by lottery method.

4.6: Data collection tool and technique

A structured close and open ended questionnaire was adopted from different literature developed for similar study by different authors (36). It was then reviewed to suit the local condition. Originally it was developed in English, then translated into local language (Afan Oromo) and back translated to English by investigator to check for its consistency. Data collectors were trained on the purpose and scope of the study, how to approach the respondents, how to conduct the interview and other data collection procedures. Data was collected by 5 data collectors through direct interview of respondents for three consecutive days. There was also two supervisors: i.e. one health officer and one Bsc nurse. Supervisors and principal investigator were made frequent check on the data collection process to ensure the completeness and consistency of the gathered information.

4.7: Data analysis

After accomplishment of data collection, the collected data was edited, cleaned, coded, and entered into SPSS version 20 for analyzing. Then it was summarized by using simple frequency tables, graphs and charts. Univariate, bi-aviate and multivariate analysis was carried out to see the association between independent and dependent variable. Logistic regression modeling was also carried out to identify potential predictor variables.

4.8: Study Variable

4.8.1: Independent Variable

- Age
- Parity
- Educational status of respondents
- Educational status of partners /husbands
- Religions
- Ethnic origin
- Occupational status
- knowledge of contraceptive method
- Decision about contraceptive practice
- Family size
- Desired number of children
- Marital status
- Socio economic status
- contraceptive practice

  Current user

  Ever user

  Non user

4.8.2: Dependent variables

Prevalence of Unmet need and unintended pregnancy.

4.9: Operational definitions

- **Unmet need**: refers to the contraceptive need of fecund women currently married or living In union and not using any contraceptive method and Want child latter or not at all, or who are pregnant or amenorrheaic, as a result of mistimed or unwanted pregnancy.
- **Current users**: are women who are using contraception until the day of interview.
- **Ever users**: are women who have used contraceptive some times in the past, but have discontinued during the time of the survey.
- **Fecundity**: Physiological capacity to conceive
- **Infecundity** :Lack of the capacity to conceive
- **Never user**: is a woman who has never used contraception till the day of survey.
- **Unwanted pregnancy:** is the pregnancy that has occurred when no children, or no more children, were desired.
- **Mistimed pregnancy**: is pregnancy, which has occurred without intention of the woman or the couples at specific time, but wants to be pregnant and have a child sometime in the future.
- **Unintended pregnancy**: includes both unwanted and mistimed pregnancies.
- **Intended pregnancy**: is a pregnancy that is wanted and planned.
- **Knowledge of contraceptive methods:** a woman aware of at least one method of contraceptives.
- **Post- partum amenorrhea**: refers to women whose menstruation had not resumed since the birth of the last child.
- **Cluster**: refers to *primary health care unit* of my study district, which includes one central health center and 6 or 7 surrounding kebeles.

Table 1: measurement of variables and their category.

Independent Variables	Description	Categories
Age	Complete age of women at the time of survey	1 = <14 2 = 15-19 3 = 20 and above
Wealth index	Wealth status of respondents compared to their neighbors	1 = poorest 2 = poor 3 = rich 4 = richest
Occupation	Type of women's current work status(during the survey)	1=house wife only 2= Government and Nan gov worker 3= merchant 4=workless/ family dependent
Educational status of respondents	Women's educational status	1 = no education 2 = primary 3 = secondary and Higher
Partners educational Status	Educational status of husband of respondent	1 = no education 2 = primary 3 = secondary and Higher
Age at first marriage	Respondents completed age at first marriage	1 = <14 2 = 15-19 3=20 and above
Age at first birth	Respondents' completed age at the time of first birth	1 = "<14 2 = 15-19 3=20 and above
Children ever born (parity)	Number of children given by the respondents	1 = 0 2 = 1-2 3=3-4 4=5 and above
Ideal number of desired Children	Women's concept or preferences about the number of Children she want to have in her life	1 = 1-2 2 = 3-4 3 = 5-6 4=7-8 5=9 and above
Decision concerning contraceptive practice	Autonomy on contraceptive practice.	1= respondent alone. 2 = respondent and partner 3 = partner alone 4=did not responded
Knowledge of contraception	Knowledge of respondents about family Planning. at least one method	1=yes 2=no
Exposure to media		

Newspaper Exposure	Respondents were asked if they read newspaper almost every day, at least once a week, less than once a week, do not read. Then it was coded as 2=No who do not read newspaper and 1=Yes to other responses.	1=Yes 2=No
Television exposure	Respondents were asked if they watch television almost every day, at least once a week, less than once a week, do not watch. Then it was coded as 2=No who do not watch television and 1=Yes to other responses	1=Yes 2=No
Radio exposure	Respondents were asked if they listen to radio almost every day, at least once a week, less than once a week, do not listen. Then it was coded as 2=No who do not listen to radio and 1=Yes to other responses.	1=Yes 2=No

4.10: Data Quality management

Before the actual data collection was commenced, pre test was conducted in adjacent kebele on 5% of respondent to ensure the validity of the tools. Supervisors and principal investigator have made frequent check on the data collection process to ensure the completeness and consistency of the gathered information. Any error that was found during the process was corrected immediately. Then, the completed questioner was analyzed to ensure future data quality.

4.11: Ethical Consideration

Ethical clearance was obtained from Jimma university ethical review board and submitted to Daro Labu district Health and administrative office. This formal letter was also submitted to kebele leader. The purpose, objective and importance of the study was explained to them and informed consent was secured from each participant before starting interview. Confidentiality was maintained at all levels of the study. Participation in the study was up on voluntary bases. Participants who were unwilling to participate in the study and those who wish to quit from the study at any point in time was informed to do so without any restriction.

4.12: Dissemination and Utilization of Results

The researcher would provide the results of the study to the Zonal health office and district health authorities. After accomplishment of the project, the results and recommendations would discuss in meetings with Zonal health office, and district health office, as well as another concerned body including NGO Who is mandated to work on family planning. Based on the findings, interventions can be designed to improve the public health problems of family planning.

CHAPTER FIVE: RESULTS.

5.1: Socio demographic characteristics of the study population

From a total of 532 women's studied, 519 (97.5 %) were involved in the study. While 13 subjects refused to participate yielding a response rate of 97.5%. Their age ranged from 15-49 years. The majority were 20 and above years old. The Dominant ethnic group were Oromo 436 (84%) followed by Amara 37 (7.1%), Somale 36 (6.9%) and Orgoba10 (1.9%). Most of them were Muslim 474 (91.3%) followed by Orthodox 56 (10.6%) . One hundred seventy seven (32.9%) were able to read and write, while more than half of them 348 (67.1%) were illiterate. Four hundred sixty three (89.2%) were married, while, 56 (10.8%) were unmarried. Concerning wealth status of them; most of the respondents were poor 295 (56.8), whereas 60 (11.6%) were rich and 84 (16.2%) were poorest and 25 (4.8%) were richest when compared to their neighbors. Most of them 433 (83.4%) were house wife, whereas 25 (8.4%) were merchants and 53 (10.2%) were family dependents. More than half of the respondents have an average of 5-9 children 290 (55.9%) (Table 2)

Table 2: Socio-demographic characteristics of the study population in DaroLabu District, may, 2014.

I. Variables	Number	percent
Current Age (years)	**519**	
<=14	0.0	0.0
15-19	117	22.5
20 & above	402	77.5
Ethnicity		
Oromo	436	84.0
Amara	37	7.1
Somaale	36	6.9
Orgoba	10	1.9
Religion	**519**	
Muslim	474	91.3
Orthodox	45	8.7
Family size	**463**	
1-4	57	11.0
5-9	290	55.9
10 & above	116	22.4
Educational status of respondents	**519**	
No education (illiterate)	349	67.2
Primary education	77	14.8
Secondary and higher education	93	19.9
Educational status of husbands/partners	**463**	
No education (illiterate)	211	40.7
primary education	148	28.5
Secondary and higher education	104	20.0
Wealth status of respondents	**463**	
Poorest	84	16.2
Poor	295	56.8
Rich	60	11.6
Richest	25	4.8
Marital status	**519**	
Married	463	89.2
Unmarried	56	10.8

5.2: Reproductive characteristics of the study subjects.

More than half of the respondents, 336 (64.7%) have got their first marriage between 15-19 years old and also majority of them 389 (75.0%) have got their first delivery during this age interval. Almost half of them 250 (48.2%) had 5 or more children. Two hundred thirty nine (46.1%) had desire to have 7-8 children in their life. Ninety (17.3%) were currently pregnant and 82 (15.8%) were in their post partum period. Out of 82 women who had an unintended pregnancy 59 (34.3%) were mistimed and 23 (13.3%) were un wanted (table 3).

Table 3: Reproductive characteristics of the study population in DaroLabu District may,2014.

I. Variables	**No**	**(%)**
Age at first marriage	**463**	
<=14	117	22.5
15-19	336	64.7
20 & above(>=20)	10	1.9
Age at first delivery	**438**	
<=14	14	2.7
15-19	389	75.0
20 & above(>=20)	35	6.7
No of children alive	**463**	
0	91	17.5
1-2	65	12.5
3-4	57	11.0
5 and above	250	48.2
Parity	**463**	
0	30	5.8
1-2	124	23.9
3-4	59	11.4
5 and above	250	48.2
Desired number of children	**519**	
3-4	1	0.2
5-6	136	26.2
7-8	239	46.1
9 and above	143	27.6
Current pregnancy status	**519**	
Yes	90	17.3
No	429	82.7

Pregnancy intention among currently pregnant women	**90**	
Intended	49	9.4
Unintended	41	7.9
From unintended pregnancy	**41**	
Mistimed	33	6.4
Unwanted	8	1.5
Post partum amenorrheaic status	**519**	
Yes	82	15.8
No	437	84.2
Pregnancy intention among currently Post partum amenorrheaic women	**82**	
Intended	41	50
Unintended	41	50
Total pregnancy	**172**	
Total Intended pregnancy	90	17.0
Total unintended pregnancy	82	15.8
From total unintended pregnancy	**82**	
Total mistimed pregnancy	59	11.36
Total unwanted pregnancy	23	4.43

5.3: Contraceptive utilization.

One hundred sixty-nine (32.6%) were current users of contraceptive, 157 (30.3%) were ever users and 193 (37.2%) were non user. The commonly use contraception currently were inject able 110 (21%), implant/Norplant 37 (7.1%) and pills 23 (4.4%).when asked about their reasons for not using contraceptive 56 (10.8%) said that, they were not sexually active and 25 (4.8%) were due to religion problem, 27(5.2%) lack of awareness,38 (7.3%) fear of side effect, 23 (4.4%) were little perceived risk of pregnancy,8 (1.5%) were medical problem,7 (1.3%) were husband disapproval and 13 (2.5%) were due to other problems. The main reason for discontinuing among ever user were revealed that: 91 (17.5%) discontinued due to fear of side effect, 16 (3.1%) desired to have more children, 12(2.3%) had little perceived risk of pregnancy, 13 (2.5%) had medical problem, 12(2.3%) due to un availability of preferred method, 10(1.9%) religion problem and 3 (0.6%) were due to other problems (table 4)

Table 4: Contraceptive utilization of the study population in DaroLabu District may,2014.

