

Contraceptive Choice and Switching Pattern among Married Women in Rural Community of South East Ethiopia

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Abstract

Background: Expanding access to long acting and permanent contraceptive methods has multiple benefits. They give women greater choice in selecting a contraceptive that meets their needs for delaying, spacing, or limiting pregnancy. They have the highest continuation rates of all family planning methods, and are more effective in actual use than short-acting methods for preventing unintended or closely spaced pregnancy. The study assessed the contraceptive knowledge, choice and switching pattern of married women in Agarfa District, Oromia, 2014.

Method: A community based cross-sectional study was conducted in Agarfa district. A total of 788 married women aged 15-49 years were involved in the survey. They were selected through systematic random sampling technique. The data were collected by using structured interviewer administered questionnaire, and analyzed by using SPSS version 21.

Result: The most ever known (98.5%) and ever used (81.5%) type of modern contraceptive was Depo-provera. Permanent methods were rarely recognized as contraceptive method. Three forth (75.9%) of the participants were on modern contraceptive during the interview time. Twenty nine percent of those who want to limit their birth were not taking any modern contraceptive (MC). Nearly half (45%) of the participants stated fear of side effect was their main reason for non use of MC. Thirty percent (29.4%) of the participants had history of method shift from one MC to other MC method. The highest shift was observed from pill to depo-provera (49.1%), followed by depo-provera to implants (26.7%).

Conclusion: Women's awareness and choice of contraceptives is limited to short acting methods. There is perceived fear of side effects of modern contraceptive. Women desiring no more children were not using any method. Therefore, strengthening the FP counseling to address fears of side effects and increase client awareness of expected and unexpected side-effects of all methods is essential.

Keywords: Contraceptive switching; contraceptive choice; Agarfa; Bale zone; Oromia; Ethiopia

Introduction

Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices. Modern contraceptives (MC) include short acting, long acting, and permanent methods. Long acting and permanent contraceptive methods (LAPMs) are convenient for users and effectively prevent pregnancy and cost-effective for programs over time, can result in substantial cost savings for couples, governments, and contribute directly to reaching national and international health goals by providing long-lasting contraceptive protection. This includes methods like implant, intra uterine device (IUD), and sterilization [1]. Long acting reversible contraceptives are safe and reversible, require little to no maintenance, and have much better compliance rates than other hormonal methods [2]. In contrary, the utilization of these methods is very low. A discrepancy exists between the proportion of women who wish to stop having children and the proportion who are using LAPMs [3].

The national prevalence rate of MC use among currently married women was 29%. Thirty seven percent of women want no more children but only 2% of married women were using IUD, 3% implant and less than 1% reported having been sterilized. Injectables (21%) were the most popular methods [4]. The magnitude of modern contraceptive (MC) utilization in Mojo town was 38.3%. Injectables was the most frequently used (55.45%) followed by pills (26.06%), condom (7.1%), IUD (5.21%) and Norplant (0.95%) [5]. A study conducted in Goba South East Ethiopia, showed that the overall utilization rate of LAPMs was 8.7% [6].

Fewer people have knowledge of IUD, tubal ligation and vasectomy than of other methods [7, 8]. The 2011 Ethiopian demographic health survey (DHS) showed that the knowledge of any MC among currently married women was high (97%). But specific knowledge of each LAPMs was very much low. The finding indicated that female sterilization (39.8%), male sterilization (10.8%), IUD (26.4%) and implants (69.2%) [4].

In a country like Ethiopia with high fertility rate and unmet need of contraceptives shifting towards one of the long acting or permanent contraceptive methods is an important strategy. But the situation is controversial. The contraceptive method mix is dominated by short acting methods like pills and injectables [9-11]. The Ethiopian reproductive health (RH) strategy has been planned and is working on the provision of all FP methods, especially LAPMs. There are at least two health extension workers and/or community-based agents in every Kebele with the training, knowledge, and skills needed to provide basic FP services and refer for LAPMs [12]. Despite of this

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and the presence of all modern contraceptive methods, utilization is very low especially LAPMs and limited very much to the short term methods such as pills and injectables [10].

