

**KNOWLEDGE, ATTITUDE AND PRACTICE OF MODERN
CONTRACEPTIVES AMONG STREET GIRLS OF
BOLE SUB-CITY, ADDIS ABABA**

BY: KIDIST HABTEMARIAM

**ADDIS ABABA UNIVERSITY
SCHOOL OF SOCIAL WORK**

OCT, 2014

**KNOWLEDGE, ATTITUDE AND PRACTICE OF MODERN
CONTRACEPTIVES AMONG STREET GIRLS OF BOLE SUB-
CITY, ADDIS ABABA**

BY: KIDIST HABTEMARIAM

**A THESIS SUBMITTED TO THE SCHOOL OF SCOCIAL WORK ADDIS
ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER'S
OF SOCIAL WORK**

ADVISOR: WOUBE KASSAYE (PhD)

**ADDIS ABABA UNIVERSITY
SCHOOL OF SOCIAL WORK**

OCT, 2014

ADDIS ABABA UNIVERSITY

SCHOOL OF SOCIAL WORK

**KNOWLEDGE, ATTITUDE AND PRACTICE OF
MODERN CONTRACEPTIVES AMONG STREET OF BOLE
SUB-CITY, ADDIS ABABA**

BY: KIDIST H/MARIAM LEGESSE

APPROVED BY BOARD OF EXAMINERS

Advisor

Signature

Date

Internal Examiner

Signature

Date

External Examiner

Signature

Date

ACKNOWLEDGEMENT

I extend my deepest gratitude and appreciation to my advisor Dr. Weube Kassa and my husband Beleta Gathun for their invaluable comments and suggestions. It could not have been possible to develop the research proposal and finalize the study, which has given me a tremendous knowledge, skill and experience.

I am extremely grateful to Ato Belete Getahun for his support in data entry and analysis.

My sincere thanks also go to Ato Kumalchw Tekalign and Rheal H/Mariam for their unreserved support in the data collection process.

TABLE OF CONTENT

TABLE OF CONTENTS

	Page
Abstract.....	i
Acknowledgements.....	ii
List of Acronyms	iii
List of Tables and list of figure	iv
CHAPTER ONE - INTRODUCTION.....	1
1.1 Background of the study	1
1.2 Statements of the Problem.....	3
1.3 Research question.....	5
1.4 Objectives.....	5
1.4.1 General objective 5	
1.4.2 Specific objective 5	
1.5 Significance of the study.....	6
1.6 Limitation of the study	7
1.7 Strengths of the study.....	7
1.8 Definition of terms	7
1.9 Operational definitions.....	8
CHAPTER TWO - LITERATURE REVIEW	9
2.1 Background	9
2.2 General situation of street children in Ethiopia.....	11
2.3 Street Children.....	12
2.4 Characteristics of street children	12
2.5 Sexual abuse.....	14
2.6 Unprotected sex.....	14
2.7 Contraceptive	15

2.8 Contraceptive knowledge and use.....	15
2.9 Contraceptive Challenges.....	16
2.9 The practice of using modern contraceptives.....	17
2.10 Pregnancy and Homelessness	18
2.11 Pregnancies and abortion	19
2.12 The practice of condom use	19
2.13 The practice of using modern contraceptives.....	19
2.14 Pregnancy and abortion.....	20
2. 15 Theories and Models	20
2.15.1 The Rational Choice Model	21
15.1.2 Stress Theory	22
2. 15 .3 "Knowledge, Attitude, Practice", KAP Model	23
2.17 Conceptual Framework	24
CHAPTER THREE - RESEARCH METHODOLOGY	25
3.1 Study Area and selection.....	25
3.2 Study population	25
3.3 Study Design	25
3.5 Eligibility Criteria	26
3.5.1 Inculcation Criteria	26
3.5.2 Exclusion Criteria	26
3.6 Sample size Determination.....	26
3.7 Sampling techniques	26
3.8 Data collection techniques	27
3.9 Study Variables	27
3.9.1 Independent Variables	27
3.9.2 Dependent Variables	27
3.10 Data processing and analysis.....	28
3.10.1 Data Processing	28
3.10.2 Analysis of the data	28
3.11 Ethical considerations	29
CHAPTER FOUR - PRESENTATION AND ANALYSIS OF THE DATA	30

4.1 Socio demographic characteristics	30
4.2 Knowledge of modern contraceptive among street girls.....	32
4.2.1 Relation between the level of knowledge of modern contraceptive and socio-demographic variable	34
4.2.2. Logistic regression analyses socio demographic variables and knowledge of modern contraceptive	36
4.3 Attitudes of modern contraceptive by the study groups.....	38
4.3.1 Socio demographic variables and attitude towards modern contraceptive above and below mean cross tabulation	39
4.4. Sexual and modern contraceptive use practice	41
4.4.1 Association between modern contraceptive practice and socio demographic variable	43
CHAPTER FIVE - DISCUSSION.....	45
CHAPTER SIX - CONCLUSIONS AND RECOMMENDATION	48
6.1 Conclusions	48
6.2 Recommendations	48
6.2.1 Institutional Structural	48
6.2.2 Institutional - Functional	49
Reference	50
Annex I Questioners	
Declaration	

LIST OF TABLES

Table1. Socio - demographic data on street girls,.....	34
Table.2 Knowledge on different type of contraceptive.....	35
Table. 3 Source of information/knowledge received.....	37
Table.4 The source of modern contraceptive service.....	38
Table.5 The attitude to warded modern contraceptive.....	40
Table.6 Respondents who answered yes to attitude questions.....	24
Table. 7 Sexual practices of street girls.....	43
Table. 8 The Sexual and contraceptive practice when first time sexual intercourse.....	44
Table. 9 knowledge above the mean and below mean Cross tabulation.....	45
Table. 10 logistic regression of Attitude towards modern contraceptive.....	47
Table. 11 Multivariate analysis includes all variable.....	52

LIST OF FIGERS

Figure 1 Conceptual framework	29
Figure. 2 contraceptive methods known by the respondents	38

LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
BSS	Behavioral surveillance survey
CSA	Central statistical authority
DHS	Demographic and health survey
FGD	Focus Group discussion
FDRE	Federal Democratic Republic of Ethiopia
FSCE	Forum on Street Children Ethiopia
HIV	Human immunodeficiency virus
KAP.....	Knowledge, Attitude and Practice
PAI	Population Action International
STI	Sexually transmitted infections
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Abstract

The general objective of this study was to assess the knowledge, attitude and Practice of modern contraceptives among street girls of the Bole sub-city, Addis Ababa. A cross sectional quantitative survey was conducted, on 84 street girls in the Bole sub-city, Addis Ababa. Participants were recruited from “cluster” sites such as main road sides, isolated slum areas, around Churches and/or Mosques (in the mornings on Sundays and other religious feast days) and streets where street girls usually reside and/or sleep. The primary Data were collected using a structured interview questionnaire in local language (Amharic) after informed verbal consent. To analyze the data Data were then entered into SPSS version 20.0 for analysis, logistic regression models were fitted to assess associations. Associations were measured by the Odds ratio and its 95% confidence interval. The study revealed that more than 57% street girls have heard of modern contraceptives and have knowledge of at least one contraceptive. The three most commonly identified modern contraceptives among the respondents were 22.6% condom, 10.7% injectable and 9.5% pills age of 20–25 years (AOR=3.71), income per month greater than 1,000 ETB (AOR =6.71) and education level, who attend high school (AOR=4.25) and above high school (AOR=6.31) were associated with modern contraceptive use. Most of 79.8%, the study subjects have interest to know more about modern contraceptives Moreover, 81% of the respondent consider modern contraceptive method do not have harmful effects on health and 58% recommend modern contraceptive methods to be used by others In general about 73.8% have a favorable or a positive attitude towards modern contraceptive. About 97% of street girls who had sexual intercourse, has more than one sexual partner and first time sexual intercourse was at the mean age of 15 years. Nearly 78% of the street girls had a chance to be pregnant, 42.8% gave birth in their stay at street and 78% ever used contraceptive methods. Despite their Knowledge about the methods significant number of respondents were associated with positive attitude towards modern contraceptive. There is critical need to teach with consideration of street girls context about the modern contraceptive practice to overcome the reproductive health problems.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The increasing growth of population has become an urgent problem in Ethiopia. The Ethiopian population grew at an alarming rate from about 40 million in 1984 to 54 million in 1994 and about 94 million in (2013 DSH) of the total population, 13% and 17% are children and youth respectively.

Nevertheless, these productive populations could not be fully enrolled in school and other productive activities due to the low economic situation of the country. A number of children also become orphans every year, mainly due to HIV/AIDS (UNICEF, 2010). These children and youth living in difficult conditions are forced to go out of their home and family in pursuit of the good life that will in turn make them vulnerable to street life. Though street children are hard to count, however, (UNICEF, 2010) estimates that there are approximately 100 million street children worldwide with that number constantly growing.

What is certainly known is that their numbers are increasing for various reasons, including the global population growth, poverty, rapid urbanization, and the AIDS pandemic (Meindert et al., 2006). As a relatively recent estimate indicates, the number of street children in

The United Nations Children's Fund (UNICEF) estimated 600 thousand street children in the country and more than 100 thousand reside in the capital, Addis Ababa.

Furthermore, UNICEF and others estimate this number to be much higher. Many also agreed that the number of street children is increasing to major urban centers, particularly in Addis Ababa (FDRE, 2007).

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity (WHO, 2006). People with adequate sexual and reproductive health have a satisfying and safe sexual life, can have children, and can make a choice as to whether they would like to have children and, if so, when and how to have them (Tyler, 2007). Unfortunately, the youth in general is at greater risk of abnormal sexual and reproductive health compared to other age groups due to risky sexual behaviors. Homeless children and youth are likely to be at even higher risk for several different reasons (Atanu, 2007).

Street woman is the most vulnerable to many physical, economic, social and psychological problems. Their vulnerability was also aggravated by their lack of understanding of the changes associated with adolescence skills that could help them to make healthy choices and their inability to access the appropriate services (Demelash et al., 2013).

Related to the low level of contraceptives unintended pregnancy and induced abortion remains common outcome in many developing countries. Worldwide, nearly 80 million unintended pregnancies occur where more than 40 million ended in abortion, 36 million terminated in developing and 10 million in the developed world (WHO, 2012). Of those abortion 20 million are carried out under illegal and unsafe conditions (PAI, 2005).