I. Variables	No	(%)
Contraceptive practice	**519**	
Current user	169	32.6
Ever user	157	30.3
Nan user	193	37.2
Type of contraception currently using	**169**	
Inject able	108	20.8
Implant / Norplant	37	7.1
Pills	24	4.4
Reasons for non-use of contraception among non users	**197**	
Not sexually active(for all unmarried women)	56	10.8
Fear of side effect	38	7.3
Religion problem	25	4.8
Lack of awareness	27	5.2
Little perceived risk of pregnancy	23	4.4
Husband disapproval	7	1.3
Medical problem	8	1.5
Other problems	13	2.5
Reasons for discontinuing among ever user	**157**	
Fear of side effect	91	17.5
Desired to have more children	16	3.1
Little perceived risk of pregnancy	12	2.3
Medical problem	13	2.5
Unavailability of preferred method	12	2.3
Religion problem	10	1.9
Other problems	3	0.6

5.4 : knowledge and practice on contraception .

Half of decision about contraceptive practice were made on the mutual understanding of husband and wife 267(51.4%) and respondent's alone decision making was found among only 142 (27.4%). Most of the respondents 505 (97.3%) had knowledge about family planning methods. whereas, only 14 (2.7%) had no such knowledge. From this result we can see that, most of them had knowledge about family planning. But, the use of family planning methods is only 168 (32.4%). More than half of them 355 (68.4%) have got contraceptive information from health workers. Almost half of them 241(46.4%) had listen the radio, where as 88 (17%) had read news paper and only13 (2.5%) watch television **(**Table 5).

Table 5: knowledge and contraceptive practice of the study population in DaroLabu District may,2014.

I. Variables	No	(%)
Decision concerning contraceptive practice	**423**	
Mainly respondents(women)	142	27.4
Mainly husbands(partner)	37	7.1
Joint decision	267	51.4
No response	17	3.3
Knowledge about contraceptive	**519**	
Yes	505	97.3
No	14	2.7
Sources of information about contraception	**519**	
Health worker	355	68.4
Friends	123	23.7
Radio	30	5.8
News paper	8	1.5
TV	3	0.6
Exposure to radio	***519***	
Yes	243	46.8
No	276	53.2
Exposure to TV	***519***	
Yes	13	2.5
No	506	97.5
Exposure to reading news paper	***519***	
Yes	88	17.0
No	431	83.0

5.5: Unmet need and unintended pregnancy

In the survey data, the responses for unmet needs were categorized as never had sex, unmet needs to space, unmet needs to limit, using to space, using to limit, , desire to have child before 2 years, and in fecund women. The response as unmet needs to space and unmet needs to limit was taken as having unmet needs and all other response category was taken as not having unmet needs. There were 191 (36,8%) total unmet needs for family planning in the district. Out of which 137 (26.4%) had unmet needs for spacing and 54 (10.4%) had unmet needs for limiting. The results from this study reveals that, total unintended pregnancy among study population, was: 82(15.8%) (59(11.36%) mistimed and 23(4.4%) unwanted pregnancy) from total study population and 82(47%) (59 (34%) mistimed and 23(13%) unwanted) from surveyed pregnant and amenorrheaic women (figure 3).

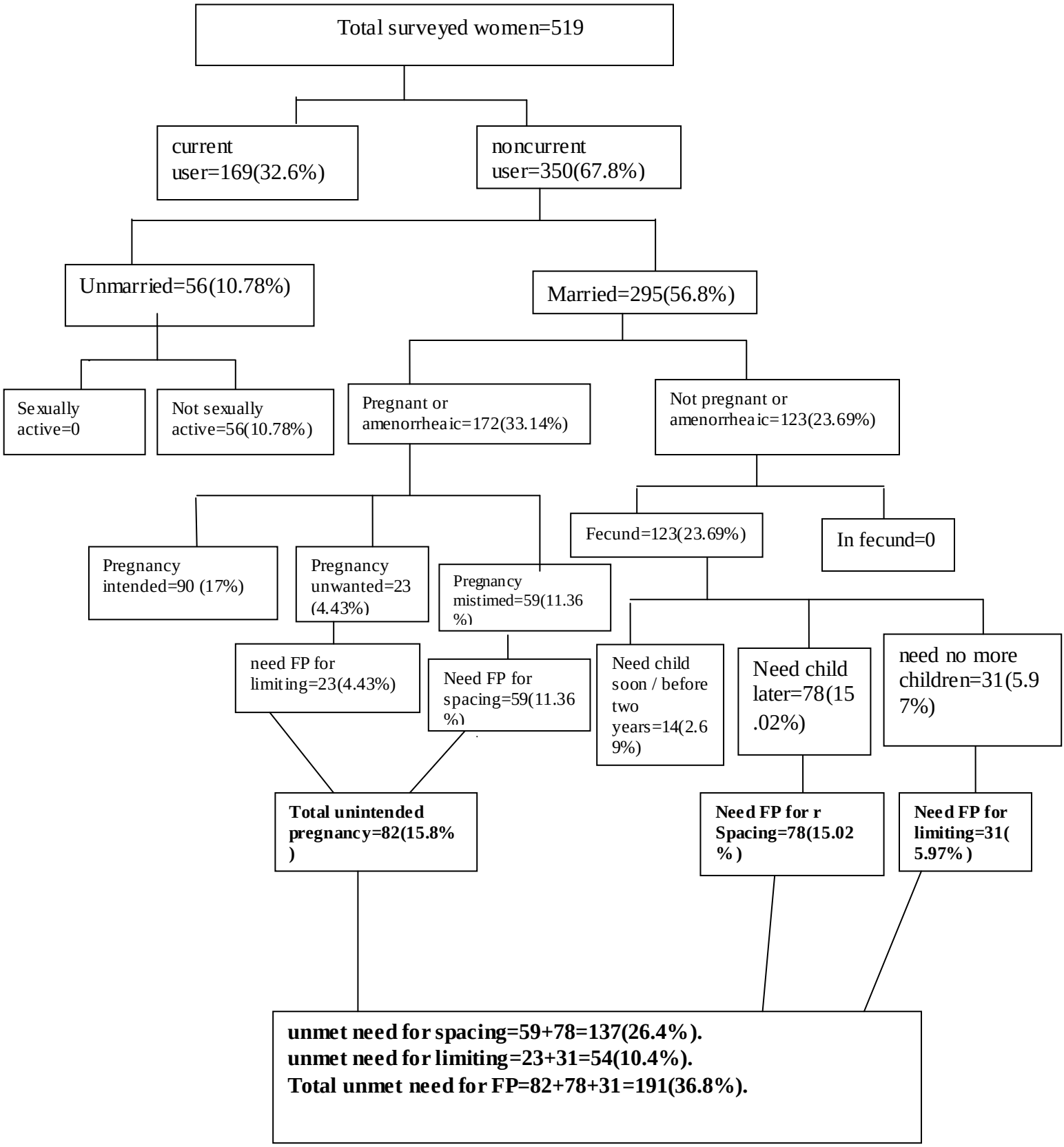

Figure 3:Unmet need for family planning and unintended pregnancy among reproductive age women in DaroLabu district, may,2014.

5.6: Factors associated with unmet need for family planning and un intended pregnancy on bivariate Analysis.

On bivariate analysis, unmet need for family planning shows statistically significant association with: current age, respondents educational status, partners educational status, parity, wealth status of respondents compared to their neighbor, number of children alive, contraceptive practice, person decides on contraceptive practice, knowledge of contraceptive method and exposure to media (newspaper and radio) at ($P<0.05$). while unintended pregnancy were associated with: current age, respondents educational status , total family size, parity, number of children alive and exposure to media (newspaper and radio) at ($P<0.05$). (Table 6 & 7)

Table 6: Parameter estimates of selected variables from binary logistic regression to predict unmet need for family planning,in Daro Labu district, may 2014

I. Variables	**D.V,= unmet need for family planning**			
	Yes, No (%),	**NO No (%)**	**COR(95%CI)**	**No (%)**
Current Age (years)				
15-19	16(3.1),	101(19.5)	4.866(2.77-18.545)	117 (22.5)
20 & above(>=20)	175(33.7),	227(43.7)	1	402 (77.5)
Ethnicity				
Oromo	156(30.1),	280(53.9)	0.769(0.196-3.017)	436 (84.0)
Amara	15(2.9),	22(2.2)	0.629(0.140-2.826)	37 (7.1)
Somaale	17(3.3),	19(3.7)	0.479(0.107-2.152)	36 (6.9)
Orgoba	3(0.6),	7(1.3)	1	10 (1.9)
Religion				
Muslim	175(33.7),	299(57.6)	0.943(0.498-1.785)	474 (91.3)
Orthodox	16(3.1),	29(5.6)	1	45 (8.7)
Family size				
1-4	20(4.3) ,	37(8.0)	1.050(0.541-2.037)	57 (11.0)
5-9	129(27.9),	161(34.8)	0.708(0.454-1.104)	290 (55.9)
10 & above	42(9.1),	74(16.0)	1	116 (22.4)
Educational status of respondents				
No education (illiterate)	156(30.1),	193(37.2)	0.116(0.055-0.248)	349 (67.2)
Primary education	27(5.2),	50(9.6)	0.174(0.074-0.413)	77 (14.8)
Secondary and higher education	8(1.5),	85(16.4)	1	93 (19.9)
Educational status of husbands/partners				
No education (illiterate)	111(24),	100(21.6)	0.365(0.221-0.604)	211(40.7)
primary education	50(10.8),	98(21.2)	0.795(0.461-1.369)	148 (28.5)
Secondary and higher education	30(6.5),	74(16.0)	1	104 (20.0)
Wealth status of respondents				
Poorest	48(9.2),	36(6.9)	0.065(0.014-0.295)	84 (16.2)
Poor	120(23.1),	175(33.7)	0.127(0.029-0.548)	295 (56.8)
Rich	21(4.0),	39(7.5)	0.161(0.035-0.743)	60 (11.6)
Richest	2(0.4),	23(4.4)	1	25 (4.8)

Marital status			
Married	191(36.8), 272(52.4)	0.000	463 (89.2)
Unmarried	0(0), 56(10.8)	1	56 (10.8)
Occupation			
House wife only	186(35.8), 247(47.6)	0.000	433 (83.4)
Gov and non gov worker	2(0.4), 6(1.2)	0.000	8 (1.6)
Merchant	3(0.6) 22(4.2)	0.000	25 (4.8)
Work less/ family dependent	0(0), 53(10.2)	1	53 (10.2)

Age at first marriage			
<=14	48(10.4), 68(14.7)	0.616(0.152-2.503)	116 (25.1)
15-19	140(30.2), 196(42.3)	0.600(0.152-2.361)	336 (72.5)
20 & above(>=20)	3(0.6), 7(1.5)	1	10 (2.1)
Parity(no of children she gave birth)			
0	9(1.9), 21(4.5)	2.020(0.890-4.584	30 (6.4)
1-2	37(8.0), 87(18.8)	2.035(1.288-3.218)	124 (26.8)
3-4	29(6.3), 30(6.5)	0.896(0.508-1.580)	59 (12.8)
5 and above	116(25.1), 134(28.9)	1	250 (54)
Age at first delivery			
<=14	5(1.1), 9(2.1)	1.064(0.293-3.866)	14 (3.2)
15-19	168(38.4), 221(50.5)	0.777(0.380-1.588)	389 (88.9)
20 & above(>=20)	13(3.0), 22(5.0)	1	35 (8)
No of children alive			
0	23(5.0), 68(14.7)	2.643(1.549-4.508)	91(19.7)
1-2	23(5.0), 42(9.1)	1.632(0.927-2.874)	65 (14.1)
3-4	27(5.8), 30(6.5)	0.993(0.558-1.767)	57 (12.3)
5 and above	118(25.5), 132(28.5)	1	250 (54)
Desired number of children			
3-4	0(0), 1(0.2)	9513(0.000-	1 (0.2)
5-6	46(8.9), 89(17.2)	1.152(0.705-1.883)	135 (26.1)
7-8	92(17.8), 147(28.4)	0.941(0.613-1.443)	239 (46.2
9 and above	53(10.2), 90(17.4)	1	143 (27.6)
Parity			
0	9(1.9), 21(4.5)	2.020(0.890-4.584)	30 (6.4)
1-2	37(8.0), 87(18.8)	2.035(1.288-3.218)	124 (26.8)
3-4	29(6.3), 30(6.5)	0.896(0.508-1.580)	59 (12.8)

