



SALALE UNIVERSITY

COLLEGE OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH

MODERN CONTRACEPTIVES UTILIZATION AND ASSOCIATED  
FACTORS AMONG UNMARRIED FEMALE ADOLESCENT AGE  
15-19 YEARS IN SIBU SIRE HIGHSCHOOL, EAST WOLLEGA  
ZONE, ETHIOPIA, 2024

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## **Acronym and Abbreviations**

AOR: -----Adjusted Odds Ratio

CI: -----Confidence Interval

DHS: -----Demographic Health Survey

IUCD: -----Intrauterine Contraceptive Device

LMICs: -----Low- and Middle-Income Countries

MC: -----Modern Contraceptive

SDGs: -----Sustainable Development Goals

SSA: -----sub-Saharan Africa

STI: -----Sexually transmitted Infection

SRH: -----Sexual and Reproductive Health

WHO: -----World Health Organization

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## **Abstract**

**Background:** Contraception utilization reduces pregnancy-related health risks for women, particularly among unmarried adolescent girls. However, fewer than 30% of 15 to 19 years adolescents utilize contraception globally. Despite these there are a few studies done regarding the contraceptive utilization and its barriers in Ethiopia.

**Objectives:** The objective of this study is to assess the level of modern contraceptives utilization and associated factors among unmarried female adolescent aged 15-19 years in Sibule High School, East Wollega Zone, Ethiopia, 2024.

**Methods:** An Institution based cross sectional study was conducted among 404 unmarried female adolescents aged 15-19 years in Sibule high schools using simple random sampling technique. Data was collected using pretested self-administered questionnaire. The collected data was coded and entered into Epi-data version 4.6 and exported to SPSS v.27 for the final analysis. A Bivariate and multivariable logistic analysis was conducted. Variables with P-value <0.25 in bivariate logistic regression analysis was entered to multivariable logistic regression analysis to control the possible effect of confounders and identify significant predictors of modern contraceptive utilization while p-value<0.05, at 95% confidence interval was considered as cut off point to declare the presence of statistically significant association.

**Results:** A total of 400 unmarried female adolescents aged 15-19 participated in the study, yielding a response rate of 99%. The findings indicated that the magnitude of modern contraceptive (MC) utilization was 24% (95% CI: 20.0-28.5). Factors significantly associated with MC utilization included older age (AOR = 3.58, 95% CI: 1.69-7.54), higher grade level (AOR = 3.53, 95% CI: 1.68-7.39), receipt of voluntary counseling and testing services (AOR = 4.08, 95% CI: 1.94-8.58), the presence of a youth club in school (AOR = 2.61, 95% CI: 1.33-5.14), a history of abortion (AOR = 3.49, 95% CI: 1.73-7.09), and discussions about MCs with boyfriends (AOR = 4.18, 95% CI: 2.32-7.55).

**Conclusion:** The study concluded that the magnitude of modern contraceptive utilization among unmarried female adolescents in the study area was a relatively low. The study also identified older age, higher grade level, receipt of voluntary counseling and testing services, the presence of a youth club in school, a history of abortion, and discussions about contraceptives with boyfriends as key determinant factors of MC utilization among the study participants.

**Keywords:** Adolescent, high school female students, modern contraceptive, East Wollega

# 1. Introduction

## 1.1 Background

World Health Organization (WHO) defines adolescents as persons with the age group of 10-19 years (1). A time of both vulnerability and possibility, adolescence is marked by rapid physical changes (puberty), cognitive advancements (abstract reasoning), emotional complexities (identity exploration, mood swings), and social engagements (friendships, experimentation, developing values) (1, 2).

Adolescent are more likely to have severe health problems or even die from accidental pregnancies compared to older women (3). In fact, the WHO estimates that a third of young women needing hospital care for abortion complications are under 20 years. This is partly because many young people, especially students, are sexually active before marriage but often don't use birth control, leading to unwanted pregnancies in many countries (4) .

Utilization of modern contraceptives (MCs) are key to understanding profound changes in fertility and improving reproductive health(4). MCs refer to a variety of methods used to prevent unintended pregnancies and include hormonal methods like oral pills, implants, patches, and vaginal rings, intrauterine devices (IUDs), emergency contraception, condoms, sterilization, and the lactational amenorrhea method(5).

The use of MCs has numerous benefits for individuals, families, and countries, including improved health, economic stability, and increased autonomy and empowerment(6). Contraception reduces pregnancy-related health risks for women, particularly adolescent girls, and when expressed in terms of interbirth intervals, children born within 2 years of an elder sibling have a 60% increased risk of infant death, and those born within 2-3 years have a 10% increased risk, compared to those born after an interval of 3 years or longer (5, 7).

The use of MCs has significant benefits beyond preventing pregnancy-related health risks specially among adolescent students. It can lead to expanded education opportunities, empowerment, and economic development(8). Additionally, these contraceptives offer protection against sexually transmitted infections (STIs), addressing a significant health concern among adolescents and contributing to the overall health and well-being of young girls.

Several strategies including peer education, consumer engagement, mass media, community-based approaches, school-based approaches, comprehensive sexuality education and youth centers have been employed to increase access to contraceptives among adolescent female students (6, 9).

In Ethiopia, there is a push to increase contraceptive prevalence rates by reaching more women and adolescent girls with MCs service utilization. To increase uptake of contraceptive utilization among adolescents aged 15-19, integrated interventions aimed at empowering adolescents with comprehensive sexuality education, addressing negative attitudes and beliefs surrounding contraception through community engagement, media campaigns, and involving religious leaders and influencers would be beneficial to improving adolescent contraceptive utilization (10, 11).

## **1.2 Statement of the Problem**

Adolescent pregnancies are a global problem and complications from pregnancy and childbirth are the leading causes of death in adolescent girls aged 15- 19 in low- and middle-income countries

(LMICs)(12). In LMICs, adolescent girls are more likely to experience unintended pregnancies due to limited access to reproductive health services, including modern contraception. Every year, an estimated 21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million of them give birth(5, 7).

Ethiopian adolescent girls also often engage in early sex, leading to unintended pregnancies. Over one in three births occur to women aged 15-19 (13), with 45% of total births occurring among adolescent girls and young women. The number of births among women aged 15- 19 years is also 99 per 1,000 women (14).

Unintended pregnancies among adolescent girls often result in school dropout, stigma, discrimination, and social rejection(15). In a study done in Ghana, 86% of teenage pregnant girls had dropped out of school(16). Moreover, unintended pregnancies among adolescents can lead to serious health complications, increased risk of maternal mortality, and long-term social and economic consequences(1, 17).

Utilizing MC reduces high-risk pregnancies and pregnancy-related health risks, thereby reducing unplanned pregnancies and deliveries (5, 18). However, studies have indicated that the use of MCs among adolescent and young women in sub-Saharan Africa (SSA) remains an issue that needs urgent attention (19).

Globally, fewer than 30% of teenagers and young women aged 15 to 19 years utilize contraception in 2022. Adolescents in Australia and New Zealand, as well as Europe and Northern America, utilizes contraception more frequently. In contrast, the proportion of 15 to 19-year-olds adolescent using any contraceptive technique is less than 5% in Northern Africa, Western Asia, and Central and Southern Asia (5).

Ethiopia has seen promising progress in family planning programs for the past two decades, with modern method usage jumping from 8% in 2000 to 41% in 2019 (20). This progress wasn't even across communities, and unfortunately, most adolescents, who make up a huge part of the population, haven't been effectively reached yet. Their specific needs for family planning haven't gotten enough attention, even though they could benefit greatly from these programs (10, 20). Furthermore, low contraceptive prevalence has been reported among adolescents at 40% (10). The proportion of adolescents' MCs utilization in Ethiopia ranged from 12% (21) to 79%(22).

Available evidences have also shown that uptake of contraceptive among adolescent is influenced by individual, sociocultural, healthcare, and knowledge-related factors (21, 23-26).

As part of its efforts to address these sexual and reproductive health (SRH) challenges, the United Nations established the Sustainable Development Goals (SDGs) in 2015 with goal 3.7 focuses on ensuring universal access to SRH services, including family planning by 2030 (27). The achievement of this goal, particularly for adolescent female who frequently face SRH challenges, relies on the consistent and effective use of MCs (25).

The Ethiopian government also aims to achieve SDGs and planned to increase contraceptive prevalence from 41% to 50% and reduce the adolescent fertility from 12% to 3% by 2024/25, providing contraceptives for free of charge in public health facilities (28). However, most research conducted so far has concentrated on how women aged 15-49 use modern contraception, often overlooking adolescents aged 15-19. Additionally, these studies have failed to assess female students' contraceptive utilization specifically, as they have typically encompassed both sexes. Furthermore, prior studies on access to modern contraception have primarily centered on married women exclusively. Therefore, this study aimed to assess the magnitude of modern contraceptives utilization and associated factors among unmarried female adolescent aged 15-19 years in Sibu Sire High School East Wollega Zone, Ethiopia in 2024.

### **1.3 Significance of the study**

Studying contraceptive utilization among female students aged 15-19 in Ethiopia is significant for addressing public health concerns related to unwanted pregnancies and STIs, improving reproductive health outcomes, and enhancing awareness and access to modern contraceptives among young women.

Evidence from this study can inform policymakers and program implementers to design targeted interventions that increase contraceptive uptake and ultimately improve the sexual and reproductive health of young women in Ethiopia specifically for female students.

By identifying the factors that limit access to contraceptives for adolescents, this research can contribute to improving the sexual and reproductive health of young women in Ethiopia and ultimately contribute to a healthier and more prosperous society by increasing the uptake of contraceptive services.

For healthcare providers, this study holds significant value as it offers a deeper understanding of the specific contraceptive needs, behaviors, and challenges faced by unmarried female adolescents aged 15-19 in Ethiopia. By identifying the factors that influence MCs utilization, healthcare providers can tailor their services to better address the unique needs of this demographic.

## **2. Literature Review**

### **2.1 Prevalence of Modern Contraceptive Utilization among unmarried female adolescent**

Global contraceptive use among teenage girls has doubled from 5.9% to 10.2% from 1990-2019, with married adolescents using contraception more, while unmarried teens' use is expected to rise from 3.8% to 8.6% in 2030 (8).

In Europe and Northern America, 23.5% of adolescent women aged 15–19 years were using some method of contraception in 2019 (8). For instance, in Spain, early sexual initiation and marriage postponement have led to a rise in sexual activity before marriage, with 90% of sexually active single youth reporting contraceptive use (29).

Even though the majority of young people prefer to avoid pregnancy, only 40% in low- and middle-income countries have access to effective contraception (5). A survey study analyzing data from 261 surveys in 103 low- and middle-income countries between 2000 and 2017 found that only 31.6% of adolescent girls used MCs, highlighting unmet contraceptive needs in 73 countries (30). Furthermore, a study conducted among 29 municipalities in western Nepal found that contraceptive utilization was 11.9% (31). In Indonesia, of 691 weighted samples, more than half (60%) of respondents use MCs methods (32).

