

Full Length Research Paper

# Factors Affecting Women's Contraceptive Use in Ethiopia: Analysis based on EDHS 2011 Dataset

**Nega Jibat**

MA, Assistant Professor of Sociology at Jimma University, Ethiopia. .

Article history

Received: 02--09-2017

Revised: 12-09-2017

Accepted: 24-09-2017

Corresponding Author

**Nega Jibat**

MA, Assistant

Professor of Sociology at  
Jimma University,  
Ethiopia.

Abstract

Contraceptive use has been suggested as a means of curbing negative effects of fast population growth and to ensure sustainable development. As a result, reproductive health services in general and fertility control in particular has become social, economic, political and human right agenda. However, contraceptive use is usually reported low in less developing countries including Ethiopia yet they have high fertility rates. Factors affecting contraception uptake in Ethiopia require series of analyses to uncover how they operate either as barriers or facilitating forces. Such analyses also give clue about patterns of change in women's use of contraceptives through time. Women's and men's awareness about contraceptives, effects of women's residential and religious backgrounds on their propensity of using contraceptives are analyzed in this paper. Effects of women's visit to health facilities on their likely use of contraceptives are also examined along their place of residence and religious affiliations. Ethiopian Demographic and Health Survey 2011 (EDHS 2011) dataset was analyzed using SPSS version 20. The analysis revealed that about 95% of women and 98% of men in Ethiopia have awareness about at least one contraceptive method. However, only 31% of women have used any contraceptive method so far and only about 20% of the total women in reproductive age were using any type of contraceptive methods at the time of data collection in 2010. Women's contraceptive use is affected by their religious affiliations, visit to the health facilities, whether they hear information about contraceptives on the radio and type of residence. Christians in general and Orthodox followers in particular are relatively more users of contraception than other religious groups. Explanations of the possible reasons for why this is the case requires further investigation. Larger proportion of urban women contraceptive users than their rural counterparts was also observed though there was no difference in their level of awareness about the methods. Identification of factors contributing for the variation also requires further analysis. It is concluded that disseminating knowledge is not sufficient to ensure women's utilization of contraceptives and there is no significant differences between rural and urban residents in access to information about contraceptives but urban residents have better access to the services.

**Key terms:** Contraceptive use, Family planning, Fertility control, Women, EDHS 2011, Ethiopia

**Introduction**

Fast population growth has been globally recognized as a problem in many aspects (UNFPA, 2011a). Among others, fast population growth creates shortage of farm land; it thereby worsens unemployment and other poverty conditions. The negative effects of high fertility rate account for the rapid population growth and serious problems for maternal and infant health (UNFPA, 2011b). Given these facts, fertility control has become social, economic, political and human right agenda. Concern of population growth is also agenda of environmental degradation and use of natural resources. Consequently, improvements in reproductive health services are planned to reduce population growth which in turn is believed to lead to development (Prata and Summer, 2015). Use of contraceptives is considered as a major mechanism of fertility control; induced abortion is another. The former is emphasized in this article. "Fertility control refers to patterns of human behavior that have as their primary objective the prevention of unwanted pregnancies and births. Individuals and couples adopt these patterns in accordance with their cultural values and reinforced by formal or informal social pressures" (Macmillan 1968:382).

Contraceptives of one form or another are used almost in all regions of the world. Contraceptive use is broadly considered advantageous for the individual user (a woman), her children and the family at large. Use of family planning is also partly understood as basic right of couples to decide freely and responsibly whether, when and how many children to have (Ahmed et al., 2012 and Bhutta et al., 2014). Contraceptive use is considered low in the least developed countries (40%); it is even lower in Africa (33%) (United Nations, 2015). Ethiopia was characterized by high fertility rate (4.8%), high induced abortion and low uptake of modern

contraception. It was one of the leading countries in the world in the number of maternal death (Prata and Summer, 2015). Even though, the maternal mortality ratio declined from 1,200 per 100,000 live births in 1994 to 500 in 2013 (Jones et al, 2014), it was still among the higher. Like in other developing countries, information about sexual and reproductive health was inadequate for girls and women in Ethiopia (Options, 2008). Public sector is the primary provider of reproductive health services supported by NGOs and the service is integrated at primary health care system having health extension workers at forefront in the village to increase access to the services (Prata and Summer, 2015). Even though family planning service was offered for free, Ethiopia remained among countries with low contraceptive use prevalence rate with only 29% for all women and 42% for married women during the survey (CSA, 2014).

