SUICIDAL IDEATION, ATTEMPT AND ASSOCIATED FACTORS AMONG PEOPLE LIVING WITH HIV/AIDS AT JIMMA UNIVERSITY MEDICAL CENTER, ART CLINIC, SOUTH WEST, ETHIOPIA, 2019

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A RESEARCH THESIS TO BE SUBMITTED TO JIMMA UNIVERSITY, INSTITUTE OF HEALTH SCIENCE, DEPARTMENT OF PSYCHIATRY, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SCIENCE IN INTEGRATED CLINICAL AND COMMUNITY MENTAL HEALTH.

OCTOBER, 2019

JIMMA, ETHIOPIA

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OCTOBER, 2019

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ACKNOWLEDGEMENT

My deepest gratitude goes to my advisors to Dr Alemayehu Negash, Mrs. Almaz Mamaru, Mr Hailemariam Hailesilasse and Mr Lemessa Dube for their invaluable support, guidance and constructive suggestions and comments. Also I would like to thank Jimma University for giving me the chance to do this research, Jimma university medical center and Jimma health center, ART clinic staff for their collaboration through the process of the research. My heartfelt thanks goes to study participants and data collectors. Last but not least for my family and friends for their enormous love and support.

LIST OF ABREVATIONS

AIDS-Acquired Immuno Deficiency Syndrome

ART/-Anti Retro Viral Therapy

CD4- cluster of differentiated cell count

EDHS- Ethiopian Demographic Health Survey

HAART-Highlly Active Anti Retro Viral Therapy

HIV-Human Immuno Deficiency Virus

ICCMH- Integrated Clinical and Community Mental Health

ERB- Ethical review board

JUMC-Jimma University Medical Center

LMICs- low and middle income country

PLWHIV- People Living With Human Immuno Deficiency Virus

PIS- Percived and internalized stigma

SPSS- Statistical package for social science

SSA- Sub-Saharan Africa

WHO-World Health Organization

ABSTRACT

***Background**: Suicide is a worldwide public health problem, psychiatric emergency and more severe health problem among patients living with human immune deficiency virus/ acquired immune deficiency syndrome in comparison with the general population. However, in low and middle income countries like Ethiopia, there is limited data on patient's suicidal ideation and attempt and associated factors among those patient.*

***Objectives:** To determine prevalence and associated factors of suicidal ideation and attempt among people living with human immune deficiency virus/ acquired immune deficiency syndrome at Jimma University medical center, anti-retro viral clinic 2019.*

***Methods:** A cross-sectional study was conducted from April 20 to June 20, 2019 at Jimma University Medical Center antiretroviral therapy follow up clinic on 299 participants. Data was collected by using suicide behavioral questionnaire. Participants were selected by using consecutive sampling techniques. Data were entered into Epidata 3.1 and exported to Statistical package for social science version 20 for analysis. Descriptive statics, bi-variate & multi-variate logistic regression analysis at 95% confidence interval were done. Statistical significance was declared at p-value of <0.05.*

***Result:** A total of 299 participants were involved in this study with 100% response rate. In this study prevalence of suicidal ideation and suicidal attempt were 20.1% and 8.0% respectively. Being single[AOR=5.17, 95%CI(1.572,17.038)], substance ever use[AOR=2.49,95%CI(1.193,5.199)], no self-stigma [AOR=0.08,95CI(0.032,0.202)] and poor social support[AOR=3.33,95%(1.384,7.998)] were associated with suicidal ideation. Income status <749ETB [AOR=7.42, 95% CI (2.216, 24.858)], substance ever use [AOR= 0.05,95%CI (0.010, 0.217)] and no self-stigma [AOR= 0.04,95 CI(0.005,0.292)] where associated with suicidal attempt.*

***Conclusion and recommendation:** Around one fourth of the study participates suffer from suicidal ideation and close to one tenth from suicidal attempt. Factors like being single, ever substance use, self stigma, poor social support and low income were associated with suicidal ideation and attempt. Therefore early screening and intervention for substance use, counseling for Self stigma and routinely screening for suicidal ideation and attempt for patients with poor social support, low income and single is recommended.*

***Key words:** suicidal ideation, suicidal attempt, HIV/AIDS.*

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CHAPTER ONE: INTRODUCTION

1.1 BACK GROUND

Suicide is defined as self-inflicted death wish or explicit evidence that the person intended to die, where suicidal ideation is thought of serving as the agent of one's own death. Seriousness may vary depending on the specificity of suicidal plan and the degree of suicidal intent and suicidal attempt is self-injurious behavior with a non-fatal outcome accompanied by explicit evidence that the person intended to die (1). Psychiatric disorders are common complaints in patients with chronic diseases including Human Immunodeficiency Virus (HIV) positive individuals (2). HIV infection itself can affect the patients' quality of life and cause mental problems (2).

Currently, an average of 37.9 million people live with Human Immuno deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) worldwide and around 25% of new HIV infections occure in eastern and southern Africa(2). In Ethiopia, The average prevalence rate of HIV infection in the adult population is estimated to be 0.9% in 2017, with seven times more prevalent in urban areas than in rural areas(3). Almost 90% of AIDS cases were 20 to 49 years old which constitutes the most economically productive part of the population, that puts high economic burden on the country(4).

Globally, every year around 800,000 to a million people die due to suicide with 75% of all cases in low and middle- income countries(5). Suicide is the 10th leading cause of death worldwide and third leading cause of death among those aged from 15–44 years(6). It is also predicted that, by 2020, the rate of death due to suicide will be increased to one in every 20 seconds. When compared to the general population, people living with HIV/AIDS have 7 to 36 times greater risk of completed suicide(4). The risk of having suicidal ideation and attempt are high among People living with HIV/AIDS. Having suicidal ideation can be a predictor of future suicidal attempt and an important phase before patients commit suicide which can also be associated with poor adherence to antiretroviral therapy and reduced quality of life (6).

Suicidal ideation among people living with HIV/AIDS can be there at any point of time. This can be the result of very difficult bio-psychosocial challenges that they face. PLHIV commonlly have feeling of shame, sadness, anger, guilt, anxity and hoplessness and see no options to alleviate their distress other than commit suicide. Many factors can be associated with suicide risk among HIV/AIDS such as, the recognation of having opportunistic infection, dealing with its pain, viral load, lower CD4 count and unemployment due to stigma(10).

1.2 STATEMENT OF THE PROBLEM

Suicide, attempted suicide, and suicidal ideation are complex clinical issues associated with life-threatening conditions such as human immune deficiency virus (HIV) infection(6). Suicide is a worldwide public health problem and major leading causes of death in different populations(6).

Compared to the general population, people living with HIV/AIDS have greater risk for suicidal ideation and attempt(6). A systematic review of suicidal behavior in HIV-infected individuals calculated the crude mean prevalence rates for suicidal behaviors across 66 studies conducted in America, Latin America, Australia, Asia, and Africa reveled crude mean prevalence rates for suicidal ideation 26.9%, plan 22.2% and attempts 19.9%. This is much higher than the pooled cross-national prevalence rates which were 9.2% for ideation, 3.1% for plans, and 2.7% for attempts in the Surveys conducted by World Mental Health on the general population in 17 countries which include Africa, Asia and the Pacific, Middle East, Europe, and the Americas (8).

In Ethiopia as far as the investigator's knowledge the overall magnitude of suicidal ideation and attempt among people living with HIV/IDS is not clearly known but there are different facility based studies conducted on different groups such as; youths, high school students, psychiatric patients and same on PLWHIV which almost all studies show high prevalence of suicidal ideation and attempt. There is one population based study conducted on adults at Addis Ababa on 1994 E.C with a result of 2.7% for suicidal ideation and 0.9% for suicidal attempt (14).

Sensitive topics like HIV/AIDS and suicide are difficult to discuss in many third-world countries like Ethiopia due to stigma, taboo, misunderstandings, shame, guilt and rejection. Rejection or lack of awareness about HIV/AIDS and suicide significantly limits the ability of effective and proper care for people living with HIV/AIDS and their families. It is very important to speak about the feelings and reactions like suicide in people living with HIV/AIDS. These patients often dive into sadness because of their loss they experienced or the one they expect. Diagnosis of HIV/AIDS infection often brings feelings of guilt from the possibility of infecting the other people or from the previous way of life which led to rejection of colleagues, relatives and loved ones and often people can very quickly lead to loss of self-esteem and social identity, which leads to the feeling of one´s own worthlessness. They may see suicide as a way out from pain and difficult situation, out of their shame and grief for their loved ones (15).

Several associated factors have been reported for increased risk of suicidal ideation and attempt in HIV positive individuals. These factors consisted of patients' demographic factors (such as advanced age, female sex, unemployment due to stigma, substance and alcohol abuse), socioeconomic factors (such as living single, low income, social support, discrimination and stigmatization), mental disorders (such as depression and anxiety), feelings (such as hopelessness), severity of the disease, HIV related physical symptoms, the recognation of having opportunistic infection, antiretroviral regimen, CD4 count and ART related adverse drug reactions[12, 10, 22].

Although HIV/AIDS have been given priority in our country like showing commendable Progress in rolling out universal access for HIV and AIDS prevention, treatment, support and care, its relation with suicide has been a low priority for both government and policy-makers (21)(6). Due to this HIV/AIDS continues to be an under recognized risk for suicidal ideation, suicidal attempt, and completed suicide(6). Relatively suicidal ideation and attempt had been well studied in the general population but its relationship with HIV infection was less well documented(22). In addition in Ethiopia, particularly in southwestern part, little is known about suicidal ideation and attempt among people living with HIV/AIDS. Therefore, by doing this research on assessing the prevalence of suicidal ideation and suicidal attempt and identifying factors associated with them this study will contribute to fill the gap.

1.3 SIGNIFICANCE OF THE STUDY

HIV/AIDS is an under recognized risk for both suicidal ideation and suicidal attempt. In Ethiopia, particularly in southwestern part where majority of the country's population occurred, little is known about suicidal ideation and attempt among people living with HIV/AIDS. Therefore, by doing this research on assessing the prevalence of suicidal ideation and suicidal attempt and identifying factors associated with them it will contribute to fill the gap. This study will also provide important information for the government and policy makers to understand current practice and design future policy plan for prevention and intervention to address the problem. To give insight for health professionals who work with patients living with HIV/AIDS to routinely assess for suicidal ideation and attempt. Furthermore it will help as a stepping stone for those who will be interested to conduct further study on suicide issue and also have paramount benefit for PLWHIV to reduce mortality due to suicide by early detection and preventing possible risk factors.

CHAPTER TWO: LITERATURE REVIEW

2.1 OVER VIEW OF SUICIDE

Suicide is a serious act which results in losing one's own life. However, there is a range between thinking about suicide and acting it out. Some people plan for days, weeks, or even years before acting, while others take their lives impulsively without notice. Suicide is psychiatric emergency which currently ranked the tenth leading cause of death in the United States(1).

Every year, almost one million people die due to suicide around the world. Suicide is among the three leading causes of death of those aged 15-44 years worldwide (both sexes). Moreover, for every suicide, there are many more people who attempt suicide each year(23). Rates of suicide are also elevated in patients with chronic conditions like HIV infection (1).

