

ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE OF

INTRA UTERINE DEVICE AMONG REPRODUCTIVE AGE WOMEN(15-49)

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REASEARCH PROPOSAL ON ASSESSEMENT OF KNOWELDGE,
ATTITUDE AND PRACTICE OF INTRA UTERINE
CONTRACEPTIVE DEVICE AMONG REPRODUCTIVE WOMEN
OF AGE 15-49 YEARS

TO BE SUMMITTED TO BULE HORA
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List of abbreviations

FP -Family planning

UN -United Nations

CSA -Central statistical Agency

IUD -Intra uterine contraceptive device

LAPMs - Long acting and permanent contraceptives Methods

CPR -Contraceptive Prevalence Rate

EDHS -Ethiopian Demographic Health Survey

WHO -World Health Organization

UNICEF -United Nations Children Fund BC-Before Christ Birth

CDC -Center of Communicable Disease Control

FGAE- Family Guidance Association of Ethiopia RH-Reproductive Health

MOH- Ministry of Health

UNFPA-United Nation Population Fund

TFR-Total Fertility Rate

LARC -Long acting Reversible Contraceptives

CBRH - Community Based Reproductive Health

Summary of Proposal

Background: The intrauterine device (IUD) is one of the most cost effective methods of reversible. contraception available but is not well known or understood and consequently not well used in the----- woreda. This has not always been the case, when family planning was first introduced in Ethiopia. The IUD was the most widely used method. Over the decades its use has dwindled to a point where less than one percent of women of reproductive age use it as their preferred method of contraception.

The government and non-government organizations are concerned about the rising costs of providing family planning to a growing population of need. The IUD has therefore created much interest from these parties due to its cost-effectiveness. In order to increase the use of the IUD, demand must be created. To increase demand, the reasons for the present low use must be understood.

Objectives: This proposal identifies the KAP of use of the IUD in -----woreada, by employing quantitative methodology.

Methodology: Descriptive community based cross sectional study design will be used to conduct the study.

Time schedule and budget: The research will be conducted from

Chapter one

Introduction

Family planning (FP) could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space birth, avoid unintended pregnancies and abortion and stop childbearing when they reached their desired family size (1). As of July 2008, the world's population is estimated to be just over 6.684 billion. In line with population projections, this figure continues to grow at rates that were unprecedented before the 20th century, although the rate of increase has almost halved since its peak of 2.2 percent per year, which was reached in 1963(1,2). Currently, 500 million women in the developing world are using some form of family planning, thereby preventing 187 million unintended pregnancies, 60 million unplanned births, 105 million induced abortions, 2.7 million infant deaths, 215,000 maternal deaths and 685,000 children from losing their mothers due to pregnancy related deaths each year. However, another 200 million women throughout the developing world who would like to delay or limit their births lack access to contraceptives. Providing these women with the services they need would prevent an additional 52 million unintended pregnancies and 23 million unplanned births each year. Evidence suggests that more than half of all couples in the developing world are using family planning to delay, space or limit future pregnancies, yet the need for FP keeps increasing as the number of women of reproductive age continues to grow. An estimated 137 million women worldwide have unmet need for FP, that is, they are not using any method and report that they want to avoid pregnancy (2).

In the past 40 years, family-planning programmers have played a major part in raising the prevalence of contraceptive practice from less than 10% to 60% and reducing fertility in developing countries from six to about three births per woman. However, in half of the 75 larger Version No 1, version

Date 11/06/2014 Page 12 low-income and lower-middle income countries (mainly in Africa), contraceptive practice remains low and fertility, population growth, and unmet need for family planning are high. The crosscutting contribution to the achievement of the Millennium Development Goals makes greater investment in family planning in these countries compelling (3).

Ethiopia is one of the developing countries where population issue has become a major area of concern during the last few decades. The country began family planning services through Family Guidance Association of Ethiopia, established in 1966. However, the fertility regulation efforts made so far in Ethiopia through Family Guidance Association and other organizations are minimal (4). Ethiopian Demographic and Health Survey of 2005 revealed that knowledge of contraception has remained consistently high in Ethiopia over the past five years with 88% of currently married women having heard of at least one method of contraception. However, actual contraceptive practice among women of reproductive age group remained very low (4, 5). During the last few years, studies have documented that FP service is influenced by various factors which includes demographic characteristics, psychological, knowledge and attitudinal factors and the like (4). Others are social factors such as the organization of contraceptive health care, the quality of the information given by professionals and the influence of the mass media, which all play significant role in contraceptive (4,6,7). The contraceptive prevalence rate for married Ethiopian women is 29 %. Almost all of these users are using modern methods. The most widely used method is injectable (21%). But the prevalence of long acting and permanent method is very low and it accounts; female sterilization 0.2%, intrauterine devices IUD 0.4%, Implants 2.0% among all women (5). Version No 1, version Date 11/06/2014 Page 13

Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices,

including long-acting and permanent methods (LAPMs) these are: IUDs, implants, female sterilization, and vasectomy. LAPMs are convenient for users and effectively prevent pregnancy. They are also cost effective for programs over time, can result in substantial cost savings for governments, and contribute directly to reaching national and international health goals. Despite these advantages, LAPMs remain a relatively small, and sometimes missing, component of many national reproductive health and family planning programs.(4) and the fact that FP services are made accessible nearly at all major urban areas in Ethiopia (including the study area, and in most instances at lower or no cost, the decision that lead women to use the services seems to occur within the context of their marriage, household and family setting. It is thus important to examine the extent to which women are making use of the services and answer why large majority of women do not use the services especially the IUCD. The present study therefore aims at examining both the level and factors affecting the utilization of IUD contraceptive methods in one of the fast growing town of Ethiopia,

1.1. Statement of the problem

Population growth is a major concern in developing countries in view of its impact on broader socio-economic development. In Sub-Saharan Africa, including Ethiopia continued high fertility levels, along with declining mortality rates, have resulted in a wide gap between birth and death rates, and subsequently in high annual population growth rate. Factors contributing to high fertility include low socio-economic development, deeply ingrained cultural values for large family size, and low levels of contraception (8). Version No 1, version Date 11/06/2014 Page 14

