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VULNERABILITY OF MARRIED WOMEN TO HIV INFECTION AND FACTORS CONTRIBUTING TO VULNERABILITY IN NAZARETH, ETHIOPIA

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
CI	Confidence interval
DHS	Demographic and Health Survey
MTCT	Mother to child transmission
HIV	Human Immuno deficiency Virus
NCTPE	National Committee on Harmful Traditional Practices
OR	Odds ratio
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted infections
UNAIDS	Joint United Nation Program on AIDS
UNFPA	United Nations Population Fund Agency
UNIFEM	United Nation Development Fund for Women
VCT	Voluntary counseling and testing

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ABSTRACT

HIV\AIDS was recognized as a disease of inequality and marginalization. Women are becoming more vulnerable to HIV infection than men. Africa leads the HIV infection at a forefront and nearly 60% of people living with HIV were women of child bearing age at the end of the year 2001. AIDS virus, also, appears to be increasingly infecting married women in developing countries

A total of 1276 married women aged 15 to 49 were selected in Nazareth town, the capital city of Eastern Shoa zone, using multi stage sampling method. The study aimed at assessing vulnerability of married women to HIV infections and their risk-awareness level measured by reported history of STDs or high-risk sexual behaviors by married couples and worry to have been infected by HIV respectively, using a structured questionnaire. The study also attempted to assess socio-economic factors contributing to vulnerability to HIV

Results showed significant proportion of married women (26.8%) to have been vulnerable to HIV infection as measured by either of the reported prevalence of STIs in married women, which was 16.8% or prevalence of extra marital sexual relationship in either of the couples which was 2.3% and 9.3% in married women and married men respectively. Also, of the 26.8% of married women who were vulnerable to HIV infection, more than two third (66.1%) did not know they were at risk.

Women who depend economically on their husband and also whose marriage decision to have been motivated for the reason of financial security are found to be more vulnerable to HIV infection. Significant proportion of such women was also found to be not aware of their being at risk.

In conclusion, significant proportion of married women were vulnerable to HIV infection and, the majority of married women who were vulnerable did not know they were at risk of acquiring HIV. Vulnerability is more in women who were economically dependent on their husband.

Hence, there is a need in to empower women economically by creating job opportunity and also need of awareness creation on safe sex practices in married life and need on a skill of sexual negotiation especially by targeting married women and engaging married men as well.

INTRODUCTION

AIDS is the major health crisis of our time and one of the terrible pandemics of history. HIV/AIDS is also recognized as a disease of inequality and marginalization (1). While the disease itself is a health issue the ever growing epidemic is not. The epidemics have reached such uncontrollable proportions because gender inequality is not seen as a basic reality (2).

A decade ago, women seemed to be on the periphery of the epidemic. Today they are at the epicenter. This is because women are becoming more vulnerable than men. New infections are also rising rapidly among married women. While the rate of HIV transmission may be falling due to condom use and other measures in some countries, the AIDS virus appears to be increasingly infecting married women in developing countries (3). The male to female ratio among HIV infected persons is beginning to equalize and in some of the worst affected countries, women out number men. Women disempowered status in their relationships, households, and communities are recognized as important contributors to their susceptibility to HIV and other sexually transmitted diseases.

Ninety five percent of globally infected people live in developing countries including Africa. Africa leads the HIV infection at the forefront. The share is about 70.1%. In this region 2.2 million deaths of adults and children has occurred in 2001 alone. Of the 26 million adults living with HIV AIDS in Sub-Saharan Africa, almost three-fifth of them was women. Women now represent half of those infected with HIV worldwide and 58 percent of those infected in sub-

Saharan Africa, the region most severely affected by AIDS epidemic (4). In sub-Saharan Africa, rates among women have now surpassed those among men, and rates of infection among pregnant women are extremely high in many countries.

Ethiopia, as most other African countries has been experiencing severe HIV/AIDS epidemics. In addition to the wide spread of poverty, the HIV/AIDS pandemic is affecting all sectors of the society. AIDS case surveillance and sero-epidemiological surveys in Ethiopia indicate the extent of HIV epidemic and its rapid progression. It spread at an alarming rate since the appearance of the first reported evidence of HIV infection. The estimated adult HIV prevalence reached 3.2 percent in 1993, 7.4 percent in 1994, and was 9.3 percent at the end of 1998 (5). The estimated number of adults and children living with HIV/AIDS at the end of 2001 is 2.1 million. In this country 160,000 people have died of AIDS (4).

In Ethiopia more women are infected than men. Of the 1.9 million adults living with HIV/AIDS 1.1 million of them are women of child bearing aged 15 to 49 years. In women attending ANC in the year 2001, 14.9 percent prevalence in urban area was reported as of end 2001(4).

Despite women's vulnerability to AIDS, there has been a general lack of attention to the seriousness of the problem of AIDS in women. Even if different studies that have been done at different times in Ethiopia showed knowledge of protecting oneself from getting infected to be high in different population sub groups including married couples, there is a limited information on how far married women are at risk of acquiring the infection and the level of

decision making ability in sexual matters particularly decisions pertaining to safe sex practices. In general HIV-related gender based studies are lacking in Ethiopia.

In order to direct the various efforts in mitigating the impact of AIDS, realization of the contribution of gender inequality in the further spread of HIV/AIDS in the country is needed. Also, addressing gender issues is critical to any sustainable response to the HIV/AIDS pandemic. This study therefore attempts to assess the magnitude of vulnerability of married women to HIV infection, their risk awareness level, their sexual decision making ability and also the factors contributing for their vulnerability.

LITRATURE REVIEW

STIS/AIDS in women

The feminization of the AIDS epidemic is becoming more visible in most developing countries. For instances, in Mozambique the over all rate of HIV infection among young married women (15 percent) is twice that of boys their age (6). In India 1 out of every 4 women are HIV+, in South and South East Asia women are at a 5 times greater risk than men of contracting HIV (7). More over in many of the developing countries new infections are rising rapidly among married women.

STIs are of major public health concern in developing countries, not least because they facilitate transmission of HIV. Sexually transmitted infections are a marker for unprotected sex, which is a high risk activity for HIV. In one study done in rural South Africa, of women aged 15 to 49, 24.9% were infected on any given day with at least one of Trichomonas vaginalis, Neisseria gonorrhoeae, and Chiamydia trachomates (8).

In Ethiopia, studies showed the prevalence of STIs to be high. For instance one study done in Addis Ababa revealed a high prevalence of STDs. High titer seroposetivity suggestive of active infection was: gonorrhea 10%, genital Chlamydia 31%, HBV 5%. Despite the frequency of this condition it was noted that few women (4%) complained of vaginal discharge (9). Many STIs go undetected since women have few, if any, symptoms. It is also well established that 60 to 70% of gonococcal and chlamydial infections in women are asymptomatic (8). The high prevalence among ante natal

attendant also reflects the relative prevalence of STDs in the community. In one community prevalence survey done in South Africa 15% of examined women had either gonococcal or Chlamydia infection (8).

High-risk sexual behavior

In the United States and several sub-Saharan African nations, HIV is now spreading faster among women than men. While the rate of HIV transmission may be falling due to condom use and other measures, the AIDS virus appears to be increasingly infecting married women in developing countries. In countries such as Thailand many married men visit commercial sex workers and do not use condoms, either with the prostitutes or with their wives (1). Men's risky sexual behavior may begin prior to marriage with female sex workers or with "love" relationships.

In one study done in India, which was conducted on 134 HIV infected female, 81 percent was housewives and 88 percent reported a history of monogamy. Single partner heterosexual sex with their husband was the only HIV risk factor for the majority of the women (10). In studies conducted in Cuba, 49 percent of men and 14 percent of women in stable relationships admitted they had had an affair in the past year (11). In South Africa one study showed prevalence of extra marital relation ship by married men to be 3%, and in Colombia the prevalence of extramarital sexual relation ships found to be 52% (10).

In studies done in industrialized countries on cervical cancer and the number of sexual partners, married women with cervical cancer who claimed not to have had a sexual partner other than their husbands, the number of sexual partners of the husbands was found a significant risk factor for cervical cancer (12). In India a study of married and monogamous women at STD clinics found a high rate of HIV and other STDs in this apparently low risk groups. The strongest predictor for HIV infection among these women was having a husband who has been diagnosed with STD (8).

Of the factors which have significant effect upon reproductive health in Africa is high prevalence of a marital and commercial sex activity. In Mozambique, the over all rate of HIV infection among young women (15 percent), is twice that of boys their age, not because the girls are married by age 18, but 40 percent of them married to much older sexually experienced men who expose their wives to HIV (6). In most of the cases, even if women suggest avoiding risky sexual acts using condom, they often encounter male refusal, are accused of adultery or promiscuity, are suspected of already being infected with HIV or are said to accuse their partner of infidelity (10). Monogamous women living with steady partners, who have multiple sexual contacts though they are aware of this, feel powerless to change the situation.

In Uganda, 30% of surveyed women believed themselves to be at risk because they could not stop their partners from having sex with others, while in Belize 68% of interviewed women believed the same (13). For instance, in Cambodia it was reported that one of the

major factors in the spread of HIV is men visiting prostitutes and then taking the disease back to their wives (14).

In a study done in Ethiopia, which was aimed at comparing the clinical and serological aspects of the gynecologic conditions of women involved in prostitution with a group of women still married to their husbands and reporting having had only one sexual partner the sero-prevalence rates of STDs in prostitutes were high, gonorrhea 88%, genital Chlamydia 78%, and PID 67%. In comparison, rates for women married to their first and only sexual partner were; gonorrhea 40%, genital Chlamydia 78%, and PID 47%. While the very high prevalence of STDs in women in prostitution is not so unexpected, the high rate of STDs in women still married to their first and only sexual partner is indicative of male factor or male promiscuity (12).

The inability of women to refuse sex with their husband, even when they know that he is HIV positive has been a major cause of transmission to women. The simple fact of having various liaisons would not pose danger if women could be sure to avoid risky behaviors, but this is found to be extremely difficult. Women's lack of strong negotiation base in sexual relations is indicated by survey that showed more than four -fifth of all HIV positive women are infected by a male sexual partner, and studies in Africa and else where have shown that many married women have been infected by their only sexual partner, their husband (6,10).

Studies found out that man's attitude towards contraception was largely motivated by the desire to limit family size. However, with reference to condoms as a specific method of contraception, they are not a popular method of family planning and there is much more resistance to use. An important reason being condom to be associated with illicit sex and promiscuity. These negative attitudes are major obstacles to the development of condoms as a means of protecting against the spread of HIV especially in stable, ongoing relationships (6).

The high rate of heterosexual transmission of HIV for women underscores the need for sexually active as well as married women to be aware of the risk they face from partners whom they do not know well and who they do not know about the past sexual practice of their partner. Part of the problem for women's vulnerability is perception: for instance, 80 percent of women and 85 percent of men in Brazil believe they are not at risk of contracting HIV (11). In other studies, many women said they would not ask their partner to use a condom, even if they knew he is sleeping with other (11).

Socio-cultural Factors

HIV/ AIDS is a gender issue because men and women are vulnerable in different ways. Vulnerability to HIV is influenced by interaction of a wide range of factors broadly divided into personal factors and societal factors. Personal factors can be sexual history, ability to protect oneself and others, knowledge about treatment and support programs, and skill to access and use them. Societal factors are cultural norms, laws, societal practices, and health and health care beliefs (1).

Women are seen by recent researchers as a population subset that is denied economic emancipation, decision-making roles and religious and cultural support (15). The Balance of decision making in male-female relation ship varies across class and culture, but the majority of women in the developing world do not have equal status in decision that concern either male or female sexuality.