From the cohort study conducted in Swiss from 1988 to 2008 on 15,275 HIV patients; it had been shown repeatedly that patients with HIV infection are more likely to die by suicide than are HIV-negative individuals before the introduction of highly active antiretroviral therapy (HAART). This is not surprising, considering the bleak prognosis of HIV infection and AIDS in the pre-HAART era. Anxiety, substance abuse, depression, stigma, discrimination, and social isolation may also contribute to elevated suicide rates, which are common in HIV infected patients.(23)

2.2 PREVALENCE OF SUICIDAL IDEATION AND ATTEMPT AMONG HIV PATIENTS

Studies show that prevalence of suicidal ideation among peoples living with HIV/AIDS is high (24). In a cross-sectional survey done among 322 PLWHIV in the Kathmandu Valley, Nepal, Suicidal ideation within 2 weeks was reported by 14% of the participants. From this, 43% had ever thought about ending their lives and 17% had suicide attempt since they first know their HIV status, and 35 individuals report having more than once suicide attempting experience. This finding also shows that 43% had ever thought about ending their lives and 17% had actually attempted suicide since being diagnosed with HIV (25).

An institutional based cross-sectional study conducted at Benin city on 150 HIV infected persons, findings revealed that participants who have suicidal ideations were 63(42%), most of them, 38 (25.3%), experiencing it daily and 3(2.1%) had very intense thoughts of committing suicide(26).

In a cross-sectional study done at semi urban Uganda among 543 HIV positive patients, 10% of the study participants met criteria for suicidality. The prevalence of Suicidal ideation in the preceding year was reported by 8.8% while attempted suicide in the same period was 3.1%, in addition 3% had attempted suicide at some other time in their life time(27). Another community survey done on 2400 PLWHIV at post-conflict Northern Uganda shows the prevalence of suicidal ideation and attempts were 12.1 % and 6.2 %, respectively(28).

A research conducted at Debarek district hospital, North West, Ethiopia showed that from the total of 393 respondents 132 (33.6%) had suicidal ideation and of them, 22 (23.4%) reported that they had suicidal ideation within 6 months after they knew their serum status. Life time suicidal attempt was 20.1% in the participants. From the total participants, 1.8% had suicidal attempt in the last one month whereas 13 (2.4%) of the respondents attempted suicide within 3 months after knowing their serum status. Regarding the frequency of suicidal attempt 29 (50.0%), 21 (36.2%), and 8 (13.8%) of respondents attempted once, twice and more than two times in their life time, respectively(12).

Another cross sectional study conducted in Zewditu memorial hospital show that, ninety-four (22.5%) and 58 (13.9%) of the study participants had suicidal ideation and suicidal attempt, respectively. Twenty-two (23.4%) of the respondents having suicidal ideation reported that they had it within 3 months after they knew their sero-status. Among the respondents who had suicidal ideation, 66 (70.2%) of them were female. Meanwhile, 13(22.4%) respondents attempted suicide within 3 months after they knew their positive HIV test result. Among those who attempted suicide, 45 (77.6%) were female (29).

2.3 FACTORS ASSOCIATED WITH SUICIDAL IDEATION AND ATTEMPT AMONG HIV PATIENTS

2.3.1 Socio demographic factors

In a cross-sectional study done in post-conflict Uganda among 2400 HIV positive individual in 3 district hospital those who were unemployed and those who were females had a higher risk to both suicide attempt and ideation than males(30). Another cross-sectional study's conducted in Ethiopia on 393 PLWHIV shows more risk of suicide in those who are single, lives alone and females(13). Also in South Africa a cross-sectional study among 190 PLWHIV reveled suicidal ideation and attempt were high among male and age less than 30(44).

2.3.2 Clinical factors

A study conducted in Ethiopia shows that patients with CD4 level <500 were 2.5 times more likely to have suicidal ideation than those with CD4 level >500. Patients who have OI were two times more likely to attempt suicide as compared with their counterparts. This may be due to being physically weak and emaciated which results in hopelessness and end up with suicide attempt(12). On a study conducted in Nigeria one in three subjects of those that were physically ill had suicidal behavior as compared with 13.8% of subjects that were physically healthy. This shows there was a significant association between physical state and suicidality(31).

Another cross sectional study done in Zewditu Memorial Hospital shows that WHO clinical stage of HIV was significantly associated with suicidal ideation. Those who had WHO clinical stage IV condition were 6.5 times more likely to have suicidal ideation as compared to those who were asymptomatic; this may be due to the fact that clinical stages are classified based on the presence and absence of opportunistic infections. HIV-positive patients who are on advanced clinical disease may have decreased quality of life which may lead them to think of death. Not being on HAART was significantly associated with suicidal ideation. HIV-positive patients who were not on HAART were 2.5 times more likely to have suicidal ideation and 3.5 times more likely to have suicidal attempt as compared to those who were on HAART(13).

2.3.3psychiatric co-morbidity

In a community survey conducted at post- conflict northern Uganda among 2400 HIV patients reveled that both suicidal ideation and attempts were significantly higher among individuals with Major depressive disorder(MDD), Generalized anxiety disorder(GAD), Post traumatic stress disorder(PTSD) and HIV/AIDS; the odds of individuals with suicidal tendencies were almost ten times higher among the individuals with MDD (adjusted OR = 9.5; 95%CI: 7.4, 12.1) and three times among individuals with PTSD (adjusted OR =2.4; 95%CI: 1.6, 3.6) than among individuals without these conditions. Further, results also show that the higher the number of co-morbidities, the higher the odds that someone will think about, plan, or attempt suicide. Individuals with MDD, PTSD and GAD occurring together had thirty times the odds of ideating or attempting suicide(30).

On other cross-sectional study done in Iran among 150 HIV positive sample; Anxiety, depression, sleep quality, physical morbidity, employment, living single, family support and sexual contact (as

route of HIV infection transmission) were detected as the suicidal ideation correlates (13). On a study conducted in Nigeria on a sample of 299 respondents one hundred and seventy (56.7%) meet the criteria for a depressive disorder and states that many HIV-positive patients have high levels of depressive symptomatology, as well as the fact that those with suicidal ideation reported increased levels of such symptoms(22).

Another cross-sectional study done at Kaduna, Metropolis, Nigeria, among 250 HIV positive participants shows that; one in 20 subjects reported to have had past history of psychiatric illness. Two of the subjects reported depressive illness, 1 reported psychosis and 10 could not classify their psychiatric illness. Previous suicidal attempt was also found to be significantly associated with suicidality(31). On a study done in North America among all 1560 participants, 405 (26%) reported history of lifetime suicidal ideation, plan or attempt. Among individuals who endorsed depressive symptoms on the CIDI, the rate of lifetime suicidal ideation, plan or attempt was 41.3%(32).

2.3.4 substance use

In a cross sectional study conducted in Ethiopia among 417 HIV positive individuals those who ever used substance in their life were 3.4 times more likely to attempt suicide as compared to those who had no history of substance use in their life(12). In a cross sectional, multi-site, prospective, observational study done among 1560 HIV patients at North America those who attempted suicide have higher rate of substance ever use than non-attempters(32).

2.3.5 Psychosocial Factors

2.3.5.1 Social support

A cross sectional survey conducted in Nepal on 322 adults living with HIV stated that perceived family support as a composite construct emerged as a major correlate of both depression and suicidal ideation. Participants reporting the highest level of perceived family support were over five times less likely than those at the lowest level to register depression and four times less likely to endorse suicidal ideation. This result extends theory on the link between perceived family support and psychological distress to an HIV specific population, elucidating the strong and potentially protective effect of perceived family support in terms of depression and suicidality risks(25).

An institution based cross-sectional study conducted among 393 HIV patients at Debark, Ethiopia also confirms that social support was another factor for suicidal attempt by which Patients having poor

social support were 2.2 times more likely to have suicidal attempt than those who have good social support(33).

2.3.5.2 Stigma

A cross-sectional survey conducted at semi urban Uganda on two different HIV clinic stated that, among the identified stigma factors, isolating self from friends and family, feeling ashamed of the HIV-positive status and being assaulted by a spouse were associated with higher odds for suicidal ideation and attempts(27). Another institution based cross-sectional study done among 417 HIV positive sample at Zewditu memorial hospital, Ethiopia shows that patients who were stigmatized had been exposed 3 times to suicidal attempt compared to those who were not being stigmatized(13).

2.4 CONCEPTUAL FRAMEWORK

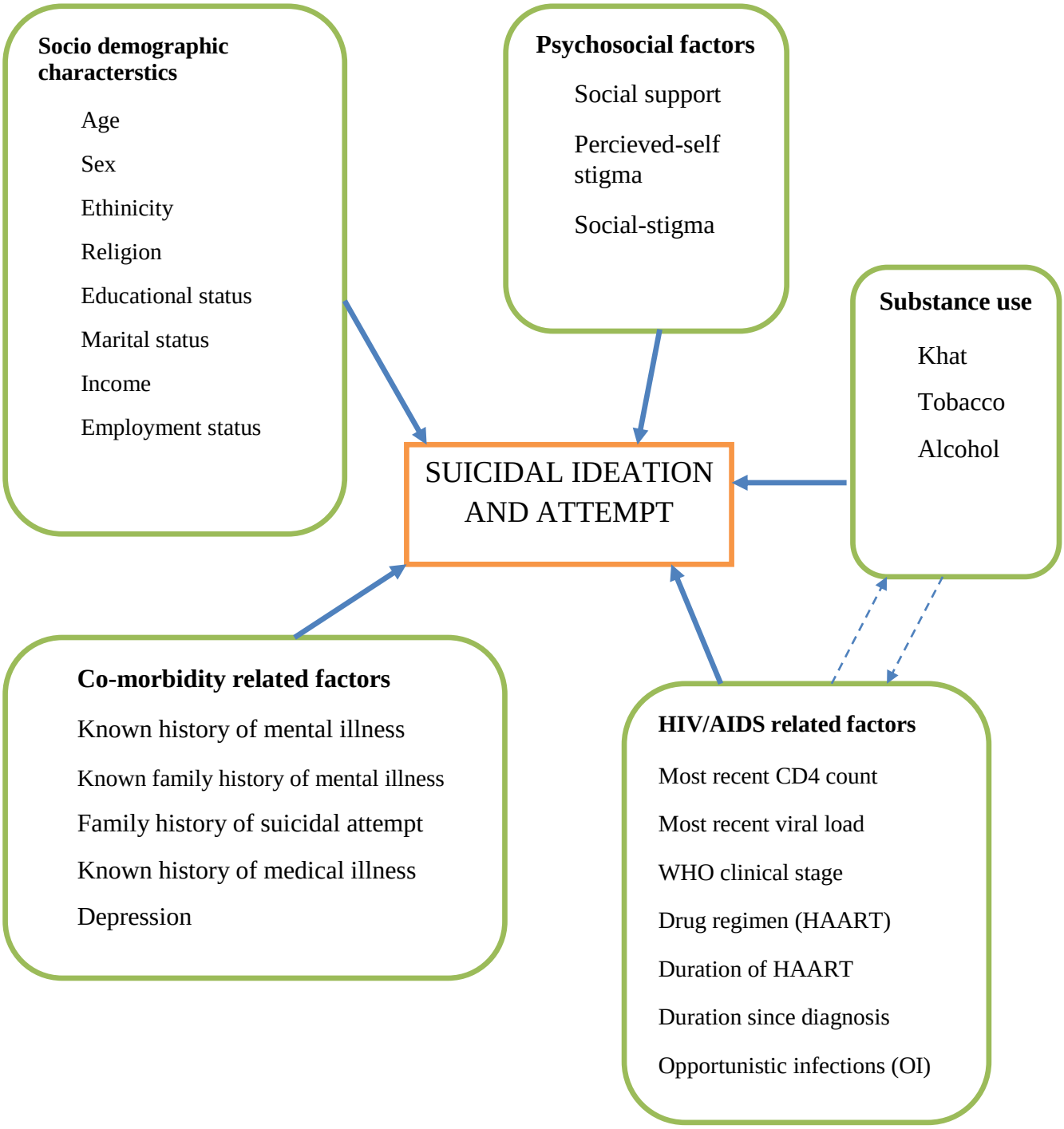

Figure 1: conceptual frame work of suicidal ideation attempt and associated factors among people living with HIV/AIDS at JUMC, ART clinic 2019.

