

**GUIDELINES FOR GENDER SENSITIVE HIV AND AIDS PREVENTION
STRATEGIES AMONG REPRODUCTIVE AGE WOMEN IN ETHIOPIA**

by

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ABSTRACT

Background

AIDS remains one of the world's most serious health challenges affecting more females than men. The differences in the spread of Human Immunodeficiency Virus (HIV) among gender groups stem from biology, sexual behaviour and socially constructed gender differences between women and men in roles and responsibilities, access to resources and decision-making power. It could also be due to the females' status in society which could be justified by lower economic and decision making ability.

Purpose

The purpose of this study was to explore and describe the role of gender in the spread of HIV among women of reproductive age in Ethiopia; with the view of developing gender sensitive HIV and AIDS prevention strategies.

Methods

The study used sequential mixed method with quantitative and qualitative paradigm. During first phase of the study, health facility based descriptive cross-sectional study design was used. Data was collected from 422 respondents using a structured questionnaire. Forty participants were recruited by purposive sampling from representatives working in reproductive health or related fields.

Results

About 83.2% of respondents reported that sexual intercourse discussion should be initiated by male partners. This showed that majority of respondents were dependent on their male partners in decision-making regarding sexual matters in their relationship.

Multiple sexual partners were common among the respondents. One third of the respondents reported to have had intercourse with more than one partner during the past twelve months of the study period. Higher proportion of respondents (61.4%, n=259) had never used condom during sexual intercourse with their partner/s. As a result these risky sexual practices are a potential threat for spread of HIV and AIDS among women. Thus developed guidelines would alleviate the existing problems through implementation of strategies of HIV and AIDS prevention to enhance women's status at household and different administrative structure level.

Conclusion

Gender disparities in relation to negotiating sexual relations among the study respondents were found to be still relevant. The culture that has placed men at the helm of leadership in sexual matters is strongly upheld and that includes who recommends use of preventive measures and who regulates when and how to enter into a sexual relationship. Guidelines for gender sensitive prevention strategies if applied appropriately would educate women and men to make decision about what directly affects their health.

KEY WORDS

Gender; Gender-sensitive; Guidelines; HIV and AIDS; Magnitude of HIV Vulnerability; Prevention strategies; Vulnerability; Women of reproductive age

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DECLARATION

I declare that **GUIDELINES FOR GENDER SENSITIVE HIV AND AIDS PREVENTION STRATEGIES AMONG REPRODUCTIVE AGE WOMEN IN ETHIOPIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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10 February 2015

DATE

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Dedication

This thesis is dedicated to my mother and father for having laid the foundation for my educational development. They have been there all my life time in supporting for everything that I did.

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LIST OF ABBREVIATIONS

AfDB	Africa Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AUC	African Union Commission
CAC	Comprehensive Abortion Care
CDC	Centers for Disease Control and Prevention
D	Margin of error
EDHS	Ethiopian Demographic and Health Survey
FGAE	Family Guidance Association of Ethiopia
FMOH	Federal Ministry of Health
HAPCO	HIV and AIDS Prevention and Control Office
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
MCNH	Mother, Child and Neonatal Health
MOH	Ministry of Health
N	Sample size
NACP	National AIDS Control Program
NGO	Non-governmental organisation
P	Proportion
PICT	Provider-Initiated (HIV) Testing and Counseling
PMTCT	Prevention of mother to child transmission
PNC	Postnatal care
P-value	Probability value
RH	Reproductive health
SNNP	Southern Nations and Nationalities and People
SPSS	Statistical Package for Social Sciences
STD	Sexually transmitted diseases

STI	Sexually Transmitted Infections
TOT	Training of trainer
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Program on HIV AND AIDS
UNDAW	United Nations Division for the Advancement of Women
UNDP	United Nations Development Programs
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
UNISA	University of South Africa
USA	United States of America
VCT V	Voluntary Counseling and Testing
WHO	World Health Organization
X^2	Chi-square
Z	Standardised normal distribution curve

LIST OF ANNEXURES

Annexure A Ethical Clearance Certificate of UNISA to grant proposal approval

Annexure B Permission letter from Family Guidance Association to conduct study

Annexure C Letter to notice intent to submit thesis for examination

Annexure D Letter to seek consent from respondents

Annexure E Questionnaire

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) still remains one of the world's most serious health challenges given the global efforts that have been put in place to prevent the spread of the disease and to allay the symptoms brought about by AIDS. The number of people newly infected with HIV (Human Immunodeficiency Virus) in the globe is continuing to decline but national epidemics continue to expand in many parts of the world (UNAIDS 2012:8). At the end of 2011, an estimated 34 million people were living with HIV in the whole world (UNAIDS 2012:8). During the same year, an estimated 0.8% of adults aged 15-49 years were living with HIV in the world, although the burden of the epidemic continues to vary considerably between countries and regions (UNAIDS 2012:8).

In Ethiopia, HIV was first detected in 1984 and the first two AIDS cases were reported in 1986. A National AIDS Control Program (NACP) was established at a Department level under the MOH in 1987. The HIV and AIDS Policy was formulated by MOH and adopted by the Council of Ministers in 1998. There are many factors that promote the spread of the disease including the presence of sexually transmitted infections, gender inequality, multiple sexual partners, prostitution, men with disposable income and alcohol. According to the sample collected from 82 health facilities in 2005, there was a wide variation on the HIV prevalence across the facilities. In the same year, the national HIV prevalence was estimated to be 6.5% of which 4.0% was contributed by females. In 2005, among people living with HIV and AIDS (PLWHA), 55% were females and during the same year females contributed 54.5% of AIDS deaths (FMOH/HAPCO 2006:8, 25). This figures show the high rates of HIV prevalence among females.

There are many factors that contribute gender inequalities, some of those factors can negatively influence the prevention and care strategies for HIV and AIDS. For instance, the biological make-up of women make-up of women provide an easy entrance of HIV into the body and also provide an ideal place for the virus to grow (UNAIDS 2012:40).

The vulnerability of females is also due to the socio-economic status of women, which in most cases is dependent on men and inadequate decision-making of women which is influenced by the cultural roles of women in society (Gatta & Thupayagale-Tshweneagae 2012:26). In Ethiopia, for instance, HIV is higher in females than males (Federal Ministry of Health 2012:5). Therefore, identifying factors related to these differences and implementing appropriate interventions to address these challenges on HIV spread is crucial to reduce HIV vulnerability difference between two genders.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Gender is both visibly accessible and culturally meaningful, making it one of the primary categorisations systems used in African settings (Seloilwe & Thupayagale-Tshweneagae 2010:16). It is this categorisation that has led to the secondary role of women in particular to be dependent for a lot of things on their male partners. Decisions on sexual matters are by and large dependant on males (Fiske 1998:879). According to Bourg (2003:4) categorisation by gender is the root cause of gender-inequality in most societies. This assertion is supported by UNICEF (2010:4,7) report that social and economic powerlessness and low status relative to that of men is the root cause of women's and girls' greater vulnerability to HIV infection (UNICEF 2010:4, 7). The same report alludes to the increased number of infections among women and girls in sub-Saharan Africa. According to UNICEF (2010:4) in sub-Saharan Africa, the rate among women (12.2 million) has already surpassed that of men (10.1 million) and AIDS is a leading cause of death among women aged 20-40 in sub-Saharan Africa. At the same time, half of all new HIV infections are in young people aged 10 to 25, with adolescent girls in some places as much as five times more at risk than adolescent boys. Leading global institutions working in HIV and AIDS prevention agree that programs must address these social, economic and political factors if they are to be successful (UNICEF 2010:4, 7).

In most societies men and boys have multiple sex partners, whether they are single, in steady relationships or married (Gatta & Thupayagale-Tshweneagae 2012:26). Staying with only one man does not by itself protect the female partner from contracting HIV and AIDS. Young girls are put at particular risk by having sex with older men who are more likely to have been exposed to HIV through multiple partners Muula (2008:424). Due to low value placed on girls and women, most women do not have the power to ensure

that men use condoms. Globally, families may not be willing to spend scarce resources on women education so this limits their access to the information, skills and power to protect them. A gender perspective is a critical tool in health matters related to sex because it aims for both women and men to be able to make informed and free sexual and reproductive decisions and gives them the means to do so (UNICEF 2010:5-7).

The idea that sexually transmitted diseases (STI) are primarily transmitted by women still prevails, despite the fact that it is easier for an HIV positive man to infect a woman than the opposite. Married women are frequently suspected of promiscuity if they ask their husbands to use condoms, which is probably why many women become infected with HIV at home. Cultural norms condoning men having different sexual partners and refusing to use condoms contribute significantly to spreading HIV and are especially hard to change in most societies (Thupayagale-Tshweneagae, Seloilwe & Dithole 2009:6). Women's position within the society, usually submissive to men, greatly increases their individual vulnerability to HIV and AIDS (Pathfinder International 2008:7-8). In many countries and all regions, cultural and ethnic beliefs, taboos and myths can place the woman in extremely vulnerable conditions. Further poverty increases HIV and AIDS vulnerability; the epidemic itself increases poverty among infected people, their families and communities (Pathfinder International 2008:7-8).

Ethiopia Department of Health Services (2011) reported that the HIV prevalence among women aged 15-49 in Ethiopia was 1.9 percent. The same report also indicated the increase in HIV prevalence among this population with age to a peak of 3.7 percent at age 30-34 (Central Statistical Agency 2012:234, 243).

An estimated 84,189 HIV positive pregnant women in 2009, only 8 percent received antiretroviral prophylaxis. Knowledge of using condoms as a means of avoiding HIV was 40 percent. The predominant reasons for HIV testing were to plan for the future (61 percent) and perception of HIV risk (31 percent). The proportion of women having had two or more partners was 0.2 percent in 2005 and 1.3 percent in 2008 and those who reported having had higher risk sexual intercourse was 2.7 percent in 2005 and 5.3 percent in 2008. HIV positivity rate was 5.3 percent (3.6 percent males and 8.6 percent females), while 25.3 percent of clients who identified themselves as sex workers were HIV positive. In 2009, more than 616,763 pregnant women made at least one antenatal clinic visits during the last fiscal year and 417,841 underwent HIV testing of which

10,267 (2.4 percent) of the pregnant women tested positive. During the same year, in rural and semi-rural areas of Amhara, Tigray, Oromia and SNNP, 234,618 women accessed ANC services of which 78 percent got tested and received their results with a percent HIV positivity rate (FHAPCO 2010:8, 20, 43, 44, 46).

1.3 RESEARCH PROBLEM

The need for gender based HIV-related studies in Ethiopia has been highlighted by the Central Statistical Agency in 2012, which pointed to the facts that few studies in the country have looked at HIV from gender perspectives (Central Statistical Agency 2012:189). The existing literature showed that women of the reproductive age in Ethiopia are more affected by HIV and AIDS than their male counterpart (Central Statistical Agency 2012:189). These differences would be attributed to the gender role, more precisely the level of decision-making ability regarding sexual and reproductive health issues. The association between HIV status and a woman's ability to take independent decision regarding sexual and reproductive health issues is not well known. Studying and integrating variables that are known to enhance woman ability to take independent decision regarding sexual and reproductive health issues (level of education, secure income, means to access healthcare services and personal believes about gender norms) into existing HIV prevention strategies is crucial.

The researcher deems that the understanding of the influences of the ability of women to take independent decision on HIV status and how to integrate variables of the above ability into existing HIV and AIDS prevention strategies would assist in moving toward HIV and AIDS gender-sensitive prevention strategies. The implementation of such strategies might lead to reducing the prevalence of HIV infection among reproductive age women.

1.4 RESEARCH PURPOSE

The purpose of this study is to explore and describe the role of gender in the spread of HIV among women of reproductive age in Ethiopia with the view of proposing guidelines for gender-sensitive HIV and AIDS prevention strategies.

1.5 RESEARCH OBJECTIVES

Three objectives of this study were divided into phases of study:

Phase 1: Quantitative

To explore and describe the reproductive age women' vulnerability to the spread of HIV and AIDS in terms of

- knowledge and attitudes regarding HIV transmission and prevention
- risky sexual behaviour
- decision-making ability with regard to the spread of HIV and AIDS and demographic factors associated with these abilities

Phase 2: Qualitative

The qualitative phase had two steps:

1st step:

To validate the phase 1 findings through focus group discussions

2nd step:

To develop guidelines that could be used by health professionals to formulate gender-sensitive HIV prevention strategies for reproductive age women in Ethiopia

1.6 SIGNIFICANCE OF THE STUDY

There was limited information focusing on gender roles in HIV spread among reproductive age women. Thus the current study would attempt to answer the question why this population is at particular risk to HIV spread. At the same time, it is empirical to carry out the study to know more about the nature of HIV vulnerability among this population since this could assist health program managers to plan for proper interventions to address HIV vulnerability among these population groups. Similarly, the study could also emphasise on identifying the characteristics of HIV vulnerability among women. In addition, the study would provide evidences on those factors contributing to

the spread of HIV infection among study population to address their vulnerability. Moreover, the findings could help health program managers to understand, design strategies and appropriately implement gender sensitive strategies to narrow gender related gaps which are facilitating increased risk for female gender. Finally, the researcher hopes that the study findings would end up with development of guidelines which will help health care practitioners and policy makers to come up with gender sensitive interventions to target this gender group.

1.7 DEFINITIONS OF TERMS

This section defines common terms that were used throughout the study.

1.7.1 AIDS

AIDS is a global abbreviation for Acquired Immune Deficiency Syndrome which is a disease where there is severe loss of the body's cellular immunity, which greatly lowers the resistance to infection and malignancy (Avert 2013:1)

1.7.2 Feminism

Feminism is the radical notion that women are people and need to be equal to men in all aspects of life (MacDonald 2013:1)

1.7.3 Gender

Gender refers to the socially determined ideas and practices of what it is to be female or male (Reeves & Baden 2009:10)

1.7.4 Guidelines

A statement by which to determine a course of action (AIDSinfo 2008:23)

1.7.5 HIV

HIV is a human immunodeficiency virus Type 1 and 2 and are retroviruses capable of causing fatal AIDS American Society for Microbiology 2015:3)

1.7.6 HIV vulnerability

The probability that a person may acquire HIV infection because they have reduced ability as individuals and communities to avoid infection (UNAIDS 2013:43).

