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COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

DEPARTMENT OF NURSING

PREVALENCE AND ASSOCIATED FACTORS OF DEPRESSION AMONG HIV/AIDS PATIENTS ATTENDING ANTI-RETROVIRAL THERAPY CLINICS AT GURAGE ZONE SELECTED GOVERNMENT HOSPITALS, SOUTH WEST, SNNPR, ETHIOPIA, 2018

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A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY, DEPARTMENT OF NURSING IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR MASTERS OF SCIENCE DEGREE IN ADULT HEALTH NURSING

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Prevalence and associated factors of depression among HIV/AIDS patients attending Anti-Retroviral Therapy clinics at Gurage Zone selected Government Hospitals, South west, SNNPR, Ethiopia, 2018

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I hereby certify that I have read and evaluate this Thesis entitled " prevalence and associated factors of depression among HIV/AIDS patients attending Anti-Retroviral Therapy Clinic at Gurage zone selected governmental Hospitals, SNNPR, Ethiopia, 2018". I recommend that it is submitted as fulfilling the thesis requirement.

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ABBREVIATIONS AND ACRONYMS

AAU	Addis Ababa University
AOR	Adjusted Odds Ratio
ART	Anti-Retro Viral Therapy
BSC	Bachelor of Science
COR	Crude Odds Ratio
CI	Confidence Interval
CSA	Central Statistical Agency
EDHS	Ethiopia Demographic Health Survey
ETB	Ethiopian Birr
IHRERC	Institutional Health Research and Ethical Committee
HAART	Highly Active Anti-Retro Viral Therapy
HIV	Human Immunodeficiency Virus
PHQ	Patients Health Questionnaires
PLWHA	People Living With HIV/AIDS
SNNPR	South Nations, Nationalities and Peoples' Region
SPSS	Statistical Package for Social Sciences
SRS	Simple Random Sampling
SSA	Sub-Saharan Africa
SSQ	Social Support Questionnaires
UNAIDS	United Nations Programme on Human Immune Deficiency Virus
WHO	World Health Organization

ABSTRACT

Background: Currently HIV/AIDS is the major burden and public health problems globally and two third of the PLWHA are living in Sub-Saharan Africa. The prevalence of HIV/AIDS is also high in Ethiopia. Mental disorders particularly depression is the most prevalent among PLWHA than the people without HIV/AIDS. Currently even if the management of HIV/AIDS is modified and updated through time, the diagnosis as well as the management of depression among PLWHA did not get any consideration.

Objective: The main aim of this study was to assess the prevalence and associated factors of depression among HIV/ AIDS patients attending ART clinics at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018

Methods: An institution based cross sectional study was conducted with a total of 328 HIV/ AIDS patients attending ART clinics at Gurage zone selected government Hospitals from March 1-30/2018.The collected data was entered into Epi-data 4.2.0.0 and exported to SPSS version 25 for analysis. Binary and multivariable Logistic regression was performed to determine each factor and to check the association between independent variable and depression.

Result: The prevalence of depression among PLWHA attending attending ART clinics at Gurage Zone selected Government Hospitals, Southwest, SNNPR, Ethiopia, 2018 was 37.5%.This study confirmed that sex, monthly income, internally stigmatized, social support, duration of HAART and HAART interruption were associated with depression where as age category, ethnicity, religion, marital status, educational level, occupation, lost jobs, living condition, CD4 count, WHO HIV/AIDS clinical stages and drug regimen were not associated.

Conclusion and recommendation: the prevalence of depression among PLWHA attending ART clinics at Gurage Zone selected Government Hospitals, Southwest, SNNPR, Ethiopia, 2018 was high. Sex, monthly income, internalized stigma, social support, duration of HAART and HAART interruption were significantly associated with depression. Therefore there should be a priority care for PLWHA who are females, have low monthly income, internally stigmatized, have low social support and who did not take their ART properly.

Keyword: depression, HIV/AIDS

1. INTRODUCTION

1.1. Background

Depression is a mental disorder which is manifested by the sign and symptoms of poor appetite, sadness, sleep disturbance, poor concentration and feelings of exhaustion. It affects an individual's capability to function at any work and to handle the daily of life properly. When depression is progressed and becomes sever it can lead to hopelessness, injuring one's self, suicide and may also lead to death (1).

Globally it is estimated that 36.7 million people are living with HIV/ AIDS; from this 34.5 million are adults, 1.8 million people became newly infected with HIV, 1 million people died with AIDS related illnesses in 2016 (2). Despite the management of HIV/AIDS has becoming modified and advanced, it is still the major global public health issue. Since the start of the epidemic, totally an estimated 78 million people have become infected with HIV/AIDS and 35 million people have died with it. From the world PLWHA population the majority (70%) are living in the sub-Saharan Africa. Among this group 19.4 million PLWHA are living in East and Southern Africa which saw 44% of new HIV infections globally in 2016(3, 4). In Ethiopia it is estimated that 710 000 people were living with HIV, among those 650 000 are adults, 30 000 people became newly infected with HIV, 20 000 people died due to HIV/AIDS in 2016 (5). According to the Gurage zone Health office report in the zone 3432 PLWHA are attending ART clinic in 2017 (6).

Mental disorders particularly depression is the most prevalent among PLWHA than people without HIV/AIDS (7, 8). Depression disturbs the quality of life, social interactions, work, and influence on the adherence to medical care and survival of life (7). The co-existence of depression and HIV/AIDS would resulted to poor health outcomes due to obstacles to treatment and deterioration of medical outcomes, including treatment resistance, more chance for recurrence and increase the demand for the utilization of medical resources and increase the morbidity and mortality of PLWHA (8). According to the meta-analysis study PLWHA are nearly 2 times more likely to have had a recent episode of major depressive disorder than people without HIV/AIDS (9).

1.2. Statement of the problem

Since its discovery, the distribution of HIV/AIDS epidemic has been considered an issue of great concern. Currently even if there is a modified and advanced treatment available for HIV/AIDS and increased in life expectancy of PLWHA, still there are several complications occurred among PLWHA along with different comorbidities. Particularly there is high morbidity and mortality due to the common co-existence of HIV/AIDS and depression (9-11).

Depression is the most common mental disorder among PLWHA. Studies show that PLWHA are more likely to develop depression than people without HIV/AIDS(12). A meta-analytic study shows that the prevalence of depression in PLWHA ranges from 7.2% to 71.9% and 2 times higher in PLWHA than people without HIV/AIDS. The newly diagnosed with HIV/AIDS patients start to think and worry due to different life-changing conditions and it leads to depression (9, 13).

The study conducted in Myanmar shows that the prevalence of depression among PLWHA was 30% (14). The Majority of PLWHA were under diagnosed and untreated for depression. Depression is the significant disease burden and related with poor health outcomes like poor ART adherence, resulting for ART inefficient and reduced the quality of life and lifespan among PLWHA (14, 15). Lifetime prevalence of depression among PLWHA in the USA was 20-40%, up to two times higher than the general population (16). The study in Delhi, India shows that the prevalence of depression among PLWHA under ART was 58.75%. The unemployed, unmarried, uneducated, having low family income and low social support are the most determinant factors for depression (17). More than half of PLWHA that suffer from depression have not diagnosed properly as well as not treated (18). The study in Korea shows that the prevalence of depression among PLWHA was 21% and it was associated with poor adherence. Among these only 4% of the depressive patients were referred to psychiatric evaluation and treatment. It indicated that there is low level of recognition and management of depression among PLWHA (19).

As the majority of the world's PLWHA are living in SSA, the prevalence of depression among PLWHA is also high (4). Even if depression may fasten the progression of HIV/AIDS and result for the development of ART resistance, diagnosis and treatment of depression among PLWHA has not been a priority in Africa. For PLWHA the poor health outcomes is resulted due to the development somatic symptoms that may include fatigue, weight loss, and

insomnia and neurocognitive impairment including slowed thinking, poor concentration and forgetfulness (4, 20).The prevalence of depression among PLWHA in Nigeria was 39.1% and it was 5 times more common among PLWHA than the general populations (21).

Acording to the National Health Survey in Ethiopia, depression is one of the most common psychiatric disorders with the prevalence of 9.1% in the general populations (22). How ever there is high prevalence of depression among PLWHA. Studies show that the prevalence of depresion among HIV/AIDS Patents Attending ART Clinic was 38.94% at Debrebirhan Referral Hospital, North Showa, Amhara Region, Ethiopia(23), 44.4% at Zewditu Memorial Hospital, Addis Ababa , Ethiopia(24), 45.8% at Harar Town, Eastern Ethiopia(25) and 48% at Metu Karli Hospital Iluababor Zone , South West, Ethiopia(26). If depression is diagnosed early, it is an avoidable and a separate illness that can be treated, even when PLWHA are under ART (12). Early detection and proper treatment of depression is very important to improve the the health outcomes as well as the quality of life (27).

1.3. Significance of the study

This study was identified the factors for the presence of high prevalence of depression among HIV/ AIDS patients. It provided initiative recommendation and direction about the problems and the solutions towards depression among PLWHA. It also would help for the policy makers to revise the health policies, law and regulation to reduce high prevalence of depression among PLWHA, to plan for the management of depression among PLWHA in addition to HAART and treatment of other opportunistic infections in the study based on the finding. Furthermore the study would possibly generate information in the area of the topic for other researchers to investigate further empirical evidences to control those factors attributable to high prevalence of depression among HIV/ AIDS patients in the study area.

2. LITERATURE REVIEW

2.1. Prevalence of depression among HIV/ AIDS Patients

Several studies which were conducted in different part of the world indicate that the prevalence of depression among HIV/ AIDS patients were high. Institutional based cross sectional study design which was conducted at Guru Teg Bahadur Hospital in Delhi India (2014) and at Korean university hospitals (September 2009 and February 2010) among 160 patients and 82 participants shows that the prevalence of depression were 58.75% and 21% respectively (27, 28).A total of 63 patients and 425 patients were interviewed at Kingston, Jamaica (2010), and Yangon region, Myanmar (2016) and the prevalence of depression were 43% and 30.12% respectively (10, 14).

Cross sectional studies which was conducted at Khartoum Hospital, Sudan (Jan 2015-Jan 2016) and at Entebbe district, Uganda (2011) among 362 patients and 618 patients shows that the prevalence of depression among PLWHA were 63.1% and 8.1%) respectively (29, 30). The studies at Teaching Hospital in Imo State, South East Nigeria (January and March 2015), at Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria(Jan 2009-June 2009) and at University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu, Southeast Nigeria(2011) among 271 patients, 130 patients and 122 patients shows that the prevalence of depression were 39.1%, 23.1% and 21.3% respectively (21, 31, 32). The Cross sectional studies which was conducted at Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015) and at Yaoundé, Cameroon (February and March 2011) among 300 participants and 100 participants shows that the prevalence of depression were 26.7% and 63% respectively (15, 33).

Institution based cross sectional studies at Alert hospital AA, Ethiopia (May, 2015) and at Zewditu Memorial Hospital, AA, Ethiopia (August 1 to September 1, 2013) among 417 patients and 384 patients shows that the prevalence of depression were 41.2 % and 44.4% respectively (8, 24). A total of 416 patients, 740 patients and 380 patients were interviewed at Debrebirhan Referral Hospital, North Showa Ethiopia(April to May, 2013), at Harar Town, Eastern Ethiopia (March 1st to March 31 2013) and at Metu Karli Hospital, South West, Ethiopia (May 2012) shows that the prevalence of depression were 38.94%, 45.8% and 48% respectively (23, 25, 26). Studies at Debre Markos Town North West Ethiopia and at Tigray,

North Ethiopia(November, 2011 to July, 2012) among 412 patients and 269 patients shows that the prevalence of depression were 11.7% and 43.9% respectively (7, 34).

2.2. Factors associated with depression among HIV/ AIDS Patients

2.2.1. Socio demographic factors

Institutional based cross sectional study design which was conducted at Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015) indicates that the proportion of patients ≤40 years with depression was higher than those >40 years(15). Institutional based cross sectional study design which was conducted at Zewditu Memorial Hospital, AA, Ethiopia (August 1 to September 1, 2013) and Alert hospital, AA, Ethiopia (May, 2015) indicate that age 18-24 years were 4 times and age 18-29years were almost 2 times more likely to be depressed as compared to participants whose age are greater than 45 years and 50 years respectively (8, 24). The Study at Debrebirhan Referral Hospital, North Showa Ethiopia (April to May, 2013) shows that Age between 30-39 years 2.8 times, Age between 40-49 years 3.8 times and Age between 60-69 years 19.6 times more likely to develop depression than the age category between 20-29 years respectively (23).

