

**Assessment of Dual contraceptive method utilization and associated factors among HIV positive women attending ART Clinic in G/tsadik Shawo Hospital, Keffa Zone, SNNPR, South West Ethiopia**

**BY**

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**Research thesis submitted to Jimma University College of Public Health and Medical Science Department of Nursing and Midwifery for partial fulfilment of the requirment for Masters Degree in Maternity Nursing**

**June 2013**

**Jimma, Ethiopia**

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**Assessment of dual-contraceptive method utilization and associated factors among HIV positive women attending ART Clinic in G/tsadik Shawo Hospital, Bonga Town, Keffa Zone, SNNPR, South West Ethiopia**

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**May 2013**

**Jimma, Ethiopia**

## Summary

**Background:**-Ethiopia is among the countries most affected by HIV epidemic with an estimated adult prevalence of 1.5%. Approximately 800,000 peoples are HIV positive and about 1 million aids orphans in Ethiopia (1). The sexual and reproductive health of HIV positive people is fundamental to their well-being and that of their partners and children. So the simultaneous protection against both unwanted pregnancy, HIV and other STIs is referred to as dual protection (4).

**Objective:**-The objectives of this study is to assess dual - contraceptive method utilization and associated factors among HIV positive women attending ART Clinic in G/Tsadik Shawo Hospital, Bonga Town, Keffa Zone, SNNPR, South West Ethiopia.

**Methods and materials:** Institution based cross-sectional study that included both quantitative and qualitative methods of data collection was employed on 243 HIV positive mothers who were selected by using lottery method simple random sampling technique. Data was collected by six (4 Bachler degree and 2 Diploma) nurses using structured data collection tools. Quantitative datas were analyzed by SPSS-16.0 verssion soft ware using binary and multivariate logistic regression test. Qualitative data was obtained from 18 respondents who were purposively selected and manual thematic analysis method was used.

**Result:** This study finding indicated that the experience of practicing dual contraceptive method after HIV diagnosed was 40.7% but the prevalence of effective dual contraceptive method utilization practice responded was only 19.8%. Variables found to be statistically significant in this study were Age, AOR 2.445 95% CI(1.131,5.284); marital status AOR 4.018, 95% CI(1.219, 13.21); Residence AOR 0.709, 95% CI(0.317, 0.985); amount of CD4 count AOR 8.516, 95% CI(1.005,72.168), received counselling AOR 0.42, 95% CI(.016, 0.111) and open discussion with partner AOR 10.23, 95% CI(3.53, 29.72). In indepth interview participants emphasized on partiners less commitment to practice dual contraceptive method and less open discussion experience about dual contraceptive method utilization were mentioned.

**Conclusion and Recommendation:** As the finding indicates use of dual contraceptive method was very low in the study area. It needs encouragement of both HIV positive male and female to use dual contraceptive methods during every episode of sexual intercourse to prevent unintended pregnancy and further STIs infection. Training of health care providers, regarding counselling approach about dual contraceptive method is fundamental to improve utilization habits among HIV positive people.

## Acknowledgment

First and for most I would like to express my deepest gratitude to my advisors Mr. T/Brihan Tema (RN Bsc Msc. Ass't Professor) and Mr. Fekadu Yadassa (RN, Bsc. Msc) for their unreserved all rounded, support and enriching comment throughout the study period.

I will extend my thanks to Jimma University for sponsoring this thesis project. My appreciations also go to all staffs of Nursing and Midwifery for their unreserved support throughout the course and thesis works.

I want to thank staffs in G/tsadik Shawo Hospital and Kefa Zone health Department, who facilitated the data collection process. Special thanks go to S/r Banchiwork Ayichew head of ART Unit in the Hospital who provided available information about the study respondents throughout the study (data collection) period.

My special thanks also go to my parents, friends and classmates for their continuous encouragement, moral and material support throughout my academic life.

Last but not least I would like to thank the data collectors, supervisors and all research participants who took part in the study.

## Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral therapy
<b>ARV</b>	Anti retrovirus
<b>CPR</b>	Contraceptive prevalence rate
<b>EDHS</b>	Ethiopian Demographic Health Survey
<b>FMOH</b>	Federal Ministry of Health
<b>FP</b>	Family Planning
<b>HAART</b>	Highly Active Anti Retroviral Therapy
<b>HAPCO</b>	HIV/AIDS Prevention and Control office
<b>HIV</b>	Human Immune Deficiency Virus
<b>IDI</b>	In-depth Interview
<b>LPV/r</b>	Lopinavir/Ritonavir
<b>MDG</b>	Millennium Development Goal
<b>NASCOP</b>	National AIDS and STDs Control Program
<b>NL</b>	Nelfinavir
<b>NVP</b>	Nevirapine
<b>PMTCT</b>	prevention of mother to child transmission
<b>RTV</b>	Ritonavir
<b>SNNPRs</b>	Southern Nation, Nationalities Peoples Regional State
<b>SPSS</b>	Statistical package for social sciences
<b>STDs</b>	Sexual Transmitted Diseases
<b>STI</b>	Sexually Transmitted Infections
<b>VCHW</b>	Voluntary community health workers
<b>VCT</b>	Voluntary Counselling and Testing
<b>WHO</b>	World Health Organization

<b>Table of Contents</b>	<b>Page</b>
Summary.....	iii
Acknowledgment.....	iv
Acronyms .....	v
List of figures .....	ix
Chapter 1: Introduction.....	1
1.1 Background.....	1
1.2 Statement of the problems .....	3
Chapter 2:-Literature review .....	6
Chapter 3: Objectives .....	13
Chapter 4: Methods and materials.....	14
4.1. Study area and period .....	14
4.2 Study design .....	14
4.3 Source and study population .....	14
4.3.1 Source population.....	14
4.3.2 Study population.....	14
4.4 Sample size determination and sampling technique.....	15
4.4.1 Sample size determination.....	15
4.4.2 Sampling technique .....	15
4.4.4 Qualitative study.....	16
4.5 Study variables .....	16
4.6 Operational definition.....	16
4.7 Data quality assurance.....	17
4.8 Pre-test.....	17

4.9 Inclusion and exclusion criteria.....	18
4.10 Data processing and analysis.....	18
4.11 Ethical consideration .....	19
4.12 Plans for dissemination and utilization of results.....	19
Chapter 5: Results.....	20
Chapter 6: Discussion.....	35
Chapter 7: Conclusion and recommendations.....	39
Annex I: - References.....	41
Annex II: - Questionnaires .....	44

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## List of table's

<b>Table1:-</b> Socio demographic characteristics of HIV positive women attending art clinic at G/tsadik shawo Hospital, kefa zone, SNNPR, Ethiopia, 2013 .....	20
<b>Table2:-</b> Distribution of client related factors on dual contraceptive method utilization of HIV positive women on art and follow up clinic at G/tsadik Shawo Hospital, kefa zone, SNNPR, Ethiopia, 2013 .....	24
<b>Table 3:-</b> Distribution of Community related factors on dual-contraceptive utilization of HIV positive women on ART and follow up care at G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013 .....	28
<b>Table 4:-</b> Distribution of Services delivery factors on dual contraceptive utilization of HIV positive women on ART and follow up care at G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013 .....	30
<b>Table 5:-</b> Associated factors of modern family planning utilization of HIV positive women on art follow up care in G/tsadik shawo Hospital, kefa zone, SNNPR, Ethiopia, 2013 .....	32
<b>Table 6:-</b> Association of dual contraceptive method utilization of HIV positive women who attending ART Clinic in G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013 .....	34



## List of figures

<b>Figure 1:-</b> conceptual framework (sources: developed by principal investigator based on literature review) .....	11
<b>Figure 2:-</b> Indicates distribution of different types of contraceptive method utilization among HIV positive women.....	25
<b>Figure 3:-</b> Shows distribution of dual-contraceptive method utilization pattern among F/P user HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013. ....	26
<b>Figure 4:-</b> shows the distribution of discussion to partner about dual contraceptive utilization among HIV positive women attending G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013.....	29

## Chapter 1: Introduction

### 1.1 Background

The emergence of HIV epidemic is one of the biggest public health challenges in the world. In the last three decades HIV has spread rapidly and affected all sectors of society (such as young's, adults, men, women, the rich and poor). Sub-Saharan Africa is at the epicentre of the epidemic and continues to carry the full brunt of its health and socioeconomic impact [1].

Though the present worldwide HIV pandemic consists of many regional epidemics, globally, at the end of 2010, there were 2.7 million new HIV infections with a total of 34 million people living with HIV. Sub-Saharan Africa remains the worst affected region by the pandemic being home to two-thirds (67%) of the global total of 34 million people living with HIV. Even in Sub-Saharan Africa, HIV prevalence varies considerably ranging from below 2% in several countries of West and Central Africa to above 15% in 7 Southern African countries one of which is South Africa [2].

Ethiopia is among the countries most affected by the HIV epidemic. With an estimated adult prevalence of 1.5%, it has a large number of people living with HIV (approximately 800,000); and about 1 million AIDS orphans. The Government of Ethiopia is making tremendous efforts towards containing the epidemic. As part of this endeavour, 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 [1].

The sexual and reproductive health of peoples living with HIV/AIDS is fundamental to their well-being and that of their partners and children [3]. Simultaneous protection against both unwanted pregnancy and STIs is referred to as dual protection [4].

Theoretically, dual protection can be accomplished by consistent male condom use alone; however, typical use of male condoms as a contraceptive method results in a one-year cumulative incidence of unintended pregnancy of about 15%. Other contraceptive methods, including male

and female sterilization, intrauterine devices, and oral hormonal contraceptives, are much more effective than condoms in preventing pregnancy, but do not protect against STIs/HIV [5]. Thus, the most prudent approach to dual protection is the use of dual-contraceptive methods: condom use in combination with a highly effective pregnancy prevention method. Although promotion and adoption of dual-contraceptive methods pose more challenges than promotion of a single method, in a setting where both unintended pregnancy and STI/HIV transmission are of great concern, adoption of dual-contraceptive methods is necessary for optimal sexual and reproductive health [5].

The use of contraception had been advocated on three major grounds - demography (population control), health (women and children) and human (women) rights. In recent times the use of contraception has been identified as a potent instrument in the control of HIV/AIDS in women and children. According to UNAIDS, 2009 over 50% of the infected adults were women who acquired the infection predominantly through heterosexual route. Children (under 15 years) account for 2.5 million of the infected population and majority (90%) were acquired through mother to child transmission route. Over 90% of the yearly 420,000 new infections in children occur in Africa [6].

In sub Saharan Africa where the prevalence and burden of HIV/AIDS is high, contraceptive prevalence rate is also low. A recent United Nations report showed that the CPR for sub Saharan Africa in 2010 was 28% compared with the global average of 62%. It has been estimated that an increase in CPR in sub-Saharan Africa with corresponding reduction in primary HIV infections and unintended pregnancies in HIV infected women has potential to decrease the proportion of infants infected with HIV by 35-55%. Hence the provision of appropriate contraceptive information, counseling and services will play a significant role in reducing the burden of HIV /AIDS in Africa [7]. Reported rates of dual-method use have ranged from 3% to 42%, depending on study design, country, combination of methods used, period of assessment, users' and partner characteristics and the relationship [9].

The use of a condom has become very important as it serves a dual purpose of contraception and prevention of STIs and sexual transmission of HIV [10]. However, its main drawback is that it requires male participation which may be difficult to negotiate especially in power imbalanced.

Male condom use offers a high degree of protection against sexual transmission of HIV and STIs. Apart from abstinence, condom is the only recommended method of reducing sexual transmission of HIV and other STIs. Condoms are user dependent and can only be used at the time of coitus [11]. In sero-concordant couples where both partners are HIV-positive, condom use may be necessary not only to prevent pregnancy and STIs but also to prevent HIV drug resistant due to super infection. In sero-discordant couples, where one partner is HIV positive and the other negative, consistent condom use provides about 80% - 95% protection [12, 13].

Dual protection should be recommended for men and women on ART. To ensure effective and appropriate contraception is available, specifically for women on ART with nevirapine (NVP), lopinavir/ritonavir (LPV/r), nelfinavir (NLF) and ritonavir (RTV), dual protection is recommended. HIV-positive women on ART with any of the above ARTs who are also using COCs need to be monitored closely. Rifampicin often used to treat tuberculosis in HIV- positive clients, also decreases effectiveness of COCs by reducing circulating oestrogen. So woman on Rifampicin and COCs should use dual contraceptive methods [14].

## **1.2 Statement of the problems**

One major consensus at the International Conference on Population and Development (ICPD) in 1994 was the rights of women to decide freely on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence, and the need to improve access to services so that couples and individuals can decide freely the number, spacing and timing of their children. HIV positive women are also entitled to these rights. The increasing availability and use of highly active retroviral therapy (HAART) has improved the prognosis, life expectancy and quality of life of people living with HIV [15].

A study published in March 2010 gave a population estimate that all women in the United States who use one highly effective contraceptive method added a second one, such as a condom, then approximately 80% of unintended pregnancies and abortions among these women could be prevented. This would result in an annual reduction of 786,000 unintended pregnancies and nearly 152,000 abortions [16]. It is estimated that HIV-positive pregnant women are at 1.5–2 times greater risk of maternal mortality [17]. Dual Protection has been advocated as strategy for reducing the risks of unplanned pregnancy, horizontal transmission of HIV to a non-infected

partner, transmission of resistant virus to a partner with HIV infection, and the risk of acquisition of other STIs like Human Papilloma virus and Hepatitis B&C [18].

A cross-sectional survey done in US examined the rates of dual method use varied by age, race, ethnicity, education, marital status, pregnancy history, insurance status, and number of sexual partners. In particular, young women (15–20 years) who are at highest risk of both STI and unintended pregnancy reported the highest rates of dual-method use (22.8%). African American women had higher rates of dual-method use (9.4%) compared with Caucasian or Hispanic women. Education was associated with rates of dual-method use with the highest levels among women with some college education (12.0%). Never married women were most likely to report dual-method use (18.9%), as were null gravid women (16.0%). Continuously insured women were more likely to report dual-method use (8.0%) than those with some period of no insurance (5.6%) [20].

Furthermore, providing safe and effective contraception to HIV-infected women who desire it has also been identified by World Health Organization as a primary strategy for prevention of paediatric infections. Public health programs that emphasize dual family planning methods that are highly effective modern contraception coupled with condom use will ensure protection from both unintended pregnancy&STIs. It also avoids acquiring other strains of HIV that may lead to develop ART drug-resistance. Addressing dual contraceptive utilization practise should form the cornerstone of reproductive health care. In HIV care and treatment programs, medication adherence counseling provides a unique window of opportunity to address preventive health recommendations, including family planning and STI prevention [19- 21].

Protease Inhibitor and Non-nucleoside reverse transcriptase inhibitor ART drugs interact with combined oral contraceptives and resulting in possible decreases in ethinyl estradiol or increases in estradiol or norethindrone levels. These changes may decrease the effectiveness of the oral contraceptives or potentially increase the risk of estrogens or progestin related side effects. Non nucleoside reverse transcriptase inhibitor such as Efavirenz reduce active metabolites of norgestimate, Nevirapine reduce ethinyl estradiol and norethindrone. Boosted Protease inhibitor drugs such as Ritonavir, Lopinavir andTipranavir reduce ethinyl estradiol. Therefore, for sero-

positive women on ART medication and taking oral contraceptives needed additional reliable method of barrier contraception or dual-contraceptive methods [20, 21].

Ethiopia is one of the countries' most severely hit by the HIV epidemic. Besides the dominant heterosexual transmission, the vertical virus transmission from mother to child accounts for more than 90% of paediatric HIV/AIDS infection [14].

Literature search showed that no study done on issue of dual contraceptive utilization among HIV sero-positive women in study area as well as in our Country as the knowledge of the investigator. Due to this the principal investigator interested to study about dual contraceptive method utilization as well as associated factors among HIV-infected women receiving pre- ART and ART treatment, attending Bonga G/tsadik Shawo Hospital ART clinic.

## Chapter 2:-Literature review

A cross-sectional survey done in united state reveals, dual method use prevalence is 7.3% from 5,178 women included in the sample. Correlates of higher rates of dual contraceptive method use included age younger than 36 years and non married marital status. Lower rates of dual method use were observed for women with less than a high School education and women without consistent health insurance in the past year. Compared to women using oral contraceptives, use of injectable or long acting reversible contraceptive was associated with lower dual-method use. Ring users were most likely to report dual-method use with 32.6% dual use at last intercourse, whereas 21.7% of pill users, 16.7% of injectable users, and 16.0% of patch users reported dual-method use at last intercourse [20].

Population-based telephone survey Study done in California reveal 26% reported using condoms for dual protection against STIs and pregnancy [22].

