

Unmet Need for Family Planning and Associated Factors Among Married Women of Reproductive Age in Shebedino District, Southern Ethiopia, 2020

Matewos Wotango Wonago (✉ matewoswotango@gmail.com)

Southern Nation Nationalities Peoples Regional State Health Bureau, Disease Prevention and Health Promotion Core process, Health Extension program Hawassa, Ethiopia

Desalegn Tsegaw Hibstu

Hawassa University College of Medicine and Health Sciences

Research

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Abstract

Back Ground: The Ethiopia Demographic and Health Survey, report indicates that high level with slight decrement of unmet need for family planning among married women that is, 37%, 25%, and 22% in 2000, 2011 and 2016 respectively. One of the consequences of unmet need is unwanted pregnancy with its serious squeal of induced abortion, and ultimately results in high maternal morbidity and mortality. The risk would increase in developing countries considerably (10). Therefore, this study focused on assessing magnitude of unmet need for FP and associated factors among married women of reproductive age group in Shebedino district, Sidama Zone, South Ethiopia, 2019.

Methods: Community-based cross-sectional study was conducted from April 12 to 28, 2019. Data on married reproductive age groups women were collected using a pre-tested and interviewer administered structured questionnaire from 447 women using systematic random sampling technique. The data were entered using Epi Data version 3.1 and then exported in to SPSS version 20.0 Software for analysis. The result of bi-variable and multi-variable was reported by Adjusted Odd Ratio with 95% confidence.

Result: A total of 447 married reproductive age group (15-49 years) women were included in the study with 100 % response rate. Fifty Six (12.5%) 95% CI: 9.5%-15.5%) women had unmet need for family planning [42 (9.4%) for spacing and 14 (3.1%) for limiting]. Age of the respondents [AOR= 6.02, CI: 2.73, 13.27], Age at first marriage [AOR= 9.3, CI: 1.9, 45.42], birth interval, [AOR= 2.9, CI, 1.3, 6.3], Number of alive children, [AOR= 9.3, CI: 1.9, 45.42], and Age at first start to use family planning to control birth (AOR= 3.69, CI: 1.44, 9.45) were identified as a positively associated factors.

Conclusion: The level of unmet need for family planning in this study (12.5%) was lower than both the national (22%) and South Regional State (21%). Thus, spacing among births for at least two or more years, enforcing the law on minimum age for the first marriage, involvement of men in shaping reproductive preferences, reducing early marriage and participating relevant stakeholders to minimize mistimed and unwanted pregnancies and unmet need for family planning are recommended.

Background Of The Study

Family Planning is a principal strategy in controlling population growth and promoting maternal and child health through an adequate spacing of births and avoiding unwanted pregnancy. Contraceptive use has increased markedly in the recent years in most developing countries, due to desire for smaller families; however, millions of women still want to delay or avoid pregnancy but are not using contraception to limit or to spacing their birth [1].

The primary aim of family planning programs is to meet up the demand for contraception and thereby reduce or eliminate unmet need. A well-organized family planning program having a substantial information, education, and communication component can, on average, reduce unmet need by 10% and raise contraceptive use by 22% [2].

Couples who use contraception have the ability to control the number and spacing of their children. Contraceptive use prevents unintended pregnancies, abortions and deaths related to pregnancy and childbirth [3, 4].

However, the absolute number of women with unmet need has increased from 127 million to 142 million, because of the growth of population. For instance, Asia accounts for 84 million women having unmet need in 2010, followed by sub-Saharan Africa at 32 million [2]. Globally about 222 million women have an unmet need for family planning and 645 million women have their needs met through the use of a modern contraceptive method [5].

Among more than 220 million women with unmet need, three regions-sub-Saharan Africa, South Central Asia and Southeast Asia are dwelling to more than half of these women [6]. Sub-Saharan Africa continues in 2010 to be the region with the lowest level of CPR, 24% and highest level of unmet need 25%. Among the 35 countries in sub-Saharan Africa, 24 have unmet need of more than 20 percent, and in 7 of these it was more than 30 percent in 2011 [6].

The percentage of women having unmet need varies broadly across countries with the highest levels of unmet need observed in Oceania and Sub-Saharan Africa. The level of unmet need in Latin America and the Caribbean ranges from 9% in Colombia to 35% in Haiti, in Asia ranges from 11% in Indonesia to 32% in Timor-Leste and in Africa, ranges from Egypt (12%) and highest in Sao Tome and Principe (38%) and in Ghana and Liberia (36% each) [7].