Studies which were conducted at Entebbe district, Uganda (2011) and at Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria(Jan 2009-June 2009) indicates that females were twice more likely to be depressed than male (30, 31). The study at Debrebirhan Referral Hospital, Ethiopia (April to May, 2013) shows that female were 2 times more likely to be depressed than male (23), but other study which was conducted at Harar Town, Eastern Ethiopia (March 1st to March 31 2013) shows that males were 1.6 times more likely to be depressed than females (25).

The study at Guru Teg, Bahadur Hospital in Delhi, India (2014) shows that unmarried had higher prevalence of depression as compared to Married, divorced or widows/widowers. Patients who were not living with their spouse were 2 times more likely to be depressed than to those patients who were living with their spouse (27). Similarly the study at Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015) shows that unmarried participants had a higher prevalence of depression (31.9%) than married participants (20.7%))(15). The studies at Harar Town, Eastern Ethiopia(March 1st to March 31 2013) shows that widowed were 3 times more likely to depressed than those who have been single

(25) and at Metu Karli Hospital, South West, Ethiopia (May 2012) shows that being single were 5.5 times more to be depressed than married and Divorced (23).On the other hand studies at Yangon region, Myanmar (2016) and at Khartoum Hospital, Sudan (January 2015-January 2016) shows that the rate of depression was reported highest among married people 53.3% and 71.8% respectively (14, 29).

The Studies at Alert hospital, AA, Ethiopia (May, 2015) and Khartoum Hospital, Sudan (January 2015-January 2016) shows that being illiterate were 2 times more to be depressed and the prevalence of depression among illiterate patients were (73.3%) respectively(8, 29). The studies at Yangon region, Myanmar (2016) and Guru Teg, Bahadur Hospital in Delhi, India (2014)) shows that the prevalence of depression was the highest in illiterate (75%) with compared to other educational levels and there was a high prevalence of depression was found in the uneducated and in patients that attended school till lower standards (14, 27). But the studies at Entebbe district, Uganda (2011), at Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria (Jan 2009), Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015), Yaoundé, Cameroon (February and March 2011), Teaching Hospital in Imo State, South East Nigeria (January and March 2015) and Harar Town, Eastern Ethiopia (March 1st to March 31 2013) shows that there are no association between educational status and depression(15, 25, 30-33, 35).

The study at Zewditu Memorial Hospital, AA, Ethiopia (August 1 to September 1 2013) shows that Muslim and orthodox were 2.45 and1.23 times more depressed than protestant respectively(24). But the studies at Entebbe district, Uganda (2011), at Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria (Jan 2009-June 2009, Teaching Hospital in Imo State and South East Nigeria (January and March 2015)shows that there are no association between religions and depression(21, 30, 35).

According to the studies which was conducted at Guru Teg Bahadur Hospital in Delhi, India (2014) there was high prevalence of depression among low income groups i.e. those not earning money or earning up to 5000RS than in higher income groups (27) and at Harar Town, Eastern Ethiopia(March 1st to March 31 2013) clients who were income <500 ETB were almost 2 times more risk of developing depression than who had income > 1500 ETB (25). The Study at Debrebirhan Referral Hospital, North Showa Ethiopia (April to May, 2013) shows that Income < 200 birr 4 times, Income between 201- 400 birr 2.8 times and Income

between 401-700 birr 2.6 times more likely to develop depression than those with income greater than 700 birrs respectively(23). Another study at Tigray, North Ethiopia (November, 2011 to July, 2012) shows that patients with income < 200 birr were 4.4 times more likely to be depressed than Income >1000 birr (34).

Study at Guru Teg Bahadur Hospital in Delhi, India(2014) indicates that the prevalence of depression in unemployed was 70.6% than government employee 46.6% or in private sector 43.6% and 71.4% were working as a daily wager (27). The study at Tigray, North Ethiopia (November, 2011 to July, 2012) shows that being government employed were 3.5, unemployed 2.7 times more likely to be depressed than self-employed respectively (34).

2.2.2. Psychosocial factor

The study which was conducted at Debre Markos Town Northwest Ethiopia shows that living alone were 2.5 times more likely to be depressed than living with family (7).

The studies which were conduct at Alert hospital Addis Ababa (May, 2015), at Debrebirhan Referral Hospital, North Showa Ethiopia (April to May, 2013) and at Zewditu Memorial Hospital, AA, Ethiopia (August 1 to September 1 2013) shows that internalized stigma had 3.6 times, 3.6 times and 2 times more likely to be depressed as compared to patients who had not internalized stigma respectively (8, 23, 24). Another studies at Debre Markos town Northwest Ethiopia, Harar town, Eastern Ethiopia (March 1st to March 31 2013) and Metu Karli Hospital, South West, Ethiopia(May 2012) shows that that internalized stigma had 3.4 times, 2.7 times and 5.5 times more likely to be depressed as compared to patients who did not internalized stigma respectively (7, 25, 26).

The studies at Alert hospital Addis Ababa, Ethiopia (May, 2015) and Guru Teg Bahadur Hospital in Delhi, India (2014), shows that having low social support were 2 times more likely to be depressed as compared to high social support and high prevalence of depression was seen in patients having low social support (100%) compared to those patients having a high social support respectively (8, 27). The studies at Debre Markos Town Northwest Ethiopia and Metu Karli Hospital, South West, Ethiopia(May 2012) shows that having low social support were 10 times and 2 times more likely to be depressed as compared to high social support (7, 26).

Institutional based cross sectional study which was conducted at Debre Markos Town Northwest Ethiopia and Guru Teg Bahadur Hospital in Delhi, India (2014) shows that losing job due to HIV had 2.7 times more likely to be depressed than not losing job and depression was highest in those lost their jobs due to HIV than not losing job respectively (7, 27).

2.2.3. HIV/AIDS related factor

Studies at Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015) shows that the prevalence of depression in PLWHA with CD4 count <200 cells/µl was higher than PLWHA with a CD4 count >200 cells/µl (52.2% vs. 24.9% (15). Other study at Metu Karli Hospital South West, Ethiopia (May 2012) shows that having CD4 count <250 cell/µl had 2 times more likely to be depressed than CD4 count >250 cell/µl (26).

The study at Guru Teg Bahadur Hospital in Delhi, India (2014) shows that depression rate was highest in Stage III than the preceding HIV stages (27). Other study at Alert hospital Addis Ababa, Ethiopia (May, 2015) and Debrebirhan referral Hospital, North Showa Ethiopia (April to May, 2013) shows that having HIV stage III 2.8 times and 2.3 times more likely to be depressed than HIV stage I respectively(8, 23).

Study at Guru Teg Bahadur Hospital in Delhi, India (2014) indicates that the prevalence of depression decreases with duration of treatment with HHART (27). The study at Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015) shows that there was no association between duration of treatment with HHART and depression (15).

The studies at Kingston, Jamaica (2010) and Southwest Regional Hospitals of Cameroon (16 October 2014 to 12 January 2015) shows that there were no association between HAART regimen and depression (10, 15).

2.3. Conceptual Framework

This conceptual frame work is developed by reviewing different literatures. It includes the dependent variable which is depression and the independent variables those includes the socio-demographic variables, psychosocial variables and HIV/AIDS related variables. Those independent variables were associated for the presence of depression in different studies.

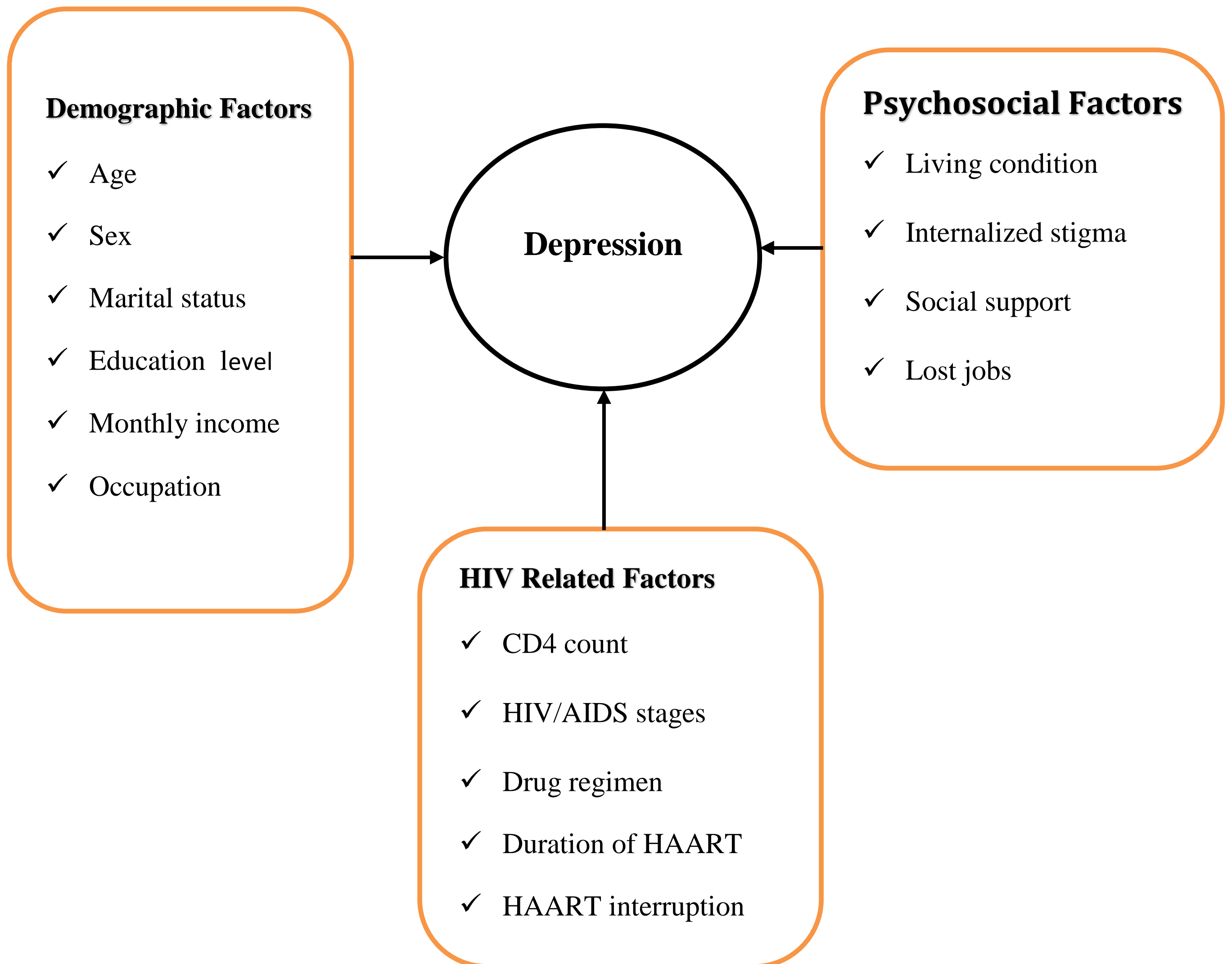

Figure 1:Conceptual frame work for factors associated with depression among HIV/ AIDS patients attending ART clinic at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018 developed through reviewing different literatures (7, 23-26)

2.4. Justification

There is a stong relationship between the co-existence of depression and HIV/AIDS. The presence of one is favorable for the existence of other. Currently in Ethiopia even though a lot of changes and modifications have been done to address the impact of HIV/AIDS, the impact of depression among PLWHA did not receive adequate attention. In Ethiopia there are some studies regarding to this topic but the problem is still exist so it needs further studies and investigations. In addition to this in Ethiopia there was no any special consideration service for HIV/AIDS patients regarding the psychiatric service. However there was evidence that indicates mental wellbeing is an important factor in the management of HIV/AIDS specially related to the treatment effectviness and healthy life style modifications. Specifically there was no any published study about the prevalence of depression and associated factors among PLWHA in SNNPR as well in Gurage Zone. Therefore, this study addressed this gap by assessing the prevalence and associated factors of depression among PLWHA in the selected Hospiatals of Gurage zone.

3. OBJECTIVES OF THE STUDY

3.1. General objective of the study

To assess the prevalence and associated factors of depression among HIV/ AIDS patients attending ART clinics at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018

3.2. Specific objectives of the study

To determine the prevalence of depression among HIV/ AIDS patients attending ART clinic at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018

To identify factors associated to depression among HIV/ AIDS patients attending ART clinic at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018

4. METHODS AND MATERIALS

4.1. Study area and period

This study was conducted in selected government hospitals of Gurage Zone, SNNPR from March 1-30, 2018. Gurage Zone is one of the Zones found in SNNPR with the capital city of Wolkite. It is located 153 Km South west of Addis Ababa, the capital city of Ethiopia and 178 Km North West Hawssa, the capital city of SNNPR region. Gurage Zone is bordered on the Southeast Hadiya and Yem special woreda, on the West, North and East Oromia Region and on the Southeast Silt'e Zone. It is situated between 1910m and 1935m above sea level (36).