Institution based cross sectional study conducted in New York show dual-method use has been correlated with being younger, having higher education, having received instruction in condom use or education about HIV, using the pill, having an elevated STD risk, being in shorter-term or less committed relationships and making shared decisions about contraceptives [9]. The other study done in New York reveal participants those who had heard of dual protection were the only people to use dual protection methods. Only 41.7% of respondents had heard of dual prevention methods, which is much lower than in South Africa, where 70% of study participants knew of condoms for dual risk prevention [24]

In Indonesia Wealthier women who want significantly fewer children than did moderately or extremely poor women are more likely to approve of family planning (93% vs. 87%) and were more likely to believe their spouses approved. Better off (wealthier) women have higher odds of using modern contraceptives which are more effective than do extremely poor women. In addition, those who wanted two or fewer children had higher odds of using a modern method [25]. There is association between monogamy and non utilization of contraception. However, women in polygamous marriages were more likely not to use contraception when they were older than 35 years, had four or more living children, had no male child, had three or more female children, or lived in rural areas. There is also association between non-utilization of

contraception and number of male children. Cultural norms and expectations are varied and include among others; fatalism attributed to HIV disease, fear of infecting the unborn child, gender roles designated by society such as the role of women in child bearing and the demand for large families [26].

A cross-sectional survey done in Finland to assess condom use and barriers finding, showed that condoms use during the last occasional intercourse was only 36.8% of males and 47.5% of females. In a study to explore religious beliefs among men and their influence their use of condoms showed that for religious reasons, most (63%) of the men avoided using condoms and were opposed to women's contraceptive use [27].

Prevalence and barriers to dual contraceptive methods use among married HIV positive men and women in India reveals 5% of married HIV positive people reported use of dual contraceptive methods prior to their HIV diagnosis (4% of men, 5% of women), which significantly increased to 23% of married HIV Positive people after their diagnosis (15% of men, 30% of women). Thus, over three fourths of the participants did not use dual contraceptive methods following their HIV diagnosis; instead, 70% only used condoms (77% of men, 63% of women), 3% only used an effective pregnancy prevention method (3% of men, 2% of women), and 5% used neither (4% of men, 6% of women). Married HIV positive People were significantly more likely to report using dual contraceptive methods if they were female had received post test HIV counseling, used contraception to prevent the risk of transmission of HIV to their partner or used contraception due to partner's preference. Higher CD4 count was associated with less use of dual contraceptive methods among both men and women. In addition, among women, use of contraception to prevent the risk of transmission of HIV to their partner was associated with dual contraceptive methods use [28].

Descriptive research done in Stellenbosch University, about 90% of the women have received counselling on dual protection as the method of choice for sexually active, 75% know actually that dual protection is the preferred contraceptive method sexually active HIV positive women but only 8% of them have positive perception to the use of dual protection. In practice, only 4% of them are practising dual protection [18].



A cross-sectional survey study result in Sowetom, South Africa shown, HIV positive women overall were significantly more likely to use dual protection compared with HIV negative women (33% and 14%, respectively). Much of this difference was accounted for by HAART users, of whom 40% reported using dual protection compared with 24% of not using HAART women and 14% of HIV negative women. HAART users were also significantly more likely to report using condoms (with or without hormonal/permanent methods) 68% and hormonal/permanent methods (with or without condoms) 58% compared with not using HAART and HIVnegative women. Only 4% of the participants are practising dual protection whereas 92% of them have received counselling on dual protection as a preferable contraceptive method of choice for HIV positive women and 8% of them having positive attitude to the use of dual protection [29].

The study finding in Lusaka Zambia indicated 7,503 (40.8%) HIV positive women not using modern contraception, 737 (9.8%) HIV positive women desired contraception after counseling and 71 stated an intention to use dual methods. 454 of 737 (61.6%) HIV positive women who desired contraception successfully accessed family planning services within 90 days of their counseling visit. It indicates that nearly 40% of HIV positive women who desired reproductive health services were unable to access public sector services (i.e, free from point of service user fees). Among the 10,904 HIV positive women who reported use of a modern contraceptive method at their counseling visit, 1,927 (17.7%) stated that they used dual methods for both pregnancy and STI prevention. About 18,407 HIV positive women included in the analysis, 10,904 (59.2%) reported current use of a modern contraceptive method: Among the 10,904 HIV positive women who reported use of a modern contraceptive method at their counseling visit 1,927 (17.7%) stated that they used dual methods for both pregnancy and STI prevention [30].

A dual contraceptive use among women irrespective of their HIV status in Sub Saharan Africa showed that partner approval is more likely to be associated with use of dual contraceptive in all the six countries that included Kenya, Malawi, Tanzania, Ivory Cost, Burkina Faso, and Ghana. Partner approval was four times more likely to be associated with modern dual contraceptive use in Malawi and in Kenya. Partner opposition was found to cause a statistically significant increase in unmet need accounting for as much as 20% of unmet need reported by women and a shift in contraceptive use favouring traditional methods over modern methods [31].

Mixed method study done in Uganda factors significantly associated with the use of dual contraception were having ever gone to school, discussion of family planning with a health worker or with spouse, not attending the Catholic run clinic and spouses' not desire for children [26]. Other retrospective study in Uganda AIDS control program national guidelines advocate for dual family planning methods (condoms plus another contraceptive method) to prevent HIV/STI transmission and unintended pregnancies for HIV-positive individuals, only 2% used dual protection. Use of condoms or dual contraception methods may have been low in the study; however, 70% of married women reported having HIV infected spouses; they may have been less likely to use condoms to prevent sexual transmission of HIV [32].

From Mixed methods research conducted in Kenya Nairobi, the most commonly cited reasons for using condom for both regular and casual partner during last sex was prevention of re-infections (61% and 53% respectively), followed by the need to avoid infecting other sexual partners (28% and 36% respectively) and dual protection against HIV and pregnancies (9% and 6% respectively)[33].

Use of any contraceptive method in Ethiopia varies notably by region, ranging from 63% in Addis Ababa to 4% in the Somali region. Use of any modern contraceptive methods is highest in Addis Ababa (56%) and lowest in the Somali and Affar regions (4 and 9%, respectively). Current contraceptive use increases with women's education. 22 % of women with no education report current use of any method, compared with 68% of women with more than secondary education. Similarly, current use of any contraceptive method increases with wealth, from 13% of women in the lowest to 52 of women in the highest wealth [34].

A community-based stratified cross-sectional survey done in Adwa town showed that employment, educational status and sex were the socio-demographic variables significantly associated with dual contraception utilization. Of the reproductive health variables, approval of condom use within marriage and discussion about dual protection with family planning provider or partner remained significantly associated with dual protection after adjustment for other factors. Overall, 19.7% of respondents (29.8% of men and 9.8% of women) said they used some form of dual protection. When individuals who reported use of non-barrier methods and multiple sexual partners or inconsistent condom use were excluded, the prevalence of effective dual

protection (condom plus hormonal contraceptives) was only 13.8%. 13.1% respondents (109 women) feared social stigma if they used dual prevention methods, and 10% of respondents, (3% of men and 16.9% of women) said their spouse or partner would not allow them to use dual protection. For sero-positive women communication about the risk of unintended pregnancy and further STI or HIV/AIDS with partners is an important predictor of dual method use. Those who had discussed about dual contraceptive methods are more likely to use dual protection than those not discussing [35].

Study done in Asella Hospital shows 41.7% (61.2% of men and 22.6% of women had heard of dual protection. Of these, 43.3% knew that dual protection could be achieved by using a non-barrier contraceptive plus condom and 41.4% that it could be achieved by using non-barrier contraceptives in a long-term mutual monogamous relationship. Only 8.3% knew that condoms on their own could be used for dual protection. Nearly 10% of the respondents had negative or equivocal attitudes towards dual protection methods. Overall, 19.7% of respondents said they used some form of dual protection. However, three of those stating they achieved dual protection by using non-barrier contraceptives in a long term monogamous relationship. 70% of respondents did not know of methods of dual protection; 34.9% said they wanted to have more children [36].

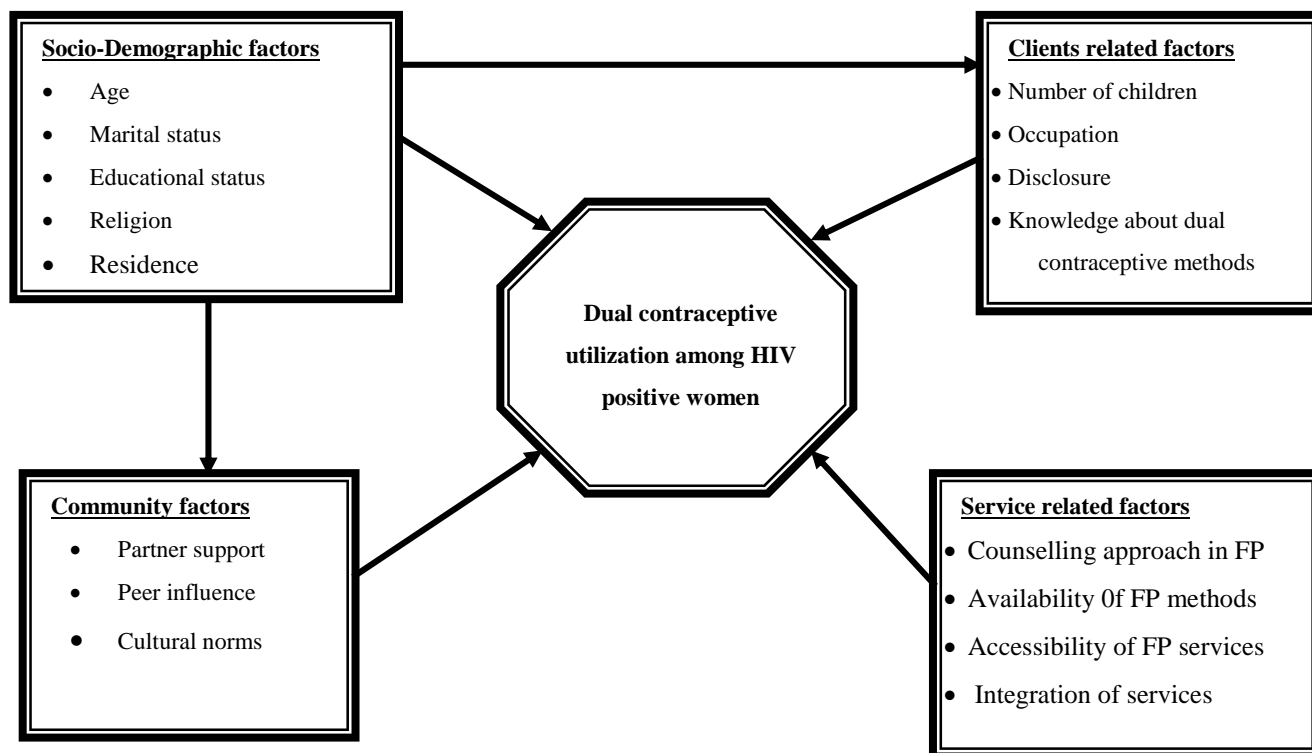
A cross sectional facility based study in Addis Ababa on 548 HIV positive women reveals dual method of contraception was practiced by 13.4% of the women while 11.8% used condom alone[37].

## 2.2 Research Questions

1. What is the pattern of dual-contraceptive services utilization among sero- positive women?
2. What factors are influencing utilization of dual-contraceptive methods among sero-positive women?

## Conceptual framework

The conceptual framework below shows various factors and how they are associated with dual contraceptive utilization. These factors included the sociodemographic, client, community and clinical service related factors. This study focused on the association between these factors and the dual Contraceptive method utilization.



**Figure 1:-** conceptual framework (sources: adapted by principal investigator based on literature review)

### 2.3 Significance of the Study

Public health programs emphasize that dual-contraceptive methods utilization will ensure protection from both unintended pregnancy and STIs/HIVs. Therefore dual contraceptive utilization is the cornerstone of reproductive health care for sero-positive clients. World health organization identified that providing safe & effective contraception to HIV-infected women is a primary strategy for prevention of paediatric HIV infections.

The finding of this study will contribute towards the understanding of the extent of dual-contraceptive utilization and how it varies from individual to individual depending on the various factors. It will help to improve the Nursing management, care and support of sero-positive people to incorporate their desires as other people. The outcome will also shade some light about the importance of correct and consistent use of dual contraceptive methods service among people living with HIV/AIDs as well as other sexually active peoples to promote reproductive health service by reducing unintended pregnancy, HIV and other sexually transmitted infections.

And also, this study will enable the health service managers & planners to look at the problems during their planning phase about reproductive health service for sero-positive people. Furthermore, since there was limited studies related to the topic in the country, Regions & particular in the study area, this study will be used as a baseline data for future studies.

## **Chapter 3: Objectives**

### **3.1. General objective**

The general objectives of this study is to assess dual contraceptive method utilization and associated factors among HIV positive women attending ART clinic in G/Tsadik Shawo Hospital, Keffa Zone, SNNPR, South West Ethiopia.

### **3.2. Specific objectives.**

1. To assess the dual contraceptive method utilization practice among sero-positive women attending ART clinic in G/Tsadik Shawo Hospital, Bonga Town, Keffa Zone, SNNPR, South West Ethiopia.
2. To identify factors that influence uptake of dual contraceptive services among sero-positive women attending ART clinic in G/Tsadik Shawo Hospital, Bonga Town Keffa Zone, SNNPR, South West Ethiopia.

## **Chapter 4: Methods and materials**

### **4.1. Study area and period**

This study was conducted in SNNPR State, Keffa Zone, Bonga Town G /tsadik Shawo Hospital ART Clinic. Keffa zone is located in the South West of SNNP Region; about 449Kms from Addis Ababa and 115 kms from Jimma University with a total population about 1,011,781, in which 49.36% are male and 50.64% are female (2007 senses). About 929,523(91.87 %) people are living in rural area while only 82,258 (8.13 %) people are living in Urban. Majority of the population living condition is depending on agricultural economy. The zone has one district Hospitals, 32 Health Centres and 246 Health Posts. These make geographical health coverage of the zone 80%. Like other part of the SNNPR HIV/AIDS is one of the major health problems in Keffa zone with huge social and economic impact. About 3,224 people are now a day HIV positive in the zone. From those HIV positive people about 1,050(332 male, 718 female) are attending ART and pre-ART services from this G/Shawo Hospital. Study was conducted from February 20<sup>th</sup> to March 30<sup>th</sup> of 2013.

### **4.2 Study design**

Facility based Cross sectional study design with triangulation of both quantitative and qualitative data to assess the dual contraceptive method utilization and associated factors among sero-positive women.

### **4.3 Source and study population**

#### **4.3.1 Source population**

- All HIV positive women in Kaffa Zone who are under follow up in G/tsadik Shawo Hospital ART clinic.

#### **4.3.2 Study population**

- Sampled HIV positive women who were under follow up in G/tsadik Shawo Hospital during data collection Period

## 4.4 Sample size determination and sampling technique

### 4.4.1 Sample size determination

Determination of the sample size was according to study finding from previously done in Lusaka, Zambia about modern Contraceptive and Dual Method Use among HIV-Infected Women. In this study the prevalence of effective dual contraceptive utilization reported was 17.7% (30).

The actual sample size was calculated using the formula:

$$n = \frac{(Z_{\alpha/2})^2 P(1-P)}{(d)^2} = \frac{(1.96)^2 0.177(1-0.177)}{(0.05)^2} = 223.8$$

**n**=the required sample size

**p**=the proportion of dual contraceptive utilization to be 17.7 %

**Z $\alpha/2$** = confidence interval of 95% and **Z $\alpha/2$**  is the value of the standard normal distribution corresponding to a significant level of alpha ( $\alpha$ ) 0.05, which is 1.96.

**d**=the margin of error between the sample and the population 5%.

To compensate for non response rate due to unseen conditions 10% of the sample was added;

Final sample size  $224 + 22 = \underline{246}$  HIV positive women were selected as the study respondent.

### 4.4.2 Sampling technique

A simple random sampling technique was used to select participants from all 718 HIV positive women attending ART clinic by using their ART unique identification numbers from their registration book. The List's of clients who had an appointment during the study period was used as a sampling frame for lottery method simple random sampling technique study unit selection.

### 4.4.3 Data collection technique and instrument

Quantitative data was collected by face to face interview using structured tools. Six health professionals experienced in data collection and having minimum of diploma in Nursing/Midwifery were recruited for data collection from catchment area health center staff. They were trained for 2 days on the purpose of the study, contents of questionnaires, data collection methods, process of assigning study participants, and ethical concerns during data collection. In addition, two supervisors were assigned from the Hospital to handle any problem; ensure data quality and to check proper completeness of questionnaire.