CHAPTER THREE: OBJECTIVES

3.1 General Objective

- To assess the prevalence and associated factors of suicidal ideation and attempt among People living with HIV/AIDS at Jimma University Medical Center, ART clinic 2019.

3.2 Specific Objectives

- To determine prevalence of suicidal ideation among people living with HIV/AIDS.
- To determine prevalence of suicidal attempt among people living with HIV/AIDS.
- To identify factors associated with suicidal ideation among People living with HIV/AIDS.
- To identify factors associated with suicidal attempt among People living with HIV/AIDS.

CHAPTER FOUR: METHODS AND MATERIALS

4.1 Study area and period

This study was conducted from April 20, 2019 to June 20, 2019 at Jimma University Medical Center, ART clinic. It is found in Jimma town and located at 352km southwest of Addis Ababa. Currently it is the only teaching and referral hospital in the southwestern part of the country, providing services for approximately 15,000 inpatient, 160,000 outpatient attendants, 11,000 emergency cases and 4,500 deliveries in a year coming to the hospital from the catchment population of about 15 million people(29). Out-patient treatment services for HIV were established in 2005 and now provide care for a total of 3200 patients: they all receiving ART follow-up. In this study, data were collected from adult patients living with HIV/AIDS attending ART clinic for follow up care.

4.2 Study design

Institution based cross-sectional study design was employed.

4.3 Population

4.3.1 Source population

All HIV/AIDS positive patients who have follow up visit at Jimma University Medical Center, ART clinic.

4.3.2 Study Population

A sample of all adult HIV/AIDS positive patient presented at Jimma University medical center, ART clinic during the study period, which fulfills the study inclusion criteria.

4.4 Inclusion and Exclusion Criteria

4.4.1 Inclusion Criteria

- ✓ All adult HIV patients presented during study period.

4.4.2 Exclusion Criteria

- ✓ Acutely ill and unable to communicate and particepate due to their illness.

4.5 Sample Size and Sampling Technique

4.5.1 Sample Size Determination

Sample size was calculated using single population proportion formula as follows.

$$n = \frac{(z_{a/2})^2 * p * (1-p)}{d^2}$$

Where n =initial sample size

a= confidence interval (95%)

p= prevalence of suicidal ideation(23%), and attempt (14%) which is taken from previous study conducted at Zewditu memorial hospital, Ethiopia(13).

d= is the margin of sampling error tolerated (5%) so, we calculate for both

For attempt (14%)

$$n = \frac{(1.96*1.96)*0.14*0.86}{(0.05*0.05)}$$

n= 185

For ideation (23%)

$$n = \frac{(z_{a/2})^{2*} p*(1-p)}{d^2}$$

$$n = \frac{(1.96*1.96)*0.23*0.77}{(0.05*0.05)}$$

n= 272 so, we take this larger sample

Hence, considering 10% non-response rate the total sample size was 272+27= 299

Therefore, the total sample size of the study was 299 of patients living with HIV/AIDS.

4.5.2 Sampling Procedure

To select study paricipants consecutive sampling technique was used and HIV patients who came for follow up during the study period; and who fulfilled the inclusion criteria were included in the study until the final study sample size is reach.

4.6 Data Collection Procedure and tools

A structured questionnaire was used to collect data. The tool contains socio-demographic characteristics like (age, sex, ethnicity, religion, education, residence, occupation, living condition employment status yearly income and marital status). Social support was assessed by Oslo social support scale(39). Suicidal Behavior Questionnaire revised (SBQ-R) was adopted to assess suicidal ideation and attempt. It was validated with 88% sensitivity, 87% specificity and internal consistency (Cronbach's alpha of 0.80)(36). To screen depression we used Patient Health Questionnaire (PHQ-9) which has 9 items with specificity (67%) and sensitivity (86%) which was validated in Ethiopia with Amharic and Afan Oromo version with cronbachs alpha of 0.85(35). Stigma was screened with HIV-related stigma scale(38). Patient chart was reviewed to collect data on CD4count, WHO clinical stage of HIV, duration on HIV status to be now, drug regimen, duration of HAART, most recent viral load, and co-morbid medical illness. On the current study, from the pre-test the internal validity for the main tool were cronbaches alpha of 0.82.

Finally, the questionnaire was translated from English into Amharic and Afaan-Oromo languages by native speakers of the languages who are proficient in English and then back-translated into English by other translators to check its consistency in translation. Data were collected through interview by 5 BSc mental health professionals that ware composed of psychiatry nurses and it was supervised by 2 MSc in ICCMH students.

4.7 Variables of the Study

4.7.1 Dependent Variable

- ✓ Suicidal ideation
- ✓ Suicidal attempt

4.7.2 Independent Variables

- ✓ **Socio-demographic:** include age, sex, marital status, religion, ethnicity, living condition, educational status, employment status, yearly income,
- ✓ **Clinical factors:** HIV/AIDS related factors; WHO stage of HIV status classification, Most recent CD4 count, Most recent viral load, opportunistic infections (OI), HAART component, Duration of HAART, Duration since diagnosis
- ✓ **Psychiatric co-morbidity:** History of mental illness, family history of suicide attempt, Family history of mental illness, Comorbid depression

- ✓ **Psychosocial factors:** Social support, percieved stigma, self-stigma
- ✓ **Substance use:** Khat, Tobacco**,** Alcohol and cannabies

4.8 Operational Definitions

Suicidal ideation: Suicidal ideation is defined as if the respondents with answer for the question: have you ever thought/brief passing thought about committing suicide?(36).

Suicidal attempt: suicidal attempt is defined as if the respondents answer with ”yes” for the question: have you ever attempted to kill yourself?(36).

Depression: Participants who score 10 and above on Patient Health Questionnaire (PHQ9)(37)

Stigma: Participants who score above the mean score were stigmatized by measuring HIV stigma scale(38)

Social support: During interviewing by using Oslo-3 Social Support Scale (OSS-3) if those participants scores:

- ✓ 3-8, they have poor support
- ✓ 9-11, they have moderate support &
- ✓ 12-14, they have strong support(39).

Substance ever use: those respondents who answer ‘yes’ for question; have you ever use any of the substances mentioned like Tobacco(cigarettes), Alcohol, Cannabis, Amphetamine type stimulants (khat) and Sedatives or Sleeping Pills Diazepam(40).

Substance current use: those respondents who answer ‘yes’ for question; in the past 3 month have you use any of the substances mentioned like Tobacco (cigarettes), Alcohol, Cannabis, Amphetamine type stimulants (khat) and Sedatives or Sleeping Pills Diazepam(40).

4.9 Data Quality Management

Two days of training for data collectors and supervisors ware given about data collection methods and how to handle ethical issues. Pre-test was conducted on 5% of the study sample size at Jimma health center a week before the main study was collected; identified impending problems on data collection instruments were corrected. Regular supervision by the supervisor (two MSc second year ICCMH students) and the principal investigator made ensure that all necessary data are properly collected. Each day during data collection, filled questionnaires was cheeked for completeness and consistency by supervisors and principal investigator.

4.10 Data Processing and Analysis

The collected data were cleaned, coded, and entered into Epi-data version 3.1 then, data ware exported to SPSS version 20 for analysis. The patients' socio-demographic and illness-related characteristics ware analyzed using descriptive. Multicolliarity wes checked by using variance infleted factor(VIF). To identify predictor value, first bivariant analysis ware done and variable with p-value < 0.25 was candidate for final model then multiple logistic regression analysis were done to determine the assocated factors of sucidal ideation and attempt among people living with HIV/AIDS. Statistical significance was considered at p-values less than 0.05. Finally, the result of the study was summarized by using tables, graphs and narrative description

4.11 Ethical Consideration

Ethical clearance was obtained from Ethical review board (ERB) of Jimma University Institute of Health Science. After ethical clearance received, permission to conduct the research was obtained from the clinical director of the hospital and the head of the Psychiatric Clinic. Also permission was obtaind from head nurse of ART clinic to review patients chart and to interview patients. Information sheet was prepared and read to all eligible participants of the study. All participants were informed the purpose of the study and their participation was on voluntary basis. Written informed consent was received from all participants. Name of the participant was omitted from the questionnaire; instead code number was used to ensure confidentiality. Participants with history of suicidality, depression and substance use were linked to clinician working at ART clinic who is trained on integrated mental health for HIV patients for further evaluation and intervention.

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CHAPTER FIVE: RESULTS

5.1 Socio-demographic Characteristics of Respondents

A total of 299 respondents were involved in the study with 100% response rate. Of this 189(63.2%) were female. 131(43%) of the respondents were greater than age 40. More than half of participants 159 (53.2%) were married. Nearly half of the study subjects were Oromo in ethnicity 133(44.5%) followed by Amhara 84 (28.1%). Almost half of the study participants 143(47.8%) were Orthodox followed by 98(32.8%) Muslim. Concerning educational status, 140(46.8%) of the respondents attended elementary and 30(10.0%) were illiterate. Regarding occupation private employee 72(24.1%) and 9(3.0%) of them were farmers. More than half of the study participants 176(58.9%) had income status more than 1200 ETB.

Tabel 1: Socio-demographic characteristics of the sampled (n = 299) among people living with HIV/AIDS who have follow up visit in ART clinic at JUMC, south west, Ethiopia, 2019

Variable	Category	Frequency	Percent(%)
Age	20-24	8	2.7
	25-29	38	12.7
	30-34	53	17.7
	35-39	69	23.1
	>40	131	43.8
Sex	Male	110	36.8
	Female	189	63.2
Religion	Orthodox	143	47.8
	Muslim	98	32.8
	Protestant	56	18.7
	Catholic	1	0.3
	Jehovah witness	1	0.3
Ethnic group	Oromo	133	44.5
	Amhara	84	28.1
	Tigre	9	3.0
	Gurage	13	4.3
	Other[E]	60	20.1
Educational status	Illiterate	30	10.0
	Elementary	140	46.8
	high school	79	26.4
	diploma and above	50	16.7
Marital status	Single	27	9.0

	Married	159	53.2
	Divorced	63	21.1
	Widowed	50	16.7
Occupation	Governmental employee	69	23.1
	private employee	72	24.1
	Merchant	42	14.0
	Farmer	9	3.0
	house wife	37	12.4
	daily laborers	51	17.1
	no job or unemployed	19	6.4
	other^{O}	33	8
Monthly income	<749	68	22.7
	750-1199	55	18.4
	>1200	176	58.9
Living arrangement	Alone	70	23.4
	With family	229	76.6

NB :
Other^{O} includes (students and retire)
Other^{E} includes (Dawro, Silte, kefa and Wolayta)

5.2 Clinical and Mental Health Related Characteristics

From the total study participants, 166(55.5%) of them have current (most recent) CD4+ cell count >500 cells/mm^3. About current (most recent) Viral load from the total participants 129(31.5%) had >50 viral copies. From the total participants 9 individuals have no updated reported on most recent viral load o their chart. Regarding duration of diagnosis from the total participants 117(39.1%) has 6-10 years and duration of ART medication those who take for about 5-9 years were 106(35.5%). More than half 176(59.5%) of participants were taking 1E (TDF-3TC-EFV) ARV regimen.