Global decreasing of unmet need would prevent around 30% of maternal deaths, reduce child mortality by up to 20%, and avert 36 million women of healthy life lost each year (8). In Ethiopia, helping women and couples plan their families and increased access to contraceptive services to reduce unmet needs would contribute directly to attaining three MDGs: reducing child mortality, improving maternal health and promoting women's empowerment and equality [9].

One of the consequences of unmet need is unwanted pregnancy with its serious sequel of induced abortion, and ultimately results in high maternal morbidity and mortality. The risk would increase in developing countries including Ethiopia considerably. Thus, meting the unmet need and spacing among births for at least two years are relevant to avoid these deaths and morbidity [10].

The EDHS indicated that Ethiopia with high level of unmet need for family planning among married women that is, 37% in 2000, 25% in 2011 and 22% in 2016 [11]. Reducing the unmet needs averts unsafe, secret abortion, and its outcomes greatly as the recent reports suggested that only 27% of the 382,000 induced abortions that occurred in 2008 were legal and Some 52,600 women were hospitalized for complications from unsafely induced abortion [2]. Therefore, this study aimed to assessing magnitude of unmet need for FP and associated factors among married women of reproductive age groups in Shebedino district, Sidama Zone, South Ethiopia, 2020.

Methods

Study setting and period

The study was conducted in Shebedino District, Southern Ethiopia, from February to June 2019. The study District is known for producing coffee as an important cash crop globally. It is located in Southern Nation Nationalities People Region Ethiopia, at a distance of 300 kilo meter from Addis Ababa, capital city of Ethiopia and 24 km from Hawassa, capital city of SNNPR.

The District is one of the 36 Districts & 4 City administrations of Sidama Zone with 21 rural Kebeles (*kebele is the smallest administration unit in Ethiopia*).

According to the 2007 projected Population and Housing Census, Shebedino District has a total population of 181,460 accounting for about 8% of the Sidama Zone's population in the year 2018. Married Women among reproductive age groups (15-49) years make up close to 37,017 (20.4%). Among the total population 85% are living in rural areas. It has a total of 21 health posts, six functional health centers and one primary hospital providing preventive, promotive, curative and rehabilitative services [41].

Study Design and Population

Community based cross-sectional study was employed. The source population was all reproductive age group women in the district and the study population were sampled married women found in their reproductive age groups.

Sample size and Sampling procedures

The sample size is determined using single population proportion formula with the following assumptions and the second objective with G-power software version 3.1.9.1. Therefore, the values for assumption are 95% confidence level (1.96), 5% margin of error (d), proportion (P) of unmet need in family planning is taken as 21% (0.21) from the 2016 EDHS (14), design effect $n = 1.5$ and non-response rate is 5%. Then, using the following formula the total sample is determined to be **447**.

From Shebedino District a total of 6 Kebeles were selected using simple random sampling technique. Households with married reproductive age women were taken from family folder of health extension workers (HEW) using simple random sampling technique. Study participants were allocated proportionally to each kebele based on number of married reproductive age women in selected kebeles. Lottery method was used to select one reproductive age women when there is more than one woman in the selected household.

$$n = \frac{\left(Z_{\left(\frac{\alpha}{2} \right)} \right)^2 P (1-P)}{d^2} =$$

Sample size	Prevalence of unmet need for family planning
n=	n=284
n ⁺ 5% of non-response	298
Design Effect	1.5
n ⁺ +5% non-response rate*1.5 of design effect	Total sample size 447

Variables

Dependent variable (outcome variable) is unmet need for family planning (1=Yes, 0=No) The independent variables /Exposure variables/include, Socio economic and demographic factors: age of the women, marital status, ethnicity, religion, educational status of the women and the partner, women occupation, residence, husbands occupation, household's monthly income, family size, Sex of child, number of live children. Reproductive History and health factors: age at the first marriage, age at the first pregnancy, history of pregnancy, parity, desired number of children, side effect of contraception, knowledge and practices of family planning use, exposure to family planning messages via the media.

Operational Definition

Unmet need for Family planning: is referring to those women who prefer to space or limit childbearing but is not using any effective modern contraceptive to fulfill its desire.

Women are defined as having an unmet need if they are fecund, married or living in union, but not using any contraception or **have a mistimed or unwanted current pregnancy**, or are postpartum amenorrhoeic and their last birth in the last 2 years was mistimed or unwanted [14].

