

Health Seeking Behaviour for STDs Among Soldiers in Core One Hundred Eighth of the Ethiopian Army

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Abstract

A community based descriptive cross-sectional survey was conducted to describe the health-seeking behaviour for STDs and determine the factors associated with the health-seeking behaviour of soldiers in Core One Hundred Eighth of the Ethiopian army. The study was conducted in Tigray Regional State from December 2002 to February 2003. A sample proportionate to population size was drawn from each units of the Core and subjects were selected using a systematic random sampling technique. Data were collected from 384 subjects that reported having had one or more STD related genital symptoms during the one year recall period using a structured questionnaire. Among the sample, while awareness about gonorrhoea, syphilis, chancroid, and lymphogranuloma venerum was found to be fairly high, knowledge about the other STDs was low. A substantial number of respondents were found to have misconceptions and/or erroneous knowledge about the risk factors and preventive methods of STDs. Among study subjects, more urethral discharge, genital ulcer, genital blister, and painful micturation were found to be associated with STDs than the other genital symptoms (OR = 9.87 (5.29 – 19.27)). Peers were found to be the most important sources of information for STD related genital symptoms. The rate of treatment-seeking was 72.1%. Thought of having some kind of illness during having the symptom, severity of symptoms, perceived source of most effective treatment for the symptom and working assignment units were found to be significantly associated with treatment receipt ($P < 0.05$). Geographic proximity to units, marital status, and age were found to be significant determinants of choice of treatment sources (between those under Ministry of Defence and outside Ministry of Defence) ($P < 0.05$). Geographic proximity to units, association of genital symptoms with STDs, severity of symptoms, and working assignment units were found to be significantly associated with time of attendance to treatment sources ($P < 0.05$). In addition, attendance to

treatment sources at earlier symptomatic stages was found to correlate with longer military service ($P < 0.05$). Health education interventions should be strengthened and expanded to include the second generation STDs. Health education interventions should emphasise the risk factors, and preventive methods of STDs, and on the creation of demand and positive attitude towards modern services. The Ministry of Defence needs to look for a way to allow soldiers with STD related genital symptoms to receive care at any of the Ministry's treatment centres nearby their locations at times when they are away from their units. Studies concerning quality of treatment sources under Ministry of Defence should be carried-out to improve social accessibility of the treatment sources.

Introduction

The control of sexually transmitted diseases (STDs) is now recognised as a global priority (1 - 5). The list of sexually transmitted agents has been on the rise throughout this century and now numbers more than twenty (3, 6). Most cases of HIV (which is clearly a major cause of premature death) are the result of sexual transmission (1). The presence of an STD increases the likelihood of HIV transmission by a factor of five to twenty (7). The relation between certain STDs and cancer are now being established (2 - 5, 8). The morbidity and costs of STD complications has been increasing (3).

The magnitude of STD problems as well as the costs of STD complications are far higher for developing countries. For instance, while the prevalence of curable STDs among the adult population in Sub-Saharan Africa is between 11% and 35%, the prevalence in Western Europe and North American is between 1% and 4%. In developing countries, STDs are one of the five major causes of loss of productive life (2). Differences in social, political and health systems account for differences in the magnitude and costs of STD complications between developed and developing countries. The demographic and social transitions which many less developed countries are undergoing will further increase the magnitude of STD problems in developing countries during the next two or three decades (3).

STDs represent a major public health problem for Ethiopia as they are among the ten top causes for outpatient visits (6, 8, 9, 10). Alarming high prevalence rates of STDs have been reported from various population groups (11, 12). In Ethiopia, STD with its sequelae of pelvic inflammatory disease (PIDs) is a major cause of morbidity and mortality among women (13). For instance, 30% of all gynaecological admissions in 1985 were for PIDs (3, 13). The economic and social consequences of PID (many women with PID require

prolonged hospitalisation, infertility often leads to divorce, etc.) are severe (13). Available evidence also indicates that STDs are associated with increased transmission of HIV in the population. For instance, according to analysis of data of AIDS cases from 1986 to 1991, three-quarters of cases had history of episodes of STDs (14).

Military personnel are a population group at special risk of exposure to STDs. In peacetime, STD infection rates among armed forces are generally two to five times higher than in civilian populations; and in time of conflict the difference can be fifty times or more higher (2, 15, 16).

Although STD prevalence estimates are lacking, the available evidence indicates that STDs are the seventh highest cause for outpatient visits among the Ethiopian military and their families (17). A study in 2001 also reported a 26.8% prevalence rate of high risk sexual behaviour among military personnel in the Ethiopian ground force (18).

High STD rates among the military could impair national economy, threaten national security, (2) and could increase the prevalence of STDs in the general population (15). On the other hand, the better availability of resources in the military than the other social sectors, and the strong organisations traditions (for instance, discipline) provide better opportunities for STD control interventions (2, 9, 15). These facts make the military a major target group for STD control programmes.

One of the major problems in STD control programmes is that many cases do not comply with effective treatment early in the course of their disease (1). Despite the availability of treatment for about half of the STDs (2), world-wide, millions of cases left untreated (1).

Many cases also use methods of STD treatments which are unsafe and of unproven efficacy (4, 19). Many others also resort to self-medication, which usually involves taking inadequate dosage of often-inappropriate antibiotics (4). Of those presenting to public health facilities, many do late in the course of their disease and/or after visiting other treatment sources (20).

These practices could lead to continued transmission of STDs in the population, the development of complications among the infected and to the development of resistance to antibiotics by STD pathogens (1, 2, 4). As a result of inappropriate use of antibiotics, gonorrhoea and chancroid have become resistant to penicillins, sulphonamides and tetracyclines (4). Recently, fluoroquinolone resistant gonorrhoea has been reported from some parts of the world (21).

Promotion of health-seeking behaviour is one of the main strategies to controlling these problems (1). Hence, information on health-seeking behaviour of people with STDs, i.e., what people do and where they go when they suspect that they have a sexually transmitted disease is essential. In addition to knowledge on the local epidemiology and current management of STDs in health care settings, for STD control programmes to be most effective, they should be based on local assessment of health seeking behaviour in the population (1).

But in Ethiopia to date, no studies into the health seeking behaviour of military personnel for STDs have been carried-out. Because soldiers have differing background characteristics, the applicability to the group of the available studies findings is also limited. Therefore, this study was designed and conducted to describe the health-seeking patterns for STDs and identify factors associated with the health-seeking behaviour among soldiers in Core One

Hundred Eighth of the Ethiopian army. The findings of the study can assist health programme planners in designing and implementing appropriate health-seeking behaviour promotion interventions within the military sector.

Literature review

The Military Environment and the Risk of STDs.

The armed forces employ large numbers of young men who are in the most sexually active age bracket (a high risk group for STDs). Young people typically have feelings of invulnerability that distort their perceptions of risk. Military duty takes soldiers away from home for long periods of time. The lack of support, plus peer pressure from other soldiers can lead to risky behaviours, such as casual sex and commercial sex (2, 7, 15).

The need to relieve stress, loneliness and boredom leads to risky behaviour. Further, the use of alcohol and other drugs contribute to excessive risk taking (2, 7, 15). A study in Zambia in 1992 reported that the use of condoms by soldiers declined when they got drunk (22). Post-training and post-deployment periods are especially dangerous for contraction of STDs, including HIV (2, 7, 15).

Military personnel, camps and installations are known to attract sex workers and those who deal in illicit drugs and the level of risk goes up (2, 7, 15). The prevalence of STDs among Commercial Sex Workers is high (4). A study in Ethiopia in 1990 reported a 47.9% prevalence rate of STDs among Commercial Sex Workers of Addis Ababa (12). In Ethiopia, prostitution is accountable for 80% to 95% of STD transmissions (6). Soldiers, particularly on deployment, regularly have sexual contacts with sex workers and the local population. For instance, 45% of Dutch Navy and Marine personnel on peacekeeping duty in Cambodia had sexual contact with sex workers or other members of the local population on a 5-month tour (15). According to a 2001 study in Ethiopia, while 81.2% of soldiers in the army had sexual contact with Commercial Sex Workers, 8.2% had similar contact with non-commercial non-regular sex partners in the previous 12 months (18). Often soldiers do not use condoms

consistently during sexual contact with Commercial Sex Workers and/or non-commercial non-regular sex partners. In Zambia, according to a study in 1992, only 56% of soldiers used condoms during casual sex (22). A study in Ethiopia in 2001 reported that 27.6% of soldiers in the army did not use condoms during sexual contact with commercial or non-commercial non-regular sex partners in the previous 12 months (18). Off-duty soldiers can be counted on to have cash-but not necessarily condoms in their pockets (2, 7, 15).

It may be possible to speculate that characteristics that are valued in the military such as risk taking and aggressiveness, can lead to a greater danger of contracting STDs when carried into sexual situations. War and social upheavals dislocate populations, increasing the number of persons who use sex as a means of survival. Since soldiers are deployed in these periods of stress, there may be increased opportunities for sexual encounters (2).

Health seeking behaviour in relation to STDs

The two main aims of STD control programmes are interruption of transmission of STD infections and prevention of the development of complications and sequelae among the infected (1, 2). The provision of care to those with chronic or terminal disease forms the third part of most programmes (1).

The standard epidemiological model for STDs suggests that the basic reproductive rate (R_0) of STD in a population is a function of the efficiency of transmission (B) (the average probability of transmitting infection from an infected individual to a susceptible person), the average rate of acquisition of new sexual partners in the population (c), and the average duration of infectiousness (D). In a simple multiplicative way: this can be expressed as;

$R_0 = BcD$. Interventions directed to reducing any parameters should be of use in reducing

incidence of STD. Therefore, reducing the duration of infectiousness should be important in STD control (1). Consequently, health-seeking behaviour is central in controlling STDs. The early recognition of symptoms, presentation to health facilities and compliance with effective treatment should reduce the spread of treatable STDs (2). Although treatment for most viral STDs is palliative, recognition of disease can help reduce further transmission through avoiding sexual contact when the disease is active and through measures to avoid vertical transmission. In relation to HIV infection, early diagnosis can lead to better management, for instance, earlier and more aggressive treatment of opportunistic infections (1). In addition, provision of effective treatment to cases early in the course of their disease could prevent the development of complications. (1, 2). Hence, in relation to STDs, promotion of health-seeking behaviour could reduce the STDs burden.

In view of the above, studies on health seeking behaviour for STDs can assist programme planners in many ways. The studies help to design and initiate appropriate health education interventions. In most countries, following the introduction of mixed or free market economies, there exist various types of health care providers in addition to public health services. Information on which type of alternative health care providers people with STDs resort to can assist programme planners to design a strategy for involving them in the programme. Recognition of barriers to presentation to modern health facilities can assist programme planners to remove or reduce barriers (1). In addition, information on what people do and think concerning STDs can help programme planners to clearly demarcate areas of intervention and select target group(s) for interventions. As a result, there can be efficient utilisation of available resources. Promotion of health-seeking behaviour is among the major strategies in STD control programmes (1, 2, 4, 5, 8). Materialisation of this strategy may be possible through detection of barriers to presentation to modern treatment sources (2).

Information on health seeking behaviour for STDs can, therefore, have a great appeal to health programme planners.

Health-seeking behaviour is part of a wider concept, health behaviour. Health-seeking behaviour is a term which includes attention to pain and symptomatology, the processes by which symptoms are defined, accorded significance and socially labelled, to the extent of seeking help, and the change in life regimen as a result. For the purposes of planning health programmes it is generally health seeking behaviour, which is of interest, more specifically the use of modern health care facilities.

In developing countries, most studies on health-seeking behaviour tend to concentrate on the non-use of modern health care facilities. Although such a focus is very "practical" and in line with much operations research, it will weaken and potentially bias results if it is seen in this context. This is because; health-seeking behaviour is dependent on the acceptability and accessibility of interventions; both of which relate to broader social factors than simply decisions about "presentation to modern treatment sources for treatment" (1).

Studies dealing with the description of health-seeking behaviour for STDs should try to identify the normal and abnormal genital conditions believed to be STDs, the normal and abnormal non-genital conditions believed to be STDs and the abnormal genital conditions not believed to be STDs by people. In addition, the investigation should explore the actions people take when they have the genital and non-genital conditions believed to be STDs and the abnormal genital conditions not believed to be STDs (1).

Health-seeking behaviour in relation to STDs is dependent on a number of interacting factors.

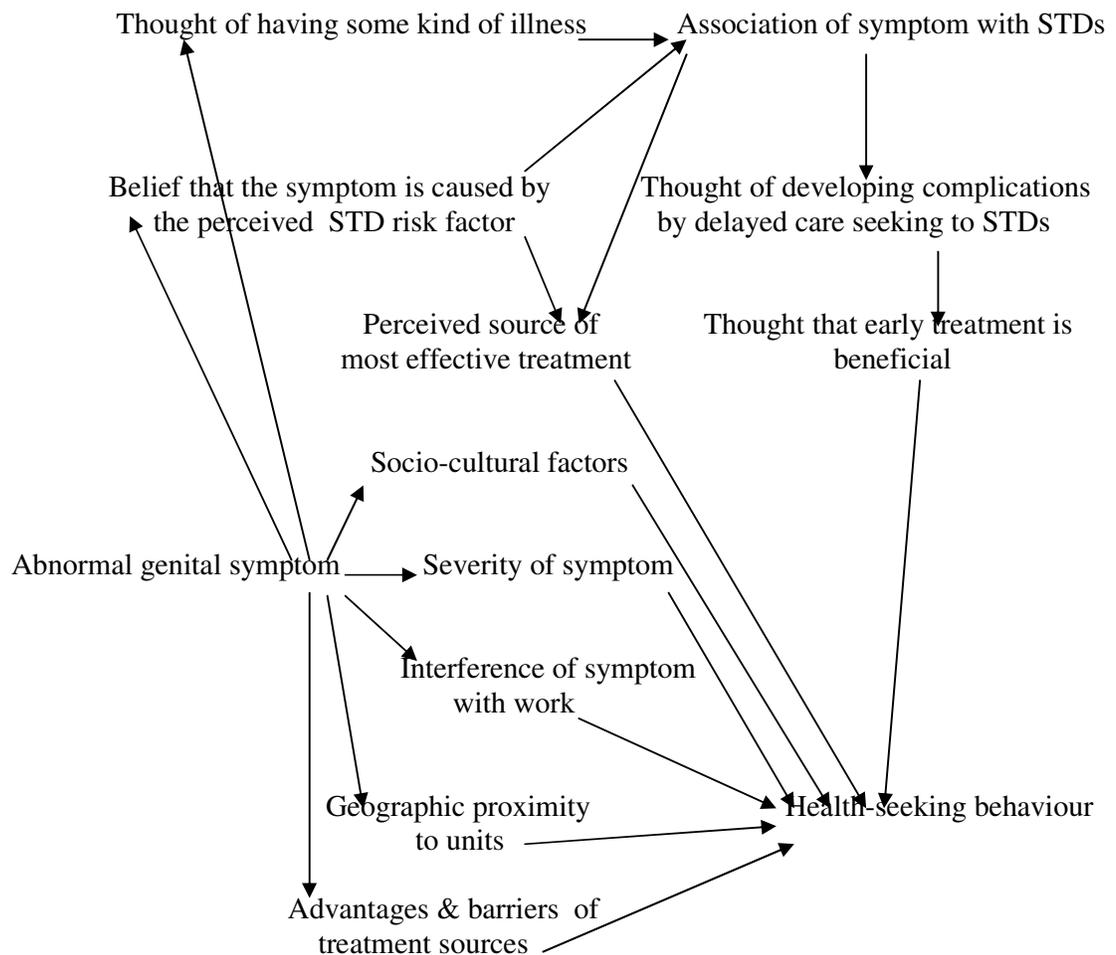
Recognition of symptoms is a starting point for most health-seeking behaviours. Recognition of symptoms is dependent on characteristics of the disease and characteristics of the subject. Depending on the nature and stage of infection, STDs may be asymptomatic, mildly symptomatic or highly symptomatic (1, 2, 4, 6, 24). In women, half the curable STDs show no outwardly detectable signs (2). For various reasons, the rate of asymptomatic STDs is by far higher for women than for men. For instance, while 80% of gonococcal infections are asymptomatic in women, only 10% are asymptomatic in men (24).

The lack of specificity of many STD symptoms hinders the recognition of symptoms. While genital ulceration and urethral discharge are relatively specific to STDs, vaginal discharge and pelvic pain in women and inguinal lymphadenopathy are not so specific and may occur with other infectious and non-infectious conditions (1, 8). As compared to males, the clinical symptoms in women are more subtle and the clinical signs are less easily detectable (25). In addition, there may be an uncertainty about normality, particularly for women in relation to vaginal discharge but also genital ulceration which can be regarded as a result of trauma and therefore to be expected after vigorous sex (1). These factors influence the association of symptoms with STDs. Consequently, genital symptoms which are clearly STD related in view of health workers may not be associated with STDs at all, in the minds of people. In studying health-seeking behaviour in relation to STDs, developing a taxonomy of abnormal genital conditions and exploring the links between symptoms, signs and perceptions of causes of these conditions is, therefore, useful (1).

There have been two broad frameworks for looking at the health-seeking behaviour. These frameworks are the Pathway and the Determinant's models. The Determinant's model is based on a more bio-medical and quantitative approach and can be used to outline a set of

factors influencing the health-seeking behaviour. According to the model, following recognition of symptoms, health-seeking behaviour is influenced by the personal threat of the disease, thought of having some kind of illness, the type of disease associated with the symptoms, severity and frequency of symptoms, the extent to which symptoms disrupt family, work and other social activities, the availability of treatment sources, physical proximity to treatment sources, psychological and monetary costs of taking action, beliefs in the efficiency of recommended health care, perceptions of risk in delaying care, age, sex, income, formal education, and marital status(1). For the purpose of this study, the Determinant's model was adapted and used. Accordingly, the following conceptual framework was developed and used.

Figure 1. Conceptual framework for the study



Health-seeking behaviour in relation to STDs in Ethiopia

Illness perception is the state of health as perceived by affected people which is not based on bio-medical knowledge but on subjective, personal assessment that depends on a wide range of personal experience, knowledge or ideas about a particular disease. Illness perception could influence health-seeking behaviour (29).

In Ethiopia, more than twenty sexually transmitted agents have been identified. However, while public awareness about syphilis (*kitign in Amharic*) and gonorrhoea (*chebt in Amharic*) appears to be fairly high, knowledge of the other STDs is poor, and public knowledge about the prevention and treatment of all STDs is also inadequate (6).

The first linguistic evidence of syphilis appears in sixteenth century. Syphilis is traditionally believed to be caused by eating diseased fowls or living in the neighbourhood of someone who is more than usually afflicted. Persons believing themselves infected would seek the advice of everyone but would not begin treatment until there were unmistakable signs of infection (30).