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 (8). Fortunately, the vast majority of maternal and newborn

deaths can be prevented with proven interventions to ensure that every pregnancy is wanted using modern contraceptive and every birth is safe (6). Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices, including long acting and permanent contraceptive methods (LAPMs). Despite of these advantages, LAPMs are given in few areas and sometimes are missing component of many national reproductive health and family planning programs. More than 350 million couples worldwide have limited or no access to effective and affordable FP, especially to LAPMs (4). Thirteen percent of the world's married women use the Intrauterine Contraceptive Device (IUCD) as their method of contraception (9, 10). In developing countries, 20 to 30% of women who use oral contraceptives or injectable stop within two years of starting because of side effects or other health concerns. Many of these women could benefit from switching to LAPMs (11). In Sub-Saharan Africa a quarter of women and couples have unmet needs for contraception (6, 8). 14% used modern contraceptives and most births in the region are still spaced closer than two years (9).

Ethiopia is the second most populous nation in Africa. Its population has increased nearly seven times from 11.8 million at the beginning of the 20th century to about 80 million today (4). The total fertility rate of Ethiopia is 4.8 children per women, population growth rate is estimated at 2.7% per year, contraceptive prevalence rate (CPR) is only 15% and an unmet need for family

planning is 34 percent. Implants and female sterilization are the least used methods of modern contraceptive each accounting only for 0.2 %.(9). The prevalence of LAPMs use in OROMIA region is rather very as low as IUCD 4.12%(10). The overall the percentage of women who are currently using any method of contraceptive for OROMIA region is --- % (9). A number of factors could contribute to the lack of availability and access to LAPMs. Evidences in other countries and within Ethiopia showed that many factors

including fertility related reason, opposition to use, lack of knowledge, method related reason could act as barriers to LAMPs use (10). Health personnel may not provide LAMPs to clients because of unnecessary or outdated restrictions, such as age or the number of children a woman has (3). Myths and misconceptions are also widespread for these methods (9). There is no study that documented KAP IUCD of women in OROMIA region, ----- town. This study will assess (IUCD) contraceptive methods among married women of reproductive age (15-49 years) in -----woreda, Southern Region, Ethiopia

Rationale and Significance of the Study

Contraceptive use has increased worldwide over the last decade. Yet, Africa—like many other regions of the developing world—continues to have a high unmet need for family planning. Approximately 25 percent of women

and couples in sub-Saharan Africa who want to space or limit their births are not using any form of contraception. More than half of the people in Africa are younger than 25 years old, so unmet need is only expected to increase as these individuals enter their reproductive years. Over time, the use of IUD has not kept pace with that of short-acting methods, such as oral contraceptives and injectable. Data from demographic and health surveys from four sub-Saharan countries show that the proportion of women currently using IUD is significantly lower than the proportion using short-acting methods. In many countries in the region, including Ethiopia, fewer than 5 percent of women who are using contraception are using IUD. Thus there is a need to assess KAP for IUD in diverse developing country setting including Ethiopia. The findings or results obtained from this research can be useful in many ways. Governmental and non-governmental organizations will take intervention measures and set appropriate plans to reduce and improve the existing level of awareness and practice IUD contraceptives by identifying and taking measurement on factors which influences the utilization of IUCD. And it helps individuals (women and men) to have enough knowledge about the practice of IUD. It is hoped that this study will contribute to the improvement of family planning services in the ----- through assessing and identifying KAP of IUD.

Chapter two

Literature Review

2..1 Overview of Family Planning

According WHO, family planning is defined as birth spacing, preventing unwanted pregnancies or secure wanted pregnancy (6) . Family planning is adopted voluntarily through the practice of contraception or other methods of birth control on the basis of knowledge, attitude and responsible decision by individuals and couples, in order to promote the health welfare of the family and contribute to the social and economic development of the country (6, 10). Family planning has been identified by the World Health Organization (WHO) as one of the six essential health interventions needed to achieve safe motherhood and by United Nations Children Fund (UNICEF) as one of seven strategies for child survival. Both women and men's use of contraception have been going on for centuries. Traditional methods such as coitus interrupts is described in Bible, periodic abstinence was used in ancient India and the precursor to the condom was used by the Egyptians back in 1350 BC (6). The practices of modern contraceptive methods offer many advantages in health and economy of the couple and the country. The primary aim of family planning enables women and men to plan their families and space their children through the use of modern contraceptives (1,2,9).

Raising a child requires significant amounts of resources: time, social, financial, and environmental. "Family planning benefits the health and well-being of women and families throughout the world. Most of the countries with lowest rates of contraceptive use, highest maternal, infant, and child mortality rates, and highest fertility rates are in Africa. Only about

30% of all women use birth control, although over half of all African women would like to use birth control if it was available. China's one-child policy forces couples to have no more than one child Version No 1, version Date 11/06/2014 Page 18

. Beginning in 1979, the policy was instated to control the rapid population growth that was occurring in the nation at that time. (9)

2.2 Situation of family planning in the world

The era of modern contraception began in 1960s, when both the birth control pill and intrauterine contraceptive device (IUCD) became available. These effective and convenient contraceptive methods resulted in widespread changes in birth, fertility and demography in the United States. Between 1800 and 1900, the family size in the United States declined from 7.0 to 3.5 children, and by 1933, the average family size had declined to 2.3 children. Since 1972, the average family size had leveled off at approximately two children, with increasing safety, efficacy, diversity, accessibility and use of contraceptive methods. Between 1990 and 1994, the global average contraceptive use by married women of reproductive age rose from 57% to 60% (13). Even in developed countries, the situation is far from ideal and policies and provision of services vary considerably within each country. Unwanted side effects, inconvenience of the chosen method, and media scares about safety of modern contraceptives are some of the issues that limit their acceptability. Poor contraceptive use is further compounded by ignorance among users and providers of wide range of methods available now and likely to be so in the future. Giving women reproductive autonomy through comprehensive and up-to date information about all methods is vital for successful and long-term use of contraception

(empowering the women and availing information and services where they can get easily help women's to use LAMPs). (14, 15).

