A Community Based Study of HIV/AIDS Knowledge, Attitude & Practice among Pastoral Women in Gewane woreda, Afar Regional State, Ethiopia

A DISSERTAION

Submitted to Indira Gandhi National Open University (IGNOU),

for the partial fulfillment for the attainment of

Master of Arts (M.A) in Rural Development

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Addis Ababa, Ethiopia

DECLARATION

I hereby declare that the Dissertation entitled "**A COMMUNITY BASED STUDY OF HIV/AIDS KNOWLEDGE, ATTITUDE & PRACTICE AMONG PASTORAL WOMEN IN GEWANE AFAR REGIONAL STATE, ETHIOPIA"** submitted by me for the partial fulfillment of the M.A in Rural development to Indira Gandhi National Open University, (IGNOU), New Delihi is my own original work and has not been submitted earlier either to IGNOU or to any other institution for the fulfillment of the requirement for any course of study. I also declare that no chapter of this manuscript in whole in part is lifted and incorporated in this report from any earlier work done by me or others and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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CERTIFICATE

This is to certify that Amanuel Kassie Yigzaw student of M.A (R.D) from Indira Gandhi National Open University (IGNOU), New Delhi was working under my supervision and guidance for his project work for the course MRDP-001. His project work entitled, **"A COMMUNITY BASED STUDY OF HIV/AIDS KNOWLEDGE, ATTITUDE & PRACTICE AMONG PASTORAL WOMEN IN GEWANE AFAR REGIONAL STATE, ETHIOPIA" ,** Which he is submitting, is his genuine and original work.

Place: Addis Ababa, Ethiopia

Date: _____

Signature: _____

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DEDICATION

This work is dedicated to my father the late Kassie Yigzaw and to my mother Manalebish Denkayehu for the role that they played in raising me since my formative years, helping me to be knowledgeable in every and many aspects, create a vision for my future, encouraging me to learn and supporting my education.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BSS	Behavior Surveillance Survey
CBO	Community-based Organization
EIFDDA	Ethiopian Interfaith Forum for Dev. Dialogue &Action
FGC/M	Female Genital Cutting /Mutilation
FGD	Focused Group Discussion
FHAPCO	HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
FSW	Female Sex Worker
HAPCO	HIV/AIDS Prevention and Control Office
HEWS	Health Extension Workers
HHs	Households
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practice
IEC	Information, Education & Communication
KAP	Knowledge, Attitude and Practice
MARP	Most At-risk Population
NGO	Nongovernmental Organization
OVC	Orphaned and Vulnerable Children
PA	Pastoral Association
PLHIV	People Living with HIV

PMTCT	Prevention of Mother-to-Child Transmission
STI / D	Sexually Transmitted Infection/Disease
TB	Tuberculosis
UNGASS	UN General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ABSTRACT

The HIV epidemic has penetrated almost all population groups, including the hard-to-reach rural areas. In addition to expanding geographically, the epidemic is spreading from high-risk groups to the general population. The epidemic affects women hardest, increasing the vulnerability of poor rural women in particular. As women are affected more, the reproductive potential of the society is reduced. It is thus very important to exert much of the prevention efforts on women.

The objective of the study was to assess HIV/AIDS Knowledge, Attitude & Practice among Pastoral Women in Gewane woreda of Afar regional State, Ethiopia.

The study was a community based cross sectional assessment and was carried out during the period May- July 2011, and involved women in the age range of 15-49 years. The level of knowledge, attitude and practice were assessed by means of a questionnaire which focused on transmission, prevention, STI's, harmful traditional practice, sexual relationship and family discussion on HIV/AIDS.

A total of 140 women were interviewed. Their mean age was 28.44 +/- 0.81(mean +/- SE) years. The majority (62.9 %) of them were married. More than one half of the respondents (52.86%) did not have any education. Most of the women (62.86%) had siblings. About 99.3 % of the interviewed women reported to have heard about HIV/AIDS for whom the main source of information was family/ friends/ neighbor (46.43%). The majority reported unprotected sex (91.43%) and sharing sharp materials like razor blades or needles contaminated with infected blood (85 %) as common ways of HIV transmission. Majority of the women (76.43 %) of the women believed a person can avoid or reduce the chances of getting HIV. For those who have heard of HIV/AIDS only 64.29 % of the women had heard about STI's. The women, just like the general population, were stigmatizing people living with AIDS. Educated women demonstrated favorable attitude with regard to sex and risk of infection i.e. any one can be infected by HIV/AIDS (p value= 0.002) or the best prevention is to have only one sexual partner (p value=0.013). Similarly, educated women demonstrated favorable attitude towards the risk factor a healthy looking person can be infected with and transmit HIV/AIDS (n=140; p< 0.001) and Sexually Transmitted Infections (STI's) increase the risk of getting HIV/AIDS (n=90; p= 0.001). Overall 35.7 % of the women reported that they had discussed

sexuality and HIV/AIDS issues with their family. The study indicated that the common traditional circumcision (77.86%) was the primary harmful practice. A large proportion (81.43%) of the women had agreed that sexual intercourse should not be committed before marriage. Married women (n= 128; P value=0.005) perceive that condom prevents AIDS better than those who never got married /single/ divorced / widowed.

The knowledge about how HIV is transmitted and the protection method was incomplete among women. Awareness level on protection against HIV was also insufficient among women and there were misunderstandings about it. The study also has indicated that FGM/ FGC were widely practiced harmful traditional practice among pastoral women. The level of understanding of the women on the use of condom and their belief in the prevention of AIDS was very high, though in terms of practicing it is still at a lower level.

Key concepts: HIV/AIDS, knowledge, attitude, Practice, Women and pastoralism.

CHAPTER 1

Introduction and Back ground information

Introduction

The 2007 UNAIDS update indicated that the HIV prevalence was leveling off and there was a fall in the number of new infections globally. This was good news for the massive interventions that have taken place in the last few years. Unfortunately, Sub-Saharan Africa accounts for the majority of the estimated cases of HIV, including the new infections occurring each year, and AIDS has remained the major cause of death in the region (MOH, 2008).

Sub-Saharan Africa bears the greatest burden of the diseases where 22.5 million people living with HIV/AIDS at the end of 2007. In 2006, the AIDS epidemic in Africa had claimed 1.6 million people and more than 11 million children had been orphaned by AIDS (WHO, 2006).

With a total population of 73.9 million (50.5% male), Ethiopia is a low-income country with an economy largely dependent on the agriculture sector. According to UNDP Human Development Index (HDI 2007) Ethiopia ranks 169th out of 177 countries. Similarly, the

Human Poverty Index value rank of 54.9 puts Ethiopia 105th among the 108 developing countries (MOH, 2002).

HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986 (MOH, 2002). Since then, the disease has been spreading at alarming rate throughout the country (MOH, 2002).

With an estimated 1.1 million people living with HIV, Ethiopia has one of the largest populations of HIV infected people in the world. However, HIV prevalence among the adult population is lower than many sub- Saharan African countries (FMOH, 2007).

The AIDS epidemic is one of the most urgent threats to public health in Ethiopia. The Ethiopian Ministry of Health (2006) estimates the adult HIV prevalence at 3.5%.

According to Ethiopia's 2007 single point estimates, the national adult (ages 15-49) HIV prevalence for 2008 is 2.2 percent (male 1.8 percent and female 2.6 percent), with an urban and rural HIV prevalence of 7.7 percent and 0.9 percent, respectively (FMOH, 2007).

Ethiopia's HIV/AIDS epidemic pattern continues to be generalized and heterogeneous with marked regional variations. The adult HIV prevalence for Afar region is reported to be 2.0 percent, close to the national estimate.

The HIV epidemic has penetrated almost all population groups, including the hard-to-reach rural areas. In addition to expanding geographically, the epidemic is spreading from high-risk groups to the general population.

The main transmission route in developed countries is through needle sharing among injecting drug users and homosexuality while heterosexual transmission plays a major role in developing countries.

HIV in Ethiopia is predominantly spreading through unprotected heterosexual intercourse, which accounts for approximately 88% of all HIV infections. Mother, or parent, to child transmission (MTCT) accounts for 8-10%, and 2-5% of HIV infections can be attributed to blood and blood-contaminated products (including un-sterilized needles).

Behavioral factors such as, multiple sexual partnering, socio-cultural attitudes about sex, alcohol & substance abuse (especially the use of Chat), and the lack of awareness about HIV and high level of untreated sexually transmitted diseases (STDs),all help drive the epidemic. HIV can be both a cause and a symptom of poverty. Given the high rates of unemployment and poverty at the household level, increasing number of women turn to selling sex for survival.

The behavioral surveillance survey in 2005 revealed that comprehensive knowledge of HIV/AIDS is minimal and misconceptions are high among at-risk population subgroups, including in- and out-of-school youth, female commercial sex workers (FSWs), truckers and intercity bus drivers, uniformed government employees, and pregnant women (FMOH 2006). These subgroups are commonly referred as most-at-risk populations (MARPs) because of their occupation, lifestyle, age, and other factors that increase their risk of contracting HIV.

The catastrophic impact of HIV infection on mankind needs no highlighting. The sheer magnitude of the problem, coupled with the lack of any effective vaccine or chemotherapy, and certainty of

painful death following infection, easily make it one of the most devastating health problems that mankind has ever faced (Getnet M. etal, 2005).

In addition to morbidity and mortality, the HIV/AIDS pandemic in Ethiopia has adversely impacted the country's development. HIV/AIDS is affecting the agriculture, education, business & industry, and health sectors. Family & communities have also all been significantly affected by the pandemic.

The economic effects of HIV/AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy (Lori B. etal, 1999).

Substantial progress has been made in understanding the epidemiological and psycho-social determinants of this disease, during the past two decades. Available evidence indicates that hetero-sexual promiscuity is the major determinant of transmission. Thus, creating awareness and providing motivation to create an attitude of healthy sexual practices is going to be a major tool in the battle against AIDS, in the next decade or so.

Back ground

There are several studies on knowledge, attitude and practice of various population groups towards HIV/AIDS in the world. Encouraging results were found to show the baseline risk behavior and also to follow the progression of such factors.

Women in sub-Saharan countries are considered to be one of the most vulnerable populations in the world for HIV. Three quarters (76% or 13.2 million) of all HIV positive women live in this part of the world (UNAIDS, 2006).

While women in many parts of the world have a longer life expectancy than men, in four countries of sub-Saharan Africa – Kenya, Malawi, Zambia and Zimbabwe – the life expectancy of women has been driven lower than that of men as a result of AIDS (UNAIDS, 2006).

A wide range of biological, economic, and socio-cultural factors increase vulnerability of African women to HIV infection. African women and girls typically have poor access to education and health information, suffer inequality in marriage and sexual relations, are economically dependent on their male partners, and are part of

cultural traditions that reinforce gender inequalities (S.S Lal etal, 2000).

Additionally, women are physiologically more vulnerable to HIV infection than men (WHO, 200) particularly, women with sexually transmitted infections.

Therefore, it is vital that all African women know about HIV and AIDS (S.S Lal etal, 2000) Women not only need to know about the disease but also about methods of transmission, to understand and reject misconceptions regarding HIV/AIDS, and know how to protect them-selves from infection.

This Study will be conducted to assess HIV/AIDS Knowledge, Attitude & Practice among Pastoral Women in Gewane woreda of Afar regional State, Ethiopia. The study will help to identify the gaps in knowledge and attitude, risk behavior, misconception and practices towards HIV/ AIDS that might need a prompt public health attention.

Statement of the Problem / justification:

Most of the studies in relation to HIV/ AIDS are urban-based, and there was little information on the rural population where the majority lives. Information is limited with regard to the extent of misconceptions, stigma and discrimination, and knowledge, attitude and practice on HIV/AIDS. Urban-rural transmission of HIV/AIDS and sexual networks are poorly understood. The urban-rural network may be galvanized by mobile populations and increased economic activities that are taking place in growing and transforming small towns. These small towns are serving as flourishing areas (hotspots) for marketing and political centers close to the rural areas.

HIV/AIDS epidemic affects women hardest, increasing the vulnerability of poor rural women in particular. Women generally shoulder the burden of carrying for the sick and dying. This diverts their energies and prevents them from being engaging in child care and other works that would provide an income to the household. This in turn results household food insecurity, declining nutrition and health, the withdrawal of girls from school to provide extra labor at home which has a threatening future implications on human resource development.

The statement from the previous Secretary- General of the United Nations Kofi Annan, about the health and necessary focus on Africa's women stated as below.