In Ethiopia, gonorrhoea is considered by many peoples as a natural, non-preventable disease (6). The disease is believed to be transmitted from toilet seats (27), and in rural areas, in highlands, it is expected to affect almost every adolescent male as a mark of maturity (6).

Many Ethiopians do not consider STDs as serious health problems (6). Many others also believe that STDs confer permanent immunity (27). In Ethiopia, among the STDs, gonorrhoea, herpes simplex, hepatitis and scabies are treated traditionally by medicinal

plants, and syphilis is treated by both medicinal plants and thermal springs (29). Among the population, for STDs, there is a faith in injectable penicillin as a cure (6).

In Ethiopia, studies into the health-seeking behaviour for STDs among various groups reported widely varying rates of treatment-seeking. A study in 1995 in Adammi-Tulu district (woreda) reported a 26.8% treatment-seeking rate among civilian population groups (23). In 1990, a study among commercial sex workers with STDs in Addis Ababa reported a 97.7% treatment-seeking rate (12). Several studies reported that the treatment sources for STD patients include: public health facilities, private clinics, self-treatment, private pharmacy and traditional healers (20, 23, 27, 28). One study reported that the association of perceived severity of symptoms with the rate of treatment-seeking for STDs (23). Another study reported that attendance to treatment sources at earlier symptomatic stages to correlate with higher educational level in males (20).

The Ministry of Defence's effort in controlling STDs

In Ethiopia, military personnel are recognised as groups that are at higher exposure to STDs (9). According to information from health services under the Ministry of Defence, STDs are the seventh highest cause for out patient visits among the military and their families (17). The risk of acquiring HIV infection can be increased by the presence of STD infections (1 - 6, 8, 9). The resulting morbidity and mortality can impair national economy and threaten national security (2). The spread and incidence of STDs in the population can also be increased (7, 15, 16). These facts necessitate the control of STDs among military personnel in the Ethiopian army. Cognizant of the fact that soldiers in the Ethiopian army are groups highly exposed to STDs, including HIV/AIDS, the Ministry has initiated an integrated HIV/AIDS and STD control programme.

Promotion of health seeking behaviour is among the components of STD prevention and control programmes among the military. In addition to provision of treatment services free of charge to soldiers and their families, provision of information and education about STDs and encouraging soldiers and their families to seek early treatment for STDs are among the strategies cited to promoting health-seeking behaviour. Management of STD cases based on the nationally accepted syndromic management of STDs is also among the STD control strategies among the group (17).

Rationale of the study

The advantage of provision of effective treatment as early as possible to STD cases for the infected and for the community has long been known. Provision of effective treatment for STD cases is among the main strategies to curb the HIV/AIDS epidemic. Provision of effective treatment for cases as early as possible could reduce the burden of STDs by reducing the incidence and by preventing the development of complications among the infected (1, 2). Various factors put soldiers at higher risk of getting infected with STDs than other civilian population groups. High STD rates among the military could impair national economy, threaten national security, and could increase the incidence of STDs in the population. On the other hand, the military represents several specific opportunities for STD control interventions (2, 9, 15). These facts make the military a major target group for STD control interventions. As STDs control strategy, provision of effective treatment for cases early in the course of their disease is most important among groups where the rate of partner change is high (1). The rate of partner change among soldiers is high (2, 7, 15). Hence, provision of effective treatment to infected soldiers as early as possible could be one of the most important strategies to controlling STDs among the group. For materialising this strategy, information on health-seeking behaviour of cases in the group is crucial. However in Ethiopia to date, no studies into the health seeking behaviour of soldiers for STDs are available. Because soldiers have differing background characteristics and there is also variations in some of the determinants of health-seeking behaviour (such as provision of treatment free of charge to the military) between the military and other civilian population groups, the applicability to the group of the available findings is also limited. In view of this, this study was designed and conducted to provide some information on health-seeking behaviour of soldiers for STDs. The findings could assist health planners in designing appropriate health-seeking promotion strategies in relation to STDs within the military sector.

Objectives

1.1 General objectives

To describe the patterns of health-seeking behaviour for STDs and identify factors associated with the health-seeking behaviour among military personnel with STD related genital symptoms in Core One Hundred Eighth of the Ethiopian army.

1.2 Specific objectives

1. To assess the knowledge level about STDs among military personnel with STD related genital symptoms in Core One Hundred Eighth of the Ethiopian army.
2. To assess the attitude towards STDs among military personnel with STD related genital symptoms in Core One Hundred Eighth of the Ethiopian army.
3. To describe the patterns of health-seeking behaviour for STDs and identify the factors associated with the health-seeking behaviour among military personnel with STD related genital symptoms in Core One Hundred Eighth of the Ethiopian army.

Methods and Materials

Study area

The study was conducted in the northern part of Ethiopia; in Tigray Regional State, around an area known as Shire Endeselasie. In this area, Core One Hundred Eighth of the Ethiopian army was assigned to look after the borders between Eritrea and Ethiopia. The Core has four Divisions, three of which are Infantry and one of which is Mechanised. Each Infantry Division has four Brigades and the Mechanised Division has three Brigades. Each Brigade of the Infantry and the Mechanised Divisions has four battalions.

Study design

A community-based descriptive cross-sectional survey was conducted from December 2002 to January 2003.

Source population

All active male soldiers with the listed STD related genital symptoms in Core One Hundred Eighth of the Ethiopian army were the source population.

Study population

Among the randomly selected active male military personnel; all those reported having one or more of the STD related genital symptoms during the one-year recall period were the study population. Female soldiers were excluded from the study as their proportion in the Ethiopian army was less than 5% (17) and due to characteristic variation of STDs among males and females (8, 24, 25).

Sample size determination

The sample size was determined in two steps.

Step 1. In the first step the number of soldiers with STD related genital symptoms that are required for estimation of the rate of treatment-seeking were determined. In doing so, the statistical formula for estimation of a single population proportion was used. Since the treatment-seeking rate of soldiers for STDs in the Ethiopian army was unknown, we assumed a 50% treatment-seeking rate. Assuming to have a 5% marginal error and to get a 95% confidence interval, the estimated sample size was 384.

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

Assumptions

d = degree of precision = 0.05

P = Rate of treatment seeking for STDs among soldiers = 50%

$\alpha = 0.05$ or $Z_{\alpha/2} = 1.96$

Step 2. Since the study was a community-based study, we estimated the total number of soldiers from which 384 subjects with STD related genital symptoms (i.e., that was estimated in step one) could be obtained. For lack of published data on the prevalence rate of STDs among the military in Ethiopia, we took the average prevalence rate of curable STDs among adult population in Sub-Saharan Africa (23%) (2). Considering the fact that in peace time the prevalence rate of STDs among soldiers is 2 to 5 times higher than that in civilian population groups, taking a prevalence rate of 23% could give us a logical estimate of the total number of subjects to be selected for the study. Accordingly, the estimated sample size was 1670. Assuming a 10% non-response rate the estimated total number of soldiers to be selected for the study were 1837.

Assumptions

P = Average prevalence rate of curable STDs among adult population in Sub-Saharan

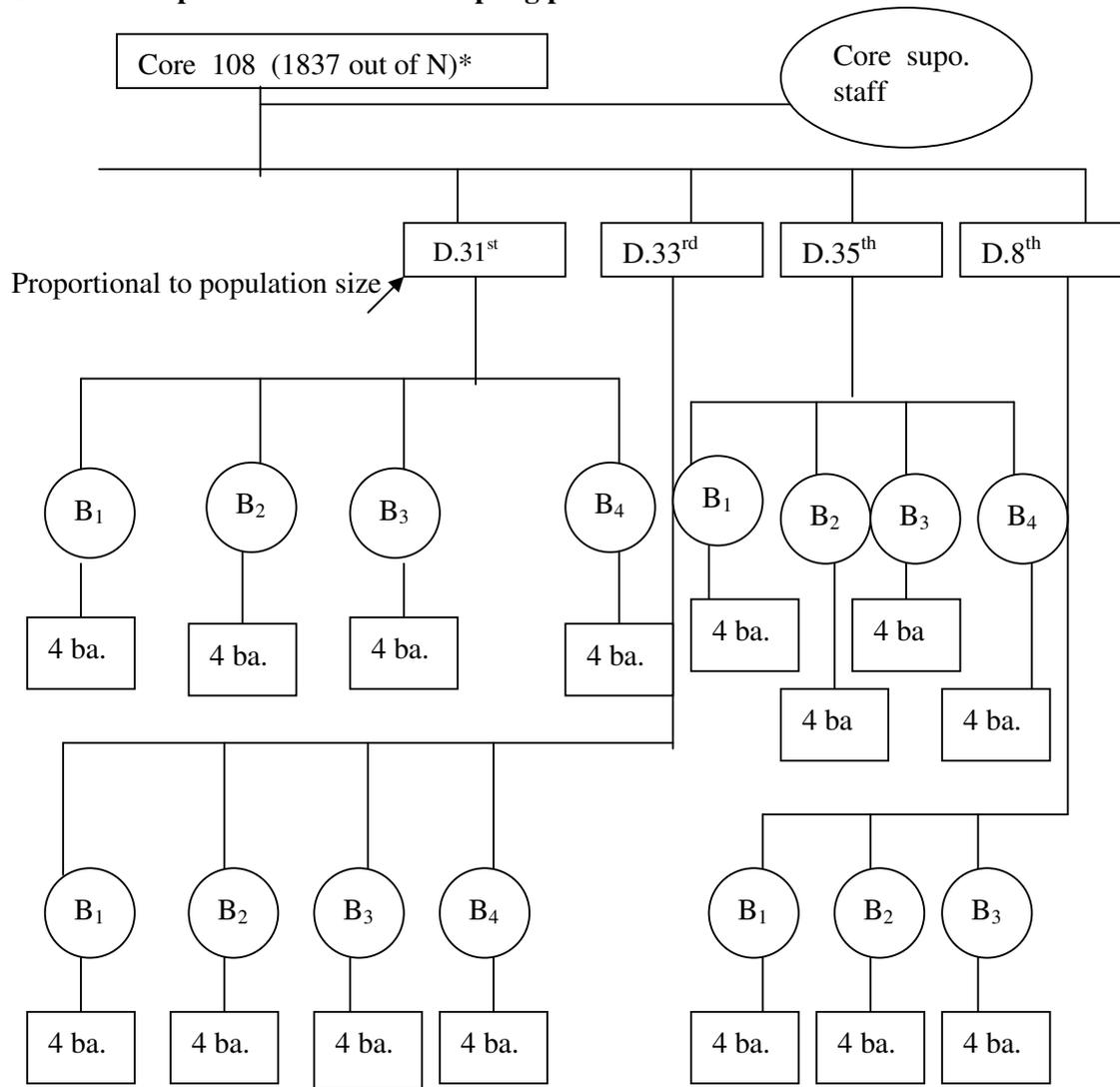
Africa = 23%

Non-response rate = 10%

Sampling technique

The Core's checklist for the month September 2002 was used to identify the total number of active male soldiers in the Core. Exclusion of inactive male soldiers and female soldiers was carried-out with the help of military personnel officials. The total number of subjects to be randomly selected from each units of the Core was determined using a proportionate to population size method. From each units of the Core, the determined number of subjects' were selected using a systematic random sampling technique. The Core's checklist for the month September was used for applying the systematic random sampling technique. From the randomly selected subjects, all that reported having the STD related genital symptoms during the one-year recall period were included in the study.

Schematic representation of the sampling procedure.



Variables selected for the study

Dependent variable

Health-seeking behaviour for STDs.

Independent variables

- Socio-demographic variables (Working assignment units, age, military rank, educational level, ethnic group, religion, marital status, military service year, monthly wage).
- Severity of symptoms.
- Belief that the symptom is caused by the perceived STD risk factor.
- Thought of having some kind of illness while having the symptom.
- Association of symptom with STDs.
- Geographic proximity to working units.
- Interference of symptoms with performance of usual work activity.
- Thought that getting early treatment for STDs is beneficial.
- Thought that delayed care seeking for STDs could result in complications.
- Perceived source of most effective treatment for the symptom.
- Perceived advantages and barriers of treatment sources.

Operational definitions of terms

Association of symptom with STDs: - At the time when the subject had the symptom, thought of having been ill with an illness perceived to be an STD by him/her and which is among the scientifically accepted STDs.

Belief that the symptom is caused by the perceived STD risk factor:- Believing that the cause of the symptom is among the risk factors of STDs perceived by him/her.

Geographic proximity to working units: - Whether subjects were in their working assignment units or had left their unit (for vacation or duty) during onset of symptoms.

Belief that toilet seats (areas of urination) can transmit STDs: - Belief that urinating while facing the sun, the moon, urinating at a hot place, and/or at a place where a dog has urinated can transmit STDs.

Non-regular sex partner: - Sex partner (other than spouse) that didn't last more than twelve months.

Unprotected sex: - Sex with non-regular sex partner without using condom.

STD related genital symptoms: - Urethral discharge, painful micturition, genital ulcer, genital/around genitals itching, genital swelling, scrotal swelling, Inguinal bubo/swelling of the lymph nodes over the groin area, genital rash, genital wart and genital blister.

Health-seeking behaviour for STDs: - The action taken by people for genital symptoms and when, where and why do people take those actions.

Other ranks: - Military personnel having a military rank of lance corporal, corporal, sergeant, sub-lieutenant, and lieutenant.

Data quality assurance

The prepared questionnaire was evaluated by advisors. The Amharic version of the questionnaire was back translated by a neutral person who has a bachelor degree in English language studies to ensure its consistency before fieldwork. The Amharic version of the questionnaire was pre-tested among 20 randomly selected soldiers with STD related genital symptoms. Accordingly, corrections were made before the actual data collection process. All data collectors and supervisors were male military health professionals.

Data collectors and supervisors were trained for two days. The training was aided by a training manual. The training was given by the principal investigator. After the training session, the data collectors and supervisors were evaluated for acquiring the necessary skills. To minimize social desirability bias, the data collectors and supervisors were assigned outside their working assignment units.

Military personnel in the Core were sensitised about the study before the data collection process. Military officials of the Core carried-out the sensitisation process. Unlinked anonymous information was collected and subjects were told about this before the data collection process. Subjects were interviewed at private settings.

The principal investigator together with the supervisors supervised the data collection process. Completed questionnaires were edited on a daily basis by the principal investigator and supervisors. Questionnaires with incomplete, inconsistent, suspicious and/or unlikely responses were returned to the data collectors and corrected on the next day.

Data entry and analysis

Data was entered and cleaned using EPI-INFO version 6. Analysis was carried out using EPI-INFO version 6 and SPSS version 10 statistical package software programmes. The principal investigator analysed the data. Some of the independent variables and most of the outcome variables were dichotomised and analysed. Association of the independent variables with the dichotomised dependent variables was tested using bivariate and binary logistic regression analysis. Correlation analysis was employed in testing for association between time of attendance to treatment sources and military service years and age.

Ethical considerations

Ethical clearance was obtained from Addis Ababa University, Medical Faculty, Ethical Clearance Committee. A letter written from the Addis Ababa University, Department of Community Health, was used to communicate with officials at Ministry of Defence's Head Quarter of the Health Command. Officials down in the organisational hierarchy of the Ministry of Defence were communicated through official letters written from the Ministry of Defence's Head Quarter of the Health Command. Informed consent was obtained from each subject before the data collection process. Health education about the need of treatment was given to those who reported having the genital symptoms during the study period.

Results

Response rate and socio-demographic characteristics

Out of the randomly selected 1837 subjects, 1689 (91.9%) were interviewed. One hundred forty eight (8.1%) subjects were not interviewed since 84 subjects were not available during the study period, 11 subjects were unwilling to participate in the study, and seven subjects were hospitalised due to various illnesses. There was a language barrier which prevented interview with one of the subjects.

Among the randomly selected and interviewed subjects, information was collected from only those who reported having had one or more of the STD related genital symptoms during the one year recall period. Accordingly, information was collected from 384 subjects. Among respondents, while the minimum reported age was 18 years, the maximum reported age was 42 years. Nearly 60% of respondents were aged between 20 and 25 years. The mean \pm standard deviation age of respondents was 25.4 ± 4 years and the median age of study participants was 25 years. With regard to educational level, nearly half (48.7%) of the respondents were grade one to six while 138 (35.9%) of the respondents were grade seven and above. The remaining 59 (15.4%) of the study subjects did not attend any formal education. Almost three-quarters (74.7%) of the respondents were private soldiers, 85 (22.1%) were non-commissioned officers and 12 (3.1%) were commissioned officers by military rank. Among respondents, while the minimum reported military service year was three years, the maximum reported military service years was twenty two years. About 90% of the respondents served in the military for three to five years. The

mean \pm standard deviation military service year of respondents was 4.2 ± 2.8 years and the median military service year of respondents was three years. With regard to marital status, the majority (68.2%) of the respondents were never married, 106 (27.6%) were married, and the rest 16 (4.2%) of the respondents were divorced and separated. Ethnically, 129 (33.6%) of the respondents were Amharas, 111 (28.9%) of the respondents were Oromos and 50 (13%) of the respondents were Tigres. While the rest 94 (24.5%) study participants were from Southern Nations and Nationalities Region, Somale and Afar Regions. Regarding religion, the majority (68.5%) were Orthodox Christians. The distribution of respondents by socio-demographic characteristics is shown in Table 1 below.

**Table 1: Distribution of respondents by socio-demographic characteristics.
Tigray Regional State: around Shire, Dec., 2002. (n = 384)**

Socio-demographic characteristics		Frequency	Percentage
Unit			
	Core staff	10	2.6%
	Division 31 st	111	28.9%
	Division 33 rd	110	28.6%
	Division 8 th	41	10.7%
	Division 35 th	112	29.2%
Ethnicity			
	Tigre	50	13%
	Amhara	129	33.6%
	Oromo	111	28.9%
	Others	94	24.5%
Religion			
	Orthodox	263	68.5%
	Muslim	68	17.7%
	Catholic & Protestant	53	13.8%
Marital status			
	Married	106	27.6%
	Never married	262	68.2%
	Divorced & separated	16	4.2%
Military service years			
	3 years	230	59.9%
	4 years	76	19.8%
	5 years	38	9.9%
	≥ 6 years	40	10.4%
Educational level			
	Illiterate	36	9.4%
	Only read and write	23	6%
	Grade one to six	187	48.7%
	Grade seven to eight	60	15.6%
	Grade nine and above	78	20.4%
Military rank			
	Private soldier	287	74.7%
	Lance corporal	66	17.2%
	Corporal	12	3.1%
	Sergeant	7	1.8%
	Sub-lieutenant	7	1.8%
	Lieutenant	5	1.3%

Age			
	18 – 20 years	28	7.3%
	21 – 23 years	124	32.3%
	24 – 26 years	108	28.1%
	27 – 29 years	67	17.4%
	> 29 years	57	14.8%
Monthly wage			
	200 to 400 Ethiopian Birr	367	95.6%
	401 to 600 Ethiopian Birr	17	4.4%

Knowledge and Perceptions of the cause, risk factors and prevention of STDs

A total of 379 (98.7%) respondents had heard about diseases that can be transmitted through sexual contact. Three hundred seventy six (97.9%) of the respondents mentioned one or more and 359 (93.5%) of the respondents mentioned two or more sexually transmitted diseases (STDs). Among the STDs, gonorrhoea was known to 367 (95.6%), chancroid was known to 295 (76.8%), lymphogranuloma venerum was known to 244 (63.5%), syphilis was known to 243 (63.3%), and HIV/AIDS was known to 150 (39.1%) of the respondents. While genital wart, genital herpes, and genital scabies were known to 11 (2.9%) of the respondents. One (0.3%) respondent mentioned smallpox to be among the STDs.

