

Factors associated with unintended pregnancy in Ethiopia; further analysis of the 2016 Ethiopian demographic health survey data.

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Abstract

Background Unintended pregnancy is an important public health problem in Ethiopia. It causes adverse physical, mental, social and economic outcomes. Identifying factors associated with unintended pregnancy may help to reduce unintended pregnancy and hence adverse outcomes. There are few studies about the prevalence and associated factors of unintended pregnancy in Ethiopia. But these studies were based on few sample size and fragmented. Therefore, this analysis was done to identify factors associated with unintended pregnancy in Ethiopia based on nationally representative data.

Methods The study used the 2016 Ethiopian demographic and health survey data. The data was downloaded from The DHS program with permission. A total of 1135 women were included in the final model. Data was weighted to consider disproportionate sampling and non-response. Multivariable logistic regression was used to identify factors associated with unintended pregnancy among women.

Result About 30% (95% CI: 25.33 -34.39) pregnancies were unintended. Married women (AOR; 0.034; 95% CI: 0.01- 0.14), woman living in developing regions (AOR; 0.14; 95% CI: 0.07- 0.27) and women who reported distance not a big problem to get medical care (AOR 0.59; 95% CI: 0.36 - 0.99) had lower odds of unintended pregnancy. On the other hand, multi-para (AOR; 3.77; 95% CI: 1.71 - 8.33), grand multi-para (AOR; 6.72; 95% CI: 2.74 - 16.49) women and women who ever used contraceptives (AOR; 1.86 95% CI: 1.06 - 3.26) had higher odds of unintended pregnancy.

Conclusion Although high, the magnitude of unintended pregnancy in Ethiopia was lower compared to the global level. Marital status, region, perceived distance to seek medical care, parity and history of contraceptive use were found significant predictors of unintended pregnancy in Ethiopia.

Introduction

Unintended pregnancy, defined as pregnancy that is reported as either unwanted (pregnancy that occurred when no more children were desired) or mistimed (pregnancy that occurred earlier than the desired time), is a global problem that affects the health of women, families and relatives. Unintended pregnancy occurs due to non-use or inconsistent uses of contraceptives or method failure(1, 2).

Globally, 44% pregnancies were unintended in 2010 to 2014. From 1990 to 2014, the rate of unintended pregnancies decreased by 30% in developed regions but only 16% in developing regions. Unintended pregnancy accounted for 65% of all pregnancies in developing countries. About 59% of these pregnancies end with abortion. Annually 302,000 mothers die due to pregnancy related complications in developing countries. Sub-Saharan African countries accounted for 66% of all maternal deaths. Unsafe abortion was among the main cause of maternal death in the Sub-Sahara region (2-4). About 1.9 million and 620,300 Ethiopian women had unintended pregnancy and abortions every year respectively. It represents an annual rate of 28 abortions per 1000 women age 15 to 49 years (5-7).

Studies conducted in Kenya, Egypt, Nigeria and South Africa indicated that the prevalence of unintended pregnancies was 24%, 30.7%, 35.9% and 64.33% respectively (8-11). According to studies conducted in different parts of Ethiopia, the prevalence of unintended pregnancy ranged from 13.7% to 41.5%. In

addition, the prevalence of unintended pregnancy in Ethiopia based on study in 2011 EDHS was 32% (12-19).

Studies conducted in different African countries identified that age, place of residence, marital status, ethnicity, types of employment, educational status, numbers of living children, monthly income and women autonomy, parity, gravidity, knowledge on contraceptives, accessibility of contraceptives as determinants of unintended pregnancy (8-11, 20). Similarly, studies conducted in various parts of Ethiopia identified age, residence, religion, marital status, parity, visiting health professionals, history of abortion, age at first birth, family size, educational status, gravidity, distance from health facility, history of still birth and knowledge on modern contraceptive methods as determinants of unintended pregnancy (12-19).

