



***Risky Sexual Practice, Accessibility and  
Utilization of HIV Service among People with  
Disabilities in Addis Ababa***

**By**

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*Addis Ababa University, College of Health Science,  
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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community Based Organization
CSA	Central Statistic Agency
CSW	Commercial Sex Worker
DHS	Demographic Health Survey
EWDNA	Ethiopian Women with Disability National Association
FENAPWD	Federation of National Associations of Persons with Disabilities
FGD	Focus Group Discussion
FHAPCO	Federal HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KAP	Knowledge, Attitude and Practice/Behavior
MOLSA	Ministry of Labor and Social Affair
OVC	Orphan Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PWD	People with Disability
UNAIDS	Joint United Nations Program on HIV and AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## Abstract

**Background:** HIV/AIDS is known to be one of the most catastrophic diseases that have confronted humanity in living memory. Even though there are segments of disadvantaged social groups who are at risk HIV infection due to their lower level of socio economic capacity it is believed that people with disability are more vulnerable to HIV infection.

**Objective:** To assess the risky sexual practices, accessibility and utilization of HIV service among people with disability in Addis Ababa City Administration.

**Materials and methods:** Between September 2010 and April 2011, a cross sectional community based survey was conducted using interviewer administered questionnaire of 417 people with disabilities found from associations of people with disabilities in Addis Ababa City Administration. This was supplemented with focus group discussions with disabilities for access and utilization of HIV services. The findings were described and analyzed using SPSS version 16.

**Result:** Based on the findings, more than half (60%) of study participants were sexually active and a third of them (28.4%) had initiated sex before 18 years. Almost half (48%) of these did not use condoms consistently and 33.6% had multiple sexual partners. Majority (92.8%) have information for existence of HIV services in the country. About 72% of all participants have ever utilized some kind of HIV services ever. Female respondents were nearly 2.5 times more likely to use condoms than males irrespective of type of disabilities [AOR (95%CI) 2.46 (1.28-4.71)]. Those ever married were 2.5 times more likely to use condoms than singles [AOR (95%CI) 2.54(1.49-4.35)]. Visually impaired participants are about 2 times more likely to have multiple sexual partners than those of physically impaired [AOR (95%CI) 1.90(1.02-3.55)]. In addition, those who were singles are 45% less likely to have multiple sexual partners than those of ever married [AOR (95%CI) 0.55(0.31-0.97)]. Regarding utilization of HIV services, hearing impaired participants were about two times more likely to have utilized any HIV services than those of visual impaired [AOR (95%CI) 2.12(1.13-3.98)].

**Conclusions:** In general, the findings in this study showed poor access to information, less convenient of facilities and low utilization of HIV service among people with disabilities. Improving access to information on HIV through targeting PWDs, support to HIV service providers in developing disability sensitive communication materials and improving health service delivery systems to take care of disability are recommended.



## Introduction

### ***Back ground***

HIV/AIDS is known to be one of the most catastrophic diseases. A recent global report shows that, the number of people living with HIV worldwide continued to grow, reaching an estimated 33.3 million in 2009[1]. In Ethiopia, currently, 1.2 million people live with HIV with an adult HIV prevalence of 2.4 percent. A total of 397,818 people with HIV are estimated to be in a need of antiretroviral treatment [2].

Even though there are segments of disadvantaged social groups who are at risk HIV infection due to their lower level of socio economic capacity, it is believed that people with disability are more vulnerable to HIV infection [3].

There is no single definition of disability.WHO defines it as a “physical, sensory, intellectual, or mental health impairment that has a significant and long-lasting effect on the individual’s daily life and activities” [4].

In “Negarit Gazeta” of the transitional government of Ethiopia, proclamation no. 101 of 1994 “a disabled person” is referrers as a person who is unable to see, hear or speak or is suffering from mental retardation or from injuries that limit him or her due to natural or man made causes [5].

It is estimated that 650 million people or ten percent of the world’s population are believed to be persons with disability (PwD), living therefore with one or another type of sensory, physical or mental/intellectual impairment.Eighty percent of them reported to live in sub- Saharan Africa [6].

According to the Ethiopian Population and Housing Census of 2007, there were 805,492 people with disabilities in Ethiopia (1.09 per cent of the population) of this total figure, the major type of observed disabilities in terms of their prevalence rates from census of 2007 are: vision Problem 30.9 percent, hearing Problem 12.5 percent, non-functional, upper or lower limbs, gripping, handling, standing, walking problem (Physical) 27.4 percent [7].

People with disabilities (PwDs)are among the most socially and economically disadvantaged segment of the population. Besides their physical suffering from pain and immobility, these

individuals are socially distressed from various forms of stigma and discrimination, mental anxiety, dependency and rejection [3].

UNAIDS policy document of 2009 also indicate that people with disabilities are at risk of HIV infection resulted from high prevalence of sexual violence, limited access to HIV /AIDS information, treatment ,care and support compare to non disabled peers [8].

This study will try to show how disability, sexual risk practice, accessibility and utilization of HIV service interrelated and also indicate there knowledge about HIV/AIDS, information about HIV service interconnected and have contribution to HIV infection.

### ***Statement of the Problem***

Persons with disabilities within society faces a unique challenge for them to access basic social services including HIV/AIDS. As a result, they are exposed to all known risk factors of the HIV/AIDS infection [9].

Service providers may lack knowledge about disability issues, or have misinformed or stigmatizing attitudes this has impacts on access to health care services and may lead to discriminatory attitudes of health workers[8].Health practitioners can often lack the necessary knowledge, skills and resources to provide accessible, appropriate services to PwDs at risk for, or livings with HIV/AIDS [10].

PwDs may experience physical barriers to accessing health services such as voluntary counseling, care and treatment. For example, poor road conditions may limit travel, offices and clinics may only be accessible by stairs, and written and verbal information may not be provided in an accessible format (e.g. plain language, braille, through sign language interpretation)[10] that leads to many individuals with disability are not reached with HIV/AIDS messages, are unaware of the symptoms of HIV/AIDS. Many who depend on others for transportation or sign language interpretation report delaying seeking testing or care even after symptoms appear because of reluctance to disclose personal sexual history. There is anecdotal evidence from many countries of individuals with disability coming to clinics with full-blown AIDS only days before death; many others die without diagnosis or care. Finally, where access to AIDS medications or health services are not sensitive to human rights considerations and are prioritized in terms of “quality of life” or “contribution to society,” individuals with disability are too often placed at the bottom of the list[11],Therefore this study aims to address the following questions:-

- Are there risky sexual practices that may expose PwDs to HIV infection?
- How far people with disabilities are aware about HIV service?
- Do disabled people have access and utilize HIV services?
- What are the factors that affect accessibility and utilization of HIV services for PwD?

### ***Significant of the Study***

Persons with disabilities are one of the social categories that are usually neglected in HIV/AIDS prevention, management and care. Many HIV/AIDS programs and projects do not target the disabled persons. However, it is evident that the disabled like other groups are also at the risk of contracting HIV/AIDS and therefore should be targeted. Involving the disabled adds value to the programs, as they not only become beneficiaries but also participants. There was limited data in relation to disability and HIV/AIDS. The available data were not quantitatively indicative the individual situations of persons with disabilities. The findings from this research will complement to the existing body of knowledge on the area which will help to; provide information about the level of awareness and knowledge of PwD about HIV services; design appropriate educational services about HIV/AIDS for people with disability and arrange well organized and integrated HIV services so that PwDs can benefit a lot.

## ***Literature review***

### **Disability and HIV/AIDS**

“With an estimated about 600 million individuals who live with a disability are among the poorest, least educated, and most marginalized of all the world’s peoples. They are at serious risk of HIV/AIDS and attention needs to be focused on them“. Available information about the impact of HIV/AIDS on persons with disability globally is scarce and sketchy. This is mainly because HIV/AIDS prevalence studies conducted on disability population are too few, However, the review the existing small amount of literature indicates that the person with disability are exposed to all major risk factors that fuel the spread of HIV infection [9].

A result of rapid assessment done in Zimbabwe on People with disabilities shows that 90 percent of respondents perceived them selves at risk of HIV infection. Most women indicated that most men want to experience sexual intercourse with a disabled woman. This indicates that although the knowledge on HIV&AIDS is high they still have misconception on the modes of transmission of HIV. They believe that transmission is only through sexual contact and through multiple relationships, all the respondents also indicated that the female disabled person is at higher risk because they can be easily be raped [12].

Another study also indicates low risk perception is evident among the disability community, and the majority also exhibits risky sexual behavior. Not only their risk perception low, but they also engaged in risky sexual behavior. In addition, they are at elevated risk of sexual violence, often perpetrated by intimate friends whom they trust. Combined all this factors intensify the vulnerability of people with disability to HIV infection and its complex consequences [13].

The study undertaken in 2010 by World Bank’s AIDS Campaign Team for Africa ,which reached 250 persons with disabilities across five districts in Uganda, found that 31 percent of persons with disabilities were aware of a person with a disability who had died of an AIDS related illness and 18 percent knew of a person with a disability living with AIDS, another baseline study on HIV/AIDS and disability in Uganda surveyed 462 persons with disabilities in

three districts found that relatively high percentages of persons with disabilities reported suffering from STIs ,thus an indication of vulnerability to HIV infection [14].