In Africa, AIDS Has a Woman's Face

". . . today, as AIDS is eroding the health of Africa's women, it is eroding the skills, experience and networks that keep their families and communities going. Even before falling ill, a woman will often have to care for a sick husband, thereby reducing the time she can devote to planting, harvesting and marketing crops. When her husband dies, she is often deprived of credit, distribution networks or land rights. When she dies, the household will risk collapsing completely, leaving children to fend for themselves. The older ones, especially girls, will be taken out of school to work in the home or the farm. These girls, deprived of education and opportunities, will be even less able to protect themselves against AIDS…If we want to save Africa from two catastrophes (HIV/AIDS and famine), we would do well to focus on saving Africa's women."

Source: Kofi Annan, Secretary-General of the United Nations cited in (Gladys B. 2005)

The study was conducted mainly for three reasons for conducting the study are:

It is assumed that the study area was threatened by HIV/AIDS, as it is increasingly becoming the case in all living areas, a high risk HIV corridor along with the Djibouti port route.

Though the disease indiscriminately attacks people irrespective of race, religion, sex, age, etc, it is believed that women are particularly more vulnerable to the virus than men.

The loss of young adults in their most reproductive years of life is the major effect of the disease. Thus, as women are affected more, the reproductive potential of the society has been reduced.

Thus, a special emphasis must be put on assessing the knowledge, attitude and practice of HIV/AIDS on rural women and identifying situation in which women could be exposed to the virus.

Objectives

The main objective of this study is to measure pastoral women knowledge, attitude and behavioral practices towards HIV/AIDS and

other related chronic diseases that contribute to the overall health and wellbeing of the pastoral community.

The specific objectives were:

- To establish findings that can be used as a bench mark for future assessment and study
- To determine the level of knowledge on HIV/AIDS among pastoral women in Gewane woreda, Afar regional State
- To identify attitudes related to HIV/AIDS among pastoral women in Gewane woreda, Afar Regional State

Accordingly, this study would help to strengthen the capacity of the community based HIV/AIDS prevention Programs in the pastoral area of Afar regional State, Ethiopia.

Specifically, the study will attempt to answer the following research questions:

1. What is the level of knowledge on HIV/AIDS among pastoral women?
2. What are the knowledge gap, practice and cultural influence that negatively affect rural women's attitude towards people living with HIV/AIDS?

3. What is the attitude of pastoral women towards HIV/AIDS issues?

Significance of the study

There are no adequate researches with regard to the level of knowledge, attitude and practice of the rural people on HIV AIDS in general and pastoral people in particular. In rural Ethiopia, it is believed that most of the people are illiterate and far from the information about HIV/ AIDS.

This study seeks to provide good information regarding the extent of the problem, an insight into the HIV/AIDS knowledge, attitude and practice among pastoral women in Gewane, Afar Regional State, Ethiopia. The result of this study will contribute to the implementation of HIV/AIDS prevention program in the area. The result will also provide the necessary information that helps to design strategies for community based HIV/AIDS prevention interventions in the Afar regional State.

Universe/ Coverage of the study

The study will be conducted on pastoral rural women living in Gewane woreda of Afar Regional State. The woreda is 365 km East of Addis Ababa along the Ethiopia -Djibouti port route. It comprises a total population of about of 31,318 people and the female- male sex ratio is estimated to be 0.8:1 respectively (CSA, 2007).

Definition of basic / key operational terms

HIV/AIDS:

HIV stands for **H**uman **I**mmunodeficiency **V**irus. When the HI Virus enters the body, it attacks and slowly destroys the immune system i.e. the body's defense system against infections and diseases (THETA, 2003). As a result, a person who has the HI Virus will find it harder and harder to resist and fight infections and diseases which lead to serious illnesses, and often death (THETA, 2003). What's important to remember is that it may take ten years, or even longer, for the HI Virus to totally destroy the immune system (THETA, 2003). That's why a person who is infected may look and feel well for a long time before they have any symptoms of HIV or become seriously ill. Also remember that a person with HIV does not necessarily have AIDS (THETA, 2003).

AIDS, which stands for **A**cquired **I**mmune **D**eficiency **S**yndrome, is the final stage of HIV (THETA, 2003). It's not a single disease but rather a combination of different illnesses caused by the immune system's total breakdown and inability to protect the body against opportunistic infections e.g. oral thrush, tuberculosis (TB), etc (THETA, 2003) .

Knowledge:

According to Oxford Advanced Learners Dictionary, knowledge refers to organized body of information on an issue. Knowledge might also be defined as belief which is in agreement with fact (Tajudeen O, 2008). Guided by the knowledge indicators for monitoring the **U**nited **N**ations **G**eneral **A**ssembly Special Session on HIV/AIDS (UNGASS), knowledge will include identification of ways of preventing sexual transmission of HIV and clarification of major misconceptions about HIV transmission (Tajudeen O, 2008). In this study therefore, HIV/AIDS knowledge among pastoral women included the knowledge of transmission and prevention of HIV, as well as ability of women to correctly clarify misconceptions about HIV/AIDS.

Attitude:

The Oxford Advanced Learners Dictionary defined attitude as ways of thinking or behaving. Attitude was also defined as physical expression of an emotion (Tajudeen O, 2008). Attitude related to HIV/AIDS in this study included feelings, opinions, intentions, belief and thoughts about people infected with HIV and actions related to HIV/AIDS issues.

Pastoral areas: it is an area where by pastoralists live and practice their way of life, the so called pastoralism. The pastoral areas mainly characterized by unpredictable and unstable climatic conditions, as well as, ecologically fragile environment (Mohammed, M 2004). Pastoral areas are also characterized by extreme poverty, low human development, frequent drought, conflict, flood and food insecurity as well as inadequate facilities and infrastructure (Mohammed, M 2004).

Pastoralism: Pastoralism is one of the oldest livelihoods or socio-economic systems and a way of life in which livestock husbandry in open grazing areas represents the major means of subsistence for the pastoralists (Mohammed, M 2004). Pastoralism in Ethiopia constitutes a unique and important way of life for close to 15 million

people living in about 7 regions in the country (Mohammed, M 2004).

Pastoralists: Pastoralists are societies that belong to a certain ethnic group and practice pastoralism as their way of life. In Ethiopia pastoralists belonged to about 29 different ethnic groups occupying 60% of the territory and constituting about 12% of the total population (Mohammed, M 2004).

People Living with HIV/AIDS (PLWHA):

PLWHA are people who have been tested and confirmed to be living with HIV/AIDS. They are people with the HIV antibodies in their blood.

Stigma: HIV related stigma referred to - prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV/AIDS, as well as the individuals, groups, and communities with which they are associated.

CHAPTER 2

Literature Review

Although most African women have heard of HIV and AIDS, less is known about how HIV is spread or how to protect against infection etc. The importance of appropriate HIV/AIDS knowledge and attitude among women in the implementation of HIV/AIDS prevention in the pastoral area is limited. Thus, the literature reviewed below provides a snapshot of the current state of knowledge and attitude about HIV/AIDS in women and general population.

The review included literature among adult population and rural women other than pastoral area since women are subset of the adult population and the availability of literature on HIV/AIDS knowledge and attitude among women in pastoral area is very limited.

Specific attributes related to HIV/AIDS knowledge and attitudes were reviewed to provide focus for the study. HIV/AIDS knowledge explored around the level of awareness and source of HIV/AIDS information; the routes of HIV transmission; misconception related

to HIV transmission; methods of prevention of HIV transmission; symptoms and knowledge on STDs. Attitude related to HIV/AIDS explored in the review is the stigma and discrimination towards PLWHA; attitude towards treatment; susceptibility of to HIV/AIDS and willingness to discuss with HIV/AIDS. Health seeking behaviors related to HIV explored are preference for treatment and the experience of harmful traditional practices. Practice of sexual relationships related to HIV/AIDS like sexual relationship before marriage; use, practice and perception of condoms, and exposure to STD and treatment preference are also explored in the review.

Pastoralism and HIV/AIDS:

Pastoralists live in the least developed regions of the country, characterized by poverty, high level of illiteracy, inadequate infrastructure particularly roads, the worst served by health services and receiving the least external support. Women in these regions are considered to be in an even poorer state than men, especially in terms of health conditions. This is because the illiteracy rate is higher among women, poverty is worse, access to health services is lower and the prevalence of harmful traditional practices that negatively impact on women's health is serious and

widespread. Furthermore, the capacity to deal with the situation is extremely limited.

HIV prevalence in the regional states where pastoralists mainly reside was 1.9% (in Afar region) and 0.8% (in Somali region) according to the 2007 Single Point Estimate (HAPCO, 2010). According to a study conducted among pastoralist communities in Somali Region, cultural and traditional practices, and low awareness and knowledge about HIV/AIDS due to limited HIV/AIDS interventions were the main factors that put pastoralist communities at risk of HIV infection (FMOH, 2006; HAPCO, 2010).

History of HIV/AIDS:

Since its detection in 1981, HIV/AIDS has become one of the most challenging problems of our age. According to the UNAIDS 2007 report, an estimated 33.2 million people were living with HIV worldwide and 2.5 million became newly infected with the virus while 2.1 million lost their lives to AIDS (UNAIDS, 2007).

The number of people living with HIV continues to rise - in 2006 there were an estimated 32.7 million living with HIV/AIDS and in 2007 the number rose to 33.2 million. Globally, this means that

every day, 6,800 people have been infected and 5,700 die from HIV/AIDS. AIDS remains the single largest cause of death in Africa and the worst public health crisis worldwide (Fikremarkos M, 2010).

Africa has remained to be the most devastated by the epidemic. In 2007, Sub-Saharan Africa accounted for more than two thirds (68%) of all persons infected with HIV, and 72% of global AIDS deaths. HIV/AIDS affects society and economies at various levels, from the family and community to the national and international levels - particularly by eroding the human capital (Fikremarkos M, 2010).

HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986 (MOH, 2002).

A National HIV/AIDS taskforce was established in 1985 and the National AIDS Control Program (NACP) was established at a Department level at the MOH in 1987. HIV/AIDS surveillance activities began in 1989.

HIV/AIDS impacts the society at many levels and thus requires a multicultural approach. In order to address this devastating impact,

the Ethiopian government has underscored its commitment to fight the epidemic by launching its quadrennial strategic plan for intensifying multi-sectoral HIV/AIDS response (2004 – 2008) with the goal of reducing the spread of HIV infection and alleviating its social and economic impact.

Vulnerability of women to HIV/AIDS:

Women and girls are one of the highly vulnerable groups to HIV infection. The scale of vulnerability may vary from society to society. In Sub-Saharan Africa, where gender dimension of the virus is more apparent, 61 percent of people living with HIV/AIDS in 2007 were women (UNAIDS, 2007).

The vulnerability of women and girls include not only increased exposure to the virus but also lack of access to relevant HIV prevention, treatment and care services and information.

Vulnerability of women and girls to HIV infection results from biological, social, cultural, economic, legal and other factors that adversely affect their capacity to protect themselves from the risk of HIV infection (UNAIDS 1998).

HIV/ AIDS and Rural Economy:

HIV/AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal (Lori B etal, 1999). The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs (Lori B etal, 1999).

1. Labor Supply

- The loss of young adults in their most productive years will affect overall economic output.
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates.

2. Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans

- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth.

HIV/AIDS Knowledge and Awareness:

Basic Knowledge

The awareness of HIV/AIDS is the first step in acquiring knowledge of the AIDS epidemic. Sustaining the knowledge require identification of different sources of HIV/AIDS information. This section explored the levels of HIV/AIDS awareness and the common sources of HIV/AIDS information among women and other relevant population.

Basic knowledge about HIV/AIDS appears to be quite limited in some African communities. For instance, in a survey of 1200 women of reproductive age in Bida Emirate of Niger State, Nigeria, only 15% were able to describe HIV/AIDS as a deadly disease. Over 90% of these women had no or only rudimentary levels of education (Amy D, 2008).

In a study conducted among tea sellers in Khartoum, most of the respondents 93.1% had heard of HIV/AIDS. The main source of knowledge was radio (51.2%), the second one was friends and relatives (47.1%). while in community based KAP study conducted in Gambella town only 4.5 % of the participants reported that they didn't hear about HIV/ AIDS , the main source of information was found to be mass media 82.8% (Yayeh N etal, 2000).

A study conducted among pastoralist communities in Somali Region, Ethiopia revealed an awareness level of 85%, which is lower than the national figure documented in DHS 2005 (90% women and 97% men) (FMOH, 2006; HAPCO, 2010). In other Surveillance among pastoralists, 82.7% had heard of HIV/AIDS (87.3% male and 78.0% female participants). Of these, 51.2% knew someone who was infected with or had died of HIV/AIDS and 8.6% reported that the affected person was a close relative or friends or both (Getnet M etal 2005).