1.7.7 Magnitude of HIV vulnerability

The extent to which individuals or communities have a reduced ability to avoid HIV infection (UNAIDS 2013:43)

1.7.8 Vulnerable

A concept that defines one as being susceptible to one's power and privilege (Higgins, Hoffman & Dwokin 2010:435).

1.8 THEORETICAL FOUNDATIONS OF THE STUDY

The researcher utilised Liberal feminism theory to guide the study. Feminism is concerned with the criticism of a historical consciousness of gender imbalances between dominant patriarchal systems and subservient females (Tong 2009:5). By questioning society's conception of gender, sexuality and perceived inequalities between women and men. The idea is to draw attention to the inferiority of women in different social settings as it may have consequence in HIV vulnerability. Conceptions and perceptions of stereotypical representations can be accounted for by the philosophical thrust of feminist interpretation (Tong 2009:1-10).

Liberal feminism claims that gender differences are not based in biology, thus women should have the same rights, educational access, liberation, work opportunities and civil rights as men. It is Lens of gender and gender equality. It explains that society must allow individuals to exercise their freedom and fulfil themselves. The goal of women's

liberation is freeing women from oppressive gender roles. It led to advances in the economic sphere, equality opportunity and civil rights (Tong 2009:11-46). It plays role in reducing challenges posed by society to reproductive age women by giving them lower value within society when compared to men. This could fuel their vulnerability to HIV infection. Thus it is important to narrow gap between male and women. This approach would enhance women's status in society primarily through identifying factors more exposing reproductive age women to HIV vulnerability so that appropriate agency to give appropriate solution on this vulnerability.

Socio-economic characteristics are variables which were used for the current study. Thus the researcher considered that understanding factors favouring reproductive age women vulnerability to HIV is crucial to address existing challenges appropriately. In this regards, it was important to recognise the extent of HIV infection vulnerability among reproductive age women. Similarly exploring the level of HIV infection vulnerability among study population is the best approach to design appropriate intervention to these challenges. Further, it was imperative to identify factors posing this group of population to the HIV vulnerability so that appropriate authority to set up the way to tackle these setbacks.

Vulnerability to HIV infection was another variable. This variable was used to identify the factors which pose HIV vulnerability among reproductive age women. By identifying factors exposing this population to the epidemic of HIV, it was possible to develop guidelines to address the vulnerability of this population group to HIV. This would help to narrow HIV vulnerability difference between male and women. This further could give highlight in identifying HIV risk awareness level among study population for the current study.

Sexual negotiation in relationship was another variable to be used in this study. It seemed there was difference in sexual negotiation among male and female in different societies. Similarly the same challenge in sexual negotiation could occur even between married men and women due to lower societal value assigned to women. This could oppress women due to lower power given by society. Identifying the most sever factors and design appropriate action points to be implemented by appropriate bodies was crucial so that the problem would no more prevalent in the society.

1.9 RESEARCH METHODS

Both quantitative and qualitative paradigm was used sequentially. The qualitative phase of the study had role in supplementing the quantitative phase (first and predominant phase) of the study. The outcomes from both phases of the study could guide the development of the guidelines to indicate appropriate interventions to improve decision making ability among women and consequently reduce HIV vulnerability among them.

1.10 SCOPE OF THE STUDY

The participants of study were reproductive age women visiting Family Guidance Association Clinics during study period. The findings of the study could be generalised for all reproductive age women visiting Family Guidance Association Clinics in Addis Ababa. Further the findings could be generalised for all reproductive age women in the country and even beyond. Researcher hoped that the guidelines could be used by any entities to address reproductive age women vulnerability to HIV and AIDS.

1.11 STRUCTURE OF THE THESIS

The thesis was divided into the following chapters:

Chapter 1: Orientation to the study

Chapter 2: Literature review for the study

Chapter 3: Research design and method

Chapter 4: Presentation and discussion of the results for phase one

Chapter 5: Guidelines for gender sensitive HIV and AIDS prevention strategies

Chapter 6: Conclusions, recommendations and limitations

1.12 CONCLUSION

This chapter gave an orientation to the study. The chapter incorporated an introduction to the study, background information for the research problem, research problem, research purpose, research objectives, and significance of the study, definition of key terms, theoretical foundation to the study, research paradigm, research design and method, scope of the study and structure of the thesis. The next chapter reviewed the literature relevant to the study topic.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presented literature review of the previously existing sources in the field of study. A literature review is a manuscript written by someone to reflect on the significant points of recent understanding as well as theoretical and procedural contributions to a study subject matter (Burns & Grove 2011:107). The main goals of literature review for this study was to place the study within the body of literature and to provide the context for this study. Thus the researcher assumed the literature review as a staple for the current study to fasten the current study with the pre-existing knowledge in the study field.

The researcher consulted different literature sources to arrive at appropriate literature for the study. Consulted literature sources include electronic sources, published and printed materials from different libraries, different data basis and different internet search engines. During literature searching period, the researcher used key words such as gender, HIV, AIDS, reproductive health, sexuality, reproductive age group, reproductive health services and women to find relevant existing knowledge in the field.

Finally, the researcher read all literature sources collected and tried to sort them based on their appropriateness to the current study. After appropriate literature sorted, then the researcher started the process of write up on this chapter as evidence was presented under different sub section of the chapter.

2.2 HIV AND AIDS VULNERABILITY IN GENDER

Globally, many women compared to men are dying of HIV and AIDS (United Nations 2013:33). However, there are important differences between women and men in the underlying mechanisms of HIV infection and social and economic consequences of HIV and AIDS (Higgins, Hoffman & Dwokin 2010:435) As these stem from biology, sexual behaviour and socially constructed gender differences between women and men in

roles and responsibilities, access to resources and decision-making power (United Nations 2013:33).

2.2.1 Biological risk factors

Womens' biological make-up predisposes them to HIV infection (Ramjee & Daniels (2013:1). This is mainly due to the larger mucosal surface which makes it easier for viruses to develop and grow. Women between the ages 15-24 are more at risk because of the immature cervix which increases the trauma and hence exposure to microbes and viruses leading to an increase in sexually transmitted diseases (Gender dynamics 2010:6). Since sexually transmitted diseases are a sequel for HIV and AIDS this then explains why more women than men are at risk of acquiring the HIV (Baratedi, Thupayagale-Tshweneagae & Ganga-Limando 2014:5).

2.2.2 Socially constructed gender differences

Differences in power relations between men and women, which is attributed to culture, economic dependence and women' vulnerability has been identified as major players in the spread of HIV and AIDS among women and young girls (Dwokin 2005:615; Global Coalition on Women and AIDS 2008:3). In an unpublished study by Seloilwe (2015:8-12) it is alluded that most of the women at risk are the married ones because it has been ingrained on them that a man should not use a condom in a marital bed and this has not escaped even the learned women who are assumed to understand their rights first as individuals and second as partners in marriage.

2.2.3 Gender variations on rate of infections

UNAIDS 2013:56-68) reported the prevalence of HIV and AIDS in sub-Saharan Africa where the majority of those affected are women. The report further states that 61% of those affected by HIV are women aged between 15-to-49 years and that a large proportion of those are found in Southern Africa, particularly in Botswana, Lesotho, Swaziland and South Africa (UNAIDS 2013:56-68).

According to WHO (2014), a total of 35 million people were living with HIV in 2013 and 16 million of those were women. All this estimates demonstrate the gender risk of HIV infection. In Ethiopia, sex workers who are women mostly and university and high

school students were reported to be at risk of contracting HIV (UNAIDS 2014:3). It is therefore clear from the reports that strategies aimed at empowering women should be put in place.

The United Nations assertion is that by empowering women to be able to protect themselves and make informed decisions about their health and children can reduce the HIV and AIDS spread (UNAIDS 2013:7). Improved availability of birth control methods and technologies for reproductive age women with fully informed consent and freedom to choice on the type of family planning methods to be used by each client would avoid unplanned pregnancies and consequently reduce the infection rate among them.

Ethiopia has made substantial gains in increasing access to HIV prevention and treatment services among pregnant women living with HIV and children between 2009 and 2012. On other hand in the country, only 38.0% of eligible pregnant women living with HIV are receiving antiretroviral therapy for their own health (UNAIDS 2013:20).

2.3 GENDER AND SEXUAL VIOLENCE

A UNAIDS report based on research conducted in seven countries (Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines and Zimbabwe) found that notions of masculinity encourage young men to view sex as a form of conquest. The same report said that since ignorance is construed as a sign of weakness, men are often reluctant to seek out correct information on HIV and AIDS prevention (World Health Organization (WHO) 2003:2).

Feminist theories of patriarchy have identified men's presence and dominance of political institutions as a major obstacle to women's equality. The expert group agreed that the emphasis on men should be seen as a paradigm shift that allows political actors to focus on gender equality training for men in representative and participative arenas. The socio-economic position of women in societies negatively affects their participation since normally, women earn less than men and the sexual division of labour in society also imposes burdens on women. Most societies fail to organise in a manner that enables both men and women with families to share these responsibilities, particularly

considering that child-rearing responsibilities tend to fall disproportionately on women (UNDAW 2005:14).

Violence is not only a risk factor for HIV infection but also becoming increasingly clear result of the epidemic. In Kenya, 19% of HIV positive women experienced violence from partners. Women are more vulnerable to interpersonal violence than men (WHO 2000:11).

Violence against women is widespread and rising numbers of women at risk from AIDS as a result of high risk sexual behaviour on the part of their partners. In a number of countries, harmful practices control women's sexuality and led to great suffering (United Nations' Programme of Action 1994:38).

The Fourth World Conference on Women drew attention to the persisting inequality between men and women in decision making. It undermines the concept of democracy, which, by its nature, assumes that the right to vote and to be elected should be equally applied to all citizens. The absence of women from political decision-making has a negative impact on the entire process of democratisation. Without the perspective of women at all levels of decision-making, the goals of equality, development and peace cannot be achieved. The outcome of 2005 World Summit also reaffirmed commitment to the equal participation of women and men in decision-making (UNDA 2005:7).

Given the global commitments to the prevention of HIV spread, there are significant sex and age differences in the decision making processes. This point is supported by study done in USA on factor affecting gender decision making as statistical analyses revealed significant differences due to gender and age in participants' perception of the factors (Lizárraga, Baquedano & Cardelle-Elawar 2007:387).

Violence in the form of coerced sex or rape may also result in the acquisition of HIV, especially as coerced sex may lead to the tearing of sensitive tissues and increase the risk of contracting the HIV virus. According to WHO report, adolescents' first sexual intercourse was forced particularly for women. Women may be more affected by stigma and discrimination than men because of social norms concerning acceptable sexual behaviour and more economical vulnerability (WHO 2003:3).

Study done in Tanzania reported that the influence of gender, wealth, ethnicity and education presents substantial challenges. The findings have revealed that fairness principles in health care decision making processes are greatly undermined in the study district. This notion posed a very real threat in health care decision making as they may systematically undermine the views and experiences of particular segments of the population (Shayo, Norheim, Mboera, Byskov, Maluka & Kamuzora 2012).

Overall, there is a need to mobilise entire communities to change the social, cultural and economic conditions that support unsafe sexual behaviours. Women still have to ask their male partner for permission to test for HIV or to access health services; permission to protect themselves. Unless accompanied by broader structural interventions in both the political and occupational realm, people's ability to make changes in behaviour will continue to be severely constrained by prevailing social conditions (Chersich & Rees 2008:8).

2.4 GENDER AND SOCIO-ECONOMIC EXISTENCE

During the past several decades, the formulation, implementation, monitoring and evaluation of population policies, programmes and activities have been benefited from the findings of social and economic researches. These researches highlighted how population change results from and impacts on complex interactions of social, economic and environmental factors. It was believed that social and economic researches are clearly needed to enable programs to take into account the views of their intended beneficiaries especially women, the young and other less empowered groups to respond their specific needs (United Nations' Programme of Action 1994:72).

A gender gap was said to be a difference in any aspect of the socio-economic status of women and men. On other account, gender discrimination is different treatment given to one gender by comparison with other gender. Further gender oppression is male monopoly of decision-making process by maintaining male privilege and preserving male leisure. Deliberately underlying systemic discrimination against women is the maintenance of patriarchal power for the purpose of retaining male privilege (UNESCO 2001:14).

Whether it is in the public or private sphere, women continue to be denied opportunities to participate in decision making processes that have been affecting their lives. The suppression of women's voices in many areas has been contributing to the persistence of gender inequality and limits to human development. On other hand, it is widely recognized that increasing women's bargaining power within the household could improve children's nutrition, survival rates and literacy. According to United Nations Report, of all the decisions could be made at the household level, the majority of women were free to decide when to visit friends, families, relatives and how to manage their own health. But the situation is worse for women when it comes to money-related decisions as money related matters are disproportionately concentrated on the hands of men (United Nations 2013:23).

Study done in Nepal on women's role and choices of skilled birth attendants indicated that several socio-economic, cultural and religious factors played a significant role in the use of this service. The same study also revealed that availability of transportation means, distance to the health facility, poor infrastructure, lack of adequate services, availability and accessibility of the those services, cost and convenience of services, staffs' shortages and their attitude, gender inequality, status of women in society, women's involvement in decision making processes and women's autonomy were significantly affecting factors on use of skilled birth attendants (Baral, Lyons, Skinner & Van Teijlingen 2010:1). This study concluded that different socio cultural, religious, financial and demographic factors have a significant role in uptakes of the service (Baral et al 2010:5).

According to study done in Madhya Pradesh State of India on factors affecting the use of maternal health services indicated that very strong positive influence of higher household socio-economic status on the use of maternal health services. The same study brought into picture as religion casts considerable influences on the use of ANC and safe delivery services, though religion posed no noteworthy influence of these factors during use of post-natal care (Jat, Nawi & Sebastian 2011:9).

