



**PREVALENCE AND PREDICTORS OF MODERN CONTRACEPTIVE
USE AMONG HOMELESS WOMEN IN ADDIS ABABA: THE HEALTH
BELIEF MODEL PERSPECTIVE**

PRINCIPAL INVESTIGATOR: -BEZA ALEMAYEHU MAMO (BSC)

ADVISORS: - ESHETU GIRMA (MPH, PhD, Associate Professor)

NIGUSSIE ASSEFA (MPH)

**A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY COLLEGE
OF HEALTH SCIENCES SCHOOL OF PUBLIC HEALTH IN PARTIAL
FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF
MASTER OF PUBLIC HEALTH**

**ADDIS ABABA, ETHIOPIA
JUNE 2018**

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THIS THESIS BY BEZA ALEMAYEHU (BSC) IS ACCEPTED IN ITS PRESENT FORM BY BOARD OF EXAMINERS AS SATISFYING THESIS REQUIREMENT FOR THE DEGREE MASTERS IN PUBLIC HEALTH

RESEARCH ADVISOR

DR. ESHETU GIRMA

_____	_____	_____
FULL NAME	SIGNATURE	DATE

INTERNAL EXAMINER

_____	_____	_____
FULL NAME	SIGNATURE	DATE

EXTERNAL EXAMINER

_____	_____	_____
FULL NAME	SIGNATURE	DATE

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COLLEGE OF HEALTH SCIENCE
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ACRONYMS AND ABBREVIATION

- ❖ ANC _____ Antenatal Care
- ❖ AOR _____ Adjusted Odds Ratio
- ❖ CDC _____ Communicable Disease Control
- ❖ CI _____ Confidence Interval
- ❖ COR _____ Crudes Odds Ratio
- ❖ CPR _____ Contraceptive Prevalence Rate
- ❖ EDHS _____ Ethiopian Demographic and Health Survey
- ❖ ETB _____ Ethiopian Birr
- ❖ GIS _____ Global Information System
- ❖ HBM _____ Health Belief Model
- ❖ HBQ _____ Health Belief Question(er)
- ❖ HIV/AIDS ___ Human Immuno-Deficiency Virus/ Acquired Immune Deficiency Syndrome
- ❖ HSTP _____ Health Sectors Transformation Plan
- ❖ IUD _____ Intra Uterine Devise
- ❖ MCs _____ Modern Contraceptives
- ❖ RH _____ Reproductive Health
- ❖ SNNP _____ Southern Nations, Nationalities, and Peoples
- ❖ STDs _____ Sexually Transmitted Diseases
- ❖ UNICEF _____ United Nations Children's Fund
- ❖ WHO _____ World Health Organization

ABSTRACT

Background: *Access to contraceptive services and supplies are fundamental to the well-being of women during their reproductive years.*

Objectives: *To determine the prevalence and predictors of modern contraception use among homeless women in Addis Ababa using health belief model.*

Methods: *A cross-sectional mixed methods study used from June 2017- June 2018. A 178 reproductive age group (15-49) homeless women living in Addis Ababa involved in the study. A multi stage sampling technique used to reach individuals. A structured questionnaire mainly with constructs of health belief model and in-depth interview guide used to collect the data. The quantitative data was analyzed using SPSS version 21 statistical software. The data analysis included Univariate, Bivariate analysis and multivariable analysis via logistic regression model with 95% CI and p-value < 0.05. The qualitative data transcribed and analyzed by using a thematic analysis method using the open code software version 3.6.*

Results: *The mean age of respondents was 25 (± 6.293) years. All of the respondents had information about Modern contraceptives (MCs). Where the majority 151 (88%) got the information from health professionals. 159 (93%) of the respondents had chance of pregnancy, 140(81.9%) of the respondents, have ever used modern contraceptives and currently, 122 (71.3%) of the respondents were using modern contraceptives and among those currently using more than half, 65 (53.3%) of them were using Norplant. A unit increase in score of perceived threat the odds ratio of using MCs increased by 1.044. AOR 1.044 (95%CI 1.015, 1.074)*

Similarly, a unit increase in sum score of perceived net benefit the odds ratio to the current use of MCs increased by 1.066. AOR 1.066 (95%CI 1.006, 1.129) Limited knowledge of MCs and reproduction, desire to have more children, thinking to be sexually not active and carelessness, fear of being infertile and also no reason was among the reasons for nonuse of MCs while situation of homeless life, life experience and advice from others were the cues to action to use MCs.

Conclusion and recommendation: *This study concluded that, all of the study respondents have information about MCs and most of them agree on the benefits of MCs. The prevalence of MC use among homeless women in Addis Ababa is good. The high threat perception about negative reproductive health (RH) outcomes and high net perceived benefit of MCs are the major contributing factors for the MC use improvement. MOH and health sectors at different level should develop strategies that can approach and increase the awareness of threats and knowledge about benefits, use and service availability and accessibility of MCs among homeless women.*

CHAPTER ONE: INTRODUCTION

1.1 Background

Contraception or birth control designed to prevent a woman from getting pregnant. The methods can be broken down into several different types and choosing one or more birth control methods is a personal decision, and can depend on once overall health, age, the frequency of sexual activity, the number of sexual partners, the need to have children in the future, and even family history of specific diseases(1).

WHO clarify that modern contraceptive methods are essential for preventing pregnancy-related health risks in women, reducing infant mortality, helping to prevent HIV/AIDS, empowering people and enhancing education, reducing adolescent pregnancies, and slowing population growth(2).

In Los Angeles among homeless women who reported being pregnant, 73% was unintended and 48% had history of STDs or pelvic inflammatory diseases. Additionally non-use of modern contraceptives was high (3). Similarly, In Northwest Ethiopia, from 48% of homeless women had history of unintended pregnancy, whereas the contraceptive prevalence rate is 34.3% (4).

Currently the yearly population growth rate of Ethiopia is 2.45% and this puts the country at twelveth highest populous country in the world with more than 105 million people according to worldometer 2017's live report (5). Rapid population growth rate is closely linked to persistent poverty as it reduces overall economic growth. It strains the environment as competition for scarce resources and public goods expands (6).

Poverty is one of the big reasons for much homelessness (7). It is impossible to untie homelessness and poverty. Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs (8).

In addition to poverty, there is a relationship between homelessness and the health care, social services and criminal justice systems. People who do not have safe, secure, affordable shelter have more health problems than the general population, experience social problems that may be exacerbated by their lack of shelter (9).

Access to contraceptive services and supplies are fundamental to the well-being of women during their reproductive years. AddisAbaba met need for contraceptive among married women reaches 61% in 2016 (10). Within the homeless population, this fundamental concern holds true, but is often neglected by both health care providers and the health care system (11). Even though, most studies agree on the idea of high exposure of homeless people, girls and women in particular to sexual exploitation, rape, and prostitution. And notify the great importance efforts that should be done to let them use contraceptive options to prevent unwanted pregnancy and Sexually Transmitted Diseases such as HIV/AIDS, to the extent of the investigator's knowledge, so far studies on the predictors of modern contraceptive use among homeless women are hard to find in Ethiopia.

1.2 Statement of the problem

Homeless women specially are prone to sexual abuse, unsafe sexes and rapes at working place and unsafe dwelling places during night-time begging (12). Afterward they usually engage in multiple types of relationships and sexual behaviors. Emotion & attachment also play critical roles in risky sex choices that might direct them to face unintended pregnancy. Moreover being homeless by itself makes reproductive conditions like pregnancy even more stressful, due to already having compromised health and lacking support systems(4).

Additionally, homelessness influences every facet of a child's life — from conception to young adulthood. The experience of homelessness inhibits the physical, emotional, cognitive, social, and behavioral development of children (13).

Therefore, the unwanted pregnancy and its consequences make the need of modern contraceptive use essential to control birth. In general, STDs and unintended pregnancies in addition to homelessness have negative consequences on the women themselves, for their children, siblings and the societies as a whole(14).

But, even though, few researches have been conducted in the area of homelessness particularly on the associated factors of homelessness and street children's knowledge, attitude and practice of modern contraception globally as well as nationally, studies that can determine the predictors of contraceptive use among homeless women in general are hard to find.

1.3 Significance of the study

The results of this study will hopefully, provide information about the prevalence and predictors of modern contraceptive use of the most neglected segments of the population, homeless women. This study applied a health belief model constructs and the evidences would optimistically be helpful for designing and improving the modern contraceptive practices of homeless women. Thus, the findings will certainly offer expectantly evidences for reproductive health programs, family planning care services, policy makers, decision makers and other major stakeholders related of this specific service.

Very implicitly, this study implies to understand how homeless women make decisions for modern contraceptive use. This evidence alludes to critically design and implement some effective strategies for service care access, utilization, and continuation of service use. Linked with this, this research would help to fall unintended pregnancy and ensure improved maternal and child health.

In addition, it can expectantly be helpful reference for further investigation and other organizations to undertake further research.

CHAPTER TWO: LITERATURE REVIEW

2.1. Contraceptive and its importance

Contraceptive is a widely used and effective method of preventing unintended pregnancy. Most of the studies done on contraception use agree on contraception benefits to both the mother and the child's health. Appropriate use of modern contraceptives improves the women's health by reducing unintended pregnancy and pregnancy related complications. In addition, it develops child's health by reducing the child mortality via preventing infants' malnutrition and improving breastfeeding through birth spacing. In addition, it improves the social and economic status of women as well the relationship of mother with her children while supporting the health and development of communities (15-18).

Generally contraceptive has many benefits that support the women, the children, the community and as well the country. There are different types of modern contraceptives. In particular, male and female condoms provide dual protection against unintended pregnancies and against STDs including HIV and forth (2, 16).

2.2. Unintended pregnancy

According to CDC unintended pregnancy is a pregnancy that is reported to have been either unwanted or mistimed. Unintended pregnancy is a core concept that is used to better understand the fertility of populations and the unmet need for contraceptive and family planning. It results mainly from not using contraceptives, or inconsistent or incorrect use of effective contraceptive methods.

As study done on unintended pregnancy worldwide levels, trends, and outcomes show the 20 percent declined rate of unintended pregnancy worldwide, between 1995 and 2008. However, the proportion of unintended pregnancy is still high where near half (86 million) pregnancies were unintended by the same year 2008. According to these studies the decline of unwanted pregnancy in developing countries is by less than 20% but in the developed world, it was 29% (19).

Similarly, by 2012 a study states that approximately 40 percent of pregnancies worldwide, or 85 million pregnancies, were unintended (20).

Additional studies done in Ethiopia focusing Prevalence of unwanted pregnancy and associated Factors reported the proportion of unintended pregnancy between the years 2014 and 2016 ranged from 27.5% to 37.8% (21-23).

In Ethiopia the major contributing factors mentioned to the increase of unintended pregnancy were Socio-economic factors and lack of reproductive health services, such as economic status, education, religion, place of residence, peers and partners' behaviors, family and community attitudes, gender and age, and mass media. In addition, lack of access to contraceptive methods and reproductive health education (24).

The high-unintended pregnancy rate among women that are poor and with low income, lead to the thought to be obvious that the issue is more serious among homeless women that face tragic sexual violence in every day of their lives. In fact, homeless women have a high incidence of pregnancy and a higher proportion of these are unintended pregnancies. As studies done in Ethiopia shows majority of homeless women has no desire to have children while they are homeless. Although most women desired future children or were ambivalent about future pregnancies, none wanted to be pregnant or to have more children while they were homeless (25, 26).

2.3. Sexually Transmitted Diseases (STDs)

Sexually transmitted diseases (STDs) are the infections that transmit through genital, anal, or oral mucosal contact and resulting clinical syndromes caused by approximately 30 infectious organisms and cause various acute and chronic consequences (27). The risk of acquiring a sexually transmitted infection can be prevented by abstinence from sex, by being faithful to partners and by safer sexual practices such as consistent use of male or female condoms. But still, more than 1 million sexually transmitted infections are acquired every day worldwide (28).

According to a study done on sexually transmitted diseases in sub-Saharan Africa and associated interaction with HIV, STDs are major cause of adult morbidity and mortality in Sub-Saharan Africa, resulting in serious health problems particularly for women and children. The study also states that though certain sociological and demographic factors influence the spread of STDs, including urbanization and family living, patterns of STDs tend to persist in core groups of individuals who practice high-risk behaviors (29).

Despite the fact that in Ethiopia 72% of women attending ante natal clinics in Addis Ababa had serological evidence of two or more STDs (30). In fact, homeless people especially women are a vulnerable group to sexually transmitted diseases (STD) and even though it is hard to find evidences in Ethiopia focusing on them, it will not be hard to see how big the pictures would be when compared to what is available. Therefore, improving access to modern contraceptives is essential for them.

2.4. Contraceptive utilization

Considering one or more of the benefits, the utilization of contraception is increasing worldwide. Though even with different choices served considering the needs of various individuals, the use in developing countries is still low (31). Contraceptive prevalence almost doubled in the world between 1970 and 2015, from 36% to 64%. As the report implies in 2015, 64 per cent of married or in-union women of reproductive age worldwide were using some form of contraception. However, contraceptive use was much lower in the least developed countries and was particularly low in Africa. In fact, most of the time contraceptive is used by married or in-union women all over the world (24).

In the context of Ethiopia, the current married women's contraceptive prevalence rate has increased progressively from 8 percent in 2000 to 36 percent in 2016 and among sexually active unmarried women, 58 percent are currently using a contraceptive method. And in Addis Ababa, the met need for contraceptive is reported to be about 75% (10).

Numerous reasons have been mentioned for not using contraceptives worldwide including fear of side effects, being sexually not active, Unaffordable cost, fear of health problems (32).