In Ethiopia, the estimated number of street children is 150 to 200 thousand with approximately 50 to 60 thousand street children live in Addis Ababa (DHS, 2005). A survey

conducted in Addis Ababa showed that 38.9% of the admissions for abortion complications were adolescents, under the age of 20 (UNICEF, 2011). Also the study confirmed, 78% and 69.2% of aborted pregnancies were unplanned and unwanted respectively (Gadisa, 2004). Contraceptive use can prevent at least 25% of all maternal deaths by allowing women to prevent unintended pregnancies and unsafe abortions, and to protect themselves from sexually transmitted diseases including HIV/AIDS (Yiman, 2002).

Female Street Youths are vulnerable to unprotected sex and sexual abuse, which makes the risk of unwanted pregnancy greater among them (Demelash et al., 2013). As to the researcher's knowledge, little is known about KAP (Knowledge, Attitude and Practice) of modern contraceptive in relation to street girls. Hence undertaking this study in the study area was believed to provide information on their reproductive health status in relation to modern contraceptive knowledge, attitude and practice of street girls and relevant information was generated that could help organizations to design appropriate sexual and reproductive health programs and improve future services for this street girl

1.2 Statements of the Problem

The street of Addis Ababa is assumed to be home to a population of between 60, 000 to 100, 000 street children. Of this, 25% are women, has become one of the major social problems in the city (CSC, 2009). This figure indicates how the problem is severe in the city more than any other parts of the country. Street youth is exposed to suburbs culture, such as smoking, drug, alcohol and substance abuse, gambling, engaging in sexual activities, or selling sex for survival (Consortium for Street Children, 2009).

The circumstances in which they live and work increase their vulnerability also to sexual exploitation and abuse and put them at a higher risk of unplanned pregnancies, sexually transmitted infections and HIV/AIDS (Demelash et al., 2013). The problem was further compounded by the lack of access to sexual and reproductive health information and services, street girls should be provided information on growth and development, sexual and reproductive health, substance use, prevention of disease, promotion of good health and other issues such as rights and laws (Yimam, 2007).

Addis Ababa attracts many children and youth who are searching for employment. The city has a large population of street youth who are engaged in the informal sectors (Demelash et al., 2013). It is one of the areas which have a higher population of street girls and youth (Demelash et al., 2013). Therefore, the area was selected purposely for the study based on the high concentration of street youths and researcher interest. It is not unusual to see street girls with their baby in Bole streets. These devastating problems like unwanted pregnancy, unsafe abortion is the primary concern and problems of female street youth, because it leads to a harsh life style for them.

Few studies on the sexual behavior of street youth in Addis Ababa show that these youths are more familiar with high-risk behavior and are sexually active at an early age (FSCE, 2003). Despite these alarming realities, street youth rarely has a voice in the sexual and reproductive health discourse. Governmental and nongovernmental organization's intervention programs do not grounded in the realities of street children (Meindert, 2006). This is because these organizations work through the existing societal structures such as hospitals, schools, local communities and facilities from which street girls are disconnected. To study homeless girls is very essential and of course the duty of all helping professions especially social work.

Additionally, since most of them are under eighteen they may not be possible to give birth because they are not physically capable. Pregnancy in the teenage also leads them to different health complication and consequent outcome. Few studies were conducted on the family planning prevalence and use of modern contraceptives among street girls (Kebede, 2000 and Sorsa, et al., 2001) however, none of them assessed contraceptive knowledge, attitude and practice of street girls of the Bole sub city that are economically, socially and nutritionally disadvantaged part of the population, street women have the right to family planning information (knowledge) and access. It is a common observation to see women pleading with the streets of major cities in Ethiopia having one or two babies by their sides. This study wants to assess contraceptive KAP of utilizing modern contraceptive among street girls.

1.3 Research question

1. To what extent street girls in the Bole sub city have the knowledge of modern contraceptive?
2. What is the attitude of street girls towards modern contraceptives of Bole sub city?
3. What is the practice of using modern contraceptives among street girls in the Bole sub city?
4. What are the contributing factors associated with the knowledge and practice of modern contraceptive among street girls in the Bole sub city?

1.4 Objectives

General objective: To assess the knowledge, attitude and practice of modern contraceptives among street girls of the Bole sub city.

Specific objective

1. To describe the knowledge of contraceptives among street girls in the Bole sub city.
2. To determine attitude towards modern contraceptive among street girls in the Bole sub city.
3. To assess the practice of using modern contraceptive and sexual practice among street girls in the Bole sub city
4. To determine the factors that contribute to practice of modern contraceptive street girls.

1.5 Significance of the study

This study tried to assess the level of knowledge ,Attituded and practice of modern contraceptives among street girls in the target area.

- The study has the following significance, to create a good insight for the policy makers, Non-governmental organizations and other governmental service provider, shows directions to concerned bodies on how to implement the service in order to overcome the problem,
- To show to decisions maker bodies the need of reproductive health services for street girl's particularly contraceptive accessibility and also can be used as a reference for further investigation and other organizations to undertake further research.
- In addition, it helps to design a good strategy for the provision of reproductive health services in general and contraceptive service in particular, to tackle the growing problem in their context

1.6 Limitation of the study

The study has involved only in Bole Sub city of Addis Ababa. Due to the shortage of resources and time constraint and there is no comprehensive baseline data available on the size of the street-girls in Bole sub cities in general and KAP of modern contraceptive in particular to street girls. It is therefore difficult to estimate whether the KAP is getting better or worse.

1.8 Definition of terms

Knowledge is a set of understandings it is also one's capacity for imagining, one's way of perceiving (Librhim, 1995).

Attitude is a way of being, a position. Attitudes are not directly observable as are practices, thus it is a good idea to assess them (Librhim, 1995).

Practices or behaviors are the observable actions of an individual in response to a stimulus. This is something that deals with the concrete, with actions (Librhim, 1995).

1.9 Operational definitions

Street girls, Females, who make their lives on the street by begging, sleep at the streets or roadsides and those who have no formal house to live and sleep.

Knowledgeable: From the knowledge questions on modern contraception who respond correctly above the mean value.

Not knowledgeable: Those who score less than the median value.

Positive attitude is an opinion, outlooks, values, position and intentions of the study subjects towards the utilization of modern contraceptive methods. Study subjects who have concerns and negative opinion about modern contraceptive and responded negatively to attitude items will be regarded to have a negative attitude towards modern contraceptive.

Practice: is the utilization skill or ever use of modern contraceptive when the study subjects are exposed to sexual intercourse to prevent an intended pregnancy.

CHAPTER TWO

LITERATURE REVIEW

2.1 introductions

This literature review chapter provides essential background, knowledge about the similarities and differences between research studies relevant to knowledge, attitude practice on modern contraceptive.

Street youths are exposed to situations that make them vulnerable to sexual and reproductive health problems on a day-to-day basis. According to the (DOH, 2005) there are various factors that influence contraceptive usage, the socioeconomic status, knowledge about contraceptives, attitudes about issues related to contraceptives, residential area, educational

status, counseling received on contraceptives, the attitudes of the contraceptive providers, and cultural values, norms and beliefs. Their vulnerability to these situations is increased from their lack of understanding of the changes associated with adolescence, the lack of knowledge and skills that could help them to make healthy choices and their inability to access the appropriate services. (Valencia et al., 2005). Another study shows that youth on the street has risky sexual behaviors that increase the likelihood of adverse sexual and reproductive health consequences like unwanted pregnancy, unsafe abortion, HIV/AIDS and other STIs (WHO, 2000).

Several studies conducted in developed and developing countries show that adolescent's high-risk behaviors are more common among out of school adolescents compared with those who are attending school, (Jejeebhoy, 1998 and Egata, 2005). There is increasing concern for young people who are disconnected from social institutions such as schools, Youth clubs and workplace. The UN-estimates that 404 million or 38% of youth under the ages of 18 in less developing countries do not attend school. These youths are vulnerable to sexual exploitation and are disproportionately at high risk of unintended pregnancy and STIs including HIV/AIDS. These adolescents often lack access to health information, counseling, legal protections, and health and other services. Variations in relative health and well being of adolescents are also related to where they live (Jejeebhoy, 1998).

Reproductive health is a major concern of the young adult period, In part because young women are reaching menarche earlier and, in some countries, marrying later. As a result, a significant number of adolescents of childbearing age around the world is sexually active, and an increasing proportion of sexual activity is occurring outside of marriage (www.rho.org, 1997-2010). At the same time youth on the street, have risky sexual behaviors that increase the likelihood of adverse sexual and reproductive health consequences like unwanted pregnancy,

unsafe abortion, HIV/AIDS and other STIs (WHO, 2000). Young people face a variety of reproductive health risks, sexually transmitted diseases, injury, illness and death for mother and infant and unintended pregnancy, often leading to unsafe abortion and its complications.

Young people may know little about reproductive health, have incorrect information about fertility and contraception, have heard rumors, or have received misleading information about contraception. Many have negative attitudes (STDs) including AIDS and too-early pregnancy and childbearing with an increased risk of about contraceptives. Thus, meeting the reproductive health needs of youth requires not only providing services, but also changing attitudes, overcoming community opposition, building understanding and educating adults about young people's reproductive health needs. Numerous studies have documented on the KAP of contraceptive use for the female in both in developed and developing countries and in Ethiopia as well. However, little is known about the use of contraceptives among street children in developing countries (Gaydon, 1989)

2.2 General situation of street children in Ethiopia

In a social history of Ethiopia, Pankhurst (in Kaplan 1994) stated that, “Early historical data on Ethiopian children is so scant that it is almost as though they were neither seen nor heard.” Although consolidated data is not available, Ethiopian children have suffered and are still suffering the cumulative effects of poverty and underdevelopment.

Traditional practices of different ethnic groups are the other worst adversary of Ethiopian children (Tefera, 1996). The infanticide of both legitimate and illegitimate children was documented in studies dealt with child related malpractices in Ethiopia. Child sacrifice also constituted another traditional practice among a few ethnic groups (Eshetu, 2002).

The practice of Female Genital Mutilation (FGM) is still widespread in Ethiopia. Depending on the ethnic group, FGM in Ethiopia ranges from partial to complete excision of the external genitalia, which are then stitched earlier, closed in many cases. It is often performed in unsanitary settings by a community 'specialist' using nothing more than an unclean blade (OMCT, 2001).

