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**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

Institute of Population Studies (IPS)

**Knowledge, Attitude and Behavior (KAB) on HIV/AIDS
among Members of Ethiopian National Association of
Blind (ENAB)**



YONAS TESFAYE MIDEKSA

July, 2008

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**A Thesis Submitted to Institute of Population Studies (IPS) In
Partial Fulfillment of the Requirement for the Master of Science
Degree in Population Studies**

YONAS TESFAYE MIDEKSA

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***Knowledge, Attitude and Behavior (KAB) on HIV/AIDS Among
Members of Ethiopian National Association of Blind (ENAB)***

**By
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College of Development Studies**

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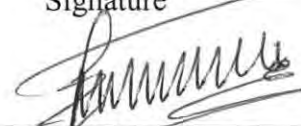
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndromes
CARDOS	Center for Applied Research Development- Oriented Service
CDS	College of Development Studies
CRDA	Christian Relief and Development Association
CSA	Central Statistical Authority
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
ENAB	Ethiopian National Association of Blind
ENAD	Ethiopian National Association of Deaf
HIV	Human Immunodeficiency Virus
IPS	Institute of Population Studies
KAB	Knowledge, Attitude and Behavior
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
NGOs	Non-Government Organizations
NRC	National Research Council
PLWA	People Living with AIDS
PwDs	People with Disabilities
SPSS	Software Packages for Social Sciences
STDs	Sexually Transmitted Diseases
UNAIDS	United Nations Program of AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Abstract

This study targeted to assess Knowledge, Attitude and Behavior (KAB) on HIV/AIDS among members of Ethiopian National Association of Blind (ENAB) using both quantitative and qualitative data. A total of 442 members of ENAB from Addis Ababa were taken as study subjects by simple sampling technique. A cross-sectional study design was employed in this study.

This study discusses the sampling procedure employed and the quality of data and examines the relationship between knowledge, attitude and behavior (KAB) and selected background characteristics of the study population using uni-variate, and multivariate statistical techniques of data analysis. In multi-variate analysis, logistic regression model has been used.

The dependent variables (KAB) were tested against the independent variables: age, religion, ethnicity, income level and place of previous residence were used as significant variables.

The findings showed that universal knowledge of HIV/AIDS among members of ENAB in Addis Ababa. However, knowledge of HIV/AIDS by itself doesn't guarantee for sexual behavior change among the study population. There were significant variations in sexual behavior among the study population with their age, current marital status, income level and place of previous residences. Attitude (perception) towards the disease was found almost equal chance to be infected with the disease among male and female respondents. Misconception also was observed in the mode of HIV/AIDS transmission among the study population.

The study has found that the youth (15-19), Never Married, No income Group and those previous places of residence was not Addis Ababa need protection.

Finally, the study concluded by providing possible recommendations, that may help to improve the existing high level of knowledge, attitudinal and behavioral modification among the study population.

CHAPTER ONE

INTRODUCTION

1.1. Statement of the Problem

Ethiopia as one of the sub-Saharan Africa country the prevalence of HIV is very high. According to WHO, between 7 percent to 10 percent of sexually active population is HIV positive (WHO). The virus is also highly spread among disabled population (Visual disabled, hearing disabled etc.)

The AIDS pandemic began spreading around 1980 in North America, West Europe and Sub Saharan Africa. Since then, HIV/AIDS has rapidly reached throughout the world (WHO, 2000).

Various studies have shown the same timing of spread of HIV/AIDS in Sub Saharan African Countries. In Ethiopia the first AIDS case was reported in 1986 (MOH, 1996). In Uganda, it was found in 1982 (CRDA, 1996) and in Tanzania, it was found 1983 (CRDA, 1996).

The HIV/AIDS pandemic have become a serious public health problem because no cure or no vaccine and the infection invariably lead to death. Infection is followed by years of slow destruction of the immune system, rendering carriers increasingly vulnerable to fatal opportunistic infections such as pneumonia and cancers (Bongaarts, 1996).

The state of persons with disabilities in Ethiopia is more tragic and sever due to the existence of various pre and post natal disabling factors like infections disease, difficulties contingent to delivery, under nutrition malnutrition, harmful traditional practice, law of proper child care and management, civil war, draught and famine and the

absence of early primary and secondary preventive action (UNICEF, 1988).

International Rehabilitation Reviews show that nearly 10 percent of world's populations are disabled, of which 80 percent are concentrated in developing world. Most of these people do not have access to rehabilitation service because of poor economic status.

Very low literacy rates among disabled people and difficulty to address messages through radio and television for the deaf and blind people create challenges to diffuse information. Sex education programs for these people are not designed very well. Furthermore, the access to health services is also extremely poor due to social and economical obstacles. Disabled people living with HIV in developing countries particularly in Africa usually face discrimination from being disabled, poor and HIV positive (CARDOS and Action Aid, 2007).

HIV/AIDS is a serious and almost unrecognized problem among disabled people in the world. According to the Global survey on HIV/AIDS and disability (2004), individual with disabilities are at equal or higher risk of HIV infection compared to people without disabilities. Disabled people are more likely to have several sexual partners in a series of instable relationships because they are less likely to marry (UNAIDS, 1995). They are also more likely to be victims of sexual abuse and rape.

Fasil (2005) discusses that though Ethiopia is at the van in fighting the HIV/AIDS pandemic, the issues and needs of PwDs have not been given due and appropriate attention. According to the report, PwDs have been intentionally or unintentionally forgotten. In this connection Fasil says that there has been not effort made to "package

and adapt" the Ethiopian health system and AIDS communication strategies to suit to PwDs and this puts them at further risk to HIV/AIDS. Girls and women with disabilities are more vulnerable because they are less likely to be educated, to be unemployed or marginally employed and more likely to be exposed to sexual violence and to live in unstable relationships due to the gender inequalities.

Fasil points out the following challenges in preventing HIV/AIDS among PwDs:

- Social perception: 85 percent of the respondents without disability assume that PwDs are not at risk of being infected with the virus.
- Perceptions of PwDs: Only 2 percent of PwDs in the study have access to HIV awareness and prevention services. 20 percent of PwDs reported that they are at a high risk of HIV/AIDS.
- The Ethiopia government, even if it initiated a creditable program to address the HIV/AIDS epidemic as well as the collection and analysis of data for measuring the achievements of forgets, the concerns of PwDs are not mainstreamed in activities.
- Except two NGOs (IDPDA and Handicap International) that work on disability, there is hardly any NGO working on HIV/AIDS and disability. Most NGOs contributed very limited finance to PwDs (Fasil, H. 2005).

For a long time persons with visual disability have been marginalized when it comes to the campaign against HIV/AIDS. While NGOs and governmental organizations have set up programmes and campaign to create awareness on how to prevent, manage and live positively with

HIV/AIDS. Unfortunately, these programmes and campaigns are rarely made accessible to visual disabled persons. Hence, blind people have been left behind in the campaigns against HIV/AIDS.

Some challenges that visually disabled people face:

- Most of the information on HIV/AIDS and related issues is not available in accessible formats like Braille or large print. Lack of information on HIV/AIDS implies that they are a high risk category and also have no knowledge of how to live with HIV/AIDS or how to care for others with the disease.
- If a blind person contracts HIV/AIDS there is little support from the community due to social stigma. Lack of deliberate efforts to target them because of the perception that they are not infected with HIV. Therefore, most of blind people eventhough they may be infected they do not know where to access treatment. Counseling and support services are not modified to suit the special needs of persons with disabilities.

1.2. Current Situation of HIV/AIDS in Ethiopia

Ethiopia is one of the Sub-Saharan African countries that are highly affected by the HIV/AIDS epidemic. According to MOH, the estimated adult HIV prevalence was 3.5 percent (urban 10.5 percent and rural 1.9 percent). The number of people living with HIV/AIDS was 1,320,000 (3 percent male and 4 percent of female) out of which about 150,000 were children under 15 years of age. Since then the number of new HIV infections is 129,000 and new AIDS cases in the adult population is 137,000 while in children it is 22,000. Some 277, 800 living with HIV/AIDS were in need of antiretroviral treatment. A total of 4,885,000 children under 17 years of age are estimated to be orphans for different reasons of which 744,100 are due to AIDS (MOH, 2006).

The age group most affected by HIV/AIDS (15-49 years) occupies a very critical position in families and communities as a whole. It is normally this group that occupies the role of household bread winners. They are the major source of the labor force, and very often society leadership evolves from this group. As a result, HIV/AIDS has touched every aspect of national life and development including behavior, the role and functions of the family, communities, the care and support system and the economy, which in turn has aggravated the persistence of poverty in the country (MOH, 2006).

The social impact of HIV/AIDS manifests itself both at individual and group levels. All members of rural and urban families hit by HIV/AIDS are likely to be affected economically and socially. Family members with AIDS both in rural and urban settings are unable to work or carry out farming operations promptly and efficiently. Resources and assets are diverted from production to maintain family needs.

At the same time, women (whether infected or not) and their children are especially vulnerable to hardship, malnutrition, sickness and death. Traditionally, women are providers of food, care and labour to the family. In times of distress, they are normally over burdened with more responsibilities. The situation worsens if she is infected with the disease. This leaves no option but to transfer the responsibilities to the available female minor, thus perpetuating gender inequity (MOH, 2006).

According to MOH projection, the magnitude of orphan hood due to AIDS could increase to 1.8 million in 2009. Some of these children could be HIV positive themselves increasingly becoming unable to acquire services from the already meager care and support opportunities. At present many of these orphans are not getting

adequate assistance of survival. They may be “child caretakers” of surviving parents, younger siblings and other invalids in the extended family structure. In a bid to make ends meet, these children may seek employment in the informal sector as commercial sex workers or engage in other offensive roles, jeopardizing their status including physical abuse, sexual exploitation, petty crime and street loitering (MOH, 2006).

These hurdles of life predispose them to risks including vulnerability of HIV infection; problems faced by AIDS orphans include lack of food, shelter, clothing and other material necessities, access to healthcare and education. They also face discrimination, stigmatization, economic and sexual exploitation and lack of support and attention to their social and emotional needs (MOLSA, 2003).

The fate of HIV/AIDS affected families may also be subjects to a wide array of unconventional survival means of reliance on the roles of positive traditional practices. Effective and sustainable responses to HIV /AIDS require building the capacity of individuals (PLWHAs) the family and community and integrating them into conventional services. Therefore, community-based care and support mechanism to protect PLWHAs have to be designed in parallel with other HIV/AIDS epidemic responses.

Ethiopia and its development partners have been working hard to contain the epidemic through the creation of an enabling policy and intervention environment and by putting in place the necessary tools and implementation mechanisms. The ‘HIV/AIDS Policy’ and the Multi-sectoral Strategic Framework’ are the two major policy documents at the top of the country’s HIV/AIDS prevention and mitigation agenda including care and support for persons affected by

the epidemic. These policy instruments do not only stipulate the high priority given to HIV/AIDS prevention and control, they also articulate the roles of partners, the organizational structure from the apex to the grass roots level, programs and implementation arrangements, coordination among partners, monitoring and evaluation of interventions and the mobilization of resources. The multi-sectoral responses are today firmly in place starting from the national level to community level, and there have been major achievements from numerous schemes empathizing preventive, the rape tic, care and support measures that include:

- The presence of an organizational structure and capacity in most of the woredas of the country that are addressing concerns related to HIV/AIDS;
- Enhancement in the provision of community-based home care and support to infected and affected persons and families;
- Increase access to VCT service;
- The production of several guidelines and manuals on various aspects of HIV/AIDS and putting facilities in place for easy access; and
- The existence of relatively improved networking among organization that are involved in HIV/AIDS prevention and control activities in one way or another.

Despite this, the country is still in a situation far from idea. Health and support institutions are overburdened with an infected and affected population. AIDS patients occupy over 50 percent of hospital beds, exacerbating the limited health facilities and services. Demand for care and support for PLWHAs has been steadily growing and it is anticipated that will continue to increase in the foreseeable future. The alarming magnitude of the HIV/AIDS problem is crowding out the

response in the public, private and NGO sectors (CARDOS and Action Aid, 2007).

The prevailing need for care and support of PLWHAs is indeed far beyond the existing capacity of public, NGO and private institutions. This is well noted in the policy documents mentioned above. It is indeed high time to make a call for increased and more active participation of the informal sector, rural and urban communities and families in the national effort to provide care and support to PLWHAs and other affected groups.

1.3. Impact of HIV/AIDS

AIDS is a distressful enemy of human kind. The problem that results from AIDS can be well understood by considering its impact to the individual, the family, the community and the society at large.

1.3.1. Demographic Impacts: Population Size and Growth

AIDS have a huge impact on population size. However, it will not cause population growth to stop or become negative. The projection shows that the total fertility rate (the average number of birth per women during her lifetime) declines, from about 6.3 by 1998 to 5.2 by 2015 (MOH, 1998).

If there were no AIDS epidemic, the total population of Ethiopia would increase from about 55 million by 1998 to 92 million by 2014 the population would be growing at 2.8 percent per year (MOH, 1998).

According to the MOH, the cumulative number of AIDS death was 1,267,000 by 2005 and is projected to reach 1.9 million by 2010 if present trends continue. However, the projected and estimated

population losses due to HIV/AIDS will not bring a halt to the general population growth (MOH, 2006).

1.3.2. Health Care Impacts

AIDS is an expensive disease that will require a considerable amount of resources from the health system. A study (1994) estimated that the cost of hospital care for AIDS patients range from 425 to 3140 Ethiopian birr during the course of the illness. By 2014, expenditures for AIDS care could amount to one-third of the budget of the Ministry of Health. Clearly, this would place a tremendous burden on the public health care system to provide adequate care for AIDS patients and still try to meet all the other health needs of the population (MOH, 1998).

AIDS also affects child survival; about 30-40 percent of babies born to infected mother will also be infected with HIV. Most of these babies will develop AIDS and die within two years (MOH, 1998).

AIDS could soon become the major cause of death for children under the age of five, worse than other major causes such as diarrhea and respiratory diseases. The increasing number of child due to AIDS threatens to reverse many of the recent gains of child survival programmes.