Data collection tool and Procedure

Data were collected using pretested, structured questionnaire and semi-structured questionnaire. The questionnaire is initially prepared in English and translated to local language (Sidaamu afoo) and then the Sidaamu afoo questionnaire was back translated to English to maintain the consistency in the meaning of the words and/or concepts. The Sidamigna versions were used for data collection after pre-testing on five percent of the actual sample size in other similar settings to ensure that respondents understand the questions and to check the wording, logic and skip order of the questions in a sensible way to the respondents. An amendment was made accordingly after the pre-tested.

The data collection was done by 12 females' degree holder with 6 teams. Each team comprising two data collectors and six supervisors were supervised the overall data collection process. One day training was

given to all data collectors and supervisors to have common understanding on the data collection tools and process.

After data collection, questionnaires were reviewed and checked every day for completeness by the supervisors. The investigator was also given the necessary feedback for the data collectors immediately. Finally, the data was cleaned and coded before entering in to computer.

Data processing and analysis

Data were checked, coded and entered to Epi-data 3.1 versions and SPSS version 20 statistical package software and analysis was made. Before analysis of the data, missing observations were cleaned and presence of cells of each category under each variable with zero values was checked by cross tabulation of each independent variable against the dependent variable. Categories containing cells with zero values are going to be merged with the other category within the variable to have better validity on its result.

The results of the analysis were presented in the form of tables, figures and summary statistics. For categorical variables, frequencies, percentages and figures are going to be used in the socio-demographic part and for continuous variables after checking their normality using figures like box plot or scatter plot, mean and standard deviation for normal distributions and for those that are not normally distributed median and inter quartile range was used.

Analysis of the data involved descriptive statistics of the demographic profile of the participants and testing and identifying potential predictors of unmet need using the simple and multiple binary logistic regression techniques. Simple binary logistic regression analysis for each independent variable was performed against the dependent variable to see the impact of each factor on the pattern of unmet need for family planning, the dependent variable in the sampled observations, without adjusting for the effect of other variables.

Goodness of the models was also be tested by diagnosing correctness of formulation of the models by using Hosmer-Lemeshow and Omnibus test of model coefficients that are the values (p value >0.05 and <0.05 respectively).

Results

Socio-demographic and economic characteristics of the r

A total of 447 (100%) married women respondents of age between (15-49 years) were included in the study. Nearly two in seven 123 (27.5%) of the respondents are in the age group of 15-24 years, 186 (41.6%) accounted for the age group of 25-34.

The mean and (\pm SD) age of the study subjects was **29.78** and **7.32** years. Three among five 274 (61.3%) reported to be Protestants by religion, and more than three-fourth 362 (81.0%) was reported to be Sidama people.

On the basis of the educational status, only 76 (17.0%) and 154 (34.5%) women and husbands attended secondary education and 25 (5.6%) women and 84 (18.8%) husbands attended above secondary education. Of the total women, more than half of the respondents 229 (51.2%) are house wives and 172 (38.5%) of their husbands are farmers by occupation.

Three hundred twenty two household members (72.0%) had monthly income of >1500 ETB(s) and nearly three in ten 139 (31.2%) of the respondents owned radio as a means of communication. Concerning the total household size, 261(58.4%) had a house hold size of >5 with an average house hold size. **[Table 1]**

Reproductive and family planning characteristics

Two hundred fifty one (56.2%) women were married at the age of < 18 years. Almost all 428 (95.7%) of interviewed women had history of pregnancy. Two hundred sixty one (61.4%) of the study participants got pregnancy below the age of 18 years.

About 168 (39.3%) of respondents reported birth interval 2-3 years and 6 (1.4%) reported 4-5 years. Of the total pregnancies 38 (8.5%) and 18 (4.0%) were mistimed and unwanted and 17 (3.8%) of the pregnancies were intended. Almost one among ten, 56 (12.5%) women in reproductive age group had unmet need for contraceptive and 42 (9.4%) had unmet need for spacing **[Table 2]**.

Knowledge and practice of the respondents

Four hundred forty seven married women included in the study. Out of this number, 211 (47.2 %) women are contraceptive users. Nearly three in five 207 (59.7%) obtained rumor information about family planning from defaulters while 43 (9.7%) got rumor about family planning from the different sources.

Among family planning users the majority 403 (91.8%) of respondents were used injectable method and nearly eight among ten women 349 (78%) were reported jointly decision on contraception. On the other hand, nine in ten 438 (89%) was reported to be the distance < 30 minutes from their home to access contraceptive **[Table 3]**.