Lack of knowledge about contraceptive methods is among the most cited barriers to fertility regulation which is a commonly analyzed variable in DHS based reports. Bongaarts and Bruce (1995) for instance indicated lack of knowledge as a principal reason for not practicing family planning. Another factor associated with less utilization of contraception is misconceptions about contraceptive methods and fear of the side effects of using those methods. Contraceptive use is suspected of harming women's health and fertility. Stereotypes and social stigma are other variables identified by studies. Contradictory messages about whether to use contraceptives from partners, parents, teachers, cultural leaders and health workers were identified as key obstacles to uptake contraceptive use in Uganda (Nalwadda et al. 2010). It is also reported that health workers may communicate negative rumors about different types of contraceptives (Adera et al. 2015). Likewise, men's sexual jealousy discourages women from contraceptive use in Tanzania (Schuler et al., 2011). The study found that men worried that women's use of contraception might allow them to be promiscuous and unfaithful when there is no fear of conceiving. Cultural beliefs and sentiments are also among the important factors associated with fertility control. Casterline et al., (2001) noted that socio-cultural and religious disapprovals of contraception are important obstacles to use contraceptive methods. Providers' bias in terms of excluding the youth from using contraception and limiting the service only to women also plays significant negative roles in fertility control. Lack of suitable and effective contraceptive methods for men has become a growing concern among both men and women (Bullock 1997, Ahmed et al. 1998 and Adera et al. 2015). Community-level fertility norms are important determinants of contraception use. More specifically, the number of children desired by others in the community affects use of contraception by a woman. Family planning services are also considerably affected by several socioeconomic factors in Ethiopia such as, religious and traditional views, economic conditions, restrictions on women in decision making, cultural values, women's position in the family and society at large (Tolassa 2004). Therefore, use of family planning is affected by factors operating at the levels of individual, family, friendship and peer group, neighborhoods and community, institutional and the policy environments.

Public response to the need of reproductive health services in the country goes back to the 1993's Population Policy of Ethiopia which is the departing point from the Imperial and Military rulers in taking the issue of population growth into considerations (Prata and Summer, 2015). The policy approaches population in relation to food shortage and pointing at importance of keeping balance between need for food, population growth and the socioeconomic development of the country. Among the objectives of the policy were to reduce fertility rate from 7.7 to 4 and increase prevalence of modern contraception use from less than 5% to at least 44% among married women. However, some NGOs had been providing modern family planning services in previous regimes and a new development in post-ICPD was that the government created conducive environment for NGOs working on reproductive health. The National Population Policy resulted in reduction of fertility rate of 5.5 in 2000 to 4.8 in 2011 and almost doubled prevalence of contraceptive use from 15% to 29% during same period (Prata and Summer, 2015).

This paper is intended to assess the awareness, prevalence and factors related to contraceptive use among women of reproductive age in Ethiopia based on 2011 EDHS dataset. Specifically, it attempted to analyze prevalence of people's awareness about and utilization of contraceptive methods in Ethiopia; to determine the relationships between religious affiliation and women's contraceptive use; to examine the relationships between type of residence and women's contraceptive use; and to analyze effects of three selected covariate factors on women's contraceptive use.

### Materials and Methods

Ethiopian Demographic and Health Survey (EDHS 2011) dataset obtained from Central Statistics Authority was used as data source for this analysis. Descriptive and inferential statistics and SPSS version 20 were used for the analysis. Frequency distribution was used to examine women and men's awareness about contraceptive methods and prevalence of women using contraceptives. The chi square was used to test hypothesis for independence between contraceptive use and some selected independent variables. The chi square was preferred being nonparametric or "distribution-free" test. Chi square is also flexible as it can be used with variables at any level of measurement and with variables that have many categories or scores. Its model assumptions are also easily satisfied (Healey, 2009). Whether contraceptive use is independent from religious affiliation and place of residence of the respondents was tested. The null hypotheses were that contraceptive use was independent from religious affiliation and type of residence. In order to measure association between the dependent variable (contraceptive use) and the two independent variables (religious affiliations and type of residence), phi and Cramers V were employed. Moreover, logistic regression was applied to predict the likely effects of three independent variables on the dependent variable. The independent variables or the predictors include visit of health facilities, hearing

information about family planning on radio and type of place of residence. Therefore, this article is an output of purely secondary analysis of quantitative data.