### **Disability and risk sexual practice**

The widespread belief in certain societies that an HIV-positive man can rid himself of the infection by having intercourse with a virgin places those with disability at increased risk “virgin cleansing”. Reports from Africa and Asia indicate that both females and males with disability, who are assumed to be asexual and therefore virgins, are being raped by non disabled individuals desperate to rid themselves of the virus [11].

According to the Uganda Demographic and Health Survey in 2006, more than two-thirds of Ugandan women experience violence from their partners. In South Africa, one in three women can expect to be raped in her lifetime and one in four to be beaten by her domestic partner [14].

A survey done in Orissa India in 2004, shows that deaf women were sexually abused by family members and close friends. Women with physical disabilities appear to be at risk for emotional, physical and sexual abuse to the same extent as women without physical disabilities [15].

The results of the study conducted on Kampala among PwD indicate that awareness about condoms is over 90 percent for either sex and ever use of condoms is 44 percent among men compared to 27 percent of the women with disability current use of condoms is only 24 percent and 10 percent of men and women respectively and disabled street women in Kampala have multiple partners but do not use a condom [16].

A study done in Addis Ababa on burden of AIDS in PwDs, shows that more than half of the participants (57 percent) have had sex; and the median age at first sex was 19. Among those who have had sex, 59 percent have regular sexual partners. PwDs, however, admit that they are less likely to marry ,are more likely to have unstable relationship, and may use sex as a way to meet their economic needs [17].

Need assessment study carried out in Tanzania indicates twelve of the forty people (30 per cent) interviewed thought it was ‘common’ for people living with disability to have sex with many partners. When asked why it was common, eight people ticked “to get money”, seven marked “being forced (raped)”, six “due to drunkenness” and four people put it down to having “no spouse” [4].

### **Disability and HIV services**

Until the UNAIDS new document on disability and HIV Policy brief call for HIV service to be inclusive of people with disabilities on April 2009 , there is no clear policy guide line related to the high risk of HIV infection among people with disability [18].

The Ethiopia National HIV and AIDS Policy of 1998 focuses on HIV/AIDS effective prevention and control measures; provision of treatment, care, and support, and protection of human rights for PLWHA; promotion of research, capacity building, and coordination [19].

High risk groups include Commercial Sex Workers (CSWs) and their clients, mobile groups (long distance truck drivers, military personnel), youth groups, street children, refugees, prisoners, and others. Unless and otherwise “others” is considered to include PwDs, no specific reference is made to PwDs in the document as population groups that need serious attention[20].

Most of the world’s people living with a disability reside in rural areas, which may be some distance from health facilities. They are less likely than their non-disabled peers to have money for transport or health service costs. Physical limitations (blindness, paralysis etc) may further complicate access. Once at the clinic, they may face environmental obstacles (Missing ramps, steep steps) and communication difficulties (few health staff know sign language lack of information in appropriate formats). The negative attitude of health staff (presumed or actual) is frequently seen as a barrier to accessing health services service providers may lack knowledge of the special needs of people with disabilities, or have misinformed or stigmatizing attitudes towards them. They may also consider them to be a low priority for their care, attention or treatment [4].

Reaching disabled individuals with HIV and AIDS messages, clinical care and reproductive health services presents unique challenges. Even when AIDS messages do reach disabled populations, low literacy rates and limited education levels complicate comprehension of these messages [21].

Result of the vulnerability, impact, and coping mechanisms of the disabled people on *HIV/AIDS* in Zimbabwe shows the majority of the respondents were aware of the existence of HIV and AIDS programmes and services in their communities. They named VCT, HBC, youth programme and orphan care. However, the access and utilization of these services by the disabled people was limited because of stigma and failure to communicate using sign language. Even in voluntary counseling and testing centers, there are no services like counseling in sign language. All respondents mentioned that, they were not participating in most programmes because they are not invited, lack of support services in respect to some types of disabilities; facilities not user friendly like climbing stairs [12].

According to qualitative study done by FHAPCO & FENAPWD the data gathered across the study sites showed the fact that disability is not integrated in most HIV and AIDS prevention and control programs. Services available for the general population are not tailored in a way to suit the needs of PwDs. For instance, FGDs conducted with the deaf in Addis Ababa, Dessie, Hawassa, and Mekelle indicated that there is a lack of access to HIV and AIDS information due to absence of effective communication medium particularly sign language interpreters. The discussants further mentioned that this in turn exposes them to third party involvement and disclosure of their privacy. Thus, there is very low utilization of the services by this segment of the population [20].

### **Factors affecting of HIV services accessibility for people with Disabilities**

Persons with disabilities may not benefit fully from HIV, sexual and reproductive health services for the following reasons [10].

- Service providers may lack knowledge about disability issues, or have misinformed or stigmatizing attitudes towards persons with disabilities.



- Services offered at clinics, hospitals and in other locations may be physically inaccessible, lack sign language facilities or fail to provide information in alternative formats such as braille, audio or plain language.
- Confidentiality for persons with disabilities in HIV testing and counselling may be compromised, for example, by the need for a personal assistant or a sign language interpreter to be present in order to access HIV-related services.

The study Undertaken in 2010 by World Bank's AIDS Campaign Team for Africa in South Africa, Uganda, and Zambia a number of study respondents emphasized the need to differentiate among various types of disabilities in the context of HIV/AIDS. For example, the challenges that blind, deaf, and physically impaired people face regarding HIV/AIDS are not identical. For blind and deaf people, information format is a crucial barrier as it is not available in forms that are accessible to the deaf (sign language and television subtitles, for example) or the blind (such as Braille). On the other hand, people with physical disabilities are more likely to struggle with physical access to service sites and appropriate and affordable transport [14].

However, most of literatures or studies are on KAP towards HIV/ AIDS to asses risk behavior of people with disability especially on women with disability.

Even those researches done to review awareness HIV counseling and testing service addressed only people with hearing impairment and neglected other disabilities. It can be therefore be said that a major rational behind conducting this research is to fill the identified gap on how people with disability will access and utilize HIV services.

## Objectives

### ***General Objectives***

The general objective of the study was to assess the risky sexual practice and utilization of HIV service among people with disability in Addis Ababa.

### ***Specific Objectives***

- To identify risky sexual practice predisposing people with disabilities to HIV/AIDS
- To assess and explore accessibility to HIV prevention, care and support services for people with disabilities.
- To assess and explore HIV service utilization by People with disability
- To identify barriers and concerns related to HIV services and its uses among disabled.

## Methods

### *Study Design*

Cross sectional facility based study was conducted to under take the study using both quantitative and qualitative research methods to answer the research question.

### *Study Area*

The study was conducted in Addis Ababa. According to the Population and Housing Census of 2007, Addis Ababa has a total population of 2,739,551 of which 1,305,387 (47.6 percent) are males and 1,434,164 (52.4 percent) are females. In the city there are 32,630 people with disabilities (1.2 per cent of the population) of the total figure, females constitute about 45 percent [7].

Ethiopian Federation of Persons with Disabilities is a national organization which is established in order to overcome problems of people with disabilities and safeguard to their rights and privileges. According to types of disability this umbrella association is sub divided into four associations namely, Ethiopia National Association of Deaf (ENAD), the Blind (ENAB), Physical Handicapped (ENAPH) and Mentally Handicapped (ENAMH)

Those institutions included in the study through their members who served as study subjects are Ethiopia National Association of Deaf (ENAD), the Blind (ENAB), and Physical Handicapped (ENAPH).

### *Source Population*

All disabled people residing in Addis Ababa.

### *Study Population*

Individuals who are members of Addis Ababa National Association of Deaf, Blind and Physical handicapped served as study population of the study.

**Inclusion criteria:** Those disabled people of Age greater than 18 years old and who are enrolled as a member of the association at the time of data collection were included in the study.

**Exclusion criteria:** Those who are mentally handicapped and those who are not member of the associations were excluded from the study.

### ***Sample Size***

The sample size was determined using the formula for single population proportion. Significance level of 95% ( $\alpha= 0.05$ ) and 5 percent margin of error was taken. Since risky sexual practice and HIV service accessibility and utilization among study subjects is unknown a maximum prevalence estimate of 50% was taken to obtain sufficiently large sample size, and 10% was also added to compensate for non response. So a total of 422 disabled young people were include in the study.

$$n = Z \frac{\alpha}{2}^2 \times p \frac{(1-p)}{d^2} = (1.96)^2 \times \frac{0.5(0.5)}{0.05^2} = \mathbf{384}.$$

Taking a 10% refusal to participate rate =  $384 \times 1.1 = \mathbf{422}$ .

### ***Sampling Procedure***

Association of the deaf, the blind, physical disabled are selected using purposive sampling technique, the associations preferred for convenience to handle the study subjects at the existing associations.

According to 2007 CSA data there are 32,630 PWDs found in Addis Ababa, out of which Visual impairment account 30.9 percent, hearing impairment 12.5 percent, and Physical disabilities 27.4 percent. The sample size of 422 was allocated proportionally to each disability categories, 186, 77 and 159 for the Blind, Deaf and Physical Disabled respectively.

The eligible study subjects from the association were selected from the registration book of each association by simple random sampling method. For those absent on the date of data collection the next subject was substituted from the same registration. For the FGD members were selected purposeful male and female from each association who can express and able to share their ideas freely.