From the total respondats 109(36.5%) have mild to sever depression using PHQ-9 with cut of point greater than 10. About 15(5.0%) have history of comorbid mental illess, 20(6.7%) have family history of mental illness and 11(3.7%) have family history of suicidal attempt.

Tabel 2: clinical and mental health related characteristics of the sampled (n = 299) among people living with HIV/AIDS who have follow up visit at ART clinic, JUMC, south west, Ethiopia, 2019

Variable	Category	Frequency	Percent(%)
Current (most recent) CD4+ cell count, cells/mm3	<200	14	4.7
	200-350	50	16.7
	351-500	69	23.1
	>500	166	55.5
Current (most recent) Viral load	<50copies(Undetectable)	248	82.9
	>50 copies (detected)	42	14.8
	Missing value =9	9	3.0
Time since HIV diagnosis	<6 year	103	34.4
	6-10 year	117	39.1
	>10 year	79	26.4
WHO Clinical staging of HIV/AIDS	Stage 1	287	96.0
	Stage 2	6	2.0
	Stage 3	5	1.7
	Stage 4	1	0.3
HAART component	1c(AZT-3TC-NVP)	78	26.1
	1d(AZT-3TC-EFV)	17	5.7
	1e(TDF-3TC-EFV)	176	59.5
	1f(TDF-3TC+NVP)	15	5.0
	Other	11	3.7
Duration of HAART	<5 year	104	34.8
	5-9 year	106	35.5
	>9 year	89	29.8
Presence of opportunistic infection(OI)	No	275	92.0
	Yes	24	8.0
Presence of comorbid hypertension	Yes	19	6.4
	No	280	93.6
Presence of comorbid diabetic mallets	Yes	16	5.4
	No	283	94.6
Presence of comorbid mental illess	Yes	15	5.0
	No	284	95.0
Family history of mental illess	Yes	20	6.7
	No	279	93.3
Family history of suicidal attempt	Yes	11	3.7
	No	288	96.3
Depression	Yes	109	36.5
	No	189	63.2
Substance ever use	Yes	134	44.8
	No	165	55.2
Substance current use	Yes	52	17.4
	No	247	82.6
Social stigma	Yes	156	52.2
	No	143	47.8
Precieved-self stigma	Yes	149	49.8
	No	150	50.2
Social support	Poor	94	31.4
	Moderate	92	30.8
	Strong	113	37.8

Other: 2f(AZT-3TC-ATV/r),2g(tdf-3TCLPV/r) and 2h(tdf-3tc-ATV/r)

5.3 Prevalence of suicidal ideation and attempt among people living with HIV/AIDS

In this study the life time prevalence of suicidal ideation was 60(20.1%) and life time prevalence of suicidal attempt was 24(8.0%) as shown in the graph below.

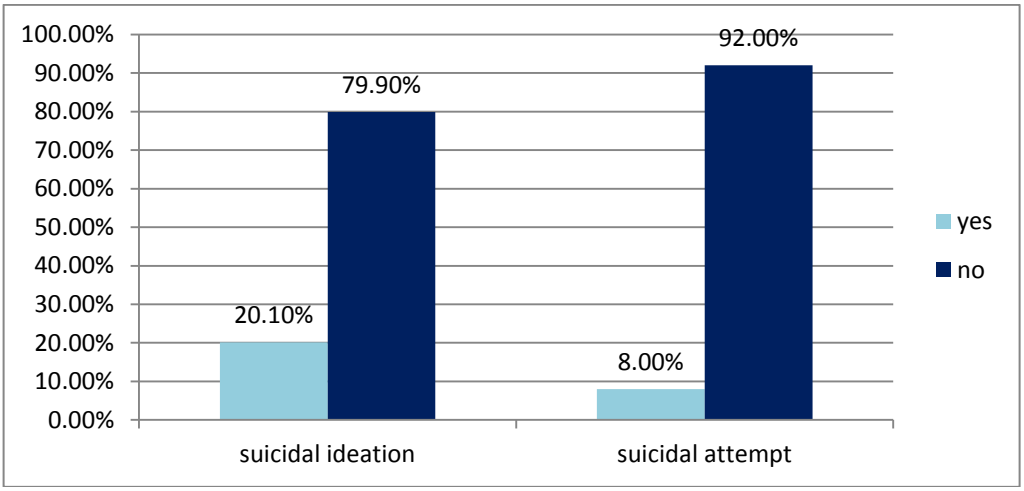

Figure 2: prevalence of suicidal ideation and attempt among people living with HIV/AIDS who have follow up visit at JUMC, ART clinic ,south west, Ethiopia, 2019

5.4 Factors associated with suicidal ideation

5.4.1 Bivariate and multivariate logistic regression analysis of factors independently associated with suicidal ideation

In the bi-variate logistic regression analysis, variables with p-value <0.25 like marital status, income status, educational status and living arrangment, ever substance use, depression and social support, social and perceived stigma were candidate for multivariate logistic regression analysis. From this, four variables were found to be statistically significant at p-value<0.05. Accordingly: marital status, substance ever use, social support and self-stigma of study participants were demonstrated statistically significant association with suicidal ideation.

As of this result, participants who were single were 5 times more likely to have suicidal ideation [AOR=5.174, 95%CI (1.572, 17.038)] than married.. Participants who have substance ever use were 2.4 times more likely to have suicidal ideation than none users [AOR= 2.490, 95%CI (1.193, 5.199)]. Having poor social support were 3.3 times more likely to have suicidal ideation than strong social support [AOR=3.327, 95% (1.384,7.998)]. The likelyhood of having suicidal ideation were decreased by 8% among participants having no self-stigma than who have self-stigma[AOR= 0.080,95CI(0.032,0.202)].

Tabel 3: Bivariate and multivariate analysis of factors associated with suicidal ideation among people living with HIV/AIDS who have follow up visit at JUMC, ART clinic, south west, Ethiopia, 2019

Variable	Categories	Suicidal ideation No N(%) Yes N(%)	COR(95%CI)	p-value	AOR(95%CI)	p-value
Age	**20-29**	31(67.4) 15(32.6)	1.93(0.74,5.03)	**0.176***		
	30-39	102(83.6) 20(16.4)	0.78(0.32,1.88)	0.586		
	40-49	70(81.4) 16(18.6)	0.91(0.37,2.27)	0.914		
	Above 50	36(80.0) 20(9.0)	1			
Marital status	**Single**	16(6.7) 11(18.3)	3.52(1.47,8.44)	**0.005***	5.17(1.57,17.03)	**0.007***
	Divorced	48(20.1) 15(25.0)	1.59(0.78,3.27)	**0.199***	0.99(0.39,2.45)	0.976
	Widowed	42(17.6) 8(13.3)	0.97(0.41,2.31)	0.953	0.36(0.12,1.03)	**0.057***
	Married	133(55.6) 26(43.3)	1		1	
Educational status	**Illiterate**	22(9.8) 8(13.3)	3.27(0.96,11.18)	**0.058***		
	Elementary	108(45.2) 32(53.3)	2.67(0.98,7.28)	**0.056***		
	High school	64(26.8) 15(25)	2.11(0.72,6.22)	**0.176***		
	Diploma and above	45(18.8) 5(8.3)	1			
Income	**<749**	47(19.7) 21(35)	2.97(1.51,5.84)	**0.002***		
	750-1199	39(16.3) 16(26.7)	2.73(1.32,5.65)	**0.007***		
	>1200	153(64.) 23(38.3)	1			
Living arrangment	**Alone**	49(20.5) 21(35)	2.09(1.13,3.87)	**0.019***		
	With family	190(79.5) 39(65)	1			
Substance ever use	**No**	145(60.7) 20(33.3)	1		1	
	Yes	94(39.3) 40(66.7)	3.08(1.70,5.60)	**<0.001***	2.49(1.19,5.19)	**0.015***
Depression	**No**	166(69.5) 23(39)	1			
	Yes	73(30.5) 36(61)	3.56(1.97,6.43)	**<0.001***		
Perceived-Self stigma	**No**	142(59.4) 8(13.3)	0.11(0.05,0.23)	**<0.001***	0.08(0.03,0.20)	**<0.001***
	Yes	97(40.6) 52(86.7)	1		1	
Social support	**Poor**	58(24.3) 36(60)	4.77(2.34,9.73)	**<0.001***	3.33(1.38,7.99)	**0.007***
	Moderate	81(33.9) 11(18.3)	1.05(0.44,2.46)	0.920	0.99(0.37,2.59)	0.983
	Strong	100(41.8) 13(21.7)	1		1	
Social stigma	**No**	128(53.6) 15(25)	1			
	Yes	111(46.4) 45(75)	3.46(1.83,6.54)	**<0.001***		

NB: ∗ indicates variables which show p-value of < 0.05 at multi-variate analysis.

5.5 Factors associated with suicidal attempt

5.5.1 Bivariate and multivarite logistic regression analysis of factors independently associated with suicidal attempt

In the bi-variate logistic regression analysis, variables p-value <0.25 like income status, living arrangement, ever substance use, social and perceived stigma were included in to multivariate analysis for backward logistic regression. From the total variables included in to the logistic regression models, three variables were found to be statistically significant at the level of p<0.05. Accordingly: income status, ever substance use and self-stigma of study participants were demonstrated statistically significant association with suicidal attempt.

According to the result, participants who have income less than 749ETB were 7.4 times more risk for suicidal attempt [AOR=7.42, 95%CI (2.216, 24.858)] than income greater than 1200ETB. The likelyhood of having suicidal attempt were decreased by 5% among participants having no history of substance ever use than ever users [AOR= 0.05, 95%CI (0.010, 0.217)]. Regarding self-stigma the likelyhood of having suicidal attempt were decreased by 4% among participants having no self-stigma than who have self-stigma [AOR= 0.04,95 CI(0.005,0.292)].