Knowledge on routes of transmission and Prevention

According to an evaluation of progress against the 2004-2008 strategic plans, comprehensive knowledge about HIV prevention and transmission is still low (HAPCO, 2010).

The 2005 DHS report showed that young women age 15-24, especially never-married, are generally somewhat more knowledgeable of the various modes of prevention than older women, while the opposite pattern is observed among men (HAPCO, 2010).

In the 2005 BSS round two, Only 29.0% of pastoralists (39.3% male and 18.5% female) were able to name all three programmatically important HIV preventive methods; and 30.2% (17.3% male and 43.5% female) could not mention any of them (Getnet M etal 2005) .

A national survey conducted in 2008 for the Health Impact Evaluation found that comprehensive knowledge of HIV prevention and transmission was 12.5% among women – lower than the 16% reported by DHS 2005 (HAPCO, 2010).

According to this survey, knowledge levels were lowest among women above the age of 30, married, lowest wealth index, rural, uneducated and from emerging regions (Afar, Somali, Benshangul-Gumuz, and Gambella) (HAPCO, 2010)

Knowledge on routes of HIV transmission

The common ways of transmission of HIV in most African countries are unprotected sex, mother-to-child transmission, transmission through blood and blood products, and sharing of sharp instruments including hypodermic needles, and the use of un-sterilized tattoo and grooming equipment (Gladys B. 2005)

In a community based study conducted in Gambella, Ethiopia the commonly reported ways of transmission were unprotected sex (79.8 %) and unsafe transfusion (64.2%). Only 0.9 % reported to know that HIV is transmitted from mother to child [30]. In other tea sellers women studies in Khartoum (72.1 %) of the respondents knew that HIV could be transmitted by heterosexual contact, (38.1%) by blood transfusion, (3.5%) during pregnancy (Amira S, 2005).

In BSS, 2005 it is reported that about 48% of respondents were aware that an HIV infected pregnant woman could transmit the virus to her unborn child; however, only a small proportion of this group (13.7%) knew that taking anti-retroviral therapy could reduce the risk of transmission of the virus to the unborn child

(Getnet M etal 2005). About 30% of these respondents recommended consulting health professionals, 12.8% thought that nothing could be done, and 0.8% suggested abortion as a strategy to reduce the risk. In this study 55.0% (63.8% male and 46.1% female) of pastoralists were aware that an HIV infected mother could transmit the virus to her newborn baby through breastfeeding (Getnet M etal 2005).

A study conducted among pastoralist communities in Somali Region, Ethiopia revealed About two-third (38%) were found to know that HIV is transmitted from infected mother to child – higher than the regional average of 6% and national average of 20% documented in 2005 DHS (FMOH, 2006; HAPCO, 2010).

Knowledge on methods of HIV prevention

The methods of prevention of HIV include prevention of mother to child transmission (PMTCT); behavior change strategies like abstinence, being faithful to a partner and consistent use of condom; transfusion of screened blood, use of sterilized sharp object, and taking universal precaution by health workers.

It is also stated that the transmission of HIV and AIDS will be prevented through the promotion of safe sexual behavior,

appropriate use of condoms, safe supply of blood and blood products, implementation of voluntary counseling and testing, prevention of mother-to-child transmission, early treatment of sexually transmitted infections (STI), and youth focused interventions.

The best known methods for preventing HIV among respondents were, (64.5%) avoiding un protected sex, (12.1%) loyalty to one partner, (47.4%) avoidance of sharing skin piercing instruments, (3.5%) condom use (Amira S, 2005).

In a community based in Gambella Faithfulness to partner, condom use and abstinence were reported to be ways of prevention by the majority of respondents (78%, 76.5% and 64%, respectively) (Yayeh N etal, 2000).

In a study conducted among pastoralist communities in Somali Region, Ethiopia, only 33.3% and 52.4% mentioned that abstinence from sex and a faithful relationship with an uninfected partner can protect a person from contracting HIV infection (FMOH, 2006; HAPCO, 2010) .

The 2008 Health Impact Evaluation found that only 54.4%, 46.5% and 41.3% of the women indicated that abstaining from sexual intercourse, limiting sex to one uninfected partner and using condom every time they have sexual intercourse reduce the risk of getting the AIDS virus, respectively (GFHIE, 2008 ;HAPCO, 2010)

Knowledge of misconception about HIV/AIDS transmission

Addressing misconceptions related to the transmission of HIV is an important issue in the context of HIV-related knowledge and has implications for promoting behavior change especially among learners (Tajudeen O, 2008).

The knowledge that a healthy looking person can be infected with HIV is important in promoting positive behavior associated with HIV/AIDS. The knowledge of common health problems of people living with HIV/AIDS is likewise important.

Among tea seller's women in Khartoum, it was reported that (32.7%) were aware that healthy looking person could be infected with HIV (Amira S, 2005). In a community based study in Gambella town it is reported that 83.8% believed that even healthy looking individuals could transmit the virus (Yayeh N etal, 2000).

The 2008 Health Impact Evaluation found that only 53.2% of women know that a healthy-looking person can have the virus, compared to 37% in the DHS 2000 and 51% in the DHS 2005 (GFHIE, 2008; HAPCO, 2010).

Knowledge on Sexually transmitted infection / diseases

According to BSS 2005 round two, 78.7% of male and 30.3% of female pastoralists had heard of STIs. Of these, a significant proportion could not mention any symptom of STIs in women (46.5% male and 50.6% female respondents). The three commonest symptoms of STIs in women mentioned by respondents were; burning sensation on urination (28.1% male versus 38.5% female respondents), genital discharge (25.7% male versus 17.4% female), and genital ulcer or sore (26.0% male versus 8.5% female) (Getnet M, etal, 2005). For symptoms of STIs in men, the responses were; burning sensation on urination (59.3% male versus 27.9% female respondents), genital ulcers or sores (51.1% male versus 20.2% female) and genital discharge (49.6% male versus 19.4% female) (Getnet M, etal, 2005) . Respondents were more aware of male STI symptoms than female, and male respondents were more aware of symptoms in men than in women (Getnet M, etal, 2005).

In Tea sellers women study in Khartoum, hearing of STD that can be transmitted through sex seems uncommon among them, only (8%) had vaginal discharge, (3.7% had itching and, (8%) genital ulcer (Amira S, 2005).

Males reported sexually transmitted diseases more frequently than females (21.1% and 12.2%, respectively), genital discharges being the major symptoms (85.9). STDs were also reported by 17.3% of the singles and 16.6% of the married ones (Yayeh N etal, 200).

HIV/AIDS Attitude and Stigma:

Stigma and discrimination

A multi-site study on knowledge, attitude and behavior study conducted by the faith-based network EIFDDA in 33 woreda's among the general population found that 30% of the respondents had acceptable attitudes regarding PLHIV on all four indicators (willingness to care for PLHIV, to buy from PLHIV, allow PLHIV to teach their children and keep family member's HIV result secret) (HAPCO, 2010).

Amongst pastoralists who had heard of HIV/AIDS, 99.5% had at least one stigmatizing attitude towards PLWHA, and 58.3% of respondents had at least three stigmatizing attitudes (44.2% males vs. 74.4% females) (Getnet M etal, 2005). Among these, the major stigmatizing attitudes were: unwillingness to buy food from a shop keeper whom they knew to be HIV positive, 81.9% (83.8% male and 79.7% female respondents); unwillingness to share a meal with an HIV positive person, 67.8% (53.2% male and 84.3% female respondents); unwillingness to deliver home care to a female family member who had AIDS, 45.3% (29.0% male and 63.8% female respondents); unwillingness to deliver home care to a male family member who had AIDS, 45.1% (28.1% male and 64.3% female respondents); and advocating quarantine for PLWHA, 41.1% (35.5% male and 47.5% female respondents) (Getnet M etal, 2005) .

More than half of the respondents did not think that infected people should participate in community meetings, and more than three quarters thought that an infected youth should not look after cattle (Getnet M etal, 2005).

Regarding fear of stigma, respondents were asked whether or not it should remain secret if a family member were sick of HIV/AIDS, and 15.2% of respondents (15.0% male and 15.3% female) replied that it should. Overall, highly stigmatizing attitudes towards PLWHA were found among pastoralists (Getnet M etal, 2005).

(50.1%) of women tea sellers were willing to provide care for a relative with HIV/AIDS, (39%) willing to take meal with PLWHA, (15.3%) willing to buy food from shopkeeper infected with HIV while (29.4%) agree to allow HIV infected teacher to continue working (Amira S etal, 2005).

A recent study found that 8% of PLHIV respondents had experienced human rights violations such as denial of employment (3%), eviction from home (3%), and loss of job (2%) as a result of their HIV status. In addition, 18% had verbal insults directed at them because of their HIV status (HAPCO, 2010). Those directing verbal insults included neighbors (48%), family or relatives (14%), co-workers (11%), friends (11%), strangers and social acquaintance (8%) (HAPCO, 2010; Yemane B etal, 2007).

Willingness to discuss HIV/AIDS

Discussing HIV/AIDS issues with friends, family, health professionals and in the public is an important manifestation of HIV/AIDS knowledge and a major step in adopting appropriate HIV/AIDS related attitude (Tajudeen O, 2008).

A study conducted among youth in Addis Ababa found that discussion about HIV and AIDS, condoms and sex life with male friends wasn't a problem, but talking to family members and doctors was. It was reportedly easier to talk about HIV and AIDS (41% to family members, and 23% to doctors) than sex life (7% each to family members and doctors) and condoms (11% to family members, and 18% to doctors) (Yibeltal A etal, 2009).

Health seeking behavior:

Preferences for treatment

In a study conducted among males in rural population, it is reported that there was no stated specific preference for a private practitioner or government service if one had HIV/AIDS. However, most respondents (48%) preferred English medicine to the

traditional systems for treatment for HIV/AIDS (K. Sobhan etal, 2004).

Harmful traditional Practices predisposing to HIV/AIDS

In many societies, a number of traditional practices harmful to women and girls are justified under the guise of cultural values, traditions and religious tenets (Fikremarkos M, 2010).

FGM is a cultural practice harmful to women but widely practiced in Africa and the Middle East. Its prevalence rate varies from country to country ranging from 99% in Guinea, 97% in Egypt, 80% in Ethiopia, to 17% in Benin. FGM increases the risk of HIV transmission for different reasons. Firstly, the use of un-sterilized razors and knives with a possibility of HIV contamination may transmit the virus from one girl to another. Secondly, it may make the genitals more likely to tear during intercourse and thus increasing the possibility of infection. Thirdly, penetration especially in case of infibulations may probably lead to bleeding thereby facilitating transmission of the virus (Fikremarkos M, 2010).

In a community based study in Gambella, Common traditional practices such as tattoos, vulvoctomy, and circumcision tooth

extraction were reported to predispose to HIV infection by the majority (65 %-82.5%) (Yayeh N etal, 2000).

Practice of sexual relationships:

Sexual relationships before marriage

In a community based study it is reported that nearly 80% of both sexes agreed that sexual intercourse should not be committed before marriage. This was also true for 94.4% of those who have heard of HIV/AIDS while only 2.5% of those with no information about HIV/AIDS had the same reply. In this study it is also reported that about 85% of females and 96.4% of males supported testing for HIV before marriage while the overall rate was 91.4 % (Yayeh N etal, 2000).

Use and practice of condom

In BSS 2005, it is reported that most pastoralists (74.8% male and 69.5% female) had heard of male condoms (Getnet M, 2005). Many male respondents (60.3%) knew where they could obtain them; whereas only 11.9% female participants knew where they could be obtained (Getnet M, 2005). The most common places or persons mentioned by respondents were: shops, health centers or hospitals

and pharmacies, which were mentioned by 58.4%, 47.8% and 29.5% of respondents, respectively (Getnet M, 2005). Only 27.8% of male and 8.4% of female pastoralists were aware of the existence of female condom (Getnet M, 2005).

Many causes were mentioned for condom use; such as to avoid pregnancy (76.5%), (5.9%) to avoid STDs and (5.9%) to avoid HIV/AIDS (Amira S etal, 2005).

Only 35 pastoralists (2.2%) reported that they had ever used male condoms (Getnet M, 2005) .Many respondents, particularly men, thought that condoms decreased pleasure during sex. Similarly, respondents thought that condoms took the fun out of sex, got in the way of sex, prevented flesh to- flesh contact, and reduced intimacy (Amy D etal, 2008).

Perceptions on condoms to prevent HIV/AIDS

Condoms are promoted as one of the primary prevention methods for HIV infection because they can prevent pregnancy and reduce the risk of HIV and other sexually transmitted infections.