Factor affecting unmet need

In the multivariate logistic regression analysis: Age of respondents, age at first marriage, Birth interval, number of alive children and age at first start to use family planning to control birth were identified as independent predictors of unmet need in family planning among married women of reproductive age group.

In this study, age of the respondents ≥ 35 years were 6.02 [AOR, 6.02, 95% CI, 2.73-13.27, P=0.001] times more likely to have unmet need for family planning compare to those who were the age between 15-24 years.

Other important predictor was age at first marriage. It was found that unmet need in family planning < 18 years were 9.3 [AOR, 9.3, 95% CI, 1.90- 45.42, p=0.006], times more likely to have unmet need family

planning compare to those who were the age ≥ 18 years.

On the other hand women who have a pregnancy interval of, 4-5 years was 2.87 [AOR, 2.9, 95% CI, 1.32-6.24, $p=0.008$] times more likely to have unmet need for family planning to compare with one and half years average age of consecutive pregnancy.

The other result also indicates that number of alive children, Women have no children 9.3 [AOR, 9.3, 95% CI, 1.90-45.41, $p=0.006$] and women who have 1-4 alive children 2.84 [AOR, 2.84, 95% CI, 1.26-6.39, $p=0.012$] times more likely to have unmet need for family planning compared with women who have >4 alive children.

Age at the first start to use family planning ≥ 18 years were 3.69 (AOR = 3.69, 95 % CI: 1.44–9.45, $p=0.007$) times more likely to have unmet need for family planning compared to those who were < 18 years [Table 4].

Goodness of the models was also be tested by diagnosing correctness of formulation of the models by using Hosmer-Lemeshow and Omnibus test of model coefficients. In Hosmer-Lemeshow test the study result shows that non-significant (p -value = 0.307) and Omnibus test of model the tests results indicated that significance of the model at (p -value <0.01). Therefore, both test results are acceptable the goodness of the model at all levels. [Table 5&6].

Discussion

The unmet need in the current study 12.5% is relatively in line with the studies conducted in Latin America and Caribbean (9%), Asia (11%), Egypt (12%), Eastern Asia, Eastern Europe, Northern America, Northern Europe, South America and Western Europe and Tanzania (10%), and Addis Ababa, Ethiopia (11%) [7, 14].

However, the overall unmet need for family planning in this study was relatively lower than studies conducted in Sab-Saharan Africa (20%), Indonesia (32%), Ghana and Liberia (36%), Cameroon (20.4%), Nepal (25%), Sao Tome (38%) and (22%) Ethiopia Demographic and Health 2016 survey [2, 7, 9, 11, 18, 33]. Therefore, these differences might be because of the differences in the access to health services and awareness level of the communities.

This might be attributed to increased more awareness, access to information, education and communication and family planning services as a result of the increased effort of expansion of health extension program in recent times in the study area compared to when the time that the previous studies were conducted. This therefore, may be an alert for more giving attention and merely focusing on the implementation of family planning programs in the study area as well as in the region.

The study demonstrated that significant association was observed with age of the women. Women who are greater than 35 year age groups had more unmet need in family planning. This implies that older women have more unmet need which might be attributed to lack of interest contraceptive uptake for limiting birth among this age group. However, young women do have unmet need probably due to lack of

knowledge on contraceptives and the desire to have more children. This study is consistent with previous studies in Burundi and Kenya [26, 44].

The other significant association was observed with Birth interval. It was figured out that women who spaced their birth 4-5 years were more likely to have unmet need in family planning compare with women one and half years birth interval. Women who join marriage before their 18 years were more likely to have unmet need in family planning. This could be due to as younger women not only have better awareness and information about family planning but also they are psychologically and physically not matured to determine the number of children compared to women who join marriage after the age of 18 years. This finding is consistent with studies in Southern part of Ethiopia [21].

On the other hand, total number of live children in household plays significant role on in unmet need in family planning. Unmet need in family planning among married reproductive age group with four and less children was more likely to occur unmet need compared to women having greater than four children. This finding is in line with the study conducted in Nepal and Burkina Faso [32, 43]. This might be due to that women who had inadequate number of children could have not awareness about the consequences of repeated pregnancy and child birth so that, they would have better awareness about family planning and utilize contraceptive in order to limit the number of their family size.

It might be explained as women the age greater than 18 years start to use family planning at first time would have a positive association with unmet need for family planning. Therefore, women who married and started to practice sexual intercourse at early age should use contraception to control mistimed and unwanted pregnancy.