Tabel 4: Bi-variate and multivariate analysis of factors associated with suicidal attempt amongpeople living with HIV/AIDS at JUMC, ART clinic, south west, Ethiopia, 2019

Variable	Categories	Suicidal attempt No N(%) Yes N(%)	COR(95%CI)	p-value	AOR(95%CI)	p-value
Income status	<749	56(20.4) 12(50.0)	6.07(2.18,16.93)	**0.001***	7.42(2.22,24.86)	0.001*
	750-1199	49(17.8) 6(25.0)	3.47(1.07,11.24)	**0.038***	2.31(0.63,8.43)	0.204
	>1200	170(61.8) 6(25.0)	1		1	
Living arrangement	Alone	62(22.5) 8(33.3)	1			
	With family	213(77.5) 16(66.7)	1.72(0.70,4.20)	**0.236***		
Substance ever use	No	163(59.3) 2(8.3)	0.06(0.02,0.27)	**<0.001***	0.05(0.01,0.22)	<0.001*
	Yes	112(40.7) 22(91.7)	1		1	
Perceived-Self-stigma	No	149(54.2) 1(4.25)	0.04(0.01,0.27)	**0.001***	0.04(0.01,0.29)	0.002*
	Yes	126(45.8) 23(95.8)	1		1	
social stigma	No	141(51.3) 2(8.3)	0.09(0.02,0.37)	**0.001***		
	Yes	134(48.7) 23(91.7)	1			

NB: ∗ indicates variables with p-value of < 0.05 at multi-variate analysis.

CHAPTER SIX : DISCUSSION

The finding of this study showed that the life time prevalence of suicidal ideation among HIV positive patients was 20.1% (n=60 CI: 15.5-24.6). This finding is in line with a study conducted at Addis Ababa, Ethiopia which was 22.5%(13) and South Africa 20.5%(47). However, the finding of this study was higher than a study conducted in a clinic sample of people living with HIV, in Uganda (8.8%), and community survey conducted at Nigeria on HIV/AIDS positive sample (14.3%)(27)(42). The variation may be because of different in sample size and study setting in Uganda which was 2400 in 3 district hospital, and in Nigeria study design and sample size which were survey among 1187 PLWHIV and different screening tools use. Also the finding of this study was lower than that of a study conducted at Debarek district hospital, Ethiopia on sampled HIV positive patients which was 33.6%(12). The probable reason for the different prevalence rate might be due to difference in screening tools. Also other study conducted at Zambia, VCT clinic at state general hospital which were 31%(43), and Benin City 43%(25), was higher than our study. This variation can be explained by the difference, at Benin difference in health status of study participants, which were PLWHIV with comorbid opportunistic infection and in Uganda it was immediately after knowing their HIV positive status at VCT clinic, also different tool used which were suicidal screening risk scale SSRS also cultural difference of study participants might be other explanation.

In this study the life time prevalence of suicidal attempt was 8% (n=24 CI: 4.9-11.1). This finding is in line with the study conducted at HIV clinic in Nigeria which was 9.3% and community survey done among PLHIV at Uganda 6.2%(30). However it is lower than a study conducted on HIV patients at Debrek district hospital 20.1%(12), North America 13%(32), Nepal 17%(25) and New York 13% (45). This can be explained by difference in screening tools used at Debrek district hospital and study subjects socio-demographic and cultural difference in North America, Nepal, Switzerland and New York, which is in developed countries people might report there suicidal history well but in our set up due to fear of stigma and discrmiation their may be underreport. But, it is higher than community survey conducted in Nigeria 2.9% (42), facility based study in Uganda 3.9% at HIV clinic(30). This variation might be in Uganda duo to diffrence in health status of study participant's that from the total sample only 6.9% were HIV postive.

Regarding factors associated with suicidal ideation this study finding revealed that marital status, substance ever use, self-stigma and social support were significantly associated with suicidal ideation.

In this study those respondents who were single was 5 times more risk to have suicidal ideation than married [AOR=5.174, 95%CI (1.572, 17.038)] . The possible reason might be while being single they have stress, economical burden and having feeling of lowliness which may triger suicidal ideation. This finding is supported by study conducted in Debark district hospital(12), Zewditu memorial hospital, Ethiopia(13) and a study done in Abuja Nigeria(29), South Africa(42) and Benin(26).

In this study respondents having poor social support were 3.3 times more risk to have suicidal ideation than those having strong social support[AOR=3.327, 95% (1.384,7.998)]. This can be explained by where support is available alternative options may be available before a person decides to think about death (12). This result is supported by study conducted in Ethiopia at Debark(12), Uganda(25), Nepal(24) and South Africa (44). Also this study revealed that the risk of having suicidal ideation were decreased by 8% among participants having no self-stigma than who have self-stigma[AOR= 0.080,95CI(0.032,0.202)]. This may be explained by stigma leads to hopelessness and despair which increases the possibility of suicidal ideation. This finding is supported by study conducted in Greece and South Africa [47,46].

The result of this study found that ever use of substance was another factor for suicidal ideation among HIV-positive participants. Those who have substance ever use were 2.4 times more risk to attempt suicide as compared to those who had no history of substance use in their life [AOR= 2.490, 95%CI (1.193, 5.199)]. The finding may be due to the fact that use of substance could disturb normal function of the brain by lowering inhibition and impiring decision mking may also be the economic impact of substance use. This finding is supported by study done in Entebbe District Uganda and Nigeria [6,42].

On factors associated with suicidal attempt our study found that income status, ever substance uses and self-stigma were significantly associated with suicidal attempt. In this study those participants who have income status less than 749ETB where 7.4 times more risk to attempt suicide than that of participants with income status more than 1200ETB [AOR=7.422, 95%CI (2.216, 24.858)]. This may be due to difficult to live without a supplementary living allowance which may exacerbate any ongoing deterioration in psycho-logical well-being, and eventually leads to suicidal attempt (48). This is supported by studies conducted in Benin City and South Korea (26)(48). Regarding self-stigma this study revealed that the risk of having suicidal attempt were decreased by 4% among participants having no self-stigma than who have self-stigma [AOR= 0.04,95 CI(0.005,0.292)]. This may be

explained by when having stigma towards one self it may leads to having low self estem, feeling of insignificant and guilty feeling that they may lead them to thinking they do not deserve to live which increases the possibility of suicidal attempt. This finding is supported by study conducted in South Africa (47).

The result of this study found that ever use of substance was another factor for suicidal attempt among HIV-positive participants. The risk of having suicidal attempt were decreased by 5% among participants having no history of substance ever use than ever users [AOR= 0.05, 95%CI (0.010, 0.217)]. The finding may be due to the fact that use of substance could disturb normal function of the brain, which could contribute to attempting suicide. Another explanation may be the economic impact of substance use that is, when people are substance users and when they cannot afford to buy it they may think of attempting suicide. This finding is supported by study done in and Entebbe District Uganda(6).

6.1 Limitations of the study

This study has some limitations. In this study other than depression only known comorbid psychiatric problems were assessed but there may be other undiagnosed comorbid problems which can be factor for both suicidal ideation and attempt in HIV patients. It is difficult to generalize for all HIV positive patients because children and adolescent patients are not included in the study. Also recall bias is another limitation.

CHAPTER SEVEN : CONCLUSION AND RECOMMENDATION

7.1 Conclusions

In this study from the total respondats around one fourth suffered from suicidal ideation and near to one tenth experinced suicidal attempt among people living with HIV/AIDS and factors like being single, substances ever use, low social support and having self-stigma were found to be associated with suicidal ideation, where as low income, substances ever use and having self-stigma were assocated with suicidal attempt in this group of patients.

7.2 Recommendations

For policy makers, governmental and NGO

Establishing public awareness on the impact of suicide on HIV patients.

To work on prevention of HIV related stigma.

For JUMC and ART clinicians

To strengthen integrted mental health service at ART clinic. Clinicians working at ART clinic are recommended to routinely assess patient for suicidal ideation and attempt. Also screening for depressive symptoms and substance use and when positive findings are present link to psychiatric clinic. Furthermore, counseling on substance use and its consequences and early identification of HIV-positive people with poor social support have to be considered.

For researchers

It is important to conduct further study on this topic in order to clarify cause-effect relationships between suicidal ideation and attempt and its effect on treatment outcome and quality of life among people living with HIV. Also it is recommended to do popultion based study to know the over all magituid of suicid among HIV/AIDS patients in Ethiopia.

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ANNEXES

JIMMA UNIVERSITY: INSTITUTE OF HEALTH SCIENCES, SCHOOL OF GRADUATE STUDIES, DEPARTMENT OF PSYCHIATRY

CONSENT AND INFORMATION SHEET

My name is Tsega Hailu, I am here on behalf of Jimma University College of Health Sciences, Department of psychiatry. I am doing this study for the partial fulfillment of the requirements for a Master's of Science in Integrated Clinical and Community Mental Health. The objective of this study is to asses prevalence and associated factor of suicidal ideation and attempt among people living with HIV/AIDS at Jimma university medical center, south west Ethiopia, 2019.

Your cooperation and honest participation in the study will provide me valid result and show me real status and help to make intervention; hence I request to participate honestly. Your participation in the interview and every aspect of the study is completely voluntarily. Your name will not be written in this form and all information that you give me will be kept confidential. You may skip any question that you prefer not to answer, but we would appreciate your cooperation. You may also ask me to clarify questions if you don't understand them .Your responses to our questions are identified only by number, never by name.

Do you agree to participate in this study?

1. Yes 2. No

Signature of participant----------date----------

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

Name of supervisor ----------signature----------date----------

ENGLISH VERSION QUESTIONNAIRE

PART ONE: Socio-demographic characteristics

S/N	Variables	Answers
101.	Age	_____ years
102.	Sex	1. Male 2. Female
103.	Religion	1. Orthodox 2.Muslim 3.Protestant 4.Catholic 5. Others(specify)
104.	Ethnicity	1.Oromo 2.Amhara 3.Tigre 4.Guraghe 5.others(specify
105.	Educational status	1. Illiterate 2. Elementary 3. High school 4. Diploma and above
106	Marital status	1. Single 2. married 3.divorced 4.widowed
107.	Occupation	1. Government employee 2. Private employee 3. Merchant 4. Farmer 5. House wife 6. Daily laborers 7.no job 8. Others specify---
108.	Monthly Income	_____Ethiopian birr
109.	With whom do you live?	1. Alone 2. with family

PART TWO: Medical history - see chart of the patient

201.	Duration of disease since diagnosis	_____ year
202.	Stage of the disease	1. Stage I 2.stage II 3. Stage III 4. stage IV
203.	Current(most recent) CD4 count	----------cells/mm3
204.	Duration of HAART	_____years
205.	ARV drug classes used as HAART component	
206.	Most recent viral load	----------copies
207.	Presence of opportunistic infection	1. No 2. Yes
208.	Presence of co morbid DM	1. No 2. Yes
209.	Presence of co morbid HTN	1. No 2. Yes
210.	Known history of mental illness	1. No 2. Yes
211.	Known family history of mental illness	1. No 2. Yes
212.	Any family history of suicidal attempt	1. No 2. Yes

PART THREE: Substance use related questions

From Alcohol, smoking and substance involvement screening test (ASSIST V 3.0)