One hundred forty seven (38.3%) of the respondents either did not know and/or think that people who had an STD earlier and got cured from that STD can catch it again. Forty-four (11.5%) of the respondents either did not know and/or think that a person cannot catch any of the STDs by having unprotected sex with a non-regular asymptomatic sex partner. Two hundred fifty five (66.4%) of the respondents either do not know and/or do not think that uncircumcised males are at risk of getting infected with STDs than circumcised ones.

About three percent of respondents did not know how STDs can be transmitted. While about 97% of the respondents thought that unprotected sex can transmit STDs, about 9% thought that toilet seats can transmit STDs. Two (0.5%) of the respondents thought that kissing and sweat of infected person can transmit STDs while 1 (0.3%) of the respondents thought that dirt in the stomach can cause STDs. The distribution of respondents by perceived risk factors of STDs is shown in Table 2 below. For a large majority (95.6%) of the respondents exposure to unprotected sex is the most threatening STD risk factor while for 1 percent of the respondents toilet seat is the most threatening STD risk factor.

Table 2: Distribution of respondents by perceived risk factors for STDs. (n = 384)

Perceived STD risk factors	Frequency	Percentage
Unprotected sex	373	97.1%
Toilet seats	36	9.4%
Contaminated blades, needles, etc. by blood/saliva and/or infected blood transfusion	36	9.4%
Kissing/sweat of infected person	2	0.5%
Clothes contaminated by genital discharges of Infected person	16	4.2%
Incorrect application of condom	5	1.3%
Dirt in the stomach	1	0.3%
Don't know	11	2.9%

NB. More than one answer was possible

A total of 370 (96.4%) respondents believed that they could protect themselves against STDs while nine (2.3%) of the respondents did not. Among the STD protective methods,

use of condom was known to 359 (93.5%), having one faithful sex partner was known to 237 (61.7%), and abstinence from sex was known to 204 (53.1%) of the respondents. Only two (0.5%) of the respondents thought that sex with a person screened and proved free from STD infections can protect STD infections. About 9% of the respondents thought that private use of clothes/materials, urinating at certain places/directions, refraining from drinking alcohol or before having sex no, maintaining the warmth of genitalia and keeping personal hygiene can protect against STD infections. About 20% of the respondents believed that abstinence from sex to be the most effective STD protective method and 22.4% of the respondents believed that having one faithful sex partner to be the most effective STD protective method. The distribution of respondents by perceived most effective STD protective method is shown in Table 3 below.

Table 3: Distribution of respondents by perceived most effective STD protective method. (n = 384)

Perceived most effective STD protective method	Frequency	Percentage
Abstinence from sex	77	20.1%
Having one faithful sex partner	86	22.4%
Use of condom	202	52.6%
Sex only with a person screened and proved free from STD infections	1	0.3%
Do not believe and/or do not know STD protective methods and/or don't know most effective protective method	18	4.7%
Total	384	100%

Twenty two (5.7%) of the respondents did not know any symptoms of STDs in men. Thirty five (9.1%) of the respondents mentioned one and 327 (85.2%) of the respondents mentioned two or more symptoms of STDs in men. Among the genital STD symptoms, genital discharge was known to 339 (88.3%), painful micturation to 283 (73.7%), and genital ulcer to 182 (47.4%) of the respondents. Among the other genital symptoms of STDs, genital swelling was known to 78 (20.3%), scrotal swelling to 22 (5.7%), inguinal swelling to 23 (5.99%), genital warts to two (0.5%), genital rash to 16 (4.2%), and genital blister was known to 7 (1.8%) of the respondents. A total of 32 (8.3%) respondents mentioned loss of weight, generalised body weakness, diarrhoea, fever, back pain, loss of appetite, pain around umbilicus, swelling of kidneys, dribbling of urine, joint pain, anuria and hematuria to be among symptoms of STDs in men.

Regarding the advantage of getting early treatments, twenty three (5.9%) of the respondents did not know and/or did not believe that getting early treatments for STDs is beneficial. Forty four (11.5%) of the respondents did not know and/or did not believe that delay in getting treatment for STDs can result in additional health problems (complications) to the infected person. Among the possible complications of delayed treatment mentioned by the respondents were increased likelihood HIV infection if having sex before getting cured from his/her STDs (by 47.1% of the respondents), sterility (by 37.5% of the respondents), and urethral stricture (by 21.4% of the respondents). A total of 107 (27.9%) respondents mentioned vertebral deformity, diarrhoea, death, penile amputation, cachexia, paralysis or handicapping, giving birth to a sick or a dead child, anxiety, development of resistance to antibiotics, abdominal distension, and making a person handicap to be among the STD complications.

Self-reported genital symptoms and health seeking behaviour.

A total of 10 kinds of STD related genital symptoms were reported. The distribution of respondents according to self-reported most recent genital symptoms during the one year recall period is shown in Table 4 below. Urethral discharge was the most commonly (33.3%) reported symptom while genital blister was reported by only 1.3% of the respondents. The urethral discharge to genital ulcer ratio was found to be 2.4:1. According to data from 348 (90.6%) of the respondents, the time of onset of genital symptoms ranged between one and 365 days. Among these respondents, The mean \pm standard deviation time of onset of symptoms was 134.5 ± 113.2 days and the median time of onset of symptoms was 105 days. A total of 36 (9.4%) respondents reported having left their working units during onset of symptoms. One hundred thirty four (34.9%) of the respondents consulted others about their genital symptoms. Of those who made consultation, the majority 94 (70.1%) consulted their peers. Seventy one (18.5%) of the respondents reported past history of similar genital symptoms. During the study period, the reported genital symptoms were present in 111 (28.9%) of the respondents.

Table 4: Distribution of respondents by self-reported genital Symptoms. (n = 384)

Self-reported genital symptoms	Frequency	Percentage
Urethral discharge	128	33.3%
Painful micturation	96	25.0%
Genital ulcer	54	14.1%
Genital/around genital itching	17	4.4%
Genital swelling	6	1.6%

Scrotal swelling	17	4.4%
Inguinal swelling	31	8.1%
Genital rash	18	4.7%
Genital warts	12	3.1%
Genital blister	5	1.3%
Total	384	100%

With regard to perceived causes of symptoms, 68 (17.7%) of the respondents did not know the causes and 6 (1.6%) believed that there was no cause for the genital symptoms they had. Two hundred twenty nine (59.6%) of the respondents believed that the causes of their genital symptoms were among the risk factors of STDs they perceived while the rest 81 (21.1%) did not believe that the causes of their genital symptoms were among the risk factors of STDs they perceived.

According to perceived causes of the symptoms, 6 (1.6%) of the respondents believe that no effective treatment for the symptom exists, twenty seven (7.0%) of the respondents do not know the source of most effective treatment, twenty eight (7.3%) of the respondents believe that symptoms could disappear without treatment, and 1 (0.3%) of the respondents believe that keeping personal hygiene to be the most effective treatment for the symptom they had. On the other hand, while 239 (62.2%) of the respondents believe that the most effective treatment for the symptom could be obtained from modern treatment sources, fifteen (3.9%) of the respondents believe that the most effective treatment for the symptom could be available from traditional treatment sources.

At the time of appearance of genital symptoms, a total of 322 (83.9%) respondents reported that they had thought of having some kind of illness. The rate of perceived STDs was 50.5%. Of these, a large majority (78.9%) perceived gonorrhoea, 28 (14.4%) chancroid, 5 (2.6%) lymphogranuloma venerum, 4 (2.1%) syphilis, 3 (1.5%) HIV/AIDS and one (0.5%) perceived genital warts to be the STDs associated with the genital symptoms they had. Among study participants, urethral discharge, genital ulcer, genital blister, and painful micturation were found to be associated with STDs than the other genital symptoms (OR = 9.87 (5.29 - 19.27)). More specifically, compared to the other genital symptoms, while urethral discharge and painful micturation were found to be associated with gonorrhoea (OR = 71.49 (22.26 - 259.97)), genital ulcer was found to be associated with chancroid (OR = 57.2 (16.97 - 204.71)) among the study subjects.

A total of 107 (27.9%) respondents did not receive treatments for the genital symptoms they had. The distribution of respondents by reasons for receiving no treatments is shown in Table 5 below. The reasons reported by the majority (85.9%) of the respondents receiving no treatments were unavailability of effective treatment for the symptoms, non-seriousness (mildness) of the symptoms and the belief that the symptoms would disappear without treatment. In addition, about 11% of the respondents receiving no treatments reported that they didn't receive treatments due feelings of shame while discussing the matter with a health professional.

Table 5: Distribution of respondents by reasons for not receiving treatment for genital symptoms. (n = 107)

Reported reasons	Frequency	Percentage
Absence of effective treatment	16	14.9%

Symptom is not serious (mild)	27	25.2%
Symptom could disappear without treatment	49	45.8%
Feel guilty discussing the problem with a health professional	12	11.2%
Unavailability of traditional healer in the area	1	0.9%
Lack of time	1	0.9%
Long distance to treatment sources	1	0.9%
Total	107	100%

A total of 277 (72.1%) respondents reported receiving treatment from one or more treatment sources. One hundred thirteen (29.4%) of the respondents reported receiving treatment from two or more treatment sources. Among respondents reporting receiving treatments, those who reported urethral discharge and genital ulcer were found to be more likely to receive treatment than those reporting other symptoms (OR = 10.2 (5.4 - 19.8)). Of the respondents who reported receiving treatment, the majority (82.7%) reported visiting the Ministry of Defence's health facilities while 48 (17.3%) reported visiting treatment sources outside the Ministry of Defence. The distribution of respondents by visited first treatment sources is shown in table 6 below.

Table 6: Distribution of respondents by visited first treatment sources visited. (n = 277)

First treatment source	Frequency	Percentage
Health facilities under MOD	229	82.7%
Public (MOH's) clinics and health centres	11	3.9%
Private clinics	19	6.9%
Private pharmacies	12	4.3%
Traditional healers	2	0.7%
Self-treatment	4	1.4%
Total	277	100%

Among respondents whose first treatment sources were health facilities under Ministry of Defence (MOD), a large majority (85.6%) visited Battalion Clinics. The reasons reported by about 56% of the respondents for visiting the treatment sources under MOD were short distance and provision of care free of charge. Among respondents whose first treatment sources were treatment sources outside MOD, the majority (64.6%) visited private clinics and private pharmacies. The reasons reported by about 63% of the respondents for resorting to the treatment sources outside MOD were having been away from working assignment units during onset of symptoms and the desire to maintain confidentiality of data. The distribution of respondents by reasons to visit treatment sources is shown in table 7 below. Among respondents reported receiving treatments, those who reported the desire to maintain confidentiality of data and having been away from unit during onset of symptoms as reasons were found to be less likely to visit treatment sources under the Ministry of Defence than those reporting other reasons (OR = 0.03 (0.01 – 0.08)).

Table 7: Distribution of respondents by reasons for visiting first treatment sources.

(n = 277)

Reported reasons	Treatment sources			
	Under MOD		Out side MOD	
	Frequency	Percentage	Frequency	Percentage
Good treatment	62	27.1%	8	16.7%
Short distance	91	39.7%	6	12.5%
Confidentiality of data	12	5.2%	17	35.4%
Having been away from unit	0	0%	13	27.0%
Short waiting time	1	0.4%	1	2.1%
Others	63	27.6%	3	6.3%
Total	229	100%	48	100%

N.B. Other reported reasons include know treatment, presence of qualified personnel, good reception, maintenance of privacy, provision of care free of charge, provision of good advice at visited sources and referral.

A total of 269 (70.1%) respondents reported the time interval between onset of symptoms and presentation to first treatment sources. Among these respondents, the time interval ranged between one and 30 days. The mean \pm standard deviation time interval between onset of symptoms and presentation to treatment sources was 6.4 ± 4.7 days and the median time interval was 5 days. The majority (58.7%) of the respondents presented to first treatment sources within a week (7 days).

Among respondents whose first treatment sources were outside MOD, 17 (35.4%) visited the Ministry of Defence's health facilities for additional treatments. The reason (for all) to visit the Ministry of Defence's health facilities was getting no cure from treatments received from the first treatment sources. Among these respondents, the range of time between visit to first treatment sources and visit to treatment sources under MOD was between three and 90 days with a mean of 19.8 days.

Determinants of health seeking behaviour.

Regarding receipt of treatment, respondents who thought of having some kind of illness during having the symptoms were found to be more likely to receive treatments than those who did not (OR = 49.3 (13.1 - 185.4)). Study participants that reported symptoms to be severe and very severe were found to be more likely to receive treatments than those who reported symptoms to be very mild and mild (OR = 16.1 (3.5 - 74.4)). Respondents who did not know the source, believed that effective treatment for the symptom is unavailable and those who believed that effective treatment for the symptom could be available from traditional or other treatment sources were found to be less likely to receive treatments than

those who believed that effective treatment for the symptom could be available from modern treatment sources (OR = 0.15 (0.07 - 0.33)). Determinants of treatment receipt are shown in Table 8 below. On bivariate analysis, respondents who perceived the cause of their symptoms to be among the risk factors of STDs they perceive; respondents who associated genital symptoms with STDs; and respondents who reported symptoms interfered with work were found to be more likely to receive treatments than those who didn't and whose symptoms did not. However, on logistic regression, these associations didn't remain significant.

Table 8: Determinants of treatment receipt among soldiers. (n = 384)

Variables	Receipt of treatment		Crude OR (95% CI)	Adjusted OR (95% CI)
	Yes n (%)	No n (%)		
	Believed that symptom is caused by the perceived STD risk factors			
Yes	196 (85.9)	32 (14.1)	5.67 (3.4-9.55)*	1.19 (0.5-2.93)
No	81 (51.9)	75 (48.1)	1	1
Association of symptoms with STDs				
Yes	177 (91.2)	17 (8.8)	1	1
No	100 (52.6)	90 (47.4)	0.11 (0.06-0.19)*	1.13 (0.5-2.79)

During having the symptom, think having some kind of illness				
Yes	274 (85.1)	48 (14.9)	112.3 (33.8-571.7)*	49.3 (13.1-185.4)*
No	3 (4.8)	59 (95.2)	1	1
Reported severity of symptoms				
Very mild & mild	110 (55.0)	90 (45.0)	1	1
Moderate	74 (84.1)	14 (15.9)	4.32 (2.23-8.82)*	1.69 (0.8-3.84)
Severe & v. severe	93 (96.9)	3 (3.1)	25.36 (7.9-128.4)*	16.1 (3.5-74.4)*
Interference of symptom with work performance				
Yes	62 (92.5)	5 (7.5)	5.88(2.28-19.26)*	0.73 (0.21-2.6)
No	215 (67.8)	102 (32.2)	1	1
Perceived source of most effective treatment.				
Other than modern	64 (44.1)	81 (55.9)	0.10 (0.05-0.17)*	0.15 (0.07-0.3)*
Modern	213 (89.1)	26 (10.9)	1	1

***P < 0.05**

Respondents working in Division thirty-first (OR = 2.2 (1.2 - 4.1)) and in Division thirty-third (OR = 2.5 (1.4-4.7)) were found to be more likely to receive treatments than those working in Division thirty-fifth. Socio-demographic determinants of treatment receipt are shown in Table 9 below.

Table 9: Socio-demographic determinants of treatment receipt among soldiers.

(n = 384)

Variables	Receipt of treatment		Crude OR (95% CI)	Adjusted OR (95% CI)
	Yes n (%)	No n (%)		
Assignment unit				
Core staff	7 (70)	3 (30)	1.51 (0.32-9.49)	1.32 (0.28-6.13)
Division 31 st	85 (76.6)	26 (23.4)	2.12 (1.14-3.96)*	2.23 (1.21-4.1)*

Division 33 rd	86 (78.2)	24 (21.8)	2.32 (1.24-4.39)*	2.54 (1.4-4.7)*
Division 08 th	31 (75.6)	10 (24.4)	2.01 (0.85-5.04)	1.9 (0.78-4.7)
Division 35 th	68 (60.7)	44 (39.3)	1	1
Marital status				
Married	81 (76.4)	25 (23.6)	1.36 (0.79-2.38)	1.54 (0.88-2.7)
Single, divorced & Separated	196 (70.5)	82 (29.5)	1	1
Military Rank				
Private sold	204 (71.1)	83 (28.9)	1	1
Other ranks	73 (75.3)	24 (24.7)	1.24 (0.71-2.20)	1.28 (0.60-2.72)
Education level				
≤Grade 6	176 (71.5)	70 (28.5)	0.92 (0.56-1.52)	1.0 (0.56-1.78)
>Grade 6	101 (73.2)	37 (26.8)	1	1
Monthly wage				
200 - 400 Et.br.	265 (72.2)	102 (27.8)	1	1
401 - 600 Et.br.	12 (70.6)	5 (29.4)	0.92 (0.29-3.43)	1.01 (0.28-3.61)

***P < 0.05** **N.B. Odds ratio was adjusted for ethnic group, religion, age and military service year.**

Other ranks: - *Military personnel having a military rank of lance corporal, corporal, sergeant, sub-lieutenant, and lieutenant.*

To analyse the factors influencing the choice of treatment sources, respondents whose first treatment sources were among health institutions under Ministry of Defence were categorised in one group and respondents whose first treatment sources were outside Ministry of Defence were categorised in another group. Based on this categorisation, respondents located in their working unit during onset of symptoms were found to more likely visit treatment sources under Ministry of Defence than those who were not (OR = 12.9 (5.6 - 30)). Of the respondents reported receiving treatments from the Ministry of Defence's treatment sources, while about 77% believed that the most effective treatment for their symptoms could be obtained from modern treatment sources, about 23% didn't know, believed traditional healers, or believed that keeping personal hygiene to be the

most effective treatment for their symptoms. There was no statistically significant difference among those who believed that the cause of their genital symptom is among the perceived risk factor of STDs and who did not, and among those who associated their symptoms with STDs and who did not in the choice of treatment sources. Determinants of choice of treatment sources are shown in Table 10 below.