2.3 Family planning in Ethiopia

Modern FP services in Ethiopia were pioneered by the Family Guidance Association of Ethiopia (FGAE), which was established in 1966. FGAE's first FP services were provided from a single-room clinic run by one nurse. FGAE's programmatic activities and services gradually spread all over the country, with a network of eight branches, 18 clinics, 26 youth centers, 740 community-based reproductive health (RH) service outlets, 242 outreach sites, six marketplace sites, and eight workplace sites. The ministry of health (MOH) also began to enhance the effort through provision of maternal and child health (MCH) and FP services in health facilities.

Since 1980, the MOH further expanded its FP services through cyclic country support programs by the United Nations Population Fund (UNFPA) and other stakeholders (16). Knowledge of FP has increased to 87% among currently married women. However, FP use is still lagging, at 13.9% in 2005—though a recent survey with representative samples from Ethiopia's four most populous regions demonstrated the CPR to have reached 32% there (17). Knowledge about FP and about HIV is higher among men than among women. Knowledge among all women about any method of contraception is 86.1%, compared with 91% among all men. The average number of contraceptive methods known is 2.7 among women, compared with 3.6 among men. Yet women bear most of the burden of using FP methods: Male-dependent or male-dominated contraceptive methods account only for 1.1% among the 13.9% CPR. This is despite better knowledge about male-dependent methods than about female-dependent methods (7). Early marriage is common in Ethiopia. Women aged 15–49 years constitute 23.4% of the total population. Among women aged 25–29 at

the time of the 2005 survey, 61.7% had been married by 18 years of age .
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In addition, 12.7% of 15–19-year-olds were already married by age 15. (This is despite the fact that the legal age at marriage in Ethiopia is 18 years.) Among adolescents aged 15–19, 20.4% had had a live birth by age 18. Nearly half (46.1%) of women aged 20–24 in 2005 had given birth before they were 20 years old (7). The total fertility rate (TFR) in Ethiopia is 4.8 lifetime births per woman (EDHS 2011). The contraceptive acceptance rate is 56.2%. The contraceptive prevalence rate (CPR) among married women is 13.9% in 2005 and 32% in 2008 (Central Statistical Agency [Ethiopia] and ORC Macro, 2006; Health and Health related indicators 2008/2009, FMOH, L10K study). Maternal deaths accounted for 21% of all deaths among women aged 15–49 in 2005 (9).

2.4 Trends in TFR and CPR in Ethiopia

Ethiopia has set its own goals for population, which is articulated in the population policy and HSDPIV as a TFR of 4.0 and a CPR of 65% by 2015. The population size has increased by five and one-half times in a little over a century, from 11.5 million in 1900 to 74 million in 2007. The demographic transitions in Ethiopia are characterized by an initial slow growth at a rate of less than 1.5% per annum until the 1940s, followed by acceleration between 1955 and 1995 up to 3%, after which the annual growth rate declined slowly to the current level of 2.6%. The population doubling time currently is estimated to be 23 years (9).

The increase in population size is mainly the result of two very important demographic events: the gradual decline in the crude death rate over the last four decades, from around 30 per 1,000 to about 15 per 1,000; and the maintenance of the crude birth rate at between 40 and 50 births per 1,000 from 1960 to 2000. The country's TFR increased over three decades, from about six lifetime births per woman to 7.7 in the 1990s, after

which it gradually declined to 4.8 by 2011 (Central Statistical Agency [Ethiopia] and ORC Macro, 2006). Version No 1, version Date 11/06/2014
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Although the urban TFR started declining as early as 1984 and was half of the rural TFR by 2000, the decline in rural TFR has not only lagged behind but has also been small, having dropped by only one birth in a decade. Another problem is that couples in Ethiopia rely more on short-term methods of contraception than on long-acting and permanent methods (12,15).

2.5 Use of LAPMs

Long-acting reversible contraceptives (LARCs) are novel medical devices that are highly effective at preventing unintended pregnancy over long periods of time, but are easily reversible, allowing for pregnancy later in life. These methods function to eliminate the effect of user error on contraceptive failure rates – they can claim virtually no distinction between perfect and typical use failure rates. In a 2012 study, Winner and colleagues (2012) enrolled a prospective cohort of 7,486 women in a 3 year study where participants were provided their choice of hormonal contraception at no cost. Contraceptive failure rates were found to be much higher among those using the patch, pill, and ring compared with LARC methods even after adjusting, for age, education, and pregnancy history (13).

The 2002 Maternal and Child Health Survey in Guatemala showed that 43% of married women in fertile age use a contraceptive method, 34% of which use a modern method. Among these users, the most popular methods are female sterilization (17.8%), injectable (9.0%), oral contraceptives (3.4%), and condoms (2.3%). Only 1.9% of women living in union use IUDs, a smaller figure than that recorded in 1999 (2.2%) and in 1995 (2.8%). More women in urban areas (3.4%) use IUDs compared to women in rural areas (0.9%); more non-indigenous use IUDs (2.4%) than indigenous women

(0.4%). Therefore, a population group that has greater access to services and a comparatively higher socioeconomic level uses the IUD (12).

In Ethiopia in areas where strong donor supported family planning programs were carried out through CBRH programs, use of LAPMs is much higher than the national one (8) A study done on prevalence and factors affecting use of LAPMs in 2008, in Jinka, SNNPR, Ethiopia showed the prevalence of contraceptive among participants was about 39.5%. Of these LAPMs contributes for 7.3%. Implant is the most widely used method from LAPMs contributing to almost half (50%) of the LAPMs users. There was very low (18%) knowledge of LAPMs in Jinka town. Among LAPMs, Implant is known by most (76.1%), and the least known is male sterilization (17.4%). A considerable proportion, (63.5%) of participants had intentions to use LAPMs in the future (13).