SUBSTANCE HISTORY			
301	In your life, which of the following substances have you ever used? (NON-MEDICAL USEONLY)	No	Yes
	1. Tobacco products (cigarettes, chewing tobacco,cigars,etc.)	0	1
	2. Alcoholic beverages (beer,wine, spirits,etc.)	0	1
	3. Cannabis (marijuana, pot, grass, hash,etc.)	0	1
	4. Amphetamine type stimulants (khat,diet pills,etc.)	0	1
	5. Sedatives or Sleeping Pills (Diazepam ,etc.)	0	1
	6.Other -specify:	0	1
Probe if all answers are negative: "Not even when you were in school?" If "No" to all items, stop interview. If "Yes" to any of these items, ask Question 302 for each substance ever used.			
302	In the past three months, have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	No	Yes
	1. Tobacco products (cigarettes, chewing tobacco,cigars,etc.)	0	1
	2. Alcoholic beverages (beer,wine, spirits,etc.)	0	1
	3. Cannabis (marijuana ,pot, grass, hash, etc.)	0	1
	4. Amphetamine type stimulants (khat,diet pills,etc.)	0	1
	5. Sedatives or Sleeping Pills (Valium,etc.)	0	1
	6. Other -specify:	0	1

PART FOUR: Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

S/N		Not at all(0)	Several days(1)	More than half the days(2)	Nearly every day(3)
401.	Little interest or pleasure in doing things				
402.	Feeling down, depressed, or hopeless				
403.	Trouble falling/staying asleep, sleeping too much				
404.	Feeling tired or having little energy				
405.	Poor appetite or overeating				
406.	Feeling bad about yourself or that you are a failure or have let yourself or your family down				
407.	Trouble concentrating on things, such as reading the newspaper or watching television.				
408.	Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.				
409.	Thoughts that you would be better off dead or of hurting yourself in some way.				
410.	If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all(0)	Somewhat difficult(1)	Very difficult(2)	Extremely difficult(3)

NB: 1 several days (2-6 days)

2 More than half the days (7-11days)

3Nearly every day (12-14 days)

PART FIVE: Patient Social Support Part (Oslo Social Support Scale)

NB: choice only one

S/N	Item	1	2	3	4	5
501.	How many people are so close to you that you can count on them if you have serious problem?(select only one)	None	One or two	Three or five	Above five	-
502.	How much concern do people show in what you are doing?(select only one)	None	Little	Uncertain	Some	A lot
503.	How easy can you get help from neighbors if you should need it?(select only one)	Very difficult	Difficult	Possible	Easy	Very easy

PART SIX: HIV stigma scale

S/N	Negative attitudes	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
601.	Families of people living with HIV AIDS should be ashamed.	1	2	3	4	5
602.	People living with HIV AIDS should be ashamed.	1	2	3	4	5
603.	*People who have HIV AIDS are cursed.	1	2	3	4	5
604.	People who have AIDS are disgusting.	1	2	3	4	5
605.	People living with HIV AIDS deserve to be punished.	1	2	3	4	5
606.	It is reasonable for an employer to fire people who have AIDS.	1	2	3	4	5
607.	People with AIDS should be isolated from other people.	1	2	3	4	5
608.	People with HIV should not have the same freedoms as other people.	1	2	3	4	5
609.	People living with HIV AIDS in this community face rejection from their peers.	1	2	3	4	5
610.	People who have HIV-AIDS in this community face verbal abuse or teasing.	1	2	3	4	5

611.	People living with HIV AIDS in this community face neglect from their family.	1	2	3	4	5
612.	People who are suspected of having HIV-AIDS lose respect in the community.	1	2	3	4	5
613.	People living with HIV AIDS in this community face physical abuse.	1	2	3	4	5
614.	*Most people would not buy vegetables from a shopkeeper or food seller that they knew had AIDS.	1	2	3	4	5
615.	People with AIDS should be treated similarly by health professionals as people with other illnesses	1	2	3	4	5
616.	People with HIV should be allowed to fully participate in social events in this community.	1	2	3	4	5
617.	A person with AIDS should be allowed to work with other people.	1	2	3	4	5
618.	People who have HIV-AIDS should be treated the same as everyone else.	1	2	3	4	5

PART SEVEN: Self-reporting suicidal behavior questionnaire (**SBQ-R)**

The following questionnaire consists of 2questions. Please read each item carefully and then pick out the one alternative choice in each group that best describes past suicidal ideation, attempt including today. Be sure that you do not choose more than one statement for any item.

S/N	Questionnaires	Alternative response
701	Have you ever thought/brief passing thought about killing yourself?	1.never 2.yes
702	Have you ever attempted to kill yourself?	1.never 2. yes

የፍቃደኝነት መጠየቂያ ቅጽ

ጤና ይስጥልኝ, ፀጋ ሀይሉ እባላለሁ:: በጅማ ዩኒቨርስቲ የጤና ሳይንስ ዘርፍ በስነ አይምሮ ጤና ትምህርት ክፍል ተማሪ ነኝ፡፡

ይህ መጠይቅ በኢንተግሬትድ ክሊኒካል እና ኮሚዩኒቲ ሜንታል ሔልዝ ለድህረ ምረቃ መመረቂያ ማሙያ የተደረገ ጥናት ነው፡፡ የዚህ መጠይቅ አላማ በኤችአቪ ኤድስ የተጠቁ ሰዎች ላይ የሚደርሰውን የራስን ማጥፋት ሀሳብ እና ሙከራ ብዛትና ተጎዳኝ ጉዳዬች ማጥናት ነው፡፡ ይህም ጥናት በጅማ ዩኒቨርስቲ የጤና ማዕከል በደቡብ ምስራቅ ኢትዮጲያ 2011 ዓ.ም ላይ የሚደረግ ነው፡፡

የዚህ መጠይቅ ተጨባጭ ውጤት በኤችአቪ ኤድስ የተጠቁ ሰዎች ላይ የሚደርሰውን የራስን ማጥፋት ሀሳብ እና ሙከራ ለመከላከል ስለሚረዳ የተሳታፊው ቀና ትብብርና ግልጽነት ለጥናቱ እጅግ ጠቃሚ ነው፡፡ስለዚህም ስል የተሳታፊውን/ዋን ግልጽ እና ቀና ትብብር በአክብሮት እጠይቃለሁ፡፡ ይህ መጠይቅ በፍጹም ፈቃደኝነት ሊሞላ ይገባል፡፡ የተሳታፊው/ዋ ስም በመጠይቁ ላይ አይገለጽም ፤ የሚሰጡት ሀሳብም በታማኝነት ይጠበቃል፤ ተሳታፊው/ዋ ሁሉንም ጥያቄዎች እንዲመልሱ ቢበረታቱም፤ ሊመልሱ ያልወደዱትን ጥያቄ የመዝለል መብታቸው ግን የተጠበቀ ነው፡፡ ተሳታፊው/ዋ ግልጽ ላልሆኑላቸው ጥያቄዎች ማብራሪያ መጠየቅ ይችላሉ፡፡ የሁሉም ጥያቄዎች መልስ በቁጠር እንጂ በስም አይሰጥም፡፡

ይሕንን መጠይቅ ለመሙላት ፈቃደኛ ኖት?

1. አዎ 2. አይደለሁም

የተሳታፊው/ዋ ፊርማ----------

የመረጃ ሰብሳቢው ስም----------ፊርማ----------ቀን----------

የተቆጣጣሪ ----------ፊርማ----------ቀን----------

የአማርኛ መጠይቅ

የጥናቱ ተሳታፊ መለያ ቁጥር_____

ክፍል አንድ: ማህበራዊ እና ዲሞግራፊያዊ ሁኔታን የሚመለከቱ ጥያቄዎች

ተ/ቁ	ጥያቄዎች	ምላሾች
101.	ዕድሜ	_____ዓመት
102.	ፆታ	1. ወንድ 2. ሴት
103.	ሃይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3.ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ(ግለፅ)_____
104.	ብሄር	1. ኦሮሞ 2. ኣማራ 3.ጉራጌ 4.ትግራይ 5. ሌላ (ግለፅ)____
105.	የትምርት ሁኔታ	1. ያልተማረ 2. አንደኛ ደረጃ 3. ሁለተኛ ደረጃ 4. ዲፕሎማና በላይ
106.	የአሁኑ ወቅት የጋብቻ ሁኔታ	1. ያላጋባ 2. ያገባ 3. የፈታ/የተለያየ 4. ባል/ሚስት የሞተበት
107.	ስራ	1. የመንግስት ሰራተኛ 2. የግል ሰራተኛ 3. ነጋዴ 4. አርሶአደር 5. የቤት እመቤት 6. የቀን ሰራተኛ 7.ስራ የሌለው 8. ሌላ ካለ ይግለፁ-----
108.	ወርሃዊ ገቢ	----------ብር
109.	ከማን ጋር ነው የሚኖሩት	1.ብቻዬን 2.ከቤተሰቦቼ ጋር

ክፍል ሁለት፡ የጤና ሁኔታ

ማስታዎሻ፣ይህ መረጃ ከታካሚው ካረድ ላይ ይወሰዳል

201.	ኤች ኣይቪ ቫይረስ በደም ውስጥ ከታወቀ ጀመሮ ያለው የቆይታ ጊዜ **(በኣመት)**	-------በኣመት
202.	ህመሙ ያለበት ደረጃ	1.ደረጃ1 2.ደረጃ2. 3 ደረጃ 3. 4ደረጃ4
203.	የቅርብ ጊዜ የሲዲ 4 ቁጥር	----------
204.	የኤች ኣይቪ ቫይረስ መድሀኒት መዉሰድ ከጀመሩ ስንት ጊዜ ሆነዎት	-------በኣመት
205.	ለኤች ኣይቪ ኤድስ ህመሙ የሚጠቀሙት የመድሀኒት ዓይነት	_____
206.	ኦፖርቹንስቲክ ኢንፊክሽን	1. አዎ 2. የለም
207.	ከኤች ኣይቪ ቫይረስ በተጨማሪ የደምግፊት የመጨመር ህመም አለባቸው	1. አዎ 2. የለም

208.	ከኤች አይቪ ቫይረስ በተጨማሪ <u>የስኩር ህመም አለባቸው</u>	1. አዎ 2. የለም
209.	የቅርብ ጊዜ <u>የቫይረሱ መጠን</u>	----------
210.	በሐኪም የታወቀ የአዕምሮ ህመም አለቦት	1. አዎ 2. የለም
211.	በሐኪም የታወቀ የአዕምሮ ህመም ያለበት የቤተሰብ አባል አሎት	1. አዎ 2. የለም
212.	እራሱን ለማጥፋት የሞከረ የቤተሰብ አባል አሎት	1. አዎ 2. የለም

ክፍል ሶስት፡ ሱስን በተመለከተ መጠይቅ

መመሪያ: መልሱን በትክክል ያክብቡ

አሲስት መጠይቅ			
301	በህይወት ዘመንዎ፣ ከሚከተሉት አደንዛዥ ዕፆች መካከል የትኞቹን ተጠቅመዋል?(**ለሕክምና ከሚሰጡ ውጭ ያሉትን)**	የለም	አዎ
	ትንባሆ	0	1
	የአልኮል መጠጦች	0	1
	ካናቢስ	0	1
	ኮኬት	0	1
	የእንቅልፍ ክኒን(ዲያዜፓም)	0	1
	*ሌላ ካለ ይጥቀሱ _____	0	1
ማሳሰቢያ: የ 1ኛው ጥያቄ መልስ ተጠቅሞ የማያውቅ ከሆነ መጠይቁን ያቁሙ			
302	ባለፉት ሦስት ወራት ውስጥ፣ ከላይ የተጠቀሱት አደንዛዥ ዕፅ ተጠቅመዋል?	የለም	አዎ
	ትንባሆ	0	1
	የአልኮል መጠጦች	0	1
	ካናቢስ	0	1
	ኮኬት	0	1
	የእንቅልፍ ክኒን(ዲያዜፓም)	0	1
	*ሌላ ካለ ይጥቀሱ _____	0	1