#### **4.4.4 Qualitative study**

To complement the quantitative results, in-depth interview was conducted on purposively selected eighteen (18) participants ( HIV positive women who attending ART clinic and these were out of quantitative study participants). Purposive sampling method was used to select the qualitative study subjects after quantitative data collection to have insight of the subject. It is essential to generate more factors which might be missed or blurred by the questionnaires of the quantitative part. The individuals included in qualitative in-depth interview were volunteer HIV positive women. The objectives and benefits of the study were explained and one to one discussion was done after verbal consent was taken. In-depth interview was conducted by the principal investigator using interview guide-line and the field report was analyzed on daily; not to miss or change the meaning of the respondent's ideas.

#### **4.5 Study Variables**

##### **4.5.1 Dependent variable**

- Dual contraceptive utilization

##### **4.5.2 Independent (predictor) variables**

**Socio demographic characteristics** (age, marital status, educational status and religion)

**Community factors** (Partner support, Peer influence, Cultural norms)

**Clients condition** (number of children, knowledge of dual contraceptives, occupation, and disclosure)

**Service related factors** (training/skills including-systematic counseling about contraceptive utilization, availability and accessibility of FP services, integration of services)

#### **4.6 Operational definition**

**Dual protection:** - The practise of FP methods by HIV positive people, that can prevent STI/ further HIV infection and unwanted pregnancy by using simultaneously two methods (condom plus other effective FP methods).

**Dual Contraceptive:** - Contraceptive methods utilized by HIV positive women, that are one barrier method (condom) plus other types of contraceptives (COCs, Injectable, Norplant, IUCD).

**Effective dual contraceptive method utilization:** - utilization of dual contraceptive methods always correctly and consistently in every episode of vaginal sex among HIV positive women.

**HIV Positive women on ART:** - HIV positive women who had at least one visit to the selected ARV treatment and care clinic for receiving ARV treatment.

**Unwanted pregnancy:** - is a pregnancy that is identified by the HIV positive mother as either mistimed or occurring earlier than wanted at the time of conception irrespective of the number of children.

#### **4.7 Data quality assurance**

To insure the quality of data questionnaires were translated to Amharic and Kaffi Noono then back to English by language expert for the sake of keeping consistency. Two supervisors were followed the quantitative data collection process and the qualitative data collection was carried out by the principal investigator. Two days training was given for data collectors and supervisor. The issue of confidentiality and privacy was stressed during the training session. A client exit interview was done in separate rooms or in a place where no one else could have heard the interview. Supervisor was followed the data collection activity daily and checked at spot for completeness. Any mistakes were been corrected timely and the filled questionnaires was reviewed together with the group of data collectors and principal investigator each evening and morning.

#### **4.8 Pre-test**

A pre-test of the questionnaire was done on 5% HIV positive women attending in Jimma University Specialized Hospital ART clinic ten days prior to main study periods. It was used to confirm the appropriateness of the tool, whether it is too long or not, difficult or easy to understand, check for clarity of the questionnaire items and to eliminate ambiguity, difficult wordings or uncomfortable questions. The participants in the pre test were given the opportunity to seek clarity where necessary and to give their suggestions.

## **4.9 Inclusion and exclusion criteria**

### **4.9.1 Inclusion criteria**

- Female clients diagnosed to have HIV and attending the ART and care service
- HIV positive women who have at least one appointment at G/tsadik Shawo Hospital during data collection period
- Adult HIV positive women age greater than or equal to 18 years
- HIV positive women who were voluntary for participation in the study

### **4.9.2 Exclusion criteria**

- Those who seriously ill and, mentally impaired
- Age less than 18 years
- Clients who were not voluntary for participation

## **4.10 Data processing and analysis**

Quantitative data were entered, cleaned and analyzed using SPSS version 16.0 statistical software. Errors related to inconsistency of data was checked and corrected during data cleaning. The univariate analysis such as proportions, percentages, ratios, frequency distributions and appropriate graphic presentations besides measures of central tendency and measures of dispersion were used for describing data. Bivariate analysis of socio-demographic, client's circumstance, community related factors and Service providers and availability of modern contraceptive services consistently were included. Then multivariate logistic regression model were employed to control confounding variables. Variables included in the model were those significantly related or supposed to be significantly associated to out comes at the bivariate level.

In the qualitative data the entire audio taped In-depth interview was transcribed and then translated to English. The translated transcript was reviewed and examined line-by-line and highlighted using different colours and then categorized in to primary codes or themes. Later data was reviewed and combined in to broader concepts. The concepts were coded in to major themes and analyzed accordingly.

#### **4.11 Ethical consideration**

Ethical approval of the research proposal was received from Ethical approval committee at Jimma University college of public Health and medical science and letter of permission was taken from department of Nursing and Bonga G/tsadik Shawo Hospital). Individuals' verbal informed consent was taken and confidentiality with privacy was ensured for all participants.

Everyone was given right to voluntarily participate or decline to participate in the interview at any step. The data collector would respect the client's ability to choose, make decision, and change in the light of his/her own beliefs, values and circumstances. The individual could refuse or interrupt at any step of the participation. Whether or not responded no harm to the individuals with regard to the service they intend to get.

The interaction was made between one interviewer and the interviewee. The room and environment was made conducive to make communication private and maintain confidential. The individuals were convinced that the information they gave would be kept private, secret and not disclose to a third party. The data collector would make thorough explanation about the objective of the study and confidentiality ahead of the each interview. They were told that the information from respondents would not be used for other purpose rather than this research. They were confirmed that their name was not written on the questionnaires. They were communicated that the questionnaire papers will be discarded with care after research completion.

#### **4.12 Plans for dissemination and utilization of results**

The primary objective of this paper is a partial fulfilment of the degree of masters in Maternity Nursing . So it was submitted to department of Nursing, College of public Health and Medical science of Jimma University. However, findings from this study will serve as baseline information as well as a reference material for further researchers, experts or policy makers for intervention at National, Regional and Zonal level. Therefore, it can serve as a reference in the library. In addition, a copy of this material would be given to, Bonga G/tsadik Shawo Hospital. Effort will be made to publish on local, national and international scientific journal.

## Chapter 5: Results

In this institution based cross-sectional study a structured questionnaire was administered to 243 study participants and the response rate of quantitative study is 98.78%. The qualitative data was collected from 18 sero-positive women (five community mother support worker and 13 other clients attending ART services) by in-depth interview using in depth interview guideline to support and complement the quantitative data.

### 5.1.1 Socio demographic characteristics of quantitative study HIV positive women attending ART unit G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013

A total of 243(98.78%) of total sample size HIV positive women participants were conducted in this study. The mean  $\pm$  SD of maternal age of all study participants was 28.43  $\pm$  6.70 years. From those 94(38.7%) were age 25-29 years, 70(28.8%) were age group of 30-39 years and 4.9% were age group of 15-19 years. Among the respondents those attained primary school were 120(49.4%) and 12<sup>th</sup> and above were 19(7.8%) where as 55(22.6%) were illiterate. Concerning ethnicity, among the participants 159 (65.4%) were Kefa, 32(13.2%) were Amhara while 7(2.9%) were others (Wolyita Yem and Dawuro). Majority were followers of Orthodox religion about 160(65.8%), where as Muslim 30(12.3%), protestant and catholic 34(14%) and 19(7.8 %) respectively. The marital status distribution shows over half 132(54.3%) of the study groups were currently married, 30(12.3%) were widow. Occupational distribution shows house wives 86(35.4%), daily labourer 45(18.5%), students and bar ladies were 23(9.5%), 13(6.2%) respectively (Table.1).

**Table1:- Socio demographic characteristics of HIV positive women attending art clinic at G/tsadik shawo Hospital, kefa zone, SNNPR, Ethiopia, 2013**

Characteristics(variables)	Frequency(n)	Percent (%)
Age		
15-19 years	12	4.9
20-24 years	50	20.6
25-29 years	94	38.7
30-39 years	70	28.8
40-49 years	17	7.0

Religion	Orthodox	160	65.8
	Catholic	19	7.8
	Protestant	34	14.0
	Muslim	30	12.3
Education	Illiterate	55	22.6
	Primary (1-8 <sup>th</sup> grade)	120	49.4
	Secondary (9-12 <sup>th</sup> grade)	49	20.2
	Tertiary (12 <sup>th</sup> +)	19	7.8
Ethnicity	Keffa	159	65.4
	Amhara	32	13.2
	Gurage	8	3.3
	Oromo	27	11.1
	Tigray	10	4.1
	Others*	7	2.9
Marital status	Single	37	15.2
	Married	132	54.3
	Divorced	44	18.1
	Widowed	30	12.3
Occupation	Gov't employee	25	10.3
	private employee	16	6.6
	Daily labourer	45	18.5
	House wife	86	35.4
	Merchant	33	13.6
	Student	23	9.5
	commercial sex worker	15	6.2
Residence	Urban	182	74.9
	Rural	61	25.1

\* Wolyita, Yem & Dawuro

### **5.1.2 Socio demographic characteristics of qualitative study participants of HIV positive women attending ART unit in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013**

Eighteen female participants were interviewed and their age ranges 20 to 49 years while educational level ranges illiterate to first degree. Fourteen of them were married, two widowed and, two single. The occupational status was from most categories, eleven house wives, three NGO employee mother support worker, two merchants, one Government employees, and one daily labourer. In ethnic group thirteen keffa, three Amhara and two Oromo respondents were participated .Regarding to residence majority of the respondents were from urban, those were sixteen and two were from rural area .

### **5.2 Distribution of client related factors on dual contraceptive utilization of HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013**

Above half 135(55.6%) of the respondents CD4 count was  $>350\text{cells}/\text{mm}^3$  and 37(15.5%) respondents CD4 count  $< 250\text{ cells}/\text{mm}^3$ . From those HIV positive women included in the study 130 (63.4%) women's partners were tested for HIV, 29(14.1%) women didn't know whether their partners tested or not. Out of 205married HIV positive women 95(46.3%) male partners were HIV positive (have concordant results) while 35(17.1) male partners were HIV negative (have discordant result). 199(81.9%) of sero-positive women have sexual intercourse practice after knowing their HIV diagnosis result and 44(18.1%) women preferred and practiced abstinence after knowing their sero-status. Prevalence of any modern contraceptive method utilization practice among all study respondents is 69.1%. Nearly half 103(42.4%) of respondents have Knowledge about dual contraceptive methods and 99(40.7%) had dual contraceptive method utilization experience but only 48(19.8%) women used dual contraceptive method correctly and consistently.Major reasons why they used dual contraceptive methods were, 104(42.8%) to prevent pregnancy, 76(31.3%) to prevent extra sero-type HIV infection and 17(7%) to prevent HIV transmission to discordant partners (table 2).

*The finding has related with in-depth interview responses:-*

*A woman (35years old and widowed) said: “since my husband was died and I knew HIV virus present in my blood, I haven’t done any sexual contact and I preferred abstinence because I was informed about varies species of HIV virus and it differ from person to person . So I fear additional infection and committed to myself not to do any sexual contact”.*

*A woman (25 years old and divorced) stated; “I have three children even if now I am divorced due to discordant HIV test result, I don’t want to make sexual contact until I will get the same HIV positive man by marriage. Using family planning method is not allowed in my religion, so I don’t want to use any type of F/P methods now and even for future”.*

*A 23 years old woman and mother support worker mentioned; “I know what does dual contraceptive method mean and its importance. Dual contraceptive method utilization prevents unintended pregnancy, extra infection with other strain of HIV virus, STIs such as syphilis Gonorrhoea and others. I and my partner discuss openly when and what types of F/P methods we should use. So we use now condom correctly and consistently plus depo provera to prevent pregnancy”.*

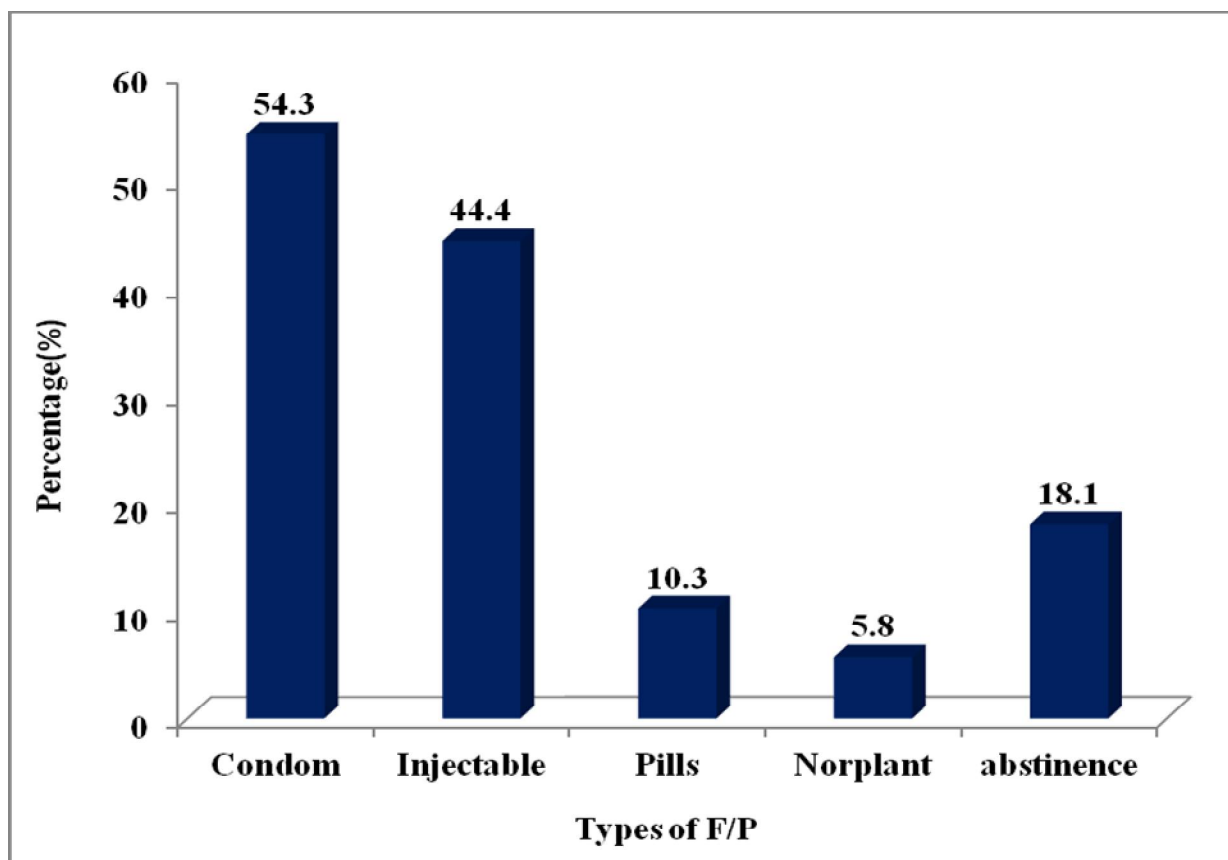
*28 years old, married and mother support worker said: “I know about Dual contraceptive methods and its function. Condom can prevent pregnancy and transmission of HIV virus to others. So I used condom during sexual contact but we miss some time when we haven’t got it”.*

*A woman (36 years old, widowed and mother support worker) said; “dual contraceptive method means utilization of two different types of FP methods together to prevent pregnancy and STIs. For example utilising condom appropriately plus taking Depo provera injection. I always use condom plus Depo provera to prevent the related problems what I mentioned above”.*



**Table2:- Distribution of client related factors on dual contraceptive method utilization of HIV positive women on art and follow up clinic at G/tsadik Shawo Hospital, kefa zone, SNNPR, Ethiopia, 2013**

<b>Characteristics</b>	<b>Catagories</b>	<b>Frequency</b>	<b>Percent</b>
<b>Current CD4 count amount</b>	CD4<250 cells/ mm <sup>3</sup>	37	15.2
	CD4 250-350 cells/ mm <sup>3</sup>	71	29.2
	CD4 >350 cells/ mm <sup>3</sup>	135	55.6
<b>Partner's sero-status (n=205)</b>	Positive	95	46.3
	Negative	35	17.1
	I don't know	75	36.6
<b>Sexual intercourse practice after HIV dx</b>	Yes	199	81.9
	No	44	18.1
<b>Utilization of any contraceptive methods</b>	Yes	168	69.1
	No	75	30.9
<b>Knowledge about dual-contraceptive</b>	Yes	103	42.4
	No	140	57.6
<b>Utilization experience of dual-contraceptive</b>	Yes	99	40.7
	No	144	59.3
<b>Pattern of dual-contraceptive utilization</b>	Always	48	19.8
	Some time	61	25.1
	Not use	134	55.1
<b>Reasons they use dual-contraceptive ; to prevent:-</b>	Pregnancy	104	42.8
	STDs	65	26.7
	HIV transmission	17	7.0
	HC provider advice	35	14.4
	Other sero type HIV	76	31.3