4.5.1.1. Perceived Cost

LAPMs are cost-effective for programs over time. When compared with the use of other methods, use of LAPMs results in fewer unintended pregnancies and fewer clinic visits. This eases the burden on already overextended health systems and providers. If used for at least three years, the IUD, vasectomy, and implants are considered the three most cost-effective methods when all direct medical costs associated with the methods, side effects, and unintended pregnancies are taken into account, but most clients consider the first time cost of methods which is technically greater than any other methods. In this regard client may not tend to realize the overall cost, so that they will not use those methods (15).

4.5.1.2. Educational status

Women with secondary or higher education and urban women show higher demand for and use of contraception than their less educated or

rural counterparts, and they are nearing the replacement-level of fertility (TFR of 2.2-2.4). Women in Addis Ababa have a TFR of 1.4, markedly below replacement-level fertility and more in common with Italy or Singapore. Only 10 percent of women with no education use contraception, though it is used by 53 percent of women with secondary education (7). Unmet contraceptive need is 35 percent for women without education, while only 17 percent of women with secondary or higher education have unmet need. (11) In addition, the study done in Guatemala showed that more women with high school or higher education (5.2%) use IUDs than women with elementary education (1.4%) or without formal schooling (0.4%)

4.5.1.3. Myths and misconceptions

A study done on LAPMs in Uganda showed that poor knowledge about the effect of the use of long-term methods on fertility as well as poor understanding of the procedures, particularly for vasectomy, have led to the fuelling of myths and beliefs that hinder the successful promotion and adoption of the services. Myths and beliefs like: - Vasectomy involves removal of the testicles and that it thus renders a man unable to achieve an erection, man who has undergone vasectomy would also be unable to ejaculate and so would suffer weight gain, possibly shrinking of the penis and loss of interest in sex. Norplant and tubal ligation causes weakness, weight gain, possibly loss of menstrual cycle, vaginal dryness (loss of sexual fluids) and loss of interest in sex (16).

4.5.1.4. Partner influence and Age

Perceived spousal support for contraception and support through discussion about family planning have been found to be factors affecting the use of family planning services. The retrospective study on vasectomy users in Uganda found that in only about one half of the cases (44.4%) the decision to opt for vasectomy had been shared by both partners (17). Studies on family planning in developing countries have long focused on

women as the subject of interest. Very little work in this area has focused on men. It is now increasingly recognized that the actions required achieving improvements in reproductive health outcomes in general and maternal health in particular should also encourage men's active participation (11). The biological and social interdependence between husbands and wives in their plan for the family and practice of contraception makes the importance of including men in this area of research (11, 19, and 20)

Chapter 5. Objective of the study

5.1. General objectives

To assess KAP among women of age group 15-49 years at -----woreda West Guji Zone, Ethiopia.

5.2. Specific objectives

- To describe socio demographic factors
- To assess knowledge towards IUD,
- To assess practice towards IUD
- To assess attitude toward IUD

Chapter 6. Method and Materials

6.1. Study Area and Period

----- is one of the 12 Woredas in the OROMIA Region of Ethiopia. It is located ---- Kms West of the capital Addis Ababa. The woreda has an estimated total population of ----- of whom ----- are men and -----are

women. The Health system is represented by ----- hospital, ----- health centers and ----- governmental health posts. In addition, there are higher and lower clinics owned by private sectors. The woreda has technical & vocational school, ---- preparatory and ---- high schools, and there are other private owned colleges. The data will be collected from ----month to ---- month, 2016.

6.2. Study design

A descriptive cross-sectional community-based study will be conducted at -----woreda of West Guji zone, OROMIA Region, and south of Ethiopia

. 6.3. Source and study population

6.3.1 Source population

For quantitative study: - The source population will all women in the age group of 15-49 years, who resides in the woreda at the time of study.

.

6.3.2. Study population

All sampled women in the age group 15-49 years, will be selected for the study in the study area.

Inclusion criteria: - All women aged 15-49 years' old who reside in the woreda at least for two months.

Exclusion criteria: - All married women of aged below 15 or above 49 years women - When two or more women are encountered in one household, Only one woman will be considered in the study on random to avoid intra-class correlation.

4.5. Sample size and Sampling procedure:

4.5.1 Sample size

The sample size for this particular study will be calculated using formula for a single population proportion considering the following assumptions.

Assumptions: 95% confidence level, margin of error (0.05), ($p = 0.5$) will substituted in the following single population proportion formula. $n = \frac{(Z_{\alpha/2})^2 p(1-p)}{d^2}$

Where: n = required sample sizes

$Z_{\alpha/2}$ = critical value for normal distribution at 95% confidence Level which equals to 1.96 (z value at $\alpha = 0.05$)

P = Prevalence of women of reproductive age 15-49 using LPM

d = an absolute precision (margin of error 5%).

None response rate 10%

$$\frac{(Z_{\alpha/2})^2 p(1-p)}{d^2} = \frac{(1.96)^2 * 0.5(1-0.5)}{0.05^2} = 384.16 \sim 384$$

The formula yields $n = 384$ when we add none response it will be 422 this the final sample size

$$10\% * 384 / 100 + 384 = \underline{422}$$

4.4.2. Sampling procedure

The required sample size of 422 will be selected from the list of ----- households (Get the number by the formula, House hold = Total population / 4.5% for south region) by simple random sampling technique.

A total of 2 kebeles will be randomly selected by lottery method. From each kebele ---households will be required as the study subject. Assuming that the kebeles have uniform number of households, and each Kebele will be organized into --- equal sub-units called Gots or Ketenas. And from each

Gots or ketena --- households would be selected until the total required sample size obtained by using systematic random sampling. After the first household is selected, we will proceed in every $k=N/n$ households (random walk method). All 15-49years old, women in the selected households will be studied.

4.6. Data collection

A semi-structured, pre-tested, and standardized questionnaire will be used for data collection. The instrument first prepared in English, translated to Amharic and back to English again to check validity. Four data collectors and two supervisors will be assigned. One-day intensive training will be given to the data collectors and supervisors before the pre-test undertaken.