ክፍል አራት፡ ስለ አእምሮ ጤና ሁኔታ መጠይቅ (PHQ-9)

ማስታወሻ፡ 1. አልፎ አልፎ ብቻ /2-6 ቀናት/

2. በዛ ላሉ ጊዜ /7-11 ቀናት/፤

3. ከሞላ ጎደል በየቀኑ /12-14 ቀናት/ መሆኑን ይግለፁ

ተ.ቁ	ላለፉት ሁለት ሳምንታት ከነዚህ ከምዘረዝራቸው ችግሮች ውስጥ /በየትኞቹ ተቸግረው/ እንደ ነበር	የለም (0)	አልፎ አልፎ ብቻ (1)	በዛ ላሉ ጊዜ (2)	ከሞላ ጎደል በየቀኑ (3)
401.	ላለፉት ሁለት ሳምንታት የዕለት ተዕለት ተግባርዎን ለማከናወን /ለመስራት/ ያለዎት ተነሳሽነት ወይም ፍላጎት በጣም ቀንሶ ነበር?				
402.	ላለፉት ሁለት ሳምንታት የመከፋት የመደበር ወይም ተስፋ የመቁረጥ ስሜት ይሰማዎት ነበር?				
403.	ላለፉት ሁለት ሳምንታት እንቅልፍ አልወስድ ብልዎት ወይም በደንብ መተኛት አቅትዎት ይቸገሩ ነበር? ወይም እንቅልፍ በዝቶብዎት ይቸገሩ ነበር?				
404.	ላለፉት ሁለት ሳምንታት የድካም ወይም የአቅም ማነስ ስሜት ይሰማዎት ነበር?				
405.	ላለፉት ሁለት ሳምንታት የምግብ ፍላጎትዎ ቀንሶ ነበር? ወይም ከተለመደውበላይ ጨምሮ ነበር?				
406.	ላለፉት ሁለት ሳምንታት ራስዎን የመጥላት ወይም ዋጋ የለኝም የማለት ወይም ራሴንም ሆነ ቤተሰቤን አሳዝኛለሁ የሚል ስሜት ተሰምትዎት ነበር?				
407.	ላለፉት ሁለት ሳምንታት በሚሰሩት ስራ ላይ ሃሳብዎን ለመሰብሰብ/ትኩረት መስጠት አስቸግርዎት ነበር? /ለምሳሌ ከሰዎች ጋር ሲጨዋወቱ ትኩረት ስጥቶ ማዳመጥ/?				
408.	ላለፉት ሁለት ሳምንታት ለሌሎች ሰዎች እስከ ሚታወቅ ድረስ በእንቅስቃሴዎ ወይም በንግግርዎ በጣም ቀስብለው ነበር? ወይም ለሌሎች ሰዎች እስከ ሚታወቅ ድረስ መረጋጋት አቅቶዎት አንድ ቦታ አርፎ መቀመጥ ወይመ መቆም እስከ ማይችሉ ሆነው ነበር ?				
409.	ላለፉት ሁለት ሳምንታት ከምኖር ብሞት ይሻለኛል ብለው አስበው ወይም ራስዎን በሆነ መንገድ ሊጎዱ አስበው ነበር?				
410.					

	ከተዘረዘሩት ችግሮች ውስጥ አንዳቸውም አዎ የሚሌ መልስ ከተሰጠ የሚከተለውን ይጠይቁ፡፡ በነዚህ ችግሮች ምክንያት ስራዎን መስራት የቤት ኃሊፊነትዎትን መወጣት ወይም ከሰዎች ጋር ተስማምተው መኖር ምን ያህሌ አስቸጋሪ ሆኖብ ዎት ነበር?	በጭራሽ አልተቸገርኩም (0)	በመጠኑ ተቸግሬ ነበር (1)	በጣም ተቸግሬ ነበር (2)	እጅግ በጣም ተቸግሬ ነበር (3)

ክፍል አምስት: የማህበራዊ ግንኙነት እና የግል ተሞክሮዎን ይመለከታል

ማስታዎሻ ፣ አንድ ብቻ ይምረጡ

501.	ምን ያህል ሠው አደጋ (ችግር) በሚያጋጥሞት ጊዜ በቅርብ የችግርዎ ተካፋይ ሊሆኑልዎት ይችላል?	1. ምንም
		2. 1 ወይም 2
		3. **3-5**
		4. ከ 5 በላይ
502.	ምን ያህል ሠው ስለ እርስዎ ግድ ይለዋል?	5. ብዙ
		4. ጥቂት
		3. አርግጠኛ አይደለሁም
		2. በጣም ትንሽ
		1. ምንም
503.	ከቅርብ ጎረቤትዎ በተጨባጭ እርዳታ የማግኘት እድልዎ ምን ያህል ነው?	5. በጣም ቀላል
		4. ቀላል
		3. መጠነኛ
		2. ከባድ
		1. በጣም ከባድ

ክፍል ስድስት፡ ስለመገለል መጠይቅ

	አሉታዊ አመለካከቶች	በጭራሽ አልስማማም	አልስማማም	ሀሳብ የለኝም	እስማማለሁ	በጣም እስማማለሁ
601.	በኤችአቪ ኤድስ የተጠቁ ግለሰቦች ቤተሰቦች ሀፍረት ሊሰማቸው ይገባል፡፡	1	2	3	4	5
602.	በኤችአቪ ኤድስ የተጠቁ ግለሰቦች ሀፍረት ሊሰማቸው ይገባል፡፡	1	2	3	4	5
603.	ኤችአቪ ኤድስ የያዛቸው ሰዎች የተረገሙ ሰዎች ናቸው፡፡	1	2	3	4	5
604.	ኤችአቪ ኤድስ የያዛቸው ሰዎች በማህበረሰቡ ዘንድ የተጠሉ (የተገፉ) ናቸው፡፡	1	2	3	4	5
605.	በኤችአቪ ኤድስ የተጠቁ ሰዎች መቀጣት አለባቸው፡፡	1	2	3	4	5

606.	አንድ ቀጣሪ በኤችአቪ ኤድስ የተጠቃ ሰራተኛውን ቢያባርር ምክኒያታዊ ነው፡፡	1	2	3	4	5
607.	በኤችአቪ ኤድስ የተጠቁ ሰዎች መገለል አለባቸው፡፡	1	2	3	4	5
608.	በኤችአቪ ኤድስ የተጠቁ ሰዎች ከሌሎች ሰዎች እኩል ነጻነት ማግኘት የለባቸውም፡	1	2	3	4	5
609.	በዚህ ማህበረሰብ ውስጥ በኤችአቪ ኤድስ የተጠቁ ሰዎች በአቅራቢያቸው ባሉ ሰዎች/ገደኞቻቸው ይገፋሉ፡፡	1	2	3	4	5
610.	በዚህ ማህበረሰብ ውስጥ በኤችአቪ ኤድስ የተጠቁ ሰዎች የቃላት ትንኮሳ/ጥቃት ይገጥማቸዋል፡፡	1	2	3	4	5
611.	በዚህ ማህበረሰብ ውስጥ በኤችአቪ ኤድስ የተጠቁ ሰዎች ቤተሰቦቻቸው ችላ ይሉዋቸዋል፡፡	1	2	3	4	5
612.	ኤችአቪ ኤድስ አለባቸው ተብሎ የሚጠረጠሩ ሰዎች የማህበረሰቡን ክብር አያገኙም፡፡	1	2	3	4	5
613.	በዚህ ማህበረሰብ ውስጥ በኤችአቪ ኤድስ የተጠቁ ሰዎች አካላዊ ጥቃት ይደርስባቸዋል፡፡	1	2	3	4	5
614.	አብዛኛው ማህበረሰብ በኤችአቪ ኤድስ የተጠቃ ሰዉ ከሚሸጥበት ሱቅ ወይም አትክልት ቤት ሄዶ አይገዛም፡፡	1	2	3	4	5
615.	ኤችአቪ ኤድስ የያዛቸው ሰዎች ሌላ ህመም እንዳለባቸው ሰዎች ተመሳሳይ እይታ ከጤና ባለሙያዎ ማግኘት ይጠበቅባቸዋል፡፡	1	2	3	4	5
616.	ኤችአቪ ኤድስ የያዛቸው ሰዎች በማህበራዊ ጉዳዮች ላይ በሙላት እንዲሳተፉ መፈቀድ አለበት፡፡	1	2	3	4	5
617.	ኤችአቪ ኤድስ ያለበት/ባት ሰው ከሌሎች ሰዎች ጋር እንዲሰራ ሊፈቀድለት/ላት ይገባል፡፡	1	2	3	4	5
618.	ኤችአቪ ኤድስ ያለባቸው ሰዎች እነደማንኛውም ሰው ሊታዩ ይገባቸወል፡፡	1	2	3	4	5

ክፍል ሰባት ፡- እራስዎትን የመጉዳት ባህሪን (እራስን ለማጥፋት ማሰብ፣ ማቀድ እና መሞከር)

የተመለከቱ መጠይቆች መመሪያ፡ ትክክለኛ የነበረዎትን ባህሪ ወይም ስሜት የሚዎክለዉን አንድ አማራጭ ይምረጡ፡፡

701	በሂወት ዘመንዎ እራስዎን ለማጥፋት አስበዉ ያዉቃሉ?	1. በፍፁም የለም 2. አዎ
702	በሂወት ዘመንዎ እራስዎን ለማጥፋት ሞክረዉ ያዉቃሉ?	1. በፍፁም የለም 2. አዎ

Fuula odeeffannoo fi walii galtee

Maqaan koo _____ yoo ta'u Yuunivarsiitii Jimmaa Kolleejjii Fayyaatti Murna Fayyaa Sammuu irraan dhufe. Qorannoo kana kanin hojjechaa jiru sagantaa "integrated clininical and community mental health" tiin digirii lammaffaa fudhachuuf ulaagaa barbaachisu guuttachuuf dha. Kaayyoon Olaanaan qorannoo kanaas hammantaa yaada lubbuu ofii balleessuu (of ajjeesuu) fi kan isaan walqabatanii kan Namoota Vaayirasii HIV waliin jiraatan kanneen Giddugala Fayyaa Yuunivarsiitii Jimmaatti yaalamaa jiran, Kibba dhiha Itoophiyaa kan bara 2019 irraa baruuf dha.

Garagaarsi fi hirmaannaan amanamummaa keessan akkan bu'aa qabatamaa fi fudhatama qabu argadhu akkasumas tarkaanfiin yaalii gaarii fudhatamuuf na gargaara. Kanaafuu amanamummaadhaan akka hirmaattan kabajaan is gaafadha. Qorannoo kanarratti Hirmaanaan keessan kan gaaffii fi deebiis ta'e kan biraa fedhii keessan qofa irratti kan hundaa'eedha. Maqaan keessan waraqaa kanarratti gonkumaa hin barreffamu; akkasumas odeeffannoon isin kennitan kamiyyuu icciitiidhaan kan qabamu ta'a. Gaaffiin isin deebisuu hin barbaanne yoo jira ta'e deebisuu dhiisuudhaaf mirga guutruu qabdu, haa ta'u malee hirmaannaan keessan ni jajjabeeffama. Gaaffiin ifa hin taane yoo jiraate akkan ibsa gahaa isiniif kennuuf na gaafachuu dandeessu. Deebiin isin qorannoo kanarratti kennitan maqaan osoo hin taane lakkoofsa qofaan kan bakka bu'u ta'a .