Based on the Gurage Zone Health Office 2017 Report, this Zone had a total population of 1,648,695. Gurage Zone had 4 governmental Hospitals with one General and 3 primary hospitals. There were 3432 HIV/AIDS patients who were attending ART clinics in the zone and among those 1639 PLWHA were attending in the governmental hospitals(6).

4.2. Study design

Institutional based cross-sectional study design was used.

4.3. Populations

4.3.1. Source population

All adult HIV/AIDS patients who were attending ART clinics at Gurage zone governmental Hospitals during the study period

4.3.2. Study population

All adult HIV/AIDS patients who were attending ART clinics at Butajira General Hospital and Gunchire primary Hospital, Gurage zone, SNNPR, Ethiopia, 2018 during the study period

4.3.3. Study subject

All randomly selected adult HIV/AIDS patients who were attending ART clinics at Butajira General Hospital and Gunchire primary Hospital, Gurage zone, SNNPR, Ethiopia, 2018 during the study period.

4.4. Eligibility criteria

4.4.1. Inclusion criteria

All adult HIV/AIDS patients who were attending ART clinics at Butajira General Hospital and Gunchire primary Hospital, Gurage zone, SNNPR, Ethiopia, 2018 during the study period and who had at least one previous visit at ART clinics.

4.4.2. Exclusion criteria

All HIV/AIDS Patients who were seriously ill for interview

4.5. Variables

4.5.1. Dependent variable

Depression

4.5.2. Independent variables

Age
Sex
Ethnicity
Religion
Marital status
Education level
Monthly income
Occupation
Lost jobs
Internalized stigma
Living condition
Social support
CD4 count
HIV/AIDS stages
Drug regimen
Duration of HAART
HAART interruption

4.6. Operational definition

Not depressed -Based on the Patient Health Questionnaire- 9 score who scored was ≤ 4.

Depressed - Based on the Patient Health Questionnaire- 9 score who scored was≥ 5 (15,21, 23-25).

Internally stigmatized-Based on 10 items internallized stigma scale that scored higher than the mean

Not Internally stigmatized-Based on 10 items internallized stigma scale that scored lower than the mean (26).

High social support- Based on the SSQ-6 who scored higher than the mean.

Low social support- Based on the SSQ-6 who scored lower than the mean (26).

4.7. Sample size determination and sampling procedure

4.7.1. Sample size determination

The sample size was determined by using a single population proportion formula considering the following assumptions: standard normal distribution with confidence interval (CI) of 95% ($Z_{\alpha/2}$=1.96), absolute precision or tolerable margin of error (d=0.05), and the prevalence of depression at Harar Town, Eastern Ethiopia, 2013 was 45.8%(25).

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

$$\mathbf{n} = \frac{(1.96)^2 * 0.458(1-0.458)}{(0.05)^2} = 381$$

Since the number of source population (N) is <10,000, so using the correction formula

$$nf = \frac{no}{1+{no}/{N}}$$

$$nf= \frac{381}{1+381/1639} =309$$

By considering 10% for non-responses then the final sample size was 340.

4.7.2. Sampling procedure

Gurage Zone had four governmental Hospitals with one General and three primary hospitals. By lottery method the 2 hospitals Butajira General and Gunchire primary Hospitals were selected among 4 governmental Hospitals. The study participants were selected from those two Hospitals by proportionally allocating then by simple random sampling from the appointment log of March (fig.2).

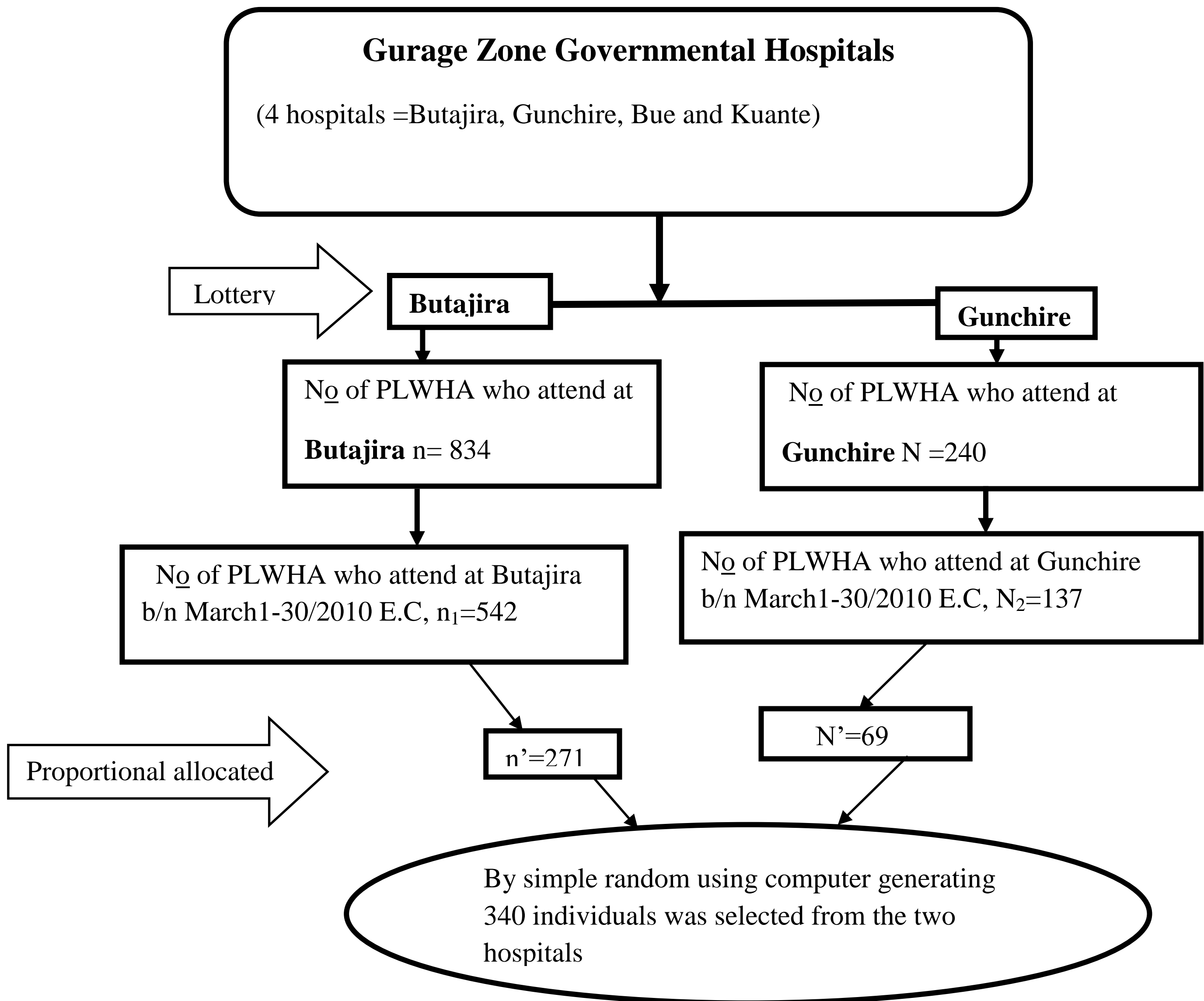

Figure 2: schematic presentation of sampling procedures for the study conducted among HIV/ AIDS patients attending at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018

4.8. Data collection instrument

A structured Patients Health Questionnaires- 9 was used to measure the depression status among HIV/AIDS patients which was adapted from similar studies. It has 9 items and for every item there is a value from 0 to 3 (not at all = 0; several days = 1; more than half of the days = 2; nearly every day = 3) and by adding the value; the depressed status was determined as depressed or not.The PHQ-9 has acceptable reliability, validity and a sensitivity of 88% and a specificity of 88% for depression diagnosis (23).

A questionnaire format with socio demographic characteristics (age, sex, ethnicity, religion, educational level, occupation, marital status, monthly income and occupation), psychosocial factors (internalized stigmatized, social support, living condition and lost jobs) and HIV/AIDS related factors (CD4 count, WHO HIV/AIDS stages, ART interruption and drug regimen) was used to measure the association with depression among HIV/AIDS patients.

The internalized stigma scale and social support questionnaire was adapted from similar studies. The internalized stigma scale consisted of 10 items rated on a 5-point response format ranging from "strongly disagree" (1) to "strongly agree" (5) based on the extent to which a respondent felt about him/herself since being diagnosed with HIV. A total score (possible range = 10-50) will be obtained by summing responses to all items. From the mean the higher scores indicating internally stigmatized and lower scores indicating not internally stigmatized. The cronbach alpha of these items was 0.92 (26).

Social support- assessed by (SSQ-6) it included 6- items scale that assessed the number of available social support. The number of persons available to provide the type of support described in each item was coded as either "no one" (0) or "one or more" (1). The total score is obtained by summing all 6 items with a possible range of 0 to 6. From the mean the higher scores indicates higher levels of available social support where as below the mean indicates lower level of available social support. The reliability coefficient for these items was 0.86 (26).

4.9. Data collection procedures

The data was collected by using interviewer administered questionnaires. Three BSc nurses to collect the data and two supervisors who were controlled and managed the data collection procedures were recruited. They were oriented on how to fill the questionnaire, about the ethical principles, confidentiality and data management prior to their involvement for data collection.

4.10. Data quality control

Translation of instrument was made from English language to local language Guragegna and Amharic language and back to English language by different experts who were familiar on the field of area in order to ensure its consistency. To check the methods and materials the questionnaires were pre-tested before the actual data collection period in 5% of the participants at Bue primary hospitals at Gurage Zone, SNNPR, Ethiopia and modifications were taken.Three data collectors and two supervisors who can speak both Amharic and Guragegna languages were recruited. The supervisors checked the completeness, accuracy, and consistency of the collected data in the whole period of data collection. Two days training was given for data collectors by Amharic language on how to ask and fill the questions, and how to approach the respondents. On each data collection days the collected data were reviewed by supervisors and principal investigator, and any problems that faced in the time of data collection were discussed and immediate solution were given.

4.11. Data processing and analysis

Data was checked for completeness and cleaned before it was entered to a computer. Then it was coded and entered into EpiData version 4.2.0.0 and importing to SPSS version 25 software packages for data analysis. The outcome variable was re-coded to dichotomous outcomes: either the respondents are depressed or not. Based on PHQ-9, depressed or respondents who had scored ≥5 were coded as '1' and those respondents who had scored ≤4 were coded '0'**.** The independent variables were coded based on previous related studies and distribution of responses in the data. Frequencies and proportions were used to describe the study participants. The data is presented by using tables and graphs.

Bivariate analysis and crude odds ratio with 95% confidence interval (CI) was used to see the association between independent variable and the outcome variable by using binary logistic regression. Independent variables with p-value of ≤0.25 were included in the multivariate analysis to control confounding factors. Hosmer-Lemeshow's test was found to be insignificant (p-value = 0.99) and Omnibus tests was significant (P-value = 0.00) which indicate the model was fitted. Adjusted odds ratio along with 95% CI was estimated to identify the factor associated with depression among PLWHA using multivariable logistic regression analysis. Level of statistical significance was declared at P-value ≤ 0.05.

4.12. Ethical consideration

The study was reviewed and approved by Addis Ababa University College of Health science, department of nursing and midwifery. The ethical clearance was obtained from Addis Ababa University Institution Research Board. Letter was submitted to Gurage zone health office, Butajira general Hospital and Gunchire primary Hospital and then permission was obtained from those bodies. Prior to interview; all participants recruited to the study were receive written informed consent about the study. The participants did not gain any incentives and direct benefit, yet the result can be used as a baseline for further studies that can be done in the study area and identified problems associated to depression among HIV/AIDS in those hospitals as well as in our country. The result will be disseminated to different bodies. The study has no any risk for the participants and interview were private to make safe participants from any fear. Respondents were insured about the confidentiality of information obtained and the respondents did not ask to tell their names.

5. RESULT

5.1. Socio-demographic characteristics of study participants

In this study, the data were collected from 328 respondents through face-to-face interviews with the response rate of 96.5%. Among those 177(54%) were female. 143(43.6) were in the age group of 30-39 and the mean age of the participants' was 37.6 years with range from 18 to 68. From the study participants 257(78.4%) were Gurage in ethnicity, 140(42.7) were Muslim in religion, 205(62.5%) were married, 119(36.3%) were Illiterate and 98(29.9 %) were farmer. Monthly income of respondents involved in the study was less than or equal to 500 birr for 88(26.8%) clients and more than 2000 birr for 76 (23.2%) clients (Table 1).