From the global perspective, many women are at risk for HIV infection not because of their high risk behaviors but because they are constrained by social, economic, biologic factors which are beyond their control (16). There are various economic, social, and cultural factors that increase a woman's risk for HIV. Unequal gender relations, discrimination, sexual violence, poverty, and low self esteem, may lead to behaviors or situations associated with high rates of HIV among women (17).

All over the world, social factors stemming from gender inequalities also make women particularly vulnerable to HIV infection, caused not by their own behavior, but by that of their partner. Women are often expected to remain monogamous, yet being married often places them at high risk for infection (because men are not often expected to be monogamous, and in some cases, are even encouraged to have multiple partners). Women lack the social power to reduce their risk for infection. The threat of physical violence, the fear of abandonment, or loss of economic support can act as significant barriers for women to negotiate condom use, discuss fidelity with their partners, or leaving relationships they perceive to be risky. Often, women are socialized to leave

sexual decision-making to men. They are in general at higher risk of getting HIV since most are reluctant to ask their partners to use condom or are ashamed to ask their partners to undergo a health check before having a sexual relationship. Also for many women what ever the cultural context, to suggest to their husband or partner that he use a condom is seen as evidence of the woman's infidelity or is felt by the man as defiance or insolence. The result is at best painful discussions and a breach in the relationship, or at worst the woman being beaten and abandoned (1).

Lack of access to or control of resources for decision-making, particularly in the sexual relationship appear to be one key to the vulnerability of women in AIDS epidemics. The most important reasons for the explosion of HIV infection among women around the world are less biological than social status, such as women inability to effectively protect themselves in sexual interactions (14).

Cultural factors

Cultural norms often deny women knowledge of sexual health. When women possess knowledge of sexual health, it is often considered inappropriate for them to reveal this knowledge, which makes partner communication about risk and safety impossible.

Women are unlikely to discuss with their husbands the lack of condom use and other risky sexual behaviors because their culture discourages discussion of sexual behavior out side efforts at birth control (18). Discriminatory cultural practices such as child marriage and dowry leave even monogamous married women increasingly vulnerable to both unsafe sex and to infection due to the behavior of their husbands (3).

While sex may be pervasive in the mass media, movies and jokes, personal discussion about the topic are often discouraged and people find it very difficult or embarrassing to broach the subject, in many societies sex is not considered a fit topic for discussion between men and women. This makes the changing norms, which must support permanent behavioral change, even more difficult (13).

In Ethiopia, early marriage and marriage by abduction are among the harmful traditional practices surveyed by NCTPE.

Economic factors

In many situations around the world, women are economically dependent on men. More than two-third of the world's women is illiterate and 70% live in poverty. They earn 30-40% less than men for the same work, and most of those who are working are employed outside the formal sector in jobs characterized by income insecurity and poor working conditions (19). In Ethiopia, in urban areas, women have fewer employment opportunities than men do, and jobs available do not provide equal pay for equal work (37).

In a study in India in women on low income in long term relationships, the women believed that the economic consequences of leaving a relationship that they perceived to be risky were far worse than the health risks of staying in the relationship (20). Also a study done in Ghana which attempted to examine the factors that mediated

women's ability to protect themselves from infection, the poverty experienced by many of the women during their childhood years, coupled with a societal belief that favored the education of males, restricted the respondents' educational and vocational opportunities. With limited education and few vocational skills, many of the women took boy friends to assist them with purchase of food, clothing and shelter, as a strategy for survival (21).

Due to their socio-economic conditions, some women do not have autonomy or resource of their own. Their fear that their husband may abandon them makes it difficult for many women to negotiate safe sex. For many women, sexual intercourse is not a question of choice but rather a question of survival. As a result, they have very little control over how and when they have sex. In many cases, women are not able to negotiate safer sex practices with their partners because they do not want to jeopardize the relationship. Marriage provides forms of economic and social support that would not be available to them if they were to remain single. Due to such economic imbalance, men have considerable power over women, especially when it comes to sexual relations between males and females (1).

Sexual violence

Women's ability to negotiate the timing and condition of sex with their partners is central to their ability to control a variety of reproductive health outcomes. Sexual negotiation is a process of interaction leading to the decision to have sex. It is characterized by four stages starting with normative precedents for decision making around sex and

progressing to communication, disagreement, and conflict resolution (22). Communication between partners is a key factor in achieving correct and consistent use of barrier methods. Yet, in many societies, few couples ever talk to each other about reproductive issue. The couples that do not talk are at a greater risk of STD and AIDS (23).

Women often have little control over their bodies and little decision making power; men make most decisions about when, where, and how to have sex. The fear of violence limits the ability of many women to protect themselves against HIV/ AIDS, by negotiating safe sex practices with their partners. Violence against women is linked to HIV risk in two primary ways: the biological vulnerability because of increased abrasions and vaginal dryness, and the lack of sexual communication and negotiation for risk-reducing behavior (24).

In resent study done in Zimbabwe it was showed that 26% of married women reported being forced to have sex by their partners. Another survey indicated that 78% of HIV positive women reported being forced to have sex with their partners. South African woman has a one in three chance of being raped in her life time. Such a grim context poses a significant risk of HIV infection for women and challenges the premise of most HIV prevention schemes, which assume that all individuals have equal capacity to make behavioral change (24).

Among married couples communication seems to improve contraception use. In Kenya survey, it was found that 36% of couples who communicated frequently about sex used contraception compared with 12% of women who did not communicate with their spouses (23). Both men and women in stable union face barriers to decision and use of condoms, but women are relatively more disadvantaged than men through sexual double standards, cultural prohibitions against women, economic dependence on men that limits women's negotiating ability (25).

In Ethiopia, even though studies are lacking regarding sexual violence in married life, culturally-based abuses including wife beating and marital rape are pervasive social problems (37).

The inability of women to refuse sex with their husband, even when they know that he is HIV positive has been a major cause of transmission to women. The simple fact of having various liaisons would not pose danger if women could be sure to avoid risky behaviors, but this is found to be extremely difficult. Women's lack of strong negotiation base in sexual relations is indicated by survey that showed more than four -fifth of all HIV positive women are infected by a male sexual partner, and studies in Africa and else where have shown that many married women have been infected by their only sexual partner, their husband (6).

Studies found out that man’s attitude towards contraception was largely motivated by the desire to limit family size. However, with reference to condoms as a specific method of

contraception, they are not a popular method of family planning and there is much more resistance to use. An important reason being condom to be associated with illicit sex and promiscuity. These negative attitudes are major obstacles to the development of condoms as a means of protecting against the spread of HIV especially in stable, ongoing relationships.

Voluntary counseling and testing before marriage is being practiced in some countries and communities, but in most of the cases it is not given great consideration particularly within marriage. For instance a study was done in Abidjan to demonstrate the feasibility, from the public health stand point, of preventing MTCT of HIV type 1 in Africa. 87.2% of the ANC attendant benefited from individual counseling and pre testing. Over all prevalence was 12.8%. 87.2% informed their sero status and the possibility of preventing MTCT of HIV. Most of them started treatment and completed prophylaxis (26).

OBJECTIVES

General

- To assess STIs/ HIV risk-awareness level, vulnerability, and associated factors in married women of reproductive age.

Specific

- To determine the magnitude of vulnerability to HIV infections in married women

- To assess the level of risk perception of HIV infections by married women

- To asses factors contributing to married women's vulnerability to HIV infections

MATERIALS AND METHODS

Study design

The study utilized a community based cross-sectional design on a sample of married women in Nazareth town.

Study area

The study was conducted in Nazareth town, the capital town of East Shoa zones of Oromia. There were four sub districts and twenty kebeles in the town. The number of households was 26,513, and the total population of the town was estimated to be 127, 842 of which the number of male was 61,965 and female was 65877.

According to the 1994 housing and population census report, the majority of the inhabitants were followers of Orthodox and Muslim religion. Amhara and Oromo were the dominant ethnic groups in the town. Data for married women aged 15 to 49 years of Nazareth town was not available. However,the total population of women greater than 10 years old in urban Oromia was 761,502 of which 266,786 (35%) was married (27). Nazareth is one of the towns with the highest prevalence of HIV reported. 13.6**%** prevalence was reported in women attending ANC.

Nazareth was also known for its center for high trade activities and transport hub for the roads and railway in the national and international net works.

Source and study population

All women who were married and within the reproductive age group of 15 to 49 years living in Nazareth town during the study time served as a source population. Study subjects were included from eight kebeles that were selected randomly.

Inclusion criteria

All women aged 15 to 49 years who are married, living with a husband, and having sexual relationship with a husband.

Sample size determination

To determine the sample size using the formula for a single population proportion, the following assumptions were made. Significance level of 95% (α =0.05) and a four percent margin of error was taken. Since the previous prevalence of risk behaviors among married women was not known, a 50% high risk behaviors of un-safe sexual practice is taken to obtain sufficiently large sample size, and taking non-response rate of 15% the sample size was 690. Multistage sampling technique was used. And hence the calculated sample size was doubled for design effect to obtain a total sample size of 1380.

$$n = \frac{Z^2 \alpha/2 \, P(1-P)}{d^2} + 15\% \text{ contingency}$$

where:

n = sample size

p = 0.5 (50%)

z = 1.96

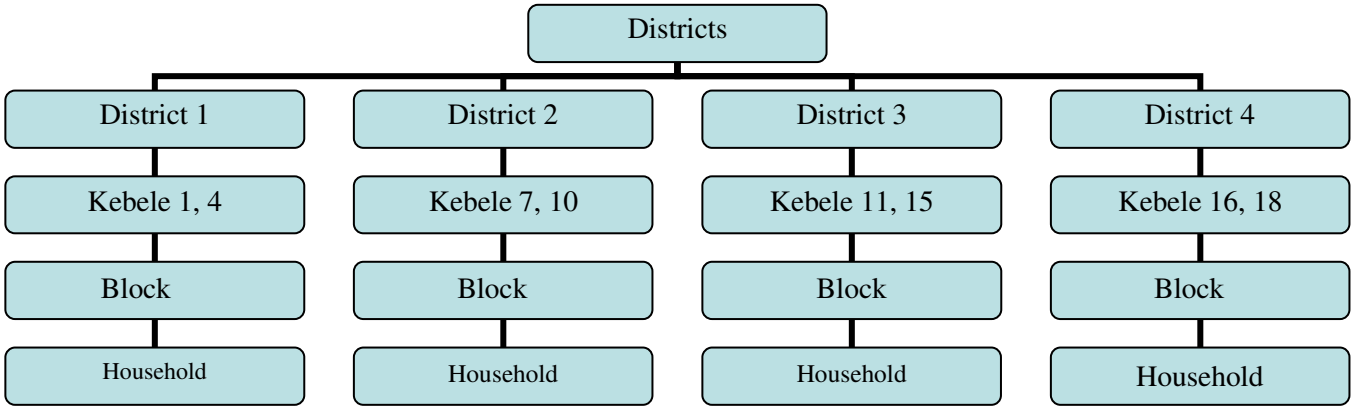
d = 0.04 (4%)

Sampling Technique

There were four sub districts (Highers) and 20 kebeles in the town. From the 20 kebeles found in the town, 2 kebeles from each higher were selected randomly. Thus, 8 kebeles were included in the study. The sample size (1380) was allocated to each kebeles according to proportional size of the population. The inclusion of eight kebeles was intended to increase the representativiness of the sample population.

