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Awareness on Use of Modern Family Planning Methods among Female Students at Sendafa Town Youth Center, Finfine Special Zone, Ethiopia

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Abstract

***Background**: - Family planning does have a wider view, dealing with birth control, reproductive health, as well as premarital and pre conception counseling. Understanding why people do not use family planning is critical to address unmet needs and to increase contraceptive use. Studies showed that 38% and 78% of the potential demand for family planning was not achieved in Ethiopia and Oromia, respectively. The **aim** of this study was to assess knowledge, attitude and intention use of modern family planning methods. **Method: -** Cross sectional designed, Sample size (n=348), SSPS-20, Chi-square test and P< 0.2. **Results**: - Over all knowledge 60.6% and positive attitude by 62.4% of respondents and near three fourth (68.4%) intended to use in the future. **Conclusion: -** Respondents have a high knowledge and a positive attitude towards family planning methods. The multivariable analysis of the final result model female youth students time the live in urban, place they birth and grew, pocket money, and living with parents were found significant barriers for plan to use modern family planning methods and high major predictors of strength association.**Recommendations:**- Increase effort to reproductive health services, well motivated and Continuous effort to educate all young equally in rural and urban.*

Keywords: Contraceptive method, Family Planning, Modern Family Planning and Youth Center

1. INTRODUCTION

Family planning (FP) is an important strategy in promoting maternal and child health. It improves health through adequate spacing of birth, avoiding pregnancy at high-risk maternal age and high parity. It is often used as a synonym for birth control. However, it does have a wider view, dealing with birth control, reproductive health, as well as premarital and pre conception counseling[1]. In addition to these, the contraceptive methods use that it reduces women's by STIs mortality and improves women's health by preventing unwanted and high-risk pregnancies and reducing the need for unsafe abortions. That is, avoiding too early and too late pregnancies, limiting the number of pregnancies and preventing abortion. MFP services in Ethiopia first started in 1966, led by the Family Guidance Association in Ethiopia (FGAE). The Ministry of Health designed new outlets for FP services in the form of community-based distribution, and social marketing and work-based services, in addition to the pre-existing facility based and outreach family planning services [2].

Despite the fact that contraceptive usage has increased over a period of time, there exists a Knowledge, Attitude and Practice-gap regarding contraception [3,4]. The reasons for not using any family planning methods are lack of knowledge and education, religious belief and fear of side effects. FP has two main objectives; firstly, to have only the desired number of children and secondly, pro-per spacing of pregnancies [5]. The widespread adoption of family planning represents one of the most dramatic changes of the 20th century[6].

Besides of this, globally the burden of sexual and reproductive health remains considerable. It has been suggested that sexual and reproductive conditions account for 18.4% of the global burden of diseases and 32.0% of the burden of diseases were among women age 15-49 years [7]. .Hence, the sexual health of young people (15-24 years) is a matter of intense public health concern. The adverse consequences of unsafe sexual behavior such as pregnancy and sexually transmitted infections; including HIV/AIDS and other STI are common among young women[8,9].

In addition to these, the annual rate of increase varies from country to country, on average the world population is growing at 1.5% every year[9]. If this growth rate continues, the world population will be 12 billion by 2050. According to the 2007 Ethiopian census, the population was increasing by 2.6% (about two million) each year and should this rate of growth continue, it is estimated that the population of the country will double every 23 years. As a result of the high fertility rate, poor health conditions in general, and inadequate availability of medical care, the risks of pregnancy are higher in Africa than anywhere else. An African woman's chance of dying from pregnancy-related causes, such as obstructed labour, post-partum hemorrhage and infections, hypertensive disorders of pregnancy and unsafe abortion, averages 900 per 100,000 live births.

In contrast, the risk of maternal death in the industrialized nations averages 27 per 100,000 live births. In Ethiopia, for instance, an average of 673 women per 100, 000 live births die from pregnancy-related causes. On other side, according to Ethiopia reproductive health strategy[10] actions already have been taken by reducing the current total fertility rate of children per woman 7.7 to 4.0; and increasing the prevalence of contraceptive use from 4.0% to 44.0%. But a better understanding of FP services of why young women have difficulty using contraceptives continuously even when they do not want to become pregnant and sexually transmitted diseases including HIV infection continues to be a major reproductive health problem as a result of increasing levels of sexual activity and unsafe sex[4, 10,11,12,13]

Other than these, expanding access to FP at youth systems level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs) in 2030 [13] and took actions according to the Ethiopian Demographic and Health Survey married women and sexually active unmarried women age 15-49, modern contraceptive method (MCPR) currently used, based on background characteristics of Ethiopia(10) increased from 6%-35%, but still 38% of the potential demand for FP is being unmet, Modern contraceptive use (MCPR) of Oromiya state 28%.And near 29 % of the potential demand of them still unmet . Furthermore, in the study area between 1994 and 2007 the population size of the Sendafa town was growing on the average at 3.82 percent per annual. But between 2007 and 2011 population of Sendafa town growth rate increased to 5.1%[10].