Table 1:Socio- demographic characteristics of study participants at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018 (n=328).

Variable		Frequency	Percent (%)
Age	18-29	59	18.0
	30-39	143	43.6
	40-49	82	25.0
	≥ 50	44	13.4
Sex	Female	177	54.0
	Male	151	46.0
Ethnicity	Gurage	257	78.4
	Silte	34	10.4
	Amhara	22	6.7
	Oromo	5	1.5
	Others	10	3.0
Religion	Muslim	42.7	42.7
	Orthodox	40.9	40.9
	Protestant	15.2	15.2
	Catholic	1.2	1.2
Marital status	Single	49	14.9
	Married	205	62.5
	Widowed	55	16.8
	Divorced	19	5.8
Educational status	Illiterate	119	36.3
	1-4	79	24.1
	5-8	58	17.7
	9-12	50	15.2
	College or university	22	6.7
Occupation	Daily labor	53	16.2
	Government employee	48	14.6
	Farmer	98	29.9
	Merchant	48	14.6
	Student	13	4.0
	unemployed	39	11.9
	others	29	8.8
Income	≤500	88	26.8
	501-1000	75	22.9
	1001-1500	39	11.9
	1501-2000	50	15.2
	>2000	76	23.2

5.2. Psychosocial factors of depression

Among the study participants 26(81.4%) were living with their family, 222(67.7%) were internally stigmatized, 257(78.4%) had high social support from their families or other supportive bodies and the majority 304 (92.7%) did not lose their jobs due to HIV/AIDS related illness (Table 2).

Table 2:Psychosocial factors of study participants at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018 (n=328).

Variable		Frequency	Present
Living condition	Alone	58	17.7
	With family	270	82.3
Internalized stigma	Yes	106	32.3
	NO	222	67.7
Social support	low social support	71	21.6
	High social support	257	78.4
Lost jobs due to illness	Yes	24	7.3
	No	304	92.7

5.3. HIV/AIDS related factors of depression

Among the study participants 238(72.6%) of the respondents were WHO HIV/AIDS clinical stage I, 272(82.9%) had CD4 counts greater than 250, the most of the respondents 320(97.6%) have taking first line ART and 295(89.9%) had taking their HIV/AIDS medication properly without interruption (Table 3).

Table 3: HIV/AIDS related factors of study participants at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018.

Variable		Frequency	Present
Stage	stage I	238	72.6
	stage II	52	15.9
	stage III	17	5.2
	stage IV	21	6.4
Recent CD4 count (cell/µl)	≤250	56	17.1
	>250	272	82.9
Duration of HHART(in month)	≤6	62	18.9
	>6	266	81.1
HHART interruption	Yes	33	10.1
	No	295	89.9
Drug Regimen	1st line	320	97.6
	2nd line	8	2.4

5.4. The Prevalence and level of depression

The prevalence of depression among PLWHA at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018 was 37.5%

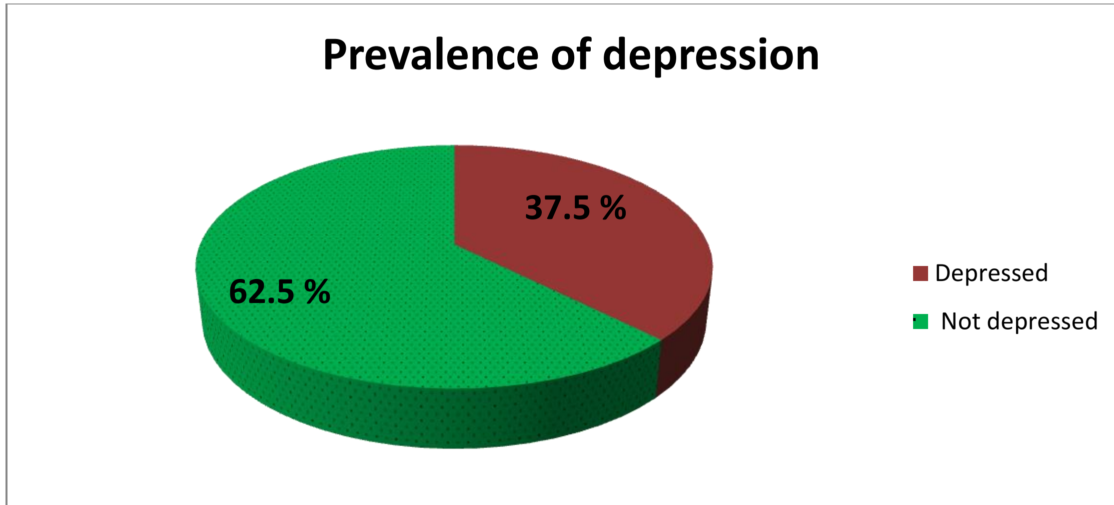

Figure 3:prevalence of depression among PLWHA attending ART clinic at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018 (n=328).

5.5. Factor associated with Depression among HIV/ AIDS patients

Those variables with a P-value of ≤ 0.25 in the Binary logistic analysis was entered to multivariable logistic analysis using enter method to identify the independent factors associated with depression among HIV/ AIDS patients. In bivariate analysis the covariates: age, sex, marital status, monthly income, lost jobs, internalized stigma, living condition, social support, CD4 count, WHO HIV/AIDS stages, drug regimen, duration of HAART and HAART interruption were associated with depression among HIV/ AIDS patients. In multiple logistic regression analysis, the covariates: sex, monthly income, internalized stigma, social support, duration of HAART and HAART interruption were statistically significant at 5% level of significant and were found to be the associated factors of depression among HIV/ AIDS patients.

Females were 2 times more likely to develop depression than males [AOR=2.43; 95%CI (1.27-4.64)].Those with income less than 500 birr were 4 times, income between 501-1000 birr were 3.6 times, income between 1001-1500 birr were 3.2 times and income between 1501-2000 birr were 3 times more likely to suffer from depression than those with income ≥2000 birr [AOR=4.07;95%CI (1.65-10.04)], [AOR= 3.62; 95%CI (1.44-9.09)], [AOR= 3.25; 95%CI (1.11-9.51)] and [AOR=2.90; 95%CI (1.02-8.27)] respectively. Those patients who had duration of ART ≤6 months were 3 times more likely to develop depression than patients who had duration of ART >6 months [AOR=2.95; 95%CI (1.42-6.04)] and patients who had not taken their ART properly were 3.4 times more likely to develop depression than patients who have not taken their ART properly [AOR= 3.43; 95%CI (1.17-10.04)].

Regarding to internalized stigma, patients who were internally stigmatized were 4 times more likely to develop depression than patients who were not internally stigmatized [AOR=4.16; 95%CI (2.21-7.84)].Those patients who had low social support were 4 times more likely to develop depression than patients who had high social support [AOR= 4.00; 95%CI (1.72-9.27)].

Table 4: Binary and multivariable Logistic regression analysis of factors associated with depression among PLWHA at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018

Variable	Depression		COR (95%CI)	AOR (95%CI)
	Yes	No		
Sex				
Female	80(45.2%)	97(54.8%)	2.07(1.306-3.285)	**2.43(1.27-4.64)***
Male	43(28.5%)	108(71.5%)	1.00	1.00
Average monthly Income				
≤500	44(50%)	44(50%)	5.33(2.53-11.23)	**4.07(1.65-10.04)**
501-1000	31(41.3%)	44 (58.7%)	3.76(1.74-8.11)	**3.62(1.44-9.09)***
1001-1500	17(43.6%)	22 (56.4%)	4.12(1.70-9.97)	**3.25(1.11-9.51)***
1501-2000	19(38.0%)	31(62.0%)	3.27(1.41-7.58)	**2.90(1.02-8.27)***
≥2000	12(15.8%)	64(84.2%)	1.00	1.00
Duration of ART(in months)				
≤ 6 months	35(56.5%)	27(43.5%)	2.62(1.49-4.61)	**2.95(1.42-6.04)***
>6 months	88(33.1%)	178(66.9%)	1.00	1.00
HHART interruption				
Yes	22 (66.7%)	11 (33.3%)	3.84 (1.79-8.24)	**3.43(1.17-10.04)***
No	101(34.2%)	194 (65.8%)	1.00	1.00
Internally stigmatized				
Yes	66(62.3%)	40(37.7%)	4.78(2.91-7.84)	**4.16(2.21-7.84)*****
NO	57(25.7%)	165(74.3%)	1.00	1.00
social support				
Low social support	44(62.0%)	27(38.0%)	3.67(2.12-6.35)	**4.00(1.72-9.27)****
High social support	79(30.7%)	178(69.3%)	1.00	1.00

*p-value<0.05, **p-value<0.001 and ***p-value<0.000

6. DISCUSSION

6.1. Prevalence of Depression

The prevalence of depression in this study was 37.5%. This finding was relatively comparable with study reported from Alert hospital AA, Ethiopia and Debrebirhan Referral Hospital, North Showa Ethiopia in which prevalence of depression among PLWHA were 41.2% and 38.94% respectively (24, 23). This result was also comparable with study done at Teaching Hospital in Imo State, South East Nigeria and that shows the prevalence of depression among PLWHA were 39.1% (21).

This prevalence was lower than the studies conducted at Zewditu Memorial Hospital, AA, Ethiopia, Tigray, North Ethiopia, Harar Town, Eastern Ethiopia and Metu Karli Hospital, South West, Ethiopia that shows the prevalence of depression were 44%, 43.9% 45.8% and 48% respectively (24, 25,26 34). This result was also lower than findings reported from studies done at Guru Teg Bahadur Hospital in Delhi India, Khartoum Hospital, Sudan and Yaoundé, Cameroon shows that the prevalence of depression were 58.75%, 63.1 % and 63% respectively (27, 29, 33). The variation might be due to the change and modification of management protocol. Currently there is a great modification and changes have been done regarding to HIV/AIDS screening, diagnosis and management protocol. In addition to this currently better attention has been given for PLWHA patients regarding to covering the range of services needed, covering the populations in need of services and covering the costs of services and accessibility of the infrastructures which leads to decrement of the prevalence of depression among PLWHA.

But this prevalence was higher than the study conducted at Debre Markos Town North West Ethiopia that shows the prevalence of depression were 11.7% (7). The variation might be occured due to the study conducted at Debre Markos Town North West Ethiopia was community based but this study was institutional based so even if the population were the same the study settings were differs. This result was also higher than findings reported from studies done at Yangon region, Myanmar Southwest Regional Hospitals of Cameroon, at Korean university hospitals, Entebbe district, Uganda at Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria and University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu, Southeast Nigeria shows that the prevalence of depression were 30.12%, 26.7%, 21%, 8.1% and 23.1% respectively (14, 15, 21, 30, 31). This variation might be occurred due to differ in tools, sampling technique, sample size and socioeconomic characteristics. The studies which were conducted at Korean university hospitals and at University of Nigeria Teaching Hospital, Ituku-Ozalla,

Enugu, Southeast Nigeria used the difference tools that wre the Beck Depression Inventory (BDI) with a 21-item tool with scores of ≥21 and Hospital Anxiety and Depression Scale (HADS) with a 7-item tool with scores of ≥11 indicating depression and used small sample size only 82 and 122 HIV-infected patients respectively with convenient (non-probability sampling techniques). But this study had 340 study participants and it used PHQ-9 items tool with score of ≥5 indicating depression.

6.2. Factors associated with depression among HIV/AIDS Patients

In this study gender was one of the important significant factors for depressions among PLWHA i.e. females were ststically significance with depression. Females were 2 times more likely to develop depression than males This was similar with studies conducted at Debrebirhan Referral Hospital, Ethiopia, Entebbe district, Uganda and Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria (23, 30, 31). The reason why females were more depressed than males might be due to biological (females have strong genetic predisposition and more subjected to fluctuating hormone), psychological (more ruminative and more invested in relationship) and sociocultural (more stressful) variation. But this result was contradicted with other study which was conducted at Harar Town, Eastern Ethiopia (25). This difference might be occurred due to sociocultural difference.

Those with income less than 500 birr were 4 times, income between 501-1000 birr were 3.61 times, income between 1001-1500 birr were 3.25 and income between 1501-2000 birr were 2.90 times more likely to suffer from depression than those with income≥2000 birr. This finding was consistent with studies conducted at Debrebirhan Referral Hospital, North Showa Ethiopia, Harar Town, Eastern Ethiopia, Guru Teg Bahadur Hospital in Delhi, India and Tigray, North Ethiopia (23, 25, 27, 34). The possible explanation for this might be PLWHA who have low income cannot easily fulfill their needs, have difficult to get balanced diet and to cover health expense. In addition to their disease status, financial hardship leading to psychological distress and frustration, so they might easily develop depression.