5 and above	116(25.1), 134(28.9)	1	250 (54)
Contraceptive practice			
Current user	0(0.0%), 169(32.6)	86.137(20.770-357.233)	169 (32.6)
Ever user	91(17.5), 66(12.7)	0.748(0.489-1.144)	157 (30.2)
Nan user	98(18.9), 95(18.3)	1	193 (37.2)
Decision concerning contraceptive practice			
Mainly respondents(women)	59(11.4), 83(16.0)	4.572(1.420-14.721)	142 (27.4)
Mainly husbands(partner)	29(5.6), 8(1.5)	0.897(0.229-3.517)	37 (7.1)
Joint decision	90(17.3), 177(34.1)	6.392(2.026-20166)	267 (51.4)
No response	13(2.5), 4(0.8)	1	17 (3.3)
Knowledge about contraceptive			
Yes	179(34.5), 326(62.8)	10.927(2.419-49.367)	505 (97.3)
No	12(2.3), 2(0.4)	1	14 (2.7)
Sources of information about contraception			
Health worker	129(24.9), 226(43.5)	1.083(0.710-1.654)	355 (68.4)
Friends	47(9.1), 76(14)	999(0.000	123 (23.1)
Radio	14(2.7), 16(3.1)	0.707(0.316-1.580)	30 (5.8)
News paper	1(0.2), 7(1.3)	4.329(0.516-36.305)	8 (1.5)
TV	0(0), 3(0.6)	1	3 (0.6)
Exposure to media			
Exposure to radio			
Yes	15(2.9), 229(44.1)	27.141(15.234-48.353)	244 (47)
No	176(33.9), 99(19.1)	11	275 (53)
Exposure to TV			
Yes	0(0), 13(2.5)	97954(0.000-	13 (2.5)
No	191(36.8), 315(60.7)	1	506 (97.5)
Exposure to reading news paper			
Yes	1(0.2), 87(16.8),	68.589(9.467-496.946)	88 (17)
No	190(36.6) , 241(46.4)	1	431 (83)

Table 7: Parameter estimates of selected variables from binary logistic regression to predict un intended pregnancy, in Daro Labu district may 2014.

I. Variables	**D.V= un intended pregnancy**			
	Yes, No (%),	**NO No (%)**	**COR(95%CI)**	**No (%)**
Current Age (years)				
15-19	8(4.7),	21(12.7)	2.938(1.221-7.073)	29 (17.4)
20 & above(>=20)	75(43.9),	67(39.2)	1	142 (83.1)
Ethnicity				
Oromo	62(36.3),	71(41.5)	1.718(0.278-10.616)	133 (77.8)
Amara	11(6.3) ,	5 (2.9)	0.682(0.085-5.448)	16 (9.2)
Somaale	7(4.1),	10(5.8)	2.143(0.281-16.369)	17 (9.9)
Orgoba	3(1.8),	2(1.2)	1	5 (3.0)
Religion				
Muslim	71(41.5),	81(47.4)	1.956(0.730-5.238)	152 (88.9)
Orthodox	12(7.0),	7(4.1)	1	19 (11.1)
occupation				
House wife only	81(47.4),	85(49.7)	0.525(0.047-5.899)	166 (97.1)
Gov and non gov worker	1(0.6),	1(0.6)	0.500(0.013-19.562	2 (1.2)
Merchant	1(0.6),	2(1.2)	1	3 (1.8)
Family size				
1-4	8(4.7),	13(7.6)	0.903(0.305-2.668)	21 (12.3)
5-9	60(35.1),	48(28.1)	0.444(0.213-0.928)	108 (63.2)
10 & above	15(8.8),	27(15.8)	1	42 (24.6)
Educational status of respondents				
No education (illiterate)	58(33.9),	58(33.9)	0.381(0.156-0.929)	116 (67.8)
Primary education	17(9.9),	9(5.3)	0.202(0.064-0.635)	26 (15.2)
Secondary and higher education	8(4.7),	21(12.3)	1	29 (17)
Educational status of husbands/partners				
No education (illiterate)	29(17.0),	34(19.9)	0.969(0.442-2.121)	63 (36.9)
primary education	35(20.5),	31(18.1)	0.732(0.337-1.590)	66 (38.6)
Secondary and higher education	19(11.1),	23(13.5)	1	42 (24.6)

Wealth status of respondents			
Poorest	15(8.8), 19(11.1)	0.633(0.102-3.938)	34 (19.9)
Poor	54(31.6), 54(31.6)	0.500(0.088-2.845)	108 (63.2)
Rich	12(7.0), 11(6.4)	0.458(0.070-3.017)	23 (13.4)
Richest	2(1.2), 4(2.3)	1	6 (3.5)
Marital status			
Married	83(45.8), 88(51.5)		171 (97.3)
unmarried	0(0.0), 0(0.0)		0 (0.0)

Age at first marriage			
<=14	24(14.0), 25(14.6)	0.347(0.034-3.574)	49 (28.6)
15-19	58(33.9), 60(35.1)	0.345(0.035-3.411)	118 (69)
20 & above(>=20)	1(0.6), 3(1.8)	1	4 (2.4)
Age at first delivery			
<=14	2(1.2), 4(2.5)	1.333(0.16-11.075)	6 (3.7)
15-19	76(47.2), 69(42.9)	0.605(0.164-2.235)	145 (90.1)
20 & above(>=20)	4(2.5), 6(3.7)	1	10 (6.2)
No of children alive			
0	7(4.1), 27(15.8)	5.961(2.33-15.254)	34 (19.9)
1-2	14(8.2), 17(9.9)	1.877(0.817-4.312)	31 (18.1)
3-4	11(6.4), 11(6.4)	1.545(0.602-3.970)	22 (12.8)
5 and above	51(29.8), 33(19.3)	1	84 (49.1)
Desired number of children			
3-4			
5-6	22(12.9), 21(12.3)	0.784(0.348-1.769)	43 (25.2)
7-8	38(22.2), 39(22.8)	0.843(0.415-1.714)	77 (45)
9 and above	23(13.5), 28(16.4)	1	51 (29.9)
Parity			
0	4(2.3), 11(6.4)	4.083(1.19-13.922)	15 (8.7)
1-2	17(9.9), 33(19.3)	2.882(1.385-5.999)	50 (29.2)
3-4	13(7.6), 11(6.4)	1.256(0.503-3.141)	24 (14)
5 and above	49(28.7), 33(19.3)	1	82 (48)
Contraceptive practice			
Current user	0(0.0), 0(0.0)	0.000(0.000	0 (0.0)
Ever user	73(42.7), 72(42.1)	0.625(0.266-1.470)	145 (84.8)
Nan user	10(5.8), 16(9.4)	1	26 (15.2)

Decision concerning contraceptive practice			
Mainly respondents(women)	23(13.5), 22(12.9)	1.339(0.369-4.855)	45 (26.4)
Mainly husbands(partner)	9(5.3), 11(6.4)	1.711(0.403-7.271)	20 (11.7)
Joint decision	44(25.7), 50(29.2)	1.591(0.471-5.373)	94 (54.9)
No response	7(4.1), 5(2.9)	1	12 (7)
Knowledge about contraceptive			
Yes	81(47.4), 84(49.1)	0.519(0.092-2.909)	165 (96.5)
No	2(1.3), 4(2.3)	1	6 (3.6)
Exposure to media			
Exposure to radio			
Yes	10(5.8), 51(29.8)	10.062(4.59-22.05)	61 (35.6)
No	73(42.7) , 37(21.6)	1	110 (64.3)
Exposure to TV			
Yes	0(0), 2(1.2)	155912(0.000	2 (1.2)
No	83(48.5), 86(50.3)	1	169 (98.8)
Exposure to reading news paper			
Yes	5(2.9), 22(12.9)	5.200(1.866-14.491)	27 (15.8)
No	78(45.6) , 66(38.6),	1	144 (84.2)

5.7:Factors associated with unmet need for family planning on bivariate Analysis

The bivariate result of unmet need showed that, the unmet need for family planning was lower among 15-19 age group compared with that of 20 and above reference group.15-19 age group has 5 times more probability not to have unmet need compared to that of 20 and above age group[**COR**=4.866(2.7718.545)]. According to level of education, there was decrease in unmet need as educational status of respondents increase from no education to secondary and higher education. The respondents those had no education had 88% less probability not to have unmet need compared to secondary and higher education [**COR**=0.116(0.055-0.248)] , while those who are primary education had 83% less likely not to have unmet need than secondary and higher education reference group[**COR**=0.174(0.074-0.413)] . Partner's educational status had also significant role on unmet need of family planning. Those women whose partners had no education had 63%less likely not to have unmet need compared to those whose partners were secondary and higher education [**COR**=0.365(0.221-0.604)]. The number of children in the family i.e. parity shows that, with increase in parity there was an almost gradual decrease in unmet needs. Those respondents who had 1-2 children have 2 times more likely not to have unmet need compared to those women who have 5 or more children [**COR**=2.035(1.288-3.218)]. In case of wealth status, we can see that, with increase in wealth status of respondents compared to their neighbor, there was decrease in unmet needs. The poorest age group had 93% less likely not to have unmet need [**COR**=0.065(0.014-0.295)] and the poor and rich age group had 87% [**COR** 0.127(0.029-0.548)] and 84%[**COR**=0.161(0.035-0.743)] less likely not to have unmet need respectively compared to the richest age group. By decision concerning contraceptive practice, those women who decide by themselves on contraceptive practice had 5 times more likely not to have unmet need[**COR**=4.572(1.420-14.721)] and those who decide jointly with their partners have 6.4 times more likely not to have unmet need[**COR**=6.392(2.026-20166)] when compared to those participants who were refused to give response .Those women who had knowledge about contraceptive method have 11 times more likely not to have unmet need[**COR**=10.927(2.419-49.367)] compared to those who had no any knowledge about contraception. Concerning contraceptive practice, those women who are current user have 68 times more likely not to have unmet need [**COR**=86.137(20.770-357.233)] compared to non

users. Level of exposure to media has also significant association with unmet need. Those women who read newspaper have 69 times more likely not to have un med need [**COR**=68.589(9.467-496.946)] compared to those who didn't. Similarly, those women who listens radio had 27 times more likely not to have unmet need [**COR=**27.141(15.234-48.353)] compared to those women who didn't (Table 8).

Table 8: variables that shows significant association with unmet need on bivariate analysis at (p value <0.05) in Daro Labu district, may 2014.