The infant mortality rate is the number of infants who die during the first year of life per 1000 live birth. It is currently around 110, without AIDS infant the mortality rate might be expected to decline to 79 by 2014. However, with AIDS, it would decline to only about 87 (MOH, 1998).

The child mortality rate is the number of children who die before reaching their fifth birthday per 1000 live births. It is currently around 190 without AIDS it might be expected to decline to around 127 by 2014, because of child survival programs such as diarrhea control and immunization: However, with AIDS it is likely to decline only to about 153 (MOH, 1998).

1.3.3. Economic and Social Impacts

AIDS have an impact on the economic development of Ethiopian in a number of ways. The loss of young adult in their most productive years of life will certainly affect overall economic output. If AIDS is more prevalent among the economic elite, the best-educated people with the highest paying jobs, then the impact could be much larger than the absolute number of AIDS death (MOH, 1998).

Another impact is on social, all members of families hit by AIDS are likely to be affected. Grandparent may have to assume full responsibility for raising the children when the parents die. Children are more likely to become malnourished, may become orphans and may have fewer opportunities for education if the family cannot the expense of education or needs the children to work in the home (MOH, 1998).

AIDS can have a very serious impact on the lives of women when it strikes a family member. In most cases women do not have a secure occupation which can provide a steady and adequate income. Thus, if the husband dies, the remaining wife and children can be particularly vulnerable. Some women may be exploited or may have to resort to selling sex to provide cash income (MOH, 1998).

Women are also especially vulnerable to AIDS because they may have limited ability to protect themselves from HIV infection. A woman may be at risk of getting HIV even though a woman is faithful to her husband, because her husband has outside sexual partners. She may have little or not control over her husband's actions and no ability to protect her by having her husband use condom (MOH, 1998).

One of the worst impacts of AIDS death to young adults is an increase in the number of orphans. Some children could be lost their father or mothers to AIDS and many more children were lost both parents because of AIDS. The number of AIDS orphans could increase to 620,000 by 2000 and to 1.8 million by 2009 (MOH, 1998).

1.4. Rationale for the study

Although there are some studies conducted in the country, none of these studies tried to provide comprehensive overviews about the awareness of the blind people towards HIV/AIDS and related issue, and this situation has created a huge knowledge gap about the extent of the problem in the area.

Therefore, this study has the purpose of filling the knowledge gap in exploring the level of knowledge, attitude and behavior (KAB) towards HIV/AIDS among members of Ethiopian Association of Blind (ENAB) and the factors that affect their knowledge, attitude and behavior among member of ENAB towards HIV/AIDS.

1.5. Objectives of the study

1.5.1. General Objective

The general objective of this study is to explore the level of knowledge, attitude and behavior of HIV/AIDS among the members of Ethiopia National Association of blind (ENAB).

1.5.2. Specific Objectives

- To explore the knowledge, attitude and behavior of the study population on their socio-economic and demographic characteristics of the study population.
- To describe the sexual behavior among the study population which are risk factors for HIV transmission.
- To find out the needs of study population on HIV prevention and recommend possible suggestions based on the findings of the study.

1.6. Hypotheses

This study was tried to test the following hypotheses:

1. Age has a direct impact on attitude and sexual behavior of the study population.
2. Current marital status and income have impact on sexual behavior of the study population.
3. There is no difference between males and females in their attitude and sexual behavior in relation to HIV/AIDS in the study population.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. Disabilities and HIV/AIDS

There are two sources of legal definitions relation to disability that Ethiopia has adopted. According to the order for Establishment of the Rehabilitation Agency for the Disabled (No. 70/1971) defined a people with disabilities (PwDs) as:

Any person who, because of limitations of normal physical or mental health, is unable to earn his livelihood and does not have one to support him; and shall include any person who is unable to earn his livelihood because of young or old age (Frew, 2001; Workie, 1997).

A PwD is defined in the proclamation No. 101/1994 as:

A person who is unable to see, to hear to speak or suffering from injuries to his limbs of from mental retardation, due to natural or man made causes; providing however, the term does not include persons who are alcoholic, drug addicts and those with psychological problems due to socially deviant behaviors.

A global research conducted by the World Bank/Yale University (2004) indicated that the people with disabilities are not assumed to be at higher risk of HIV infection because they are believed to sexually inactive not to use drugs or alcohol and at less risk of sexually transmitted diseases than people without disabilities.

Disabled people are the poorest, most stigmatized and most marginalized societies. World's condition of poverty such as poor nutrition and lack of accessibility to social services are the major causes of disability. About 80 millions of people in Africa living with disability (visual disability, hearing disability, etc). These make up to

20 percent of people in the poorest communities, which are also affected by HIV/AIDS (UNAIDS, 1995). Individuals with disabilities have equal or greater exposure to all known risk factors for HIV infections than non-disabled. The stigma experienced by persons with disabilities means that they are less likely to marry and three times more likely to have several sexual partners in a series of unstable relationships (UNAIDS, 1995).

According to CARDOS, PwDs are at significant risk becoming HIV infected in Ethiopia. The risk factors identified by the study includes; poverty, lack of education, lack of information and resources to ensure 'safer sex', sexual violence and lack of legal protection, stigma and substance abuse (CARDOS and Action Aid, 2007).

Reaching disabled people with HIV/AIDS message is complicated. Where HIV/AIDS campaigns are run through newspapers and billboards, blind people are not distinct advantage; where HIV/AIDS campaigns have concentrated on radio, deaf people are often uninformed.

Treatment care for visually disabled people living with HIV/AIDS has been difficult in hospitals of developing countries. Most of the visually disabled people find it better to visit witch doctors than going to the hospitals because of the poor treatment they receive there. Most of the medical personnel have not learned how to handle people with disabilities and especially visually disabled persons (African Union of the Blind, 2006)

Table 2.1 Visual Disability by Sex Ratio in Ethiopia

Type	Total	Sex ratio
Total blindness	117,739	88:100
Partial blindness	201,455	99:100
Total	319,194	94:100

Source: CSA, 1994

2.2. Living Conditions of People with Disabilities (PwDs)

Disabled people are among the poorest, most stigmatized and most marginalized of all the world's citizens. Disability and poverty form a vicious circle. Conditions or poverty such as poor nutrition and lack of access to health service of safe living and working conditions create disabilities that can occur from birth to old age (Elwan, 1999).

According to baseline survey conducted on disabilities in Ethiopia, 50.2 percent (314) respondents are unemployed out of 625 valid cases. The remaining 40 percent and 9.8 percent are employed and retired respectively (Tirussew et.al, 1995).

A study conducted on PwDs living in Shashemene and Kuyera towns indicate that about 55.3 percent of the respondents depend on family, neighbors and friends for their livelihood while 42.3 percent have their own income. Out of those said to have their own income, beggars make up 28.3 percent and urban employed (street dweller, local drink brewers and housemaids) 16.3 percent (APDO, Universita La Sapienza and LAVIA, 2005).

The health status of PwDs in Ethiopia is extremely poor. As the overall situations indicate, these people receive poor level of care by all standards. The poor socio-economic condition in which these people are living in manifested by high disease burden and very low

utilization of the meager health services available. The greatest problems of PwDs, with respect to utilization of health services, are lack of information coupled with harmful traditional beliefs and the physical distance of health facilities. Payment for transportation is also a problem for most as transportation may require special arrangement, which in turn would make it more expensive (PACT/WAF, 2003).

2.3. HIV Prevalence in Ethiopia

Ethiopian demographic and health survey (EDHS) showed that 1.4 percent of Ethiopian adults age 15-49 are infected with HIV. HIV prevalence in women is nearly two percent, while for men 15-49; it is just under one percent. The female to male ratio of 2:1 is higher what has been previously assumed in the Ethiopian situation. For both men and women that HIV prevalence levels has been raised with age, peaking among women in their late 30s and among men in their early 40s. The age pattern suggests that young women are particularly vulnerable to HIV infection compared with young men (EDHS, 2005).

Urban residents have a significantly higher risk of HIV infection (6 percent) than rural residents (0.7 percent). HIV infection levels increase directly with education among the women and men are markedly higher among those who have a secondary or higher education compared with those with less education. Employment is also related to HIV levels among both women and men, with those who are employed being more likely than the unemployed to be infected (EDHS, 2005).

EDHS, 2005 indicated that marital status is closely related to HIV prevalence. Women and men who are widowed, divorced, or separated have significantly higher rates than those who are married or living together (EDHS, 2005).

2.4. Knowledge, Attitude and Behavior on HIV/AIDS

HIV/AIDS is one of the diseases threatening the live of many people in developing countries. The essential step to design effective intervention strategy to understand the risk factor. The main risk factors affect primarily knowledge, attitude and behavior.

2.4.1. Knowledge on HIV/AIDS

The common way of asking knowledge on HIV/AIDS is by asking its mode of transmission. Accordingly, different findings have been documented for various independent socio-economic and demographic factors.

The Benin DHS (1997) reported that knowledge of AIDS was almost universal. In Ethiopia, the difference in the level of knowledge about AIDS among women and men was very small (EDHS, 2005). The knowledge of college students on HIV/AIDS did not show significant difference in relation to their sex (Beyene Petros et.al, 1997). The knowledge difference among the males and females may be attributed to their difference in educational level. As it can be observed in the study college students, where their educational level is on the same level, their knowledge difference was insignificant. In Ethiopia in general, education level was higher for males than females (EDHS, 2005).

The effect of age on the level of knowledge about HIV/AIDS has exhibited mixed results for men and women in different countries. In Benin, for women the knowledge increased from age group 15-19 and 25-29 and declined in the subsequent age groups. For men the index declined throughout as age increased (KAB, Benin, 1997). In some other African countries, there was no definite pattern in the relationship between knowledge and age for both women and men.

The other significant determined variable for the knowledge of individual is education. The KAB study conducted among long distance bus drivers in Ethiopia, the knowledge gap ranged from 80 to 97 percent for those who only read and write and for those who have completed grade 12 and above respectively (Eleni, 1998). In Benin, for men with no education and with secondary and above, the gap stood from 90.4 to 100 percent respectively. For women, the gap was still wider ranging from 76 to 91.3 percent (KAB, Benin 1997). Marital status as one of the determinant variables, play a huge role on the knowledge of respondents. Those in Union have better knowledge than those Formerly In Union but lower knowledge when compared to the Never married ones (DHS, Benin 1997).

Globally, there is high illiteracy rate among disabled people. This factor affects the knowledge of disabled people toward HIV/AIDS. Even where AIDS education is available, however, students with disabilities may be often excused from such instruction because teachers assume that they will not need the information (World Bank, 2003).

Where sex education is taught within the home, people with disabilities often receive little information because it is believed that

they do not need such knowledge. This lack of information increases the risk of acquiring HIV infection (UNICEF, 1999).

2.4.2. Attitude on HIV/AIDS

In the era of AIDS pandemic, behavioral change is the only means to protect the transmission of the disease. Behavioral change, however, is difficult to achieve.

Several models have been used to explain behavioral change in relation to disease before and since the advent of HIV/AIDS. The development of most of these models has been based on experiences in the developed countries and may not apply in the developing countries with their different cultures and outlooks. However, some of the theories can be extended to HIV/AIDS in Sub Saharan Africa. Two of these which seem to be most applicable are the Health Belief Model, and the AIDS Risk Reduction Model (Lindan et.al, 1991; Pollak 1992, as cited in Ntozi. al, 1997).

The Health Belief Model assumes that the individual's attitude plays an important role in prevention of a disease, especially his/her perception of susceptibility to the disease, seriousness of the disease and benefits of health action, and this attitude is modified by demographic factors (Pollak, 1992, as cited in Ntoszi et.al, 1997). According to this model, sufficient knowledge of the disease is essential but not the only precondition for behavioral modification.

The AIDS Risk Reduction Model includes some of the above factors like knowledge of disease transmission, belief in the severity of the disease, and perceived risk of becoming infected. It also includes peer support for safe behavior, self-belief in one's ability to avoid disease,

and skills in communicating and enacting safe behavior (Lindan et.al 1991; Livingston 1992, as cited in Ntozi et.al, 1997).

Among different theories, one by Reboult (1992) stresses on the relationship between exposure to the patients of HIV/AIDS and prevention seeking behavior. Precisely it runs as, human beings need the rude shock of many death in order to awaken their senses and change their behavior (Reboul, 1992 as cited in Ntoz; et.al, 1997).

This theory, probably, has benefited Ethiopia, where the voluntary movement of peoples living with AIDS (PLWA) have created a favorable conditions for the public to develop a healthy attitude towards them and to practice safe sex to mitigate the spread of AIDS.

2.4.3. Sexual Behavior

Studies that were conducted on sexual behavior in Sub-Saharan African share certain broad assumptions about the historical and social background of the study populations (NRC, 1996)

- It is believed that colonial urbanization fundamentally changed the term of family life and gender relations
- As taxation monetized the economy, women were forced to earn money where they could.
- Polygamy was common in nearly all Sub-Saharan African societies and remains so, but to varying degrees. Formal polygamy is more common in rural areas.

In the center of the above assumptions, as NRC, 1996, has put it, in all Sub-Saharan societies, sexual contact forms part of an exceedingly complex network of relations that may involve formal and informal marriage. Permanent support of a woman or her children, regular or

occasional gifts, or strait payment for sex, either on a repeated or as a signal event.

Under such complex network, to bring a desired sexual behavior requires on immense work in this regard. To achieve the desired sexual behavior to reduce risk, people should have access to the means to achieve it. Here, some people may decide to have a safe, one-to-one relationship, no sex at all or use condom during sexual intercourse.

Studies on sexual behavior among people with disability show almost similar result regarding the risk factors of HIV. According to these studies, disabled people (visual disability) are identical in terms of behavioral risk factors of HIV to those for the general population.