Therefore, unplanned pregnancy and sexually transmitted infections among young women can be prevented through effective use of contraception[14]. Insight of these justifications, the outcomes of this research work expect to important for identifing why young women have difficulty using contraceptives continuously even when they do not want to become unplanned pregnant and showed the gap inconsistent contraceptive use among women.

On other hand, young people enter the reproductive years the demand for FP services will increase[15]. Therefore, the present study was initiated to assess knowledge and attitude on use of modern family planning methods and barriers among female students at Sendafa Town Youth Center, Oromia Regional, Ethiopia.

2. MATERIALS AND METHODS

2.1. Study Area

The study was carried out in Berek district of Sendafa Town Youth Center, Surrounding Finfine Special Zone, and Oromia State, Ethiopia. Sendafa Town is located at about 38 km northeast of Addis Ababa [16], along the Addis Ababa to Mekele highway (Figure 1).

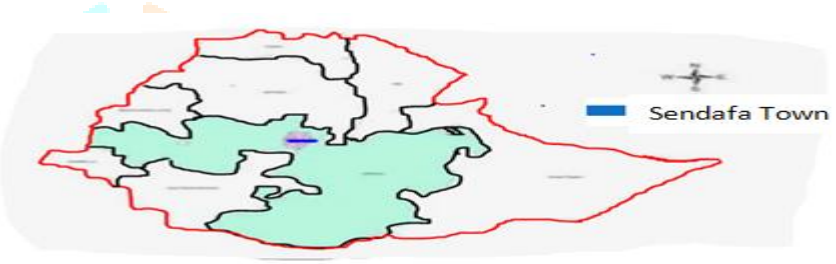

Figure 1: Sendafa Town (Source: GIS - atlas of Central Oromia in 2001)

The total population of the town was 25,578, from this male 13,099(51.2%) and 12,479(49.8%) were female[17], 66.9% were in 15-64 age group and 2.5% were above 64 years of age. But the youth population age group from 15-24 in the town was 7,593(45.7%), from this 3,660(22%) female youth and duration of the study from May, 2/2020- January, 30/2021.

2.2. Study population

The study population consisted of non-pregnant female students aged 15-24 years who were in the youth age group according to the WHO [14] definition. Additionally, those who lived in the area for at least six or more months and married or unmarried ladies were also included. On the other hand those critically ill excluded.

2.3. Study Design

A cross sectional study was designed. Structured questionnaires were developed in Afan Oromo and Amharic languages. A systematic sampling for quantitative; purposive for qualitative; SPSS 20 statistical applied. Sample size determination based on P (50%) –there was no similar study in area, d (5%), α (5%) and $Z_{\alpha 12}$ (1.96). The researchers had to use a population infinities correction factor.

Therefore, $n_o = \frac{(Z\,\alpha 12)^{2\cdot} P\,(1\text{-}P)}{d^2}$ n_o is 384.

Since N=3660, we have to use again a population finite correction factor, formula

$$n_f = \frac{no\ .}{1+ no/N} \qquad n_f \text{ is } 348$$

Where us, n_o = the sample size from infinite population, N = finite population and nf = finite sample size calculated based on finite population correction formula which it was N is less than 10,000 we should add 10 percent for non- responses resulted in a final sample size of 348 for quantitative; and qualitative used 12 KIIs; and P < 0.2 used as cut off point with Chi- square(X^2-test) . For consistency and reliability, triangulate with the qualitative results.

3. RESULTS

3.1. Socio demographic characteristics of the participants

The socio-demographic characteristic of this study revealed that all of the respondents were in the age group of 15-24 with the mean age 17.15 ± 1.73SD. Median and modal age were 18 year (Figure 1).