A better understanding of patterns of contraceptive use will help inform program and policy approaches for encouraging consistent and effective contraceptive method use. It is, therefore essential to examine the pattern of method shift and contraceptive choices so that well targeted interventions could be undertaken. The result of this study can be used as a baseline information for further studies in that area and provide important information for program managers and other concerned bodies to enable them provide proper health services to these segments of the population and the community at large.

Methods

During March to May 2014 a community based cross sectional study was conducted in Agarfa District which is one of the Districts found in Bale Zone, Oromia National Regional State in Ethiopia. A total of 788 married women (15-49 years of age) with history of modern contraceptive use found in Agarfa district were included in the study. Married women with history of modern contraceptive use but were severely ill or unable to respond for the questionnaires were excluded from the study. Out of 21 Kebeles in the district, 10 Kebeles were selected using simple random sampling technique. Then the sample was proportionally allocated to the size of the Kebeles. After calculating the sampling interval (K value), the households (HH) with married women with history of modern contraceptive use was selected by systematic random sampling technique. When there was no eligible woman in the selected HH, the next HH was selected for interview. When two or more eligible women were present in one household, only one woman was considered by lottery method.

Questionnaire was prepared first in English then translated to local language (Oromifa) by language expert. To ensure consistency of the translation with the English version; the questionnaire was translated back to English by another language expert. Before the actual data collection, the questionnaire was pre-tested on 5% (39 women) of the sample size in the same district from those Kebeles not included in sample. Based on the pre-test, the time needed for the completion of interview was estimated, questions were revised, edited, and those found to be unclear or confusing were modified. Data were collected using structured and pretested interviewer administered Oromifa version questionnaire. Ten Oromifa speaker who had a minimum 12th grade completed were collected the data. Two Bachelor degree holders supervised the data collectors. Data collectors and supervisors were trained for one day on the study instrument and interviewing techniques. The interviews were conducted in a place where the woman feels free to express her feelings and ideas. Moreover, in occasions where the sampled women are not accessed for absence, up to three visits was considered for interview to minimize the non-response rate. Daily close supervision and spot checks of filled in questionnaires was made by the field supervisors and investigator deployed with the data collectors.

Data were first entered to Epi-Info version 3.5.1 and cleaned. Then data were exported to Statistical Package for Social Sciences (SPSS) version 21.0 for analysis. Descriptive analyses were carried out for each of the variables. Ethical clearance was obtained from Ethical and Review Committee of Madawalabu University. Official permission letter was obtained from Madawalabu University, College of Medicine and Health sciences to Bale Zone Health Office then to Agarfa Health office. Oral informed consent was obtained from all study participants

after the explanation of study objectives. All the information obtained from the respondents remained confidential and anonymous.

Results

Socio-demographic characteristics of the participants

Table 1 shows the socio-demographic characteristics of the participants. The mean age of the participants was 31+ 6.3 years. Most of the participants were Oromo (86.3%) by Ethnicity and Muslim (49.4%) by religion (Table 1). About three fourth (73.9%) and 29.9% of

Socio- demographic characteristics	Frequency (n)	Percentage (%)
Age group of participants		
15-19	8	1
20-24	86	10.9
25-29	270	34.3
30-34	175	22.2
35-39	156	19.8
40-44	71	9
45-49	22	2.8
Religion		
Orthodox	347	44
Muslim	389	49.4
Protestant	21	2.7
Catholic	31	3.9
Ethnicity		
Oromo	680	86.3
Amhara	105	13.3
SNPP	2	0.3
Summali	1	0.1
Educational level of participants		
Can't read and write	178	22.6
Can read and write	68	8.6
Grade (1-4th)	227	28.8
Grade (5-8th)	215	27.3
Grade (9-12th)	87	11
Grade 12+	13	1.6
Educational level of their partner		
Can't read and write	54	6.9
Can read and write	44	5.6
Grade (1-4th)	165	20.9
Grade (5-8th)	287	36.4
Grade (9-12th)	177	22.5
Grade 12+	61	7.7
Occupation of participants		
House wife	616	78.2
Government employee	36	4.6
Private employee	108	13.7
Daily labourer	16	2
Farmer	12	1.5
Occupation of their partners		
Government employee	88	11.2
Private employee	245	31.1
Daily labourer	29	3.7
Farmer	426	54.1
*Family monthly income (ETB)		
<300	196	24.9
300-800	425	53.9
>800	167	21.2
*income was categorized based on quartiles, ETB-Ethiopian birr		