A study analyzing data from 45,054 adolescents aged 15-19 in 18 of the least developed Sub-Saharan African nations revealed a significant gap between sexual activity and contraceptive use. While 21.6% of the surveyed adolescents reported engaging in recent sexual activity, a staggering 92.4% indicated they were not using any form of contraception (33). Moreover, A mixed-effects multilevel analysis of data from 29 demographic and health surveys (DHS) in sub-Saharan Africa revealed that only 24.7% of adolescents used MCs methods (25).

Studies in Ghana show that only a small percentage of adolescents use MCs, despite a significant increase in contraceptive use between 2003 and 2008 from 23.7% to 35.1% (34). Despite over half of unmarried female adolescents engaging in sexual activity, only 22.9% used contraceptives (35), with 18% never using it in Atwima Kwanwoma District (24) and 73.6% in Nabdan District (36). Over 90% of adolescents in North and South Kivu, Democratic Republic of the Congo, know at least one MCs method. However, 31.7% of adolescents aged 15-19 have unmet contraceptive

needs, and only 16.5% use modern methods (37). Similarly, study involving 2,639 adolescent girls and young women in Mali found a 17.1% prevalence of MCs use (38).

A study in Kenya found that despite 77.5% of adolescent girls making their sexual debut by 15, contraception use is extremely low at 43% (39). Similarly, though Zambia's contraceptive use rate has slightly increased from 7.6% in 1996 to 10.9% in 2013/14, but overall remains low, according to a DHS study (40).

A 2016 Uganda DHS revealed a 9.4% prevalence of MCs use among female adolescents (41) while a 30.9% prevalence was found among 337 adolescents in urban and rural regions (42). In Nigeria, 15.3% of unmarried women engaged in sexual intercourse in 2017, while 45.3% of sexually active adolescents used MCs (43). In 2018, another study found that 15.8% of sexually active single adolescents use MCs, with half planning to use them in the future. (44).

A survey in North-Western Tanzania found that 48.7% of unmarried sexually active women aged 15-19 use modern contraception methods (45). Similarly, contraceptive use among Sierra Leonean adolescent girls increased from 5.9% in 2008 to 21.0% in 2019, while unmet family planning needs declined from 15.4% to 11.3%. Among sexually active girls, MCs use rose from 13.1% to 43.5% (46). Moreover, a 2020 Rwanda DHS revealed that only 17.4% of sexually active adolescent girls use modern contraception, with 88% having inadequate understanding (61.54%) (47). Another study revealed that while 88% of participants were aware of contraception, their understanding was inadequate, and the prevalence of contraceptive use was low, 17% (48).

A systematic review found that 40% of adolescents in Ethiopia use contraceptives methods (10), with low rates in East Ethiopia, 39.3% (26), East Gojjam, 21% (49), Debre Tabor, 14.9% (50) and Tigray, 12.3% (21).

In 2020, a study in southern Ethiopia showed that only 24% used contraception methods (51). Another study conducted in the country's southern region, KambataTambaro, found Only 9.75% of adolescent females utilized MCs (52).

In Oromia region where this study was conducted available evidences have shown that small proportion of sexually active adolescents are using contraceptive methods. For instance, a study done among in-school adolescents in Toke Kutaye woreda found that, 40.2% used one contraceptive method (53). Another study done in Jimma city found that 17.6% of adolescent females reported utilizing contraceptive services, suggesting a relatively small proportion of adolescents in the city are using these services (54).

## **2.2 Factors associated with utilization of contraceptive among unmarried female adolescent**

### **2.2.1 Socio-demographic factors**

Socio-demographic factors like education, age, residence, family's education and socioeconomic status, sexual debut age, religion, and cultural/religious norms significantly shape contraceptive behaviors among adolescent female students.

Studies show that females aged 15-19 are less likely to utilize contraceptives compared to those aged 20-24, possibly due to better understanding and affordability issues (25, 31, 36, 55). A study in Zambia, Rwanda, and Uganda revealed that older adolescent girls are more likely to use contraception than younger ones (40, 42, 47).

Level of education impacts adolescent's contraceptive use. Studies have shown that high education is linked to higher use, with comprehensive sex education raising odds of first-time use (56). Similar results were reported from studies done in Zambia, Ghana, Uganda, Nigeria, and Ethiopia (22, 36, 40, 43). In contrast, study done in Uganda showed that adolescents with low education were more likely to ever-use contraceptives (42).

The educational status of a mother has been found to be a significant factor in the use of contraceptives by her daughter. Several studies in Ethiopia have shown a strong correlation between maternal educational status and the use of contraceptives. For example, studies done in Toke Kutaye and Gondar showed that Adolescent whose mothers were illiterate were four times higher for nonuse of contraceptive than adolescents whose mother were educated above secondary schools (22, 53).

Religion significantly influences contraceptive utilization, with Muslim females showing lower odds of contraceptive use and Orthodox Christians utilizing MCs more than Muslims, according to studies in Ethiopia and SSA (25, 55). Another study done in eastern Ethiopia reported that Orthodox Christians were more likely than Muslims to utilize MCs (26).

Economic empowerment helps women access contraceptives at lower costs. Adolescents in disadvantaged communities (rural areas, communities with low literacy level and low socioeconomic status) are less likely to use contraceptive methods (25, 38, 51, 55). Urban areas and high socioeconomic status are associated with higher contraceptive use (36, 43). However, study done in Uganda contradicts this findings where adolescents from rural settings were more likely to ever-use MC methods (42).

Related with fear of the participants not wanting their parents to see them pregnant, staying or living with both parents is associated with higher odds of using MC(24).

### **2.2.2 Knowledge, Accessibility, and Attitudes related factors**

The knowledge of adolescent women about sexuality and contraception varies widely across different countries and regions and significantly affect contraceptive use. A study conducted in Mali and Kenya showed that those who had low knowledge of modern contraception had the lower odds of using MC(38, 39). Study done in Toke Kutaye, Ethiopia also showed that, adolescents who never heard about contraceptive were three times higher for nonuse of contraceptive as compared to adolescents who know at least one method of contraceptive (53). Another studies in Ethiopia also show that young women with good knowledge about contraceptive methods are more likely to use them than those with poor knowledge (51, 55).

Studies show that exposure to mass media, including radio and newspapers, increases the likelihood of contraceptive use among women. For Example, In study conducted in Tigray, Ethiopia, adolescent women who heard about contraceptives through media were more likely to use them (21). Study done among 29 African countries also reported similar finding (25). In Nigeria too, women who had not heard about contraception in the last 12 months were significantly less likely to use it (43).

Fear of side effects can affect the utilization of contraceptives among adolescents. According to a study conducted in Ghana, fear of side effects was reported as a barrier to contraceptive use by 42.2% of adolescent mothers (11). Another study conducted in Guinea found that fear of side effects of MCs products was perceived as a limiting factor in the decision of girls to use contraceptives (57).

Not knowing a place in the community where contraceptives may be obtained was also found to strongly predict non-use of contraceptives. Adolescents in Ghana and Nigeria who know where to obtain contraceptives are more likely to use them (35), while those without a history of health facility visits have lower odds of using contraceptive methods (18, 21, 58).

The attitude of healthcare providers can significantly affect adolescents' contraceptive utilization (36, 59, 60). Over half of health care providers in Nigeria view contraceptive provision for unmarried adolescents as promoting sexual promiscuity, with 42.7% believing it's unsupported by Nigerian culture. About half, 51.7% believe abstinence is more important than MCs(60).

The presence of Youth clubs in their immediate vicinity influences the use of SRH services. Adolescents in areas with functioning youth clubs have a higher chance of using MC compared to those in non-functioning areas (51).

Emerging data suggest that mobile phones and social media are promising means of increasing contraceptive use among adolescents. Study done in Nigeria revealed that, adolescent who use internet are more likely to use MC (44).

### **2.2.3 Sexual and Reproductive health related characteristics**

Empirical evidence supports the idea that peer social networks play an important role in adolescent contraceptive behavior. A study conducted in Ghana showed that those adolescent having peer influence was identified as having higher odds of using MC (61). Another study in Ghana found that not having drunk sex and not feeling pressured to have unprotected sex significantly influenced contraceptive utilization (35). Moreover, limited sex education, and poor access to services also contribute to low contraceptive usage among adolescents(62).

Male partners can influence contraceptive use positively or negatively. They can either obstruct contraceptive use or provide social support and information, which can improve contraceptive uptake and use (63). Studies in Ethiopia show discussing contraceptive use with boyfriends increases adolescents' likelihood of using MC (63) and those discussing family planning are more likely to use it (22, 26). In Nigeria, women's likelihood of using MC is lower for those who perceive their partners and friends' lack of support for contraception (43).

Adolescents with romantic sexual relationships and a long duration of their last sexual relationship are more likely to utilize contraceptive services. Moreover, adolescents with a long duration with their last sexual relationship were more likely to use a service compared to those with a short duration (22, 47). Another study conducted in South Africa also reported that those women whose last relationship was more than a month were more likely to use contraceptives than women whose last relationship lasted less than a month (64).

Research suggests that contraceptive use patterns vary across relationships, with factors such as the nature of the relationship, partner attributes, and sexual history playing a role in contraceptive use and consistency (65). Study in Nigeria also showed that having a sexual partner and multiple sexual partners increase the likelihood of using MC (44).

Parental discussions about SRH service positively influence adolescents' adoption of MC services, with a higher chance of usage compared to those without discussions in Ethiopia (51).

Adolescent girls with a history of a sexually transmitted infection (STI) have been found to have a higher likelihood of using MC compared to those with no STI history (47). History of abortion may influence contraceptive choices. Study done in Ghana showed that having abortion increase the chance of using MC among sexually adolescent (66).