**Figure 2:- Indicates distribution of different types of contraceptive method utilization among HIV positive women.**

**5.3 Distribution of different types of contraceptive method utilization among HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013.**

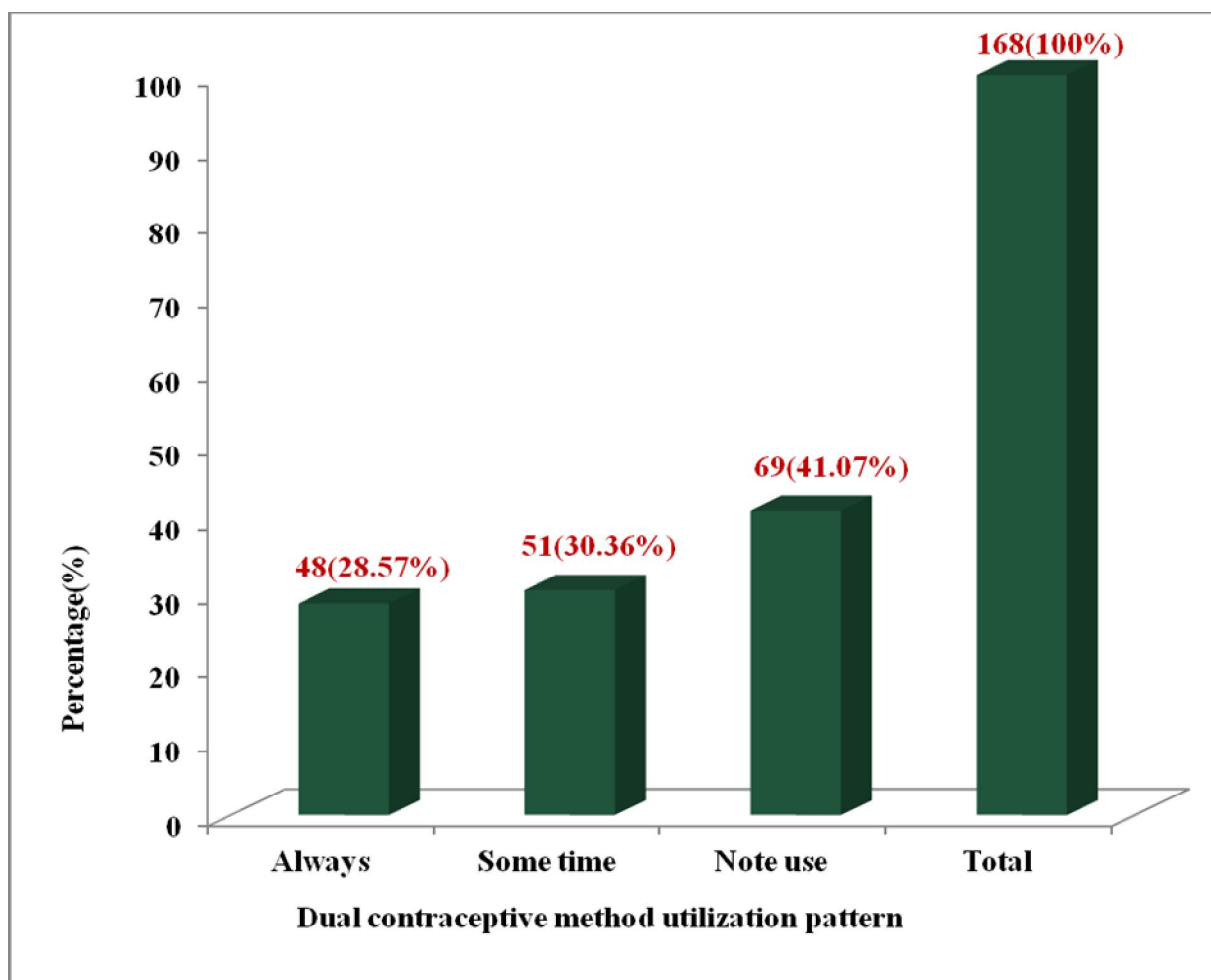
Among the types of contraceptive methods used by HIV positive women respondents attending ART Clinic, condoms were the most commonly used (54.3%), inject able (depo provera) 44.4% and 18.1% respondents abstained from sexual intercourse after they diagnosed HIV Positive.

*The finding has similarity with in-depth interview responses:*

*A woman (24 years old and married) expressed; “Health professional counselled me many times concerning dual contraceptive methods utilization, so I accepted their counselling and now a day I use condom to prevent STIs and cross transmission of HIV virus from me to my*

husband and vice versa; depo provera to prevent unintended pregnancy by agreement with my spouse. As we have only one female child now, we planned to have additional child for future”.

A woman (26 years old and married) said: “I used only depo provera to prevent pregnancy; I never used condom during sexual intercourse and we do free sex as usual. I have no any experience and idea about dual contraceptive method utilization”.



**Figure 3:- Shows distribution of dual-contraceptive method utilization pattern among F/P user HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013.**

#### **5.4 Distribution of dual-contraceptive method utilization pattern among F/P user HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013.**

From all Different types of contraceptive method user HIV positive women 48(28.6%) respondents use dual contraceptive method always during sexual intercourse, 57(33.9%) use dual method some time and the rests not practise dual method even if they use family planning methods (fig.3).

*From In-depth interview response;*

*A woman (28 years old and married) mentioned; “after health professional counselled me about dual contraceptive methods essentiality and benefits, we also discuss openly at home about dual contraceptive method. We use condom always to prevent STIs infection and additionally I use Norplant to prevent pregnancy”.*

#### **5.5 Distribution of Community related factors on current FP utilization of HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013**

About 79(32.5%) of respondents revealed by itself HIV positivity affect dual contraceptive utilization practice. 28(11.5) Load of medication and 27 (11.1%) fear to go to family planning service unit affect dual contraceptive method utilization. 14.4% respondents feared to their Culture/norm and 8.6% of respondents said their spouse or partner would not allow them to use dual protection (Table 3).

*The explanation from in-depth interview strengthens the above response as follow:*

*A woman (27 years old and married) explained; “I never used any type of FP methods because my husband is not voluntary to use condom and even not allowed me to use other type of FP methods”.*

A woman (38 years old and widowed) said: “Really I don’t want to come to Hospital ART Clinic at mid time or clients over crowded period, so always I come at morning or afternoon when all clients returned, this is because of fearing not to meet peoples who know me at ART clinic, their talk affects our psychology more than the pathological affection of HIV viruses”.

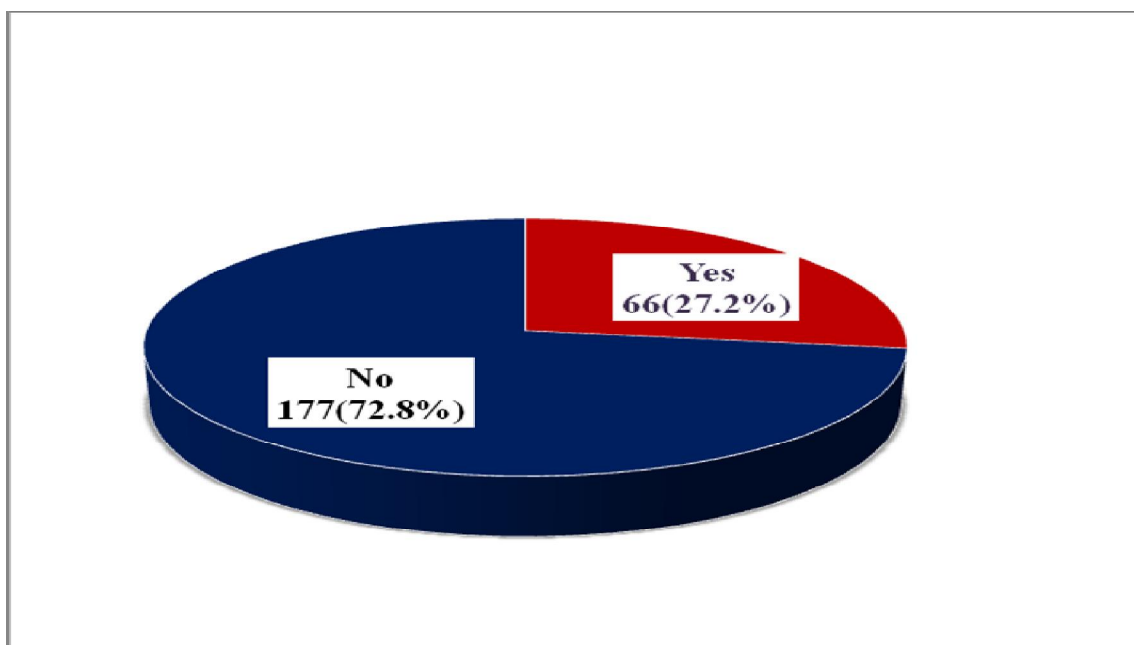
“In my opinion one of the factors which affect our dual contraceptive methods utilization is related to some MCH department workers who Know our HIV sero positivity suspect us, we are doing free sex without condom and we are worrying only to prevent pregnancy but the fact is not that, we wanted Depo provera, Pills and others in addition to condom as dual contraceptive method which used to prevent Pregnancy, STIs and extra HIV virus cross transmission” (23 years old, married and mother support worker women said).

**Table 3:- Distribution of Community related factors on dual-contraceptive utilization of HIV positive women on ART and follow up care at G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013**

Characteristics	Categories	Frequency	Percent
Effect of HIV positivity on dual-contraceptive utilization	Yes	79	32.5
	No	164	67.5
	Total	243	100.0
How HIV positivity affect dual-contraceptive utilization	Side effect of ART drugs	13	5.3
	Load of medication	28	11.5
	Fear to go to FP service	27	11.1
	Others*	11	4.5
Factors which affect dual-contraceptive utilization	Spouse	21	8.6
	Peers	16	6.6
	Faith or religion	19	7.8
	Culture/norm	35	14.4
	Others**	2	0.8

\*stress,

\*\* Sterility



**Figure 4:- shows the distribution of discussion to partner about dual contraceptive utilization among HIV positive women attending G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013.**

**5.6 Distribution of discussion to partner about dual contraceptive method utilization among HIV positive women attending G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013**

Partner communication about dual–contraceptive utilization is low, as the response from this study indicated. Only 66(27.2%) of respondents had discussed with their spouse or partner. 177(72.8%) respondents had no free discussion with their spouse/partner concerning dual contraceptive method utilization

*The explanation from in-depth interview strengthens the above respons:*

*20 years old married woman explained; “my husband is not voluntary to know whether he is HIV positive or not, in addition he is not voluntary to use any type of FP methods. Therefore, even if I know the benefits of dual contraceptive method utilization, I couldn’t practice it”.*

*A woman (22 years old and single) mentioned; “I don’t know about dual contraceptive methods. Before I become pregnant we use condom during sexual contact and still I haven’t disclosed my result for anyone even for my current boyfriends”.*

**5.7 Distribution of Services delivery factors on dual contraceptive utilization of HIV positive women on ART and follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013**

Regarding to the source and access of modern contraceptive 153(91.1%) would have got family planning service from Gov’t health institution and 62(36.9%) from Private pharmacy. From 168 family planning users 160(95.2%) had family plan access and only 95 (39.1%) respondents received counselling about dual-contraceptive method, 148(60.9%) was not get counselling about dual contraceptive method utilization

*A woman (33 years old and married) described; “I have no idea about dual contraceptive methods, I use only Depo provera to reduce irregular menstruation but not to prevent pregnancy”.*

*23 years old woman said: - “As I am community mother support worker, I contact many HIV positive mothers and discuss about chronic care services and ART drug adherences. Most of the HIV positive mothers do not use condom correctly and consistently, even some of them considerer’s as shame using and talking about condom utilization. Some of them discard and others sale to shop and Hotel when they got condom from Government health institution or other donators”.*

**Table 4:- Distribution of Services delivery factors on dual contraceptive utilization of HIV positive women on ART and follow up care at G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013**

Characteristics	Categories	Frequency(n)	Percent (%)
Source of FP service (n=168)	Gov’t health institution	153	91.1
	NGO health institution	14	8.3
	Private pharmacy	62	36.9
Access of FP	Yes	160	95.2
	No	8	4.8
	Total	168	100.0
Received counselling about dual-contraceptive method	Yes	95	39.1
	No	148	60.9
	Total	243	100.0

## 5.8 Associated factors

### 5.8.1 Associated factors to modern Family Planning Utilization of HIV positive Women on ART follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013

A multivariate Logistic regression analysis indicated current family planning service utilization among HIV positive women was significantly associated with some predictor variables. Such as age  $\geq 30$  years were more use than age group of 15- 24 years old women by COR 3.857, 95 % CI(1.837,8.100); AOR 2.842, 95% CI(1.140,7.085). Marital status such as widowed women were utilise family planning service more than 2 times than married HIV positive women of study group by COR 8.45, 95% CI(2.800,25.554)); AOR 2.34, 95% CI(1.566, 9.665). HIV positive women with current CD4 count amount  $>350$  cells/mm<sup>3</sup> were utilise more family planning service than CD4 count less than 250 cells/ mm<sup>3</sup> women's of study participant AOR 9.20, 95% CI(1.024,82.720). HIV sero-positive women's, those who have more than three children were utilise more family planning service than those women who have no child , COR 3.71, 95 % CI(1.511,9.112); AOR 1.74, 95% CI(1.38,7.89). In this study HIV positive women living in rural area were utilise less family planning service than those who have residence in urban, OR 0.545, 95% CI(0.298, 0.999); AOR 0.709, 95% CI(0.317, 0.985). women's who haven't got counselling about family planning services were also less F/P service utilise than women who received counselling regarding F/P service, COR 0.022, 95% CI(0.005,0.093); AOR 0.091, 95% CI(0.020, 0.423). Variables such as educational status, Occupation and partner's sero-status showed statistically insignificant relation between current family planning service utilization and not utilise by multivariate logistic regression analysis (Table 4).



**Table 5:- Associated factors of modern family planning utilization of HIV positive women on art follow up care in G/tsadik shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013**

Characteristics		Utilizing F/P	Do not use F/P	Statistical Significance	
		N (%)	N (%)	COR (95% CI)	AOR(95% CI)
Age (years)	15-24	49(79%)	13(21%)	1.00	1.00
	25-29	76(80.9%)	18(19.1%)	0.893(.402,1.984)	0.761(.301,1.928)
	>=30	43(49.4%)	44(50.6%)	3.857(1.837,8.100)**	2.842(1.140,7.085)**
Education	Illiterate	30(54.5%)	25(45.5%)	1.00	1.00
	Primary(1-8 <sup>th</sup> )	81(67.5%)	39(32.5%)	0.578(0.300,1.111)	0.947(0.342,2.623)
	Secondary(9-12 <sup>th</sup> )	42(85.7%)	7(14.3%)	0.200(0.077,0.522)*	0.309(0.080,1.199)
	Tertiary(12 <sup>th</sup> +)	15(78.9%)	4(21.1%)	0.320(.094,1.088)	0.868(0.149,5.046)
Marital status	Married	104(78.8%)	28(21.2%)	1.00	1.00
	Single	29(78.4%)	8(21.6%)	0.976 (0.402,2.369)	0.210(0.058, 0.753)
	Divorced	26(59.1%)	18(40.9%)	2.510(0.935,6.733)	1.124(0.328, 3.854)
	Widowed	9(30%)	21(70%)	8.458(2.800,25.554)**	2.339(1.566,9.665)**
Occupation	Employee	33 (80.5%)	8(19.5%)	1.00	1.00
	Daily labourer	27 (60%)	18(40%)	2.750(1.036,7.297)*	1.606(0.359, 7.171)
	House wife	61 (70.9%)	25(29.1%)	1.691(.686, 4.166)	3.935(0.825,18.773)
	Merchant	17(51.5%)	16(48.5%)	3.882(1.385,10.884)*	3.086(0.654,14.562)
	Students	15 (65.2%)	8(34.8%)	2.200(0.693 6.979)	0.933(0.167, 5.204)
	Bar ladies	15(100%)	0	0.000	0.00
Residence	Urban	132(72.5%)	50(27.5%)	1.00	1.00
	Rural	36(59%)	25(41%)	0.545 (0.298,999)*	0.709(0.317,0.985)*
Current CD4 count t	<250 cells/ mm <sup>3</sup>	35(94.6%)	2(5.4%)	1.00	1.00
	250-350 cells/ mm <sup>3</sup>	50(70.4%)	21(29.6)	7.350(1.618,33.383)*	6.939(0.71,67.75)
	>350 cells/mm <sup>3</sup>	83(61.5%)	52(38.5%)	10.964(2.53,47.518)**	9.204(1.02,82.72)*
Partner's HIV test	Yes	98(75.4%)	32(24.6%)	1.00	1.00
	No	27(58.7%)	19(41.3%)	2.155(1.060,4.382)*	1.369(0.512, 3.659)
	I don't know	15(51.7%)	14(48.3%)	2.858(1.246,6.558)*	2.029(0.688, 5.981)
Partner's sero-status	Positive	67(70.5%)	28(29.5%)	1.00	1.00
	Negative	31(88.6%)	4(11.4%)	0.309(0.100,0.957)*	0.340(0.096,1.207)
	I don't know	42(56%)	33(44%)	1.880(.997,3.545)	---
Number of children	No child	41(75.9%)	13(24.1%)	1.00	1.00
	1-3 children	110(72.4%)	42(27.6%)	1.204(0.587,2.469)	0.487(0.139,1.708)
	>3 children	17(45.9%)	20(54.1%)	3.710(1.511,9.112)*	1.740(1.383,7.896)*
Received counselling about F/P	Yes	93(97.9%)	2(2.1%)	1.00	1.00
	No	75(50.7)	73(49.3)	0.022(0.005,0.093)***	0.091(0.020,0.423)***

