

ST. PAUL'S HOSPITAL MILLENNIUM MEDICAL COLLEGE

DEPARTMENT OF PUBLIC HEALTH



**ASSESSMENT OF KNOWLEDGE ATTITUDE PRACTICE OF
CONTRACEPTIVE USE AMONG FEMALE ADOLESCENT IN
SODDO COMPREHENSIVE AND PREPARATORY SCHOOL**

RESEARCH REPORT

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Abstract

Background

Decision making to use contraceptives by female adolescent students involves a complex interaction of individual, social, family and peer factors. Unsafe sexual activity among adolescents is a problem and has drawn attention from most parts of the world, including Ethiopia. However, there is scarcity of data on the sexual behaviors, and the extent and trend of contraceptive use among adolescents in Ethiopia including soddocomprehensive high school.

Objective

To assess knowledge attitude and practice of contraceptive use among female adolescent in soddocomprehensive and preparatory school.

Methods

A cross sectional study design was used. The data was collected from 200 selected female students of Soddocomprehensive and preparatory school by using pre-tested structured questionnaire. Data was entered using scientific calculator and analyzed by SPSS version 20. Descriptive statistics was computed.

Results

In this study the prevalence of contraceptive use among sexually active adolescent was 80.6% and over all female adolescent was 48%. Out of the total respondents, 119 (59.5%) were sexually active. From 116 (97.3%) respondents that had sex in the last 12 months, more than half (63.7%) had used contraceptives and (37.3%) did not use contraceptive. Embarrassment to buy, fear of side effects and lack of information where to get the method were the main reasons for not using contraceptives.

Conclusion and recommendation

Though the respondents' information about contraceptives and attitude towards contraceptive use is optimum, the magnitude of non use contraceptive was found to be high among sexually active participants. Peer to peer discussions and pursuing mutual responsibility among sexual partners can enhance use of contraceptives among female adolescent students. The school and local health bodies should work together to improve contraceptive use among sexually active students.

Key words: contraceptives, adolescent

Acronyms

AAU	Addis Ababa University
FDRE	Federal Democratic of Republic of Ethiopia
FGAE	Family Guidance Association of Ethiopia
GBV	Gender based violence
IUCD	Intra uterine contraceptive device
KAP	Knowledge, Attitude, Ppractice
MDGs	Millennium development goals
MMR	Maternal Mortality Rate
MoH	Ministry of Health
SNNP	South Nation and Nationalities People
SPSS	Statistical package for social sciences
SRH	Sexual and reproductive health
WHO	World Health Organization

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Introduction

Background information

Reported contraceptive use by adolescents has increased in recent years. From 1991 to 2013, the percentage of sexually active high school students who reported using a condom the last time they had sexual intercourse increased from 46.2% to 72.8% in 2013.^[1] Despite this increase, consistent use of any contraceptive method remains a challenge for most adolescents.

Centers for Disease Control and Prevention's 2005 Youth Risk Behavior Surveillance Summary indicated that less than half (46.8%, down from 49.9% in 2008) of all high school students reported having had sexual intercourse in their lifetimes, and approximately one third (34.3%, down from 37.5% in 1991 and 36.3% in 2008) of all students reported having sexual intercourse during the 3 months preceding the survey and are considered currently sexually active.^[2-3]

Each year, almost 850,000 adolescent girls become pregnant. The adolescent pregnancy rate has dropped steadily over the past decade. As of 2009, it was estimated that approximately 41.2% of all pregnancies are to adolescents 15 to 19 years of age.⁴ The pregnancy rate for 15- to 17-year-olds has dropped by 43% to 22.1% of all pregnancies.⁵ Approximately 20% of abortions are in adolescents, although these rates continue to decrease.^{6,7} Decreases in pregnancy rates are thought to reflect a decrease in reported rates of sexual intercourse and an increase in reported use of longer-acting, more effective contraceptive agents.⁸⁻¹² Over the last decade, evaluations of curricula suggest that those with a comprehensive approach to sexuality education have been effective in improving sexual behaviors and, thus, may also contribute to this trend.¹³⁻¹⁵ Despite these declining rates of pregnancies and births, adolescent childbearing (22% of women report giving birth before age 20) is still more common.¹⁶

Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners.¹⁶ In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to experience negative outcomes related to sexual activity.¹⁷ Two school-based studies that demonstrated a delay of onset of sexual intercourse used a comprehensive approach to sexuality education that included a discussion of contraception.^{18,19}

Race, ethnicity, age, marital status, education, income, requirements for confidential care, and fertility intentions have all been demonstrated to affect contraceptive choice. Trends in methods of contraception used by adolescents over the past 2 decades show an increase in oral contraceptive pill (OCP) use and an increase in male condom use.²⁰ In recent years, the number of adolescents reporting OCP use has remained stable at approximately 18% to 20%.²¹ Use of injectable contraception by adolescents 15 to 19 years of age has increased from 0% to 13% between 1995 and 2010.

Factors that contribute to lack of contraceptive use or inconsistent use include issues related to adolescent development, such as reluctance to acknowledge one's sexual activity, belief that one is immune from the problems or consequences surrounding sexual intercourse or pregnancy, and denial of the possibility of pregnancy. Other important factors are lack of education and misconceptions regarding use or appropriateness of contraception.

2.1 Statement of the problem.

Unsafe sexual activity among adolescents is a problem and has drawn attention from most parts of the world, including Ethiopia.

In Ethiopia, sexual intercourse is expected to occur only within marriage circles. Age at first marriage has increased from 18.3 for females and around 25 years for males in 2003, (National Population Council 2004) to around 21.4 and 20.9 years for urban and rural dwelling females respectively and 26.1 for urban and 24.9 for rural males (Ethiopian statistical service, 2008). A lot of people especially females tend to spend more time in school now than ever. This increases their age at first marriage. This situation has increased conditions for premarital sex. In a study conducted in Ethiopia among adolescents, it was discovered that, 30% and 16% of the females and males aged 15 to 19 respectively have had sex with a majority of it being premarital.

According to the report of the Ethiopia National Demographic and Health Survey 2007, of the 15 to 19 year olds interviewed, among those who have had sex, 73.6% of the females and 96.2% of the males had sexual intercourse with someone who was neither their spouse nor a co-habiting partner and 19.4% of them were in concurrent relationships (Ethiopia statistical service, 2008).