### 2.3 conceptual frame work

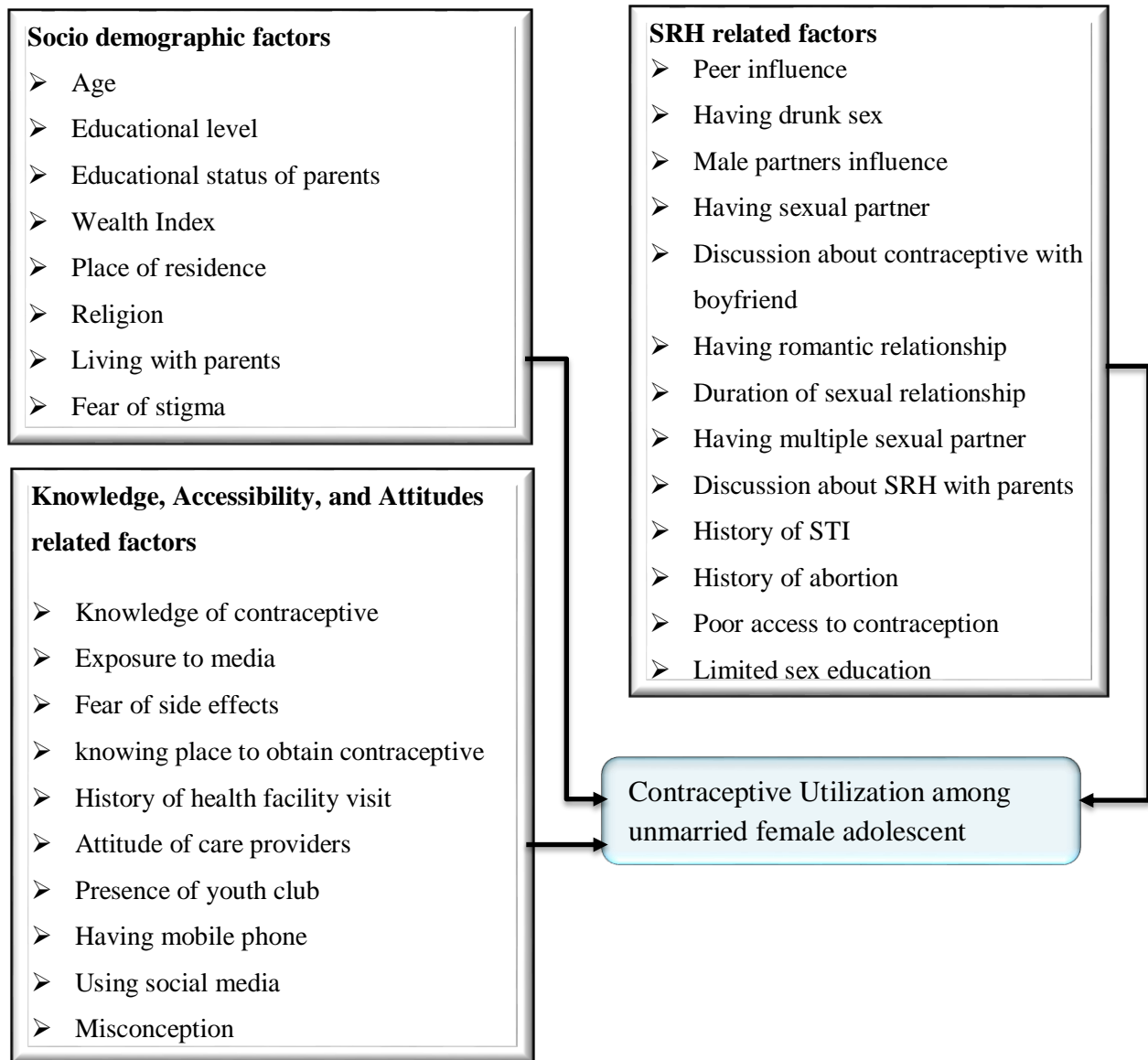


Figure 1: Conceptual frame work of factor influencing utilization of contraceptives among adolescent female, adapted from (10, 21, 23, 26, 35, 51, 55).

### **3. Objective**

#### **3.1 General Objective**

- To assess the magnitude of modern contraceptives utilization and associated factors among unmarried female adolescent aged 15-19 years in Sibu Sire high school East Wollega Zone, Ethiopia, 2024

#### **3.2 Specific Objective**

- To determine the magnitude of modern contraceptives utilization among unmarried female adolescent aged 15-19 years in Sibu Sire high schools East Wollega Zone, Ethiopia, 2024
- To identify factors associated with modern contraceptives utilization among unmarried female adolescent aged 15-19 years in Sibu Sire high schools East Wollega Zone, Ethiopia, 2024

## **4. Methods**

### **4.1. Study area and period**

The study was conducted in Sibu Sire District, East Wollega Zone of Oromia Regional State, Western Ethiopia. The area is located 281 km west from Addis Ababa and 50 km east from Nekemte, the administration town of the East Wollega Zone. It has a total population of 172,573. It is divided into 19 rural and 4 urban kebeles (small administrative unit in Ethiopia). The existing health facilities rendering health services in the town include one primary Hospital, three health centers, twenty-three health post, seven middle-level clinics and 13 small private clinics, five drug stores and supplies, three pharmacies, and five rural drug vendors. Moreover, there are 6 high schools in the town. The total number of female adolescent students in the town is 1,755.

The study was conducted between May 23, 2024 to June 01, 2024.

### **4.2. Study design**

- An institution based cross-sectional study design was employed.

### **4.3. Population**

#### **4.3.1 Source population**

- All unmarried female adolescent aged 15-19 years in Sibu Sire High schools.

#### **4.3.2 Study Population**

- All unmarried female adolescent students aged 15-19 years enrolled in randomly selected high schools in Sibu Sire district during the study period.

### **4.4. Inclusion and Exclusion Criteria**

#### **4.4.1. Inclusion criteria**

- All unmarried female adolescent aged 15-19 years attending their regular education in selected high schools in Sibu Sire was included in the study.

#### **4.4.2. Exclusion Criteria**

- Night shift students, and seriously ill students who can't able to give response was excluded from the study.

#### 4.5. Sample size determination

Sample size for the first specific objective was determined based on single population proportion formula considering the utilization level of MC among adolescents in Anchar District, West Hararghe Zone, Oromia Region, East Ethiopia which was 39.3 % (26), 95% confidence level, 5% marginal error, and 10% non-response rate.

Using the formula:  $N = (Z \alpha/2)^2 \times P (1-P)/d^2$  Where; N = Desired sample size

Z = 1.96 for 95% confidence level

P = utilization level of MC

d = Degree of precision = 0.05

$$N = \frac{(1.96)(1.96)(0.393)(0.607)}{(0.05)(0.05)} = 367 \text{ plus } 37 \text{ (10\% non-response rate)} = 404$$

Sample size for the second specific objective was determined by using EPI-info version 7, considering assumptions of 95% confidence interval (CI), 5% marginal error, power 80%, and 10% non-response rate.

Table 1: Sample size calculation to identify factors associated utilization of contraceptive among unmarried adolescent in Sibule high schools, East Wollega, Ethiopia, 2024.

Associated Factors	Proportion of exposed with outcome	Proportion of unexposed with outcome	Adjusted Odds Ratio (AOR)	Power	Calculated Sample Size	Reference
Being Orthodox Christian	47.6	52.4	3.45	80	124	<b>(26)</b>
Ever discussed about family planning	83.3	16.7	12.98	“	33	

Comparing the sample size calculated for both specific objectives, the largest sample size which is 404 was used for this study.

## 4.6 Sampling technique and procedure

From the total of 6 high schools in the Sibuu Sire Woreda three high schools were selected randomly using lottery methods. From all selected schools the list of all female will be obtained. The study units were allocated to all three schools proportional to their population size (number of adolescent girls) and a simple random sampling was employed to select study participants from each school by using the list of students from the class roster as a sampling frame.

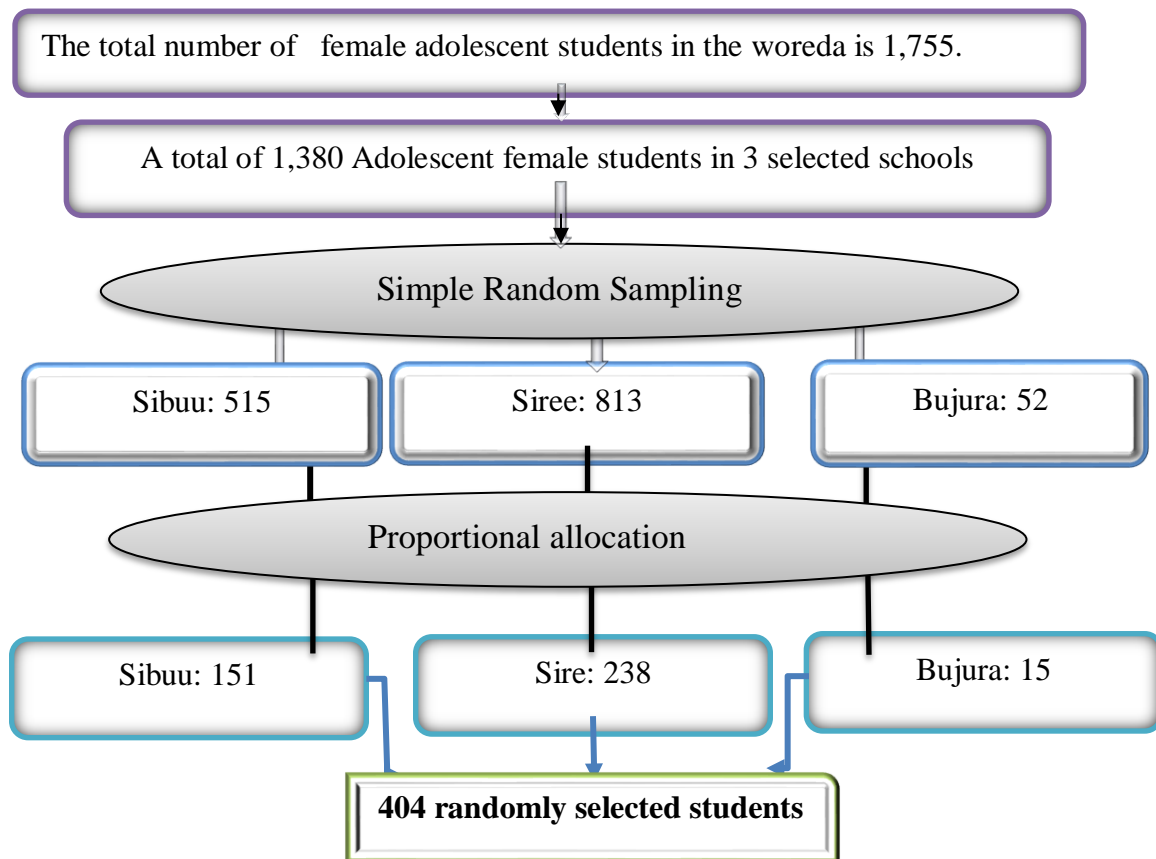


Figure 2: Schematic presentation of sampling procedure among unmarried female adolescent in Sibuu Sire high schools, East Wollega, Ethiopia, 2024

## 4.7. Study variables

### 4.7.1. Dependent variable

- Modern Contraceptive utilization (Yes or No).

#### 4.7.2 Independent variables

**Sociodemographic factors:** Age, educational status, place of residence, father educational status, religion, and wealth index.

**Knowledge, Accessibility, and Attitudes related factors:** knowledge about contraceptive, exposure to media, fear of side effects, knowing place to obtain contraceptive, history of health facility visit, attitude of healthcare providers, presence of youth club, having mobile and using social media.

**Sexual and Reproductive health related characteristics:** peer influence, having drunk sex, male partners influence, having sexual partner, discussion about contraceptive with boyfriend, having romantic relationship, duration of sexual relationship, having multiple sexual partner, discussion about SRH with parents, history of sexually transmitted infection and abortion.