\* Statistically significant at p< 0.05, \*\* statistically significant at p< 0.01 and \*\*\* statistically significant at p< 0.001

### **5.7.2 Association of dual contraceptive method Utilization of HIV positive Women on ART follow up care in G/tsadik Shawo Hospital, Kefa Zone, SNNPR, Ethiopia, 2013**

A multivariate Logistic regression analysis indicated dual contraceptive method utilization among HIV positive women was significantly associated with some predictor variables. Such as age  $\geq 30$  years women were more users than age group of 15- 24 years old women by COR 3.350, 95 % CI(1.655, 6.781); AOR 2.445, 95% CI(1.131, 5.284). Marital status such as widowed women were more utilise dual contraceptive method serve than married HIV positive women of study group, COR 4.940, 95% CI(1.632, 14.953); AOR 4.018, 95% CI(1.219, 13.21). HIV positive Women with current CD4 count amount greater than 350 cells/mm<sup>3</sup> were utilise more dual contraceptive methods than CD4 count amount  $< 250$  cells/mm<sup>3</sup> women's of study participant COR 7.389, 95% CI(3.200, 17.06); AOR 8.516, 95% CI(1.005, 72.168). Both partners who have free discussion and common decision on contraceptive method services, utilise more dual contraceptive methods than those partners who have no open discussion, AOR 17.45, 95% CI(8.198, 37.14) ; COR 10.234 95% CI(3.525, 29.718). Women living in rural area were less dual contraceptive method utilizing than those who have residence in urban, COR 0.471, 95% CI (0.251, 0.886); AOR 0.309, 95% CI (0.317, 0.985). women's who haven't got counselling about dual contraceptive method services were also less dual contraceptive method utilizing than women who have received counselling regarding dual contraceptive method services, COR 0.015, 95% CI(0.006, 0.034); AOR 0.042, 95% CI(0.016, 0.111). Variables such as educational status, Occupation and number of children showed statistically insignificant relation between dual contraceptive method utilization and not utilization by multivariate logistic regression analysis (Table 5).

**Table 6:- Association of dual contraceptive method utilization of HIV positive women on art follow up care in G/tsadik Shawo Hospital, Kefa zone, SNNPR, Ethiopia, 2013**

Characteristics		Dual - contraceptive method users	Not using dual contraceptive methods	Statistical Significance	
		N (%)	N (%)	COR (95% CI)	AOR (95% CI)
<b>Age (years)</b>	15-24	31(50%)	31(50%)	1.00	1.00
	25-29	48(51.1%)	46(48.9%)	0.958(0.505,.505)	0.874(0.427,1.790)
	>=30	20(22.9)	67(77.1)	3.350(1.655,6.781)*	2.445(1.131,5.284)*
<b>Education</b>	Illiterate	17(30.9%)	38(69.1%)	1.00	1.00
	Primary(1-8 <sup>th</sup> )	47(39.2%)	73(60.8)	1.938(0.653, 5.752)	0.812(0.362, 1.823)
	Secondary(9 <sup>th</sup> 12 <sup>th</sup> )	23(46.9%)	26(53.1%)	2.663(0.978, 7.250)	0.626(0.232, 1.687)
	Tertiary(12 <sup>th</sup> +)	12(63.2%)	7(36.8%)	3.832(1.284,11.438)*	.272(0.055, 1.334)
<b>Marital status</b>	Married	57(43.2%)	75(56.8%)	1.00	1.00
	Single	19(51.4%)	18(48.6%)	0.720(0.347, 1.495)	2.097(0.727,6.052)
	Divorced	19(43.2%)	25(56.8%)	1.000(0.502, 1.991)	1.303 (0.542 3.135)
	Widowed	4(13.3%)	26(86.7%)	4.940(1.632, 14.95)**	4.018(1.219, 13.21)**
<b>Occupation</b>	House wife	36(41.9%)	50(58.8)	1.00	1.00
	Daily labourer	16(35.6%)	29(64.4%)	1.305(0.619,2.751)	0.801(0.273,2.353)
	Employee	22(53.7%)	19(46.3%)	0.622(0.294,1.314)	0.995(0.293,3.374)
	Merchant	6(18.2%)	27(81.8%)	3.240(1.213,8.658)*	3.194(0.927,10.999)
	Student	4(17.4)	19(82.6)	3.420(1.072,10.91)*	0.720(0.145,3.573)
	Bar ladies	15(100%)	0	.000	.000
<b>Residence</b>	Urban	82(45.1%)	100(54.9%)	1.00	1.00
	Rural	17(27.9%)	44(72.1%)	0.471(0.251,0.886)*	0.309(0.317, 0.985)*
<b>Current CD4 count amount</b>	<250 cells/dl	28(75.7%)	9(24.3)	1.00	
	250-350 cells/dl	31(43.7%)	40(56.3%)	4.014(1.656,9.731)*	6.905(0.749,63.61)
	>350 cells/dl	40(29.6%)	95(70.4%)	7.389(3.200,17.06)*	8.516(1.005,72.168)**
<b>Number of children</b>	No child	30(56.6%)	24(44.4%)	1.00	1.00
	1-3 children	58(39.6%)	94(61.4%)	2.026 1.080, 3.799)*	3.299(0.817, 13.318)
	more than three	11(29.7%)	26(70.3%)	2.955(1.218,7.166)*	2.623(0.427, 16.100)
<b>Received counselling about F/P</b>	Yes	84(88.4%)	11(11.6%)	1.00	1.00
	No	15(10.1%)	133(89.9%)	.015(.006, .034)***	.042(.016, 0.111)***
<b>Discussion with partner</b>	Yes	56(84.8%)	10(15.2%)	17.45(8.198,37.14)***	10.234,(3.525,29.718)***
	No	43(24.3%)	134(75.7%)	1.00	1.00

\* Statistically significant at  $p < 0.05$ ; \*\* statistically significant at  $p < 0.01$ ; statistically significant at  $p < 0.001$

## Chapter 6: Discussion

### 6.1 Discussion

This facility based cross-sectional study assessed dual contraceptive method utilization and associated factors of HIV positive women who were on antiretroviral treatment and follow up at ART unit during study period February to March 2013. This mixed-methods investigation suggests that dual-contraceptive methods are not widely used by HIV positive women. Only about one-fifth of participants in the study reported using dual-contraceptive methods condom use in combination with an effective pregnancy prevention method (OCPs, injectables, or Norplant). We know that no previous studies conducted that examined the prevalence of dual-contraceptive methods use among HIV positive women in study area and even in national level in Ethiopia. The prevalence of dual-contraceptive methods use among HIV positive women in this study is (19.8%) which is quite approached when compared with finding from study conducted on HIV sero positive women in Lusaka Zambia 17.7% [30], study on both men and women in India 23% [28] but this study finding is lower than that a cross-sectional survey result in Soweto, South Africa on HIV-positive women shows, (33%) [29], in USA California 26% [22]. One study done about dual contraceptive method utilization in Adewa, Northern Ethiopia shows 13.8% [35] of dual contraceptive utilization prevalence, which is lower than from this study finding, this is due to study population difference (study conducted in Adewa, study population includes both HIV Negative and positive adults). This current our study result is also higher when we compare with Uganda HIV positive people's dual contraceptive utilization prevalence 2% [32], this difference may be due to presently strengthened HIV service integration with family planning and health service extension workers all over the community and they are working on awareness creation.

An important factors that made statistically significant association with dual contraceptive method utilization in this study are age, marital status, residence, CD4 count, receiving counselling and discussion with health professional as well as partners. As this study finding reveals, those who have age greater than or equal to 30 years use dual contraceptive methods more than two times than age less than or equal to 25 years, this study result may be differ from Lusaka Zambia finding with  $\geq 35$  years old (AOR: 0.63; 95% CI (0.52–0.77)), uses less dual contraceptive method than age  $< 25$  years. This difference may be due to study area back

ground Zambia study conducted in capital Town Lusaka but this study conducted in rural small Town. this finding supported by qualitative study part , most of the In-depth interviewed married young respondents said they need to have child in their life, vice versa aged HIV positive married women as well as divorced or widowed interest to have child is low, due to this their dual contraceptive utilization habit is better than from youngest. The marital status specially widowed HIV positive women use dual contraceptive method about four times than married HIV positive women, COR 4.940, 95% CI (1.632, 14.953); AOR 4.018, 95% CI(1.219, 13.21). It is related to a cross-sectional survey done in united state not married were Correlated with higher rates of dual-contraceptive-method use [20]. As dual method utilization needs both partners' agreement and participation, the qualitative in-depth interview response reveals most of the spouse not cooperative to use dual method (only 8.6% according to this study finding). In other way widowed women's sexual intercourse decision includes both partners agreement. So this both side agreement and decision before sexual intercourse may be one factor to improve dual contraceptive utilization practice among widowed women.

Residence of the respondents was one of the significantly associated factors for dual contraceptive method utilization, HIV positive women who come from rural area were less dual contraceptive method user than those from urban area, COR 0.545, 95% CI (0.298, 0.999); AOR 0.709, 95% CI (0.317, 0.985). This variation is caused by information gape among rural and urban area and accessibility of family planning services and logistics in urban than rural area. The number of children was also significant factors for HIV positive women to use or not dual contraceptive methods. Women's who have more than three children uses dual contraceptive method more than 1.7 times than women who have no child, COR 3.71, 95 % CI (1.511, 9.112); AOR 1.74, 95% CI (1.38, 7.89). This finding is similar with cohort study result in Zambia, (AOR: 2.07; 95% CI: (1.59–2.70) [30], HIV positive mothers who have no child needs to have child , and in addition the expansion of PMTCT service in primary health care units encourages their need of child and consequently their family planning practice became low. In qualitative in-depth interview the respondent said ,as other HIV negative mother ,we have chance to get HIV negative child , due to this their family planning service need became lower.

CD4 cell count amount was significantly associated with dual contraceptive utilization in both binary and multivariate logistic regression analysis, CD4 count greater than 350 cells/mm<sup>3</sup> women use more dual contraceptive methods than CD4 count less than 250 cells/mm<sup>3</sup> with COR 7.389, 95% CI (3.20,17.06); AOR 8.516, 95% CI (1.005,72.168). The study result in Zambia reveals the related finding AOR: 1.25; 95% CI: (1.091.45) [30]. This implies, when the /8/CD4 cell amount increased the health condition of the client is improving and the physiological needs like sexual intercourse interest may be increase and they might use dual contraceptive method than clients with CD4 lower. Free discussion with partner as well as with health professional and receiving counselling about dual contraceptive methods are associated with current dual contraceptive method utilization practice .HIV positive women who have open discussion with partner use dual contraceptive methods ten times more than women who have no discussion with their partners COR =10.23 95% CI (3.53,29.72). This finding is similar with finding from India [28], Soweto South Africa [29], Lusaka Zambia [30], Uganda [26] and Adwa northern Ethiopia [35]. Most of the respondents in in-depth interview mentioned, even if they know the benefits of dual contraceptive method utilization and they wanted to use, their partners were not volunteers to use. To improve the practise of dual contraceptive method utilization, counselling both partners and making them to discuss and come to common decision about dual contraceptive method are the important points identified from this study finding.

## 6.2 Strengths and Limitations

### 6.2.1 Strengths

- This study is supplemented by qualitative studies to enrich the information which are not addressed by the quantitative results.
- Use of pretested questionnaire
- It identified important factors associated with use of dual contraceptive methods.
- It offered useful information for designing interventions to promote utilization of dual-contraceptive methods among HIV positive people in study area and even in national level.

### 6.2.2 Limitation of the study

- There may be social desirability bias so they may hide the real information.
- Cross sectional nature of the study design precluded determining causal relation
- The sample size is small, taken from a hospital and hence not possible to generalize.

## Chapter 7: Conclusion and recommendations

### 7.1 Conclusion

This study finding revealed that the prevalence of effective dual-contraceptive method utilization practice among HIV positive women is only 19.8%. This indicated many women are placing themselves at risk for STIs and unplanned pregnancies that can be avoided by using dual contraceptive method (Condom plus highly effective contraceptive method such as Pills, depo provera, Norplant, IUCD and the likes). The majority of the study respondents did not practice dual contraceptive method services. Less than half of the participants have awareness on dual contraceptive method services. The major reasons for not using dual contraceptive method were less participation of partner on F/P service utilization decision, and absence of open discussion with partner. Age, Marital status, Residence, CD4 count, receiving counsel about F/P and discussion with partner were predictors for utilization of dual contraceptive method

what we conclude from qualitative study finding that some women who were on antiretroviral treatment and follow up care came to the ART unit after their pregnancy advanced. They responded that unplanned pregnancy happened after having sexual intercourse with men of unknown HIV status . so such kind of pregnancy carried double risks first to the man whose sero-status unknown and second to the fetus that the woman carried. Therefore to reduce or prevent such kind of problems, the integrated Health service needed among ART, PMTCT and MCH department to improve the awareness and utilization experience of dual contraceptive methods among HIV positive people.



## 7.2 Recommendations

- Regional Health bureau, Zonal Health department and District Health office should give attention on HIV positive people's reproductive health Services by availing necessary logistics, monitoring and evaluating the activities.
- Health professional in Hospital and Health center level workers should be committed to integrate ART PMTCT and FP service and strengthen counselling HIV sero-positive people to improve awareness about dual contraceptive method and utilization.
- Health Extension and Voluntary community Health workers should give focus and support on HIV positive people by counselling and continuously discussing on male participation importance specially to implement dual contraceptive method.
- Further study should be needed for more investigation on utilization of dual contraceptive method on HIV positive people including both males and females

## Annex I: - References

1. Federal Democratic Republic of Ethiopia, Country Progress Report on HIV/AIDS Response, 2012
2. UNAIDS. World AIDS day report. 2011
3. (EDHS) Ethiopia Demographic and Health Survey, 2011
4. UNPF & WHO; Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and Their Children in Resource-Constrained Settings, WHO, Geneva, Switzerland, 2006.
5. Trussell R. Hatcher J. Trussell A. Nelson W. Cates Jr. Stewart H, and Kowal D. “Choosing a contraceptive efficacy, safety, and personal considerations,” in *Contraceptive Technology*, Eds., Ardent Media, New York, NY, USA, 19th edition, 2008.
6. Townsend, C. Mario Cortina-Borja A. Catherine S. Peckham A. Annemiek H., et al. Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000 – 2006. *Lippincott Williams & Wilkins*, 22, 973–981.
7. Chris O. Contraception in the Context of HIV/AIDS; *African Journal of Reproductive Health*, 2012; 16(4):1-25
8. USAID, Interagency gender working group subcommittee on men and women reproductive health; Theme Statement on dual protection, 2003.
9. Joanne E.Mantell S. Hoffman T. Exner, Z. & Kim S. Family Planning Providers’ Perspectives on Dual Protection; *New York State Psychiatric Institute; USA*, 2003, 35(2), 71-78.
10. Davis K. Weller S. The effectiveness of condom in reducing heterosexual transmission of HIV. *Family Planning Prospect*, 1999, vol.31, 272-279.
11. WHO, Effectiveness of male latex condoms in protecting against pregnancy and sexually transmitted infections. Geneva; Fact Sheet No.243, 2010.
12. Fakoya A. Lamba H. Mackie N. Nandwani, R. et al. Guidelines for the management of the sexual and reproductive health of people living with HIV infection; *British HIV Association & HIV Medicine*, 2008; 9, 681–720.
13. World Health Organization (WHO), Effectiveness of condoms in preventing sexually transmitted infections.2008; 9, 681-720.
14. Federal HIV/AIDS Prevention and Control Office under Federal Ministry of Health. Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia, 2011; pp. 1–224.