African Millennium Development Goals Progress Report in 2012 brought into attention that HIV and AIDS is worsening health, economic and social issue in sub-Saharan Africa. The same report showed that in 2010, Africa was the only continent where HIV prevalence was higher among young women than young men. According to the report

HIV prevalence among young females aged 15 to 24 years was 3.3% whereas the HIV prevalence among young males of same age group was 1.4% in that year. Thus the report summed up that the trends in age/sex differentiated HIV prevalence rates for people aged 15-24, since the situation for young women has worsened considerably in most African countries (AUC, UNECA, AfDB & UNDP 2012:82).

UNAIDS/UNFPA/UNIFEM (2004:8) puts poverty as factor which could push some women into risky behaviour. This is because women without other options, they may choose sex work to fulfil their personal needs and feed their families. This could be evidenced as in Southern Africa, many older men seek out young women and adolescent girls for sexual favours while providing them with school fees, food and highly sought after consumer goods (UNAIDS/UNFPA/UNIFEM 2004:8). In addition to women's economic hardship which could lead to risky sexual practices, in countries that are hard-hit by the epidemic, particularly in sub-Saharan Africa, women are responsible to provide necessary support and care for HIV and AIDS patients at household level (UNAIDS/UNFPA/UNIFEM 2004:8).

According to Smith (2002:9), development programmes have focused on women of reproductive age as the prime target for community projects due to this age is at peak people's economic productivity age. However, HIV and AIDS is leading to demographic changes and changes in the traditional roles and responsibilities of different age groups. The HIV and AIDS epidemic has been fuelled by gender inequality, unequal power relationship, sexual coercion and violence for women of all age groups, seeing that this could result in an array of negative effects on female sexual, physical and mental health (Smith 2002:1). The same study also showed that women and girls of various ages are vulnerable to the infection. Further the study pointed out that women are in the need of support for the survivors to overcome the economic and social effects of the epidemic (Smith 2002:9).

According to study done in Cape Town, South Africa on ethnic differences in HIV risk revealed that over a third of the participants had unprotected sex during their last sexual encounter. The same study presented that greater proportion of Coloured participants had unprotected sex (53.79%) compared to Black African participants (Myers, Kline, Browne, Carney, Parry, Johnson & Wechsberg 2013:4). The finding in line with CDC report as declared multiple contextual factors could contribute to disparities in infectious

diseases; therefore, social and cultural differences in HIV vulnerability should be considered when prevention strategies are to be developed and implemented (CDC 2006:121).

Another study done in Nigeria on religious and gender dimension of HIV and AIDS risk revealed that religions play positive or negative or both roles in HIV and AIDS risk and prevention. According to the study finding, both Islam and Christianity advocate abstinence as the best way to prevent HIV and AIDS infection. The same study indicated that Christians believed as the punishment for committing fornication and adultery is from God and not from a Sharia court of law. Moreover, Christians are also of the opinion that they serve a merciful God who is able to forgive their sins of fornication and adultery if they ask for forgiveness. Therefore, Christians are more likely to engage in extramarital affairs or premarital sex when compared to their Muslim counterparts. From the standpoint of abstinence as a prevention method, Muslims are better off adopting this method when compared to Christians. The fear of being punished for adultery and fornication under the Sharia law, the seclusion of opposite sex in the name of religion and the enforcement of virginity and early marriage for young Muslim women could help reduce the chances of engaging in premarital and extramarital sex (Durojaiye & Kammerer 2012:45).

Another study done in South Africa on Education and HIV vulnerability implied that attending formal schools can lead to behaviour change through changing the socio-cognitive determinants of behaviour, influencing social networks and leading to a change in socioeconomic status (Jukes, Simmons & Bundy 2008:S42). The same study conveyed message as students attending school have a smaller sexual network and a stronger motivation to avoid the consequences of unprotected sex than their out-of-school peers (Jukes et al 2008:S45-S46). The study further disclosed that increased education levels can influence the kind of people one meets and the way of behaving (Jukes et al 2008:S43).

According to UNFPA, in many African societies, women's primary role is still seen as bearing and nurturing children. On the other hand men's role is perceived to be earning a living expenses and dealing with the broader issues of society on the behalf of family. This type of labour division between genders could have consequences on prolonged women's economic dependence on men in family and broader society context.

Moreover, this significantly contributes to ignorance in women's right to access information that can help them to protect themselves from HIV infection. Furthermore, such economic vulnerability also fuels women's recourse to selling sex to enable them to survive through improving financial incomes to attend their personal and family needs (UNFPA 2000:5).

On other accounts, according to the International HIV and AIDS Alliance, there are individuals and population groups who are more vulnerable than others in every society. The Alliance also revealed that vulnerability to HIV is a result of a combination of factors including more personal circumstances such as age, social mobility, education, gender identity, women, ethnic or religious minorities and migrants; and also environment variables such as poverty, gender discrimination or lack/inadequacy of services. Thus these norms can undermine girls' and women's autonomy and direct them less resistance on sexual abstinence or condom use during sexual intercourse by their male partners (The International HIV and AIDS Alliance 2010:1).

According to gender inequalities and HIV and AIDS epidemic in sub-Saharan Africa 2007 report, both women and men living with HIV and AIDS experience discrimination and stigma. However, women were more affected by stigma and discrimination than men due to discriminatory social norms on sexual behaviour in women and women's economically vulnerable on men (TEMAH 2007:11). As a result to fight against HIV and AIDS focusing on poverty reduction and narrowing down income and education gaps between men and women have added value. Furthermore, tackling gender inequality and discriminations would have leveraging effect on the other determinants of HIV and AIDS (TEMAH 2007:27).

On the other depiction, Booyesen and Summerton (2002:287) reported that nearly 82% of the women in the bottom quintile did not use a condom during last sexual intercourse with a casual acquaintance compared to 80.8% of the women in the top quintile. As a result, more work is required to establish how specific factors other than knowledge on HIV and AIDS and socioeconomic status stand to enhance the vulnerability of women to HIV and AIDS. These factors could include gender and power relationships, violence and coercion and negative perceptions about condom use.

2.5 GENDER AND PARTNERSHIP CIRCUMSTANCES

The pattern of women's and men's roles and relationships in Africa puts women at greater risk. In this sense, polygamy, sexual coercion and violence against women all contribute to the distressing gender gap in HIV and AIDS (TEMAH 2007:5). The first pattern of marital life that puts women at greater risk of infection in sub-Saharan Africa is polygamy. Polygamy is inherently discriminatory because the man may be having unprotected sex with multiple partners thus exacerbates the risk of HIV transmission (Makua 2015:12).

Roberts and Kennedy (2006:35-36) affirmed that the young women's first sexual experience was 13–24 years with 44% under age 16 years at first coitus and 10% at 14 years or younger. The same study reported that average number of lifetime partners was 5; 43% had 4 or more partners; 17% had 10 or more partners; and 5% had more than 20 lifetime partners. Regarding to STD risk perception among College women's, 93% of white women were categorised moderate to high risk behaviour scores than African Americans (73%) and Latinas (67%). The study also located 38% of women high risk score, 43% moderate risk score and 19% low risk score. Female students (61%) were grieved that their parents' approval influenced their choices. There was also disparity in disapproval by parents of sexual relationships (54%) versus multiple sexual relationships (89%) (Roberts & Kennedy 2006:35-36).

According to study done in Bangladeshi and India on Vulnerability to HIV and AIDS, over three-fourths of female respondents, much higher than men, got married before the age of 18. Over two-thirds of male respondents were married between the ages of 18-24. The study also disclosed that the mean age at marriage did not differ significantly when disaggregated by source district, place and duration of stay in India (Sultana, Das, Sultana, Samuels & Zarazua 2010:19).

Another study done in Pakistan on marriage decision making, the mean age for marriage was 16.4 years. The study justified as physical maturity (16%) and ability to accomplish household work (19.9%) were reasons for young women to be got married. The same study also indicated that one third of them were married with spouses of the same age; 33.9% of them had married with spouses older than between 1-5 years; and

29.9% of them had married with spouses older than more than 5 years (Hamid, Stephenson & Rubenson 2011:3).

According to Santhya, Jejeebhoy and Ghosh (2008:17-18), sexual relations within marriage have social sanction, for that reason marriage does not inherently make sex safe or voluntary, particularly for young women. The findings from the same study showed that substantial proportions of young women had initiated sex within marriage at a young age particularly in Guntur; 45 percent of young women and 37 percent in Dhar and Guna had begun cohabiting at age 15 years or below. Moreover, about three-fourth of young women in both settings had cohabited before they reached the age of 18 years. Conversely, only a small number of young men in both settings had cohabited at age 15 years or below; however, about two-fifths of young men in Guntur and three-fifths in Dhar and Guna had cohabited before they reached the age of 21 years which is the legal age at marriage for boys in India (Santhya et al 2008:17-18).

Another study conducted in South India on sexual risk vulnerability, 46% of the women was reported as they had Married in less than or equal to 20 years old; pre-marital sex prevalence was 13% among participant women and reported sexual coercion was among 43% of the women (Thomas, Suresh, Watson, Jamuna, Vijayalakshimi & Swaminathanl 2013:9, 13).

According to study done in Ethiopia on relationship between sexual violence and HIV, the median age at first sexual intercourse was 16 years. The same study pointed out that 70% of the respondents had had sexual intercourse before age of 18 years (Hassen & Deyassa 2013:3).

The disproportionate burden of HIV infection among women is more noticeable among those who are unmarried (Magadi 2010:6). The same study also found that younger women between the ages of 15-24 and 25-34 are mostly affected. HIV prevalence is significantly higher for women than men in most countries (Magadi 2010:6). Therefore it is appropriate that research should find interventions that would reduce the burden of HIV infection for women, especially those of childbearing age.

2.6 REPRODUCTIVE HEALTH AND ATTITUDE ON ITS SERVICES AMONG WOMEN

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system, its functions and processes (Magowe 2014:19). Reproductive health therefore implies that people are able to have a satisfying and safe sex life; they have the capability to reproduce and the freedom to decide when and how often to do so. Implicit in this is that the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility and the right of access to appropriate health care services. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community (Magowe 2014:20).

Worldwide, unmet need for family planning dropped from 15 percent in 1990 to 12 percent in 2011. Current levels of unmet need range from a low of 4 percent in Eastern Asia to a high of 25 percent in Oceania and sub-Saharan Africa. By 2015, total demand for family planning among married women is projected to grow to more than 900 million, mostly due to population growth. This is one indication of the unfinished agenda in reproductive health and the scale of efforts needed to keep pace with the demand for contraceptives, especially more effective modern methods (United Nation 2013:32). Increasing access to voluntary and non-coercive family planning services for all women can avoid unintended pregnancies and enables women to choose the number and spacing of their children thereby improving their health and well-being (UNAIDS 2013:13-14).

Study conduct in Nepal on women's role and choices regarding use of skilled birth attendants indicated that utilisation of the maternal health services is influenced by the characteristics of the available health system such as quality of the services, cost, conveniences, accessibility and availability of services and its use. Other factors such as the socio-cultural and religious structure of the communities and individuals characteristics should also be considered in promoting the utilisation of effective maternal health services (Baral et al 2010:329).

Another study done in Madhya Pradesh state of India on factors affecting the use of maternal health services indicated that better educated women are more aware about their health, know more about availability of maternal health care services and use this awareness and information in accessing the health care services (Jat et al 2011:9). The household socioeconomic status and mother's education also identified as the most important factors associated with the use of ANC and skilled attendance at delivery thus empowering women and promoting mother's education would yield greater results in increasing the use of maternal health services (Jat et al 2011:10). According to UNAIDS, improved access to family planning could further reduce the number of new HIV infections among children and improve maternal health (UNAIDS 2013:21).

On other hand, the rising rates of HIV infection among girls and women require approaches to prevention to address their specific needs and realities. Effective prevention is composed of many facets including education, health services, media campaigns, behaviour change, life skills building and job training. All these components must address the critical role that gender plays in sexual and reproductive life and how it affects HIV prevention (UNAIDS/UNFPA/UNIFEM 2004:11).

On other explanations, in 2012, the level of worldwide unmet family planning need among women aged 15–49 was estimated to be 11%. In sub-Saharan Africa, the estimated unmet need for family planning among 15–49 year reproductive women was about 25% and may be higher for women living with HIV during the same year. The lack of female controlled methods of HIV prevention and low levels of condom use place women and girls at increased vulnerability to HIV infection. Hence new investments into research for female controlled HIV prevention options and safe contraceptive methods are essential to be focused on (UNAIDS/WHO 2012:2).

Regarding to reproductive rights, the majority of women were dependent on their husbands for deciding whether to use contraceptive techniques or not and how large family size to have. As 81% of women agreed that there was nothing they could do to change the mind of their partner when he refused to use modern methods of child spacing. However, it was interesting to note that 54% of the women agreed that even if their husbands did not want them to use family planning, they would go ahead without the husband's knowledge due to the fact that the family planning clinics in Malawi and

elsewhere in Africa target only women and easily hidden from husbands. On contrast women expressed the risk of such decision without consent of their husband as once their husband find out, the consequences could be tragic for the woman (Kalipeni & Ghosh 2005:327).

According to study done in India on early marriage and reproductive health risk indicated that condom use in extra-marital relationships was limited in study settings. This problem was considerably more likely among young men than young women as reported during extra-marital relationships. Among young women, the proportion of respondents who reported that they always used condoms in all types of extra-marital sexual relationships was roughly similar to those who reported ever use of condoms due to the fact that most women who reported extra-marital sexual relationships had such experiences only with a single partner. However, among young men, considerably smaller proportions just over 10 percent reported consistent use compared to ever use of condoms in extra-marital relationships (Santhya et al 2008:20-21).