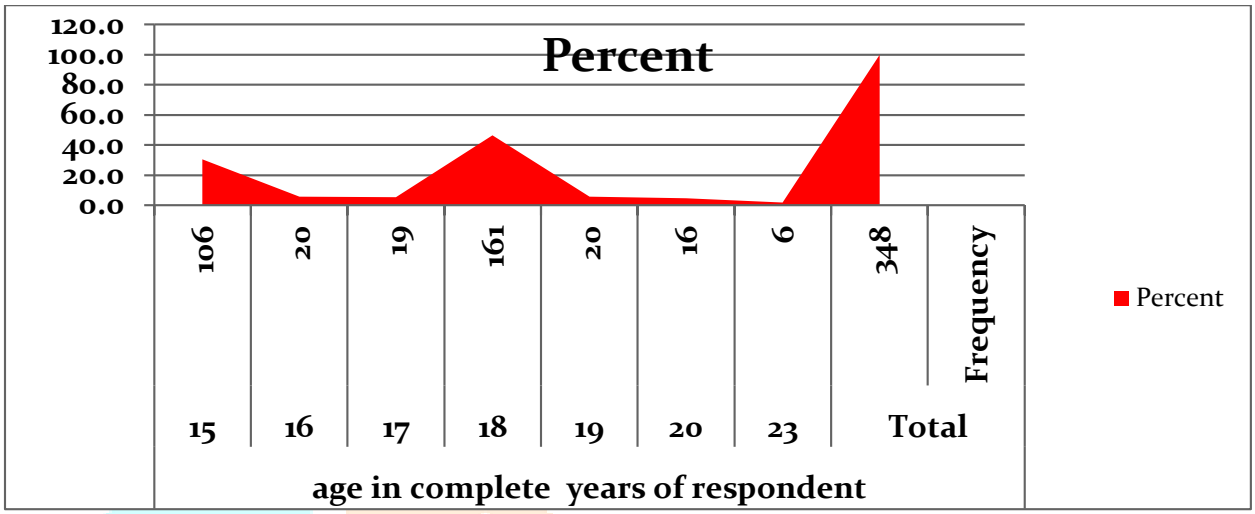

Figure 2: Area graph of ages of respondents of female students found at youth center in Sendafa town.

High average monthly refund pocket money they got from their parents (60%) of the participants was up to hundred birr. The respondents were living in the area up to one year (64.7 %)(Table 1).

Table 1: The Frequency and percentage of the socio-demographic characteristics of female students at youth center of Sendafa Town August, 2019

Variables	Frequency (**N**)	Percentage (**%**)
Religion (N=348)		
Christianity	259	74.4
Islam	45	12.9
Others	44	12.6
Education level (N=348)		
Primary school	38	10.9
Secondary school	238	68.4
Above secondary school	72	20.7
Birth place (N= 348)		
Urban	238	68.4
Rural	110	31.6
Marital status (N=348)		
Never Married	253	72.7
Married	50	14.4
Divorced	8	2.3
Widowed	37	10.6
Living arrangement (N=348)		
With both parent	152	43.7
With relatives	171	49.1
Lonely (Renting house)	25	7.2
Regular refund pocket money(N= 348)		
Yes	257	73.9
No	91	26.1
Average monthly income money(N=348)		
Less than100	209	60
Above 100	139	40
Duration of stay in the area(N=348)		
Less than 1 year	225	64.7
Above 1 year	123	35.3

3.2. **Reproductive Health characteristics of Respondents**

Two hundred twenty nine (72.2%) of the respondents reported having had practice of casual sex and from the total 348 of the respondents 91.1% female youths had boyfriends. The reason for abortion among female youth those responded (73.2%, n=131) was pregnancy affected their studies. One hundred sixty nine (48.6%) Of those respondents who had used FP methods during their life time, no pregnancy and across all female youths had used modern contraceptives with other factors constant (Table 2).

Table 2: Sexual activity and reproductive health of female students at youth center of Sendafa Town August, 2019

Variable Categories	N	%
Presence of boyfriend(N=348)		
Yes	317	91.1
No	31	8.9
Number of previous boyfriends (N=317)		
One only	245	77.3
Two and above	72	22.7
Have you practice of casual sex (N=317)		
Yes	229	72.2
No	88	27.8
Number of pregnancy (N=179)		
One time	149	83.2
Two times	12	6.7
Three and above times	18	10.1
Ever seen miscarriage/abortion(N=179)		
Yes	105	58.7
No	74	41.3
Number of abortion happened (N=179)		
One times	145	81
Two and above times	34	19
Reason for abortion (N= 179)		
Unmarried/ Affected Study	131	73.2
Complete Family	7	3.9
Economic Problem	27	15
Spacing	14	7.9
Number of children had (N= 74)		
One child	48	64.9
Two and above children	26	35.1

3.3. Knowledge of contraceptives and family planning

Over all knowledge of respondents about modern family planning methods was more than half (60.6%). This universal answer is from "Yes" and "No". For method specific knowledge, to capture multiple answers from six variables and these got four mean values and above got knowledgeable and these less than four mean values got not knowledgeable for modern family planning (Figure 3).