Despite improvements in contraceptive use, the level of unintended pregnancy in Ethiopia was slight decline from 42% in 2008 to 39% in 2014. Ethiopia planned to end all preventable cause of maternal mortality in 2030. Preventing unintended pregnancy is one of the key intervention areas to minimize maternal mortality (20-23).

There are different intervention was planned and performed in the area of HSDP IV and HSTP to improve the CPR and reduce unmet need in the country to minimize the impacts of unintended pregnancy. Assessing of the current prevalence and associated factors of unintended pregnancy in Ethiopia was important. Therefore, this analysis was done to identify the prevalence and factors associated with unintended pregnancy in Ethiopia based on nationally representative data.

Methods

Data

We used the 2016 EDHS data for this analysis. The 2016 EDHS is a community based cross sectional survey collected from January 18 to June 25, 2016. The survey was designed to provide key indicators at national and regional level. The survey used a two-stage stratified random sampling technique. First, each region was stratified into rural and urban areas. Then, enumeration areas (EA) were selected with probability proportional to enumeration area size. After this, household listing in the selected EAs was done. In the second stage, a fixed number of 28 households from each cluster were selected and included using systematic random sampling technique. In both surveys, women aged 15-49 who were either permanent residents of the selected households or visitors who stayed in the household the night before the survey were interviewed. Interviewer administered questionnaire was used to collect data. The details of the methodology; sampling technique, data collection and data quality assurance are available from EDHS reports (24). A total of 15,683 reproductive age women were included in the survey. From these, 1135 pregnant women at the time of survey were included in the analysis.

Measurement

The outcome variable for this analysis was unintended pregnancy, which had two categories (yes or no). The 2016 EDHS questionnaire asked all reproductive age women involved in the survey whether they were pregnant or not at the time of survey. If the woman responded she was pregnant, then she was asked if the pregnancy was wanted, wanted later or not wanted at all. When the woman reported the pregnancy was wanted at the time of survey, the outcome variable was considered “no”. On the other hand, if the woman reported the pregnancy was wanted later or was not wanted at all, the outcome variable was considered unintended and coded “yes”.

The independent variables included in this analysis were socio-demographic (age, educational status, marital status, household wealth index, residence, religion, working status of the woman and region), reproductive health (parity, history of abortion, history of previous contraceptive use and knowledge of contraceptives), access to health service (distance to health facility to seek medical care) and woman’s autonomy related variables (can refuse sex, refusing sex is justified if she suspects (STI)).

Analysis

We used STATA software for this analysis. The data were weighted to adjust for over sampling or under-sampling and non-response. Descriptive statistics were calculated for all variables. Correlation between independent variables was checked before fitting the final regression model. Multivariable logistic regression analysis was done to identify factors associated with unintended pregnancy. When two independent variables were found to be correlated at ≥ 0.6 , one was dropped. In addition, complex survey analysis techniques were employed when computing odds ratios since DHS used a two-stage stratified sampling technique.

Results

Background characteristics of pregnant women

Five hundred fifty five (48.93%) women were in the age range of 25 to 34 years. Six hundred three (53.20%) respondents reported that they didn’t attend formal education. Two hundred fifty seven (22.67%) participants were from households with the poorest wealth index. Majority of the respondents (96.59%) were married or living in union. Nine hundred seventy four (85.83%) respondents were rural residents. About three-fourth of these pregnant women were not working at the time of the survey (table 1).

Reproductive health characteristics of pregnant women

Four hundred fifty six (40.23%) mothers were multi-parous. One thousand twenty five (90.33%) respondents haven no history of abortion. Six hundred seventeen (54.37%) respondents had never used contraceptives. Six hundred thirty five (56.01%) respondents reported distance was a big problem to get medical care. Six hundred fifty two (57.51%) respondents reported that they would notrefuse sex when

the husband request. One thousand one hundred six (97.49%) respondents were knowledgeable about contraceptives (table 2).