I. Variables	**D.V= unmet need for family planning**			
	Yes, No (%), **NO No(%)**	**COR(95%CI)**	**p value**	**No (%)**
Current Age (years)			**<0.000**	
15-19	16(3.1), 101(19.5)	4.866(2.7718.54)	0.000	117(22.5)
20 &above(>=20)	175(33.7), 227(43.7)	1		402(77.5)
Educational status of respondents			**<0.000**	
No education (illiterate)	156(30.1), 193(37.2)	0.116(0.055-0.24)	0.000	349(67.2)
Primary education	27(5.2), 50(9.6)	0.174(0.074-0.41)	0.000	77(14.8)
Secondary and higher education	8(1.5), 85(16.4)	1		93(19.9)
Educational status of husbands/partners			**<0.000**	
No education (illiterate)	111(24), 100(21.6)	0.365(0.221-0.60)	0.000	211(40.7)
primary education	50(10.8), 98(21.2)	0.795(0.461-1.36)		148(28.5)
Secondary and higher education	30(6.5), 74(16.0)	1		104(20.0)
Wealth status of respondents			**<0.000**	
Poorest	48(9.2), 36(6.9)	0.065(0.014-0.29)	0.000	84(16.2)
Poor	120(23.1), 175(33.7)	0.127(0.029-0.54)	0.006	295(56.8)
Rich	21(4.0), 39(7.5)	0.161(0.035-0.74)	0,020	60(11.6)
richest	2(0.4), 23(4.4)	1		25 (4.8)

No of children alive			**<0.000**	
0	23(5.0), 68(14.7)	2.643(1.549-4.50)	0.000	91(19.7)
1-2	23(5.0), 42(9.1)	1.632(0.927-2.87)		65 (14.1)
3-4	27(5.8), 30(6.5)	0.993(0.558-1.76)		57 (12.3)
5 and above	118(25.5), 132(28.5)	1		250 (54)
Parity(no of children she gave birth)			<0.002	
0	9(1.9), 21(4.5)	2.020(0.890-4.58)		30 (6.4)
1-2	37(8.0), 87(18.8)	2.035(1.288-3.21)	0.002	124(26.8)
3-4	29(6.3), 30(6.5)	0.896(0.508-1.58)		59 (12.8)
5 and above	116(25.1), 134(28.9)	1		250 (54)
Contraceptive practice			<0.000	
Current user	0(0.0), 169(32.6)	86.137(20.77357.23)	0.000	169(32.6)
Ever user	91(17.5), 66(12.7)	0.748(0.489-1.14)		157(30.2)
Nan user	98(18.9), 95(18.3)	1		193(37.2)
Decision concerning contraceptive practice			<0.011	
Mainly respondents(women)	59(11.4), 83(16.0)	4.572(1.42-14.72)	0.011	142(27.4)
Mainly husbands(partner)	29(5.6), 8(1.5)	0.897(0.229-3.51)		37 (7.1)
Joint decision	90(17.3), 177(34.1)	6.392(2.026-2016)	0.002	267(51.4)
No response	13(2.5), 4(0.8)	1		17 (3.3)

Knowledge about contraceptive			<0.002	
Yes	179(34.5), 326(62.8)	10.92(2.41-49.36)	0.002	505(97.3)
No	12(2.3), 2(0.4)	1		14 (2.7)
Exposure to media			<0.000	
Exposure to radio			<0.000	
Yes	15(2.9), 229(44.1)	27.14(15.23-48.35)	0.000	244 (47)
No	176(33.9), 99(19.1)	1		275 (53)
Exposure to reading news paper			**<0.000**	
Yes	1(0.2), 87(16.8),	68.58(9.46-496.94)	0.000	88 (17)
No	190(36.6),241(46.4)	1		431 (83)

5.8: Factors associated with un intended pregnancy on bivariate Analysis.

Bivariate results of un intended pregnancy also revealed that, women with 15-19 age group had 3 times more likely not to have unintended pregnancy compared with that of 20 and above age group[**COR**=2.938(1.221-7.073)] . Unintended pregnancy was also found to be associated with women's educational status. women with no education had 64% less likely not to have unintended pregnancy[**COR**=0.381(0.156-0.929)] and those with primary education had 98% less likely not to have unintended pregnancy[**COR**=0.202(0.064-0.635)] compared to those with secondary and higher education .Those respondents who have 5-9 total family size had 56% less likely not to have unintended pregnancy[**COR**=0.444(0.213-0.928)] compared to those who have 10 and above. Concerning parity those respondents who had no children had 6 times more likely not to have un intended pregnancy[**COR**=5.961(2.330-15.254)] compared to those who have 5 and above children. By media exposure, those women who listen radio had 10 times more likely not to have unintended pregnancy [**COR**=10.062(4.590-22.056)] compared to those who didn't and those who read news paper had 5 times more likely not to have un intended pregnancy[**COR**= 5.200(1.866-14.491)]compared to those who didn't (Table 9).

Table 9: variables that shows significant association with un intended pregnancy on bivariate analysis (at p value<0.05) in Daro Labu district, may 2014.

I. Variables	**D.V= un intended pregnancy**			
	Yes No (%), **NO No (%)**	**COR(95%CI)**	**p value**	**No (%)**
Current Age (years)			**<0.016**	
15-19	8(4.7), 21(12,7)	2.938(1.221-7.073)	0.016	29 (17.4)
20 & above(>=20)	75(43.9), 67(39.2)	1		142 (83.1)
Family size			**<0.031**	
1-4	8(4.7), 13(7.6)	0.903(0.305-2.668)		21 (12.3)
5-9	60(35.1), 48(28.1)	0.444(0.213-0.928)	0.031	108 (63.2)
10 & above	15(8.8), 27(15.8)	1		42 (24.6)
Educational status of respondents			**<0.000**	
No education (illiterate)	58(33.9), 58(33.9)	0.381(0.156-0.929)	0.034	116 (67.8)
Primary education	17(9.9), 9(5.3)	0.202(0.064-0.635)	0.000	26 (15.2)
Secondary and higher education	8(4.7), 21(12.3)	1		29 (17)
No of children alive			**<0.000**	
0	7(4.1), 27(15.8)	5.961(2.330-15.254)	0.000	34 (19.9)
1-2	14(8.2), 17(9.9)	1.877(0.817-4.312)		31 (18.1)
3-4	11(6.4), 11(6.4)	1.545(0.602-3.970)		22 (12.8)
5 and above	51(29.8), 33(19.3)	1		84 (49.1)
Parity			<0.005	
0	4(2.3), 11(6.4)	4.083(1.198-13.922)	0.025	15 (8.7)
1-2	17(9.9), 33(19.3)	2.882(1.385-5.999)	0.005	50 (29.2)
3-4	13(7.6), 11(6.4)	1.256(0.503-3.141)		24 (14)
5 and above	49(28.7), 33(19.3)	1		82 (48)
Exposure to media			<0.000	
Exposure to radio			<0.000	
Yes	10(5.8), 51(29.8)	10.062(4.590-22.056)	0.000	61 (35.6)
No	73(42.7), 37(21.6)	1		110 (64.3)
Exposure to reading news paper			<0.002	
Yes	5(2.9), 22(12.9)	5.200(1.866-14.491)	0.002	27 (15.8)
No	78(45.6), 66(38.6)	1		144 (84.2)

5.9:Factors associated with unmet need and unintended pregnancy by multivariate Analysis

Multivariate analysis was performed with all variables that shows significant association with unmet need for family planning and unintended pregnancy during bivariate analysis at (P value <0.05).Those independent variables that shows significant association with unmet needs for family planning by multivariate analysis at (P value<0.05) were: educational status of respondents, wealth status of respondents compared to their neighbor, knowledge of contraceptive method and exposure to media (newspaper and radio).while those associated with un intended pregnancy by multivariate analysis were: Educational status of respondents, parity, and exposure to media (listening radio).During multivariate analysis only few explanatory variables were associated with outcome variables and the magnitude and strength of some variables were also changed. For instance, when we see level of education, there was gradual decrease in unmet need as educational status of respondents increase from no education to secondary and higher education. The respondents that had no education have 80% less probability not to have unmet need[**AOR**=0.202(0.087-0.473)] compared to secondary and higher education, while those who are primary education have 79% less likely not to have unmet need[**AOR**=0.208(0.081-0.534)] than secondary and higher education. In case of wealth status we can see that, with increase in wealth status of respondents compared to their neighbor, there was gradual decrease in unmet need. The poorest age group have 94% less likely not to have unmet need[**AOR**=0.060(0.013-0.278)] and the poor and rich age group have 86%[**AOR**=0.135(0.031-0.591)] and 84%[A**OR**=0.161(0.034-0.774)] less likely not to have unmet need compared to the richest respectively. By decision concerning contraceptive practice, those women who decide by themselves on contraceptive practice had 4 times more likely not to have unmet need[**AOR**=4.24(1.260-14.265)] and those who decide jointly with their partners had 6.4 times more likely not to have unmet need[**AOR**=6.430(1.952-21.186)] when compared to those participants who were refused to give response .Those women who had knowledge about contraceptive method had 17 times more likely not to have unmet need [**AOR**=17.466(2.180-139.938] compared to those who had no knowledge about contraception. Exposure to media had also significant association with unmet need. Those women who read newspaper had 83 times more likely not to have un met need[**AOR**=82.578(7.977-854.903)] compared to those who didn't. Similarly ,those

women who listen radio had 31 times more likely not to have unmet need[**AOR**=30.921(16.486-57.994)] compared to those women who didn't. Multivariate results of unintended pregnancy revealed that, .women with primary education had 72% less likely not to have unintended pregnancy [**AOR**=0.279(0.083-0.943)] compared to those with secondary and higher education and those women who have no children had 6 times more likely not to have un intended pregnancy[**AOR**=5.914(2.125-16.463)] compared to those who have 5 and above children. By media exposure those women who listen radio had 8 times more likely not to have unintended pregnancy [**AOR**=8.421(3.701-19.162)] compared to those who didn't (Table 10 & 11).

Table 10: variables that shows significant association with unmet need by multivariate Analysis at (p value <0.05) in Daro Labu district, may 2014.

I. Variables	D.V=Unmet need for family planning			
	Yes , No No (%) No(%)	COR(95%CI)	AOR(95%CI)	No(%)
Educational status of respondents				
No education (illiterate)	156(30.1),193(37.2)	0.116(0.055 -0.248)	0.202(0.087-0.473)*	349(67.)
Primary education	27(5.2), 50(9.6)	0.174(0.074-0.413)	0.208(0.081-0.534)*	77 (14.8)
Secondary and higher education	8(1.5), 85(16.4)	1	1	93 (19.9)
Wealth status of respondents				
Poorest	48(9.2), 36(6.9)	0.065(0.014-0.295)	0.060(0.013-0.278)*	84 (16.2)
poor	120(23.1),175(33.7)	0.127(0.029-0.548)	0.135(0.031-0.591)*	295(56.)
Rich	21(4.0), 39(7.5)	0.161(0.035-0.743)	0.161(0.034-0.774)*	60 (11.6)
richest	2(0.4), 23(4.4)	1	1	25 (4.8)
Decision concerning contraceptive practice				
Mainly respondents(women)	59(11.4), 83(16.0)	4.572(1.420-14.721)	4.24(1.260-14.265)*	142(27.)
Mainly husbands(partner)	29(5.6), 8(1.5)	0.897(0.229-3.517)		37 (7.1)
Joint decision	90(17.3),177(34.1)	6.392(2.026-20166)	6.43(1.952-21.186)*	267(51.)
No response	13(2.5), 4(0.8)	1	1	17 (3.3)

Knowledge about contraceptive				
yes	179(34.5),326(62.8)	10.927(2.419-49.367)	17.46(2.18-139.93)*	505 (97)
no	12(2.3), 2(0.4)	1	1	14 (2.7)
Exposure to media				
Exposure to radio				
yes	15(2.9), 229(44.1)	27.14(15.23448.353)	30.92(16.48-57.99)*	244(47)
no	176(33.9), 99(19.1)	1	1	275(53)
Exposure to reading news paper				
yes	1(0.2), 87(16.8),	68.58(9.467-496.946)	82.57(7.97-85.90)*	88 (17)
no	190(36.6),241(46.4)	1	1	431(83)

N.B *= significant at P-value< 0.05 for **AOR**

Table 11: variables that shows significant association with un intended pregnancy by multivariate Analysis at(p value<0.05) in Daro Labu district, may 2014.