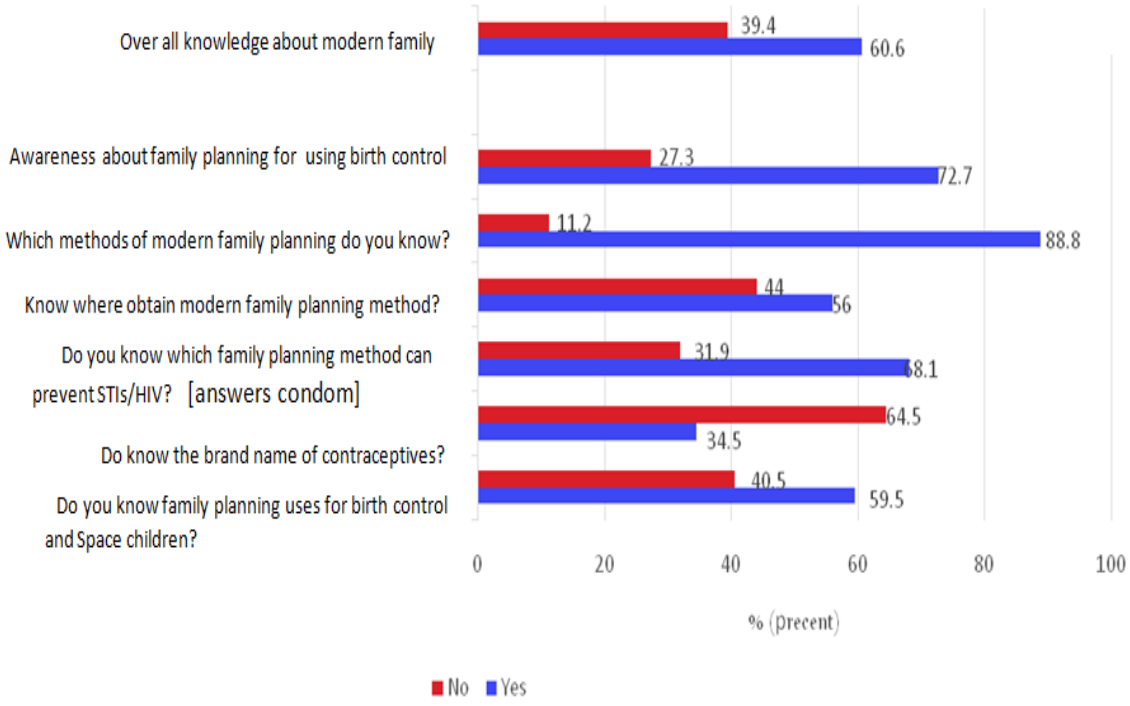

Figure 3: Over all Knowledge of contraceptives and family planning among female students at youth center of Sendafa Town

3.4. Attitude toward contraceptive

Over all attitudes of respondents about modern family planning methods (FPM) was more than half (62.4%) were good attitudes about family planning. This answer came from "Yes" and "No". For method specific attitude, to capture multiple answers from eight variables and these got three mean values and above got good attitude and these less than three got not good attitude (Figure 4).