The interviewers will be the same gender of the respondents in order to decrease embarrassment.

4.7. Data management and quality control measures

The instrument will be derived from standard data collection tools prepared by EDHS &WHO. Before the actual data collection, the questionnaire will be pre-tested on 5% (---- women) in ---kebele which is ---- km far from study area and found on ---- from the woreda . Based on the pre-test, the time needed to complete interview and the number of data collectors in need is estimated. The principal investigator will train 4 clinical nurse students as data collectors and 2 urban health extension workers as supervisors for two consecutive days on objective, data collection tools and interview techniques. The interview will be conducted in a place where the Woman feels free to express her feelings and ideas. After analyzing the pre-test result, necessary modifications are made accordingly before using it in the actual survey. Principal investigator will closely follow the day-to-day data collection process and ensure completeness and consistency of the collected questionnaire daily.

6.8. Study variables

6.8.1 Dependent variables

KAP

6.8.2. Independent variables

- Age
- Religion
- Education
- Ethnicity
- Marital status
- Incomes
- Family size
- Knowledge about IUCD
- Attitudes about IUCD
- Practice about IUCD
- Parity
- Side effects of IUCDS

6.9. Operational Definitions

Contraceptive utilization: - The utilization of family plans method to regulate the number and spacing of children in a family through the practice of contraceptive or other method of birth control.

Knowledge of contraception methods: a woman aware of IUCD

A Pap smear is a test to detect abnormal cancer cells in the mouth of the womb that may lead to cancer. When performing this test, the doctor or nurse places an instrument called a speculum (spoon) in the woman's vagina so that he/she can see the mouth of the womb and the test is done.

Contraceptives Residents of kebele: Those who lived in the selected kebeles for more than six month

6.10. Data Entry and Analysis

quantitative data will be cleaned, coded, and analyzed using manually. Descriptive analysis will take place

6.11. Ethical clearance

It will be obtained from the Ethical committee of the Department of Midwifery, College of Health Sciences. Officials at different levels including the study woreda and administrative office and selected Kebele's will be communicated through formal letters by the School of health science Department of Midwifery, WSU. Participants will be informed about the purpose and objective of the study. They will also be told that they have every right to discontinue or refuse to participate in the study and verbal consent will be obtained from each study participant. Confidentiality of the information will be assured and privacy will be maintained.

6.12. Dissemination of results

The final report will be presented as partial fulfillment of degree of Midwifery, WSU and the results of this study will be communicated to the community of the study woreda administration, and to relevant NGOs working on family planning. It will also be accessed to interested researchers and academicians through the department of Midwifery, College of Health Sciences and Medicine. Health managers and policy makers at Zonal, Regional level will gain from the input of this study.

6.13. Measurement

women's knowledge will be measured by the total number of correct answers to 10 items on knowledge with a minimum score of 0 and maximum of 10. To measure the knowledge it will be categorized based on the percent of knowledge of the distinct characteristics of IUCD as:—high—those who knew 80% and above, —moderate—those who know 60 - 79% and —low—those who knew less than 60%. Items on attitude of women about the use of IUCD will be grouped in to three as follows:—strongly agrees/agree—were labeled as—agree—and—strongly dis-agree/disagree—as—disagree, while —not sure—was categorized as it is. To measure the attitude of the women two categories will be assigned: Positive Attitude -those who scored above the mean on attitude items and —Negative Attitude—those who scored the mean or below mean to attitude items.

For analyzing the attitude, women to the use of IUCD will be grouped into three—strongly agrees—and —agree—will be grouped together as—agree, —strongly dis-agree— and—disagree— will be grouped together as—disagree—while not sure is categorized as it is. To measure the attitude of the married women, two categories will be assigned: Positive Attitude - those who scores above mean to the correct answers from attitude measuring IUCD questions. Negative Attitude - those who score mean and below mean to the correct answers from attitude measuring IUCD questions.

[illegible]

8	Data analysis										
9	Preparation and submission of first draft										
10	Second draft submission										
11	Preparation of final report										
12	Thesis defense										

Chapter 7. Work Plan and Budget

7.1. WORK PLAN

Table 1 work plan for assessing KAP of IUD among reproductive age group of women from December to Jun 2008 E.C at x worded, wolaita zone, SNNPR, Ethiopia.

7.2. Budget Break down

Table 2 Estimated cost of supplies ,Personnel, Transportation and Communication for assessing KAP of IUCD of ---- woreda from ---month to ---month,2016

S.No.	Description	No. of participants	Qualification	No. of days	Unit cost in Birr	Total cost in Birr
I	Training					
1	Data collectors	8	Twelve grade complete	2	50	800
2	Supervisors	2	B.Sc. Midwife and health officer	2	80	320
	Sub total					1120
II	Pretest					

1	Data collectors	8	Twelve grade complete	1	50	400
2	Supervisors	2	B.Sc. midwives nurse and Health Officers	1	80	160
3	Sub total					560
III	Data collection					
1	Data collectors	8	Twelve grade complete	30	50	1200 0
2	Supervisors both for qualitative and quantitative	2	B.Sc. midwife nurse and Health officers	8	80	1280
3	Payment for tape recorder with tape rent	1		2	100	200
4	Subtotal					1348 0
	Grand total					1516 0

Table 3. Cost of supplies

S.N o.	Item	Unit	Quantity	Unit price in Eth. birr	Total price in Eth. Birr
1	Pencil	piece	20	1	20
2	Pen	piece	15	5	75
3	Note book	each	12	10	120

4	Photo copy for questionnaire, Proposal and final Research paper	page	2930	.50	1465
5	Proposal and final Research paper print	page	540	1	540
	Total				2220

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ANNEX

English version questionnaire

Interviewer instructions

Write the participant's study identification number on the top right corner of

Each page of the interview – either before you start or after you complete

The interview. This is important in the event that pages become detached.

Please write the participant's name in clear block capital letters. If the

Participant has a folder, please be sure to place a sticker in the “participant

Sticker” box. If they only have their clinic card, please write down the

Folder number.