The majority of men and women surveyed believed that condoms can protect against pregnancy, sexually transmitted infections and HIV/AIDS. Most men and women also believed that condoms are important to use every time and using them shows that Care about your own and your partner's health. Over 70% of men and women also agreed that condoms are safe to use. Negative attitudes and beliefs about the acceptability and safety of condoms, however, must be addressed if condom use is to increase (Amy D etal, 2008).

The 2008 Health Impact Evaluation found that Knowledge of using condoms as a means of avoiding HIV was 40%, similar to the DHS 2005 result of 41%. The proportion of women having had two or more partners was 0.2% in 2005 and 1.3% in 2008, and those who reported having had higher risk sexual intercourse was 2.7% in 2005 and 5.3% in 2008 (GFHIE, 2008).

Measures against HIV/AIDS:

The Government of Ethiopia has been taking measures to curb the spread of HIV/AIDS for the past 20 years. A National Task Force on HIV was established in 1985. The focus has been on information, education and communication (IEC), condom promotion, surveillance, patient care and expansion of HIV screening

laboratories and voluntary counseling and testing (VCT) services (HAPCO, 2010). The initial work was mainly in urban areas, where the prevalence of HIV/AIDS is highest. Work expanded into rural areas of the highlands, but has been minimal in the rural lowlands. These more marginal parts of the country have a high proportion of pastoralists in the population. The outreach of social services such as education and health in these areas is extremely low.

The Government of Ethiopia is also further making tremendous efforts towards containing the epidemic. As part of this endeavor, the Government put in place a national HIV/AIDS policy in 1998 to create an enabling environment to fight the pandemic. Overall, support and commitment in relation to HIV and AIDS has increased over the years, and progress has been made in the development of specific HIV/AIDS related legislation and revising the HIV policy to promote and protect human rights. Moreover, there have been some encouraging efforts to enforce the existing policies, laws and regulations. Civil society involvement in the process of planning, monitoring and evaluation of HIV/AIDS responses at various levels are improving (HAPCO, 2010) .

Ethiopia, as a UN Member State, joined the international community in the Political Declaration on HIV/AIDS of the UN General Assembly issued on June 2006, which committed all countries to move towards universal access to HIV prevention, treatment, care and support by 2010 (HAPCO, 2010) . Since then Ethiopia has made notable achievements in the response against HIV and AIDS. These include joint planning to harmonize the efforts of stakeholders around a comprehensive multi-sectoral national HIV/AIDS strategic plan.

The Government of Ethiopia declared HIVAIDS a public health emergency in 2002. Currently, the response is guided by the Second multi-sectoral Strategic Plan for 2009–2014, focusing on creating an enabling environment, capacity building, community involvement, prevention, increasing quality of chronic care, and enhanced use of strategic information (HAPCO, 2010).

In line with the national development plan – the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) – the country is implementing a 20-year rolling Health Sector Development Plan (HSDP) (HAPCO, 2010).

The Health Extension Program (HEP) is one of the major pillars of the health service delivery system in Ethiopia. The program aims to improve access and equity in the delivery of essential health services at village level across the country, including HIV/AIDS, STI and TB prevention and control, maternal and child health and sanitation. A cumulative number of 31,831 HEWs were trained and deployed up to the end of Ethiopian Fiscal Year (EFY) 2001, which is above the target of 30,786. HEWs are actively involved in community mobilization and education activities of the HIV/AIDS programs through Community Conversations (HAPCO, 2010).

CHAPTER 3

Research Methodology

Study design:

A descriptive cross sectional community based study on both qualitative and quantitative data collection was employed to obtain the necessary information. Primary data was collected through questionnaire feed back of individual household members and through Focused Group discussion (FGC). Secondary data was also collected from review of key institutional records, including Finance and Economic Bureau, Health Bureaus, local/international nongovernmental organizations (NGOs).

Study area:

Afar region has an estimated total population of 1,390,273 (615,156 Female and 775,117 Male). The region is subdivided administratively into five zones, which in turn are divided into a total of 30 woredas (CSA, 2007). The region shares common borders with countries of Eritrea in the north and Djibouti in the east. The people of Afar are predominately pastoralists; hence their

livelihoods and economy heavily relies on their livestock and livestock products.

The study was conducted in Gewane woreda, zone three administrative of Afar Regional State. The woreda comprises of 10 PA's (pastoral Association) two urban and eight rural Kebeles, and a total human population that estimated to be 31,318 (14,147 Female and 17,171 Male). (CSA, 2007)

Study population:

The source populations in this study were Female residents of Gewane Woreda, comprising of 15-49 years of age. The data collection period was May-July, 2011.

Inclusion criteria:

- Female of 15-49 years age were included for this study
- Those who agreed to participate

Exclusion criteria:

- Any women who is not with in this range of age
- No double counting for any candidate

Sample unit:

For this study rural women in the district were sampled using the probability- proportionally to size, i.e. 10% of the population being a sample of the group for the study and also women of 15-49 years of age living in the study area were taken as the study unit.

Sample size:

The sample size was calculated using a standard formula which uses the level of confidence, probability of target groups, design effect, the desired and expected margin of error.

Assuming that 5% probability (p) level is used for confidence interval (Z=1.96), desired or expected margin of error (q= 0.975), the design effect (deff = 2) yielded the minimum sample size of 129.6 (=130) by using the following standard formula.

$$n = \frac{Z^2 pqX\ d}{d^2}$$

Where:

n= sample size

z=the value of normal curve corresponding to the level of confidence 95%

p= probability of target group

q= the expected margin of error

d= the desired margin of error

deff= the design effect

$$n = \frac{(1.96)^2\ (0.05)\ (0.0975)\ (2)}{(0.017)^2} = 129.6\ (=130)$$

Though the minimum sample size was worked out to be 130, a sample size which was larger i.e. 140 was studied.

Thus, one hundred forty (140) individuals (female) from households were approached to fill the questionnaire. That is, a total of 140 female individuals were interviewed.

Sampling method:

For the purpose of the study the PA in Gewane woreda was categorized to four town kebeles and rural kebeles which further divided to three centers, west and east in terms of location. From each four categories one PA is randomly selected. These were Gewane 01 from the town, Geliladura East, Urafitta center and Beida west locations.

The sample size was distributed to the four randomly selected PAs based on probability proportional to their household sizes. From

each selected PA's all villages were included and households were selected using systematic sampling.

Individual woman aged 15-49 years in each HH's were randomly selected and interviewed. When the woman in the specific age group was not found in the HHs, the next nearest HHs was included in the study. Repeated visits were made in cases of unavailability of the selected subjects.

Tools for Data Collection / Tools and Procedures:

Method of data collection and analysis in social research depend very much on the nature of the subject of the research. Thus, different tools were applied to collect the data so as to develop a nearly accurate understanding of the subject of the research.

The main tool of data collection was the printed questionnaire which can be used as means of collecting the data from the households in the village.

The questionnaire contained 53 questions in five sections. It mostly comprised of close ended questions and were developed based on (GFHIE, 2008), and further modified based on advice of experts. The draft questionnaire was pilot tested on a sample of 20 women

and accordingly refined. The subjects of the pilot study were not included in the final analysis.

The questionnaire was translated to Amharic and administered, and translators were also used for the Afar groups who did not understand Amharic.

Inclusion criteria and instructions of the questionnaire were put in mind. The women responded to the instructed questionnaire, no names was written in the questionnaire but a code known only to the interviewers for identification if needed. All the women involved in the study gave a verbal consent to fill up the questionnaire.

The data were collected by the researcher and other assistant data collector who took two-three days orientation on how to collect data. It was checked by a team leader at the end of the day and subsequently coded to ease analysis, and then coded raw data were entered via prepared excel data sheets in the computer.

In addition, a total of 4 focus group discussions (FGDs), with community leaders; community facilitators and health personnel; Community based organizations like women income generation

groups, and PLHIV association members. The discussions were captured through field notes.

Data Analysis/ Data Processing:

The qualitative information collected from different respondents through FGDs was divided into meaningful parts and was analyzed on the spot. Themes were extracted in line with the objectives of the assessment and summarized through “descriptive thematic analyses” and incorporated in the report.

All the quantitative information collected through questionnaire was organized to thematic categories. Descriptive statistics were used to evaluate the responses of women to the questions.

Categorical variables were also summarized using frequencies and percentages while mean and standard deviation was calculated for age.

The Chi - square statistics and Fisher’s exact test were used in testing for associations between categorical variables. All analysis were done using the statistical package for social Sciences (SPSS) version 17.

CHAPTER 4

Result and Discussion

Distribution of respondents by PA:

There were one hundred forty female respondents from four PAs in Gewane District, Afar regional State who participated in this study. The PAs were selected randomly.

The majority of the respondents (50%) were residing in Gewane 01 PA, 20.71% in Ourafita, 15.71% Geliladura and 13.57% in Beida. Surprisingly, equal proportions (50%) of the respondents were residing located in town PA (Gewane 01) and rural PA (Ourafita, Geliladura & Beida) (table 1).

Table 1. Distribution of respondents by PA (n=140)

Variables (PA's)	Frequency	Percent
Beida	19	13.57
Geliladura	22	15.71
Gewane	70	50.00
Ourafita	29	20.71
Total	140	100.00

Socio-demographic characteristic of the study population:

The study participants were 140 women in the age group of 15-49 years from Gewane Woreda of Afar regional state, Ethiopia.

Age:

The age distribution of the respondent indicated that 26.43%, 25%, 15.71% and 13.57 % for age groups 25-29 years, 20-24 years, 15-19 years and 35-39 years, respectively (Table 2).

The size of the population steadily declines with increasing age and forty two percent of both women and men are 15 to 24 years old (EDHS 2011). Similarly, in this study 41% of the respondents were 15 to 24 years old (Table 2).

Table 2. Age distribution of respondents (n=140)

Variables (age group in years)	Frequency	Percent	Cum.
15-19	22	15.71	15.71
20-24	35	25.00	40.71
25-29	37	26.43	67.14
30-34	9	6.43	73.57
35-39	19	13.57	87.14
40-44	6	4.29	91.43
45-49	12	8.57	100.00

The mean age of the respondents were 28.44 +/- 0.81(mean +/- SE) years with the majority of the respondents therefore were aged 20- 44 years of age accounting for 75.72 % of the total number. This is the most important sexually active and productive sector of the community rescued for high HIV prevalence and STI's. In addition, the age composition reveals that the study population dominated by the younger age group. This is evidenced by the fact that more than half i.e. 57.86% of the study population was aged 20-34 years. This young age group represents a particular segment of the population which was at high risk for transmission of HIV/AIDS and STI's.

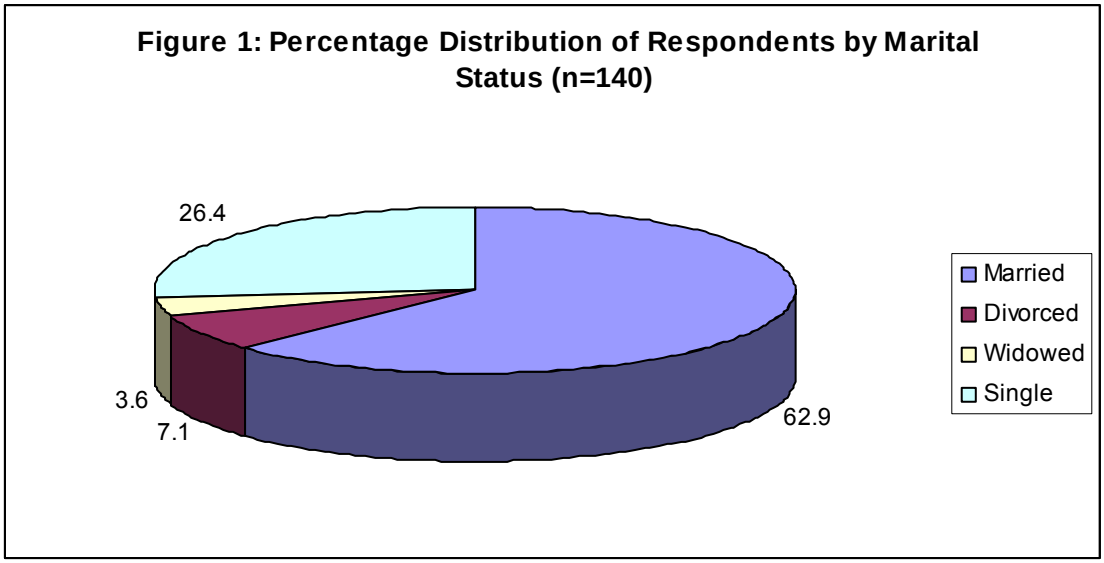
Martial status:

According to EDHS 20011, Women who are in union (i.e., currently married or living with a man) constitute over three-fifths (62 %) of all interviewed women.