#### 4.7. Operational Definition

- **Modern contraceptive utilization** was defined as a woman in the reproductive age group reported utilizing at least one method of modern family planning or contraceptives (e.g. injectable, regular pills, emergency pills, Implants, intrauterine contraceptive device (IUCD), and condom (21). It is labeled as ‘Yes’ for those who uses at least one of the contraceptive methods currently and ‘No’ for non-users.
- **Adolescent:** an individual in the age group 15-19
- **Sexually active:** those respondents who stated that, within the previous four weeks, they had engaged in sexual activity regardless of their marital status.

#### 4.8 Data collection tools and procedures

The data was collected through pretested self-administrated questionnaire. The data collection questionnaire was adapted using tools used to assess contraceptive utilization in previous studies with similar objective (11, 41, 54, 58). The questionnaire has three parts. The first part assessed about socio-demographic characteristics. The second part focused on focused on SRH health related characteristics while the last part assessed Knowledge, Accessibility, and Attitudes related factors. Six trained Nurses and three public health officers collected and supervised the data respectively.

## **4.9 Data Quality Assurance**

The questionnaire was first prepared in English, translated into Afan Oromo (local language), and later, back to English to ensure the accuracy of the meaning.

Pre-test of the questionnaire was done on 5% (21 students) out of the study area to check the response, language clarity, and appropriateness of the questionnaire two weeks before data collection period. Modifications and corrections like; wording, logical sequence and skip patterns has done immediately based on the result. A one-day orientation was provided to the data collectors and supervisors on the aim of the study, method of data collection, contents of the questionnaire, how to keep confidentiality, responders' right, and informed consent before they start the data collection.

The data collection process was closely monitored and the collected data was checked for any incomplete content by a supervisor and then by the principal investigator on daily bases. The overall activity was supervised by the principal investigator of the study.

## **4.10. Data processing, and analysis**

The collected data was thoroughly reviewed for completeness before being coded and entered into Epi Data version 3.1 software, then exported to SPSS version 27 for further analysis, with the findings presented using a combination of texts, tables, and figure. Bivariate Logistic Regression Analysis was employed to examine the initial relationship between the dependent and independent variables, and variables with a P-value of 0.25 or lower will be included in the Multivariable Logistic Regression Analysis to account for potential confounding factors and identify significant predictors of adolescent female students' contraceptive utilization. Linear Regression was used to assess for Multi-Collinearity among the independent variables using the Variance Inflation Factor (VIF), and the Hosmer-Lemeshow Statistics was used to evaluate the logistic regression model's fitness, with a value greater than 0.05 indicating a good fit. P-value of less than 0.05 was used as the threshold to determine the presence of a statistically significant association between the variables.

#### **4.11. Ethical consideration**

Ethical approval was obtained from internal review of committee of Salale University. Permission letter was obtained from Sibu Sire woreda Education Bureau. Then Letter of cooperation was also be written to each school from woreda education bureau. Written consent was be obtained from each study participant. For those aged below 18 years, informed verbal consent was taken from their guardian's (any responsible person on the study subject) before their voluntarism and assent from the participants for interview. In addition, affirmation that they were free to withdraw consent and discontinue participation without any form of prejudices is made. Confidentiality of information and privacy of participants was also assured.

#### **4.12 Dissemination of findings**

The result will be presented to Salale University. The paper will also be given to Schools in which actual data collection will take place and the woreda education office. Publication on a scientific journal and presentation on the research conferences will also considered.

## 5. Results

### 5.1 Socio-demographic characteristics of the participants

Out of 404 study participants, 400 participated in this study, with a response rate of 99%. The participants had a mean age of 16.96 years (SD = 1.42). The majority of participants identified as Protestant, accounting for 163 (40.8%) of the sample. Ethnically, most students were Oromo, representing 362 (90.5%) of the participants. In terms of living arrangements, nearly half, 179 (44.8%), lived with both parents. Regarding household assets, approximately three-quarters, 308 (77%), reported having a TV or radio at home. The vast majority, 354 (88.5%), owned a mobile phone, although only 51.7% (207) used social media. Additionally, about two-thirds, 264 (66%), reported receiving regular pocket money from their families (Table 2).

Table 2: Sociodemographic characteristics of unmarried female adolescent age 15-19 years in Sibule high schools, East Wollega Zone, Ethiopia, 2024 (N=400)

Variables	Categories	Frequency (N=400)	Percentage (%)
Age of the participants	15-16	161	40.3
	17-19	239	59.7
Grade level	9-10	194	48.5
	11-12	206	51.5
Religion	Protestant	163	40.8
	Orthodox	136	34.0
	Muslim	44	11.0
	Others <sup>®</sup>	57	14.1
Ethnicity	Oromo	362	90.5
	Amhara	38	9.5
Father's educational status	Can't read and write	106	26.5
	Can read and write	78	19.5
	Primary (1-8)	99	24.8
	Secondary (9-12)	45	11.3
	College and above	72	18.0
Fathers occupation	Government employee	72	18.0

	Merchant	72	18.0
	Farmer	256	64.0
Mother's educational status	Can't read and write	155	38.8
	Can read and write	132	33.0
	Primary (1-8)	41	10.3
	Secondary (9-12)	72	18.0
	College and above	155	38.8
Mother's occupation	Housewife	162	40.5
	Merchant	121	30.3
	Government employee	72	18.0
	Students	45	11.3
Place of residence	Urban	198	49.5
	Rural	202	50.5
Living arrangement	Both parents	179	44.8
	Single parent	29	7.2
	Alone	80	20.0
	With friends	112	28.0
Distance from home to health facility	< 30 minutes	244	61.0
	>= 30 minutes	156	39.0
History of health facility visit	Yes	271	67.8
	No	129	32.3

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## 5.2 Sexual and reproductive health related characteristics of the study participants

The majority of, 261 (65.3%), the study participants, have engaged in sexual intercourse at least once. The mean age of sexual debut was reported at 15.83 years old, with SD of 0.84 years. Approximately one-fourth of the participants, totaling 112 individuals (28%), had experienced pregnancy. Among those who had been pregnant, 85 (21%) reported having undergone an abortion. Out of those who had abortions, 23 individuals (27.1%) received unsafe abortion services from traditional healers. More than half of the students, specifically 226 (56.5%), reported having had a sexual partner, with 48 students (21.2%) indicating they had more than two sexual partners.

Moreover, 18 (4.5%) of the participants reported being diagnosed with sexually transmitted diseases by a healthcare provider (Table 3).

Table 3: Sexual and reproductive health characteristics of unmarried female adolescent age 15-19 years in Sibu Sire high schools, East Wollega Zone, Ethiopia, 2024 (N=400)

Variables	Categories	Frequency	Percentage (%)
Ever had sexual intercourse	Yes	261	65.3
	No	139	34.7
Age at sexual debut (n=261)	Below mean (< 15.83)	105	40.2
	Above mean ( $\geq$ 15.83)	156	59.8
Do you have sexual partner	Yes	226	56.5
	No	174	43.5
How long you live together (n=226)	$\leq$ 1 year	87	38.5
	>1 year	139	61.5
Number of sexual partner (n=226)	One	178	78.8
	Two and more	48	21.2
Had sexual intercourse in last one year (n=226)	Yes	180	79.6
	No	46	20.4
Do you drink alcohol (n=400)	Yes	365	91.3
	No	35	8.8
Ever had sexual intercourse after getting drunk (n=35)	Yes	22	62.9
	No	13	37.1
Is there youth club in your school (n=400)	Yes	184	46.0
	No	216	54.0
Received sex education from youth club (n=180)	Yes	119	66.1
	No	61	33.9
Received VCT service	Yes	97	24.3
	No	303	75.7

### 5.3 Study participants' information on MCs utilization

The majority of the participants, 359 (89.8%) revealed that they had ever heard of MC. Regarding the sources of information, majority of the study participants 316 (79%) and 253 (62.3%) of the study participants heard about MC from TV/Radio, and friends as their primary information sources respectively. Depo Provera, 287 (71.8%) and Condom, 260 (65%) were the most commonly mentioned MC methods by participants. Information about the benefit of MCs was also obtained from the participants and the result showed that prevention of unintended pregnancy, 253 (82.1%) and spacing, 240 (77.9%) of pregnancy was the most commonly mentioned methods by participants (Table 4).

Table 5: Information on Modern Contraceptive Utilization Among Unmarried Female Adolescents Aged 15-19 Years in Sibu Sire High Schools, East Wollega Zone, Ethiopia, 2024(N=400).

Variables	Categories	Frequency	Percentage
Ever heard of MCs	Yes	359	89.8
	No	41	10.3
MCs method you heard (n=359)	Pills	209	58.2
	Depo Provera (injectable)	287	79.9
	Implanon	238	66.3
	Jadelle	29	8.1
	IUCD	94	26.2
	Male condom	260	72.4
	Emergency contraceptive pills	186	51.8
	Permanent methods	57	15.9
Source of information (n=359)*	Teacher	177	49.3
	Internet	219	61.0
	Health care provider	113	31.5
	TV/Radio	316	88.0
	Friends	253	70.5
Benefit of MCs (n=359) you know*	Prevention of unwanted pregnancy	253	70.5
	Reduce pregnancy related risks	228	63.5
	Avoid closely spaced pregnancy	240	66.9

Prevent sexually transmitted diseases	176	49.03
Financial benefit	163	45.4
Women empowerment & education	176	49.03
Limit number of children	239	66.6
Others <sup>β</sup>	73	20.3

\*-multiple response,  $\beta$ -delays early childbearing in young girls, Contributes to sustainable population growth and economic development for countries

#### 5.4 Magnitude of modern contraceptive Utilization among unmarried female adolescent aged 15-19

In this study the magnitude of modern contraceptive utilization is 24% (95% CI: 20.0-28.5%). (Figure 3).

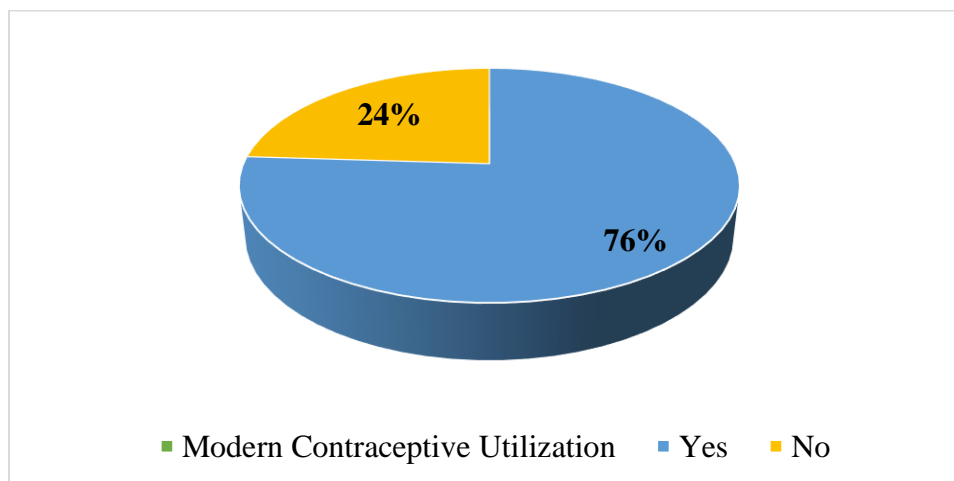


Figure 3: Magnitude of Modern Contraceptive utilization among unmarried female adolescent age 15-19 years in Sibule Sire high schools, East Wollega Zone, Ethiopia, 2024 (N=400)

#### 5.5 Sources and Role of Boyfriends in MC Usage

Participants were also asked about where they typically obtained MCs, with findings indicating that pharmacies were the primary source for 39 (40.6%) of them. The preference for pharmacies was largely influenced by factors such as confidentiality of information, 29(74.4%) and short waiting times 25 (64.1%). The majority of participants, 329 (82.3%) did not use MCs during their

first sexual encounter. Additionally, fewer than half, 145 (36.3%) reported discussing MCs with their boyfriends, while 96 (24%) stated that their boyfriends supported the use of MCs (Table 5).