Table 1: Socio-demographic characteristics of married women in the reproductive age group, Agarfa District, May, 2014 (n= 788).

the participants had radio and TV in their home, respectively. Almost all (96.4%) of the participants were living with their husband during the interview time. Ninety four percent (94.3%) of the participants reported as their husband have only one wife. Whereas the rest 41 and 4 of the participants reported as they were the second and third wife of their husband, respectively.

Reproductive history of the participants

Almost all (97.3%) of the participants have history of birth. The mean age at first marriage and first birth of the participants was 18.6 + 2.1 years and 20.1 + 2.2 years, respectively. The mean number of alive birth was 4.3 + 2.3 children per women. The mean ideal desired number of children to have was 5.5 + 1.7 children ranging from 1 to 12 children. More than half (58.6%) of the participants do not want to have child within two years. Of those, 40.3% was to limit their birth (Table 2).

The most ever known type of modern contraceptive was Depo-provera (98.5%) followed by pills (82.5%). Female and male sterilization were recognized as contraceptive method by only one participant. The participants mentioned health professionals (70.8%) as their

Variables	Frequency (n)	Percentage (%)
<18years	222	28.2
18 – 25 years	564	71.6
>25 years	2	0.3
Ever birth (n= 788)		
Yes	767	97.3
No	21	2.7
<18years	104	13.6
18 – 25 years	658	85.8
>25 years	5	0.7
Number of living children (n= 788)		
≤ 3	338	42.9
4-5	227	28.8
≥ 6	223	28.3
Number of more child wanted (n=765)		
0	199	26
2-Jan	460	60.1
≥ 3	106	13.9
Wants more children with in 2 years (n=788)		
Yes	326	41.4
No	462	58.6
Reason for not wanting (n=462)		
To space	276	59.7
To limit	186	40.3
Discussion on FP with partner (n= 788)		
Yes	430	54.6
No	358	45.4
How often do you discuss (n= 430)		
Always	65	15.1
Sometimes	187	43.5
Occasionally	178	41.4
Decision on the number of children (n= 788)		
Husband	25	3.2
Wife	32	4.1
Both	513	65.1
God	218	27.7

Table 2: Reproductive history of married women's in the reproductive age Agafar District, May, 2014 (n=788) Knowledge about modern contraceptives of the participants.

main source of information for the modern contraceptive they ever knew. More than one third (39.3%) of the participants had history of discussion on MC with their female friends and almost all of them were comfortable discussing FP methods with their female friends (Table 3).

Participants' beliefs and perceptions on modern contraception

Eighty five percent of the participants stated that their husband supports FP use. Majority of the participants (97.1%) perceived that using contraceptive method is good for family. More than a quarter (30%) of the participants perceived that prolonged use of FP methods could lead to various diseases or even death (Table 4).

Modern contraceptive utilization pattern of the participants

The most ever used type of MC was Depo-provera (81.5%) followed by Pills (38.3%). Three forth (75.9%) of the participants were on modern contraceptive during the interview time. The most common contraceptive method currently used by respondents was depo-provera (65.2%). Nearly half (45%) of the participants stated fear of side effect was their main reason for not currently using MC. About contraceptive decision making, most of all the women (83.4%) said they had joint decision with their husbands and only (8.4%) were making sole decisions (Table 5).

Modern contraceptives switching pattern of the participants

Thirty percent (29.4%) of the participants had history of method shift from one MC to other MC method. The highest shift was observed from pill to depo-provera (49.1%), followed by depoprovera to implants (26.7%).The main reason stated for their shift was inconvenience of previous method (Table 6).

Discussion

The most ever known type of modern contraceptive was Depo-provera (98.5%) followed by pills (82.5%). This is comparable with the finding obtained in Adigrate town, Northern Ethiopia [13]. Even though the study was conducted among ever users of modern contraceptives, only one participant recognized permanent contraceptive methods as a contraceptive method. Method 15 specific knowledge levels varied from 12% for vaginal contraceptives (diaphragm, foam, jelly) to 94% for pills and injectable contraceptives [14]. Majority of the participants (97.1%) acknowledged the importance of contraceptive for their family but 30% of the participants perceived that prolonged use of FP methods could lead to various diseases even death.