The situation of children in Ethiopia is one of general malnutrition, poor hygiene, lack or shortage of proper clothing, essential social services (such as health, education, and recreation) and displacement due to natural and man made disasters. The problems of homelessness (including those of street children) and child labor are quite common. With regard to girls, early marriage and abduction, harmful traditional practices such as female genital mutilation, incisions, cutting the tonsils/uvula and child prostitution are still widespread. In short, the poverty that pervades the society is obviously observed in the living condition of children in the country (OMCT, 2001)

2.3 Street Children

A street child or youth is any girl or boy who has not reached adulthood, for whom the street (in the broadest sense of the word, including unoccupied dwellings, wasteland, etc.) has become her or his habitual abode and/or sources of livelihood, and who is inadequately protected, supervised or directed by responsible adults " (Inter-NGOS, 1985).

2.4 Characteristics of street children

A review of the literature reveals a number of characteristics of children who taken from the streets (Taqon, et al., 1991). These characteristics are summarized as follows. However, their

furtive, hunted expressions and devil-may-care attitude toward the world reveal a maturity beyond their years. Females who have been sexually abused often turn to prostitution, while males are prone to violence, such as rape. There is an alarming acceptance of male violence by female street children. They also are concerned about loneliness and being unloved. They desire respect and “yearn become someone.” Street children tend to see themselves as nice people who behave badly, the ones everybody loves to hate (Taqon, et al., 1991).

Contrary to popular belief, street children are not necessarily society's dropouts, but rather victims of unfortunate circumstances. Most come from the lower socioeconomic status. Children merely working on the street in order to supplement family income who return home regularly—predominantly are loyal to, and have a positive relationship with, family members, in contrast to permanent children of the streets. Most street children have unfavorable family histories in common. They often come from nuclear families, especially single-parent households headed by the mother. Frequently, they have no positive father figure and suffered parental rejection and physical hardship. Consequently, they are reluctant to trust adults and find any authority or control imposed upon them. Yet most desire to return home, if the familial factors that drove them away change. However, the longer they spend on the streets, the worse their prognosis for educational rehabilitation. When the street children band together, they represent an exceptional companionship system, which replaces the family as source of emotional and economic support. The group offers protection, support, friendship, and solidarity. Its members generally show strong loyalty to each other. In addition, their use of street jargon gives them a special identity.

Nevertheless, they place a high premium on personal freedom. They live by their wits and survive by begging or performing “pseudo-services,” such as carrying shopping bags and

directing motorists into parking spaces. However, these dirty and badly neglected children often condemned by the indifference or hostility of others; they struggle to support themselves and have low self-esteem because of their negative experiences. The longer children spend on the streets, the more likely it is that they will become involved in criminal activities; but the popular beliefs that the streets are "schools of crime " and that all street children inevitably become criminals are not true. However, they are often guilty of antisocial or self-destructive behavior. This self-destructive behavior frequently results from a lack of knowledge, rather than from negative and fatalistic attitudes. The consumption of drugs serves as a temporary escape from their harsh reality. The use of intoxicants, such as the inhalation of glue, petrol/gasoline, and benzene, is widespread. The more time children spend on the streets, the greater the likelihood that they will show signs of cognitive or emotional dysfunction. In addition, AIDS is spreading at an alarming rate among street children.

2.5 Sexual abuse

Defined as, the involvement of a child in a sexual cavity that he or she does not fully comprehend, is unable to give informed consent to or that violate the laws or social taboos of society WHO estimates that globally, 8% of boys and 25% of girls under age 18 are estimated to suffer sexual abuse of any kind every year with unprotected Sexual Intercourse.

According to a report distributed by the (UNICE, 2003) many of the child prostitutes have been victims of serious sexual and physical abuse on the street. Homeless street females in Ethiopia are disproportionately impacted by high levels of poverty, gender based discrimination, rape, other types of violence and illiteracy, and their numbers are increasing (UNICEF, 2003).

Street girls are at a greater risk of experiencing certain health problems than boys. Girls are more vulnerable to sexual exploitation and both physical and sexual abuse.

2.6 Unprotected sex

Unprotected sex is common among street children. This could result in a variety of sexual and reproductive health problems. Street children spend a lot of time in settings where casual sexual encounters occur (bar or “crack houses”) (G. Atone, 2007). Their risk of acquiring blood borne diseases and STDs such as HIV, syphilis, and hepatitis is increased by the fact that they often have sex with persons at high risk for these diseases like people with multiple sexual partners or that sharing injection equipment for substances. Research results highlight the critical need for sexual and reproductive health programs for street children. For example, a study in Awassa showed that, Among the 280 respondents who practiced sex, 216 (77.1%) did not use any of the modern methods of contraception (Solomon, et al., 2002). In Ethiopia the median age at which women age 25-49 had a first sexual intercourse is at 16. Three in ten Woman in by this group have had sex, age 15, and tow in three by age 18 and 20 and more than 80% by age 20. Moreover, young woman age 25-24 are more likely to have had sexual intercourse than young men in the same age group (Aklilu, et al., 2002).

2.7 Contraceptive

Contraception's or birth control helps stop from becoming pregnant. Each month an egg is released from the female ovary (ovulation). Contraceptive knowledge is another factor that is considered crucial for the use of contraceptives. Research that has been previously done have shown that women who are knowledgeable about contraceptive use are more likely to use contraception (Hogan et al., 1999). However study done by (Regmi, 1980) noted that higher

knowledge did not necessarily lead to higher level of contraceptive use, Even though knowledge is a pre-requisite to contraceptive use.

2.8 Contraceptive knowledge and use

Contraceptive knowledge is another factor that is considered crucial for the use of contraceptives. Research that has been previously done have shown that women who are knowledgeable about contraceptive use are more likely to use contraception (Hogan et. al., 1999 and Degraff, 1991). Therefore, a woman's who has a higher knowledge of contraceptive method, the more likely for to use contraception. Various studies have shown that there is a strong relationship between the knowledge of methods, and its use. Nevertheless, a study by (Regmi, 1980) noted that higher knowledge did not necessarily lead to higher level of contraceptive use; knowledge was a pre-requisite to contraceptive use. He argued with giving the example of the Pakistan fertility survey and the Bangladesh fertility survey where the highest level of knowledge on contraception was followed by relatively low use of contraception.

2.9 Contraceptive Challenges

Using contraceptives is neither a simple nor a straightforward process. It is complicated and is accompanied by many challenges that hamper its effective implementation and sustained usage.

Effective management of these challenges could enhance contraceptive use. Belfied stated that to be an effective and efficient contraceptive provider, one needs to know why and how people make contraceptive choices. To minimize unintended pregnancies will depend on the user's maximum satisfaction and confidence with the method, and the method's effectiveness.

To develop a method that is perfect is next to impossible, because that method has to be 100% safe, effective, without side-effects, non-intercourse related, reversible and cheap. To admit that no contraceptive method is suitable for everyone poses a big challenge to contraceptive providers. Speizer, Hotchkiss, Magnani, Hubbard and Nelson (2000) stated that it is uncommon for contraceptives to be without challenges, whether they are facility, policy, provider or legislation related. South Africa is a country with limited resources and facilities, so the effective use of contraceptives has a potential to improve not only the lives of the men, women and children involved, but also those of their families and the communities. The primary reason for having sex is not always procreation (Visser, 2000).

According to the (DOH, 2001) there are various factors that influence contraceptive usage, the socioeconomic status, knowledge about contraceptives, attitudes about issues related to contraceptives, residential area, educational status, counseling received on contraceptives, the attitudes of the contraceptive providers, and cultural values, norms and beliefs.

Orem's General Theory of Nursing was used to correlate contraceptive challenges experienced before a woman initiates the use of contraceptives and those that are experienced during the use of contraceptives. These theoretical applications were discussed in section 1.6 of this dissertation.

2.9 The practice of using modern contraceptives

Relatively few adolescent women are currently using contraceptives. A study conducted to assess determinants of contraceptive use for / of urban youths in Ethiopia, reported that there is a large discrepancy between knowledge and actual practice of contraception, (Tesfaye, 1997). The study shows that most widely (90.0%) known contraceptive method among sexually active

male respondents was condom while pills was the most (87.0%) widely known among females. However, only 15.0% of males and 39.0% of females had used condoms and contraceptives respectively, (Tesfaye, 1997). Similarly, evidence from Harar, indicated that nearly two thirds of young respondents (69.3% of males and 63.9% of females) reported to have known, at least one contraceptive method while only about one fourth (27.0% males and 22.6% females) reported having ever used a method, (Ismail, 1997). Another study conducted in northwest Ethiopia shows that only 25.0% of sexually active females used modern contraceptives (Kebede, et al., 1997).

2.10 Pregnancy and Homelessness

According to Greene and Ringwalt (1998), pregnancy is particularly common to homeless adolescents. Most women who are homeless have been pregnant at some points in their lives (Greene & Ringwalt, 1998). Their study revealed that, in a United State survey of runaway females age 14-17 years, 12 %of street dwelling youths and 10% of those residing in shelters were pregnant. Pregnancy statistics from multi par show that among homeless youth aged 15-22 years, over half of the young women had been pregnant at least once (Halcon, 2004). Furthermore, Youth who is homeless may be at increased risk of multiple pregnancies. (Lifson, 2004) reported that almost 30% of the young women in their sample had been pregnant two or more times. Becker and colleagues (1992) reported that half of all women in a New York City homeless sample had experienced pregnancy four or more times (cited in Bassuk & Weinreb, 1993). Homelessness may have serious negative consequences of the health of pregnant women, regardless of age at which they become pregnant. However, these effects may be more pronounced among younger women. Adolescent pregnancies tend to be difficult physically and emotionally even among young women who are housed and have intact support systems

(Goldberg, 2002). Bassuk and Weinreb (1993) pointed out those homeless women who become pregnant are usually young and there is evidence that they are likely to suffer from acute and chronic health problems. Although homeless women rarely plan to conceive, victimization, economic survival, lack of access to contraceptives, and the need for physical closeness and intimacy contribute to their becoming pregnant (Ensign, 2000). Homeless, pregnant women are at increased risk of adverse pregnancy outcomes related to economic, social, and medical problems (Stein et al., 2000). Women who are pregnant and homeless typically are younger have experienced more frequent family disruptions suffer from more acute and chronic health problems and report more cigarette, drug, and alcohol use (Lifson, 2004). While pregnant, they continue to face threats to health, including poverty, substance abuse, rape, physical violence, and STIs (Ensign, 2000).