Most of the kebeles in Nazareth town had blocks which were arranged in a way it could be easily identified. Thus, selection of kebeles was made randomly and blocks were selected systematically. Of the randomly selected eight kebeles seven of them were arranged in blocks and only one kebeles had a haphazardly arranged residential houses. Firstly, the total number of blocks in a given kebele counted and every other two blocks was selected for the study to reduce the risk of contamination. And then the total households to be included in a given kebele was allocated for the selected blocks after counting total number of houses in that block. Then, according to the proportional size of the number of households in the selected blocks, the number of house holds to be included for one block was determined. Then every nth household was interviewed. For the other kebeles which was not arranged in blocks, firstly, the center of the kebeles was identified by the help of the local community leader. Using bottle rotation, the direction to select the first house to be taken was identified. Then, the first household from the selected direction was the first to be interviewed. The interview continued to every third house until the required sample size was obtained. One candidate from each house holds was interviewed. When a

candidate was not present in the selected household, the next nearest household was included for replacement. Where more than one married woman was found in the selected household, a lottery method was used to select one.



Data Collection

Questionnaire was developed to collect information on socio-demographic and economic variables, indicators for vulnerability to HIV infection as well as factors for vulnerability to HIV and other sexually transmitted infections among married women

Data collectors were 7 female nurses and 5 female health assistants recruited from Adama hospital. One physician and three nurses as a supervisor were also recruited from the hospital. To check the work of the data collectors, one supervisor was assigned for two

kebeles and each supervisor assessed performance of the data collectors and corrected any problems encountered together with the principal investigator.

Three days training was given to data collectors as well as the supervisors. In the training sessions, the data collectors were oriented on the objectives of the study, how to collect data and confidentiality of information obtained. Data collection was conducted from January 7, 2003 to February 2, 2003.

Data Quality

Pre-testing was done in one kebeles which was not included in randomly selected kebeles. During the pre-testing the questionnaire was assessed for its clarity understandability and completeness. Also the sensitivity of the subject matter and pattern of response was assessed and corrections done accordingly.

On each day until the end of the study period, the trained data collectors collected data by interviewing the study subjects and fill out the questionnaire. The data collectors submitted the filled questionnaire to their respective supervisor on daily basis, and then all the collected data was checked for the completeness, accuracy and consistency by the supervisors and the principal investigator, and then corrected accordingly.

Since the nature of the questions is sensitive, each data collector was required to take adequate time for interviewing and capable enough to get the honest response of the respondents. Data quality was also maintained by minimizing the duration of data

collection and increasing the number of the data collectors. Therefore, by doing so, data contamination is assumed to be minimized.

VARIABLES

Independent

- Socio-economic characteristics of married couples
- Marital situation
- Perceived risk of HIV infection by married woman
- Sexual negotiation in married couples

Dependent variables

1. Vulnerability measured by

Reported STIs symptoms in married couples

Extra marital sexual relation ship of husband

2. Risk perception (risk-awareness level)

Operational definitions

Communication on sex: discussing on sexual matters, on timing, frequency, and other conditions like desire and satisfaction.

Conflict in negotiating: act of arguing or misunderstanding one another when negotiating.

Conflict resolution: Reaching to agreement after conflicts.

Risk perception: Worry to have been infected with HIV by married woman or fear of possible infection at any time (risk anticipation)

Sexual negotiation: Sexual communication with out conflict or sexual communication with conflict resolution.

STDs in a married woman: Reported symptom of STIs or diagnosed to have STDs in the last 12 months; at least one of these; vaginal discharge, pain during micturation or genital ulcer in married woman.

STDs in a married man: Symptoms of STIs at least one of these; urethral discharge, pain during urination, genital ulcer, or swelling around genitalia in married man in the last 12 months (reported by married woman).

Vulnerability: Vulnerability to STDs\ HIV; diagnosed to have STIs or history of reported symptoms of STD in either of the couples with or with out extra marital sexual affaires by a husband, or extra marital affairs by a husband with or with out history of STDs in either of the couples. Thus, in this study we classified a woman as vulnerable when she or her husband had either reported symptom of STDs or history of extra marital affair by her husband.

Economic dependence: Here, a woman is classified as economically dependent when a woman is not having income of her own but reported the income earned by her

husband to be sufficient for the family expenses. However, woman whose husband's income is not sufficient and also who does not have her own income was not assumed to be economically dependent on her husband.

MW/ income	**MW/ Sufficient**	**H/income suff**	**E.dependent**
Yes	Yes	Yes	NO
Yes	Yes	No	NO
Yes	No	Yes	**YES**
Yes	No	No	NO
No	No	Yes	**YES**
No	No	No	NO

Data Entry and Analysis

Data was entered, cleaned and analyzed using EPI-INFO version 6 and SPSS version 10 statistical package. Frequencies and proportions of all variables were determined. Cross tabulations were done to observe associations between the dependent and independent factors. The X^2 – test and odds ratio with 95% confidence interval were calculated to describe associations between variables. Possible effect of confounders has been controlled using simple logistic regression.

Ethical considerations

The study was done with the informed consent from the study participants. Study subjects were included in the study voluntarily after being informed about the objective and the confidentiality of the study. Ethical clearance was obtained from Addis Ababa University Faculty of Medicine through Department of Community Health. Maximum efforts were done to keep confidentiality of the information during data collection by limiting access to the study team only.

RESULTS

Socio-demographic and economic back ground of married women

Of the total calculated 1380 sample size the responses of 1276 (92.4%) respondents was analyzed. 32 (2.5%) respondents were not available at the time of visits despite repeated visits. Also the responses of 72 (5.6%) interviewed women were analyzed for there was considerable inconsistencies in responses.

The majority, 1018 (79.7%) were in the age group 20-39 years. Amhara was the dominating ethnic group (42.3%) followed by Oromo (31%). Orthodox Christianity was dominant religion accounting for 67.9% followed by Islam 21.8%, the rest 11.8% were other religious followers. Almost 50% of the respondents were illiterate or attended only elementary school. only 5.8% of the respondents attended higher education. Majority in this study, 79.5%, were house wives. As regards to the economic situation of married women 1011 (79.2%), reported not to have getting income of their own. Of those women (265) who were getting monthly income, almost two third of them were earning less than the mean monthly income which was 250 to 500 birr. The majority who reported to have been getting income of their own claimed the amounts they were getting was not sufficient to satisfy their economic need without their husband income added (Table 1)

History of STDs in married couples in the last 12 months

Of the total respondents, 342 (26.8) married women were believed to be vulnerable. That is, they either had symptom of STDs or history of husband's extra marital sexual

relationship in the last 12 months. Of these women who were believed to be vulnerable, a significant proportion (66.1%) did not consider them selves to have been at risk.

172 (13.5%) married women reported to have lower abdominal pain, 157 (12.3%) vaginal discharge, 32 (2.5%) genital ulcer, 140 (11.0%) pain during urination, and 57 (4.5%) diagnosed to have STDs. Those who reported to have symptom of STDs (216), had one or more symptom of STDs in the last 12 months. As a result, reported STDs prevalence in married women was 16.9%. Regarding STD symptoms in respondents husbands', even though many of married women claimed they did not know whether their husbands had symptoms of STDs or not, some of them who for sure know their husbands' STD situation responded. According to the report by married women, 3.2%, 2.3%, 2.0%, 1.1%, and 1.65% of married men were having urethral discharge, genital ulcer, pain during urination, and swelling around genital area respectively (Figure 1).

Sexual experience of married couples

33.9% (423) of married women admitted to have pre marital sexual affairs. Only 13.9% reported to have used condom consistently in all occasions. 30 (2.3%) admitted they had extra marital sexual relation ship. Almost fifty percent of the relation ships were within the last 12 months. And only 9 (28%) used condoms consistently in all occasions.

Regarding sexual experiences of their husbands, there are uncertainties with almost three fifth of the women regarding their husbands' faithfulness to marriage. However, according to the claim by those women who were certain to know about their husbands' sexual history before as well as after marriage, 699 (54.8%) of the respondents' husbands had sexual partner before getting married of whom only 9.9% used condom consistently in all occasions of sexual intercourses. 119 (9.3%) had sexual partner other than their wives. 98% of this were in the last 12 months. Only 8.1% used condom consistently in all occasions (Figure 2).

In examining the association of some selected socio-economic variables with vulnerability, ethnicity, religion, age and education were not found to be significant.
On the other hand, being a housewife was found to have a statistical significance at OR and AOR 3.57 (1.42, 10.0) and 5.21 (2.01, 13.4) respectively by both bivariate and multivariate analysis. Regarding the association of economic status of married women with vulnerability, earning own regular income and the amount of monthly income earned was not found to be significant. Unexpectedly, married women who reported the total amount of income earned by both when added or by the husband alone, to have been sufficient, found to be more vulnerable compared to women who claimed the total income not to have been sufficient. However, this association failed to be statistically significant when other economic factors were controlled. But, more importantly, regardless of a woman having income of her own or not, being fully dependent on husband's income was found to be statistically significant at OR 17.7 and AOR 26.1 with CI of 13.5 to 34.7 and 15.1 to 55.2 respectively. (Table 3)

Table 1: Socio-demographic and economic back ground of married women. Nazareth, January 2003.

Variable	Number	Percent
Age (n= 1276)		
15-19	64	5.0
20-39	1018	79.8
≥ 40	194	15.2
Ethnicity (n=1276)		
Amhara	540	42.3
Oromo	396	31.0
Other	340	26.7
Religion (n=1276)		
Orthodox	866	67.9
Muslim	278	21.8
Other	132	10.3
Education (n=1276)		
Can not read and write	322	25.2
Only read and write	30	2.4
Grade 1-6	209	16.4
Grade 7-11	424	33.2
Grade 12	217	17.0
12 plus	74	5.8
Occupation (n=1276)		
Housewife	1014	79.4
Govt. org. employee	130	10.2
Private business	96	7.5
Other	36	2.9
Regular income (n=1276)		
Yes	265	20.7
No	1011	79.2
Monthly income (n=265)		
<250 Birr	95	35.8
250-499 Birr	62	23.4
500-749 Birr	69	26.0
750-999 Birr	23	8.8
≥1000 Birr	16	6.0
Woman's income		

Sufficient (n=265)		
Yes	57	21.8
No	208	78.2
Total income sufficient		
Yes	712	55.8
No	564	44.2

Marriage characteristics

Regarding the duration of marriage, almost two third (72.7%) of currently married women were in married life for 14 years and less. The dominant age range of age at first marriage was from 15 years to19 years and two fifth (42.1%) of them married at less than 18 years. Almost a quarter of women (22.7%) were either forced to marry with out their willingness by parents, relatives or a spouse, or their marriage decisions were motivated for securing their financial situation. (Table 2)

Whether association exists between vulnerability and either of motivation to get married other than affection or forced to marry was analyzed by both bivariate and multivariate analysis. Women who were married to satisfy their economic needs or were forced to marry were 2.43 and 2.08 times more likely to be vulnerable to STDs/HIV infection compared to women whose the only motivating factor to have been married was affection to their spouse (95%CI (OR) 1.18, 3.22 and 95% (AOR) 1.49, 2.94 respectively). Age at first marriage was not found to be associated with vulnerability to HIV infection. (Table 3).

Regarding the risk perception level of vulnerable married women, both age at first marriage and being motivated for marriage other than love or forced to marry, were found to be significantly associated with not perceiving risk while vulnerable. (Table

Table 2: Marital condition of married women. Nazareth, January 2003.