## Results

### *People's Awareness Level about Contraceptive Methods*

In this sub-section, women's and men's awareness level about contraception was computed, interpreted and analyzed. Towards this end, the original data arranged in four variable categories in the EDHS dataset were recoded into only two categories so as to identify those who know at least a contraceptive method from those who do not know any method. Accordingly, 15633 (94.7%) of women in reproductive age (15-49) had awareness about at least one contraceptive method whereas only 882 (5.3%) do not know any contraceptive method. When we look at the general types of contraceptive methods, almost all women do not know about non-modern contraceptive methods as nearly all of those who know at least one method are aware of modern contraceptive methods. Only 52 (0.3%) respondents know either only folkloric or only traditional method compared to 15581 (94.3%) who know modern methods. This might be because of either the traditional methods are of limited type or less promoted if exists in a sufficient manner. User's views about differences in the feasibility, accessibility and effectiveness of the two methods might also be another possible reason for such wider variations. Knowing details of these requires a more focused study which is beyond the scope of this article.

It appears that information about the modern contraceptive methods is sufficiently disseminated nearly to all people in rural and urban residence areas. Given the large majority of women live in rural areas in Ethiopia, it is fairly possible to assume that even rural women have adequate access to information about contraceptive methods. One may also argue that the modern contraceptive methods had almost replaced the folkloric or traditional methods of contraception or the latter are not provided as alternative services. Likewise, men's awareness about contraceptive methods in general and by types of contraceptive in particular was also assessed. The result shows that nearly 98% of men had awareness about at least one contraceptive method at national level and all of these know about the modern contraceptives. The relative higher proportion of men's awareness about contraceptive methods could be the result of men's better access to public information than women because of their gender positions and roles. Men's better access to education and higher level of educational attainment could also result in such relative differences even though women are more targeted by reproductive health service programs.

### *People's Utilization of Contraception*

In sub-section 3.1, women's and men's awareness about contraception methods was examined whereby widest coverage of information dissemination was assumed with minor differences between the two sex categories. However, people's awareness about contraception may not guarantee their utilization of the methods hence knowing about it is not a sufficient condition to practice. So, it can be easily understood that other personal, interpersonal, cultural or structural factors determine the propensity of women's use of contraceptives. People's values and capability to use contraceptive methods may intermediate their actual practices.

In contrary to the highest proportion (nearly 95%) of women who know about at least one contraceptive method, 69% of them did not use any technique or did not attempt to delay or avoid pregnancy in their life. That is, only 31% of all women had ever used any technique or had attempted to delay or avoid getting pregnancy at least once. Even though this evidence tells us about women's overall experience in relation to their practice of fertility control, it does not clearly depict the actual proportion of women in reproductive age who were using any contraceptive method for fertility control. Manipulation of another related variable, current use of contraceptive, gives clearer coverage of contraceptive use at the time of data collection in 2010. Accordingly, only about 20% of the total women in reproductive age were using any type of contraceptive methods. This is quite lower even if there are sexually inactive women who are not supposed to use contraceptive right at the data collection time. The EDHS data reveals that about 62% of the total women respondents were either married or in union at the time which could be derived from their current marital status.

### **Chi-square Test 1: Contraceptive Use and Religious Affiliations**

Is there difference in using contraceptive methods among people of different religions? The null hypothesis for the chi square test is that the variables are independent. Values for the chi square (critical) at alpha .05 and  $df= 5$  is 11.070, the Chi square (obtained) is 364.491 and the exact significance of the chi square is .000 which is less than the standard indicator of a significant result (alpha .05). So, we may conclude that there is statistically significant relationship between religious background and contraceptive use as contraceptive use is dependent on religious affiliation. Hence, we reject the null hypothesis of independence between the two variables.

A significant chi square means that the variables are (probably) dependent on each other in the population. That is, religious affiliations make a difference in whether women use or do not use contraceptives. To determine the exact nature of the relationship, column percents allow us to examine the bivariate relationship in a more detail. By comparing the column percents for the various scores of the independent variable, we can exactly see how the independent variable affects the dependent variable (Healey, 2009: 267-269). That is, column percents help to make the relationship between the two variables more obvious (*See table 1*). The column percents show that 91% of traditional religious followers in this sample are high on not using vs. only 76% of Orthodox Christians

whereas the Protestant, the Catholic and the Muslims are on the continuum between the two religious followers. We have already concluded that the relationship is significant, and now we know patterns of the relationship. The Orthodox Christians were more likely users of contraceptives. We already knew that this relationship is significant because it is unlikely happen by random chance and now, with the aid of column percents, we know how the two variables are related. According to these results, however, religious background is not as such important factor in determining the contraceptive use which become more evident comparing the three religions other than Orthodox and the Traditional religion, the remaining three religions have closer percentages to each other. Their difference with Traditional and Orthodox is also not considered large enough.