2.11 Pregnancies and abortion

Young women who have not reached full physical and physiological maturity are almost three times as likely to die from complications in childbirth, as older women are, (Haile, et al., 2003). Unintended pregnancy may lead to an induced abortion, which in the case of an experienced or ashamed adolescent is likely to take place later in the pregnancy and involve greater risks to life, Health and future fertility. The proportion of adolescents who seek abortion has been increasing, especially among younger adolescents (15-17 years) (WHO, 2004).

2.12 The practice of condom use

Studies have widely reported that condoms are understood to diminish sexual pleasure and are inconvenient to use (Zewdie, 2005). Perceived negative consequences are among the most frequently reported reasons for non use in Ethiopia. Fear of reduced sexual pleasure and

perceived unreliability of condoms because of presumed susceptibility to tearing and slipping off during intercourse have often been cited (Tadelle, 2000). Another study conducted in Eastern Gojam reported that 64.6% out of school youth does not use condoms consistently (Dawud, 2003).

2.13 The practice of using modern contraceptives

Relatively few adolescent women are currently using contraceptives. A study conducted to assess determinants of contraceptive use for urban youths in Ethiopia, reported that there is a large discrepancy between knowledge and actual practice of contraception, (Tesfaye, 1997). In this study the most widely (90.0%) known contraceptive method of sexually active male respondents were condoms while pills were the most (87.0%) widely known among females. However, only 15.0% of males and 39.0% of females had used condoms and contraceptives respectively, (Tesfaye, 1997). Similarly, evidence from Harar, Indicated that nearly two thirds of young respondents (69.3% of males and 63.9% of females) reported to have known, at least one contraceptive method while only about one fourth (27.0% males and 22.6% females) reported having ever used a method, (Ismail, 1997). Another study conducted in northwest Ethiopia shows that only 25.0% of sexually active females used modern contraceptives (Kebede, et al., 1997).

2.14 Pregnancy and abortion

Young women who have not reached full physical and physiological maturity are almost three times as likely to die from complications in childbirth, as older women are, (Haile, et al., 2003). Unintended pregnancy may lead to an induced abortion, which in the case of an experienced or ashamed adolescent is likely to take place later in the pregnancy and involve

greater risks to life, Health and future fertility. The proportion of adolescents who seek abortion has been increasing, especially among younger adolescents 15-17 years (WHO, 2005).

2. 15 Theories and Models

The theoretical framework of this research takes into account the following theories and one model which is much related with the research topic.

2.15.1 The Rational Choice Model

Some authors have argued that many street children have made a measured choice to become involved in street life, choosing at some level the Street, and giving up their lives at home (Apetkar 1998, Felsman 1981). In these terms, it may be said that street children are viewed as being agents, not only victims having exhibited some degree of rationality in choice in the decision to move to the street and use modern contraceptive.

Rationality in Simon's terms (1978) is inherent in the functionality of the behavior of the individual or society. An action or behavior is considered rational as long as it contributes to meeting the needs or goals of the individual or the society. Bounded by cognitive limitation and imperfect knowledge, the individual does not necessarily seek out the set of conditions which will maximally satisfy needs, but a set of conditions that are at least, sufficient.

If the principles of this model are applied to the situation of street children, it implies that involvement in the street, at some level, fulfills function for the child or youth and that this involvement is a rational adaptation to the context of the respective child's life, given his or her environment, past circumstances and experiences, and the choices open to him or her.

Adaptation of this model, however, does not mean that the one state that evolves in somehow “better” than other states of being; but that there exist multiple ways of satisfying the same needs. This adaptation is not optimal, but merely is good enough or satisfactory. In this model, a factor in the process of choice is the actor’s internal representation of the decision environment (Newell, 1972 and Simon, 1978).

An important element in understanding the factors which drive the grills to and maintain her in the street therefore is to understand the grills perception of the street compared to that of his/her home to use modern contraceptive (Veale, 1996)

15.1.2 Stress Theory

Low-income parents are less likely to nurture and supervise their children adequately, and are more likely to use inconsistent, erratic and harsh discipline (Elder et al., 1985). Such problems have been shown to increase when low-income families suffer from stress such as absence of a supportive partner, depression or drug use, and to improve when families enjoy social support from family friends or neighbors. Moore and Vandivere (2000) argue that the means by which parents cope with stressful circumstances, such as poverty and ill health, influence children’s experience of a stressful environment. For example, parents who are stressed are less likely to be able to provide optimal home circumstances and more likely to use coercion and harsh methods of discipline.

Conger and colleagues in the United States (Conger et al., 1993) undertook a series of researches involving middle class farming parents who were caught up in a severe economic downturn in the 1980s. The researchers found that the emotional well-being and behavior of adolescents whose families moved into economic hardship was adversely affected, but mainly

because of disruptions in parenting rather than the direct effects of economic hardship. They showed that parents who moved into relative poverty became distressed and depressed, and their marital relationship deteriorated. This in turn caused disruption to their parenting practices, which were the immediate cause of the deteriorating adjustment of their adolescent children.

Simply put the theory states that: Materially deprived parents face more stress than affluent parents. This causes them to be more depressed, irritable or angry than affluent parents. Higher levels of stress negatively affect parenting style, and these parents tend to be more authoritarian or inconsistent. This in turn affects their children's outcomes in a negative way.

2. 15 .3 "Knowledge, Attitude, Practice", KAP Model

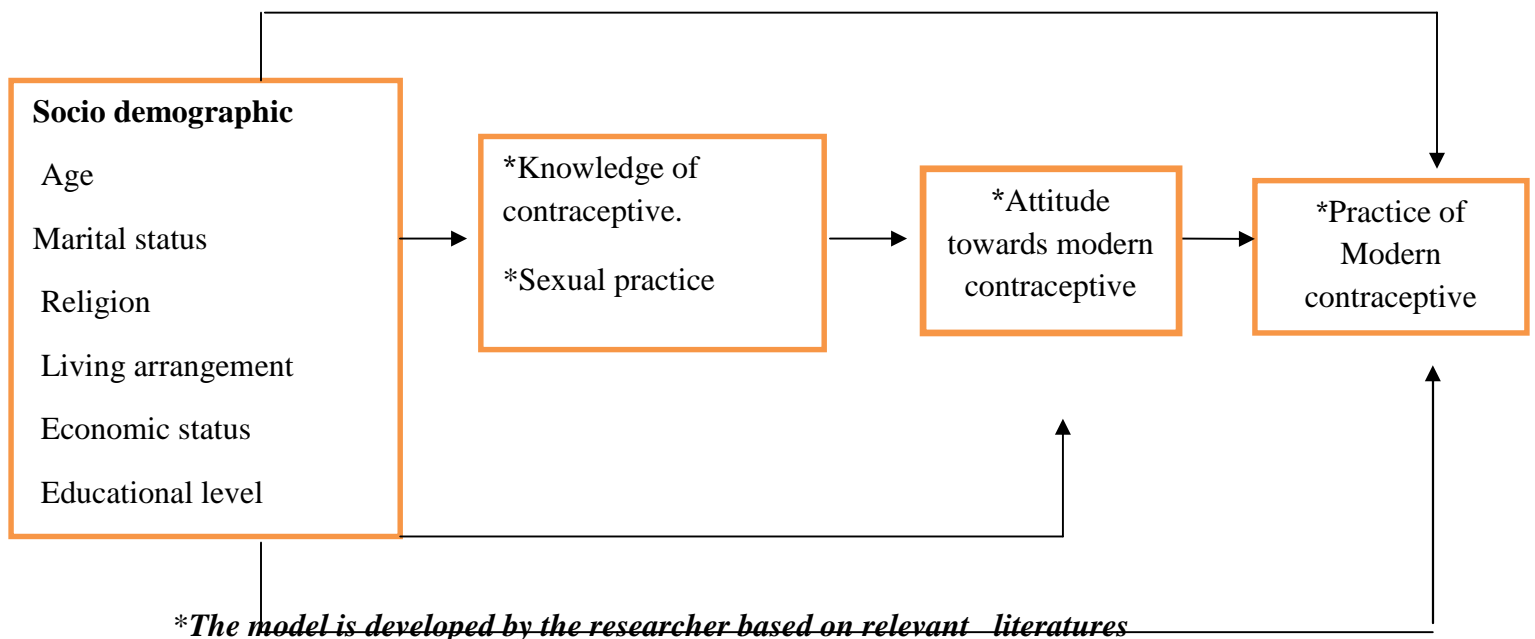
Based on different research framework, surveys were conducted throughout the world in the 1960s and 1970s (KAP survey, 1982). At the beginning framework was introduced into KABP, knowledge, Attitudes, Behavior and Practice. After applying the KABP, It had been found that inconvenience of measuring the behavior of human beings by the survey. Then the KABP framework became as the KAP. It helped to change the existing practices of human (Rupasingh, 1992). Many of these scholars have argued with the KAP gap and the failure of programs and the projects (McCarthy, 1991). In that regards KAP theory is very applicable for looking at the levels and patterns of contraceptive knowledge and the use. Studies find that knowledge will directly affect the attitude and practice, and that attitude will directly affect practice or intention, except that the degree of impacts that knowledge affects practice through attitude is better than that of knowledge affects practice directly (Lee, et al., 2006). Therefore, this article uses KAP framework of the base to develop the required assessment tool.

The Behavioral Model to research since behavior to be modified is observable symptoms are the same as other responses that the behavior is mainly respondent or operant. Problematic behavior, learned through the process of conditioning.

2.17 Conceptual Framework

To assess the KAP of modern contraceptives in this study, the following sociodemographic status, age, living arrangements, educational level, and socioeconomic states considered as independent variables. Dependent variables are knowledge, attitude and practice of modern contraceptive.

Knowledge means the ability of pursuing and using information and by understanding, experience and identifying the available technologies (Librhim, 1995). Attitude is the result of making a reaction against some way, observes, and explain based on reaction (Librhim, 1995). Practice indicates what knowledge and attitude work together (Librhim, 1995).



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study Design

A quantitative descriptive cross-sectional study was conducted in the Bole sub city. Primary data were collected via self-administered structured questionnaires extracted from standardized questions that are applied previously indifferent KAP study. (Galva, et al., 2000; Aziken, et al, 2003; Birhanu, 2006) to assess street girls' Knowledge, Attitude and Practice toward modern contraception.

3.2 Study Area and selection

Addis Ababa, the capital city of Ethiopia, has an area of 540 square kilometers. Administratively, Addis Ababa is divided into 10 sub cities (Kifle Ketema). The study was conducted in Addis Abeba, Bole sub city, one of the 10 sub cities. As of 2011, the Bole sub city has 328,900 populations in 122.08 sq.km area in its 14 weredas. The sub city is located in the southeastern suburbs of the city. It borders with the sub city are Yeka, Kirkos, Nifas Silk-Lafto and Akaky Kaliti. (http://wikipedia.org/Addis_Ababa) The bole sub city is one of among the highly populated street children (Demelash et al, 2013).