Variable	Number	Percent
Duration of marriage (n=1276)		
<5 years	302	23.7
5-9 years	371	29.1
10-14 years	255	20.0
>15 years	348	27.3
Age at first marriage (n=1276)		
<18years	537	42.1
≥18 years	739	57.9
Married willingly (n=1276)		
Yes	1100	86.2
No	176	13.8
Reason for marriage Without willingness (n=176)		
Parent's influence	134	76.1
Abduction	17	9.7
Spouse's influence	14	8.0
Relative's influence	11	6.2
Motivation for marriage (not for love) (n=1100)		
Yes	119	10.8
No	981	89.2
Reason for motivation (n=119)		
For financial security	114	95.7
Other	5	4.3

Contraception preference and attitude on condom by married couples

Fifty three percent of married women used modern contraception in the last 12 month. Higher proportion of them (54.2%) recommended condom for any couples including married ones; nevertheless, only 4.4% used it as contraceptives. The majority (86.8%) gave their reasons for recommending condom by justifying that condom, unlike most other methods is able to protect a woman both from pregnancies and infections. Other few reasons mentioned were low health risk of condom and its convenience. On the other hand of those who do not recommend it, the dominant reasons for not recommending condom were either they do not like it, or asking a husband to use condom rather raises suspicions of being infidel or the wife might have been caught by HIV \AIDS. Among other few reasons given was easily availability of other methods, less effectiveness of condom, and transmission of HIV through condom (Table 5).

Table 3: Association of married women's vulnerability to STDs/HIV infection with some selected variables, Nazareth, January 2003.

Variable	Vulnerability to HIV Yes	No	Crude OR (95%CI)	Adjusted OR (95%CI)
Negotiation on sex				
Yes	99	358	1.00*	
No	243	576	1.37 (1.05,1.80)	1.09 (0.80, 1.50)
Motivated or forced to marry				
Yes	120	170	2.43 (1.18,3.22)	2.08 (1.49,2.94))
No	222	764	1.00*	
Economic dependence				
Yes	127	30	17.7 (13.5,34.7)	26.1 (15.1,55.2)
No	215	904	1.00*	
Age at first marriage				
<18 years	154	383	1.18 (0.91,1.52)	1.11 (0.81,1.51)
≥18 years	188	551	1.00*	
Regular income				
Yes	54	131	1.15 (0.80,1.64)	1.01 (0.45,2.26)
No	288	803	1.00*	
Total income sufficien				
Yes	174	538	1.31 (0.01,1.69)	1.63 (1.01,2.04)
No	168	396	1.00*	
Education				
Only read and write	179	391	1.22 (0.67,2.30)	1.96 (0.80,4.0)
Grade 1-6	50	118	1.13 (0.58,2.27)	1.36 (0.57,3.22)
Grade 7-11	95	377	0.67 (0.36,1.29)	0.9 (0.46,2.08)
12 and above	18	48	1.00*	
Occupation				
Has job	85	177	1.14 (0.74,1.62)	0.99 (0.42,2.22)
Housewife	257	757	1.00*	

Sexual negotiation between married couples

Five hundred three (39.4%) of married couples had practice of communicating on sex. In fifty percent of married couples communication on sex was initiated by husband alone. Less than 50 percent of couples equally initiate communication on sex. Of the 503 couples who communicate on sex, 103 (21.6%) had conflict during time of negotiation of which 4.9% disagree always, 32.0%, most of their time, and 63.1% occasionally. In couples (103) in whom there were conflicts when communing on sex, 10.3% reach to solution always, 44% most of the time, 34.0% occasionally, and the rest 10.7% have never reached to conflict resolution. (Table 4)

Women who had no practice of negotiating on sex with their husbands were found to be more vulnerable compared to those women who had practice of sexual negotiation, with a statistical significance (OR (95% CI): (1.37 (1.05, 1.80)) by a bivariate analysis. However, the association lost its significance when adjusting for other variables. (AOR (95% CI): (1.09 (0.80, 1.50)). (Table 3)

Table 4: Practice of sexual negotiation between married couples. Nazareth, January 2003.

Variable	Number	Percent
Communication on sex (n=1276)		
Yes	503	39.4
No	773	60.6
Initiation of Communication (n=477)		
Only husband	240	50.3
Only wife	36	7.5
Both	201	42.1
Ever conflict during s Sexual communication (n=477)		
Yes	103	21.6
No	374	78.4
Frequency of conflict During negotiation (n=103)		
Always	5	4.9
Most of the time	33	32.0
Occasionally	65	63.1
Frequency of conflict Resolution (n=103)		
Always	11	10.7
Most of the time	46	44.7
Occasionally	35	34.0
Never	11	10.6

Risk perception of HIV infection by all married women

Two hundred six (16.1%) married women responded to have been worried of being infected with HIV. The majority (95.6%) have been worried in the last12 months. 60.2% feared that they might have been infected through sexual route. The reasons given for their worry were, their husbands' were not faithful for their marriage and because they were not sure of their husbands' sero status to HIV from the very beginning. Only few doubted they themselves might have been carrier of the virus. The rest 39.2% incriminated their fear of being infected to other different reasons other than sexual route. The dominating reason given by them were; contamination by injection at health institutions, delivery at hospitals, injury at home by sharp objects and when giving care for member of a family who were infected with HIV.

295 (23.1%) married women were pregnant in the last 12 months. 26 (8.8%) of them worried of mother to child transmission. But the majority, 12 (84.6%) decided to proceed with the pregnancy and gave birth. Of those who perceived risk (pregnant as well as non pregnant), only 32 (2.5%) of them were able to use condoms consistently, and none of them abstained from sex or took any other measure. Regarding voluntary counseling and testing before marriage, 63 (4.9%) married couples made VCT before getting married. Of married women who were asked whether they will be willing for future VCT if assumed necessary, the majority 1023 (80.2%) were responded to be willing. (Table 5).

Table 5: Risk perception to HIV infection and attitude on condom to be used as contraception by married women. Nazareth, January 2003.

Variable	Number	Percent
Ever worried of being Infected (n=1276)		
Yes	206	16.1
No	1070	83.9
Worried in the last 12 Months (n=206)		
Yes	197	95.6
No	9	4.4
Reason for worry (n=197)		
Husband infidelity	50	25.4
Not sure of husband's previous sero status	46	23.4
Not sure of self sero status	14	7.1
Other	87	44.1
Ever been pregnant (last 12 months) (1276)		
Yes	295	23.2
No	981	76.8
Worried of mother to child transmission (n=295)		
Yes	26	8.8
No	269	91.2
Measures taken to prevent transmission to child (n=26)		
Continued with the pregnancy	25	96.2
Terminated the pregnancy	1	3.8
Condon accepted by a woman (n=1276)		
Yes	691	54.2
No	585	45.8
Condom by husband (n=1276)		
Yes	584	45.8
No	692	54.2

Figure 1 Reported symptoms of STIs in married women

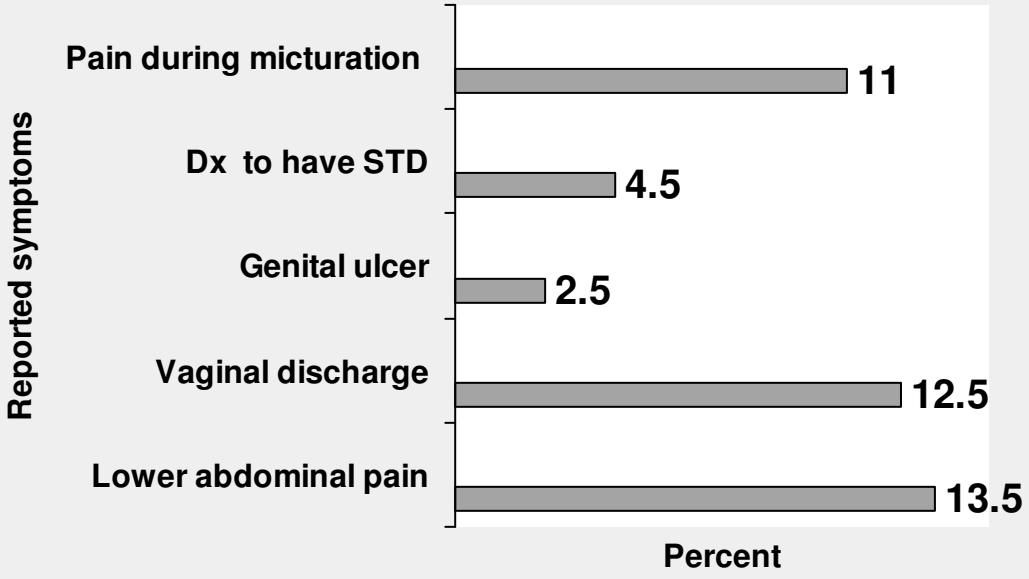
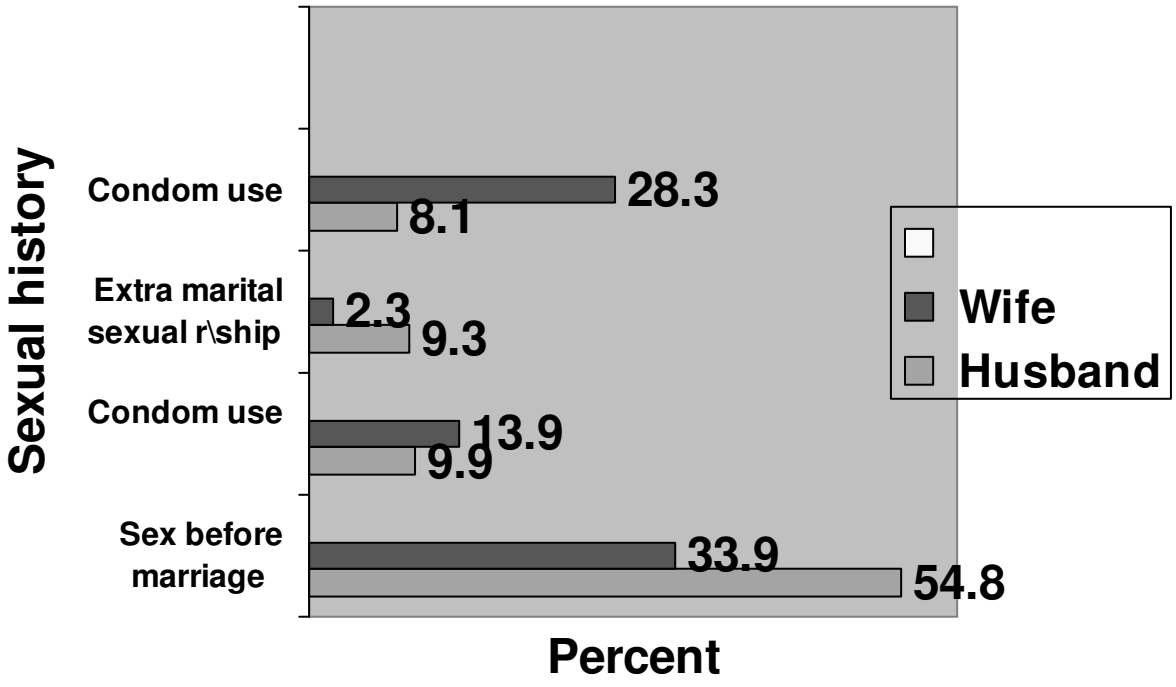


Figure 2 Sexual history of married couples. Nazareth, January 2003



DISCUSSIONS

Significant proportions of married women (26.8%), were believed to be vulnerable to HIV infection. And also, greater than two third of these vulnerable women did not consider them selves to have been at risk.