Table 10: Perception and location related determinants of choice of treatment Sources among soldiers. (n = 277)

Variables	Treatment source		Crude OR (95% CI)	Adjusted OR (95% CI)
	Under MOD n (%)	Outside MOD n (%)		
Believed that symptom is caused by the perceived STD risk factor				
Yes	162 (82.7)	34 (17.3)	1.00 (0.46-2.05)	1.3 (0.51-3.1)
No	67 (82.7)	14 (17.3)	1	1
Association of symptoms with STDs				
Yes	144 (81.4)	33 (18.6)	0.77 (0.37-1.56)	0.8 (0.34-1.8)
No	85 (85)	15 (15)	1	1
During onset of symptoms, present in unit				
Yes	218 (88.3)	29 (11.7)	12.9 (5.20-33.0) *	12.9 (5.6-30) *
No	11 (36.7)	19 (63.3)	1	1

***P < 0.05**

Regarding socio-demographic determinants, married respondents were found to be more likely to visit treatment sources under Ministry of Defence than those who were single and divorced (OR = 2.5 (1.1 - 5.7)), and respondents aged 25 years and less were found to be more likely to visit treatment sources under Ministry of Defence than those aged above twenty five years (OR = 2.9 (1.5 - 6.2)). On bivariate analysis, respondents whose educational level was grade 6 and less were found to be more likely to visit treatment sources under Ministry of Defence than those who were grade 7 and above. However, on logistic regression, it did not remain significant. Socio-demographic determinants of choice of treatment source are shown in Table 11 below.

Table 11: Socio-demographic determinants of choice of treatment sources among soldiers. (n = 277)

Variable	Treatment sources		Crude OR (95% CI)	Adjusted OR (95% CI)
	Under MOD n (%)	Outside MOD n (%)		
Assignment unit				
Core staff	6 (85.7)	1 (14.3)	2.1 (0.20-107.8)	1.6 (0.1-17.4)
Division 31 st	73 (85.9)	12 (14.1)	2.12 (0.66-6.42)	1.5 (0.5-4.79)
Division 33 rd	75 (87.2)	11 (12.8)	2.37 (0.73-7.35)	1.7 (0.5-5.69)
Division 35 th	52 (76.5)	16 (23.5)	1.13 (0.36-3.29)	0.68 (0.2-2.1)
Division 08 th	23 (74.2)	8 (25.8)	1	1
Education level				
≤ Grade 6	153 (86.9)	23 (13.1)	2.19 (1.11-4.32) *	1.4 (0.65-2.9)
> Grade 6	76 (75.2)	25 (24.8)	1	1
Military rank				
Private soldiers	172 (84.3)	32 (15.7)	1.51 (0.72-3.07)	0.9 (0.34-2.5)
Other ranks	57 (78.1)	16 (21.9)	1	1
Marital status				
Married	71 (87.7)	10 (12.3)	1.71 (0.78-4.06)	2.5 (1.10-5.7) *
Single & divorced	158 (80.6)	38 (19.4)	1	1
Monthly wage				
200-400 Et.br.	219 (82.6)	46 (17.4)	1	1
401-600 Et.br.	10 (83.3)	2 (16.7)	1.05 (0.21-10.2)	1.6 (0.2-10.8)
Age				
≤25 Years	144 (88.3)	19 (11.7)	2.59 (1.31-5.19) *	2.9 (1.5-6.17) *
>25 Years	85 (74.6)	29 (25.4)	1	1

***P < 0.05** **N.B. Odds ratio adjusted for ethnic group, religion, and military service year.**

Other ranks: - Military personnel having a military rank of lance corporal, corporal, sergeant, sub-lieutenant, and lieutenant

To assess the factors influencing the time of attendance to first treatment sources, respondents presented to treatment sources with in 5 days were categorised in one group and those presented to treatment sources after 5 days were categorised in another group (5 days is the median time interval from onset of symptoms to presentation to first treatment sources for the sample). Based on this categorization, respondents who associated genital symptoms with STDs were found to be more likely to present to treatment sources with in five days time interval than those who did not (OR = 2.2 (1.2 - 4.3)). Respondents who

were located in their working units during onset of symptoms were found to be more likely to present to treatment sources within five days time interval than those who were not (OR = 4.2 (1.7 - 10.8)). In addition, respondents who reported symptoms to be severe and very severe were found to be more likely to present to treatment sources with in five days time interval than those who did not (OR = 9.4 (4.1 - 22.0)). Perception and location related determinants of time of attendance to treatment sources are shown in Table 12 below.

Table 12: perception and location related determinants of time of attendance to treatment sources among Soldiers. (n = 269)

Variables	Time interval		Crude OR (95% CI)	Adjusted OR (95% CI)
	≤ 5days	> 5days		
Believed that symptom is caused by the perceived STD risk factor				
Yes	100 (52.1)	92 (47.9)	0.77 (0.44-1.36)	0.56 (0.28-1.11)
No	45 (58.4)	32 (41.6)	1	1
Association of symptoms with STDs				

	Yes	102 (58.6)	72 (41.4)	1.71 (1.00-2.93) *	2.24 (1.17-4.29) *
	No	43 (45.3)	52 (54.7)	1	1
Think developing complications by delayed care seeking for STDs					
	Yes	132 (54.3)	111 (45.7)	1.10 (0.44-2.73)	1.00 (0.4-2.51)
	No/didn't know	13 (52.0)	12 (48)	1	1
Think early treatment for STDs is beneficial					
	Yes	141 (54.4)	118 (45.6)	1.49 (0.31-7.69)	1.62 (0.33-8.02)
	No	4 (44.4)	5 (55.6)	1	1
During onset of symptoms, present in units					
	Yes	135 (56.5)	104 (43.5)	2.60 (1.10-6.47) *	4.24 (1.66-10.8) *
	No	10 (33.3)	20 (66.7)	1	1
Reported severity of symptoms					
	Very mild & mild	41 (38.7)	65 (61.3)	1	1
	Moderate	33 (45.8)	39 (54.2)	1.34 (0.70-2.57)	1.40 (0.73-2.68)
	Severe & v. severe	71 (78)	20 (22)	5.63 (2.87-11.18) *	9.45 (4.1-22.03) *
Interference of symptom with work performance					
	Yes	37 (61.7)	23 (38.3)	1.50 (0.81-2.84)	0.50 (0.22-1.14)
	No	108 (51.7)	101 (48.3)	1	1

***P < 0.05**

With regard to socio-demographic determinants of time of attendance to treatment sources, respondents working in Division thirty-first (OR = 4.8 (1.7 - 13.3)) and in Division thirty-fifth (OR = 3.4 (1.2 - 9.5)) were found to be more likely to present to treatment sources within 5 days time interval than those who were working in Division eighth. In addition, seeking care at earlier stages of symptoms was found to be correlated with years of military service (Pearson's correlation coefficient = 0.182, P = 0.003) but not age. Socio-demographic determinants of time of attendance to treatment sources are shown in Table 13 below.

Table 13: Socio-demographic determinants of time of attendance to treatment sources among soldiers. (n = 269)

Variable	Time interval	Crude OR	Adjusted OR
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	≤ 5 days	>5 days	(95% CI)	(95% CI)
Assignment unit				
Core staff	4 (57.1)	3 (42.9)	3.83 (0.50-30.96)	5.25 (0.9-32.98)
Division 31 st	53 (63.9)	30 (36.1)	5.08 (1.88-14.63) *	4.79 (1.73-13.3) *
Division 33 rd	41 (50)	41 (50)	2.88 (1.08-8.26) *	2.54 (0.92-7.01)
Division 35 th	39 (59.1)	27 (40.9)	4.15 (1.49-12.25) *	3.42 (1.23-9.49) *
Division 08 th	8 (25.8)	23 (74.2)	1	1
Education level				
\leq Grade 6 th	97 (57.1)	73 (42.9)	1.41 (0.83-2.39)	1.08 (0.59-1.98)
$>$ Grade 6 th	48 (48.5)	51 (51.5)	1	1
Military rank				
Private Soldiers	113 (57.4)	84 (42.6)	1.68 (0.94-3.01)	1.10 (0.50-2.47)
Other ranks	32 (44.4)	40 (55.6)	1	
Marital status				
Married	43 (56.6)	33 (43.4)	1.16 (0.66-2.06)	1.65 (0.89-3.06)
Single & divorced	102 (52.8)	91 (47.2)	1	1
Monthly wage				
200 - 400 Et.br.	14 (54.7)	117 (45.3)	2.11 (0.52-10.04)	1.24 (0.23-6.75)
401 – 600 Et.br.	4 (36.4)	7 (63.6)	1	1

*P < 0.05N.B. Odds ratio was adjusted for ethnic group, religion, military service year and age.

Other ranks: - *Military personnel having a military rank of lance corporal, corporal, sergeant, sub-lieutenant, and lieutenant*

Discussion

In Ethiopia, studies on health seeking behaviour of soldiers for STDs are generally lacking. Lack of comparable studies is the main limitation of the present study. Nevertheless, the study can offer important views on behavioural features of soldiers with STD related

genital symptoms. In addition, findings of the study can also have a great appeal to health programme planners in designing and implementing realistic and appropriate health seeking behaviour promotion interventions in relation to STDs within the military sector.

Concerning knowledge about STDs, the findings of the present study indicate that while knowledge about the classical STDs (gonorrhoea, chancroid, syphilis, and lymphogranuloma venerum) is relatively high, knowledge about the other STDs is very low. Studies among other groups also support this fact (28). Among the genital STD symptoms in men, while urethral discharge; painful micturation, and genital ulcer were found to be known by a relatively higher proportion of respondents, the proportion with knowledge of the other STD related genital symptoms is low.

An interesting finding of this study is that a significant proportion of respondents have either erroneous knowledge and/or misconceptions about the risk factors and preventive methods of STDs. About 38% of the respondents in the present study either do not know and/or think that a person who had STDs earlier and got cured from that STD cannot catch it again. About 12% of the respondents do not know or do not think that a person can catch STDs by having unprotected sex with asymptomatic non-regular sex partner. About 66% of the respondents also do not know or do not think that uncircumcised males have higher risk for STD infections than circumcised ones. About 3% of the respondents do not know how STDs can be transmitted and 2.9% do not believe in getting protected from STDs. In addition, the study revealed that around 9% of respondents think that things like having sex before drinking alcohol and urinating at selected areas/directions can prevent a person from STD infections. In Ethiopia, earlier studies have reported the existence of some of these misconceptions/erroneous knowledge among other groups (6, 27).

However, from the perspective of STD epidemiology, the lack of knowledge and/or having misconceptions about STDs, risk factors, symptoms and/or preventive methods of STDs among soldiers could have different meanings from that in other civilian population groups. This is because: factors such as military culture, factors related to their occupation, and factors related to their socio-demographic characteristics (such as age) already put soldiers at higher risk of STD infections than other civilian population groups (2). Obviously, such misconceptions and/or lack of knowledge when complemented with the already existing risk factors, could increase the likelihood of STD infections among the group.

The results of the present study also demonstrated that 22.7% of respondents either do not know and/or do not perceive that delays in seeking care for STDs can result in additional health problems to a person. This finding is lower than that reported among out-of-school youth (42.1%) (28).

In the present study, peers were found to be a major source of consultation (70.1%) for the STD related genital symptoms. Although the available studies do not provide figurative reports for comparison, studies in Ethiopia among other groups (11), and studies among other groups abroad (31) have reported that peers are a major source of consultation for STDs. A study in 1995, in Nigeria, has also reported the fact that majority of police officers were consulting their peers about their STDs (16). Obviously, the fact that soldiers stay long away from their families could be a reason for their resorting to their peers for consultation on their STD related symptoms.

The proportion of respondents that associated genital symptoms with STDs in the present study is 50.5%. This finding is much higher than that reported by a study among other civilian population groups in Ethiopia (4.3%) (23). The reason for the differences in the findings between the present study and the previous study could be that: in the present study, the majority (59.4%) of the respondents perceived that the main cause of their genital symptoms to have been among the perceived most threatening STD risk factors for them.

In the present study, among the genital symptoms, urethral discharge, painful micturation, genital ulcer and genital blister were found to be more associated with STDs than the other genital symptoms. Also a large majority (78.9%) and 14.4% of the respondents associated genital symptoms with gonorrhoea and chancroid. This might be because, gonorrhoea, chancroid, urethral discharge, painful micturation and genital ulcer were the STDs and the STD related genital symptoms known by a relatively higher proportion of respondents among the group. In addition, the relatively greater specificity of urethral discharge and genital ulcer to STDs than the other symptoms (1) could be a reason for association of these symptoms with STDs among the group.

The results of the present study indicated a treatment seeking rate of 72.1% for STD related genital symptoms among the group. This finding is much higher than that reported by a study among civilian population groups in Ethiopia (26.7%) (23). The differences in the findings could be attributed to the differences in the accessibility to health care facilities among the study participants in the two studies (soldiers have more access to health care facilities as health care services are provided free of charge by Ministry of Defence).

In the present study; among respondents who reported receiving no treatments, 42.3% had the symptoms during the study period. More than 65% of these respondents reported having urethral discharge, painful micturation, genital ulcer, and genital rash. Among those reported receiving treatments, 23.1% reported having the symptoms during the study period. More than three-quarter (76.5%) of these reported having urethral discharge, genital ulcer, and painful micturation. Most (84.4%) of these respondents reported visiting health institutions under the Ministry of Defence as their first treatment sources. In addition, above half (57.8%) of these respondents reported receiving treatments from two or more treatment sources.

Looking this finding from the perspective of STD epidemiology, and in the context of the higher rate of high risk sexual behaviour among soldiers (a large proportion of soldiers engage in casual sex, in extramarital sexual relations, in sexual relations with commercial sex workers and the rate of partner change among soldiers is high) (2, 7, 15, 16, 18), one can speculate that a high spread to the community of both STDs and HIV. In addition, the findings show that the group is in danger of developing STD complications.

Among the major reasons mentioned for receiving no treatments among the sample were, perceptions related to treatment efficacy and severity of symptoms (85.9%), and being ashamed to discuss the problem with a health professional (11.2%). Studies conducted outside Ethiopia reported similar reasons to be given by respondents receiving no treatments for STDs (1).

The pattern of treatment seeking behaviour among the sample was similar to that reported by studies among civilian population groups (1, 6, 9, 11, 12, 16, 20, 23, 26, 31). However, unlike that reported by other studies, in this study, a large majority (82.7%) reported visiting the Ministry of Defence's treatment sources.

The present study demonstrated that, thought of having some kind of illness during having symptoms, severity of symptoms, perceived source of most effective treatment and working assignment units were all associated with the rate of treatment seeking. Considering that symptoms are abnormal, i.e., thought of having some kind of illness could influence health-seeking behaviour (1). A study among civilian population groups in Ethiopia in 1995 reported that the rate of treatment seeking behaviour for STDs to have been associated with perceived severity of symptoms (23). In addition; in the present study, respondents reported having urethral discharge and genital ulcer were found to receive treatments more than those who reported other symptoms. This is because: of the respondents reporting urethral discharge and genital ulcer, about 99% thought that they had some kind of illness and about 72.5% associated symptoms with gonorrhoea and chancroid. Moreover, 77.5% of the respondents reporting these symptoms believed that the most effective treatment for their symptoms could be obtained from modern treatment sources (the Ministry of Defence's treatment sources are modern) and about 89.6% reporting these symptoms reported having been in their units during onset of symptoms (i.e., they are nearer to the treatment sources in their units). Availability of treatment sources and geographic proximity to treatment sources could determine treatment seeking behaviour (1). Differences in rate of treatment seeking among working assignment units could be attributed to differences in the distribution of reported symptoms among the units. While urethral discharge and genital ulcer (the symptoms for which treatment was found to

be more likely received among the sample) were reported by 25.3% of the respondents in Division 35th, they were reported by 29.1% of respondents in Division 31st and by 31.9% of respondents in Division 33rd. On the other hand, while the other symptoms were reported by 32.7% of respondents in Division 35th, they were reported by 28.7% of respondents in Division 31st and by 25.7% of respondents in Division 33rd. The lower share of reported urethral discharge and genital ulcer and the higher share of other reported genital symptoms in Division 35th than in Division 31st and 33rd could, therefore, be a reason for differences in the rate of treatment seeking between the units. In addition, choice of treatment sources was found to have significant associations with subject's area of location (geographic proximity to units during onset of symptoms), marital status and with age. A variety of reasons could explain this. Soldiers located away from their unit during onset of symptoms could be prevented from presentation to treatment sources in their unit by far distance. To present themselves to Ministry of Defence health facilities nearby their locations and outside their working units, they may be required to produce referral papers. Hence, visiting other treatment sources could be the only choice left for them. Of the respondents associated symptoms with STDs, about 72% were single and divorced. Of those aged above twenty five years, about 52% associated symptoms with STDs while of those aged twenty five years or less about 49% associated symptoms with STDs. Hence, due to perceiving symptoms as STDs, those single and divorced, and those aged above twenty five years might resort to other treatment sources as a result of the stigma attached to STDs.

Overall, factors associated with early treatment seeking behaviour in the present study were association of symptoms with STDs, having been in or away from units, severity of symptoms, military service year and working assignment units. Some of these findings are

similar to findings of studies among other groups (1). Contrary to reports of earlier studies (20), educational level was not found to correlate with earlier time of attendance to treatment sources. Differences in time of attendance to treatment sources among units could be attributed to differences in distribution of reported symptoms among the units. While urethral discharge, genital ulcer, genital blister and painful micturation (symptoms found to be associated with STDs among the sample) were reported by about 28% of the respondents in Division 31st and by about 30% of the respondents in Division 35th, they were reported by about 12% of respondents in Division eighth.

Strengths and limitations of the study

1. Strengths

As there is no published data on the health seeking behaviour of soldiers for STDs in Ethiopia, the results of this study can provide some information on behavioural features of soldiers with STD related genital symptoms.

By including a wide range of genital symptoms, the study tried to assess the type of abnormal genital symptoms soldiers associate with STDs.

Sampling of subjects was carried out using proportionate to population size method (from Divisions and from Core staffs) and using systematic random sampling technique from each Division and Core staffs. This procedure allows a representative sample of soldiers in the 108th Core.

To reduce the social desirability bias, before data collection process, a strong sensitisation effort by military officials in the Core was made. Moreover, data collectors were assigned outside their working units, and soldiers are generally relatively open to sensitive issues than civilian population groups. Hence, there might be less social desirability bias.

2. Limitations

The study did not incorporate qualitative methods that enable triangulation of the generated information.

