



**ADDIS ABABA UNIVERSITY  
SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES**

**THE EFFECT OF MODEL HOUSEHOLD TRAINING ON HIV/AIDS  
RISK BEHAVIORS; IN CHEHA WOREDA-GURAGHE ZONE, SNNPR.**

*A community based comparative study.*

*By*

*Hayatu Muze Abdo (BSc. in Public Health)*

**A thesis submitted to the school of graduate studies of Addis Ababa University  
In partial fulfillment of the requirement for the degree of Master in Public health.**

Advisor: Adamu Addissie Nuramo (MD MPH MA), Assistant Professor.

May 2011,  
Addis Ababa.

**ADDIS ABABA UNIVERSITY  
SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES**

**The Effect of Model Household Training on HIV/AIDS Risk Behaviors  
in Cheha Woreda-Guraghe Zone, SNNPR.**  
*A community based comparative study.*

By

Hayatu Muze Abdo (BSc. in Public Health)

Approved by the Examining Board

---

Chairman, Dep. Graduate Committee

Adamu Addissie Nuramo (MD MPH MA),  
Assistant Professor

---

Advisor

---

Examiner

---

Examiner

## Declaration

I the undersigned, declare that this is my original work and has never been presented by another person in this or any other university and that all the source materials and references used for this thesis have been duly acknowledged.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Place \_\_\_\_\_

Date of submission \_\_\_\_\_

The thesis has been submitted for examination with my approval as a university advisor.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# TABLE OF CONTENTS

<u>Title</u>	<u>Page</u>
Table of contents .....	I
Acknowledgement.....	II
Acronyms .....	III
Abstract .....	1
Introduction .....	2
Literature review .....	4
Rational of the study .....	10
Objective .....	11
Methodology.....	12
Study area .....	12
Study design .....	13
Study population .....	13
Sample size determination .....	14
Sampling procedure .....	15
Ethical consideration.....	19
Result .....	20
Discussions .....	34
Strength and limitation .....	39
Conclusion.....	40
Recommendations.....	41
References .....	42
Annex I (Guideline for FGD) .....	44
Annex II (Structured questionnaire) .....	45
Annex III (Amharic Questionnaire) .....	55

## **ACKNOWLEDGEMENT**

I deeply indebted to my advisor Dr. Adamu Addissie for his advice and technical support, especially for his responsibility thinking, tolerance, and sympathy during my sickness throughout the thesis proposal and implementation period.

My thanks go to the librarians of AAU school of public health for their collaboration in facilitation of the necessary articles and materials. I shall extend my thanks to some of my classmate friends for their cooperation in providing some lessons I missed and their due support on providing timely information from department

I also extend my appreciation to Cheha Woreda health Office staff, my informants, data collectors and supervisors without whose cooperation the completion of this thesis would not have been possible.

Finally, I believe it is time that I pay tribute to my wife who had always been besides me in all My endeavors. While many people have contributed to the timely completion of this thesis I, however, take the responsibility for errors or omissions.

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ANC	Antenatal Care
BSS	Behavioral surveillance survey
CBHS	Community Based Health Service
CBO	Community Based Organizations
CCE	Community Conversation for community Enhancement
CSA	Central Statistics Agency
CSW	Commercial Sex Worker
DHS	District Health Service
DHO	District Health Office
EDHS	Ethiopian Demographic and Health Survey
EJHD	Ethiopian Journal of Health Development
ETB	Ethiopian Birr
FGD	Focus Group Discussion
FHP	Family Health Program
FMOH	Federal Ministry of Health
HIV	Human Immuno-Virus
HH	Household
HEWs	Health Extension Workers
HSEP	Health Service Extension Program
HSDP	Health Sector Development Program
MDGs	Millennium Development Goals
MHPT	Model household package training
NMHPT	Non-model household package training
MPH	Masters of Public Health
NGO	Non-Governmental Organizations
OR	Odds Ratio
PASDEP	Plan for Accelerated & Sustained Development to Eradicate Poverty
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PPS	Probability Proportional to Size
SNNPR	Southern Nations Nationalities and People Region
SPSS	Statistical package for social sciences
SRS	simple random sampling
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TB	Tuberculosis
W H O	World Health Organization
WoHO	Woreda Health Office
VCT	voluntary counseling and testing

## **1. Abstract**

**Background:** Primary Health Care (PHC) and Community Based Health Care (CBHC) were seen as the most practical approach in achieving the overall objective. PHC is an integral part of the overall social and economic development of the community. In 2003, the Ethiopian Federal Ministry of Health (FMOH) launched a new health care plan, the “Accelerated Expansion of Primary Health Care Coverage,” through a comprehensive Health Extension Program (HEP).

**Objective:** To compare between model training members and non model training members towards the HIV/AIDS risk behaviors related to night markets and mobility.

**Methods:** A cross-sectional comparative community based study was conducted in Guraghe Zone from January 15, 2011 - April 15, 2011. A total of 70 villages and 706 study subjects were selected from the HH model training groups and the control groups; the cross tabulation was computed using dependent and independent variables to determine the proportions of respondents and the existence of association between independent variables and some selected sociodemographic characteristics of household respondents. Odds ratio and their 95% of confidence interval were calculated to assess the strength of association between the variables. To see the relative effect of independent variable on the dependent variable, logistic regression analysis was carried out to SPSS version 17.0. For **qualitative data** four FGDs with 29 members conducted; the participants were selected purposively, tape recorder was used, the responses were transcribed and translated in to English, the statements were arranged in respective of its questions then analyzed and grouped into themes and incorporated in to quantitative part.

**Results and Discussion:** 1.7% of the trained and 3.7% of the non-trained had sexual practice related to night markets. 3.2% of trained and 4.7% of non-trained had casual sex related to mobility. 4.5% night market attendants had casual sex related to night markets compared to non-attendants [OR (95%CI) =5.2(2.0, 9.0)]. 6.5% mobile persons had casual sex related to night markets [OR (95% CI) =3.7(1.4, 9.6)]. 13% of mobile persons had casual sex related to mobility compared to non-mobile persons [OR (95%CI) =7.4(3.4, 13)]. Of the respondents 1.4% of the trained and 7.2% of the non-trained had extramarital sex; but 7.2% of the night market attendants had extramarital sex compared to non-attendants. [OR (95%CI) =1.8(1.1, 7.0)]. Of the respondents 15.4% of mobile persons had extramarital sex compared to non-mobile persons. [OR (95%CI) =7.07(3.4, 15)]. 60% of trained and 55% of the non-trained had used condom regularly the last 12 months they had sex with non-regular partner.

**Recommendations:** Small markets at night should be shifted to the day time, better to avoid some of the night markets through integration of the Woreda Council and social sectors Continuous capacity building and refresher training for the previously trained household members should be done by the Woreda and zonal health offices.

## 2. Introduction

Global summary of the HIV epidemic showed 83.2 million people were living with HIV in 2010. This figure includes the estimated 2.5 million adults and children, who were newly infected in the HIV in 2009. In many regions of the world new HIV infections are heavily concentrated among young people of age 15-24 years (1).

Sub Saharan Africa countries to bear the highest share of the global HIV burden. Two thirds (68%) of all adults and children are found in sub-Saharan Africa. Almost three quarters (76%) of all adults and child deaths due to AIDS occur in this region; that is about 1.6 million out of the global total of 2.1 million deaths. Among those who are newly infected with HIV 1.43 million (68%) reside in sub-Saharan Africa (1).

In sub-Saharan Africa the main risk factors for high HIV transmission include population movement, poverty and/or unequal distribution of wealth, gender inequality and various cultural influences(2, 3). United Nations Educational, Scientific and Cultural Organization (UNESCO) and Joint United Nations Program on HIV/AIDS (UNAIDS) report on Migrant Population and HIV/AIDS stated that mobile people are in a greater risk of poor health in general and HIV/AIDS in particular(3, 4). However, different researchers demonstrated that mobility alone does not account for risk taking behavior by migrants, rather various socio-cultural and economic factors link migration to the spread of HIV/AIDS(5, 6). The most significant socio-cultural and economic factors which place migrants in a high risk situation are the movement of people from their rural areas without a stable sexual partner, fragmented social networks, reduced availability and accessibility of health services, economic transitions and an urban lifestyle which exposes migrants to participate in sexual risk-taking behavior (4, 7, 8).

According to the yearly published health and health related indicators by FMOH, about 2.1% of Ethiopia's adult population were living with HIV in 2008. In this year, 603, 560 people were living with HIV of which 2.6% females and 1.7 males with infection levels more than five times higher in urban than in rural areas 7.7% versus 0.9% respectively(9).

In Guraghe Zone there are many night markets than the daily wide markets. Different studies had shown that night shops and rural migration in many ways contribute a lot for HIV exposure and transmission. In addition the young and young adult males in the Zone migrate transiently and even for considerable period of the year to the nearby towns and far cities searching for work opportunity and employment. Since these

males have low or no formal education and/or specific skills to accomplish in the urban setting, most of the time they will be obliged to involve in small scale labour based activities.(10, 11)

Though various studies have been made both at national and local levels to assess the sexual behaviors of different population groups considered to be potentially high risk. In addition a lot has been done in the zone to minimize risk behaviors for HIV transmission. But the effect of model household training package and its implementation on risk behaviors for HIV transmission at the study area were not yet touched since the model household training is in its infancy stage. The researcher wanted to investigate comparatively between the trained and non-trained the effect of model household training package on risk behaviors for HIV in the local area.

### **3. Literature Review**

#### **3.1 HIV/AIDS Risk Behaviors**

The HIV/AIDS epidemic is one of the greatest challenges ever to global well-being. AIDS threatens food security, productivity, human resource availability and development and may even jeopardize national and regional security. The epidemic has negative impact on labor productivity. The social consequences of the epidemic are also grave as caregivers and income generating members of the family die leaving behind orphans and other dependents. This event further leads to an aggravation of the problem of poverty and social instability(12, 13).

There are many factors influence the practice of risk HIV/AIDS behaviors including social, economic, and factors related to access to health services. In addition behavioral change does not occur in an overnight. To address multiple factors influencing risks and vulnerability requires careful planning time and a lot of other resources that will help in tracing behaviors(14, 15). Poverty and lack of employment opportunities in the rural areas have driven the majority of male migrants to town in order to escape rural poverty and search for employment(16, 17). The largely seasonal or temporary character of migration, with mobile people returning home to their families on a regular basis has facilitated the rapid spread of the virus (16).

Mobility can play a significant role in transmitting infectious diseases and migrants are more vulnerable to HIV infection than their non-migrant counterparts. Different studies in Africa and elsewhere show that the epidemiology of HIV/AIDS is closely linked to the process of mobility and mobile populations in general have played a significant role in the initial spread of HIV in Africa (18, 19). A study on HIV and mobility in Uganda demonstrated the existence of strong correlation between HIV infection and migration. People who have moved within the past five years were three times more likely to have been infected with HIV than whose residence had been stable for more than ten years (21). Other study done to assess the impact of migration on the transmission of HIV among couples of South African adults revealed a 25.9% versus 12.7% rate of seropositivity for the migrant and non-migrant group respectively(17).

In Ethiopia there is wide spread poverty, low educational levels, poor nutritional status, a high fertility rate, together with low levels to health services utilization contributing to the high burden of ill health in the country. Infectious and communicable diseases account for about 60 – 80% of the health problem in the country. It is convinced that there is a remarkable gap in the health seeking behavior of individuals, households and the community at large(18). Rural people who migrate to urban areas become infected with HIV being agitated by alcohol consumption and/or chewing Khat; they might visit CSW.

Later on rural dwellers returning after time away from home proceed to infect others in rural areas. They in turn spread into the general population. Economic vulnerability increases the chance of exchange of sex for food and money, lack of information how to do safe sex, the predominant culture of silence and passive regarding sexually active women who try to access for health service like STDs. This restricts some people from information, especially adolescent and women and this might lead them to expose for risky sexual behaviors (19, 20).

As seen from the distribution of HIV in Africa, it's evident that the spread is taking place at a very alarming speed, and the same may also be happening in Ethiopia(21). The rural households that cannot meet their food requirements or obtain cash undertake the range of income-generating activities such as participating in night markets for petty trade, selling of firewood and agricultural product to supplement their income. Those who do not have the ability to diversify the source of income are particularly vulnerable to HIV infection transmission. Since, they might exchange sex with money or materials where there is risk for unprotected sex. The most important determinant of spread of HIV was the proportion of men engaged in sexual relationship with people other than their wives (11).

In some areas alcohol drinking is closely related to night markets. In rural areas problems with alcohol abuse reside mostly with men than women, but due to gender inequality, economic dependency and negligible negotiation power, females may practice unsafe sex.(2) In some rural areas drinking alcohol is very common during weddings, night parties, funeral rites, holidays, Mahber. Alcohol drinking individually or in groups in locally selling tukuls at night is common

To date a little attempt has been made to assess night markets and mobile people in contributing for HIV infection spreading in rural community where most of people live in Ethiopia. A night market especially in this study area is usually assembled. At present night markets in the area are common in different villages. The holding time is commonly after 4:30 p.m to 7:30 p.m on average. Almost all participants were females except in some weekly night market. These women travel to their home from 7:00pm- 8:00 pm.