Table 6: Utilization of modern contraceptives among unmarried female adolescent age 15-19 years in Sibule high schools, East Wollega Zone, Ethiopia, 2024 (N=400)

Variables	Categories	Frequency	Percentage
Which MCs you are currently using (n=96) <sup>α</sup>	Depo Provera	53	55.2
	Implanon	30	31.3
	Male Condom	74	77.1
	Emergency contraceptive pills	39	40.6
From where you obtained MCs (n=96) <sup>α</sup>	Pharmacies	39	40.6
	Health post	29	30.2
	Health center	28	29.2
	Public Hospital	23	23.9
	Private clinic/hospital	20	20.8
Why pharmacies (n=39) <sup>α</sup>	Doesn't need prescription	12	30.8
	Short waiting time	25	64.1
	Fear of bad health workers attitude	23	58.9
	Confidentiality respected	29	74.4
Do you discuss about MCs with family (n=400)	Yes	155	38.8
	No	245	61.2
With whom you discuss (n=160) <sup>α</sup>	Mother	121	75.6
	Sister	132	82.5
Can you access MCs easily (n=400)	Yes	91	22.8
	No	309	77.2

**α-multiple response**

## 5.6 Reasons given by the study participants for not using modern contraceptives

The primary reasons cited by participants for not using modern contraceptives were their lack of a sexual partner/boyfriend, 135 (44%) and the fear that contraception would cause infertility, 132 (43.4%) (Figure 4).

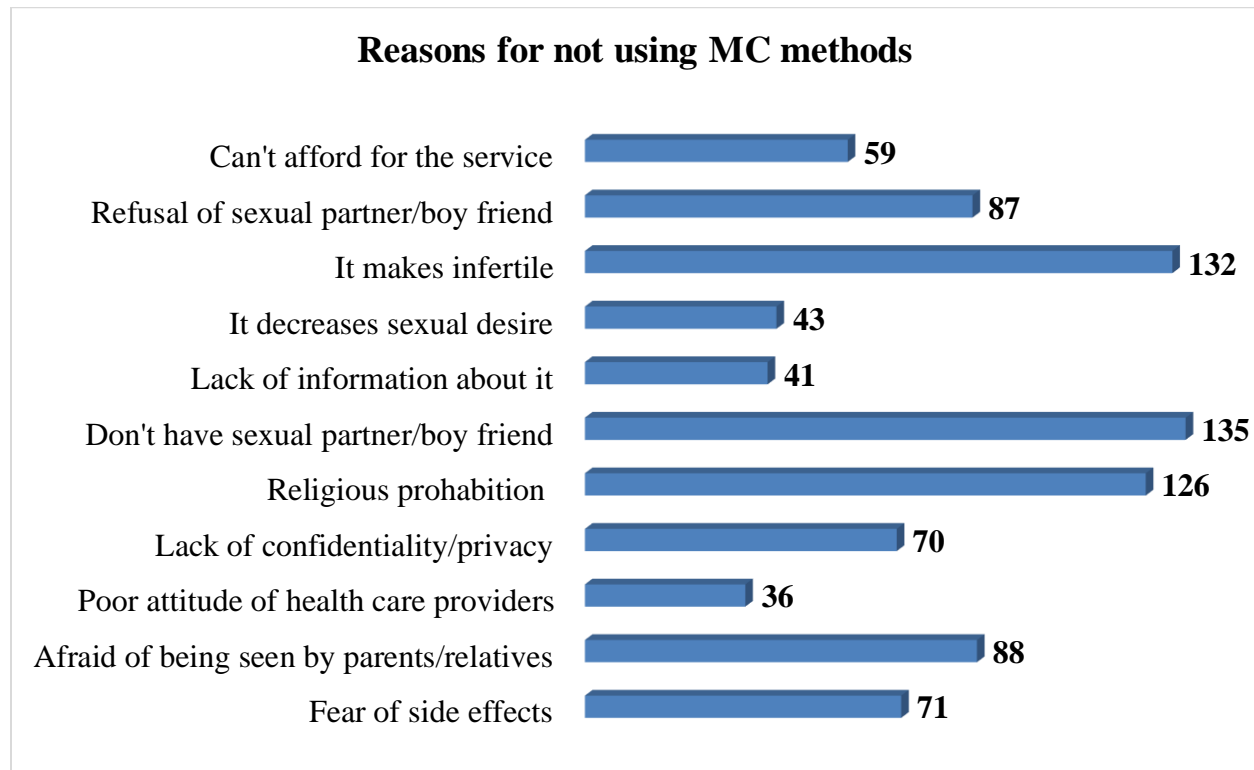


Figure 4: Reasons for not using modern contraceptives among unmarried female adolescent age 15-19 years in Sibu Sire high schools, East Wollega Zone, Ethiopia, 2024 (N=400)

### 5.5 Factors affecting MCs utilization among unmarried female adolescent

On the bivariate analysis age, grade level, place of residence, access to modern contraceptives, discussion about modern contraceptives with family and boyfriends, receiving VCT services, presence of a youth club in the school, history of abortion, history of pregnancy, social media use, and distance from home to the health facility were significantly associated with modern contraceptive use among the unmarried adolescent students. Whereas students age, grade levels, presence of youth club in the school, discussion about MCs with their boyfriends, history of abortion, and distance of home from health facilities were the variables that showed association with MCs utilization among unmarried adolescent female students aged 15-19 in multivariable logistic regression.

Accordingly, students aged 17-19 were 3.58 times more likely utilizes MCs compared to their younger counterparts aged 15-17 (AOR = 3.58, 95% CI: 1.69-7.54). Similarly, students attending grades 11-12 were 3.53 times more likely to utilize MC compared to those in grades 9-10 (AOR = 3.53, 95% CI: 1.68-7.39). Moreover, students who received VCT services were 4.08 times more likely to utilize MCs than those who did not (AOR = 4.08, 95% CI: 1.94-8.58). Furthermore, students engaged in school's youth club were 2.61times more likely utilized MC compared to those without a school youth club (AOR = 2.61, 95% CI: 1.33-5.14). On the other hand, students with a history of abortion were 3.49 times more likely utilized MC utilization compared to those who had no history of abortion (AOR = 3.49, 95% CI: 1.73-7.09). Lastly, Adolescent students who discussed about MCs with their boyfriends were 4.18 times more likely utilize the modern contraceptive compared to those who did not discuss it with their partners (AOR = 4.18, 95% CI: 2.32-7.55) (Table 7).

Table 7: Factors associated with utilization of MC among unmarried female adolescent age 15-19 years in Sibule Sire high schools, East Wollega Zone, Ethiopia, 2024 (N=400)

Variables	Categories	MCs Utilization		COR (95% CI)	AOR (95% CI)
		Yes (%)	No (%)		
Age of the participants	15-16	19 (11.8)	142(88.2)	1	1
	17-19	77 (32.2)	162 (67.8)	3.55 (2.05-6.16)	3.58 (1.69-7.54)**
Grade level	9-10	30 (15.5)	164 (84.5)	1	1
	11-12	66 (32)	140 (68)	2.58 (1.58-4.19)	3.53 (1.68-7.39) **
Place of residence	Urban	66 (33.3)	132 (66.7)	2.87 (1.76-4.67)	0.84 (0.26-2.69)
	Rural	30 (14.9)	172 (85.1)	1	1
Can you access MCs easily	Yes	47 (51.6)	44 (48.4)	5.67 (3.39-9.46)	1.99 (0.95-4.16)
	No	49 (15.9)	260 (84.1)	1	1
Discuss about MCs with family	Yes	58 (37.4)	97 (62.6)	3.26 (2.03-5.24)	0.98 (0.44-2.21)
	No	38 (15.5)	207 (84.5)	1	1
Received VCT service	Yes	37 (38.1)	60 (61.9)	2.55 (1.55-4.19)	4.08 (1.94-8.58)**
	No	59 (19.5)	244 (80.5)	1	1
Presence of youth club in school	Yes	60 (32.6)	124 (67.4)	2.42 (1.51-3.88)	2.61 (1.33-5.14)*
	No	36 (16.7)	180 (83.3)	1	1
Had history of abortion	Yes	43 (50.6)	42 (49.4)	5.06 (3.02-8.49)	3.49 (1.73-7.09)*
	No	53 (16.8)	262 (83.2)	1	1
Discuss about MCs with boy friend	Yes	65 (44.8)	80 (55.2)	5.87 (3.57-9.66)	4.18 (2.32-7.55)**
	No	31 (12.2)	224 (87.8)	1	1
History of pregnancy	Yes	42 (37.5)	70 (62.5)	2.60 (1.60-4.22)	0.44 (0.13-1.48)
	No	54 (18.8)	234 (81.3)	1	1
Use social media	Yes	66 (31.9)	141 (68.1)	2.54 (1.56-4.14)	1.08 (0.28-4.17)
	No	30 (15.5)	163 (84.5)	1	1
Distance of home from health facility	< 30 minutes	28 (27.9)	128 (72.1)	1.77 (1.08-2.89)	2.05 (0.94-4.48)
	>30 minutes	68 (27.9)	176 (72.1)	1	1

1-Reference category, \*-p-value<0.05, \*\*p-value<0.005

## 6. Discussion

This study aimed to assess the magnitude of MCs utilization and associated factors among unmarried female adolescent students aged 15-19 years in Sibu Sire high schools, East Wollega Zone, Ethiopia. The findings of this study showed that the overall magnitude of modern contraceptive utilization among the study participants was 24% (95% CI: 20.0–28.5%). This rate suggests a moderate level of contraceptive use within the study population

The magnitude of modern contraceptive utilization observed in this study aligns with findings from previous research in various regions of sub-Saharan Africa. Similar rates have been reported in 29 sub-Saharan African countries (24.7%)(25), Ghana (22.9%) (35), as well as in other parts of Ethiopia, such as East Gojjam (21%) (49) and Southern Ethiopia (24%) (52). However, the utilization rate in this study is lower than that reported in a multi-country analysis of 261 surveys across 103 low- and middle-income countries, where the prevalence was found to be 31.6% (30). Additionally, studies conducted in Kenya (43%)(39), Nigeria (45.3%)(43), and Tanzania (48.7%)(45) report higher rates of contraceptive use among adolescents, as do some studies in different regions of Ethiopia (10, 26, 53).