The most ever used type of MC was Depo-provera (81.5%) followed by Pills (38.3%). Three forth (75.9%) of the participants were on modern contraceptive during the interview time. About fifty nine percent (58.8%) of the participants want to space or limit their birth but 25.3% of them were not using any contraception methods. Twenty nine percent of those who want to limit their birth were not taking any MC. The most dominant method used was depo-provera (65.2%). In contrast to our finding, over half of the women in Nepal were using either female or male sterilization [15]. This could be due to the low level of knowledge of long acting and permanent contraceptive methods. Another explanation for this could be due to the convenience of the method (Depo-provera) in terms of decreasing number of visit and remembrance to take, and the potential secrecy to use [13].

Nearly half (45%) of the participants stated fear of side effect was their main reason for not using MC. Similarly, participants have fear or perceived side effects of contraceptives, like being infertile after use of the method [16,17]. Is indicates the need of addressing negative information about each contraceptive methods. Health providers

Variables	Frequency (n)	Percentage (%)
*Types of modern contraceptives known (n= 788 each)		
Pills	650	82.5
Depo-Provera	776	98.5
Implants	425	53.9
IUD	110	14
Tubal ligation	1	0.1
Vasectomy	1	0.1
Condom	213	27
(n=788)		
Neighbours/friends/relatives	78	9.9
Health professionals	569	72.2
Health Development Army	130	16.5
Mass media	6	0.8
Husband	5	0.6
Best source of information about FP		
Neighbours/friends/relatives	16	2
Health professionals	558	70.8
Health Development Army	133	16.9
Mass media	31	3.9
Husband	50	6.3
Discuss about modern FP method with your female friends		
Yes	310	39.3
No	478	60.7
Are you comfortable discussing FP methods with your female friends		
Yes	297	95.8
No	13	4.2
Exposure to MC message within 12 months		
Yes	286	36.3
No	502	63.7
*Type of media (286 each)		
Television	96	33.6
Radio	208	72.7
Print media	7	2.4
*Each of the percentages does not add up to 100.0 because respondents could choose several responses		

Table 3: Knowledge about modern contraceptives of married women in the reproductive age group, Agarfa District, May, 2014.

Statements regarding perceptions on MC	Level of agreement		
	Agree, n(%)	Neutral, n(%)	Disagree, n(%)
Your husband supports FP use	668(84.8)	15(1.9)	105(13.3)
Using contraceptive method is good for my family	765(97.1)	20(2.5)	3(0.4)
Couples who jointly decide to use contraceptive method have healthier children	727(92.3)	47(5.9)	14(1.8)
Using family planning methods will benefit your family financially	725(92.0)	38(4.8)	25(3.2)
Using family planning methods is beneficial for women's health	674(85.5)	60(7.6)	54(6.9)
Longer use of FP methods could lead to various diseases/even death	240(30.5)	79(10.0)	469(59.5)
Access to choice of methods	713(90.5)	42(5.3)	33(4.2)
There are competent providers in the facilities	672(85.3)	60(7.6)	56(7.1)
Providers can be trusted to maintain confidentiality	646(82.0)	116(14.7)	26(3.3)
Discuss with spouse or convince spouse to use	683(86.7)	46(5.8)	59(7.5)
Contraceptives can harm a woman's womb	207(26.3)	62(7.9)	519(65.9)

Table 4: Beliefs and perceptions on modern contraceptives among married women in the reproductive age group, Agarfa District, May, 2014, (n= 788).