Duration of ART was highly significant with depression. Those patients who had duration of ART ≤6 months were 3 times more likely to develop depression than patients who had duration of ART >6 months This finding is similar with studies conducted at Guru Teg Bahadur Hospital in Delhi, India (27). The reason might be PLWHA who started ART might be worry to adapt ART and face different adverse effects with in the first 6 months and this might be leads to depression.

ART interruption was highly significant with depression. Patients who had not taken their ART properly were 3 times more likely to develop depression than patients who interrupt their ART. The possible explanation might be as PLWHA interrupt the ART, there might be increment of diseases progression, probability of occurrence of opportunistic infections and burden.

Internalized stigma was highly and positively significant with depression. patients who were internally stigmatized were 4 times more likely to develop depression than patients who were not internally stigmatized.This finding was consistent with studies done at Debre Markos Town Northwest Ethiopia, Alert hospital Addis Ababa, at Debrebirhan Referral Hospital, North Showa Ethiopia, Zewditu Memorial Hospital, AA, Ethiopia, Harar Town, Eastern Ethiopia and Metu Karli Hospital, South West, Ethiopia (7, 8, 23-26).This might be occurred as PLWHA were internally stigmatized, they fear and frustrate about gossip from others and decrease their social network.

Social support was highly significant with depression. Those patients who had low social support were 4 times more likely to develop depression than patients who had high social support. This was similar with studies conducted at Debre Markos Town Northwest Ethiopia, Alert hospital Addis Ababa, Ethiopia, Metu Karli Hospital, South West, Ethiopia and Guru Teg Bahadur Hospital in Delhi, India (7, 8, 26, 27). This might be occurred due to social support were significantly influenced the mental health status of the respondents. When PLWHA got high social support, the probability of developing depression was less likely because they might be more confidential, free from psychosocial distress, resulting in a better quality of life.

Generally, the study assessed the prevalence of depression among PLWHA and identified its associated factors and it can be an input for health institutions to give an integrated HIV/AIDS treatment with depression management for PLWHA. In the future the researcher should conduct a prospective study in which depressed patients are followed up to determine whether they are subsequently depressed or not.

7.3. Strengths and Limitations

Strengths;

- ✓ Many different variables were assessed to identify factors associated to depression among PLWHA and new varibables were assessed.
- ✓ Standard and valid questionnaires used in other studies was adopted and adapted for the study.

Limitations;

- ✓ The study did not include PLWHA who were attending at health centers and private health institutions and who did not visit any health institutions.
- ✓ The study was cross-sectional, it did not show the real cause-effect relationship

8. CONCLUSION AND RECOMMENDATION

8.1. Conclusion

The prevalence of depression among PLWHA who were attending at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018 were 37.5%. Sex, monthly income, internalized stigma, social support, duration of HAART and HAART interruption were significantly associated with depression among HIV/ AIDS patients.

8.2. Recommendation

Based on this finding the following recommendations were forwarded;

To Gurage Zone health beaureau:

The Zone health beaureau should link those PLWHA with different governmental, NGO or any other supportive groups to get economical support, social support, training related to stigmatization and for other care

To Gurage zone government Hospitals:

Those health care provider should give special consideration for PLWHA; who are females, have low monthly income, are internally stigmatized, have lower social support, with in the first 6 month of ART duration and who did not taken their ART properly. There should be proper routine psychiatric screening.

To Gurage Zone administration:

The administration of Gurage zone should support PLWHA especially who are females, have low monthly income and have lower social.

To Ministry of Health:

MOH should support PLWHA by supporting economically and by giving training regarding to stigmatization and ART addherance.

Nursing practice:

Nurses should connect PLWHA with different Governmental and non Non-governmental organizations to get economical and social support.

Nurses should also give training and health education for PLWHA and their family, particularly by giving emphasis on how to recognize depression, how to help the clients and how to report them.

To researcher: Further research that might include private health institutions and health centers to solve the problems of HIV/AIDS comorbidity with depression. In addition to this prospective study should be conducted about deprehealthssion among PLWHA.

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APPENDIXES

I. Questionnaire English version

To the data collector facilitators: Please inform the respondents about the aim of the study as described below!

Benefit of the study: The participants will not gain any incentives and direct benefit, yet the result can be used as a baseline for further studies that can be done in Butajira general Hospital and Gunchire primary Hospital and identify problems associated to depression among HIV/AIDS in those hospitals as well as in our country.

Risk of the study: The study has no any risk for the participants and interview will be private to make safe participants from any fear.

Dear respondents:

This questionnaire is only for research purpose. I assure you that confidentiality and anonymity will be fully maintained. To strengthen this you are not expected to write anything such as name, ID, address… that may lead to your identification.

Your participation is purely voluntary, and you can withdraw at any time after you get involved in the study without compromising your right. However, I hope that you will participate in this study since your responses are quite important. If you are willing to take part in the study, you are kindly requested to respond to all questions honestly!

Now do you agree to participate in the study? Yes _____ No _____.

Thank you very much for your co-operation!

Data collector facilitators name ______________ signature ____________

Date ________ month______ year____________

Supervisor name _______________________ signature ________________

Date ________ month______ year____________

Addis Ababa University College of health sciences, school of allied health sciences department of Nursing and Midwifery

Questionnaire prepared to assess the Prevalence and Associated factors of depression among HIV/ AIDS patients attending ART clinic at Gurage zone selected government Hospitals, southwest, SNNPR, Ethiopia, 2018.

Please indicate your response by circling your choice or by writing the appropriate information on the space provided!

Part I. Socio-demographic characteristics

101.	Age:	___________years old
102.	Sex:	A. Female B. Male
103.	Ethnicity:	A. Gurage C. Amhara B. Silte D. Oromo E. Others (specify) ___________
104.	Religion:	A. Muslim C. Protestant B. Orthodox D. Catholic E. Others (specify) ___________
105.	Marital status:	A. Single C. Widowed B. Married D. Divorced
106.	Educational status (Circle only the highest grade or degree completed):	A. Illiterate B. 0-4 C. 5-8 D. 9-12 E. College or university graduated F. Others (specify)______
108.	What is/was your occupation?	A. Daily laborer B. Gov't employee D. Merchant E. Student C. Farmer F. Others(specify)
109.	Average income	____________________birr/month

Part II. Psychosocial factors

201.	With whom you live?	A. alone. B. with my family C. Others (specify) ________
202.	Have you lost your job due to HIV/AIDS illness?	A. Yes B. No

3. The following questions are related to Internalized Stigma

All of the following statements refer to the way you feel (not what you think others think about you since you were diagnosed with HIV infection.

How You feel about yourself:		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
301.	You feel so ashamed about having HIV/AIDS.	1	2	3	4	5
302.	You feel marked, labeled or different.	1	2	3	4	5
303.	HIV infection hinders your ability to interact with other people.	1	2	3	4	5
304.	HIV infection hinders your ability to be intimate with other people.	1	2	3	4	5
305.	You feel that you are undesirable.	1	2	3	4	5
306.	You feel inhibited from making new friends.	1	2	3	4	5
307.	You are deceitful when it comes to telling other people that you have HIV infection.	1	2	3	4	5
308.	Having HIV infection is like being branded with a terrible mark of shame.	1	2	3	4	5
309.	You try to hide the fact that you have	1	2	3	4	5

	HIV infection.						
310.	You feel that you need to hide your illness.	1	2	3	4	5	

4: The following questions are related to availability of Social support .Those questions provide whom you can count on for help or support. Give the person's relationship to you.

	Who helps you with each of the following?	Who provides the support?
401.	Who can you really count on to help you not think about your worries when you feel under stress?	0. No one 1. Family 2. Friends 3. Organization 4. Religious father/persons 5. Unknown persons
402.	Who can you really count on to help you feel more relaxed when you are under pressure or tense?	0. No one 1. Family 2. Friends 3. Organization 4. Religious father/persons 5. Unknown persons
403.	Who accepts you totally, including both your worst and best points?	0. No one 1. Family 2. Friends 3. Organization 4. Religious father/persons 5. Unknown persons
404.	Who can you really count on to care about you, regardless of what is happening to you?	0. No one 1. Family 2. Friends 3. Organization

		4. Religious father/persons 5. Unknown persons
405.	Who can you really count on to help you feel better when you are feeling generally down-in- the dumps?	0. No one 1. Family 2. Friends 3. Organization 4. Religious father/persons 5. Unknown persons
406.	Who can you count on to comfort you when you are very upset?	0. No one 1. Family 2. Friends 3. Organization 4. Religious father/persons 5. Unknown persons
Part III. HIV related factors (if the patients do not know their HIV/AIDS conditions refer from card)		
501.	Which is your HIV/AIDS stage?	A. Stage I C. Stage III B. Stage II D. Stage IV
502.	How much is your recent CD4 count?	______________cell/µl
503.	How long time did take your HIV/AIDS medication?	___________in months
504.	Have you taking your HIV/AIDS medication properly without interruption?	A. Yes B. No
505.	Drug Regimen (refer from card)	A. 1st line B. 2nd line C. Others (specify)_____

Part IV. Questionnaire for depression screening of patient (PHQ-9)

Instructions: this interview consists of nine items. Please listen carefully what I am going to read each items of statement for you, and then tell me the **one number** in each item that best describes the way you have been feeling during the **past two weeks.**

s.n	Questions	Respondents possible answers			
		Not at all	Several days	More than half the days	Nearly every day
601.	Little interest or pleasure in doing things	0	1	2	3
602.	Feeling down, depressed, or hopeless	0	1	2	3
603.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
604.	Feeling tired or having little energy	0	1	2	3
605.	Poor appetite or overeating	0	1	2	3
606.	Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
607.	Trouble concentrating on things, such as reading the newspaper or watching Television	0	1	2	3
608.	Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
609.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

THANK YOU

I have finished my interview

If you have any question/suggestion regarding to the study you can contact with the owner of the stdy by the following address

Name Haile Workye Tell no_09-35-03-34-09

email:haileworkye21@gmail.com

II. Amharic version questionnaires

የስምምነት ቅፅ

ለሰብሳቢው፤እባክህ ከዚህ በታች የተገለጹትን የጥናቱ ዓላማዎች ለጥናቱ ተሳታፊዎች አስረዳ!

የጥናቱ ጥቅም፤ ተሳታፊወች ከዚህ ጥናት በቀጥታ የሚያገኙት ምንም አይነት ጥቅም ወይም ክፍያ የለም: ነገር ግን ይህ ጥናት በቀጣይ በቡታጅራ እና በጉንችሬ ሆስፒታል እንድሁም በሀገሪቱ በኤችአይቪ/ኤድስ ህመምተኞች ላይ የድብርት ስርጭት እና ተዛማጅ ሁኔታዎች በተመለከተ ለሚደረጉ ጥናቶች እንደ መነሻ ያገለግላል።

የጥናቱ ጉዳት፤ ይህ ጥናት በተሳታፊወች ላይ ምንም አይነት ጉዳት አያደርስም፤መጠይቁ የተሳታፊወች ሚስጥር በተጠበቀ መንገድ ይከሄዳል።

ውድተሳታፊዎች

የዚህ መጠይቅ ዓላማ ለምርምር ብቻ ሲሆን ይህም በቡታጅራ አጠቃላይ ሆስፒታል እና በጉንችሬ የመጀመሪያ ደረጃ ሆስፒታል በኤችአይቪ/ኤድስ ህመምተኞች ላይ የድብርት ስርጭት እና ተዛማጅ ሁኔታዎች ለማጥናት ነው።እኔ ላረጋግጥልዎት የምፈልገው፤በዚህ መጠይቅ ላይ የሚሰጡት መረጃ ሚስጢራዊነት እና ማንነትን ሙሉ በሙሉ የተጠበቀ ይሆናል።እናም በዚህ መጠይቅ ላይ የእርስዎንማንነት ሊያመራ የሚችል ስምዎት፣መለያ ቁጥሮትን እና አድራሻዎትን አይፃፍም። በዚህ ጥናት መሳተፍ የሚችሉት በፈቃደኝነት ብቻ ነው።በማንኛውም ሰአት የእርስዎን መብት የሚጋፉ በመሰሎት ጊዜ ማቆም ይችላሉ።ነገር ግን የእርስዎ ተሳትፎ በጣም አስፈላጊ ስለሆነ ይሳተፋሉ ብለን ተስፋ እናደርጋለን።በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ከሆኑ የምንጠይቅዎትን መረጃ ሙሉ ለሙሉ በሐቀኝነት ይመልሱልን ዘንድ እንጠይቅዎታለን።

አሁን ጥናት ውስጥ ለመሳተፍ ይስማማሉ? አዎ ______አልስማማም ______

በጣም እናመሰግናለን!