Another study done in Kenya on attitude towards family planning divulged that there were 448 (87%) women who indicated they intended to use family planning methods; 44 (8%) did not intend to use family planning methods and 25 (5%) did not know any family planning methods. The same study traced half of the women had discussed about family planning methods with their spouse or partner whereas nearly the same number of women, 254 (49%), had not discussed with their spouse or partner. The study also proved that the 262 (50%) respondents felt their spouse or partner would approve the use of family planning method; 122 (23%) of respondents thought their spouse or partners would not approve the use of family planning and 135 (26%) respondents said that the feelings of their spouse or partner were unknown. On other hand, the study revealed that 186 (36%) of respondents reported their spouse or partner wanted the same number of children as they want; 90 (17%) reported their spouse or partner wanted more children; 25 (5%) of respondents stated they wanted fewer and 143 (27%) of respondents indicated they did not know the number of children their spouse or partner wanted (Akelo et al 2013:4).

Roberts and Kennedy, 2006 reported that 84% of respondents' intention, attitude and skill related high condom use. In this particular study, women reported high intention to acquire or discuss condoms (65%), to purchase (84%) and use condoms in the next

sexual encounter (80%). Only 39% had positive attitudes about condoms including not being embarrassed to purchase condoms (75%) and not affecting the mood (66%). Study participant Women said condoms did not affect their personal pleasure (56%) but believed that condoms affected their partner's pleasure (62%). Regarding the resistance of male partners to condom use, most subjects (57%) experienced low partner resistance to condoms, whereas 43% of them experienced resistance by partners. Further Women with regular sexual partners experienced more resistance to condom use (Roberts & Kennedy 2006:36).

Various reasons on the insistence of consistent condom use by the study respondents were reported. These included fear of contracting sexually transmitted diseases such as HIV and other STIs, negative health and social consequences, experiencing death of family member due to HIV, the desire to stay healthy to provide for their children and the need to prioritise good health over pleasure (Pillai, Bhattacharjee, Ramesh & Isaac 2012:16). On other hand, some respondents stressed the importance of using condoms even with their husbands to avoid infections. On contrast despite knowledge and awareness about using condom, majority of respondents cited their inability to use condoms with their husband due to fear of being blamed by the spouse as having an ulterior motive such as multiple partners and doubting the spouses' loyalty to the marriage (Pillai et al 2012:16).

2.7 HIV VULNERABILITY IN RELATIONSHIP AMONG WOMEN

Risk of sexual ill health begins with the onset of unsafe sexual activity and continues as long as the unsafe activity or harmful sexual practices are engaged in (UNAIDS 2012:16). As alluded to in the previous sections unequal power relations between men and women increase their vulnerability to HIV infection (Higgins, Hoffman & Dworkin 2010:436).

Study done in South Africa on women and HIV in sub-Saharan Africa reported on those factors such as contextual variability in risk, physiological factors and socio-economic vulnerabilities (Ramjee & Daniels 2013:2-4). The study proposed interventions which are both behavioural and structural that can counteract women's vulnerability to HIV infection.

Study done in Namibia on HIV Prevention among Adult Women reported that alcohol consumption was consistently critical risk factor underpinning the ongoing pattern of new HIV infections. Alcohol consumption was directly linked to HIV vulnerability and risk for women. Participants said if woman has drunk she will have sex with someone who she does not know well. Being drunk was often used as an excuse for HIV-risk behaviour (Parker & Borwankar 2012:17-18).

According to Santhya et al (2008:19-20), even though extra-marital sex was not as prevalent as premarital sexual partnerships, a small minority of young women and men in study settings had engaged in extra-marital sexual relationships. Young women were less likely than young men to report such experiences as 5 percent or less of young women in both settings compared to one-tenth of young men reported such experiences.

Study done in Bangladesh on vulnerability to HIV and AIDS publicised that 81% of respondents were having a sexual relationship in the previous 12 months. These respondents were reported 96% of them with regular partners, 99% of them with spouses and 95% of them with mobile persons affirmatively. Overall, among those who had sex in the last 12 months, 29% had reported using a condom. 72% of those with regular partners did not use condoms. The reasons for condom use by those who reported using condoms includes avoiding pregnancy, protecting themselves from STI/HIV and defending their partner from STI/HIV and AIDS (Sultana et al 2010:41).

At the end, lack of trust in their lover's fidelity was the primary reason why they used condoms with lovers and partners. For street-based sex workers, barriers to using condoms with lovers and partners included issues related to intimacy, trust and their inability to convince them to use condoms, however; respondents denied unprotected sex with their clients (Pillai et al 2012:17). Believing that protected sex is a mistake, trusting their husband and fear of conflicts in the relationship were the reasons that prevented them from practicing safe sex with their intimate sexual partners (Pillai et al 2012:52).

The most recent study done in Botswana reported that More females than males experienced physical abuse. It is also indicative that both verbal abuse and emotional abuse do occur. Abusive relationships can predispose women to unprotected sexual

relationships. In these relationships women cannot also negotiate anything (Seloilwe & Thupayagale-Tshweneagae (in Press)). Their study also quoted previous studies that have indicated that in abusive relationships, most women would not be able to negotiate safe sex.

2.8 COUPLES' SEXUAL NEGOTIATION

In settings with unequal sexual power and economic disparities, women will continue with limited ability to negotiate protected sex and few alternatives to adopting practices. Thus counselling and condom promotion cannot focus on sexual behaviour alone because a woman does not make sexual decisions in isolation within her life context. Consequently, it is necessary to increase women's education and condom negotiation skills to ensure continued condom use among men who may perceive themselves to be fully protected against HIV (Chersich & Rees 2008:7). Moreover, they need to learn not only how HIV is transmitted but also how to negotiate abstinence, unwanted sex or safer sexual relations because women are more vulnerable to coercion, more likely to be economically dependent on men and less likely to be able to negotiate methods of protection (Elliot & Umberson 2008:392).

Similarly gender norms and inequalities increase vulnerability to HIV both men and women differently. Gender relationships that are characterised by unequal balance of power between women and men increase the chances that women do not enjoy equal rights with men in many aspects of sexual decisions such as protected sex, faithfulness of their partners or refusal to have sex. Women's vulnerability ensure that women lack the ability to determine if, when and with whom to engage with sexual relationships and increase the chances that more women than men will get infected with HIV. In addition to that inaccessibility to relevant information for women does not allow them to seek the information on HIV prevention, treatment, support and care. Hence sexual behaviour is greatly influenced by the individual's culture, sexual orientation, experience and knowledge (UNAIDS 2009:3).

Condom negotiation differs considerably for men compared to women. Men have more influence over whether and when to have sex but the majority of women claim to have denied and misunderstood. Blanc and Wolff found that about one third of study participant women had never thought about discussing on condom use with their

partners. The reasons mentioned not discussing on condom use with their partners were the partner would think that the respondent is promiscuous worthy; the partner wouldn't like using a condom and the respondent is too afraid or embarrassed to raise the subject (Blanc & Wolff 2013:20).

According to Harvey, Bird, Galvotti, Duncan and Greenberg's (2013:76) report, 16.4% of study participant women said their partner has more power in decision making. Similarly decisions regarding whether to use condoms and type of sexual activity, a larger percentage of women agreed that their partners made decisions (Harvey et al 2013:76).

According to study done in India on early marriage and sexual and reproductive health risks, a substantial proportion of young women, particularly in Dhar and Guna, reported that forced sexual initiation within marriage (46% in Dhar and Guna compared to 14% in Guntur) had forced sex in the 12 months. While fewer men report perpetrating to forced first sex: 28% and 3% of young men in Dhar and Guna, and in Guntur respectively (Santhya et al 2008:18).

Another study in Malawi on fish traders female vulnerability to HIV and AIDS reported that extra marital sexual relationships were common among fishers like relationships between boat owners and women fish traders, in some cases when the boat owners have no working capital, they resort to borrow money from women to buy fuel for boat engines, gas for lamps or pay crew members. The study reported that about 17% of the respondents indicated their husbands (fishers) normally away from home following good fishing grounds depending on the weather and the moon. Then the practice occurred with communities left migrant fishers, some men would identify which men had gone away for fishing so that meanwhile they could entice their wives into extra marital affairs. On the other hand, when the fishers also migrated to a distant fishing ground for a longer period, they engage in temporary marriages in those fishing grounds hence increasing their risk of HIV infection and infecting their original wife upon return (Kambewa, Nagoli & Hüsken 2009:19).

2.9 HIV INFECTION'S RISK PERCEPTION AMONG WOMEN

A Joint UNAIDS/UNFPA/UNIFEM report indicated that rising rates of HIV infection among girls and women require approaches to prevention that address their specific

needs and realities and that are linked with other reinforcing elements along a broad continuum of prevention, treatment and care. Effective prevention is composed of many facets including education, health services, media campaigns, behaviour change, life skills building and job trainings. All these components must address the critical roles that gender plays in sexual and reproductive life and how it affects HIV prevention (UNAIDS/UNFPA/UNIFEM 2004:11). For many girls and women, knowledge is not enough. So they need to learn not only how HIV is transmitted but also how to negotiate abstinence, unwanted sex or safer sexual relations. And they need to find safe ways to financially support themselves because women have unequal access to resources, consequently more likely to be economically dependent on men and less likely to be able to negotiate methods of protection (UNAIDS/UNFPA/UNIFEM 2004:13-14).

According to study done in Malawi on vulnerability and risk to HIV and AIDS, knowledge about HIV and AIDS among the women was high but the practices and attitudes were not congruent with this knowledge. This argument supported by 86% of the women's view which use of a condom with a spouse to protect against AIDS is not acceptable. Similarly only 44% of the women had ever talked to their husbands about the chances of infection with the virus. However, 70% of them suspected their husbands on possibility of sexual relationship with unknown women and their fellow women. Thus Women are afraid to raise issues concerning neither HIV and AIDS nor how to protect themselves from the virus while their husbands are cheating (Kalipeni & Ghosh 2005:328).

Another study done in Zambia on HIV prevention among adult Women revealed that both men and women said to enhance their social status sexual activities are crucial as for women, social status was expressed through symbols of economic independence such as clothing, money and cell phones whereas for men achieved higher status when they had many sexual partners. In relationship, condom use was more likely common with new sexual partner but it could soon fall away when partners trusted each other. People in such relationships could jump from one relationship to another without being answerable to anyone due to being unmarried as in a relationship was seen as having much less accountability. When there was no formal and committed relationship, having other partners could not be construed as cheating. Even in the marriage, there was still a risk of exposure to HIV through extramarital relationships (Parker & Borwankar 2012:17).

Regarding to knowledge on HIV and AIDS transmission, sexual relationship was identified as a source of infection for almost all individuals. The use of condoms in all relationships during the last 12 months was reported by 14% of respondents. There was no significant difference between time of living together with partner and condom use. The same study also revealed that 17% of respondents reported extramarital sexual practices during the last 12 months of whom 71% were male. Among interviewees that had extramarital sexual practices, 9% of them did not use condoms (Maial, Guilhem & Freitas 2008:3).

According to study done in Bangladeshi and India on Vulnerability to HIV and AIDS, unprotected sex sexual practices with multiple partners was reported by 59.3% of respondents at destination. This mode was reported by a higher proportion of women (65%) than to men (35%) (Sultana et al 2010:36).

Study done in Zambia on multiple sex partners indicated that 13% of participants reported having two or more sexual partners during the last 12 months and 31.5% of respondents considered themselves to be at risk of HIV infection, 36.5% of them thought they were at risk of HIV infection. The same study also indicated that more than 60% of men and women in the sample still thought that women should not carry condoms. On other hand, only 18% of the participants had an HIV test within the last year and a similar proportion knew the sero-status of their last partner (Do 2008:5).

Another study done in Kenya among disabled people on knowledge, attitude, practice and access to HIV and AIDS service revealed that the respondents reported higher risk of contracting HIV and AIDS compared to other members of the community as 80% of them felt that they were at risk of contracting HIV and AIDS. The same study reported that caregivers of persons with mental disability also shared the same perception with 82% of them feeling that a person with mental disability is at a higher risk of contracting HIV. Overall, the two major factors that put persons with disability at a higher risk were lack of information on HIV and AIDS and vulnerability to sexual violence or sexual exploitation (Handicap International [s.a.]:15). Similarly condom non usage may be attributed to the perception due to the fear that one does not trust the partner, belief that condom reduce sexual pleasure and perception that condoms are not effective in HIV prevention, religious beliefs discouraging use of condoms, lack of knowledge on how to

use condom and possible absence of condoms at the time of need (Handicap International [s.a.]:14).

Another study done in Zimbabwe on factors influencing the attendance of voluntary counseling and HIV-testing found that 98%, 98% and 91% of respondents were reported that abstinence, condom use and getting tested respectively identified as important factors in HIV protection. Respondents also added their own perception of a good form of protection from the infection (Moyo & Plessis 2009:50).

Study done in Zimbabwe on influencing factor of the attendance of VCT identified that 32% of respondents have visited a VCT centre. The reason of their testing was 31% of them due to get pregnant or were pregnant; 50% of them wanted to know their HIV status, 10% of them tested for medical reasons, 6% of their partners had tested positive for HIV and 3% of them tested for other reasons. On other hand, 67% of them had never been tested for HIV (Moyo & Plessis 2009:54-55).

Further study done in Zimbabwe on PMTCT indicated that 100% of respondent women knew as breastfeeding could transmit HIV to the baby during breastfeeding. Because of their knowledge, many of them preferred to avoid breastfeeding to safeguard their kids (Sibanda 2008:79).

Furthermore, study done in Nigeria on HIV and AIDS knowledge and attitude reported that 56.2% of the respondents were knowledgeable about possibility of HIV transmission from infected mother to the baby during pregnancy (Oyewale & Mavundla 2008:78). The same study also found that 18.2% of respondents lacked the knowledge which mosquito bites cannot transmit HIV (Oyewale 2008:80). The study also presented its finding that 72.5% of the respondents knew a healthy-looking person can be infected with HIV (Oyewale 2008:82).

On other account, according to study done in Ethiopia on relationship between sexual violence and HIV, about half of the respondents had only one partner and other half of them had two or more partners. Similarly 17.6% of the subjects had an extra partner sexual practice during the last 12 months (Hassen & Deyassa 2013:3).