A study done in Ethiopia Tigray region also recognized reason for not using modern contraceptive methods as the majority of women mentioning more than one reason not to practice modern contraceptives. And the most common reason mentioned is being unmarried & second frequently mentioned reason is desire to have more children followed by fear side effect, medical problem, fear of infertility and few reported far service place to get Modern Contraceptive Methods (33).

2.5. Characteristics of homeless women and their contraceptive use

More than 100 million people in the world's poorest countries projected to be living below the basic subsistence level of a dollar a day by 2015. The causes of homelessness are diverse and multi-faceted, a report said, lack of affordable housing, speculation in housing and land for investment purposes, privatization of public services, and unplanned urban migration are some of the reasons (34).

As researches done in Ethiopia explain majority of homeless women has no desire to have children while they are homeless (25, 26). Certainly homeless mothers who become pregnant are often least prepared economically and emotionally to care for their infants. They usually lack gainful employment, as a result live in an unstable conditions and lead an economically hardship life. However, the prevalence of modern contraceptive use among homeless women is still low and lot homeless mothers have 2-4 children which to some extent implies the risk of maternal and child health adverse outcomes (4, 12, 35).

As some studies in Ethiopia mentioned- fear of side effects, being sexually not active, Unaffordable cost, fear of health problems, and partner dislike of condoms are some of barriers that prevent homeless women in Ethiopia from using existing sexual health services (4, 36).

But, a qualitative study done in US explored several barriers related to the context of being homeless such as; An inability to prioritize health because of competing demands, a reliable place to store contraceptive methods, little to no secure space in the shelters, horrific provider practices and feeling less in control of their sexual choices when homeless ware also mentioned. In addition, most women described feeling overwhelmed by the stresses caused by being homeless, resulting in a decreased priority placed on their own personal health. Women reported their time is consumed by trying to secure housing, food, employment, and health care for their children. Personal health care appointments were frequently not made or skipped(25).

Therefore, these facts revealed that a mixed approach study focusing on predictors of homeless women's modern contraception seeking behaviors in Ethiopia, Addis Ababa will be much help in improve modern contraception use among homeless women in the country.

2.6. Health belief model

The Health Belief Model originated in the 1950s to help predict public attitudes and actions around health issues. It assumes that people are largely rational in their thoughts and actions, and will take the best health-supporting action if they: Feel that it is possible to address a negative health issue, have a positive expectation that taking the proposed action will be effective in addressing the issue and believe they are able to take the proposed action(37). It breaks down health decisions into a series of stages and offers a catalogue of variables that influence health action; it does not provide a model of exactly how these operate. In the HBM, the likelihood of a person will follow a preventive behavior is influenced by their subjective weighing of the costs and benefits of the action.

The perceived threat (combination of perceived susceptibility and seriousness), is the first condition in the Model. The perceived threat has a cognitive component and influenced by information. It creates a pressure to act, but does not determine how the person will act. Even if the person has perceived threat, whether this perception leads to behavior change will be influenced by his/her belief regarding perceived benefits of the available actions which means individuals exhibiting optimal beliefs in susceptibility and severity are not expected to accept any recommended health action unless they also perceive the action as potentially beneficial. In addition perceived barriers are potential aspects of a particular health action that may act as impediment to undertaking recommended behaviors (38, 39). The balance between benefits and costs may suggest the person's likelihood of acting and their preferred course of action but do not determine that they will act. Therefore, thought that readiness to action potentiated by cues to action, which are internal or external factors that move the person change. Additionally, to overcome perceived barriers and take action self-efficacy is important (37, 39).

Therefore, in order to understand homeless women's health seeking behavior from an individual level as well as the mechanisms of their decision making process for contraceptive use, this study will be using the Health Belief Model framework from behavioral science to get help that define a set of factors specifically suitable to local health beliefs and behaviors. Consequently; this study may help to show the gap and could be used as a clue in the case of the of homeless women's health behaviors that may or may not be associated with their practice for both developed and developing countries.

2.7. Conceptual framework

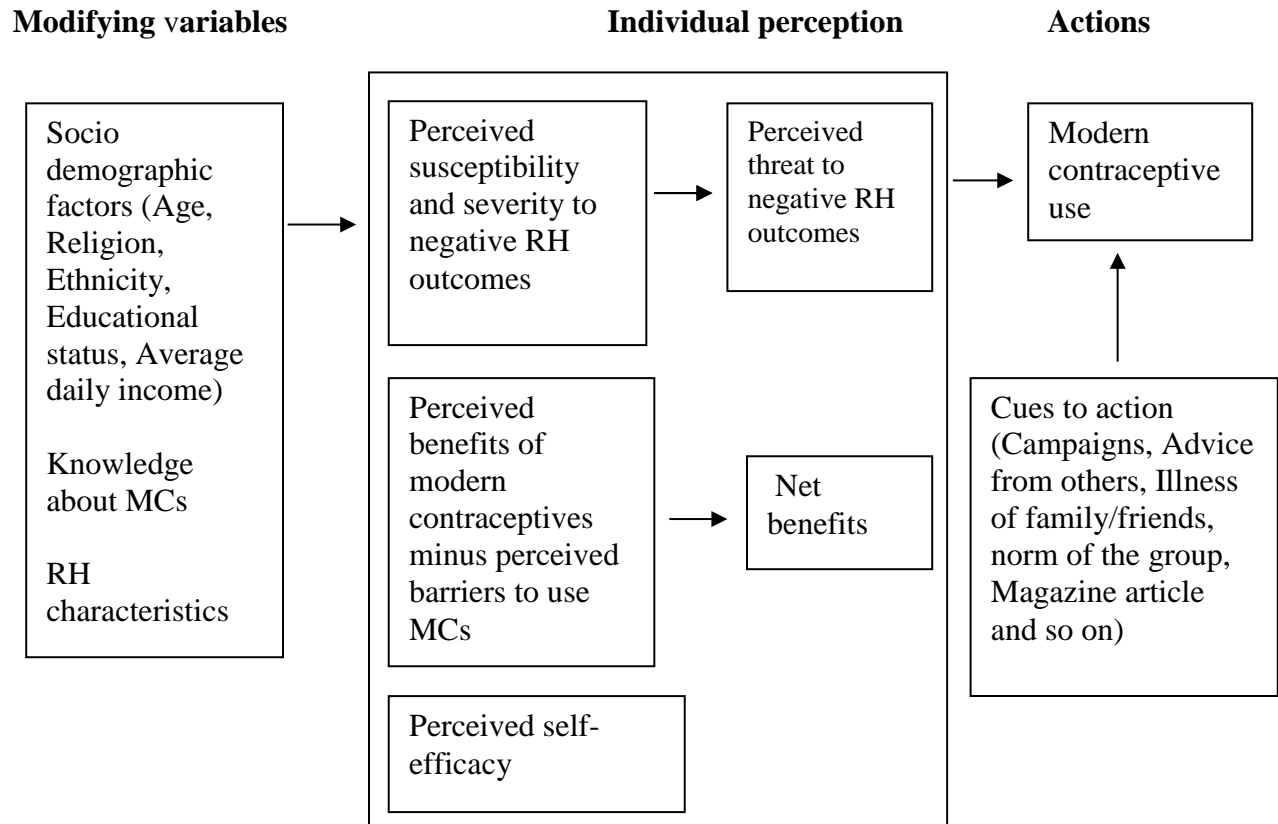


Figure 1: Conceptual framework based on the Health Belief Model (39).

CHAPTER THREE: OBJECTIVES

3.1. General objective

The general objective of this study is to determine the prevalence and predictors of modern contraception use among homeless women, using health belief model in Addis Ababa Ethiopia, 2018.

3.2. Specific objectives

- ✓ To determine the magnitude of modern contraceptive use among homeless women in Addis Ababa.
- ✓ To identify the perceived threats of negative RH outcomes among homeless women in Addis Ababa
- ✓ To identify the modern contraceptive use perceived net benefits among homeless women in Addis Ababa
- ✓ To identify the Self efficacy of homeless women in Addis Ababa to use modern contraceptives
- ✓ To identify the cues to action to use modern contraceptives among homeless women in Addis Ababa
- ✓ To describe the perceived barriers to the practice of modern contraceptives among homeless women in Addis Ababa
- ✓ To describe homeless women's decision making process of contraceptive use in Addis Ababa

CHAPTER FOUR: METHODS

4.1. Study area

Addis Ababa is located in the heart of the country surrounded by Oromia. The area covers about 540 Km² of which 18.2 Km² are rural. According to the 1994 census, the population of Addis Ababa is 2.3 million. The city is divided into 10 sub-cities called Addis Ketema, Akaki kality, Arada, Bole, Gullele, Kirkos, Kolfe Keranio, Lideta, nifas silk-lafto, Lideta and Yeka (40). Addis Ababa in addition is home for more than 6500 homeless people according to the 2014/15's, 6th and last round national survey done in by Addis Ababa city administration labor and social Affair office. Of these 232 were women between the ages of 15 to 49 Years(41).



Figure 2 : Map of Addis Ababa City

Source:

https://lawexplores.com/wpcontent/uploads/2015/12/A333520_1_En_1_Fig3_HTML.gif

4.2. Study period

This study was conducted from June 2017 to June 2018.

4.3. Study design

A cross-sectional study in both quantitative and qualitative (mixed) methods.

4.4. Population

4.4.1. Source population

All homeless women in Addis Ababa in the reproductive age group (15-49).

4.4.2. Study population

All homeless women in the reproductive age group (15-49years), living in five sub-cities (Kirkos, Lideta, Arada, Addis ketema, and Nifas silk lafto sub city) of Addis Ababa.

4.5. Eligibility criteria

4.5.1. Inclusion criteria

Homeless women, whose age was 15-49 years and who has lived around churches, mosques and streets shelters for at least 3 months.

4.5.2. Exclusion criteria

Homeless women who are unable to hear and speak.

4.6. Sample size determination

4.6.1. Quantitative sample size

The sample size for the quantitative part of the study was calculated using single population proportion formula based on the assumptions: modern contraceptive prevalence among homeless women is 34.3% (4), 5% margin of error and 95% confidence interval. As a multistage sampling to control for design effect the sample is multiplied by 2. Then, using a contingency of 10% for non-respondent the sample size become 761.

$$n = \frac{[Z_{\alpha/2}]^2 p (1-p)}{d^2} = 346$$

$$(346 \times 2) + 10\% = 761$$

However, since our population is smaller than 10,000, using the correction formula:

$$n_{\text{final}} = \frac{n}{1 + \frac{n}{N}} = \frac{761}{1 + \frac{761}{232}} = 177.8 \approx 178$$

Where n: number of samples

N: total number of homeless women in Addis Ababa

4.6.2. Qualitative sample size

When planning data collection for a qualitative research study, enough amounts is where additional participants do not provide any additional insights. It is known as phenomenon “saturation”. Saturation is when you are no longer learning very much (if anything) from each subsequent interview, observation, and so on (42). Therefore, we prepared an interview guide containing important points to explore the perceptions and behaviors of the homeless women towards the practice of modern contraception. And used it until information reached the saturation level, which means until no more additional new information, where to this study it was nine respondents.

4.7. Sampling procedures

4.7.1. Quantitative procedure

A multistage sampling technique used to select the respondents. First, among the ten sub-cities of Addis Ababa five sub-cities (Kirkos, Lideta, Arada, Addis ketema, and Nifas silk lafto sub city) selected that this assumed inclusion of sufficient study area or population. The sample size was then distributed equally to the sub cites assuming that these sub cities (as a central city of the country) has equal homeless concentration. Second, three districts from each sub cities selected by simple random sampling technique (Figure 3). After that, due to special nature of the study respondents, a special strategy used to reach the individuals. Which is considering all possible areas where homeless women particularly used to live preparing plastic shelters, the data was collected by a take-all approach but we only go to each site once and get everyone we could in the period of two hours no more or less. In this case, any homeless woman that was present in her plastic house or sleeping row had an equal chance of being interview as long as she fulfills the inclusion criteria.