የተሳታፊ ፊርማ______________

የመረጃ ሰብሳቢ ስም ___________ፊርማ_____ቀን __________ ወር________ ዓ.ም________

የተቆጣጣሪ ስም________________ፊርማ_____ቀን __________ ወር________ ዓ.ም________

ጥናቱን የተመለከተ ማንኛዉም ዓይነት ጥያቄ ወይንም አሰተያየት ካለዎት በሚከተለው አድራሻ ከጥናቱ ባለቤትመረጃ ማግኘት ትችላላችሁ።

ስም፡ ሀይሌ ወርቅዬ **ስልክ ቁጥር፡** 09-35-03-34-09

እባክዎትን የእርስዎን ምርጫ በማክበብ ወይም በቀረበው ቦታ ላይ ተገቢው መረጃ በመጻፍ ምላሽዎን ይፃፉልን

ክፍል አት: ማህበራዊና-ሕዝብ አወቃቀር ባህርያት		
101.	እድሜ:	___________ዓመት
102.	ፆታ:	ሀ. ሴት ለ. ወንድ
103.	ብሔርዎ ምንድነው?	ሀ. ጉራጌ ሐ. አማራ ለ. ስልጥ መ. ኦሮሞ ሠ. ሌላ (ይገለጥ) ___________
104.	ሃይማኖት:	ሀ. ሙስሊም ለ. ኦርቶዶክስ ሐ.ፕሮተስታንት መ. ካቶሊክ ሠ. ሌላ (ይገለፅ)___________
105.	የጋብቻ ሁኔታ	ሀ. ያላገባ/ች ለ. ያገባ/ች ሐ. የሞተችበት/ባት መ. የፈታ/ች
106.	የትምህርት ሁኔታ(ከፍተኛ ያጠናቀቁት ክፍል ወይም ኮለጅ ብቻ ያክብቡ):	ሀ. ምንም ያልተማረ ለ. 0-4 ሐ. 5-8 መ. 9-12 ሠ. ከኮሌጅ ወይም ከዩኒቨርሲቲ የተመረቀ ረ. ሌላ(ይገለፅ)_________
108.	የስራ ሁኔታ	ሀ. የቀን ሰራኛ ሐ. ገበሬ ለ. የመንግስት ሰራተኛ መ. ነጋዴ ሠ. ተማሪ ረ. ሌላ (ይገለፅ) ___
109.	በወር አማካይ ገቢ	___________________ብር/ወር

ክፍል ሁለት: የስነ-አእምሮ እና ማህበራዊ ሁኔታወች		
201.	ከማን ጋር ነው የምትኖረው?	ሀ. ብቻዬን ለ. ከቤተሰቤ ጋር ሐ. ሌላ(ይገለጽ)________
202.	በኤች አይቪ/ኤድስ ህመም ምክንያት ስራህ/ሽን አቁመሃል/ሻል?	ሀ. አዎ ለ. አላቆምኩም

ክፍል ሁለት ለ: ከውስጥ ሃፍረት ጋር ተዛማጅ ጥያቄዎች ሁሉም የሚከተሉት መግለጫዎች የሚጠቅሱት ከኤችአይቪ ጋር መሆንዎን ካወቁ ጀምሮ እርሶ በሚሰማወት መልኩ (ሌሎች ሰለ እርሰዎ ምን እንደሚያስቡ ያሰቡትን ሳይሆን)						
ስለራሰዎ ምን ይሰማዎታል?		በጣም አልስማ ማም(1)	አልስማማ ም(2)	ገለልተ ኛ (3)	እስማማለ ሁ(4)	በጣም እስማማለሁ (5
301	ኤችአይቪ/ኤድስ ስላለቦት እፍረት ይሰማዎታል					
302	በግልጽ ከሌሎች ሰዎች ተለይተዉ የሚታወኩ ወይም የሚታይ፣ መስሎ ይሰማዎታል					
303	በኤችአይቪ በመጠቃትዎ ከሌሎች ህዝቦችጋር የመሳተፉ ችሎታዎን አደናቅፎታል					
304	በኤችአይቪ በመጠቃትዎ ችሎታዎን ከሌለው ህዝቦች ጋር ወዳጅነት እናዳይኖሮት አደናቅፎታል					
305	ደስ የማይል አይነት ስሜት ይሰማዎታል					
306	አዲስ ጓደኝነት ለመመስረት እፍረት ይሰማዎታል					
307	የኤችአይቪ ተጠቂ መሆንዎትን ለሌሎች ለመናገር በሚፈልጉበት ጊዜ ቅድመ ሁኔታ ወይም የማባበያ ሀሳቦችን አቅርበዋል					
308	በኤችአይቪ መጠቃት በጣም መጥፎ እና አስደንጋጭ የሀፍረት ምልክት ነው					
309	በኤችአይቪ መጠቃቶትን እውነቱን ለመደበቅ ሞክረዋል					
310	ህመሞን ለመደበቅ ፍላጎት ይሰማዎታል					

ክፍል ሁለት ሐ: ከማህበራዊ ድጋፍ ተደራሽነት ጋር ተዛማጅ ጥያቄዎች እነዚህን ጥያቄዎች የሚደግፎትን ወይም ረዳቶትን እንዲቆጥሩ ቀረበልዎ፡፡		
	በሚከተሉት ሁኔታዎች ውስጥ ማነው እርስዎን የሚረዳዎ	ማነው ድጋፉ የሚያደርግለወት?
401	እርስዎ በጭንቀት ውስጥ በሚሆኑበት ጊዜ ስለጭንቀትዎ እንዳያስቡ የሚያደርግዎ ትክክለኛ ረዳት ብለው የሚቆጥሩት ማነው?	0. ማንም የለም 1. ቤተሰብ 2. ጎደኞች 3. ድርጅት 4. የሀይማኖት አባት/ግለሰብ 5. የማይታወቁ ሰዎች
402	እርስዎ በጣም ጫና በሚበዛብዎት ጊዜ ዘና እንዲሉ የሚያርግዎት ትክክለኛ ረዳት ብለው የሚቆጥሩት ማነው?	0. ማንም የለም 1. ቤተሰብ 2. ጎደኞች 3. ድርጅት 4. የሀይማኖት አባት/ግለሰብ 5. የማይታወቁ ሰዎች
403	በጣም የከፋ ነገርዎንም ሆነ ምርጥ የሆነውን ሙሉ ለሙሉ የሚረዳዎ ማነው	0. ማንም የለም 1. ቤተሰብ 2. ጎደኞች 3. ድርጅት 4. የሀይማኖት አባት/ግለሰብ 5. የማይታወቁ ሰዎች
404	በእርስዎ ላይ ምንም አይነት ነገር ቢፈጠር የሚጠብቅዎ እና ለእርስዎ ይጨነቃል ብለው የሚሉት ትክክለኛ ረዳት ብለው የሚቆጥሩት ማነው?	0. ማንም የለም 1. ቤተሰብ 2. ጎደኞች 3. ድርጅት 4. የሀይማኖት አባት/ግለሰብ 5. የማይታወቁ ሰዎች
405	እርስዎ ሙሉ ለሙሉ የመውደቅ ስሜት ውስጥ በሚሆኑበት ጊዜ የተሻለ እንዲያስቡ የሚያግዝዎ ትክክለኛ ረዳት ብለው የሚቆጥሩት ማነው?	0. ማንም የለም 1. ቤተሰብ 2. ጎደኞች 3. ድርጅት 4. የሀይማኖት አባት/ግለሰብ

		5. የማይታወቁ ሰዎች
406	እርስዎ በጣም በተበሳጨ ጊዜ ምቾት እንዲሰማዎ ያደርጋል የሚሉት ትክክለኛ ረዳት ብለው የሚቆጥሩት ማነው?	0. ማንም የለም 1. ቤተሰብ 2. ጎደኞች 3. ድርጅት 4. የሀይማኖት አባት/ግለሰብ 5. የማይታወቁ ሰዎች

ክፍል ሶስት፡- የኤችአይቪ ተያያዥ እውነቶች (ምናልባት ታካሚዎች የኤችአይቪ/ኤድስ ሁኔታቸውን የማያውቁ ከሆነ ከካርዳቸው ላይ የሚጠቀስ ይሆናል)

501.	የእርስዎ ኤችአይቪ/ኤድስ ደረጃ የትኛው ነው?	ሀ. ደረጃ I ለ. ደረጃ II ሐ. ደረጃ III መ. ደረጃ IV
502.	የቅርብ ጊዜ CD4 መጠን ስንት ነው?	___________cell/μl
503.	የኤች አይቪ/ ኤድስ መድሀኒትህን/ሽን መውሰድ ከጀመርሽ/ህ ስንት ጊዜ ሆነህ/ሽ??	________________በወር
504.	የኤች አይቪ/ ኤድስ መድሀኒትህን/ሽን ሳታቋርጥ/ጪ እና በአግባቡ ትወስዳለህ/ጃለሽ ?	ሀ. አዎ ለ. አይደለም
505.	የሚወስዱት የመድሀኒት ደረጃ ወይም ምድብ (ከካርድ ላይ የሚጠቀስ)	ሀ. የመጀመሪያ ደረጃ ለ. ሁለተኛ ደረጃ ሐ. ሌላ (ይገለጥ) __

ክፍል አራት-፡-የድብርት ስርጭትን በህመምተኞች ላይ መኖሩን ለማውቅ የተዘጋጀ መጠይቅ እባክዎን የማነበውን እያንዳነዱን በጥሞና ያዳምጡ እና ባለፉት ሁለት ሳምንታት ውስጥ በይበልጥ እርስዎን የሚሰማዎትን ይመልሱ

ተ.ቁ	ጥያቄዎች	የተሳታፊወች መልሶች			
		በፈጹም	ከሰባት ቀናት ያነሰ	ከስባት ቀናት በላይ	ከሞላ ጎደል በየቀኑ
601.	ነገሮችን ሲሰሩ ፍላጎትዎ ወይም የሚያገኙት ደስታ በጣም ትንሽ (እምብዛብ) ነበር?	0	1	2	3
602.	የትከዜ፤ የበታችነት፤የጭንቀት፤የመደበር ወይም ተስፋ የመቁረጥ ስሜት ነበረብዎት?	0	1	2	3
603.	እንቅልፍ የመተኛት፤ተኝቶ የመቆየት ችግር ወይም ከመጠን በላይ የመተኛት ችግር ነበረብዎት?	0	1	2	3
604.	ድካም የመሰማት ወይም አቅም የማነስ ሁኔታ ነበረብዎት?	0	1	2	3
605.	የምግብ ፍላጎት አለመኖር ወይም በጣም ብዙ የመብላት ችግር ነበረበዎት?	0	1	2	3
606.	ስለራስዎ መጥፎ ስሜት ተሰምቶት ወይም አልተሳካልኝም ብለው አስበው ፤ወይም ቤተስብን አሳፈርኩ ብለው አስበው ነበር?	0	1	2	3
607.	ነገሮች ላይ ሀሳብዎትን መሰብሰብ ወይም ልብ የማለት ችግር ነበረብዎት፤ ለምሳሌ ጋዜጣ ሲያነቡ ወይንም ቴላቭዥን ሲመለከቱ?	0	1	2	3
608.	ከተለመደው ውጭ እረፍት የማጣት፤ወዱያ ወዱህ የማለት ወይንም በተቃራኒው ሌሎች ሰዎች ሉገነዘቡት በሚችሉት ሁኔታ ቀስ ብል የመናገር ወይም የመንቀሳቀስ ችግር ነበረብዎት?	0	1	2	3
609.	ብሞት ይሻላልወይንም እራሴን በሆነ መንገድ ብጎዳ ይሻላል ብለው ያሰቡበት ጊዜ ነበር?	0	1	2	3

III. Guragegna version questionnaires

A. Meskangna

ለሰብሳቢው: ጦሳሃ ተዚ በተት የዘረዘርየ የትናናቱ ኢላማዎች በጥናቱ ይሳተፎይ አትረዳ

የጥናቱ ፋይዳ: ይሳተፎይ ሰቦች በዚ ጥናት ይረህቦይ ሚንም አይነት ጥቅም ወይንም ክፍያ ዔነን ቢኸንም ዚ ጥናት ቢቁትሉ በቡታጅራ እና በጉንችሬ አሂም ቤት እንደገናም በሀገሬ በኤች አይቪ/ኤድስ በታቆይ ስቦች በነን (ፎሪ) የኸኸርት ወስፋፋት እንደገናም ተዚጌ የትበባል ዘንጋዎች በትመለከተ ይሸኩችየ ጥናቶች ልክ እንደ ውጥን ያገለግላል