2.10 CONCLUSION

Current chapter presented existing knowledge in the study field. Both new and grey literature were used to help the researcher situate his own study. In order to focus on specific aspects of the study, the chapter has divided in to subsections as follow: introduction to study, HIV and AIDS vulnerability in gender, gender and sexual violence, gender and socio- economic existence, gender and partnership circumstances, reproductive health and attitude on its services among women, HIV vulnerability in relationship among women, couples' sexual negotiation and HIV infection's risk perception among women. Each sub section presented evidences based on available literature. Finally, the chapter ended with conclusion of its content. The next chapter would present research design and method for the study.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter explained the research design, research methods, data managements, external validity and ethical considerations undertaken during the study.

3.2 RESEARCH DESIGN

The research design is the plan, structure and strategy of investigations to answer the research question. It is also called the overall plan or blue print to carry out study (Babbie & Mouton 2009:55).

The quantitative study provided a method to collect statistical data for analysis and reporting for the current study. The main purpose of scientific research is to explore the association among primary variables in an effort to gain a better understanding of the phenomena under study (Haber & Lobiondo-Wood 2006:206).

Qualitative research is aimed to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour. The qualitative method investigates why and how of decision making, not just what, where, when with smaller and focused samples (Burns & Grove 2011:61).

A mixed-method approach combining qualitative and quantitative data collection and analysis was used.

1ST PHASE QUANTITATIVE METHOD

Quantitative research may be viewed as exploratory. It functions this way through measurement of variables and statistical analysis. Quantitative methods can be limiting in exploring and explaining reasons why a particular phenomenon occurs. During first phase of the study, health facility based descriptive cross-sectional study design was

used to explore and describe the roles of gender in the spread of HIV among women of reproductive age in Ethiopia.

2ND PHASE QUALITATIVE METHOD

A qualitative approach to data collection is claimed to be one of the most reliable research methods in studying health service and its delivery (Parahoo 2006:63). The author suggests that qualitative research has a distinctive feature of exploration, which is necessary in providing in-depth understanding of people's perceptions, emotions, intentions, behaviour and experience. In this phase the researcher employed focus group discussion (FGDs) among representatives of clinics women affairs, HIV program manager, on-governmental organizations and policy makers. All these are affiliated members of the Family Guidance Association of Ethiopia (FGAE). Four FGDs consisting of 10 members purposively sampled were conducted with the stakeholders of FGAE. Family Guidance Association of Ethiopia is a national NGO which was established by a few volunteer Ethiopians in 1966. FGAE is an affiliate member of the International Planned Parenthood Federation (IPPF). It has eight Area Offices in different geographical regions of the country. Currently, FGAE operates 18 reproductive health (RH) clinics of which 4 of them located in Addis Ababa.

3.3 RESEARCH METHOD

In this section, the research methods that were used to conduct the study were described. These included the study setting and period, population, sampling, data collection and analysis, external validity and ethical consideration of the study. Thus research methods are procedures and strategies that were used in a study to collect, analyse and interpret data (Holloway & Wheeler 2010:293). This study consisted of two sequential phases. Eventually each phase was designed to address objectives, specific population, sampling, data collection and analysis. Further validity and ethical considerations were given due emphasis in all phases of the study.

3.3.1 Study setting

The study was conducted in Addis Ababa City, the capital of Ethiopia. There are ten sub Cities and 116 Districts in the City. The total population of the city was estimated to be

2,738,248 of which the number of female was 1,433,730 (Federal Demographic Republic of Ethiopia Population Census Commission 2008:10, 13). According to the 2007 housing and population census report, the majority of the inhabitants were followers of Christianity religion (Federal Demographic Republic of Ethiopia Population Census Commission, 2008:10, 13). EDHS 2011 reported that Addis Ababa City was one of Cities in Ethiopia with high prevalence of HIV infection. Prevalence of HIV among women attending ANC was 3.1% (Central Statistical Agency 2012:235). It was clear that ANC data was collected from only pregnant women who visited health facility during their pregnancy so it couldn't represent pregnant women who don't visit ANC and non-pregnant women in the same age group.

Family Guidance Association of Ethiopia (FGAE) is national NGO which was established by a few volunteer Ethiopians in 1966. FGAE is an affiliate member of the International Planned Parenthood Federation (IPPF). It has eight Area Offices in different geographical regions of the country. Currently, FGAE operates 18 reproductive health (RH) clinics of which 4 of them located in Addis Ababa. Area Offices and their frontline service delivery structures manage wide varieties of service delivery outlets. The FGAE provides mostly focusing on many-options in family planning methods, MCNH (ANC, skill delivery, PNC, immunisation, infant care), Safe abortion and CAC, gynaecological care, medico-legal services for rape survivors, STIs management, pregnancy and other laboratory tests, VCT, PICT and PMTCT, HCBC and palliative care, early detection of cervical cancer, TOT and basic training for Health professionals and different RH and youth skill development programmes.

3.3.2 Sampling method

Sampling methods might be classified in to generic types or approaches: probability and non-probability sampling. Probability samplings are those in which sample elements are automatically selected by some scheme under which a particular sample of given size from a specified population has some known probability being selected. It uses some form of random selection when choosing the sample units (Basavanthappa 2007:195).

Careful sample selection using one of the methods of probability sampling enhances the likelihood that samples will be representative. The result of any one probability sampling

procedure can be placed in a larger known pattern of variation (Handcock & Gile 2011:369).

Non-probability sampling techniques are one in which the things or people being sampled do not have a known probability of being selected. However, all forms of non-probability sampling suffer from distinct and damaging disadvantages of sampling error in such samples cannot be estimated, which means the accuracy of the result or inaccuracy of the result obtained can never be determined (Handcock & Gile 2011:367).

Non-probability samplings are those in which the sample elements are arbitrarily selected by the sampler because in this judgment the elements thus chosen will most effectively represent the population. Here elements are chosen by non-random methods. Essentially there is no way of ensuring that every element has a chance for inclusion in the non-probability sample (Burns & Grove 2011:385).

Therefore; during first phase of current study, probability sampling method was used to arrive at each representative sample for the study. Simultaneously, the researcher used arbitrary sampling technique to arrive at specific sampling unit at the period of second phase of the study.

3.3.2.1 Population

Population refers to a total category of persons or objects that meets the criteria for study established by the researcher or any set of persons, objects or measurements having observable characteristics in common. Similarly the target population refers to the population that the researcher wishes to study and about which the researcher desires to make generalisation (Burns & Grove 2011:290). For current study, women living in Addis Ababa, Ethiopia were the study population. The target population was reproductive age women (15-49 year old) who visited Family Guidance Association Clinics during study period.

Further the accessible population refers to the aggregate of cases which conform to the designate criteria and which to accessible the researchers as a pool of subjects for the study that means that aggregate must meet the criteria for inclusion in the study and available to the researcher/investigator during study period (Gay, Mills & Airasian

2006:109-110). For contemporary study, accessible population referred to reproductive age women who visited two Family Guidance Clinics which were incorporated in study during study period.

3.3.2.2 Sampling

Sampling is selecting a small number of units from the population in such a manner that they can be used to make estimates about the whole group. Defining population upon which the survey is to focus, the researcher must make sampling decisions early in the overall planning of a survey (Polit & Beck 2012:59).

According to Polit and Beck (2012:59), sampling is a process of selecting a subset of a population in order to obtain information regarding a phenomenon in a way that represents the entire population. It is consisted of seven sequential steps such as defining the population, specifying the sampling frame, specifying sampling unit, specifying the sampling method, determining sample size, specifying sampling plan and selecting the sample as discussed under different sub-section of this chapter.

In general, quality samples produce characteristics of population, free from bias, free from random sampling error, there should not be any substitution of original selected unit, should not suffer from incomplete coverage of the unit selected, relatively small and properly selected (Basavanthappa 2007:194). Hence high quality sampling approaches would yield sample with good representation to original population under study.

For recent study, the researcher pursued all steps to maintain high quality information access. Thus high quality data would indicate approximately correct gap and also could disclose next appropriate actions to address identified gaps.

3.3.2.3 Sample size

For the first phase of the study, the sample size was calculated using single population proportion formula as follows:

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

Where: n=sample size

Z=the standardised normal distribution curve value for the 95% confidence interval (1.96)

P=proportion of population among reproductive age group women with the awareness about HIV vulnerability which was taken 50% as P since no study has been done on the area and at the same time maximum sample size could be achieved by using that proportion for P.

d=margin of error which was taken as 5%

And 10% non-response rate was added to the calculated sample size

Thus

$$n = \frac{(1.96)^2 (0.5) (0.5)}{(0.05)^2} = 384$$

$$\text{Non-response rate} = 384(10\%) = 38$$

$$\text{Total sample size} = 384 + 38 = 422$$

For second phase of the study, the sample size was determined based on the findings from the first phase of the study which indicated some information about sample size for the second phase of the study. Based on the findings from first phase of study, it was decided to have representatives of clinics, women affairs, HIV program managers, non-government organisation and policy makers to be part of focus group discussion. Due to involvement of these key stakeholders during focus group discussion, developed guidelines were fully enriched.

3.3.2.4 Inclusion criteria

The researcher would like to highlight the importance of demarcating who would be part of study. Accordingly the following points used to aid in sampling of appropriate sample.

- Women in age range between 15 to 45 years
- Women who were not involved during pre-testing of data collection instruments
- Those women who visited Family Guidance association Clinics during study period
- Those women who were agreed to participate and signed on consent form
- Those women eligible based on sampling interval

3.3.2.5 Sampling procedure

Random sampling technique is the simplest form of random sampling. The description of simple random sampling is to select “n” units out of “N” has an equal chance of being selected and use a table of random numbers, a computer random number generator or a mechanical device to select the sample (Streubert & Carpenter 2011:90).

Systematic random sampling technique applies the following steps: number of units in the population from 1 to N, decide on the n (sample size) that $k=N/n$ =the interval size, randomly select an integer between 1 to k and then take every k^{th} unit in order to achieve sampling unit (Burns & Grove 2011:373).

For this study, the researcher used the following mechanism to arrive at representative samples. In Addis Ababa city administration, there were four Family Guidance Association Clinics which were functioning. In order to select a fairly representative sample of reproductive age women, simple random sampling (lottery method) was employed to include two Family Guidance Association (FGA) Clinics in the study. Accordingly FGA clinic 1 and FGA clinic3 were selected by lottery method.

Similarly the study participants were also selected by systematic random sampling technique. The sampling fraction from each of the selected Family Guidance Association Clinics was determined proportionally to the average number of clients attended in each Family Guidance Association Clinics in the last three months at the

time of data collection to be started. Then systematic sampling method was applied to select the Family Guidance Association Clinic clients from each Clinic, where the sampling interval was the average number of clients were seen daily in the clinic divided by the number of clients to be interviewed daily from each Family Guidance Association Clinics.

The estimation for average daily interviewees was obtained during pre-testing of data collection tool. As a result the sampling interval was seven as indicated under Table 3.1. The first interviewee was obtained by lottery method after assigning number one to seven for clients visiting the clinics. Accordingly number five was drawn as first number to be included every fifth comer in the interview. After the first interviewee obtained by lottery method, then the subsequent interviewee was captured by adding number five for every fifth comer to determine next respondent until planned sample size was achieved.

Table 3.1 Sampling procedures

List of FGA Clinics	Randomly selected FGA Clinics	Total number of women visited each clinics last three months	Average number of clients daily visited each clinics	Number of clients daily interviewed
FGA clinic 1	FGA clinic 1	6,311	70.12	10.00
FGA clinic 2		6,039	67.10	9.00
FGA clinic 3	FGA clinic 3	6,575	73.06	12.00
FGA clinic 4		6,397	71.08	10.00
Average		6,331	70.34	10.25
N=70.34				
n=10.25				
$k=N/n=6.86=7$				

Source: FGA Clinics Records (unpublished)

3.3.3 Data collection

Information is the foundation upon which research is based. Information in general and data specifically are critical to the problem identification phase of the study as they can shape researcher’s planning strategies. Primary data are often gathered directly from original units of observation by the researcher and are processed through careful

analysis. On other hand, secondary data are obtained from published or accumulated sources for the study and can be borrowed for the particular project by the researcher (Burns & Grove 2011:52).

Moreover, the phenomena in which researchers are interested and must ultimately capture and translate in to data that can be analysed. Without high quality data collection methods, the accuracy and robustness of the conclusions are subject to challenge. Important dimensions that are varying data collection methods are structure, quantifiability, researcher obtrusiveness and objectivity (Polit & Beck 2012:371). Research data for quantitative studies are collected according to a structured plan that indicates what information is to be gathered and how to gather it. Data that will be analysed statistically must be quantified. Structured data collection approaches usually yield data that are easily quantifiable. On other hand, research obtrusiveness methods differ in the degree to which people are aware of their status as participants for study since participants are most likely to distort their behaviour and their responses to questions under certain circumstances. Objectivity refers to the degree to which two independent researchers can arrive at similar observations regarding the concept of interest (Polit & Beck 2012:373).

For the first phase of the study, the researcher used carefully structured data collection tool to answer objectives of the study with its high level objectivity to the study. Similarly the second phase of the study used focus group discussion with full capturing of each comment by members of focus group discussion participants. Further each step of data collection was in view of ethical principles to maximise its ethical accuracy.

3.3.3.1 *Data collection approaches and methods*

In developing data plans, researchers made many important decisions including the decision about the basic types of data to gather. Most frequently three approaches were used by researchers include self-reporting, observation and bio-physiologic measures (Polit & Beck 2012).

During self-reporting, a good deal of data could be gathered by questioning people. Self-report methods normally depend on respondents' willingness to share personal

information, but projective techniques are sometimes used to obtain data about people's way of thinking indirectly (Polit & Beck 2012).

Observational methods are quite versatile and can be used to gather a variety of information including characteristics and conditions of individuals, verbal communication, activities and behaviours, skill attainment, performance and environmental conditions. A number of factors with objective observations: emotions, prejudices, attitudes and value of observers may result in faulty inference, personal interest and commitment, anticipation of what is to be observed, hasty decisions before adequate information to be collected (Polit & Beck 2012).