I. Variables	**D.V=unintended pregnancy**			
	Yes NO No (%), No(%)	**COR(95%CI)**	**AOR(95%CI)**	**No(%)**
Educational status of respondents				
No education (illiterate)	58(33.9),58(33.9)	0.381(0.156-0.929)		116(6.8)
Primary education	17(9.9), 9(5.3)	0.202(0.064-0.635)	0.279(0.083-0.943)*	26(15.2)
Secondary and higher education	8(4.7), 21(12.3)	1	1	29 (17)
Parity (No of children alive)				
0	7(4.1), 27(15.8)	5.961(2.330-15.254)	5.91(2.125-16.463)*	34(19.9)
1-2	14(8.2), 17(9.9)	1.877(0.817-4.312)		31(18.1)
3-4	11(6.4), 11(6.4)	1.545(0.602-3.970)		22(12.8)
5 and above	51(29.8), 33(19.3)	1	1	84(49.1)
Exposure to media				
Exposure to radio				
Yes	10(5.8), 51(29.8)	10.062(4.59-22.056)	8.42(3.701-19.162)*	61(35.6)
No	73(42.7), 37(21.6)	1	1	110(64.3)

N.B *= significant at P-value< 0.05 for **AOR**

CHAPTER SIX: DISCUSSION

6.1: Unmet need for family planning (Relation to the previous studies)

Result indicates that the unmet needs for family planning among reproductive age women of the study area were 36.8% (26.4% for spacing and 10.4% for limiting births). Which is higher than regional(30%) and national (25%) figure (8). This may be due to diverse tradition, cultural and religious denominations. Generally, in west Africa, unmet need ranged from 16 to 34 percent and in Eastern and Southern Africa, it ranged from 13 to 38 percent (35).Even if this finding is higher compared to national figures, it is consistent with the results of other studies. For instance, a study done in southern nations, nationalities and peoples regions of Ethiopia, indicated unmet need to be 35.1% in 2000 to 37.4% in 2005 (23.9% for spacing and 11,2% for limiting in2000 and 24% for spacingand13.3% for limiting in 2005.) (35). It is also consistent with the results of study done in southern parts of Ethiopia around Awassa in 2003, which founds total unmet need for family planning of 35.0% (26.5% for spacing and 8.5% for limiting).(36).and also it is in line with the study done in Eastern Sudan which found total unmet need for family planning 48.8% (37). In this study, there was decrease in unmet need for family planning with increase in women's educational status. In most populations, women's education is an important determinant of unmet need for family planning and this has been found to be true in this study area, where women with no education and primary education had significantly higher level of unmet need compared with those who had secondary and higher education. The possible explanation for this could be that women empowered through education have better access to health facilities and information about modern contraceptive methods than uneducated women. The main reason for this might be that, educated women are more informed about different choices, methods and have more availability. This is possibly due to the level of awareness of fertility control and preference for a smaller number of family is less understood among the less educated, while the better educated women appreciate the value of small and planned family as well as the means in achieving it. These results are consistent with the findings of other studies. Hogan, et al also showed that literacy was the most important factor in increasing contraceptive knowledge and the desire to limit or space births (36). Studies elsewhere in Africa also document that unmet need is lower for women with better education. For instance in Uganda, unmet need was lower for women with secondary or higher education and in Kenya, women with primary incomplete education were 2 times more likely to experience

unmet need for family planning compared to those with primary complete or higher education (35).. Also in Iran, decrease in unmet needs with increase in educational attainment was found (44). This was also seen in Rwanda with 69% unmet needs among those who received less than 3 years of education and 27% among those with at least 10 years of education (45). Also, in a study done in resettlement colony in Delhi there was decrease in unmet needs with increase in educational attainment, illiterate group (30.1%), primary education (22.9%), secondary or higher education (22.4%) (46). Wealth status is inversely related to unmet need in this study. There was a gradual decrease in unmet needs with increasing respondents' wealth status. This is mainly because rich people have access to more things, are better educated and have the capacity to make their own decisions. Similar result was found in Kenya, with first quartile i.e. having the lowest income have highest unmet needs and then there was gradual decrease with second quartile (OR 0.84), third (OR 0.77), fourth (OR 0.67) and fifth (OR 0.59) (38). In DHS comparative report 14, the similar trend was seen with unmet needs inversely related to wealth in most of the countries with only few exceptions (47). In a study conducted in resettlement area in Delhi, India similar result of decrease in unmet needs was seen with increase in per capita income (41). Decision about contraceptive practice was also associated with un met need for family planning. In this study those women who were decided about contraceptive practice by themselves and decided jointly with their husbands had low unmet need for family planning when compared to those who were refused to give response. The possible explanation for this could be that, if couples discuss with each other about family planning issue they can concern about the value of small and planned family in multi dimension and how to get such types of family which can leads to contraceptive practice, This results were also supported by the study done in southern parts of Ethiopia around Awassa . Women who have not discussed family planning issues with their husbands have 5 times more likely to have unmet need for family planning than women who have discussed family planning issues with their husbands.(36). Knowledge of contraceptive method was also found to have significant effect on unmet need for family planning. In this study women who have no knowledge about contraceptive method were more likely to have unmet need for family planning than those who have knowledge. The possible explanation for this may be that, women who had low knowledge were less likely to know the available option, more likely to complain with minor side effects and less likely to use method correctly, which can leads to the probability to have high unmet needs This finding is nine with the finding of study done in southern parts of Ethiopia around Awassa .where, Women who have no knowledge about family planning were 27 times more likely to

have unmet need for family planning than women who have knowledge about contraception(36). In addition, other studies in Asia indicate that, Lack of knowledge of modern contraceptive methods and their mechanism of action have been cited one of major reasons for the women's non use of contraception(50).Exposure to media was one of the strongest variable associated with unmet need for family planning.(radio listening and reading news paper).In this study, women who didn't listen radio at all have significantly higher probability to have unmet need for family planning compared to those women who have listen the radio at least once a week. and those women who didn't read news paper at all had extremely higher probability to have unmet need compared to those women who read news paper at least once a week. The possible explanation might be that, media (radio) can use effective communication channels to address barriers affecting contraceptive use and can increase their level of contraceptive knowledge. which can leads to contraceptive practice. Other possible reason is that, those women who can read news paper can get reading materials easily from nearby health post or from health extension workers when they round in the community house to house, therefore they can get better understanding and have high probability to use family planning than those who didn't, This results are supported by study done in Pakistan which found that, married women of reproductive age having more media exposure had low unmet need in comparison to those women who had less media exposure.(50).

6.2: unintended pregnancy (Relation to the previous studies)

Forty seven percent of pregnant and amenorrheaic women in the study area were perceived their pregnancy unintended.(34% mistimed and 13% unwanted).which is higher than national (29%) figure (8). This may be due to diversity of traditional, cultural, religious and way of living across the country from place to place .when it is compared with other studies, this result was consistent with the findings of study from Southern parts of Ethiopia, which revealed that nearly 43 % of currently pregnant married women had unintended pregnancy (42). Other Study conducted in Nepal in 2013 also found total un intended pregnancy 54% (40% mistimed and 14% unwanted) (51). Study from USA indicates that, nearly 52% of the teen pregnancies were unintended (52). Another Study from Japan indicates that nearly 47 percent of Japanese women experience unintended pregnancy (53) which is lined with these findings. This study revealed that, unintended pregnancy decrease with increasing women's educational status. The possible explanation for this could be that more-educated women

generally marry and begin their childbearing later than those who are less educated; they tend to know more about family planning, including where to obtain family planning services and how to use it. As a result, they are less likely to have an unplanned pregnancy. Other possible explanation for this could be that women empowered through education have better access to health facilities and information about modern contraceptive methods than uneducated women. A study conducted in Awassa (54) has showed similar results. Bongaarts (1997) also noted that education reduces the chance of discontinuity of contraceptives. Other Study from USA revealed that women with less education were more likely to experience unintended pregnancy (52) which coincides with the finding from current study. This may be due to that, education improves women's decision making power leading to avoidance of unintended pregnancy. Number of previous births or parity was also associated with un intended pregnancy. In this study, unintended pregnancy increase with increasing number of living children or parity. The possible reason for this may be that, women with less than five living children do not wish to stop childbearing due to fear of child death. However, when women have five or more living children, they appear to feel secured of child mortality and wish to stop or space childbearing. Study from Indonesia shows that, Number of previous births or parity was strongly related with the odds of unintended pregnancy (19). Exposure to media had also showed strong association with unintended pregnancy, Level of exposure to media shows inverse relation with occurrence of un intended pregnancy. In this study those women who listen radio had less probability to have unintended pregnancy compared to those who didn't. The possible explanation for this could be that, media can provide wide and crucial information about contraceptive practice, and how un intended pregnancy can be occurred and prevented. As a result, those women who had media exposure (radio) may have more understanding and have high probability to use contraception. Study from Southern parts of Ethiopia indicates that,(42) there is decreased risk of facing unintended pregnancy with increased exposure to media.

6.3: Strength of the study

Potential recall bias was addressed by including only the women who were pregnant and post partum at the time of survey to investigate un intended pregnancy. In this study, use of logistic regression helped to control possible confounding factors in order to assess the relative effect of independent variables.

6.4: Limitation of the study

The major limitation of this study was emanated from the nature of the subject and method it employed. Since the study design is a Cross- sectional study design, it is difficult to obtain temporal relation. Because, this type of study design shows the exposure and outcome at the same point in time, so that it is difficult to formulate cause and effect relationship. Other possible limitations are: Reliability of answers due to sensitivity of the nature of the study.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

7.1: CONCLUSION

Thirty six point eight percent of Women in the study area had unmet need for family planning (36.8% for spacing and 26.4% Limiting) and had his try of un intended pregnancy. Forty seven point six percent of pregnant and amenorrheaic women in the study area were perceived their pregnancy were unintended.(34.3% mistimed and 13.3% unwanted). The independent variables associated with unmet needs for family planning at (P value<0.05) were: educational status, wealth, decision about contraceptive practice, knowledge of contraceptive method and exposure to media (newspaper and radio). While those associated with unintended pregnancy were: educational status, parity and exposure to media (listening radio). fear of side effect, lack of awareness, religion problem, little perceived risk of pregnancy, medical problem and husband disapproval were revealed reasons for not using contraception among non users. while, Fear of side effect, desire to have more children, medical problem, little perceived risk of pregnancy, unavailability of preferred method and religion problem were main reasons to discontinue use of contraception among ever users. In general, high unmet need for family planning was found among women, with no education or primary education, with no knowledge of family planning method, low wealth status, didn't decided about contraceptive practice by themselves or jointly with their husbands and those didn’t exposure to media(news paper and radio).and high unintended pregnancy was found among women with no education or primary education, higher parity, and didn't exposure to media (listening radio).