### ***Data Collection Procedures***

The data for the quantitative section of the study were collected by trained data collectors using structured questionnaires adopted from DHS, CSA, and from other sources (literature reviewed).The questionnaire was translated in to Amharic and back to English. Data collection was conducted for 15 days and data from those with hearing impairment were collect by trained

data collectors who know sign language. A total of eight data collectors and two supervisors were selected based on their health and social science background and data collection experience and minimum twelve grades completed to conduct the interview and FGD. Two days intensive training was given for both data collectors as well as supervisors on objectives of the study, data collection tools, collection procedure and ethical consideration for both qualitative and quantitative methods by principal investigator.

After the collection of quantitative data, six focus group discussions were conducted two groups per association based on the saturation of the information. The principal investigator guided the discussion by using semi structured questions to explore sexual risk practice and knowledge, access and utilization of HIV service of disabled people. The discussion was gender segregated and the number of participants in each group ranged from 5-8 individuals. The discussion was conducted in Amharic and one trained research assistant was there for tape recording and took note of all discussions. A sign language interpreter was used to moderate FGDs with the deaf. The discussion was transcribed and translated to English.

Prior to data collection in order to determine the understandability and applicability of the data collection instrument Pre- test of the questionnaire was done in the same population but outside of the association like schools, which not be included in the study. Then the instrument was reconstructed and standardized based on the finding.

### ***Data Quality Management***

For both qualitative and quantitative methods data collection tools and the quality of data was assured through careful design, translated to Amharic and retranslation of the questionnaire. Pre-test of the questionnaire was done in the same population but outside of the association like schools, which was not included in the study. Then the instrument was reconstructed and standardized based on the findings.

Data collection process was supervised closely by principal investigator and the supervisor to ensure information are properly collected and recorded.

The collected data was checked for consistency and completeness during data collection, before entered in a predetermined data entry form. In addition, data cleaning and checking was done

before analysis and a unique code number was labeled for each individual questionnaire in case any missed value is found during analysis to retrieve back.

### ***Data analysis procedure***

Data were checked for completeness and internal consistency of responses manually. Data were then coded; entered cleaned and analyzed using Epi Info version 3.51 and SPSS version 16 statistical packages. Frequencies, proportions, were calculated and used to describe the study population; then Chi-squared test was used to determine the presence of statistically significant associations between the dependent variable Risky sexual practice and access and utilization of HIV service and the independent variables socio demographic characteristic and types of disability. Statistical significance was considered at  $p \leq 0.05$ . The degree of association between dependent and independent variables was assessed using crude odds ratio with 95% confidence interval. Adjusted odds ratio was also calculated using logistic regression to control for potential confounding variables.

All focus group discussions was taped, the tape recorded data were transcribed carefully in to Amharic and arranged with the written notes taken at the time of discussion. The information was translated in to English. Thematic or content analysis was employed in order to describe the exploratory idea obtained from FGD.

### ***Operational Definitions***

#### **Persons with Disabilities**

A person with a condition caused by an accident, trauma, genetics or disease that may limit mobility, hearing or vision.

#### **Risky sexual practice**

People who had sex earlier than 18 years of age, or have sex with non-regular sexual partner, or have more than one sexual partner or use condoms inconsistently / not at all

#### **Accessibility of service for HIV/AIDS**

The existence of these services like VCT, PMTCT, ART,IEC/BCC, etc common to all people. The study was further considered HIV and AIDS services which are especially designed to or friendly to People with disabilities.

### **Utilization of HIV/AIDS services**

To have had at least one type of HIV and AIDS services by PWDs.

### **Casual Sex**

Sexual activity with someone who is a stranger on the same day of their meeting and usually never meet again afterwards

### **Forced Sex**

A type of sexual assault usually involving sexual intercourse ,which is initiated by one or more persons against another person with out that person's consent.

### **Convenience**

HIV service facilities that are suitable in physical structure, accessibility, ease of communication with service providers and user friendly with People with Disabilities.

### **Barriers**

Anything that prevents People with Disabilities from full participating in HIV service utilization.

## ***Study Variables***

### **Independent Variables**

- Age, gender ,religion, marital status, Educational status, occupational status
- Type of Disability

### **Dependant Variable**

- Access and Utilization of HIV service
- Risky Sexual Practice

## **Ethical Consideration**

Ethical clearance was obtained from the Institutional Review Board at the College of Health Science. The Letter was handed to Federation of National Associations of Persons with Disabilities and each of Addis Ababa National association of Deaf, the blind, physical disabled.

Prior to data collection study subjects were briefed about the benefit, harm and objective of the study. The result of this study will help to provide information about risky sexual practice, accessibility and Utilization of HIV service among people with disability and they were granted a full right to be part of the study or not. Confidentiality was assured by omitting names of the study subjects from the questionnaire. In addition confidentiality was maintained by the data collectors, supervisors and investigators throughout the study.



## Results

### Quantitative findings

#### Socio Demographic characteristic of study population

A total of 417 (278, Male and 139, Female) age >18 years participated in the study obtaining a response rate of 98.8%. As shown in table 1, nearly half of the study subjects (49.9%) were in the age group of  $\leq 24$  years. The mean age of participants was 26. Regarding ethnic composition, Amhara and Oromo accounted for 207(49.6%) and 88 (21.1%), respectively. Majority of the respondents were followers of Orthodox Christianity 284(68.1%) followed by Muslims 73(17.5%). Majority of the study subjects were literate 384 (92.1%) while 33(7.9%) were illiterate. Regarding type of disability; Visual, Physical and Hearing impairments accounted, 186 (44.6%), 154 (36.9%) and 77 (18.5%), respectively.

Concerning occupation of the respondents, out of the total 417 subjects, 156 (37.4%) were students, 126 (30.2%) were private employees, 99 (23.7%) were unemployed, 23 (5.5%) were civil servants, 8(1.9%) were retired and 5 (1.2%) were house wives. Three hundred two (72.4%) of the study subjects were singles, 75(18%) of them were married and 26(6.2%) were divorced. Out of the total respondents, 233(55.9%) had regular income.

**Table1: Socio-demographic characteristics of people with disabilities in Addis Ababa City Administration, February 2011, (n=417).**

<b>Variable</b>	<b>Number</b>	<b>Percent</b>
<b>Sex</b>		
Male	278	66.7
Female	139	33.3
<b>Forms Of Disability</b>		
Visual	186	44.6
Hearing	77	18.5
Physical	154	36.9
<b>Age Group</b>		
18-24	208	49.9
25-34	144	34.5
35-44	57	13.7
≥45	8	1.9
<b>Educational status</b>		
Illiterate	33	7.9
1-8	133	31.9
9-12	206	49.4
Above 12	45	10.8
<b>Religion</b>		
Orthodox	284	68.1
Muslim	73	17.5
Protestant	54	12.9
Catholic	6	1.4
<b>Ethnicity</b>		
Amhara	207	49.6
Oromo	88	21.1
Gurage	61	14.6
Tigray	31	7.4
Southern	30	7.2
<b>Marital Status</b>		
Married	75	18
Single	302	72.4
Divorced	26	6.2
Widowed	5	1.2
Living together	9	2.2
<b>Occupation</b>		
Government employee	23	5.5
Private employee	126	30.2
House wife	5	1.2
Student	156	37.4
Unemployed	99	23.7
Retired	8	1.9
<b>Regular in come</b>		
Yes	233	55.9
No	184	44.1

## Risky Sexual Practices

As shown in table 2 below, more than half (60%) of study participants were sexually active. Quite large proportion of respondents (28.4%) had initiated sex before 18 years old and the majority (65.6%) commenced sex with own interest. On the other hand, almost half (48%) of those who are sexually active did not use condom consistently and 84 of the 250 had multiple sexual partners. In addition, 17.2% and nearly 18% had casual sex and ever had been forced to have sex or attempted, respectively, which exposes respondents to risky sexual practices.

**Table 2: Risky Sexual Practices of People with Disabilities in Addis Ababa City Administration, February 2011, (n=417).**

<b>Variable</b>	<b>Number</b>	<b>Percent</b>
<b>Ever Had Sex</b>		
Yes	250	60.0
No	167	40.0
<b>Age of Sexual Initiation, (n=250)</b>		
<18 Years	71	28.4
≥18 Years	179	71.6
<b>Factor to Start Sex, (n=250)</b>		
Marriage	39	15.6
Own interest	164	65.6
Peer pressure	36	14.4
Forced sex	3	1.2
Don't remember	8	3.2
<b>Consistent Condom Use, (n=250)</b>		
Yes	130	52.0
No	120	48.0
<b>Multiple Sexual Partner, (n=250)</b>		
Yes	84	33.6
No	166	66.4
<b>Ever had Casual Sex, (n=250)</b>		
Yes	43	17.2
No	207	82.8
<b>Ever had forced Sex, (n=414)</b>		
Yes	26	6.3
No	340	82.1
Attempted	48	11.6

### Condom use

One hundred and thirty (52.0%) of those sexually active used condom consistently. There were significant association between some socio-demographic characteristics and consistent condom use among people with disabilities in the study. Female respondents were nearly two and half times more likely to use condoms than males irrespective of type of disabilities [AOR (95%CI) 2.46 (1.28-4.71)]. Surprisingly, married study participants are more than two and half times more likely to use condoms consistently than singles, which is statistically significant [AOR (95%CI) 2.54(1.49-4.35)]. All the other variables do not have significant association with consistent condom use (Table 3).