3.3 Study population

The study populations in this research are street girls, aged 15-24 years, in the Bole sub city, Addis Ababa, who are living or working independently on the street of the Bole sub city

3.5 Eligibility Criteria

3.5.1 Inculcation Criteria The street girls 15-24 years old who are living or working in the Bole sub city selected street.

3.5.2 Exclusion Criteria The street girls, who are not in the age boundary, 15-24, and not willing to participate

3.6 Sample size Determination

Considering the absence of previous data in Ethiopia in this specific study area and groups to obtain sample size the following assumptions were undertaken. Where "p" is 50% expected level of KAP toward modern contraceptive, since there are no previously described data, "C" 0.05 error allowance, "z" 1.96 two-sided critical value for 95% confidence level, " " 0.05 level of KAP significance, 2 for design effect compensation since cluster in the Bole sub city categorized into different areas, and 10% contingency for non-response rate.

Therefore, Sample size (SS) = $(Z^2) P (1-p) \backslash (C2) * 2$

$SS = (1.96)^2 0.5 (0.5) / (0.05)^2 = 384 * 2 = 768$, then this calculated sample size to whole Addis Ababa, divided into ten sub city, became 77 for one sub city by adding 10% contingency the sample size is 84.

3.7 Sampling techniques

The street girls living in the Bole sub city categorized, clustered into their woreda streets where they reside. Among these clustered streets Bole Delldey, Bole Medhanialem, Atlase, Ureal Megenagna and Guerd Shola streets were randomly selected. The calculated sample size was distributed to selected villages. The study participants were selected by using systematic random

sampling techniques, every other street girl recruited until determined sample size fulfilled based stated inclusion criteria.

3.8 Data collection techniques

The data were collected through self administered questionnaires by the researcher. The survey questionnaire was first adopted in English and translated to the Amharic language (Local language) and then back to English for its consistency. The data collection was done after 5pm and during night time, a time street girls are more likely available for consecutive six weeks. Street girls were interviewed at the streets and roadsides where homeless girls are located in.

3.9 Study Variables

3.9.1 Independent Variables

Socio-demographic factors (age, marital status, religion, educational status, living arrangements, and economic status).

3.9.2 Dependent Variables

The dependent variables include: Knowledge of contraceptive, Practice of contraceptive and Attitude towards contraceptive

3.10 Data processing and analysis

3.10.1 Data Processing

The data collected from the respondents through questionnaires were checked and assured by face validity. The data were classified systematically, coded and some internal consistency checks (data cleaning) were made to assess the quality of data.

3.10.2 Analysis of the data

Data collected from the survey entered into the computer for analysis by using Statistical Package for social Science (SPSS) version 20 software. The analysis part consists of descriptive statistics, percentage, weighted mean, frequency, and cross tabulation and logistic regression was carried out to determine the association between socio demographic factors with the knowledge, attitude and practice of modern contraceptive among study participants. Regarding to the knowledge of modern contraceptive to generate the summarized level of knowledge, response to each question was first scored and a cumulative/total score weighted mean was calculated. And then the respondents who were scored above and below the mean value classified as knowledgeable and not knowledgeable. Attitude indicator items regarding modern contraceptive in the questionnaires were responded as “Yes” or “No”. To make the summarized level of attitude responses for each attitudinal items were totally score and calculated weighted mean. And those respondents score above and below mean value was considered as being a ‘*positive attitude*’ and ‘*negative attitude*’ respectively.

3.11 Ethical considerations

Considering the fact that street youth's life is at stake and their freedom is much constrained by their environment, needs, expectations and lifestyles, it is imperative to consider some ethical issues in conducting research. The rights of the participants regarding to confidentiality and oral consent were taken and maintained. No data were collected without the knowledge of each participant. In addition, each of them informed of the confidentiality of the data and the respondents were informed as they can skip, as they do not want to answer fully or partly and to quit the process at any time if they want to do so and their participation was voluntary. At the end of the interview participants were given with 30 ETB to compensate the time they spent with me during the interview and discussion.

Table 1. Socio-demographic characteristics of the study population

RESULTS

This chapter describes the findings on the relevant variables which were extracted from the collected data from street girls of the Bole sub city.

4.1 Socio demographic characteristics

In this study, 84 street girls were interviewed. All questions in the questionnaires were responded. As it is shown in Table 1 the age of study participants are ranging from 15-24 years. Respondents' age mean, and standard deviation were 19 and 3.7, respectively. Fifty seven percent of respondent's age is between 15 - 19 years old. Pertaining to the survey, finding of the marital status of street girls is 76.2% (64) single, 4.8% (4) married, and divorced 19% (16). The distribution of respondents based on their religion is 52.4% (44), Protestant, 19% (16) Orthodox, 19 % (16) Catholic and 9.5% (8) Muslim. Respondents' education level who writes and read 4.8% (4), attended elementary school 64.2(54), attended elementary and above are 16.7%(14) and 14.2(12) respectively

Socio-demographic characteristics	Frequency(n=84)	Percent
Age group (year)		
15-19	48	57
20-24	36	43
Income per month in ETB		
<100	26	10.7
101 – 500	30	
501-1000	18	35.7
>1000	10	31.0
Religion		
Protestant	44	52.4
Orthodox	16	19.0
Catholic	16	19.0
Muslim	8	9.5
Educational level		
Write and read	4	4.8
Elementary	54	64.2
High school	14	16.7
Above high school	12	14.2
Marital status		
Single	64	76.2
Married	4	4.8
Divorced	16	19.0

4.2 Knowledge of modern contraceptive among street girls

To assess the level of knowledge, a series of seven knowledge questions on contraceptive method, identification; the purpose; sources of knowledge; and places where modern contraception can be found were interviewed to those street girls who had heard of modern contraception. To generate the summarized level of knowledge, the response to each question was first scored and a cumulative or total score weighted mean was calculated. And then the respondents who were scored above and below the mean value classified as knowledgeable and not knowledgeable.

To examine the respondent's awareness about modern contraceptive respondents were asked had ever heard about modern contraceptives. Nearly 75% respondents heard about modern contraceptive and about 64% of the respondent's sources of information are peers on modern contraceptive.

Table 2. Modern contraceptives awareness and source of information received.

		Frequency	Percent
Have you ever heard of modern contraceptives	Yes	45	75.5
	No	35	25.5
From whom or where have you heard the information about contraceptive	School teacher	10	15
	Sister/brothers	8	5.5
	Peers	54	64.2
	Health professionals	10	15
	Magazines	2	2.5

The respondent’s knowledge of different type of modern contraceptive methods is 70% (59) pills, 51.2% (58) condom, 50% (43) injectable, 28.6% (24) natural method, 17.9% (15) female sterilization, 15.5% (13), IUD, 9.5% (8) norplant, 9.5% (8) foam/gel and 4.8% (4) male sterilization. All over about 57% of respondents scored above the mean value are knowledgeable

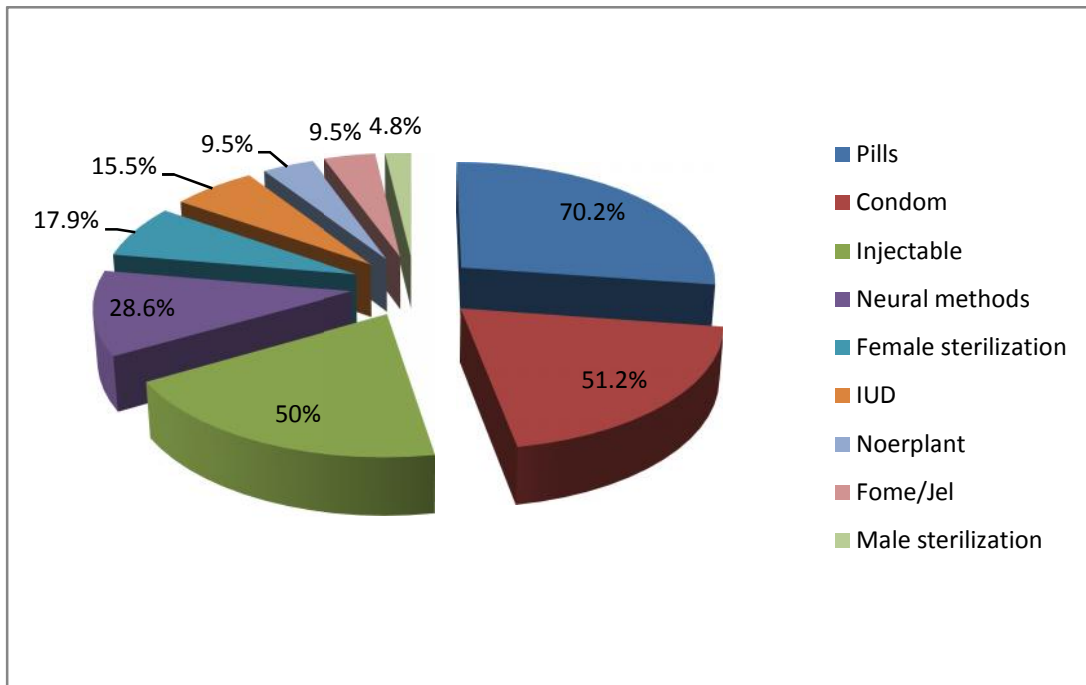


Figure 2 : Contraceptive methods known by the study group

Regarding the knowledge of having modern contraceptive resources are as follows is 10.7% (9) health center, 16.7% (14) clinic, 6% (5) hospital, 10.7% (9), Keble, 4.8% (4) health center and clinic, 9.5% (8) health center and Kebele, 10.7% (9) health centers and hospital, 9.7% (8) clinic and hospital, (6) 7.1%, clinic and Keble and 14.3% (12) health center, clinic and hospital..

Table.3 The source of modern contraceptive service by the study group (Multiple response).