In Mulindwa's Uganda Survey, 80 percent PwDs reported ever being sexual active. Adolescent with most types of disabilities (visual disabled) reach puberty at the same age as non-disabled peers. Disability status among adolescents, however, compounded many of the risks related to HIV transmission. For example, disabled adolescents are frequently excluded from social activities, limiting their opportunities to learn and ultimately, lowering their sense of self worth. This often compromises their ability to refuse when pressured to have sex. In developed countries like France, disabled adolescents are reported to have higher rates of sexual intercourse than non-disabled peers as well as more sexual partners (Nora Ellen Groce, 2004).

The sexual behavior among women with disability is quite different from non-disabled women. Women with disability are often considered unmarriageable. In some countries, women with certain disabilities

cannot obtain marriage licenses and may have no options other than to live in unstable relationships with a series of sexual partners. This situation with few prospects for employment or marriage, these women has a limited ability to negotiate safe sex (Nora Ellen Groce, 2004).

Extreme poverty associated with disability status is also a factor forcing some into sex work (World Bank, 2003). Women with disability are up to three times more likely to be rape than non-disabled women (UNICEF, 2005). Many women disability are physically unable to defend them. Hundreds of thousands of individuals world wide are frequent targets of sexual assault (Nora Ellen Groce, 2004).

CHAPTER THREE

METHODOLOGY

3.1. Profile of the Study Area

Addis Ababa is geographically located in central part of a country. It lies in 9° 2' North Latitude and 38° 42' East Longitudes. The population of Addis Ababa is estimated to be 2,973,000 (CSA, 2005).

In the capital 13.1 percent of population are without education and 86.9 percent were educated. Total fertility rate of Addis Ababa is extremely low compared to other towns in Ethiopia (1.4 children per woman). Regarding knowledge of HIV/AIDS 99.4 percent of male know about HIV/AIDS and 99.2 percent of females have knowledge about it (EDHS, 2005).

The research was conducted on Ethiopian National Association of Blind (ENAB) which is found in Addis Ababa. ENAB is a volunteer based Non-Governmental Organization established in 1967 with 30 members with a view of transforming the life of blind people who are leading miserable life as a result of lack of access to basic education, health and housing.

Currently, ENAB has 10,414 members in country level. In Addis Ababa, there are 6,560 members. Out of this, 3,433 are male and 3,127 are female.

There were 45,936 disabled people (2.2 percent of the total population excluding the homeless) in Addis Ababa with sex ratio of 141 males per 100 female. Of the total disabled people, 11.5 percent are with in the young age group, 60 percent are with in the adult age group and 28.5 percent in the old age groups (CSA, 1994).

Visual disabled shares a good number among the major disability types in Addis Ababa, (CSA, 1994). Ethiopia has one of the highest levels of HIV/Prevalence in Sub-Saharan Africa. Disabled people like blind communities are vulnerable group due to poverty, illiteracy, stigma and marginalization. And most of the information on HIV/AIDS is not available in accessible formats like Braille or large print. This makes them a high risk category. The study population was consisted of those people in their national association in Addis Ababa.

3.2. Study Design

This is a cross sectional study that was conducted on knowledge, attitude and behavior (KAB) among members of ENAB towards HIV/AIDS in Addis Ababa. This study design helps to assess the factors that affect the knowledge, attitude and behavior HIV/AIDS among members of ENAB. To meet this purpose both quantitative and qualitative method were employed. Qualitative method was used as a primary source of data through questionnaires and qualitative method was used for supplementing the data collected through questionnaire.

3.3. Sample Design and Sample Size

The sample design that was employed for this study is stratified random sampling technique. The sample frames were prepared from the list of members that available in the Ethiopian National Association of Blind (ENAB) for male and female separately.

In the determination of the sample of this study, in Ethiopia so far, there are no enough information or research findings in this area. However, some studies, which had been undertaken in different countries, related to knowledge of disabilities on HIV/AIDS have indicted that disabilities in general lack of sufficient information or

knowledge on HIV/AIDS. Therefore, the maximum error (E) to be tolerated in estimating the proportion of members of ENAB who have knowledge about HIV/AIDS (P) is set to be 50 percent. Taking P to be 0.5, in order to secure maximum sample size determined as follows.

$$\begin{aligned}
 n &= \frac{(Z_{\alpha/2})^2 p^*q}{E^2} \\
 n &= \frac{(1.96)^2 * 0.25}{(0.05)^2} + 15\% \\
 &= 384 + 15\% \\
 &= \underline{442}
 \end{aligned}$$

Where, n= requires sample size

$Z_{\alpha/2}$ = confidence interval (95%)

p= expected frequency (50 %)

E= level of error (5 %)

3.4. Sources and Instruments of Data Collection

3.4.1. Quantitative Method

The major source of data for study population (442) is primary from the sample that is drawn from the members of ENAB.

Quantitative research method was employed to generate the required primary data. The method was functional through a standardized questionnaire. The questionnaire contains three sections (background characteristics, socio-economic and demographic characteristics and HIV/AIDS issue).

The questionnaire was designed in English language and translated into Amharic and capture the required information. To ensure accuracy and flexibility, the questionnaire was pre-tested in the near

20 members (12 of them were males and 8 females) of ENAB and modified accordingly.

Regarding the validity of the instrument (questionnaire), content validity of the questionnaires was proved. First, it was given to different people that have professional background in the area of HIV/AIDS and related issue. Then, they confirmed that the questions have direct relationship with topic of the study (KAB towards HIV/AIDS).

Finally, the researcher has made some modification about the content of questionnaire. The questionnaire contains thirty eight items that is nine items for socio-economic and demographic information, nineteen items for knowledge and attitude on HIV/AIDS and ten items for sexual behavior.

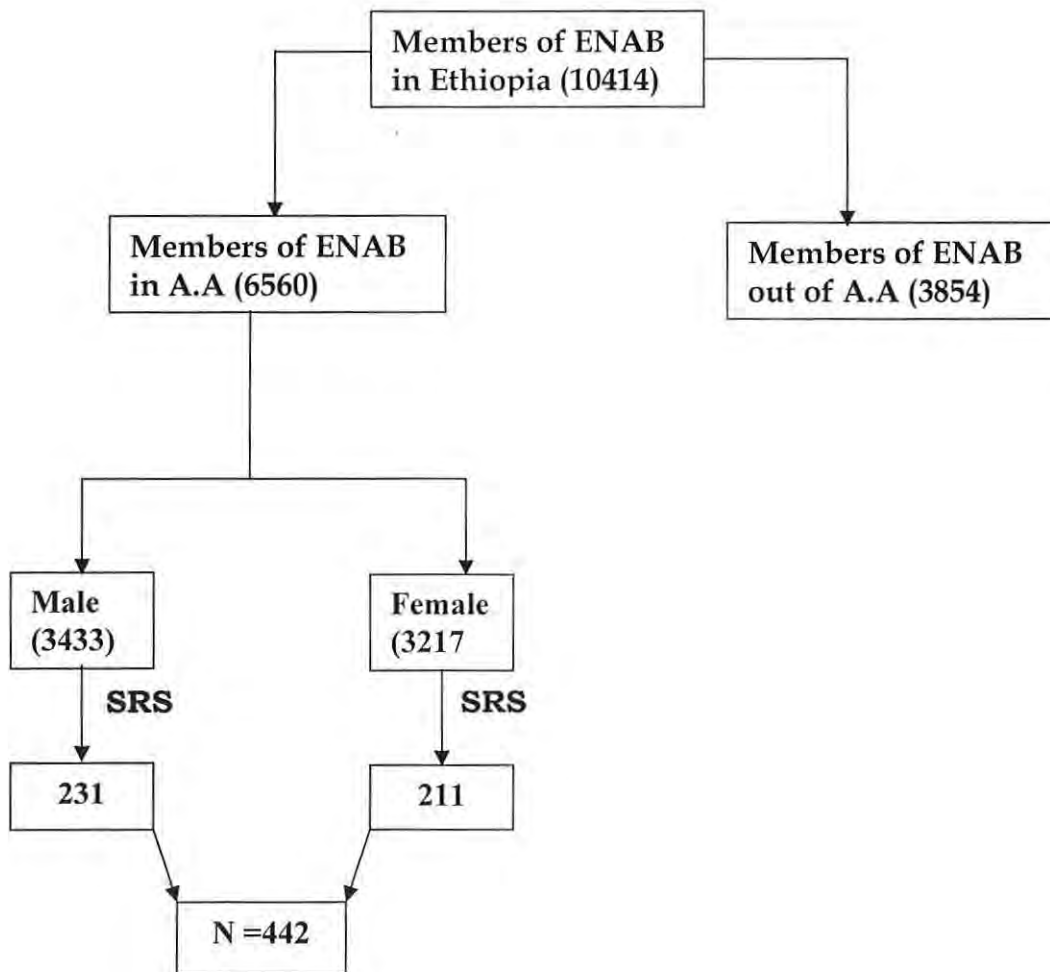
3.4.2. Qualitative Method

In-depth interview: Involved interviewing member face-to-face situation. Such interview was conducted with 5 purposefully selected members of ENAB based on age and sex distribution of study population. Interviews were use tape recorder with the informed consent of the interviewee.

3.5. Sample Procedure

In order to distribute this sample size, 442 among members of ENAB that are living in Addis Ababa to represent male and female equally in the sample, the sampling frame were prepared separately for male and female members of ENAB in Addis Ababa. Sampling frames, by using the simple random sampling the respondents were selected.

Diagram 1- Sampling Procedure



Key

ENAB= Ethiopian National Association of Blind

SRS= Simple Random Sample

3.6. Data Processing and Analysis

After completion of data collection/field work, start data processing. It included field editing and office editing (coding, data entry, data cleaning and consistency checking). The obtained data from the

respondents was entered, cleaned and prepared tabulated plan for using statistical data analysis (using SPSS software) technique.

The analysis employed uni-variate and multi-variate statistical methods. In multi-variate analysis, logistic regression model was used.

Logistic regression model was well in describing and testing hypothesis to determine the significance of the test.

The odds ratio concept considered to be the base of logistic regression. The odds ratio is the ratio of two odds. Odds, in turn, are themselves ratio of the number of events to the number of non-events.

Conversion between odds and proportions can be expressed as $O(\text{Odds}) = p/(1-p)$, where p is the probability that the event Y occurs, $p(Y=1)$ and $(1-p)$ is the probability that the event Y does not occur, $p(Y=0)$. Based on this probability of the outcome variable and occurring can be estimated as $\text{prob}(\text{no event}) = 1 - \text{prob}(\text{event})$

The logistic regression model can also put in the model as follows:

$$\ln \frac{p}{(1-p)} = a + \beta x + e$$

Where, $\ln$ = natural logarithms

p = the probability that event Y occurs $p(Y=1)$

$p/(1-p)$ = the "odds ratio"

$\ln \frac{p}{(1-p)}$ = the log odds ratio or logit

3.7. Ethical Consideration

This study has got official approval from the Institute of Population Studies (IPS), College of Development Studies (CDS) and Ethiopian

National Association of Blind (ENAB). All respondents were asked for verbal informed consent before participation. Moreover, confidentiality and privacy were mentioned for all respondents.

Detail explanation about the objective and importance of the study was given verbally to all respondents, and name and other identifiers remain undisclosed in the study. They were informed that the study is for the purpose of academic research and provide information about the existing problems that you face to the concerned bodies.

3.8. Description of Variables

3.8.1. Dependent Variables

The dependent variables to be measured in this study were knowledge, attitude, and sexual behavior. The data on knowledge of HIV/AIDS was collected by asking whether the respondents had ever heard about HIV/AIDS. If the answer is “yes” the respondents were asked about their attitude and sexual behavior.

3.8.2. Independent Variables

Based on the literature reviews, independent variables were selected. The literature shows that various socio-economic and demographic factors are likely to influence knowledge, attitude and behavior on HIV/AIDS among members of ENAB. The independent variables include present age, sex, marital status, education, employment, religion, income, ethnicity and place of previous residence.

3.9. Limitation of the Study

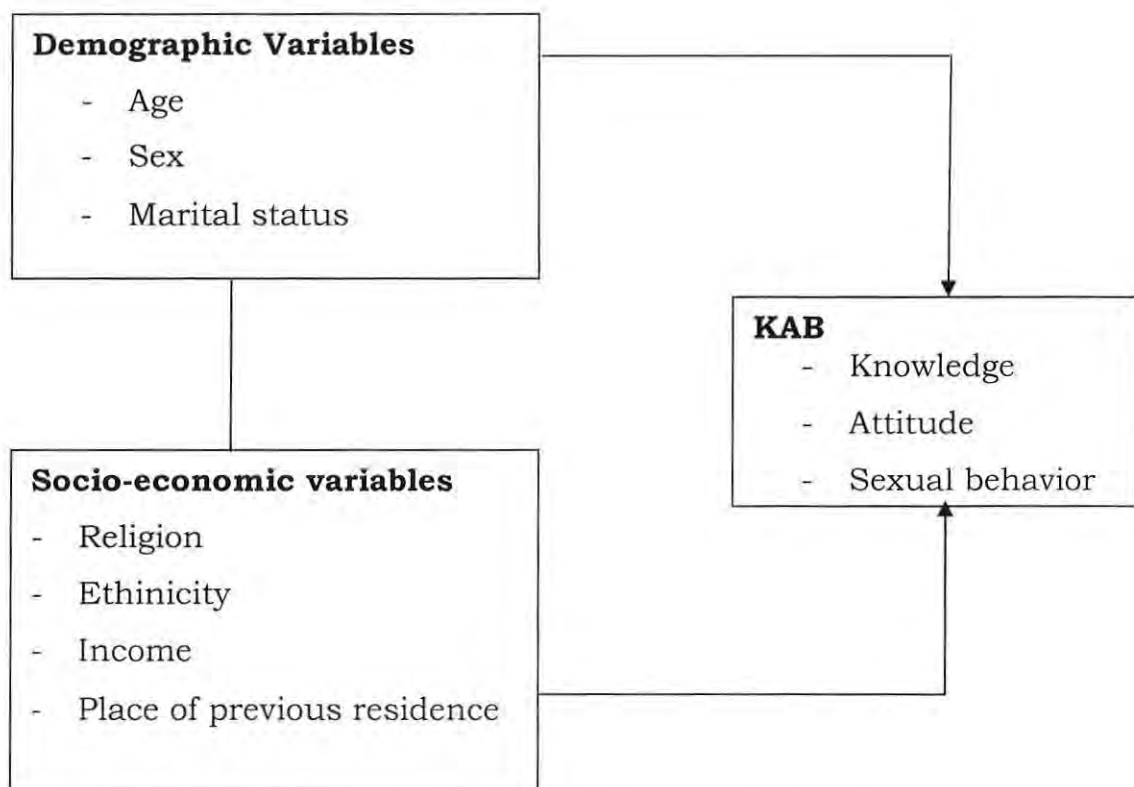
Major limitation in resource, time and nature of fragmented studies available resulted in restricted treatment of the subject. The limited resource raised for the study could only support to assess situation of disability in general instead of the situation of visual-disability in

particular. Due to the nature of study time constraints is one of the major limitations. The available studies are fragmented and in accessible also hampered the research.