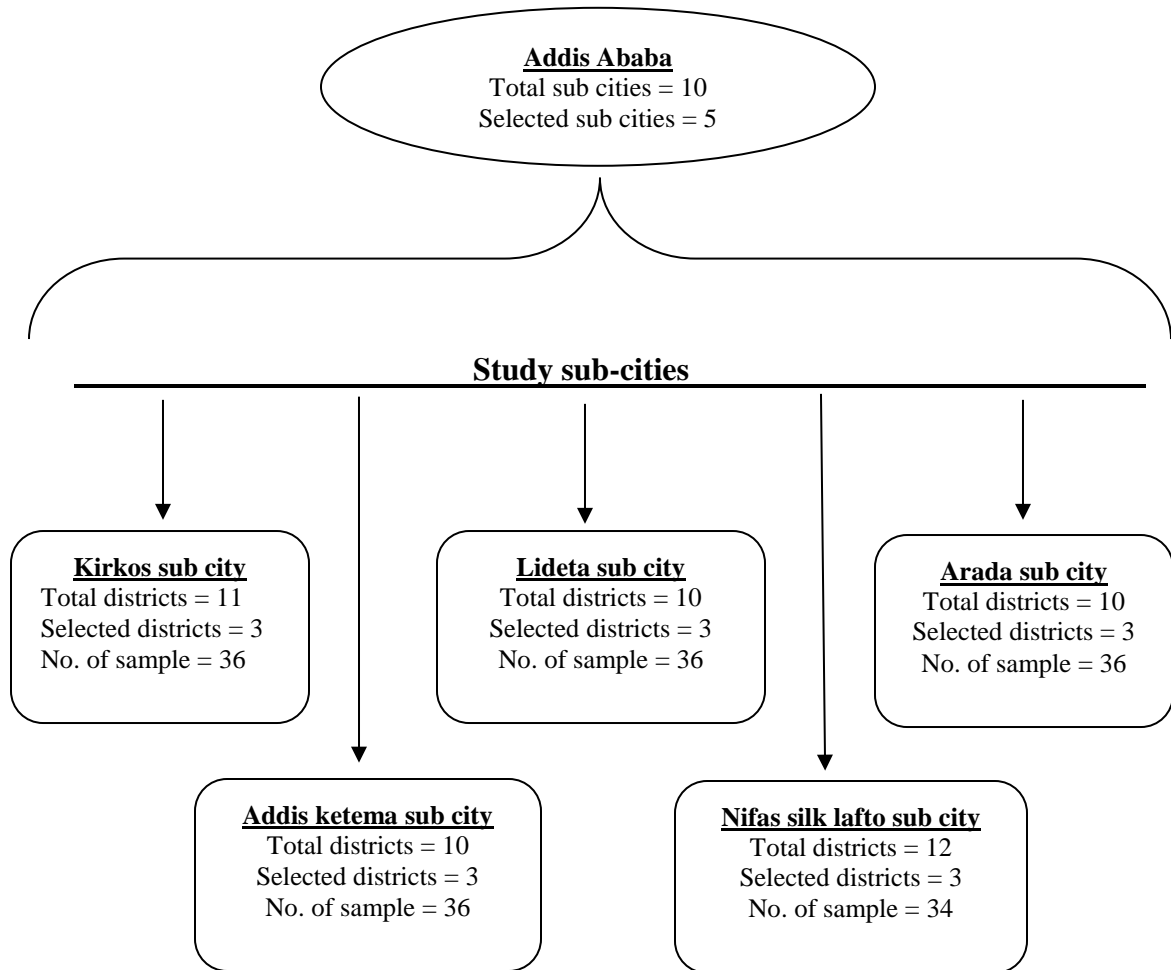


Figure 3: Flow chart indicating the sampling procedure for a study conducted on prevalence and predictors of modern contraceptive use among homeless women in Addis Ababa: the Health Belief Model perspective April 2018.

4.7.2. Qualitative procedure

From the ten sub-cities of Addis Ababa, five sub cities similar to the quantitative section selected. Then, Homeless women who were living around churches, mosques and streets and those who fulfill the inclusion criteria selected and interviewed.

4.8. Variables

4.8.1. Dependent variable

- Modern contraceptive use

4.8.2. Independent variables

- Modifying variables
 - ✓ Socio demographic factors (age, Religion, Ethnicity, Educational status, average daily income)
 - ✓ Knowledge about MCs and
 - ✓ RH characteristics
- Individual perceptions
 - ✓ Perceived threat,
 - ✓ Perceived net benefits, and
 - ✓ Self-efficacy
- Cues to action

4.9. Data collection procedures

4.9.1. Quantitative data collection instrument and measurements

Interviewer administered structured questionnaire based on the health belief model of Champion's 1993 was designed with 57 items. Including; socio- demographic characteristics (age, marital status, educational status, religion, ethnicity and average daily) that holds seven items, information and knowledge of an individual towards modern contraceptives were measured with 14 items, reproductive health history with nine items. In addition, for the Health Belief Model constructs total of 27 items (Perceived susceptibility and perceived seriousness of negative reproductive health outcomes 5 items each, perceived benefits, perceived barriers, cues to action and perceived self-efficacy of using modern contraceptives 4, 5, 4, and 4 items respectively) used as data collection instruments. All of HBQ (health belief question) items had five response choices that ranged from strongly disagree (scoring 1) to strongly agree (scoring 5). The questionnaire derived from various published studies that used health belief model to attain their objective and revised champion health belief

model. Then, two trained data collectors (1 male 1 female) collected the data using face-to-face interview. The aim of the study initially explained to the women and informed written consent obtained prior to the data collection. The result of the questionnaire reliability test showed that reliability coefficients (Cronbach's alpha) ranged from 0.69 to 0.89 for the constructs considered (Perceived susceptibility, perceived severity, perceived benefit, perceived barrier, self-efficacy and cues to action) and the average reliability coefficient was 0.80 for the 27 items.

4.9.2. Qualitative Data collection procedure and tools

In-depth interview helps to get thorough information about the health beliefs and behaviors of homeless women towards modern contraceptive use and to identify hidden barriers to the practice of modern contraceptive(43). Therefore, an in-depth interview guide focusing on nonnumeric information prepared and used with nine cases selected for detailed analysis. Moreover, while interviewing, the dialogue was recorded on audio (tape recorder), and in addition, field note taken using notebook and pen/pencil.

4.10. Data quality management

4.10.1. Both quantitative and qualitative

Training given for the data collectors on sampling procedures, techniques of interview and data collection process.

4.10.2. Quantitative data quality assurance

An objective based and standardized questionnaire was prepared. The questionnaire was initially prepared in English then translated in to local language (Amharic). Pre testing of questionnaire undertaken to check the understandability by taking 10% of sample, which were not included in the actual data. The data collection was point in time, which means it was carried out at one night for an area in order to minimize double counting. There was a close day-to-day supervision in the data collection process. The questionnaires checked to ensure completeness and consistency each day. Non-over lapping numerical code was given for each question and the coded data have been entered into Epi data software version 4.2 prepared templates. Data cleaning and analysis done with SPSS version 21 software and saved with password protection. Hard copies of the completed data kept and stored in a locking place.

4.10.3. Qualitative data Trust worthiness

Instruments of in-depth interview checked for functioning every day before the data collection starts. Field notes were taken side by side with the tape recorder and it was expanded within 24hours to use it as a backup incases if the records made fail. All field notes, transcripts and recorded interviews checked on each day for errors to correct timely. Then, the interviews transcribed carefully, data coding, and analysis done carefully with open code software.

4.11. Operational definitions

Homeless women: Women that live in a plastic shelter (veranda) for at least three months.

Contraceptive users: Women that are using any kind of modern contraceptive method currently during the study time

Negative RH outcomes: Sexual abuse, unintended pregnancy and STDs

Knowledge: Measured with total sum score of Knowledge related questions. Where those with the highest score considered as knowledgeable and those with lowest score considered as the reverse.

Perceived threat: Respondents perceived susceptibility to negative RH outcomes plus perceived severity of negative RH outcomes. (Measured on a 5-point scale, ranging from “strongly disagree” to “strongly agree”)

Perceived susceptibility: Individual’s awareness about the risks of negative RH outcomes. (Measured on a 5-point scale, ranging from “strongly disagree” to “strongly agree”)

Perceived severity: Respondents’ awareness about the consequences of negative RH outcomes. (Measured on a 5-point scale, ranging from “strongly disagree” to “strongly agree”)

Net benefits: The net score of respondents’ perceived benefits minus perceived barriers to use MCs. (Measured on a 5-point scale, ranging from “strongly disagree” to “strongly agree”)

Perceived benefits: Beliefs about the positive outcomes associated with using MCs. (measured on a 5-point scale, ranging from “strongly disagree” to “strongly agree”)

Perceived barrier: Respondents' sensitivity to obstacles that let them avoid using MCs. beliefs about the positive outcomes associated with using MCs. (measured on a 5-point scale, ranging from "strongly disagree" to "strongly agree")

Cues to action: Advice from others and having exposure to negative RH outcomes that initiates use of MCs. (measured on a 5-point scale, ranging from "strongly disagree" to "strongly agree")

Self-efficacy: The respondents' perception on their ability to use MCs. beliefs about the positive outcomes associated with using MCs. (measured on a 5-point scale, ranging from "strongly disagree" to "strongly agree")

4.12. Data Analysis

4.12.1. Quantitative data management and analysis

After the questionnaires were checked to ensure completeness and consistency, non-overlapping numerical code were given for each question and the data were entered into Epi data software version 4.2 prepared templates and were exported to SPSS statistical software version 21. Then, Univariate analysis using frequency distribution and measure of central tendency, bivariate analysis to determine the association between factors and the current MC use and multivariable logistic regression to identify the independent predictors of current MC use made. For this, current MCs use used as dependent variable and modifying variables (socio demography, knowledge and RH history), individual perceptions and Cues to action as independent variables and those with the p-value of less than 0.05 and 95% confidence interval (CI) were considered as having significant association with the dependent variable. Finally, results presented by using appropriate table, figures and diagrams.

4.12.2. Qualitative data management and analysis

The in-depth interviews were listened repeatedly and translated to English by principal investigator. Each transcript entered into open code software and then meanings formulated from important statements and phrases. Afterwards, the formulated meanings were stored into categories; sub-themes and themes, characterized based on the fundamental findings and integrated into description of the experiences of the study respondents in this particular study.

4.13. Ethical consideration

Ethical approval obtained from Research Ethical Review Committee School of Public Health Addis Ababa University. Support letters given for each sub cities and permission granted. After getting permission from the sub-cities, the necessary explanation about the purpose, procedures, benefits, risks and their right on decision of participating in the study made with all the respondents. Additionally, privacy and confidentiality of the interviews and information gathered assured, and the names of the respondents have not been included in the questionnaire. Finally, informed written consent obtained from each respondent.

4.14. Dissemination of results

The final report of this study submitted to Addis Ababa University, College of Health Sciences and School of Public Health through soft copy, hard copy and presentation. It will be sent to Addis Ababa City Administration health office. Additionally, efforts will also be made to disseminate the result through publication and presentation in scientific conferences.

CHAPTER FIVE: RESULT

Socio demographic characteristics of respondents

The response rate of this study was 96%. The mean age of respondents was 25 (± 6.293) years that ranged from age of 16 years to 48 years. Regarding educational background of respondents about one-third 52 (30.4%) were illiterates. Among all the respondents 103 (60.2%) of them were born out of Addis Ababa, 95 (55.6%) of them were married, 131(76.6%) were Orthodox Christians, and 66 (38.6) were Amhara Ethnicity. The mean of the respondents' average daily income was 33ETB ($SD\pm 18.67$) with minimum zero and maximum 80ETB (Table 1).

Table 1: Socio-demographic Characteristics of Homeless Women in Addis Ababa April 2018

Variables	Responses	Frequency	Percentage
Age	15-19	37	21.6
	20-24	56	32.7
	25-29	45	26.3
	30-34	19	11.1
	35-39	9	5.3
	40-44	2	1.2
	45-49	3	1.8
Educational background	Illiterate	52	30.4
	Literate	119	69.6
Religion	Orthodox	131	76.6
	Muslim	26	15.2
	Protestant	14	8.2
Ethnicity	Amhara	66	38.6
	Oromo	51	29.8
	SNNP	42	24.6
	Tigre	12	7.0
Birth place	Addis Ababa	68	39.8
	Out of Addis Ababa	103	60.2
Marital status	Single	29	17.0
	Married	95	55.6
	Divorced	47	27.5

Respondents for the qualitative section

In the qualitative section, which involved nine respondents, the minimum age was 20 while the maximum was 40. Majority of them were married. Concerning the educational background, the majority (6 out of 9) have had exposure to formal education. Working a daily works and begging the respondents average daily income was 36ETB though as most of the respondents explain their daily income for religious holidays were about 80- 200ETB for those days particularly (Table 2).

Table 2: Socio demography of homeless women in the qualitative section April 2018

	Age	Marital status	Educational back ground	Average daily income (ETB)
Respondents 1	28	Divorced	Literate	30
Respondents 2	21	Married	Illiterate	50
Respondents 3	25	Divorced	Illiterate	40
Respondents 4	22	Divorced	Literate	10
Respondents 5	20	Married	Literate	30
Respondents 6	21	Married	Literate	40
Respondents 7	25	Married	Illiterate	30
Respondents 8	40	Divorced	Literate	20
Respondents 9	20	Married	Literate	80

Knowledge and source of information about MCs

As it is illustrated in table 3 and figure 3, all 171 (100%) of the respondents in the quantitative section of the study have ever heard about MCs and 151 (88.3%) get the information from health professionals followed by friends 45 (26.3%). Taking the total sum score of individuals from the total of 12 questions prepared to measure knowledge about modern contraceptives, the mean score was 5 ($SD\pm 1.150$) where the minimum and the maximum was 2 and 9. Similarly, all of the respondents in the qualitative section had information about MCs. Where 6 out of 9 respondents get the information from health professionals.

Table 3: Information and knowledge about MCs among homeless women in Addis Ababa April 2018

Variables	Responses	Frequency	Percentage
Ever heard about MCs	Yes	171	100
	No	0	0
Variables***	Mean	Minimum	Maximum
Scores for knowledge questions	5(\pm 1.150)	2	9

***continues variables

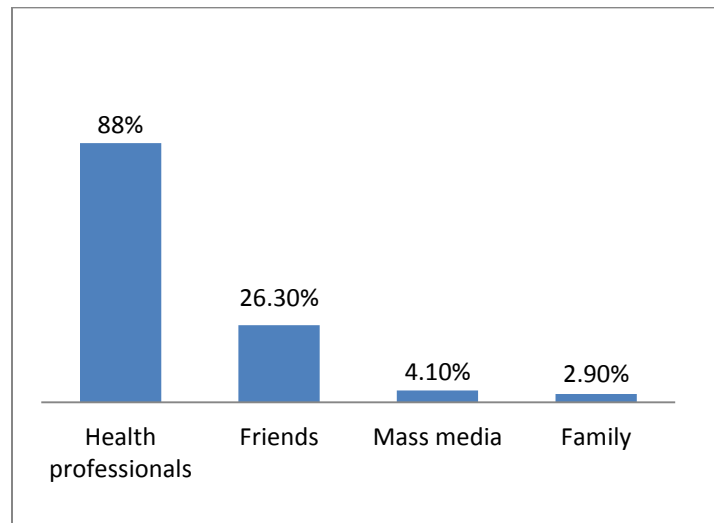


Figure 4: Proportions for source of information about modern contraceptives for homeless women in Addis Ababa, 2018

Reproductive health history of respondents

The majority, 159 (93%) of the respondents ever had history of pregnancy. From those, 67 (39.2%) have experienced pregnancy twice. The mean number of pregnancies was 2 (\pm 1.003) with minimum 1 and maximum 6. Whereas, among the respondents 23 (13.5%) ever had abortion. From those, the mean incidence of abortion was 1 (\pm 0.388). From all abortions, only 2 (8.7%) were in health facility with the help of health professionals. (Figure 4). As well, all of the qualitative section respondents had history of pregnancy.