15. UNAIDS and WHO, HIV/AIDS epidemic update.2011; pp.1–29.
16. Pazol K. Kramer M. Hogue C. Condoms for dual protection patterns of use with highly effective contraceptive methods. Public Health Rep, 2010; 125(2), 208–17.
17. Cole Bundersa. Differences in perceptions on sexual and reproductive health between service providers and people living with HIV, 2010.
18. Oluwole O. Factors influencing the choice of contraceptive methods by HIV positive women in the Cofimvaba, Stellenbosch University, 2012.
19. Aboud S. Msamanga G. Read J.et al. Genital tract infections among HIV-infected pregnant women in Malawi, Tanzania and Zambia. International Journal of STD and AID, 2008; Vol.19 (12):824–832.
20. David L.Jenifer E. Et.al Correlates of Dual-Method Contraceptive Use by analysis of the National Survey of Family Growth 2006–2008 ; Journal of Infectious Diseases in Obstetrics and Gynecology; Washington University , 2011; Vol.12(717163),6
21. Barbara N. Jianghong L. Sandra C. Christopher G. & Jaya E. Family planning among people living with HIV in post-conflict Northern Uganda; Makerere University; September, 2011;5(18), 1-12.
22. Bethany P. Assunta M. Joel M. Moskowitz P. et al. The Use of Existing Prevention Methods for Contraception and Sexually Transmitted Infections and Interest in Microbicides among Women in California. Unpublished theses, 2005.
23. Westhoff S. Oral contraceptive discontinuation due to side effects matter; American Journal of Obstetrics and Gynecology, 2007; Vol. 196(4), 412-417.
24. Guttmacher I. Facts on Investing in Family Planning and Maternal and Child Health. New York, USA; 2010.
25. Ria R. Iwu U. Peter M. contraceptive Use Pattern among among married women in Indonesia; Indonesia National Family Planning Coordinating Board, 2009; Vol 31(3).
26. Audu S. Polygamy and the use of contraceptives; International Journal of Gynaecology & Obstetrics, 2006; Vol 101(1), 88 - 92.
27. Degni F. Mazengo C. Vaskilampi T. and Essén B. Religious beliefs prevailing among Somali men living in Finland regarding the use of the condom by men and that of other forms of contraception by women; Eur Journal of Contraception and Reproductive Health Care, 2008; Vol 13(3).

28. Venkatesan C. Kershaw T. Murali S. Newman, P. et al. Prevalence of and Barriers to Dual-Contraceptive Methods Use among Married Men and Women Living with HIV in India. Hindawi Publishing Corporation Infectious Diseases in Obstetrics and Gynecology, 2011; vol. 11(10) 1–8.
29. Kaida A. Laher, F. Strathdee S. Money D. Janssen P. Hogg R. & Gray G. Contraceptive Use and Method Preference among Women in Soweto, South Africa. HIV, HAART, and Contraception, 2010; 5(11), 1–11.
30. Chibwesa C. Matoba C. Mbewe R. Stringer J. & Stringer E. Modern Contraceptive and Dual Method Use among HIV-Infected Women in Lusaka, Zambia, 2011(261453), 1–8.
31. Isabella, b. Contraceptive utilization and associated factors among HIV positive women in Mulago ISS clinic, Makerere University, unpublished theses, May 2009.
32. Winnie M. Fatch R. Steinfield R. Matthews L. et al. Contraceptive Use and Associated Factors among Women Enrolling into HIV Care in South western Uganda. Infectious Diseases in Obstetrics and Gynecology, 2012(340782), 1–9.
33. Eliud W. A new lease of life : sexual and reproductive behaviour among PLWHA in the ART era in Nairobi slums; London School of Economics and Political Science, 2012.
34. Kibuuka H. Guwatudde D. et al. Contraceptive use in women enrolled into preventive HIV vaccine trials: experience from a phase I/II trial in East Africa. Pub Med - indexed for Medline, May 12, 2009.
35. Teklu T. and Gail D. Which factors influence North Ethiopian adults' use of dual protection from unintended pregnancy and HIV / AIDS; Ethiop.J.Health, 2008; 22(3), 226–231.
36. Tadesse L. and Belachew A. Assessment of Fertility Desire and Family Planning Utilization among HIV positive people who are on antiretroviral treatment, Asella Hospital, Arsi Zone, Oromia Region unpublished theses, 2011.
37. Zewdu G. Mekonen A. & Betre M. Unmet Reproductive Health Care Needs and Occurrence of Unintended Pregnancy among HIV Positive Women in Antiretroviral Treatment Units in Addis Ababa , Addis Ababa University, Ethiopia,2011.

## Annex II: - Questionnaires

**Jimma University College of public health and medical science, department of nursing and midwifery structured questionnaire on assessment of dual-contraceptive method utilization and associated factors among HIV positive women (English)**

### Consent form:-

My name is \_\_\_\_\_ I am a part of research work team of Jimma University at hospital on HIV positive people who are on ART follow up care. This research will assess the dual contraceptive utilization and the associated factors among peoples' living with HIV/AIDS. It does not cause any harm other than expensing you a few minute for filling the questioners and interview. I would also like to assure you about the confidentiality of information. The information will only be used for this research. You have full right to reject, to participate or to interrupt the interview at any time. The information that you will give us is very important to meet the objective of study to bring changes on dual –contraceptive service provision, program implementation and policy formulation for people living with HIV/AIDS.

Are you willing now to participate in the study? Tick one. Agree\_\_\_\_\_ do not agree\_\_\_\_\_ thank you.

If they are not willing, do not force people to participate in the study but as much as possible convince by clarifying the aim of study.

Date of data filled \_\_\_\_\_

Participant's ID No\_\_\_\_\_

## I. Socio-demographic characteristics

S/No	Questions	Responses	Skip
Q101	How old are you?	_____	
Q102	Educational level	<ol style="list-style-type: none"> <li>1. Illiterate</li> <li>2. Primary education (1-8<sup>th</sup>)</li> <li>3. Secondary education (9<sup>th</sup>-12<sup>th</sup>)</li> <li>4. Tertiary education (12<sup>th</sup> +)</li> </ol>	
103	Ethnicity	<ol style="list-style-type: none"> <li>1. Keffa</li> <li>2. Amhara</li> <li>3. Gurage</li> <li>4. Oromo</li> <li>5. Tigray</li> <li>6. Others, Specify_____</li> </ol>	
Q104	Religion	<ol style="list-style-type: none"> <li>1. Orthodox</li> <li>2. Catholic</li> <li>3. Protestant</li> <li>4. Muslim</li> <li>5. Others, Specify_____</li> </ol>	
Q105	Marital status	<ol style="list-style-type: none"> <li>1. Single</li> <li>2. Married</li> <li>3. Divorced</li> <li>4. Widowed</li> <li>5. Others, Specify_____</li> </ol>	
Q106	Occupation	<ol style="list-style-type: none"> <li>1. Government employee</li> <li>2. private employee</li> <li>3. Daily labourer</li> <li>4. House wife</li> <li>5. Merchant</li> <li>6. farmer</li> </ol>	

		7. Student 8. commercial sex worker 9. Other specify _____	
Q107	What is your total monthly income?	_____Ethiopian Birr	
Q108	Residence	1. Urban 2. Rural	

## II. Clients related factors

Q201	How long since you did HIV diagnosis?	1. Write the time- 2. Do not remember 3. Other, specify_____	
Q202	Do you started Anti retrovirus treatment?	1. Yes 2. No	If no skip to Q 204
Q203	How long have you been receiving ART treatment?	1. Write the time_____ 2. Do not remember 3. other, specify_____	
Q204	How much is your recent CD4 count?	_____	
Q205	Did your partner tested HIV?	1. Yes 2. No 3. I don't know	If no skip to Q 208
Q206	If Q 205 is yes, what was the result?	1. Positive 2. Negative 3. I don't know	
Q207	If Q 205 is no, what is the reason?	1. He /She was not voluntary 2. I did not disclose my status 3. Other, specify_____	
Q208	How many children do you	1. No child 2. 1-3	

	have?	3. More than three	
Q209	Do you have child who is sero-status positive?	1. Yes 2. No	
Q210	Have you had sexual intercourse after you know your HIV diagnosis?	1. Yes 2. No	If no skip To Q 216
Q211	If Q210 response is yes, Are you currently using any contraceptive methods?	1. Yes 2. No	
Q212	If Q212 yes, what FP method are you using?	1. Condom 2. Pills 3. Injectable 4. Norplant 5. Permanent method 6. IUCD 7. Other, Specify————	
Q213	If Q212 is yes have you ever used condom?	1. Yes 2. No	
Q214	If Q214 response is yes, How and when do you use condoms?	1. Some times 2. Consistently &correctly? 3. Other specify————	
Q215	If Q213 is yes What is the primary reason for condom use?	1. To prevent pregnancy 2. To prevent other STDs 3. My partner's HIV status is negative 4. Health care provider advice me to use condom 5. To prevent cross transmission of various sero- type of HIV 6. other, specify————	



Q216	Do you know about dual-contraceptive method service?	1. Yes 2. No	
Q217	Have you ever used dual-contraceptive methods (condom plus other FP methods)?	1. Yes 2. No	If no skip Q 218 and Q219
Q218	If Q217 response is yes, when do you use?	1. Always 2. some times 3. other specify_____	
Q219	If Q217 is yes, What is the primary reason to use dual - contraceptive methods?	1. To prevent pregnancy 2. To prevent other STDs 3. My partner HIV status is negative 4. Health care provider advice me to use condom 5. To prevent cross transmission of various sero- type of HIV 6. other, specify_____	

### III. Community related factors

Q31	The presence of HIV/AIDS in your blood affects your utilization of dual contraceptive?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	
Q302	If Q301 response is yes, Explain how HIV/AIDS affect your utilization of dual contraceptive?	<ol style="list-style-type: none"> <li>1. Side effect of ART drugs</li> <li>2. Over load of medication</li> <li>3. Fear of going to FP service area</li> <li>4. Other specify—————</li> </ol>	
Q303	Do you openly discuss with your sexual partner about dual-contraceptive method utilization?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	
Q304	What affects your utilization of dual contraceptive method services?	<ol style="list-style-type: none"> <li>1. Spouse</li> <li>2. peers</li> <li>3. faith (religion)</li> <li>4. culture /norm</li> <li>5. other, specify—————</li> </ol>	

**IV. Services delivery factors**

Q401	From where do you use FP methods services?	<ol style="list-style-type: none"> <li>1. Governmental health institute</li> <li>2. From Non government health institute</li> <li>3. Private Pharmacy</li> </ol>	
Q402	Do you have access to FP methods whenever you need to use?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	
Q403	Have you ever received counseling about how to use dual- contraceptive methods?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	
Q404	Does ART medication affect your dual contraceptive method utilization?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	
Q405	If Q404 response is yes, How?	<ol style="list-style-type: none"> <li>1. Side effect of ART drugs</li> <li>2. Over load of medication</li> <li>3. Fear of going to FP service area</li> <li>4. Other</li> </ol>	
Q406	Do you have any side effects of dual contraceptive methods that influence your choice of method?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	
Q407	If Q40 response is Yes, please mention it	_____	

**Thank you for your participation!!!**

**Jimma University College of public health and medical science, department of nursing and midwifery In-depth interview guide line for assessment of dual-contraceptive method utilization and associated factors among HIV positive women (English)**

**Consent form**

Dear respondent;-

My name is----- I am working for research undertaking by Jimma University on assessment of dual contraceptive utilization and associated factors among HIV positive women attending ART clinic in Bonga G/tsadik Shawo Hospital Keffa Zone South West Ethiopia. Today, I would like to ask you few questions about dual contraceptive utilization experience and what factors affect negatively and positively the practice of dual contraceptive utilization. I would like to tape record our discussion with you-this will ensure that we correctly represent your views. May I need your permission to do it. What you say here today is confidential and will be used only for research purpose and help us to incorporate with our finding Are you willing now to participate in the study?

Tick one. Agree \_\_\_\_ do not agree \_\_\_\_ thank you!

If they are not willing, do not force people to participate in the study.

Date of data filled \_\_\_\_\_

Participant's ID No \_\_\_\_\_

## **In-depth interview guide line for HIV positive women (English)**

**Participants:-** age -----, Residence-----, education-----, occupation -----  
marital status-----, ethnicity-----, and Religion-----

### **Points for in-depth interview**

- 1) Can you tell when you were tested and knew your sero status and when you started pre-ART or ART services?
- 2) Do you have any information about dual contraceptive methods?
- 3) Do you think HIV positive clients practice dual contraceptive methods? What about you?
- 4) How do you see the safety of dual contraceptive methods practice?
- 5) What problems do HIV positive women face related to dual contraceptive utilization?
- 6) What are the factors that affect dual contraceptive utilization practice in positively or negatively? related to:-
  - Sociodemographic
  - Health status
  - Services
  - Community
- 7) What is your experience regarding openly discuss about dual -contraceptive utilization with your sexual partner
- 8) What do you recommend in general about dual -contraceptive?

**Thank you for your participation!!!**

በጅማ ዩኒቨርሲቲ የሕብረተሰብ ጤናና የሕክምና ትምህርት ኮለጅ የነርቨንግ እና አዋላጅ ጤና ትምህርት ክፍል የእናቶች ጤና የድህረ-ምረቃ ትምህርት ክፍል፤ ኤች.አይ.ቭ. ቫይረስ በደማቸው ያላቸው ሴቶች ጥምር-የቤተሰብ ምጣኔ አጠቃቀም እና ተዛማች ሁኔታዎችን ለማጥናት የተዘጋጀ የግለሰቦች ፍቃደኝነት መጠየቅያ ቅፅ (Amaharic) ::

እንደምን አደሩ/ዋሉ? ስሜ \_\_\_\_\_ ይባላል። በጅማ ዩኒቨርሲቲ የሕብረተሰብ ጤናና የሕክምና ትምህርት ኮለጅ የነርቨንግ እና አዋላጅ ጤና ትምህርት ክፍል የእናቶች ጤና የድህረ-ምረቃ ትምህርት ክፍል የጥናት ቡድን አባል ነኝ :: የዝህ ጥናት ዋና አላማ ኤች አይ.ቭ ቫይረስ በደማቸው ያሉት ሴቶች ጥምር የቤተሰብ ምጣኔ ዘዴን አጠቃቀማቸውን እና እንዳይጠቀሙ የምያደራጉ ተዛማች ሁኔታዎችን ለማጥናት ነው። እርሶዎ በጥናቱ እንድካተቱ የተደረጉት በዕጣ ነው :: የእረሶን የጥምር ቤተሰብ ምጣኔ ፈላጎት እና ተዛማች ሁኔታዎችን በምመለከት እጠይቅዎታለሁ። ቃለምልልሱ በግምት ከ10-15 ደቂቃዎች ይፈጃል። እርሶዎ የምስጢኝ መረጃ ምስጥራዊነቱ ሙሉ በሙሉ የተጠበቀ ነው። የእርሶዎ ስምም ሆነ መለያ መረጃዎች አይመዘገቡም :: እርሶዎ በጥናቱ የመሳተፍም ሆነ ያለመሳተፍ፤ ያለመመለስ ወይም የማቋረጥም መብትዎ የተጠበቀ ነው። ነገርግን እርሶ የምስጢት መረጃ በማዕከላቱ የምሰጠውን አገልግሎት ለማሻሻል እና ፖሊሲዎችን ለማወጣት ጠቃም ነው።

እባክዎት ጥናቱን በተመለከተ የምጠይቁኝ ነገር አለዎት?

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት?