**Table 1: Women’s Contraceptive Use by Religious Groups in Ethiopia (2010)**

		Religious Affiliations						Total
		Orthodox	Catholic	Protestant	Muslim	Traditional	Other	
Current contraceptive use	Not using	5315	149	2418	5451	85	130	13548
		76.0%	84.2%	82.4%	88.3%	91.4%	95.6%	82.1%
	Using	1680	28	518	719	8	6	2959
		24.0%	15.8%	17.6%	11.7%	8.6%	4.4%	17.9%
Total		6995	177	2936	6170	93	136	16507
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Chi-square Test 2: Contraceptive Use and Types of Residence**

Taking all points discussed in the previous variable as they are, the following features make this test differ. The two variables here (type of residence and contraceptive use) are both simple dichotomies. That is, people have been classified as either urban or rural by residence and as either using or not using contraceptives. The question is whether contraceptive use is affected by type of residence.

**Table 2: Women’s Contraceptive Use by Types of Residence in Ethiopia (2010)**

		Type/place of residence		Total
		Urban	Rural	
Current contraceptive use	Not using	3956	9598	13554
		74.2%	85.8%	82.1%
	Using	1373	1588	2961
		25.8%	14.2%	17.9%
Total		5329	11186	16515
		100.0%	100.0%	100.0%

As the obtained chi square (328.275) is larger than the critical one (3.841 at sig.000), the test statistic falls into the critical region and, therefore, we reject the null hypothesis of independence for these two variables (type of residence and contraceptive use). That is, the variables are dependent on each other in a sense that contraceptive use is affected by respondents’ type of residence. The test statistic (328.275) clearly falls into the critical region (which begins at 3.841; df=1), so we may reject the null hypothesis. These data suggest that contraceptive use varies by type of residence in a nonrandom fashion. Evidences provided in Table 2 indicate that while 26% of urban women were using contraceptive, only 14% of rural women were using it.

**Measures of Association**

In the previous sub-sections, we dealt with the hypothesis tests for statistical significance of the relationships between variables to know whether the relationships or differences between the variables are mere random chance or reflections of patterns in the populations from which the samples were selected. Measures of association address how strong is the relationship between the variables and the direction or pattern of the relationship, information complementary to tests of significance. Measures of association enable us to examine the theoretical importance of relationships between variables that the tests of significance may not tell us. Two measures of association between contraceptive use and the other two variables (Types of Residence and Religious Affiliation) are presented in this sub-section. Phi and Cramer’s V were used to measure associations of the two variables respectively.

**Contraceptive Use and Type of Residence**

To assess the strength of the association between the two variables a phi was used. We already knew that the relationship was statistically significant at the 0.05 level but Phi, as a measure of association, adds information about the strength of the relationship. It is found that there is a moderate-to-strong relationship between these two variables.



**Table 3:** Strength of Association between Contraceptive Use and Type of Residence

		Type of place of residence		Total
		Urban	Rural	
Current contraceptive use	Not using	3956	9598	13554
		74.2%	85.8%	82.1%
	Using	1373	1588	2961
		25.8%	14.2%	17.9%
Total		5329	11186	16515
		100.0%	100.0%	100.0%

The computed value of phi or  $V$  of 0.141 (at Sig.000) means there is a weaker-to- medium association between contraceptive use and type of residence. Although measures of association represent relationship between variables in a single number, inspecting the patterns of cell frequencies or percentages in the table along with the summary measure of association maximizes the amount of information about the relationship (Healey, 2009: 315). As for the pattern of the association, the column percentages in Table 3 shows that urban women are more users of contraceptive methods than rural women. Accordingly, rural residences tend to have weaker association with contraceptive use than urban.

*Contraceptive Use and Religious Affiliation*

By applying the same logic used in 3.5.1 except Cramer’s  $V$  is used here because of size of the table, the strength of association between contraceptive use and religious affiliation is determined as follows. Cramer’s  $V$  is used because it is a more general statistic to measure association when either the row or the column is greater than 2 which cannot be properly measured by phi. In a similar fashion, the computed value of  $V$  of 0.149 (at Sig. 000) means there is a weaker-to-medium association between contraceptive use and religious affiliation. For additional information, the percentage column in Table 4 indicates that orthodox religious followers were more users of contraceptive methods whereas traditional and ‘other’ religious followers tend to be reluctant in using. Catholic, Muslim and Protestant followers are medium in using contraceptive methods.