### **3.2 Community Based Health Care –A Basis to define Accessible Health Services for the Community**

At the Alma-Ata conference in 1978, the world community committed itself to the achievement of a health status consistent with socially and economically productive life. It was recognized that health is not commodity to be delivered but a quality of life to be cared for. Primary Health Care (PHC) and Community Based Health Care (CBHC) were seen as the most practical approach in achieving the overall objective is an integral part of the overall social and economic development of the community. It opens a whole new dimension and direction to the health system in contrast to the more conventional approach based on the provision of basic health services alone. CBHC is a basic component of PHC which emphasis community participation in health promotion activities, prevention of diseases, and establishment of health committees for the overall community health management in their respective localities. The commitment of many nations never translated into real effect and the concept of PHC/CBHC has hardly achieved its goal.(22)

Community Based Health Service is defined as the “services that consumers/patients can access nearest to home, which encourages participation by people, responds to the needs of the people, encourages traditional community life and creates responsibilities. WHO define CBHS as “community-based care that the consumer or patient can access nearest to home, which encourages participation by people, responds to the needs of people, encourages traditional community life and creates responsibilities”. Community training - the philosophy and principle is the right knowledge and skill should be transferred to households so that they can take responsibility for producing and monitoring their own health. Community participation emphasizes the bottom-up approach in planning and implementation of development programs including health. (23). These services are part of the Primary Health Care programmes that are Preventative, Promotive , including limited Curative and Rehabilitative health services. It is rendered by community organizations. Primary health care (PHC) – is the health care that is provided at the first level of contact that people have with the health care system. It entails essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It should be universally accessible to people in their communities and is integral to a country’s health system(24).

Different studies showed that different countries follow varieties of modalities as a strategy to effect in the PHC principles. In many developing countries, health care initiations are inadequate and not easily accessible however, if there is an implementation of basic health services at household level by coordinating the community, the community health workers and health care providers, the limited resources available at institutions can be fully utilized to help those most in need. Another approach is to encourage the active

involvement of individuals and their family, the community and health care providers with the aim of helping people to understand how to look after their own health. Simple and scientifically sound technology, suitably adapted to local conditions, is also needed(22).

With an estimated total population of 73 million in 2010, Ethiopia is the second most populous country in Sub-Saharan Africa. A very large proportion of the population (84%) Live in the rural areas the country experiences a heavy burden of disease mainly attributed to communicable infectious diseases (25, 26).

The Ethiopian Government has formulated a series of Health Sector Development programs in line with plan for accelerated and sustained development to end poverty (PASDEP) and to achieve the health-related Millennium Development Goals. An audacious plan to achieve universal access to primary health care has been prepared and embedded in HSDP III. This plan aims to address the service coverage problem of the health system through an accelerated expansion and strengthening of primary health care services. It focuses on both physical availability and accessibility of essential health services by sufficiently reducing physical distance between primary health care facilities and health care users and by making essential health services available in the facilities(27).

### **3.3 The role of model household training on HIV/AIDS prevention/control and behavior change**

The prime target is expansion of essential health system inputs towards the achievement of the Millennium development goals launched a new health care plan, the "Accelerated Expansion of Primary Health Coverage," through a comprehensive Health Extension Program (HEP), which serves as effective mechanism for shifting health care resources from predominantly urban to rural areas, where majority of the country's population resides. Therefore, HSEP could be considered as the most important institutional framework for achieving the MDGs. Moreover, the government has focused on "providing quality promotive, preventive, and selected curative health services in an accessible and equitable manner to reach all segments of population, with special attention to mothers and children. Within the framework of HIV/AIDS prevention and control, the policy and strategy of the FDRE incorporates intensive and continuous advocacy for involvement as well as mobilization of the community, NGOs, CBOs in capacity building, resource mobilization, and leadership and mainstreaming (22, 28, 29).

The role of health workers, HEP workers and CHW who are involved in the health extension package program were to provide the household with the opportunity to improve and/or acquire knowledge to boost their health seeking behavior and skills to practice the basic preventive and promotive health practices to improve their health status. Creating this opportunity through their full participation; increases adoption of

healthy behaviors and practices as per the set standards and guidelines at the household level and their compliance to the different health service provision.

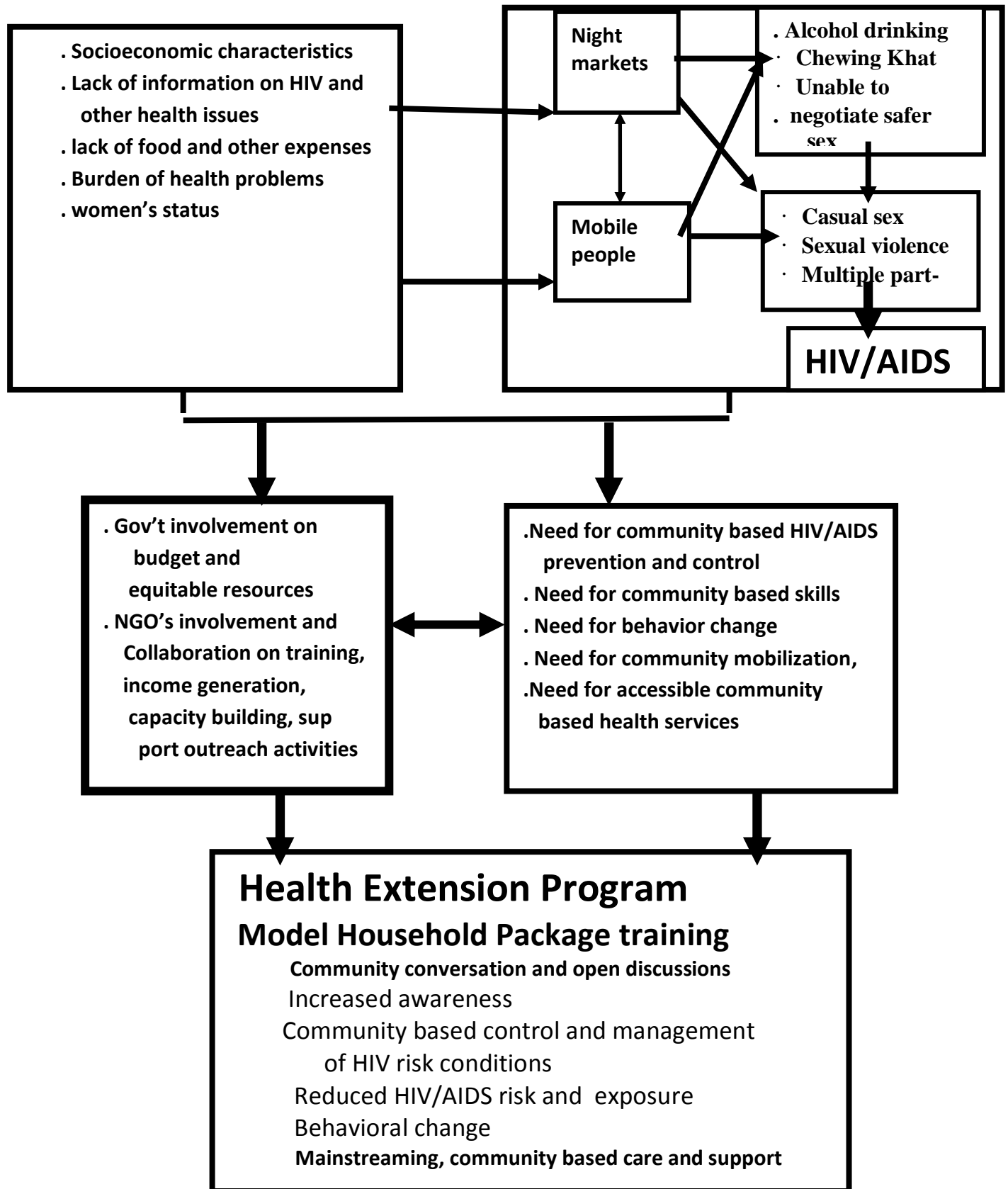
Model Family /model household identify and train model families that have acceptance and credibility in the community as early adopters of desirable health practices to become role models in line with health extension packages. Model families help diffuse health messages leading to the adoption of the desired practices and behaviors by the community. Health Service Extension Program model household training is a newly

introduced community based approach and the fact that it has been in place of implementation exercise not more than as a pilot for two to three years would make it possible to assess the its effect on HIV/AIDS risk behaviours and come up with base line information to help in district and regional level decision making (30).

Model household package training incorporated HIV/AIDS prevention skills risk behaviors known in the local area are touched in the program especially through the program entitled “community conversation for community enhancement”. Community conversation for community enhancement (CCE) is a special program in the health extension program held three hours program per week, a total of 96 hours in ten months. It focuses on HIV/AIDS risk behaviors related to local areas. It incorporates skills, experience sharing, delineation and mapping of green and risk zones within a town/village, field practices. After successful training and implementation it the community members expected to propagate HIV/AIDS preventive behaviors. The community members also capable of control some socioeconomic conditions related to HIV transmission (31, 32).

In Guraghe zone there are many night markets putting the HIV/AIDS risks to be fire on (10). The working age group especially males are known for their mobility to cities for trade and search of job for considerable period. In the zone, a lot has been done and many achievements have recorded at HSEP and HIV/AIDS prevention and control. But, there is some evidence of casual sex in relation to night markets in the area. Since, studies are scarce to assess this type of risky sexual behavior for HIV infection in rural area; hence, it needs to be studies in detail. Therefore, this study attempted to fill the gap through assessment of the effect of model HH package training on HIV/AIDS risk behaviours related to the night market and mobility spreading in rural community using structured questionnaire.

**Fig.1 Conceptual Framework of the study**



### **3. RATIONALE OF THE STUDY**

1. Model household package training is not evaluated as it is implemented recently.
2. Health Service Extension Program is the basic implementation strategy in provision of basic health services to significant number of rural population in countries like Ethiopia which needs close follow up
3. This study can serve as a base line for future similar studies
4. To understand HIV/AIDS risk behaviors associated to socioeconomic and traditions of different population groups so that strengthen prevention and control of HIV/AIDS through making the community aware of those risk behaviors.

## **4. Objectives**

### **General Objective;**

To compare the effect of model household package training on HIV/AIDS risky behaviors in relation to night markets and mobility among trained and non-trained groups.

### **Specific objectives**

1. To compare sexual practices related to night markets between HH model trained members and non model trained members
2. To compare mobility induced sexual practices between model trained and non-trained members
3. To describe the association of some independent variables with sexual practices related to night markets, mobility
4. To compare extramarital sex between the model trained and non-trained groups and association of sociodemographic variables with extramarital sex.

## 5. Methodology

### 5.1 Study area

The study was conducted in Cheha Woreda –one of the districts in Guraghe zone, SNNPR. Guraghe zone is located at the northernmost of the SNNPR, 515KM far from the capital of SNNPR- Hawassa. Guraghe zone has population of 1,418,931. It is bounded by Oromia to the north, Oromia and Silte zone to the east, Hadiya zone to the south, and Yem special Woreda and Oromia to the west. The populations are residing to 13 Woredas and two big towns; 87% of the population resides at rural areas. The population density varies from 602.2/ KM sq. which is the highest district to 221/ KM sq. the lowest. According to the zonal health department report of 2002 E.C., there is 1 hospital 58 full health centers, no growing health centers, and 371 health posts owned by the government. There are 8 drug stores, 131 rural drug vendors 67 clinics owned privately. There are two NGO hospitals. Currently 773 HSEWs are deployed in 371 health posts, and 80 are on training. According to the zonal report, TB is fueled by overcrowding, malaria burden has reduced significantly There is on- and -off malnutrition problem in some Woredas at dry seasons(10, 33).

Cheha Woreda is located southwest and 188KM from Addis Ababa and 30KM from the zonal town-Wolkitte. Based on the 2007 census then projected for the year 2011, the district has population of 129,961(M=63, 171 F=66,790). There is one NGO hospital, 5 health centers, and 40 health posts Cheha Woreda is one of a few areas in SNNPR where HSEP was started as a pilot Project in 4 selected Kebeles in the year 2004. When HSEP gets fully progressing from its pilot years, the model house hold training was started; household members are selected among different community groups and have training on selected packages. After being completed the training-about 70% of the 16 packages basic elements the members try to implement on their own family and take time to expand good performances to neighbour. After graduation they set time for discussion and their own committee, the HH members are graduated and certified by the Woreda Health Office. The households are supervised at least two times per week by HSEP supervisors. HESP supervisors, HSEWs and respected groups held meeting and evaluation monthly with the Woreda HSEP process. The supports given to model households are government and political commitment training, some materials and technical advice(10, 33).

This study was conducted from January 15 to April 15, 2011. The impact of model HH training, specially comparison among trained and non-trained groups were examined since the selection of the specified Woreda is vital because the HSEP is preliminary implemented as pilot project and hence greater experience and base line information is available.,

## **5.2 Study Design**

A community based comparative cross-sectional design was conducted to assess the extent of risk sexual behaviors in relation to night markets and mobility between model household trained and non-trained groups. The study was reinforced by a qualitative study- focus group discussion.

## **5.3 Source population**

The eligible source population includes all age >18 year people who were trained in HSEP model HH training packages and who were implementing them; as well as non-trained comparative control groups (non-model HH training) areas in the Woreda who live for the last two years.

## **5.4 Study population**

### Quantitative study

Randomly selected households; in Cheha Woreda, people lived more than two years.

### Inclusion criteria

Intervention groups of households that were involved in the HEP program model package training and implementing the packages after being graduated before the year 2002 E.C. and live in the study duration. Non-intervention groups; households that were not involved in HEP model training program, but with the same- socio demographic characteristics as the intervention groups (have been lived there for 2 years)

Exclusion criteria; Control groups households that have lived in the village for less than two years. Intervention groups households who did not complete the training and/or live for less than two years. Age less than 18 years for both sexes.

### Qualitative study

Inclusion criteria-The FGD members in parts other than the study area in the Woreda who lived 2 years and above

### Exclusion criteria

The FGD members in the non-model HH package training areas that live less than 2 years in the Woreda.