Qorannoo kanarratti hirmaachuuf fedhii qabduu?

1. Lakki 2. Eeyye

Mallattoo hirmaataa ----------

Mallattoo nama odeeffannoo funaanee ----------

Mallattoo suupparvaayizaraa ----------

OROMIFFA VERSION QUESTIONNAIRE

Part 1. Odeeffannoo dhukkubsataa

Lakk.	Jijjiiramaa	Deebii
101.	Umrii	_____ waggaadhaan
102.	Saala	1. Dhiira 2. Dhalaa
103.	Amantaa	1. Orthodoksii 2. Musliima 3. Protestaantii 4. Kaatolikii 5. Kan biraa_____
104.	Sabaa	1. Oromoo 2. Amhaaraa 3. Guraagee 4. Tigree 5. Kan biraa_____
105.	Sadarkaa barnootaa	1. Hin baranne 2. Kutaa 1-8 3. Kutaa 9-12 4. Diploomaa fi isaaol
106.	Haala fuudhaa fi heerumaa	1. Hin fuune/heerumne 2. Kan fuudhe/heerume 3. Addaan bahe 4. Kophaa
107.	Hojii	1. Hojii mootummaa 2. Hojii dhuunfaa 3. Daldalaa 4. Qonnaan bulaa 5. Haadha Manaa 6. Dafqaan bulaa 7. Hin qabu 8. Kan biraa_____
108.	Galii Ji'aa	_____Qarshii Itiyoophiyaan
109.	Eenyu waliin jiraatta	1. kophaa 2. Nama waliin

Kutaa II. Seenaa meedikaalaa – Kaardii dhukkubsataa ilaali

201.	Erga dhibee HIV qabaachuun mirkanaa'ee hangami?	_____ waggaan
202.	Sadarkaa dhukkubichaa	1. sadarkaa 1 2. sadarkaa 2 3. sadarkaa 3 4. sadarkaa 4
203.	Baayi'ina CD4 yeroo ammaa	
204.	Erga qoricha farra HIV AIDS jalqabanii hangami	_____waggaa dhaan
205.	Gosa qoricha farra HIV AIDS	
206.	Baay'ina vaayirasii HIV(dhiyeenyatti)	
207.	Argama dhukkuboota HIV tti maxxanuun dhufanii	1. Lakki 2.Eeyyee
208.	Argama dhukkuboota Dabalataa	1. Lakki 2. Eeyee

209.	Dhukkubni sDhiibbaa Dhiigaa yoo jiraate	1. Lakki 2. Eeyee
210.	Jiraachuu Dhukkuba Sammuu beekamaa	1. Lakki 2.Eeyyee
211.	Maatii irra jiraachuu dhukkuba sammuu beekamaa	1. Lakki 2.Eeyyee
212	Maatii keessa kan of ajjeesuuf yaale jiraachuu	1. Lakki 2.Eeyyee

Kutaa IV: fayyadamaa arradallee addaa addaa waalin (ASSIST V 3.0)

wa'ee fayyadamaa arradaa		
301	Umrii kee keessatti, arraddaa kan kanatti aanan keessa kam fuudhatte?	lakkii eeyyee
	1. omishaa tamboo (sigarraa, tamboo alanfatamuu,.fi knf)	0 1
	2 dhugaati alkooli (biraa, wayinni, fi knf.)	0 1
	3.kannabisi (mariwaana,hashish fi knf.)	0 1
	4.arradda nama dadamaqasuu (caatii,fi knf.)	0 1
	5.qorricha hiriba (valiyemii, knf.)	0 1
	6. kan biroo:	0 1
Deebiin kee armaan hundi yoo lakki ta'e "yeroo mana barumsaa turtetti illee" Deebiin kee yoo lakki ta'e gaaffii fi deebii dhaabi. Yoo deebiin kee eyyee ta'e gara gaaffii 302 darbi.		
302	Arraadoole armaan gadi keessaa ji'oota sadaan darban kessaatii hagamin fayyadamataa?	lakkii eeyyee
	omishaa tamboo (sigarraa, tamboo alaaftamuu,.fi knf)	0 1
	dhugatti alkoholi (biraa, wayinni, fi knf.)	0 1
	kannabisi (mariwaana,hashish fi knf.)	0 1
	arradda nama dadamaqasuu (caatii,speed,ecstasyfi knf.)	0 1
	qorricha hiriba (valiyemii, knf.)	0 1
	kan biroo:	0 1

Kutaa 4. PHQ-9 Hubachissa 1.darbe darbee. /2-6 guyyoota/

2. yahoo bayeef /7-11guyyoota /ɜ

3.guyyaa guyyaan/12-14 / guyyoota

SNo	Torbaan 2 darbe kessa, yeroo meqaf rakkolee armaan gadi isiniti mudate?	hin jiru (0)	darbe darbee (1)	yeroo bayee (2)	guyyaa guyyaan (3)
401	Fedhii tiqa ykn gammachu wantota tokko tokko godhun				

402	Gadi antumma issiniti dhagahama ykn gaddaa ykn abdi kutu				
403	Hirribni si qabu didu ykn hirribaa dadammaquu ykn halaa barame calaa rafuun ?				
404	Dadhabi isiniti dhagahamma ykn human xiqa qabdu?				
405	Torbe 2 darban kessaa fedhiin nyataa kessaan xiqatee ykn dabalee?				
406	Of jibbuu ykn gatti hinqabu jechuun ykn ofis tahe matti gaddisise jechuu				
407	Rakkoo yadda walliti qabu fakenyaaf namottaa waliin taphachuu?				
408	Kan namonni biraa hubatan tasgabhu dadhabun bakka tokkko dhabachu ykn ta'u dhadhabun jira ?				
409	Karra kamiyuu ta'ee yadda kan osoo dutan garri akka tahe ykn off midhuu				
410	rakkolle eramanif deebin kessan eyyee yoo ta'e kan itti anu gafadha.rakko kanan kan ka'ee hajji hojachuuf halaftina mana bahuuf ykn namotta wajjin walli galtani jirrachuuf hagam takka isin rakkisee?	siruuma hin rakkane (0)	darbe darbee (1)	yeroo bayee (2)	guyyaa guyyaan (3)

Kutaa IV(B): gaaffiwwan gargaarsaa hawaasaa maddaalii illaaltu(oslo)

501.	Namoonni yeroo rakkoon cimaan si mudatu si grgaaran kan itti amantu meeqatu jiru	1. Homtuu 3. 3 hanga 5 2. Tookko ykn lama 4 shanii ol
502	Hojiati hojjattuf namoonni hammam sitti dhimmamu?	Baayee baayee 2. baayee 3. Hin beekamu 4.xiiqoo 5. Hin jiru
503.	Yeroon rakkoo si qunnamu gargaarsa olla argachuun hammam sitti salphata?	1. Baayeesalphaa 2. salphaa 3. Ni ta'a 4.rakkisaa 5. Baayeerakkisaa

KUTAA JA'A. Safara /iskeelii/ Dhiibama HIV

S.No	Ilaalchawwan Badaa	Cimina an nan morma	Nan morma	Hin mormu, ittiin walii hin galus.	Ittiin walii gala	Ciminaan ittiin walii gala
601.	Maatiin namoota dhukkuba HIV AIDS waliin jiraatanii qaana'uu qabu	1	2	3	4	5

602.	Namootni dhukkuba HIV AIDS waliin jiraatan qaana'uu qabu	1	2	3	4	5
603.	Namootni dhukkuba HIV AIDS waliin jiraatan abaaramoodha.	1	2	3	4	5
604.	Namootni dhukkuba HIV AIDS waliin jiraatan jibbisiisoodha.	1	2	3	4	5
605.	Namootni dhukkuba HIV AIDS waliin jiraatan adabamuu qabu.	1	2	3	4	5
606.	Hojjachiisaan tokko Nama dhukkuba HIV AIDS waliin jiraatu hojii irraa ariyatus sababa quubsaa qaba	1	2	3	4	5
606.	Namootni dhukkuba HIV AIDS waliin jiraatan namoota biroo irraa gargar bahuu qabu	1	2	3	4	5
607.	Namootni dhukkuba HIV AIDS waliin jiraatan namoota biroo waliin walabummaa walqixa qabaachuu hin qaban	1	2	3	4	5
608.	Namootni dhukkuba HIV AIDS waliin jiraatan hawaasa kana keessatti hiriyoota isaaniitiin dhiibamanuun isaan mudateera.	1	2	3	4	5
609.	Namootni dhukkuba HIV AIDS waliin jiraatan hawaasa kana keessatti arrabsooon isaan quunnameera.	1	2	3	4	5
610.	Namootni dhukkuba HIV AIDS waliin jiraatan hawaasa kana keessati maatii isaaniitiin dagatamuun isaan mudateera.	1	2	3	4	5
611.	Namootni dhukkuba HIV AIDS qabaachuun shakkaman hawaasa keessatti kabaja hin qaban	1	2	3	4	5
612.	Namootni dhukkuba HIV AIDS waliin jiraatan hawaasa kana keessatti miidhaan qaamaa irra gaha	1	2	3	4	5
613.	Namoonni baay'een daldalaa dunkaana qabu ykn nyaata garaagaraa gurguru dhukkuba HIV AIDS qabaachuu isaa yoo beekan muduraa fi nyaata garaa garaa irraa hin bitan	1	2	3	4	5
614.	Namootni dhukkuba HIV AIDS waliin jiraatan ogeessota fayyaa biratti namoota dhukkuba biraa qabaniin walqixa ilaalamuu qabu.	1	2	3	4	5
615.	Namootni dhukkuba HIV AIDS waliin jiraatan hawaasa kana keessatti hirmaaannaa hawaasummaa guutuu akka qabaatan	1	2	3	4	5

	eeyyamamuufii qaba					
616.	Namni Dhukkuba AIDS qabu namoota biroo waliin akka hojjetuuf eeyyamamuufii qaba.	1	2	3	4	5
617.	Namootni dhukkuba HIV AIDS qaban akkuma namoota birootti ilaalamuu qabu	1	2	3	4	5

Kutaa 7: Guca waa'ee lubbuu ofii balleessuuf godhamu irratti ofiin gabaasuu ilaallatu.

Gucni armaan gadii gaafilee afur of keessaa qaba..Maaloo,tokkoon tokkoo gaafii of eeggannoon erga dubbistanii booda kan haalaan waa'ee amala lubbuu ofii balleessuuf yaaduu ,yaaluukan yeroo darbee kan har'aa dabalatee sirriitti ibsu tokko filadhaa., Hima filannoo tokkoo ol akka hin filanne mirkaneeffadhaa.

Lakk.	Gaafilee	Filannoo deebii
701	Kana dura yaada of ajjeessuuf yaaddee beektaa?	1.gonkumattuu 2. Eeyee
702	Kana dura yaalii of ajjeessuuf gootee beektaa?	1. gonkumattuu 2. Eeyee