**Table 3: Factors influencing Condom use among sexually active people with disabilities in Addis Ababa City Administration, February, 2011, (n=250).**

Variable	Condom Use		Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
	Yes(130)	No(120)		
<b>Sex</b>				
Male	109	82	1.00	1.00
Female	21	38	2.41(1.31-4.41)	<b>2.46(1.28-4.71)</b>
<b>Type of disability</b>				
Visual	55	49	0.93(0.54-1.61)	0.89(0.49-1.60)
Hearing	24	22	0.95(0.47-1.92)	0.86(0.39-1.87)
Physical	51	49	1.00	1.00
<b>Occupation</b>				
Employed	65	55	1.00	1.00
Unemployed	65	65	1.18(0.72-1.94)	1.26(0.74-2.15)
<b>Marital Status</b>				
Single	87	54	1.00	1.00
Ever Married	43	66	2.47(1.48-4.13)	<b>2.54(1.49-4.35)</b>

## Multiple Sexual Partners

As depicted in table 4 below, 84 (33.6%) of those sexually active People with disabilities have had engaged in multiple sexual practices, the majority were males (66). Multiple regressions with various independent variables showed some association with marital status and type of disability. Visually impaired participants are about two times more likely to have multiple sexual partners than those of physically impaired [AOR (95%CI) 1.90(1.02-3.55)]. Respondents who were singles are found about 45% less likely to have multiple sexual partners than those of ever married, which is statistically significant [AOR (95%CI) 0.55(0.31-0.97)].

**Table 4: Factors influencing Multiple Sexual Partners among sexually active people with disabilities in Addis Ababa City Administration, February, 2011, (n=250).**

Variable	Multiple Sexual Partner		Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
	Yes(84)	No(166)		
<b>Sex</b>				
Male	66	124	0.81(0.43-1.51)	0.81(0.42-1.58)
Female	18	42	1.00	1.00
<b>Type of disability</b>				
Visual	29	76	1.63(0.91-2.94)	<b>1.90(1.02-3.55)</b>
Hearing	17	29	1.06(0.52-2.19)	1.17(0.54-2.51)
Physical	38	61	1.00	1.00
<b>Occupation</b>				
Employed	36	84	1.00	1.00
Unemployed	48	82	0.73(0.43-1.24)	0.68(0.39-1.19)
<b>Marital Status</b>				
Single	55	86	0.57(0.33-0.98)	<b>0.55(0.31-0.97)</b>
Ever Married	29	80	1.00	1.00

### Age of sexual initiation

Seventy one (28.4%) of the sexually active People with Disabilities have commenced sexual practice before the age of 18 years. The association of sexual initiation with sex of participants was statistically significant; males were nearly three times more likely to commence first sex before their eighteenth birthday than females. Age of sexual initiation among the other socio-demographic variables does not have any significant association in both binary and multiple regressions (table 5).

**Table 5: Factors influencing Age of Sexual Initiation among sexually active people with disabilities in Addis Ababa City Administration, February, 2011, (n=250)**

Variable	Age of Sexual Initiation		Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
	<18 (71)	≥18 (179)		
<b>Sex</b>				
Male	42	149	3.43(1.86-6.34)	<b>2.92 (1.53-5.57)</b>
Female	29	30	1.00	<b>1.00</b>
<b>Type of disability</b>				
Visual	28	76	0.77(0.40-1.45)	0.95(0.48-1.86)
Hearing	21	25	0.34(0.12-0.71)	0.47(0.21-1.05)
Physical	22	78	1.00	1.00
<b>Occupation</b>				
Employed	30	90	1.00	1.00
Unemployed	41	89	0.72(0.41-1.26)	0.82(0.45-1.48)
<b>Marital Status</b>				
Single	42	99	0.85(0.49-1.49)	0.89(0.49-1.63)
Ever Married	29	80	1.00	1.00

### Accessibility and Utilization of HIV Services

The majority of study participants (92.8%) have information for existence of some kind of HIV services in the country. Three hundred (71.9%) of those who have information for HIV services have ever utilized some kind of HIV services. Among disabled study participants who have ever utilized any of the HIV services (300), only about a third of them reported that services were accessible for them with respect to physical barrier of facilities, economical (fee for services) and information about where service are available. Of those who utilized any of the HIV services, the

majority (81.3%) visited government facilities. On the other hand, only 56 (18.7%) have reported that services were convenient for them with respect to infrastructure of facilities, communication with providers, privacy, confidentiality and waiting time for the services. Regarding providers approach during service provision, 166 (55.3%) were welcoming whereas the remaining were not.

Among the HIV services, study participants were asked whether they had ever been tested for HIV or not. Based on that nearly half 192(46%) of all study participants had been tested for HIV despite the research did not explore further on the status of test (table 6).

**Table 6: Accessibility and Utilization of HIV Services among People with Disabilities in Addis Ababa City Administration, February 2011, (n=417).**

<b>Variable</b>	<b>Number</b>	<b>Percent</b>
<b>Information about HIV Service</b>		
Yes	387	92.8
No	30	7.2
<b>Utilized any HIV services</b>		
Yes	300	71.9
No	117	28.1
<b>Service accessibility, (n=300)</b>		
Yes	95	31.7
No	205	68.3
<b>Place of services, (n=300)</b>		
Government Health Facility	244	81.3
Non Governmental HF	56	18.7
<b>Service convenience</b>		
Yes	56	18.7
No	244	81.3
<b>Response of Service providers</b>		
Welcoming	166	55.3
Disgusting	134	44.7
<b>Ever been tested for HIV</b>		
Yes	192	46.0
No	222	53.2
No response	3	0.7

As shown in table 7 below, accessibility of HIV services with parameters mentioned above did not show any association with any of the independent variables neither in crude odds ratio nor in adjusted odds ratio. But those of higher educated, employed, male and physical impaired participants were more likely to have access than their counterparts.

**Table 7: Factors influencing Accessibility of HIV Services among people with disabilities in Addis Ababa City Administration, February, 2011, (n=300).**

Variable	Accessibility of HIV Services		Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
	Yes(95)	No(205)		
<b>Sex</b>				
Male	65	138	1.00	1.00
Female	30	67	1.05(0.62-1.77)	0.89(0.49-1.57)
<b>Type of disability</b>				
Visual	53	91	0.75(0.44-1.27)	0.85(0.46-1.62)
Hearing	9	38	1.83(0.79-4.22)	1.92(0.79-4.67)
Physical	33	76	1.00	1.00
<b>Occupation</b>				
Employed	37	81	1.00	1.00
Unemployed	58	124	0.98(0.59-1.61)	1.12(0.64-1.98)
<b>Educational Status</b>				
Illiterate	10	18	1.52(0.55-4.20)	1.62(0.55-4.82)
1-8	28	70	2.11(0.95-4.67)	1.89(0.77-4.69)
9-12	41	98	2.01(0.94-4.29)	1.73(0.77-3.90)
Above 12	16	19	1.00	1.00

### Utilization of HIV Services

HIV service utilization was explained in that whether study participants had ever used any of the HIV services during the last twelve months. Association of HIV service utilization among the various independent variables was done as shown in table 8. Based on this; type of disability, showed some significant association with utilization; i.e., of the three disability types included in this study, hearing impaired participants were about two times more likely to have utilized any HIV services than those of visual impaired, which is statistically significant [AOR (95%CI) **2.12(1.13-3.98)**]. Similarly, physically impaired were found to utilize HIV services 1.6 times more likely than the visually impaired, though not statistically significant Being male, employed



and better educated favoured for more utilization for services of HIV prevention and care among the study participants.

**Table 8: Factors influencing Utilization of HIV Services among people with disabilities in Addis Ababa City Administration, February, 2011, (n=417)**

Variable	Utilization of HIV Services		Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
	Yes(300)	No(117)		
<b>Sex</b>				
Male	203	75	1.00	1.00
Female	97	42	1.17(0.75-1.84)	1.02(0.63-1.66)
<b>Type of disability</b>				
Visual	144	42	1.00	1.00
Hearing	47	30	2.19(1.23-3.88)	<b>2.12(1.13-3.98)</b>
Physical	109	45	1.42(0.87-2.31)	1.62(0.90-2.92)
<b>Occupation</b>				
Employed	118	39	1.00	1.00
Unemployed	182	78	1.29(0.83-2.03)	1.36(0.83-2.22)
<b>Educational Status</b>				
Illiterate	28	5	0.63(0.19-2.04)	0.71(0.21-2.41)
1-8	98	35	1.25(0.56-2.79)	0.92(0.37-2.26)
9-12	139	67	1.69(0.79-3.61)	1.29(0.57-2.89)
Above 12	35	10	1.00	1.00

## **Qualitative findings**

The study finding was complemented with focus group discussions among the three types of disabilities separately. Therefore, a total of six focus group discussions each having 5-8 discussants were conducted to explore about their general information and access to HIV services, accessibility and utilization of those HIV services, as stated below.

### **Information about HIV Service**

The findings from all focused group discussions indicated that most of the respondents have information about some kind of HIV services by mentioning some; HIV testing, ART, awareness raising programs. In addition, some discussants mentioned about prevention of mother to child transmission services provided in health facilities.