.

7.2: RECOMMENDATIONS

Based on the findings of our study, the following recommendations are forwarded.

- The District health office should work with community elder, Idirs, other influential persons and District women's & child affairs office to increase family planning service utilization.
- The District health office should encourage Health extension worker to improve the door to door visiting and teaching of the community to increase the level of family planning service utilization.
- Opportunities for provision of family planning service should be exploited to the full, by district health office, especially for higher-parity women and women with lower socioeconomic status
- Female education should be a prioritized program by the government, as education is the most determinant of unmet need and un intended pregnancy
- Spousal communication is an important intermediate step toward adoption and use of contraception, therefore, district health office and women's & child affairs office should encourage communication between couples as much as possible.
- Even though the knowledge of contraceptive is high, there is low contraceptive prevalence rate, therefore, district health office should focus on means of improving family planning service utilization.
- The district and zonal health office should take appropriate action on those factors identified in this study affecting unmet need and unintended pregnancy..

REFERENCE

1 .Johns H. Population Reports Meeting Unmet Need. Newark: School of Public Health, 1996.

2 Elizabeth L, Sunshield S and Sadie A. Fertility Regulation behaviors and Their Costs. Froze Chow hurry, 2007.

3 http://www.unescap.org/esid/psis/population/popseries/apss158/part2_2.pdf

4 World Health Organization (WHO). Trends in Maternal Mortality 1990 to 2008 Estimates. Geneva: Developed by WHO, UNICEF, UNFPA and the World Bank, 2010.

5 Jacob R, Bahamian L and Pile M. Threatened and still greatly needed Family planning programs in Sub-Saharan Africa. New York: The acquire Project/Engender Health, 2008.

6 United Nations Population Fund (UNFPA). Population Issues Briefing Kits. New York: 1996, p 2-24.

7 UNDP. Development cooperation report. Addis Ababa, Ethiopia, 1997.

8 Central Statistical Authority (CSA) and ORC Macro. Ethiopia Demographic and Health preliminary report 2011. Addis Ababa Ethiopia and Calverton Maryland USA: Central Statistical Authority and ORC Macro, 2011.

9 .Adhikari, R., Soonthorndhada, K. & Prasartkul, P. 2009, "Correlates of unintended Pregnancy among currently pregnant married women in Nepal". BMC International Health and Human Rights. 2009, 9 (1): p 17.

10 World Health organizations (WHO). World health day side mother hood .7 April 1998.

11 Ethiopian office of prime minister. National population policy of Ethiopia. Addis Ababa, April 1993.

12 Daro Labu District Health Office. Annual reports of 2013.

13 Bradley SEK, Croft TN and Fishel JD. Revising Unmet Need for Family Planning DHS Analytical Studies. Calverton Maryland USA: ICF International West off, 2012, (25): p 93.

14 Cater line JB and Siding SW. Unmet Need for Family Planning in Developing Countries and Implications for Population Policies. Population Dev Rev, Dec 2000; 26 (4): p 691–723.

15 John A, Ross and William I. Contraceptive use, intention to use and Unmet need during the extended period. International family planning Perspectives, March 2001, 27 (1).

16 Ministry of Health of Ethiopia. Health and health related indicators. Addis Ababa: Planning and Programming Department, 2007.

17 Velar J. Job pattern of routine antenatal care for low risk pregnancy. (Coherence review), 2004.

18 Tadele G. Factors Influencing Husband-Wife Attitude and use of contraceptive methods. Addis Ababa University: Master thesis, 1999.

19 Henderson D. Third of women in UK who have unintended pregnancy blame contraceptive failure. BMJ, 2009, p 399.

20 Mosher W D, Jones J & Amber J C. "Intended and unintended births in the United States, 1982-2010". National health statistics reports, 2012, 55 (55) p 1-28.

21 World Health Organization (WHO). Why do so many women still die in pregnancy or childbirth? Viewed on 11March ,2013.

22 Institute for Population and Reproductive Health. Family Planning improves the lives of Women and their Families around the World, 2011 Report, p 1-5

23 Kilmer CS. "Unintended pregnancy, Consequences and solutions for a worldwide Problem". Journal of nurse-midwifery, 2010, 43 (6): p 483-491.

24 World Health Organization (WHO). Family Planning [Available online]: http://www.who.int/mediacentre/factsheets/fs351/en/index.htm, Updated July 5, 2012.

25 UNFPA. Ensuring that, every pregnancy is wanted. [Available online]: http://www.unfpa.org/rh/planning.htm, Updated January 25, 2012.

26 Daniel S. Determinants of Contraceptive use, None Use and Unmet Need among Married Women in Urban Ethiopia. Journal of Health Development in Ethiopia: Master thesis, Ababa University, 1995.

27 Tizazu A. Deferential in Effectiveness of Contraception use in Dale Wereda. MPH Thesis, South Ethiopia, 1994.

28 Ali M and Cleland J. Contraceptive Discontinuation in Six Developing Countries. Cause specific analysis. International Family Planning Perspectives, Sep 1995, (3): p 92-97.

29 Bong arts J and Bruce J. The Cause of unmet need for family planning and it's Social consequences. Studies in Family Planning, March 1995, 26 (2): p 57-75.

30 Population Information Program. New Strategies Meeting Unmet Need. Population reports, USA: The Johns Hopkins School of Public Health, 1996, (43).

31 AShabir I and Melaku D. Family planning Survey in North Gondar. Journal of Health Development, 1996, (34): p 173-181.

32 .Schuler S.R, Claque M.E and Brace S. Studies in Family Planning .Misinformation, Mistrust and Mistreatment .Among Bolivian Market Women, July- Aug 1994,25 (4): p 211-221.

33 Ferguson AG. Fertility, Contraception and discontinuation rate in Rural Kenya. Studies in Family Planning, 1992, 23 (4): p 257-267.

34 Gessessew A. "Abortion and unwanted pregnancy in Adigrat Zonal Hospital Tigray North Ethiopia.". African Journal of reproductive health, 14 (3): p 183-188.

35 Factors Affecting Unmet Need for Family Planning in Southern nations, nationalities and Peoples Region, Ethiopia. Ethiop J Health Sci. Jul 2011; 21(2):p 77–89. .

36 Sahle S ,Assessment of the magnitude and determinants of Unmet need for family planning among currently married women in urban and Per urban Community in Awassa, Southern Ethiopia,2003

37 .Factors affecting unmet need for family planning in Eastern Sudan. BMC Public Health, 2013, (13):p102

38 Ojakka D. DHS Working Papers: Trends and Determinants of Unmet Need for Family Planning in Kenya. Calverton ,Maryland, USA :Macro International Inc.; 2008Aug:p36.Availablefrom: http://www.measuredhs.com/pubs/pdf/WP56/WP56.pdf

39 . Bhandari GP, Premarajan KC, Jha N, Yadav BK, Paudel IS, Nagesh S. Prevalence and determinants of unmet need for family planning in a district of eastern region of Nepal. Kathmandu Univ Med J (KUMJ), 2006,4(14):p203-210.

40 .Anand BK, Singh J, Mohi MK. Study of Unmet need for family planning in Immunization clinic of a teaching hospital at Patiala, India. The internet journal of Health, 2010; 11 (1).

41 Woldemicael G, Beaujot R. Currently married women with an unmet need for contraception in Eritrea: Profile and determinants. Can Stud Popul. 2011,(38), 1-2:p61-81.

42 43.Hailemariam A, Haddis F. Factors affecting unmet needs for family planning in southern nations, nationalities and people's region, Ethiopia. Ethicon J Health Sci. 2011 July;21(2):p77-88.

43 Devi DR, Restage SR, Rutherford RD. Unmet need for family planning in uttar Pradesh. India: National family Health Survey Subjects,1996. May:p27. Available from:http://scholarspace.manoa.hawaii.edu/bitstream/handle/10125/3482/NFHSsubjrpt001.pdf?sequence=1

44 Ahmadi A, Iranmahboob J. Unmet need for family planning in Iran. Paper presented at: XXV IUSSP International Population Conference; 2005 July 18-23..

45 Ndaruhuye DM, Boethius A, Hooimeijer P. Demand and Unmet need for means of family limitation in Rwanda. Int Percept Sex Reprod Health. 2009;35(3):p122–130.

46 .Saini NK, Bhasin SK, Sharma R, Yadav G. Study of unmet need for family planning in a resettlement colony in east Delhi. Health Popul Perspect Issues. 2007;30(2):p124-133.

47 .West off CF. New estimates of Unmet need and the demand for family planning: DHS Comparative reports no. 14. Calverton, Maryland, USA: Macro International Inc.;2006Dec:p83. Available from:http://www.measuredhs com/pubs/pdf/CR14/CR14.pdf.

48 Sultan MK, Bakr I, Ismail NA, Arafat N. Prevalence of unmet contraceptive need among Egyptian women: a community-based study. J prev med hyg, 2010(51): p62-66.

49 . Global Journal of Health Science; Published by Canadian Center of Science and Education, ISSN 1916-9736 E-ISSN 1916-9744,Vol. 5, No. 5; 2013.

50 .Determining the factors associated with Unmet need for family planning: a cross-sectional survey in 49 districts of Pakistan. PJPH Volume.1 Issue. 1 December 2011

51 Unintended Pregnancy Among Currently Pregnant Married Women In Nepal, Master' thesis, School of Health Sciences University of Tampere (Public Health), October,2013.

52 .Crosby, R.A., Di Clemente, R.J., Win good, G.M., Rose, E. & Lang, D. 2003,"Correlates of unplanned and unwanted pregnancy among African-American female teens.", *American Journal of Preventive Medicine*, vol. 25, no. 3, pp. 255-258.

53 .Goto ,A., Yasumura, S., Reich, M.R. & Fukao, A. 2002, "Factors associated with unintended pregnancy in Yamagata, Japan.", *Social science & medicine*, vol. 54, no. 7: pp1065-1079.

54 . Akalework B (2008). Determinants and magnitude of Unintended Pregnancy among Selected married women in Awassa town. SNNPR, AAU, Addis Ababa:p1065-1079.

Annex

Annex 1:English Questionnaire**.**

Letter of informed consent

Dear participant,

My name is _____ and I am working with Mr. **Zekeriya Mohammed**. He is conducting a research on unmet need for family planning and occurrence of unintended pregnancy and associated factors among reproductive age women's as partial fulfillment for Master's Degree in Public Health/ Reproductive Health at Jimma University. this study has been reviewed and received ethical clearance from Jimma University. The purpose of this study is to investigate the prevalence of unmet need for family planning and unintended pregnancy and associated factors ammo reproductive age women's in DaroLabu district. I would like to provide you with more information about this project and what your involvement would entail if you decide to take part. The Ethiopian government are doing remarkable efforts to improve the reproductive health problems of the country. But, the country are still facing many problems related to reproductive health, including unmet need for family planning and unintended pregnancy. which is the main cause for maternal mortality and morbidity of the country including DaroLabu district. This has pulled me to conduct this research to investigate the factors contributing to unmet need and unintended pregnancy among. reproductive age women. I would like to include you in this study as you are one of those affected by the situation. I believe you are one of the best suited to know the causes of unmet need for family planning and unintended pregnancy. Participation in this study is voluntary. It will involve an interview of approximately 30 minutes. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study. There are no known or anticipated risks to you as a participant in this study. I hope that the results of my study will have benefit to improve the situation of reproductive age women of the study area and the country as a whole for a better life.