**Table 4:** Strength of Association between Contraceptive Use and Religious Affiliation in Ethiopia (2010)

		Religion						Total
		Orthodox	Catholic	Protestant	Muslim	Traditional	Other	
Current contraceptive use	Not using	5315	149	2418	5451	85	130	13548
		76.0%	84.2%	82.4%	88.3%	91.4%	95.6%	82.1%
	Using	1680	28	518	719	8	6	2959
		24.0%	15.8%	17.6%	11.7%	8.6%	4.4%	17.9%
Total		6995	177	2936	6170	93	136	16507
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Logistic Regression*

The dependent variable of interest in this analysis, that is, contraceptive use is categorical (using or not using) in which logistic regression allows us to test models to predict categorical outcomes with two or more categories. SPSS procedure labeled as Binary Logistic was used as the dependent variable has only two categories (Pallant, 2002, 2005). In this analysis, three covariate or predictable variables namely, types of residence, visit to the health facilities and hearing information about family planning on radio were treated. The value .000 (which really means  $p < .0005$ ) indicates that the model (with our set of variables used as predictors) is better than SPSS’s original guess which assumed that everyone would report not using contraceptive. The chi-square value which we need to report in our results is 890.240 with 3 degrees of freedom. Values for the Cox & Snell R Square and the Nagelkerke R Square values in the Model Summary.053 and .086 respectively are suggesting that between 5.3% and 8.6% of the variability is explained by this set of variables. The Classification tables (*not presented in this paper*) indicate that the model correctly classified 82.1% of cases overall which is equal to the 82.1% in Block 0.

The value of the statistic for each predictor in the Wald test in the column labeled Wald looking for the Sig. is less than .05. Therefore, the variables contribute significantly to the predictive ability of the model. The three significant variables ( $V_{025} p=.000$ ,  $V_{384} p=.000$ ,  $V_{394} p=.000$ ) respectively represent visits to the health facilities, hearing information about family planning on radio and type of residence. In this case, among the major factors influencing whether a person reports using contraceptive, these three variables are considered to know the share they contribute in affecting the dependent variable. The variable measuring whether the respondent has

visited health facilities showed a negative B value (-.448) that indicates those who have visited the health facilities less likely report using contraceptives. For the two other significant categorical variables (hearing family planning on radio and place of residence), the B values are positive. This suggests that women reported they have heard family planning information on radio or those who live in rural areas are more likely to answer using contraceptive to the question whether they currently use any contraceptive.

**Table 5:** Variables in the Equation

		B	S.E.	Wald	Df	Sig.	Exp(B)	95% C.I. for EXP(B)	
								Lower	Upper
Step 1 <sup>a</sup>	V025(1)	-.479	.045	111.424	1	.000	.620	.567	.677
	V384A(1)	.387	.045	73.128	1	.000	1.472	1.347	1.609
	V394(1)	.903	.042	456.833	1	.000	2.468	2.272	2.681
	Constant	-1.757	.048	1335.045	1	.000	.172		
a. Variable(s) entered on step 1: V025, V384A, V394.									

Odds ratios (OR) in the Exp(B) column among persons answering they currently use contraceptive is 0.62 times lower for someone who reports visited health facilities than for a person who did not visit, all other factors being equal. In contrary, the odds for persons answering they currently use contraceptive is 2.468 times higher for someone who reports heard family planning on radio than for a person who did not. Although visiting health facilities is also a significant predictor (Sig. value p=.000), the odds ratio for this variable is .62, a value less than 1 which indicates that the more a person visits health facilities, the less likely he/she is to report using contraceptive. For every extra visit a person does, the odds of her reporting contraceptive use decreases by a factor of .62, all other factors being equal. For each of the odds ratios Exp(B) shown in the Variables in the Equation table, the confidence interval for our variable living in rural area (V394 OR=0.409) ranges from 2.272 to 2.681. So, although we quote the calculated OR as 0.409, we can be 95% confident that the actual value of OR in the population lies somewhere between 2.272 and 2.681. The confidence interval in this case does not contain the value of 1, therefore this result is statistically significant at p<.05.