Item Answer Key

A.Participant Phone Number_____

B. Participant Sticker (Folder Number)

Folder Number

C. Study ID Number ____ _

E. Enrolment Site_____

F Date

____ / ____ / ____

Day Month Year

G. Interviewer

Surname Name

H Interviewer: Does the participant meet the study eligibility criteria?

0 = No

1 = Yes

I Interviewer: Has the participant completed the informed consent process?

0 = No 1=yes

English questionnaire on IUCD reversible contraceptive method and its associated factors among reproductive aged women. Kebele
 ----- Interviewer No. ----- Interviewee No.
 -----Woreda/Town----- Date of interview-----

Code	Questions	Possible responses	Skip
01	How old are you? Age at interview in completed year	1. 15-24 2. 25-34 3. 35-44 4. I don't remember	
02	What is your marital status?	1. Single 2. Married 3. Widowed 4. Divorced 5. Separated 6. Cohabiting 99. Others _____	
03	What is your religion?	1. Orthodox 2. Muslim 3. Protestant 99. Others _____	
04	What is your ethnicity?	1. Amhara 2. Oromo 3. Gurage 4. Tigre 5. Woliata 99. Others _____	
05	What is the level of school you have completed?	1. No education 2. Elementary (1-8) 3. Secondary (9-12) 4. Diploma (level I-V) 5. Higher education (BSC and above)	
06	What is your occupation? 1. Government employee 2. Self employee 3. Merchant 4. Handcraft makers 5. Housewife 6. Daily laborer	1. Government employee 2. Self employee 3. Merchant 4. Handcraft makers 5. Housewife 6. Daily laborer	

Code	Questions	Possible responses	Skip
07	Have you ever been tested for HIV?	0 = No 1 = Yes - 9 = Refused	If the answer is No or Refused SKIP to Question 08
08	What is your HIV status?	0 = Negative 1 = Positive 2 = Don't know -9 = Refused	If the answer is Negative or Don't know or

Sexual activity and Contraceptive History

Code	questions	Possible answer	skip
13	How old were you when you first had sexual (vaginal) intercourse?	1.less than 15 2. 15-24 3. 25-34 4. 35-44 5. I do not remember	
14	How many sexual partners have you had in the past year?	0 = 0 1 = 2 3. =3 4 more than three	
15	. Are you currently in a sexual relationship?	0 = No 1 = Yes -9 = Refused	: If the answer is No SKIP to Question 16
16	Are you currently in a sexual relationship? Interviewer:	0 = No 1 = Yes -9 = Refused	If the answer is No SKIP to Question 17

17	. How would you describe this relationship? READ CHOICES	1 = Married 2 = Not married, living together 3 Girlfriend/ boyfriend (not living together) 4 = Other specify -----		
-----------	---	---	--	--

18	Does your partner or husband have more, less or the same amount of education that you do?	1 = Less 2 = More 3 = Same 4 = Don't know		
19	Have you ever used a contraceptive method?	0 = No 1 = Yes	If the answer is No SKIP to Question 20	
20	What contraceptive method(s) have you used?	a. Oral contraceptive pill b. 2-month injectable c. 3-month injectable d. IUD/loop e. Male sterilization f. Female condom g. Male condom h. Diaphragm.		

		Other method - specify: 		
21	Have you used a contraceptive method in the past 12 months?	0 = No 1 = Yes	If the answer is No SKIP to Question 22	
22	It is my own behavior which determines when or if I become pregnant. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree		
23	Often I feel that no matter what I do, if I am going to become pregnant, I will become pregnant. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree		

		6 = Strongly agree		
24	It seems that whether or not I become pregnant is greatly influenced by chance. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree		
25	I am in control of whether or not I become pregnant. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree		
26	If I become pregnant accidentally, it is my	1 = Strongly disagree 2 = Moderately		

	own fault. [READ CHOICES AND SHOW CARD]	disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree	
27	When it comes to whether or not I become pregnant, I just have to let nature run its course. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree	
28	Whether or not I become pregnant is largely a matter of good fortune. [READ CHOICES AND show Whether or not I become pregnant depends on if I use	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree 1 = Strongly	

	contraception. [READ CHOICES AND SHOW CARD]	disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree	
30	If I take contraception, I can avoid becoming pregnant. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree	
31	Even if I take contraception, it's easy to become pregnant. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately	

		agree 6 = Strongly agree	
32	If it's meant to be, I will become pregnant. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree	
33	If I take contraception, I can prevent pregnancy. [READ CHOICES AND SHOW CARD]	1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Slightly agree 5 = Moderately agree 6 = Strongly agree	

Contraceptive Preferences

code	question	Possible answer	skip
34	The following characteristics of a contraceptive are a. Effective at preventing pregnancy [READ CHOICES AND SHOW CARD]	1 = Not important 2 = Somewhat important 3= Very important	
35	. Effective at preventing HIV/STIs [READ CHOICES AND SHOW CARD]	1 = Not important 2 = Somewhat important 3= Very important	
36	Undetectable by male partner	1 = Not important 2 =	

	[READ CHOICES AND SHOW CARD	Somewhat important 3= Very important	
37	. Not necessary to remember daily or with sexual activity [READ CHOICES AND SHOW CARD]	1 = Not important 2 = Somewhat important 3= Very important	
38	Lasts for a long time without requiring a medical visit [READ CHOICES AND SHOW CARD]	1 = Not important 2 = Somewhat important 3= Very important	
39	Does not require a medical provider to receive [READ	1 = Not important 2 = Somewhat important	

	CHOICES AND SHOW CARD]	3= Very important	
40	. Does not cause mood changes [READ CHOICES AND SHOW CARD	1 = Not important 2 = Somewhat important 3= Very important	

Knowledge statements

Code	question	Possible answer	skip
41	. IUCD can prevent pregnancies for more than 10 years	1. Yes 2 . No 3. Not sure	
42	. IUCD is not appropriate for female at high risk of getting STIs	1. Yes 2. No 3. Not sure	
43	. IUCD has no interference with	1. Yes 2. No	

	sexual intercourse or desire	3. Not sure	
44	. IUCD is immediately reversible (become pregnant quickly when removed)	1. Yes 2. No 3. Not sure	
45	. IUCD cannot cause cancer	1. Yes 2. No 3. Not sure	