### **Access to information on HIV/AIDS**

Some discussants from all groups have mentioned that media, friends and associations are their main source of information. However, lack of access to proper information on HIV/AIDS programmes and services also identified as a major problem by majority of participant particularly by those Visual and Hearing impaired participants.

*A 22 years, male hearing impaired unemployed said, " ...despite I have access to National Television transmission, the programs do not reached to me as the programs are not translated in sign language with in the same screen"*

*A 26 year old female visual impaired participant remarked "I have heard about the importance and benefits of condom use, but I am opposed by my partner to use because I don't have enough knowledge to convince him and cannot read leaflets of condom use; in addition, information found on the cover of condoms are not prepared on Braille"*

### **Accessibility & Utilization of HIV/AIDS related services**

The result of focused group discussion indicated that physical accessibility of health institutions and the behavior or perceptions of providers on PwDs are discouraging to utilize the services.

A 23 years male unemployed Physical handicapped discussant stated that *“some health facilities’ building by itself is a problem for us, they are not built in considering disabled people, stairs are difficulty to walk by using wheelchair, crunch or white stick “.*

The visual impairment discussants also mentioned that there is no proper information exactly where HIV services are provided. For example, a 31 years old visual impaired female said, *“I have visited many health institutions for VCT service but I couldn’t get service because no one can direct me to the place, even though I am worried about confidentiality, I took my relative with me”.*

Another visual impairment discussant also mentioned that there is lack of relevant and appropriate information through mass media *“once I heard announcement as there is mobile VCT service around Aratkilo and some other place in Addis but the announcer does not mentioned the exact direction where the service is provided”.*

The other issue raised by discussant is the language barrier between health care providers and disabled clients which force them to call for the involvement of a third person; especially hearing impaired people do not use HIV and AIDS services.

A19 years old hearing impaired woman said that *“while I was pregnant, I went to a nearby health centre for PMTCT, the nurse told me that there was no trained counselor in sign language and they gave me referral to hospital but I faced the same problem there”.*

Similarly, another a 20 years hearing impaired male student said, *“It is very hard for me to utilize VC service, this is because there is no confidentiality of your test result at all. As you know there are no VCT centers, which are especially meant for people with hearing impairment. As a result, a third party should involve in the counseling process as well as while the test results are*

*reported .Hence, it is not conducive to me to make use of VCT while there are people who know my private secret.”*

## **Discussion**

The study revealed that more than half (60%) of study participants were found to be sexually active and quite large proportion of them (28.4%) had initiated sex before 18 years of age. The median age at first sex was 19. The finding of this study was the same to a similar study done by Miz-Hasab Research Center in Addis Ababa in 2010(17) in that, more than half of PwDs (57%) were sexually active; and the median age at first sex was 19. Another study done in Tanzania in 2009 showed that nearly half of people with disabilities are sexually active; half have had sex by the age of 19 (4). A study done in Kenya on KAP study in 2007 found 89% of disabled individuals were sexually active and 29% people with disabilities commence first sexual practice below the age of 16 (24).

Regarding condom use and casual sex, this study showed 52% of those sexually active were used condoms and 17.2% have had non-regular sexual partner. This finding is almost similar to the study done in Tanzania in 2009 (4) where it showed a quarter had had sex with a non-regular partner, and most of those (78%) did not use a condom when doing so. A study done in Addis Ababa by Tigist in 2008 among People with disabilities on adolescents (10-24) showed 20.7% had sex with a casual sexual partner and 58.3% of them used condoms consistently (25).

Eighty four (33.6%) of those sexually active People with disabilities have had engaged in multiple sexual practices, the majority were males, that is 26.8%. A study done by Tigist in Addis Ababa showed similar findings, 32.2% (25). A study done in Tanzania in this regard showed nine out of forty people interviewed people with disabilities said they had had sexual relations with someone other than their spouse or regular partner (4).

With regard to information about the available HIV services, the findings showed that majority of study participants (92.8%) have information for existence of some kind of HIV services in the country. This finding is supported with findings from the focus group discussion among the same study participants. In addition, the result is similar to the study done in Zimbabwe among PWDs

(date not mentioned) in that majority of study respondents were aware of the existence of HIV and AIDS programs and services in their community (12).

In this study, only about a third of them reported that services were accessible for them with respect to physical barrier of facilities, economical (fee for services) and information about where service are available. A study done in Zimbabwe (date not mentioned) revealed that access and utilization of HIV services by people with disabilities were limited (12). A baseline study conducted by Handicap International (2006) in Yeka sub-city of Addis Ababa, Ethiopia, revealed that people with disabilities are severely segregated and denied of sexual, HIV/AIDS, and reproductive health educations (83% of the respondents reported that they have ever attended such programs so far) (26).

Another finding from Uganda in 2005 showed that, persons with disabilities may not benefit fully from HIV and related sexual and reproductive health services for the following reasons: service providers may lack knowledge about disability issues, or have misinformed or stigmatizing attitudes towards persons with disabilities. Services offered at clinics, hospitals and in other locations may be physically inaccessible, lack sign language facilities or fail to provide information in alternative formats such as Braille, audio or plain language (27).

The FGD findings in this study also strengthened this fact; i.e., physical handicapped discussants stated that the health facilities' buildings by itself is a problem for them because their floors and stairs are difficult for those who use wheel chair, crunch and white sticks. This finding is similar to a similar study done in Addis Ababa in 2010 by Ministry of Labour and Social Affairs, which revealed issues concerning the physical inaccessibility, service providing institutions are not friendly to PwDs and inconvenient of the internal structures of the facilities with the situation of PwDs (e.g. stairs). It was also stated that advertisements and signs are put in inaccessible areas making it difficult for PwDs to locate the service centers (29).

The reasons for limited proportion of PwDs to have access to information for the available HIV services were explained by findings from FGDs. It has been found that, lack of PwDs oriented media, lack of written and audio messages designed for PwDs needs, poor family and

community support and limited investment by the health sector in general were mentioned among others. This finding was similar to findings done in 2004, Malawi, it showed that persons with disabilities may be turned away from HIV education forums or not be invited by outreach workers, because of assumptions that they are not sexually active or do not engage in other risk behaviours such as injecting drugs (28).

Three hundred (71.9%) of all PwDs participated in this study reported that they have had utilized some kind of HIV services either from governmental or nongovernmental health facilities. As HIV testing is an entry point for all HIV services, the study explored proportion of study participants ever been tested for HIV and found 46% of them had been tested. The finding in Kenya KAP study found slightly above half (55%) had been tested for HIV (24), so this finding is almost similar to the finding in this study.

Of those who utilized any of the HIV services, the majority (81.3%) visited government facilities. This finding is slightly higher than the result found in another study in Addis Ababa done on sexual behaviour of women with motor disorders, 63.1% of participants undertook HIV testing service in government Health institutions (30). A study done in Zimbabwe also showed that PwDs prefer public health facilities for their HIV services (12). The finding from the focus group discussion in this study showed that, majority of them are oriented the existing of HIV/AIDS service and prefer to use in the nearby government health facilities. This finding is similar with a study done by MOLSA in 2010 in Addis Ababa, Ethiopia, which revealed study participants were more knowledgeable about the availability of the services in government health institutions with particular reference to them to use VCT and ART (29).

On the other hand, of 300 who ever utilized any of the HIV services only 56 (18.7%) have reported that services were convenient for them with respect to infrastructure of facilities, ease of communication, privacy and confidentiality for the services. But the finding from the focus group discussion showed very few favoured for its' conveniences with respect to physical structure, behaviour of health professionals and language barrier with providers, which is similar to a finding in South Africa in which one hearing impaired discussant reported his experience of having his HIV positive status disclosed to him by a doctor writing in large letters on a piece of paper and holding it up in front of his face, he receive no counseling or explanation (14).

In general, the findings in this study showed poor access to information and services to HIV; in addition, utilization of HIV services was very low. Qualitative findings complemented discouraging factors for poor access to information and services among the study participants. These findings are similar to previous findings done in Addis Ababa. For example a qualitative study done by EWDNA in 2009 revealed how the community and health professionals' attitude discourage PwDs from accessing and utilizing HIV and AIDS services. For instance a blind girl living with HIV said that she always faces discouragement from health professionals and patients whenever she appears in the ART centre for the reason that there is a wrong perception towards the sexuality of PwDs (19).

Another study done in Uganda on challenges faced by PwDs in utilizing HIV/AIDS and related health service, the findings confirm the extent that health organizations lack the capacity to provide sufficient communication facilities and services for people with disabilities (31).

## **Strengths and Limitations of the study**

### **The study can be considered strong in that:**

- ❖ Considering the unreached group of population
- ❖ The study combines both quantitative and qualitative data collection methods
- ❖ A study might be a pioneer and base line for further researches
- ❖ Using trained data collectors who knew sign language

### **Some of the limitation of this study might be:**

- ❖ Shortage of Literature particularly studies on similar topics
- ❖ Some problems in collecting data from those hearing impairment and physical impairment

## **Conclusion and recommendation**

### ***Conclusion***

The over all study result indicate that more than half of respondents of people with disabilities are found sexually active. Early age of sexual initiation of the respondent and not to use condom consistently is evidence that people with disabilities are at elevated risk of sexual practice to exposed them to HIV. The study also revealed that experience of multiple sexual partners and having casual sex is common among people with disabilities.