The lack of studies with similar methodological approach and on subjects with similar background characteristics did not allow comparison of results.

Conclusions

In spite of the limitations of the present study, it is possible to conclude the following.

1. Knowledge about the classical STDs (gonorrhoea, syphilis, chancroid, and lymphogranuloma venerum) is relatively high among study subjects. However, knowledge about the second generation STDs is very low.
2. A substantial number of respondents have misconception and/or erroneous knowledge about the risk factors, mode of transmission and preventive methods of STDs. In addition, a significant number of respondents do not know/do not think that delays in care seeking for STDs can result in complications.
3. Peers are a major source of consultation for STD related genital symptoms among soldiers.
4. A significant proportion of soldiers do not receive treatments for STD related genital symptoms. Perceptions related to treatment efficacy, severity of symptoms and guilty feeling discussing the problem to a health professional appear to be major reasons for receiving no treatments for STD related genital symptoms.
5. Illness perception, perceived severity of symptoms, perceptions related to sources of most effective treatment and working assignment units are significantly associated with rate of treatment seeking for STD related genital symptoms among soldiers. In

addition, soldiers receive treatments for urethral discharge and genital ulcer than for other STD related genital symptoms.

6. As that of civilian population groups, soldiers visit a variety of treatment sources for STD related genital symptoms.
7. Area of location during onset of genital symptoms (geographic proximity to working units), marital status and age are significantly associated with choice of treatment sources among soldiers.
8. Time of attendance to treatment source is significantly associated with area of location during onset of symptoms (geographic proximity to working units), perceived severity of symptoms, association of genital symptoms with STDs, military service year, and working units of soldiers.
9. Creation of demand and positive attitude towards modern services are among the strategies that should be targeted for enhancing health care seeking behaviour for STDs.

Recommendations

Based on the finding of the study, one can recommend the following.

1. Health education interventions should be designed to cover the second generation STDs their risk factors, sign and symptoms, preventive methods and their complications and treatment;
2. Considering that the rate of partner change among soldiers is relatively higher than among civilians and considering the increasing probability of HIV transmission in the presence of both ulcerative and non-ulcerative lesions, health education interventions should be targeted on the need to receive prompt treatment for any abnormal genital symptoms(regardless of its cause);
3. The Ministry of Defence's Head Quarter of the Health Command need to look for a way of allowing soldiers to get health care at any of Ministry of Defence's treatment sources whenever they are far from their unit(for vacation or duty reasons) and with out producing referral papers;
4. Peer education need to be incorporated in the health education intervention efforts. This is because, as indicated by the result of the study, a majority of soldiers consult their peers about their STD related genital symptoms. Moreover, there can be more

openness in discussing the matter, and there can be more understanding among peers when discussing about the matter;

5. Health education efforts should be expanded to incorporate creation of positive attitude towards treatment, and cultural change about the stigma attached to STDs;
6. Research concerning quality of treatment sources under Ministry of Defence should be carried out to improve social accessibility of the treatment sources.

References

1. WHO. A Rapid Assessment of Health Seeking Behaviour in Relation to Sexually Transmitted Diseases; Draft Protocol : Geneva: June, 1995: 1-46.
2. Civil-Military Alliance to Combat HIV and AIDS. Winning the War Against HIV and AIDS: A Handbook on Planning, Monitoring and Evaluation of HIV Prevention and Care Programmes in the Uniformed services. Hanover, New Hampshire and Rolle: 1999: 1-195.
3. Brown S., Zacarias F., Arak S. STD Control in Less Developed Countries. International Journal of Epidemiology. 1985; 14(4)
4. WHO. Consultation on Prevention and Control of STDs in Population Groups at Risk. Programme for STDs: STD Control in Prostitution. Geneva, 1988 Oct; 1-30
5. WHO. Guidelines for the Management of Sexually Transmitted Infections. WHO/HIV-AIDS/2001.01:1-20
6. Feleke W., Kloos H. Sexually Transmitted Diseases. In: Kloos H., Ahmed Z., editors. The Ecology of Health and Disease in Ethiopia. Boulder, Colorado and Oxford: Westview Press, 1993: 295-304.
7. Kingma S. AIDS Prevention in Military Populations: Learning the Lessons of History. International AIDS Society Newsletter, 1996 Mar; (4).

8. Ethiopian Ministry of Health. HIV/AIDS and Other STIs Prevention and Control Team: National Guideline for the Management of STIs Using Syndromic Approach. Addis Ababa: 2001 Dec.
9. National AIDS Council. Strategic Frame Work for the National Response to HIV/AIDS in Ethiopia (2001-2005). 2001 June; 1-34.
10. Ethiopian Ministry of Health: Planning and Programming Department. Health and Health Related Indicators. 2001 Dec; 35.
11. Assefa T. Sero Prevalence of HIV-1 Infection Among Antenatal Care Attendees and Determinants of High Risk Behaviour Among Different Population Sub Groups in Doubti Town, Afar Region: MPH Thesis. In Press. 2002.
12. Desta S., Feleke W. Yusuf M., Mehret M., Geyid A. , Ghidinelli M., et al. Prevalence of STD and STD Related Risk Factor in Sex Workers of Addis Ababa EJHD 1990, Nov; 4(2): 149-153.
13. Duncan M, Meheri I; Tibaux G., Pelzer A. Social Aspects Obstetrics and Gynaecology: in: Kloos H., Ahmed Z., editors. The Ecology of Health and Disease in Ethiopia. Boulder, Colorado and Oxford: Westview Press, 1993: 307- 316.
14. Khodakevich Lev, Zewde D. Appearance, Prevalence, and Geographic Distribution of HIV in Ethiopia. In: Kloos H., Ahmed Z., editors. The Ecology of Health and Disease in Ethiopia. Boulder, Colorado and Oxford: Westview Press, 1993: 319-334.
15. UNAIDS. AIDS and The Military: Best Practice Collection. 1998 May: 1-8
16. Olutope E. Sexual Networking, STDs, and HIV/AIDS Transmission Among Nigerian Police Officers. Health Transition Review 1995; Suppl 5: 113-121.
17. Ethiopian Ministry of Defence's Head Quarter of the Health Command. Anti-AIDS Campaign Among Military Personnel (2001-2005), 2001; 1-97.

18. Ayele R. Knowledge, Attitude and Practice Towards HIV/AIDS Among Members of the Ethiopian Ground Force at Badime Front: MPH Thesis. In Press: 2002.
19. Women's Health and Action Research Centre. The Adolescent Health and STD/HIV Prevention Project Office. An Intervention Study to Improve the Health Seeking Behaviour of In-School Adolescents in Midwest Nigeria, as Posted on the Gender AIDS Forum-Gender Aids @ Hevinet Ch. Placed on the Communication Initiative Web Site July 28, 2001.
20. Feleke W., Ghidinelli M., Desta S. , Yusuf M. Some Social Features of STD Patient in Addis Ababa- Ethiopia. EJHD 1990 Nov; 4(2): 143-147.
21. CDC National Center for HIV, STD, and TB Prevention. CDC News: Medical News Mailto Prevention –News @ cdcnpin. Org Monday 25, Nov 2002 . 14:22:39-0500.
22. Musanda J. Condom Use Among Soldiers in Tug- Argan and Arakan Barracks, Zambia. 1992. (in press)
23. Tesfaye F. Health- Seeking Behaviour in Adami- Tulu Woreda (Ethiopia), with Emphasis to Individuals with STD Symptoms: MPH Thesis. In Press: 1995.
24. Zalanbesa-Egela Front Health Command of the Ethiopia Army in Collaboration with M.S.F. Manual for the Syndromic Management of STDs. 2001 Apr; (1).
25. Editorial. Contraception and STDs. STDs Workshop Proceedings. Printer-friendly Version (81k, Adobe^R Acrobat^R).
26. Kalonga, E. Health- Seeking Behaviour Patterns in Relation to STDs Among the youth in Lusaka Urban. Zambia: Lusaka. In Press.
27. Gebre S. Sexual Behaviour and Knowledge of AIDS and Other STDs: A Survey of Senior High School Students. EJHD 1990 Nov; 4(2): 123- 131.
28. Taffa N. Sexual Activity of Out –of- School Youth, and Their Knowledge and Attitude About STDs and HIV/AIDS in Southern Ethiopia. EJHD 1998 Apr; 12(1): 17-22.

29. Vecchiato L. Traditional Medicine. In: Kloos H., Ahmed Z., editors. The Ecology of Health and Disease in Ethiopia. Boulder, Colorado and Oxford: Westview Press, 1993: 167-175.
30. Pankhurst R. An Introduction to the Medical History of Ethiopia. The Red Sea Press, Inc. Trenton: New Jersey, 1990; 71 - 80.
31. Zambian Ministry of Health. Factors Determining Health Seeking Patterns in Lusaka, Zambia – with Particular Relevance to Sexually Transmitted Diseases. Applied Health Research, 1995. Report No.1.

Annexes

Questionnaire prepared for collecting information on health seeking behaviour for STDs and some selected variables among military personnel with STD symptoms in core 108 of the Ethiopian army in Tigray Regional State.

Consent form

001. Questionnaire identification number /-----/-----/

002. Region: Tigray

003. Core: 108

Greetings

Introduction:

My name is _____. I am working as a data collector in a survey conducted by the collaboration of MOD's health command and Addis Ababa University, Medical Faculty, Department of Community Health to find out factors influencing the health seeking behaviour of STD cases. I am going to ask you some personal questions. Your name will not be written on this form and will never be used with any information you tell me. You don't have to answer any questions that you don't want to answer and you may end this interview at any time you want to. However, your onset answers to these questions will help us better understand what people think and do about STDs. We would greatly appreciate your help in responding to this survey. Would you be willing to participate?

Signature of interviewer certifying that informed consent has been given verbally by respondent.

Result codes: completed 1, respondent not available 2, refused 3, partially completed 4, others 5

004: Interviewer code [-----/-----] Name _____

005: Date of interview: [-----/-----/-----]

Checked by supervisor: Name _____

Signature _____

Date _____

Section one: Symptoms

No	Questions and filters	Responses/answers	Coding	Skip to
101	<p>During the past twelve months that is between _____date ____month 1994 up to now, which of the following symptoms did you have? More than one answer is possible. Read out the options</p> <p>If none is mentioned, thank respondent and go to the next interviewee.</p>	<ol style="list-style-type: none"> 1. Genital discharge 2. Burning pain on urination 3. Genital ulcer/sores 4. Genital/around genital itching 5. Penile swelling 6. Scrotal swelling 7. Swelling in groin area 8. Genital rash 9. Genital warts 10. Blister on genitalia 		
102	<p>Of the symptom mentioned, which one did you have most recently?</p>	<ol style="list-style-type: none"> 1. Genital discharge 2. Burning pain on urination 3. Genital ulcer/sores 4. Genital/around genital itching 5. Penile swelling 6. Scrotal swelling 7. Swelling in groin area 8. Genital warts 9. Genital rash 10. Blister on genitalia 		
103	<p>Do you have the most recent symptom now?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 99. No response 		
104	<p>Have you had this symptom (the most recent symptom) in previous times (Any time in your life)?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 88. Don't remember 99. No response 		

105	When did you start to have the most recent symptom?	1.day _____ 2.Month _____ 88. Don't remember 99. No response		
106	How was the severity of the most recent symptom? Circle only one	1. Very mild 2. Mild 3. Moderately severe 4. Severe 5. Very severe 99. No response		
107	Did the most recent symptom prevent you from performing your usual work?	1.Yes 2.No 99.No response		
108	When you had this symptom, did you think of having some type of illness?	1.Yes 2.No 99.No response	→	201
109	If yes to Q 107, what do you think is the name of your illness? Circle only one	1. Gonorrhoea 2. Syphilis 3. Chancroid 4. Lymphogranuloma venereum 5. Genital warts 6. Genital scabies 7. Pubic lice 8. Genital herpes 9. Hepatitis 10. Others _____ 88. Don't know 99. No response		

Section two: geographical proximity

201	When you started to have the most recent symptom (at the time of onset), have you been in your unit?	1. Yes 2. No 88. Don't remember 99. No response	→	301
202	If no to Q. 201, For what reason have you been outside your unit?	1. Vacation 2. Duty purposes 3. Others (specify)____ 88. Don't remember 99. No response		

Section three: health-seeking behavior

301	For the most recent symptom you had, have you received any treatment?	1. Yes 2. No 88. Don't remember 99. No response	→	309
302	For the most recent symptom, which one have you received? Self-treatment= Regardless of its dose, using any substance (drugs, ointment, herbs,	1. Self-treatment 2. Treatment from traditional healers Treatment from 3. Battalion clinic		

	<p>tsebel, antiseptic solution, etc.) without getting prescription from a health professional or a traditional healer.</p> <p>Traditional medicine= getting treatment from herbalist, Kalicha, TBAs, tsebel atmaki (priests) or any other traditional healer.</p> <p>Circle all mentioned Readout the options</p>	<p>4. Division hospital 5. Core hospital 6. MOD's referral hospital (eg.AFGH) 7. MOH's health post 8. MOH's clinic 9. MOH's health center 10. MOH's hospital 11. Private clinic 12. Private pharmacy 13. Private hospital 14. Local injector 15. Others_____</p> <p>88. Don't remember 99. No response</p>	
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303	<p>If treatment is received from more than one treatment source, from which did you receive the first treatment?</p> <p>Circle only one</p>	<p>1. Self-treatment 2. Treatment from traditional healers Treatment from</p> <p>3. Battalion clinic 4. Division hospital 5. Core hospital 6. MOD's referral hospital (eg. AFGH) 7. MOH's health post 8. MOH's clinic 9. MOH's health center 10. MOH's hospital 11. Private clinic 12. Private pharmacy 13. Private hospital 14. Local injector 15. Others_____</p> <p>88. Don't remember 99. No response</p>		
304	<p>How many days' and/months did you have the most recent symptom before you receive the first treatment?</p>	<p>1. day _____ 2. Month _____</p> <p>88. Don't remember 99. No response</p>		
305	<p>What was the most important reason for receiving treatment from the first treatment source?</p> <p>Circle or write only one main reason</p>	<p>1. I know the treatment 2. Treatment is good 3. Reception is good 4. Qualified personnel 5. Maintain data confidentiality 6. Maintain privacy 7. Short distance 8. Short waiting time</p>		

		9. Cost is cheaper 10. No charge 11. Consultation is good 12. Others _____ 99. No response		
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Go back to Q.303. Ask questions 306, 307, and/or 308 only respondents whose response to question 303 is not either of the options 3,4 5, or 6.

306	After you received treatment from the first treatment source, from which MOD's health units have you received additional treatment? Circle only the first treatment source visited from MOD	1. Battalion clinic 2. Division hospital 3. Core hospital 4. MOD's referral hospitals(eg.AFGH) 00. From none 88. Don't remember 99.No response	→	401
307	After how many days and/or months of receiving the first treatment, have you visited the MOD's health units mentioned in Q 306? Circle only one	1.day _____ 2.Month _____ 88. Don't remember 99. No response		
308	What was the most important reason for receiving additional treatment from the MOD's health units mentioned in Q. 306?	1. Didn't get cure 2. No charge 3. Referred 4.Others _____ 99. No response		
309	If response to Q. 301 is no, what is your most important reason for not receiving any treatment?	1. Thought symptom is incurable 2. Symptom not serious 3. Thought getting well from symptom without treatment 4. Don't know where it can be treated 5. No effective treatment is available 6. Lack of time 7. Lack of money 8. Feel guilty telling my problem to a health worker 9. Long distance 10. Others _____ 99. No response		

Section four:- About consultation

401	For the most recent symptom, from whom have you asked an advise most? Readout Circle or write	00. From none 1. From your wife 2. From your regular sex partner you haven't married 3. From your non-regular sex partner you haven't married 4. From your male friend 5. From your mother	→	501
-----	---	---	---	-----

	only one	6. From your father 7. From your brother 8. From your sister 9. Others _____ 99. No response		
402	If not received treatment, was that based on the advices you received from any of the persons you consulted?	1. Yes 2. No 99. No response		
403	If received treatment, have you received the first treatment from the first treatment source based on the advice/s you received from any of the persons you consulted?	1. Yes 2. No 99. No response		

Section five: Knowledge & attitude towards STDs and STD treatment services

501	Have you ever heard of diseases that can be transmitted through sexual intercourse?	1. Yes 2. No 99. No response	→	601
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502	Can you mention any of the diseases that can be transmitted through sexual intercourse?-----any other? Don't read out the options Circle or write all mentioned	1. Gonorrhea 2. Syphilis 3. Chancroid 4. Lymphogranuloma venerum 5. Genital warts 6. Genital scabies 7. Pubic lice 8. Genital herpes 9. Hepatitis 10. Others _____ 88. Don't know 99. No response		
503	How do you think can people get infected with any of the STDs? - ----any other? Don't read out Circle or write all mentioned Unprotected sex= having sex with non-regular sex partner without using condom	1. By having unprotected sex with non regular sex partner 2. By facing the sun while urinating 3. By facing the moon while urinating 4. By urinating at a place where a dog has urinated 5. By urinating on a hot place 6. Due to impurities/dirt in the stomach 7. Due to Sorcery 8. Others(specify) _____ 88. Don't know 99. No response	→	508
504	Of mentioned, exposure to which one/s makes you	00. To none 1. To unprotected sex with non-regular sex partner 2. To facing the sun while urinating 3. To facing the moon during urination		

	feel at greatest risk of getting infected with STDs?	4. To urinating at a place where a dog has urinated 5. To urinating on a hot place 6. To impurities/dirt in the stomach 7. To sorcery 8. Others (specify) _____ 88. Don't know 99. No response		
505	Of mentioned, which one do you believe was the main factor for the most recent symptom you had? Don't read out Circle or write all mentioned	00. to none 1. Having unprotected sex 2. Facing the sun while urinating 3. Facing the moon during urination 4. Urinating at a place where a dog has urinated 5. Urinating on a hot place 6. Impurities/dirt in the stomach 7. Sorcery 8. Others (specify) _____ 00. To none 99. No response	→	506

506	If none to Q. 505, what do you believe was the main cause of the most recent symptom you had?	1. It has no cause 2. Others _____ 88. Don't know 99. No response	→	508
507	According to the main cause of your most recent symptom, from where do you believe is the best treatment available? Read out Circle or mention only one	00. Symptom has no cure 1. Symptom disappears without treatment 2. From traditional healers 3. From modern health institutions 4. Others _____ 88. Don't know 99. No response		
508	Do you believe that you can get protected from getting infected with any of the STDs?	1. Yes 2. No 88. Don't know 99. No response	→	512
509	How do you think can you get protected from getting infected with any of the STDs? Don't read out the options Circle or write all mentioned	1. By using condom every time you have sex with non regular sex partner 2. By having only one faithful sex partner 3. By abstaining from sexual intercourse 4. Others (specify) _____ 88. Don't know 99. No response	→	512
510	Of mentioned, which one do you believe is the best preventive method?	1. Using condom every time you have sex with non regular sex partner 2. Having only one faithful sex partner 3. Abstaining from sexual intercourse		