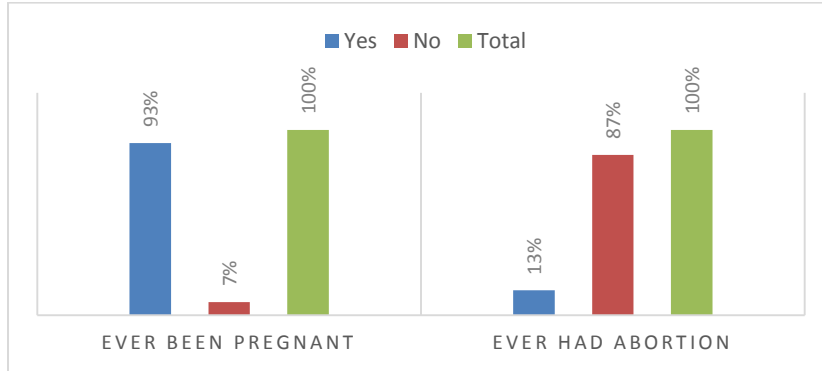


Figure 5: Proportions for respondents profile about ever exposure to pregnancy and abortion April 2018

Near half, 70 (40%) of the respondents have one alive child. The mean number of currently alive children was $2(\pm 1.08)$ and the maximum range was 4 children (Table 4). Majority (6 out of 9) respondents of the qualitative section had two children alive currently.

Table 4: Profile for number of pregnancy, number of abortion and number of currently alive children of homeless women in Addis Ababa April 2018

Variables***	Mean (SD)	Minimum	Maximum
Number of pregnancy	2 (± 1.003)	1	6
Number of abortion	1 (± 0.388)	1	2
Number of currently alive children	2 (± 1.08)	0	4

*** continues variables

Prevalence of MC use

A 140(81.9%) of the respondents, have ever used modern contraceptives. Currently, 122 (71.3%) of the respondents were using modern contraceptives (Figure 5). Similarly, most (7 out of 9) respondents of the qualitative section were using modern contraceptives currently.

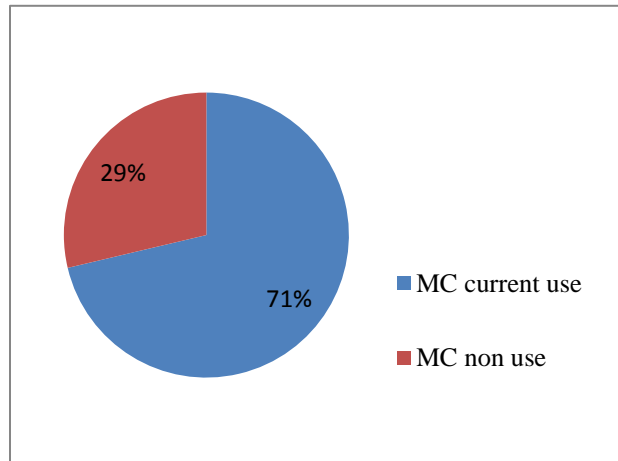


Figure 6: Prevalence of current modern contraceptive use among homeless women in Addis Ababa, April 2018

Among the current modern contraceptive users, more than half, 65 (53.3%) of them were using Norplant followed by 36 (29.5%) injectable, 14 (11.5%) pill, 9 (7%) condom and 5 (4.1%) IUD (Figure 6). In addition, majority (5 out of 7) MC users of the qualitative respondents were using Norplant.

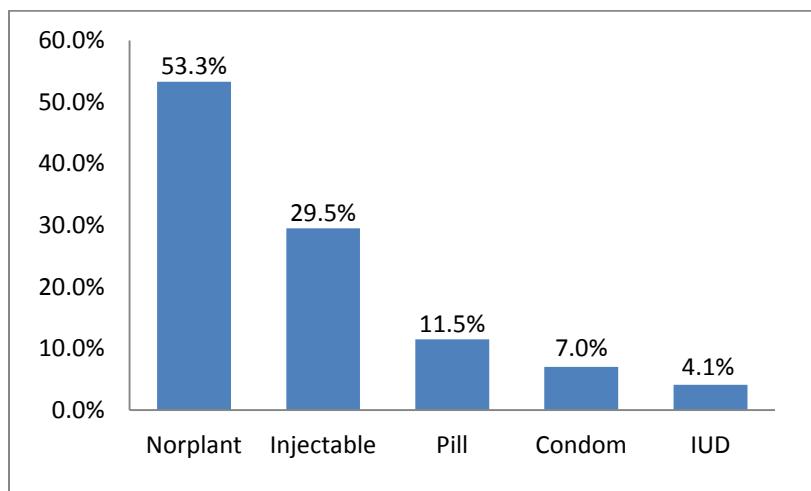


Figure 7: Proportions of currently on use modern contraceptive methods by homeless women in Addis Ababa, April 2018

Reason for use of long acting MC methods by respondents

Additionally, respondents in the qualitative section were asked about the preferable MC method for homeless women in their thoughts and their reasons. Two of the respondents think that it is not any different from the other women. However, the majority (7 out of 9) told me that the preferable MC methods are implant and IUD. As the respondents explained, this is because using the short acting MC their friends, for some themselves usually forget the short appointments, and end up on unintended pregnancy.

” Now, I (paused), wait (paused), let me tell you my experience. I had unintended pregnancy (Paused) now my son was not intended, while I was taking inject able every three month, it is because I missed the day that I get pregnant. Of course that was why I conceived, because I missed the time.... if any other, once in a while they miss. Look if it is the tablet you say I took today, it’ll not happen tomorrow and so, but this, once you get it that is it.”

Respondent 5

“Because it is better, you know how, this is for three years or so, but if it is for three month you will forget and may get pregnant.”

Respondent 9

Perceptions of respondents

Perceived Susceptibility and severity (threat) to negative RH outcomes

For the items set to measure perceived susceptibility to negative reproductive health outcomes, most 100 (58.5%), 87 (50.9%), 89 (52%), 91 (53.2%) and 97 (56.7%) of the respondents strongly agree for the five items accordingly (Table 5).

Women interviewed in qualitative section of this study also did perceive negative RH outcomes as a threat that would cause undesirable consequences to their family life. They believe that they are out front to sexual abuse, unintended pregnancy and STDs. Almost all of the respondents agree on their being exposed to the negative RH outcomes. They reported that it is very common to face sexual abuse and unintended pregnancy as a homeless woman. Some of the respondents said:

“Yes, how could I not, sleeping out here, you have to think about it. Why? (Paused) of course, you say somebody might come and do something to me while I’m sleeping and whatever and get scared.”

Respondent 6

“Sexual abuse, definitely I am. Well, you know, the pregnancy is good, did you get me? The pregnancy is good, it is just a child, of course your life will be really challenging while raising it all by yourself. At rest, the child will stand for you some day in the future. But furthermore, there are various things that will come following sexual abuses like uterine problems, STDs, HIV and more, so this and that things will come to my mind.....Not only for myself, even for my daughters. I am afraid that something might happen to my little girl.”

Respondent 8

Table 5: Profile of perceived susceptibility to negative RH outcomes among homeless women in Addis Ababa April 2018

Items	Responses					Mean (SD)	Total score Mean (SD)
	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)		
In my opinion, as I live on the street, I am prone to sexual abuse (e.g. rape)	100 (58.5)	5 (2.9)	2 (1.2)	0 (0)	64 (37.4)	3.45 (±1.919)	16.53 (±7.619)
In my opinion, my chance of unintended pregnancy is high	87 (39.8)	13 (7.6)	0 (0)	3 (1.8)	68 (39.8)	3.28 (±1.914)	
In my opinion, my chance of having STDs (e.g. Syphilis, Gonorrhea, HIV...) is high	89 (52.0)	5 (2.9)	2 (1.2)	8 (4.7)	67 (39.2)	3.24 (±1.921)	
I worry a lot about having unintended pregnancy	91 (53.3)	4 (2.3)	0 (0)	4 (2.3)	72 (42.1)	3.22 (±1.958)	
I worry a lot about having STDs (e.g. Syphilis, Gonorrhea, HIV,...)	97 (56.7)	2 (1.2)	0 (0)	6 (3.5)	66 (38.6)	3.34 (±.941)	

And for the items set to measure perceived severity to negative reproductive health outcomes again the great numbers 127 (74.3%), 125 (73.1%), 132 (77.2%), 128 (74.9%) and 109 (63.7%) indicated to strongly agree in accordance to the items (Table 6). When I asked about the consequences of negative RH outcomes, most of the respondents explain that even though they know it is possible, it is hard to accept specially the pregnancy. Some of the respondents explained where the sexual abuses usually lead and few of them additionally believe it was a duty to pass through sexual abuses as long as they live on the streets.

28 years old divorced woman who is raising her children by washing clothes, burning *Asharo* and also begging sometimes said that:

“.....so if he comes here (paused) ere ... he could be an HIV carrier there are various things and again he may be holding sharps, now in that moment I will get raped, it is your life ha, okay. He gives you a choice and says “if you do not agree I will stab you, so go on” now what else can you do here in this place! It is very, very bad time now. And me well I will fulfill my duty! That is it. He will do it and go, and then when I go and get tested, I may get HIV and start to live with it. That even happen only if I go get the test early if not, that is it, it will suck and finish me, then after everything is over, even if I want to take the medications, it could be too late.”

Respondent 1

Other respondents also agree with her. In addition, explained what worries them more than the sexual abuse. Some of the respondents said:

“...Specially those who are not using the medicine (MCs), Of course, it also does not have something good for life. If you didn't protect yourself (Paused) Okay, yes you will get raped; this is something common! But, if you are not using that medicine too, lots of suffering will wait for the child you are going to produce. It may be born safe and sound, but here what is waiting for it is not something good. It is very bad.”

Respondent 2

“That is something bad for life. Here if you have unwanted pregnancy while not having anybody to help you, and if you are not going to have proper follow up, that might lead child’s and your life to death.”

Respondent 9

“I can’t accept. Come on (Paused) why? (Paused) Think about it, I suffer, my kid suffer, that means we both are going to live on street. You know? I may accept to live on the street by myself, but I want a better life for my child.....”

Respondent 2

In addition, the other two of the respondents reported that even though they will pass through the assaults without complaining, they believe they even dare to commit suicide if unintended pregnancy occurs to them again.

A 25 years old respondent who started to use MC only recently after two unintended pregnancies and live raising her two children alone, answered me emotionally when I asked her how she would take it if she face unintended pregnancy again as;

“...now (paused) that, if I have unintended pregnancy again, I will either try to abort it or die drinking poisons. That is it.”

Respondent 3

One other respondent also agrees with her about it, but she was confident about the MCs that she starts to use after unintended pregnancy as well.

“.....I am going to commit suicide. To tell the truth it will not happen, coz. I have contraceptives. I know lots of methods now.”

Respondent 9

Table 6: profile of perceived severity to negative RH outcomes among homeless women in Addis Ababa April 2018

Items	Responses					Mean (SD)	Total score Mean (SD)
	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)		
The thought of sexual abuse (e.g. Rape) scares me	127 (74.3)	5 (2.9)	0 (0)	4 (2.3)	35 (20.5)	4.08 (±1.639)	20.06 (±7.043)
The thought of unintended pregnancy scares me	125 (73.1)	6 (3.5)	0 (0)	3 (1.8)	37 (21.6)	4.05 (±1.662)	
The thought of STDs (e.g. Syphilis, Gonorrhea, HIV,...) scares me	132 (77.2)	3 (1.8)	0 (0)	3 (1.8)	33 (19.3)	4.16 (±1.603)	
I am afraid to even think about the consequences of unintended pregnancy	128 (74.9)	4 (2.3)	0 (0)	2 (1.2)	37 (21.6)	4.08 (±1.659)	
In my opinion, to have a child on the street decreases my income	109 (63.7)	8 (4.7)	0 (0)	2 (1.2)	52 (30.4)	3.7 (±1.831)	

The mean for total score of perceived threat to negative RH outcomes was 37 (SD± 13.293) with minimum and maximum score of 10 and 50.

Perceived benefit and perceived barrier (net benefit) to current use MCs

For the items set to measure perceived benefit 139 (81.3%), 137 (80.1%), 109 (63.7%) and 134 (78.4%) of the respondents strongly agree in accordance to each benefit items mentioned (Table 7).