Source of modern contraceptive service	Frequency	Percent	
	Health center	6	10
	Clinic	10	15
	Hospital	12	7.5
List all contraceptive sources you know	Keble	8	10
	Health center and clinic	4	5
	Health center and Keble	6	10
	Health center and hospital	6	10
	Clinic and hospital	6	10
	Clinic and Keble	12	7.5
	Health center, Clinic and hospital	14	16.6

4.3 Relation between the level of knowledge of modern contraceptive and socio-demographic variable

To determine the relationship between the dependent variables (the knowledge and attitude towards modern contraceptive) and independent variables cross tabulation was used. Respondents age, marital status, income and educational states in relation to their knowledge of modern contraceptive whose age 20 and above the knowledge of modern contraceptive is 69% (25) and whose age less than 19 is 49.9% (23), marital statues base of two categories ever married, 80% (16), unmarried, 50% (32), income above the mean is a 78.6% (33) and income below the mean 35.7% (15), Education based on the three category Primary Education 46.6%(27),high school % (16)and college is 83%(5).

Table. 4 Socio demographic variables and knowledge of modern contraceptive above and below mean cross tabulation

			Knowledge above the mean and below mean		Total
			> =6	<=5	
Age(year).	<= 19	% within age in two categories ninety and below	33.1%	67.9%	100.0%
	20+	% within age in two categories, twenty and above	69.4%	30.6%	100.0%
Marital status.	Single	% within marital status in two categories	20.0%	80.0%	100.0%
	Married	% within marital status in two categories	50%	50%	100.0%
Incomeper month ETB.	<= 796	% within Income in two categories using mean 796	35.7%	64.3%	100.0%
	797+	% within Income in two categories, using mean 796	78.6%	21.4%	100.0%
Education	Primary education	% within education in three categories	36.6%	64.4%	100.0%
	High school	% within education in three categories	80.0%	20.0%	100.0%
	Above high school	% within education in three categories	83.3%	16.7%	100.0%
Religion	Protestant	% within Religion in four categories	20 1%	79.9%	100.0%
	Orthodox	% within Religion in four categories	9%	91%	100.0%
	Catholic	% within Religion in four categories	8%	92%	100.0%
	Muslim	% within Religion in four categories	4.5%	95.5.5%	100.0%

4.2.2. Logistic regression analyses socio demographic variables and knowledge of modern contraceptive

In multivariate analyses socio demographic variables like religion and marital status showed no statistically significant difference. But girls in the age group 20-24 years, were 3.71 times more likely know modern contraceptive as compared to age group 15-19 years.

Multivariate analysis also showed significant differences for income level that street girls income per month between 501-100 and greater than one thousand were 3.59-6.71 times more than income less than hundred and literacy status, where those educated in high school and above high school level were know modern contraceptives 4.25-6.31 times more than the illiterate or who write and red ones respectively. (See table 4).

Table 5 Association between knowledge of modern contraceptive and socio- demographic variable

Socio- demographic variable	Percentage(f)of knowledge above the mean	AOR	95% Confidence interval
Age (year)*			
15-19	57(48)	1.00	
20-24	43(36)	3.71	(1.14, 8.09) *
Income per month in ETB*			
< 100	10.7(9)	1.00	
101 – 500	35.7(30)	2.70	(1.33, 5.52)*
501-1,000	31(26)	3.59	(1.05, 9.43) *
>1,000	11.9(10)	6.71	, (1.71, 12.3)*
Religion			
Protestant	52.4(44)	1.00	
Orthodox	19(16)	0.84	(0.79,0.99)
Catholic	19(16)	0.94	(0.84,1.06)
Muslim	9.5(8)	1.05	(0.93,1.18)
Educational level *			
Write and read	4.8(4)	1.00	
Elementary	64.2(54)	0.97	(0.82,1.16)
High school	16.6(14)	4.25	(1.54, 6.87)*
Above High school	14.2(12)	6.31	(1.92,10.16)*
Marital status			
Unmarried	76.2(64)	1.00	
Divorced	19(16)	1.29	(0.08,2.08)
Married	4.8(4)	1.14	(0.71,1.84)

4.3 Attitudes of modern contraceptive by the study groups

Respondents were again questioned about their attitudes toward modern contraception. The six items were answered as either 'yes' or 'no'. For positively-worded statements, those who selected 'yes' were regarded as having a positive attitude and those who chose 'no' were considered to have a negative attitude. Conversely, for those who worded as negatively worded statements, were categorized as having a negative attitude and for those who put as positively-worded statements were clustered as having a positive attitude. To make the summarized level of attitude the responses to each attitudinal item were totally scored and weighted mean calculated. And those respondents score above and below mean value was considered as being a '*positive attitude*' and '*negative attitude*' respectively.

As stated in the above, attitude indicator items regarding modern contraceptive were asked to determine their attitude towards modern contraceptive. As shown in the Table 2 79.8% (67) and 58.3% (49) respondents like to know more and discuss with their friends about modern contraceptive methods, respectively. Moreover, 81% of the respondent consider modern contraceptive method do not have harmful effects on health and 58% recommend modern contraceptive methods to be used by others. In general the attitude towards modern contraceptive how scored above the mean is about 73.8% (62) have a favorable or a positive attitude towards modern contraceptive.

Table. 6 Attitude indicators towards modern contraceptive of the study population (Multiple response)

Attitude Indicators	Yes/No	Frequency	Percent
Do you like to know more about modern contraceptive methods?	No	17	20.2
	Yes	67	79.8
Do you discuss about modern modern contraceptive with your friends?	No	35	41.7
	Yes	49	58.3
Do you consider that contraceptive is harmful for health?	No	68	81.0
	Yes	14	16.7
Do you feel that contraceptive is important?	No	31	36.9
	Yes	53	63.1
Do you consider that contraceptive is not important like others say?	No	61	72.6
	Yes	23	27.4
Do you recommend the use of modern contraceptive to adolescent?	No	35	41.7
	Yes	49	58.3

4.3.1 Socio demographic variables and attitude towards modern contraceptive above and below mean cross tabulation

Street girls' attitude towards modern contraceptive based on age categories is as follows; whose age under 19 and has positive attitude modern contraceptive are 47.9% (23), street girls who are unmarried and have positive attitude is 50% (32), street girls whose income below the mean and positive attitude toward modern contraceptive is 35.7% (15). Educational level of street girls, who are high school completed and above high school and who has a positive attitude towards modern contraceptive are 80.0% (16) and 83.3% (18) respectively.

Table.7 Socio demographic variables and attitude towards modern contraceptive above and below mean cross tabulation

Socio demographic variable			Attitude above the mean and below mean		Total
			>=4	<=3	
Age(year)*	<= 19	% within age in two categories ninety and below	47.9%	52.1%	100.0%
	20+	% within age in two categories, twenty and above	69.4%	30.6%	100.0%
Marital status.	Unmarried	% within marital status in two categories	50.0%	50.0%	100.0%
	Ever married	% within marital status in two categories	80.0%	20.0%	100.0%
Income per month ETB.	<= 796	% within Income in two categories using mean 796	35.7%	64.3%	100.0%
	797+	% within Income in two categories, using mean 796	78.6%	21.4%	100.0%
Education Level	Primary education	% within education in three categories	46.6%	53.4%	100.0%
	High school	% within education in three categories	80.0%	20.0%	100.0%
	Above high school	% within education in three categories	83.3%	16.7%	100.0%
Religion	Protestant	% within Religion in four categories	20%	80%	100.0%
	Orthodox	% within Religion in four Categories	11.2%	88.8%	100.0%
	Catholic	% within Religion in four categories	8.4%	91.6%	100.0%
	Muslim	% within Religion in four categories	5.1%	94.1	100.0%

4.4. Sexual and modern contraceptive use practice

Respondents were asked whether they had ever had sexual intercourse and, if so, whether they had a history of pregnancy and at what age they became pregnant. Among the respondents about 97% of street girls who had sexual intercourse, has more than one sexual partner and first time sexual intercourse was at the mean age of 15 years. Nearly 78% of the street girls had a chance to be pregnant, 42.8% gave birth in their stay at street and 78% ever used contraceptive methods

Table. 8 Sexual practices and use of modern contraceptive by the study population(multiple response)

Variable	Yes/No	Frequency(n=84)	Percent
Do you have more than one sexual partner?	Yes	82	97.6
	No	2	2.4
Have you ever had sexual intercourse?	Yes	80	95.2
	No	4	4.7
Have you ever been pregnant?	Yes	66	78.5
	No	18	21.4
Have you ever used contraceptive method?	Yes	18	21.4
	No	66	78.5
What was the outcome of the pregnancy?	Abortion	30	35.7
	Live birth	30	35.7
	Live birth & abortion	6	7.1
Do you have a plan to use a contraceptive method in the future	Yes	50	59.5
	No	34	40.5

A respondent who ever discussed with their partner and used modern contraceptive methods for the first time and last time during sexual contact was only 9.5 % and 36%, respectively. Twenty two percent of the respondents used condom, 10.7 % pills, and 9.5% injectable whereas 57% did not use modern contraceptive during their last time sexual contact. In general the practice of modern contraceptive by street girls is poor.

Table. 9 The Sexual and contraceptive practice when first time sexual intercourse (multiple respos)

Variable		Frequency(n=84)	Percent
Have you and your partner discusses/used contraceptive methods 1st time you had sex	Yes	8	9.5
	No	59	70.2
	I do not remember	17	20.2
What method did you or your partner use 1st time you had sex	Condom	8	9.5
	Pills	6	7.1
	Injectable	4	4.7
	Not used any method	66	78.5
Have you or your partner used contraceptive method last time you had sex	Yes	31	36.9
	No	48	57.1
	I do not remember	5	6.0
What was the method used	Condom	19	22.6
	Injectable	9	10.7
	Pills	8	9.5
	Not used any method	48	57.1
How often you or your partners have used contraceptive methods	Always	19	22.6
	Sometimes	31	36.9
	Never used	34	40.5

4.4.1 Association between modern contraceptive practice and socio demographic variable

When compared to the age group of 15-19 years to those respondents in the age group of 20-24 years, 15- 19 age groups were 2.91 times more likely to use modern contraceptive, (AOR = 2.91; 95%CI=1.32, 4.56). The odds of practicing modern contraceptive were educational status who attended high school was 4.77 times (AOR=4.77; 95% CI =1.67, 7.70) higher than who were not being able to read and write. The odds of practicing modern contraceptive were income per month in ETB 101-500 was 3.91 (AOR=3.91; 95% CI =1.67, 4.70) times higher than those whose income per month in ETB less than hundred, 4.32(AOR= 4.32; 95%CI=1.85, 6.80) times higher than who has income per month ETB was 501-1000 and 6.85 (AOR=;6.85; 95%CI=3.60, 10.1) times higher than who has income per month ETB was greater than 1000. Among socio demographic variables, religion and marital status had no association with the modern contraceptive practice among street girls of the bole sub city.