In contrast, the magnitude of in this study is higher than the utilization rates reported in countries such as Mali (17.1%) (38), Uganda (9.4%) (41), and Rwanda (17.4%) (47), as well as other studies from various regions within Ethiopia(50, 51, 54). These discrepancies in contraceptive utilization rates can likely be attributed to a range of factors, including differences in socio-cultural norms and attitudes towards contraceptive use, variations in the availability and accessibility of youth-friendly reproductive health services, and differences in the levels of adolescent sexual activity across regions.

For example, in countries and regions with lower utilization rates, cultural taboos, stigma surrounding adolescent sexual activity, and limited education on sexual and reproductive health may discourage contraceptive use. On the other hand, higher utilization rates in countries like Kenya, Nigeria, and Tanzania may reflect greater availability of youth-friendly services, more comprehensive sexual health education programs, and more positive societal attitudes towards adolescent contraceptive use.

The results suggest that there may be regional differences within Ethiopia itself, with certain areas exhibiting higher or lower contraceptive use due to local cultural and socioeconomic factors. These variations highlight the importance of understanding the unique needs and challenges of different communities in order to design more effective, context-specific interventions aimed at increasing modern contraceptive use among unmarried female adolescents.

Ultimately, the findings of this study underscore the need for continued efforts to promote access to modern contraceptive services for unmarried female adolescents in Ethiopia. It is essential to not only increase awareness and knowledge of available contraceptive methods but also address the social and cultural barriers that may limit adolescents' ability to use them. Improving access to youth-friendly reproductive health services, enhancing education on sexual and reproductive health, and fostering supportive attitudes from families, communities, and partners are critical steps toward achieving higher rates of contraceptive utilization and better reproductive health outcomes for adolescents in Ethiopia.

Those students aged between 17-19 years old had positively associated with MCs utilization. This finding is supported by previous studies done in Zambia(40), Rwanda(42), and Uganda (47)which revealed that older adolescent girls are more likely to use contraception than younger ones. This might be because as adolescents get older, they are more likely to be sexually active and face the risk of unintended pregnancy. This increased risk perception may motivate older adolescents to seek out and use contraceptives more than younger teens. Moreover, older adolescents may be more likely to be in stable relationships that involve discussions about contraception and joint decision-making to use MCs. Younger teens may be less likely to have these relationship dynamics.

Students attending grades 11-12 were positively associated with MCs use compared to those in grades 9-10. The results of the previous study conducted in Ethiopia also support this finding(67). This could be because students in the later secondary grades may be more likely to be in stable romantic relationships that involve discussions and joint decisions about contraceptive utilization(22, 47).

Receiving VCT services had also positively enhanced MCs utilization. This is related to the fact that VCT services likely provided the students with comprehensive information and education on MC methods, their benefits, and proper usage. This increased knowledge may have motivated them to adopt MCs. In addition, VCT services often include direct referrals or linkages to

contraceptive service delivery points, making it easier for students to access and obtain modern contraceptive methods(25, 68).

Adolescents' participation in school-based youth clubs positively impacts their utilization of MCs. This is consistent with previous studies done in southern Ethiopia (51) and Zambia (69) which highlights the role of youth clubs in enhancing access to health education and services. This is because youth clubs often provide platforms for health education, awareness-raising, and even direct linkages to contraceptive service delivery. This improved access to information and services can facilitate modern contraceptive uptake (70). This implies that, it is crucial to support and expand youth clubs within schools, ensuring they are adequately funded and staffed.

Students history of abortion had also been positively linked with MCs utilization. This finding is in line with the previous study done in Ghana (66). Having experienced an unintended pregnancy and the consequences of abortion may have heightened these students' awareness of the importance of contraception. This personal experience could have motivated them to be more proactive about using modern contraceptive methods to prevent future unintended pregnancies. Students who had an abortion may have received post-abortion care and counseling, which could have provided them with information, skills, and linkages to access modern contraceptive services. This support may have facilitated their contraceptive adoption.

Lastly, having discussion with boyfriend (sexual partner) had positively impacted adolescent students MCs utilization. The findings from the previous studies conducted in Nigeria(43) and Ethiopia (22, 26) support the notion that partner communication is a critical determinant of modern contraceptive use among adolescent students. This is because discussing modern contraceptives with their partners allows the students to communicate their reproductive health needs and preferences. This open dialogue can facilitate joint decision-making and increase the likelihood of contraceptive use. This implies that, involving partners in the discussion can also facilitate access to contraceptive services and supplies, as the boyfriends may be willing to accompany the students or provide support in obtaining the methods.

## **7. Strength and Limitation of the study**

### **7.1 Strength of the study**

- The study addresses an important public health issue concerning contraceptive use among unmarried female adolescents, a group often at risk of unintended pregnancies and related health consequences.
- Findings from the study could potentially influence school-based health education programs, reproductive health policies, and healthcare service delivery strategies targeted at unmarried female adolescents in similar settings.

### **7.2 Limitation of the study**

- The use of self-administered questionnaires may introduce social desirability bias, where participants underreport sensitive behaviors like sexual activity and contraceptive use.
- The study was conducted in a specific geographic area (Sibu Sire high schools) and may not be generalizable to all unmarried female adolescent students in Ethiopia and beyond.
- The study overlooked attitudes towards contraceptives, cultural norms, and stigmatization of adolescent sexual activity that could affect both reporting in the questionnaire and actual contraceptive behavior.

## **8. Conclusion and recommendation**

### **8.1 Conclusion**

This study concluded that the magnitude of modern contraceptive utilization among unmarried female adolescent students aged 15-19 in the study area was relatively low. The study also identified older adolescents, those in grades 11-12, and those who had received Voluntary Counseling and Testing services were more likely to utilize modern contraceptives. Additionally, students attending schools with youth clubs, those with a history of abortion, and those who communicated about contraception with their boyfriends showed significantly significant associated with modern contraceptive use.

### **8.2. Recommendation**

Based on the finding the following recommendations are forwarded.

#### **School administrators and educators**

- Have to strengthen existing youth clubs or establish new ones within schools to provide a platform for discussions on sexual and reproductive health (SRH) topics, including MCs.
- Should better establish partnerships with local health facilities to conduct educational sessions at schools, provide access to contraceptives, and offer counseling services.

#### **Healthcare Providers**

- Have to provide comprehensive counseling on contraceptive methods, emphasizing their effectiveness, potential side effects, and proper usage. Address myths and misconceptions that may deter adolescents from seeking contraceptives.
- Should conduct outreach programs targeting schools and communities to raise awareness about SRH and contraceptive options. Engage with adolescents in culturally appropriate ways to promote health-seeking behaviors.

#### **Zonal and Woreda Health office**

- Provide training for healthcare providers on adolescent-friendly SRH services, including counseling on contraceptive methods.
- Establish partnerships with local schools to conduct regular SRH education sessions and outreach activities.
- Implement monitoring and evaluation systems to track the utilization of SRH services by adolescents, including contraceptive uptake.

### **Future Researchers**

- Supplement quantitative findings with qualitative research to delve deeper into the socio-cultural factors influencing contraceptive decision-making among adolescents.

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## 10. Declarations

### 10.1 Assurance of the investigator

I undersigned agrees to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as preterm and conditions of the research and publications office of the university.

Name of the student: Tolani Gore

Date: 5/4/2024 Signature:

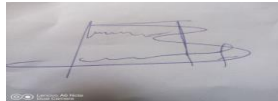


### 10.2 Advisors approval

This is to certify that the research project entitled *“modern Contraceptives utilization and associated factors among unmarried female adolescent age 15-19 years in Sibusire Highschool East Wollega Zone, Ethiopia; school based cross sectional study”* submitted in partial fulfilment of the requirements for the degree of Master with specialization in General MPH, and has been carried out by Tolani Gore, under our supervision. Therefore, we recommend that the student has fulfilled the requirements and hence hereby can submit the thesis to the department for defense.

Approved by:

1. Mr. Mulugeta Mekuria



5/4/2024

Major Advisor

Signature

Date

2. Dr. Diriba Gameda



5/4/2024

Co-Advisor

Signature

Date



Salale University  
Institutional Research Ethics Review Committee (SIU-IRERC)

Date: 12/10/2016

Ref. No: SIV-IRERC-212/201

To: **Tolani Gore**

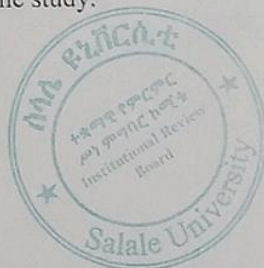
Subject: Research Ethics Approval Letter

This is to kindly notify you that your project protocol entitled “**Modern Contraceptive Utilization and Associated Factors among Unmarried Female Adolescent Age 15-19 Years in Sibru Sire Highschool, East Wollega Zone, Ethiopia, 2024.**” has been approved for the intended one-year period of implementation. The review process of the Research protocol has been carefully conducted by Salale University institutional research ethics review committee (SIU-IRERC). The protocol is ethically sound to be implemented through adhering to the research ethics principles during the implementation. Thus, the committee is pleased to inform you that your study protocol has been approved.

The committee would like to remind you that the research principal is expected to submit a progress report of the research at least once before the end of its implementation. The committee also looks forward to receiving the final technical report and recommendations that will be generated from the study.

Sincerely,

  
Solomon Balami(Phd)  
Salale University IRB  
Chairperson



CC:

- Salale University Institutional Research Ethics Review Committee
- Salale University Health Sciences College CARD

**Examiner approval form**

As mentioned of the bord of the MPH thesis open defense, we here by certify that we have examined the research thesis entitled “Modern contraceptive utilization and associated factors among unmarried female adolescent age 15-19 years in Sibu sire high school, East Wollega Zone, Ethiopia; school based cross sectional study” submitted in partial fulfilment of the requirements for the degree of Master with specialization in General MPH, and has been carried out by Tolani Gore, under our supervision. Therefore, we recommend that the student has fulfilled the requirements and hence hereby can submit the thesis to the department for defense.

**Examiners:**

_____	_____	_____
<i>(Chairperson)</i>	<i>(Signature)</i>	<i>(Date: DD/MM/YY)</i>

_____	_____	_____
<i>(External Examiner)</i>	<i>(Signature)</i>	<i>(Date: DD/MM/YY)</i>

_____	_____	_____
<i>(Internal Examiner)</i>	<i>(Signature)</i>	<i>(Date: DD/MM/YY)</i>

**Head, Department**

_____	_____	_____
<i>(Name)</i>	<i>(Signature)</i>	<i>(Date: DD/MM/YY)</i>

## 12. Annexes

### 12.1 English Version Participant Information Sheet & Voluntary Consent Form

**Introduction:** My name is \_\_\_\_\_, and I'm collecting data for Tolani Gore, a Master's student in Salale University, who is conducting a research study in this school. I'm here to explain the study in detail and see if you'd be interested in participating.