	Circle or write only one	4. Others (specify)_____		
		88. Don't know		
		99. No response		
511	Of mentioned, Mainly due to failure to use which method do you believe you had the most recent symptom? Circle or write all mentioned	00. none 1. Not by using condom every time you have sex with non regular sex partner 2. Not by having only one faithful sex partner 3. Not by abstaining from sexual intercourse 4. Others (specify)_____		
		88. Don't know		
		99. No response		
512	Do you believe that once a person had STDs he/she cannot catch it again?	1. yes 2. No 88. Don't know 99. No response		

513	Can you mention any symptoms of STDs in men?-----any others? Don't read out Circle or write all mentioned	1. Genital discharge 2. Burning pain on urination 3. Genital ulcer/sores 4. Genital/around genital itching 5. Penile swelling 6. Scrotal swelling 7. Swelling in groin area 8. Genital warts 9. Genital rash 10. Blister on genitalia 11. Others_____		
		88. Don't know	→	515
		99. No response		
514	Among symptoms of STDs in men you mentioned in question 513, which one do you believe can only be due to STDs? Don't read out Circle all mentioned	1. Genital discharge 2. Burning pain on urination 3. Genital ulcer/sores 4. Genital/around genital itching 5. Penile swelling 6. Scrotal swelling 7. Swelling in groin area 8. Genital warts 9. Genital rash 10. Blister on genitalia 11. Others_____		
		88. Don't know		
		99. No response		

515	Can a person catch STDs from having unprotected sex with someone who doesn't show any of the symptoms of STDs?	1. Yes 2. No 88. Don't know 99. No response		
516	Do you think that uncircumcised males can be more exposed to STDs than circumcised ones?	1. Yes 2. No 88. Don't know 99. No response		
517	Do you believe that getting early treatments is beneficial for people infected with any of the STDs?	1. Yes 2. No 88. Don't know 99. No response		
518	Do you think that people infected with STDs can develop additional health problems (complications) unless they get early treatments?	1. Yes 2. No 88. Don't know 99. No response	→	522
519	What additional health problems (complications) can people that do not get early treatments for STDs can develop? Don't read out circle or write all mentioned	1. Exposure to HIV 2. Sterility 3. Urethral stricture 4. Cancer 5. Others _____ 88. Don't know 99. No response	→	522
520	Of mentioned, which one/s do you feel at risk of developing unless you get treated for any of the STDs? Don't read out circle or write all mentioned	00. None 1. Exposure to HIV 2. Sterility 3. Urethral stricture 4. Cancer 5. Others _____ 88. Don't know 99. No response		
521	Of mentioned in Q.520, which one do you think is most serious? Don't read out circle or write only one	00. None 1. Exposure to HIV 2. Sterility 3. Urethral stricture 4. Cancer 5. Others _____ 88. Don't know 99. No response		

Go back to Q.502. From Q. 522to 532 ask respondents by only mentioning the STDs they mentioned in Q.502. If the response to Q. 502 is either of don't know or no response go to Q.533

522	Of the STDs you mentioned in Q. 502, for which one do you prefer to remain untreated at most? Read out only those mentioned by respondents for Q. 502	1. Gonorrhoea 2. Syphilis 3. Chancroid 4. Lymphogranuloma venereum 5. Genital warts 6. Genital scabies 7. Pubic lice		
-----	--	--	--	--

	Circle only one	8. Genital herpes 9. Hepatitis 10.others_____			
		To none	→		524
523	What is the most important reason for preferring to remain untreated for the STD you mentioned above? Circle only one main reason	1. Disease is not serious 2. Get well from disease without treatment 3. Disease is not curable 4. No effective treatment is available 5. Cost is expensive 6. Feel guilty discussing my problem 7. Attitude of health professionals is bad 8. Maintain confidentiality 9. Others_____			
		99.No response			

524	Of the STDs you mentioned in Q. 502, for which one do you prefer getting self-treatments at most? Among mentioned under Q. 502 readout leaving only that mentioned under Q. 522 Circle only one	1. Gonorrhoea 2. Syphilis 3. Chancroid 4. Lymphogranuloma venereum 5. Genital warts 6. Genital scabies 7. Pubic lice 8. Genital herpes 9. Hepatitis 10. others_____			
		00. To none	→		526
		99. No response			
525	What is the most important reason for preferring self-treatments for the STD you mentioned above? Circle only one main reason	1. Know the treatment myself 2. Disease is not curable 3. No effective treatment is available 4. Disease is not serious 5. Cost is expensive 6. Maintain confidentiality 7. Feel guilty discussing my problem 8. Reception is not good 9. Long waiting time 10. Others_____			
		99. No response			

526	Of the STDs you mentioned in Q. 502, for which one do you prefer getting treatments from any of the traditional healers at most? Among mentioned under Q. 502 read out leaving those mentioned under Q.522 and 524 Circle only one	1. Gonorrhea 2. Syphilis 3. Chancroid 4. Lymphogranuloma venerum 5. Genital warts 6. Genital scabies 7. Pubic lice 8. Genital herpes 9. Hepatitis 10. others _____ 00. To none 99. No response	→	528
527	What is the most important reason for getting treatments from traditional healers for the STD you mentioned above? Circle only one main reason	1. Treatment is only available from traditional healers 2. Cost is cheaper 3. Treatment is effective 4. Maintain confidentiality of data 5. Maintain privacy 6. Reception is good 7. Provide good advice 8. Short waiting time 9. Others _____ 99. No response		

528	Of the STDs you mentioned in Q. 502, for which one do you prefer getting treatments from any of the modern health institutions at most? Among those mentioned under Q. 502 readout leaving those mentioned under Q. 522, 524, and 526 Circle only one	1. Gonorrhea 2. Syphilis 3. Chancroid 4. Lymphogranuloma venerum 5. Genital warts 6. Genital scabies 7. Pubic lice 8. Genital herpes 9. Hepatitis 10. others _____ 00. To none 99. No response	→	533
529	From which MOD's health units do you most prefer getting treatments for the disease you mentioned in Q.528? Read out Circle only one	1. Battalion clinic 2. Division hospital 3. Core hospital 4. MOD's referral hospital (eg.AFGH) 00. From none 99. No response	→ → → →	532 532 532 532
530	What is the most important reason for not preferring getting	1. Reception is not good 2. No qualified personnel 3. Treatment is not good		

	treatment for the STD you mentioned in Q. 528 from any of the MOD's health units? Circle or write only one	4. Lack of confidentiality of data 5. Lack of privacy 6. Long waiting time 7. Drugs are not available 8. Good drugs are not available 9. No good advice 10. Others _____ 99. No response		
531	From which health institution do you most prefer getting treatments for the diseases you mentioned in Q. 528? Circle only one	1. MOH's health post 2. MOH's clinic 3. MOH's health center 4. MOH's hospital 5. Private clinic 6. Private pharmacy 7. Private hospital 8. Local injector 9. Others (specify) _____ 99. No response		

532	What is your most important reason for preferring getting treatments from the health institution you mentioned above? Circle only one reason	1. No charge 2. Cost is cheaper 3. Short distance 4. Treatment is good 5. Reception is good 6. Personnel qualified 7. Maintain confidentiality of data 8. Maintain privacy 9. Good advice 10. Short waiting time 11. Good drugs are available 12. Others (specify) _____ 99. No response		
533	In which of the following MOD's health units do you think STD treatments are available? Read out the options. Circle one for all mentioned.	Battalion clinic Division hospital Core hospital MOD's referral hospitals (eg.AFGH)	<u>Yes</u> <u>No</u> <u>Don't kn</u> <u>No Rresp</u> 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99	

	Circle two for all not mentioned. Circles 88 for all don't know. Circle 99 for all no response.			
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Section six: Background characteristics

601	Division	0. Core staff 1. 35 2. 33 3. 31 4. 08		
602	Brigade	1. 1 2. 2 3. 3 4. 4		
603	Battalion	1. 1 2. 2 3. 3 4. 4		
604	Age(in completes years)	1. In completed years _____ 88. Don't know 99. No response		

605	Educational level	00. Cannot read and write 1. Only read and write 2. Grade 1-6 3. Grade 7-8 4. Grade 9-12 5. Above grade 12 99. No response		
606	Current military rank	1. Private soldier 2. Lance corporal 3. Corporal 4. Sergeant 5. Sub lieutenant 6. Lieutenant 7. Captain 8. Major 9.L.colonel 10.Colonel 11.Jeneral 99. No response		
607	Current marital status	1. Married		

		2. Single 3. Divorced 4. Widowed 5. Separated 99. No response		
608	Service years (Military service years in completed years)	00. Below one year 1. In completed years _____ 99. No response		
609	Ethnic group	1. Amhara 2. Tigre 3. Oromo 4. Others (specify) _____ 99. No response		
610	Religion	00. No religion 1. Orthodox Christian 2. Catholic 3. Protestant 4. Muslim 5. Others (specify) _____ 99. No response		
611	Monthly wage in Ethiopian Birr	1. 200- 400 3. 401- 600 4. 3. 601-800 4. 801-1000 5. > 1000 99. No response		

Go back to question 103. If the response to question 103 is yes, give health education about the need of treatment and about the availability of STD treatment services in MOD health institutions. Now this is the end of the questionnaire. Thank you very much for taking time to answer these questions. We appreciate your help.

ክፍል አንድ፡ ምልክቶች

ቁጥር	ጥያቄዎችና ማጣሪያቸው	መልሶች	ኮድ	ዝላል
101	ባለፈው አንድ አመት ጊዜ ውስጥ ማለትም ከ _____ ቀን _____ ወር 1994 እስከ ዛሬ ድረስ የትኞቹ ምልክቶች ነበርዎት? ይነበባቸው የጠቀሱት ሁሉ ይክበብ	1. የብልት ፈሳሽ 2. ሽንት ሲሸኑ የማቃጠል ስሜት 3. የብልት ቁስል 4. የብልት ወይም የብልት አካባቢ ማሳከክ 5. የብልት እብጠት 6. የዘር ፍሬ ከረጢት እብጠት 7. የብሽሽት እብጠት 8. የብልት ላይ ሽፍታ 9. የብልት ላይ ኪንታሮት 10. ውሃ መሰል ፈሳሽ የቂጠረ የብልት ላይ እብጠት		
ተጠያቂው ከተዘረዘሩት ውስጥ ቢያንስ አንዱ እንኳን የለኝም ካሉ አመሰግኖታቸው:: አንድ ወይም ካንድ በላይ ምልክት ከነበራቸው ወደ ሚቀጥለው ጥያቄ እለፍ::				
102	ከጠቀሷቸው ውስጥ በቅርቡ የነበርዎት የትኞቹ ምልክት ነው? የጠቀሱት አንድ ብቻ ይክበብ	1. የብልት ፈሳሽ 2. ሽንት ሲሸኑ የማቃጠል ስሜት 3. የብልት ቁስል 4. የብልት ወይም የብልት አካባቢ ማሳከክ 5. የብልት እብጠት 6. የዘር ፍሬ ከረጢት እብጠት 7. የብሽሽት እብጠት 8. የብልት ላይ ሽፍታ 9. የብልት ላይ ኪንታሮት 10. ውሃ መሰል ፈሳሽ የቂጠረ የብልት ላይ እብጠት		
103	በቅርቡ የነበርዎት ምልክት አሁን አለዎትን?	1. አዎ 2. የለኝም 99 መልስ የለኝም		
104	ከዚህኛው ምልክት ውጪ የቅርቡ አይነት ምልክት ኖርዎት ያውቃል? (በየትኛውም የህይወት ዘመን ሊሆን ይችላል)	1. አዎ 2. የለም 88. አላስታውስም 99. መልስ የለኝም		
105	በቅርቡ የነበርዎት ምልክት የጀመርዎት መቼ ነው? ከአንድ ወር (ከ30 ቀን) በታች ከሆነ ወር በሚለው ቦታ ላይ 0 ይጻፍ አንድ ወር (30 ቀን) ብቻ ከሆነ ወር በሚለው ላይ 1 ቁጥርን ብቻ በመጻፍ ቀን በሚለው ላይ 0 ይጻፍ ከአንድ ወር (ከ30 ቀን) በላይ ከሆነ የወሮቹ ቁጥርና የቀኖቹ ብዛት ይጻፍ	1. ቀን _____ 2. ወር _____ 88. አላስታውስም 99. መልስ የለኝም		
106	በቅርቡ የነበርዎት ምልክት ያስከተለብዎ የህምም ወይም የስቃይ ደረጃ ምን ይመስላል? የጠቀሱት አንድ ብቻ ይክበብ	1. በጣም ቀላል 2. ቀላል 3. መካከለኛ 4. ከፍተኛ 5. በጣም ከፍተኛ 99. መልስ የለኝም		
107	በቅርቡ የነበርዎት ምልክት የተለመደ ስራዎን ከመስራት ከልክልዎት ነበርን ?	1. አዎ 2. የለም 99. መልስ የለኝም		

108	የቅርቡ ምልክት በነበርዎት ወቅት ታምሜያለሁ ብለው አስበው ነበርን?	1. አዎ 2. የለም 99. መልስ የለኝም	→	201
109	ለጥያቄ ቁጥር 108 መልስዎ አዎ ከሆነ የበሽታው ስም ምን ይመስልዎታል?	1. ጨብጥ 2. ቂጥኝ 3. ከርክር 4. ባንቡሌ (ፍርንትት) 5. የብልት ላይ ኪንታሮት 6. የብልት ላይ ወይም የብልት አካባቢ እኩክ 7. የብልት አካባቢ ቅማል 8. የብልት ምች ወይም ግርፋት 9. የወፍ በሽታ 10. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም		

ክፍል ሁለት: ርቀት

ቁጥር	ጥያቄዎችና ማጣሪያቸው	መልሶች	ኮድ	ዝላል
201	የቅርቡ ምልክት ሰጂምርዎት ወይም ምልክቱ እንዳለዎት ለመጀመርያ ጊዜ ባስተዋለሁት ወቅት በስራ ክፍልዎ ውስጥ ነበሩን?	1. አዎ 2. የለም 88. አላስታውስም 99. መልስ የለኝም	→	301
202	በስራ ክፍልዎ ውስጥ ካልነበሩ ከክፍልዎ ውጭ የነበሩት በምን ምክንያት ነው? አንድ መልስ ብቻ ይከበብ ወይም ይጻፍ።	1. ለእረፍት ሃጂ 2. በስራ ምክንያት ወጥቼ 3. ሌሎች _____ 88. አላስታውስም 99. መልስ የለኝም		

KFL isTY yHKMÁ h#n@-

301	በቅርቡ ለነበርዎት ምልክት ህክምና ወስደዋልን?	1. አዎ 2. አልወሰድኩም 88. አላስታውስም 99. መልስ የለኝም	→	309
302	በቅርቡ ለነበርዎት ምልክት ህክምና የወሰዱት ወይም የታከሙት የት ነው? - ----ሌላ? በራስ መድሀኒት መውሰድ:-የሚቀባ የሚዋጥ እንደ አልኮል ወይም ኮፒ(ጂ.ቪ) ያሉ ለቁስል ማከሚያ የሚውሉ መድሀኒቶች ጠበል ወይም ሌላ የባህል መድሀኒት የጤና ባለሙያን ወይም የባህል ህኪምን ስለምልክቱ ሳያማክሩና በግ ወይም ያለግ ከዘመድ ከጓደኛ ከሌሎች ሰዎች ወይም ለሌላ በሽታ ማከሚያ የተሰጣቸውን መድሀኒት መውሰድ የባህል ህክምና አዋቂ ጠበል አጥማቂ ቁስ፣ ቃልቻ፣ በለዛር፣ በቅጠላቅጠል ወይም በስራ-ስር የሚያክም፣ ጠንቂይ፣ የልምድ አዋሳጅ፣ ወጊሻ፣ እና የመሳሰሉት ሊሆን ይችላል። ይነበብላቸው። የጠቀሱት ሁሉ ይከበብ	1. የጤና ባለሙያ ወይም የባህል ህኪም ሳያማክር እራስ መድሀኒት ወስጃለሁ 2. ከባህል ህክምና አዋቂ 3. ከሻለቃ ክሊኒክ 3. ከክ/ጦር ሆስፒታል 4. ከኮር ሆስፒታል 5. ከመከላከያ ሪፈራል ሆስፒታል (ለምሳሌ ጦር ሀይሎች) 6. ከጤና ጥበቃ ጤና ከላ 7. ከጤና ጥበቃ ክሊኒክ 8. ከጤና ጥበቃ ጤና ባብያ 9. ከጤና ጥበቃ ሆስፒታል 10. ከግል ክሊኒክ 11. ከግል ፋርማሲ 12. ከግል ሆስፒታል 13. ከመንደር መርፌ ወጊ 14. ሌሎች _____ 88. አላስታውስም 99. መልስ የለኝም		

303	<p>ህክምና የወሰዱት ከሁለት ወይም ከዚያ በላይ ከሆኑ ቦታዎች ከሆነ የመጀመሪያውን ህክምና የወሰዱት ከየት ነው?</p> <p>የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ።</p>	<ol style="list-style-type: none"> 1. የጤና ባለሙያ ወይም የባህል ህኪም ሳላማክር እራስ መድሃኒት ወስኛለሁ 2. ከባህል ህክምና አዋቂ 3. ከሻለቃ ክሊኒክ 4. ከክ/ጦር ሆስፒታል 5. ከኮር ሆስፒታል 6. ከመከላከያ ሪፈራል ሆስፒታል (ለምሳሌ ጦር ህይሎች) 7. ከጤና ጥበቃ ጤና ከላ 8. ከጤና ጥበቃ ክሊኒክ 9. ከጤና ጥበቃ ጤና ጣብያ 10. ከጤና ጥበቃ ሆስፒታል 11. ከግል ክሊኒክ 12. ከግል ፋርማሲ 13. ከግል ሆስፒታል 14. ከመንደር መርፌ ወገ 15. ሌሎች _____ 88. አላስታውስም 99. መልስ የለኝ 		
304	<p>በቅርቡ የነበርዎትን ምልክት ካስተዋሉ ወይም ህመሙ ከጀመረዎት ከምን ያህል ጊዜ በኋላ ነው የመጀመሪያውን ህክምና የወሰዱት?</p> <p>ከአንድ ወር (ከ30 ቀን) በታች ከሆነ ወር በሚለው ቦታ ላይ 0 ይጻፍ አንድ ወር (30 ቀን) ብቻ ከሆነ ወር በሚለው ላይ 1 ቁጥርን ብቻ በመጻፍ ቀን በሚለው ላይ 0 ይጻፍ ከአንድ ወር (ከ30 ቀን) በላይ ከሆነ የወሮቹ ቁጥርና የቀኖቹ ብዛት ይጻፍ</p>	<ol style="list-style-type: none"> 1. ቀን _____ 2. ወር _____ 88. አላስታውስም 99. መልስ የለኝም 		
305	<p>ከመጀመሪያው የህክምና መስጫ ቦታ ህክምና የወሰዱበት ዋነኛ ምክንያት ምንድነው?</p> <p>አንድ ዋነኛ ምክንያት ብቻ ይገለጽ</p>	<ol style="list-style-type: none"> 1. ህክምናውን ስለማውቅ 2. ህክምናው ጥሩ ስለሆነ 3. አቀባባላቸው ጥሩ ስለሆነ 4. የሀኪሞቹ የሙያ ችሎታ ጥሩ ስለሆነ 5. ሚስጥር ስለሚጠብቁ 6. ሰያክሙ ብቸኝነትን ስለሚጠብቁ 7. ቅርብ ስለሆነ 8. ህክምናውን ለመስጠት ብዙ ስለማያስጠብቁ 9. ከሌሎች ሲወዳደር አነስተኛ ገንዘብ ስለሚከፈልበት 10. ህክምናው ነፃ ስለሆነ 11. ጥሩ ምክር ስለሚሰጡ 12. ሌሎች _____ 99. መልስ የለኝም 		