For the present study, both self-reporting and observation were used to collect data from study participants during both phases of the study. The researcher confidently deemed that these approaches could help in achieving the objectives of the study due to efficient data collection method under use.

3.3.3.2 Data collection instrument

Data collection plan for quantitative studies should yield accurate, valid and meaningful data that are maximally effective in answering the research questions. These are rigorous requirements, typically requiring considerable time and effort to achieve (Polit & Beck 2012:375). Even before validity and reliability tests are carried out, researchers can refine their questionnaires by administering them to a small group of people similar in characteristics to the intended respondents. Moreover; researchers are professionals whose language and culture can be different from those of the potential participants in their study. As a result it is important for them to realise that their questionnaires reflect their values positions and may create a different impression on respondents from the one they anticipate (Kader 2006:309).

For this study, after preliminary decisions had been made regarding basic data collection methods to be used, researcher determined the availability of instrument for measuring study constructs. The primary consideration was whether the instrument was conceptually relevant and whether the instrument could yield data of sufficiently high quality. At the same time, researcher also considered resource availability, availability

and familiarity of the instrument, norms and comparability, population appropriateness, administration issues and reputation.

After the above considerations, data collection instrument was developed mainly focusing on variables such as demographic and socio-economic characteristics of reproductive age woman, HIV vulnerability among reproductive age women and decision making pattern among reproductive age women in English language. Then drafted tool was sent to supervisor/co-supervisor for feedback and further enrichment. After incorporation of supervisors' feedbacks, validity and reliability of the instrument was checked carefully.

Developed tool was pre-tested at Family Guidance Association Clinic number 2 which was not included in the study before actual data collection process start so that the quality and completeness of the instrument to be improved. Based on pre-testing, data collection tool was finalised and retain current format and structure.

Then the actual data collection process was carried out by using standardised structured questionnaires to measure the demographic and socio-economic characteristics of respondents, HIV vulnerability among respondents and decision making pattern among respondents to attain the purpose and objectives of current study. Before actual data collection process took place, the researcher delivered one day train for data collectors on data collection tool to enhance quality of data to be collected. Thus the actual data was collected through interviewing the respondents by use well trained data collectors who were first Degree holder. The researcher supervised and monitored the overall activities of data collection process throughout. During study period, the researcher and data collectors reviewed and checked the completeness and consistency of data on daily basis. Finally, data collectors handed over the collected data to the researcher on daily basis.

During second phase of the study, guidelines development started mainly by using qualitative approach to promote its compatibility. These guidelines development process focused on findings from first phase of the study. Consequently after drafting the guidelines, it was presented for representatives from clinics, respondents, HIV program managers, women affair, non-governmental organisations and health policy makers to enrich the guidelines further qualitatively. Based on outcome from focus group

discussion the drafted document was revised. This revised version of the guideline was sent to supervisor/co-supervisor for further feedback and completeness. After supervisor's/co-supervisor's feedback addressed, then the final guidelines prepared. As a result these prepared guidelines included on the mother thesis document as Chapter 6.

3.3.3.3 *Pre-testing of the data collection instrument*

Pre-testing of the data collection instrument was carried out at the end of the planning phase of research instruments in order to explore and test the research elements (Rea & Parker 2000:40). Pre-testing would improve reliability and validity of data collection tool.

For the current study, data collection instruments were pre-tested using the same procedure and with a similar target group at Family Guidance Association Clinic 2 which was not part for actual study. At the same time, the respondents, who were involved in pre-testing, was not participated in the actual study. Based on pre-testing findings, the questionnaires were re-evaluated and developed to current form.

3.3.3.4 *Reliability of data collection instrument*

Reliability is the degree to which observations are consistent or stable (Robert & Ralph 1984:76). The reliability can occur when an observation is repeated and if it yields sufficiently similar results even though the situation is changed (Robert & Ralph 1984:81).

Reliability of a questionnaire refers to the consistency with which respondents understand and respond to all the questions unambiguously enough in the same way and interpret the instructions similarly (Herzog 1996:100).

For this regards, the researcher conducted pre-testing study for data collection instruments at Family Guidance Clinic number 2 before actual data collection process take place. Based on output from pre-testing, the instrument was modified and adjusted. In addition to that, feedback from supervisors and ethical committee was used to enhance instruments' reliability.

3.3.3.5 Validity of data collection instrument

Validity is defined as the degree to which the researcher has measured what set out to measure (Smith 1991:106).

The validity of the questionnaire is the extent to which it addresses the research questions, objectives or hypothesis set by researcher to answer the research question and adequate representation of different attributes of the study concepts being studied (Kader 2006:300).

For present study, the researcher designed data collection instruments so that it could measure what it was supposed to measure. In view of validity, pre-testing was done as one of mechanism to boost validity of the data collection tools.

3.3.3.5.1 Content validity

Content validity refers to the degree to which the instrument includes a representative sample of the content of construct (Babbie & Mouton 2009:123). For this study the researcher tried to ensure adequately representation of the question on the phenomenon being studied. This was clearly done after pre-testing of the questionnaires as some irrelevant questions were removed and modified.

3.3.3.5.2 Face validity

Face validity is the extent to which the assessment instrument subjectively appears to be measuring what it is supposed to measure (Araoye 2003:151). To enhance face validity, researcher carefully designed and pre-tested data collection instrument for this study.

3.3.3.5.3 Construct validity

Construct validity of measurement is the degree to which certain explanatory concepts account for performance on the measurement. The construct validity is to confirm the conceptual relationships underlying some theory (Smith 1991:109). For in progress

study, all concepts, which were used, are in line with theory employed to guide this study.

3.3.3.5.4 Credibility

Credibility is a criterion for evaluating integrity and quality in qualitative studies (Polit & Beck 2012:751). The researcher ensured credibility by describing participants experiences accurately (Holloway & Wheeler 2010:8). The researcher took appropriate scientific approach to enhance the credibility of current study to establishing that the results of qualitative research to be believable from the perspective of the participants in the current study.

3.3.3.5.5 Dependability

The dependability of qualitative data refers to the stability of data over time and over conditions (Polit & Beck 2012:175). The dependability of the current study was carefully done so that the repeatability of this study can be increased. The researcher carefully monitored any changes that could be occurred in the setting and how these changes could affect the way of this research approach.

3.3.3.5.6 Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others (Polit & Beck 2012:539). The researcher took any appropriate action to present its confirmability. The researcher was documenting the procedures for checking and rechecking of the data throughout the study.

3.3.3.5.7 Transferability

Transferability refers to the ability to generalise the data: the extent to which the findings from data can be transferred to other settings or groups (Polit & Beck 2012:539). The researcher seized appropriate action to improve transferability by doing a thorough job of describing the research context and the assumptions. Transferability also refers to the degree to which the results of the research can be generalised to other contexts or settings.

3.3.3.6 Data collection process

For first phase of the study, after decision to select the respondent by using both random and systemic sampling technique, each respondent was first given a consent form to read and sign in based on understanding and absolute willingness. There were 20 data collectors used. The data collectors were drawn from professional nurses, health care officers and previously trained research assistants. All of them had a basic degree and were trained for two days on what they have to do as data collectors. Signed and completed consent forms were placed in a box provided by the researcher, which was sealed once all the forms had been placed in the box on daily basis. The consent forms were not attached to the questionnaires thereby preserving anonymity. Additional boxes were provided for filled and completed questionnaires. The researcher/data collector started interviewing the respondents after a thorough explanation and following informed consent was obtained. The Data collector filled in the questionnaire and dropped them in the box once data collection course finished by each interview epoch. When each day data collection was over, the data collector handed over sealed box and kept it in the researcher's office. During handing over the collected data, each data collector and researcher checked out the quality and completeness of each questionnaire so that appropriate action to be taken for incomplete and less quality questionnaire on timely basis.

2ND PHASE QUALITATIVE

Sampling for qualitative research

The study utilised purposive sampling through the involvement of representatives of clinics, women affairs, HIV program manager, non-government organizations and policy makers. Four focus group discussions consisting of ten key informants drawn from the representatives stated above. A total of 40 key informants participated in the discussions.

Inclusion criteria for FGDS

To be involved in focus group discussions participants should be:

- working in one of the FGAE maternal health clinics
- a policy maker in reproductive health issues
- between 18 to 60 years of age
- willing to participate in the study as part of focus group
- available at the time of the interviews

Exclusion criteria for FGDS

To be excluded from the FDGS participants should be:

- under the age of 18
- not working in one of the FGAE that do not offer maternal health services
- not working as a policy maker for reproductive health
- unwilling to participate in the study

FOCUS GROUP DISCUSSIONS

The participants for FGDS were mobilised from their work places and discussions were held in the conference room at FGAE which was booked specifically for the FGDs. The FGDs participants were included because their work was somehow related to reproductive health and were people who could influence policies related to reproductive health. They are also well positioned to use the guidelines during planning and implementation of different programs. A guide for FGDS was a draft guideline. This allowed participants to interrogate it as a way of enriching it. Participants were free to discuss all elements of the drafted guidelines. The discussions took at least one and half hours to two hours. The discussions were recorded with their permission and a moderator also documented the discussions as participants were discussing.

3.4 DATA MANAGEMENT

Regarding to data management, both data collectors and researcher had full access to the data during data collection period. After data collection period ended, both researcher and supervisors had full access to collected and stored data. After then, the researcher would keep the collected data for at least five years in locked cabinet with full protection. After five year, the data could be destroyed by researcher and other aids.

3.4.1 Data entry

During the first phase of the study, the researcher and statistician had manually checked and ensured that whether each questionnaire's had been fully answered. After researcher and Statistician satisfied with the quality of collected data with manual checking, then questionnaires were coded and each variables and attributes were entered into the Statistical Package for Social Sciences (SPSS) for Windows Version 16.0. Once data entering was done, the data was ready for analysis. Then quantitative analysis was done to answer objectives of the study.

For the second phase of study, the main input was the outcome from first phase of the study. During this phase of the study, important feedbacks from focus group discussion were captured for more maturity of the document. Finally, the feedbacks were incorporated in to the drafted guidelines to further enrichment of the document qualitatively.

3.4.2 Data analysis

Data analysis is the process of reducing, organising and giving meaning to data (Burns & Grove 2011:733). Data was first verified for completeness and accuracy. Quantitative data was collated and entered into CSPro data entry template before being exported to excel and Statistical Package for Social Scientists (SPSS) version 16.0 for analysis. A codebook was developed to enter themes and categories for the management of the coding system. The quantitative questions were pre-coded before data collection and analysis.

The data from qualitative phase of study was also analysed by grouping the responses under main section of the guidelines. The guideline sections served as themes. Finally researcher submitted the guidelines to the supervisors after incorporation of focus group comments on drafted guidelines. At the end of the second phase of the study, the researcher contributed the guidelines for the study field.

3.5 EXTERNAL VALIDITY OF THE STUDY

External validity refers to the generalisability of the study findings from a sample to the population (Araoye 2003:151). Accordingly external validity is the validity with which the relationship between the variables investigated holds over different people, settings, times, treatment variables and measurement variables. The researcher believed that the current study would have external validity. For that reason, the researcher confidently suggested that the output of this study could be used to address HIV and AIDS vulnerability among women of reproductive age in all locations in globe. In the same way, the findings could be used in scientific community as an important resource for scientific innovations in the field of study.

3.6 ETHICAL CONSIDERATIONS

In any discipline that involves research with human beings or animals, researchers must address a range of ethical issues (Polit & Beck 2012:167). For current study, the researcher made use of different ethical approaches to put ethical issues are top priority of the study so that the study could sound in all aspect of its conduct.

3.6.1 Informed consent and participant authorisation

Informed consent means that participants have adequate information regarding to the research, are capable of comprehending the information and have the power of free choices, enabling them to consent to or decline participation voluntarily (Polit & Beck 2012:175-177). For the current study, participants were clearly understood the distinction between research and treatment, the overall goals study, the type of data to be collected, the description of the data collection procedures, about researcher's self- sponsorship of this study, the way of participant selection, about no potential risk being participated in this study, about potential benefit of this study, confidentiality, voluntary

consent, right to withdraw and withhold information, contact information in information form.

The age of consent in Ethiopia is starting from 15 years (FMOH and Federal HAPCO 2007:4), thus the respondents for this study were capable enough to give their own consent. And the ethical protection of reproductive age women was maintained throughout this study. Before the study begins, ethical clearances were obtained from Health Studies Higher Degrees Committee of College of Human Sciences at University of South Africa (UNISA) (Annexure A). Similarly institutional consent was gained from the Family Guidance Association Office after communicating with formal letter prepared by researcher (Annexure B).

At the same time, informed consent was also obtained from respondents before they fill in questionnaires (Annexure E). Specifically, respondents were informed about the objectives of the study and its benefits in reducing HIV vulnerability among women of reproductive age in writing so that the information could be the same for all participants. Based on information provided to the study participants, they were fully informed about the right to participate or withdraw at any point of interview process if they feel necessary.

3.6.2 Beneficence

One of most fundamental ethical principles in research is that of beneficence which imposes a duty on researchers to minimise harm and maximise benefits. This principle covers multiple dimensions such as the right to freedom from harm and discomfort, the right to protect from exploitation (Polit & Beck 2012:170-171). According to Campbell (2005:26), actions taken under this rule must benefit others.

Current study also emphasised on a moral responsibility to do things for the benefit of others. The researcher and research assistants guarded against any discomforts that might occur and immediately phrase the question so that it could not appear to be a personal experience.

In general, before the participants were interviewed: the purpose of study was clearly communicated; the role of study findings in improving the spread of HIV among women

of reproductive age was clearly informed; confidentiality of the information was assured; about no need of personal identifier was told; value of information to be provided by each participant will be clearly communicated and emphasised; and likewise the right of each participant to join or withdraw from study at any point of interview process if they feel necessary was guaranteed.

3.6.3 Non-maleficance

Researchers should not engage in discriminatory, harmful or exploitative practices or harassment. Researchers should ensure that the actual benefits to be derived by the participants or society from the research clearly outweigh possible risks and that participants are subjected to only those risks that are clearly necessary for the conduct of the research. Similarly researchers should ensure that the risks are assessed and that adequate precautions are taken to minimise and mitigate risks (UNISA 2007:5, 10).