Table 7: Profile of perceived benefits of MCs among homeless women in Addis Ababa April 2018

Items	Responses					Mean (SD)	Total score Mean (SD)
	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)		
In my opinion, if I use MC, I do not need to worry about having unintended pregnancy	139 (81.3)	28 (16.4)	0 (0)	0 (0)	4 (2.3)	5.928 (±0.861)	23.15 (±3.175)
In my opinion, if I use MC, I can space my children	137 (80.1)	31 (18.1)	0 (0)	0 (0)	3 (1.8)	5.936 (±0.792)	
In my opinion, if I use MC, I do not need to worry about having STDs (e.g. Syphilis, Gonorrhea, HIV...)	109 (63.7)	48 (28.1)	0 (0)	1 (0.6)	13 (7.6)	5.497 (±1.366)	
In my opinion, if I use MC, I can Limit the number of my children	134 (78.4)	28 (16.4)	0 (0)	1 (0.6)	8 (4.7)	5.789 (± 1.142)	

For the barriers of using MCs 125 (73.1%), 111 (64.9%), 130 (76%), 127 (74.3%) and 130 (76%) of the respondents strongly disagree for the barriers mentioned consequently as well (Table 8). However, under this second major theme (perceived barriers to MC use) set to the qualitative section, five sub-themes were identified as:

Limited knowledge of MCs and reproduction

Most of the respondents agree on limited knowledge about MCs and reproduction to be the major barrier among homeless women in Addis Ababa to use modern contraceptives. When I asked about the possible reasons they think, why a homeless woman may not be using MC, some of the respondents answered me that:

“Lack of knowledge (paused), Lack of knowledge (paused), it is lack of knowledge. She just doesn’t get it. Or, maybe she has no idea how difficult it is to raise a child on street, coz. If she pass through the problems once, she would definitely use.....”

Respondent 8

“Well (paused) may be she doesn’t know, I think, when we see ere ... but also there are some women that does not accept it when you tell them, they may seem they understand and act as if they will go to health centers, but before they take action they conceive. What else can they do then?”

Respondent 1

Desire to have more children

Some (2 out of 9) of the respondents suppose that every woman knows well about modern contraceptives and believe if she is not using, it is only because she wants to get pregnant to have more children.

“... not using while they can! This is nothing. You can’t say they don’t know ... Come on (Paused) at this time, every health center you go, I mean everywhere you go, unless she wants to have a child, any health center she go she can take the contraceptive. It is a free service. I mean you don’t pay. If you had to pay, there could be a difficulty to pay right? But it is free.”

Respondent 2

“Of course, to have a child ..., that is what I think. If she doesn’t use the injection, it is because she wants to have a child.”

Respondent 6

Thinking to be sexually not active and carelessness

Some respondents reported that being currently not sexually active and carelessness about the upcoming consequences were also the barriers to MC use. They explained it using their own experience as well.

“...ere Some of them may say they are abstained. For example me since I get divorced with my husband, I decided not to have any relationship on the street. Maybe that is why. Again some of them (Paused) ere ... I don’t know, hopelessness. There are these hopeless

women, they just give birth and give it to some organization, or for the riches, that is in the name of adoption. Just like that, some say let it be born, this is just not thinking any further.”

Respondent 4

“.....but some say “who cares, it (the child) will grow by its chance”. Yes if it is born already, it will grow. But there are lots and lots of suffering. You will suffer and the child will suffer.”

Respondent 8

Fear of being infertile

Among the respondents, few mentioned fear and concern about MCs. The main concern that is particularly mentioned was fear of being infertile.

“... sometimes it may be lack of knowledge, sometimes they may need to have a child or maybe they are afraid like me. Me myself, ere... from the beginning I wanted to use the implant you know, it was the father of my first child who told me that this thing (the MC) will lead to infertility, so that I changed my mind. But after that when I get another child without a father, I felt really bad and put it in.”

Respondent 9

“...if I tell them to use they probably say “she has children, she say this because she already has her own children” that is because they think it makes them infertile....”

Respondent 1

No reason

The other point raised during the qualitative survey as a barrier to MC use was no reason for nonuse. As one of the respondents who was very explanatory about the negative RH outcomes, benefits and barriers of MC use reply, when I asked her why she has never used MCs in her life with all her high perceptions about negative RH outcomes and knowledge about MCs, answered me that:

“... I just don't like it ... yes; it is because I don't like it. I don't like it.”

Respondent 8

“Some people don't like it, they don't like it, they don't like to use this staff, and even if you force them they'll never agree they just don't like it. Therefore, they also don't want to use any.”

Respondent 5

Table 8: profiles of perceived barriers to use MCs among homeless women in Addis Ababa April 2018

Items	Responses					Mean (SD)	Total score Mean (SD)
	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)		
In my opinion, using modern contraceptive is difficult for homeless women	32 (18.7)	5 (2.9)	5 (2.9)	4 (2.3)	125 (73.1)	1.92 (±1.603)	9.53 (±6.332)
In my opinion, using modern contraceptives has side effects.	44 (25.7)	8 (4.7)	4 (2.3)	4 (2.3)	111 (64.9)	2.24 (±1.771)	
In my opinion, the process to modern contraceptives is time consuming	25 (14.6)	0 (0)	0 (0)	16 (9.4)	130 (76.0)	1.68 (±1.409)	
In my opinion, using modern contraceptives, interferes with my daily activities	35 (20.5)	2 (1.2)	0 (0)	7 (4.1)	127 (74.3)	1.89 (±1.624)	
In my opinion, to get modern contraceptive, I need to give up some thing	32 (18.7)	0 (0)	0 (0)	9 (5.3)	130 (76.0)	1.8 (±1.555)	

Computing the net benefits of using MCs the total score mean was 14 (SD ± 7.046) with minimum of -10 and maximum of 20.

Perceived self-efficacy and cues to action to current use MCs

Similarly, indicating their degree of agreement 159 (93%) and 161 (94.2%) respondents strongly agree for the first two items while 153 (89.5%) and 158 (92.4%) of respondents strongly disagree to the last two self-efficacy items (Table9).

Table 9: profiles of self-efficacy to use MCs among homeless women in Addis Ababa April 2018

Items	Responses					Mean (SD)	Total score Mean (SD)
	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)		
I know how to use modern contraceptives, if I want to use.	159 (93.0)	7 (4.1)	0 (0)	1 (0.6)	4 (2.3)	4.85 (±0.669)	19.117 (±2.501)
I know how to use modern contraceptives, if I want to use.	161 (94.2)	5 (2.9)	0 (0)	4 (2.3)	1 (0.6)	4.88 (±0.566)	
In my opinion, if I use modern contraceptive, it is because my friends are using it.	12 (7.0)	3 (1.8)	0 (0)	3 (1.8)	153 (89.5)	4.65 (±1.087)	
In my opinion, if I use modern contraceptive, it is because my friends suggested it	9 (5.3)	2 (1.2)	0 (0)	2 (1.2)	158 (92.4)	4.74 (±0.948)	

For cues to action items 157 (91.8%), 161 (94.2%), 136 (79.5%) and 105 (61.4%) of the respondents indicate strongly agree consequently (Table 10). The study respondents in the qualitative section additionally reported different cues to action to use modern contraceptives like:

Situation of homeless life

Majority (6 out of 9) of the respondents reported that the main reason they are using MC is themselves, observing the situation they are living in being horizontal to negative RH

outcomes. A respondent explained it very well when I asked her why she used MC currently and if her friends have role in her use:

“Considering the situation I am in... my friends live for themselves, not for me. At this time, living on the street, you need to be careful. Why? If you are good, I may be bad, if he is good, and his friend may be bad... Look even if someone suggests you to have a child, you need to consider your life and it is a must to. At this time forget my girlfriends, even if my husband wants me to have a child, I will not do it.”

Respondent 2

Exposure to negative RH outcomes (Life experience of self and others)

Almost all (7 out of 9) of the respondents have witnessed exposure to negative RH outcomes on themselves or on others that makes them believe they need MCs. Even among the non-user respondents, one of them reported that these experiences are starting to make her think that she needs to use one.

” ...I even saw women that end up with retracted uterus, when they get raped. Furthermore, they get pregnant and they don't even know who the father is. So yes I have seen that.”

“... When I think about it sometimes, there may be rape, there are lots of problems. Anyways, I am thinking these days about using one. Even though I have never used before, I think I will use.”

Respondent 4

The other respondent explains that her own exposure to unintended pregnancy forced her to use

” As I told you first someone frightened me about modern contraceptives and end up on unwanted pregnancy. That was it! No more listening to what others says. See, now I use.”

Respondent 9

Advice from others

Only one of the Respondent reported that it was the advice she took from others that helped her to use MC. She explained that she had no hint about MCs, while she gives birth for her two children.

“...When they (her friends) say this and that about preventing pregnancy, I told them I don't know such thing. So it was themselves whom took me there and let me have one. But I didn't know. I may not go. When I say I am not going, they push me to go and let me have it.”

Respondent 3

Table 10: Profile of cues to action to use MCs among homeless women in Addis Ababa April 2018

Items	Responses					Mean (SD)	Total score Mean (SD)
	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)		
I have heard good things about modern contraceptives	157 (91.8)	5 (2.9)	0 (0)	0 (0)	9 (5.3)	4.76 (±0.905)	17.32 (±3.911)
I know where to get modern contraceptives, if I want to use.	161 (94.2)	9 (5.3)	0 (0)	0 (0)	1 (0.6)	4.92 (±0.376)	
I have seen women dealing with unintended pregnancy	136 (79.5)	0 (0)	0 (0)	0 (0)	35 (20.5)	4.18 (±1.619)	
I have seen women suffering from STDs (e.g. Syphilis, Gonorrhea, HIV...)	105 (61.4)	0 (0)	0 (0)	0 (0)	66 (38.6)	3.46 (±1.953)	

Association between socio demographic characters with current MC use in bivariate analysis

Among the variables of socio demographic characteristics there was no significantly associated ($p < 0.05$) variable with current modern contraceptive use of homeless women in Addis Ababa (Table 11).

Table 11: Association between socio demographic characteristics with current MC use in bivariate analysis, for homeless women in Addis Ababa April 2018

Variables	Responses	COR (95%CI)	P-value
Age	15-19	1	
	20-24	1.588 (0.629, 4.010)	0.328
	25-29	1.484 (0.564, 3.904)	0.424
	30-34	0.823 (0.258, 2.622)	0.742
	35-39	0.600 (0.136, 2.646)	0.500
	40-44	0.480 (0.018, 8.348)	0.614
	45-49	0.960 (0.079, 11.662)	0.974
Educational Background	Illiterate	1	
	Literate	1.708 (0.848, 3.439)	0.134
Religion	Orthodox	1.141 (0.336, 3.879)	0.832
	Muslim	0.545 (0.135, 2.204)	0.395
	Protestant	1	
Ethnicity	Amhara	1.250 (0.521, 2.998)	0.617
	Oromo	0.733 (0.304, 2.998)	0.491
	Tigre	1.200 (0.276,5.209)	0.808
	SNNP	1	
Birth place	Addis Ababa	1.196 (0.604, 2.370)	0.608
	Out of Addis Ababa	1	
Marital status	Single	1	
	Married	1.056 (0.398, 2.799)	0.913
	Divorced	0.430 (0.154, 1.201)	0.107

Association between information and knowledge about MCs with current MC use in bivariate analysis

Among the variables of information and Knowledge about MCs, there was no significantly associated ($p < 0.05$) variable with current modern contraceptive use of homeless women in Addis Ababa (Table 12).

Table 12: Association between information and knowledge about MCs and current MC use in bivariate analysis for homeless women in Addis Ababa April 2018

Variables	Responses		COR (95%CI)	P-value
Source of information	Health professionals	Yes	1.789 (0.682, 4.689)	0.237
		No	1	
	Friends	Yes	0.643 (0.310, 1.332)	0.235
		No	1	
	Mass media	Yes	2.483 (0.291, 21.177)	0.406
		No	1	
	Family	Yes	0.592 (0.096, 3.659)	0.573
		No	1	
Knowledge score***			1.068 (0.799, 1.427)	0.659

*** Continues variable

Association between RH characters with current MC use in bivariate analysis

Again from the variables of RH characteristics, there was no significantly associated ($p < 0.05$) variable with current modern contraceptive use of homeless women in Addis Ababa (Table 13).

Table 13: Association between RH characteristics and current MC use in bivariate analysis for homeless women in Addis Ababa April 2018

Variables	Responses	COR (95%CI)	P-value
Ever been pregnant	Yes	0.477 (0.101, 2.259)	0.351
	No	1	
No. of pregnancy***		0.781 (0.561, 1.086)	0.142
Ever had abortion	Yes	0.906 (0.348, 2.359)	0.839
	No	1	
No. of abortions***		0.356 (0.039, 3.256)	0.361
No. of currently alive children***		1.027 (0.754, 1.399)	0.867

*** Continues variables

Association between CHBM subscales and current MC use in bivariate analysis

Among the construct of Health Belief Model, perceived threat to negative RH outcomes, perceived net benefits and cues to action to MC use were significantly associated ($p < 0.05$) with current MC use. However, perceived self-efficacy was not (Table 14).

Table 14: Association between CHBM subscales and current MC use in bivariate analysis for homeless women in Addis Ababa April 2018

Variables***	Minimum score	Maximum score	COR(95%CI)	P-value
Perceived threat	10	50	1.031 (1.006, 1.057)	0.015
Net benefit	-10	20	1.077 (1.028, 1.128)	0.002
Cues to action	4	20	1.094 (1.008, 1.187)	0.031
Perceived self-efficacy	4	20	1.103 (0.975, 1.248)	0.119

*** continues variables

Independent predictors of current MC use

Table 15 described about the predictors of MC current use among homeless women. Those with P-values less than 0.25 in bivariate analysis were included in multi variable analysis. Among socio demographic, information and knowledge variables as well as RH variables, none of them was significantly associated with the current use of MCs. According to the HBM, perceived threat and net benefit directly influence the likelihood of committing an action (39). As well, the multivariable logistic regression analysis showed that both were statistically significant predictors of the current modern contraceptive use among homeless women in Addis Ababa.