In the other study, only 18% and 27% of adolescent males and females who have had sexual intercourse mentioned that they used condoms in their maiden sexual encounter. Besides that, consistent contraceptive use was recorded among just 24 and 20 percent of males and females respectively, with reference to their current relationship. Unprotected premarital sex among adolescents (girls in particular) predisposes them to unwanted pregnancies, abortion complications or sexually transmitted infections. From January 2009 to May 2013 about 3% of adolescent's age (15-19 years) in Ethiopia got pregnant. Unwanted pregnancy and early motherhood has the propensity to bring to a halt one's education with untoward effects on subsequent employment opportunities. It also makes her less productive to be able to contribute fully to the socioeconomic development of the country. The pregnant adolescent who does not give birth and decide to abort the pregnancy may bring upon herself long term effects such as infertility arising from abortion complications or even death, if it was an unsafe abortion. Also, adolescents' ideas are usually not taken into account in the planning programme and services.

2.2 Justification.

Within the frame-work of World Health Organisation's (WHO) definition of Health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, reproductive health addresses the reproductive system, its functions and processes in all stages of life. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (UNICPD, 1994).

This suggests that, adolescents have the right to full sexual and reproductive health information and services which should be convenient for them, and tailored towards their needs, only adolescent reproductive health interventions carried out in the school are occasional health talks held for schools. In addition to this, there are no youth friendly centers in this school, where adolescents can conveniently and confidently seek for services. Most importantly, there is scarcity of data on the sexual behaviours, the extent and trend of contraceptive use among adolescents in Soddo Comprehensive High School. Because no research of this kind has ever been conducted in Soddo Comprehensive High School, it was prudent to carry out a local survey to ascertain the sexual behavior of adolescents and contraceptive use amongst them, which will serve as a starting point for further extensive research leading to appropriate interventions.

3. Literature Review.

3.1 Introduction

Contraception has been known since ancient times. In order to present evidence based discussion and reviewing literature that is relevant for the aim of the study will be necessary. This section presents a review of the literature on the factors that assumed to have effect on adolescents contraceptive use. It consists of two sections. The first section introduces the general thoughts about the history of contraception and the relation with population growth. The last section enlightens the review of literature on different demographic, socio economic and FP factors that influence use of adolescent use of contraceptive.

3.2 General overview on population contraceptives use

A review of the existing literature on the relationship between fertility and contraceptive use and some demographic and socioeconomic factors with the use of contraceptive and unmet need for family planning presented here.

Rapid population growth impacts on many aspects of our lives: health, education, water, food, employment and the environment. The world's population is approaching billion and apparently increasing at rate of about 78 million per year (CIA World Fact Book). At the current annual growth rate of 1.19%, it is expected to double within 60 years. However, the projection of 9 billion by 2050 by UN is improvement over an earlier 40 years estimate (1960 to 2000) during which the population of the world practically doubled, from 3 to 6 billion.

Especially since 1960, several developments have dramatically reduced infant and child mortality through out the world due to some basic reasons such as the fabricated of different medicines to eradicate fatal diseases and introducing of childhood immunization programs over the world. During the same period, the "green Revolution" greatly boosted food output through the cultivation of disease resistant crops, and the use of fertilizers and more effective farming methods. These changes have contributed to increase in human population growth rates.

Different countries have different population structure, leading to different types of problems. The population increase in the less developed countries will be largely in the reproductive age classes. Even if average family size were brought down radically in the near future, the population will still increase substantially as the huge pre adult population in the developing world reaches child bearing age and reproduces.

Family planning programs help million of women by providing reproductive health care that saves lives, preventing unintended pregnancies and offering the opportunity for many people worldwide to plan their families using contraception. While fertility levels are falling rapid population growth remains a critical issue in many developing countries, where needs are great but resources are scarce.

Population growth in developing countries can be restricted by establishing some kind of social security system for the elderly, mandating a minimum age for marriage, discouraging people from getting married or having a child in the absence of a steady income, and requiring women to attend a prescribed class on sexuality, health, childbearing, family planning and birth control before marriage. Since the dawn of history, women and men have wanted to be able to decide when and whether to have a child. Contraceptives have been in one form or another for thousands of years throughout human history and even prehistory. In fact, family planning has

been widely practiced, even in societies dominated by social, political or religious codes that require people to “be fruitful and multiply” from the era of Pericles in ancient Athens

The levels and trends of contraceptive use are influential variables in fertility change, and causal inference about fertility conditions and changes. This must be supported by some empirical knowledge about what cause people to regulate contraception voluntarily by using contraception. Recent studies among surveyed countries have shown that fertility is declining in most developing countries caused by the rise in the level of contraceptives use (UNICEF, 2007).

At the outset of the 1990s, Ethiopia was among the African countries with the highest fertility. During the subsequent decade, the TFR dropped from 6.4 to 5.4 children per women of reproductive age. Early studies of the fertility transition in Sub-Saharan Africa documented significant declines in fertility in Botswana, Kenya, South Africa, and Zimbabwe (Van de Walle and Foster 1990; Caldwell and Caldwell 1993; Cohen 1993); Ethiopia was not considered among the countries at or near the Using data from reproductive birth histories collected in 1990 national survey, (Lindstrom and Berhanu, 1999) identified a pattern of moderate but steadily declining fertility in the second half of the 1980s, but they could only speculate as to the long-term progress of this decline. In a national context of high fertility, an unexpected sharp decline in fertility was under way in the capital Addis Ababa. Between 1990 and 2000, the TFR in Addis Ababa dropped by 39%, from 3.1 to 1.9 births per woman. The low fertility in the capital had become even lower, and it is the first time to be under the replacement rate in the history of Africa (Kinfu 2000; CSA and ORC Macro 2001). Moreover, Ethiopia has one of the lowest levels of contraceptives use in the world, with a contraceptive prevalence rate 14.7% (EDHS 2005). In contrast, use of modern methods in Addis Ababa is 45%, Amhara 15.7% and Oromiya 12.9% (CSA & ORC Macro 2005).