This principle stipulates that care should be taken to prevent harm which could be emotional, social or physical. For this study questions was phrased and re-phrased in a manner that they are general. A question that appears to ask for personal responses were dropped or re-phrased. The researcher and the assistants emphasised that the responses were not experienced but were envisaged.

This section clearly described the steps undertaken to avoid possible adverse events with respect to physical, social and psychological which could be experienced by the participants due to their participation in the study. Firstly, the data collectors communicated to each participants prior to actual data collection process took place about no discomfort could be posed due to being participated in the study. Secondly, each participant was informed about no psychological problem can be manifested to them on rationale of their participation in the study. Thirdly, each study participant was informed about ethicality of the study. In the same way, the participants were also clearly communicated about anonymity and confidentiality of all responses made by them. Further, they were also assured as no personal identifier could be used in the questionnaires thus nobody can correlate them with their response.

3.6.4 Respect for human dignity

Respect for human dignity is another ethical principle which includes the right to self-determination and the right to full disclosure (Polit & Beck 2012:171-172). The principle is one of principles for current study to enhance its ethicality.

3.6.5 Principle of distributive justice

Justice is another ethical principle which includes right to fair treatment and privacy (Polit & Beck 2012:173-174).

In this study participant who was felt not emotionally ready to discuss about HIV vulnerability with data collector was assured the right to withdraw himself from study immediately if he felt necessary. All participants in the study were equally respected and were given similar information on the study.

3.6.6 Autonomy

Autonomy is the right of participants or institutions to do the things they want to do (Pera & Van Tonder 2011:53-54). Participants were told that their participation in the study is voluntary and they are free to decline to participate or that they can withdraw from the study at any time. Those who agreed to participate were told that if they want to withdraw or not answer some or all questions during the interview, assured as they are free not to answer or even withdraw from the study without any punishment.

3.6.7 Privacy and anonymity

Privacy and anonymity was ascertained by using codes and not the participants' names in the questionnaires. The participants would not be asked to give their names even for focus group discussion. Contact details of the researcher and the supervisor was also given to each participants.

3.6.8 Confidentiality

Participants were assured that information provided whether orally or written would be used only for the research purpose and will therefore be strictly anonymous and confidential. For focus group discussion name was substituted with letters to allow the person interviewing to identify respondent. The researcher also asked research assistants at the beginning of focus group discussion that once outside the interview setting, he would not indicate who made specific comments during the group discussion. For both phase of studies, the data from the participants was placed under lock and key at the centre where the researcher works.

3.6.9 Ethical clearance process

To secure ethical approval, the researcher followed the succeeding procedures:

- Preparation of study proposal and its approval by Health Studies Higher Committee of College of Human Sciences at UNISA.
- Present request letter prepared by researcher along with ethical certificate (Ref: HSHDC/214/2013) from UNISA Health Studies Higher Committee to Family Guidance Association Administration to request institutional consent.
- Institutional consent was granted from the Family Guidance Association Administration after communicating with letter prepared by researcher and ethical certificate indicating approval of proposal.
- Take formal permission letter from Family Guidance Association Administration to clinics and inform the clinics management about the study and secure oral permission to conduct study in respective clinics.
- Start formal data collection process as per sampling procedure.
- All relevant bodies were informed about the right to request and access the final report of this study output.
- Each steps of the current study was given due emphasis to maintain its ethicality.

3.7 CONCLUSION

The chapter elaborated on the research design and methods used for this study. It also emphasised in ethical conduct of the study so that scientifically sound findings could be achieved. Finally, this chapter of the study could guide other parts of existing study. And next chapter would present research results for the study.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE RESULTS

4.1 INTRODUCTION

The purpose of this study was to explore and describe the role of gender in the spread of HIV among women of reproductive age in Ethiopia with the view of proposing guidelines for gender-sensitive HIV and AIDS prevention strategies. The study was conducted in two phases. The results are presented and discussed according to the two phases. However, the results of phase 2 are presented and discussed in Chapter 5.

4.2 PHASE 1: RESPONDENTS' VULNERABILITY TO THE SPREAD OF HIV AND AIDS

The first phase of this study focused on the first research objective, which was to describe the reproductive age women' vulnerability to the spread of HIV and AIDS in terms of (1) knowledge about HIV transmission and prevention, (2) risky sexual behaviour, (3) the decision making ability with regard to the spread of HIV and AIDS and demographic factors associated with these abilities.

As discussed in Chapter 3, a quantitative descriptive survey design was used to address the above objective. A total of 422 women of reproductive age completed and returned the questionnaires. All these questionnaires were considered for analysis.

This section of the report was structured according to the three sub-sections of the first objective. The findings of the demographic and socio-economic characteristics of the respondents were used as an introduction to the results and discussions.

4.2.1 Demographic and socio-economic characteristics of the respondents

The respondents were described according to their demographic (age, marital status, and highest level of education) and socio-economic (religious affiliation, ethnic group, employment status, household composition, and the main bread winner) characteristics. Table 4.1 provides a summary of these characteristics

Table 4.1 Demographic and socio-economic characteristics of the respondents (N=422)

Characteristics		Frequency	Percentage (%)	Cumulative Percent (%)
Age (in year):	15-24	80	19.0	19.0
	25-34	196	46.4	65.4
	35-44	123	29.2	94.6
	45-49	23	5.4	100.0
Marital Status:	Single	96	22.7	22.7
	Married	272	64.5	87.2
	Divorced/separated	41	9.7	96.9
	Widowed	13	3.1	100.0
Highest Level of Education:	Never been School	30	7.2	7.2
	Primary	42	10.0	17.2
	Secondary	234	55.5	72.8
	College/University	116	27.3	100.0
Religious Affiliation:	Muslim	63	14.9	14.9
	Christian	359	85.1	100.0
Ethnic Group:	Oromo	85	20.1	20.1
	Amhara	208	49.3	69.4
	Guraghe	67	15.9	85.3
	Tigre	44	10.4	95.7
	Others	18	4.3	100.0
Employment status:	Employed	256	61.0	61.0
	Unemployed	166	39.0	100.0
Household composition:	1-3 people	221	52.4	52.4
	4-6 people	172	40.8	97.2
	More than 6 people	29	6.8	100.0
Household breadwinner:	Partners	268	63.5	63.5
	Self	87	20.6	84.1
	Others	67	15.9	100.0

4.2.1.1 Demographic characteristics

The age of the respondents ranged from 15 to 49 years old and the mean age was 31.24 years with a standard deviation of 7.513. As indicated in Table 4.1, majority (65.4%) of the participants were between 15 and 34 years old with 46.4% being between 25-34 years old and 19.0% being between 15-24 years old. The majority (64.5%) of the respondents were married and the minority (35.5%) were single, divorced/separated or widowed. The majority (82.8%) of the respondents had a sort of

formal education, which ranged from primary to college or university level and only 7.2% did not have any formal education.

The high proportions of educated and married women among the respondents reflect the general trend in the country. Data from the Ethiopia Mini Demographic and Health Survey indicated that 41.0% of women are literate and that this literacy varied according to age and to urban/rural distribution. The report showed that literacy among women in reproductive age group has doubled in the last fifteen years. It increases from 18.0% among women age 45-49 to 70.0% among women age 15-19. About seven in ten (71.0%) women in urban areas were literate compared with about one third (32.0%) women in rural areas (EDHS 2014:24). The high proportion of married women is due to early marriage practices in the country. Data indicated that 63.0% of women in Ethiopia are married by age 18 or a median of 16.5 years at first marriage for women age 25-49. This median age increases at 23.8 years with education (CSA 2011:4).

4.2.1.2 Socio-economic characteristics

As indicated in Table 4.1, the majority of the respondents (85.1%) were Christians. More than sixty percent of the respondents belonged to two ethnic groups: Amhara with 49.3% and Guraghe with 15.9%. The majority (61.0%) of the respondents were employed. This proportion included those who were employed in formal and informal (self-employed) sectors. Of the 166 unemployed respondents', a small proportion (9.7%) were in fact students. With regard to the household composition, more than half of the respondents (52.4%) were living in households consisted of 1 to 3 people and 40.8% were in households of 4 to 6 people. The majority of the respondents (63.5%) depended on their partners' as sole breadwinners.

The socio-economic characteristics of the respondents as summarised in Table 4.1 are not different from the socio-economic profile of similar women in the country. Like in the general population, Christian denominations represent 65.5% of the population, and the two ethnic groups (Amhara and Guraghe) represent 61.4% of the population (CSA 2012:6). The result on the composition of the household corroborates with the trend in the general population which estimate the household size at 3.8 in urban areas. There is a discrepancy between the proportion of the employed women (61.0%) and the dependence of the respondents on their partners as the breadwinners (63.5%).

Previous studies have linked the employment among women to economic freedom and independent decision making power (Chersich & Rees 2008:6; United Nations 2013:35). However, in this study it appears that the majority of women still expect their partners to maintain the households despite their economic activities. Could this be attributed to the disparity in income or cultural values?

It should also be noted that due to existing economic vulnerability, deciding to have smaller family size is obligatory for both women and men. For this reason, insistence on consistent condom use and birth control method is crucial. Coherently the reason is to stay healthy to provide for their children and to prioritize good health over pleasure (Pillai et al 2012:16). Despite the advantages of condom use, it is challenging for women to use condom with their husband due to fear of being exposed as a sex worker, trust in his loyalty and an inability to convince the husband (Pillai et al 2012:16).

Finally, it is important to note that ethnicity play important role in society as specific ethnic group has its own value and practices. The argument supported by finding from study done in Tanzania as gender, wealth, ethnicity and education posed a very real threat in health care decision making due to their systematically undermine the views and experiences of particular segments of the population (Shayo et al 2012:10). The argument further supported by another study done in South Africa as it reported a greater proportion of Coloured participants had unprotected sex (53.79%) than Black African participants (Myers et al 2013:4). Therefore, social and cultural differences in HIV vulnerability should be considered when prevention strategies to be developed and implemented (CDC 2006:121)

4.2.2 Knowledge about HIV transmission and prevention

Eleven measurements variables were used to describe the respondents' knowledge about HIV transmission and prevention. These variables were used to gain additional information regarding the characteristics of the respondents within the context of HIV and AIDS. Therefore, the researcher limited the analysis of these variables at the summary descriptive level. The results are presented in Tables 4.2a and 4.2b.

4.2.2.1 Knowledge about HIV transmission and prevention

Six of the eleven measurement variables were related to knowledge about the transmission of HIV.

Table 4.2a Knowledge about HIV transmission (N=422)

Variables		Frequency	Percentage (%)
1. Awareness of the existence of HIV and AIDS:	Yes	410	97.1
	No	11	2.9
2. HIV can be transmitted through mosquito bites:	Yes	151	35.8
	No	271	64.2
3. HIV can be transmitted by sharing a meal with someone who is HIV positive:	Yes	386	91.4
	No	36	8.6
4. HIV positive pregnant woman can transmit the virus to her unborn child:	Yes	314	74.4
	No	108	25.6
5. HIV positive woman can transmit the virus to the child through breastfeeding:	Yes	370	87.7
	No	52	12.3
6. HIV Positive person may be healthy looking:	Yes	353	83.6
	No	69	16.4

From the results presented in Table 4.2a, it is clear that the majority of the respondents were knowledgeable about the transmission of HIV. The proportion of the respondents with good knowledge regarding the six measurement variables ranged from 64.2% for the role of the mosquito in the transmission of HIV to 97.1% for the awareness on HIV and AIDS. The above results should be viewed within the education characteristics of the respondents and their employment status. Educated and working women can easily access the information regarding HIV transmission through various media than uneducated and unemployed women (UNAIDS 2013: 18).

In addition, the results of this study are similar with various studies conducted in the developing countries which showed high level of knowledge about the transmission of HIV (Handicap International [s.a.]:14; Kalipeni & Ghosh 2005:329; Moyo & Plessis 2009:50; Oyewale 2008:82; UNAIDS 2009:3; UNAIDS/UNFPA/ UNIFEM 2004:13-14).

4.2.2.2 Knowledge about HIV prevention

Five of the eleven measurement variables were related to knowledge regarding the prevention of HIV.

Table 4.2b Knowledge about HIV prevention (N=422)

Variables		Frequency	Percentage (%)
1. Knowledge about where to get tested for HIV:	Yes	386	91.5
	No	36	8.5
2. Been tested for HIV in last 12 months:	Yes	357	84.6
	No	65	15.4
3. Condom use can reduce the risk of contracting HIV:	Yes	307	72.7
	No	115	27.3
4. Sexual abstinence can reduce the risk of contracting HIV:	Yes	217	51.4
	No	205	48.6
5. Being faithful to one uninfected partner can reduce the risk of contracting HIV infection:	Yes	203	48.0
	No	219	52.0

With regard to HIV prevention, the majority of the respondents (91.5%) knew where to get tested for HIV; 84.6% were tested for HIV in the last 12 months; 72.7% agreed that condom use can reduce the risk of contracting HIV; 51.4% agreed that sexual abstinence can reduce the risk of contracting; and 48.0% agreed that being faithful to one uninfected partner can reduce the risk of contracting HIV.

The above results should be viewed within the same context of the results on knowledge regarding the transmission of HIV. As stated earlier, educated and working women can easily access the information regarding HIV transmission through various media than uneducated and unemployed women (UNAIDS 2013: 18).

Similar trend regarding the knowledge on HIV prevention is discussed in the literature (Booyesen & Summerton 2002:287; Maial et al. 2008:3; UNAIDS/UNFPA/UNIFEM 2004:11; WHO 2003:3; WHO 2006:8). It is argued that individuals who know where and the benefits of HIV testing are likely to engage in preventive measures (UNAIDS

2013:12-13). The high proportion of women who tested for HIV should be attributed to the government policy which included HIV testing into the routine antenatal care in the country.