Similarly, in this study 62.9 % of the respondents were married and living together, 26.4 % never married or single while 10.7 % divorced or widowed. This social status by itself is a predisposing factor for HIV/AIDS and related diseases (Figure 1).

African women may turn to prostitution as means of survival after the loss of their husband (the source of economic support) through divorce, widowhood, or other reasons, such as the husband leaving to look for employment prospects elsewhere (WHO, 2000).

Figure 1: Percentage Distribution of Respondents by Marital Status (n=140)



Educational status

Education is an important factor influencing an individual's attitude and outlook on various aspects of life. In this study, more than half (52.86%) of the respondents do not have any education i.e. illiterate, 4.29 % read and write, 10.71% grade one to six, 26.43 % grade 7-12 and 5.71% of them are above grade twelve (Table 3)

A similar finding reported in EDHS 2011, that Educational attainment in Ethiopia varies by sex and more women have never

attended formal education than men (51% of women and 30 % of men).

Table 3. Educational Status of Respondents (n=140)			
Variable/Educational status	**frequency**	**Percent**	**Cum.**
No education/illiterate	74	52.86	52.86
Only writing and reading	6	4.29	57.14
Grade 1-6	15	10.71	67.86
Grade 7-12	37	26.43	94.29
Grade 12 & above	8	5.71	100.00

The level of education of studied population was low, this may be due to the fact that access to education is very limited to women, due to traditional customs and taboos, lack of power and effects of poverty play an important role in preventing them to pursue their education. Early marriage or pregnancy could also be important factors. This high level of illiteracy would have an implication in the design and implementation of health education and awareness strategies to the targeted population in relation of HIV/AIDS and related diseases.

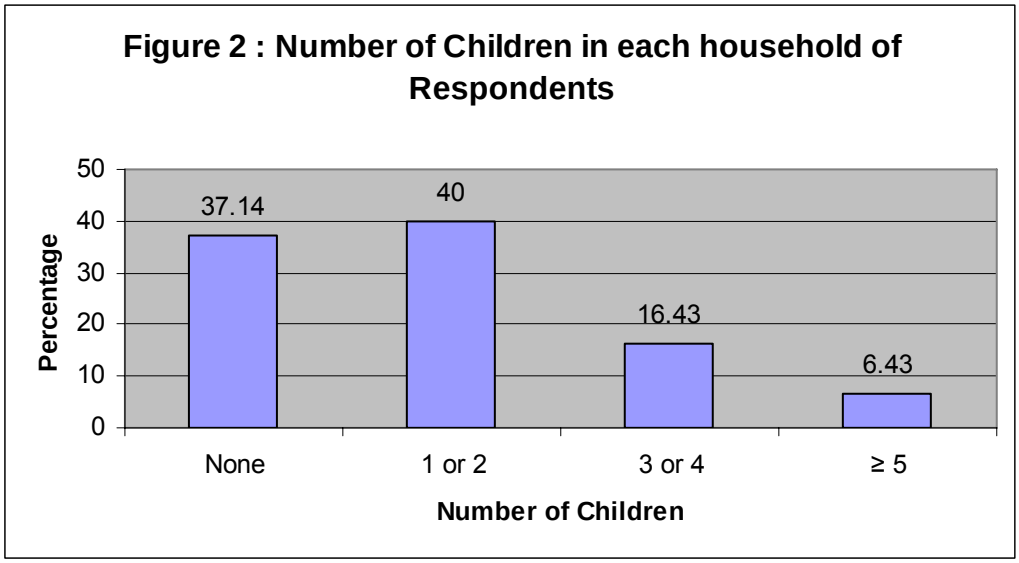
Low level of literacy proves to be an important barrier to the KAP of the rural community, thus the pastoral rural areas should be

covered under strategically integrated livelihood activities aiming at improving the educational status of the community. Further-more, in the pastoral area educational status may be improved through integrating livelihoods intervention with the alternative basic education and pastoral field or mobile schools.

Education gives women more opportunities for employment and gender equality (UNAIDS, 2006) and increases the likelihood of protection against HIV infection (Amy D etal, 2008).

Number of children:

Most of the women (62.86 %) had siblings, (40%) had one or two Children, (16.43 %) three or four and (6.43 %) had five or more than five children (figure 2).



Knowledge and awareness on HIV/AIDS and STI:

The understanding of the different concepts on HIV/AIDS and STI's including basic knowledge, source of knowledge, the modes of transmission, the methods of prevention and knowledge on STI's among respondents are discussed in this sub-section.

Basic knowledge/ awareness

Awareness of HIV/AIDS is universal in Ethiopia where 97 percent of women and 99 percent of men have heard of AIDS (EDHS, 2011). In this study, the level of awareness was high as 139 out of 140 (99.3 %) of the interviewed women had heard about HIV/AIDS.

This enlightenment could be attributed to increased availability of information now then ever in the media or through the existing local indigenous information exchange system, the so called the "Dagu System". In addition, the timing of this study coincides with the time when an increased level of awareness is with among the populace.

Similar study has been reported from other parts of the world. In Khartoum State, a study that tried to assess HIV/AIDS knowledge, attitude and practice among tea seller women showed that 93.1% of the women had heard about HIV/AIDS. Similar finding reported

in a community based cross sectional study among school and college –going teenagers from rural back ground in India which assessed awareness and attitudes, 150 out of 151 girls (99.3%) had heard about AIDS.

Awareness does not vary much by background condition except by education, those with no education being less likely to have heard of HIV/AIDS (EDHS, 2011).

Exposure to HIV/AIDS information widens the horizon of understanding and helps in the prevention and control of HIV/AIDS. Knowing the common source of information for HIV helps in the design and use of appropriate channels for HIV/AIDS and other health related issues.

Table 4. Respondents view on source of information to the community		
Variable / characteristics	**Frequency**	**Percent**
News paper	5	3.57
Radio	57	40.71
TV	24	17.14
Health workers	34	24.29
Family/friends/neighbors	65	46.43
Religious gathering	29	20.71
Others	25	17.86

* Multiple responses

The major source of information on HIV/AIDS for most of the respondents came from family/ friends/ neighbors (46.43%), radio (40.71%), health workers (24.29%) & religion (20.71%).

This reflects the impact of family / friends/ neighbors (locally called Dagu system) and Radio as a channel for disseminating information about health issues including HIV/AIDS and STI's. Peer education would, therefore, be a useful strategy for communication. The electronic media notably radio play an important role as evidenced from other study. Use of radio is recommended as it reaches a wide area and is cost effective as it does not depend on constant electric

power supply which is lacking in many rural communities.

Health workers most importantly the Health Extension Workers (HEW) are becoming a reliable channel for disseminating health issues following family/friends/ neighbors and radio. However, News papers were the least source of information. This might be attributed to the less availability or the high level of illiteracy in the studied Woreda.

In similar studies conducted among women tea seller's in Khartoum, radio (51.2%) and friends/ relatives (47.1%) have been reported as the main source of knowledge in the order of importance respectively (Amira S etal, 2005). Similarly, in other study on knowledge, attitude and practice of rural women in relation to HIV/AIDS in Wad-Eyesus woreda of Amhara region in Ethiopia, Radio (39%) and friends (33%) were reported to be the source of Knowledge for HIV/AIDS (Getnet A, 2008).

It is thus very important to include radio, friend/ neighbors and HEWS as means of communication while designing health education and awareness creation campaign to disseminate HIV/AIDS and related health issues in rural areas.

Knowledge on transmission and prevention

HIV is transmitted from one person to another mainly through sexual intercourse, contaminated blood or blood products, and from mother to child.

Table 5. Respondents knowledge on transmission and prevention of HIV/AIDS		
Variable/ characteristics	**Frequency**	**Percent**
1. Knowledge on transmission		
unprotected sex	128	91.43
mother to child	41	29.29
unsafe blood transfusion	56	40.00
sharing sharp materials	119	85.00
Do not know	5	03.57
2.knowledge on prevention		
Abstain	63	45.00
Faithfulness	77	55.00
Use condom	80	57.14
No prevention	28	20.00
do not know	5	03.57

* Multiple responses

In this study, unprotected sex (91.43%), sharing sharp materials like razor blades or needles contaminated with infected blood (85 %), transfusion of infected blood (40 %), and from infected mother to her fetus or baby (29.29 %) was the major mode of transmission mentioned by participants (Table 5).

The Proportion of respondents who knew on the existence of the HIV/AIDS was very high. Similarly, high proportions of respondents were aware that HIV could be transmitted via unprotected sex and sharing of sharp materials. However, the proportion of respondents who knew all the modes of transmission (20.86%) and Mother to Child transmission (29.29 %) as one of the modes of transmission was found to be alarmingly low. It is obvious that missing one of the modes of transmission expose people to the infection. Thus, communities are highly in danger due to lack of awareness on the routes of transmission.

Mother-to-child transmission is the major means for HIV infection in children, as up to 40% of children are born to HIV positive women become infected themselves unless the mother is undergoing preventative treatment . Of the children infected via mother-to-child transmission, two thirds of children are thought to be infected

during pregnancy and delivery, and one third during breastfeeding (Amy D etal, 2008).

This critical gaps in knowledge of mother to child transmission needs to be addressed in educational programs and awareness campaign aimed at all sexes of the target community.

To assess the most common misconceptions about AIDS and HIV transmission, respondents were asked whether it is possible for a healthy-looking person to have and transmit HIV virus. The result shows that 60.71 % of the women respondents in the woreda had misconception with lack of accurate knowledge about the ways in which the HIV virus can be transmitted. This is, therefore, a very important message in the campaign enhancing exposure to HIV/AIDS epidemic in order to avoid casual sex with healthy looking persons. A similar study carried out among tea sellers in Khartoum State revealed similar findings that almost 37.5 % of the respondents knew healthy looking person can be infected (Amira S etal, 2005). However, a community based study in Gambella, Ethiopia revealed quite high level of awareness with regard to misconception i.e. 84% of the participants knew that even healthy looking people can have AIDS (Yayeh N etal, 2000).

Lack of knowledge and misconception with regard to routes of transmission can result in unfavorable attitude towards the care for HIV patients and the spread of HIV/AIDS.

HIV & AIDS prevention programs focus on three programmatically important HIV preventive methods: these are delaying sexual debut in young persons (abstinence), limiting the number of sexual partners/ staying faithful to one partner, and use of condoms (Jemal A etal, 2011).

As indicated in table 5 above in the study woreda, 76.43 % of the study participants believed a person can avoid or reduce the chances of getting HIV and 20% reported the absence of prevention. Slightly more than half knew using condom during sexual intercourse (57.14%) and limiting sex with faithful uninfected partner (55%) while only about 45 % knew abstaining from sexual intercourse as preventive methods. Moreover, only 20.14% of the proportion of the respondents knew that all three methods are most common preventive methods- Abstaining, faithfulness and use of condom.

Similarly in EDHS, 2011 it is reported that 56% of women and 82% of men with ages 15-49 years know that consistent use of condoms is a means of preventing the spread of HIV.

The knowledge on the methods for preventing HIV/AIDS among respondents in different studies was more variable. In EDHS 2011, it is reported that 65% of women and 74% of men know that limiting sexual intercourse to one faithful and uninfected partner can reduce the chances of contracting the disease.

Similarly, in a community based study in Gambella, Ethiopia faithfulness to partner, condom use and abstinence were reported to be ways of prevention by the majority of respondents 78.2 %, 76.5% and 64%, respectively (Yayeh N etal, 200). However, in a similar study among women tea sellers in Khartoum State, the best known methods for preventing HIV among respondents were, 64.5% avoiding un - protected sex, 12.1 % loyalty to one partner, 47.4 % avoidance of sharing skin piercing instruments and 3.5 % condom use (Amira S etal, 2005).

Knowledge on STI's

In the study woreda it was interestingly observed that a significant proportion of respondents (99.3%) had awareness on HIV/ AIDS,

while with regard to STIs 64.29 % of the respondents have heard about STI's. This shows that there is still inadequate knowledge of the relationship between STI's and HIV/AIDS. Out of those who have heard STI's, 83.33 % knew where to go if they experienced infection. The proportion of respondents in this study is higher than reported in BSS 2005 round two, where 78.7% of male and 30.3% of female pastoralists had heard of STIs (Getnet M. etal, 2005)

The discrepancy between knowledge of STI's and HIV/AIDS in this study is not surprising, as a similar finding has been reported from developed countries (S.S LAL etal, 2000). The association between HIV/ AIDS and other STI's needs to be integrated and delivered through any HIV/AIDS and other health related training program. It is widely accepted that eradication of STIs at the population level is difficult. However, an understanding of the link between STIs and HIV transmission will probably promote safe sexual practice (S.S LAL etal, 2000) (Table 6).