Based on the fact as expected, contraceptive prevalence is higher in urban areas than in rural areas (47 %t versus 11 %). There is also substantial variation in current use by region. Current use is highest in Addis Ababa (57%) and lowest in the Somali Region (3%). Urbanized areas like Dire Dawa and Harari also have much higher levels of current use (34% each) than the other regions (EDHS 2005). The CPR in Oromiya and Amhara regions are much lower than the capital city (14% and 16% respectively). AA has a remarkably low TFR for Sub Saharan Africa and compare to 5.2 in Ethiopia generally (EDHS 2005). These contrasting figures are a result of several significant trends in fertility determinant in Ethiopia. Several studies have analyzed EDHS data from 2000 to identify the factors that are most significant to the fertility decline in Addis. In those studies, contraceptive use was found to be a significant factor in decline.

Many studies have been conducted in order to uncover obstacles of family planning acceptance and its continued use. The use of contraceptives and contraceptive services is influenced by a number of factors that either motivate or discourage women to use contraceptives effectively.

3.3. Age and contraceptive use

Age pattern of fertility decline in population making the transition from natural to controlled levels of fertility suggest that family limitation by married couples is an innovation that is diffused throughout societies (J. Kondel, 1974). Older women with more children were the first to limit fertility in both European and Asian population but other individuals were increasingly likely to adopt this innovative behavior overtime (Van de Walle & Kondel, 1980).

Age has been identified as an important factor that influences contraceptive practices. The fertility of adolescent and young adults is influenced by many of the same proximate determinants that affect the fertility of older women of reproductive age. Studies on different sub Saharan countries showed that age patterns of fertility vary among regions, countries & different

groups within countries. Its peak extends to age 29 in half of all surveyed countries and women over 40 contribute an average of 0.5 children to the TFR. .

The contraceptive prevalence rate for the married women aged less than 20 years is only 24% compared to the CPR of 44% for the women aged 20-29 years (Mitra et. al., 1994). This indicates that much for the increased contraceptive prevalence is attributable to the higher rates of contraceptive use and FP acceptance among the relatively older, higher parity women. Other study conducted on contraceptive prevalence in Indonesia showed that younger women were more likely to be currently using or have used contraceptive than were older women (Molyneaux, 1999).

Contraception in most countries is of lowest prevalence among young women, reaches a peak among women in their thirties and declines among older women (Robey, 1992; CSA, 2005). According to EDHS 2005 the contraceptive prevalence among currently married women is lower at younger age (15-19) and at older age (45-49). It reaches its peak among women at their late thirties. This may reflect a high desire for child bearing among young women, and a high growing interest of spacing and limiting births among women in their older age.

3.4. Women's level of education and contraceptive use

Women's education has a constructive effect on socio economic processes in the developing world (Fallon 1999; Glick and Sahn 1997; Odaga and Henevald 1995). Women's education occupies a unique place in demographic discourse and policy because a large amount of empirical research has revealed that educated women delay marriage use contraceptive, reduce fertility and produce many other beneficial reproductive and child health outcomes.

There is also a common assumption that education leads to autonomy (technical, social and physiological ability to obtain information) as it helps women to stand up to their husband and provides them a forum to learn about fertility control and make effective use of the health care system. Moreover, increased education and the autonomy that comes with it may influence women's reproductive decisions regarding issues such as contraceptive use, as well as their actual and desired Education has a positive effect on the use of contraceptive. Female education has been seen as a key determinant of contraceptive use. Better educated women, being more exposed to family planning information are more likely to practice contraceptive than uneducated women. A study conducted by Koc, 2000 revealed that a positive association between the educational level of women and the use of contraceptive methods in Turkey.

The study which was conducted in rural Ghana during the 1980s, which examines whether a woman's interest in fertility regulation and contraception is influenced by the education of other women in her community have shown that net of her own characteristics, a woman interest in limiting fertility and using modern contraception increases with the percent of women with education in her community and it suggested that female education has a greater capacity to introduce novel reproductive ideas and behaviors into rural areas of Africa and thereby transform the demographic landscape the region than is currently believed.

Other theories argue that the education of women in a community changes the institutional setting in ways that reduce the incentive to have many children. Some claim that the education of some women in a community initiates social and ideational changes that undermine traditional patriarchal power and reduce men's interest in having large numbers of children as it becomes difficult for them to devolve the costs of childbearing onto their wives (McNay et al. 2003).

According to the theories, elite educated women develop a heightened awareness and become empowered to adopt those (Johnos- Hanks, 2003). The NFFS (1990) has shown that in Addis Ababa FP use was 32.8% and the use of family planning also increased with the educational

level of women. The population of women who use FP method was 2.7%, for those with no education, 4.9% for those with formal education. The 2005 EDHS report showed that contraceptive use differs significantly across educational categories. Current use increases five-fold from 10 percent among women with no education to 53 percent among those with secondary and higher levels of education.

In urban areas, literate women were more likely than illiterate women to have reached or exceeded the number of children they desired. Women whose fertility was sufficient or excessive were more likely to use contraception presumably to avert future pregnancies. Therefore, greater literacy among urban women explained an important part of the higher contraceptive prevalence among urbanites for averting unwanted conception.

In developing countries surveyed since 1990, contraceptive use is higher among women with more education. Differences in contraceptive use by education are greatest in sub-Saharan Africa, where total contraceptive use is the lowest of any region. Even after taking account of other factors, researchers consistently have found that better educated women are more likely to use contraception.

3.5. Religious affiliation

Very little work has been completed specifically on the relation between birth control and religious institutions. Religious affiliations may impact on the use of contraceptives due to differing beliefs regarding birth control. According to Popenoe, Cunningham and Boulton (1998) Christian churches had, in the past, generally believed that using birth control are opposing against God's word that people shall multiply and be many and reproduction is one of the primary goals of marriage and, as a result, they were opposed to the use of contraceptives. Now a days there is little to no condemnation of using birth control in most major religions promote fertility because they date back to eras when high fertility rates could mean the difference between the survivals or death of a community.

The study on contraceptive use in Kinshasa by Shapiro (1994) revealed the relationship between religion and contraceptive use. All non Catholic religious groups had slightly higher rates of contraceptive prevalence compared with catholic women. Other study in Sierra Leone by Amin et al (1992) reported that there is low contraceptive prevalence among women who followed Islam religion than among those affiliated with catholic and other Christian religion. The implication of this may connected with the desire of to have more children by those Muslim women.