Prevalence of unintended pregnancy

The prevalence of unintended pregnancy in Ethiopia was 29.66% (95% CI, 25.33 -34.39). Unintended pregnancy was high in Oromia region and low in Harari region.

Unintended pregnancy by characteristics of women

One hundred sixty nine (50.36%) respondents among women who have unintended pregnancy and 387(48.38%) respondents among women who haven't unintended pregnancy were in the age groups of 25 to 34 years. One hundred ninety (56.69%) respondents women's who have unintended pregnancy and 414(51.74%) respondents among women's who haven't unintended pregnancy did not attained formal education while only 27 (7.81%) respondent among women who have unintended pregnancy and 108 (13.44%) respondents among women's who haven't unintended pregnancy did attained secondary or higher education. Three hundred eight (91.63%) respondents among women who have unintended pregnancy and 666(83.38%) respondents among women's who haven't unintended pregnancy was lived in rural residence (Table 3).

Factor associated with unintended pregnancy in Ethiopia

On the multivariable analysis, marital status, region, perceived distance from health facility to get medical care, parity and history of contraceptive use were found significantly associated with unintended pregnancy.

The odds of having unintended pregnancy among married women was 0.034 times lower than those to women who were single, divorced and widowed (AOR; 0.034; 95% CI: 0.01 -0.14). Women who were living in developing regions were 84% less likely to have unintended pregnancy compared to women who were living in major regions (AOR; 0.14, 95% CI: 0.07 -0.27). Women who reported distance to health facility was not a big problem to get medical care were 41% less likely to have unintended pregnancy compared to those who reported distance was a big problem to seek medical care (AOR 0.59; 95% CI: 0.36 - 0.99) (Table 4).

The odds of having unintended pregnancy among multi-parous and grand multi-parous women was 3.77 (95% CI: 1.71 - 8.33) and 6.72 (95% CI: 2.74 - 16.49) times higher compared to nuli-parous women respectively. Similarly, women who ever had used contraceptives had 1.86 times higher odds of having unintended pregnancy compared to those who never used 1.86 (95% CI: 1.06 - 3.26) (Table 4).

Discussion

The prevalence of unintended pregnancy in the study area was 29.66% (95% CI:25.33 - 34.39).The finding of this study was in line with studies conducted in Maichew Ethiopia (17) and Addis Zemen Ethiopia(18).

However the finding was lower than studies conducted in Arsi Negele and Jimma Ethiopia (12, 14), Nigeria(10) and South Africa(11). This might be due to the low contraceptive prevalence rate in Nigeria compared to Ethiopia (25-27). The difference compared to the study in South Africa might be the difference in the proportion of married women in these studies; only 36% sexually active women were married or living in union in South Africa compared to 65% in Ethiopia(27, 28).The presence of unmarried sexually active women may increase the risk of unintended pregnancy.The finding of this study was higher than study conducted in Belesa Ethiopia, Addis Zemen Ethiopia (16, 18) and Kenya(8). This might be due to difference in the study area. The difference compared to the study in Kenya might be high contraceptive prevalence rate in Kenya compared to Ethiopia(29).

Married or in union women had lower odds of having unintended pregnancy.This finding was consistent with studies conducted in Ethiopia(15, 19), South Africa(11) and Kenya(8). This may be due to the value of community on marriage and fear of social stigma on having child outside of marriage(30). In addition, women may fear to face economical burden for rearing the baby alone(31).

Mothers who live in developing regions had lower odds of having unintended pregnancy compared to those living in major regions. This finding was consistent with a study conducted in Ethiopia(32). The reason for this might, low demand for family planning in developing region (Afar, Somali, Benshangul Gumuz and Gambela) (27). Moreover, fertility preference among women in these regions was higher compared to those in other regions (33).

Mothers who reported distance was not a big problem to seek medical care had 41% lower odds of having unintended pregnancy compared to women who reported distance as a problem. This finding was consistent with studies conducted in Ethiopia(15, 34).This might be related to access to family planning services. When women did not perceive distance as a problem, they may tend to use contraceptives (35). In addition, it increases the indirect cost of the family planning service utilization like transportation cost and lost from other productive activities(36, 37).