Do you have any questions?

Can I proceed with the Questions?

Yes_____ (Thank and continue)

No _____ (Thank and stop)

Survey questioner to assess the prevalence of unmet need and unintended pregnancy and associated factors among reproductive age women of Darolabu district of west Hararghe zone, Oromiya regional state

Result 1= Completed

Result 2=Respondents are not available

Result 3= Respondent refused

001=interviewer code----------/----------/name--------

002=house hold number----------

003=Date of interview in Ethiopian calendar---------/-------/---------/time----------

004=checked by supervisor

Signature----------/day----------/month----------/year----------

PART ONE –DEMOGRAPHIC AND SOCIO ECONOMIC CHARACTERS				
No	Questions	Choice of answer	code	Remark
102	How old are you?	----------age in year		
103	Educational status	1=can't write and read 2= can read and write 3=elementary school(1-6) 4=Junior school(2-10) 5=Preparatory school(10-12) 6=Higher education		
104	occupation	1=house wife 2=farmer 3=student 4=government employee 5=Daily labor 6=Merchant 7=Jobless(family dependent)		
105	Ethnic origin	1 = Oromo 2 = Amara 3= Somale 4 Garage 5=others		
106	Marital status	1= married 2= unmarried 3 = Divorced 4 =widowed 5 =separated		

		6 = others		
107	Monthly income in Ethiopian birr	1,----------Ethiopian birr 2, no response		
108	If you compare your monthly income with your neighborhood, where you put your economic status	1= poorest 2= poor 3=rich 4=richest 5=richest		
109	Family size	1= male--- 2= female--- 3= total---		
110	What is your religion?	1 =Muslim 2= orthodox 3= protestant 4= catholic 5= other		

PART TWO: REPRODUCTIVE HISTORY				
Question No	Question	Choose of answer	code	Skip to question no
201	Have you ever married?	=yes, = no		
202	At what age were you first married?	----------enter age in year		
203	Have you ever been pregnant?	1=yes 2,=no		
204	How many pregnancies have you had?	----------enter number		
205	How many live children do you have?	----------enter number		
206	How old were you when your first child was born?	----------enter number		

207	If you could go back to the time you do not have children and could choose exactly the number of the children to have in your whole life how many children could be that?	----------enter number		
208	How many children would you like to have in your life?	----------enter number		
209	Are you currently pregnant?	1=yes 2=no 3= don't know		
210	If the answer was yes is the pregnancy	1= intended 2= mistimed 3= unwanted 4= no response		
213	If you have been pregnant when you do not want to, what was the reason you could not avoid becoming pregnant?	1 = lack of awareness of contraception method 2= poor access to contraception method 3= husband or partner disapproval 4=relative disapproval 5= contraceptive failure 6 = little perceived risk of pregnancy 7= religion prohibition 8 = culture prohibition 9 =other specify		
215	Time since previous birth	----------enter the time in month		
216	Have you ever become pregnant in previous 12 month?	1= yes 2= no 3= no answer		

217	If the answer is yes, was it	1 =intended 2= unintended 3= no response		
218	After the birth of the child you are expecting now, do you think that you will use any method to delay or avoid pregnancy at any time in the future? (For pregnant women).	1= yes 2= no 3= not decided 4= do not know		
219	Do you intend to use family planning in the future to delay or avoid pregnancy? [For post partum amenorrhea women]	1= yes 2= no 3= not decided 4= do not know		
220	220 If the answer were yes, would you Like to use method to space or limit pregnancy?	1= for spacing 2= for limiting 3= not decided		
21	If you were not going to use any method to delay or avoid pregnancy at any time in the future would you tell me the reason?	1= not aware of contraception 2= fear of side effect 3 = fear of infertility 4= un accept able in my culture 5= medical problem 6= preferred method is not available 7= desire to have more children 8= Husband or partner disapproval 9= Due to religion problem 10= Little perceived risk of pregnancy 11= Other specify		

223	If you are not pregnant or amenorrhea would you like to have another child or not.	1= have child 2 = no more child 3 = cannot give birth 4 =un decided 5= do not know		
224	If you like to have a child, how long would you like to wait from now before the birth of another child?	1=,_____enter month if less than 2 years 2=2-3 years 3=3- 4 years 4= more than 4years 5= don't now		

PART THREE: PRACTICE OF CONTRACEPTIVE METHOD				
No	question	Choice of answer	code	Remark
301	Please tell me to which group you belong regarding to contraceptive practice?	1= current user 2 =ever used 3= non user 4= Other specify		
302	If you have ever used contraceptive method, how old were you when you first started to use?	----------enter age in year		
303	How many living children did you have at that time?	--------enter number of children		
304	What was the method you used then?	1= pills 2= IUCD 3= inject able 4= implant or Norplant 5= condom 6= female sterilization 7 =Other specify		

305	What was the main reason that you stopped using contraceptive method?	1= fear of side effect 2= fear of infertility 3= medical problem 4= preferred method is not available 5= desire to have more children 6= little précised risk of pregnancy 7 = un accept able in my culture 8= religion problem 9= other specify		
306	Do you intend to use any method to delay or avoid pregnancy at any time in the future?	1= yes 2= no 3 =not decided 4= do not now		
309	If you are currently using contraceptive method for what purpose?	1= limiting birth 2= spacing birth 3= do not now 4= other specify		
310	What type of contraceptive method do you use currently?	1= pills 2= IUCD 3= inject able 4= implant or Norplant 5= condom 6= female sterilization 8= Other specify		
311	Would you say that using contraception is mainly your decision or your husband or partner decision or did you both decided together?	1= mainly respondents 2 = mainly husband or partner 3= joint decision 4= no response		
314	Time taken to travel to the source of contraceptive method?	--------write the time in minute		

PART FOUR: KNOWLAGE ABOUT CONTRACEPTIVE METHOD				
QN	Questions	Questions answer	code	
401	Have you ever heard of family planning method?	1= yes 2= no		
402	Do you know any methods that women or men can use to delay or avoid pregnancy?	1= yes 2= no		
403	If yes is it possible to obtain this method?	1= yes 2= no		
404	Which of the following contraceptive methods do you know about?	1= pills 2 =IUCD 3= inject able 4= implant or Norplant 5= condom 6= female sterilization 8= natural method Other specify		
405	Sources of information for family planning	1= health worker 2= TV 3= radio 4= news paper 5= friends 6= other specify		
406	Do you have radio and TV in your house?	1 = radio only 2= TV only 3= both radio and TV 4= none		

End of the interview

Thank you very much for you participation

Annex 2: Afan Oromo Translated version of questioner.

Gaafii gaafachuun dura hirmaattoota hayyamsiisuun waliigaltee irra ga,uu.

kabajamtoota gaafiif deebii kanaa,maqaan kiyyaa obboo/addee---------n ja,ama

Duraan dursee gaafiif deebii kaqna irraatti fedhiin akka hirmaattan kabajaan isin gaafachuun barbaada.kuniis ani yeroo ammaa barataa digrii 2ffa ogummaa fayyaatiin universitii Jimmaatti waaniin hojjachaa jiruuf qorannoo eeybaa aanaa kana irraatti gaggeeysuu barbaadeeti.Matadureen qorannoo kiyyaas,sadarkaa guutaminsi fedhii karoora maatiifi osoo hin barbaadin ulfaa,uu fi wantoota isaaniin walqabatan dubartoota umrii da,umsaa keeysa jiran irratti aanaa Daaroo Labuu keeysatti gaggeeysuufi. Mootummaan keenya,fayyaa haadholee eeguufi du,aatii da,immaanii hirrisuuf sochii ol,aanaa godhaa turera.Haata,uumalee biyyi keeny a aanaa keenya dabalatee biyyoota fayyaan haadholii gadi bu,aa ta,ee fi du,aatiin haawwanii ol,aanaa ta,e keeysaa isii tokkoodha.Kanaafuu kaayyoon gudaan qorannoo kanaatiis sababoota fedhiin karoora maatii akka hin guutamne godhan fi ulfi hin yaadamin akka uumamu godhan irraatti qorannaa gageeysuun adda baasuudha .Kanaafuuu isiniis qaama rakkoo kanaan miidhamaa jiru keeysaa tokko waan taataniif akka hirmaattan shakki hinqabu.Qoranno kana irratti hirmaachuun kan fedhii keeysan irratti hundaa,eefi asirraatti hirmaachuu keeysaniif rakkoon tokkoleen kan isinirra hingeenye ta,uu akka beeytaniin barbaada.Gaafiif deebii godhamu kanarraatti maqaan keeysan hin dhahamu, ragan isin nuuf kennitaniis icitiin qabamee qorannoo qofaaf kan ,ooluudha.Kanaafuu qorannoon kun rakkoo haawwanii akka biyyaatti jiru, keeysattuu fayyaa haawwanii eeguufi du,aatii haawwanii hirrisuu irratti bi,aa ol,aanaa waan qabuuf akkasumaas isiniis qaama rakkoo kanaan miidhamaa jiru keeysaa tokko waan taataniif barbaachisumaa qorannoo kanaa akka ,amantan mammii hin qabu.kanaafuu gaafii kiyya ittiin fufamoo niin dhaaba? Yoniif eyyee itti fifi jatte gaafiif deebiikee ittifufi.Yooniif lakkii hin hirmaadhu jatte galateeyfadhuu dhiisii bira dabri

Uunkaa ragaan dubartoota umrii da,umsaa keeysa jiran Qoranno waa,ee guutaminsa fedhii karoora maatii fi ossoo hin barbaadin ulfaa,uu ilaalchisee Naanno oromiyaaGodina H/Lixaa Anaa DaarooLabuu irratti qorannoo gaggeysuuf ragaan ittiin guuramu.

lakk 1=guutameera

lakk 2=gaafatamaan hin argamne

lakk 3=gaafatamaan deebisuuf hayyamamaamiti

001=koodii gaafataa-----/----/maqaa guutuu

003=guyyaa ragaan itti guurame-------/----/----/sa,aati----

004 =supper viysara mirkaneeyse.maqaa--------/mallattoo---/guyyaa---/ji,a----/bara-----