Perceived threat to negative RH outcomes was significantly associated with current MC use of homeless women in Addis Ababa. This study showed that one-unit increase in total score of perceived threat the odds of using MCs increased by 1.044. AOR 1.044 (95%CI 1.015, 1.074)

Similarly, perceived net benefit of MC use was significantly associated with current MC use of homeless women in Addis Ababa. By controlling the effect of all other variables constant,

the result indicated that one-unit increase in sum score of perceived net benefit the odds of the current use of MCs increased by 1.066. AOR 1.066 (95%CI 1.006, 1.129)

However, perceived self-efficacy and cues to action were not significantly associated with current MCs (Table 15).

Table 15: Multi variable logistic regression model to identify the independent predictors of current MC use of homeless women in Addis Ababa April 2018

Variables	Responses	COR (95%CI)	P-value	AOR (95%CI)	P-value	
Educational back ground	Illiterates	1		1		
	Literates	1.708 (0.848, 3.439)	0.134	1.472 (0.621, 3.492)	0.380	
Marital status	Single	1		1		
	Married	1.056 (0.398, 2.799)	0.913	0.679 (0.193, 2.381)	0.545	
	Divorced	0.430 (1.154, 1.201)	0.107	0.502 (0.129, 1.957)	0.321	
Source of information	Health professionals	Yes	1.789 (0.682, 4.689)	0.237	1.725 (0.461, 6.452)	0.418
		No	1		1	
	Friends	Yes	0.643 (0.310, 1.332)	0.235	0.710 (0.252, 2.004)	0.518
		No	1		1	
No. of pregnancy***		0.781 (0.561, 1.086)	0.142	0.783 (0.517, 1.186)	0.249	
Perceived threat***		1.031 (1.006, 1.057)	0.015	1.044 (1.015, 1.074)	0.002	
Net benefits***		1.077 (1.028, 1.128)	0.002	1.066 (1.006, 1.129)	0.031	
Self-efficacy***		1.103 (0.975, 1.248)	0.119	1.017 (0.870, 1.188)	0.834	
Cues to action***		1.094 (1.008, 1.187)	0.031	1.064 (0.966, 1.172)	0.206	

*** Continues variables

CHAPTER SIX: DISCUSSION

This study intended to produce a better understanding and picture to determining the prevalence and predictors of modern contraception use among homeless women in Addis Ababa in 2018, using health belief model by supplementing the survey with qualitative data.

Access to contraceptive services and supplies are fundamental to the well-being of women during their reproductive years. However, a study showed that homeless population often lack access to the health care (11). In this study, all of the respondents had information about MC which is concurrent (about 93%) with a study done in Ethiopia, 2010. Nevertheless, this study finding was higher than with another study (75%) conducted in Ethiopia at 2014 (4, 35). The variation may be due to the different time and place among studies.

Unlike these other studies in Ethiopia, which underline that the source of information being peers(4, 11, 35) and mass media (36), majority 151 (88%) of the respondents in this study get the information from health professionals which shows a better performance of health sectors in giving an enhanced attention to these neglected population. Moreover, this may be because of the pregnancy these women had which lead them to the health facilities due to delivery that can possibly gave them the chance to communicate with the health professionals.

The great number 159 (93%) of the homeless women in Addis Ababa have the chance to be pregnant with frequency median of 2 time and the mean no of children in this study was 2. This is in line with studies done in Ethiopia that was two (4, 12). This may be due to the increased access and utilization of MCs in Ethiopia in general according to EDHS 2016(10).

In this study, the ever use of MCs and the prevalence of MC use among homeless women was 104 (81%) and 122 (71.3%) accordingly. This result was higher than studies under taken in Ethiopia previously where ever use of MCs was 21.4% and 47.1% (4, 35) and the prevalence of MC use was 34.3% (4). The difference may be due to the high level of literacy in addition to the reasons already mentioned.

The preferable MC method used to be pills followed by condoms(35) and inject able followed by pills (4, 33) as found by other studies. However, to the current study the preferable MC method by the majority 65 (53.3%) was Norplant followed by 36 (29.5%) inject able. This can be explained by the high emphasis given to the long acting MC methods

by the health sectors in Ethiopia in the past five years(44). Additionally, as mentioned by respondents in the qualitative section of this study through in-depth interviews, the reason for the current preference of the long acting MCs among homeless women in Addis Ababa was mainly their long-term appointment.

The use of condom as a MC method in this group of homeless women 9 (7%) women were using condom plus another MC method which is higher than homeless women in northwest Ethiopia (3%)(4). This difference may be due to the difference between the study populations and the high awareness about the threat existence in addition to the reasons already mentioned.

Unlike other studies that highlight MC use increase with women's age, educational background, birthplace, marital status and income (4, 10, 35), the current MC use of homeless women in Addis Ababa was not significantly associated. This may be due to their improved awareness of their exposure with their high perception of susceptibility to negative RH outcomes and their high perceptions of net benefits to use MCs according to the current study.

In our study, perceived threat to negative RH outcomes and perceived net benefit of MCs were significant predictors of current MC use of homeless women in Addis Ababa. This is in line with health belief model and other studies (39, 45, 46) and can be the result of respondents' awareness about the threat existence, focusing on severity and susceptibility along with communicating the benefits being high.

In other way according to the current study perceived self-efficacy and cues to action were not significant predictors of homeless women MC use which is similar to other study findings done among female sex workers and among junior high school students (46, 47).

Similar to the other studies done in Ethiopia (4, 33, 36) limited knowledge of MCs and reproduction, desire to have more children, thinking to be sexually not active and fear of being infertile were among the reasons mentioned for no use of MCs among homeless women in this study too. Additionally blind hate or no reason established from the qualitative part of this study.

STRENGTH AND LIMITATION OF THE STUDY

Strength

This study deliberated on neglected and disregarded part of the population about whom the information was scarce.

Using a mixed method approach, this study shares the strengths that offset the weakness of both quantitative and qualitative researches

Limitations

Although the research has, reaches its aim, there were some unavoidable limitations:

The study was conducted on a unique population, which makes generalization to the whole population difficult.

The sample size calculated with the base of a survey done by Addis Ababa labor and social affairs office in 2014/15 for the total population of homeless women in Addis Ababa. However, due to the unstable nature of homelessness this number might increase or decrease.

Due to the sensitive nature of this topic, participant honesty and disclosure may be limiting factors in the information obtained.

Selection bias was the other limitation of this study.

This study additionally shares limitations of cross-sectional study designs.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

7.1. CONCLUSION

This study concluded that, all of the study respondents have information about MCs and most of them agree on the benefits of MCs. The prevalence of MC use among homeless women in Addis Ababa is good. The high threat perception about negative RH outcomes and high net benefit perception of MCs are the major contributing factors for the MC use improvement. Thus, these constructs of the HBM would help to accelerate the use of MC practice among these segments of population.

Limited knowledge of MCs and reproduction, desire to have more children, fear of infertility, thinking to be sexually inactive and no reasons are the barriers to MC use among homeless women in Addis Ababa.

7.2. RECOMMENDATIONS

MOH and health sectors at different level should develop different strategies that can approach and increase the awareness and knowledge about MCs different methods, use and service availability and accessibility among homeless women.

Health professionals and health extension workers should keep on improving their approach to homeless women and promoting long acting MCs.

Health education that integrates well-organized homeless women's groups and community health workers may be helpful in reducing women's fear of potential side effects. Additionally to correct the misinformation too.

Finally, further research recommended to be conducted on homeless women including rural and urban areas of the country to potentiate previous findings and come up with new findings that is capable to fill the remaining gaps.

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ANNEXES

ANNEX ONE: English permission asking form

Hello, my name is Beza Alemayehu. I am a student in School of public health at Addis Ababa University attending masters program in general public health. I come to conduct in-depth information on modern contraceptive use of homeless women in Addis Ababa. The aim of this study is to determine the prevalence and predictors of modern contraception use of homeless women in Addis Ababa in Health Belief Model perspective. Your response will provide valuable information about the issue under this study. And I believe that it will help to improve family planning service in the future to meet your need. The study will not cause any harm to you except giving information. These interviews only involve those women fulfilling the inclusion criteria. The information will be collected using in-depth interview guide on issues affecting use of modern contraceptive methods among homeless women in Addis Ababa. Participating in this interview is entirely voluntary which means you have the right to participate or not to participate and you can end the interview whenever you like too. Your basic identity will be left anonymous when confidentiality becomes a concern. Also your name will not be printed. This process will take an approximate of one hour of your time. Your time in participating is greatly appreciated. If you have any question depending on the research you are welcome. Now are you willing to participate?

YES

NO

If yes, say thank you and let us proceed to the consent form

If No, say thank you and do not reinforce to respond

ANNEX TWO: English consent form

I have read the agreement form or the agreement form has been read to me in my own language and I understand about the circumstances.

Date of the interview _____

Signature of the participant _____

The Result of Interview

Complete

Partially Complete

Refuse

Name of interviewer _____ signature _____

Questionnaire number _____

Started hour _____ minute _____ interview ended hour _____ minute _____

Name of supervisor _____ signature _____

Date checked _____

ANNEX THREE: In-depth interview guide

First of all, I would like to thank you for agreeing to take part in this study, now:

1. Background history?

Probe about:

- ✓ Age
- ✓ Educational background
- ✓ Religion
- ✓ Marital status
- ✓ What you do for living
- ✓ Average daily income in ETB

2. With whom do you live now?

3. Reproductive health history

Probe about:

- ✓ Have ever been pregnant
- ✓ Number of currently alive children

4. Please tell me all you know about modern contraceptives?

Probe about:

- ✓ Source of information
- ✓ Types of MC methods
- ✓ Source of MC methods
- ✓ Her choice, and why?

5. In your opinion how do you explain your extent of exposure to

- ✓ Sexual abuse,
- ✓ unintended pregnancy, and
- ✓ STDs

6. Please explain to me about the sexual abuse events you know that are faced by homeless women?

7. Please explain to me about the unintended pregnancy events you know that is faced by homeless women?

8. Please explain to me about the STDs you know that are faced by homeless women?

9. What comes to your mind when you hear the word

- ✓ Sexual abuse
- ✓ Unintended pregnancy
- ✓ STDs

10. How do you take it if you:

- ✓ Are sexually abused in your current situation while you are homeless?
- ✓ Get pregnant in your current situation while you are homeless?
- ✓ Get STDs in your current situation while you are homeless?

11. In your opinion, what could be the benefits of MCs?

12. In your opinion, which type of modern contraceptive do you think is more preferable for homeless women? Why?

13. Do you currently use any modern contraceptives?

14. Which type of modern contraceptive are you using?

15. When do you start using MCs first?

16. In your opinion, what could be the reason for you to use or not to use MC? Why?

- ✓ Friends' suggestion
- ✓ Friends' influence

17. In your opinion, what could be the possible reason of a homeless woman for not using modern contraceptives?

18. Did you experience any life events during the past 1 year that has affected your modern contraceptive use behavior? E.g. death of family member/intimate friend/ anyone you think is important to you, unemployment, severe disease, divorce, marriage, child bearing, abortion

THANK YOU FOR YOUR PARTICIPATION

ANNEX FOUR: Questionnaire

Code: -----

Addis Ababa University Graduate School of public health

The objective of the questionnaire is in partial fulfillment of the requirement for degree of Masters of general public health. It is designed to collect data about contraceptive use among homeless women. The data collected from this questionnaire will all be used for the purpose of the research and believe that it will help to improve family planning service in the future to meet your need. You do not need to write your name on the questionnaire. I hereby request you to be open and honest while responding so that the research could succeed and achieve the intended goal.

Please fill your answers in the proper place or mark X in the box of your choice for questions with choices.

Finally, dear respondents I appreciate your cooperation and willingness in the name of Addis Ababa University Graduate School of public health, thank you.

PART ONE: Background Information

1.01. Age _____

1.02. Educational background

Illiterate

Literate

1.03. Religion

Orthodox

Protestant

Muslim

Others specify-----

1.04. Ethnicity?

Oromo

Tigre

Amhara

SNN

Other specify _____

1.05. Place of origin

Addis Ababa Outside of Addis Ababa

1.06. Marital status

Single Married
 Divorced Other specify _____

1.07. Have you ever been pregnant?

Yes No

1.08. If yes, how many times? _____

1.09. Have you ever had abortion?

Yes No

1.10. If yes, how many times? _____

1.11. Where do you usually go for abortion service? _____

1.12. Number of children _____

1.13. Average daily income enter the number in Birr _____

PART TWO: Information and knowledge about modern contraceptive methods

No.	Questions		
2.01	Have you ever heard about modern contraceptives?	Yes <input type="checkbox"/>	
		No <input type="checkbox"/>	

2.02	<p>What modern contraceptive method do you know?</p> <p>More than one answer is allowed.</p>	<p>Pill <input type="checkbox"/></p> <p>Inject able <input type="checkbox"/></p> <p>Condom <input type="checkbox"/></p> <p>Norplant <input type="checkbox"/></p> <p>IUD <input type="checkbox"/></p> <p>Female sterilization <input type="checkbox"/></p> <p>Male sterilization <input type="checkbox"/></p> <p>None <input type="checkbox"/></p> <p>Other specify -----</p>	
2.03	<p>From whom/ where do you get the information about modern contraceptives?</p> <p>More than one answer is allowed.</p>	<p>Family <input type="checkbox"/></p> <p>Friends <input type="checkbox"/></p> <p>Health professionals <input type="checkbox"/></p> <p>Mass media <input type="checkbox"/></p> <p>Others specify -----</p>	
2.04	<p>If you want to use modern contraceptive, do you know where to get it?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	
2.05	<p>Which of these are sources of contraceptives?</p> <p>More than one answer is allowed.</p>	<p>pharmacy <input type="checkbox"/></p> <p>health centers <input type="checkbox"/></p> <p>health posts <input type="checkbox"/></p> <p>hospitals <input type="checkbox"/></p> <p>Others specify</p> <p>_____</p>	

PART TWO: Modern contraceptive use

No.	Questions	
2.01	Have you ever used modern contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.02	Do you currently use any type of modern contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.03	If yes for question number 2.02, Which method?	Pill <input type="checkbox"/> Inject able <input type="checkbox"/> Condom <input type="checkbox"/> Norplant <input type="checkbox"/> IUD <input type="checkbox"/> I do not know <input type="checkbox"/> Other specify -----

PART FOUR: The Health Belief Model constructs

Section A: Questions on perceived susceptibility		Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)	Strongly disagree (1)
A-4.01	In my opinion, as I live on the street, I am prone to sexual abuse (e.g. rape)					
A-4.02	In my opinion, my chance of unintended pregnancy is high					
A-4.03	In my opinion, my chance of having STDs (e.g. Syphilis, Gonorrhoea, HIV,...) is high					
A-4.04	I worry a lot about having unintended pregnancy					
A-4.05	I worry a lot about having STDs (e.g. Syphilis, Gonorrhoea, HIV,...)					