Access to HIV/ AIDS services information by all the disabled is high. Among the disabled who have information level of accessibility and utilization of HIV services are very low.

The majority of respondent claims that HIV/AIDS services are inaccessible for them the major reasons mentioned that prevent them from accessing the services are luck of information were the service provided, infrastructure and fee of services.

High proportion of PwDs preferred government health facilities for the service how ever low proportion of PwDs reported that services are convenient some reasons raised why the services are not convenient for them are infrastructure of health facilities, response of service providers, luck of proper communication skills , fear of failing privacy and confidentiality and long waiting time.



## ***Recommendations***

As indicated in the analysis part of the study people with disabilities were exposed them self to HIV and they are the most challenged in accessing HIV prevention and care programs. This study should be used as starting point in to further understanding of issues of disability and HIV/AIDS .In order to reach them effectively based on the study result we would like to recommend the following:-

### National Level (Programmatic level)

- Support to HIV service providers in developing disability sensitive communication materials and translating the existing one to reach needy.
- Include disability in the training programs of health professionals.
- Training of HIV service providers in sign language in order to guarantee confidentiality among people with hearing impairment.
- Availing programs on public Medias both on television, radio, and written documents to advocate the issues of disability and HIV/AIDS to the general public as well as persons with disabilities and their families.

### Health Institutions

- Health and other institutions working on HIV/AIDS program should link with these special community groups, associations and different organization working for PwDs to provide appropriate HIV prevention and control information.
- Health service delivery systems should be improved to take care of disability specific needs.

### PwDs Associations

- Improve access to information on HIV/AIDS through targeting PwDs in general but also specific disabilities through there associations.
- Periodical sensitization meeting/work shops for members to improve(updated) knowledge on HIV/AIDS of PwDs.

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## Annexes

### *Questionnaire*

#### **Consent form that certify the respondents agreement before the interview**

Name of the Association/School \_\_\_\_\_

Questioner identification number \_\_\_\_\_

Good morning/afternoon, my name is \_\_\_\_\_ We are conducting assessment of Situation of HIV service for people with disability namely the blind, the deaf, and the physically handicapped in Addis Ababa. The purpose of this assessment is to generate Quantitative and qualitative information on risky sexual practice, accessibility and Utilization of HIV service among people with Disability. The aim of this research is purely for academic purpose and the information used only for the study. A code number will identify every participant and no names will be used. If a report of the result is published, only summarized information of the total group will appear. You have the right to participate or not to participate at any time during the interview. However the answer that you provided here will have great benefit to the researcher and the target community.

If you participate in this study, you may not get direct benefit but your participation is likely to help us to identify gaps regarding to the level of awareness and knowledge of PWD about HIV services; design appropriate educational services about HIV/AIDS and arrange well organized and integrated HIV services so that PWDs can benefit a lot, there is no invasive procedure that harm you. To assurance confidentiality name will not be written on the questionnaire. In addition confidentiality will be maintained by the data collector, investigator and the research assistant throughout the study.

Was the information and objective of the study clear?

1. Yes       2. No

(If not clear you are able to ask the principal investigator.)

Are you willing to participate in the study?

1. Yes       2.No

**Thank You Very Much!!!**

Name of Data collector \_\_\_\_\_

Tel.no \_\_\_\_\_ E-mail \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_

## Structured Questionnaire

### Part one: Socio demographic Variables

No	Question	Classification	Remark
1.	Form of Disability	1. Visual 2. Hearing 3. Physical	
2.	Sex of the client	1. Male 2. Female	
3.	How old were you at your last Birth Day	_____Years(full yrs)	
4.	What is Your Religion	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 411Other(Specify)	
5.	To which Ethnic group do you belong	1. Amhara 2. Oromo 3. Gurage 4. Tigray 511Other(Specify)	
6.	What is your current marital status	1. Married 2. Single 3. Divorce 4. Widowed 5. Living together	
7.	What is your complete Years of Education	1. 1-6 2. 7-8 3. 9-12 4. Higher education 5. Illiterate	
8.	What is your current occupation	1. Government employee 2. Private employee 3. Merchant 4. House wife 5. Student 6. Un employed 811.Other(Specify)_____	
9.	What is your average house hold income per month?	_____Birr In cash	

**Part Two: HIV/AIDS Knowledge and Attitude**

No	Question	Classification	Remark
21.	Have you ever had access for information about HIV/AIDS?	1. Yes 2. No	If no skip to no 23
22.	If yes from Where did you get the information	221.From Health professionals 222.From Mass media 223.Leaflets 224.News papers 225.Friends 226.School 227.PWDs Associations 228.Parent 229.Neighbours 2210.Others specify_____	
23.	If No What is the reason	1. Luck of proper written documents (brail or sign language) 2. Most of the people have know knowledge of proper communication media 3. All media programmes prepared only for non disabled people 4. There is no any HIV centre for PWDs	
24.	Is there anything a person can do to avoid/prevent getting STIs and HIV/AIDS?	1. Yes 2. No 3. Don't know	
25.	If Yes, How can one prevent HIV/AIDS? ( multiple answer is possible)	271 Abstain from sexual intercourse. 272 Avoid casual sex. 273 Remain faithful to a partner. 274 Use condoms in every act of sexual Intercourse 275 Avoid sex with CSWs 276 Avoid unsafe injections 277 Avoid contaminated sharp objects 278 Others specify -----.	
26.	Do you know any one who is infected with HIV or who has died of AIDS?	1. Yes 2. No	
27.	May a Healthy looking person be positive for HIV?	1. Yes 2. No	

		3. Don't know	
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**Part Three: Sexual Practice of Person with Disability**

No	Question	Classification	Remark
31.	Have you ever had sexual intercourse?	1. Yes 2. No	If No skip to No 10
32.	How old were you when you had sexual intercourse for the very first time (if ever)?	Years_____	
33.	What are the factors that contribute to your initiation to sex?	1. Marriage 2. by own interest 3. Due to peer pressure 4. Forced to have sex 5. Don't remember 331.others (specify) _____	
34.	The last time you had sexual intercourse was a condom used?	1. Yes 2. No	
35.	Would you like to use a condom ever time when you had sexual intercourse?	1. Yes 2. No	
36.	The last time you had sexual intercourse do you or your partner drink alcohol	1. Yes 2. No 3. Not remember	
37.	In total, with how many different people have you had sexual intercourse in the last 12 months?	No of partners_____ 371.Don't remember	
38.	Have you ever had sexual intercourse with casual sex partner in the past 12 month?	1. Yes 2. No 3. Don't remember	
39.	How often you have discussed the issue of HIV/AIDS with your partner?	1. Regularly 2. Sometimes 3. Not at all	
310.	Have you ever been forced to have sex?	1. Yes 2. No 3. Attempted	

**Part Four: HIV Service Access and utilization**

No	Questions	Classification	Remark
41	Have you ever heard about HIV service?	1. Yes 2. No	
42	Please mention all HIV Service what you know [Multiple answers are possible]	421 VCT 422 PIHTC 423 PMTCT 424 Home based care 425 ART 426 Palliative care 427 Psychosocial care 428 TB/HIV 429 Awareness creation 4210 Other/Specify_____	
43	Do you know where the service is provided?	1. Yes 2. No	
44	Is it possible for you to get those services?	1. Yes 2. No 3. No need	
45	What are the barriers to get those services?	451 .Physical 452 Communication 453 Financial 454 No barriers 455 Other(specify)	
46.	Did you seek any kind of HIV service during the last 12 months?	1. Yes 2. No	
47.	Where do you go?	1. Government Hospital 2. Government H/Centre 3. Private Clinic 4. NGO Clinic 471.Other (specify)	
48	Have you got the service what you need?	1. Yes 2. No	
49.	If your answer is no what is/are the barriers?	491.Too far health institutions 492.Too expensive services	



		<p>493.Providers fail to keep privacy and confidentiality</p> <p>494. Poor handling and scolding by health workers</p> <p>495.Too much waiting time to get the service</p> <p>496.The health institutions infrastructure</p> <p>497. Communication barriers.</p> <p>498 .Don't know</p> <p>499 .Others, specify-----</p>	
410.	I don't want to know the result, but have you ever had an HIV test	<p>1. Yes</p> <p>2. No</p> <p>3. No response</p>	
411.	How do caregivers and service providers respond to people with disabilities when they come for their services?	<p>1. Well coming</p> <p>2. Disgusting</p> <p>3. Don't know</p>	
412.	Which is your major source of HIV service information (Multiple answers are possible)	<p>4121.TV/Radio</p> <p>4122.News paper</p> <p>4123.schools</p> <p>4124.Parents</p> <p>4125.Associations(CBOs)</p> <p>4126.Friends</p> <p>4127.Health Institutions</p> <p>4128.Others specify-----</p>	
413.	Do you think the available health care facilities physically accessible to you as disabled person?	<p>1. Yes</p> <p>2. No</p>	

### መጠይቅ

#### በጥናቱ ለመሳተፍ የፈቃደኝነት ማረጋገጫ

የማህበሩ ስም----- የመጠይቁ መለያ ቁጥር -----

ጠና ይስጥልኝ ስሜ----- ይባላል የመጣሁት ከአ.አ ዩኒቨርሲቲ ሜዲካል ፋካልቲ የህብረተሰብ ጠና ት/ቤት ነው እኔና እርሶ ለአጭር ጊዜ በውይይት ቆይታ ይኖረናል።