Multi-para women had higher odds of having unintended pregnancy compared to nuli-para women. This finding was consistent with studies conducted in Addis Zemen(18), Arsi Negele Woreda(12) and Debre Brhan town(15) and Kenya (8). The reason for this is that fertility preference among multipara women is lower than nuli-para. Therefore, the pregnancy among multi-para women is more likely to be unintended.

Women who ever used contraceptives had higher odds of having unintended pregnancy compared to their counter parts. The finding of this study was in line with studies conducted in Ivory Coast(38) but contradict with study in Legabo Woreda, North East Ethiopia (39). The reason for this may be women who ever used contraceptives were not using it just before the pregnancy occurred. In addition, women who ever used contraceptives may had experienced side effects and declined to use (40). Method failure may be the other reason for unintended pregnancy. Social desirability bias may have affected the results of this study. Many women in Ethiopia rationalize the pregnancy and report as intended although the pregnancy was mistimed or unintended.

Conclusions

Although still high, the magnitude of unintended pregnancy in Ethiopia was lower compared to the global prevalence. Marital status, living in developing regions, perceived distance to seek medical care, parity and history of modern contraceptive use were found predictors of unintended pregnancy. Unintended pregnancy prevention efforts should be strengthened among unmarried and multi-para women. Further study is needed to evaluate the quality of family planning programs since women who have ever used had more odds of unintended pregnancy in this study.

Declarations

Ethics approval and consent to participate

The 2016 EDHS protocol was reviewed and approved by the National Ethics Review Committee of the Federal Democratic Republic of Ethiopia, Ministry of Science and Technology and the Institutional Review Board of ICF International. The STATA format data was downloaded from the DHS program with permission.

Consent for publication

Not applicable

Availability of data and material

Upon request, the data is available on The DHS program website at <https://www.dhsprogram.com/data/available-datasets.cfm>

Competing Interests

The authors declare that there is no conflict of interest.

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Authors' contributions

Y.A.B initiated and performed the analysis and prepared the manuscript. GAF involved equally in the analysis and preparation of the manuscript. All authors read and approved the final manuscript.

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References

1. Centers for Disease Control and Prevention (CDC). Unintended Pregnancy Prevention 2015 [Available from: <https://www.cdc.gov/reproductivehealth/unintendedpregnancy/index.htm>].
2. Being The Parent. 2018. Unplanned Pregnancy And Its Effects 2018 [Available from: <https://www.beingtheparent.com/unplanned-pregnancy-and-its-effects/>].
3. Bearak J, Popinchalk A, Alkema L, Sedgh G. Global, regional, and subregional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian hierarchical model. *The Lancet Global Health*. 2018;6(4):e380-e9.
4. Alkema L, Chou D, Hogan D, Zhang S, Moller A-B, Gemmill A, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *The Lancet*. 2016;387(10017):462-74.
5. Unintended Pregnancy in Ethiopia, 2014 [Internet]. 2017. Available from: <https://www.guttmacher.org/infographic/2017/unintended-pregnancy-ethiopia-2014>.
6. Facts on Unintended Pregnancy and Abortion in Ethiopia [Internet]. 2010. Available from: <https://www.guttmacher.org/sites/default/files/factsheet/fb-up-ethiopia.pdf>.
7. Induced Abortion and Postabortion Care in Ethiopia [Internet]. 2017. Available from: <https://www.guttmacher.org/fact-sheet/induced-abortion-ethiopia>.
8. Ikamari L, Izugbara C, Ochako R. Prevalence and determinants of unintended pregnancy among women in Nairobi, Kenya. *BMC pregnancy and childbirth*. 2013;13(1):69.
9. Mohamed EA-EB, Hamed AF, Yousef FM, Ahmed EA. Prevalence, determinants, and outcomes of unintended pregnancy in Sohag district, Egypt. *Journal of the Egyptian Public Health Association*. 2019;94(1):14.
10. Lamina M. Prevalence and determinants of unintended pregnancy among women in South-Western Nigeria. *Ghana medical journal*. 2015;49(3):187-94.
11. Haffejee F, O'Connor L, Govender N, Reddy P, Sibiyana MN, Ghuman S, et al. Factors associated with unintended pregnancy among women attending a public health facility in KwaZulu-Natal, South Africa. *South African Family Practice*. 2018;60(3):1-5.
12. Fite RO, Mohammedamin A, Abebe TW. Unintended pregnancy and associated factors among pregnant women in Arsi Negele Woreda, West Arsi Zone, Ethiopia. *BMC research notes*. 2018;11(1):671.
13. Yenealem F, Niberet G. Prevalence and associated factors of unintended pregnancy among pregnant woman in Gondar town, North west Ethiopia, 2014. *BMC research notes*. 2019;12(1):161.
14. Beyene GA. Prevalence of unintended pregnancy and associated factors among pregnant mothers in Jimma town, southwest Ethiopia: a cross sectional study. *Contraception and Reproductive Medicine*. 2019;4(1):8.
15. Kidest Getu Melese, Mignote Hailu Gebrie, Martha Berta Badi, Wubalem Fekadu Mersha. Unintended pregnancy in Ethiopia: community based cross-sectional study. *Obstetrics and gynecology international*. 2016;2016.