3.6 Place of residence and contraceptive use

In developing countries, urban population size is growing rapidly. Continued rural-urban migration contributes sizably to this growth, especially since most people who migrate to the cities are young. The rise of women in the labor force, adoption of modern ideas, increased need for child labor, and the breakdown of the extended family contribute to these changes. Factors which decrease fertility are falling proportions of people marrying at an early age, increased age at first marriage, increased spousal separation, and increased use of contraception. Socioeconomic differentials and issues of equity explain, to a certain extent, the high fertility and low contraceptive use in some poor urban areas.

The place of residence has shown to have relationship with the use of contraceptive. A study conducted by Malhotra and Thapa in Sri Lanka (1991) and Rutenberg et al (1991) found that the use of contraceptives was higher among urban women than rural women. In the study conducted on developing countries, rates of contraceptive use among married women in rural areas are lower than in urban areas. The exception is Jamaica, where rural and urban levels of use are

equal. In surveyed countries of Eastern Europe and Central Asia, differences in contraceptive use between rural and urban areas are quite small. As with differences in contraceptive use by level of education, differences by rural or urban residence vary among countries. In countries where contraceptive use is widespread, rural-urban differences are smaller than where contraceptive prevalence is low.

In many studies it has been found that acceptance and the use of contraception was higher among those who reside in urban than in rural areas. The reason is may be the accessibility and sufficient availability of family planning methods and services and the other possible reason may be that urban women get chance to be educated than rural women and it leads to prefer to have less number of children to maintain the family size based on their economic status.

According to EDHS 2000 in Ethiopia the contraceptive prevalence rate is high in urban areas than rural areas (36% and 4% respectively) and it is less slightly higher in 2005 (47% and 11% respectively).

3.7 Ethnic group and Contraceptive use

As in many African countries, ethnic groups in Ethiopia have been distinct for a long time. This long period of exclusiveness, compounded by ethnic competition for political power, has resulted in an increased intensity of ethnic affiliation (Library of Congress 2002).

Some researchers have found that ethnic and religious differences affecting fertility control especially in developing countries. Ethnic groups are a major cultural force in reproduction, however, and different religious affiliations are present within the ethnic groups, providing a context allowing greater understanding of the effects of religion on birth control.

3.8 Types of methods and contraceptive use

Young women experience a high risk of unplanned pregnancy and HIV because of their limited knowledge about sexual and reproductive health.

Lack of knowledge and unnecessary myths are the main points that deter people from adopting contraceptive methods. From hormonal contraceptives to barrier methods and natural methods, the types of birth control available today.

Providing the correct information is the key to create the right contraceptive behavior. However, before using a contraceptive, women must first have knowledge of different methods. In Senegal and Burkina Faso, more than 85 percent of young women surveyed knew at least one form of modern contraception, but far fewer (67 percent and 66 percent, respectively) knew three or more modern methods. Knowledge in Ethiopia was lower, with only 76 percent of young women knowing one method and only 56 percent having knowledge of three or more.

3.9 Knowledge about contraceptive

Youth around the world especially young women experience a high risk of unplanned pregnancy because of their limited knowledge about sexual and reproductive health. Knowledge of contraceptives and contraceptive use are important indicators of reproductive health among women.

The available data from the Demographic and Health Surveys (DHS) conducted in three West African countries explored the variation in sexual knowledge and practice among youth women. The article reported on 2009 that in Senegal and Burkina Faso, more than 85 percent of young women surveyed knew at least one form of contraception, but far fewer (67 percent and 66 percent, respectively) knew three or more methods of contraception.

4. Objectives of the Study

4.1 General objective

To assess knowledge attitude and practice of contraceptive use among female adolescent in soddo comprehensive and preparatory school.

4.2 Specific objectives

1. To assess the level of knowledge of contraceptive use among female adolescents in soddo comprehensive and preparatory school
2. To assess the level of attitude toward contraceptive use among female adolescents in soddo comprehensive and preparatory school.
3. To determine the level of practice of contraceptive use among female adolescents in soddo comprehensive and preparatory school

5.Method

5.1 study setting

Wolayita is a Zone in the Ethiopian Southern Nations, Nationalities, and Peoples' Region (SNNPR). it is named for the Welayta people, whose homeland lies in this Zone. Wolayita is bordered on the south by Gamo Gofa, on the west by the Omo River which separates it from Dawro, on the northwest by Kembata Tembaro, on the north by Hadiya, on the northeast by the Oromia Region, on the east by the Bilate River which separates it from Sidama, and on the south east by the Lake Abaya which separates it from Oromia Region. The administrative center of Wolayita .[2]

Based on the 2007 Census conducted by the Central Statistical Agency of Ethiopia (CSA), this Zone has a total population of 1,501,112, of whom 739,533 are men and 761,579 women; with an area of 4,208.64 square kilometers, Wolayita has a population density of 356.67. While 172,514 or 11.49% are urban inhabitants, a further 1,196 or 0.08% are pastoralists. A total of 310,454 households were counted in this Zone, which results in an average of 4.84 persons to a household, and 297,981 housing units. The largest ethnic group reported in this Zone is the Welayta (96.31%); all other ethnic groups made up 3.69% of the population. Welayta is spoken as a first language by 96.82% of the inhabitants; the remaining 3.18% spoke all other primary languages reported. 71.34% were Protestants, 21% of the population said they practiced Ethiopian Orthodox Christianity, and 5.35% embraced Catholicism.[3]

Soddo comprehensive and preparatory school was established in 1955 by grandson of kawo tona and it celebrates its 50th anniversary 4 years back and currently the total no of students is 2400 with a female 951 and 1449 male with a total of 16 grades

5.2 study design

Descriptive cross sectional study was conducted to carry out this research.

5.3 study population

Female adolescent students studying in soddo comprehensive and preparatory school

5.4 Study unit and period

Female adolescent student studying in soddo comprehensive and preparatory school and it was carried out from January to March 2017 G.C.

5.5 Sample size determination

The sample size will be determined by using single population proportion formula. Since there is a research done previously at Dilla city secondary school I took the sample size of 85%. A Z

value of 1.96 is used at 95% Confidence level and margin of error is 5%.Accordingly, the sample size (n) of the study was calculated as follows,

$$n = \frac{Z_{\alpha/2}^2 p(1-p)}{d^2}$$

Where

n=sample size

d= margin of error

P=proportion of students having awareness of contraception to be 85 %

α =degree of accuracy

$$n = \frac{(1.96)^2 0.85(1-0.85)}{(0.05)^2} = 196$$

$$n = \frac{n_0}{1 + \frac{n_0}{N}} = \frac{196}{1 + \frac{196}{2400}} = 182$$

On the calculated sample size 10% will be added to compensate for non- response rate giving a total of 200 study participants.