Section B: Questions on Perceived seriousness/ severity		Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)	Strongly disagree (1)
B-4.0 1	The thought of sexual abuse (e.g. Rape) scares me					
B-4.0 2	The thought of unintended pregnancy scares me					
B-4.0 3	The thought of STDs (e.g. Syphilis, Gonorrhea, HIV,...) scares me					
B-4.0 4	I am afraid to even think about the consequences of unintended pregnancy					
B-4.0 5	In my opinion, to have a child on the street decreases my income					
Section C: Questions on Perceived benefit		Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)	Strongly disagree (1)
C-4.0 1	In my opinion, if I use MC, I do not need to worry about having unintended pregnancy					
C-4.0 2	In my opinion, if I use MC, I can space my children					
C-4.0 3	In my opinion, if I use MC, I do not need to worry about having STDs (e.g. Syphilis, Gonorrhea, HIV...)					
C-4.0 4	In my opinion, if I use MC, I can Limit the number of my children					
Section D: Questions on Perceived barriers		Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)	Strongly disagree (1)
D-4.0 1	In my opinion, using modern contraceptive is difficult for homeless women					
D-4.0 2	In my opinion, using modern contraceptives has side effects.					

D-4.0 3	In my opinion, the process to modern contraceptives is time consuming					
D-4.0 4	In my opinion, using modern contraceptives, interferes with my daily activities					
D-4.0 5	In my opinion, to get modern contraceptive, I need to give up some thing					
Section E: Questions on Cues to action/motivation		Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)	Strongly disagree (1)
E-4.0 1	I have heard good things about modern contraceptives					
E-4.0 2	I know where to get modern contraceptives, if I want to use.					
E-4.0 3	I have seen women dealing with unintended pregnancy					
E-4.0 4	I have seen women suffering from STDs (e.g. Syphilis, Gonorrhea, HIV...)					
Section F: Questions on Self-efficacy		Strongly agree (5)	Agree (4)	Uncertain (3)	Disagree (2)	Strongly disagree (1)
F-4.0 1	I know how to use modern contraceptives, if I want to use.					
F-4.0 2	I know how to use modern contraceptives, if I want to use.					
F-4.0 3	In my opinion, if I use modern contraceptive, it is because my friends are using it.					
F-4.0 4	In my opinion, if I use modern contraceptive, it is because my friends suggested it?					

ANNEX FIVE: Amharic version of permission asking form

ቅጥያ አምስት፡ የአማርኛ ትርጉም የጥናት ፈቃደኝነት መጠየቂያ ቅጽ

እንደምን አደሩ?/ ዋሉ?

ስሜ ቤዛ አለማየሁ ይባላል። በአዲስ አበባ ዩኒቨርሲቲ የህብረተሰብ ጤና ሳይንስ ትምህርት ቤት የሁለተኛ ዲግሪ ተማሪ ነኝ። የመጣሁት በአዲስ አበባ የሚኖሩ ቤት የሌላቸው (የጎዳና ተዳዳሪ) ሴቶች የእርግዝና መከላከያ አጠቃቀምን በተመለከተ ጥልቅ መረጃ ለመስብሰብ ነው። የዚህ ጥናት ዋነኛ አላማ በአዲስ አበባ የሚኖሩ የጎዳና ተዳዳሪ ሴቶች ለእርግዝና መከላከያዎች ያላቸውን አመለካከት እና እንዳይጠቀሙ የሚከለክሏቸውን ወይም የሚያግዷቸውን ጉዳዮች በተመለከተ ነው። እርስዎ የሚሰጡት መረጃ በጣም ጠቃሚ እና ወደፊት የእናንተን የቤተሰብ እቅድ አገልግሎት ፍላጎት ለማሳደግ የሚረዳ ይሆናል ብዬ አምናለሁ። መረጃ ከመስጠትዎ ውጭ በመሳተፍዎ የሚያጡት ነገር አይኖርም። ቃለመጠይቁ የሚያካትተው የጥናቱን መስፈርት የሚያሟሉትን ሴቶች ብቻ ይሆናል። መጠይቁ የሚደረገው የቃለ መጠይቅ መመሪያ በመጠቀም ነው። ይህ ቃለ መጠይቅ በፈቃደኝነት ላይ የተመሰረተ ነው። ማለትም መሳተፍዎ ሆነ አለመሳተፍ እንዲሁም በመሃል ማቋረጥም ሆነ የማይፈልጉትን ጥያቄ አለመመለስ ይችላሉ።

ሌላው ላረጋግጥልዎ የምወደው ነገር ማንኛውም መረጃ በሚስጥር የሚያዝ መሆኑን ይሆናል። ስምዎም አይጻፍም። ይህ ቃለመጠይቅ የቀንዎን አንድ ሰአት ያክል ይወስዳል። ከጥናቱ ጋር የተያያዘ ማንኛውንም ጥያቄ መጠየቅ ይቻላል። ጥያቄዎን ከጨረሱ አልያም ከሌለዎት እንቀጥል።

አሁን በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ነዎት?

1. አዎ ፈቃደኛ ነኝ

2. አይ ፈቃደኛ አይደለሁም

- ፈቃደኛ ከሆኑ፤ አመሰግናለሁ በማለት የስምምነት ቅጹን እንዲፈረሙ ይደረግ
- ፈቃደኛ ካልሆኑ፤ አመሰግናለሁ መሄድ ይችላሉ።

ANNEX SIX: Amharic version of informed consent

ቅጥያ ስድስት: የስምምነት ማረጋገጫ ቅጽ

ከላይ ያለውን የስምምነት መረጃ በሚገባኝ ቋንቋ አንብቤ ወይም ተነባኝ ተረድቼዋለሁ እናም በጥናቱ ለመሳተፍ ፈቃደኝነቴን በፊርማዬ አረጋግጣለሁ።

የመጠይቁ ቀን -----

የተሳታፊ ፊርማ -----

የቃለ-መጠይቁ ውጤት

1. አጠናቀዋል

2. በከፊል አጠናቀዋል

3. አላጠናቀቁም

የጠያቂው ስም ----- ፊርማ -----

የጥያቄ ወረቀቱ ቁጥር -----

መጠይቁ የተጀመረበት ሰአት ----- መጠይቁ ያለቀበት ሰአት -----

የተቆጣጣሪ ስም ----- ፊርማ -----

የተረጋገጠበት ቀን -----

ANNEX SEVEN: Amharic version interview guide

ቅጥያ ሰባት፡ የቃለመጥይቅ መወያያ ነጥቦች የአማርኛ ትርጉም

በመጀመሪያ በጥናቱ ለመሳተፍ ፈቃረኛ በመሆንዎ በድጋሚ አመሰግናለሁ

1. አጠቃላይ ታሪክ

የትኩረት ነጥቦች፡-

- ✓ እድሜ፤
- ✓ የትምህርት ሁኔታ፤
- ✓ ሃይማኖት፤
- ✓ የትዳር ሁኔታ፤
- ✓ ለመታዳደሪያ የሚሰሩት ስራ፤
- ✓ የቀን ገቢ በአማካኝ በብር፤

2. ከማን ጋር ነው የሚኖሩት?

3. የስነ ተዋልዶ ጤናን በተመለከተ

የትኩረት ነጥቦች፡-

- ✓ እርግዝና አጋጥሞዎት ያውቃል?
- ✓ አሁን ስንት ልጆች አለዎት?

4. እባክዎ ስለ እርግዝና መከላከያ መንገዶች የሚያውቁትን ሁሉ ይንገሩኝ?

የትኩረት ነጥቦች፡-

- ✓ መረጃውን ከየት ሰሙ
 - ✓ ስንት አይነት የእርግዝና መከላከያዎችን ያውቃሉ
 - ✓ ከየት እንደሚገኝ
 - ✓ የእርስዎ ምርጫ የትኛው አይነት ዘመናዊ እርግዝና መከላከያ ነው? ለምን?
5. በእርስዎ አመለካከት ለጾታ ጥቃትምን ያህል ተጋላጭ ነኝ ይላሉ?

- ✓ ላልተፈለገ እርግዝናስ፤
- ✓ ለተለያዩ የአባላዘር በሽታዎችስ?

6. እባክዎ በጎዳና ህይወት ሴቶች ለጾታ ጥቃት የተጋለጡባቸውን እርስዎ የሚያውቁትን አጋጣሚ ያስረዱኝ?

7. እባክዎ በጎዳና ህይወት ሴቶች ላልተፈለገ እርግዝና የተጋለጡባቸውን እርስዎ የሚያውቁትን አጋጣሚ ያስረዱኝ?

8. እባክዎ በጎዳና ህይወት ሴቶች በአባላዘር በሽታዎች የተያዙበትን እርስዎ የሚያውቁትን አጋጣሚ ያስረዱኝ?

9. ስለ ጾታ ጥቃት ሲሰሙ በመጀመሪያ በሃሳብዎ የሚመጣው ምንድን ነው?

- ✓ ስለያልተፈለገ እርግዝናስ ሲሰሙ?
- ✓ ስለአባላዘር በሽታዎችስ ሲሰሙ?

10. አይበለውና በጎዳና እያሉ የጾታ ጥቃትቢያጋጥም እንዴት ይቀበሉታል?
 - ✓ ያልተፈለገ እርግዝናስ?
 - ✓ የአባላዘር በሽታዎቻችንስ?
11. በእርስዎ አመለካከት የእርግዝና መከላከያ ጥቅሞች ምን ምን ናቸው?
12. በእርስዎ አመለካከት የትኛው አይነት የእርግዝና መከላከያ ነው በጎዳና ለምትኖር ሴት ተመራጭ የሚሆነው? ለምን?
13. በአሁኑ ሰዓት እርስዎ ዘመናዊ የእርግዝና መከላከያ ይጠቀማሉ?
14. ምን አይነት ዘመናዊ የእርግዝና መከላከያ ነው የሚጠቀሙት?
15. መቼ ነበር መጀመሪያ መጠቀም የጀመሩት?
16. በእርስዎ አመለካከት የእርግዝና መከላከያ ለመጠቀምም ሆነ ላለመጠቀምም ዋነኛ ምክንያት ምንድን ነው?
 - ✓ የጓደኛ ምክር፣
 - ✓ የጓደኛ ማስገደድ፣
17. በእርስዎ አመለካከት በጎዳና የሚኖሩ ሴቶች ዘመናዊ የእርግዝና መከላከያ ሳይጠቀሙ ቢቀሩ በምን ምክንያት ሊሆን ይችላል?
18. ባለፈው አንድ አመት ውስጥ ለእርግዝና መከላከያዎች ያለዎትን አመለካከት የቀየረ አጋጥሚ ተፈጥሮ ነበር? ለምሳሌ የጓደኛ መሞት፣ ስራ ማጣት፣ ልጅ ማሳደግ፣ ውርጃ...

ANNEX EIGHT: Amharic version questionnaire

ቅጥያ ስምንት: አማርኛ መጠይቅ

መለያ ቁጥር: _____

አዲስ አበባ ዩኒቨርሲቲ ህብረተሰብ ጤና ሳይንስ ትምህርት ቤት

ይህ ጥናት በአዲስ አበባ የህብረተሰብ ጤና ሳይንስ ትምህርት ቤት ለሁለተኛ ዲግሪ ትምህርት ማሟያ የሚደረግ ነው። የተቀረጸውም በአዲስ አበባ ውስጥ በሚኖሩ ቤት የሌላቸው ሴቶች የእርግዝና መከላከያ አጠቃቀምን በተመለከተ ነው። ከዚህ ጥናት የሚሰበሰበው መረጃ የሚውለው ለዚህ ጥናት ብቻ ሲሆን ወደፊት ቤት ለሌላቸው ሴቶች የሚሰጠውን የቤተሰብ እቅድ አገልግሎት ያሳድጋል /ያሻሽላል/ ብዬ አምናለሁ። የመረጃው ሚስጥራዊነት የተጠበቀ ነው። በመጠይቁ ላይ ስም አይጻፍም። ጥናቱ የታሰበለትን ግብ ይመታ ዘንድ ትክክለኛ ምላሽዎን በተገቢው ቦታ በመሙላት እንዲሁም ምርጫ ላላቸው ጥያቄዎች ደግሞ የ “X” ምልክት በሰጥኑ ውስጥ በማስቀመጥ ይተባበሩን። በመጨረሻም ውድ ተሳታፊዎችን ፈቃደኛ ሆነው በጥናቱ ስለተሳተፉ ከልብ እናመሰግናለን።

ምእራፍ አንድ: የኋላ ታሪክ

1.01. እድሜ _____

1.02. የትምህርት ሁኔታ

ምንም አይነት መደበኛ ትምህርት ያልተማረ መደበኛ ትምህርት የተማረ

1.03. ሃይማኖት

ኦርቶዶክስ ፕሮቴስታንት
 ሙስሊም ሌላ ይግለጽ-----

1.04. ብሄር

ኦሮሞ ትግሬ
 አማራ ደቡብ ሌላ ይግለጽ-----

1.05. የተወለዱበት ቦታ

አዲስ አበባ ከአዲስ አበባ ውጭ

1.06. የጋብቻ ሁኔታ

ያላገባ ያገባ
 የተፋታ ሌላ ይገለጽ _____

1.07. እርግዝና አጋጥሞዎት ያውቃል?