This study revealed vulnerability to be more in married women who were dependent on their husbands' income. Also, such women, in addition to have been vulnerable, they were found to have lacking knowledge of being at risk.

It is known that most of the world women are poor and most of the world's poor are women. They earn 30-40% less than men for the same work, and most of those who are working are employed outside the formal sector in jobs characterized by income insecurity and poor working conditions (19). Women's economic vulnerability and dependence on men increase their vulnerability to STDs and HIV infection by constraining their ability to negotiate the use of condom, discuss fidelity with their partners, or leave risky relationships. An evidence of this could be a study of women on low income in long term relationships in Mumbai, India. The women believed that the economic consequences of leaving a relationship that they perceived to be risky were far worse than the health risks of staying in the relationship (20). Also a study done in Ghana which attempted to examine the factors that mediated women's ability to protect themselves from infection, the poverty experienced by many of the women during their childhood years, coupled with a societal belief that favored the education of males, restricted the respondents' educational and

vocational opportunities. With limited education and few vocational skills, many of the women took boy friends to assist them with purchase of food, clothing and shelter, as a strategy for survival. For most women, the use of condoms with sexual partners was restricted by the women's limited ability to influence decision making in this area.

An economically disadvantaged woman has little say in sex issue and obviously is less likely able to recognize the consequences of unsafe sex. Several studies done for various aim revealed house hold expenditure per capita to be highly affecting reproductive health status of women in general.

Women who depends on their husband for financial security are likely to be uneducated, thus likely to lack knowledge of consequences of unsafe sex practice. Uneducated women are likely to be unemployed the factor which make them more dependent on their husband to fulfill their families economic need. This as well will give a man the opportunity to be ominant over a woman in every aspect, which denies a woman her sexual decision making ability. And, more over such women would likely be patient and tolerant to their husbands' misbehaviors, infidelity, and other abuses.

Women who were married to secure their financial need and those who were married with out their willingness were also found to be more vulnerable to HIV infection and more likely to be unaware of being at risk. This obviously goes with the association of economic dependence to women's vulnerability, for it is likely that women who are forced to marry by parents or motivated to marry for financialsecurity are likely to be unemployed and

likely to be uneducated. Such women may be unaware of their risk status and possibly might lack the. However, the lack of knowledge (not to perceive risk while the woman is at risk) alone does not prove woman to be more vulnerable. These is because high proportion of women in this study, even if they knew condoms to be protecting from HIV infection and pregnancy, only 4.4% used them as contraceptives. This could reflect no matter a woman is conscious about risk of infection and knowledgeable enough to know how to minimize risk, as long as she is in a marriage bond, her chance of risk minimizing could be likely to be low as compared to those women who are not tightened with marriage obligations.

Though not found to be statistically significant by multi-variate analysis, sexual negotiation was showed to be protecting married women from being vulnerable. This is in agreement with other studies done elsewhere in Africa. For instance one survey showed that four fifth of HIV positive women are infected by their only sexual partner, their husband (10). Also in a survey done in Kenya it was found that 36% of couples who communicated on sex used contraception compared to 12% of women who did not communicate with their spouse (13).

More than two third (60.2%) of women who feared they could be at risk mentioned the reason for their fear to be their husbands' infidelity. This finding supports the study finding in Uganda that 30% of surveyed women believed them selves to be at risk because they could not stop their partners from having sex with other, while in Belize 68% of women believed the same (13). In India in a study of married and monogamous

women at STD clinics found a high rate of HIV and other STDs in this apparently low risk groups. The strongest predictor for HIV infection among these women was having a husband who has been diagnosed with STD. For instance in Mozambique, the over all rate of HIV infection_among young married women (15%) was twice that of younger men of their age not because the girls are married earlier , but forty percent of them married to much older , sexually experienced men who expose their wives to HIV (6).

Also, in this study 9.3% of married men as reported by their wives were having extra marital sexual relation ship. Lack of similar study in the subject had made it difficult to make adequate comparisons of findings. Even if not adequate enough to compare, one study done in South Africa showed prevalence of extra marital relation ship to be 3%, which when compared with our finding is very low (28), and the prevalence of extramarital sexual relation ships could be as high as 52% as in it was in Colombia (10).

When we looked at the prevalence of STDs in married women, it was found out to be 16.8%. Here it should also be noted that 60% to 70% of gonococcal and Chlamydial infections in women are asymptomatic and thus it is likely for this finding to have been under estimated. Though community based prevalence survey of STDs in married women is lacking in this country, in a study conducted in other developing country similar proportion, that is 15% ,of women examined had either syphilis or gonohorria.

Generally, HIV\ AIDS now is posing the foremost threat to Ethiopian development. The epidemic is systematically undermining the countries effort to reduce poverty. It is also costing Ethiopia significantly in its economic growth, further reducing the scope for poverty alleviation. For this and other reasons, it was realized not to view HIV\AIDS as merely one among many competing priorities in the nation's development (29,30).

The government of Ethiopia approved a comprehensive HIV\AIDS policy to provide an enabling environment for a multi-sectoral approach for the prevention and control of the epidemic. Among the policy objectives one is to empower women to take action to protect them selves against HIV/ AIDS. Also in the Ethiopian Constitution there are articles that protect the right of women against physical and mental brutalities, and also the right of women to choose her partner.

Among the strategies proposed are increasing the awareness of women through different women organizations so that they can fight for their own rights, increasing the awareness level of men to support reinforcement of the right of women, and support activities initiated to avoid economic dependence of women.

This findings document economic factor to be influencing married women's vulnerability to HIV infection. The countries policy and strategic frame work environment support and protect women against vulnerability to HIV infection. However, despite a government policy and proposed strategies to empower women,

initiatives and big efforts were not seen exerted to change the proposed plans into action. These strategies are obviously very important for all women in general. But also, in addition to this, targeting married women is important in particular.

Vulnerability in women include biological, social and economical. HIV vulnerability reduction strategies need to be designed to address these underlying factors which are believed to influence women vulnerability to HIV infection. Previous prevention efforts for women have been based on the unrealistic trilogy. And yet, more than twenty years into the AIDS pandemic, the favored strategies for primary prevention of HIV continue to focus on encouraging the unrealistic trilogy of abstinence, mutual monogamy, and male condom use. These messages have little relevance for the majority of women at risk; even less for those in resource poor settings. In spite of best efforts made in some countries, there are still millions of women who are simply unable to implement any of the current prevention strategies. As a result, infections among women are rising, and in some cases surpassing rates for men.

There fore, it is a must to expand the range of strategies and tools available to women for protecting themselves. Education, economic and social empowerment, and the transformation of gender roles and norms that limit women's autonomy and decision-making are all critical. But these strategies are long-term. In the meantime it is possible to add existing and emerging strategies, giving women the means to protect themselves, their children and their partners from the devastating disease.

It is also beneficial to assess initiatives being undertaken in other countries with similar problem and adopt them if found to have been successful and feasible in our setting.

For instance, in light of statistics showing AIDS as the No. 1 killer of women of child bearing age in Sao Paulo state Brazil, public health officials launched a campaign in 1999 promoting the female condom. The hopes that it will help women - especially poor women – protect themselves and their children. But the problem with female condom was its high price. There was efforts done by the Family Health Association in asking the government to help subsidize the product and to cut the taxes on condoms that makes them out of reach of many poor Brazilians. In addition to this, the previous studies done showed the high acceptance of this method because it is a product under the control of women.

According to the WHO, Global Sector Strategy for HIV/AIDS, existing family planning program, provide a clear entry point for the delivery of HIV/AIDS interventions. WHO, the World Bank, the European Union, and USAID, all strongly support integrated prevention strategies. The best approach according to the WHO is to invest heavily in integrated HIV and family programs that offer a range of services, including efforts to increase access to and use of male and female condoms and other contraceptive methods; training in partner communication and negotiation; access to voluntary counseling and testing; and programs to address sexual violence and coercion, among other things. .

Despite the overwhelming evidence of the marital unit as a significant locale for transmission for women through out the world, there have been little efforts to explore the marital relationship as a focus for intervention in the prevention of HIV.

Another instance was the initiatives by the support groups like the Garisol Foundation, who urged the Colombian government to take series action in behalf of married women, the category that was once considered almost risk free.

In Ethiopia, the constitution provides for the equity of women; however, these provisions often are not applied in practice (37). Therefore, there is a need for the government of Ethiopia to fully put into place mechanisms for the effective enforcement of these protections.

In addition to this, HIV prevention strategies also need to target married women. It is also important, in addition to sharing other countries experiences, if information could be gained through research about the formative base for the development of risk reduction interventions for married women and couples and feasibility and acceptability of joint husband-wife approaches to risk reduction.

STRENGTH OF THE STUDY

1. Using health professionals as data collectors in community based survey could possibly made the obtained results more valid. More over, refusal to respond to sensitive questions was believed to be minimized.
2. Use of married women as study subjects in relation to HIV to be the first in its type in the country.

LIMITATIONS OF THE STUDY

1. The study touch sensitive issues, therefore there could be possibility of under reporting of sexual behaviors by married women
2. Sexual history of married men, reported by their wives could possibly be under reported or over reported.
3. Possibility of social desirability bias might have affected responses for some questions for health professionals were used as data collectors.
4. Lack of similar study in the country to compare results.

CONCLUSIONS

1. Significant proportion of married women is vulnerable to STDs/HIV infection for practice of safe sex among married couple is low.
2. Economic dependence on their husband and social pressure make married women more vulnerable to HIV infection.
3. The majority of married women do not think they could be at risk of acquiring HIV infection while they are at risk.

RECOMMENDATION

1. Strong commitment is needed from government to empower women economically through education, and women should be given job opportunity.
2. Responsible bodies should design a strategy to reach married women in creating awareness on need of safe sex practices in married life, the association of STDs and HIV infection and on other risky sexual behaviors
3. Education for married men on the need for safe sex practice in married life.
4. Strongly discouraging extra marital sexual acts by men and encouraging faithfulness and share responsibility in married life through family life education.

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ADDIS ABABA UNIVERSITY

MEDICAL FACULITY

DEPARTMENT OF COMMUNITY HEALTH

A questionnaire prepared to assess married women's vulnerability to HIV infection and factors contributing for their vulnerability

Individual consent form

Dear Madam

We came from Addis Ababa University Department of Community Health. We are conducting a survey in Nazareth town to asses HIV vulnerability of married women. Married women in this study are selected randomly. For this purpose certain questions which are thought to be important will be asked. You are kindly required to respond to these questions. We want to assure you that your answers will be strictly kept secret. We will also do not keep a record of your name or address. You have the right to refuse participation at any time or not to respond to questions that you are not willing to answer. Your participation is completely voluntary but your experiences could be very helpful. Thus once again assuring you that your responses will be kept confidential, we request your keen participation in this study.