ወደዋናው ውይይታችን ከመሄዳችን በፊት ስለጥናቱ አጠቃላይ ሀሳብና ሁኔታ አነብሎታለሁና በጥሞና አዳምጠው በጥናቱ ለመሳተፍ መስማማትዎን ወይም አለመስማማትዎን ይገልጹልኛል።

ይህ ጥናት አዲስ አበባ ውስጥ በሚገኙ በአካል ጉዳተኞች ዙሪያ በሚሰሩ ማህበራት ስር በሚገኙ አካል ጉዳተኞች አባላት ላይ ስለ ወሲብ ባህሪና በኤችአይቪ ኤድስ አገልግሎቶች አጠቃቀምና ተደራሽነት ዙሪያ ያሉ ችግሮችን ለመዳሰስ ነው።

የዚህ ጥናት አላማ ለትምህርትና ምርምር ሲሆን በዚህ መጠይቅ ላይ የሚሰጡት መረጃ ሚስጥራዊነቱ የተጠበቀ ነው። እያንዳንዱ መጠይቅ የራሱ መለያ ቁጥር የሚኖረው ሲሆን በተዘጋጀው መጠይቅ ላይ ስምዎ አይገለጽም። በማንኛውም ጊዜ ይህን የጥናት ውጤት ማሳተም ቢያስፈልግ እንኩዋን ውጤቱ የሚገለጸው የጠቅላላውን የተሳታፊ ውጤት ነው።

በቃለመጠይቁ ወቅት በጥናቱ ያለመሳተፍ የማይፈልጉትን ጥያቄ ያለመመለስ እና በፈለጉ ሰዓት መጠይቁን የማቆረጥ መብትዎ የተጠበቀ ሲሆን በጥናቱ ሲሳተፉ ግን ጥናቱን ለሚሰሩትና ጥናቱ ትኩረት ላደረገባቸው የማህበረሰብ አባላት ጥቅሙ ላቅ ያለ ነው። በመሆኑም ከእርሶ የምናገኘው ቅንና እውነተኛ መልሶች ጥናቱ ለሚዳስላቸው ፅንሰ ሃሳቦች፣አካል ጉዳተኞችስለ ወሲብ ባህሪና ለኤችአይቪ ኤድስ ተጋላጭነት ላይ ያላቸውን ዕውቀት፣ ስለኤችአይቪ ኤድስ አገልግሎቶች አጠቃቀምና ተደራሽነትን ለማወቅ ከፍተኛ ግብአት ከመሆኑም በላይ ከምርምሩ የሚገኘው ውጤት ያለውን ተጨባጭ ሁኔታና በቀጣይ መሰራትና መወሰድ የሚገባቸውን እርምጃዎች መጠቀሚያ ይሆናሉ። ጥናቱ በትክክል የታለመለትን ግብ እንዲመታ የሚያደርጉትን ከፍተኛ ትብብር እናደንቃለን።

ስለጥናቱ ግልፅ ያልሆነ ነገር ወይም ጥያቄ ካለዎት የጥናቱን ተመራማሪ ማነጋገር ይችላሉ

የተሰጠው መረጃና የጥናቱ አላማ ግልፅ ነው

- 1. አዎ ( )
- 2. አይደለም ( )

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት

- 1. አዎ ( )
- 2.አይደለሁም ( )

የመረጃ ሰብሳቢው ስም----- ፊርማ-----

ስልክ ቁጥር----- አሜል አድራሻ-----

**ክፍል 1 : አጠቃላይ የግለሰብ መግለጫ**

ቁጥር	ጥያቄ	መግለጫ	
1	የአካል ጉዳት አይነት	<ol style="list-style-type: none"> <li>1. ማየት የተሳነው</li> <li>2. መስማት</li> <li>3. የእጅና የእግር</li> </ol>	
2	ጾታ	<ol style="list-style-type: none"> <li>1. ወንድ</li> <li>2. ሴት</li> </ol>	
3	ዕድሜዎ ስንት ነው	-----አመት	
4	ሀይማኖትዎ ምንድን ነው	<ol style="list-style-type: none"> <li>1. ኦርቶዶክስ</li> <li>2. ሙስሊም</li> <li>3. ፕሮቴስታንት</li> <li>4. ካቶሊክ</li> <li>5. ሌላ ካለ ይገለጽ</li> </ol>	
5	የየትኛው ብሄር ተወላጅ ነዎት	<ol style="list-style-type: none"> <li>1. አማራ</li> <li>2. አሮሞ</li> <li>3. ጉራጌ</li> <li>4. ትግራይ</li> <li>5. ሌላ ካለ ይገለጽ</li> </ol>	
6	የጋብቻ ሁኔታ	<ol style="list-style-type: none"> <li>1. ያገባ/ች</li> <li>2. ያላገባ/ች</li> <li>3. የፈታ/ች(የተለየ/ች)</li> <li>4. የሞተበት/የሞተባት</li> <li>5. አብሮ መኖር</li> </ol>	
7	መደበኛ ትምህርት ተምረው ያውቃሉ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልተማርኩም</li> </ol>	
8	ያጠናቀቁት የትምህርት ደረጃ ምን ያህል ነው	<ol style="list-style-type: none"> <li>1. ማንበብና መጻፍ</li> <li>2. አንደኛ ደረጃ</li> <li>3. ሁለተኛ ደረጃ</li> <li>4. ከፍተኛ ትምህርት</li> </ol>	
9	ስራዎ ምንድነው	<ol style="list-style-type: none"> <li>1. የመንግስት ሠራተኛ</li> <li>2. የግል ተቀጣሪ</li> <li>3. ነጋዴ</li> <li>4. የቤት እመቤት</li> <li>5. ተማሪ</li> <li>6. ስራ የሌለው</li> <li>7. ሌላ ካለ ይገለጽ</li> </ol>	
10	ወርሃዊ ገቢዎ ምን ያህል ነው	-----ብር	

**ክፍል ሁለት፡ ስለ ኤችአይቭ ኤድስ በሽታ ዕውቅትና አመለካከት**

ቁጥር	ጥያቄ	መግለጫ	
21	ስለ ኤችአይቭ ኤድስ በሽታ መረጃ ማግኘት ይችላሉ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልችልም</li> </ol>	አልችልም ከ ሆነ ወደ 23 ቁጥር ይሰሩ
22	መልስዎ አዎ ከሆነ ከየት?	<ol style="list-style-type: none"> <li>1. ከጠና ባለሙያ</li> <li>2. ከመገናኛ ብዙሃን</li> <li>3. መዕሄት</li> <li>4. ጋዜጣ</li> <li>5. ጓደኛ</li> <li>6. ትምህርት ቤት</li> <li>7. አካል ጉዳተኛ ማህበር</li> <li>8. ቤተሰብ</li> <li>9. ጎረቤት</li> </ol>	
23	መልስዎ አልችልም ከሆነ ምክንያቱ ምንድ ነው?	<ol style="list-style-type: none"> <li>1. በተገቢው መንገድ የተዘጋጀ መረጃ አለመኖሩ (በብራል ዕሁፍ / በምልክት ቋንቋ)</li> <li>2. ስለመግባቢያ መንገዶች በቂ እውቀት ባለመኖሩ</li> <li>3. አብዛኛው የመገናኛ ብዙሃን ፕሮግራሞች የሚዘጋጁት አካል ጉዳተኛ ላልሆኑት ብቻ መሆኑ</li> <li>4. በቂ መረጃ የሚሰጥ የአካል ጉዳተኛ ማህበር ባለመኖሩ</li> </ol>	
24	ኤችአይቭ ኤድስንና አባለዘርቦሽታን መከላከል ይቻላል?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አይቻልም</li> <li>3. አላውቅም</li> </ol>	
25	መልሱ አዎ ከሆነ እንዴት መከላከል ይቻላል?	<ol style="list-style-type: none"> <li>1. መታቀብ</li> <li>2. ድንገተኛ ወሲብን በመከላከል</li> <li>3. ለተጓዳኝ ታማኝ በመሆን</li> <li>4. ሁልጊዜና በአግባቡ ኮንዶምን በመጠቀም</li> <li>5. ከሴተኛ አዳሪ ጋር ወሲብ ባለመፈጸም</li> <li>6. ንጽህናው ባልተጠበቀ የህክምና መሳሪያ ባለመጠቀም</li> <li>7. ስለታም መሳሪያዎችን በጋራ ባለመጠቀም</li> <li>8. ሌላ ካለ ይገለጽ</li> </ol>	
26	ኤችአይቭ ቫይረስ በደሙ ውስጥ ያለበትና የኤድስ ህመምተኛ የሆነ የሚያውቁት ስው አለ?	<ol style="list-style-type: none"> <li>1. አውቃለሁ</li> <li>2. አላውቅም</li> </ol>	
27	በአካሉ ጠነኛ የሚመስል ሰው ኤችአይቭ ቫይረስ በደሙ ውስጥ ሊገኝ ይችላል?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አይቻልም</li> <li>3. አላውቅም</li> </ol>	