የጥናቱ ጉደታዉታ : ዚጥናት ቢሳተፎይ ሰቦች ነን ምንም ቃር ጉዳት ዔያቸኝ ጥያቄዎች የሳፎዎ ሰቦች ገበና በቂዬ ዔማ ይሸከት

<u>የተወደዲኩይ ተሳተፎይ ስቦት</u>

የዚያ ጥየቃ ዒላማ የወመራመር ብቻ ቲኸን ዚም በቡታጅራ አጠቃላይ ሃኪም ቤት እና በጉንችሬ የመጀሪያ ደረጃ ሃኪም ቤት በኤች አይቪ/ኤድስ የታቆይ ሰቦች በነን/ፏሪ ያነቦ ኸኸርት ወትላለፊ እና ተዚጌ የጥባበጠ ቃር የዋትናዉ እያ/ እነ አረጋገጥኩየ እሾን ቃር ቢነብብር በዚ ጥየቃ ነን /ፏአሪ/ የራሳሃ ማንነት ይገልጥ ይቸል ሽማሃ ልዩ ይሸክትከ ቁጥራሃ እች ትትረከበዉ ስፍር ዔይጥፍየ በዚህ ትናት የወሳተፍ ይሸሰብ በፍቃደዉታ ወህን ነነዉ : በሚንም ሰአት ያሁ መብት ይጋፋ መስረም በታየዝናሃ ግዝየ ቀቁም ትችሎ ቢኸንም ያሁ የወሳተፍ ይሸሰብ በፍቃደዉታ በብኸዉያ ያኬሽ ስለኸነ ትሳፎ ባርነም ተስፋ ኸሸክትነ፣ በዚ ጥናት ነን የወሳተፍ ፍቃደኛ በኸንኩ ኸጠይቅኔኩይ መረጃ እንማዉታ ታትዋስ ትዠብሮንነየ እጥይይቅኔኩ

ኸኂ ጥናት ዉስት የወሳተፍ ትስማሞ? ዔከ——አንስማማ———

በጥአም አመሰግን

የተሳትፎይ ፊርማ———

መረጃ ይሰባሰቢ ሽም——ፊርማ——— ከነ——መሬት——ዓ:ም———

የቁጠጠርዬ ሽም———ፊርማ——— ከነ——መሬት——ዓ:ም———

ጥናቲ በተመለከተ ሚንም አይነት ጥያቄ ባንከነም አስተያየት ባነናሁ ቢቀጥሉ አድራሻ የጥናቱ ባለቤት መረጃ ወርከብ

ሀይሌ ወርቅየ **ስልክ ቁጥር 0935033409**

Email: haileworkye21@gmail.com

ጠሳሁ ያሁ ምርጫ በዋንብብ ወይንም ባቡኩይ መንደር ነን/ፏሪ ይስማማይ መረጃ በወዳፍ መልሳሁ ፃፎንነ

ክፍል1: ማህበረሰብ እና ኸልቅ አወቃቀር ጠበዩ		
101.	እድሜ	___________ዓመት
102.	ፆታ	ሀ) ምኸት ለ) ምሶ
103.	ብሄዉምቃሩ	ሀ) ጉራጌ ለ) ስልጤ ሐ) አማራ መ) ኦሮሞ ሠ) ሌላ (ድብር)
104.	ሃይማኖታሁስ	ሀ) ሙስሊም ለ) አርቶዶክስ ሐ)ፕሮተስታንት መ) ካቶሊካ ሠ) ሌላ (ድብር
105.	የጋብቻ አቅል	ሀ) ያናገባ/ች ለ) ያገባ/ች ሐ) የሙተትወ/ባ መ) የፈታና/ች
106.	የትምህርት አቅል (ከፍተኛ የፈጀሁብ ክፍል ወይንም ኮሌጅ ብቻ አክብብ)	ሀ) ምንም ያንተማረ ለ) 0-4 ሐ) 5-8 መ) 9-12 ሠ) ኮሌጅ ወንም ዩኒቨርሲቲ የትማረ ረ) ሌላ (ድብር) ______
108.	የስራ/ሜና አቅል	ሀ. የቀን ሜናኘ ሐ. ገበሬ ለ. የመንግስት ሜናኘ መ. ነጋዴ ሠ. ተማሪ ረ. ሌላ (ድብር) __
109.	በመሬት አማካይ ገቢ	____________________ብር/በመሬት

ክፍል ሁዋት: ሀ/ የስነ-አንጎልና ሁኔታዎች		
201.	ተሚኒ ጌ ትነበር?	ሀ.ቁናኛ ለ. ታበሮስጌ ሐ. ሌላ(ድብር)
202.	በበኤች አይቪ/ኤድስ ኽቂና ሰበብ መናህ/ሽ አቆምከም/ሽም?	ሀ. ዔክ ለ. አናቆምኩ

ክፍል ሁዋት ለ: ከውስጥ ወገኛጌ የጥበባጢ ጥያቄዎች

እንም ይቀጥሎዋ ይገልጦይ ይጠቅስይ በኤች አይቪ/ኤድስ ጌ ወህናሁ ተሃርኩ ግዝየ ቀረሰም አሁ ቢስማማሁ ዔማ (ሌላይ ስላሁ ዮስበህ ማዮስበይ)

ስለራስሃ ምን ይሴማሃ ?		በጣም አንስማማ (1)	አንስማ ማ(2)	አንዌስን(3)	ኽስማማ(4	በጣም ኽስማ ማ(5)
301.	ኤች አቪ ኤድስ ስላነበብ ጊናት ይሴማሃ?					
302.	ኢልብጥጦ ተሌላ ሰቦች ተለፐሃም ይሁሩኩ ወይንም ትታዞ መሰረናሁም ይታዥሁ					
303.	ኤች አቪ ኤድስ በወጠበታሁ ተሌላ ስቦች ጌ የወሳተፍ አቅማሁ አሰናከለሁም					
304.	ኤች አቪ ኤድስ በወጠበጣሁ ተሌላ ስቦች ጌ ደቦ የመወስረት አቅማሁ አሰናከለሁም					
305.	ደስ አይብር ኢይነት ስሜት ይሰምሁ					
306.	ገደር ደቦ የወመስረት ጊናት ይሴማሁ					
307.	ኤች አቪ ኤድስ ተጠሪ ወሁናሁ ለሌላ ስቦች የወዘንጊ ብትሽሆበ ግዝየ መጀመርያ እና የዋዋብል ሀሳቦች አቀረብስም					
308.	ኤች አቪ ኤድስ በወጠብጥ በጣም ዉዶ እና ያድኔግጥ የወደንግጥ ምልክቱ					
309.	ኤች አቪ ኤድስ በወጠበታሃ በሃቅ የወሽም ምከርክም					
310.	አቂናሃ የወሽም ፍላጎት ይነብርብከ					

ክፍል ሁዌት ሐ: ከማህበራዊ ድጋፍ ተዋስላጌ የጥባብጠ ጥያቄዎች ይደግፍከይ ወይም ይረዳሃይ ትቆናሮሃማ ቀረቦም		
ተ.ቁጥር	በይቁጥሎዩ ሁኔታዎች ዉስጥ ያነይረዳሃ	ሚኒ ይረዳሃዩ ይችል
401	አሁ በጭንቀት ዉስጥ ብትሃንወግየ የጭንቀተሃ አቁስብኸማ ይሸክትኮ ትክክለኛ ረዳታነ ግሃም ትቆጥሪ ሚኒ	0.ሚንም ኤነ 1.አበሮስ 2.ዳቦችኛ 3.ድርጅት 4.የሃይማኖት አባት/ሌላ ስብ 5. ኤይሁርዬ ስቦች
402	አሁ በጣም ጉዳት ቢበዛብኩ ግዝየ ትዝናናኸማ ይሸክትኩ ትክክለኛ ግሃም ትቆጥር ሚኒ	0.ሚንም ኤነ 1.አበሮስ 2.ዳቦችኛ 3.ድርጅት 4.የሃይማኖት አባት/ሌላ ስብ 5. ኤይሁርዬ ስቦች
403	በጣም የከፋነዉም ዘንጋ ኸነ ፊያ የኸነ ቃርሃ እንቃር ይረዳሃ	0.ሚንም ኤነ 1.አበሮስ 2.ዳቦችኛ 3.ድርጅት 4.የሃይማኖት አባት/ሌላ ስብ 5. ኤይሁርዬ ስቦች
404	ባሁ ፏሪ ማንም ቃር ቢፈጠር ይቅየሁ እና ያሁ ይጨነቅ ባሁም ቴስቦይ ትክክለኛ ትቆጥሮይ ሚኒ	0.ሚንም ኤነ 1.አበሮስ 2.ዳቦችኛ 3.ድርጅት 4.የሃይማኖት አባት/ሌላ ስብ 5. ኤይሁርዬ ስቦች
405	አሁ ሙሉ በሙሉ የወዳቀይ ቅስም ዉስጥ ብትኾ ንወይ ግዝዬ የጠቀል ቴስቦኸማ ይሸክትኩ ትክክለኛ ረዳት ባሁም ትቆጥሮዬ ሚኒ	0.ሚንም ኤነ 1.አበሮስ 2.ዳቦችኛ 3.ድርጅት 4.የሃይማኖት አባት/ሌላ ስብ 5. ኤይሁርዬ ስቦች
406	አሁ በጣም በስባጨሁ ግዝዬ ድሎት ይሴማሁ ኸማ ይሸክት ትብሮዬ ትክክለኛ ረዳት ትብሮም ትቆጥሮዬ ሚኒ	0.ሚንም ኤነ 1.አበሮስ 2.ዳቦችኛ 3.ድርጅት 4.የሃይማኖት አባት/ሌላ ስብ 5. ኤይሁርዬ ስቦች

ክፍል 3፦ የኤች አይቪ/ኤድስ የጥባበጠ ሃቆች(ምጥልባት ታካሚዎች በኦሽ ኸትያያዘ ደናኦር የኤች አይቪ/ኤድስ ሁኔዎች ኤይሀሮ በኸነ ብርድኸኖ ባነን ይጠቅሶ ይኸን)		
501.	አሃ የኤች አይቪ/ኤድስ ደረጃ ኤቲዉ?	ሀ. ደረጃ I ሐ. ደረጃ III ለ. ደረጃ II መ. ደረጃ IV
502.	የቅርብ ግዝየ CD4 መጠንዎ ስንት ነዉ?	_____________cell/µl
503.	የኤች አይቪ/ ኤድስ መድሃኒትነ/ሽ ወውስድ ቢቀረስኪም/ሽም ምን ያህረ ግዝዬኸነናኸም/ሽም	______________በመሬት
504.	የኤች አይቪ/ኤድስ መድሃኒታነ/ሽ ወዉስድ ታታቂ ርጥ/ጭ ባግባባዉታ ትወድ/ትወስጅ ወይ?	ሀ. እንከ ለ. ባአይ
505.	ስደይ መድሃኒት ደረጃዉታ ወይንም ምድቢዉታ(ከካርድ በነን ይጠቀስ)	ሀ. በመጀመሪያ ደረጃ ለ. ሁዌተኛ ደረጃ ሐ. ሌላ(ድብር) ___________

ክፍል አርቦት-፡-የዥዥሮት ወሰራጭ በታቆይ ስቦች ፋር ወንብረዉታ የዋትኪየር ያዝንጂ መጠየቅ ጠሳሁ አንባቢ እያታተዉታ ጭጭበሮም ስም እና ባለፎይ ሁዌት ሳማንት ዉስጥ በብዛታሁ ይስማማሁ ዘብሮ