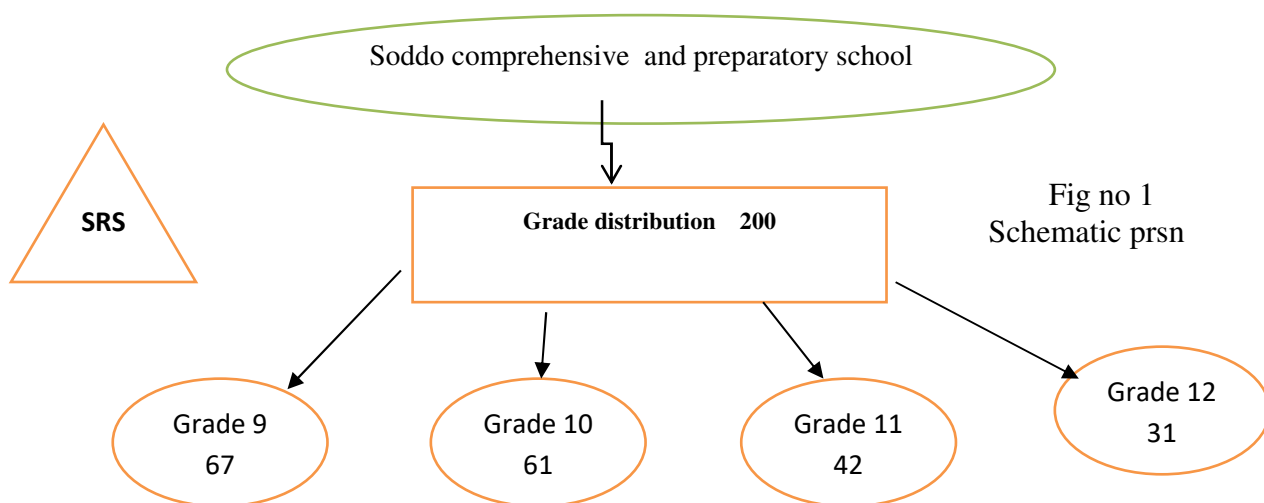
5.6 Sampling procedure

Source of data: Female adolescent student.

Type of data: A full list of female adolescent students who are studying in soddo comprehensive school. These lists will be used to calculate the number of each category of student in the school.

Categorization to be used: grade 9, 10,11 and 12

The number of each student to be selected from each category will be proportional to the size of the category. Within each category, the number of respondents to be surveyed in each grade will be determined by Probability proportional to size. From a particular grade, respondents will be selected by simple random sampling method (lottery method)



5.7 Data collection instrument

Self-administered and pre tested questionnaire was used for data collection. The questionnaire was pretested on the female adolescent at chora preparatory school. Pretesting will be done with

an aim to check sequence of question, comprehension of the questions among the participants and duration.

5.8 Study variable

Dependent variable

KAP of contraceptive use

Independent variable

Sociodemographic character, students level of education, religious affiliation.

5.9 Data management and analysis

The completed questionnaire was checked for completeness and consistency by the principal investigator. Code was given to the completed questionnaire. The coded questionnaire was categorized by institution. The principal investigator with an experienced data clerk was entered the data using scientific calculator and SPSS 20 statistical packages. Data clean up was performed to check for, accuracy, consistencies, & values. Any error was then be identified and corrected. Central tendency & dispersion was used, analyzed and described in the form of frequency tables & depicted graphically. Internal comparison was made.

5.10 Ethical issues.

Ethical clearance and scientific approval for this study was requested from administrative authority of the school and to guarantee the safety and confidentiality of the study participants, informed consent was sought from the adolescents.

5.11 Inclusion & exclusion criteria

Inclusion criteria

All female adolescent students studying at soddoo comprehensive and preparatory school whose grade is between 9 and 12.

Exclusion criteria

Those who doesn't want to participate in the research

Those whose age above 19

5.12 operational definition

Knowledge-information about contraceptive, place where they did get it and knowing place that provides the service. Total knowledge scores can range between 0-15

Knowledge scores more than 8 was considered as having good knowledge regarding contraceptive and Knowledge scores from 0 to 7 were considered as poor knowledge

Positive attitude: - Attitude towards contraceptive was assessed using a 5-item questionnaire and scores from 6 to 12 were considered as positive attitude

Negative attitude: - Attitude scores below 5 were considered as negative attitude,

poor practice:-8-item questionnaire were used to assess practice and each item has one score and those who scores 0-3 were considered as poor practice

good practice:-those who scores 4-8 were considered as good practice

6.Result

6.1 Socio-demographic characteristics of respondents

The mean age of respondents was 16.2 years. The respondents religious affiliation is dominated by protestant 133(66.5%) followed by orthodox 31 (15.5%) followed by muslim 28(14%) and others 8 (4%). Most of the respondents were single 194 (97%) and 6 (3%) were married. The distribution of respondents by year of study indicated that more than half 127 (63.5%) of them were grade 9 and 10 students, 41 (20.5%) grade 11 and 32 (16%) fourth year.

Table 1: Socio-demographic characteristics of respondents among Female students of soddocomprehensive and preparatory school(n= 200)july, 2017.

Characteristic		Frequency	(%)
Age	15	62	31
	16	65	32.5
	17	33	16.5
	18	40	20
	19 or above	0	
Religion	Protestant	133	66.5
	Orthodox	31	15.5
	Muslim	28	14
	Others	8	4
Marital status	Single	194	97
	Married	6	3
	Separated	0	
Current grade of study	Grade 9	67	33.5
	Grade 10	60	30
	Grade 11	41	20.5
	Grade12	32	16

6.2 Sexual Experiences of respondents

Of all the respondents, 119(59.5%) reported that they have ever had sex. Out of those that had sexual experience, 116 (97.4%) said they had sex in the past one year. The mean age at first sex was found to be 16. The result also showed that 24 (20.1%) of the sexually active students in the past one year had more than one sexual partner. Of the total sexually active respondents, 47 (39.4%) had unplanned sex. From respondents who had sex, 10 (8.4%) of the respondents were drunk when they had sex. out of the total sexually experienced respondents, 15 (12.6%) reported ever experiencing pregnancy. The number of reported pregnancies was ranging from one to two times. Some respondents 13 (10.9%), have reported unwanted pregnancy. From the total respondents ever had pregnancy, 13 (10.9%) of them experienced induced abortion.