### 5.5 Sample size determination

The sample size was determined based on the difference between two population proportions. P1 was determined from a study done (proportion of HIV risk behavior /extramarital sex) =20%; with an assumption that proportion in non – intervention area is greater than by 10% = 30%) with confidence interval ( $Z_{\alpha}$ ) =95%; power of 80% with (r= 1:1);

$$N \text{ (in each group)} = \frac{\left( Z_{1-\alpha/2} \sqrt{\left[ \frac{1}{1+r} P \right] (1-P)} + Z_{1-\beta/2} \sqrt{\frac{p_1(1-p_1) + p_2(1-p_2)}{(P_1-p_2)^2}} \right)^2}{P_1-p_2^2}$$

Key:

$$P \text{ (population proportion)} = \frac{p_1 + r p_2}{1+r}; r=1$$

$Z_{\alpha/2}$  = value of standard normal distribution = value of 0.05= 1.96

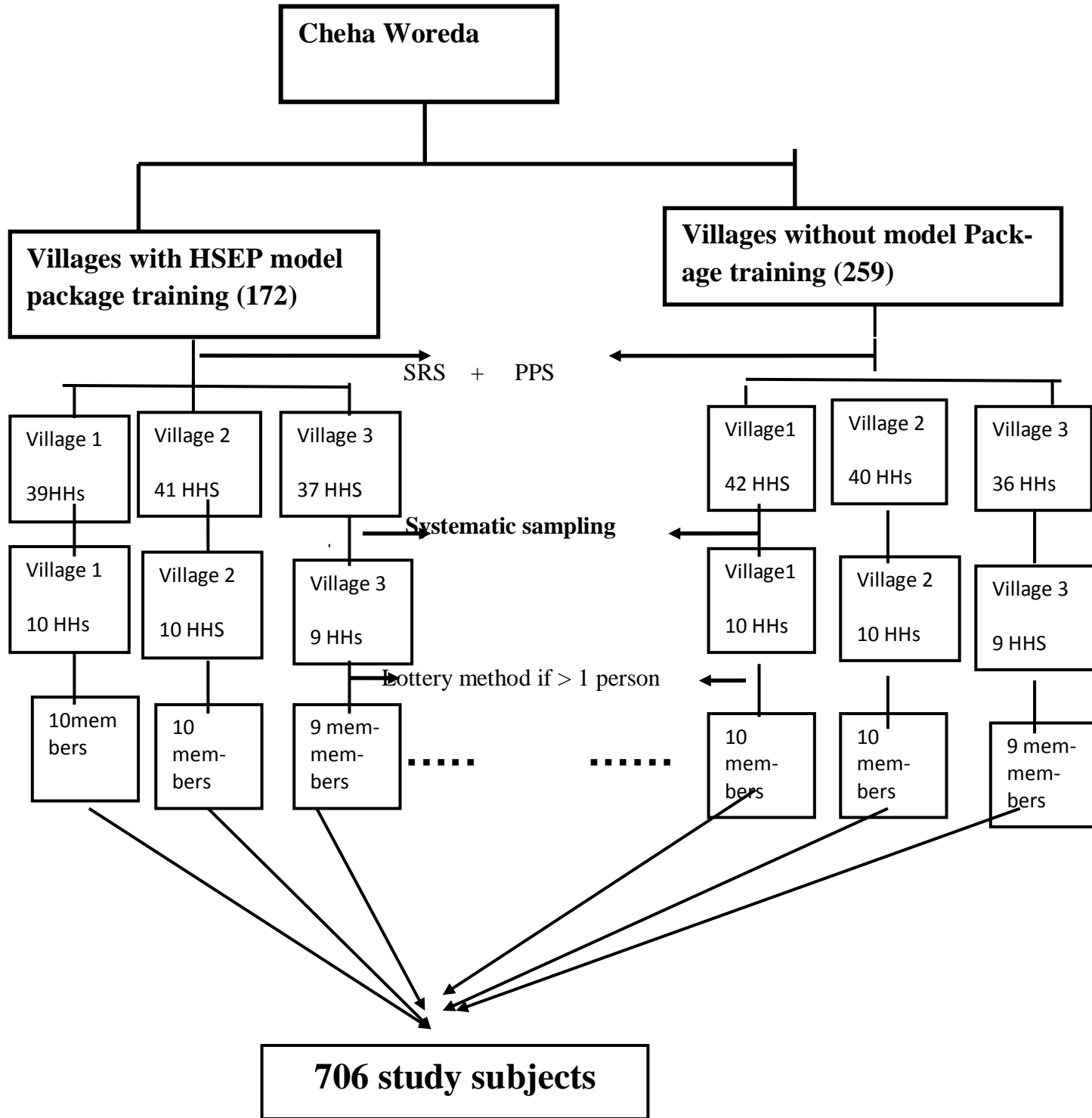
$Z_{1-\beta}$  =value of standard normal distribution corresponding to power of 80%= 0.84

Non-response rate = 10%=64; n1= 353 and n2= 353

## **5.6 Sampling procedure**

The registration of households and villages with graduated members for model HH training until 2002 E.C. were obtained from the Woreda Health Office. There were 422 rural villages of which 172 are HSEP model HH training has implemented. There were 259 villages on which the model household training is not implemented. 35 villages from intervention areas (21%) and 35 villages from non-intervention areas (15%) were randomly selected. Each village has 30 to 40 households on average, (a total of 1715 graduated households). From each village 9 to 10 HHs were chosen (every 4<sup>th</sup> to 5<sup>th</sup> HH) using systematic sampling method. 353 members in model family trained and 353 in non-trained villages were included and interviewed.

**Fig. 2**  
**Sampling architecture (sampling frame)**



SRS=simple random sampling

PPS=probability proportional to size

## 5.7 Variables

**Independent variables;** include socio- demographic characteristics such as age, sex, educational status, marital status, religion, family size, being trained for model household package of the HSEP, alcohol drinking, mobility, attend night markets

**Dependent variables** (outcome variables are);

HIV/AIDS risk behaviors- casual sexual practices induced by (night markets, mobility), number of sexual partners, extramarital sex, condom use,

**5.8 Measurement-** a structured questionnaire was administered to assess the socio demographic characteristics and HIV risk behaviors.

## 5.9 Data collection

### Quantitative data

Data were collected by interview of the study subjects using standardized and structured questionnaire. Model HH package trained members and non-trained members in selected houses were interviewed. The questionnaire was adapted from standard behavioral test and functionality/practice test surveys. The questionnaire was initially prepared in English and then translated to Amharic, and back translated to English to check for consistency. The Amharic version questionnaire was pretested before the actual data collection, outside the study area then appropriate Correction done. Data were collected from January 15 to April 15, 2011 by ten nurses (degree and diploma) and ART counselors trained, and three degree nurses and one Woreda HIV/AIDS office coordinator were assigned for supervision. The intervention villages and control villages were 35, total 70 villages.

### Qualitative study

Qualitative assessment was done to reinforce and understand issues on the benefit that are gained by the training to help the house hold members to prevent HIV/AIDS, Semi structured questions were used to guide the FGD. The qualitative data was collected from 20-30 February, 2011 by setting four groups each had 7 to 10 individuals (female and male). The groups comprise different members in non mode household trained areas; **the first group**-HSEWs; **second group** front line volunteer health workers; **third group** and **forth** - members in non- model HH trained areas.

The principal investigator conducted the FGDs with the two supervisors involved as note takers. Tape recorder was used. The FGD were held by clusters sub Woredas on which the villages of FGD members are placed adjacently. Each participant was given enough time to speak, and forward ideas. Individual talking and dominance were controlled. On average 60 minutes given.

## 5.10 Data quality assurance

Data collectors are selected based on previous experience and ability to communicate with local language. A three days training was given to data collectors and supervisors. The questionnaire checked daily by the supervisors for completeness and consistency. The principal investigator rechecked the data filling. When things are not clear, explanation and corrective measures was given as feedback. The principal investigator supervised five households randomly from each village surveyed to confirm that the selected HHs is visited. The Amharic questionnaire was pretested prior to the actual data collection and corrections made.

## 5.11 Operational definitions

**Night markets-** comprise two distinct features:

A. Market places made by small number of people from 3 to 5 villages, and mostly occurred after 5:00pm. At local time, existed 4 to 6 days per week;

B. Serving at night in the houses where the head of HH move to towns for trade, houses of widowed women/men, in local alcohol selling rural tukuls of even until mid-night in the situation is referred locally as “shengo/wuckier”. Social and sexual affairs are the main objective of shengo.

**Model household;** HEWs identify and train model families that have acceptance and credibility in the community as early adopters of desirable health practices to become role models in line with health extension packages

**Risky behavior to HIV/AIDS:-** Type of activities were predisposing to HIV/AIDS and other STIs that includes alcohol drinking, sex without condom, serving in alcohol selling houses at night, serving in houses of widowed, divorced, single women/men or in other houses of sexual affairs at night, on the way of night markets when they return back to their home in the darkness, watching bad film in the town that initiate to unsafe sex, mobile people move from place to place and having sex with difference partners.

**Resource mobilization;** involvement in labour, material, money contribution in health development.

**Mobile people:** -People who move from place to another places temporarily, seasonally or permanently for different reasons such as trade, market and searching for job.

Score greater than or equal to scores; value <7.5 (50%) low participation, value  $\geq 7.5$ (50%) =high participation according to measuring scale. (See table 10 on annex)

**Non-regular partner** sexual partners, who had been together for less than 12 months, were not married, had never lived together and did not make any payment for sexual relationship.

**Community organization:** - any formal or informal structures of society include mutual assistant organization, NGO, Idir, religious, etc.

**Adequate income:** the amount of money gained from household production or trade per year which is enough to carry out medical and health expenses given in a local health center

### **Community based health service program**

Any health activity that takes place within, or is targeted at a community and that aims to improve health outcomes. It was recently stated that ‘the desired end product [of community health] is empowered communities that develop the organizational capacity to advocate for improved health outcomes.

**5.12 Data entry and analysis-** Data were entered and cleaned using epi- info version 3.5.1, and exported to SPSS V 17.0 statistical software package. In addition the cross tabulation was computed using dependent and independent variables to determine the proportions of respondents and the existence of association between independent variables and some selected sociodemographic characteristics of household respondents. Odds ratio and their 95% of confidence interval were calculated to assess the strength of association between the variables. To see the relative effect of independent variable on the dependent variable, logistic regression analysis will be carried out to SPSS version 17.0. For qualitative data tape recorder was used. Interview/FGD was transcribed and translated into English, the statement was arranged in respect of its questions and incorporated into quantitative part.

**5.13 Dissemination and utilization of the results-**The study findings were disseminated to FMOH, RHB, Guraghe Zone health department, and Woreda Health Office.

**5.14 Ethical consideration -** Ethical clearance and approval were obtained from the school of public health, college of health sciences, AAU. The necessary permission to undertake the study also obtained from Guraghe Zone Health Department and local administration. All participants were informed about the purpose of the study they had, the right to refuse, and assured of confidentiality of responses and informed consent obtained prior to each interview.

## **6. Results**

### **6.1 A.Socio-Demographic Characteristics of Model Household Trained and non-trained Groups**

A total of 695 household members were enrolled and participated in the study after fulfilling the inclusion criteria, of which 349 from the model household package trained areas and 346 from the non-model household trained areas making the response rate to be 98.4%. (Seven questionnaires were rejected for inconsistency and incompleteness as well as four participants could not be available for the interview after three attempts.)

The number of persons in model package trained group in the age group 25-35yrs were 119(34.0%), mean age= 37.8,SD=  $\pm$  7.1); whereas 89(25.7%) members of non-trained groups found in this age group, mean = 38.4, SD =  $\pm$  7.8). This may show younger groups involved in the model package training. Regarding to education, 156 (43.5%) of the model trained group and 152 (44.8%) of the non-trained groups attain primary education or below respectively. The two groups were also comparable in case of illiteracy; 171 (48.0%) in trained group and 156 (46.0%) in non-trained group respectively.

Of the respondents 322(92.2%) of the trained group were ethnic Guraghe and only 34(9.7%) of the trained group were ethnic others (Hadya, Amhara, and Oromo). While 314 (90.7%) of the non-model trained areas reported that they were ethnic Guraghe and the rest 32(9.2%) reported to be ethnic Hadya, Amhara, and Oromo all together. Considering the religion 124 (35.5%) of the trained group and 167 (48.3%) of the non-trained group were Muslim; 138 (39.5%) of trained group and 130 (37.6%) of the non trained group were Orthodox; 66 (18.9%) of the trained and 20 (5.5%) of the non trained group were protestants whereas 21(6.0%) of trained and 29 (8.4%) of the non trained group reported that they are followers of Catholic. Of the respondents, 300 (85.9%) from the trained group and 287 (82.9) from the non trained group were living with their wife/husband in union where as 4.7% and 2.6% of the trained group and 3.7% and 3.7% for the non-trained groups were widowed and separated respectively during the survey time.

Main source of income (occupation) of both groups was farming; 51.0% for the trained and 51.7% for the non-trained. Comparable number of the respondents from both groups said that their family members had adequate income for basic health expenses categorize themselves into middle income accounting for 258 (74.0%) and 187(63.4%) for trained groups and non-trained groups respectively. Whereas 26.0% of the trained group and 36.6% of the non-trained group reported that their family had inadequate income for basic health and medical expenses, being at lower economic class.