3.10. Conceptual Framework

To identify the major determinant factors that affect knowledge attitude and behavior towards HIV/AIDS among members of Ethiopian National Association of Blind (ENAB), different variables have been taken into consideration from related materials. The independent variables may include different demographic and socio-economic variables. Knowledge, attitude, and sexual behavior are considered as dependant variables

Diagram 2- Conceptual Framework



Source: Developed by the researcher based on previous studies

In the diagram, the arrows show how independent variables affect knowledge, attitude and behavior towards HIV/AIDS among the study population.

CHAPTER FOUR

BACKGROUND CHARACTERISTICS OF THE STUDY

POPULATION

4.1. Demographic and Socio-economic Characteristics

A total of 442 visual disabled people from ENAB (Ethiopian National Association of Blind) were randomly selected and given set of interviewer administered questionnaires to assess their knowledge, attitude and behavior on HIV/AIDS. Of the total respondents 52.3 percent were male while 47.7 percent were female. In terms of their age, 17.9 percent of the respondents were in the age group 15-19. 66.3 percent of the respondents were in the age group 20-29. Similarly, 11.5 percent and 4.3 percent of the respondents were in the age groups 30-39 and ≥ 40 years old respectively (Table 4.1).

Respondents were further classified according to their educational level. The first group, Illiterate, (who could not read and write), the second, those who only read and write, the third, who reported in the Grade 1-6 followed by Grade 7-12 and the last group, college and above. Of the total population, 2.3 percent of the respondents were illiterate, 4.5 percent of the respondents were able to read and write, 7.5 percent of the respondents were between 1-6. 41.9 percent and 43.9 percent of the respondents were in grade 7-12 and college and above respectively. Regarding respondents employment status, 23.1 percent were employed where as 11.1 percent were unemployed. Similarly, 65.8 percent of the respondents were students.

The respondents have quite diverse ethnic origins. Of the total respondents 50.2 percent, 23.3 percent, 12 percent, 6.3 percent and 8.1 percent were Amhara, Oromo, Tigray, Gurage and others respectively. In terms of their religious status, 68.8 percent were

orthodox. This was followed by 14.9 percent protestant. Similarly, 9.9 percent and 6.3 percent of the respondents were Muslim and Catholic Christians respectively (Table 4.1).

Table 4.1 Proportion of Respondents by Major Demographic and Socio-economic Characteristics

Background Characteristics	sex					
	Male		Female		Total	
	No	%	No	%	No	%
Age Group						
15-19	35	15.2	44	20.9	79	17.9
20-29	143	61.9	150	71.1	293	66.3
30-39	37	16.0	14	6.6	51	11.5
>=40	16	6.9	3	1.4	19	4.3
Total	231	100.00	211	100.00	442	100.00
Educational Level						
Illiterate	5	2.2	5	2.4	10	2.3
Read and write	11	4.8	9	4.3	20	4.5
Grade 1-6	14	6.1	19	9.0	33	7.5
Grade 7-12	82	35.5	103	48.8	185	41.9
College & above	119	51.5	75	35.5	194	43.9
Total	231	100.00	211	100.00	442	100.00
Ethnic Group						
Amhara	113	48.9	109	51.7	222	50.2
Oromo	56	24.2	47	22.3	103	23.3
Tigray	36	15.6	17	8.1	53	12.0
Gurage	13	5.6	15	7.1	28	6.3
Others	13	5.6	23	10.9	36	8.1
Total	231	100.00	211	100.00	442	100.00
Religion						
Orthodox	164	71.0	140	66.4	304	68.8
Catholic	16	6.9	12	5.7	28	6.3
Protestant	35	15.2	31	14.7	66	14.9
Muslim	15	6.1	29	12.8	44	9.9
Total	231	100.00	211	100.00	442	100.00
Employment Status						
Employed	74	32	28	13.3	102	23.1
Unemployed	24	10.4	25	11.8	49	11.1
Student	133	57.6	158	74.9	291	65.8
Total						
Current Marital Status						
Never Married	171	74.0	167	79.1	338	76.5
In union	43	18.6	33	15.6	76	17.2
Formerly In Union	17	7.4	11	5.2	28	6.3
Total	231	100.00	211	100.00	442	100.00

Income Group						
No income	132	57.1	157	74.4	289	65.4
<=500	37	16.0	27	12.8	64	14.5
501-1000	30	13.0	19	9.0	49	11.1
>1000	32	13.9	8	3.8	40	9.0
Total	231	100.00	211	100.00	442	100.00
Previous Residence Area						
Addis Ababa	70	30.3	56	26.5	126	28.5
Out of Addis Ababa	161	69.7	155	73.5	316	71.5
Total	231	100.00	211	100.00	442	100.00

The current marital status of the respondents was one of the important background variables to attain the study objectives. The term "In union" is used to show those respondents who were in marital union during the interview. "Formerly In Union" include those who were widowed, separated, and divorced. The third group was "Never Married" who had never married. Of the total population, 76.5 percent were never married, 17.2 percent were "In Union" and 6.3 percent were "Formerly In Union". Regarding respondents' employment status, 65.7 percent were students where as 23 percent was employed. Similarly, 11 percent of the subjects were unemployed. Respondents were also varying in their income level, 65.4 percent of the respondents had not income, 14.5 percent and 11.1 percent of respondents were categorized under ≤ 500 and 501-1000 income group respectively. Similarly, 9 percent of respondents were categorized under > 1000 income group. Regarding previous residence area of respondents, 28.5 percent of the respondents were resided in Addis Ababa previously and 71.5 percent of respondents were out of Addis Ababa previously.

4.2. Respondents Sexual History

Of the total 442 respondents, 240(54.5 percent) of them reported that they never had sexual experiences, while 202(45.5 percent) of the respondents reported previous sexual intercourse experiences. Sex

wise, 48.1 percent male and 42.7 percent female respondents reported previous sexual experience.

Of 202 sexual experienced respondents, 65 percent have regular sexual partner where as, 35 percent of them claimed that they don't have regular partner.

Regarding age at first sex, 22.1 percent reported that they had their first sex while they were in the age group 15-19. Similarly, 17.1 and 2.6 percent of the respondents reported that their sexual contact was while they were in the age group 20-24 and 25-29, respectively.

To further analyze the respondents' sexual history, asked to tell the number of individuals with whom they had sex. Accordingly, it was found out that 3.3 percent and 0.7 percent of 202 respondents who reported they have sexual experience replied that they had sex with two and three different individuals respectively. Similarly, 3.6 percent of the respondents reported that they had sex with more than four different individuals. Regarding, a risk of acquiring HIV/AIDS or not. Out of the total 422 respondents, 13.1 percent of them reported that they have a great chance of being infected by HIV/AIDS, 38.1 percent reported that they have a little chance of being infected by HIV/AIDS and 48.8 percent reported that they have never chance to be infected by HIV/AIDS (Table 4.2).

Table 4.2 Sexual History of the Respondents

Characteristics		Frequency	Percent
Whether respondents have ever had sexual intercourse	Yes	202	45.7
	No	240	54.3
Age at first intercourse	10-14	12	2.4
	15-19	98	22.1
	20-24	76	17.6
	25-29	13	2.6
	30-34	1	.2
	Don't remember	1	.2
	Not want to tell	1	.2
Whether respondents have regular sexual partner	Yes	132	65
	No	70	35
Number of individual with whom respondents had sex during the past one year	Two	14	3.3
	Three	3	0.7
	Four	2	0.5
	More than four	15	3.6
	Not want to tell	14	3.3
Whether respondents think that they are at risk of acquiring HIV/AIDS	Never	216	48.8
	Little	169	38.1
	High	57	13.1
Ever had sex	Yes		
	Male	111	48.1
	Female	90	42.7
	No		
	Male	120	51.9
	Female	121	57.3

4.3. HIV/AIDS Knowledge and Awareness

Acquiring knowledge of AIDS is a crucial step in adopting behavior, which will prevent transmission of HIV. Table 4.3, reports that prevalence of knowledge about HIV/AIDS based on selected various background characteristics and their sources of information about the disease.

For table 4.3, respondents were asked "Have you ever heard of a disease called AIDS?". When asked if they heard of a disease called AIDS, all males and females responded affirmatively. For the other

selected background characteristics, the level of AIDS knowledge was uniform (100 percent).

Regarding the sources of information from which they had learned about AIDS, the most commonly mentioned source was mass media (Radio), which stood from 95 percent to 100 percent for all selected background characteristics. Health professional was the second largest sources of information in all cases, but with a certain degree of difference among different group of respondents.

Church or Mosque as a source of information remains low for the entire study population (51 percent of male and 50.2 percent of female). Church or Mosque was the main source of information for those of illiterate group. In the era of pandemic disease (AIDS); the role of organized institutions, such as schools are one of the best ways to pass information. From the total respondents, 93 percent has passed through the school system but only about 66 percent responded in favor of schools as a source of information, 66.7 percent of males and 67.7 percent of females responded schools as a source of information about AIDS.

On average, about 74 percent of the total respondents confirmed getting information from their friends. Both males and females were discussed among themselves about the disease, 68.4 percent and 68.7 percent respectively.

The disease as an issue was well discussed among all age groups. A friend as a source of information about AIDS was mentioned as educational level decrease except for the college and above. AIDS as an issue was well discussed among Formerly In Union than those In Union and Never Married. Friends as a source of information of AIDS

among Catholic Christian better than those of respondents in other religions. Regarding employment status, Employed were discussed about AIDS than Unemployed and Student. In terms of ethnicity, AIDS was an issue among Gurage.

Friends as a source of information about AIDS was mentioned as income level increase. In case of place of previous residence, AIDS as an issue was discussed among respondents of those who were reside in Addis Ababa than those of out of Addis Ababa previously.

Discussing AIDS, as an issue at work place is at rudimentary stage among respondents. About 30.7 percent of males responded affirmatively work place as a source of information whereas only 16.1 percent of females responded in the same direction.

ENAB (Ethiopian National Association of Blind) as a source of information remain very low for the entire study population. About 55 percent of males responded their association as a source of information whereas 56 percent of females responded positively.

Discussing AIDS, as an issue with parents is still very low among respondents. About 44.3 percent of the respondents in the age group 15-19 were reported that parents as a source of information about AIDS. And neighbors are one of the least sources of information about AIDS. 41.9 percent of males were responded neighbors as a source of information about AIDS and 35 percent of females were responded in the same direction.

Table 4.3 Respondents' Knowledge of AIDS and Sources of AIDS Information

Characteristics	Ever heard of HIV/AIDS (%)	Source of Information (%)								
		Health Professional	Mass Media	Friends	Work place	School	Church or Mosque	Your association (ENAB)	Parents	Neighbors
Sex										
Male	100.0	77.1	99.6	68.4	30.7	66.7	50.6	54.9	45.0	41.9
Female	100.0	74.0	97.2	68.7	16.1	67.7	50.2	55.9	41.2	35.1
Age Group										
15-19	100.0	69.6	98.7	64.8	6.3	77.2	45.6	48.1	44.3	41.8
20-29	100.0	75.8	98.3	64.8	18.8	67.2	57.7	52.2	38.2	32.8
30-39	100.0	78.4	100.0	84.3	60.8	57.9	70.6	76.5	62.7	60.8
≥ 40	100.0	89.5	100.0	94.7	73.7	57.9	68.4	78.9	63.1	57.9
Educational level										
Illiterate	100.0	70.0	100.00	70.0	20.0	30.0	80.0	60.0	40.0	40.0
Able to read & write	100.0	50.0	100.00	70.0	-	10.0	40.0	100.0	40.0	51.0
Grade 1-6	100.0	66.7	100.00	66.7	18.2	75.8	45.5	45.5	50.0	21.2
Grade 7-12	100.0	73.5	98.9	66.5	12.9	74.1	49.2	51.9	37.8	50.0
College and above	100.0	81.9	97.9	70.6	37.6	67.0	52.1	60.8	51.0	46.9
Religion										
Orthodox	100.0	73.7	98.0	62.5	21.4	65.8	47.0	55.0	40.1	36.8
Catholic	100.0	82.1	100.0	99.0	45.0	78.6	46.0	67.8	55.0	50.0
Protestant	100.0	72.7	99.0	75.8	45.0	71.2	66.7	74.2	57.6	45.0
Muslim	100.0	88.6	100.0	81.8	18.2	63.6	52.3	50.0	36.3	47.0
Current Marital Status										
Never Married	100.0	74.8	98.2	65.9	11.8	73.7	44.7	52.2	38.5	34.4
In Union	100.0	80.3	100.0	72.4	63.2	48.2	65.8	68.4	56.6	51.3
Formerly In Union	100.0	71.4	100.0	89.3	60.7	48.1	78.6	82.1	64.3	57.1

Characteristics	Ever heard of HIV/AIDS (%)	Source of Information (%)								
		Health Professional	Mass Media	Friends	Work place	School	Church or Mosque	Your association (ENAB)	Parents	Neighbors
Employment Status										
Employed	100.0	90.2	100.0	88.2	85.3	55.9	74.5	79.4	66.6	65.4
Unemployed	100.0	59.2	100.0	71.4	-	-	38.8	49.2	49.2	22.4
Student	100.0	73.2	95.0	61.2	-	78.4	43.9	47.7	36.8	32.3
Ethnic Group										
Amhara	100.0	75.2	97.7	63.1	22.0	72.0	56.3	64.4	42.3	38.7
Oromo	100.0	72.8	99.2	73.2	27.2	66.7	43.4	61.2	44.1	38.8
Tigray	100.0	90.6	100.0	75.5	26.4	75.5	70.0	72.4	42.1	43.4
Gurage	100.0	75.0	100.0	85.7	33.3	67.8	44.3	71.2	55.6	50.0
Others	100.0	63.9	100.0	61.1	66.7	63.9	44.5	46.3	43.4	22.2
Income Group										
No income	100.0	69.6	97.9	58.5	-	69.2	41.2	45.3	33.9	28.7
< 500	100.0	78.1	100.0	85.9	17.2	71.9	56.3	65.4	48.3	43.7
501-1000	100.0	93.9	100.0	85.9	83.7	51.2	79.6	79.3	73.4	71.4
> 1000	100.0	92.5	100.0	92.5	85.0	65.0	72.5	80.0	65.0	62.5
Place of previous Residence (before one year)										
Addis Ababa	100.0	83.3	99.2	84.1	39.6	67.5	60.3	69.8	50.8	49.2
Out of Addis Ababa	100.0	72.5	98.4	62.3	17.4	67.0	46.5	49.3	40.2	34.5

Knowledge of ways of getting AIDS is presented in table 4.5, 98.2 percent of males responded that sex with multiple partners as a means of AIDS transmission. Multiple sex partners were also mentioned as a means of AIDS transmission by 99 percent of female respondents. Here the proportion of males who mentioned multiple partners was almost similar with the proportion of females. Both male and female appeared to be conscious in this regarded. Table 4.4 indicates percentage of study population who reported various ways in which AIDS can be transmitted, by selected background characteristics.