Table 2: Sexual Experiences of respondents among Female Students of soddo preoartory school (n= 200),july 2017

Characteristic		Frequency	(%)
Ever had sex	Yes	119	59.5
	No	81	40.5
Age at first sex n=119	15	52	43.6
	16	58	58.7
	17	7	5.8
	18	2	1.6
	19 or above	0	
Sex in the last 12 months (n=119)	Yes	116	97.4
	No	3	2.6
Number of sexual partners (n=119)	One partner	95	79.8
	Two partner	22	18.4
	Three partner	2	1.6
Unplanned sex (n=119)	Yes	47	39.6
	No	72	60.4
Drunk while having sex (n=119)	Yes	10	8.4
	No	109	91.6
How many pregnancies(n=119)	0	104	87.3
	1	13	10.9
	2	2	1.6
Unwanted pregnancy (n=119)	Yes	13	10.8
	No	106	89.1
Abortion in the past(119)	Yes	13	10.8
	no	106	89.1

6.3 Respondents Information on Contraceptives

Among all the respondents 190 (95%) have heard about contraceptive methods. Of those respondents who have heard about contraceptives, 166 (83%) reported that they have known where to get if they wanted. friends 53 (26.5%), TV only 48 (24%) and Radio 29 (14.5%) are the three most sources of information reported by respondents. Government health center 88 (44%), non-governmental clinics 24 (12%) and government hospital 29(14.5%) were the three frequently spontaneously named sources of contraceptives for respondents in their respective orders.

Table 3: Information on Contraceptives of respondents among Female students of Soddo comprehensive and preparatory school, (n=200) July, 2017.

Characteristic		Frequency (n= 200)	(%)
Heard of contraceptives	Yes	190	95
	No	10	5
Knows where to get information	Yes	166	83
	No	34	17
Source of information	Radio	29	14.5
	TV	48	24
	News paper	4	2
	Health profession	7	3.5
	Family	8	4
	School education	28	14
	Youth club	6	3
	Friends	53	26.5
	All	7	3.5
Places you know for contraceptive service	Government Health Center	88	44
	Government Hospital	29	14.5
	Private hospital/ Clinic	7	3.5
	NGO Clinic	24	12
	Any open Market	2	1
	All	74	37

6.4 Attitudes of Respondents towards Contraceptives

From the total respondents 186 (93%) would like to know more about contraceptives. Only 109 (54.5%) of the participants reported that they discuss the issue of using contraceptive with their friends. A majority of the respondents 142 (71%) have reported that contraceptives are important for couples who are not ready to child birth, 23 (11.5%) the respondents have reported contraceptives as harmful and 19 (9.5%) reported not important or adolescents. From the total participants, 145 (72.5%) of them reported that they approve use of contraceptives by adolescents and 55 (27.5%) do not approve. Regarding the couple's responsibility to use contraceptives, 159 (79.5%) of the respondents have reported that it is the responsibility of both partners, 35 (17.5%) female partner and 6 (3%) male partner.

Table 4. Attitudes towards Contraceptive Use among Female students of Soddo Comprehensive and preparatory school, (n=200) July, 2017

Characteristic		Frequency	%
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Would you like to know more about contraceptive	Yes	186	93
	No	4	7
Discuss with friends	Yes	109	54.5
	No	91	45.5
Your feelings about contraceptive	Harmful	23	11.5
	Not very important	19	9.5
	Not as important as some people say	7	3.5
	Important for two couples who are not ready to child birth	142	71
	Students do not need contraceptive though sexually active	6	3
	Others	3	1.5
Do you approve use of contraceptive use by adolescents	Yes	145	72.5
	No	55	27.5
Who should take responsibility to practice contraceptive	Female partner	35	17.5
	Male partner	6	3
	Both	159	79.5

6.5. Contraceptive Use among respondents

The prevalence of contraceptive use among the student who was 48%. Among 116 respondents who had sex in the past one year 96 (80.6%) used contraceptives at least once and 23 (19.4%) never used. Among respondents who have ever had sex, 70 (58.8%) have used contraceptive during first time they had sex and 49 (41.1%) did not. From contraceptive methods used by ever users, 52(43.6%) of respondents have used condoms, 30 (25.2%) emergency contraceptive pill and 24(20.1%) oral contraceptive pills.

From the respondents who had sex in the past one year, 75 (64.6%) of them have used contraceptives and 41 (35.4%) did not use contraceptive during last time they had sex. The findings revealed that from the respondents who have reported that they used contraceptives last time they had sex, 29 (38.7%) of them have used condom, 30 (40.1%) used emergency contraceptive pill and 9 (12%) used oral contraceptive pill.

Among the reasons why they chose the contraceptive method they used, 24 (32%) of the respondents chose the method because it is easy to get, 21 (21.3%) easy for secret use, 8 (10.7%) it is given free, 22 (29.3%) have better knowledge on the method. From the respondents who have used the method, 33 (44%) of them obtained the method from private hospital/clinic, 29(38.6%) from government hospital/health centers and 9(12%) from NGO clinics.

Table 5 Contraceptive Use among sexually active respondents

Characteristic		Frequency	(%)
Ever used Contraceptive	Yes	96	80.6
	No	23	19.4

Used contraceptive first time they had sex	Yes	70	58.8
	No	49	41.1
Contraceptive method by ever users (n= 96)	Pills	24	20.1
	Condoms	52	43.6
	IUCD	1	0.8
	Injectable	4	3.3
	Emergency contraceptive	30	25.2
	Calander method	7	5.8
Have you used Contraceptive last time you had sex (n= 116)	yes	75	63
	No	44	37
Contraceptive method used on last sex (n= 75)	Pills	9	12
	Condoms	29	38.7
	IUCD	0	
	Implants	0	
	Inject able	4	5.3
	Emergency contra	30	40
	Calendar	3	4
Why you choose the method (n= 75)	Easy for secret use	21	21.3
	Easy to get it	24	32
	Cheap to buy	0	0
	It is free	8	10.7
	Have better knowledge on it	22	29.3
Place of facility you got (n= 75)	Gov't Hospital/HC	29	38.6
	Private hospital/ Clinic	33	44
	NGO Clinic	9	12
	Any open Market/shop	1	1.3
	Others	3	4
Purpose of using contraceptive (n= 75)	Prevent unintended pregnancy	64	85.3
	Prevent STI	10	13.3
	For medication	1	1.3