**ክፍል ሦስት፡የአካል ጉዳተኛ የወሲብ ባህሪ**

ቁጥር	ጥያቄ	መግለጫ	
31	ከተቃራኒ ጾታ ጋር የግብረ ስጋ ግንኙነት አድርገው ያውቃሉ?	1. አዎን አድርጌ አውቃለሁ 2. የለም አድርጌ አላውቅም	
32	ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት በስንት አመት ጀመሩ?	----- አመት	
33	የግብረ ስጋ ግንኙነት የጀመሩበት ምክንያት ምንድ ነው?	1. በጋብቻ 2. በፍላጎት 3. በጓደኛ ግፊት 4. በመደፈር 5. አላስታውስም 6. ሌላ ካለ ይገለጽ	
34	ለመጨረሻ ጊዜ የግብረ ስጋ ግንኙነት በፈጸሙት ወቅት ኮንደምን ተጠቅመው ነበር?	1. አዎ ተጠቅሟል 2. አልተጠቀምኩም	
35	በግብረ ስጋ ግንኙነት ጊዜ ሁልጊዜና በአግባቡ ኮንደምን መጠቀም አማራጭ ነው ብለው ያምናሉ?	1. አዎ 2. አላምንም 3. አልፎ አልፎ	
36	ለመጨረሻ ጊዜ የግብረ ስጋ ግንኙነት በፈጸሙበት ጊዜ እርሶ ወይም ጓደኛዎ መጠጥ ጠጥተው ነበር?	1. አዎ 2. አልጠጣንም 3. አላስታውስም	
37	ላለፉት 12 ወራት ምን ያህል የወሲብ ጓደኛ ነበሩት?	1. ----- ጓደኛ 2. አላስታውስም	
38	ላለፉት 12 ወራት ድንገተኛ ወሲባዊ ግንኙነት ፈፀመው ያውቃሉ?	1. አዎ 2. አላውቅም 3. አላስታውስም	
39	ከወሲብ ጓደኛዎ ጋር በምን ያህል ድግግሞሽ ስለ ኤችአይቭ ኤድስ ትወያያላችሁ?	1. ሁልጊዜ 2. አልፎአልፎ 3. ተወያይተን አናውቅም	
310	አስገዳጅ ወሲብ አጋጥሞዎት ያውቃል?	1. አዎ 2. አላጋጠመኝም 3. ሙከራ ተደርጎብኛል	

**ክፍል: አራት:የኤችኤይቪ ኤድስ አገልግሎት ተደራሽነትና አጠቃቀም**

ቁጥር	ጥያቄ	መግለጫ
41	ስለ የኤችኤይቪ ኤድስ አገልግሎት ሰምተው ያውቃሉ?	<ol style="list-style-type: none"> <li>አዎ</li> <li>አላውቅም</li> </ol>
42	የሚያውቁአቸውን የኤችኤይቪ ኤድስ አገልግሎቶች ይግለጹ	<ol style="list-style-type: none"> <li>በፈቃደኝነት ላይ የተመሰረተ የኤችኤይቪ ኤድስ ካውንስሊንግና የምርመራ አገልግሎት</li> <li>በባለሙያ አነሳሽነት የሚደረግ የኤችኤይቪ ኤድስ የምርመራና ካውንስሊንግ አገልግሎት</li> <li>ከእናት ወደልጅ እንዳተላለፍ የሚደረግ የኤችኤይቪ ኤድስ ካውንስሊንግና የምርመራ አገልግሎት</li> <li>የቤትለቤት የእንክብካቤ አገልግሎት</li> <li>የፀረ ኤችኤይቪ ህክምና</li> <li>በኤችኤይቪ የስነልቦናና ማህበራዊ አገልግሎት</li> <li>የቲቢና ኤችኤይቪ ቁርኝት አገልግሎት</li> </ol>
43	እነዚህ አገልግሎቶች የት እንደሚሰጡ ታውቃለህ/ሽ?	<ol style="list-style-type: none"> <li>አዎ</li> <li>አላውቅም</li> </ol>
44	ከነዚህ አገልግሎቶች ውስጥ ላንተ/ቺ አስፈላጊ የሆኑትን ማግኘት አስቸጋሪ ነውን?	<ol style="list-style-type: none"> <li>አዎ</li> <li>አይከብድም</li> </ol>
45	አገልግሎቶቹን ለማግኘት መስናክሎቹ ምንድናቸው?	<ol style="list-style-type: none"> <li>ጠና ድርጅቱን ማግኘት</li> <li>የመግባቢያ</li> <li>የአቅም/የገንዘብ</li> <li>ሌላ ካለ ይገለጽ</li> </ol>
46	ባለፉት 12ወራት ለኤችኤይቪ የህክምና አገልግሎት ለማግኘት ወደ ጠና ድርጅት ሄደው ያውቃሉ?	<ol style="list-style-type: none"> <li>አዎ</li> <li>አላውቅም</li> </ol>
47	የት ነው የሄዱት	<ol style="list-style-type: none"> <li>የመንግስት ሆስፒታል</li> <li>የመንግስት ጠና ጣቢያ</li> <li>የግል ክሊኒክ</li> <li>መንግስታዊ ያልሆነ ክሊኒክ</li> <li>ሌላ ካለ ይገለጽ</li> </ol>

48	የሚፈልጉትን አይነት አገልግሎት አግኝተው ተመለሱ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላገኘሁም</li> </ol>	
49	ለአካል ጉዳተኞች ወደ ጠና ድርጅት ሄደው የህክምና አገልግሎት እንዳያገኙ መስናክል የሚሆኑት ዋናዎና ነገሮች ምንድናችው?	<ol style="list-style-type: none"> <li>1. የጠና ድርጅቱ ርቀት</li> <li>2. የህክምና አገልግሎቱ ዋጋ</li> <li>3. የጠና ባለሙያ የተገልጋዩን ሚስጥር አለመጠበቅ</li> <li>4. የጠና ባለሙያ ተገልጋዩን በአግባቡ አለማስተናገድ</li> <li>5. አገልግሎቱን ለማግኘት የሚጠበቀው ጊዜ ረጅም በመሆኑ</li> <li>6. የጠና ድርጅቱ አመቺ አለመሆን</li> <li>7. አላውቅም</li> <li>8. ሌላ ካለ ይገለጽ</li> </ol>	
410	ውጤትህን/ሽ ማወቅ አልፈልግም ከዚህ በፊት ኤችአይቪ ተመርምረህ/ሽ ያውቃሉ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላውቅም</li> <li>3. መልስ የለም</li> </ol>	
411	አካል ጉዳተኞች ወደ ጠና ድርጅት በሚመጡበት ወቅት የጠና ባለሙያዎችና ሌሎች አገልግሎት ሰጪዎች አቀባበል ምን ይመስላል	<ol style="list-style-type: none"> <li>1. አጥጋቢ ነው</li> <li>2. ጥሩ ያልሆነ ነው</li> </ol>	
412	ስለ ኤችአይቪ ኤድስ አገልግሎቶች መረጃየሚያገኙት ከየት ነው?	<ol style="list-style-type: none"> <li>1. ቴሌቪዥን/ራዲዮ</li> <li>2. ጋዜጣ</li> <li>3. መምህራን</li> <li>4. ወላጆች</li> <li>5. ማህበራት</li> <li>6. ጉዋደኛ</li> <li>7. ጠና ባለሙያ</li> <li>8. ሌላ ካለ ይገለጽ</li> </ol>	
413	እንደ አካል ጉዳተኝነትህ/ሽ አሁን ያሉትን የህክምና ተቁማጭ በቀላሉ ማግኘት ይቻላል ብለው ያምናሉ?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አይቻልም</li> </ol>	

## ***FGD Guide***

### **Data collection tool for the assessment of situation of HIV service and disability in Addis Ababa: FGD guide for PWDs (group of individuals)**

#### **Introduction**

Good morning! Well come to our group discussion.

My name is -----, come from Addis Ababa University ,Faculty of Medicine attending a post graduate study in School of Public Health. Currently I am doing my master thesis and we are here today to discuss a bout risky sexual practice, accessibility and utilization of HIV service for people with disabilities. You are free to talk What ever information you think is important. There is no right or wrong answers. All comments, both positive and negative, are well come. We would like to have many points of view. We want this to be a group discussion, so you need not wait for me to call on you. In order not to miss any points of the discussion, we will be using a tape recorder. Please, speak one at a time so that the tape recorder can pick up everything. We would like to confirm to you that whatever information that you give me will be very useful for the study and all your comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality. Are you willing to participate in the discussion?

If yes, thank you for your willingness.

#### **I. HIV/AIDS Knowledge and Attitude of PWD:**

1. What are the factors that make PWD more at risk to HIV/AIDS?

#### **II. Knowledge and awareness regarding services on HIV/AIDS**

1. Do you have adequate information about services (relative to the totality of the community) on HIV/AIDS?
2. If you do not have sufficient awareness about HIV/AIDS services, what can be mentioned as major factors affecting your lack of awareness about the services?



### **III. Services regarding HIV/ AIDS**

1. What services are there in your area regarding the prevention and control of HIV /AIDS?
2. If not available where do you get the services from?
3. Do PWDs make use of these services?
4. If YES, what is your opinion about the accessibility and utilization of services?

### **IV. Suggestions and recommendations**

1. What do you suggest to be done?
  - To increase access and utilization of HIV service