**Table -1 Socio demographic characteristics of the Study Groups and Control Groups; Cheha Woreda, Guraghe zone, SNNPR, Ethiopia, 2011**

<b>Variables</b>	<b>Model HH trained groups N=349 N (%)</b>	<b>Non trained groups N= 346 N (%)</b>
<b>Sex</b>		
Male	191 (54.7)	216(62.4)
Female	158 (45.3)	130(37.6)
<b>Age</b>		
Below 24 yrs	16 (4.6)	23(6.6)
25-35 yrs	119(34.0)	89(25.7)
35 years and above	214 (61.3)	234 (67.6)
Mean age	37.8 SD= ±7.1	38.4 SD = ± 7.8
<b>Religion</b>		
Muslim	124 (35.5)	167 (48.3)
Orthodox	138 (39.5)	130 (37.6)
Protestant	66 (18.9)	20 (5.5)
Catholic	21 (6.0)	29 (8.4)
<b>Ethnicity</b>		
Guraghe	322(92.2)	314(90.7)
Others	34(9.7)	32(9.2)
<b>Education status</b>		
Illiterate	171(48.0)	156(46.0)
Read and write only	73(20.5)	77(22.7)
Elementary	80(22.5)	75(22.1)
Secondary and above	32(9.0)	31(9.1)
<b>Marital status</b>		
Never married	35 (10)	48(13.9)
Married	300 (85.9)	287(82.9)
Others	14 (4)	
<b>Occupation</b>		
House wife	110 (31.5)	95(27.5)
Farmer	178 (51.0)	179(51.7)
Others	61(17.5)	72(20.8)
<b>Is the respondent head of household</b>		
Yes	205(49.8)	207(50.2)
No	144(50.9)	139(49.1)
<b>Adequate income</b>		
Yes	258(74.0)	187(63.4)
No	91(26.4)	159(36.6)
<b>Radio available</b>		
Yes	284(54.0)	242(46.0)
No	65(38.4)	104(61.5)

## **6.2 Risky sexual behaviors related to night markets and mobility**

Efforts were made to expose personal and sensitive issues systematically. The synonymous for sexual practices in the local language were well addressed during training time. But special care was taken for the meanings. Responses pertaining different risk behaviors from both study groups and control groups were analyzed.

Regarding casual sexual practices, 6(1.7%) of the trained group and 13 (3.7%) of the non-trained group had practiced casual sex related to night markets; Whereas 11(3.2%) from trained and 16(4.6) from non-trained practiced casual sex in relation to mobility. There is no significant difference between the two groups on casual sexual practice in relation to night markets, mobility, or “shengo”.

Regarding extramarital sex, 10(3.3%) of trained group and 20(7.4%) of the non-trained group had practiced extramarital sex; [**OR( 95%CI)= 2.1(1.1, 4.7)**]; of which 6(60%) of trained and 11(55%) of the non-trained groups used condom regularly the last 12 months they had premarital or extramarital sexual practice.

Among the respondents 40% from the trained and 45% from non-trained reported that they didn't use condom regularly when they had extramarital sexual practice. They had given the reasons: not available (20% from trained and 20% from non-trained), partner objected (5% trained and 10% of non-trained), use other contraceptive method (10% of non-trained), and don't think of it (25% of trained and 35% of non-trained. religious (50% of trained and 25% of non-trained) When asked about the number of partners, 9(3.0%) of the trained and 17(5.4%) of the non-trained group members responded that they had more than one sexual partner, the difference was statistically significant. [**OR=1.9, 95%CI (1.8, 17.1)**]; But 298(97%) of the trained and 296 (94.5%) said that they had single partner.

Among the respondents who mentioned that they joined their partner at the first sexual intercourse, 2 males and 1 female in the trained group; 3 males and 2 females in non-trained group had sexual practice with non-regular casual partner. Whereas 4 males and 1 female from trained group and 7 males and 3 females from non-trained group had sexual practice with regular partner. Of the respondents, 90.1% from trained and 89.9% from non-trained had their sexual intercourse with their husband/wife.

**Table 2 Comparison of casual sexual practices; Cheha Woreda, Guraghe Zone, SNNPR, Ethiopia, 2011.**

Variables	non-MHHP trained N=346	MHH trained N=349	OR (95% CI)
<b>Ever had casual sexual practice</b>			
<b>In relation to night markets</b>			
Yes	13(3.7)	6(1.7)	1.6(0.5, 5.0)
No	338(96.3)	344(98.3)	1
<b>Ever had casual sexual practice in relation to (Shengo )</b>			
Yes	10(2.9)	7(2.0)	1.78(0.5, 6)
No	336(97.1)	342(98.0)	1
<b>Ever had casual sexual Practice during mobility</b>			
Yes	16(4.6)	11(3.2)	1.49(0.68, 3.26)
No	330(95.4)	338(96.8)	1
<b>Ever had extramarital sex (N=-620)</b>			
Yes	20(7.4)	10(3.3)	<b>2.1(1.1, 4.7)*</b>
No	293(92.6)	297(96.7)	1
<b>N<sub>o</sub> of sexual partners (N=620)</b>			
One	296(94.5)	298(97.0)	1
More than one	17(5.4)	9(3.0)	<b>1.9 (1.62, 17.1)*</b>
<b>Condom used regularly (N=30)</b>			
Yes	11(55.0)	6 (60.0)	0.8(0.14, 2.8)
No	9 (45.0)	4(40.0)	1

\*=significance at <0.05

### **6.3 Logistic regression of Socio-demographic and other characteristics of the study**

#### **Population with dependent variables**

Regarding the sexual practice related to night markets, the regression model shown that males, 4(3.2%) in trained and 10(8.5%) in non-trained group practiced, but with significant difference, [AOR=8.5, 95%CI (2.4, 9.5)]. The age group 25-54 years was significantly higher than other age groups to casual sex in relation to small markets during darkness.[OR= 1.3, 95%CI(1.03, 1.9)]. Alcohol drinking induced 4(21%) trained and 9(47.4%) members to have sexual practice related to night markets; the widowed/divorced/unmarried 1(2.9%) in trained and 5(12.5%) in non-trained had association with sexual practice related to night markets, but not significant statistically. Merchants and others 9(13.1% trained and 11(14.7%) the non-trained group practiced sexuality related to night markets more than others, but with no statistical significant difference. Engagement in alcohol selling has association for some of the respondents 4(23%) of trained members and 7(50%) non-trained members respectively. 4.5% night market attendants had casual sex related to night markets compared to non-attendants [OR (95%CI) =5.2(2.0, 9.0)].6.5% mobile persons had casual sex related to night markets [OR (95% CI) =3.7(1.4, 9.6)].13% of mobile persons had casual sex related to mobility compared to non-mobile persons [OR (95%CI) =7.4(3.4, 13)]

**Table 3- Sociodemographic and other characteristics of respondents in relation to casual sexual Practices in Relation to night markets. Cheha Woreda; Guraghe Zone, SNNPR, Ethiopia, 2011.**

<b>Variables</b>	<b>Yes= 19 N (%)</b>	<b>No=676 N (%)</b>	<b>COR 95%CI</b>	<b>AOR95%</b>
<b>Sex</b>				
Female	3(1.1)	285 (98.9)	1	
Male	16(4.9)	391(95.1)	<b>3.8(1.2, 14)*</b>	<b>2.2 (1.6, 8.4) **</b>
<b>Age</b>				
35yrs and above	8(7.6)	440 (92.4)	<b>1.4 (1.01, 1.6)*</b>	0.41(0.13, 1.2)
25-35	10 (5.0)	198(95.0)	<b>1.9(1.6, 8)*</b>	<b>1.3(1.03, 1.9) **</b>
Below 24	1(1.4)	38(98.6)	1	
<b>Education</b>				
Illiterate	11(3.4)	316(96.6)	1.41(0.38, 5.2)	0.34(0.053, 2.2)
Primary school	5(1.6)	300(98.4)	2.93(0.68, 12.5)	1.3(0.24, 7.3)
Secondary and above	3(4.7)	60(95.3)	1	
<b>Marital status</b>				
Never married	2(2.4)	81(97.6)	1	
Others***	3 (12)	22(88)	<b>2.2(1.07, 5.5)*</b>	1.2(0.26, 6)
Married	14(2.4)	573(97.6)	0.5(0.1, 2.2)	1.2(0.23, 6.9)
<b>Occupation</b>				
Farmer/H. wife	9(2.4)	553(97.6)	1	
Others****	10(8)	123(92)	<b>3.7(1.4, 5.4)*</b>	0.6(0.15, 2.3)
<b>Income</b>				
Adequate	7(1.6)	438(98.4)	04(0.3, 2.6)	1.15(0.36, 3.6)
Not adequate	12 (4.8)	238(95.2)	1	
<b>Area</b>				
MHPT	6(1.7)	343(98.2)	1	
NMHPT	13(3.8)	333(96.2.9)	0.44(0.16, 1.19)	0.34(0.11, 1.0)
<b>Attend night market</b>				
Yes	16(3.6)	341(96.4)	<b>5.2(2.0, 9.0)*</b>	2.0 (0.69, 6.1)
No	3(1.8)	335(98.2.)	1	
<b>Mobile person</b>				
Yes	8	116	<b>3.7(1.4, 9.6)</b>	<b>1.2(1.01, 4.1)*</b>
No	11	560	1	
<b>Drink alcohol</b>				
Yes	14(20.8)	53(79.2)	<b>3.2(1.7, 7.5)*</b>	0.6(0.12, 3)
No	5 (0.8)	623(99.2)	1	
<b>Engage in selling</b>				
<b>Local alcohol</b>				
Yes	12(16)	65(84)	<b>4(2.0, 10.9)*</b>	2.3(0.2, 7.1)
No	7(1.1)	611(98.9)	1	

\*= Association

\*\*= statistical significance

\*\*\* (others) = widowed, divorced

\*\*\*\* (others) = merchants, students, jobless

Regarding the sexual practice related to mobility the regression model shown that males, 5(2.6%) in trained and 14(6.5%) in non-trained group practiced, but with significant difference, [AOR=1.7, 95%CI (1.01, 1.9)]. Age group 25-54 years practiced sexual practice related to mobility than the age group below 24 years or above 55 years in both groups [14(6.7%) of 25-35 and 12(3.7%) of 35-54]; [AOR=2.7, 95%CI (1.36, 8.5) ]. Those who were married and mobile 24(3.1%) had association with casual sexual practice related to their movement. Merchants and others [18(13.5% of the respondents from both comparative groups practiced sexuality related to mobility more than farmers or house wives, [AOR=2.1, 95 ( 1.2, 5.1)].

On the regression model, 1(2.5%) from age group below 24 years, 25(4.8%) from age 25-54 had multiple sexual partners. [OR (95%CI) =1.5(1.06, 3.4)]. Males=, 17(4.5%) had multiple partners. [OR (95%CI) =1.3(1.05, 3.0)]. Merchants, students and jobless 19(14%) had multiple sexual partners more times than farmers or house wives. [OR (95%CI) =12.8(5.2, 31)]. Widowed/divorced, 6(25%) had multiple sexual partners more times than married or never married. [OR(95%CI)=6.6(2.3, 9.2)]. The mobile persons 14(12%) had multiple sexual partners more times than non-mobile persons. [OR (95%CI)=6.4(2.8, 14.2)]. The response of the study members regarding casual sexual practices in relation to serving at night in the houses of widowed, divorced, men/women or in the houses of men/women whose spouse had moved for work (**shengo**), male, age group 25-54, and merchant or student or jobless had statistically significant association.

In this study, education had no association with sexual practice related to night markets, mobility or shengo in both trained and non-trained groups.

**Table 4- Sociodemographic and other characteristics of respondents in relation to casual sexual practices in relation to mobility, Cheha Woreda, Guraghe Zone, SNNPR, Ethiopia, 2011.**

<b>Variables</b>	<b>Yes=27 N (%)</b>	<b>No= 668 N (%)</b>	<b>COR 95%CI</b>	<b>AOR95%CI</b>
<b>Sex</b>				
Male	19(5.6)	388(94.4)	<b>2.0(1.2, 3.8) *</b>	<b>1.7(1.01, 1.9) **</b>
Female	8(2.8)	280(97.2)	1	
<b>Age</b>				
Below 24	1(2.5)	38(97.5)	1	
25-35	14(6.7)	194(93.3)	<b>6.4(2.7, 23)*</b>	<b>2.7 (1.36, 8.5) **</b>
35 and above	12(3.7)	436(96.3)	<b>2.4(1.0, 8.4)*</b>	1.1(0.3, 4)
<b>Education status</b>				
Illiterate	8 (2.5)	319(97.5)	0.41(0.16, 1.0)	0.61(0.22, 1.7)
Primary	17(5.6)	288(94.4)	0.21(0.18, 1.65)	0.56(0.14, 2.2)
Secondary and above	2 (3.2)	61 (96.8)	1	
<b>Marital status</b>				
Never married	2(2.4)	81(97.6)	0.59(0.13, 2.8)	0.4(0.1, 1.5)
Married	24 (3.1)	563(96.9)	<b>1.1(1.01, 2.3)*</b>	1.0(0.1, 5.3)
Others***	1(10.8)	24(89.2)	1	
<b>Occupation</b>				
Farmer/H. wife	9(1.6)	553 (98.4)	1	
Others****	18(13.5)	115(86.5)	<b>9.3(4.3, 21)*</b>	<b>2.1(1.2, 5.1) **</b>
<b>Income</b>				
Adequate	17(3.8)	428(96.2)	1.0(0.46, 2.2)	0.6(0.24, 1.4)
Not adequate	10 (4.0)	240(96.0)	1	
<b>Area</b>				
MHPT	11(3.2)	338(96.8)	1	
NMHPT	16(4.7)	330(95.3)	0.63(0.29, 1.36)	0.78(0.34, 1.8)
<b>Mobile person</b>				
Yes	16(12.9)	108(87.1)	<b>7.4(3.4, 13)*</b>	<b>2.9(1.1, 8.3) **</b>
No	11(1.9)	560(98.1)	1	

\*= Association

\*\*= statistical significance

\*\*\* (others) = widowed, divorced

\*\*\*\* (others) = merchants, students, jobless

**Table 5- Sociodemographic and other characteristics of respondents to casual sexual practice in Relation to serving in widowed/divorced houses at night, Cheha Woreda, Guraghe Zone, SNNPR, Ethiopia, 2011.**