Table 4.4 Knowledge of HIV/AIDS Transmission

Characteristics	Know how HIV can be Transmitted (%)	Means of HIV Transmission (%)							
		Sex without condom	Sex with multiple partners	Blood transfusion	Curse	Physical contact with PLWA	Sex with commercial sex workers	Eating and shaking with PLWA	Infected mothers to child
Sex									
Male	100	98.3	98.2	98.3	4.8	46.8	89.6	4.9	79.7
Female	99.0	98.5	99	98.5	3.3	43.6	89.1	0.9	74.4
Age Group									
15-19	100	97.5	97.5	97.5	1.3	49.4	88.6	2.5	68.4
20-29	99.3	98.2	98.9	98.9	5.1	44.7	91.8	3.1	82.6
30-39	100	100	100	100	3.9	39.2	82.4	1.9	74.5
≥ 40	100	100	100	100	0	52.6	73.7	0	36.8
Educational level									
Illiterate	100	100	90	100	10	40	90	10	90
Able to read & write	95	95	100	95	0	45	90	0	90
Grade 1-6	100	100	100	100	3	54.5	90.9	6.1	81.8
Grade 7-12	100	98.4	97.8	97.8	4.9	49.2	89.2	2.2	73.5
College and above	99.5	98.4	100	100	3.6	40.2	89.2	2.5	77.8
Religion									
Orthodox	99.3	98.7	99.3	98.7	4.3	45.7	92.1	2.3	80.6
Catholic	100	100	100	100	0	46.4	50	3.6	57.1
Protestant	97.5	98.4	96.9	98.4	95.5	25.8	93.8	1.5	72.7
Muslim	98.9	95.5	97.8	100	4.5	70.5	90.9	6.8	72.7

Characteristics	Know how HIV can be Transmitted (%)	Means of HIV Transmission (%)							
		Sex without condom	Sex with multiple partners	Blood transfusion	Curse	Physical contact with PLWA	Sex with commercial sex workers	Eating and shaking with PLWA	Infected mothers to child
Current Marital Status									
Never Married	99.4	97.9	98.5	99.1	3.8	45.3	91.1	2.7	79.3
In Union	100	100	100	98.6	3.9	43.4	84.2	2.6	72.4
Formerly In Union	100	100	100	96.4	7.1	50	82.1	3.6	64.3
Employment Status									
Employed	100	99	99	99	3.9	42.2	78.4	2.9	68.6
Un Employed	100	97.9	100	100	2	88.5	93.9	2	75.5
Student	99.3	98.3	98.6	98.6	4.5	46	92.4	2.7	80.4
Ethnic Group									
Amhara	99.5	98.6	98.6	98.2	4.9	43.7	90.1	4.1	79.3
Oromo	100	98.1	98.1	100	1.9	46.6	89.3	0.9	76.7
Tigray	100	100	100	100	5.7	52.8	86.8	1.9	75.5
Gurage	100	100	100	100	0	42.9	75	0	71.4
Others	97.2	94.4	100	97.2	5.6	41.7	100	2.8	72.2
Income Group									
No income	99.3	98.6	99.3	98.9	4.8	48.1	93.7	3.4	81.3
≤ 500	100	98.4	95.3	98.4	1.6	34.4	84.3	1.6	76.6
501-1000	100	97.9	100	97.9	6.1	46.9	81.5	2	63.3
> 1000	100	100	100	100	0	40	75	0	65
Place of previous Residence (before one year)									
Addis Ababa	100	98.4	98.4	99.2	3.2	45.2	80.9	3.2	66.6
Out of Addis Ababa	99.4	99	99.1	98.7	4.4	45.2	92.7	2.5	81.3

From the above table, we can make a good comment on the response given by the respondents by comparing a response rate among the risk factors. Sexual intercourse without condom, blood transfusion, sex with commercial, sex workers and from infected mother to child. For the first three risk factors, both males and females responded strongly. While for the last risk factor, the report rate was very much lower. This indicated us knowledge of AIDS transmission was universal in both males and females respondents.

Misconception of the knowledge of AIDS transmission was also observed among the respondents. Curse, physical contact with PLWA and eating and sharing with PLWA were reported as a means of transmission of AIDS by both sexes at different degrees. Males were a victim of high misconception regarding knowledge of AIDS transmission compared to females. The knowledge of AIDS transmission among respondents in different age groups, it was found that close each other in major ways of AIDS transmission except the risk factor of infected mother to child. Misconception decreased as age of the respondents increased, except physical contact with PLWA.

For all major ways of AIDS transmission, the impact of education was not significantly different. However, misconception was negatively related with the level of education.

In terms of religious status, the study indicated almost similar knowledge among respondents in respect of major ways of AIDS transmission except, Catholic Christian. About 50 percent of Catholic respondents reported sex with commercial sex workers was the means of AIDS transmission and 57 percent of Catholic respondents reported that from infected mother to child was the risk factor of AIDS transmission. But, misconception was found to be higher among protestant respondent

(95.5 percent of protestant respondents given response curse was considered to be the cause of HIV/AIDS).

The difference among respondent, according to their marital status in respect to the knowledge of major AIDS transmission was not that much wide, but misconception was found to be higher for respondents who were Formerly In Union. Never married were found at a better position as far as misconception about AIDS transmission was concerned.

The knowledge of AIDS transmission among respondents in different employment status was almost similar. Sex without condom, sex with multiple partners, blood transfusion, sex with commercial sex workers were affirmatively responded while infected mother to child was not satisfactorily responded as they reported in case of risk factors. However, misconception of the knowledge of AIDS transmission was also widely observed among the respondents in different employment status. For example, 88.5 percent of Unemployed respondents reported physical contact with PLWA to be risk factor. And 42.2 percent and 46 percent of employed and students responded positively.

As knowledge of HIV transmission was evaluated among respondents in different income group, it was found that close to each other in major ways of AIDS transmission but still with a lower rate of response as a risk factors such as sex with commercial sex workers and from infected mother to child by the respondents of income group >1000. Misconception influenced by income. Here, no income group was found to be higher misconception group than income generating groups.

The difference among respondents, according to their previous residence place in respect to the knowledge of major AIDS transmission was not that much wide except sex with commercial sex workers as a risk factors (92.7 percent of respondents of those were lived out of Addis Ababa

reported sex with commercial sex workers as a means of transmission of AIDS whereas 81 percents of respondents who were lived in Addis Ababa before reported affirmatively to this risk factors). However, place of previous residence did not affect in misconception of respondents or regarding knowledge of transmission of AIDS.

Finally, a significant number of respondents reported, that physical contact with PLWA as means of AIDS transmission.

On the other hand, respondents were asked about their knowledge of ways of avoid getting AIDS. Table 4.5 indicates the overall result by selected background characteristics who reported specific ways of avoid getting HIV/AIDS.

Table 4.5 shows percentage of respondents who know of specific ways to avoid AIDS by selected background characteristics.

Table 4.5 knowledge of ways to avoid HIV/AIDS

Characteristics	Know ways of HIV/AIDS prevention (%)	Ways to avoid HIV/AIDS (%)						
		Abstinence	Avoiding sex multiple partners	Use condom during sex	Avoiding sharing sharps	Avoiding blood and fluid contact	Avoiding eating together with PLWA	Sex with regular partner
Sex								
Male	99.6	97.8	98.7	76.2	95.7	83.1	1.7	90.9
Female	99.1	99.5	99.5	81.5	94.8	84.4	0.9	86.7
Age Group								
15-19	97.5	97.5	100	79.7	94.8	80.5	0	88.6
20-29	99.7	98.3	98.9	79.5	95.6	87.7	1.7	90.1
30-39	100	98	98	82.4	96	78.4	1.9	90.2
> 40	100	100	100	52.6	100	57.8	0	68.4
Educational level								
Illiterate	100	100	100	80	70	80	0	90
Read & write	90	100	100	75	95	100	0	95
Grade 1-6	100	100	100	87.9	90.9	84.8	0	90.9
Grade 7-12	99.5	98.4	100	74.1	94.1	81.1	1.1	88.1
College and above	100	97.4	97.9	81.9	98.5	84.5	2.1	88.7
Religion								
Orthodox	99	97.6	98.6	86.5	96.4	90.1	1.6	91.1
Catholic	100	100	100	42.9	92.9	42.9	100	82.1
Protestant	100	100	100	77.3	93.9	81.8	100	80.3
Muslim	100	100	100	52.3	93.2	70.5	2.3	90.9
Current Marital Status								
Never Married	99.1	97.6	98.8	80.8	95.3	85.2	1.5	87.9
In Union	100	100	100	73.7	96.1	80.3	0	93.4
Formerly In Union	100	100	100	67.9	92.8	75	3.6	89.3
Ethnic Group								
Amhara	99.1	98.2	99.5	83.3	94.6	88.7	2.3	88.3
Oromo	100	99	100	68.9	97.1	82.5	0	86.4
Tigray	100	96.2	96.2	75.5	96.2	67.9	1.9	94.3
Gurage	100	100	100	64.3	100	71.4	0	89.3
Others	97.2	97.2	97.2	94.4	88.9	88.9	0	91.7
Income Group								
No income	98.9	98.3	98.9	85.5	95.8	89.6	1.7	89.9
≤ 500	100	98.4	100	65.6	95.3	81.3	1.6	78.1
501-1000	100	95.9	97.9	69.4	89.8	67.3	0	0
> 1000	100	100	100	62.5	97.5	65	0	85
Place of previous residence (before one year)								
Addis Ababa	99.2	97.6	98.4	68.3	92.9	69.8	1.6	80.9
Out of Addis Ababa	99.4	98.4	99.4	82.9	96.2	89.2	1.3	92.1

Respondents who had ever heard of the disease, AIDS were asked the question, "Is there anything to avoid getting of AIDS?" accordingly, 99.6 percent of males and 99.1 percent of females told us they have high level of knowledge regarding ways of avoid AIDS.

In terms of valid ways to avoid AIDS, abstinently was cited by 98 percent males and 99.5 percent of females. Avoid sex with multiple partners was reported as a means of preventing AIDS by 98.7 percent of males and 99.35 percent of females. From this premises, it is interesting to note that the recognition by both males and females to abstinently and avoid sex with multiple partners were highest than the others ways to avoid AIDS.

Use of condom during sex as a means to avoid AIDS was reported by 76 percent of males and 82 percent of females. Here, good numbers of female respondents were reported using condom during sex as a mechanism to avoid AIDS.

Having sex with regular partner was reported by 91 percent of males and 87 percent of females. 96 percent of males and 95 percent of females reported that AIDS could be prevented by avoiding sharing sharps. And 83 percent of males responded that through avoiding blood and fluid contact with PLWA.

According to this study, the researcher observed a huge awareness change among the respondents in regard to knowledge of ways to avoid AIDS. For instance, insignificant number of respondents reported by avoiding eating together with PLWA and not living with PLWA we can prevent the transmission of AIDS.

Abstinence as a way to avoid AIDS was reported on the increasing rate except a slight decline for 30-39 age group. Avoid sex with multiple

partners was reported a mechanism to avoid AIDS by 100 percent of the respondents in that age groups 15-49 and ≥ 40 . Condom use while sex was also reported as a means to prevent AIDS transmission by almost the same percentage (78 percent) in the age group 15-19 and 20-29, 82.4 percent of respondents in the age group 30-39 and 53 percent of respondents in the age group ≥ 40 . On the other hand, avoiding Sharing Sharps and avoiding blood and fluid contact with PLWA as ways to avoid getting AIDS did not show a significant variation among respondents in different age groups except the highest age group of ≥ 40 . The percentage of respondents having sex with regular partner as a means to avoid AIDS almost similar except the last age group.

Educational level shows a slight variation among respondents in their knowledge of ways to avoid AIDS. Abstinence as a mechanism to prevent AIDS did not show a significant variation among respondents in the first three educational level. But, 98 percent of respondents who were in Grade 7-12 and 97 percent of respondents who were in college and above level reported that abstinent as a means of avoid AIDS. Avoiding sex with multiple partners did not significant variation among respondents at different educational level except college and above educational level. Use condom during sex, as a mechanism to avoid AIDS reported by 88 percent of the educational level of Grade 1-6 and 74 percent of respondents in educational level of Grade 7-12, and others between these ranges.