Variables	Frequency (n)	Percentage (%)
Contraceptives ever used (n=788)		
Pills	302	38.3
Injectables	642	81.5
Implant	133	16.9
IUD	12	1.5
Emergency contraceptive	8	1
Condom	26	3.3
Your husband know you were using contraceptive		
Yes	746	94.7
No	42	5.3
Was the method what you wanted		
Yes	693	87.9
No	95	12.1
How often (37)		
Once	31	83.8
Twice	4	10.8
Three times and above	2	5.4
Opposition to MC Use		
Yes	82	10.4
No	706	89.6
Who opposed you (n=82)		
My religious leaders opposed me	4	4.8
My husband	20	24.4
My girl friend	25	30.5
My neighbours	16	19.5
My mother/mother in law	17	20.8
Current use (n=788)		
Yes	598	75.9
No	190	24.1
Which method are you using now (n=598)		
Pills	95	15.9
Injectables	390	65.2
Emergency contraceptive	1	0.2
Implant	104	17.4
IUD	8	1.3
Source of current method (n=598)		
Health center	253	42.3
Government hospital	109	18.2
Private clinic	11	1.8
Health extension workers	225	37.6
Reason for not use (190)		
I am pregnant	16	8.4
I want to be pregnant	48	25.3
Method fail while I am using	27	14.2
I fear its side effect	85	45
I am infecund	10	5
I stopped to use	2	1.1
Husband opposed me	2	1.1
Do you want to use for the future		
Yes	688	87.3
No	100	12.7
Decide on taking of your FP methods		
Husband	65	8.2
Myself (wife)	66	8.4
Both	657	83.4

Table 5: Practice of modern contraceptives among married women in the reproductive age group, Agarfa District, May, 2014.

Variables	Frequency (n)	Percentage (%)
Ever shifted (n=788)		
Yes	232	29.4
No	556	70.6
Reason for shifting (n=232)		
For inconveniency of previous method	122	52.6
For the convenience of the new method	53	22.8
Due to lack of access to the previous method	1	0.4
Due to side effect	48	20.7
Provider advised me	1	0.4
Partner influenced me	3	1.3
I forget it	4	1.7
Shifted from to (n=232)		
Pill to Injectable	114	49.1
Injectable to pill	19	8.2
Pill to implant	17	7.3
Pill to IUD	3	1.3
Injectable to Implant	62	26.7
Injectable to IUD	5	2.2
Implant to injectable	8	3.4
Implant to pill	2	0.8
Condom to pill	2	0.8

Table 6: Contraceptive Method Shift among married women in the reproductive age group, Agarfa District, May, 2014.

should provide factual information about risks, potential side effects, and incorporate it into a family planning strategy that meets each client's particular needs [18].

Reliance on ineffective and unreliable methods can lead to unintended pregnancy and unsafe abortion [18]. Thirty percent of the participants had history of method shift from one MC to other MC method. The highest shift was observed from pill to depo-provera (49.1%), followed by depo-provera to implants (26.7%). Switching rates were higher for short term contraceptives (pills and injectables). The proportion of users switching from short acting methods to long acting and reversible methods (implants and IUD) was highest for injectables followed by pills. This could indicate that the demand of long acting is increasing [13]. The main reason stated for their shift was inconveniency of previous method followed by convenience of the new method and side effect. Similarly, side effects and wanting a more effective method of contraception was the main reason of switching [19].

The finding should be interpreted taking the limitations of this study in to consideration. Since this study examined the pattern of MC utilization only among women on marriage, the sample was limited to only currently-married women at the time of the study. Hence, these results may not be able to be generalized to all women in Agarfa District. Interviewer bias may be there especially in the questions with probing. The study did not ascertain the availability of all contraceptive methods, quality of FP counseling, providers' attitudes and behaviors on MC use. Providers' attitude regarding family planning plays an important role, either in choosing or continuing contraception [18]. Therefore, further detail investigation on the availability of all contraceptives, quality of FP counseling and providers behavior on MC should be conducted.

Conclusion

Women's awareness and choice is limited to short acting methods particularly depo-provera. There is perceived fear of side effects of modern contraceptives. There is a wide gap on the knowledge of the long acting and permanent contraceptive methods of the women in the community. Women desiring no more children are not using

any method, and of those using contraception, many are using short-acting methods. Therefore, strengthening the FP counseling service to address fears of side effects and increase client awareness of expected and unexpected side-effects of all methods is essential. Promoting all choices of modern contraceptives especially long acting or permanent methods for women who want no more children can increase the awareness and utilization rate of contraceptives.

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