ƛ Agree to participate

ƛ Does not agree to participate

PART I: Socio-demographic and economic characteristics of respondents

Ser. No	Questions	Responses	Code
101.	How old are you?	-------- years	
102.	To which ethnic group do you belong?	1.Oromo 2.Amhara 3.Gurage 4. Tigre 5.Other (specify)	
103.	What is your religion?	1.Orthodox 2.Muslim 3.Protestant 4.Catholic 5.Other (specify)	
104.	Can you read and write?	1.Yes 2.No------ (skip to **Qes**.106)	
105.	What is the highest education level you have attained?	1.Only read and write 2.Grade (completed) ------- 3.Collage or university graduate------- 4.Other (specify)-------	
106.	What is your occupation?	1.House wife 2.Private business------- 3.Government employee 4.Non government employee 5.Daily laborer 6.Other (specify)-------	

107.	Do you earn regular monthly income?	1.Yes 2.No	
108.	How much do you get monthly? (in Ethiopian birr)	1.<250 2.250-499 3.500-749 4.750-999 5.1000-1500 6.>1500	
109.	Do you think the amount of money you get sufficient for you and your family?	1.Yes 2.No	
110.	What is your husband's occupation?	1.Has no job 2.Private business------- 3.Government employee 4.Non government employee 5.Daily laborer 6.Pension 7.Other (specify)-------	
111.	Does your husband earn regular monthly income?	1.Yes 2.No	
112.	What is the amount of income earned by your husband every month? (in Ethiopian birr)	1.<250 2.250-499 3.500-749 4.750-999 5.1000-1500 6.>1500 7.Do not know	
113.	Is the total family income sufficient to cove living expenses?	1.Yes 2.No	
114.	Do you have children?	1.Yes 2.No	

115.	How money children do you have?	----------	

SECTION

II: Marital situation of the respondents

Ser. No	**Questions**	**Responses**	
201.	How long is this marriage?	------- year(s)	
202.	Had you been married before?	1. Yes 2. No------(skip to **Qes.** 204)	
203.	How old were you when you first get married?	------- years	
204.	How old were you when you currently get married	------- years	
205.	How old was your husband when you get married?	------- years	
206.	How old is your husband now?	------- years	
207.	Where is your work place?	1.Inside the town 2.Out side the town	
208.	How often do you usually be away from home for work or for any other reason?	1.At least once in a week 2.At least once in a month 3.At least once in 3 months 4.At least once in 6 months 5.Occasionally 6.Never	
209.	Where is your husband's work place?	1.Inside the town 2.Out side the town	
210.	How often does your husband usually be away from home for work or for any other reason?	1.At least once in a week 2.At least once in a month 3.At least once in 3 months 4.At least once in 6 months	

		5.Occasionally 6.Never	
211.	Does your husband have another marital relationship?	1.Yes 2.No	
212.	Was this marriage happened by your willingness?	1.Yes------ (skip to **Qes.**214) 2.No	
213.	If the marriage was with out your decision, what was the reason for you for getting married?	1.Forced by parents 2.Forced by relatives 3.Forced by spouse 4.Abducted 5.Other (specify)_	
214.	Was the decision to get married motivated by other factors other than love?	1.Yes 2.No------ (skip to **Part** III)	
215.	What was the motive(s)?	1.Unintended pregnancy 2.To be supported financially] 3.Acadamic failure 4.Other------(specify)	

SECTION III: Contraceptive preference and attitude on condom by married couples

Ser No.	**Questions**	**Responses**	**Code**
301.	Have you ever used modern contraception in the last 12 months?	1.Yes 2.No	
302.	Have you used them regularly?	1.Yes 2.No	
303.	Which contraceptive have you used?	1.Oral pills 2.Injectebles 3.IUDs	

		4.Diaphragm 5.Condoms 6.Female surgical sterilization 7.Male surgical sterilization 8.Other	
304.	Is a condom accepted as contraception by your husband?	1.Yes 2.No	
305.	Do you recommend condom for contraception for married couples?	1.Yes 2.No	
306.	If yes, what could be your reason?	1.Because condom prevent both from pregnancy and infection 2.Because condom has less health risk 3.Because condom need not necessarily be taken daily 4.Othe (specify)------	
307.	If no, what could be your reason?	1.Because other methods are easily available 2.Because condom is less convenient to use 3.Because condom decreases pleasure during sex 4.Because asking husband to use condom raises suspicions by him that the wife might have STIs or HIV 5.Because if a husband asks the wife to use condom she would	

		suspect him that he might have STD or HIV 6.Other(specify)------	

SECTION IVulnerability of married women to HIV infection

Ser No.	Question	Responses	Code
401.	Have you had the following symptoms in the last 12 months?	Lower abdominal pain 1.Yes 2.No Excessive vaginal discharge 1.Yes 2.No Ulcer around genital area 1.Yes 2.No Burning pain during micturation 1.Yes 2.No Diagnosed to have STD 1.Yes 2.No	
402.	Did your husband have the following symptoms in the last 12 months?	Urethral discharge 1.Yes 2.No Ulcer around genital area 1.Yes 2.No Burning pain during Urination 1.Yes 2.No Swelling around Genitalia 1.Yes 2.No	

		Diagnosed to have 1.Yes 2.No STD	
403.	Have you had sexual affaire before you get married?	1. Yes 2.No 3.Do not know	
404.	Have you used condom in all occasions?	1. Yes 2.No 3.Do not know	
405.	Have you had sexual affaire other than your husband after you get married?	1. Yes 2.No 3.Do not know	
406.	Was this sexual affair within the last 12 months?	1.Yes 2.No 3.Do not know	
407.	Have you used condom in all occasions?	1.Yes 2.No 3.Do not know	
408.	Did your husband have sexual affaire before getting married?	1.Yes 2.No 3.Do not know	
409.	Do you think he has used condom in all occasions?	1.Yes 2.No 3.Do not know	
410.	Did your husband have extra marital sexual relation ship?	1.Yes 2.No 3.Do not know	
411.	Was the extra marital sexual affair within the last 12 months?	1.Yes 2.No 3.Do not know	
412.	Do you think he has used condom in all occasions?	1.Yes 2.No 3.Do not know	

SECTION V: Sexual negotiation between married couples

Ser No.	Questions	Responses	Code
501.	Were you having a practice of communicating on sex with your husband?	1.Yes 2.No	
502.	Who usually initiate discussion on sexual matters?	1.My husband alone 2.I myself alone 3.Both of us	
503.	Have there been any disagreements when you discuss on sexual matter?	1.Yes 2.No	
504.	How frequent do you usually conflict?	1.Always 2.Usually 3.Occasionally	
506.	How often do you reach to conflict resolutions?	1Always 2.Most of the times 3.Occasionally 4.Never	
507.	Do you discuss about family planning with your husband?	1.Yes 2.No	
508.	Do you discuss about risk of HIV infection?	1.Yes 2.No	
509.	Do you discuss about being trustful for marriage?	1.Yes 2.No	

SECTION VI: Risk perception of married women to HIV infection

Ser No.	Questions	Responses	Code

601.	Have you ever been worried that you might have been infected with HIV?	1. Yes 2. No 3. Have not thought of it	
602.	Was the worry in the last 12 months?	1. Yes 2. No	
603.	If you have been worried what made you to worry?	1. Yes 2. No	
604.	Have you been pregnant in the last 12 months?	1. Yes 2. No	
605.	Have you been worried transmission of HIV to the fetus?	1. Yes 2. No 3. Have not thought of it	
606.	If you have been worried what measure have you taken?	1. Decided to continue with the pregnancy 2. Considered pregnancy termination but continued with the pregnancy 3. Attempted termination but failed 4. Terminated the pregnancy	
607.	Have you used condom with your husband in the last 12 months?	1. Yes 2. No	
608.	Have you used them regularly?	1. Yes 2. No	
609.	For what purpose have you used them?	1. For contraception 2. To be protected from infection 3. Other (specify)--------	
610.	Have you and your husband had voluntary counseling and testing for HIV before you get married?	1. Yes 2. No	
611.	Have you been abstained from sexual	1. Yes	

	intercourse to get protected from STD\HIV infection in the last 12 months?	2. No	

To be filled by the interviewer

Code of the questionnaire----------

Name of the interviewer----------

Signature of the interviewer----------

Date of the interview----------

To be filled by the supervisor

Name of the supervisor----------

Questionnaire Complete----------

Incomplete--------

Incorrect parts ---------- ---------- ----------

---------- ---------- ----------

Corrections to be made---------- ---------- -------

አዲስ አበባ ዩኒቨርስቲ ህክምና ፋኩሊቲ
<u>የህብረተሰብ ጤና ትምህርት ክፍል</u>

ያገቡ ሴቶች በኤች አይ ቪ ያላቸው የተጠቂነት ሁኔታ እና በበሽታው ላለመያዝ የሚወስዷቸው እርምጃዎች ለማጥናት የተዘጋጀ መጠይቅ ኢትዮጵያ ታህሣስ 1995 **ዓ/ም**

<u>የስምምነት ቅጽ</u>

ውድ እመቤት

እኛ የምንሰራው በአዲስ አበባ ዩኒቨርስቲ የህብረተሰብ ጤና ትምህርት ክፍል ነው። ያገቡ ሴቶች በኤች አይ ቪ ኤድስ ያላቸውን የተጠቂነት ሁኔታና በእነዚህ ሴቶች በበሽታው ላለመያዝ የሚወስዱት እርምጃዎችን ለማወቅ በናዝሬት ከተማ ጥናት እያካሄድን ነው። በዚህ ጥናት የሚካተቱት አጋጣሚ የተመረጡ ባለትዳር ሴቶች ሲሆኑ ለዚህ ዓላማ ሲባል የተዘጋጁትን ጥቂት ጥያቄዎች በመመለስ እርስዎ እንዲተባበሩን እንጠይቃለን። የሚሰጡት መልስ በሚስጥርነት የሚያዝ ሲሆን ስም ሆነ አድራሻ ተመዝግቦ አይያዝም። በጥናቱ ያለመሣተፍ መብትዎ የተጠበቀ ሲሆን እንደዚሁም በማንኛውም ጊዜ አለመሣተፍና መልስ ሊሰጡባቸው የማይፈልጉ ጥያቄዎች ካሉ አለመመለስ ይችላሉ። ምንም እንኳን ጥያቄዎቹ የግል ሕይወትዎን የሚዳስሱ ቢሆኑም እውነተኛና ትክክለኛ መልስዎን እንዲሰጡን በአክብሬት እንጠይቃለን። በጥናቱ መሣትፍዎ ሙሉ በሙሉ በእርስዎ በጎ ፈቃደኝነት ላይ የተመሰረተ ቢሆንም ነገር ግን የህይወት ልምዶችን ማካፈሉ በእጅጉ ጠቃሚነት ይኖረዋል። በድጋሚ የሚሰጡት መልስ በሚስጢርነት እንደሚያዙ እያረጋገጥን በጥናቱ እንዲሣተፉ ፈቃደኝነትዎን እንጠይቃለን።

☐ **ለመሣተፍ ፈቃደኛ ነኝ**

☐ **ለመሣተፍ ፈቃደኛ አይደለሁም**

ክፍል አንድ፡ <u>የኢኮኖሚ ዲሞግራፊያዊና ማህበራዊ መረጃ</u>

ተ.ቁ	ጥያቄ	ምላሽ	ኮድ
101	እድሜ		
102	ብሔርዎ ምንድን ነው?	1. ኦሮሞ 2. አማራ 3. ትግሬ 4. ጉራጌ 5. ሌላ (ይቅጠሱ)	
103	ሃይማኖትዎ ምንድን ነው?	1. ኦርቶዶክስ 2. እስላም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ (ይቅቀሱ)	
104	ማጸፍና ማንበብ ይችላሉ?	1. አዎን 2. የለም (ወደ ጥያቄ 106)	
105	የትምህርት ደረጃዎ ስንት ነው?	1.	
106	ስራዎ ምንድን ነው?	1. የቤት እመቤት 2. የግል ስራ ተዳዳሪ 3. የመንግስት ሰራተኛ 4. መንግስታዊ ያልሆነ ድርጅት ሰራተኛ 5. የቀን ሠራተኛ 6. ተማሪ	
107	ቋሚ ወርሃዊ ገቢ ያገኛሉ?	1. አዎ 2. የለም (ወደ ጥያቄ 110)	
108	በራስዎ ሰርተው የሚያገኙት ወርሃዊ ገቢ ስንት ነው?	1. 250 ብር ብቻ 2. ከብር 150 - 499 3. ከብር 500 - 740 4. ከብር 750 - 999	