16. Tsegaye AT, Mengistu M, Shimeka A. Prevalence of unintended pregnancy and associated factors among married women in west Belessa Woreda, Northwest Ethiopia, 2016. *Reproductive health*. 2018;15(1):201.
17. Kassahun EA, Zeleke LB, Dessie AA, Gersa BG, Oumer HI, Derseh HA, et al. Factors associated with unintended pregnancy among women attending antenatal care in Maichew Town, Northern Ethiopia, 2017. *BMC research notes*. 2019;12(1):381.
18. Goshu YA, Yitayew AE. Prevalence and determinant factors of unintended pregnancy among pregnant women attending antenatal clinics of Addis Zemen hospital. *PloS one*. 2019;14(1):e0210206.
19. Tebekaw Y, Aemro B, Teller C. Prevalence and determinants of unintended childbirth in Ethiopia. *BMC pregnancy and childbirth*. 2014;14(1):326.
20. Moore AM, Gebrehiwot Y, Fetters T, Wado YD, Bankole A, Singh S, et al. The estimated incidence of induced abortion in Ethiopia, 2014: changes in the provision of services since 2008. *International perspectives on sexual and reproductive health*. 2016;42(3):111.
21. Women 2017. Women's Reproductive Rights Is One of the Biggest Issues of the Century. It is Being Violated Almost Everywhere in the World 2018 [Available from: <https://women-s.net/womens-reproductive-rights/>].
22. Sustainable Development Goal 3, Ensure healthy lives and promote well-being for all at all ages [Internet]. 2015. Available from: <https://sustainabledevelopment.un.org/SDG3>.
23. The Federal Democratic Republic of Ethiopia Ministry of Health(FDRE-MOH). Health Sector Transformation Plan (HSTP) 2015/16 - 2019/20. 2015.
24. Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF; 2016.
25. National Population Commission (NPC) [Nigeria] and ICF International. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.2014.
26. Ezire O, Idogho O, Theophilus A, Ikani S, Oluigbo O. Study on the patterns and trend in contraceptive use in South-South and North-Western zones of Nigeria: 2003–2011. *Open Access Journal of Contraception*. 2014;5:65.
27. Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF2016.
28. National Department of Health (NDoH) SSASS, South African Medical Research Council (SAMRC), and ICF. 2018,,. South Africa Demographic and Health Survey 2016 Key Findings. . Pretoria, South Africa, and Rockville, Maryland, USA: NDoH, Stats SA, SAMRC, and ICF.
29. National Council for Population and Development (NCPD) [Kenya] and ICF International. Kenya Demographic and Health Survey 2014. Nairobi, Kenya, and Rockville, Maryland, USA: NPC and ICF International2015.
30. Mohammed F, Musa A, Amano A. Prevalence and determinants of unintended pregnancy among pregnant woman attending ANC at Gelemso General Hospital, Oromiya Region, East Ethiopia: a