ተ.ቁ	ጥያቄዎት	የተሳተፎይ ስቦች ምላሽ			
		በጭራ ሽ	ከሰባት ከነ የቀበል	ከሰባት ከነ የነን	ከሞላ ጎደል በየኮነ ዉታን
601.	ሚንም ቃር ትትሸክቶ ፍላጎታሁ ወይንም ትረህቦይ ብልቃት በጣም አችም/እምብዛም/ ባነ?	0	1	2	
602.	የወተከዝ የበተትነት የወጭናነቅ የዥዥሮት ወይም ተስፋ የወረጥ ስሜት በነኮከ?	0	1	2	3
603.	ሞኜት የወገደር ተገደርኮም ደግሞ የዋክስ ችግር ወይም ተመጠን ያለፈ የወገደር ችግር ነበረብኩ?	0	1	2	3
604.	ቂጭና የወሰማ ወይንም ጉልበት የወነሰ ሁኔታ ግነብኩ?	0	1	2	3
605.	ምግብ ያለወብራ ችግር ወይም በጣም ብዥ የወብራ ችግር ግነብኩ?	0	1	2	3
606.	ስለራስሃ ዉደ ስሜት ተሴማናነም ወይንም አንትሳካኒ ግሃም ኤስበኮም ወይም አበሮስ አዋረድኩም ግሃም ኤስማ ነገር ነነ?	0	1	2	3
607.	ዘንጋዎች ፏሪ ሃሳባዉ ወስብስብ ወይም ስብ የወበር ችግር ባነብኩ ለምሳሌ ጋዜጣ ትታነቦ ወይም ቴሌቪዥን ትታዝ?	0	1	2	3
608.	ተለመድኩዬ ሌላ እረፍት የወቅብጥ ተዛየ ትዝዬ የወበር ወይም በተቃራኒዉ በሌላ ሰቦች ትትረደዬ ብትችሎይ ሁኔታ ቀስ ባሁም የወዘንጊ ወይም የንቀሳቀስ ችግር ባነብኩ	0	1		3
609.	ብንሙኽት ይጠቅል ወይንም እራሰኛ በኸነ ኤማ ብንጎዳ ይጠል ግሁም ዬስብኩቦ ወቅት ባነ?	0	1	2	3

B. Enmurgna

ኧዋ ያጠኖይዳ ሁዳ አለማሓ ኢትምራምርን ብቻን ኤኛአር አላማ ኤነንዳ አትምህ ሹው ኸረ ማነድን አይሂርዳ በዋ ጥናት ኢሳተፋቃ ሰቭ በግን ፍቃዳ ብቻን አንሳተፍካ ኻዋርት ኢችል ሰቭ መሰረን በትሳተፌጋ ትክክለኛ መረጃ አወት አነው አትሳሳተአር አውት ኤኖዳ

ኢጠይካሰቭ ሽው ------------ፊርማን ---------

ቀንን------------ በኘን --------አመተምህርትን ----------

ይቅጠጠርካ ስቭ ሹው -----ፊርማን------------

ቀንን---------- በኘን---------- አመተምሬትን-------------

መጠይቅ

ባዲሳበባ ኢንቨርስቲ ኸጤና ሳይንስ ኮሌጂ ኸነርስና ኸሚድዋይፈሪ ት/ት ቢድ ዋዳ ይጠይቁዳአር አዝጋጀምታ በቡታጂራይ አኪምቢድይ በጉንችሬየ አኪም ቢድአ በኤድስ በኦሽ ኸጠበጠኖዋ ሰብ ኸተኸ በምረኸ ኢደብርኮኸ እንገድ ቃር ደግሞ ኤኛአር ሁኔታሁነዋ ያጠኖይ ኸዝጋጀዳናአር

ብይንኪታወረቀት አሁዋ/አሃ ትክክለኛ ኸኸረ ኸመሰረና ሃአረ በኤድንይ አግብባይ /አግቡቡዋ

ክፍል1: በገኘንራ ሰቭ ኸተኸ ኢረምር		
101.	እድሜያኸ/ እድሜያሸ ምራካናአ	___________ዓመት
102.	ፆታ ምራፌድን	ሀ) ገረዲ ለ) ኸች
103.	ብሔራኸ ምራፌድን	ሀ) ጉራጌ ለ) ስልጤ ሐ) አማራ መ) ኦሮሞ ሠ) ኤኛአርጽፍብዋ______
104.	ሃይማኖታኸ ምራፌድን	ሀ) ቶባ ለ) ጦመኘ ሐ) ፔንጤ መ) ካቶሊካ ሠ) ኤኘአርጽፍብዋ
105.	ኸትዳር ሁኔታ	ሀ) አናገፓን ለ) አገፓሁ ሐ) ሞዴይ መ) ገፎርኘ
106.	ምራኸረኛ ሰነጋ ተማረኸለ/ሽም	ሀ) 0-4 ለ) 5-8 ሐ) 9-12 መ) ዲፕሎማ ሠ) ዲግሪ ረ) ማአስተር ሰ) ኤኛራር በርበረናኸ
108.	ኸቨና/የሜና/ሁኔታ	ሀ) ኸዋአሪያሜነኛ ለ) አቨንግስትሜና

		ሐ) ተማሪ መ) ገበሬ ሠ) ነጋዴ ረ)ሌኛአር_________
109.	በሸን ምራኅአር ትረኸም	___________________ብር/ወር

ክፍል2: በኸሽሁዳ አጠበጠነዋ ሁነዋ ተሰብ አተ ኸይረውርዋ		
201.	ተማን ትረምይዋ?	ሀ) አወጣማሽ/ኸ ለ) ተቢደስቭ ሐ) ከኤኛኃበኸረ________
202.	በኤድስ አማአሜናኸ/ሸ አሸከምሸም	ሀ) እንብ ለ) አናሸከኃ
3. ተዋቆጡወ ኢጠይካሁደ በኦሽኃ ኦነቨሸህ/ድ.በሐርሽጋ/ኸጋ ኸትሰማናኸ/ሸ ሁዳይጠይካናአር		

	አሻ/ኸ ምርይስማኸ	በጣም ኸስማማካ (1)	አስማማ ካ (2)	መካከለኛ ንሁ (3)	ኸስማማካ (4)	በጣም ኸስማ (5)
301.	ኤድስ አነቭይ ኸቅመጭ					
302.	ሰቭቲያሻ/ኸዳ ምልክት አነቭኸደአረኸ ኢሙስርሄ					
303.	ኤድስ አነቭሄ/ሽይ ተሰቭ ትደበሪ ኢኸራሄ/ሽ					
304.	ኤድስ አነቭሄ/ሽይ ተኤኛ ሰቭ አትደበይዋኸቆፍት ኸረመሸ/ሄ					
305.	ኦሻ/ኦኸ አተሲኡክ/ኢ ስሜት ተሰማናሁሚ					
306.	ኤኛ ኌደኛ ትጠጢ ትቅምጭ					
307.	ኤድስ በአሸ አነቭኸ/ሔ ኸኤኛ ሰቭ ትትኢድኩዳምን ተሰማናኸ/ሸ					
308.	በኤድስ በኦሸ መጀመሪያ ጊዚየ ሙጥጣአር ኸቁወጭትኒ					
309.	ኤድስ አነቭሸኸ/ኸ ደረርሁምባ					
310.	ህበአሸኃ ትደእሪ/ዋይ ስኤሸም					

4. ኧሰብ ደጋፍ በትሞለከተ አሻ/አኸ ኢደግፍኸ ር/አር ሰብ ጠይቁችይ		
ተ.ቁጥር	ማን ይረዳኸ/ሸ	ማንደን ይነግፍኸዳ
401	አሻ/ኸ ቲጭናንቅኸደ/ሻ ማን ይሸኸረሽ	0.ኦትሞኃ 1.ቢደሰሸኛ 2. ጓዲኛኛ 3.ድርጂት 4.ቄስ/ሺህ 5.ኦንሂርኮዋ ሰብ
402	አሻ/ኸ አዕምሮአሁዋ ቲጨንቅሁዋታ ያጨዲጋ ሰሸ አነነሁሽ/ሄ	0.ኦትሞኃ 1.ቢደሰብኛ 2. ጓዲኛኛ 3.ድርጂት 4.ቄስ/ሺህ 5.ኦንሂርኮዋ ሰብ
403	ሞእ ጠፍት ቢረምር ማን ይሰራነህ	0.ኦትሞኃ 1.ቢደሰብኛ 2. ጓዲኛኛ 3.ድርጂት 4.ቄስ/ሺህ 5.ኦንሂርኮዋ ሰብ
404	በኦሻ/ኸ ማኘ ኢአር ሙጥጥ ዘንጋ ቢትፊጠር ኢጨነቅነሽዋታ ር ማንደን	0.ኦትሞኃ 1.ቢደሰብኛ 2. ጓዲኛኛ 3.ድርጂት 4.ቄስ/ሺህ 5.ኦንሂርኮዋ ሰብ
405	በአሻ/ኸ በኸም ኸም ኦቸም ሙጥጥ ዘንጋ ቲብአንካ ያብርታካኢር አቸ ኢያነሁ ይንካኦር ማንደን	0.ኦትሞኃ 1.ቢደሰብኛ 2. ጓዲኛኛ 3.ድርጂት 4.ቄስ/ሺህ 5.ኦንሂርኮዋ ሰብ
406	ኧኸ/ሻ በትብሳጪሽ/ኧ ጊዚየ አትብሳጪኧ ይመህርኧዳኢር ያጪድኧዳኢር ማንደን?	0.ኦትሞኃ 1.ቢደሰብኛ 2. ጓዲኛኛ 3.ድርጂት 4.ቄስ/ሺህ 5.ኦንሂርኮዋ ሰብ

ክፍል 3፡- ከኤችአይቪ/ኤድስ በኦሽ ኸትያያዘ ደናኦር		
501.	አኸሻይ ኤችአይቪ/ኤድስ በኦሾ ምርአህርኛ ደረጃን?	ሀ. አንደኛን ሐ. ሶአስተኛን ለ. ውርኤተኛን መ. አርሻተራን
502.	የቅርብ ጊዚየ CD4 ምርአህርን?	______________cell/μl
503.	የኤች አይቪ/ ኤድስ በኦሾ መድኒት ኦሽት ኸቀነሰሽ/ን ምርአሂሪ በየ ኸረ?	_______________በወር
504.	የኤች አይቪ/ ኤድስ በኦሾ መድኒት ታታቋርጥ/ጪ እና በትክክል ትወስችዋ?	ሀ. እንከ ለ. ባአይ
505.	መዳኒት ሁዳ በሰቨነድ ተስማሚ ኢኸረኸ ሸርድይ እንቅስቁሴም ቲኖዋኸ ይወኸኩዋ/ይአጅግዋ? (ከካርድ ላይ ይተቀስ)	ሀ. በመጀመሪያ ደረጃ ለ. በውርኤተኛ ደረጃ ሐ. ኤኛአር በርበር __________________

ክፍል 4-፡-ኧደበረን በቫአሽኑ ምክንናተ ኧደበረን ሰቭ ኢሂርኵደነ መጠየቅ

ተ.ቁ	ጥያቄዎች	የተሳታፊወች መልሶች			
		አቾ ኤንዳ	በሳምት ያአንስከ አር	ተሳምት ይረከአር	እንግዚየ
601.	እመሀ ባረታ በኧር ባኸረአኸረ በዋግት ቀጪቀጪ ባረናኸ/ሽትሂውዋ/ር?	0	1	2	3
602.	ሀሳብ ሀሳብ ኧዋርት ፧ኧንሰነድ ኢጭናነቅከአር ወይ ደግሞ ከስ አንጥኸ/ሽትሂሩዋ?	0	1	2	3
603.	ኖራ ጊዚየ በግድየ ትወኧይዋ?	0	1	2	3
604.	ትትረሸዋታ ቄጭና ቄጭና ባረናሁም ወይ ደግሞ እመኸ ያቄጥሁዋ?	0	1	2	3
605.	ሸረድ ኧሁረት ወይ ደግሞ ሸረድ ኖራአር ኧውረት ችግር አነወሁዋ?	0	1	2	3
606.	አሻ/ኽ የኤች አይቪ/ ኤድስ በአሻ አነቢ ሙጥጥ ሀሳብ ወይም አንትሳከአኒዳ ዩሪዳአር ወይ ደግሞ ቢደሰብኛ አቅመጪሁ ዩሪዳ ሀሳብ አሰበሁም ትሂዋ/ር?	0	1	2	3
607.	ማኘአር ትቲኖዋታ ሀሳቡዋ ኢዝራዘርቭሁዋ ወይ ደግሞ ቀልባሁዋ በእማት አሻከከአ አወናሁይ ግብር ኢትረንሳሁም? ቴሌቭዥን ሲመለከቱ?	0	1	2	3
608.	ተኤኛ ጊዚየ አትለየር እመኸ ባረታ አምሮ ኢረብሸከአር ችረ ግድየ ይኧራከአር አነሾኸ/ሽ?	0	1	2	3
609.	ኢያሸ ብንወድ ኢፌዝ አታአር ኧጠቅምከአር ኧኸርጉ ዩረዳ ሀሳብ ማአሸሁም ትሂር/ዋ?	0	1	2	3