Conclusions

The level of unmet need for family planning in the study area (12.5 %) is lower than the national (22 %) and Southern Ethiopia Regional State (21 %). In this study, age of respondents, birth interval, age at first marriage, number of alive children women had and age at first time start to use family planning were factors affecting unmet need for family planning. Meeting the unmet need and spacing among births for at least two or more years are relevant to avoid these mistimed and unwanted pregnancies, enforcing the law on minimum age for the first marriage and providing women with full access to family planning services and avoiding socio-cultural barriers that are not practicing to use family planning during at early marriage age would be instrumental in reducing unmet need.

List Of Abbreviations

CI: Confidence interval; CPR: Contraceptive Prevalence rate; CSA: Central Statistics agency; EDHS: Ethiopia Demographic and Health Survey; FP: Family Planning; HHs: House Holds; HSTP: Health Sector Transformation Plan; KAPs: Knowledge, Attitudes and Practices; MCH: Mother and Child Health; STI:

Sexual Transmitted Infection; SNNPR: South Nations Nationalities People Region; TFR: Total Fertility Rate; UN: United Nations; UNICEF: United Nations Children Fund; WHO: World Health Organization.

Declarations

Ethics approval and consent to participate

Ethical clearance was obtained from the ethical clearance Committee of Pharma College. Official letters were taken from Regional Health bureau, Zone health department and District Health Office. Informed verbal consent was obtained from the study participants. The study participants were informed about the purpose of the study and informed verbal consent was taken. All study participants were informed that participation in this research project has no incentives or direct benefit.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no competing interests.

Availability of data and materials

The data that support the findings of this study will be available from the corresponding author upon reasonable request in the form of statistical package for social sciences (SPSS) spread sheet.

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Authors' contributions

MW took part in planning the study, monitoring data collection process, analyzes the data and writing the manuscript. DTH participated in designing the study, supervising data collection process and editing the manuscript. Both authors read and approved the final manuscript.

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Tables

Table 1 distribution of respondents by selected demographic & socio economic Characteristics, Shebedino District, 2019 (n=447)

Variables		Frequency	Percentage
Age of the respondent	15-24	123	27.5
	25-34	186	41.6
	≥35	138	30.8
Religion	Protestant	274	61.3
	Orthodox	93	20.8
	Muslim	53	11.9
	Catholic	21	4.7
	Others	6	1.3
Ethnicity	Sidama	362	81.0
	Oromo	5	1.1
	Amhara	27	6.0
	Gurage	10	2.2
	Wolaita	27	6.0
	Hadiya	8	1.8
	Others	8	1.8
Women educational status	Illiterate	98	21.9
	read and write	94	21.0
	primary education	154	34.5
	secondary	76	17.0
	above secondary	25	5.6
Husband's educational status	illiterate	46	10.3
	read and write	36	8.1
	primary education	127	28.4
	secondary	154	34.5
	above secondary	84	18.8
Woman main occupation	house wife	229	51.2
	government employee	24	5.4
	NGO	13	2.9

	Merchant	100	22.4
	Self employed	72	16.1
	others	9	2.0
Husband's main occupation	Government employee	92	20.6
	NGO	25	5.6
	Merchant	93	20.8
	Self-employee	48	10.7
	farmer	172	38.5
	others	17	3.8
HHS Monthly income (ETB)	≤500	33	7.4
	500 -1500	92	20.6
	> 1500	322	72.0
Items of the HHs owned	Electricity	116	26.1
	Radio	139	31.2
	TV	60	13.5
	Mobile phone	130	29.2
Total house hold size	≤5	186	41.6
	> 5	261	58.4

Table 2 Percentage distribution of respondents by selected Reproductive history, at Shebedino District, 2019 (n=447)

Variables		Frequency	Percentage
Age at first marriage	< 18	251	56.2
	≥ 18	196	43.8
Have you ever been pregnant	Yes	428	95.7
	No	19	4.3
Birth interval	1&1/2 years	140	32.7
	2-3 years	168	39.3
	3-4 years	114	26.6
	4-5 years	6	1.4
No. of pregnancies women had	0	22	4.9
	1- 4	278	62.2
	> 4	147	32.9
Age at first birth	< 18	164	38.6
	≥ 18	261	61.4
No. of live children	0	26	5.8
	1- 4	277	62.0
	> 4	144	32.2
Intension to have more children	Yes	216	48.3
	No	231	51.7
HHs Expected additional male to have	1 - 2	160	35.8
	> 2	268	60.0
HHS Expected additional female to have	1 - 2	289	64.7
	> 2	139	31.1
Presence of pregnancy	yes	73	16.4
	no	374	83.6
Types of unmet need	For spacing	42	9.4
	For limiting	14	3.1
Status of pregnant (n=73)	Intended	17	3.8
	Mistimed	38	8.5.