		5. ከብር 1000 - 1500 6. ከ1500 ብር በላይ 7. አላውቅም	
109	በራስዎ ብቻ ሰርተው የሚያገኙት ገቢ ለራስዎና ለቤተሰብዎ በቂ ነው ብለው ያስባሉ?	1. አዎ 2. አይደለም	
110	የባለቤትዎ ስራ ምንድን ነው?	1. ሥራ የለውም 2. የመንግስት ሠራተኛ 3. መንግስታዊ ድርጅት ያልሆነ ሠራተኛ 4. የግል ሥራ ተዳዳሪ 5. የቀን ሠራተኛ 6. ተማሪ 7. ሌላ (ይጠቀስ)	
111	ባለቤትዎ ቋሚ የወር ገቢ ያገኛሉ?	1. አዎ 2. የለም (ወደ ጥያቄ 113)	
112	ባለቤትዎ በየወሩ የሚገኙት የወር ገቢ ስንት ነው?	1. 250 ብር በታች 2. ከብር 250 - 499 3. ከብር 500 - 749 4. ከብር 750 - 999 5. ከብር 1000 - 1500 6. ከብር 1500 ብር በላይ 7. አላውቅም	
113	የቤተሰብዎ አጠቃላይ ወርሃዊ ገቢ ለመሰረታዊ የኑሮ ወጪዎች መሸፈኛ በቂ ነው ብለው ያምናሉ?	1. አዎ 2. አለም	
114	ልጆች አሉዎት?	1. አዎ 2. የለም (ወደ ክፍል ሁለት)	
115	ስንት ልጆች አሉዎት?		

ክፍል ሁለት **<u>የጋብቻ ሁኔታ</u>**

ተ.ቁ	ጥያቄ	ምላሽ	ኮድ
201	ይህ ጋብቻዎ ስንት ጊዜ ሆነው?		
202	ይህ ጋብቻዎ የመጀመሪያ ጊዜዎ ነው?	1. አዎ (ወደ ጥያቄ 204) 2. የለም	
203	ለመጀመሪያ ጊዜ ሲያገቡ እድሜዎ ስንት ነበር?	..... ዓመት	
204	የአሁኑን ጋብቻዎን ሲመሰርቱ እድሜዎ ስንት ነበር?	..... ዓመት	
205	የአሁኑን ጋብቻዎን ሲመሰርቱ የባለቤትዎ እድሜ ስንት ነበር?	..... ዓመት	
206	የእርስዎ የሥራ ቦታ የት ነው? (ይህ ጥቃቄ ሥራ ላላቸው ብቻ ይመለከታል)	1. ከተማ ውስጥ 2. ከከተማ ውጭ	
207	ለሥራ ወይም ለተለያዩ ጉዳዮች ከቤት ውጭ የሆኑበት ለምን ያህል ጊዜያት ነው?	1. ቢያንስ በጣምንት አንድ ጊዜ 2. ቢያንስ በወር አንድ ጊዜ 3. ቢያንስ በሦስት ወር አንድ ጊዜ 4. ቢያንስ በስድስት ወር አንድ ጊዜ 5. አልፎ አልፎ 6. በጭራሽ ከቤት አልወጣም 7. ሌላ (ይጠቀስ)	
208	የባለቤትዎ የሥራ ቦታ የት ነው? (ይህ ጥያቄ ባለቤታቸው ሥራ ላላቸው ብቻ ይመለከታል)	1. ከከተማ ውስጥ 2. ከከተማ ውጭ	
209	ባለቤትዎ በስራ ወይም ለተለያዩ ጉዳዮች ከቤት ውጪ የሚያሳልፉት ለምን ያህል ጊዜያት ነው?	1. ቢያንስ በጣምንት አንድ ጊዜ 2. ቢያንስ በወር አንድ ጊዜ 3. ቢያንስ በሦስት ወር አንድ ጊዜ	

		4. ቢያንስ በስድስት ወር አንድ ጊዜ 5. አልፎ አልፎ 6. በጭራሽ ከቤት አየወጣም 7. ሌላ (ይጠቀስ)	
110	ባለቤትዎ በአሁኑ ጊዜ ሌላ ትዳር አላቸው?	1. አዎ 2. የለም 3. አላውቅም	
211	ይህ ጋብቻ በርስዎ በጎ ፈቃደኝነት የተከናወነ ነበር ወይ?	1. አዎ (ወደ ጥያቄ 213) 2. የለም	
212	ይህ ጋብቻ በእርስዎ ፈቃደኝነት ተከናውኖ ካልነበረ እንዲያገቡ የተደረጉት ለምንድን ነው?	1. በወላጆቼ ተጽእኖ 2. በትዳር ጓደኛዬ ተጽእኖ 3. በቤት ዘመድ ተጽእኖ 4. ተጠልፊ 5. በራሴ ፍላጎት 6. ሌላ (ይጥቀሱ)	
213	ትዳር የመመስረቱ ውሣኔ በሌሎች በተለያዩ ምክንያቶች ግፊት ነበር ብለው ያምናሉ?	1. አዎ 2. የለም ..... (ወደ ክፍል ሦስት)	
214	እነዛ የገፋፉዎት ምክንያቶች ምንድን ነበሩ?	1. ያልታሰበ እርግዝና 2. ወላጆቼን በገንዘብ ለመርዳት 3. እራሴን በገንዘብ ለመርዳት 4. ልጆች እንዲኖሩኝ 5. የጋብቻ እድሜዬ እዳያልፍ 6. በትምህርቴ ስላልተሣካልኝ 7. ለማግባት ስል ብቻ 8. ሌላ (ይጥቀሱ)	

ክፍል ሦስት **<u>ስለ ወሊድ መቀጣጠሪያ ዘዴ</u>**

ተ.ቁ	ጥያቄ	ምላሽ	ኮድ
301	ባለፉት 12 ወራት ዘመናዊ የወሊድ	1. አዎ	

	መቆጣጠሪያ ዘዴዎች ተጠቅመው ያውቁ ነበር?	2. የለም (ወደ ጥያቄ 304)	
302	የወሊድ መቆጣጠሪያ ሁል ጊዜ ይጠቀሙ ነበር?	1. አዎ 2. የለም	
303	በተከታታይ የተጠቀሙት የትኛውን የወሊድ መቆጣጠሪያ ነበር?	1. የወሊድ መቆጣጠሪያ ኪኒኖች 2. የወሊድ መቆጣጠሪያ መርፌ 3. ሉፕ 4. ኖር ፕላንት 5. ዲያፍራም 6. ፎም 7. ኮንዶም 8. የሴቶች ቀዶ ጥገና 9. የወንዶች ቀዶ ጥገና 10. ሌላ (ይጠቀስ)	
304	ኮንዶምና የወሊድ መቆጣጠሪያ መጠቀም በባለቤትዎ ዘንድ ተቀባይነት አለው?	1. አዎ 2. የለም 3. አላውቅም	
305	ኮንዶም ላገቡ ጥንዶች ለወሊድ መቆጣጠሪያ መጠቀምን ይመክራሉ?	1. አዎ 2. የለም ..... (ወደ ጥያቄ 307)	
306	ምልስዎ አዎ ከሆነ ምክንያትዎ ምንድን ነው?	1. ኮንዶም ከእርግዝናም ሆነ ከበሽታ ስለሚከላከል 2. ኮንዶም ከሌሎቹ እርግዝና መከላከያ ዘዴዎች ይልቅ ይሚያስከትለው የጤና ችግር አነስተኛ ስለሆነ 3. ኮንዶም እንደሌሎች የወሊድ መቆጣጠሪያ ዘዴዎች የግድ በየቀኑ መጠቀም ስለማይኖርብን 4. ሌላ ይገለጽ	
307	መልስዎ አይደለም ከሆነ ምክንያትዎ ምንድን ነው?	1. ሌሎች የመከላከያ ዘዴዎች በቀላሉ ስለሚገኙ 2. ኮንዶም በቀላሉ ስለማይገኝ	

		3. ኮንዶም በግብር ስጋ ግንኙነት ጊዜ እርካታን ስለሚቀንስ 4. የትዳር ጓደኛ ኮንዶም እንዲጠቀም መጠየቅ በእርሱ ዘንድ ምናልባት ሚስቱ በሽታ ተይዛለች አልያም በኤች አይ ቪ ተይዛለች የሚል ጥርጣሬ ስለሚያስነሣ 5. የትዳር ጓደኛ ከሚስቱ ጋር ኮንዳም ለመጠቀም ቢፈልግ በአባለዘር በሽታ ተይዞ ይሆናል አልያም በኤች አይ ቪ ተይዞ ይሆናል የሚል ጥርጣሬ በሚስቱ ዘንድ ስለሚያስነሣ 6. ባለትዳሮች ልጅ ለመውለድ ሲፈልጉ ስለሚችሉ ሁል ጊዜ ኮንዶም መጠቀም ስለማይቻል 7. ሌላ (ይጥቀሱ)	

ክፍል አራት በኤች አይ ቪ የመጠቃት እድልና በሽታው የማሳሰብ ደረጃ

13	ጥያቄ	ምላሽ	ኮድ
401	ባለፉት 12 ወራት ውስጥ ከዚህ የሚከተሉት ምልክቶች ኖርዎት ያውቃል?	- የማህፀን አካባቢ ህመም 1 አዎ 2. የለም - መጠኑ የበዛ የብልት ፈሣስ 1. አዎ 2. የለም - ብልት አካባቢ ቁስል 1. አዎ 2. የለም - በምሽና ጊዜ የሚሰማ የማቃጠል ህመም 1. አዎ 2. የለም - በህክምና የተረጋገጠ የአባለዘር በሽታ 1. አዎ 2. የለም	
402	ባለፉት አስራ ሁለት ወራት ባለቤትዎ ከዚህ የሚከተሉትን ምልክቶች ኖሯቸው ያውቃል?	- የብልት ፈሣሽ 1. አዎ 2. አላውቅም - የብልት አካባቢ 1. አዎ 2. የለም ያለ ቁጥስ 3. አላውቅም	