1.አዎ

2.አይደለሁም

አወ ካሉ፤ አመሰግናለሁ ቃለመጠይቁን ይቀጥሉ

አይደለሁም ካሉ ፤ አመሰግናለሁ ደንበኛዎን አሰናብተዋል ወደ ሌላ ተጠያቂ ይለፉ

ፍካደኛ ስለመሆናቸው የጤያቸው ፍርማ \_\_\_\_\_

ቀን: \_\_\_\_\_

ኮድ ቁጥር: \_\_\_\_\_

**ኤች.ኤይ.ቭ ቫይረስ በደማቸው ያላቸው ሴቶችን በመተየቅ የምሞላ ቅፅ፤**

**ክፍል1. ማህበራዊ እና ሥነ-ህዝባዊ ገፅታዎች**

ተ.ቁ	ጥያቄዎች	መልስ	ዝላል
101.	እድመዎት ስንት ነው.	_____	
102	የትምህርት ደረጃ	<ol style="list-style-type: none"> <li>1. ያልተማረ</li> <li>2. የመጀመሪያ ደረጃ(1ኛ-8ኛ ክፍል)</li> <li>3. ሁለተኛ ደረጃ (9ኛ-12ኛ ክፍል)</li> <li>4. ከ 12ኛ ክፍል በላይ</li> </ol>	
103	ብሔረሰብ	<ol style="list-style-type: none"> <li>1. ከፋ</li> <li>2. አማራ</li> <li>3. ጉራጌ</li> <li>4. ኦሮሞ</li> <li>5. ትግረ</li> <li>6. ሌላ፣ ይግለጹ _____</li> </ol>	
104	ሐይማኖት	<ol style="list-style-type: none"> <li>1. ኦርቶዶክስ</li> <li>2. ካቶልክ</li> <li>3. ፕሮተስታንት</li> <li>4. እስላም</li> <li>5. ሌላ፣ ይግለጹ _____</li> </ol>	
105	የጋብቻ ሁኔታ	<ol style="list-style-type: none"> <li>1. ያላገባ</li> <li>2. ያገባ</li> <li>3. አግብቶ የተፋታች</li> <li>4. በሞት ምክንያት የተለዩች</li> <li>5. ሌላ፣ ይግለጹ _____</li> </ol>	
106	ሥራ	<ol style="list-style-type: none"> <li>1. መንግስት ተቀጣሪ</li> <li>2. የግል ድርጅት ተቀጣሪ</li> <li>3. የቀን ሠራተኛ</li> </ol>	

		4. የቤት እመቤት 5. ነጋዴ 6. አርሶ አደር 7. ተማሪ 8. የቡና ቤት ሰራተኛ 9. ሌላ፣ ይግለጹ _____	
107	ወራዊ ገብ መጠን(ብ ብር)	_____	
108	መኖሪያ ቦታ	1. ከተማ 2. ገጠር	

**ክፍል ሁለት:- ከታካም ጋር የተገናኙ ሁኔታዎች**

201	ቫይረሱ በደምሽ ውስጥ መኖሩን በምርመራ ያወቅሽዉ መች ነዉ.	1. _____ዓ.ም 2. አላስታዉሠዉም 3. ሌላ፣ ይግለጹ _____	
202	ፀረ-ኤች አይቭ ቫይረስ መድሃኒት ጀምረሻል	1. አዎ 2. አልጀመሪኩም	መልሱ 2 ከሆነ ወደ ጥ.ቁ 204 ዝለል
203	ፀረ-ኤች አይቭ ቫይረስ መድሃኒት የጀመርሽዉ መች ነዉ.	1. _____ዓ.ም 2. አላስታዉሠዉም 3. ሌላ፣ ይግለጹ _____	
204	በቅርቡ የተነገረሽ የደምሽ CD4 መጠን ስንት ነዉ.	_____	
205	ባለቤትሽ ተመርምሯል	1. አዎ 2. አልተመረመረም 3. አላዉቅም	መልሱ 2 ከሆነ ወደ ጥ.ቁ 208 ዝለል
206	ጥ/ቁ 205 መልሱ አዎ ከሆነ ዉጤቱ ምንድን ነዉ.	1. ቫይረሱ በደም ውስጥ አለዉ. 2. ቫይረሱ በደም ውስጥ የለም	



		3. ወ.ጤቱን አላወቅም	
207	ጥ/ቁ 205 መልሱ አይደለም ከሆነ ምክንያቱ ምንድን ነው.	1. ፍቃደኛ አይደለም 2. የራሠን ወ.ጤት ስላልነገርኩ አልጠየኩም 3. ሌላ፣ ይግለጹ _____	
208	ስንት ልጆች አለሽ	1. ልጅ የለኝም 2. ከ1-3 ልጆች 3. ከሦስት በላይ	
209	ቫይረሱ በደማቸው ውስጥ ያሉ ልጆች አሉሽ ወይ	1. አዎ 2. የለም	
210	ቫይረሱ በደምሽ ውስጥ መኖሩን ካወቅሽ በኃላ ግብረ-ሥጋ ግንኙነት አድርገሽ ታወቅያለሽ	1. አዎ 2. አላደረሁም	መልሱ 2 ከሆነ ወደ ጥ.ቁ 216 ዝለል
211	ጥ/ቁ 210 መልሱ አዎ ከሆነ፤ ማንኛውንም የቤተሠብ ምጣኔ/የወልድ መከላከያ ዘዴ ተጠቅመሽ ታወቅያለሽ	1. አዎ 2. አላወቅም	
212	ጥ/ቁ 211 መልሱ አዎ ከሆነ፤ ምን ዓይነት የወልድ መከላከያ ዘዴ ነው የምትጠቀምዉ.	1. ኮንደም 2. ክኒን 3. በመርፌ የምሰጠውን 4. በክንድ ሥር የምቀበረውን 5. ዘለቁታዊ ዘዴ 6. በማህፀን ውስጥ የምቀመጥ(ሉፒ) 7. ሌላ፣ ይግለጹ _____	
213	ጥ/ቁ 211 መልሱ አዎ ከሆነ፤ ኮንደም ትጠቀማለህ/ምያለሽ	1. አዎ 2. አላወቅም	

214	ጥ/ቁ 213 መልሱ አዎ ከሆነ፤ መች፤ መች እና እንዴት ነው የምትጠቀምዎትዎታል።	<ol style="list-style-type: none"> <li>1. አልፎ አልፎ</li> <li>2. ሁሉ እና በአግባቡ</li> <li>3. ሌላ፣ ይግለጹ _____</li> </ol>	
215	ጥ/ቁ 213 መልሱ አዎ ከሆነ፤ ከንደም የምጠቀሙበት ዋነኛ ምክንያት ለምንድን ነው።	<ol style="list-style-type: none"> <li>1. እርግዝናን ለመከላከል</li> <li>2. ሌሎች አባላዎችን ለመከላከል</li> <li>3. ባለቤቱ ከኤች.አይ.ቭ ቫይረስ ንፁህ ስለሆነ</li> <li>4. ጤና ባለሙያ ስለመከላከል</li> <li>5. የተለዩ ኤች.አይ.ቭ ቫይረስ ዝርያ እንዳይተላለፍ ለመከላከል</li> <li>6. ሌላ፣ ይግለጹ _____</li> </ol>	
216	ስለ ጥምር-ቤተሰብ ምጣኔ (dual-contraceptive ) ዘዴ አገልግሎት ታወቅዎታል።	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላወቅም</li> </ol>	
217	ጥምር-ቤተሰብ ምጣኔ (dual-contraceptive) ዘዴ ተጠቅመሽ ታወቅዎታል።	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላወቅም</li> </ol>	መልሱ 2 ከሆነ ጥ.ቁ 218፣219 ዝለል
218	ጥ/ቁ 217 መልሱ አዎ ከሆነ፤ መች፤ መች እና እንዴት ነው የምትጠቀምዎትዎታል።	<ol style="list-style-type: none"> <li>1. ሁል ጊዜ</li> <li>2. አልፎ አልፎ</li> <li>3. ሌላ፣ ይግለጹ _____</li> </ol>	
219	ጥ/ቁ 217 መልሱ አዎ ከሆነ፤ የምጠቀሙበት ዋነኛ ምክንያት ለምንድን ነው።	<ol style="list-style-type: none"> <li>1. እርግዝናን ለመከላከል</li> <li>2. ሌሎች አባላዎችን ለመከላከል</li> <li>3. ባለቤቱ ከኤች.አይ.ቭ ቫይረስ ንፁህ ስለሆነ</li> <li>4. ጤና ባለሙያ ስለመከላከል</li> <li>5. የተለዩ ኤች.አይ.ቭ ቫይረስ ዝርያ እንዳይተላለፍ ለመከላከል</li> <li>6. ሌላ፣ ይግለጹ _____</li> </ol>	

**ክፍል ሦስት፡- ከህብረተሰቡ ጋር የተገናኙ ሁኔታዎች**

301	ኤች አይቭ ቫይረሱ በደምሽ ውስጥ መኖሩ የቤተሰብ ምጣኔ አጠቃቀምሽ ላይ ተፅኖ ያደርጋል ወይ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አያደርግም</li> </ol>	
302	ጥ/ቁ 301 መልሱ አዎ ከሆነ፤ ኤች አይቭ ቫይረሱ በደምሽ ውስጥ መኖሩ የቤተሰብ ምጣኔ አጠቃቀምሽ ላይ ተፅኖ እንዴት እንደምያደርግ ግለጭ	<ol style="list-style-type: none"> <li>1. ፀረ ኤች አይቭ ቫይረስ መድሐንት ጎንዮሽ ችግር ምክንያት</li> <li>2. በቀን ውስጥ የምወሰደዉ መድሐንት መብዛት</li> <li>3. የቤተሰብ ምጣኔ አገልግሎት የምሰጥበት ክፍል የመሄድ ፍራቻ</li> <li>4. ሌላ ካለ ይገለፅ</li> </ol>	
303	ስለ ጥምር-ቤተሰብ ምጣኔ (dual-contraceptive ) ዘዴ አገልግሎት ከትዳር ጓደኛሽ ጋር ትዎያያላችዉ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላዉቅም</li> </ol>	
304	ጥምር-የቤተሰብ ምጣኔ (dual-contraceptive ) ዘዴ አገልግሎት እንዳትጠቀም የምከለክሉሽ ምክንያቶች ምን ምንድን ናቸዉ	<ol style="list-style-type: none"> <li>1. የትዳር ጓደኛ</li> <li>2. እኩያ ጓደኞች</li> <li>3. እምነት/ሐይማኖት</li> <li>4. የአካባብ ባህል/ሥረዓት</li> <li>5. ሌላ፣ ይግለጹ _____</li> </ol>	

**ክፍል አራት፡- ከአገልግሎት አሰጣጥ ጋር የተገናኙ ሁኔታዎች**

401	የቤተሰብ ምጣኔ አገልግሎት ከየት ነው የምታገኝዋል።	<ol style="list-style-type: none"> <li>1. ከመንግስት ጤና ተገም</li> <li>2. ከመንግስታዊ ካልሆኑ ጤና ድርጅት</li> <li>3. ከግል ፋርማሲ</li> <li>4. ሌላ፣ ይግለጹ _____</li> </ol>	
402	በማንኛውም ጊዜ የቤተሰብ ምጣኔ አገልግሎት ስትፈልግ ታገኝያለሽ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላገኝም</li> </ol>	
403	ስለጥምር-የቤተሰብ ምጣኔ (dual-contraceptive ) ዘዴ የምክር አገልግሎት ወስደሽ ታወቅያለሽ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልዎሰድኩም</li> </ol>	
404	የፀረ-ኤች አይቭ ቫይረስ መድኃኒት የጥምር-የቤተሰብ ምጣኔ ዘዴ አጠቃቀም ላይ ተፅዕኖ ያደርጋል	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አያደርግም</li> </ol>	
405	ጥ/ቁ 404 መልሱ አዎ ከሆነ፣ እንዴት ተፅዕኖ እንደምያደርግ ይግለፁ	<ol style="list-style-type: none"> <li>1. ፀረ ኤች አይቭ ቫይረስ መድኃኒት ጎንዮሽ ችግር ምክንያት</li> <li>2. በቀን ውስጥ የምወሰደው መድኃኒት መብዛት</li> <li>3. የቤተሰብ ምጣኔ አገልግሎት የምሰጥበት ክፍል የመሄድ ፍራቻ</li> <li>4. ሌላ ካለ ይግለፁ</li> </ol>	
406	ከጥምር-የቤተሰብ ምጣኔ (dual-contraceptive ) ዘዴ ጋር የተገናኘ ያጋጠመዎት የመድኃኒት ጎንዮሽ ችግር አለ ወይ	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. የለም</li> </ol>	
407	ጥ/ቁ 406 መልሱ አዎ ከሆነ፣ ያጋጠመዎት ችግሮችን ይግለፁ	_____	

**ሥላ-ትብብርዎ በጣም አመሰግናለሁ!!!**

በጅማ ዩኒቨርሲቲ የሕብረተሰብ ጤናና የሕክምና ትምህርት ኮለጅ የነርቨንግ እና አዋላጅ ጤና ትምህርት ክፍል የእናቶች ጤና የድህረ-ምረቃ ትምህርት ክፍል፤ አች.አይ.ቭ. ቫይረስ በደማቸው ያላቸው ሴቶች ጥምር-የቤተሰብ ምጣኔ አጠቃቀም እና ተዛማች ሁኔታዎችን ለማጥናት የተተዘጋጀ የግለሰቦች ፍቃደኝነት መጠየቅ ቅፅ (Amaharic) ::

እንደምን አደሩ/ዋሉ? ስሜ -----ይባላል:: በጅማ ዩኒቨርሲቲ የሕብረተሰብ ጤናና የሕክምና ትምህርት ኮለጅ የነርቨንግ እና አዋላጅ ጤና ትምህርት ክፍል የእናቶች ጤና የድህረ-ምረቃ ትምህርት ክፍል የጥናት ቡድን አባል ነኝ :: የዝህ ጥናት ዋና አላማ ኤች አይቭ ቫይረስ በደማቸው ያሉት ሴቶች ጥምር የቤተሰብ ምጣኔ ዘዴ አጠቃቀማቸውን እና እንዳይጠቀሙ የምያደራጉ ተዛማች ሁኔታዎችን ለማጥናት ነው:: ከዝህ በመቀጠል ስለ ጥምር የቤተሰብ ምጣኔ ዘዴ አጠቃቀማቸውን እና እንዳይጠቀሙ የምያደራጉ ተዛማች ሁኔታዎችን በተመለከተ ጥቅት ጥያቄዎችን ለመጠየቅ እፈልጋለሁ :: ለምጠይቋቸው ጥያቄዎች የእርሶን መልስ ሳይዘነፍ እና ሳይቀንስ በመቶርጎም ለመጠቀም እንድመቸኝ ዘንድ ወይይታችንን በድምፅ መቅጃ ለመቅዳት እንድፈቅዱልኝ እጠይቃለሁ? እርሶዎ የምስጡኝ መረጃ ምስጢራዊነቱ ሙሉ በሙሉ የተጠበቀ እና ለዝህ ጥናት ብቻ እንደምንጠቀም በድጋሜ ሳረጋግጥልዎ እፈልጋለሁ:: የእርሶዎ ስምም ሆነ መለያ መረጃዎች አይመዘገቡም ::

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት? 1.አዎ

2.አይደለሁም

አወ ካሉ፤ አመሰግናለሁ ቃለመጠይቁን ይቀጥሉ

አይደለሁም ካሉ ፤አመሰግናለሁ ደንበኛዎን አሰናብተዋል ወደ ሌላ ተጠያቂ ይለፉ

ፍቃደኛ ስለመሆናቸው የጤያቅወ ፍርማ \_\_\_\_\_

ለተጠያቂ የተሰጠ ኮድ \_\_\_\_\_

ወይይቱ የተጀመረበት ሰዓት \_\_\_\_\_ የተጠናቀቀበት ሰዓት \_\_\_\_\_

ቀን \_\_\_\_\_

ኤች.ኤይ.ቭ ቫይረስ በደማቸው ያላቸውን ሴቶችን የጥልቅ መጠይቅ መምርያ ነጥቦች፤

የተጠያቂው፡- ዕድሜ \_\_\_\_\_ የትምህሪት ደረጃዎ \_\_\_\_\_ ሥራ \_\_\_\_\_  
— መኖሪያ ሠፈራዎ \_\_\_\_\_ ብሔሪ \_\_\_\_\_ ሐይማኖት \_\_\_\_\_

**የጥልቅ መጠይቅ ዋና ዋና ነጥቦች**

1. ቫይረሱ በደምሽ ወሰጥ መኖሩን በምርመራ ያወቅሽዉበትንና የፀረ-ኤች አይ.ቭ ቫይረስ ሕክምና አገልግሎት የጀመርሽዉ መቻ እንደሆነ ያብራሩልኝ ?
2. ስለ ጥምር-የቤተሰብ ምጣኔ ዘዴ ምን ያህል ያወቃሉ?
3. ኤች.ኤይ.ቭ ቫይረስ በደማቸው ያላቸውን ሰዎች ጥምር-የቤተሰብ ምጣኔ ዘዴን ይጠቀማሉ ብለሽ ታስብያለሽ ? አንችስ ?
4. የጥምር-ቤተሰብ ምጣኔ ዘዴን መጠቀም ጥቅሙን እንዴት አገኘሽዉ?
5. ኤች.ኤይ.ቭ ቫይረስ በደማቸው ያላቸውን ሴቶች ከጥምር-የቤተሰብ ምጣኔ ዘዴ አጠቃቀም ጋር በተገናኘ ምን ምን ችግሮች ያጋጥማቸዋል?
6. በጥምር-ቤተሰብ ምጣኔ ዘዴ አጠቃቀም ላይ አዎንታዊም ሆነ አሉታዊ ተፅዕኖ የምያደርጉ ተዛማጅ ሁኔታዎች ምን ምን ናቸዉ ?
  - ከማህበራዊ ሁኔታ ጋር የተገናኘ
  - ከጤና ችግር ጋር የተገናኘ
  - ከጤና አገልግሎት አሰጣጥ ጋር የተገናኘ
  - ከሕብረተሰቡ ጋር የተገናኘ
7. ከትዳር አጋርሽ ወይም ከጓደኛሽ ጋር ስለ ጥምር-የቤተሰብ ምጣኔ ዘዴ አጠቃቀም የመዎያየት ልምድሽ እንዴት ነዉ?
8. በአጠቃላይ ስለ ጥምር-የቤተሰብ ምጣኔ ዘዴ ምን ትያለሽ?