Variables	Yes= 17	No= 678	OR ( 95%CI)	AOR (95%CI)
<b>Sex</b>				
Female	3 (1.1)	285(98.9)	1	
Male	14 (4.5)	393(95.5)	<b>3.4(2.0, 5) *</b>	<b>1.6 (1.03, 3.8) **</b>
<b>Age</b>				
≤ 24	1(2.6)	38(97.4)	1	
25-35	12(5.3)	196(94.7)	<b>2.0(1.07, 4.2)*</b>	<b>1.6 (1.1, 2.8) **</b>
35 and above	4(0.9)	444(99.1)	<b>1.3(1.01, 1.9)*</b>	0.12 (0.023, 1.75)
<b>Education status</b>				
Illiterate	7(2.1)	320(97.9)	0.71(0.26, 1.9)	0.27 (0.19, 3.97)
Primary	9(3.0)	296(97.0)	1.37(0.16, 11.3)	0.21(0.25, 2.17)
Secondary and above	1(1.6)	62(98.4)	1	
<b>Marital status</b>				
Never married	1(1.2)	82(98.7)	1	
Others***	2 (8.7)	23(91.3)	<b>3.7(1.37, 16.6)*</b>	<b>2.9 (1.71, 4.2) **</b>
Married	14(1.0)	573(99.0)	<b>2.0(1.07, 3.8)*</b>	1.4(0.21, 3)
<b>Occupation</b>				
Farmer/house wife	10(1.8)	552(98.2)	1	
Others****	7(5.3)	126(94.3)	<b>4.7(1.17, 16.6)*</b>	0.44 (0.08, 2.29)
<b>Income</b>				
Adequate	10(2.3)	435(97.7)	1.25(0.43, 3.3)	0.85 (0.23, 3.11)
Not adequate	7(2.8)	243(97.2)	1	
<b>Area</b>				
MHPT	5(1.4)	344(96.6)	1	
NMHPT	12(3.5)	334(96.5)	2.47(0.86, 7.1)	2.76 (0.88, 8.6)
<b>Mobile person</b>				
Yes	10	114	<b>7.6(2.8, 20) *</b>	<b>2.3(1.04, 5.4) **</b>
No	7	462	1	
<b>Attend house of Widowed/divorced</b>				
Yes	8 (13.0)	55(87.0)	<b>6(2.3, 20)*</b>	<b>2.6(1.7, 13) **</b>
No	9(1.4)	623(98.6)	1	
<b>Drink alcohol</b>				
Yes	11(16.5)	56(83.5)	0.79(0.17, 3.5)	3.9(0.49, 5.1)
No	6 (10.0)	622(90.0)	1	
<b>Engage in selling alcohol</b>				
Yes	6 (7.8)	71(92.2)	0.21(0.077, 0.59)	0.53(0.12, 2.3)
No	11(0.2)	607(99.8)	1	

\*=association

\*\*\*=others (widowed, divorced)

\*\*=statistical significance

\*\*\*\*=others (merchants, students, jobless)

Multivariate analysis of sociodemographic characteristics and other selected variables with HIV/AIDS risk behaviors shown that 10(3.3%) of the trained and 20(7.4%) of the non-trained members practiced extramarital sex, **AOR=3.1, 95%CI (1.7, 13)**, Males practice extramarital sex more in both groups [(8(2.6%) and 17(9.3%) respectively]; [**AOR=6.1, 95%CI (1.7, 21)**]. The age group 25-54 years practiced extramarital sex more than other age groups in both groups (9 from the trained and 17 from the non-trained) had extramarital sex were at the age group 25-54 years, [**AOR=1.5, 95%CI(1.02, 2.9)**]. The married 6(60%) trained and 15(75.1%) practiced more extramarital sex than non-married or others [**AOR= 5.1, 95%CI (1.8, 26)**]. Of the respondents, 6(60%) of trained and 16(80%) of the non-trained, being had occupation of merchant and others practiced more extramarital sex than other occupations. [**AOR=1.8, 95%CI (1.4, 6.8)**]. Of the respondents 4 from training group and 10 from non-trained had extramarital sex influenced by alcohol drink, [**AOR= 3.9, 95%CI (2.8, 20)**]. Engaging in alcohol selling had association with extramarital sex. [OR(95%CI)= **4.3(2.0, 9.0)**]. 7.2% of the night market attendants had extramarital sex compared to non-attendants. [OR (95%CI) =1.8(1.1, 7.0)]. Of the respondents 15.4% of mobile persons had extramarital sex compared to non-mobile persons. [OR (95%CI) =7.07(3.4, 15)].

**Table 6- Sociodemographic and other characteristics of respondents in relation to Extramarital sex, Cheha Woreda, Guraghe Zone, SNNPR, Ethiopia, 2011. (N=620)**

<b>Variables</b>	<b>Yes=30 N (%)</b>	<b>No=590 N (%)</b>	<b>COR 95%CI</b>	<b>AOR95%CI</b>
<b>Sex</b>				
Female	5(1.9)	263(98.1)	1	
Male	25(7.1)	327(92.9)	<b>4.1(1.7, 21) *</b>	<b>3.3(1.2, 8.9) **</b>
<b>Age</b>				
35yrs and above	10(2.5)	392(97.5)	<b>1.3(1.1, 1.9)*</b>	0.7(0.2, 2.2)
25-35	19 (9.5)	170 (90.5)	<b>2.1(1.2, 7.8)*</b>	<b>1.5(1.02, 2.9) **</b>
Below 24	1(1.7)	28(98.3)	1	
<b>Education</b>				
Illiterate	12(4.1)	280(95.9)	0.91(0.8, 13)	0.7(0.2, 2.4)
Primary school	15(5.5)	255(94.5)	1.49(0.8, 4.6)	1.3(0.3, 6)
Secondary and above	3(5.0)	55 (95.0)	1	
<b>Marital status</b>				
Never married	2(3.6)	53(96.4)	0.2(1.0, 2.8)	2.5(0.6, 10)
Married	27 (5.1)	517(94.9)	<b>3.1(1.3, 3.7)*</b>	<b>5.1(1.8, 26) **</b>
Others***	1(4.6)	20(95.4)	1	
<b>Occupation</b>				
Farmer/H. wife	8(1.6)	505(98.4)	1	
Others****	22(17.5)	85(79.5)	<b>6.4 (4.5, 30)*</b>	<b>1.8(1.4, 6.8) **</b>
<b>Mobile person</b>				
Yes	17(15.4)	97(84.6)	<b>7.07 (3.4, 15)*</b>	2.7(0.8, 8.6)
No	13(2.5)	493(97.5)	1	
<b>Night market attendant</b>				
Yes	21	336	<b>1.8(1.1, 7.0)*</b>	1.2(0.3, 3.4)
No	9	254		
<b>Area</b>				
MHPT	10(3.3)	306(96.7)	1	
NMHPT	20(7.4)	284(92.6)	<b>2.0(1.6, 14)*</b>	<b>3.1(1.7, 13) **</b>
<b>Drink alcohol</b>				
Yes	14(20.9)	49(89.1)	<b>6.1(1.3, 8.0)*</b>	<b>3.9(2.8, 20) **</b>
No	16 (3.0)	541 (97.0)	1	
<b>Engage in selling</b>				
<b>Local alcohol</b>				
Yes	10(13.0)	60(87.0)	<b>4.3(2.0, 9.0)*</b>	0.15(0.03, 3.7)
No	20(3.1)	530(96.9)	1	

\*=association

\*\*\*=others (widowed, divorced)

\*\*=statistical significance

\*\*\*\*=others (merchants, students, jobless)

### **Preventive behaviors to HIV/AIDS transmission**

Among the respondents 46(13.2%) from trained and 37(10.7%) from non-trained had willing to condom use as to prevent from HIV transmission. Regarding sharing sharp materials 332(95%) from trained and 329(95.1%) from non-trained reported that they never shared sharp materials or razor blade with others in the past one year. Of the respondents 103(29.5%) from trained and 48(13.8%) from non-trained had tested at least once for HIV voluntarily in the past one year. Regarding the other main methods of HIV transmission, 118(33.8%) from trained and 92(26.8%) from non-trained had willing for faithful and 66(18.9%) from trained and 54(15.6%) from non-trained had willing for abstinence from sex before marriage.

**Table 7 preventive behaviors to HIV/AIDS transmission Cheha Woreda, Guraghe Zone, SNNPR,**

#### **Ethiopia, 2011**

<b>Variables</b>	<b>Model HH trained group</b>		<b>Non-trained group</b>	
	<b>number</b>	<b>percent</b>	<b>Number</b>	<b>Percent</b>
<b>Willing to condom use</b>	46	13.2	37	10.7
<b>Not shared razor blade or sharp materials with others</b>	332	95	329	95.1
<b>Tested for HIV voluntarily</b>	103	29.5	48	13.8
<b>Willing to faithful</b>	118	33.8	92	26.5
<b>Willing to abstinence</b>	66	18.9	54	15.6

There are some predictor activities to influence the performance of casual sexual practices by the respondents. Among the respondents 25(7.2%) from trained group and 52(15%) from non trained group responded that they engaged in selling alcohol at small tukuls in their residence compound at night. [**OR=2.3, 95%CI (1.3, 3.8)**]. Of the respondents 18(5.2%) from the trained and 45(12.8%) from the non trained group had served at night in houses of widowed/divorced/people who moved to other places for work. [**OR=2.7, 95%CI (1.5, 4.8)**]. There is also difference observed regarding alcohol drink in the two groups, 46(13.3%) in the non-trained and 21(6%) in the trained group respectively. [**OR=2.1, 95%CI (1.3, 3.5)**]. Of the respondents 181(52.3%) of the non-trained groups and 122 (34.9) of the trained group members believe that some social or economic benefits could be gained by attending small markets at dusk and night. [**OR=2.0, 95%CI (1.4, 2.7)**]. Whereas 91(26.3%) of the non-trained group and 62(17.8%) of the trained group believe that some economic, social, or psychological benefits gained by serving in widowed/divorced men/women or in the houses of mobile persons at night for different pretext. [**OR=1.6, 95%CI (1.1, 2.4)**].

**Table 8 Activities helping to have casual sexual practices to be done in relation to night markets, mobility, and shengo: Cheha Woreda, Guraghe Zone, SNNPR, Ethiopia, 2011.**

Variables	non-MHHP trained	MHH trained	OR (95% CI)
<b>Attend and serving in Small markets at night</b>			
Yes	197(56.9)	160(45.8)	<b>1.56(1.15, 2.1)*</b>
No	149(43.1)	189(54.2)	1
<b>Engage in selling local alcohol</b>			
Yes	52(15.0)	25(7.2)	<b>2.3(1.3, 3.8)*</b>
No	294(85.0)	324(92.8)	1
<b>Attend and serving in Shengo</b>			
Yes	45(12.8)	18 (5.2)	<b>2.7(1.55, 4.8)*</b>
No	301(86.9)	331(94.8)	1
<b>Drink alcohol</b>			
Yes	46(13.3)	21(6.0)	<b>2.1(1.3, 3.5)*</b>
No	300 (86.7)	328(93.9)	1
<b>Mobile person</b>			
Yes	66 (18.9)	58(16.6)	0.84(0.57, 1.25)
No	280(80.9)	291(83.4)	1
<b>Believe that economic/ social benefits by serving night markets</b>			
Yes	181(52.3%)	122(34.9%)	<b>2.0 (1.4, 2.7)*</b>
No	165(47.7%)	227(65.0)	1
<b>Believe that economic/ social benefits by serving at (Shengo)</b>			
Yes	91(26.3)	62 (17.8)	<b>1.6 (1.1, 2.4)*</b>
No	255(73.7)	287 (82.2)	1

\*= significance at < 0.05

## **7. Discussion**

### **7.1 HIV/AIDS Risk behaviors**

In this study it had tried to reveal the effect of model package training of the health extension program on HIV/AIDS risk behaviors and community participation level comparatively between trained and non-trained groups. It is very crucial that the working age group serve on small markets at night for exchange of food and other materials. Young women consider them as places where they join and chat with their friends. Even though most people thought that night markets gain social as well as economic benefits they facilitate the HIV/AIDS transmission being synergized by other traditional ceremonies. It is expected that individuals will have risk behaviors to HIV/AIDS since they involved in different activities related to night markets. This study revealed most of the HIV/AIDS risk behaviors were evident at non-model package trained group than the trained.

In this study casual sexual practice related to, night markets, mobility and serving at widowed men/women were 6(1.7%), 11(3.2%), and 7(2.0%) respectively in trained group. Whereas in control group the casual sexual practice related to night markets, mobility and serving in widowed/divorced men/women at night were 13(3.7%), 16 (4.7%) and 10(2.9) respectively. There is no significant difference on casual sex practices between the two comparative groups. 16(4.9%) males, 13(12.6%) the age group 25-54 years, 3(12%) widowed and divorced than married, 10(7.5%) merchants and others were significantly higher in sexual practice related to night markets. Persons induced by alcohol drink, 14(20.8%) and persons engaged in alcohol selling at night were also significantly higher in sexual practice related to night markets.

EDHS 2005 showed that 25 percent of women and 33 percent of men who were widowed, divorced or separated said they had engaged in higher-risk sex the last 12 months they had sex(25). This study could be comparable to a study done in Kombolcha on male daily laborers revealed that 27.7% responded to have casual sexual practice(34) . Another study done in Guraghe zone shown 10% married and 3.3% never married had sexual practice in relation to night markets (11).

The low level in this study compared to other studies could be due to extensive community education and mobilization in this study area using the HIV/AIDS package-community conversation through community enhancement on prevention and control of HIV/AIDS in recent years or this study was done in rural setting, lower reporting of recent sexual history could be resulted or both.