- facility based cross-sectional study. BMC women's health. 2016;16(1):56.
31. iproject Master. THE INFLUENCE OF SOCIO-CULTURAL VARIABLES ON MARITAL STABILITY AMONG COUPLES IN LAGOS METROPOLIS [Available from: <https://www.iprojectmaster.com/EDUCATION/final-year-project-materials/the-influence-of-socio-cultural-variables-on-marital-stability-among-couples-in-lagos-metropolis>].
 32. Single-Parent Family Social Problems [Internet]. 2019. Available from: <https://www.livestrong.com/article/536203-single-parent-family-social-problems/>.
 33. Reta Lemessa Jenbere, Habte Tadesse Likassa. Multilevel Logistic Regression Analysis on Predictors of Women's Intention to Limit Child-bearing in Rural Ethiopia. Science Journal of Public Health, 2017;5(3):162-71.
 34. Kassa N, Berhane Y, Worku A. Predictors of unintended pregnancy in Kersa, Eastern Ethiopia, 2010. Reproductive health. 2012;9(1):1.
 35. Gonie A, Wudneh A, Nigatu D, Dendir Z. Determinants of family planning use among married women in bale eco-region, Southeast Ethiopia: a community based study. BMC women's health. 2018;18(1):50.
 36. Awoyemi T, Obayelu O, Opaluwa H. Effect of distance on utilization of health care services in rural Kogi State, Nigeria. Journal of human Ecology. 2011;35(1):1-9.
 37. Girma F, Jira C, Girma B. Health services utilization and associated factors in jimma zone, South west ethiopia. Ethiopian journal of health sciences. 2011;21(3).
 38. Eugène KY, Harvey A-T, Orsot TE, Simplicie DNC. Correlates of Unintended Pregnancies in Ivory Coast: Results from a National Survey. Science. 2018;6(1):6-14.
 39. Cherie N, Adane B. Kenkyu Journal of Epidemiology & Community Medicine 4: 11-17 (2018). 2018.
 40. Malalu PK, Alfred K, Too R, Chirchir A. Determinants of use of modern family planning methods: A case of Baringo North District, Kenya. Science journal of public health. 2014;2(5):424-30.

Tables

Table 1: Socio-demographic characteristic of pregnant women in Ethiopia, EDHS 2016.

Variable	Frequency (%)
Age	
15 to 24	400.31(35.26)
25 to 34	555.46(48.93)
35 to 49	179.42(15.81)
Educational status	
No education	603.93(53.20)
Primary education	397.65(35.03)
Secondary or higher	133.60(11.77)
Marital status	
Single	38.73(3.41)
Married/living union	1096.46(96.59)
Wealth index	
Poorest	257.29(22.67)
Poorer	264.88(23.33)
Middle	213.03(18.77)
Richer	198.13(17.45)
Richest	201.84(17.78)
Residence	
Urban	160.91(14.17)
Rural	974.28(85.83)
Religion	
Orthodox	364.94(32.15)
Muslim	489.51(43.12)
Other*	280.74(24.73)
Currently working	
No	839.25(73.93)
Yes	295.94(26.07)
Region	
Major region	1019.86(89.84)
City administrations	29.44(2.59)
Developing region	85.88(7.57)

*other include catholic, protestant, traditional and other none specified

Table 2 Reproductive health characteristics of pregnant women in Ethiopia, EDHS 2016.