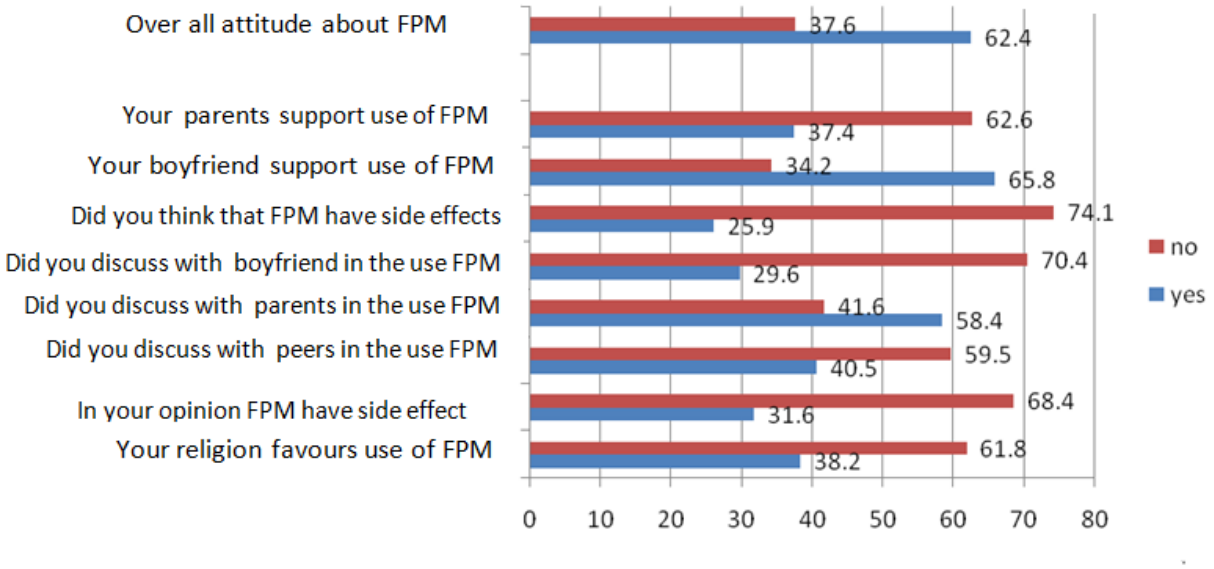

Figure 4: Over all attitudes to use modern family planning methods of female students at youth center of Sendafa Town

3.5. Plan to use modern family planning methods and services

3.5.1 Plan to use modern family planning methods

Oral pills and Condom were the most commonly used methods currently which were used by 104 (34.2%) and 79(26%) by respectively. Of the total 348, the 238 (68.4%) of respondents took intended to use modern family planning in the future (Table 3)

Table 3: Current use modern family planning methods of female students at youth center of Sendafa Town August, 2019

Contraceptive methods currently on use (N=304) .	**Frequency (N)**	**Percent(%)**
Oral pills	104	34.2
Inject able	61	19.9
IUCD	33	11
Implants	27	8.9
Condom	79	26
Reasons for current use of contraceptive methods [N=326]		
Prevent pregnancy	164	50.3
Prevent STIs/HIV	91	27.9
Enhances sexual performance	16	4.9
Treat Gynecological conditions	55	16.9
Reasons for not using current contraceptive methods [N=310]		
Not sexually active	65	21
Desire pregnancy	25	8.1
Prevent pregnancy by others	81	26.1
Feel can't get pregnant	22	7.1
Afraid of side effect	116	37.4
Presence of free discussion on use of FP with spouses (N=340)		
Yes	50	14.7
No	290	85.3
Plan or intention to use FP(N=348)		

Yes	238	68.4
No	110	31.6

3.5.2. Plan to use and perceive access to family planning services

The respondents 83.1% knew FP services depend on the distance; about 8.8 % it was two taxi drops from their house, for about 17.5% a taxi drop from their house & it was within a walking distance for about 28.4 %. The respondents 91.6% gave witness as MFP in school curriculum taught in the school, and again source of information about family planning higher in media(45.4%) than others source of information(Table 4).

Table 4: Access to family planning services among female students at youth center of Sendafa Town August, 2019

Variables	Frequency (N)	Percent (%)
Cost of obtaining FP (N=310)		
Much expensive	88	28.4
A little bit expensive	110	35.5
Acceptable	112	36.1
Are you pleased with the services?(N=342)		
Very pleased	79	23.1
Partially pleased	82	24
Don't know	139	40.6
Not pleased	42	12.6
Time to reach FP service centers(N=342)		
Within walking distance	99	28.9
A taxi drop	61	17.8
Two taxi drop	30	8.8
Outside your place of residence	110	32.2
Don't know	42	12.3
Nature of your service provider(N=341)		
Pharmacy store	42	12.3
Health center	141	41.3
Private hospital	29	8.5
Public hospital	58	17
Dedicated center	71	20.8
Sources of information about FP (N=348)		
Mass media(TV, Radio, newspaper)	158	45.4
Hospital/Health workers	100	28.7
Others *	90	25.9
Do schools to teach FP (N=345)		
Yes	316	91.6
No	29	8.4
know about FP by level of schools (N=333)		
Primary	91	27.3
Secondary	200	60.1
Tertiary	42	12.6
Availability of FP service at youth center(N=337)		
Yes	82	24.3
No	130	38.6
Don't know	125	37.1

*Internet, peers, elders, parents, relatives, scholars.