## Conclusion

The fact that nearly 95% of women and 98% of men in Ethiopia know about at least one contraceptive method but only 20% of women were using contraceptives proves that people's status of knowledge is no more an outstanding factor to determine utilization of contraceptives. Sex and rural-urban divisions are also not important factors in accessing contraceptive knowledge. Lesser utilization of contraceptives regardless of the higher proportion of women's awareness about it implies that widely disseminating information about contraceptive methods is just part of the solution by creating awareness. Cultivating favorable attitudes, values and ensuring practical usage are not yet achieved given the contraceptive utilization is still lower. Likewise, socioeconomic and cultural environments are not conducive to ensure improved contraceptive utilization. Women's propensity to use contraceptive use partly depends on their religious affiliations and type of residence hence programs and services that tend to reduce fertility rate cannot be effective by disregarding these variables. Christians are relatively more users of contraception than other religious groups. Explanations of the possible reasons for why this is the case requires further investigation. Larger proportion of urban women contraceptive users than their rural counterparts were also observed though there was no difference in their level of awareness about contraceptive. Factors contributing for this variation also require further in-depth analysis.

## References

- Addis Adera, Tilahun Belete, Asefa Gebru, Alganesh Hagos, Woldegebriel Gebregziabher. 2015. "Assessment of the Role of Men in Family Planning Utilization at Edaga-Hamuse Town, Tigray, North Ethiopia." *American Journal of Nursing Science*. Vol. 4, No. 4, 2015, pp.174-181. doi:10.11648/j.ajns.20150404.15
- Ahmed, Saifuddin and Solomon. 2012. Maternal deaths averted by contraceptive use.
- Ahmed Yusuf, Mulima Ketata, John, and Skibiak .1998. *Emergency contraception in Zambia: Setting a new agenda for research and action*. Nairobi: Population Council.
- Bhutta, Zulfiqar A. and Joshi.2014. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? *The Lancet*, vol. 384: 347-370.
- Bongaarts, John and Judith Bruce. 1995. The causes of unmet need for contraception and the social content of services. *Studies in Family Planning* 26(2): 57-75.
- Bullock and Joan.1997. Raising awareness of emergency contraception. *Community Nurse* 3(7): 28-29.
- Casterline , John B., Zeba A., Sathar, and Minhajul Haque.2001. Obstacle to contraceptive use in Pakistan: A study in Punjab." *Studies in Family Planning* 32(2): 95-110.
- CSA [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF.
- CSA [Ethiopia]. 2014. *Ethiopia Mini Demographic and Health Survey 2014*. Addis Ababa, Ethiopia.

Collier and Macmillan. 1968. International Encyclopedia of the social sciences. United States of America Vol.5 the Macmillan company and the free press. *Development* 13(3): 217-222.

Healey, Joseph. F. 2009, 2005. STATISTICS: A Tool for Social Research, eighth edition, Wadsworth Cengage Learning

Jones, N., Bekele, T., Stephenson, J., Gupta, T. and Pereznieta, P. with Emire, G., Gebre, B. and Gezehegn, K. (2014). *Early marriage and education: the complex role of social norms in shaping Ethiopian adolescent girls' lives: Country Report*. Overseas Development Institute (ODI).

Nalwadda G., Mirembe F., Byamugisha J., and Fanelid E. 2010. Persistent High Fertility in Uganda: young people recount obstacles and enabling factors to use of contraceptives. *BMC Public Health*, 10(1):530-542.

Options. 2008. *Ethiopian Women's Perspectives on Reproductive Health Results from a PEER Study in the Guraghe Zone*.

Pallant, J. 2002, 2005. SPSS Survival Manual A step by step guide to data analysis using SPSS for Windows (Version 12). Allen and Unwin

Prata, N. and Summer, A. (2015) Assessing political priority for reproductive health in Ethiopia. *Reproductive Health Matters*, 23(46):158–168.

Tolassa. 2004. The Role of Men in Family Planning in a Rural Community of Western Ethiopia, Addis Abeba :18-21

United Nations, Department of Economic and Social Affairs, Population Division .2015. Trends in Contraceptive Use Worldwide 2015 (ST/ESA/SER.A/349).

UNFPA .2011a. Population Trend <http://www.unfpa.org/pds/trends.htm> (2011 May 6th)

UNFPA. 2011b. Population and Poverty <http://www.unfpa.org/pds/poverty.html> (2011 April 5th)