WAA,EE HAWAAS- DIINAGDEE ILAALCHISEE				
lak	Gaafiii	Filannoo deebii	kood ii	yaada
102	Umriin teeysan waggaa meeqa?	----------umrii waggaan haa ibsamuu		
103	Sadarkaan barnoota keeysanii hangami?	1=dubbisuuf barreysuu hindanda,u 2dubbisuuf barreysuu ni danda,a 3=elementary school(1-6) 4=Junior school(2-10) 5=sadarkaa lammaffaa(10-12) 6=sadarkaa ol,aanaa		
104	Gosti hujii idilee teeysanii maali?	1=haadha warraa/mana keeysa hojjachuu qofa 2=qotee bulaa 3=sbarattuu 4=hojjattu mootummaa 5=hojjattu guyyaa 6=daldaltuu 7=hojii hin qabdu		
105	Sabni keeysan maali?	1 = Oromo 2= Amara 3= Somale 4= orgoba 5= somale 6= kanbiroo		
106	Sadarkaan fuudhafi	1= herumte 2= hin heerumne		

	heeruma keeysanii hoomaalirra jira?	3= wal hiikan4 widowed 4= adda bahan 5= kan biroo		
107	Galiin keeysan kan ji,aa qarshii ethiopiatin yommu shalagamu hangam ta,a?	1= qarshii etoopiyaa---- nita,a 2,=deebii hin kennine		
108	Galii kee kan ji,aa ollaa kee wajjin yoo wal bira qabdee of madaalte eeysatti of ramada?	1= baayyee hiyyeeysa 2= hiyyeeysa 3= giddugaleeysa 4 =gahaadha 5= sooreeysa		
109	Baayyinni maatii keeysanii abbaa warra dabalatee meeqa?	1= dhiira-- 2= dubara--- 3= waligala---		
110	Amantiin teeysan maali?	1= Muslima 2= orthodox dha 3= protestantidha 4= catholicdha 5= kan biroo		

KUTAA LAMAFFA SEENAA HORMAATAA FI MAATII				
lakk	gaafii	Filannoo deebii	koodii	Gafi lakk---tti darbi
201	Ammaan dura heerumtee nibeeytaa?	=eyyee =lakki hin heerumnee		
202	Yoo heerumtee jirta ta,e yeroo jalqaba heerumtu umriin tee wagga meeqa nita,a?	Waggaa------- nita,a		
203	Takkaa ulfooytee nibeeytaa?	1=eyyee 2 =lakki hin ulfooyne		
204	Yooniif ulfooytee	Yeroo----- ulfaayeetin jira		

	jirta ta,e hanga ammaatti yeroo meeqa ulfooyte jirta?			
205	Yeroo ammaa ijoollee lubbuun jiran meeqa ni qabda?	Ijoollee---n qaba		
206	Yeroo daa,ima isa jalqabaa deeysu umriin tee waggaa meeqa nita,a?	Waggaa----niinta,a		
207	Yeroo ammaa silaa yeroo ijoollee takkalee hin dhalin sanittiof booda deebitee umriiteekeeysatti joollee meeqa qabaachuu barbaadda ,amee gaafatamtee meeqa ta,u ?	Ijoollee-----n barbaada		
208	Umriitee keeysatti ijoollee meeqa qabaachuu barbaada?	Ijoollee ----n qabaachuu barbaada		
209	Yeroo ammaa ulfa garaa niqabdaa?	1= eyyee 2= lakkii hinqabu 3= hinbeeku		
210	Yooniif ulfa kan garaa qabdu ta,e ulfi kun	1= itti yaadameeti 2= fuulduraaf niin barbaada garuu amma ulfaa,uu hin barbaadne ture 3= guutumaattu dhala dhaabuu waaniin barbaadeef ulfaa,u hin barbaadneen ture 4= deebii hin kennine		
213	Osoo hin barbaadin	1= hubannoo waa,ee karoora maatii qabaachuu dhabuu		

	ulfooytee jirta yoo taye sababni itti ulfa kana ofirra ittisuu dadhabdef maalifi?	2= karoora maatiin barbaade waaniin argachuu dhabeefi 3= Abbaan warraa kiyya waan naaf hayyamuu dhabeefi 5= firri abbaa warra kiyyaa waan naaf hayyamuu dhabeefi contraceptive failure 6 = niin ulfaa,a ja,ee waanii hin yaadiniifi 7= Amantiin tiyya waan naaf hin hayyamneefi 8= Aadaan tiyya waan naaf hin hayyamneefi 9= kan biroo		
215	Daa,ima irraa boodaa erga deeyse hangam takka turte?	Ji,a-----tureetiin jira		
216	Ji,oottan 12 maan dabran keeysa takkaa ulfooytee ni beeytaa?	1= eyyee ulfaaye 2= lakkii hin ulfooyne 3= deebii hin kennine		
217	Yoo niif ulfooytee jirta ta,e , ulfi sun	1= itti yaadameeti 2= osoo ittin yaadamini 3= deebii hin kennine		
218	Ulfa amma garaa qabdu kana erga deeyse booda, fuuladuraaf ulfa addaan fageeysuuf ykn ulfadhaabuuf karoora maatii niin fayyadama jattee ni yaadda? (Dubartii ulfa garaa qabduuf).	1= eyyee 2= lakkii hin fayyadamuu 3= hin murteeysine 4= hin beeku		
219	Fuula duraaf ulfa addaan fageeysuuf ykn	1= eyyee niin fayyadama 2= lakkii hin fayyadamu 3= not decided		

	ulfa dhaabuuf karoora maatii niin fayya dama jattee niyyaaddaa? [dubartii erga daa,ima irraa boodaa deeyse daraaraan baatii ykn xuriin itti hindhufiniif]	4= gin beeku		
220	Yooniif karoora maatii niin fayyadama jatee kan yaadu tahe ulfa addaan fageeysuuf moo ulfa dhaabuuf fayyadamta?	1= ulfa addaan fageeysuufi 2= ulfa dhaabuufi 3= hin murteeysine		
21	Fuula duraaf ulfa addaan fageeysuuf ykn guutumaatti ulfa dhaabuuf karoora maatii hin fayyadamu jattee kan yaaddu yoo tahe sababni ittihinfayya dmneef maaliifi?	1= hubannoo waa,ee karoora maatii waaniin hin qabneefi 2 =miidhaa isaa waaninn sodaadhheefi 3= na masheen sa ja,ee waaniin sodaadhuufi 4 = Aadaa kiyya biratti waan fudhatama hin qabneefi 5= rakkoo fayyaa waaniin qabuufi 6= gosti karoora maattin anibarbaadu waan hin argamneefi 7 =daa,ima biroo dahuu waaniin barbaadeefi 8= Abbaan warraa kiyya waan naaf hin hayyamneefi 9= Amantiin tiyya waan naaf hin hayyanmeefi 10= niin ulfaa,a ja,ee waaniin hinyaadneefi 11= kan biroo		
223	Yeroo ammaa	1= eyyee niin barbaada		

	yooniif kan ulfa garaa hinqabne ykn daa,ima irraa boodaa erga deeyse booda daraaraan baatii kansitti hindhufin tahe fuula duraaf dahuu nibarbaadda?.	2= lakkii an ammaan bood guutumaattu da,umsa dhaabuun barbaada 3= lakki an guutumaattuu da,uu hin danda,uu 4= hin murteeysine 5= hinbeeku		
224	Fuula duraaf da,uu ni barbaadda yoo tahe yeroo ammaan tanaa tana irraa kaasee hangam takka turtee da,uu barbaadda?	1=ji,a------yoo waggaa lamaa gad tahe 2= waggaa 2-3 tti 3= waggaa 3-4tti 4= waggaa 4 ol 5= hin beeku		

KUTAA SADAFFAA ITTI FAYYA DAMA KAROORA MAATII				
lakk	gaafii	Filannoo deebii	code	
301	Itti fayyadama karoora maatii ilaachisee gareekam jalatti ramadamta?	1= yeroo ammaa itti fayyadamaatiin jira 2= duraan fayya damaatiin ture hgaruu amma dhiiseetin jira 3= Takkaa fayyadamee hin beeku 4= kan biroo		
302	Yoonnif karoora maatii fyyadamtee kanturte tahe yeroo dura itti fayya dmuu eegaltu san umriin tee waggaa meeqa nitaha?	Waggaa-----nitaha		
303	Yerooo jalqaba	Ijoollee---nqaba		

	fayyadamuu eegaltu san ijoollee meeqa qabda?			
304	Yeroo san gosa karoora maatii isa kam fayyadamtee turte?	1 =pillsii dha 2= IUCD dha 3= marfeedha 4= implant yknNorplant dha 5= condomii dha 6= kan biroo		
305	Yeroosan sabaabni itti karoora maatii fayyadamuu dhaabde maaliifi?	1= miidhaa isaa waaniin sodaadheefi 2= namaseensa ja,ee waaniin sodaadheefi 3= rakkoo fayyaa waaniin qabuufi 4 = gosti karoora maatiin ani barbaadu waan hinjirreefi 5= dahuu waaniin barbaadeefi 6 = niin ulfdaa,a ja,ee waaniin hinyaadiniifi 7= Aadaan kiyya waan naaf hin hayyamneefi 8 = Amantiin tiyya waan naaf hin hayyamneefi 9 = kan biroo		
306	Fuuladuraaf karoora maatii niin fayyadama jaattee ninyaadda?	1= eyyee 2= lakkii hin fayyadamu 3= hin murteeysine 4= hin beeku		
309	Yeroo ammaa karoora maatii kan fayyadamaa jirtu yootahe maaliifi?	1 = ammaanbooda ulfa dhaabuufi 2= ulfa addaan fageeysuufi 3= hin beeku 4= kan biroo		
310	Yeroo ammaa gosa karoora maatii isa kamfayyadamaa	1= pilsii dha 2= IUCDdha 3= marfeedha		

	jirta?	4= implant ykn Norplantii dha 5= condomii dha 6= female sterilizationiidha 8= kan biroo		
311	Itti fayyadama karoora maatii irratti eenyuu tu murteeysa jatteeti yaadda?	1= irracaalaatti dubartiidha 2= irracaalaatti abbaa warraati 3= waliin wajjiin tahuudhaani 4= deebii hin kennine		
314	Iddoo karoorri maatii itti argamu dhayxee tajaajilamuuf han gam takka sittifudhata?	Daqaiiqaa------ natti fudhata		

KUTAA AFRAFFAA HUBANNOO WAA,EE KA,EEKAROORA MAATII				
lakk	gaafii	Filannoo deebii	koodii	yaada
401	Waa,ee karoora maatii takkaa dhageeysee ni beeytaa?	1= eyyee niin beeka 2= lakkii dhagayee hin beekuu		
402	Gasa karoora maatii dhiirti ykn dubartiin ulfa ittisuuf ykn ulfa addaan fageeysuuf itti fayyadaman tokkolee ni beeytaa?	1= eyyee niin beeka 2= lakkii hin beeku		
403	Yooniif nibeeyta tahe isaan kana argachuun	1= eyyee 2= lakkii hin danda,amuu		

	nidanda,amaa?			
404	Gosoota karoora maattii kanneen keeysa tokkolle ni beeyta?	1= pillsiidha 2= IUCDiidha 3= marfee 4= implant or Norplant 5= condomii 6= female sterilizationii 7= tooftaalee uumamaa 8= kan biroo		
405	Hubannoo waa,ee karoora maatii eeysaa argattu?	1= ogeeysa fayyaa irraahi 2= TV irraahi 3= radio irraahi 4= barruulee adda addaa dubbisuudhaani 5= hiryoottan kiyya irraahi 6= kan biroo		
406	Mana keeysan keeysaa radiyoo,ykn TVniqabdaa,?	1= radiyoo qafaan qaba 2= TV qofaan qaba 3 =TV fi radiyoos lamaanuu niin qaba 4= tokkolle hinqabu		

Gaafichi xumurameera hirmaanna keeysaniif galatoomaa.