3.6. **Barriers of intention to use modern family planning**

The model fitness Hosmer and Lemshow model goodness fit test was conducted and it is significant. On the multi variable analysis: Time the live in urban was found to be major predictor of plan to use modern FP, female youths who live more than one years in urban area were 4.3 times were higher plan to utilize FP than live one years and less in urban area [AOR=4.3(1.1-18.4)], Similarly 6.7 times higher plan to utilize FP than born and grew in rural area [AOR=6.7 (1.5-30.6)] ,female youths who had monthly refund pocket money were 6 times higher plan to utilize FP than girls who had no monthly pocket money [AOR=6.05 (1.4-25.7)], and female youths who live with relatives were 38 times higher plan to utilize FP than girls who live with parents [AOR=38 (5.8-248)].

4. DISCUSSION

It has been understood that 60.6% of the respondents over all knew about the importance of contraceptive and family planning's. This is related with the study in Indian 82.2%, Sudanese 87%, Lesotho 97.5 % and Cambodia 99.3%[18,19,20,21,22,23] .The knowledge of contraceptive of the respondents finding in this study was less than four places. This variation could be due the difference in study geographical areas.

In this study the common sources of information about knowledge of contraception were Mass media (45%) followed by health worker 45%, and others personal relations i.e. Peers, relatives and internet 6.6%. This is related with past studies shows that radio use to be the highest source of information on family planning closely followed by friends and television [23,24] . But study undertaken in Iraq showed that health personnel 54%, relatives 41.2% and friends 4.8% were the major sources of information[3,25] and in this study association of knowledge of contraception of the participants with intention to use modern family planning was found to be statistically not significant .

In this study overall had been had positive attitude toward family planning (62.4%). This is related with the study in Nepal 90% had positive attitude towards family planning practice[26]. This variation could be due the difference the religion, parents, and friends of the respondents. Attitudes of women towards family planning are influenced by education and their past experiences of contraceptive[26]. In this study attitude of the participants is high . But indeed the association of overall attitude of contraception of the participants with intention to use modern family planning was found to be statistically no significant in the this study(P>3).

In this study living arrangement was found to be major predictor of plan to use modern family planning, female youths who live with relatives were 38 times plan to utilize family planning than girls who live with parents. This is also agreed with the qualitative study finding in this study. A study conducted in Kenya also indicated only 7.5% female youths were able to discuss issues of family planning with parents[21,27]. This could indicate negative attitude of parent towards contraceptive, of course it is just not intentional but unknowingly, it could also imply the fear of parents that contraceptive encourage promiscuity.

In this study, a large portion of clients of 87.4 % of sexually active female youth students currently used contraceptive. This is greater than study made in Addis Ababa which was 51% [28] and greater than study conducted by Ethiopian Demographic and Health survey which was 12% for the age group 15-24 years of female youth sexually active. Also it is greater than study conducted in Bahirdar senior secondary school female youth which was 8.5% of sexually active high school students reported use of contraceptive[29]. Off the beaten path, the researchers of this study recommended that in the future by continuous effort to educate all young equally in rural and urban, most especially the female youths (age 15-24) in preparation for a healthy sexual and reproductive future through Religions, Families and Peers group.

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AVAILABILITY OF DATA AND MATERIALS

All related data have been presented within the manuscript. The data set supporting the conclusion of this article is available from the corresponding author upon reasonable request.

DECLARATIONS ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The institutional review board of Adama Science and Technology University reviews and approved the study. Ethical clearance to conduct the study was obtained from the Institutional Review Board of Adama Science and Technology University. Study participants were informed about the purpose of the study, anticipated benefts and harm, how they are chosen to participate, data collection procedures, and their full rights to refuse, withdraw, or completely reject part or all of the study. The participant's name was not documented or recorded.

AUTHORS' CONTRIBUTIONS

Mosisa Dejene(MPH) and Bayisa Chala(PhD) were responsible for the conception of the research idea, study design, data collection, analysis and interpretation, and supervision ; Both authors participated in the data collection, entry, analysis, and manuscript write-up. All authors contributed to and approved the final version of the manuscript to be published.

COMPETING INTERESTS

The authors declare that they have no competing interests

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