Table 6. Respondents knowledge level of STIs		
Statement	**Options**	**%**
Have you ever heard about STI's? (N=140)	Yes	64.29
	No	35.71
Do you know where to go if you have STI's (n=90)	Yes	83.33
	No	16.67

Individual's knowledge of symptom of STI is an initial and important factor for health seeking behavior.

The commonest symptoms of STIs in women as mentioned by respondents who heard about STI's were; burning sensation on urination (27.78), genital discharge (25.57%), and genital ulcer or sore (11.1 %). In other studies, the three commonest symptoms of STIs in women mentioned by respondents were; burning sensation on urination (28.1% male versus 38.5% female respondents), genital discharge (25.7% male versus 17.4% female), and genital ulcer or sore (26.0% male versus 8.5% female) (Getnet M etal, 2005).

In this study, those individuals who have heard of STI's and during

Focus Group Discussion (FGD) it was revealed the existence of six different types of STIs. These were Gonorhoea, Chlamydia, Syphilis, Chancroid, inguinal bulbo and vaginal trychomoniasis.

The presence of STIs is among the major risk factors that augment and facilitate transmission of HIV and hence early diagnosis and effective treatment of STIs is an important strategy for the prevention of HIV transmission.

Attitude and stigma on HIV/AIDS

The attitude among respondents towards HIV/AIDS including stigma and discrimination on HIV infected people, preventive measures; risk factors for transmission and willingness to discuss HIV/AIDS with family are discussed below.

STIGMA and discrimination:

Two questions were used to explore the views of respondents towards People living with HIV/AIDS (PLWHA). In response to the question “if any one of your friends gets the AIDS virus what would you be doing to help him/her?”

It was reported that 68.57 % of the respondents were willing to help him/her and 51.43 % were willing to give care during sickness.

Questions related to the willingness of respondents to help or care during sickness if their friends get and live with HIV/AIDS showed that a significant proportion of the respondents revealed their willingness to help/care/ visit/ play/ advice. However, one fourth of the respondents (25%) do not know what to do in this regard, in addition the FGD carried out revealed that there were people who do not like to share their problems.

The main causes of stigma involve incomplete knowledge, fear of death and disease, and a lack of recognition of stigma. The combination of insufficient and inaccurate knowledge and fear of death and disease perpetuate beliefs in casual transmission and thus avoidance of those with HIV/AIDS (Table 7).

With regard to attitude changes towards PLWHVA a lot has to be done through awareness creation so as to reduce the stigma and discrimination that might arise out of misconception.

Table 7. Respondents view towards PLWHIV		
Variable / characteristics	**Frequency**	**%**
If any one of your friends gets the AIDS virus what would you be willing to do?		
help him/her	96	68.57
Visit him/her	57	40.71
Play together	66	47.14
Give care during sickness	72	51.43
Do not know	35	25.00

*multiple responses

In response to the question “In your community how is a person who has HIV/ AIDS usually regarded/treated?” It is reported that only 8.57 % of the respondents stated to reject him /her, and 19.29 % responded to provide friendly treatment. However, 70 % of respondents had expressed their willingness to support and help him/her.

Questions related to the willingness of the community to support people living with HIV/AIDS showed that a significant proportion of the community revealed their willingness to support PLWHA. Although the proportion of respondents willing to support was higher, 27.86 % of the respondents reported rejection and trying to

avoid. Similarly, in FGD Discussion it has been pointed out that one out of three rejects to support PLWHIVA (Table 8). Even though, the majority of the respondents were aware of the need to provide support to PLWHA, significant proportion of the respondents did not or need not do so yet, thus, this implies awareness developing schemes should be integrated on a continuous and regular basis in any of development intervention in the pastoral areas.

Table 8. Respondents view regarding community attitude towards PLWHIV (n=140)

Variable/ characteristics	Frequency	%	Cum.
In your community how is PLWHIV usually regarded/treated?"			
Most people reject him/her	12	8.57	8.57
Most people are friendly , but generally try to avoid him/her	27	19.29	27.86
The community mostly supports and helps him/her	98	70.00	97.86
Do not know	3	2.14	100

Attitude towards Sex and risk of infection of HIV/AIDS:

Over all, 69.29 % of the respondents agree that any one can be infected with HIV/AIDS. However, 30.71 % did not agree and or did not know (Table 10). It was also reported that 82.86 % of the respondents believe that the best prevention is to have only one sexual partner (Table 10). Statistically significant relationship were established between favorable attitude with regard to sex and risk of infection i.e. any one can be infected by HIV/AIDS (p value= 0.002) or the best prevention is to have only one sexual partner (p value=0.013) and attaining higher educational status.

Table 9. Respondents view towards extramarital sexual affairs (n=140)

Variable/ characteristics	Frequency	Percent	Cum.
Opinion about extra marital sexual affairs			
Good	2	1.43	1.43
Bad	85	60.71	62.14
Should be forbidden	53	37.86	100.00
Total	140	100	

With regard to extramarital sexual affairs, 60.71 % of the study participants had negative view (Table 9).

It was observed that a very large majority of the respondents had a positive and healthy attitude, in that they said that extra sexual indulgence was not acceptable to them.

Table 10. Respondents attitude regarding sex and risk of infection (n=140)									
	Educational Status								
	Illiterate			Literate					
Variable / Characteristics	Yes	No	Do not know	Yes	No	Do not know	Chi square	Df	P-value
Any one can be infected by HIV/AIDS	48 (49.48)	12 (42.86)	14 (93.33)	49 (50.52)	16 (57.14)	1 (6.67)	11.4286	2	0.002
the best prevention is to have only one sexual partner	61 (52.59)	6 (35.29)	7 (100.00)	55 (42.41)	11 (64.71)	0	8.3511	2	0.013

Attitude towards risk factor for HIV/AIDS transmission

Overall, 60.7% of the respondents realize that a healthy-looking person can be infected HIV infected person and 80% also knows that STIs increases the risk for HIV infection. Unlike this finding, a lower proportion 37.5 % of the studied tea sellers knew that a healthy looking person can be the virus carrier (Table 11).

Although the study finding show a lot of people knew about the risk, the FGD reveals that there are still attitudinal gaps in the study area. This is, therefore, a very important message in the campaign against exposure to HIV/AIDS epidemic in order to avoid casual sex with healthy looking persons.

Statistically significant relationship has been established between educational status and the knowledge on risk factors ($n=140$; $p< 0.001$) (Table 11).

Similarly, statistically significant relationship was established between the risk factor that Sexually Transmitted Infections (STI's) increase the risk of getting HIV/AIDS ($n=90$; $p= 0.001$) and educational status (Table 11).

This might be explained by the fact that education has a positive impact in the improvement of knowledge, attitude and practice of people. As educational status getting improved, favorable attitude would also be improved.

Table 11. Respondents attitude on risk factors as means for HIV transmission (n=40)									
	Educational Status								
	Illiterate			Literate					
Variable / Characteristics	Yes	No	Do not know	Yes	No	Do not know	Chi square	Df	P-value
A healthy looking person can be infected with HIV/AIDS (n=140)	33 (38.82)	30 (71.43)	11 (84.62)	52 (61.18)	12 (28.57)	2 (15.38)	17.7931	2	0.0
Sexually transmitted infection increases the risk of getting HIV/AIDS (n=90)	20 (27.78)	2 (66.67)	11 (73.33)	52 (72.22)	1 (33.33)	4 (26.67)	12.2967	2	0.001

Willingness to discuss on HIV/AIDS

Discussing HIV/AIDS issues with friends, family, and health professionals and in public is an important manifestation of HIV/AIDS knowledge and a major step in adopting appropriate HIV/AIDS prevention.

In this study, overall 35.7 % of the respondents reported they had discussed sexuality and HIV/AIDS issues with their family (Table 12).

In A study conducted among youth in Addis Ababa found that discussion about HIV and AIDS, condoms and sex life with male friends wasn't a problem, but they were shy to talk to family members and doctors. It was reportedly easier to talk about HIV and AIDS (41%) to family members, and (23%) to doctors (Yibeltal A etal, 2009).

Marital status and number of children with in a family influence discussion on issues of HIV/ AIDS and sexuality. Amazingly, women who were never married/ single and without children had discuss sexuality and HIV issues freely with their family. This is contrary to the finding that married respondents with children discussion sexuality and HIV/AIDS issues with family members (Tajudeen O, 2008).

Table 12. Respondents view on discussion about sexuality & HIV/AIDS issues with in the family (n =140)						
Variable / Characteristics		Discussed Sexuality and HIV/AIDS issues with their family		Chi square	Df	P-value
		Yes	No			
Marital status	Married	23 (26.14)	65 (73.86)	12.6397	2	0.002
	Never married	22 (59.46)	15 (40.54)			
	Divorced/Widowed	5 (33.33)	10 (66.67)			
Number of children	None	28 (53.85)	24 (46.15)	17.6727	3	0.000
	1 or 2	19 (33.93)	37 (66.07)			
	3 or 4	3 (13.04)	20 (86.96)			
	5 or more	0	9 (100.00)			

Health seeking Behavior

Preference for treatment

To get treated for any general health problem or sickness, 71.42 % of the respondents prefer to visit private clinic, larger proportion (82.14 %) visited government clinic and only 5.72% went to traditional healer. In other study conducted among male respondents in rural population, it was reported that there was no stated preference for a private practitioner or the government service (K. Sobhan etal, 2004) (Table 13)

Table 13. Respondents preference to healthy treatment and their behavior towards traditional practices

Variable / characteristics	Frequency	Percent
1.Preference to get treatment		
Private clinic	100	71.42
Government clinic	115	82.14
Traditional	8	05.72
2.Traditional practices in the area		
Tattoos	33	23.57
Tooth extraction	42	30.00
Tonsillectomy	53	37.86
Circumcision	109	77.86

*multiple responses

Harmful traditional practice predisposing to HIV/ AIDS

Traditional practices harmful to women are widely practiced in the Middle East and Africa in general and in pastoral area of eastern Africa or the Horn of Africa in particular.

The study population has reported a number of traditional practices, which involve varying degrees of incision or excision of parts of the body. Accordingly, circumcision (FGM), tonsillectomy and tooth extraction, were the widely practiced harmful tradition in the area (Table 13).

In this study circumcision (77.86%), tonsillectomy (37.86 %), tooth extraction (30 %) and tattoos (23.57%) were reported to be the existing traditional practices.

In a community based study in Gambella, common traditional practices such as tattoos, vulvoctomy, circumcision and tooth extraction were reported to predispose to HIV infection majority (Yayeh N etal, 200).

In the FGD it was expressed that the instruments which were used for FGC/FGM or for the other practice were un-sterilized. Thus, it

was one of the potential means of transmission of HIV/AIDS in the pastoral community. Thus, such malpractices should be avoided through the efforts of extension health workers, village level workers (such as volunteers and community health workers), and religious and village leaders. Providing health education on the side effect of each practice in relation to HIV/AIDS is critical.

More programs tailored to women, especially those with low education levels and those from rural areas, are required. However, these programs also need to address socio-cultural influences on sexuality, and violence against women (Amy D. etal, 2008).

Practice of Sexual relationships

Sexual relationships before marriage

It is reported that higher proportion (81.43%) of the respondents agreed that sexual intercourse should not be committed before marriage. It can be said that the remaining (18.57%) and those not responding accept sexual relationship before marriage.

Table 14. Respondents View on Sexual relationships before marriage		
Statement	**Options**	**Percentage**
Do you accept the view that sexual relationship Before marriage should not happen?	Yes	81.43
	No	16.43
	No Response	2.14

In other community based KAP study in Gambella, Ethiopia similar proportion (80%) of both sexes have agreed that sexual intercourse should not be committed before marriage.

Generally, the respondents seem to have favorable practice of sexual relationship on prevention of the disease. This may indicate that the existence of a favorable social atmosphere for VCT. In a community based study in Gambella, it was reported that about 85% of females supported testing for HIV/AIDS before marriage (Yayeh N etal, 200)

However, in other studies it is reported that many African women lack control in sexual matters, and are expected to be submissive and leave the initiative and decision making in sexual relations to men (WHO, 2000).

Use and practice of condom

Awareness on condom uses, why condom is used and the practice of it during sexual intercourse are major intervention for preventing sexual transmission of HIV.