Having sex with regular partner still remained with out significant variation among respondents at different educational level.

Almost no significant difference was observed in the knowledge of ways to avoid AIDS among respondents as different marital status. When we see in detail the response of respondents, there is a slight difference. For instance, 98 percent of those Never Married reported as a means to avoid

AIDS and 100 percent of those In Union and Formerly In Union reported that in the same direction. Use condom during sex as a mechanism to prevent AIDS was reported by 81 percent of those Never Married, 74 percent of those In Union and 68 percent of those Formerly In Union. For the other ways to avoid AIDS did not show any significant variation among respondents in different marital status.

In terms of religion, abstinent and avoiding sex with multiple partners as mechanisms to avoid AIDS reported by all respondents among different religion except Orthodox (98 percent). Use condom during sex as means to prevent AIDS was reported by 87 percent of Orthodox Christians and 43 percent of Catholic Christians. Others were between these ranges. Avoiding sharing sharps as a mechanism to avoid AIDS did not show any significant variation among different religion.

About 43 percent of Catholic respondents reported that avoiding blood and fluid contact with PLWA as a means to prevent AIDS. It is very small figures compared to others. No significant difference was observed to other ways to avoid AIDS among respondents from different religion.

When we considered ethnicity to be an independent variable to the knowledge of ways to avoid AIDS, almost no difference was seen as to abstinence and avoiding sex with multiple partners as a measures to avoid AIDS among respondents from different ethnic group. About 83 percent of Amhara were reported that use condom during sex as a way to avoid AIDS, followed by Tigrian respondents (76 percent). In regarding to avoiding sharing sharps as a mechanism to avoid AIDS was universal among Gurage respondents. About 94 percent of Tigrain respondents were responded having sex with regular partner as a means to prevent AIDS transmission. No different among the respondents from different ethnic group. Knowledge of ways to avoid AIDS increased as income increase. No variation was observed as abstinence and avoiding sex with

multiple partners among respondents in different income groups except the highest income group in the study population.

No respondents in the income group 501-1000 responded having sex with regular partner as a mechanism to avoid AIDS. But most of the respondents in the other income group were reported this way as a means to prevent AIDS transmission. Difference in employment status did not influence the knowledge of ways to avoid AIDS.

Place of previous residence did not affected significantly the knowledge of respondent in terms abstinence and avoiding sex with multiple partners as means to avoid AIDS. But, use of condom during sex as a mechanism to avoid AIDS, showed a significant variation among respondents in different place of previous residence i.e. 68 percent of respondents those who lived in Addis Ababa responded that use of condom during sex as a way to avoid AIDS and 83 percent of those who lived out of Addis Ababa before reported positively for this way to avoid AIDS. Having sex with regular partner was reported as a means to avoid AIDS by 81 percent and 92 percent of respondents who lived in Addis Ababa and out of Addis Ababa before respectively. Based on the above data respondents whose previous residence was out of Addis Ababa had better knowledge of ways of avoid HIV/AIDS. (Table 4.5)

4.4. Self-perception of the Chance of Getting AIDS

Behavioral change as an ultimate goal in curbing the spread of AIDS, can be achieved through acquiring the knowledge and then creating a desired attitude which finally leads to behavioral change. Thus, self-perception of an individual of the chance of getting AIDS may show how the individual is approaching the intended attitudinal development.

Accordingly, all respondents who had heard of AIDS were asked if they thought their chance of getting AIDS was “no chance” at all, “Moderate” and “good chance”. As table 4.7 indicates, 49 percent of males and 49.3 percent of females reported themselves as having no chance of being infected. 51 percent of males and 50.7 percent of females reported themselves as having moderate or good chance of being infected. A larger proportion of respondents in the age groups 20-29 and 30-39 perceived themselves as having chance to infect as compared to the age groups 15-19 and ≥ 40 .

Table 4.6 shows, Educational level and the chance of getting AIDS go in opposite pattern which means increasing in educational level leads to high chance of getting AIDS except those illiterate.

Respondents of Never Married reported to have lower chance to be infected than In Union and Formerly Married. 68 percent of Formerly Married respondents reported having a moderate or good chance of being infected by AIDS. In religious status, respondents of Orthodox Christians perceived themselves having high chance to be infected (56 percent) as compared to be other religion.

According to table 4.6, 58.8 percent of Amahra respondents were perceived to have a moderate or good chance of being infected by AIDS and 75 percent of Gurage respondents were perceived no chance at all getting in AIDS. When we see the income of the respondents, 62.5 percent of respondents in income group >1000 perceived themselves as having high chance to be infected than other income group. Here, the chance of getting AIDS increase with income growth except 501-1000 income group.

Finally, place of previous residence has impact on the chance of getting AIDS. i.e. respondents of those of who live in Addis Ababa before had

less chance of being infected by AIDS than those of who lived out of Addis Ababa before. 53.9 percent of respondents who lived in Addis Ababa reported no chance at all of being infected by AIDS.

Table 4.6 Perception of the Chance of Getting AIDS

Characteristics	Perceived Chance of Getting AIDS		
	No chance at all (%)	Moderate chance (%)	Good Chance (%)
Sex			
Male	48.9	38.9	12.1
Female	49.3	37.4	13.3
Age Group			
15-19	67.0	25.3	7.6
20-29	45.7	40.6	13.7
30-39	37.2	47.0	15.7
> 40	57.8	31.6	10.5
Educational level			
Illiterate	30.0	60.0	10.0
Able to read & write	60.0	40.0	-
Grade 1-6	57.6	30.3	12.0
Grade 7-12	55.0	33.5	11.4
College and above	41.8	42.8	15.5
Religion			
Orthodox	44.0	40.1	15.8
Catholic	75.0	17.8	7.1
Protestant	45.5	50.0	4.5
Muslim	72.7	20.0	6.5
Current Marital Status			
Never Married	50.9	38.2	10.9
In Union	47.4	35.5	17.1
Formerly In Union	32.0	46.4	21.4
Ethnic Group			
Amhara	41.4	45.0	13.5
Oromo	58.2	32.0	9.7
Tigray	49.0	41.5	9.4
Gurage	75.0	14.3	10.7
Others	50.0	27.8	22.2
Income Group			
No income	51.2	35.9	12.8
≤ 500	46.9	46.7	7.8
501-1000	48.9	32.6	18.4
> 1000	37.5	50.0	12.5
Place of previous residence (before one year)			
Addis Ababa	53.9	34.9	11.1
Out of Addis Ababa	47.2	39.5	13.3

4.5. Willingness to have HIV test

The major objective to ask the willingness of respondents for having HIV test was to measure the attitude of respondents towards the disease. And once the respondent has responded positively, the second objective was to know his/her reaction, if the result happens to be positive.

Table 4.7 shows the percentage distribution of male and female who are willing to have HIV test and the action that they may take if it happens to be positive by selected background characteristics.

Table 4.7 Willingness to have HIV Test and reaction if it happens to be Positive

Characteristics	Willingness of HIV test	Tell to family	Tell to friends	Don't know what to do	Commit suicide	Others
Sex						
Male	88.7	43.7	51.5	12.9	1.7	14.7
Female	90.9	42.2	49.8	19.4	3.3	14.2
Age Group						
15-19	92.4	57.2	58.9	15.1	2.7	15.1
20-29	89.1	45.2	54.0	19.5	3.1	18.8
30-39	92.2	36.2	61.7	14.9	2.1	6.4
≥ 40	84.2	81.3	68.8	12.5	0	6.3
Educational level						
Illiterate	70.0	57.2	57.2	42.9	0	14.3
Read & write	65.0	38.5	30.8	23.1	15.4	23.1
Grade 1-6	87.9	34.5	44.8	41.4	6.9	13.8
Grade 7-12	93.5	52.6	57.2	15.0	1.7	16.2
College and above	90.2	45.7	59.4	15.4	2.3	16.0
Religion						
Orthodox	90.5	46.9	57.1	17.5	3.3	19.3
Catholic	78.6	54.5	57.5	27.3	0	0
Protestant	92.4	47.5	60.7	11.5	1.6	18.8
Muslim	88.6	54.1	48.6	27.0	2.7	5.4
Current Marital Status						
Never Married	88.8	47.0	53.0	18.7	2.6	18.0
In Union	94.7	58.3	76.4	6.9	1.3	9.7
Formerly In Union	89.3	28.0	32.0	66.7	8.0	12.0
Employment Status						
Employed	93.2	52.5	60.3	15.2	1.6	2.5
Unemployed	84.2	46.4	54.2	20.2	4.5	12.0
Student	90.1	45.2	56.0	16.4	2.1	16.0
Ethnic Group						
Amhara	88.3	46.9	58.7	14.8	3.1	17.3
Oromo	93.2	48.9	53.1	21.9	1.0	13.5
Tigray	94.3	40.0	42.0	18.0	6.0	18.0
Gurage	82.1	43.5	56.5	34.8	4.3	0
Others	88.9	65.6	75.0	12.5	0	25.0
Income Group						
No income	89.6	46.7	54.1	20.1	3.5	20.1
≤ 500	82.8	50.9	50.9	11.3	1.9	11.3
501-1000	100	51.0	73.5	14.3	2.0	10.2
> 1000	90	47.2	58.3	16.7	0	2.8
Place of previous Residence (before one year)						
Addis Ababa	86.5	53.2	56.9	13.8	1.8	4.6
Out of Addis Ababa	91.1	45.8	56.3	19.4	3.1	20.9

Table 4.7 shows the result against selected background characteristics. Males and females responded apparently for the question "If the facility is available, are you willing to have HIV test?" the question was responded affirmatively by 89 percent of males and 91 percent of females. For those respondents who were willing, a second question, "If the test happens to be positive, what do you do?" the reaction of respondents was obtained through different alternatives. More males responded than females to tell the result to the family, 44 percent and 42 percent respectively. Still females were secretive to disclose the fact to tell their friend as compared to males. The other reaction proposed by respondents themselves "committing suicide."

About 2 percent of males and 3.3 percent of females responded to "commit suicide" if the result happens to be positive. Here, most of the respondents had awareness how to live with HIV for a long period of time. This is the outcome of amazing job in the creating of HIV/AIDS awareness by both governmental and non-governmental organizations. And the third alternative to responded by the respondents was "Do not know what to do" for Do not know what to do response still females were at a riskier position than males.

Some of the respondents were responded different reactions like take revenge, to change the place of residence, not to tell any one till death. These responses in the table put under "others" the same percentage of males and females responded for others.

Age wise, about 84 percent of respondents in the age group of ≥ 40 responded positively to the question "If the facility is available, are you willing to have HIV test?". This figure is much less as compared to others age groups. Again 81 percent of respondents in this age group (≥ 40) responded the response "tell to family". And 36 percent of the

respondents in the age group 30-39 responded the response "to tell family".

About 57 percent and 45 percent of respondents of the age group 20-29 and 30-39 were reported "tell to family" response. On the other hand, the percentage of respondent to responded "tell to friends" response increased as age progressed except the first age group (15-19 age group).

For the response "Don't know what to do", the percentage of respondent responded decreased as age progressed except the age group of 20-29, this is a matter of maturity in terms of age.

For response "Commit Suicide", no respondents in the age group ≥ 40 were responded as reaction if it happens to be positive. In the other age groups, some respondent were reported "Commit suicide" as response.

In terms of educational level, most of the respondents in medium and higher were willing to have HIV test. About 57 percent of respondents of those of illiterate responded to tell to family. It is largest figure than that of respondents in different educational level.

As indicated in educational level, the result would be more discussant with friends. For the response "Do not know what to do", still lower in the respondents of the lower grade. The attitude to accept the diseases and to live positively with it might probably be frustrated by the high societal stigma attached to the disease and the patients of AIDS. No respondents in illiterate educational level responded to "Commit suicide" if the result to be positive. But, 15.4 percent of respondents those of able to read and write and Grade 1-6 were responded to "Commit Suicide" if the result to be positive. These respondents need to protect.

In current marital status, more respondents of those In Union reported that they were willing to HIV test than those of respondents Never

Married and Formerly In Union. For “Tell to family” response, less percentage of respondents in Formerly In Union respond than respondents of Never Married and In Union group. Still Formerly In Union respondents were very much secretive to disclose the fact to their friends as compared to respondents in Never Married and In Union marital status. Again in terms of both responses “Do not know what to do,” and ‘Commit Suicide’ respondents of those of Formerly In Union were at riskiest position than other marital status. So they need to be protected.

Regarding religious difference, less percentage of respondent in Catholic Christians responded to willing to have HIV test than other religion in the study. Among more than half of Catholic and Muslim respondent “tell to family” if it happens to be positive. The positive result of HIV test were more discussant issue among Orthodox, Protestant and Catholic Christians than Muslim respondents. For “Do not know what to” response, protestant respondents were at risk. The amazing respond was observed for “Commit Suicide” response among Catholic Christians. No respondent were reported “commit Suicide” response if it happens to be positive.

In employment status, employed and students respondents were reported that they were willing to HIV test than those of respondents of a Unemployed. For the response “tell to family”, no significant variation among respondents in different employment status. Both Unemployed and students were much secretive to disclose the fact to their friends as compared to respondents in employed status. Again, in terms of both responses, “Do not know what to do” and “Commit suicide” respondents of those Unemployed and students were at riskiest position than those of employed respondents

No significant variation was observed in reaction if it happen to be positive among respondent of different ethnic groups.

In case of different income groups, large number of respondents in higher income group reported willingness to have HIV test than lower income group. No much variation in the response to “tell to family” among different income groups. Lower income groups (no income and $\leq$ 500) were much secretive to disclose the fact to their friends as compared to higher income groups (501-1000 and > 1000). For response “Commit Suicide” rate of respondents were decreased with income increased.