Variable	Frequency (%)
Parity	
Nuli-para	229.23(20.19)
Primi-para	181.07(15.95)
Multi-paraous	456.70(40.23)
Grand multi-paraous	268.19(23.62)
History of abortion	
No	1025.36(90.33)
Yes	109.83(9.67)
Previous contraceptive use	
No	617.17(54.37)
Yes	518.02(45.63)
Knowledge about contraceptives	
Know no method	28.51(2.51)
Knows modern method	1106.68(97.49)
Distance to health facility for medical help	
Big problem	635.78(56.01)
Not a big problem	499.42(43.99)
Respondent can to refuse sex	
No	652.89(57.51)
Yes	482.30(42.49)

Table 3 Unintended pregnancies by women's characteristics Ethiopia, EDHS 2016

Variables	Unintended pregnancy	
	Yes	No
Age		
15 to 24	100.35(29.82)	299.96(37.57)
25 to 34	169.14(50.36)	386.32(48.38)
35 to 49	67.21(19.97)	112.21(14.05)
Marital status		
Single	29.62(8.81)	9.11(1.14)
Married or living in union	307.09(91.19)	789.38(98.86)
Educational status		
No education	190.81(56.69)	413.13(51.74)
Primary	119.62(35.54)	278.04(34.82)
Secondary or higher	26.28(7.81)	107.32(13.44)
Resident		
Urban	28.18(8.37)	132.73(16.62)
Rural	308.52(91.63)	665.76(83.38)
Region		
Major region	326.62(97.05)	693.24(86.82)
City administrations	5.41(1.61)	24.04(3.01)
Developing region	4.67(1.39)	81.21(10.17)
Perceived distance to seek medical care		
Big problem	224.31(66.65)	411.47(51.53)
Not a big problem	112.39(33.35)	387.02(48.47)
Parity		
Nuli-para	36.41(10.84)	192.82(24.15)
Primi-para	47.91(14.24)	133.16(16.68)
Multi-paraous	143.90(42.76)	312.79(39.17)
Grand multi-paraous	108.48(32.23)	159.71(20)
History of Abortion		
No	301.61(89.58)	723.75(90.64)
Yes	35.09(10.42)	74.73(9.36)
Ever contraceptive used		
No	156.08(46.38)	461.09(57.75)
Yes	180.62(53.67)	337.39(42.25)

Table 4 Factors associated with unintended pregnancy in Ethiopia, EDHS 2016 (weighted).

Variable	COR(95%CI)	AOR (95% CI)
Marital status		
Single	1	1
Married or living in union	0.12(0.44-0.32)	0.034(0.01-0.14)
Educational status		
No education	1	1
Primary	0.93(0.62-1.41)	1.3(0.74-2.06)
Secondary or higher	0.53(0.26-1.06)	1.69(0.62-4.67)
Resident		
Urban	1	1
Rural	2.18(1.18-4.01)	1.59(0.59-3.67)
Region		
Major region	1	1
City administrations	0.47(0.24-0.95)	1.00(0.37-2.67)
Developing region	0.12(0.07-0.03)	0.14(0.07-0.27)
Perceived distance to seek medical care		
Big problem	1	1
Not a big problem	0.53(0.34-0.83)	0.59(0.36-0.99)
Religion		
Orthodox	1	1
Muslim	0.20(0.73-1.99)	1.23(0.74-2.06)
Other*	1.11(0.67-1.84)	1.05(0.60-1.84)
Parity		
Nuli-para	1	1
Primi-para	1.91(0.80-4.53)	2.37(0.91-6.14)
Multi-paraous	2.44(1.20-4.94)	3.77(1.71-8.33)
Grand multi-paraous	3.59(1.76-7.35)	6.72(2.74-16.49)
History of Abortion		
No	1	1
Yes	1.12(0.61-2.07)	1.03(0.53-2.01)
Ever contraceptive used		
No	1	1
Yes	1.58(0.96-2.60)	1.86(1.06-3.26)

*other includes catholic, protestant, traditional and other none specified