Tabel 10 Logistic regression of modern contraceptive practice and socio- demographic variable

Variables	Use of modern contraceptive method Practice		AOR	95% Confidence interval
	YES	NO		
Age in years *				
15-19	10	74	1.00	
20-24	23	61	2.91	(1.32, 4.56)*
Religion				
Protestant	18	66	1.00	
Orthodox	6	78	0.98	(0.88, 1.10)
Catholic	5	79	0.95	(0.84, 1.07)
Muslim	2	72	0.89	(0.77, 1.02)
Marital status				
Single	11	73	1.00	
Married	1	83	0.84	(0.79, 1.90)
Divorced	7	77	1.05	(0.93,1.18)
Educational level*				
Write and read	1	83	1.00	
Elementary	30	68	0.65	(0.31, 1.36)
High school	10	74	4.77	(1.67, 7.70)*
Above High school	6	78	6.05	(2.38, 9.73)*
Income per month in ETB*				
< 100	2	82	1.00	
101 – 500	18	66	3.19	(1.67, 4.70)*
501-1,000	27	57	4.32	(1.85, 6.80)*
>1,000	16	68	6.85	(3.60, 10.1)**

* statistically significant association

AOR Ajesuted odds ratio

CHAPTER FIVE

DISCUSSION

This study provides information about Knowledge, attitude and practice of modern contraceptive among the street girls of the bole sub city. The knowledge of modern contraceptive is important in developing country, to decrease the maternal mortality and complication related to this. WHO defined contraceptive as “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of family groups and thus contribute effectively to the social development of a country In this study the majority (75.1%) of the street girls had ever heard about modern contraceptives. This is in line with the 2011 Ethiopian Demographic Health Survey report which reported that knowledge of contraception was nearly universal in Ethiopia

Most studies reveal that the exposure to reproductive health message broadcast through different channels is effective to build up their knowledge; attitude and practice of modern contraceptive methods are important (Tigist, 2006). In this study the level of knowledge of street girls on modern contraceptive methods, based on scored mean of knowledge questions, 57% of the respondents was scored above the mean, knowledgeable. Even though knowledge does not automatically lead to practice (Regmi, 1980), women who are knowledgeable about contraceptive use are more likely to use contraception (Hogan et al., 1999). Appropriate source of information is very important to build up their knowledge properly in this study 67% of the respondent modern contraceptive knowledge source is from their peers. Similarly, in another study conducted on street children in Addis Ababa majority of the respondents’ source of

knowledge of modern contraceptive was peers (Habtamu et al 2013). Whereas in another study conducted on college students' knowledge source is from a magazine (Nibabe et al, 2013) this difference is probably due to a difference in their living arrangement and economic difference. According to (DOH, 2001) there are various factors that influence contraceptive knowledge, the socioeconomic status, residential area and educational status also in this study are factors of knowledge are similar. Different scholars stated that attitude is better than that of knowledge affects practice directly (Lee, et al., 2006). In this study, 73.3% of the respondents have a favorable attitude toward modern contraceptive. Even though they have a positive attitude towards modern contraceptive their practice is very limited.

Strong evidence shows that sexual experience and use of contraceptive method have factored in the practice of modern contraceptive (Akiliu, 2002). Even though knowing the number of partners that sexually experienced respondents have had in their lifetime may have an effect on respondents to notice more about the modern contraceptive matters like how to prevent unwanted pregnancy and HIV/AIDS (Tigist, 2006). Furthermore, in this study respondent who have more than one sexual partner is 95.5% and do not use modern contraceptive. Some factors like living arrangement, low socioeconomic status and age are contributing to poor practice of modern contraceptive". Additionally, in this study the age of respondents between 20-24 years were significantly associated with modern contraceptive knowledge and use. It is similar to the study done in Ethiopian Demographic and Health survey in 2005. Whereas the study done in the south wollo zone in 2010 on womens of the same age group had no association (29). With regard to educational status, those with high school were more likely to use modern contraceptive methods than write and read. This is like the Demography and a health survey study conducted in Ethiopia in 2005, that educated women were more likely to use modern contraceptive than

illiterate. In addition, a study done in Bardar in 2002, women educated up to high school level and above was 2 times more likely to use modern contraceptives as compared to illiterates. It is also similar to the study done in India, showed that the likelihood of modern contraceptive use was higher among educated women than illiterate. This may be related to the educated women have awareness about contraceptive.

The most used contraceptive by street girls are 22% condoms, 10.7% injectable and 9.5% pills this is nearly similar to study conducted in Addis Ababa(Tesfaye, 2005) Unlikely a study done at shire endaslasie town, tigray (Weyzer,2011) modern contraceptive which are known and practic (61%) injectable and 0.3% male sterilization Eventhough, exhibits familiarity to condom and pills as contraceptive methods, but not in the pertinent way to be accomplished, there is a large discrepancy between knowledge and actual practice to use modern contraceptive. Furthermore, 78% of the respondents had at least one time this pregnancy is high compared to Lifson's study, almost 30% of the young women had been pregnant two or more times. Youths who are homeless may be at increased risk for multiple pregnancies (Lifson, 2004). Women who are pregnant and homeless typically are younger; as a consequence have experienced more frequent suffer from more acute and chronic health problems. According to (Akiliu, 2002) in Ethiopia sexual experience for most woman is assumed to be within the context of marriage (age18), although a significant number of young women initiate sex at a younger age as presented in Table 11. In this study out of the total sexually experienced respondents, 65% had sexual intercourse practice below the age of 15 years. This means girls under age 18 and how live in the street are expected to suffer sexual abuse of any kind with unprotected Sexual Intercourse that led them to unintended pregnancy

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATION

6.1 Conclusions

The study reveals most of street girls are a teenager and have multiple sexual partners. Bole street girls have good knowledge, favorable attitude and poor practice of modern contraception by street girls and also showed the source of their knowledge is from the peer's discussion. This study concluded that Socio-demographic factors like educational status at a high School level and above, age, monthly income at the place of the survey were associated with current contraceptive use or practices. Street girls whose economic status as >1,000 monthly income 6.85 times had more chance to practice modern contraceptive methods more than <100 monthly income. The levels of knowledge, attitude and practice on modern contraceptive have shown decrement from knowledge to practice. Bole Subcity street girls start sex earlier than eighteen years old.

6.2 Recommendations

6.2.1 Institutional Structural

Conduct further study that can address as whole of street girls in Addis Ababa, Ethiopia. Institutions should be able to create or strengthen available structural units that could have a reproductive health service for street girl's particularly modern contraceptive use.

Since street girls have information from their peers, promotion of peer education in their area in order to provide information in a reasonable and matured approach to prevent unwanted

pregnancy and unsafe abortion. The government has to designate health extension workers for street girls.

6.2.2 Institutional - Functional

Institutions, concerned with the well being of girls, should formulate clear guidelines, regulations and codes of conduct for follow-up and monitor the reproductive health. Electronic media, health personnel and government organizations can play a positive role to provide knowledge and overcome the knowledge/practice gap. Street girls should have the information about contraceptives at every visit to the health services to motivate them. The most important factor is regular availability of contraceptives and adequate health care services Health care providers those working in the contraception and reproductive health service should enter into the segments of the population to provide information and service instead of waiting them their compound to safeguard the vulnerable groups before they faced the problem.

Reference

- Addis Ababa, Central Statistical Agency. (2011), *Assessment of sexual and reproductive health status of Street Children* in Ethiopia demographic and health survey
- Consortium for Street Children, (2009). “*Street children in Ethiopia briefing to IPU,*” Tech. 3.
- Central Statistical Agency ICF International. Ethiopia Demographic and Health Survey (2011). Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International; 2012
- CSA, Summary and Statistical Report of the, (2007). *Population and housing census. Addis Ababa, Ethiopia: Population and Houses Census Commission; 2008. pp. 57–60.*
- CSC (2009). Street Children in Ethiopia: Briefing to the IPU Retrieved August 22 from http://www.streetchildren.org.uk/_uploads/downloads/Street_Children_in_Ethiopia.pdf
- DOS(2005).Department of Health and Children Annual Report
- Dawud, A. (2003) *Perception of the risks of sexual activities among out of school adolescents.* South Gondar administrative Zone, Amhara Region.
- FDRE (2007). Report on Progress in Implementing theWorld Fit for Children Plan of Action in Ethiopia.RetrievedSeptember9fromhttp://www.unicef.org/worldfitforchildren/files/Ethiopia_WFFC5_Report.pdf.
- Federal Democratic Republic of Ethiopia, (2005). *Office of population and housing census commission, CSA. The Population and Housing Census.*

Forum on Street Children Ethiopia,(2003). “*Sample survey on the situation of street children in eight major towns of Ethiopia,*” Tech. Rep

G. Atanu, “Risky sexual behavior, substance abuse and sexually transmitted infections among street adolescents in India,” Tech. Rep., 2007.

Gaidsa, T. (2004). *Barriers to use contraceptives among adolescents* in Addis Ababa.

Getnet, M. (2002) . *HIV/AIDS Behavioral surveillance survey*. Round one, Ethiopia.

Hailu A. (2007). *Behaviors of youth street children on family planning*. Dessie Town.

Hogan, D.P., Berhanu ,B. and Hailermariam, A. (1999). *Household organization, women’s autonomy, and contraceptive Behavior* .Southern Ethiopia. *Studies in family Planning*, 30(4):302-314

Human Rights Reports » 2005 Country Reports on Human Rights Practices

ICF International, (2012). *Addis Ababa, Ethiopia and Calverton, Maryland, USA*: Central Statistical Agency and

Ismail S, Bitsuamlak H., and Alemu K. (1997). *High Risk sexual Behaviors for STD/HIV, pregnancies and contraception*. Among high school students in Rural Town of Northwest Ethiopia. *Ethiop.J. health Dev.*, 11(1): 29-36.

Journal of Sexually Transmitted Diseases Volume 2013 (2013), Article ID 524076, 20 pages <http://dx.doi.org/10.1155/2013/524076> Research Article Assessment of Sexual and Reproductive Health Status of Street Children in Addis Ababa Demelash Habtamu¹ and Addisie Adamu²

K. A. Tyler, L. B. Whitbeck, X. Chen, and K. Johnson, "Sexual health of homeless youth: prevalence and correlates of sexually transmissible infections," *Sexual Health*, vol. 4, no. 1, pp. 57–61, 2007. View at Publisher · View at Google Scholar · View at Scopus

Kebede Y. (2000). *Prevalence of contraceptives*. In Gondar town and the surrounding peasant associations. *Ethiop J health Dev*. 2000, 14(3):327–334

Kora A. and Haile M. (1999). *Sexual behavior and level of awareness on reproductive health among youths: Evidence from Harar, Eastern Ethiopia*. *Ethiop.J.health*, 13(2):107-113.