Table 15. Respondents view on the use of condom

Statement	Options	%
Heard about condoms (n=140)	Yes	91.43
	No	8.57
Used condom (n= 128)	Yes	28.91
	No	71.09

Condom use is one of the important ways of preventing the spread of HIV infection. In BSS (2005) it was reported that 69.5% of female pastoralists had heard of condoms (Getnet M. etal 2008). In this study however, higher proportion (91.43 %) of the respondents reported to have heard about condoms. This may indicate that the awareness level with regard to condom promotion through different outlets has increased from time to time. However, surprisingly enough out of the respondents reported to have heard about condoms, only lower than one third (28.91 %) used condom during sexual intercourse.

Low proportion of use of condom during sexual intercourse may be attributed to the low level of literacy in the study area. This is agreed with tea seller's study in Khartoum State, where women's level of education was positively correlated with condom use.

According to EDHS (2011), the proportion of people knowing both that using condoms and limiting sexual intercourse with uninfected partner is 43 percent among women and 64 percent among men.

Accordingly, 64.84 % of the respondents reported Condom use to prevent HIV/AIDS, avoid STI's (42.19) and to avoid pregnancy (52.34%). However, (24.22 %) did not respond or did not know the use of condom. Unlike this study, in other studies many reasons with variable result were mentioned for condom use, such as to avoid pregnancy (76.5%), STD (5.9%) and (5.9%) to avoid HIV/AIDS (Amira S etal, 2005) (Table 16)

Therefore, it can be said that the communities' level of understanding of the use of condom is good, however, in terms of practicing it is still at lower level. In addition, there are also respondents who did not know why condom is used. Thus, a constant and regular teaching method has to be in place so that the

community practiced using condom widely to be able to avoid HIV/ AIDS transmission. In addition, stigma could be effective strategies in the promotion of condom use among the pastoral population.

Table 16		
Table 16. Respondents view with usefulness of condoms (n=128)		
Variable/ characteristics	**Frequency**	**Percent**
Uses of condom		
Avoid STI's	54	42.19
Avoid pregnancy	67	52.34
Prevent HIV/AIDS	83	64.84
Do not know	8	6.25
No response	23	17.97

- Multiple responses

Perceptions on condoms to prevent HIV /AIDS

Condoms use is an important tool in the fight against the spread of HIV / AIDS. Condoms are promoted as one of the primary prevention methods for HIV infection and other sexually transmitted infections.

In this study, the majority (85.94 %) of the respondents who have heard of condoms believed that condom prevents HIV/AIDS while 14.06 % didn't know or didn't respond (Table 17).

Similarly, Over 70% of men and women had also agreed that condoms are safe to use (Amy D etal, 2008). The 2008 Health impact evaluation result had shown that knowledge of using condoms as means of avoiding HIV was only 40%, similar to the DHS 2005 result of 41% (GFHIE, 2008). Negative attitudes and beliefs about the acceptability and safety of condoms, however, must be addressed if condom use is to increase (Amy D etal, 2008).

Statically significant relationship (n= 128; P value=0.005) were established between perceptions on condom as prevention of AIDS and martial status. Married respondents perceive that condom prevents AIDS better than those who were never married /single/ divorced / widowed. On the contrary, there is no significant relationship (n= 90; p value= 0.174) established between respondents who had been caught by STI's and marital status.

On the basis of respondents knowledge of location of health center for help if STI's is experienced, there is no significant relationship (n= 90; p value= 0.240) between married and unmarried individuals (Table 17).

Table 17. Respondents Practices related to HIV/AIDS

Variable / Characteristics	Marital Status									Chi square	Df	P-value
	Married			Never married			Divorced/Widowed					
	Yes	No	Do not know	Yes	No	Do not know	Yes	No	Do not know			
condom prevents HIV/AIDS (n=128)	61 (55.45)	3 (75.00)	14 (100)	37 (33.64)	0	0	12 (10.91)	1 (25.00)	0	12.5837	4	0.005
Have you ever been caught by STI's? (n=90)	08 (72.73)	31 (43.66)	06 (75.00)	3 (27.27)	27 (38.03)	1 (12.5)	0	13 (18.31)	1 (12.5)	6.3596	4	0.174
Do you know where to go for help if you experience STI's? (n=90)	35 (77.78)	3 (6.67)	7 (15.56)	28 (90.32)	2 (6.45)	1 (3.23)	12 (85.71)	2 (14.29)	0	5.8747	4	0.240

CHAPTER 5

Conclusion, Limitation & Recommendations

Conclusion:

If pastoral families are affected by HIV/AIDS, their livelihood system is greatly endangered, not only because of the weakening and loss of household labor but also because the only assets that they can use to cover the costs of healthcare (both traditional and modern treatments) and funerals are animals, the basis for their livelihoods (Ann Waters-Bayer etal , 2005) . Thus, findings of this study were used to draw the following key conclusions about HIV/ AIDS, knowledge, attitude and practice among pastoral women in Gewane, Afar regional State, Ethiopia.

The knowledge about how HIV is transmitted and protective measure is incomplete among the women. Though it is reported that 99.3 % of them had heard about HIV/AIDS there are still misunderstanding and misconceptions about the disease.

The majority of the women first heard about HIV/AIDS from their friends/ neighbor and electronic media. This system became effective in spreading information, through health extension workers also play important role.

Mother-to-child transmission is a major means for HIV infection in children. Of the children infected via mother-to-child transmission, two thirds are thought to be infected during pregnancy and delivery, and one third during breastfeeding (WHO, 2000).

The proportion of respondents who knew all the modes of transmission (20.86%) and MTCT (29.29%) was very low in the study area.

In addition, 38.85 % of the pastoral women had misconception, in that “a healthy looking person can not be infected and transmit HIV virus”.

The awareness level on protection against HIV was insufficient among the women and there were misunderstandings about it.

The proportion of respondents who knew the three most common methods of prevention, i.e. abstain, faithfulness, and the use of condom as methods of prevention were found to be very low in the study area.

The most important way to prevent the rapid spread of HIV is to raise the level of knowledge about the transmission and the protection against HIV.

There was inadequate knowledge of the relationship between STI's and HIV/ AIDS. A significant proportion of respondents (99.3%) had a good level of awareness on HIV/AIDS while only 64.29% of the respondents had heard about STI's. Excluding HIV/AIDS six other types of sexually transmitted infection were known as Gonorrhoea, Chlamydia, Syphilis, Chancroid, Inguinalbulbo and Vaginal trichomoniasis were identified through FGD.

The proportion of respondents willing to support PLWHIV seems higher. However, both the quantitative study and FGD reveals that one out of three was unwilling to support PLWHIVA. Thus, a lot has to be done through awareness creation mechanism in the study area so as to reduce the stigma and discrimination that might arise out of this behavior.

The study had shown that a higher proportion of respondents had a positive and healthy attitude towards the problem and extra sexual indulgence was not acceptable to them. This has been a good message and has to be conveyed during mass awareness

creation campaign aiming at reducing casual sexual intercourse.

Statistically significant relationship were also established between educational status and the risk factor attitude towards a healthy looking person being infected with HIV/AIDS ($n=140$; $p< 0.001$) or the idea that Sexually Transmitted Infections (STI's) increase the risk of getting HIV/AIDS ($n=90$; $p= 0.001$).

With regard to sexuality and HIV/AIDS issues and discussion with in the family, the study revealed that there was statistically significant relationship between willingness to discuss issues of sexuality and HIV/AIDS and martial status ($n=140$; $p=0.002$) or the number of children in the households($p < 0.001$).

Unlike other findings, to get treatment for any general health problem or sicknesses, the majority of the respondents seem to have favorable attitude towards preference of health center for treatment. Generally, they prefer to visit private clinic and/ or government clinic. This should be considered as positive behavior and must be encouraged.

The study indicated that FGM/ FGC were widely practiced and harmful traditional practice among pastoral women. It is considered as one of the potential avenues for HIV/AIDS transmission in the pastoral community. Providing health education on the side effect of each practice in relation to HIV/AIDS is therefore critical.

The study revealed that higher proportion of the respondents agreed that sexual intercourse should not be committed before marriage. This practice of sexual relationship may indicate the existence of favorable condition for Voluntary Counseling and Testing Service (VCT) that needs to be encouraged.

The women's' level of understanding on the use of condom and their beliefs in the prevention of AIDS through condom was very good. However, in terms of practicing it is still at a lower level. This may be improved through constant and regular teaching of the community in the use of condom.

Both married and unmarried had similar perception in usefulness of condom in preventing HIV/AIDS.

Limitation:

The study was conducted among pastoralist women in Gewane woreda aged 15-49 years. Some of the respondent women might not be truth full when answering questions related to the sexuality and sexual practice. In addition, the descriptive nature of the research design may limit the ability of this study to establish causal relationship between HIV/AIDS knowledge, attitude and practice with background characteristics of respondents in this study.

Findings in this study however, indicate statistically significant relationship between:

Favorable attitude with regard to sex and risk of infection, any one can be infected by HIV/AIDS (p value= 0.002) or the best prevention is to have only one sexual partner (p value=0.013) and education can change women's attitude. With education the risk of getting HIV/AIDS infection is lowered, and the use of condom is increased, free discussion on the problem is promoted.

Moreover, the use of a questionnaire for obtaining information on sexual matters may be problematic for several reasons. Respondents are known to indulge in 'hypothesis guessing' (guess

the real purpose of the study), and 'evaluation apprehension' (provide desirable responses so as to 'look good' with regard to their answers).

Awareness of these potential limitations to questionnaires administered approach it prompted the use of the Focused Group Discussions (FGDs) as a complementary source for knowledge, attitudes and practice towards HIV/ AIDS and sexuality information.

Recommendation:

Based on the result of the study the following recommendations are forwarded:

1. Health education/ training /awareness:

- HIV/AIDS and STI education activities that can improve the knowledge, Attitude and practice of the people need to be integrated in any health and livelihoods related implementation and practices. Given the high level of illiteracy in the pastoral areas pictorial teaching aids will need to be developed.
- Increasing community awareness on the risk factors, HIV/AIDS and STI's, VCT and existing HIV&AIDS services such as PMTCT to craft utilization of the service.

- The low level of knowledge of mother-to-child transmission needs to be addressed in health education programs aimed at both sexes.
- Involve PLWHIV in education activity and encourage them to share their situation with communities to internalize the problem and humanize the disease thereby to reduce stigma and discrimination prevailing in the area
- Engage PLWHA in training on HIV/AIDS prevention to improve the knowledge on HIV/AIDS among women as well as to reduce the prejudice of community towards PLWHA, thereby to address the issue of HIV/AIDS related stigma and discrimination
- Train locally serving health care providers including HEWs and volunteers to educate and offer HIV testing and counseling to all pastoral women attending ANC.

2. Strengthening health facilities and the health service:

- Strengthening the health facilities and supporting health workers to provide HIV testing and counseling to all pastoral women attending antenatal care.
- Strengthen implementation of the existing government owned initiatives such as community conversation and health extension packages with special emphasis on maternal health

, HIV/AIDS and STI's services in order to create better understanding and increase demand for these services

- Support outreach services by HEWs , other health workers, volunteers and Community Health workers in educating pastoral women on the importance and benefit of PMTCT
- Provision of standardized and regular Care and Support for PLWHIV and involving them in income generation and livelihood diversification activities.
- The presence of STIs is among the major risk factors that augment and facilitate transmission of HIV and hence early diagnosis and effective treatment services for STIs need to be in place in the health facility of the pastoral area as a strategy for the prevention of HIV transmission.

3. Women empowerment:

- Empower women in all aspects (socially, culturally, politically and economically) by linking them with service utilization and any livelihood initiatives in the area.
- The critical mitigation intervention required to make women less vulnerable to the socio-economic impacts is empowering women to access credit and in generating income. Income generating projects have been used widely in development programs even before HIV/AIDS to address lack of access to

food, primarily economic access and as a major poverty reduction strategy. Income-generating programs for affected women can include support for micro-enterprises, micro credit schemes, and capacity building through training provision and market access and linkage.

- In addition activities designed to make women aware of their legal rights, e.g. to choose their own partners and to be protected from physical and mental brutalities (stated in the Ethiopian Constitution), will strengthen their capacities to protect themselves against HIV/AIDS.

4. Other recommendations

- Establish and support school based Anti-AIDS clubs through training provision on behavior change, communication skills and peer education strategies to cover the majority youths to take responsibility for their own health and to provide support for other young generation in the area.
- To curb the HTP such as FGM/FGC and premarital sexual practice, involve all groups of the community (boys , girls and women), public figures, religious and community leaders to serve as actors of change and influence the community members
- Like Anti-AIDS club, it is advisable to establish Anti FGC/FGM

clubs in schools and in the community that consists of boys, girls, elders and religious leaders, and the person operating circumcision so as to influence the community.