አዎ በፍጹም

1.08. መልስዎ አዎ ከሆነ፣ ስንት ጊዜ? _____

1.09. ውርጃ አጋጥሞዎት ያውቃል?

አዎ በፍጹም

1.10. መልስዎ አዎ ከሆነ፣ ስንት ጊዜ? _____

1.11. የመጨረሻውን ውርጃ ያደረጉት የት ነበር? በማን እርዳታ? _____

1.12. አሁን በህይወት ያሉ ልጆች ቁጥር _____

1.13. የቀን ገቢ በአማካኝ ብር _____

ምእራፍ ሁለት: ስለ እርግዝና መከላከያ መንገዶች ያለ መረጃ እና እውቀትን በሚመለከት

ቁጥር	ጥያቄዎች		
3.01	ስለ ዘመናዊ እርግዝና መከላከያ መንገዶች ስምተው ያውቃሉ?	አዎ <input type="checkbox"/>	
		አላውቅም <input type="checkbox"/>	
3.03	ከሚከተሉት ውስጥ የትኞቹን ዘመናዊ የእርግዝና መከላከያ መንገዶች ያውቃሉ? ከአንድ በላይ መምረጥ ይቻላል።	የሚዋጥ <input type="checkbox"/>	
		በመርፌ የሚሰጥ <input type="checkbox"/>	
		ኮንዶም <input type="checkbox"/>	
		ክንድ ላይ የሚቀበር <input type="checkbox"/>	
		ማህጸን ውስጥ የሚቀበር <input type="checkbox"/>	
		የሴቷን ማህጸን ማስቋጠር <input type="checkbox"/>	
		የወንዱን የዘር ቱቦ ማስቋጠር <input type="checkbox"/>	
		የትኛውንም አላውቀውም <input type="checkbox"/>	
		ሌላ ይገለጽ -----	

3.04	ከየት ነው ስለ ዘመናዊ የእርግዝና መከላከያ መንገዶች መረጃዎን ያገኙት? ከአንድ በላይ መምረጥ ይቻላል።	ከቤተሰብ <input type="text"/> ከጓደኞች <input type="text"/> ከጤና ባለሙያዎች <input type="text"/> ከመገናኛ ብዙሃን <input type="text"/> ሌላ ይገለጽ -----	
3.05	ዘመናዊ የእርግዝና መከላከያ መጠቀም ቢያስፈልግዎ ከየት ማግኘት እንደሚችሉ ያውቃሉ?	አዎን <input type="text"/> አላውቅም <input type="text"/>	
3.06	እባክዎ የእርግዝና መከላከያዎችን ማግኘት የሚቻልበትን ቦታ የቱ ነው? ከአንድ በላይ መምረጥ ይቻላል።	መድሐኒት መደብር <input type="text"/> ጤና ጣቢያ <input type="text"/> ጤና ኬላ <input type="text"/> ሆስፒታል <input type="text"/> ሌላ ይገለጹ _____	

ክፍል ሶስት: ዘመናዊ የእርግዝና መከላከያ አጠቃቀም

ቁጥር.	ጥያቄዎች	
2.01	ዘመናዊ የእርግዝና መከላከያ ተጠቅመው ያውቃሉ?	አዎ <input type="text"/> አላውቅም <input type="text"/>
2.02	በአሁን ሰዓት ዘመናዊ የእርግዝና መከላከያ እየተጠቀሙ ነው?	አዎ <input type="text"/> አይደለም <input type="text"/>
2.03	መልስዎ አዎ ከሆነ፣ ምንድን ነው የሚጠቀሙት?	የሚዋጥ <input type="text"/> በመርፌ የሚሰጥ <input type="text"/> ኮንዶም <input type="text"/> ክንድ ላይ የሚቀበር <input type="text"/> ማህጸን ውስጥ የሚቀበር <input type="text"/> አላውቀውም <input type="text"/> ሌላ ይገለጽ -----

ምእራፍ አራት፡ አመለካከትን የሚመለከቱ ጥያቄዎች

ክፍል ሀ፡ ተጋላጭነትን የሚመለከቱ ጥያቄዎች		ሙሉ በሙሉ እስማማለ ሁ (5)	በከፊል እስማማ ለሁ(4)	እርግጠኛ አይደለሁ ም(3)	አልስማማ ም(2)	በጭራሽ አልስማማ ም(1)
ሀ- 4.01	በእኔ አመለካከት እኔ ጎዳና ላይ በመኖሪ ለጾታ ጥቃት (ለምሳሌ፡- መደፈር) የተጋለጥኩ ነኝ።					
ሀ- 4.02	በእኔ አመለካከት ላልተፈለገ እርግዝና ያለኝ እድል ሰፊ ነው					
ሀ- 4.03	በእኔ አመለካከት በአባላዘር በሽታ (ለምሳሌ፡- ቁጥኝ፣ ጨብጥ፣ ኤች አይ ቪ...) የመያዝ እድሌ ሰፊ ነው					
ሀ- 4.04	ያልተፈለገ እርግዝና ይገጥመኛል ብዬ በጣም እጨነቃለሁ።					
ሀ- 4.05	የአባላዘር በሽታ(ለምሳሌ፡- ቁጥኝ፣ ጨብጥ፣ ኤች አይ ቪ...) ይይዘኛል ብዬ በጣም እጨነቃለሁ					
ክፍል ለ፡ የችግሩን አሳሳቢነት የሚመለከቱ ጥያቄዎች		ሙሉ በሙሉ እስማማለ ሁ (5)	በከፊል እስማማ ለሁ(4)	እርግጠኛ አይደለሁ ም(3)	አልስማማ ም(2)	በጭራሽ አልስማማ ም(1)
ለ- 4.01	ስለ ጾታ ጥቃት (ለምሳሌ፡- መደፈር) ሲነሳ ያስፈራኛል					
ለ- 4.02	ያልተፈለገ እርግዝና ሲነሳ ያስፈራኛል					
ለ- 4.03	የአባላዘር በሽታ (ለምሳሌ፡- ቁጥኝ፣ ጨብጥ፣ ኤች አይ ቪ...) ሲነሳ ያስፈራኛል					
ለ- 4.04	ባልተፈለገ እርግዝና ምክንያት የሚያጋጥሙኝን ችግሮች ማሰብ እንኳን ያስፈራኛል					
ለ- 4.05	በእኔ አመለካከት በጎዳና ተዳዳሪነት ላይ ልጅ መውለድ የአለት ገቢዬን ይበልጡን ይቀንሱብኛል					
ክፍል መ፡ ስለ ዘመናዊ የእርግዝና መከላከያ ጥቅሞች አመለካከት ላይ ጥያቄዎች		ሙሉ በሙሉ እስማማለ ሁ (5)	በከፊል እስማማ ለሁ(4)	እርግጠኛ አይደለሁ ም(3)	አልስማማ ም(2)	በጭራሽ አልስማማ ም(1)
መ- 4.01	በእኔ አመለካከት ዘመናዊ የእርግዝና መከላከያ ከተጠቀምኩ ስላልተፈለገ እርግዝና አልጨነቅም።					
መ- 4.02	በእኔ አመለካከት ዘመናዊ የእርግዝና መከላከያ ከተጠቀምኩ አራርቄ መውለድ እችላለሁ።					
መ- 4.03	በእኔ አመለካከት ዘመናዊ የእርግዝና መከላከያ(ለምሳሌ፡- ኮንዶም) ከተጠቀምኩ ስለ የአባላዘር በሽታዎች (ለምሳሌ፡- ቁጥኝ፣ ጨብጥ፣ ኤች አይ ቪ...) አልጨነቅም።					
መ- 4.04	በእኔ አመለካከት የእርግዝና መከላከያ ከተጠቀምኩ የልጆቼን ቁጥር መወሰን እችላለሁ።					

ክፍል ሰ: ለመጠቀም እንቅፋት በሆኑ ጉዳዮች ላይ ጥያቄዎች		ሙሉ በሙሉ እስማማለሁ (5)	በከፊል እስማማለሁ (4)	እርግጠኛ አይደለሁም (3)	አልስማማም (2)	በጭራሽ አልስማማም (1)
ሰ-4.01	በእኔ አመለካከት የጎዳና ተዳዳሪ ለሆነች ሴት ዘመናዊ የእርግዝና መከላከያዎችን መጠቀም በጣም ከባድ ነው።					
ሰ-4.02	በእኔ አመለካከት ዘመናዊ የእርግዝና መከላከያ መጠቀም ተጓዳኝ ችግሮች አሉት።					
ሰ-4.03	በእኔ አመለካከት የእርግዝና መከላከያ ለመጠቀም ጊዜ ይወስዳል።					
ሰ-4.04	በእኔ አመለካከት ዘመናዊ የእርግዝና መከላከያ መጠቀም የእለት ተእለት እንቅስቃሴን ያውከዋል።					
ሰ-4.05	በእኔ አመለካከት ዘመናዊ የእርግዝና መከላከያ ለማግኘት የማጣቸው ነገሮች አሉ።					
ክፍል ረ: ዘመናዊ እርግዝና መከላከያ ለመጠቀም በአበረታች ነገሮች ላይ ጥያቄዎች		ሙሉ በሙሉ እስማማለሁ (5)	በከፊል እስማማለሁ (4)	እርግጠኛ አይደለሁም (3)	አልስማማም (2)	በጭራሽ አልስማማም (1)
ረ-4.01	ስለ ዘመናዊ እርግዝና መከላከያ ብዙ ጥሩ ጥሩ ነገሮችን ሰምቻለሁ።					
ረ-4.03	ዘመናዊ የእርግዝና መከላከያ ከፈለኩ የት እንደማግኝ አውቃለሁ።					
ረ-4.03	በጎዳና እየኖሩ ያልተፈለገ እርግዝና የገጠማቸው ሴቶች አይቻሉ አውቃለሁ።					
ረ-4.04	በጎዳና እየኖሩ የአባላዘር በሽታ (ለምሳሌ:- ቂጥኝ፣ ጨብጥ፣ ኤች አይ ቪ...) የያዛቸው ሴቶች አይቻሉ አውቃለሁ።					
ክፍል ሸ: ዘመናዊ እርግዝና መከላከያ ለመጠቀም በራስ መተማመንን የሚመለከቱ ጥያቄዎች		ሙሉ በሙሉ እስማማለሁ	በከፊል እስማማለሁ	እርግጠኛ አይደለሁም	አልስማማም	በጭራሽ አልስማማም
ሸ-4.01	የእርግዝና መከላከያ ከፈለኩ እንዴት መተቀም እንዳለብኝ አውቃለሁ።					
ሸ-4.02	እኔ የእርግዝና መከላከያ የምጠቀመው ያስፈልገኛል ብዬ ካመንኩበት ነው።					
ሸ-4.03	እኔ የእርግዝና መከላከያ የምጠቀመው ጓደኞቼ ከተጠቀሙ ነው።					
ሸ-4.04	እኔ የእርግዝና መከላከያ የምትቀመው ጓደኞቼ ካሉኝ ነው።					

ANNEX NINE: Declaration

I, the undersigned, declare that this paper is my original work and has not been presented for master's degree in this or another university and that all sources used for this paper have been fully acknowledged.

Name: Beza Alemayehu (Bsc)

Signature: _____

Date: _____

Place: Addis Ababa University, School of Public Health

This thesis has been submitted with my approval as University advisor

Dr. Eshetu Girma (MPH, PhD, Associate Professor)

Signature: _____

Date: _____

Place: Addis Ababa University, School of Public Health

CURRICULUM VITAE

Name: BEZA ALEMAYEHU MAMO
Mobile number: +251-912-04-51-60, EMAIL: fikirnyidu@gmail.com

PERSONAL INFORMATION

Nationality: Ethiopian
Date & Place of birth: October 09, 1986, Harar, Ethiopia
Gender: Female
Marital Status: Married

OBJECTIVE

Seeking permission to work on a thesis for the partial fulfillment of the requirement for the degree of master of Public Health

EDUCATION

- 2005 - 2009 University Of Jimma in Gondar, Ethiopia
Bachelor of Science in public health

WORK EXPERIENCE

Seven years experience at federal prison administration hospital which includes:

1. Working as outpatient department case team leader
2. Working as in patient department case team leader

SKILLS AND ACHIVEMENTS

- ✓ Excellent communication, interpersonal and presentation skills (developed through presenting class assignments and working with colleagues).
- ✓ Worked as a team leader in several group assignments.
- ✓ Excellent Understanding, Writing and speaking skill in Amharic & English.
- ✓ I have a good computer skill and knowledge on MS window, MS office, and internet explorer.

REFERENCE

- ✓ Available Up on request