ወደ ጥያቄ ቁጥር 303 ተመለስ በጥያቄ ቁጥር 303 የጠቀሱት ከመከላከያ ውጪ ያሉትን የጤና ተቋማት ከሆነ ማለትም ከመልስ ምርጫ 3, 4, 5 እና 6 ውጪ የጠቀሱትን ተጠያቂዎች ብቻ ጥያቄ ቁ. 306, 307 እና 308 ጠይቅ

306	<p>የመጀመሪያውን ህክምና ከወሰዱ በኋላ ከመከላከያ የጤና ተቋማት ህክምና ወስደው ከሆነ ከየትኛው የጤና ተቋም ነው የወሰዱት?</p> <p>ይነበብላቸው::</p> <p>መጀመሪያ የታከሙበት አንድ ብቻ ይከበብ</p>	<ol style="list-style-type: none"> 1. ከሻለቃ ክሊኒክ 2. ከክ/ጦር ሆስፒታል 3. ከኮር ሆስፒታል 4. ከመከላከያ ሪፈራል ሆስፒታል (ለምሳሌ ጦር ሀይሎች) <p>00. ከየትኛውም አልወሰድኩም</p> <p>88. አላስታውስም</p> <p>99. መልስ የለኝም</p>	→	401
307	<p>የመጀመሪያውን ህክምና ከወሰዱ ከምን ያህል ጊዜ በኋላ ከመከላከያ ጤና ተቋም ተጨማሪ ህክምና ወሰዱ?</p> <p>ተጨማሪ ህክምና ከመከላከያ ጤና ተቋም ለወሰዱ ብቻ ከአንድ ወር (ከ30 ቀን) በታች ከሆነ ወር በሚለው ቦታ ላይ 0 ይጻፍ አንድ ወር (30 ቀን) ብቻ ከሆነ ወር በሚለው ላይ 1 ቁጥርን ብቻ በመጻፍ ቀን በሚለው ላይ 0 ይጻፍ ከአንድ ወር (ከ30 ቀን) በላይ ከሆነ የወሮቹ ቁጥርና የቀኖቹ ብዛት ይጻፍ</p>	<ol style="list-style-type: none"> 1. ቀን _____ 2. ወር _____ <p>88. አላስታውስም</p> <p>99. መልስ የለኝም</p>		
308	<p>ተጨማሪ ህክምና ከመከላከያ የጤና ተቋም የወሰዱበት ዋነኛ ምክንያት ምንድነው?</p> <p>ተጨማሪ ህክምና ከመከላከያ ጤና ተቋም ለወሰዱ ብቻ አንድ ዋነኛ ምክንያት ብቻ ይጠቀስ</p>	<ol style="list-style-type: none"> 1. ስላልዳንኩ 2. ህክምናው ነፃ ስለሆነ 3. በሪፈራል ምክንያት 4. ሌሎች _____ <p>99. መልስ የለኝም</p>		
309	<p>ህክምና ካልወሰዱ ህክምና ያልወሰዱበት ዋነኛ ምክንያት ምንድነው?</p> <p>አንድ ዋነኛ ምክንያት ብቻ ይከበብ ወይም ይጠቀስ</p>	<ol style="list-style-type: none"> 1. ምልክቱ ህክምና ስለሌለው 2. ያስከተለብኝ ህመም ቀላል ስለሆነ 3. ምልክቱ ያለህክምና ይጠፋል ብዬ ስላሰብኩ 4. ህክምና የሚሰጥበትን ቦታ ስለማላውቅ 5. በዚህ አካባቢ ጥሩ ህክምና ስለሌለ 6. ፈቃድ ስላጣሁ 7. ገንዘብ ስላልነበረኝ 8. ችግራን ለጤና ባለሙያዎች ማዋየት ስላሳፈረኝ 9. ህክምና መስጫው ቦታ እሩቅ ስለሆነ 10. ሌሎች _____ <p>99. መልስ የለኝም</p>		

ክፍል አራት ምክርን በተመለከተ				
ተ.ቁ.	ጥያቄ	መልስ		
401	በቅርቡ ለነበርዎት ምልክት ከሚከሉት ውስጥ በበለጠ ምክር የጠየቁቃት ከማን ነው?	<p>00. ማንንም አላማከርኩም</p> <ol style="list-style-type: none"> 1. ከትዳር ጋደኛዬ 2. ሕጋዊ ጋብቻ ከሌለን መደበኛ የግብረ ስጋ ግንኙነት ጋደኛዬ 	→	501

	ይነበብላቸው። አንድ መልስ ብቻ ይከበብ ወይም ይፃፍ።	<ol style="list-style-type: none"> 3. ሕጋዊ ጋብቻ ከሌለን መደበኛ ላልሆነች የግብረ ስጋ ግንኙነት ጊደኛዬ 4. ከወንድ ጊደኛዬ 5. ከእናቴ 6. ከአባቴ 7. ከወንድሜ 8. ከእህቴ 9. ከሌሎች _____ 99. መልስ የለኝም		
402	ሕክምና ካልወሰዱ ሕክምና ያልወሰዱት የማክሯቸው ሰዎች በስጦት ምክር መሰረት (ምክንያት) ነው? (ማንኛውም የማክሯት ሰው ሊሆን ይችላል)	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 99. መልስ የለኝም		
403	በቅርቡ ለነበርዎት ምልክት ሕክምና ከወሰዱ ከመጀመሪያው የሕክምና ቦታ ሕክምና የወሰዱት የማክሯቸው ሰዎች በስጦት ምክር መሰረት (ምክንያት) ነው? (ማንኛውም የማክሯት ሰው ሊሆን ይችላል)	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 3. መልስ የለኝም 		

KFL xMSTÝ SI xÆ§zR b>¬āC XWqTĀ ZNÆI@

501	በግብረ ስጋ ግንኙነት ሊተላለፉ ስለሚችሉ በሽታዎች ስምተው ያውቃሉን?	<ol style="list-style-type: none"> 1. አዎ 2. ሰምቼ አላውቅም 99. መልስ የለኝም	→	601
502	በግብረ ስጋ ግንኙነት የሚተላለፉ የአባላዘር በሽታዎችን ሊጠቅሱልኝ ይችላሉ?-----ሌላ? አታንብብ የጠቀሱት ሁሉ ይከበብ ወይም ይፃፍ	<ol style="list-style-type: none"> 1. ጨብጥ 2. ቁጥኝ 3. ከርክር 4. ባንቡሌ (ፍርንትት) 5. የብልት ላይ ኪንታሮት 6. የብልት ላይ ወይም የብልት አካባቢ እክክ 7. የብልት አካባቢ ቅማል 8. የብልት ምች ወይም ግርፋት 9. የወፍ በሽታ 10. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 		
503	ሰዎች የአባላዘር በሽታ ሊይዛቸው የሚችለው እንዴት ወይም በምን ምክንያት ነው ብለው ያስባሉ?-----ሌላ? አታንብብ መደበኛ የግብረ ስጋ ግንኙነት ጊደኛ፡-ከአንድ ሰው ጋር ብቻ ከአንድ አመት ላላነሰ ጊዜ የግብረ ስጋ ግንኙነት ያለው ሰው የጠቀሱት ሁሉ ይከበብ ወይም ይፃፍ	<ol style="list-style-type: none"> 1. ከመደበኛ የግብረ ስጋ ግንኙነት ጊደኛ ውጪ ያለኮንደም የግብረ ስጋ ግንኙነት በመፈፀም 2. ወደ ፀሀይ ዞር በመሸናት 3. ወደ ጨረቃ ዞር በመሸናት 4. ውሻ የሸናበት ቦታ ላይ በመሸናት 5. የጋለ መሬት ላይ በመሸናት 6. ሆድ ውስጥ ባለ ቆሻሻ ምክንያት 7. በድግምት 8. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 	→	508

504	<p>ከገለጻቸው ውስጥ ከሌሎቹ ሁሉ ለየትኛው ብጋላጥ በአባላዘር በሽታ መያዜ አይቀሬ ነው ብለው ያስባሉ?</p> <p>አንድ ብቻ መልስ ይከበብ ወይም ይፃፍ።</p>	<ol style="list-style-type: none"> 1. ከመደበኛ የግብረሰጋ ግንኙነት ጋር ያለው ያለኮንደም የግብረ ሰጋ ግንኙነት በመፈፀም 2. ወደ ፀሀይ ዞሮ በመሸናት 3. ወደ ጨረቃ ዞሮ በመሸናት 4. ውሻ የሸናበት ቦታ ላይ በመሸናት 5. የጋለ መሬት ላይ በመሸናት 6. ሆድ ውስጥ ባለ ቆሻሻ ምክንያት 7. በድግምት 8. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 		
505	<p>ከገለጻቸው ውስጥ የትኛውን በቅርብ ለነበረዎት ምልክት ዋና ምክንያትነብር ብለው ያምናሉ?</p> <p>አንድ ብቻ መልስ ይከበብ ወይም ይፃፍ።</p>	<ol style="list-style-type: none"> 1. ከመደበኛ የግብረሰጋ ግንኙነት ጋር ያለው ያለኮንደም የግብረ ሰጋ ግንኙነት በመፈፀም 2. ወደ ፀሀይ ዞሮ በመሸናት 3. ወደ ጨረቃ ዞሮ በመሸናት 4. ውሻ የሸናበት ቦታ ላይ በመሸናት 5. የጋለ መሬት ላይ በመሸናት 6. ሆድ ውስጥ ባለ ቆሻሻ ምክንያት 7. ለድግምት 8. ሌሎች _____ 00. ሁሉም መንስኤዎች አልነበሩም 99. መልስ የለኝም 	→	506
506	<p>ሁሉም መንስኤዎች አልነበሩም ካለ በቅርብ ለነበረዎት ምልክት ዋና መንስኤ ምን ነበር ብለው ያምናሉ?</p> <p>1_Ãቁ ቁ . 505 hLM mNSx፳āC xLnb,,M BIW lmls BÖ</p>	<ol style="list-style-type: none"> 1. መንስኤ የለውም 2. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 	→	508
507	<p>በቅርብ ለነበረዎት ምልክት ዋና መንስኤ መሰረት ምልክቱን ለያጠፋ የሚችል የበለጠ ውጤት ይለው ህክምና ከየትኛው ይገኛል ብለው ያምናሉ?</p> <p>ይነብላቸው አንድ ብቻ መልስ ይከበብ</p>	<ol style="list-style-type: none"> 00. ምልክቱን ለያጠፋ የሚችል ህክምና የለም 1. ያለህክምና ይጠፋል 2. ከባህሪ ህክምና አዋቂ 3. ከዘመናዊ የጤና ተቋማት 4. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 		
508	<p>እራሴን ከማንኛውም ዓይነት የአባላዘር በሽታ መከላከል እችላለሁ ብለው ያምናሉ?</p>	<ol style="list-style-type: none"> 1. አዎ 2. አላምንም 88. አላውቅም 99. መልስ የለኝም 	→	512
509	<p>የአባላዘር በሽታ እንዳይዘዎት እንዴት ወይም ምን በማድረግ መከላከል እችላለሁ ብለው ያስባሉ?-----ሌላ?</p> <p>አታንብብ የጠቀሱት ሁሉ ይከበብ ወይም ይፃፍ</p>	<ol style="list-style-type: none"> 1. ከመደበኛ የግብረ ሰጋ ግንኙነት ጋር ያለው ያለኮንደም የግብረ ሰጋ ግንኙነት ሁሉ ከንደም በመጠቀም 2. ከአንድ ታማኝ የግብረ ሰጋ ግንኙነት ጋር በመወሰን 3. ከግብረ ሰጋ ግንኙነት በመቆጠብ 4. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 	→	512

510	<p>ከጠቀሷቸው ውስጥ የትኛውን ከአባላዘር በሽታ የበለጠ የመከላከያ ዘዴ ነው ብለው ያምናሉ?</p> <p>አንድ ብቻ መልስ ይከበብ ወይም ይፃፍ።</p>	<ol style="list-style-type: none"> 1. ከመደበኛ የግብረ ስጋ ግኑኝነት ጋር ወይም የትዳር ጋር ይደረግ የግብረ ስጋ ግኑኝነት ሁሉ ከንደም በመጠቀም 2. ከአንድ ታማኝ የግብረ ስጋ ግኑኝነት ጋር በመወሰን 3. ከግብረ ስጋ ግኑኝነት በመቆጠብ 4. ሌሎች _____ <p>88. አላውቅም</p> <p>99. መልስ የለኝም</p>		
511	<p>ከጠቀሷቸው ውስጥ የትኛውን የመከላከያ ዘዴ አለመጠቀም በቅርቡ ለነበርዎት ምልክት ዋና ምክንያት ነበር ብለው ያምናሉ?</p> <p>አንድ ብቻ መልስ ይከበብ ወይም ይፃፍ።</p>	<p>00. አለመጠቀሚያ ምክንያት አልነበረም</p> <ol style="list-style-type: none"> 1. ከመደበኛ የግብረ ስጋ ግኑኝነት ጋር ወይም የትዳር ጋር ይደረግ የግብረ ስጋ ግኑኝነት ሁሉ ከንደምን አለመጠቀም 2. ከአንድ ታማኝ የግብረ ስጋ ግኑኝነት ጋር አለመወሰን 3. ከግብረ ስጋ ግኑኝነት አለመቆጠብ 4. ሌሎች _____ <p>88. አላውቅም</p> <p>99. መልስ የለኝም</p>		
512	<p>በአንድ አባላዘር በሽታ ተይዞ የዳነ ሰው በድጋሚ በዚያ የአባላዘር በሽታ ሊያዝ አይችልም ብለው ያስባሉ?</p>	<ol style="list-style-type: none"> 1. አዎ 2. አላስብም <p>88. አላውቅም</p> <p>99. መልስ የለኝም</p>		
513	<p>በግብረ ስጋ ግኑኝነት የሚተላለፉ በሽታዎች በወንዶች ላይ የሚያሳዩትን ምልክቶች ይግለጹ ---- ሌላ?</p> <p>አታንብብ የጠቀሱት ሁሉ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. የብልት ፈሳሽ 2. ሽንት ሲሸኑ የማቃጠል ስሜት 3. የብልት ቁስል 4. የብልት ወይም የብልት አከባቢ ማሳከክ 5. የብልት እብጠት 6. የዘር ፍሬ ከረጢት እብጠት 7. የብሽሽት እብጠት 8. የብልት ላይ ኪንታሮት 9. የብልት ላይ ሽፍታ 10. ፈሳሽ አዘል እብጠት በብልት ላይ መውጣት 11. ሌሎች _____ <p>88. አላውቅም</p> <p>99. መልስ የለኝም</p>	→	515
514	<p>ከጠቀሱልኝ በወንድ ላይ ከሚታዩ የአባላዘር በሽታ ምልክቶች ውስጥ የትኞቹ የአባላዘር በሽታዎች ብቸኛ ምልክት ናቸው ብለው ያምናሉ? --- ሌላ?</p> <p>የጠቀሱት ሁሉ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. የብልት ፈሳሽ 2. ሽንት ሲሸኑ የማቃጠል ስሜት 3. የብልት ቁስል 4. የብልት ወይም የብልት አከባቢ ማሳከክ 5. የብልት እብጠት 6. የዘር ፍሬ ከረጢት እብጠት 7. የብሽሽት እብጠት 8. የብልት ላይ ኪንታሮት 9. የብልት ላይ ሽፍታ 10. ፈሳሽ አዘል እብጠት በብልት ላይ መውጣት 11. ሌሎች _____ <p>88. አላውቅም</p> <p>99. መልስ የለኝም</p>		

515	መደበኛ የግብረ ስጋ ግኑኝነት ጊደኛ ወይም የትዳር ጊደኛ ካልሆነና የአባላዘር በሽታ ምልክት ከማይታይበት ሰው ጋር ኮንዶም ሳይጠቀሙ የግብረ ስጋ ግኑኝነት መፈፀም የአባላዘር በሽታ ሊያሰይዝ ይችላል ብለው ያስባሉ?	1. አዎ 2. አላስብም 88. አላውቅም 99. መልስ የለኝም		
516	ያልተገረዙ ወንዶች ከተገረዙ ወንዶች ይልቅ ለአባላዘር በሽታ የተጋለጠ ናቸው ብለው ያስባሉ?	1. አዎ 2. አላስብም 88. አላውቅም 99. መልስ የለኝም		
517	በማንኛውም ዓይነት የአባላዘር በሽታ ለተያዘ ሰው በፍጥነት ወይም ወዲያውኑ ህክምና ማግኘት ጠቃሚ ነው ብለው ያምናሉ?	1. አዎ 2. አላምንም 88. አላውቅም 99. መልስ የለኝም	→	
518	በአባላዘር በሽታ የተያዙ ሰዎች በፍጥነት ወይም ወዲያውኑ ካልታከሙ በስተቀር ተጨማሪ የጤና ችግር ሊያጋጥማቸው ይችላል ብለው ያስባሉ?	1. አዎ 2. አላስብም 88. አላውቅም 99. መልስ የለኝም		522
519	በአባላዘር በሽታ የተያዙ ሰዎች በፍጥነት ወይም ወዲያውኑ ባለመታከሚያቸው ምክንያት ሊያጋጥማቸው ይችላሉ የሚሉትን ተጨማሪ የጤና ችግሮች ይግለፁልን? ----ሌላ? አታንብብ የጠቀሱት ሁሉ ይከበብ ወይም ይጻፍ	1. ለኤች አይ ቪ ኤድስ መጋለጥ 2. መሀን መሆን 3. የሽንት ቱቦ መጥበብ 4. ካንሰር 5. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም	→	522
520	ከጠቀሷቸው ውስጥ ለአባላዘር በሽታዎች በፍጥነት ህክምና ካላገኘሁ በስተቀር የትኞቹ የጤና ችግሮች ያጋጥሙኛል ብለው ይሰጋሉ?---- ሌላ? አታንብብ የጠቀሱት ሁሉ ይከበብ ወይም ይጻፍ	00. የትኛውንም አላስብም 1. ለኤች አይ ቪ/ኤድስ መጋለጥ 2. መሀን መሆን 3. የሽንት ቱቦ መጥበብ 4. ካንሰር 5. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም	→	522
521	በጥያቄ ቁ. 520 ከጠቀሷቸው ውስጥ በጣም ከፍተኛ የጤና ችግር ነው ብለው የሚያስቡት የትኛውን ነው? የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ	00. ሁሉም በጣም ከፍተኛ ችግሮች አይደሉም 1. ለኤች አይ ቪ ኤድስ መጋለጥ 2. መሀን መሆን 3. የሽንት ቱቦ መጥበብ 4. ካንሰር 5. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም		