- The use and practice of condom were found to be at its lower level. Thus, a constant and regular teaching method has to be in place so that the community may widely practice using condom. In addition, wider promotion of condom use among the pastoral population may improve the practice
- Together with IEC/BCC material a “Camel Caravan” may be used as a mechanism to spread some key messages pertinent to HIV/AIDS prevention and control, as part of IEC and behavioral change campaigns among the pastoral population.

5. Further studies recommended

- Comprehensive study of HIV/AIDS knowledge among pastoral women and men
- Participatory action research on factors that affect HIV/AIDS attitude , health seeking behavior and sexual practices among both pastoral women and men
- Given the higher illiteracy rate in the area, a deeper study that explore the existing education situation, and foster the development of alternative education scheme which can improve educational status in the pastoral area.

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6. ANNEXES

Annex 1. Number of Sample HH's per selected PA

No	Selected PA	# of population	# of HHs	# of sample HH's
1	Gewane	9,305	1,861	70
2	Beida	2,464	493	19
3	Orafita	3,887	777	29
4	Geliladura	2,943	589	22
5	**Total**	**18,599**	**3,720**	**140**

Source: Adapted from Afar Regional Plan and economy Bureau,

Semera, June 2011

Annex 2. HIV/AIDS Knowledge, Attitude and Practice Study Questionnaire

A. Introduction: HIV/AIDS is one of the major development problems in Ethiopia. In order to manage the problem, we need to improve the quality of information women possess on the epidemic. By completing this questionnaire, you will be contributing to the knowledge that assists to improve the prevention and control of HIV/AIDS in the pastoral area.

This questionnaire is part of a survey being conducted in partial fulfillment of the award of Masters of Arts (M.A) in Rural Development by the University of Indra Gandhi Open University (IGNOU), India. "Information collected with this questionnaire will be treated as confidential and your answers will never be associated with your name or be kept in any other records as you are not required to provide your name in the tool.

Your participation is voluntary and you may choose to stop the interview at any time. "Giving honest information will help the understanding of HIV/AIDS knowledge and attitude among women in Gewane District, and assist to make appropriate

recommendations to prevent and control HIV/ AIDS in the pastoral area of Ethiopia.

B. Survey/Study objective: To explore HIV/AIDS related knowledge, attitudes, stigma and health-seeking practices among the pastoral women.

C. Instructions

1. The questionnaire consists of five sections and each section has a number of questions with multiple choice answers.
2. Please answer all the questions as completely as you can, by ticking or placing an X in the box of the selected answer(s)
3. Do not read responses unless the directions indicate

Thanks you very much for your cooperation.

Date: ___ / ___ / ___ Village: _____

SECTION I. GENERAL AND DEMOGRAPHIC QUESTIONS

1. How old are you? _____

2. What is the highest level of education you have completed?

1. ☐ Illiterate
2. ☐ Read & write
3. ☐ Grade 1-6
4. ☐ Grade 7-12
5. ☐ > 12

3. Please indicate your martial status?

1. ☐ Married
2. ☐ Single/never married
3. ☐ Widowed/widower
4. ☐ Divorced

4. How many children do you have?

1. ☐ None
2. ☐ 1-2 children
3. ☐ 3-4 children
4. ☐ 5 Children and above

5. What is your occupation?

1. ☐ Student
2. ☐ No job
3. ☐ Daily laborer
4. ☐ House wife
5. ☐ Livestock keeping/ Agriculture
6. ☐ Trader
7. ☐ Others, please specify

6. What is your Religion? _____

7. What is your Ethnicity? _____

II. HIV/AIDS KNOWLEDGE & AWARENESS

1. When do you hear first about HIV/AIDS?

_____

2. Where did you learn about HIV/AIDS?

1. ☐ News paper & Magazine
2. ☐ Radio
3. ☐ TV
4. ☐ Health workers
5. ☐ Family, friends, neighbors & colleagues
6. ☐ Religious leaders
7. ☐ Others (please explain) _____

3. What do you think of the cause of HIV/AIDS?

_____

_____

4. What are the signs and symptoms of HIV/AIDS?

1. ☐ Fever
2. ☐ Weakness
3. ☐ Cough
4. ☐ Weight loss
5. ☐ Diarrhea
6. ☐ Skin diseases
7. ☐ Others (please explain) _____

5. in your opinion, how serious is HIV/AIDS in your district?

1. ☐ Very serious
2. ☐ Somewhat serious
3. ☐ not very serious

6. How are HIV/ AIDS transmitted?

1. ☐ Unprotected sex
2. ☐ Mother to child
3. ☐ Unsafe blood transfusion
4. ☐ Sharing of sharp materials and needles
5. ☐ Do not know
6. ☐ Others

7. Can a healthy looking person be infected with HIV?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

8. Have you ever heard about STDs?

1. ☐ Yes
2. ☐ No

9. What signs of STI's do you know? Please also list STI's you now in local names too if possible

_____

_____

10. Does sexually transmitted infection increase the risk of getting HIV/AIDS?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

11. How can we prevent HIV/AIDS?

1. ☐ Abstain from sex
2. ☐ Use of condom
3. ☐ Faithfulness to sexual partner
4. ☐ No prevention

12. Do you discussed about HIV/AIDS with your family?

1. ☐ Yes
2. ☐ No

13. Can you know or identify any one who is infected with HIV?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

14. Have you receive information on HIV/AIDS from any training program in your area?

1. ☐ Yes
2. ☐ No

15. Have you heard about VCT?

1. ☐ Yes
2. ☐ No

16. DO HIV/ AIDS have an impact on rural economy?

1. ☐ Yes
2. ☐ No
3. ☐ No response

17. Do you know where to go for help if you have sexually transmitted infection?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

18. Have you discussed sexuality and HIV/AIDS issues with your spouse or children?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

19. in your opinion, who can be infected with HIV/AIDS

1. ☐ Any body
2. ☐ Only poor people
3. ☐ Only homeless people
4. ☐ Only alcoholics
5. ☐ Only commercial sex workers
6. ☐ Others (please explain) _____

SECTION III. HIV/AIDS ATTITUDE AND STIGMA

1. Do you think any one can be infected by HIV/AIDS?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

2. Do you believe the best prevention is to have only one sexual partner?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

3. What would be your reaction if you were found out that you have HIV/AIDS?

1. ☐ Fear
2. ☐ Surprise
3. ☐ Shame
4. ☐ Embarrassment
5. ☐ Sadness or hopelessness
6. ☐ Other: _____

4. Do you think having sex before marriage should be discouraged?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

5. What is your opinion about extra martial sexual affairs?

1. ☐ Good
2. ☐ Bad
3. ☐ Should be forbidden

6. Have you seen HV/AIDS victim or patient?

1. ☐ Yes
2. ☐ No

7. If one of your friends gets the AIDS virus would you be willing to: ___?

1. ☐ Help him/her
2. ☐ Visit him/her
3. ☐ Play together
4. ☐ Give care during sickness
5. ☐ Sadness or hopelessness
6. ☐ Other: _____

8. In your community how is a person who has HIV/AIDS usually regarded/treated?

1. ☐ Most people reject him/her
2. ☐ Most people are friendly but try to avoid him/her
3. ☐ Community mostly supports and helps him /her
4. ☐ Other (please explain) _____

9. Do you think prostitution should be banned by law?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know

10. What are the sources of information that you think can most effectively reach people like you with information on HIV/AIDS?

1. ☐ News paper & Magazine
2. ☐ Radio
3. ☐ TV
4. ☐ Health workers
5. ☐ Family, friends, neighbors & colleagues
6. ☐ Religious leaders
7. ☐ Others (please explain) _____

11. What worries you the most when you think about HIV/AIDS?

_____

_____

SECTION IV. HEALTH-SEEKING BEHAVIOUR

1. Where do you usually go if you are sick, or to get treat a general health problem?

1. ☐ Private clinic
2. ☐ Government clinic
3. ☐ Traditional / homeopathic healer
4. ☐ Other (specify)_____

2. If you are treated by traditional healer, how often and what are the kinds of treatment you got from?

_____

3. If you are not treated by traditional healer, how often do you generally seek health care at clinic?

1. ☐ Twice a year/ more
2. ☐ Once per year
3. ☐ Less than once a year but at least twice in past 5 years
4. ☐ Once in past 5 years
5. ☐ Never in past 5 years
6. ☐ Other_____

4. What traditional practice you experienced so far?

1. ☐ Tattoos
2. ☐ Tooth extraction
3. ☐ Tonsillectomy
4. ☐ Circumcision
5. ☐ Other (please specify) _____

5. What is your opinion on VCT?

1. ☐ Good
2. ☐ Bad
3. ☐ I do not know
4. ☐ No response

SECTION V. PRACTICE OF SEXUAL RELATIONSHIPS

1. Do you know about family planning method?

1. ☐ Yes
2. ☐ No

2. If yes, what type of family planning method do you know?

1. ☐ Pills
2. ☐ Loop
3. ☐ Injection
4. ☐ Condom
5. ☐ Other (specify)

3. Do you accept sexual relationship before marriage should not be done?

1. ☐ Yes
2. ☐ No
3. ☐ No response

4. Have you ever heard about condoms?

1. ☐ Yes
2. ☐ No

5. If yes, have you ever practiced it?

1. ☐ Yes
2. ☐ No

6. What do you think about the use of condoms? (Ask respondent to please explain his/her answer)

_____

_____

7. Do you think condoms prevent HIV/AIDS?

1. ☐ Yes
2. ☐ No
3. ☐ Do not know
4. ☐ No response

8. Have you ever been caught by STDs?

1. ☐ Yes
2. ☐ No
3. ☐ I do not know

9. Do you discuss about condoms with your sex partner?

1. ☐ Yes
2. ☐ No

10. Do you think your feeling in condoms is the same as without?

_____

_____

_____

_____

Annex 3: questions for focal group Discussion (FGD)

1. Can you tell what you know about HIV/AIDS and when you heard about it?

2. Do you know how HIV is transmitted and protected?

3. Have you heard/seen a condom? Did you practice it?

4. Do you know any person with HIV or AIDS?

5. Can a healthy looking person be infected and transmit HIV/AIDS?

6. Can you tell symptoms of STI you know? What STI do you know?

7. Do you think STI increases the chance of being infected with HIV/AIDS?

8. How would you react someone you know well would get HIV/ PLWHA?

9. Do you discuss about sexuality and HIVAIDS with family and /or friends?

10. Do you accept sex before marriage and what is your opinion on extra marital status?

11. Can you tell us the most practiced harmful tradition practiced in your area? How is practiced?

Annex 4: Secondary data

4.1 Gewane woreda Health facility Distribution per PA's

No	**Name of the Kebele**										
	Eigele	**Geliladora**	**Gebeyabora**	**Kedabada**	**Ourafita**	**Briforo**	**Beida**	**Adbaror**	**Meteka**	**Gewane**	**Total**
Hospital	-	-	-	-	-	-	-	-	-	-	**-**
Health center	-	-	-	1	-	-	-	-	-	1	**2**
Clinic	-	-	-	-	-	-	-	-	-	-	**-**
Health post	0	1	0	0	1	1	1	1	2	-	**7**

4.2 Gewane Woreda Existing Health Professionals and Their Distribution in Kebeles

NO	Woreda center	Eigele	Geliladora	Gebeyabora	Kedabada	Ourafita	Briforo	Beida	Adbaror	Meteka	Gewane	Total
Doctor	-	-	-	-	-	-	-	-	-	-	-	**-**
HO	2	-	-	-	-	-	-	-	-	-	-	**2**
Nurses	12	-	-	-	-	-	1	-	-	-	-	**13**
Health assistance	1	-	-	-	-	-	-	-	-	2	-	**3**
Junior nurses	-	-	1	-	-	-	-	1	1	-	-	**3**
HEW	-	2	2	2	3	2	2	2	2	2	2	**21**
Front lines	-	2	2	2	1	1	2	2	1	1	-	**14**
Malaria expert	-	-	-	-	-	-	-	-	-	-	-	**1**
Environmental Health expert	1	-	-	-	-	-	-	-	-	-	-	**1**
Lab technicians	4	-	-	-	-	-	-	-	-	-	-	**4**

NB 1) HO- Health Officer, HEW- Health Extension Workers 2) Health Extension workers and Front Lines in general, known as Community Health workers (CHW).

Source: Gewane Woreda Health Office, June, 2011