More respondents of their previous residence was out of Addis Ababa responded positively to have willingness to test HIV respondent for their previous residence was Addis Ababa. More respondent for their pervious residence was Addis Ababa responded than their previous residence was out of Addis Ababa to tell the result to family, 53 percent and 46 percent respectively. Equal percentage of respondents in both groups responded to tell the result to friends. 19.4 percent and 3 percent of respondent of whose previous residence was out of Addis Ababa respond the responses “Do not know what to do” and “Commit Suicide” respectively. They were at risk and need to be protected.

4.6. Knowledge of Members of ENAB Concerned with Fatality of AIDS

According to the study, none of the independent variables were found to be significantly associated with the respondents’ knowledge of HIV/AIDS. Here, knowledge of HIV/AIDS was almost universal among members of ENAB. But, their almost uniform level of knowledge did not guarantee to have the same attitude and sexual behavior of respondents.

Table 4.8 depicts the percentage distribution of respondents who know about the fatality of AIDS (Can AIDS be cured?) by selected background characteristics.

All respondents who had heard of AIDS were asked "Can AIDS be Cured?" As seen in table 4.8, 90 percent of males and 88 percent of females reported that AIDS can not be cured. Males were more knowledgeable about AIDS than females.

Knowledge about AIDS was reported on the increasing rate except a slight decline for age group of 30-39. In terms of current marital status, almost no difference as knowledge of AIDS. 89 percent of those Never Married, 88 percent of respondents In Union and 89 percent of those Formerly In Union were reported AIDS can not be cured.

As knowledge of respondent concerned with fatality of AIDS was evaluated among respondents in different educational level, it was found that close to each other except in those of able to read and write and college and above respondents 85 percent and 87 percent respectively.

This variation might be happened due to lack of knowledge for those who are able to read and write and their optimistic views about AIDS for those who have college and above educational level.

For the response "AIDS can not be Cured" among respondents of Orthodox (89 percent) protestant (86 percent) and Muslim (91 percent) was almost similar. But, 96 percent Catholic respondents reported that AIDS can not be cured. Here, the religious leaders should be designed the most effective and efficient ways of media of knowledge about AIDS for their followers of visual disability.

Table 4.8 Knowledge of respondents concerned with fatality of AIDS

Characteristics	Can AIDS be cured? (%)	
	Yes	No
Sex		
Female	10.0	90.0
Male	12.3	87.7
Age Group		
15-19	13.9	86.1
20-29	10.6	89.4
30-39	11.8	88.2
> 40	5.3	94.7
Current Marital Status		
Never Married	10.9	89.1
In Union	11.8	88.2
Formerly In Union	10.7	89.3
Level of Education		
Illiterate	10.0	90.0
Able to read & write	15.0	85.0
Grade 1-6	6.1	93.9
Grade 7-12	9.2	90.8
College and above	13.4	86.6
Religion		
Orthodox	11.5	88.5
Catholic	3.6	96.4
Protestant	13.6	86.4
Muslim	9.1	90.9
Ethnic group		
Amhara	10.4	89.6
Oromo	7.8	92.2
Tigray	11.3	88.7
Gurage	14.3	85.7
Others	22.2	77.8
Employment Status		
Employed	12.7	87.3
Unemployed	4.1	95.9
Student	11.7	88.3
Income Group		
No income	11.1	89.9
≤ 500	10.9	89.1
501-1000	14.3	85.7
> 1000	7.5	92.5
Place of Previous residence (before one year)		
Addis Ababa	10.3	89.7
Out of Addis Ababa	11.4	88.6

The impact of ethnicity for the knowledge of AIDS (fatality of AIDS) was not significantly different.

The difference among respondent, according to their employment status in respect to the fatality of AIDS was not much wide except the unemployed group. In other words, those respondents of employed and students, were misconception in this regard. Here, the variation might be happened among respondents in different employment status due to small size of unemployed respondents in the study.

The study revealed almost similar knowledge of AIDS particularly that fatality of AIDS among respondents, in different income group except the higher income group. This might be when income increased, the ways of knowledge of AIDS become accessible. Finally, for the response, "AIDS can not be cured" the impact of place of previous residence was not significantly different.

To show the universal knowledge of HIV/AIDS among members of ENAB, in-depth interviews were held among five members of ENAB living in Addis Ababa. According to the interviewee's response, the respondents have sufficient knowledge about HIV/AIDS like the nature of the virus and disease, ways of transmission of the disease, ways to avoid of the disease, the current situation of HIV/AIDS in Ethiopia and so on. But, their knowledge did not guarantee to have similar level of attitude and sexual behavior among members concerning the respondents knowledge of HIV/AIDS, as the researcher have mentioned earlier all respondents have good knowledge about HIV/AIDS (way of transmission and way to avoid AIDS). In this regard, 17 years old female student said that:

"AIDS is a disease which caused by HIV. It is a killer disease, has posed a serious challenge to our planet. Modes of transmission through sex without condom, sex with multiple partners, from infected mother to child etc. And people can protect themselves from AIDS through abstinence, use condom during sex and having faithful partner. Regarding VCT, it is very hard for me to utilize VCT services. This is because there is high risk of losing your private information while testing. This means that there is no guarantee to the confidentiality of your test result at all.

Similarly, other expressed his knowledge about HIV/AIDS, he was a 32 years old married man said:

"I know that HIV/AIDS is one of a serious health issue in developing countries like Ethiopia. I also know the ways of transmission and of avoid AIDS through different mechanisms. Regarding VCT, I have not make use of the service so far. This is because, in most case HIV can transmitted through sex with multiple partners. So, I didn't experience in such ways of transmission of the disease.

Regarding knowledge of the respondents of about HIV/AIDS similar results were obtained. But, this interviewee had good knowledge regarding HIV/AIDS. He was 28 years old employed.

AIDS is a disease which affects human being due to HIV. Currently, our country faces serious challenge as a result of AIDS. This is because it affected demographic, socio-economic as well as political situation of the country. Governmental and several non-governmental organizations designed different mechanism to control the spread of HIV/AIDS among the societies. Regarding VCT, I believe that VCT can possibly support the efforts being made to tackle the impact of HIV/AIDS. Therefore, I have make use of the service so far. And now, I keep myself from any means to exposed AIDS because it is uncured.

In this study, having knowledge about AIDS did not guarantee to make similar attitude of the disease and sexual behavior. Concerning this, a 25 years old female employed member of ENAB said"

"It is common issue among the societies including Visual disabled people. Like any other disease, it is preventable but it is not cured. There are several methods to protected from the disease such as, abstinence, having faithful partner and use condom while sex as a last option. If individuals didn't use the above methods to be saved, they will exposed to the disease. Regarding VCT, I haven't made use of the service so far. This is because I do trust myself."

Finally, the last participatory in the interviews explain the nature of disease in detail and his attitude about the disease. He was 42 years old teachers.

"The AIDS pandemic began spreading before 20 years in North America but, at present highly affected the sub-Saharan Africa. It transmitted through the critical biological need. In fact, there are some other ways of transmission. To secure from the disease, individuals should have a faithful partners and use condom during sex. In case of VCT, I am not willing to have HIV test. This is so because I perceive good chance of being infected by AIDS."

CHAPTER FIVE

MULTIVARIATE ANALYSIS

To see the relationship between the dependant variable separately the logistic regression analysis examines. Based on the selected background variables the researcher was able to adopted logistic regression analysis.

The first dependant variable was related with the attitude of the respondents. Therefore, to know the attitude of the respondents, the question "How would you perceive your chance of getting HIV/ AIDS?" was asked. This was entered as dummy variable where '0' was assigned for those who respond "moderate or good chance" and '1' for "no chance" Here; age, religion and ethnicity group were found to be major explanatory independent variables. These variables explained about 66 percent of the dependant variable.

Sex of respondents was not found to be significantly associated with perception. However, the result showed that, the perception of males with regard to the chance of getting HIV/AIDS was found about 16.5 percent higher than that of female. This may be probably influenced by the fact that males tended to have more sexual partners.

Age of respondents was found to be negatively associated with perception. It is significant. At this point, the perception with regard to the chance of respondents in the age group 20-29 getting HIV/AIDS was about 58 percent higher than those of too young (15-19). And in the age group 30-39 also perceived 65 percent higher than that of the reference category.

Table 5.1 Logistic Regression: Attitude with Sex, Age, Religion, Ethnicity and other Independent Variables

Variable	B	S.E	Sig.	Exp (B)
Sex				
Female	0.00			1.00
Male	0.153	0.217	0.482	1.165
Age Group				
15-19	0.00			1.00
20-29	-0.874	0.309	0.005	0.417**
30-39	-1.039	0.493	0.035	0.354*
> 40	-0.280	0.674	0.678	0.756
Religion				
Orthodox	0.00			1.00
Catholic	1.117	0.485	0.021	3.054*
Protestant	-0.017	0.305	0.955	0.983
Muslim	0.895	0.394	0.023	2.448*
Employment Status				
Student	0.000			1.000
Employed	-0.233	0.536	0.664	0.792
Unemployed	0.741	0.417	0.076	2.097
Ethnic group				
Amhara	0.000			1.000
Oromo	0.559	0.268	0.037	1.749*
Tigray	0.300	0.332	0.365	1.350
Gurage	1.199	0.500	0.016	3.318*
Others	0.352	0.386	0.362	1.421
Educational level				
College and above	0.000			1.000
Illiterate	-0.952	0.825	0.248	0.386
Able to read & write	0.290	0.570	0.610	1.337
Grade 1-6	-0.119	0.444	0.789	0.888
Grade 7-12	0.215	0.251	0.393	1.240
Income Group				
No income	0.000			1.000
≤ 500	-0.120	0.318	0.707	0.887
501-1000	0.338	0.560	0.546	1.402
> 1000	-0.222	0.648	0.733	0.801
Place of Previous residence (before one year)				
Addis Ababa	0.000			1.000
Out of Addis Ababa	0.314	0.251	0.210	1.369
Constant	0.057	0.382	0.882	1.059

* Significant at $P < 0.05$

** Significant at $P < 0.01$

Religion also had a significant association with perception. Here, respondents of Catholic were found to have a perception of being less at risk than those respondents in the reference category. The result showed that, the perception with regard to the chance of Catholic respondents getting HIV/AIDS was about 3.1 times lower than those of Orthodox respondents and Muslim respondent about 2.4 times lower chance of getting than Orthodox respondents.

Ethnicity also had a significant association with respondents' attitude. At this point, respondents of Gurage perceive about 3.3 times lower than Amhara with regard to the chance of getting HIV/AIDS. This may be probably by the fact that most of the Gurage respondents keep themselves from the risk factor. On the other hand, the Oromo respondents also perceived to have lower chance of getting HIV/AIDS than Amhara (the respondents of Oromo perceived about 1.7 times lower than Amhara). Here, most of Oromo respondents may be grew up around Addis Ababa or other major cities of the country.

The question forward to respondents was that "Ever had sex". This question could give us a general picture for those groups at risk. Here, independent variables were explained 81 percent of the dependant variable.

Table 5.2 Logistic Regression: Sexual Behavior with Sex, Age, Income and Place of Previous Residence

Variable	B	S.E	Sig	Exp (B)
Sex				
Female	0.00			1.00
Male	0.237	0.277	0.393	1.267
Age Group				
15-19	0.00			1.00
20-29	-0.764	0.401	0.050	0.466
30-39	-0.913	0.749	0.223	0.401
> 40	-0.805	1.144	0.482	0.447
Current Marital Status				
Never Married	0.00			1.00
In Union	-21.677	4,131,340	0.996	0.000
Formerly In Union	-4.384	1.239	0.000	0.012
Income Group				
No income	0.00			1.00
< 500	-0.829	0.349	0.017	0.437
501-1000	-1.764	0.816	0.031	0.171
> 1000	-2.754	1.052	0.009	0.064
Place of Previous residence (before one year)				
Addis Ababa	0.00			1.000
Out of Addis Ababa	-0.610	0.303	0.044	0.543
Constant	1.714	0.504	0.001	5.553

There is a negative relationship between age and “Ever had sex”. The result was interpreted as respondents in the age group 20-29, had lower sex experience than the respondents in the very young age group. For instance, the result showed that respondents in the age group 20-29 had 53 percent lower chance to have sex experience those respondents in the age group 15-19.

Marital status had a negative relationship with the response “yes, I had sex experience.” Here, the result showed that those who were Formerly In Union had 99 percent lower chance to have sex experience than those of Never Married respondents.

Income group also had a negative relationship with the response “yes, I had sex experience.” At this point, those who had income were found to have lower sex experience than those of who were no income group. Here, it was observed very surprised result that when income increased, the possibility of having sex experience become decreased. According to the study respondents in the income group (≤ 500) had 56 percent lower chance to have sex experience than the respondents in no income group. And respondents in 501-1000 and > 1000 income group had 83 percent and 94 percent lower chance to have sex experience than those of No Income group respectively.

Place of previous residence also had a negative relationship too. It is significant ($p < 0.05$). The result showed that, the respondents whose place of previous residence was out of Addis Ababa had almost 46 percent lower chance to have sex experience than those of respondents whose place of previous residence was Addis Ababa.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

Currently, HIV/AIDS, has posed a serious challenge to our world. The main means of transmission (through the critical biological need), its long incubation period and the absence of both vaccination and treatment have complicated the nature of this killer disease.

HIV/AIDS in third world countries, particularly in Sub-Saharan Africa, considered together with their huge impact on socio-economic and demographic conditions. Some of the studies show that people with disabilities are not assumed to be at high risk of HIV infection because they are believed to be sexually inactive, not to use drugs or alcohol and at less risk of sexually transmitted disease than people without disabilities and most of the information on HIV/AIDS is not available for these people. For example, blind people face lack of information because the information is not available in accessible format like brails.

Therefore, Sub-Saharan Africa countries, need to design strategies to behavioral change on individual sexual activity to tackle the spread of the diseases particularly among PwDs (visual disabled, hearing disabled etc...).

This study deals with the knowledge, attitude and behavior about HIV/AIDS among members of ENAB in Addis Ababa. A total of 442 individuals (231 males and 211 females) were asked through the structured questionnaire. After the quality of the data was checked, the analysis was undertaken against selected background characteristics: sex, age, marital status, educational level, religion, ethnicity, employment status, income level and place of previous residence.