**Title of Study:** Modern Contraceptive utilization and associated factors among unmarried female adolescent age 15-19 years in Sibusire Highschool East Wollega Zone, Ethiopia; school based cross sectional study

**Purpose/Aim of the study:** This study will assess the factors influencing contraceptive use, identifying trends and projections, reducing unintended pregnancies, and determining the factors affecting contraceptive use among this population. Furthermore, this research contributes to the academic field by serving as the author's thesis for a master's degree.

**Study Procedure:** the study involves just self-administered and estimated time you will commit for this study is: 25-40 minutes.

**Risks:** The risks of this study are negligible. These risks are similar to those you experience when revealing work-related information to others. The topics in the survey may indignify some respondents. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

**Benefits:** There will be no direct benefit to you for your participation in this study. However, we hope that the information obtained from this study may be useful for planning an intervention measures at facility setting.

**Confidentiality:** Participation in this study is strictly confidential. No personally identifiable information will be collected, and the research findings will be presented in aggregate form, safeguarding the anonymity of all participants and their residences.

**Right:** Participation in this study is strictly voluntary. You have the freedom to choose whether or not to participate, and the right to withdraw at any time without any negative consequences. Additionally, you are not obligated to answer any questions you find uncomfortable.

**Compensation:** There is no financial compensation to you for your participation in this study.

**Contact Address:** If there are any questions or enquires any time about the study or the procedures, please contact and speak to (principal investigator: Tolani gore, tellPhone: +251917850233, E-mail: [tolanigore4@gmail.com](mailto:tolanigore4@gmail.com))

**12.2. Declaration of Informed Voluntary Consent**

**Consent:** I confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to take out at any time, without giving a reason and without cost.

I Agree  I Disagree

Signature of Participant: \_\_\_\_\_ Date \_\_\_\_\_

Name and Signature of Data Collector: \_\_\_\_\_ Date \_\_\_\_\_

**Thank you for your cooperation!!!**

S. No.	Questions	Response	Skip
<b>Part I: Socio- Demographic Characteristics</b>			
101	Age of in years?	-----	
102	Grade level		
103	Religion	a) Orthodox b) Muslim c) Protestant d) Others (specify).....	
104	What is your Ethnicity?	a) Oromo b) Amhara c) Others (specify).....	
105	What is father's educational status?	a) Can' t read and write b) Can read and write c) Primary (grade 1-8 <sup>th</sup> ) d) Secondary (grade 9-12 <sup>th</sup> ) e) College and above	
106	What is your mother's level of educational status?	a) Can' t read and write b) Can read and write c) Primary (grade 1-8 <sup>th</sup> ) d) Secondary (grade 9-12 <sup>th</sup> ) e) College and above	
107	What is your father's occupation?	a) Government employee b) Merchant c) Farmer d) Student e) Other specify-----	
108	What is your mother's occupation?	a) Housewife b) Merchant c) Government employee d) Student	

		e) Other specify_____	
109	What is your place of residence?	1. Urban 2. Rural	
110	Does you parent give you pocket money regularly	0. No 1. Yes	
111	Current living arrangement	a) both parents b) single parents c) living a lone d) 4. with friends	
112	Family Size	_____in number	
113	Distance from your home to the nearest health facility	1.less than 30 minutes 2. more than 30 minutes	
114	Do your family have Radio/TV at home	0. No 1. Yes	
115	Do you have history of health facility visit?	0. No 1. Yes	
116	Do you have mobile phone	0. No 1. You	
117	Do you use social media (e.g., Facebook, Instagram, Tik Tok, YouTube...?)	0. No 1. Yes	

## II. sexual and RH

S.No	Questions	Responses
201	Have you ever had sexual intercourse	0. No 1. Yes
202	Age at first sexual intercourse	_____
203	Have you ever had pregnancy?	0. No 1. Yes
204	Have you ever had pregnancy termination?	0. No 1. Yes

205	If you had pregnancy termination, where have you the service?	a. Traditional healers b. Health facility
206	Do you have sexual partner?	0. No 1. Yes
207	If 'YES' for how long have been together?	_____ months
208	How many sexual partner (s) do you have?	a. One b. Two and above
209	Do you have sexual intercourse in the last 12 months?	0. No 1. Yes
210	If 'Yes' how many times	a. Once b. More than once with the same partner c. More than once with different partner
211	Duration since last sexual intercourse	_____ in month or week
212	Do you drink alcohol	0. No      1. Yes
213	Have you ever had sex after getting drunk	0. No 1. Yes
214	Is there youth club in the school	0. No      1. Yes
215	Have you received information about sex education by this club or other body?	0. No 1. Yes
216	Have you ever used Voluntary counselling and testing (VCT) services	0. No      1. Yes
217	Have you ever been told as you have STI by health care provider	0. No      1. Yes

### Part III. Knowledge and Practice of Contraceptive Methods

S.No	Questions	Responses
301	Have you ever heard of contraceptives	0. No      1. Yes
302	If 'Yes to Q301' which methods do you know? <i>(More than one answer is possible)</i>	a) Pills b) Injectables c) Implanon (for 3 years) d) Jadelle (for 5 years) e) IUCD f) Emergency contraceptives g) LAM h) Sterilization i) Others, specify_____
303	What/who was your source of information  <i>(More than one answer is possible)</i>	a. Teacher b. Internet c. Health care providers d. TV/Radio e. Friends f. Others
304	What are the benefits of using contraceptives?  <i>(More than one answer is possible)</i>	a. Prevention of unplanned pregnancy b. Reduce pregnancy related risks c. Helps avoid closely spaced pregnancies and births d. Helps prevent STI e. Financial benefits f. Empowerment and Education g. Limiting number of children

		h. Others, specify _____
305	Are you currently using modern contraceptive methods?	0. No 1. Yes
306	If 'yes' which methods are you using?	a. Pills b. Injectables c. Implanon d. Jadelle e. IUCD f. Emergency contraceptives g. LAM h. Sterilization i. Others, specify _____
307	From where did you get the contraceptive methods	a. Pharmacy b. Health post c. Health center d. Hospital e. Private clinic/hospital f. Others, specify _____
308	If you choose pharmacy, what is the reason? <i>(More than one answer is possible)</i>	a. Doesn't need prescription b. Short waiting time c. Fear of bad health workers attitude d. No health facilities near to the residence places e. Confidentiality respected f. Others, specify _____
309	Did the service providers re-assure you that any information concerning your personal situation and the service you received will remain confidential	0. No 1. Yes

310	Have you used contraceptive methods at your first sexual intercourse	0. No 1. Yes
311	Do you discuss about contraceptive with your boyfriend?	0. No 1. Yes
312	Does your boyfriend support the use of contraceptive methods?	0. No 1. Yes
313	Have you ever discussed with your family about contraceptive?	0. No 1. Yes
314	If you yes for the <b>Q 313</b> with whom you have discussed? <i>(More than one answer is possible)</i>	a. Mother b. Father c. Brother d. Sister e. Others, specify_____
315	Can you access MC easily?	0. No 1. Yes
316	Do you have fear to be noticed by family or relatives while obtaining contraceptives?	1. No 2. Yes
317	If you are not using contraceptive methods, what is your reason? <i>(More than one answer is possible)</i>	a. Fear of side effects b. afraid of being seen by parents /relatives c. Poor attitude of health providers d. Lack of privacy/confidentiality e. Religious prohibition f. I have no sexual partner g. I have no information about it h. It decreases sexual pleasure i. It makes infertile j. Refusal of sexual partner k. Can't afford for the service l. Others, specify_____

## 10.3 Annexes-II

### 9.3.1 Odeeffannoo hirmaattotaa fi hirmaannaa fedhii irratti hundaa’ e Afaan Oromootin

Seensa: Maqaan Koo \_\_\_\_\_, Jedhama. Barattuu Maastarsii Yuunivarsiitii Salaalee kan taate Tollaani Gorree tif odeeffannoo funaan jira. Isheen Qorannaa mana baruumsaa kanatti hojjachaa jirti. Wa’ee qorannoo kana tokko tokkon isinittan hima.

**Mata duree:** Haala fayyadama karoora maatii/Ittisa ulfaa barattoota shamarran hin heerumin kan umrii 15-19, Mana Baruumsa Sadarkaa 2ffaa sibuu siree, Baha Wallaggaa, Itoophiyaa, 2024

**Kaayyoo Qorannoo kana:** qorannoon kun haala fayyadama karoora maatii/Ittisa ulfaa barattoota shamarran hin heerumin kan umrii 15-19 keessa jirani maal akka fakkaatu adda baasuu, maaltu akka isaan hin fayyadamne isaan akka taasisu, fi Ulfa karoora malee ittisuu dha. Kanaan alatti qorannoon kun barattuu Tollaaniif akka isheen barnoota digirii lammaffaa akka xumurtoof ishee gargaara.

**Akkataa qorannoo kanaa:** gaaffiin isin deebistan isiniif kennama. Gaaffilee kana guutuuf tilmaaman daqiiqaa 25-40 isin gaafata.

**Miidhaa:** Qorannoo kana keessatti yoo hirmaatan miidhaan tokko isin irra hin gahu. Gaaffilee isinitti hin tolle/deebisuu hin barbaanne irra darbuu dandeessu. Qorannoo kanas yoo isinitti hin tolin yeroo barbaaddanitti adda kutuu/dhiisuu ni dandeessu.

**Faayidaa:** Qorannoo kana keessatti waan hirmaattaniif faayidan kallattiidhaan isin argattan hin jiru. Garuu hirmaannaan keessan galma ga’iinsa qorannaa kana keessatti gahee guddaa qaba.

**Icciiiti:** Hirmaannaan isin qorannoo kana keessatti taasistan hundumtuu icciitiidhan qabama. Malummaa ykn eeyyummaa keessan kan ibsuu odeffannoon tokkoyyuu hin funaanamu. Odeeffannoon isin irraa walitti qabamu akka waliigalaatti malee akka nama tokkootti hin ibsamu.

**Mirga:** Hirmaannaan keessan gutumaan guututti fedhii irratti kan hundaa’ e dha. Hirmaachuu ykn hirmaachuu dhiisuuf mirga guutuu qabdu. Erga hirmachuuf waliigaltanii boodas yeroo barbaaddanitti dhiisuu ykn adda kutuu ni dandeessu. Kanaan alatti gaafii isinitti hin tolle irra darbuuf mirga guutuu qabdu.

**Bakka buusuu:** Qorannoo kana keessatti waan hirmaattaniif faayidaan mallaaqaa isin argattan hin jiru.

**Bilbila/Email:** yoo gaafii kamiyyuu qabattan qorattuu 1ffaa qunnamuu dandeessu (Maqaa: Tollaani Gorree, Bilbila: +251917850233, Email: [tolanigore4@gmail.com](mailto:tolanigore4@gmail.com))

**10.3.2 Hirmaannaa fedhii irratti hundaa’e**

**Waliigaltee:** Odeeffaannoon armaan olii kun erga naaf dubbifamee, gaafi naaf hin galle gaafadhee ykn carraa gaafachuu argaadheen booda qorannoo kana keessatii hirmaachuuf walii galee jira.