A. Participant attitude toward the IUCD

Code	question	Possible answer	skip
46	. Is the IUD/loop a method you would ever consider using?	0 = No 1 = Yes 2= Maybe	
47	. Do you know anyone who uses or has used an IUD/loop?	0 = No 1 = Yes	If the answer is No SKIP to Question 48
48	Who do you know that has used or uses an IUD?	a. Sister b. Friend c. Aunt d. Mother	

		e. specify _____ —	
49	50 Has a medical provider ever discussed or offered an IUD to you? If the answer is No	0 = No 1 = Yes	If the answer is No SKIP to Question 50
50	Which type of provider? READ CHOICES AND CIRCLE ALL THAT APPLY	1 = Sister/Nurse 2 = Doctor 3 = Other Specify: _____	
51	If you could, would you be interested in receiving an IUD today?	0 = No 1 = Yes 2 = Maybe	

Practice/IUD uptake - Follow Up Measures

Code	question	Possible answer	skip
52	Did the participant go to Family Planning to make an appointment for IUD insertion?	0 = No 1 = Yes	
53	Did the participant get the IUD inserted?	0 = No 1 = Yes /___-___-___/___-___-___ Day/ month /year	
54	Did the participant go to Family Planning to get information about the IUD or other contraception?	0 = No 1 = Yes ___ ___ /___ ___ /___ ___ Day/ Month/ Year	

This is the end of the questionnaire. Again, I want to thank you for taking the time to complete this interview

.

Amaharic Version questionnaire

የአማርኛ መጠየቅ

ቀበሌ----- የጠያቂው የኮድ ቁ.----- የተጠያቂው የኮድ
ቁ-----

ወረዳ/ ክ/ከተማ ----- የመጠየቅ ቀን-----

ክፍሌ አንድ:- ማህበራዊና ኢኮኖሚያዊ ሁኔታ መጠየቅ

ኮድ	ጥያቄዎች	ጥያቄው መልስ ለሆነ የሚችው	ወ ቀጣይ እ
01	. እድሜዎ ስንት ነው? የመጠየቁ በተደረገበት ጊዜ	1. 15 - 24 2. 25- 34 3. 35- 44 4. አላስታውሰውም	
02	. የጋብቻ ሁኔታዎ ምንድን ነው?	1. ያላገባች 2. ያገባች 3. የሞተባት 4. የተፋታች 5. የተለያየች 6. አብሮ መኖር 7 ሌሎች _____	
03	.የምን ሀይማኖት ተከታይ ናት?	1. ኦርቶዶክስ 2. መስሊም 3. ፕሮቴስታንት 4. ሌሎች _____	
04	ብሔርዎ ምንድን ነው?	1. ወላይታ 2. አማራ 3. ኦሮሞ 4. ጉራጌ 5. ጋሞ 6. ጎፋ	

		7. ሌሎች _____	
05	05 የትምህርት ደረጃዎ ስንት ነው?	1. ማንበብና መጻፍ የማትችል 2. ያልተማረች 3. አንደኛ ደረጃ ያጠናቀቀች (1-8) 4 .ሁለተኛ ደረጃ ያጠናቀቀች(8-12. 5.ሰርተፍኬት እና ድፕልማ (ደረጃ 1-5) 6. ድግረና ከዚያ በላይ	
06	ስራዎ ምንድን ነው?	1. የመንግስት 2. የግል ድርጅት 3. ነጋዴ 4. እዴጥበብ ሰራተኛ 5. የቤት እመቤት 6. የቀን ሰራተኛ	

ክፍል ሁለት :- የሰነተዋልዶታሪክ በተመለከተ

ኮዴ	ጥያቄዎች	ጥያቄው መሌስ ሉሆን የሚችው	
07	01 መጀመሪያ ባል ስታገቢ ዕድሜሽ ስንት ነበር? 1..... 2 . አላስታውሰውም	1..... 2 . አላስታውሰውም	
08	ሌጅ ወልደሽ ታውቂያለሽ?	1. አዎ ወልጄ አውቃለው 2. አይ ወልጄ አላውቅም	
09	መልስሽ አዎ ከሆነ ፩	1. <20	

	የመጀመሪያ ልጅሽን ስትወልጄ እድሜሽ ስንት ነበር ?	2. ≥ 20 3. አላስታውሰውም	
10	ስንት ልጅ ወልደዋል?	1. 1-2 2. 3-4 3. >4	
11	አስወርደሽ ታውቂያለሽ?	1. አዎ 2. አይ	

ክፍል ሦስት፡-ስለ ዘመናዊ ወለድ መቆጣጠሪያ እና ረጅም ጊዜ የሚያገልግሉ ወለድ መከልከያ ዘዴዎች የተሳተፈው የመረጃ ምንጭ

ኮዴ	ጥያቄዎች	ጥያቄው መሌስ ሉሆን የሚችው	ወ ቀጣይ እ
12	ስለ ዘመናዊ ወለድ መቆጣጠሪያ ስምተው ያውቃሉ?	1. አዎ 2. አላውቅም	
13	02 መልስዎ አዎ ከሆነ የትኛውን የወለድ መቆጣጠሪያ ያውቃሉ ከተጠቀሱት ዉስጥ ያስታውሱትን ያክብቡ?(ከአንድ መልስ በላይ መስጠት ይችላሉ)	1. ፒልስ(የሚዋጥ እንክብል) 2. መርፌ 3. ክንድ ላይ የሚቀበር 4. (ሉፕ)በማዕጸን የሚቀመጥ 5. ኮንዶም 6. አላውቅም	
14	. ስለዘመናዊ የወለድ መቆጣጠሪያ መረጃ ከየት አገኙ?	1. ከጎረቤት/ዘመድ 2. ከባለቤትዎ 3. ከጤና ባለሙያ 4. ከብዙአን መገናኛ 5. ሌሎች _____	