The main objective of the study was to measure the awareness of HIV/AIDS in the study population. Here, all respondents reported that they have knowledge of transmission of HIV/AIDS and avoid to HIV/AIDS. None of independent variables influenced the knowledge of HIV/AIDS among members of ENAB. Because, they have access to different sources of knowledge like Radio.

HIV/AIDS is well known by the study population with a certain degree of misconception in the accuracy of the information base. Only about 75 percent of the respondents had access to the health professionals, among which males were at a better position. It requires a significant work to utilize schools, Churches/Mosques, ENAB (Ethiopian National Association of Blind), parents and neighbors as sources to knowledge of HIV/AIDS. Regarding the knowledge of means of AIDS transmission, almost all respondents know at least two ways. However, misconception was also seen. This might be happened due to relation with the source of information. In the ways to avoid AIDS, it was also observed good knowledge among the respondents.

Almost the same percentage of male and female (50 percent) respondents perceived themselves as at risk to acquire the disease. The higher age (30-39) perceived themselves in the same way. The main reasons given were having very long sexual experience with multiple partner and non use of condom during sexual intercourse.

According to this study, having the same level of knowledge to HIV/AIDS does not guarantee to have the same sexual behavior of respondents of members of ENAB. Therefore, the main focus of investment should be on the attitudinal change that favorably brings a desired behavioral change among the respondents.

At the end, to assess the degree to liberalization in the study population, willingness to have HIV test was asked. The result was indicated 89 percent of male respondents and 91 percent of female respondents were reported to be willingness to have HIV test. Here, no significant different between male and female respondents. Further more, those who reported positively were asked their reaction if the result happened to be positive. They said that they would resort to committing suicide or take revenge or changing their place of residences. These respondents should be protected.

6.2. Recommendations

1. A coordinated effort among different stakeholders and partners including ENAB, different NGOs and Governmental Organizations should be applied for the realization of development HIV/AIDS projects that benefits visual disabilities.
2. Establishing a system for the compilation of disability – sensitive data in general and visual-disabilities in particular. This means the data gathered for various purposes have to be disability disaggregated so that decision makers or researchers would have the possibility to observe the magnitude of the problems of PwDs.
3. The financial and human capacity of the different association of PwDs like ENAB and ENAD should be built a way that they could take up the issue of disability (HIV/AIDS issue among members of ENAB).
4. Establishing HIV/AIDS Victim's Association for people who are visual disabled. This will help to reduce the social stigma and to modify/change attitude and sexual behaviors among visual disabled.
5. ENAB should focus on the issue of HIV/AIDS particularly, in the modification of sexual behavior-among members through training

and resource material into accessible formats (Braille, audio, large print)

6. Providing financial support to strengthen AIDS clubs and schools and additional effort should be given to designing special means of dissemination of information about HIV/AIDS and related issue for those visual-disabled followers by Churches or Mosques.
7. Changing the assumption of people about PwDs in general and visual disabilities in particular those are not assumed to be at high risk at HIV infection because they believed to be sexually inactive and less risk of sexually transmitted disease.
8. Provision of information to mainstream service organizations regarding the unique issues faced by blind people that increased their vulnerability to HIV/AIDS; and adopt techniques to make their awareness, training and treatment programs accessible to blind people.
9. The Ethiopian health system and AIDS communication strategies should be suited PwDs in general and people with visual disabilities in particular.
10. Research should be conducted in the areas since little is known about visual disabilities and HIV/AIDS in Ethiopia.

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Survey Questionnaire
Addis Ababa University
College of Development Studies (CDS)
Institute of Population Studies (IPS)

Addis Ababa

We are conducting a survey to learn what people (members of ENAB) understand about HIV/AIDS and about knowledge and sexual behavior. The questions are very personal and related-with sexual practices. The result of this study will help us to see the effectiveness of the intervention on changing sexual behavior in this group (members of ENAB).

The answer of a respondent to this questionnaire remains confidential. There is no name on the questionnaire and there is no means for any other person to know of your answer.

Thank you in advance

I. Socio-Economic and Demographic Information

Questions	Responses
1. How old are you?	_____ (in completed year)
2. Sex of the respondent	1. Male 2. Female
3. Level of Education	1. Unable to read and write 2. Able to read and write 3. Grade 1-6 4. Grade 7-12 5. College and above
4. What is your religion?	1. Orthodox 2. Catholic 3. Protestant 4. Muslim
5. What is your current marital status?	1. Never Married 2. In Union 3. Formerly In Union
6. Respondent's Employments status	1. Employed 2. Unemployed 3. Student

7. Where did you live before?	1. Addis Ababa 2. Out of Addis Ababa
8. What is your Ethnic group?	1. Amhara 2. Oromo 3. Tigray 4. Gurage 5. Others
9. Respondent's income	_____ (Birr)

II. Knowledge and Attitude on HIV/AIDS

1. Have you ever heard about HIV/AIDS?	1. Yes 2. No																																	
2. If yes to Q. 201, where do you get information about HIV/AIDS?	<table border="1"> <thead> <tr> <th></th><th>Yes</th><th>No</th></tr> </thead> <tbody> <tr> <td>• From health professional</td><td>1</td><td>2</td></tr> <tr> <td>• From mass media</td><td>1</td><td>2</td></tr> <tr> <td>• From church/mosque</td><td>1</td><td>2</td></tr> <tr> <td>• From friends</td><td>1</td><td>2</td></tr> <tr> <td>• From workplace</td><td>1</td><td>2</td></tr> <tr> <td>• From school</td><td>1</td><td>2</td></tr> <tr> <td>• From your association</td><td>1</td><td>2</td></tr> <tr> <td>• Parents</td><td>1</td><td>2</td></tr> <tr> <td>• Neighbors</td><td>1</td><td>2</td></tr> <tr> <td>• Others _____</td><td></td><td></td></tr> </tbody> </table>		Yes	No	• From health professional	1	2	• From mass media	1	2	• From church/mosque	1	2	• From friends	1	2	• From workplace	1	2	• From school	1	2	• From your association	1	2	• Parents	1	2	• Neighbors	1	2	• Others _____		
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• Parents	1	2																																
• Neighbors	1	2																																
• Others _____																																		
3. Do you know how HIV is transmitted?	1. Yes 2. No																																	
4. If yes to Q. 203, how can a person get infected? (record all mentioned)	<table border="1"> <thead> <tr> <th></th><th>Yes</th><th>No</th></tr> </thead> <tbody> <tr> <td>• Sex without condom</td><td>1</td><td>2</td></tr> <tr> <td>• Sexual intercourse with multiple partners</td><td>1</td><td>2</td></tr> <tr> <td>• Transfusion of infected blood</td><td>1</td><td>2</td></tr> <tr> <td>• Curse</td><td>1</td><td>2</td></tr> <tr> <td>• Sex with commercial sex workers</td><td>1</td><td>2</td></tr> <tr> <td>• Sharing sharps and needles</td><td>1</td><td>2</td></tr> <tr> <td>• Physical contact with infected person</td><td></td><td></td></tr> <tr> <td>• Eating and shaking</td><td>1</td><td>2</td></tr> <tr> <td>• Mother to child transmission</td><td>1</td><td>2</td></tr> <tr> <td></td><td>1</td><td>2</td></tr> </tbody> </table>		Yes	No	• Sex without condom	1	2	• Sexual intercourse with multiple partners	1	2	• Transfusion of infected blood	1	2	• Curse	1	2	• Sex with commercial sex workers	1	2	• Sharing sharps and needles	1	2	• Physical contact with infected person			• Eating and shaking	1	2	• Mother to child transmission	1	2		1	2
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	1	2																																
5. If yes to Q. 203, do you know ways of HIV prevention?	1. Yes 2. No																																	
6. If yes to Q. 205, how can a person avoid HIV/AIDS?	<table border="1"> <thead> <tr> <th></th><th>Yes</th><th>No</th></tr> </thead> <tbody> <tr> <td>• Abstinence</td><td>1</td><td>2</td></tr> <tr> <td>• Avoiding multiple sexual partners</td><td>1</td><td>2</td></tr> <tr> <td>• Always use condom during sexual intercourse</td><td>1</td><td>2</td></tr> <tr> <td>• Avoiding sharing sharps</td><td>1</td><td>2</td></tr> </tbody> </table>		Yes	No	• Abstinence	1	2	• Avoiding multiple sexual partners	1	2	• Always use condom during sexual intercourse	1	2	• Avoiding sharing sharps	1	2																		
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• Avoiding sharing sharps	1	2																																

	• Avoiding contact with blood and other body fluids12 • Sex only with regular partner12 • Avoiding physical contact12 • Avoiding eating together12 • Not living with sick people12																		
7. If yes to Q. 203, how far do you think HIV is a risk for you?	1. Never 2. Very little 3. Little 4. Highly 5. Very highly																		
8. If yes to Q. 203, do you think HIV might have infected you?	1. Yes 2. No																		
9. If yes to Q. 208, way at risk	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>• Don't take much care while having sexual intercourse</td><td>1</td><td>2</td></tr><tr><td>• I have more than one sexual partner</td><td></td><td></td></tr><tr><td>• I don't use condom</td><td>1</td><td>2</td></tr><tr><td>• I don't trust my partner</td><td>1</td><td>2</td></tr><tr><td></td><td>1</td><td>2</td></tr></table>		Yes	No	• Don't take much care while having sexual intercourse	1	2	• I have more than one sexual partner			• I don't use condom	1	2	• I don't trust my partner	1	2		1	2
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	1	2																	
10. If your response to Q. 208 is No, what do you do to avoid the risk?	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>• I use condom when I make sex</td><td>1</td><td>2</td></tr><tr><td>• I have contact with people who are tested HIV positive</td><td>1</td><td>2</td></tr><tr><td>• Have never made sexual intercourse</td><td></td><td></td></tr><tr><td>• One faithful partner</td><td>1</td><td>2</td></tr><tr><td></td><td>1</td><td>2</td></tr></table>		Yes	No	• I use condom when I make sex	1	2	• I have contact with people who are tested HIV positive	1	2	• Have never made sexual intercourse			• One faithful partner	1	2		1	2
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• One faithful partner	1	2																	
	1	2																	
11. Do you think that some can live and work with HIV/AIDS?	1. Yes 2. No																		
12. Do you get any information related with HIV/AIDS from your association (ENAB)?	1. Yes 2. No																		
13. Do you think that persons with AIDS almost never die from the disease, sometimes die or almost always die from the disease?	1. Almost never die 2. Sometimes die 3. Almost always die 4. Do not know																		

14. Can AIDS be cured?	1. Yes 2. No		
15. Do you know personal known someone who has AIDS?	1. Yes 2. No		
16. Do you personally know someone who has died of AIDS?	1. Yes 2. No		
17. Should a person with AIDS live isolated?	1. Yes 2. No		
18. If the facility is available, are you willing to have the HIV test? (If No, skip to Q.219)	1. Yes 2. No		
19. If the test happens to be positive, what do you do?	• Tell to the family • Tell to friends • Do not know what to do • Commit suicide • Other _____	<u>Yes</u> 1 1 1 1	<u>No</u> 2 2 2 2

III Sexual Behavior

1. Have you ever had sexual intercourse?	1. Yes 2. No
2. If Yes to Q. 301, at what age did you first have sex?	1. 10-14 2. 15-19 3. 20-24 4. 25-29 5. 30-34 6. I do not remember 7. I don't want give answer
3. Do you have regular sexual partner?	1. Yes 2. No
4. If No, Q. 303, with how many different people have you had sex during the past one year	1. One 2. Two 3. Three 4. Four 5. More than four 6. I don't want give answer
5. Have you ever used condom?	1. Yes 2. No
6. Some people use a condom during sexual intercourse to avoid getting or transmitting diseases, such as AIDS or other sexually transmitted disease. Have you ever heard of this?	1. Yes 2. No
7. Have you ever used a condom with your sexual partner during sex to avoid getting or transmitting disease, such as AIDS	1. Yes 2. No
8. If 'No' to question 307, what are the main reasons for not using a condom?	1. I do not know about it 2. My Partner and I trust each other 3. I do not like it 4. Against religion
9. Has your knowledge of AIDS influenced or changed your decision about having sex or your sexual behavior	1. Yes 2. No

10. If 'Yes' to question 309, in what way?		Yes	No
	• Did not start sex	1	2
	• Stopped all sex	1	2
	• Started using condom	1	2
	• Restricted sex to one partner	1	2
	• Reduce number of sexual partners		
	• Avoid sex with commercial sex workers	1	2
	• Others _____		

Addis Ababa University
College of Development Studies (CDS)
Institute of Population Studies (IPS)

Addis Ababa

Interview Guide

Dear respondents, first of all I would like to thank you to be my interviewee. The principal purpose of this interview is to get data concerning the determinant of knowledge, attitude and behavior on HIV/AIDS among members of ENAB. You were selected for this study because you could provide adequate information on this area. Therefore, your unreserved cooperation providing genuine information will be appreciated. However, the information will be kept confidential.

In-depth Interview questions

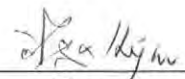
1. How do you get information about HIV/AIDS? Mention your sources of information on HIV/AIDS.
2. Have you ever been tested for HIV/AIDS? Why?
3. What, do you think, are the factors that affect the knowledge of HIV/AIDS among blind people?
4. How, do you think, should HIV/AIDS related information be given to blind people?
5. Do you think that there should be HIV/AIDS center with special emphasis on blind people?
6. What, do you think about the current HIV/AIDS situation in Ethiopia?
7. How, do you think to control the spread of HIV/AIDS in Ethiopia?

Declaration

The thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have been duly acknowledged.

<u>YONAS TESFAYE</u>	<u></u>	<u>11/07/2008</u>
Student	Signature	Date

I confirm that this thesis has been submitted with my approval as the supervisor of the same.

<u>SATHIYA SUSUMAN</u>	<u></u>	<u>11/07/2008</u>
Advisor	Signature	Date