Walii galee jira  walii hin galu

Mallattoo hirmaattuu: \_\_\_\_\_ Guyyaa \_\_\_\_\_

Maqaa fi mallattoo nama daataa funaanuu: \_\_\_\_\_ Guyyaa \_\_\_\_\_

**Galatooma!!!**

**I. Odeeffannoo dhimma hawaasummaa fi diinagdee**

101	Umrii kee meeqa?	_____
102	Kutaa meeqaaffaa baratta	_____
103	Amantaa	a) Ortodoksii b) Musliima c) Pirootestantii d) Kan biraa (Ibsi).....
104	Sabni kee maali?	a. Oromoo b. Amaara c. Kan biraa (Ibsi).....
105	Sadarkaa barnootaa abbaa keetii?	a. Dubbisuu fi barreessuu kan hin danddenye b. Dubbisuu fi barreessuu kan danda’u c. Sadarkaa 1ffaa (1-8 <sup>ffaa</sup> ) d. Sadarkaa 2ffaa (9-12 <sup>ffaa</sup> ) e. Koollejii fi isaa ol

106	Sadarkaa barnootaa harmee keetii?	a. Dubbisuu fi barreessuu kan hin danddenye b. Dubbisuu fi barreessuu kan danda'u c. Sadarkaa 1ffaa (1-8 <sup>ffaa</sup> ) d. Sadarkaa 2ffaa (9-12 <sup>ffaa</sup> ) Koollejii fi isaa ol
107	Hojiin abbaa keetii maalidha ?	a. Hojjataa mootummaa b. Dldalaa c. Qotee Bulaa d. Barataa e. Kan biro (Ibsi)-----
108	Hojiin harmee keetii maali?	a. Haadha manaa b. Daldaltuu c. Hojjattuu mootummaa d. Barattuu e. Kan biro (Ibsi)-----
109	Iddoon jireenya keetii maali dha?	a. Magalaa b. Baadiyaa
110	Maatiin kee mallaqa kuusii siif kennuu?	0. Lakki 1. Eeyyen
111	Haalli jireenya kee ammaa maal fakkaata?	a. Haadhaa fi abbaa koo wajjiin b. Haadha ykn abbaa qofa wajjiin c. Qofaa koon jiraadha d. Hiriyaa koo wajjiin
112	Maatin keessan ijoollee meeqa qabu	_____
113	Manni keessan fageenyi inni dhaabbata fayyaa irraa qabu hangami?	a. Daqiiqaa 30 gadi b. Daqiiqaa 30 oli
114	Mana keessan keessa Raadiyoo/TV'n jiraa	0. lakki 1. Eeyyeen
115	Dhaabbata fayyaa deemtee beektaa?	0. Lakki 1. Eeyyen
116	Bilbila harkaa qabdaa	0. lakki 1. Eeyyeen

117	Miidiyaa hawaasaa (fkn. Facebook, Instagram, tik tok, YouTube....) ni fayyadamtaa	0. lakki      1. Eeyyeen
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## II. Odeeffannoo wal-qunnamtii fi wal-hormaataa

T/L	Gaafiilee	Deebii
201	Wal-qunnamtii saala raawwattee beektaa?	0. lakki      1. Eeyyeen
202	Yeroo jalqaba wal-qunnamtii saalaa raawwate umriin keen hangami?	_____
203	Ulfoootee beektaa?	0. lakki      1. Eeyyeen
204	Ulfa ofirraa baastee beektaa?	0. lakki      1. Eeyyeen
205	Yoo gaafii 204 dhaaf eeyen jette eessatti ofirraa baaste?	a. Ogeessa/ttii aadaa b. Dhaabbata fayyaa
206	Hiriyaa dhiiraa qabdaa?	0. lakki      1. Eeyyeen
207	Yoo gaafii 206 dhaf eeyyen jette yeroo hangamiif waliin jiraattan?	Ji'a _____
208	Hiriyaa dhiiraa meeqa qabda?	a. Tokko      b. Lamaa ol
209	Ji'oota 12'n darban keessatti wal-qunnamtii saalaa raawwattee beektaa?	0. lakki      1. Eeyyeen
210	Yoo gaafii 209 f eeyyeen jette, si'a meeqa?	a) Si'a tokko b) Si'a tokko nama tokko wajjiin c) Si'a tokkoo ol nama garaa garaa wajjiin
211	Yeroo dhummaf wal qunnamtii erga raawwattee yeroo hangami	Torba/Ji'a _____
212	Alkoolii ni dhugdaa	0. lakki      1. Eeyyeen
213	Sababa dhugaatii dhugdee machofteef qunnamtii saalaa raawwattee beektaa	0. lakki 1. Eeyyeen

214	Gumiin dargaggotaa mooraa keessan keessa jiraa?	0. Lakki 1. Eeyyeen
215	Barnootaa waa'ee quannamtii saalaa guumiin kun ykn qaamni biro siniif laatee beekaa?	0. Lakki 1. Eeyyen
216	Tajaajila gorsaa fi qorannoo HIV argattee beektaa?	0. lakki    1. Eeyyeen
217	Dhukkuboota wal-qunnamtii saalaan daddarbaan qabda jedhamee ogeessaan sitti himamee beektaa	0. lakki    1. Eeyyeen

### III. Beekumsaa fi fayyadama mala ittisa ulfaa/karoora maatii

T/L	Gaafilee	Deebii
301	Waa'ee mala ittisa ulfaa/karoora maatii dhageessee beektaa?	0. lakki    1. Eeyyeen
302	Gaafii 301'f eeyyee yoo jette maal kam dhageessse/beekta?  <i>(Deebiin tokkoo ol filachuun ni danda'ama)</i>	a. Piilsii b. Lilmoo c. Implaanonii (Isa wagga sadii) d. Jadilii (Isa wagga shanii) e. Kan gadammessa keessa ta'uu f. Poosti piilii g. Harma hoosisuu h. Kolaasuu i. Kan biraa (Ibsi)_____
303	Maddi Odeeffannoo keetii eenyu dha?  <i>(Deebiin tokkoo ol filachuun ni danda'ama)</i>	a) Barsiisaa/stuu b) Intarneetii c) Ogeessa Fayyaa d) TV/Raadiyoo e) Hiriya f) Kan biraa (Ibsi)_____

304	<p>Faayidaan mala ittisa ulfaa/karoora maatii maali?</p> <p><i>(Deebiin tokkoo ol filachuun ni danda'ama)</i></p>	<p>a. Ulfa karoora malee ittisuu</p> <p>b. Rakkoollee ulfaan wal-qabatee dhufu ittisuu</p> <p>c. Ulfaa fi da'uumsa adda fageessuu</p> <p>d. Dhukkuboota wal-qunnamtii saalaan daddarban ittisuu</p> <p>e. Faayidaa mallaqaa</p> <p>f. Barnoota galmaan gahuu</p> <p>g. Ijoollee qusachuu</p> <p>h. Kan biraa (Ibsi)_____</p>
305	<p>Yeroo ammaa kana karoora maatii ykn mala ittisa ulfaa fayyadamaa jirtaa?</p>	<p>0. Lakki</p> <p>1. Eyyen</p>
306	<p>Yoo gaafii 305'f eeyyen jette mala kanneen keessa isa kam fayyadamaa jirta?</p>	<p>a. Piilsii</p> <p>b. Lilmoo</p> <p>c. Implaanonii (Isa wagga sadii)</p> <p>d. Jadilii (Isa wagga shanii)</p> <p>e. Kan gadammessa keessa ta'uu</p> <p>f. Poosti piilii</p> <p>g. Harma hoosisuu</p> <p>h. Wal-qunnamtii adda kutuu</p> <p>i. Marsa lagu beekuu</p> <p>j. Kolaasuu</p> <p>k. Kan biraa (Ibsi)_____</p>
307	<p>Tajaajila kana eessaa argatte/fayyadamate?</p>	<p>a. Kuusaa qorichaa</p> <p>b. Keellaa fayyaa</p> <p>c. Buufata fayyaa</p> <p>d. Hospitaala</p> <p>e. Hospitaala/kilinika dhuunfaa</p> <p>f. Kan biraa (Ibsi)_____</p>

308	Yoo gaaffii 307'f kuusaa qorichaa jette sababni isaa maali dha? <i>(Deebiin tokkoo ol filachuun ni danda'ama)</i>	a. Ajaaja ogeessaa hin barbaachisu b. Yeroo gabaabaa keessatti argatta c. Ilaalcha ogeessota fayya dhaabbata fayyaa mootumman keessan sodhaadha d. Dhaabbanni fayyaa naannoo koo hin jiru e. Iccitiin sirritti eegama g. Kan biraa (Ibsi)_____
309	Oggeessonni fayyaa dhaabbata mootummaa keessa hojjata odeeffannon keessan icciitiidhan akka eegamu sinitti himuu?	0. Lakki 1. Eyyen
310	Yeroo jalqaba qunnamtii saalaa raawwate mala karoora maatii ni fayyadamta turtee?	0. Lakki 1. Eyyen
311	Waa'ee karoora maatii/Ittisa ulfaa hiriya kee dhiiraa wajjiin ni mari'attuu?	0. Lakki 1. Eyyen
312	Hiriyaan dhiiraa kee akka ati fayyadamtu ni barbaadaa?	0. Lakki 1. Eyyen
313	Waa'ee karoora maatii/Ittisa ulfaa maatii kee wajjiin ni mari'attuu??	0. Lakki 1. Eyyen
314	Gaaffii 313'f eeyyee yoo jette eenyu wajjiin mari'attu? <i>(Deebiin tokkoo ol ni danda'ama)</i>	a) Haadhaa koo b) Abbaa koo c) Obboleessa koo d) Obboleettii koo e) Kan Biroo (Ibsi)_____
315	Taajala karoora maatii kana salphatti ni aragattuu?	0. Lakki 1. Eeyyeen

316	Yeroo karoora maatii fudhattu maatin ykn firri na araga jettee ni sodaattaa?	0. Lakki 1. Eeyyen
317	Yoo mala ittisa ulfaa kana fayyadama hin jirtu ta'e sababni isaa maali dha? <i>Deebiin tokkoo ol ni danda'ama)</i>	a) Rakkoo qorichaan wal-qabatu sodaachuu b) Sodaa maatii ykn firaa c) Ilaalcha ogeessota fayya gaarii ta'uu dhabuu d) Iccitiin hin eegamu e) Amantaan ni dhoorka f) Hiriya dhiiraa hin qabu g) Waa'ee malaa kanniinii odeeffannoo hin qabu h) Fedhi wal qunnamtii saalaa gadi buusa i) Nama maseensa j) Hiriyaan koo dhiiraa hin barbaadu k) Qaarshii isaa kaffaluu hin danda'u l) Kan biraa (Ibsi)_____

**Galatoomaa!**