The other risky HIV/AIDS behavior discussed was sexual practice in relation to mobility. 11(3.2%) from trained and 16(4.6) from non-trained practiced casual sex in relation to their departure from family for trade or search for jobs. OR (95%CI) =1.49(0.68, 3.26). Regarding the sexual practice related to mobility the regression model shown that males, 5(2.6%) in trained and 14(6.5%) in non-trained group practiced **[AOR=1.7, 95%CI (1.01, 1.9)]**. The study had revealed that 19(5.6%) males, 26(10.5%) of the age group 25-54 years, 18 (13.5%) merchants and others, 16 (12.9%) mobile persons, had significantly higher sexual practice in relation to mobility than their opponent characteristics in both comparative groups. Actually there is difference in number to each category between the two comparative groups.

A study done in Gambella showed that the individuals who engaged in unprotected sex were 24.5% of mobile merchants, 19.1% of students, 18.5% of Farmers and 17.4% of government employees(35). In this study overall 10(3.3%) from trained group and 20(7.4%) from non-trained had extramarital sex with significant difference. **[AOR (95%CI) =3.3(1.2, 8.9)]**. In both comparative groups of this study, more males 25(7.1%)] than females, 5(1.9%) had extramarital sex. Of the age groups, 25-54years, 28(12%)] of marital status, the married [21(5.1%)] of occupation the merchants, students and jobless [22(20.5%)] and those induced by alcohol drink [14(20.9)] had practiced extramarital sex. The finding is comparable with other studies. In the EDHS 2005, 4% of married males and 1% of married women practiced more than two partner, 5% unmarried men and 1% unmarried women practice more than one partner (25). Another study done in other Woreda in the same Zone found that 10% married and 3.3% non-married practiced extramarital sex; 10.8% males and 1% female had practiced extramarital sex.(11) .

Regarding the number of sexual partners, 9(16%) from the model trained and 17(29%) from the non-trained group reported to have more than one partner; **[OR= (95%CI) = (1.62, 17.1)]**. The difference between the two comparative groups is statistically significant. 1(2.5%) from age group below 24 years, 25(4.8%) from age 25-54 had multiple sexual partners. [OR (95%CI) =1.5(1.06, 3.4)]. Males=, 17(4.5%) had multiple partners. [OR (95%CI) =1.3(1.05, 3.0)]. Merchants, students and jobless 19(14%) had multiple sexual partners more times than farmers or house wives. [OR (95%CI) =12.8(5.2, 31)]. Widowed/divorced, 6(25%) had multiple sexual partners more times than married or never married. [OR (95%CI) =6.6(2.3, 9.2)]. The mobile persons 14(12%) had multiple sexual partners more times than non-mobile persons. [OR (95%CI) =6.4(2.8, 14.2)]. This result of both groups could be compared to the studies; One study done in Kombolcha on daily laborers 43.3% practiced more than one sexual partner(34). Another study done on Kenyan tea farm plantation workers revealed that 40% had more than one sexual partner concurrently;(36). A research done on HIV/AIDS vulnerability among migrant farm workers on the

South African-Mozambican border revealed that 36.0% of the respondents admit to having more than one sexual partner. (16). Another study done in Addis Ababa showed that 13.2% multiple sexual partners.(37) (Serkalem Girma-printed research). In this study the percent of having more than one partner is lowered may be due to the research was conducted in rural area.

Regarding condom use overall 60% of the trained group and 55% of the non-trained group used condom. More specifically 5 males (60%) and 2 females (15%) of trained group, on the other hand 11 males (55%) and 2 females (10%) of the non-trained group used condom regularly the last 12 months they had premarital or extramarital sex. There is no significant difference between the two comparative groups. The overall study is comparable with studies;

The Ethiopian BSS found a 34% of sexual risk groups of both sexes used condom. This could be compared to another study done in Kenya, revealed 20% females and 35% males among the risky group use condom(36). Another study in Addis Ababa showed that 47.3% condom use (Serkalem Girma).(37) The 2005 Ethiopian Demographic and Health Survey also documented a rate of 23.6% and 51.7% condom use during the last high risk sex among women and men respondents of age group 15 to 49 years respectively(25). The lower number of females in this study may be due to the study done in rural area. A study conducted in Tanzania revealed that 30% males and 12% females used condom regularly(35).

Among the respondents 40% from the trained and 45% from non-trained reported that they didn't use condom regularly when they had extramarital sexual practice. There is no significant difference between the two comparative groups. They had given the reasons: not available (20% from trained and 20% from non-trained), partner objected (5% trained and 10% of non-trained), use other contraceptive method (10% Of non-trained), and don't think of it (25% of trained and 35% of non-trained. religious (50% of trained and 25% of non-trained).

A study done in Bahir Dar to assess perceived barriers to behavioral change towards the prevention of HIV/AIDS among age groups 15 to 49 years revealed that of those who had sex in the past 12 months only 16.4 percent used condoms. The main reason for not using condom was attributed to: having interest in one partner 86.9%, followed by disliking condom 6.4%, religious disapproval 4.9%, partner objection 1.8%, and unavailability of condoms 0.6% (38).

Evidences from focus group discussions support the findings of risk sexual behaviors related to night markets and mobility. A total of four focus group discussions held with a total of 29 discussing members

aged 21-49, male and female at non-model package trained Kebeles. The Kebeles and FGD members were selected purposively and randomly. The purpose of selection at non-program area is to indirectly assess their observations and opinions to reinforce the study facts. Due attention was made not to have predominant ideas among them during discussion. The discussants made to tell stories on sensitive issues.

In the focus group discussions the members reported that night markets are widely attended by people. They are considered as fast shops since they assembled at the end of the day when labor-based activities become end. Majority of the discussion members well agreed that night markets are believed to be advantageous by the community.

- Economic
- Social
- Recreational

*A 24 years old unmarried girl said “night markets are places where we wiped out our breathes” <<Many poor women collect lumps of bread, injera, or some cubbage to grow their children; Fetan sukochachin nachew >>.*

But Most of the FGD members believed in that unprotected sex is the major way of HIV/AIDS transmission in the area. Majority of the discussion members come into agreement and some even condemned the negative effects of mobility to far cities for long time for search of job. The members made agreement in terms of:

- departure from family members and loss of family integrity, hence loneliness and lack of support and responsibility from the household head.
- Work load on women and students not follow their education smoothly
- Displaced people from towns are known to transmit unhealthy behaviors; Khat chewing, alcohol drink, shisha smoking.
- Suspicion of HIV/AIDS transmission mostly from husband to the wife since they arrive at annual local holidays.

*<<I myself and my husband join each other only during annual holiday “ Eyatefam Eyatefum nibret” meaning a type of life neither kill nor improved. He enjoyed a comfortable life, I heard. When we stand side by side nobody think that I am his wife due to body wasting! >>, one female said.*

The focus group discussion members come into consensus that sexual practice out of marriage is highly condemned in the community, but it is known that some men and women deviate the norm and have extramarital sex hidden. At times this ends with quarrel and family disintegration. Previously in Gurage night markets were seen as a market and there were no premarital and extramarital sex. It was forbidden and considered as a shameful act. However, nowadays some youngsters who travel between urban and rural developed bad habits drinking alcohol, Khat chewing, smoking shisha; in rural town areas and they reflected that in rural areas in relationship with night markets. They had engaged in risky sexual practice by frightening females in some areas of night markets. Some of the youngsters act as if they are helpful or accompany females on the ways back to home in the darkness. This condition initiates sexual desire where there were roadsides covered by false bananas and eucalyptus trees and bushes. Females hesitate to report even though they are the most affected by the problem.

A 36 years old woman said; *many problems had subsided after conversation and repeated meetings, but “Yemushra bet Kimha” meaning bride room dance and chat chewing, “Chifera” meaning holiday time street dances persisted by many young people.*

## 8. Strengths and Limitations

### Strengths

1. The study is a community based comparative type the study was conducted in rural set up; hence, selection bias was minimized. The large sample size and appropriate and probability sampling methods also helped to improve the validity of study. Utilization of appropriate data collection procedures and statistical methods played the role in minimizing bias and confounding factors.
2. The use of quantitative and qualitative methods of data collection enabled to have better information and triangulation of findings in an area where information about the issue is not addressed yet.

### Limitations

1. The disclosure of some sexual behaviors may be difficult since this is sensitive issue and the majority of study population was traditional rural community.
2. Overestimation, social desirability and subjectivity may be present due to the fact that the respondents desired to provide socially acceptable response as well as to be focused by the government/political leaders.
3. Overestimation and social desirability may be the constraint of this study since the data collectors were all health professionals even though maximum effort was tried to avoid such problems during the training time.

## 9. Conclusion

1. Night markets, mobility for search of work, serving in the houses of widowed/divorced induce HIV/AIDS transmission through sexual and other risk behaviors in the study being emerged in accordance with timely socio-economic changes; but there is no as such difference between model household trained and non-trained groups.
2. Males, age 25-54 years, merchants/students/jobless, widowed/divorced, alcohol drinkers had higher casual sexual practices in both trained and non-trained groups.
3. Males, age 25-54 years, merchants/students/jobless, married, had higher casual sexual practices in both trained and non-trained groups.
4. There are holiday and wedding related activities as well as other traditional activities firing HIV/AIDS transmission; (ceremonies related to holidays, street dance, and bride room ceremonies of the young, ceremonies by students after completion of their national examinations.)
5. The non-model trained group members had multiple sexual partners more times than the trained members. In addition the night market attendants had multiple sexual partners more times than the non-attendants. The mobile persons had multiple sexual partners more times than the non-mobile ones.
6. Members in areas where model household training was not given had extramarital sexual practice more than than that of trained areas.
7. Males, age 25-54 years, merchants/students/jobless, married, and alcohol drinkers had higher casual extramarital sex in both trained and non-trained groups.

## **10. Recommendations**

1. Small markets at night should be shifted to the day time, better to avoid some of the night markets through integration of the Woreda Council and social sectors.
2. In rural communities like that of Gurage, ceremonies by the young group related to wedding, holidays, national examinations, should be controlled.
3. Extensive public education and BCC on continuous basis should be done at market places and public collection areas.
4. Job opportunities should be tried in the local areas being integrated with bureau of small scale industries
5. Continuous capacity building and refresher training for the previously trained household members should be done by the Woreda and zonal health offices. The model household training should incorporate skills/methods enable to reduce HIV/AIDS risk behaviors related to the practices of local area.
- .6. To increase health care utilization, community mobilization and announcement should be intensified to aware the public on the services available in the nearest health centers and health posts.
7. Model household training should be further evaluated and studied with regard to different health service -es.

## 11. References

1. WHO G. AIDS Epidemic Updates. Dec 2009.
2. Peterepiot BM. The epidemiology of HIV and AIDS. AIDS in Africa 2nd edition 2002: PP: 123-124, 655. 2002.
3. UNAIDS. Technical Update. Sex work and HIV/AIDS. June 2002.
4. MOH. Disease Prevention and Control Department, AIDS in Ethiopia Technical Document for the FFTH Report. September 2004.
5. Campbell CM, Masculine Identities and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Mines", Soc.Sci.Med. 1997Vol. 45, No. 2, pp 273-281. 1997.
6. LeBeau DaPM. "The Influence of Poverty on the Epidemiology of HIV/AIDS and its Subsequent Reinforcement of Poverty among Economically Marginalised Families in Northern Namibia". Paper presented at the Southern African Universities Social Science Conference (SAUSSC), Windhoek, 3-5 December 2001. Dec. 2001.
7. LeBeau D, Tom Fox, Heike Becker and Pempelani Mufune An Anthropological Assessment of Health Care and Risk Behaviour in North-Western Namibia. DRAFT. UNAM/MoHSS: Windhoek. 1999.
8. Kaundjua M. HIV and AIDS Epidemic in Southern Africa: A Case of 'High Risk Milieu' in Namibia's Health. unpublished Master's thesis, Institute of Social Studies, The Hague. 2000.
9. FMOH. Health and Health related Indicators. 2009.
10. Guraghe ZHD. Annual Report, . 2009/2010.
11. YOUSUF J. Assessment of risky sexual behavior for HIV infection with special focus on night markets and mobile people in Gummer Woreda, Gurage Zone July 2004.
12. WHO. Coverage of selected health services for HIV/AIDS prevention and care in less developed countries in 2001. Nov. 2002.
13. Tadesse D. Disease Prevention and Control Department, Ministry of Health: AIDS in Ethiopia. Fourth Edition. Oct. 2002.
14. Richard M. Persuading people to have safer sex, Application of social sciences to the AIDS crisis, 2001, New Jersey, London. PP. 1-133. 2001.
15. Taylor ESEa. Health Psychology, 1991, USA. pp. 51-117. 1991.
16. JICA IOFM. HIV/AIDS vulnerability Among Migrant Farm workers on the South African-Mozambican border researched for JICA. South african Region Feb 2004.
17. BIBLIOGRAPHY RFADRA. Mobile Populations and HIV/AIDS in the Southern African Region, HIV/AIDS for Action Desk review and Bibliography on HIV/AIDS. May 2003.
18. WHO. Synthesis of recent and relevant reviews conducted in the health sector. Addis Ababa. 2004.
19. Bank UW. AIDS, poverty Reduction and Debt Relief, Geneva, Switzerland. March 2001.
20. UNAIDS. HIV/AIDS and STI prevention and care in Rwandan refugee camps in the United Republic of Tanzania. Geneva, Switzerland 2003.
21. S I. Routes of spread of HIV infection into rural community of Ethiopia: Limu District, South Showa region.( MPH thesis) Department of Community Health. Addis Ababa University, March 1992.
22. FMOH. Health Sector Development Plan, HSDP III. 2005/6- 2009/10.
23. WHO. Community involvement in health: challenging health services,. 1991, Geneva.
24. Health Division;South Africa. Community Based Health Service Delivery Framework,. January, 2009.
25. CSA. Ethiopian Demographic and Health Survey 2005.
26. FDRE;CSA. Population Census Commission. Summary and Statistical Report of the 2007 Population and Housing Census Results,. 2008,Addis Ababa.
27. FDRE;MOH. Essential Health Services Package for Ethiopia, . AUGUST, 2005.
28. Teweldebrhan H. Health Extension Program, Challenges, A Lesson From Field Practice,Addis Ababa. February, 2005.
29. FMOH. Expansion of Primary Health Coverage Ethiopia,. 2005-2009.
30. Centre for National Health Development; Ethiopia. Assessment of the working conditions of the first batches of health extension workers,. May, 2006; Addis Ababa.