graphical presentation of type of contraceptive by ever user

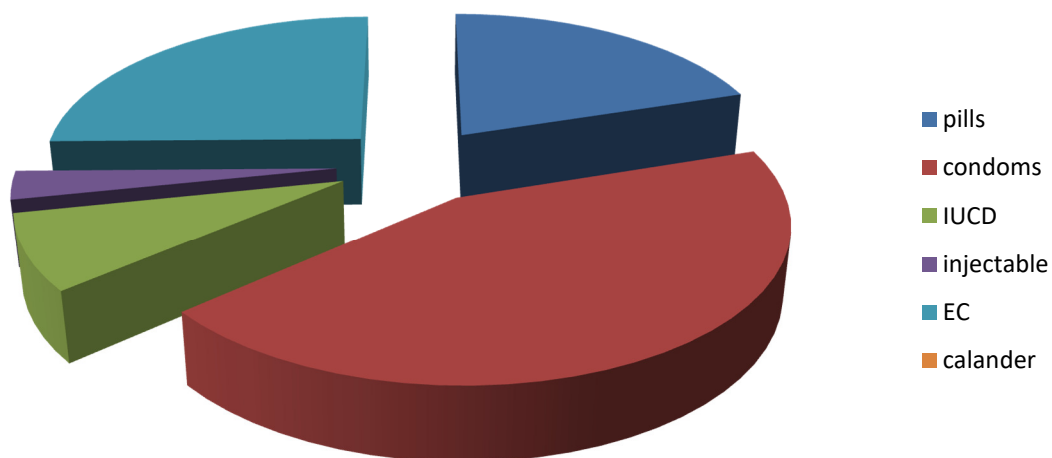


Table 6 KAP of respondent toward contraceptive

		Frequency	percent
Knowledge above the mean and below mean	good knowledge ≥ 8	120	60.0
	Poor knowledge ≤ 7	80	40.0
Attitude above the mean and below mean	Positive attitude ≥ 6	169	84.5
	Negative attitude ≤ 5	31	15.5
practice above the mean and below mean	Good practice ≥ 4	112	56.0
	Poor practice ≤ 3	88	44.0

7. Discussion

This study has resulted that almost two-third of study subjects reported that they have ever had sex in their lifetime. Similar results were reported by different studies conducted among Ethiopian university students (30) and students in dilla secondary school (6). Out of sexually active respondents, age at first sex was below 19. This was similar with studies conducted in Ethiopian Universities (10-11) universities in Asia and Africa (20-23). Unintended sex and unwanted pregnancy were notable among sexually active respondents. This reveals the behavior of female students to be reluctant to negotiate sexual relationships (5).

This study provides information about Knowledge, attitude and practice of contraceptive among Female students of Soddo comprehensive and preparatory school. The knowledge of contraceptive is important in developing country, to decrease the maternal mortality and complication related to this. WHO defined contraceptive as “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of family groups and thus contribute effectively to the social development of a country

In this study the majority (95%) of the female adolescent students had ever heard about modern contraceptives. This is in line with the 2011 Ethiopian Demographic Health Survey report which reported that knowledge of contraception was nearly universal in Ethiopia

Most studies reveal that the exposure to reproductive health message broadcast through different channels is effective to build up their knowledge; attitude and practice of modern contraceptive methods are important (Tilahun, 2006). In this study the level of knowledge of female students on contraceptive methods, based on scored mean of knowledge questions, 60% of the respondents was scored above the mean, have good knowledge. Even though knowledge does not automatically lead to practice (Regmi, 1980), women who are knowledgeable about contraceptive use are more likely to use contraception (Hogan et al., 1999). Appropriate source of information is very important to build up their knowledge properly in this study 26.5% of the respondent contraceptive knowledge source is from their friends. Similarly, in another study conducted on female students in dilla town majority of the respondents' source of knowledge of modern contraceptive was friends. Whereas in another study conducted on college students' knowledge source is from a magazine (Nibabe et al, 2015) this difference is probably due to a difference in their living arrangement and economic difference

In this study, 84.5% of the respondents have a favorable attitude toward modern contraceptive. Even though they have a positive attitude towards contraceptive their practice is limited. Regarding their feelings on contraceptives for female students, majority (71.0%) of the respondents have reported that contraceptive is important for two couples who are not ready to child birth, and on the contrary, (11.5%) reported that contraceptives are harmful and not important for female adolescent students. this has same result shown in study done in dilla secondary school. Negative attitudes and perceptions can lead students to suffer from negative outcomes of reproductive health problems.

In this study, majority (80.6%) of the sexually active respondents reported they had ever used contraceptives. Among methods used, 43.4% used condom, 25.2% used emergency pills and 20.8% used pills. Condoms and Emergency contraceptive pills to be the two most preferred methods among female students. This is similar in study done at addis ketema secondary school .there is an improvement in condom utilization comparing with today's high rate of teenage pregnancy . it indicates high proportions of the sexually active groups are at risk.

This study revealed that having information on the method, easy for secret use, and easy to get the method are three most reasons for choosing the above methods. Similarly, embarrassment to buy, fear of side effects and lack of information where to get the method are the three most reasons reported by sexually active respondents for not using contraceptives. This shows that very little attention has been given to educate this segment of population on relations of sexuality, contraceptive use and the risk of pregnancy

8. Strengths and Limitations of the study

8.1 Strengths

- To obtain reliable data and ensure confidentiality experienced health professionals and Secondary school teachers were employed and trained to instruct & facilitate data collection processes.

- Full response rate (100%).
- Different strategies of quality control considered.
- Addressing of target groups of female students at school level.