Meindert .S and C. Sonia. (2006). "Street children's sexual realities and the association for promoting social action-sexual health intervention program,"

Mekonnen .T, (2005). "Factors predisposing street children to HIV/AIDS in Addis Ababa, Ethiopia".

National Research Council, *Contraception and Reproduction: Health Consequences for Women and Children in the Developing World*, Washington, D.C.: National Academy Press, 1989, Chapter 3.

NICEF (2003). Ethiopia Newsletter. Child Protection Issue. July-September 20035(3)

Lbrahim, G. (1995). Knowledge, attitude and practice the three pillars of excellence and wisdom: a place in the medical profession. *Eastern Mediterranean Health Journal*, 1(1), 8-16.

Population action Contraceptive Use Helps Reduce the Incidence of Abortion, [2005](http://populationaction.org/policy-briefs/contraceptive-use-helps-reduce-the-incidence-of-abortion/#sthash.3bwWLzth.dpuf) See more at <http://populationaction.org/policy-briefs/contraceptive-use-helps-reduce-the-incidence-of-abortion/#sthash.3bwWLzth.dpuf>

S. Meindert and C. Sonia, "Street children's sexual realities and the association for promoting social action-sexual health intervention program," 2006.

SCUK (2004). Child Situation Analysis for Ethiopia: An iterative Document Compiled by Save the Children UK. Retrieved September 25 from.

Seifu A. (Dec.2001). *Reproductive health needs of urban and rural out of school adolescent*. East Gojam, MPH thesis.

Selassie, G. (1996). *Determinants of contraceptive use among urban youth*. In Ethiopia. J. Health Dev, 10(2), 97-104.

Shireen, J.J. (1998). *Adolescent sexual and reproductive behavior: A review of the evidence from India* .Sci. med.

Sweta, S., Georgina, G. and Josephine, V. (2005). *Youth on the streets: the importance of social interactions on psychosocial well-being* .In an African context.

Tadelle, G. and Abode, D. (2008). "*The situation of sexual abuse and commercial sexual exploitation of girl children in Addis Ababa, Ethiopia*," Tech. Rep., Forum on Street Children, Addis Ababa, Ethiopia.

Tigist Addis. (2005). *Woman in informal sectors And their Knowledge, Attituded and Practice (KAP)of contraceptive methods* .In Addis Ababa AAU.

U.S. Dept of State Bureau of Democracy, Human Rights, and Labor, March 8, 2006

UNICEF (2005).The State of the World Children: Excluded and Invisible New York:

WHO, (1993). *The health of young people: A challenge and a promise*, Geneva.United Nations office for the coordination of humanitarian affairs, "Ethiopia: focus on street children

rehabilitation project,” Tech. Rep., Integrated Regional Information Networks, Nairobi, Kenya, 2004.

WHO, (2003). *Adolescent friendly health services*.

WHO, “Module 4: understanding sexual and reproductive health including HIV/AIDS and STDs among street children,” in *Working With Street Children: A Training Package on Substance Use, Sexual and Reproductive Health Including HIV/AIDS and STDs*, p. 34, Geneva, Switzerland, 2002

Woldegerima, B. Denekew, A. (2008). *Women’s knowledge, preferences, and practices of modern contraceptive methods*. In Woreta, Ethiopia. *Research in Social and Administrative Pharmacy*. 4:302–307. doi: 10.1016/j.sapharm.2007.10.001. [[PubMed](http://www.state.gov/g/drl/rls/hrrpt/2005/61569.htm) www.state.gov/g/drl/rls/hrrpt/2005/61569.htm][accessed 4 February 2011]

Yiman, E. (2007) *Assessment of reproductive health behavior and needs of street youth in Dessie town, Amhara region [M.S. thesis]*. Addis Ababa University, Addis Ababa, Ethiopia.

Zewdie, Z. (2005). *Assessment of HIV/Risk perception and condom use among youth*. In Debre Birhan Town, Amhara Region. MPH thesis

Jemal Alim, Comparison of factors influencing Utilization of Modern Contraceptive Methods among Rural and Urban women Currently using family planning service in south wollo Zone, Amhara National Regional state, July 2010 A.A Ethiopia.

ANNEX 1

ADDIS ABABA UNIVERSITY SCHOOL OF SOCIAL WORK
A SURVEY QUESTIONNAIRES FOR STREET GIRLS OF BOLE SUB CITY

<p>Inclusion criteria</p> <p>Only Street Girls of Bole sub city reproductive age group of 13-24</p>	<p>CL</p> <p>IE</p> <p>NT</p> <p>QU</p>
---	---

QUESTIONERS

Greeting:

Hello! I would like to ask you some questions about modern contraceptive methods. I believe that it would help to improve family planning service in the future to meet your need. The purpose of this study is to assess modern contraceptive, knowledge, an attitude and practice towards these methods among Street Girls of reproductive age group (13-24), who are residents of the street of bole sub city. All information you give will be kept strictly confidential and you have the right not to respond to any questions that you don't want to. Your participation is voluntary, May I continue?

Yes -

No

Thank you!

I. Socio-demographic information			Go to
1.01	Sex of respondents	<ol style="list-style-type: none"> 1. Male 2. Female 	
1.02	What is your age?	Enter age in years _____	
1.03	What is your marital status?	<ol style="list-style-type: none"> 1. single 2. Married 3. Divorced 4. Widowed 5. Others Specify----- 	
1.04	What is the highest level of education you have achieved?	<ol style="list-style-type: none"> 1. Write and Read 2. Elementary not completed 3. Elementary Complete 4. High school not completed 5. High School Completed 6. Above High school 	

1.05	What is your religion?	<ol style="list-style-type: none"> 1. Orthodox 2. Catholic 3. Protestant 4. Muslim 5. Others specify----- 	
1.06	How many Birr do you earn per month/day?	Enter the number in Birr_____	
II. Knowledge of contraceptives			
2.01	Have you some information on modern contraceptives?	<ol style="list-style-type: none"> 1. Yes 2. No 	Q3.01
2.02	Would Please name all contraceptive methods you know?	<ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 	
2.03	Which of the following have you heard to be contraceptive Methods?	<ol style="list-style-type: none"> 1. Pill 2. Inject able 3. Condom 4. Jell/foam 5. Ampicillin 6. IUD 7. Norplant 8. Chloroquin 9. Female sterilization 	

		<p>10. Male sterilization</p> <p>11. Natural methods</p> <p>12. Other specify-----</p> <p>13. None-----</p>	
2.04	<p>From whom or where, have you heard the information about contraceptives?</p> <p>More than one answer is possible</p>	<p>1. School teacher</p> <p>2. Mother</p> <p>3. Father</p> <p>4. Brother</p> <p>5. Sister</p> <p>6. Friends</p> <p>7. Health professionals</p> <p>8. Books/ magazines</p> <p>9. Other specify _____</p>	
2.05	<p>Do you know where to get contraceptive methods if you want?</p>	<p>1. Yes</p> <p>2. No</p>	Q3.01
2.06	<p>Please name all contraceptive sources you know. More than one answer is possible. You can answer more than one.</p>	<p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p>	

2.07	Is it important to use modern contraceptive why?	-----	
III. Attitude Toward Contraceptive Methods			
3.01	Would you like to know more about modern contraceptive methods?	1. Yes 2. No	Q3.03
3.02	Why you are interested to know more about contraceptive.		
3.03	If your answers is No to Qno3.01Why you are not interested to know more about contraceptive		
3.04	Do you discuss about modern contraceptive with your friends?	1. Yes 2. No	
3.05	Which of the following best describe you're feeling about contraceptives?	1. Contraceptives are harmful for health 2. Contraceptives are not very important 3. Contraceptives are not as important as some people says 4. More people should be aware of the importance of contraceptive 5. If two people are having sex and are not ready to have a child it is very important that they use contraceptives 6. Contraceptives are very	

		important 7. Others specify_____	
3.06	Do you favor use of modern contraceptive methods by adolescents?	1. Yes 2. No 3. Others/ specify-----	
IV. Sexual History			
4.01	Do you have sexual partner	1. Yes 2. No	
4.02	Do you have more than one sexual partner?	1. Yes 2. No	
4.03	Have you ever had sexual intercourse?	1. Yes 2. No	Q5.10
4.04	How old were you the first time you had sex?	_____ Year	
4.05	Have you ever been pregnant?	1. Yes 2. No	Q5.01
4.06	What was the outcome of the pregnancy?	1. Currently pregnant 2. Abortion 3. Life birth 4. Life birth & abortion	
V. Contraceptive practice			
5.01	Have you ever used contraceptive methods?	1. Yes 2. No	Q5.10

5.02	Did you and your partner discussed about contraceptive methods the first time you had sex?	1. Yes 2. No 3. Don not remember	
5.03	Did you or your partner use contraceptive the first time you had sex?	1. Yes 2. No 3. Do not remember	
5.04	If your answer is No to the above question Why?		
5.04	If yes, What method did you or your partner used the first time you had sex?	1. Condom 2. Pills 3. Injectable 4. Withdrawal 5. Safe period 6. Others / specify _____	
5.05	Have you or your partner used contraceptive method the last time you had sexual intercourse?	1. Yes 2. No	Q5.10
5.06	What was the method you used?	1. Condom 2. Pill 3. Inject able 4. Spermicidal 5. IUD 6. Calendar /rhythm/ method 7. Other specify -----	
5.07	Why you prefer the method you used Q 0.56?	1. Easy for secret use	

		<ol style="list-style-type: none"> 2. Easy to get it 3. Cheap to buy 4. I get it for free 5. Have better knowledge about it 6. Other specify----- 	
5.08	For what purpose did you used contraceptive methods the last time you had sexual intercourse?	<ol style="list-style-type: none"> 1. Prevent unwanted pregnancy 2. Prevent sexually transmitted diseases 3. For medication 4. Space child birth 5. Other specify 	
5.09	Since from the first intercourse how often you or your partner did used contraceptive methods?	<ol style="list-style-type: none"> 1. Always 2. Some times 3. Never 	
5.10	Do you, plan to use contraceptive method in the future	<ol style="list-style-type: none"> 1. Yes 2. No 	