31. FMOH: Health Extension and Education Center. Health Extension Program in Ethiopia: Profile, Addis Ababa, Ethiopia;. June, 2007.
32. FMOH: Health Extension and Education Center. Health Extension Program Operation Guide. February, 2007.
33. Woreda Health Office; Cheha. Annual Report, . 2009/2010.
34. Endris B. Assessment of Riskyssexual Behavior for HIV/AIDS Among Male Daily Laborers inKombolchaT-town, South Wollo Zone, Amhara National Regional State, North East Ethiopia. March, 2007.
35. Nehash Y BG, Daniel B,, Mebratu B. A communitybased study on HIV/AIDS in Gambela town western Ethiopia. Ethiop J Hlth Dev. Dec. 2003. 2003.
36. Ondimu KN. Risky sexual behavior among migrant tea workers in Kenya, OSSREA. 2005.
37. Girma S. assessment of sexual behavior and barriers to condom use among federal government employees in Addis Ababa. Feb., 2006.
38. Ashebir Kidane S. Perception of risk of HIV/STIs and Condom use among high school adolescents in South-Gondar Administrative Zone, Amhara Region. 2004.

## **Annex – I Guideline for Focus Group Discussion**

Interview guide, for FGD with, Health extension workers, community members, (Members in model HH trained area and non-trained area ), Community health workers

### **INTRODUCTION**

Thank you for coming to this session, your presence is very important. (Description: - what a focus group what it like an opinion survey, but very general, broad questions).

**PURPOSE:** - We will be discussing your reaction/perception and experience about the importance, impact and challenges of implementation of packages covered in model household training in health extension packages.

- All your ideas, comments and suggestions are of great importance for us.
- There is no right or wrong answer; all comments both positive and negative are welcome.
- Please disagree to one another when necessary. We would like to have many points of view. Ask each participant to introduce him/her self.
- Name
- Something about one's self, position, work or residential experience and others as

desired. The groups comprise different members in non model HH trained areas;

**the first group**-HSEWs;

**second group** front line volunteer health workers ;

**third group** and **forth** - members in non- model HH trained areas.

### **1 – Discussion points**

A – Community perception on importance/harms of night markets.

B – The risk characteristics of small markets during the night time.

C-the risk characteristics associated with serving in houses of widowed/divorced or in the house of mobile men/women whose spouse moved to other place for trade

D-sexual practice out of marriage in the Woreda.

**ANNEXE- II**

**STRUCTURED QUESTIONNAIRE FOR QUANTITATIVE STUDY**

**Questionnaire ID Number** \_\_\_\_\_

**HOUSEHOLD QUESTIONNAIRE**

Name of Woreda \_\_\_\_\_ Kebele-----village \_\_\_\_\_

**INFORMED CONSENT**

Hello. My name is----- and I am part of a team of people who are carrying out a survey (1.read the title and tell its benefits; 2. show a letter of approval from Woreda Health Office).We would very much appreciate your participation in this survey. I would like to ask you some questions and it will take about 50 minutes. Your answers will remain confidential, and we will not be taking down your name or address, so your answers will be anonymous. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important. At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Start time\_\_\_\_: \_ End time\_\_\_\_: \_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_

RESPONDENT AGREES TO BE INTERVIEWED.....

RESPONDENT DOES NOT AGREE TO BEINTERVIEWED.....

Address of principal investigator;

Hayatu Muze Abdo

Guraghe Zonal Health Department

Tel-251-113301794

Mobile-251911879985

[Email-hayatu1395ah@yahoo.com](mailto:Email-hayatu1395ah@yahoo.com)

P.O.Box-276 Wolkite

S.no	Question	Answer	code	Skip
01	Questionnaire number	-----		
02	Name of the Kebele	-----		
03	Name of village	-----		
04	ID № of the village	-----		
05	Total population of the Kebele	-----		
06	ID №of the respondent			

**Part-1 Socio-demographic Characteristics of house hold members**

07	Sex	Male	1	
		Female	2	
08	Age in years	_____		
09	Religion	Orthodox	1	
		Muslim	2	
		Catholic	3	
		Protestant	4	
		Other(specify)-----	5	
10	Residence	Model HH study area	1	
		Non-model HH study area	2	
11	How long you lived in this Kebele?	Less than two years	1	
		Two years or above	2	
12	Ethnicity	Guraghe	1	
		Amhara	2	
		Oromo	3	
		Tigre	4	
		Other(specify)-----	5	

13	Educational status	Illiterate Read and write only Elementary High school	1 2 3	
14	Marital status	Single Married Widowed Divorced	1 2 3 4	
15	Occupation	House wife Farmer Trader Student Other(specify)-----	1 2 3 4 5	
16	Is the respondent the head of the House hold?	Yes No	1 2	→18 If yes
17	If Q 16 is no, what is your relation with the head of house hold?	Husband Wife Son Daughter Other(specify)-----	1 2 3 4 5	
18	Do you have functional radio at home	Yes no	1 2	
19	Is your income enough to fulfill basic health related needs of your family compared to others in the village/Kebele?	Yes No	1 2	

20	Did you trained and completed in model house hold Package and/or Community Conversation for Enhancement program (CCE) and graduated?	Yes No	1 2	
21	How old were you when first married	_____ Years  I Don't know	1 2	
22	Currently are you living with your spouse with whom you have sexual relationship?	Yes No	1 2	
23	If married Man: do you have more than one wife? Woman: Does your husband have	Yes No Don't know	1 2 3	
24	Have you ever had sexual intercourse?	Yes No	1 2	
25	In Q24 if the answer is yes, at what age did you first have sexual intercourse?	_____ Years Don't know	1 2	
26	Where did you have first sexual intercourse?	In _____ place  Time: Night Day	1 2	
27	With whom did you have first time sexual intercourse?	.Casual partner .Regular partner . Husband/Wife .Unknown person	1 2 3 4	

28	Have you had sex in the following place? Circle "1" for yes and "2" for no answers, More than one answers, others.	<p style="text-align: right;">Yes No</p> 1.In the night markets..... 1 2 2.Relation with mobility of trade ..... 1 2 3.In wedding place..... 1 2 4...In local ceremony..... 1 2 5. In guest place..... 1 2 6. In alcohol drinking place.		
29	Have you ever had sex out of marriage?	Yes No	1 2	
30	Have you ever had sex out of marriage influenced by alcohol consumption?	Yes No	1 2	
31	If yes for Q30, was condom used?	Yes No	1 2	
32	How many sexual partners do you have now?	One. more than one	1 2	
33	There are many night markets in the Woreda Including your Kebele, Do you or your family members attend which of the following markets in the past 6 months?	<p style="text-align: right;">Yes No</p> Night market .....1 2 Day market .....1 2 Both ..... 1 2		
34	What do you feel about their importance?	They are important They are harmful	1 2	
35	Why did you participate in night markets?	Trading Alcohol drinking Meeting partner Others	1 2 3 4	

36	Did you attend night ceremonies(shengo/wuckier) for recreation or to chat at houses of friends,	Yes No	1 2																						
37	If the answer of Q 36 is yes whose house did you attend?	<table border="0"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Local alcohol selling house-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Person's house whom husband/wife has dead-----..</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Person house whom husband/wife moved to other place for trade or work for long time-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>House of dead brother/sister to visit the children and their widowed mother/father as a reason-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>The house of husband's father/wife's mother who is Widowed-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>other(specify)-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	Local alcohol selling house-----	1	2	Person's house whom husband/wife has dead-----..	1	2	Person house whom husband/wife moved to other place for trade or work for long time-----	1	2	House of dead brother/sister to visit the children and their widowed mother/father as a reason-----	1	2	The house of husband's father/wife's mother who is Widowed-----	1	2	other(specify)-----	1	2		
	Yes	No																							
Local alcohol selling house-----	1	2																							
Person's house whom husband/wife has dead-----..	1	2																							
Person house whom husband/wife moved to other place for trade or work for long time-----	1	2																							
House of dead brother/sister to visit the children and their widowed mother/father as a reason-----	1	2																							
The house of husband's father/wife's mother who is Widowed-----	1	2																							
other(specify)-----	1	2																							
38	What do you feel about importance of ceremonies at houses of widowed/divorced men/women at night or in the house of a mobile person?	They are important  They are harmful	1 2																						

39	Do you have recreation in local alcohol selling houses in your village with friends at night the past 12 months?	Yes No	1 2	
40	Have you ever had casual sex in relation to night markets?	Yes No	1 2	
41	Have you ever had sexual violence in relation to night markets?	Yes No	1 2	
42	Have you had sex in the way of night market?	Yes No	1 2	
43	Are you a mobile person for trade?	Yes No	1 2	
44	How long do you stay outside of your partner (Husband/wife) for trade?	<p style="text-align: center;">Yes No</p> 1-6 days.....1 2 7-14 days.....1 2 15-30 days.....1 2 1 month-5 months.....1 2 5. 6 month-1 year.....1 2 6. Above 1 year.....1 2		

45	During this your stay outside of your family for trade, Have you ever had sex outside of Marriage?	Yes  No	1 2	
46	If yes, for Q45, With whom?	With _____  _____		
47	If Q45 is yes, did you use condom	Yes  No	1 2	
48	How did you use condom in outside of marriage in the last 6 month?	Usually I was used  Occasionally  I did not use	1 2 3	
49	If the answer of Q47 is not used, Why not?	•Not available  •Partner objected  •Use other method of . Contraception	1 2 3 4	
50	Have you had sex with the exchange of money or material relation to night markets?	Yes  . No	1 2	
51	Have you used a razor blade, ne sharp materials or other injections with a needle that was already used by someone else?	Yes  No  I don't know	1 2 3	
52	I don't want to know the result, but have you ever had an HIV test?	Yes  no	1 2	→55 if the answer is no
53	Did you voluntarily undergo the Voluntary HIV test, or were you required to have the test?	Voluntarily  required	1 2	
54	Please do not tell me the result, but did you find out the result of your test?	Yes  no	1 2	
55	If a relative of yours became ill with HIV, the virus that causes AIDS, would you be willing to care for him in your household?	Yes  no	1 2	

56	If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret?	Yes No	1 2	
57	Is the HP in the village/Kebele fulfilled with necessary materials and is it functional	Yes No I don't know	1 2 3	
58	Do you remember that the health professionals in HC/Woreda Health Office, HSEWs visited/supervise your or the health committee in your village/Kebele in the last three months?	Yes No I don't know	1 2 3	
60	Do you know the presence of , community radio program	Yes No I don't know	1 2 3	
61	Are CHWs available in the Kebele to provide the CBHS	Yes No	1 2	
62	Had you participated in activities to support PLWHA?	Yes No	1 2	
63	If Q62 is yes , what are the care and support ways (more than one answer is possible)	-Debo (ploughing farm, keeping cattle, maintenance of house)..... -Money contribution for any of; school, Medication payment, for covering of stationary, food, etc..... -provide social services free of payment(Idir, others....) -spiritual/psychological support Other(specify).....	1 2 3 4 5	

64	Had you or your family members utilized health services at the nearest health facility nearest to you?	Yes	1	
		No	2	
65	If Q 64 is yes, which services do you or your family members ever used? (more than one answer possible)	VCT	1	
		ART if applicable	2	
		PMTCT if applicable	3	
		Care and support if applicable	4	
		Behavior change communication or health education	5	

Starting time-----end time-----

Name of data collector-----signature-----

Date-----

# የአማርኛ መጠይቅ

የአዲስ አበባ ዩኒቨርሲቲ የህብረተሰብ ጤና ሣይንስ ት/ቤት ከጉራጌ ዞን ጤና መምሪያ ጋር በመተባበር የሚያካሄደው የድህረ ምረቃ ጥናትና ምርምር ቃለ-መጠይቅ

የተጠያቂዎች ፈቃድ መጠየቂያ ቅጽ

ጤና ይስጥልኝ

ስሜ \_\_\_\_\_ ሙያዬ \_\_\_\_\_ ነው የመጣሁት ከዚህ አካባቢ ከ \_\_\_\_\_ ነው። የመጣሁበት ዋና ምክንያት ከአዲስ አበባ ዩኒቨርሲቲ ጋር በመተባበር በቸሃ ወረዳ የሞዴል አባወራ ስልጠና በተሰጣቸውና ሥልጠና ባልተሰጣቸው አካላት ላይ የንጽጽር ጥናት ላይ መረጃ ለመሰብሰብ ነው። ጥናቱ እንዲካሄድ የተፈቀደበት ደብዳቤ ይጻፍ ለሁሉ። በዚህ ጥናት የሚገኘው መረጃ የጤና አገልግሎት ለማሻሻል ይረዳል።

ለዚህ ጥናት አስፈላጊነት በዚህ ቃለ-መጠይቅ ጥያቄዎችን አቅርብሎታለሁ። እርሶ የተመረጡት በዕጣ ነው። ተሳትፎዎን እናደንቃለን የሚፈጀው ጊዜ 50 ደቂቃ ያህል ብቻ ነው። ለዚህ ጥናት የሚሰጡት ማንኛውም መረጃ በምስጢር ይጠበቃል። ግልጽ ያልሆነ ማንኛውም ጥያቄ ሊጠይቁኝ ይችላሉ።

ተጠያቂው ተስማምቷል ልጀምር? ፊርማ \_\_\_\_\_

ጥናቱ የተሰራበት ቀን \_\_\_\_\_ የተጀመረበት ሰዓት \_\_\_\_\_ ያበቃበት ሰዓት \_\_\_\_\_ ተጠያቂው \_\_\_\_\_

አልተስማማም \_\_\_\_\_

የዋና አጥኝው አድራሻ:

ሃያቱ ሙዜ አብዶ  
ጉራጌ ዞን ጤና መምሪያ  
ስልጠና ቁጥር -251-113-301794  
ሞባይል 251911879985  
ገ.ሳ.ቁ ገ.ል.ቁ, 276  
ኢሜል hayatu1395ah@yahoo.com  
ጉራጌ ዞን ጤና መምሪያ



16. የቃለ መጠይቅ ተጠያቂው የቤቱ አባወራ ነው?-----→ አዎ ከሆነ ወደ 18 ሂድ

- 1. አዎ 2. አይደለም

17. የ16ኛ ጥያቄ መልስ አይደለም ከሆነ ከቤቱ አባወራ ጋር ያላችሁ ዝምድና ምንድነው

- 1. ባል ነኝ 2. ሚስት ነኝ 3. ወንድ ልጅ ነኝ 4. ሴት ልጅ ነኝ
5. ሌላ/ጥቀስ/ሽ -----

18. እቤት ውስጥ የሚሠራ ሬድዮ አላችሁ?