15	ስለ ረጅም ጊዜ የሚያገለግሉ ወለድ መከላከያ ዘዴዎች ስምተው ያውቃሉ?	1. አዎ 2. አላውቅም	
16	ባለፉት 12 ወራት ውስጥ ስለ ረጅም ጊዜ የወለድ መከላከያ ዘዴዎች መልዕክት ደርሶዎታል?	1. አዎ 2. አይደለም	
17	መልሶት አዎ ከሆነ የትኞቹን (ከተጠቀሱትን ዉስጥ ያክብቡ)?	1. ክንድ ቆዳ ውስጥ የሚቀበር 2. በማዕዘን የሚቀመጥ 3. ሌሎች _____	

ክፍል አራት :- ስለ ረጅም ጊዜ የሚያገለግሉ ወለድ መከላከያ ዘዴዎች የተሳተፈው ግንዛቤ

ኮዴ	ጥያቄዎች	ጥያቄው መሌስ ለሆነ የሚችው	ወ ቀጣይ እ
18	. ሉፕ (በማዕዘን የሚቀመጥ የወለድ መከላከያ) ለ 12 ዓመት እርግዝናን ይከላከላል::	1. አዎ 2. አይደለም	
19	. ሉፕ(በማህጸን የሚቀመጥ የወለድ መከላከያ) የአባዘርሰ በሽታ ይከላከላል::	1. አዎ 2. አይደለም	
20	.ሉፕ(በማህጸን የሚቀመጥ የወለድ መከላከያ)	1. አዎ	

	የግብረ ስጋ ግንኙነት ወይም ፍላጎት ላይ ተጽዕኖ ይኖረዋል፡፡	2. አይደለም	
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ክፍል አምስት ፡-ስለ ረጅም ጊዜ የሚያገለግል ወለድ መከላከያ ዘዴዎች የተሳተፈዋቸው አመለካከት

ኮድ	ጥያቄዎች	ጥያቄው መሌስ ሉሆን የሚችው	ወ ቀጣይ እ
21	. ሉፕ በሚገባበት ወቅት የግል ሁኔታና ምስጢርን አያጋልጥም፡፡	1. አዎ 2. አይደለም 3.እርግጠኛ አይደለሁም	
22	ሉፕ በማእፀን ከተቀመጠ በኃላ ወደ ሌላ የሰውነት አካል ውስጥ አይዘመትም (አይዘዋወርም)፡፡፡	1. አዎ 2. አይደለም 3.እርግጠኛ አይደለሁም	
23	. ሉፕ መጠቀም የተለመደ እንቅስቃሴዎችን ማድረግ አይገድብም፡፡	1. አዎ 2. አይደለም 3.እርግጠኛ አይደለሁም	

ክፍል ስድስት :- የዘመናዊ የወለድ መከላከያ ዘዴ □□ ስሌ ረጅም ጊዜ የሚያገለግል ወለድ መከላከያ ዘዴዎች የተሳተፈው አጠቃቀም

ኮዴ	ጥያቄዎች	ጥያቄው መሌስ ለሆነ የሚችው	ወ ቀጣይ እ
24	. የትኛውን የወለድ መከላከያ ዘዴ ተጠቅመው ያውቃሉ?(ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ፒልስ 2. መርፌ 3. በክንድ ቆዳ ስር የሚቀበር 4. ሉፕ 5.ሌሎች _____	
25	. ከአንድ ወለድ መከላከያ ወደ ሌላ ቀየረው ያውቃሉ ?	1. አዎ 2. አላውቅም	
26	. መልስዎ አዎ ከሆነ ወለድ መከላከያ ከምን ወለድ መከላከያ ወደ ምን ቀየሩ?	1.ከረዥም ጊዜ ወደ ረዥም ጊዜ የወለድ መከላከያ 2.ከረዥም ጊዜ ወደ አጭር ጊዜ የወለድ መከላከያ 3. አጭር ጊዜ ወደ ረዥም ጊዜ የወለድ መከላከያ 4.ከአጭር ጊዜ ወደ አጭር ጊዜ የወለድ መከላከያ	
27	. መልስዎ አዎ ከሆነ የወለድ መከላከያ ለምን ቀየሩ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1..የመጀመሪያው ስላልተመቸኝ 2.ስለፈለኩኝ 3.የበፊት ስለሌለ 4.የጎንዮሽጉዳት ስላሰከተለብኝ 5.የረጅም ጊዜ መከላከያ ለመቀየር 6.የባለሙያ ምክር ስላስቀየረኝ 7.የጓደኛ ተጽእኖ 8.ሌሎች _____	
28	. አሁን የትኛውን የወለድ መከላከያ ዘዴ እየተጠቀሙ ነው?	1.ፒልስ(የሚዋጥ እንክብል) 2.መርፌ 3.በክንድ ቆዳ ስር የሚቀበር 4.ሉፕ(በማህጸን የሚቀመጥ) 5.ሌሎች _____	

29	መልስዎ በ 05(3, 4) አፀደለም ከሆነ ለምን?	1. የተሳሳተ አመለካከት 2. የአጭር ጊዜ በመፈለግ 3. የተጓዳኝ ጉዳትን በመፍራት 4. በህክምና ሁኔታ የተከለከለ 5. መሆንን በመፍራት 6. ሌሎች _____	
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"ስለ ተሳትፎዎ አመሰግናለሁ!!"

Dummy Table

Scio Demographic Characteristics

**Table X Scio demographic characteristics of respondents in X town.
SNNPR/2008/E.C**

Variable	itemes	N= 422	%

How old are you? Age at interview in completed year	15-24		
	25-34		
	35-44		
	IDR		
What is your marital status?	Single		
	married		
	widowed		
	divorced		
	separated		
	cohabiting		
	99		
What is your religion?	orthodox		
	Muslim		
	porsitant		
	99.other		
What is your ethnicity?	Oromia		
	Amhara		
	tiger		
	Wolita		
	99.other		

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