8.2 Limitations

- The data was collected only from youth in schools, where only small portion of youth got chance of joining & staying in school, the result has limited power to be generalized to all youth in the study area and may overestimate the result.
- Self-reported information is subjected to reporting errors, missed values & biases, since the study touches sensitive issues the possibility of underestimation can not be excluded, even though the study was anonymous.
- Not supplemented by qualitative methods

9. Conclusions and Recommendations

9.1 Conclusions

The study reveals most of female students have good knowledge, favorable attitude and good practice contraception and also showed the source of their knowledge is from the friends's discussion. eventhough contraceptive use by sexually active students good over all prevalence is low

9.2 Recommendations

Out of the total respondents, majority of study participants (93.0%) would like to know more on contraceptives. However, only 54.5% of the respondents discuss about contraceptives with their friends. This has also been evidenced indifferent studies that, most female adolescent students do not have a trend to discuss openly on reproductive matters with friends. This is an area where most stakeholders should give due attention to bring reproductive matters as an issue among female students

References

1. World Health Organization. Programming for adolescent health and development report of WHO/UNFPA/UNICEF study group on programming for adolescents health. Geneva. WHO; 1999.
2. World Health Organization. Sexual relations among young people in developing countries, evidence from WHO case studies Geneva: 2001
3. World Health Organization. Making Pregnancy Safer Notes, Volume 1, No.1, October 2008.
4. United Nations Fund for Population Agency. State of world population 2003: Investing in adolescents' health and rights. *Bulletin*. New York 2003.
5. United Nations. World population monitoring, Reproductive rights and reproductive health. New York.(2004)
6. United Nations Fund for Population Agency. The state of world population: The new generation. *Bulletin*. New York 1998.
7. Ethiopian Central Statistical Authority. National Population Senses Summary Report. CSA 2007.
8. CORHA, Risky Sexual Behaviors and Predisposing Factors Among Ethiopian University Students May, 2011
9. Govindasamy Pav et.al, Youth Reproductive Health in Ethiopia, Calverton, Maryland: ORC Macro, 2002.
10. Central Statistical Agency [Ethiopia] and ICF International. Ethiopia Demographic and Health Survey 2011. Ethiopia and Calverton, Maryland, USA: 2012.
11. Federal Ministry of Health. National Adolescents and Youth Reproductive Health Strategy (2007-2015), FMOH, 2006.

12. Federal Ministry of Health, Standards and Minimum Service Delivery Package on Youth Friendly Reproductive Health Services, FMOH 2007.
13. Bearinger LH, Sieving RE, Ferguson J, Sharma V: Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *Lancet* 2007, 369:1220-1231.
14. Mensch BS, Grant MJ, Blanc AK: The changing context of sexual initiation in sub-Saharan Africa. *Popul Dev Rev* 2006, 32:699-727.
15. Singh S, Bankole A, Woog V: Evaluating the need for sex education in developing countries: sexual behaviour, knowledge of preventing sexually transmitted infections/HIV and unplanned pregnancy. *Sex Education* 2005, 5:307-331.
16. Plummer ML, Ross DA, Wight D, Changalucha J, Mshana G, Wamoyi J, *et al.*: "A bit more truthful": the validity of adolescent sexual behaviour data collected in rural northern Tanzania using five methods. *Sex Transm Infect* 2004, 80 (suppl II):49-56.
17. Blum RW: Youth in sub-Saharan Africa. *J Adoles Health* 2007, 41:230-238.
18. Wakgari D. and Aklilu A. Substance use and its predictors among undergraduate medical students of Addis Ababa University in Ethiopia: *BMC Public Health* 2011, 11:660 doi:10.1186/1471-2458-11-660
19. Olayinka O.,A., Kofo O., Odusote., Mopelola O.,Om,Victoria O., Ayoade A., Kehinde O. Determinants of young people's sexual behavior concerning HIV and AIDS in the practice population of a University Health center in Lagos, Nigeria; *African Journal of primary Health care & family medicine* (2011): 3(1)
20. Aggarwal O, Sharma AK, Chhabra P. Study in sexuality of medical college students in India. *J Adolesc Health* 2000; 26: 226_9.
21. Adhikari R, Tamang J. Premarital sexual behavior among male college students of Kathmandu, Nepal. *BMC Public Health* 2009; 9: 241.
22. Ma Q, Ono-Kihara M, Cong L, Xu G, Pan X, Zamani S, *et al.* Early initiation of sexual activity: a risk factor for sexually transmitted diseases, HIV infection, and unwanted pregnancy among university students in China. *BMC Public Health* 2009; 9: 111.
23. Were M. Determinants of teenage pregnancies: the case of Busia district in Kenya. *Econ Hum Biol* 2007; 5:322_39.
24. PRB (Population Reference Bureau). The world population data sheet. Washington, DC: Population Reference Bureau; 2009.

25. Agardh A, Emmelin M, Muriisa R, .O" stergren PO. Social capital and sexual behavior among Ugandan university students. *Glob Health Action* 2010; 3: 5432.
26. Agardh A, Odberg-Pettersson K, .O" stergren PO. Experience of sexual coercion and risky sexual behavior among Ugandan university students. *BMC Public Health* 2011; 11: 527.
27. Devika M, Anette A, Karen O, Petterson. Use of contraception: determinants among Ugandan university students. *Glob Health Action* 2012, 5: 113-116
28. Nigussie T. Klepp K. Sundby J. Bjune G. Psychological determinants of sexual activity and condom use intention among youth in Dilla. *International Journal of §AIDS* 2002; 13: 714-719
29. Abebe D, et.al. *Khat* chewing habit as a possible risk factor for HIV infection: A case-control study. *Ethiopian Journal of Health Development* 2005, **19**:174-181.
30. Ministry of Youth, Sport and Culture of Ethiopia (MYSC), National Youth Policy, 2004
31. United Nations Population Fund: *State of the world population 2004. The Cairo consensus at ten: population, reproductive health and the global effort to end poverty* New York: UNFPA; 2004.
32. Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J: Family planning: the unfinished agenda. *Lancet* 2006, 368:1810-1827.
33. Hubacher D, Mavranouzouli I, McGinn E: Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it. *Contraception* 2008, 78:73-78.
34. Jocelyn De Jong et.al ; Population Reference Bureau. Young People's Sexual and Reproductive Health in the Middle East and North Africa, April 2007.
35. World Health Organization. Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health, WHO 2004.
36. Senderowitz J. Making Reproductive Health Services Youth Friendly, Focus on adults, Research program and policy series, 1999.
37. Aluede et.al. Academic, career and personal needs of Nigerian university students, *Journal of Instructional Psychology*, March 2006.
38. Schinke S. Fang L. Cole K. Substance use among early adolescent girls: risk and protective factors, *Journal of Adolescent Health* 2008, 43:191-194.