- 1. አዎ 2. አይደለም

19. ከአካባቢው ሰዎች ጋር ሲነፃፀር የእናንተ የገቢ ሁኔታ የቤተሰቡ የጤና ፍላጎት ለማሟላትና ስትታመሙ ህክምና ለማግኘት በቂ ነው ትላለህ/ሽ?

- አዎ 2. አይደለም

20. የሞዴል አባወራነት ወይም የማህበረሰብ ውይይት ሥልጠና አጠናቀህ ተመርቀሃልን?

- 1. አዎ 2. አይደለም

21. ለመጀመሪያ ጊዜ ሚስት ስታገባ እድሜህ ስንት ነበር;

- 1. -----ዓመት 2. አላውቅም

22. በአሁኑ ወቅት ከትዳር ንዳኛህ ጋር አብረህ ትኖራለህ/ሪያለሽ?

- 1) አዎ 2) አይደለም

23. አግብተህ ከሆነ/አግብተሽ ከሆነ ለወንድ፣ ከአንድ በላይ ሚስት አለህን ;

ለሴት፣ ባልሽ ሌላ ሚስት አለውን;

- 1. አዎን 2. አይደለም 3. አላውቅም

24. ግብረ ስጋ ግንኙነት ፈጽመህ ታ□.ቃለህ/ሽ?

- 1) አዎ 2) አይደለም

25. የጥያቄ 24 መልስ አዎ ከሆነ ለመጀመሪ □ □□ □□ብ ረ ስጋ ግንኙነት ስትፈጽም ዕድሜህ ስንት ነበር?

- 1. -----ዓመት 2. አላውቅም

26. የግብረ ስጋ ግንኙነት ለመጀመሪያ ጊዜ ያደረግከው የት ነው?

- 1. -----ቦታ □□□.ስ

- 1. ማታ 2. ቀን

27. ከማን ጋር ነበር የግብረ ስጋ ግንኙነት ለመጀመሪያ ጊዜ ያደረገው/ሽው?

- 1. ቋሚ ንዳኛ ካልሆነ ሰው ጋር በአጋጣሚ
2. ከቋሚ ንዳኛዬ ጋር
3. ከባለቤቴ ጋር
4. ከማይታወቅ ሰው ጋር



37. የጥያቄ 36 መልስ አዎ ከሆነ ማን ቤት ነው የምትሄደው/ጂደው?

አዎ

አይደለም

- |   |   |   |
|---|---|---|
| 1. አረቄ የሚሸጥበት ቤት/አልፍኝ                             | 1 | 2 |
| 2. ባል/ሚስት የሞተባ/የሞተበት የሰፈር/የዘመድ ወንድ/ሴት ቤት          | 1 | 2 |
| 3. ለስራ ወደ ሌላ ቦታ የሄደን ወንድ/ሴት ቤት                    | 1 | 2 |
| 4. የሙዎች ወንድም እህት ቤት(ጠሙዎች ወንድም/እህት ቤተሰብ ለመጠየቅ በሚል) | 1 | 2 |
| 5. ፈት የሆነን/ችን የባል አባት/የሚስት እናት ቤት(ለመጠየቅ በሚል)      | 1 | 2 |
| 6. ሌላ ትቀስ-----                                    |   |   |

38. በማታ ባላቸው/ሚስት የሞተባቸው ወይም ፈት የሆኑ ወንዶች/ሴቶች ቤት ወይም የሌላ ተቃራኒ ጾታ ጉዋደኛቤት በመሄድ ወኪያር ወይም ሸንጎ ማምሽት ስላለው ጥቅም ምን ትላለህ/ሽ?

1. ጠቃሚ ናቸው      2. ጎጂ ናቸው

39. ባለፉት 12 ወራት ከጉዋደኞችህ ጋር በመንደራችሁ አረቄ በሚሸጥበት ቤት በመሄድ ተዝናንተህ ታውቃለህ/ሽ

1. አዎ      2. አይደለም

40. ከምሽት ገበያዎች በተያያዘ በአጋጣሚ የግብረ ስጋ ግንኙነት ፈጽመህ/ሽ ታውቃለህ/ሽ?

1. አዎ      2. አይደለም

41 ከምሽት ገበያዎች ጋር በተያያዘ የግብረ ስጋ ግንኙነት ነክ ወይም ጾታዊ ትንኮሳ ደርሶብህ/ሽ ታውቃለህ?

1. አዎ      2. አይደለም

42. ለንግድ ወይም ለስራ ወደ ሌላ ቦታ ትንቀሳቀሳለህ/ሽ?

1. አዎ      2. አይደለም

43. ለስራ ወይም ለንግድ ወደ ሌላ ቦታ ከሄድክ በሁዋላ ለስንት ቀን ያህል ከባለቤትህ/ሽ ተለይተህ/ሽ ትቆያለህ/ሽ?

	አዎ	አይደለም
1. ከ1-6 ቀናት	1	2
2. ከ7-14 ቀናት	1	2
3. ከ15-30 ቀናት	1	2
4. ከ1 ወር-5 ወራት	1	2
5. ከ6ወራት-1 ዓመት	1	2
6. ከ1 ዓመት በላይ	1	2

44. ለስራ ወይም ለንግድ ወደ ሌላ ቦታ ተንቀሳቅሰህ በሄድክብት ጊዜ በቆይታህ ወቅት ከጋብቻ ውጪ የግብረ ስጋ ግንኙነት ፈጽመህ ታውቃለህ?

- 1. አዎ 2. አይደለም

45. የጥያቄ 44 መልስ አዎ ከሆነ ከማን ጋር? ከ-----ጋር

46. የጥያቄ 44 መልስ አዎ ከሆነ ኮንዶም ተጠቅማችሁ ነበር?

- 1. አዎ 2. አይደለም

47. ከጋብቻ ውጪ የግብረ ስጋ ግንኙነት ስትፈጽም/ሚ ኮንዶም የተጠቀምከው እንዴት ነበር?

- 1. ሁል ጊዜ 2. አልፎ አልፎ 3. አልጠቀምም

48. የጥያቄ 46 መልስ አይደለም ከሆነ ለምን ንደም አልተጠቀማችሁም?

- 1. በወቅቱ ኮንዶም ስላልነበረ
2. ንደኛዬ ፈቃደኛ አልነበረም
3. ሌላ የወለድ መቆጣጠሪያ ተጠቅመናል
4. አላሰብንበትም
5. ሌላ ጥቀስ

49. ከምሽት ገብያዎች በተያያዘ አንተ/ቺ ወይም ተቃራኒ ጾታ የገንዘብ ወይም ቁሳዊ ፍላጎት ስትል/ይ ከአንተ/ቺ ጋር የግብረ ስጋ ግንኙነት

አድርገሃል/ሻል

- 1. አዎ 2. አይደለም

50. ባለፉት 12 ወራት ሌላ ሰው የተጠቀመበት ምላጭ፤ መርፌ ወይም ሌላ ስለታማ ነገር ተጠቅመህ ታውቃለህ?

- 1. አዎ 2. አይደለም

51. ግዴላም ውጤቱን ማወቅ አልፈልግም የኤች.አይ.ቪ ምርመራ አድርገሃልን? → መልሱ

አይደለም ከሆነ ወደ 54 ሂድ

- 1 አዎ 2. አይደለም

52. በፍላጎትህና በራስህ ተነሳሽነት ነው ምርመራውን ያደረከው ወይስ የሆነ አስገዳጅ ሁኔታ ተፈጥሮ

- 1. በፈቃደኝነት
2. አስገዳጅ ሁኔታ ተፈጥሮ

53. ይቅርታ በድጋሚ ውጤቱን ማወቅ አልፈልግም ከምርመራ በኋላ ውጤትህ/ሽ ተቀብለሃል/ሻል?

- 1 አዎ 2. አይደለም

54. አንድ የአንተ ዘመድ ወይም ቤተሰብ ቫይረሱ በደሙ ቢገኝ እንክብካቤና እርዳታ ታደርግለታለህ?

- 1 አዎ 2 አይደለም

55. የቤተሰብህ አባል የሆነ አንድ ሰው ቫይረሱ በደሙ ቢገኝ ምስጢሩን ትጠብቃለህ?

1. አዎ 2. አይደለም

56. አንተ በምትኖርበት ቀበሌ ያለው ጤና ኬላ በህክምና ቁሳቁስ ተሟልቶ አገልግሎት መስጠት ጀምሯል?

- 1 አዎ 2. አይደለም 3. አላውቅም

57. የወረዳ ጤ/ጥ/ት/ቤት፣ የጤና ጣቢያ ባለሙያዎች ወይም የጤና ኤክስቴንሽን ሠራተኞች የአንተን ቤት ወይም የቀበሌያችሁ የጤና ሚቴን ባለፉት 3 ወራት ድጋፍና ጉብኝት ማድረጋቸው ታወቃለህ?

- 1 አዎ 2. አይደለም 3. አላውቅም

58. በአካባቢያችሁ በህብረተሰብ አቀፍ ጤና አገልግሎቶች ላይ የሚሠሩ መንግስታዊ ያልሆነ ድርጅት መኖሩን ታወቃለህን ?

- 1 አዎ 2. አይደለም 3. አላውቅም

59. በአካባቢያችሁ ወይም በወረዳችሁ አሁን እየሰራ ያለ የማህበረሰብ ሬድዮ አለን?

- 1 አዎ 2. አይደለም 3. አላውቅም

60. የመጀመሪያ ደረጃ ወይም ግንባር ቀደም የቀበሌ ጤና ሠራተኞች በአካባቢያችሁ አገልግሎት እየሰጡ መሆኑን ታወቃለህ?

- 1 አዎ 2. አይደለም 3. አላውቅም

61. ቫይረሱ በደማቸው ላለና የኤድስ ህመምተኞች ወላጅ ያጡና ተጋላጭ ህፃናት ለመርዳት የሚደረጉ ህብረተሰብ አቀፍ በሆኑ ተግባራት ትሳተፋለህ?

- 1 አዎ 2. አይደለም

62. □□□ቱ 61 መልስ ምርጫ ቁጥር 1 ከሆነ በዚህ አካባቢ ዋና ዋናዎቹ ህ/ሰብ አቀፍ የድጋፍና እንክብካቤ ተግባራት ዘርዘር ከአንድ በላይ መልስ ይቻላል

- 1) በአካባቢ የደቦ ስራዎች ማለት እርሻቸውን ማረስ፡ ከብቶቻቸውን በነጻ ማሰማራት፡ የፈረሰ አጥርና ቤታቸውን መስራት/መጠገን
- 2) ለልጆቻቸው ት/ቤት ወጪና የጽህፈት መሳሪያ ግዢ የሚሆን፡ ለቤተሰቡ የህክምና፡ ለምግብ ወዘተ የሚሆን የገንዘብ □□□ ማ□□□
- 3) የማህበራዊ አገልግሎት ክፍያዎች መርዳት ወይም ከክፍያ ነጻ ማድረግ /እድር፣ ሌሎች መዋጮዎች/
- 4) የስነ-ልቦና □አና መንፈሳዊ □አገዛና መረጋጋትን መፍጠር፣ መምከርና ማበረታታት
- 5) ሌላ □ ቀስ

63. በጤና ኬላችሁ የሚሰጡትን የኤች አይ ቪ/ኤድስ መከላከልና መቆጣጠር አገልግሎቶች አራስህና ቤተሰብህ

ተጠቃሚ ናቸውን?

- 1. አዎ
- 2. አይደለም

64.  63 መልስ አዎ ከሆነ የትኞቹ አገልግሎቶች ናቸው የምትጠቀሙት?

- 1. የፍቃደኝነት የምርመራ አገልግሎት
- 2. የፀረ ኤች አይ ቪ/ኤድስ ህክምና
- 3. ከእናት ወደ ልጅ ኤች አይ ቪ/ኤድስ መተላለፍን የሚከላከል ህክምና
- 4. ድጋፍና እንክብካቤ
- 5. የጤና ግንዛቤ ማስጨበጫ ትምህርቶች

መጠይቁ የሞላው ሰው ስም----- ፊርማ-----

መጠይቁ ለመሙላት የፈጀው ጊዜ-----