ወደ ጥያቄ ቁጥር 502 ተመለስ

ከጥያቄ ቁጥር 522 እስከ 532 በጥያቄ ቁጥር 502 ላይ የአባላዘር በሽታዎች ናቸው ብለው ተጠያቂው የጠቀሷቸውን በሽታዎች ብቻ በመጥቀስ ጠይቅ:: ለጥያቄ ቁጥር 502 መልሱ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 533 እለፍ::

522	<p>የአባላዘር በሽታዎች ናቸው ብለው ከጠቀሱልኝ ውስጥ በበለጠ የትኛውን በሽታ አለመታከም ይመርጣሉ?</p> <p>በጥያቄ ቁጥር 502 የጠቀሱትን ብቻ አንብብ</p> <p>የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. ለጨብጥ 2. ለቂጥኝ 3. ለከርክር 4. ለባንቡሌ (ለፍርንትት) 5. ለብልት ኪንታሮት 6. ለብልት ላይ ወይም ለብልት አከባቢ እከክ 7. ለብልት አከባቢ ለሚኖር ቅማል 8. ለብልት ምች (ግርፋት) 9. ለወፍ በሽታ 10. ሌሎች <hr/> <p>00. ለሁሉም መታከምን እመርጣለሁ</p> <p>99. መልስ የለኝም</p>	→	52
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523	<p>ከላይ ለጠቀሱት በሽታ አለመታከምን የመረጡበት ዋንኛው ምክንያት ምንድነው?</p> <p>የጠቀሱት አንድ ብቻ ምክንያት ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. በሽታው ቀላል ስለሆነ 2. ያለህክምና ይደናል ብዬ ስለማስብ 3. ከበሽታው መጻን ስለማይቻል 4. ውጤታማ ህክምና ስለሌለ 5. ህክምናው ወደ ስለሆነ 6. ስለ የጤና ችግሩ ለህኪሞች ማዋየት ስለሚያሳፍረኝ 7. በበሽታው ተይዞ አገልግሎት ለሚጠይቅ ሰው የህኪሞች አመለካከት መጥፎ ስለሆነ 8. የግል ሚስጥሬን ለመጠበቅ 9. ሌሎች <hr/> <p>99. መልስ የለኝም</p>		
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524	<p>የአባላዘር በሽታዎች ናቸው ብለው ከጠቀሱልኝ ውስጥ በበለጠ ለየትኛው በሽታ የጠናና ባለሙያን ወይም የባህል ህኪምን ስለ በሽታዎ ሳያማክሩ እራስዎ መድሃኒት መውሰድን ይመርጣሉ? መድሃኒቱ የሚጠጣ የሚዋጥ ወይም የሚቀባ ማንኛውም አይነት የባህል ወይም በጠናና ተቂሞች የሚገኝና በግዢ ወይም ከአከባቢዎ ያለግዢ የሚያገኙት ሊሆን ይችላል።</p> <p>በጥያቄ ቁጥር 502 ከጠቀሱት ውስጥ ለጥያቄ ቁጥር 522 የጠቀሱትን ብቻ በመተው አንብብ</p> <p>የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. ለጨብጥ 2. ለቂጥኝ 3. ለከርክር 4. ለባንቡሌ (ለፍርንትት) 5. ለብልት ኪንታሮት 6. ለብልት ላይ ወይም ለብልት አከባቢ እከክ 7. ለብልት አከባቢ ለሚኖር ቅማል 8. ለብልት ምች (ግርፋት) 9. ለወፍ በሽታ 10. ሌሎች <hr/> <p>00. ለሁሉም በራሴ መታከምን አልመርጥም</p> <p>88. አላውቅም</p> <p>99. መልስ የለኝም</p>	→	52
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525	<p>ከላይ ለጠቀሱት በሽታ የጤና ባለሙያን ወይም የባህል ህኪምን ሳያማክሩ መድሃኒት መውሰድን የመረጡበት ዋነኛ ምክንያት ምንድነው?</p> <p>የጠቀሱት አንድ ብቻ ምክንያት ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. የበሽታውን መድሃኒት ስለማውቀው 2. የሚድን በሽታ ስላልሆነ 3. ውጤታማ ህክምና ስለሌለ 4. በሽታው ቀላል ስለሆነ 5. ህክምናው ወድ ስለሆነ 6. ሚስጥራን ለመጠበቅ 7. የጤና ችግሩን ለህኪሞች ማዋየት ስለሚያሳፍረኝ 8. የጤና ባለሙያዎችም ሆኑ የባህል ህኪሞች ጥሩ አቀባበል ስለሌላቸው 9. ህክምናውን ለማግኘት ብዙ ሰዓት ስለሚያስጠብቁኝ 10. ሌሎች _____ 99. መልስ የለኝም 	
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526	<p>የአባላዘር በሽታዎች ናቸው ብለው ከጠቀሱልኝ ውስጥ በበለጠ ለየትኛው በሽታ በባህል ህክምና አዋቂዎች መታከምን ይመርጣሉ?</p> <p>የባህል ህክምና አዋቂ ጠበል አጥማቂ ቁሳ፣ ቃልቻ፣ ባለዘር፣ በቅጠላቅጠል ወይም በስራስር የሚያክም፣ ጠንቁይ፣ የልምድ አዋላጅ፣ ወጊሻ፣ እና የመሳሰሉት ሊሆን ይችላል።</p> <p>በጥያቄ ቁጥር 502 ከጠቀሱት ውስጥ ለጥያቄ ቁጥር 522 እና 524 የጠቀሱትን ብቻ በመተው አንብብ</p> <p>የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. ለጨብጥ 2. ለቂጥኝ 3. ለክርክር 4. ለባንቡሌ (ለፍርንትት) 5. ለብልት ኪንታሮት 6. ለብልት ላይ ወይም ለብልት አከባቢ እክክ 7. ለብልት አከባቢ ለሚኖር ቅማል 8. ለብልት ምች (ግርፋት) 9. ለወፍ በሽታ 10. ሌሎች _____ 00. ለሁሉም አልመርጥም 88. አላውቅም 99. መልስ የለኝም 	→ 5
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527	<p>ከላይ ለጠቀሱት በሽታ በባህል ህክምና አዋቂ መታከምን የመረጡበት ዋነኛው ምክንያት ምንድነው?</p> <p>የጠቀሱት አንድ ብቻ ምክንያት ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. የበሽታው መድሃኒት ከባህል ህኪም ዘንድ ብቻ ስለሚገኝ 2. ከሌሎች ህክምና ቦታዎች ሲነፃፀር አነስተኛ ገንዘብ ስለሚያስከፍሉ 3. ከክሊኒኮች፣ ከጤና ጣቢያዎች ከፋርማሲዎች፣ እና ከሆስፒታሎች ሲነፃፀር የባህል ህክምናው ውጤታማ ስለሆነ 4. ሚስጥር ስለሚጠብቁ 5. በህክምናው ወቅት ብቸኝነትን ስለሚጠብቁልኝ 6. አቀባበላቸው ጥሩ ስለሆነ 7. ምክራቸው ጥሩ ስለሆነ 8. ህክምና ለማግኘት ብዙ ሰዓት ስለሚያስጠብቁኝ 9. ሌሎች _____ 88. አላውቅም 99. መልስ የለኝም 	
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ቁጥር	ጥያቄዎችና ማግሪያቸው	መልሶች	ኮድ	ዝረ
528	<p>የአባላዘር በሽታዎች ናቸው ብለው ከጠቀሱልኝ ውስጥ በበለጠ ለየትኛው፣ በሽታ ከዘመናዊ የጤና ተቋማት ህክምና መውሰድን ይመርጣሉ? ዘመናዊ የጤና ተቋማት ማንኛውም የመንግስት የግል ወይም መንግስታዊ ያልሆኑ ድርጅቶች ክሊኒክ፣ ጤና ባብያጌ፣ ፋርማሲ ወይም ሆስፒታል ሊሆን ይችላል።</p> <p>በጥያቄ ቁጥር 502 ከጠቀሱት ውስጥ ለጥያቄ ቁጥር 522, 524 እና 526 የጠቀሱትን ብቻ በመተው አንብብ</p> <p>የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. ለጨብጥ 2. ለቂጥኝ 3. ለክርክር 4. ለባንቡሌ (ለፍርንትት) 5. ለብልት ኪንታሮት 6. ለብልት ላይ ወይም ለብልት አከባቢ እከክ 7. ለብልት አከባቢ ለሚኖር ቅማል 8. ለብልት ምች (ግርፋት) 9. ለወፍ በሽታ 10. ሌሎች _____ 00. ለሁሉም አልመርጥም 88. አላውቅም 99. መልስ የለኝም 	→	53:
529	<p>በመከላከያ ውስጥም ከመከላከያ ውጪም ያሉትን፣ የሚያውቁቸውን የግል የመንግስት ወይም መንግስታዊ ያልሆኑ ድርጅቶችን ክሊኒኮች፣ ጤና ባብያጌዎች ፋርማሲዎች እና ሆስፒታሎች ያስቡ ። እላይ ለጠቀሱቸው በሽታዎች ከሚያውቁቸው ሁሉ ጋር ሲነፃፀር በበለጠ ከየትኛው የመከላከያ የጤና ተቋም መታከምን ይመርጣሉ?</p> <p>ይነበብላቸው የጠቀሱት አንድ ብቻ ይከበብ</p>	<ol style="list-style-type: none"> 1. በሻለቃ ክሊኒክ 2. በክ/ጦር ሆስፒታል 3. በኮር ሆስፒታል 4. በመከላከያ ሪፈራል ሆስፒታል (ለምሳሌ ጦር ሃይሎች) 00. ከሁሉም አልመርጥም 99. መልስ የለኝም 	→ → → →	53: 53: 53: 53:
530	<p>ከላይ ለጠቀሱት በሽታ ከሌሎች ሲነፃፀር፣ በበለጠ ከየትኛውም የመከላከያ ጤና ተቋም ህክምና ማግኘትን የማይመርጡበት ዋነኛው ምክንያት ምንድነው?</p> <p>የጠቀሱት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. የህኪሞቹ አቀባበል ጥሩ አይደለም 2. የህኪሞቹ ችሎታ ዝቅተኛ ነው 3. ህክምናው ጥሩ አይደለም 4. ሚስጥር አይጠብቁም 5. በምርመራና በህክምና ወቅት ብቸኝነትን አይጠብቁም 6. ህክምናውን ለመስጠት ብዙ ሰዓት ያስጠብቃሉ 7. መድሃኒት የላቸውም 8. ጥሩ መድሃኒት የላቸውም 9. ጥሩ ምክር አይሰጡም 10. ሌሎች _____ 99. መልስ የለኝም 		

531	<p>ከመከላከያ ውጪ የሚገኙትን የጤና ተቋማት ሁሉ ያስቡ። ከሌሎች ሁሉ በበለጠ ከየትኛው ዘመናዊ የጤና ተቋም ከላይ ለመቀሰት በሽታ ህክምና ማግኘትን ይመርጣሉ?</p> <p>ይነበብላቸው የመቀሰት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. ከጤና ጥበቃ ጤና ከላ 2. ከጤና ጥበቃ ክሊኒክ 3. ከጤና ጥበቃ ጤና ጣብያ 4. ከጤና ጥበቃ ሆስፒታል 5. ከግል ክሊኒክ 6. ከግል ፋርማሲ 7. ከግል ሆስፒታል 8. ከመንደር መርፌ ወጊ 9. ሌሎች _____ 99. መልስ የለኝም 																										
532	<p>ከላይ ለመቀሰት በሽታ ከሌሎች ሁሉ በበለጠ ከመቀሰት የጤና ተቋም ህክምና ማግኘትን የመረጡበት ዋና ዋና ምክንያቶች ምንድነው?</p> <p>የመቀሰት አንድ ብቻ ይከበብ ወይም ይጻፍ</p>	<ol style="list-style-type: none"> 1. ስለማይከፈልበት 2. አንስተኛ ገንዘብ ስለሚከፈልበት 3. ቅርብ ስለሆነ 4. ህክምናው ጥሩ ስለሆነ 5. አቀባባላቸው ጥሩ ስለሆነ 6. ህኪሞቹ ጥሩ የህክምና ችሎታ ስላላቸው 7. ሚስጥር ስለሚጠብቁ 8. በምርመራና በህክምና ወቅት ብቸኝነትን ስለሚጠብቁ 9. ምክራቸው ጥሩ ስለሆነ 10. ህክምና ለመስጠት ረጅም ጊዜ ስለማያስጠብቁ 11. ጥሩ መድሃኒት ስላላቸው 12. ሌሎች _____ 99. መልስ የለኝም 																										
533	<p>ከሚከተሉት ውስጥ በየትኞቹ የመከላከያ ጤና ተቋማት የአባላዘር በሽታዎች ህክምና ይሰጣል ብለው ያስባሉ?</p> <p>ይነበብላቸው</p> <p>አዎ ካሉ አንድ ቁጥርን ክበብ አይሰጥም ካሉ ሁለት ቁጥርን ክበብ አላውቅም ካሉ 88ን ክበብ መልስ የለኝም ካሉ 99ን ክበብ</p>	<table border="1"> <thead> <tr> <th></th> <th>አዎ</th> <th>አይሰጥም</th> <th>አላውቅም</th> <th>መልስ የለኝም</th> </tr> </thead> <tbody> <tr> <td>በሻለቃ ክሊኒክ</td> <td>1</td> <td>2</td> <td>88</td> <td>99</td> </tr> <tr> <td>በክ/ጦር ሆ/ል</td> <td>1</td> <td>2</td> <td>88</td> <td>99</td> </tr> <tr> <td>በኮር ሆ/ል</td> <td>1</td> <td>2</td> <td>88</td> <td>99</td> </tr> <tr> <td>በመከላከያ ሪፈራል ሆስፒታሎች (ለምሳሌ ጦር ሃይሎች)</td> <td>1</td> <td>2</td> <td>88</td> <td>99</td> </tr> </tbody> </table>		አዎ	አይሰጥም	አላውቅም	መልስ የለኝም	በሻለቃ ክሊኒክ	1	2	88	99	በክ/ጦር ሆ/ል	1	2	88	99	በኮር ሆ/ል	1	2	88	99	በመከላከያ ሪፈራል ሆስፒታሎች (ለምሳሌ ጦር ሃይሎች)	1	2	88	99	
	አዎ	አይሰጥም	አላውቅም	መልስ የለኝም																								
በሻለቃ ክሊኒክ	1	2	88	99																								
በክ/ጦር ሆ/ል	1	2	88	99																								
በኮር ሆ/ል	1	2	88	99																								
በመከላከያ ሪፈራል ሆስፒታሎች (ለምሳሌ ጦር ሃይሎች)	1	2	88	99																								

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ቁጥር	ጥያቄዎችና ማጣሪያቸው	መልሶች	ኮድ	ዝርዝር
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602	ብርጌድ	1. 1 2. 2 3. 3 4. 4		
603	ሻለቃ	1. 1 2. 2 3. 3 4. 4		

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605	የትምህርት ደረጃ	00. ማንበብና መጻፍ የማይችል 1. ማንበብና መጻፍ የሚችል 2. ከ1ኛ- 6ኛ ክፍል 3. ከ7ኛ-8ኛ ክፍል 4. ከ9ኛ-12ኛ ክፍል 5. ከ12ኛ ክፍል በላይ 99. መልስ የለኝም	
606	ተጠያቂው ባሁኑ ወቅት ያላቸው ወታደራዊ ማዕረግ	1. ተራ ወታደር 2. ም/፲/አ 3. ፲/አ 4. ፶/አ 5. ም/መ/አ 6. መ/አ 7. ሻ/ል 8. ሻለቃ 9. ሌ/ኮ 10. ኮሎኔል 11. ጀነራል 99. መልስ የለኝም	
607	ተጠያቂው በአሁኑ ወቅት ያላቸው የጋብቻ ሁኔታ	1. ያገባ 2. ያላገባ 3. የተፋታ 4. የሞተበት 5. የተለያዩ(ፊርማቸውን ያልቀደዱ) 99. መልስ የለኝም	
608	የአገልግሎት ዘመን(በሙሉ አመት) የውትድርና የአገልግሎት ዘመን	00. ከአንድ አመት በታች 1. በሙሉ ዓመት _____ 99. መልስ የለኝም	
609	ብሔረሰብ	1. አማራ 2. ትግሬ 3. አሮሞ 4. ሌሎች _____ 99. መልስ የለኝም	
610	ሐይማኖት	00. ሐይማኖት የለኝም 1. ኦርቶዶክስ ክርስቲያን 2. ካቶሊክ 3. ፕሮቴስታንት 4. እስልምና 5. ሌሎች _____ 99. መልስ የለኝም	
611	የወር ገቢ ደሞዝ በአትዮጵያ ብር (ከቀለብ ውጪ)	1.200-400 2.401-600 3.601-800 4.801-1000 5.>1000 99. መልስ የለኝም	

ወደ ጥያቄ ቁ. 103 ተመለስ። ለጥያቄ ቁጥር 103 መልሱ አዎ ከሆነ ለምልክቱ ህክምና አስፈላጊ ስለመሆኑና በመከላከያ ጤና ተቋም ህክምና እንደሚሰጥ የጤና ትምህርት ስጥ።

ጊዜዎትን መስዋእት አድርገው መረጃ በመስጠት ስለተባበሩን ምስጋናችን እጅግ ክፍተ ነው።