**ሥላ-ትብብርዎ በጣም አመሰግናለሁ!!!**

**Jimmi Univerisiti Maccee Iiwoonaa Dawee sayinnise Doyee Kollejje Inddeena'och Iiwee Qoqoona Guttinee Diggiri (Mastireete) Doyee kuxo Echi Ayi Vi Eeddise vaayireso boono dame dagooch beeti maachena'och wokiishim attoon baccii gaachoonaa yesheti nabeena'on Phirooch qanniti qelli qelli echo (Kaffi Noono).**

Diggoona qeyitotee/heechnitotee? Ta shigo \_\_\_\_\_geteehe. Jimmi Univerisiti Maccee Iiwoonaa Dawee sayinnise Doyee Kollejje Inddeena'och Iiwee Qoqoona Guttinee Diggiri (Mastireete) Doyee kuxe phire guupho taane. Hini Phireechi inde naboo Echi Ayi Vi Eeddise vaayireso boono damee dagooch beeti maachena'och wokiishim attoon baccii gaachoonaa yesheti nabeena'on Phiroone. Itto hini echa wochoochi qaaweto ixoonane. Itoch wokiishim attoon baccii gaache shuriyoona yesheti nabeena'onon ciinnimi eho echeemotaane. Echa wochoo gimitoona 10-15 daqiqoye bishaanoone. Ito imibeeti qiho hini phiroochi gaachoye maachi bare ashich koochona beshiita echiyaachemone. Etti shigo hini phire qihoochi qaawiyaaache. Itto hini phire echoochi Gimono, giyaachegetono, echooni woachaachegetono tuneba kuxxi neechon hakiyote. Tunebaani itto emiibeeti qiho itoshichi echeebetii gaacooni gaawuchoochi tuneba gaace yaabon qanayooch gaaciye.

Hini phirooni ciinnimi echo itto echeemo beete?

Echa-wochoochi itti giyeemoch daagiyeehote? 1. Gaawa daagiyo 2. Ta qaawachi

Bo mashaamiga gallettoye geti echooni dabiibi.

Ta qaawache bogetigaata gallettehooye geti deenichi bareewan besheb.

Echiyeechino mashaamoch echechinoch dukko \_\_\_\_\_

Deco \_\_\_\_\_

Id no:\_\_\_\_\_

**Echi Ayi Vi Eeddise vaayireso boono dame dagooch beeti maachena'on echetaa ceenemi kiirakiiro.**

Y.H	Echeena'o	Wochoo	Shaadebi
101	Eeno	—————	
102	Doyee daqqo	<ol style="list-style-type: none"> <li>1. Doyaano</li> <li>2. Ikinee daqqo(1<sup>no</sup>_8<sup>no</sup> kuxo)</li> <li>3. Guttinee daqqo(9<sup>no</sup>_12<sup>no</sup> kuxo)</li> <li>4. 12<sup>no</sup> +</li> </ol>	
103	Shiisho	<ol style="list-style-type: none"> <li>1. Kaffecho</li> <li>2. Amaro</li> <li>3. Guraago</li> <li>4. Oroomo</li> <li>5. Tigiroo</li> <li>6. Baroo; biriib —————</li> </ol>	
104	Ne gibeno	<ol style="list-style-type: none"> <li>1. Orittodokkiso</li> <li>2. Katoliko</li> <li>3. Protestaanito</li> <li>4. Esilaamo</li> <li>5. Baroo; biriib —————</li> </ol>	
105	Beemi hino	<ol style="list-style-type: none"> <li>1. Shaagano</li> <li>2. Shaagito</li> <li>3. Shaagi biichito</li> <li>4. Qitee naboona barit</li> <li>5. Baroo; biriib —————</li> </ol>	
106	Shuuno	<ol style="list-style-type: none"> <li>1. Taate shuuno</li> <li>2. Qelli guuphi shuuno</li> <li>3. Heechi shuuno</li> <li>4. Kechi gene</li> </ol>	



		5. Giixechi 6. Gochi qeyechi 7. Doyechi 8. Bune kechi shuunechi 9. Baroo; biriib _____	
107	Agenooch daneebeti gijje haddo	_____	
108	Beemi xaa'o	1. Katemo 2. Maggo	

**Kuxo 2:- dawee gaaco daamibeetina'ona yesheti naboo**

201	Echi Ayi Vi vaayireso nedamee dagooch beemon phiroona ne ariito atoobane	1. ____ nato 2. Bateti 3. Baroo; biriib _____	
202	Tsere Echi Ayi Vi vaayirese atton kottetin?	1. Kotteti 2. kotaachi	Wochoo 2 tunemonoo y.h.204 shaadebi
203	Tsere Echi Ayi Vi vaayirese atton ne kotteto atoobane?	1. ____ nato 2. Bateti 3. Baroo; biriib _____	
204	Katine gooro hadeeti ne damee CD4 hadoo ambichoone?	_____	
205	Ne mageecho bidamoo phireete	1. Phireete 2. Phiriyaache 3. Ta ariyaachi	Wochoo 2 tunemonoo y.h.208 shaadebi
206	Y.H.205 wochoo phireete imo tunemonoo daacho amone?	1. vaayireso beete 2. vaayireso aala 3. daachon ariyaach	

207	E.H.205 wochoo phiriyache imo tunemonoo naboo amone?	<ol style="list-style-type: none"> <li>1. phiriyoochi mashaamache</li> <li>2. taachi daachon tageto qajetochi echiyaachi</li> <li>3. Baroo; biriib ——</li> </ol>	
208	Ambiche bushiisho beete neechi	<ol style="list-style-type: none"> <li>1. Bushoo taachi ala</li> <li>2. 1-3 bushisho</li> <li>3. Keemoye damba</li> </ol>	
209	Vaayireso bidamooch beeti busho beete nech?	<ol style="list-style-type: none"> <li>1. Beete</li> <li>2. Aala</li> </ol>	
210	Vaayireso ne damee dagoochi beemon ariyaacha anaamona dana ariine?	<ol style="list-style-type: none"> <li>1. Ariiho</li> <li>2. Ariyaachi</li> </ol>	Wochoo 2 tunemonoo y.h.216 shaadebi
211	E.H.210 wochoo Ariiho tunemonoo Wokii shimi atte gaaco dana ariine	<ol style="list-style-type: none"> <li>3. Ariiho</li> <li>4. Ariyaachi</li> </ol>	
212	E.H.211 wochoo Ariiho immo tunemonoo; aboshiniyee ne gaachabeeto?	<ol style="list-style-type: none"> <li>1. Condom</li> <li>2. Kiniino</li> <li>3. Nappoona echebeeto</li> <li>4. Mochooche dechiich duukebeeton</li> <li>5. Ciire gaacena'o</li> <li>6. Luupo</li> <li>7. Baroo; biriib ——</li> </ol>	
213	E.H.211 wochoo Ariiho immo tunemonoo; kondomon gaachabeetin?	<ol style="list-style-type: none"> <li>1. Gaacho</li> <li>2. Gaachiyaach</li> </ol>	
214	E.H.213 wochoo gaacho immo tunemonoo ;aata, aatinaa abichaaniye ne gaachabeeto	<ol style="list-style-type: none"> <li>1. Beshibeshaan</li> <li>2. Ubbee kaalonaa gawuchaa'an</li> <li>3. Baroo; biriib ——</li> </ol>	
215	E.H.213 wochoo gaacho immo	<ol style="list-style-type: none"> <li>1. Shimo qayoch</li> </ol>	

	tunemonoo; kondomon ne gaachabeeti inde naboo amoochiye?	<ol style="list-style-type: none"> <li>2. Maacha anaame biiyena'on wushooch</li> <li>3. Ta mageecho vaayireso aaliqoodoch</li> <li>4. Iiwee qoppecho booyetoch</li> <li>5. Bare shuriyech vaayireso wushiyooch</li> <li>6. Baroo; biriib ——</li> </ol>	
216	Shimi wokiyeete atteenaa'on baccii gaache (dual-contraceptive) yawoon ariine?	<ol style="list-style-type: none"> <li>1. Ariiho</li> <li>2. Ariyaach</li> </ol>	
217	Shimi wokiyeete atteenaa'on baccii gaache (dual-contraceptive) yawoon gaacha ariine?	<ol style="list-style-type: none"> <li>1. Ariiho</li> <li>2. Ariyaach</li> </ol>	Wochoo 2 tunemonoo y.h.218: 219 shaadebi
218	E.H.217 wochoo Ariiho immo tunemonoo; aati aatinaa abichaa'aniye ne gaachabeeto?	<ol style="list-style-type: none"> <li>1. Beshibeshaan</li> <li>2. Ubbee kaalonaa gawuchaa'an</li> <li>3. Baroo; biriib ——</li> </ol>	
219	E.H.217 wochoo Ariiho immo tunemonoo; negaachabeeti inde naboo amooyichiye	<ol style="list-style-type: none"> <li>1. Shimo qayoch</li> <li>2. Maacha anaame biiyena'on wushooch</li> <li>3. Ta mageecho vaayireso aaliqoodoch</li> <li>4. Iiwee qoppecho booyetoch</li> <li>5. Bare shuriyech vaayireso wushiyooch</li> <li>6. Baroo; biriib ——</li> </ol>	

### Kuxo 3:- maccoona yesheti nabeena'on ciinimo

301	Echi Ayi Vi vaayireso nedamee dagooch beemon shimi wokiyeete atte gaachon miixibeete?	1. Miixiye 2. miixache	
302	E.H.301 wochoo Miixiye immo tunemonoo; aabichi bimiixibeetoga biriib	1. Tsere Echi Ayi Vi vaayirese attona yeshe waabeti eritoo 2. Heeyochi qoochemi atte woditino 3. shimi wokiyeete atte gaaco echeebet kuxooch hammi shato 4. Baroo; biriib ———	
303	Shimi wokiyeete atton baccii (dual contraceptive) gache yawoon namagechona nuuchona qoyito gedda ariin?	1. Ariiho 2. ariyaach	
304	Shimi wokiyeete atton baccii (dual contraceptive) gache yawoon negaachiyaachemoch miixibeete nabeena'o aaboshine?	1. Keno daage qayo 2. Baribare nuuchena'ona yesheti erito 3. Gibenoona yesheti 4. Kitaamite wogoona yesheti 5. Baroo; biriib ———	

**Kuxo 4:- gaace imona yeshet nabeena’o**

40 1	Shimi wokiye gaacoon aabicheniye nedanaabeto?	1. Taate liwee aadoche 2. Taato tuniyaani liwee guuhoche 3. Atte kexooche 4. Baroo; biriib _____	
40 2	Neqaawiti gooroche Shimi wokiye atte gaacoon danene?	1. Dano 2. daniyaach	
40 3	Shimi wokiye atton baccii (dual contraceptive) gache yawoon booyo dana ariine?	1. Ariho 2. ariyaach	
40 4	Tsere Echi Ayi Vi vaayirese atto shimi wokiye atton baccii (dual contraceptive) gache yawoon Miixiye?	1. Miixiye 2. miixache	
40 5	E.H.404 wochoo Miixiye immo tunemonoo; aabichi bimiixibeetoga biriib?	1. Tsere Echi Ayi Vi vaayirese attona yeshe waabeti eritoo 2. Heeyochi qoochemi atte woditino 3. shimi wokiye atte gaaco echeebet kuxooch hammi shato 4. Baroo; biriib _____	
40 6	Shimi wokiye atton baccii (dual contraceptive) gache yawoona yeshet danet iritoo beete?	1. Beete 2. aala	
40 7	E.H.406 wochoo Beete immo tunemonoo; neena danet eriteena’ on biriib?	_____	

**Echa-wochoochi itto ibaaretoch oogichaa galletcho!!!**

**Jimmi Univerisiti Maccee Iiwoonaa Dawee sayinnise Doyee Kollejje Inddeena'och Iiwee Qopoonaa Guttinee Diggiri (Mastireete) Doyee kuxo Echi Ayi Vi Eeddise vaayireso boono dame dagooch beeti maachena'och wokiishim attoon baccii gaachoonaa yesheti nabeena'on Phirooch qanniti birii echoch (in-depth interview) qanniti yaabo.**

Diggoona qeyitotee/heeचितotee? Ta shigo \_\_\_\_\_geteehe. Jimmi Univerisiti Maccee Iiwoonaa Dawee sayinnise Doyee Kollejje Inddeena'och Iiwee Qopoonaa Guttinee Diggiri (Mastireete) Doyee kuxe phire guupho taane. Hini Phireechi inde naboo Echi Ayi Vi Eeddise vaayireso boono damee dagooch beeti maachena'och wokiishim attoon baccii gaachoonaa yesheti nabeena'on Phiroone. Itto hini echa wochoochi qaaweto ixoonane. Itto imitti qiho shapaano shadiyaanomom hini phirooch gaachochi itti wochoon teeppona kiteemo taane. Itoch wokiishim attoon baccii gaache shuriyoona yesheti nabeena'onon ciinnimi eho echeemotaane. Echa wochoo gimitoona 10-15 daqiqoye beshaanoone. Ito imibeeti qiho hini phiroochi gaachoye maachi bare ashich koochona beshiita echiyaachemone. Etti shigo hini phire qihoochi qaawiyaaache. Itto hini phire echoochi Gimono, giyaachegetono, echooni woachaachegetono tuneba kuxxi neechon hakiyote. Tunebaani itto emiibeeti qiho itoshichi echeebet gaaconi gaawuchoocho tuneba gaace yaabon qanayooch gaaciye.

Hini phirooni ciinnimi echo itto echeemo beete?

Echa-wochoochi itti giyeemoch daagiyeehote? 1. Gaawa daagiyo 2. Ta qaawachi

Bo mashaamiga gallettoye geti echooni dabiibi.

Ta qaawache bogetigaata gallettehooye geti deenichi bareewan besheb.

Echiyeechino mashaamoch echechinoch dukko \_\_\_\_\_

Deco \_\_\_\_\_

Id no:-\_\_\_\_\_

**Echi Ayi Vi Eeddise vaayireso boono dame dagooch beeti maachena'on birii echoch qanniti yaabo.**

**Echiyeechoch:** - Eeno\_\_\_\_\_ Doyee daqqo\_\_\_\_\_ Shuuno\_\_\_\_\_  
Beemi xaa'o\_\_\_\_\_ Shoodo\_\_\_\_\_ Gibeno\_\_\_\_\_

**Birii eche indi inde teppeena'o:-**

1. Echi ayi vi vaayireso nedamee dagooch beemon phiroona ne ariiti deconaa Tsere Echi Ayi Vi vaayirese atton ne koteti gooron biriib?
2. Shimi wokiye atton baccii (dual contraceptive) gache yawoon ariine?
3. Echi ayi vi vaayireso boono damee dagooch beeti asheena'o Shimi wokiye atton baccii gache (dual contraceptive) yawoon gaachehete emi shaligoo beete? Newoche?
4. Shimi wokiye atton baccii gache (dual contraceptive) yawe gaacoon aabicha danenne?
5. Ne kenoona woye ne nuuchona Shimi wokiye atton baccii gache (dual contraceptive) yawoon gaache shimboona ihaate arihote?
6. Shimi wokiye atton baccii gache (dual contraceptive) yawoona yeshe ame ame iriteena'o daneheete.
7. Shimi wokiye atton baccii gache (dual contraceptive) yawoon deggiino tuneba sheexi kephebeeti hineena'o ame ameena'ne?
  - Iibariyoona yesheto
  - Iiwee iritoona yesheto
  - Iiwee gaacoon yesheto
  - Maccoona yesheto
8. Shimi wokiye atton baccii gache (dual contraceptive) yawoon ciinnim qiho amo geten?

**Echa-wochoochi itto ibaaretoch oogichaa galletcho!!!**

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