		- በመሸናት ወቅት 1. አዎ 2. የለም የሚሰማ የማቃጠል 3. አላውቅም ህመም - በህክምና የተረጋገጠ 1. አዎ 2. የለም የአባለዘር በሽታ 3. አላውቅም	
403	ትዳር ከመመስረትዎ በፊት የግብረ ስጋ ግንኙነት እድርገው ያውቁ ነበር?	1. አዎ 2. የለም (ወደ ጥያቄ 405)	
404	በሁሉም አጋጣሚዎች ኮንዶም ተጠቅመው ነበር?	1. አዎ 2. የለም	
405	ትዳር ከመሰረቱ በኋላ ከባለቤትዎ ውጭ የግብረ ስጋ ግንኙነት አድርገው ያውቃሉ?	1. አዎ 2. የለም (ወደ ጥያቄ 408)	
406	ይህ የሆነው ባለፉት አስራ ሁለት ወራት ነው?	1. አዎ 2. የለም	
407	በሁሉም አጋጣሚዎች ኮንዶም ተጠቅመው ነበር?	1. አዎ 2. የለም	
408	ከባለቤትዎ ጋር ከመጋባትዎ በፊት ባለቤትዎ የግብረ ስጋ ግንኙነት አድርገው ያውቁ ነበር?	1. አዎ 2. የለም (ወደ ጥያቄ 410) 3. አላውቅም (ወደ ጥያቄ 410)	
409	ባለቤትዎ በሁሉም አጋጣሚዎች ኮንዶም ተጠቅመው ነበር ብለው ያስባሉ?	1. አዎ 2. የለም 3. አላውቅም	
410	ከባለቤትዎ ጋር ትዳር ከመሰረቱ በኋላ ባለቤትዎ ከትዳር ውጪ የግብረ ስጋ ንግኙነት የሚያደርጉ ይመስልዎታል?	1. አዎ 2. የለም (ወደ ጥያቄ 413) 3. አላውቅም (ወደ ጥያቄ 413)	
411	ይህ የሆነው ባለፉት አስራ ሁለት ወራት ውስጥ ይመስልዎታል?	1. አዎ 2. የለም	
412	ከትዳር ውጪ የሚኖረው ግንኙነት በሁለም አጋጣሚዎች ባለቤትዎ ኮንዶም ይጠቀማሉ ብለው ያስባሉ?	1. አዎ 2. የለም 3. አላውቅም	
413	በኤች አይ ቪ ተለክፊ ይሆናል የሚል	1. አዎ	

	ሃኒብ አሳስቦዎት ያውቃል?	2. (ወደ ጥያቄ 416) 3. ስለዚህ ጉዳይ አስቤ አላውቅም (ወደ ጥያቄ 416)	
414	ይህ ያሳሰብዎ ባለፉት አስራ ሁለት ወራት ውስጥ ነበር?	1. አዎ 2. የለም (ወደ ጥያቄ 416)	
415	ያሳሰብዎት ምክንያት ምን ነበር?	1. ባለቤቴ የበሽታ ተሸካሚ ስለመሆኑ አለመሆኑ እርግጠኛ ስላልነበርኩ 2. የበሽታው ተሸካሚ መሆን አለመሆኔ እርግጠኛ ስላልነበርኩ 3. ባለቤቴ ለትዳሩ ታማኝ ስለመሆኑ እርግጠኛ ስላልነበርኩ 4. ክትዳር ውጭ የነበረ ግንኙነት ስለነበረኝ 5. የአባለዘር በሽታ ምልክቶች ስለነበሩኝ 6. ባለቤቴ የአባለዘር በሽታ ምልክቶች ስለነበሩት 7. የባህላዊ ቀዶ ጥገና ተደርጎልኝ ስለነበር 8. በስለታማ መሣሪያ ጉዳት ደርሶብኝ ስለነበር 9. ከሆስፒታል ቀዶ ጥገና ተደርጎልኝ ስለነበር 10. ደም ወስጄ ስለነበር 11. ሌላ (ይጠቀስ)	
416	ባለፉት 12 ወራት ውስጥ ጸንሰው ያውቁ ነበር?	1. አዎ 2. የለም (ወደ ክፍል አምስት)	
417	ጽንሱ በበሽታው ይጠቃ ይሆናል የሚል ሃኒብ አሳስበዎት ነበር?	1. አዎ 2. የለም (ወደ ክፍል አምስት) 3. ስለ ጉዳዩ አስቤ አላውቅም (ወደ ክፍል አምስት)	
418	አሳስቦዎት ከነበረ የወሰዱት እርምጃ ምንደን ነው?	1. ቢያሰስበኝም ጽንሱ እንዲቀጥል ወሰንኩ 2. ጽንሱን ለማቋረጥ ባስብም በእርግዝናው ለመቀጠል ወሰንኩ	

		3. ጽንሱን ለማቋረጥ ባስብም ነገር ግን አልተሣካልኝም 4. እርግዝናውን ለማቋረጥ (ጽንስ የማጨናገፍ ሙከራ አድርጌ ነበር ግን አልተሳካም) 5. እርግዝና እንዲቋረጥ አደረኩ (ጽንስ አጨናገፍኩ) 6. የኤች አይ ቪ ምርመራ አድርጌ በእርግዝናው ላይ ወሰንከ 7. ሌላ (ይጠቀስ)	

ክፍል አምስት በትዳር ጥንዶች መካከል ስለሚደረግ የጾታ ግንኙነት ውይይቶች

ተ.ቁ	ጥያቄ	ምላሽ	ኮድ
501	ጾታዊ ግንኙነት በተመለከተ ከባለቤትዎ ጋር ተወያይተው ያውቃሉ?	1. አዎ 2. የለም (ወደ ጥያቄ 509)	
502	በየትኞቹ የጾታ ግንኙነት ጉዳዮች ነበር የተወያያችሁት?	1. ስለ ወሊድ መቆጣጠሪያ መንገድ 2. በኤች አይ ቪ ስለመጠቃት ጉዳይ 3. በትዳር ስለመተማመን 4. ሌላ (ይጠቀስ)	
503	በአብዛኛው ጊዜ ስለጾታዊ ግንኙነት ውይይት የሚጀመረው ማነው?	1. ባለቤቴ ብቻ 2. እኔ ብቻ 3. ሁለታችንም	
504	ስለኤች አይ ቪ በተለየ ተወያይታችሁ ታውቃላችሁ?	1. አዎ 2. የለም	
505	ጾታዊ ግንኙነት በተመለከተ በምትወያዩበት ወቅት አለመግባባቶች የሚፈጠሩት ለምን ያህል ጊዜያት ነበሩ?	1. አዎ 2. የለም	
506	ጾታዊ ግንኙነት በተመለከተ	1. አዎ	

	በምትወያዩበት ወቅት አለመግባባቶች የሚፈጠሩት ለምን ያህል ጊዜያት ነበሩ?	2. የለም 3. አንዳንድ ጊዜ	
507	ለምን ያህል ጊዜያት አለመግባባቶች ሲፈጠር የመፍትሄ ሃሣብ ላይ ትደርሳላችሁ?	1. ሁል ጊዜ 2. አብዛሃኛውን ጊዜ 3. አንዳንድ ጊዜ 4. በጭራሽ አንደርስም	
508	ማናቸውንም የጾታዊ ግንኙነት ጉዳዮችን በተመለከተ ባለቤትዎን በማማመን መወሰን እችላለሁ ብለው ያስባሉ?	1. አዎ 2. የለም	
509	ከባለቤትዎት ጋር በጾታዊ ግንኙነት ጉዳዮች ላይ የማትወያዩ ከሆነ ምክንያቶችዎ ምንድን ናቸው? (ይህ ጥያቄ ለጥቃቄ ቁጥር 501 የለም ብለው ምላሽ ለሰጡ ብቻ ይመለከታል)	1. ስለ ጾታዊ ግንኙነት መወያየት ስለማልፈልግ 2. ባለቤቴ ስለጾታ ግንኙነት መወያየት ስለማይፈልግ 3. ሁለታችንም መወያየት ስለማንፈልግ 4. መወያየት እፈልጋለሁ ግን ለባለቤቴ የወሲብ ነክ ጉዳዮችን ማንሳት እፈራለሁ 5. መወያየት እፈልጋለሁ ነገር ግን ባለቤቴ አንድንወያይ አያደርገኝም 6. መወያየት እፈልጋለሁ ነገር ግን እፈራለሁ 7. ባለቤቴ መወያየት ይፈልጋል ነገር ግን እኔ እንዲያዋየኝ አላደርገውም 8. ባለቤቴ እንዲያወያየኝ ይፈልጋል ነገር ግን ወሲብ ነክ ጉይዮችን ማንሣት ይፈልጋል 9. ባለቤቴ መወያየት ይፈልጋል ነገር ግን ያፍራል 10. ሁለታችንም መወያየት እንፈልጋለን ነገር ግን እርስ በመስ እንፈራለን 11. ሁለታችንም መወያየት ብንፈልግም እንተሩፈርም 12. ሌላ (ይጠቀስ)	

ክፍል ስድስት በአባለዘር ወይም ኤች አይ ቪ በሽታ ላለመያዝ የተወሰዱ እርምጃዎች

ተ.ቁ	ጥያቄ	ምላሽ	ኮድ
6Ø1	ባለፉት አስራ ሁለት ወራት ኮንዶም ተቀቅመው ነበር?	1. አዎ 2. የለም ..... (ወደ ጥያቄ 6Ø4)	
6Ø2	ያለማቋረጥ ሁል ጊዜ ኮንዶም ተጠቅመው ነበር?	1. አዎ 2. የለም	
6Ø3	ኮንዶም የተጠቀሙት ለምን አላማ ነበር?	1. ወሊድ መቆጣጠሪያ 2. ከአባለዘርና ከኤች አይ ቪ ለመጠበቅ 3. ሌላ (ይጠቀስ)	
6Ø4	እርስዎና ባለቤዎ ከመጋባትዎ በፊት በፍቃደኝነት ላይ የተመሰረተ የምክር አገልግሎትና የኤች አይ ቪ የደም ምርመራ አድርጋችሁ ነበር	1. አዎ 2. የለም	
6Ø5	በአለፉት አስራ ሁለት ወራት በፈቃደኝነት ላይ የተመሠረተ የምክር አገልግሎት የኤች አይ ቪ/ኤድስ የደም ምርመራ አድርገው ነበር?	1. አዎ 2. የለም	
6Ø6	አሁን ሁኔታዎች ቢመቻቹ በፈቃደኝነት ላይ የተመሠረተ የኤች አይ ቪ ኤድስ መርመራ ለማድረግ ፈቃኛ ነዎት?	1. አዎ 2. የለም	
6Ø7	መልስ የለም ከሆነ ምክንያት ምንድን ነው?	1. ስንጋባ ምርመራ ስላደረግን 2. ባለፉት አስራ ሁለት ወራት ውስጥ ምርመራ ስላደረግን 3. በበሽታው እጠቃለሁ ብዬ ስለማልሰጋ 4. በበሽታው መጠቃቴን ለማወቅ ስለማልፈልግ	

		5. ለመመርመር ባለቤቴን ስለምፈራው (ስለማይፈቅድልኝ) 6. ሌላ ከሆነ ይጠቀስ	
608	ባለቤትዎ ባለፉት አስራ ሁለት ወራት በፈቃደኝነት ላይ የተመሠረተ የምክር አገልግሎትና የኤት አይ ቪ ኤድስ የደም ምርመራ አድርገው ነበር?	1. አዎ 2. የለም	
609	ለአለፉት አስራ ሁለት ወራት ውስጥ የግብረ ስጋ ግንኙነትን ከማድረግ ተቆጥበው ነበር?	1. አዎ 2. የለም	
610	መልስዎ አዎ ከሆነ የግብረ ስጋ ግንኙነት የተቆጠቡት በምን ምክንያት ነበር?	1. ከበሽታው ለመጠበቅ (ከኤች አይ ቪ እና ከሌሎች አባለዘር በሽታዎች) 2. ከእርግዝና ለመጠበቅ 3. ከባለቤቴ ስላልነበር 4. ታመሜ ሰለነበር 5. ባለቤቴ ታሞ ስለነበር 6. ሌላ (ይጠቀስ)	

<u>ማስረጃ</u>

የመረጃ ሰብሳቢ ስም .....

ኮድ .....

ፊርማ .....

ቀን .....

<u>በተቆጣጣሪዋ የሚሞላ</u>

የተቆጣጣሪ ስም .....

መጠይቁ ሁኔታ የተሟላ .....

ያልተሟላ .....

ያልተሟላ ከሆነ የተወሰደው እርምጃ .....

እናመሰግናለን።