Table 3 Distribution of respondents by selected Knowledge and practice on FP, Shebedino District, 2019 (n=447)

Variables		Frequency	Percentage
Contraceptive practices	current user	211	47.2
	ever used	228	51.0
	non user	8	1.8
Women age the first time started to use FP	< 18	73	16.6
	≥ 18	367	83.4
Types of methods users	injectable	403	91.8
	oral contraception	20	4.6
	Norplant	9	2.1
	IUCD	7	1.6
Women Interest to delay or avoid pregnancy	Yes	373	83.4
	No	74	16.6
Women Source of rumor for FP	current users	137	30.6
	Previous users/defaulters	267	59.7
	Non users	43	9.7
Decision on contraception use	wife only	34	7.7
	husband only	64	14.3
	jointly decision	349	78.0
Duration of contraception uses without interruptions (months)	< 6	339	75.9
	6 – 12	68	15.2
	> 12	40	8.8
Distance of Health facility from home (minute)	< 30 minutes	438	98.0
	≥ 30 minutes	9	2.0

Table 4 Determinants of the unmet need for family planning: Multi-variate sAnalysis

Variables	Unmet Need for FP							
	Yes		No					
	No. (%)		No. (%)		COR (95%CI)	AOR (95%CI)	P-Value	
Age of respondent								
15 – 24	16	(8.6)	170	(91.4)	1		1	
25 – 34	14	(11.4)	109	(88.6)	1.365(0.640, 2.908)		1.042(0.141, 1.253)	0.120
≥ 35	38	(27.5)	100	(72.5)	4.037(2.141, 7.613)		6.018(2.730, 13.266)	<0.001*
Women educational status								
No formal education	37	(19.3)	155	(80.7)	3.329(0.727, 15.233)		2.475(0.891, 6.875)	0.082
Primary	19	(12.3)	135	(87.7)	2.184(0.465, 10.254)		1.861(0.624, 5.545)	0.265
Secondary and above	12	(11.9)	89	(88.1)	1		1	
Monthly income (ETB)								
≤500	10	(30.3)	23	(69.7)	3.155(1.397, 7.123)		1.560(0.521, 4.674)	0.427
500 -1500	19	(20.7)	73	(79.3)	1.889(1.031, 3.461)		1.138(0.509, 2.545)	0.753
> 1500	39	(12.1)	283	(87.9)	1		1	
Birth interval								
one and half year	13	(9.3)	127	(90.7)	1		1	
2-3 years	32	(19.0)	136	(81.0)	2.299(1.155, 4.576)		1.034(0.472, 2.265)	0.933
3-4 years	13	(11.4)	101	(88.6)	1.257(0.558, 2.832)		1.764(0.733, 4.247)	0.206
4-5 years	2	(33.3)	4	(66.7)	4.885(0.815, 29.279)		2.871(1.321, 6.239)	0.008*
Age at first marriage								
< 18	49	(19.5)	202	(80.5)	2.260(1.282, 3.983)		9.294(1.902, 45.413)	0.006*
≥ 18	19	(9.7)	177	(90.3)	1		1	

Age at first birth							
< 18	30	(18.3)	134	(81.7)	1.724 (0.996, 2.985)	1.210(0.523, 2.800)	0.657
≥ 18	30	(11.5)	231	(88.5)	1	1	
No. of live children							
0	10	(43.5)	13	(56.5)	5.231(2.026, 13.507)	9.294(1.902, 45.413)	0.006*
1- 4	35	(13.1)	233	(86.9)	1.123(0.628, 2.010)	2.833(1.257, 6.384)	0.012*
> 4	23	(14.7)	133	(85.3)	1	1	
Age at first start to use FP							
< 18	2	(2.7)	71	(97.3)	1	1	
≥ 18	65	(17.7)	302	(82.3)	2.310(1.277, 4.180)	3.690(1.440, 9.455)	0.007*
No. of alive children during first use of FP							
0	9	(34.6)	17	(65.4)	5.824(2.140, 15.846)	3.405(0.928, 12.495)	0.065
1- 4	47	(17.0)	230	(83.0)	2.248(1.151, 4.389)	3.627(0.843, 15.606)	0.084
> 4	12	(8.3)	132	(91.7)	1	1	