4.2.3 Risky sexual behaviour among the respondents in the past 12 months

The researcher used both summary descriptive and bivariate analyses to describe the risky sexual behaviour among the respondents. The results of the summary descriptive analysis are presented in Table 4.3, while the results of the bivariate analyses are presented in Table 4.4.

4.2.3.1 Results of the summary descriptive analysis

Four measurements variables were used to describe the risky sexual behaviour among the respondents. These measurements looked at the risky sexual behaviour in the last 12 months and included: being sexually active, number of sexual partners, and use of alcohol or drugs before sexual intercourse and frequency of condom use during intersexual course.

Table 4.3 Results of the summary descriptive analysis

Variables		Frequency	Percentage (%)	Total cases
1. Sexually active:	Yes	357	84.6	422
	No	65	15.4	
2. Number of sexual partners:	One	223	62.5	357
	Multiple	134	37.5	
3. Use of alcohol or drugs before sexual intercourse:	Yes	134	37.5	357
	No	223	62.5	
4. Frequency of condom use during sexual intercourse:	Never	259	72.5	357
	Seldom	70	19.7	
	Always	28	7.8	

As indicated in Table 4.3, 84.6% were sexually active during the last 12 months; 62.5% had only one sexual partner; 62.5% did not take any alcohol or drugs before sexual intercourse; 72.5% have never used condom during sexual intercourse.

The large proportion (84.6%) of sexually active women among the respondents should be interpreted within the context of the marital status of the respondents as discussed earlier. In addition, a study conducted among women and men in Cape Town revealed that 83.0% of them were sexually active and admitted having sexual intercourse in the previous six months (Morrone et al 2007:29).

The high proportion of single sexual partner, low proportion of condom use among the respondents should be interpreted within the patriarchal prevailing culture which expects married women to stay faithful to their husbands and to abstain from any form of family planning technology, such condom use (Hassen & Deyassa 2013:3). Similar results are described in studies conducted in similar cultural settings (Booyesen & Summerton 2002:287; Pillai et al 2012:16; UNAIDS/WHO 2012:2). In addition, evidence suggests that Ethiopian women have less number of life time sexual partners than other countries. For example, the mean of lifetime sexual partner among Ethiopian women is estimated at 1.5 (Central Statistical Agency 2012:189, 191) while in the USA, women have from 5 to 20 lifetime sexual partners (Roberts & Kennedy 2006:35-36). In Zambia, if there is no formal and committed relationship, having other partners is not construed as cheating (Parker & Borwankar 2012:17).

Based on the results of this study as presented and discussed in this subsection, the researcher viewed the number of sexual partner as a significant variable for HIV prevention among this group of women. This variable was then further analysed against the demographic and socio-economic characteristic of the respondents that are associated with women's decision making.

4.2.3.2 Results of the bivariate analyses

Bivariate analyses were conducted between the number of sexual partners and four demographic and socio-economic variables of education, marital status, religious affiliation and employment.

Table 4.4 Results of bivariate analyses

Variables	Single sexual partner(n=223) %	Multiple sexual partners(n=134) %	Person Chi-square	P-value
Education level:				
• Educated	91.0	7.5	10.037	.817
• Not Educated	9.0	92.5		
Marital status:				
• Married	93.3	47.0	1.906	.000
• Not married	6.7	53.0		
Religious affiliation:				
• Christian	85.0	78.4	23.424	.268
• None Christian	15.0	21.6		
Employment status:				
• Employed	60.5	78.0	57.562	.000
• Unemployed	39.5	22.0		

Two variables (employment status and marital status) showed significant associations with the number of sexual partners after bivariate analyses. As indicated in Table 4.3, the majority (91.0%) of educated women had single sexual partners while 92.5% of uneducated women had multiple sexual partners. There was a high significant association between the employment status and the number of sexual partners ($X^2=57.562$, p-value=.000 at 95% CI). With regard to marital status, the majority (93.3%) of married women had single sexual partner, while 53.0% of unmarried women had multiple sexual partners. were married and 53.0% were not married. There was a high significant association between the marital status and the number of sexual partners $X^2=1.906$, p-value=.000 at 95% CI).

Marital status and employment status have been linked to positive health decision making among women. Being married does not inherently make sex safer or voluntary, particularly for young women. This argument supported by substantial proportions of young women who had initiated sex within marriage at a younger age (Santhya et al 2008:17-18). Married women can still engage in extra-marital affairs increasing their vulnerability to sexually transmitted diseases including HIV. In a study conducted in Malawi, extra marital sexual relationships were common among fishers and women fish

traders. Women in this study reported that when their husbands (fishermen) are away from home following good fishing grounds, they engaged in extra-marital affairs. On the other hand, when the fishermen migrate to a distant fishing ground for a longer period, they engage in temporary marriages (Kambewa et al 2009:19).

Employment is associated with economic freedom and independent decision making power. It is argued that women and girls are often at a disadvantage when it comes to negotiating safer sex and accessing HIV prevention information and services due to their low economic and social status in many countries (United Nations 2013:35). The disproportionately concentrated economic power on the hands of men is challenging for women to make money-related decisions at the household level (United Nation 2013:23). Consequently due to unequal sexual power and economic disparities, women will continue with limited ability to negotiate protected sex and few alternatives to adopting practices (Chersich & Rees 2008:7). Moreover, they need to learn how to negotiate safer sexual relationships as they are more likely to be economically dependent on men and less likely to be able to negotiate methods of self-protection from HIV and AIDS (UNAIDS/UNFPA/UNIFEM 2004:13).

Two variables (education level and religious affiliation) showed no associations with the number of sexual partners after bivariate analyses. As shown in Table 4.3, most (91.0%) educated women had single sexual partner, while the majority (92.5%) of uneducated women had multiple sexual partners. Measurements of association between the education status and the number of sexual partners showed no significant association ($X^2=10.037$, p-value=.817 at 95.0% Confidence Interval).

There was a similar trend in the number of sexual partners for Christians and none Christians. As indicated in Table 4.3, 85.0% and 78.4% of Christian women had single sexual and multiple sexual partners respectively. Similarly, 15.0% and 21.6% of none Christian women had single sexual and multiple sexual partners respectively. Measurements of association between religious affiliation and the number of sexual partners showed no significant association ($X^2=23.424$, p-value=.268 at 95.0% Confidence Interval).

Previous studies have positively associated the level of education to healthy health behaviour. Education can lead to behaviour change in many ways like by changing the

socio-cognitive determinants of behaviour, influencing social networks and leading to a change in socioeconomic status (Jukes et al 2008:42). Evidence suggest that educated women are more likely to use antenatal care services, to deliver in the hospital and to take HIV prevention actions than uneducated women (Jat et al 2011:10; TEMAH 2007:27). However, this study showed that the level of education does not determine the number of sexual partner a woman may have. This difference may be attributed to the characteristics of the respondents and the level of knowledge and attitude toward HIV transmission and prevention as shown in this status. As indicated in Table 4.2, the majority of the respondents demonstrated positive knowledge and attitude regarding HIV transmission and prevention for all the eleven tested variables.

The finding regarding the association between religious affiliation and the number of sexual partner is supported by previous studies. Religious values and beliefs are known to positively or negatively influence women decision to engage in healthy behaviours (Baral et al 2010:5; Jat et al 2011:9). A study conducted in Nigeria reported that religion advocates abstinence as the best way to prevent HIV infection. According to Christians, the punishment for committing fornication and adultery is from God and not from a Sharia court of law. On other hand, Christians also believe a merciful God who is able to forgive their sins of fornication and adultery if they ask for forgiveness. Thus Christians are more likely to be engaged in extramarital affairs or premarital sex when compared to their Muslim counterparts (Durojaiye & Kammerer 2012:45).

Despite the lack of significant association between the level of education and the number of sexual partner in this study, the fact that a large proportion of uneducated (92.5%) women were engaged in sexual intercourse with multiple partners should be seriously considered. Education is associated with economic power and the lack of education may make a woman economically vulnerable. This economic vulnerability may push women to resort to multiple sexual partners for the sake of survivors. This argument is supported by the 'sugar dady' phenomena where young women and adolescent girls engage in sexual intercourse with older men in exchange for material gains such as school fees, food and other consumable goods (UNAIDS/UNFPA/ UNIFEM 2004:8).

4.2.4 Decision-making ability regarding the spread of HIV and AIDS

Five measurements variables were used to describe the respondents' decision making ability with regard to the spread of HIV and AIDS. The researcher used both summary descriptive and bivariate analyses to describe the decision-making ability of women regarding the spread of HIV among the respondents. Data from the 65 respondents who were not sexually active in the last 12 months were excluded from the analyses. The results of the summary descriptive analysis are presented in Table 4.5, while the results of the bivariate analyses are presented in Tables 4.6 – 4.9.

4.2.4.1 Results of the summary descriptive analysis

The summary descriptive analysis looked at the following five measurement variables that were used to describe the decision-making ability of the respondents: ability to say no to sexual intercourse without condom, ability to decide when to have sexual intercourse with a partner, ability to initiate discussion on sexual issues with a partner, ability to initiate discussion on the risk of HIV transmission with a partner, and ability to independently use contraceptive without male partner's consent.

Table 4.5 Women' decision-making ability with regard to the spread of HIV and AIDS (N=357)

Variables		Frequency	Percentage (%)
1. Able to say no to sexual intercourse without condom:	Yes	285	80.0
	No	72	20.0
2. Able to decide when to have sexual intercourse with a partner:	Yes	299	84.0
	No	58	16.0
3. Able to initiate discussion on sexual issues with a partner:	Yes	71	19.9
	No	286	80.1
4. Able to initiate discussion on the risk of HIV transmission with a partner:	Yes	193	54.0
	No	164	46.0
5. Able to use contraceptive without the consent of the male partner:	Yes	160	44.8
	No	197	55.2

As shown in Table 4.5, the results suggest that more than fifty percent of women were able to take positive decision regarding the spread of HIV and AIDS in three of the five areas measured. Ability to decide when to have sexual intercourse was the highest area with 84.0% of the respondents, followed by the ability to say no to sexual intercourse without condom with 80.0%, and the ability to initiate discussion on the risk of HIV transmission with a partner with 54.0% of the respondents.

With regard to the inability to take decision regarding the spread of HIV and AIDS, 80.1% of the respondents were unable to initiate discussion on sexual issues with a partner, and 55.2% were unable to use contraceptive without the consent of the male partner.

The above results corroborate with the demographic and socio-economic characteristics of the respondents as well as existing literature. The high level proportion of educated and employed women among the respondents as presented and discussed earlier in this chapter can explain the ability of women to take decision on three of the five areas measured. While the high proportion of women depending on their partners as breadwinners and the high number of married women can explain working the inability to use contraceptive without the consent of the male partner, to initiate discussion on sexual issues and the low proportion of women who were able to initiate discussion on the risk of HIV transmission.

As discussed earlier, women lack of ability to take independent decision increases their vulnerability to HIV and AIDS (Rottach et al 2009:30-31; Gender Team 2005:1; Santhya et al 2008:20-21; Sultana et al 2010:36; United Nations' Programme of Action 1994:72). This lack of autonomy is due to several factors including individual demographic and socio-economic factors (Shayo et al 2012).

The results indicated that the majority of the respondents are able to independently decide on two of three measurement variables used to describe their decision-making ability regarding the spread of HIV. On contrary, despite knowledge and awareness about using condoms, majority of respondents cited their inability to use condoms with their husband due to fear of being exposed as a sex worker, trust in his loyalty towards their relationship and an inability to convince the husband to use condoms (Pillai et al

2012:16). The proportion of women who indicated being able to say no to sexual intercourse without condom (80.0%) is higher than in similar studies conducted in India, and Bangladesh. In Bangladesh, 59.3 % indicated being able to say no to sexual intercourse without condom (Sultana et al 2010:36) and In India, 10.0% of women indicated being able to say no to sexual intercourse without condom (Santhya et al 2008:20-21).

Four the purpose of this study, the researcher assumed that women’s decision-making ability regarding the spread of HIV and AIDS will be influenced by the level of education, the marital status, religious affiliation and employment status. These variables were considered for bivariate analyses.

4.2.4.2 Results of the bivariate analyses

For analysis purpose, the ability to decide when to have sexual intercourse with a partner was excluded. The researcher was of the opinion that the remaining four variables were strong enough to measure the decision making ability of women.

4.2.4.2.1 Ability to say no to sexual intercourse without condom

Table 4.6 provides a summary of the bivariate analyses of the ability to say no to sexual intercourse without condom and the demographic variables.

Table 4.6 Bivariate analyses of the ability to say no to sexual intercourse without condom (N=357)

Variables	Able to say no to sexual intercourse without condom:		Person Chi-square	P-value
	Yes (n=285) %	No (n=720) %		
Education level:			5.801	.122
• Educated	91.0	85.0		
• Not Educated	9.0	15.0		
Marital status:			6.526	.163
• Married	78.6	51.4		
• Not married	21.4	48.6		
Religious affiliation:			12.530	.014
• Christian	91.0	48.6		
• Muslim	10.0	51.4		
Employment status:			3.838	.279
• Employed	76.0	20.8		
• Not employed	24.0	79.2		

As indicated in Table 4.6, the majority of educated and Christian women (91.0% each), married women (78.6%), and employed women (76.0%) were able to say no to sexual intercourse without condoms. However, only religious affiliation (being a Christian women) showed significant association with the ability to say no to sexual intercourse without condom ($X^2=12.530$, $p\text{-value}=.014$ at 95% CI).

4.2.4.2.2 Ability to initiate discussion on sexual issues

Table 4.7 provides a summary of the bivariate analyses of the ability to initiate discussion on sexual issues with a partner and the demographic variables.

Table 4.7 Bivariate analyses of the ability to initiate discussion on sexual issues (N=357)

Variables	Ability to initiate discussion on sexual issues with a partner:		Person Chi-square	P-value
	Yes (n=71) %	No (n=288) %		
Education level:			5.464	.486
• Educated	93.0	84.0		
• Not Educated	7.0	16.0		
Marital status:			18.199	.020
• Married	39.4	84.7		
• Not married	60.6	15.3		
Religious affiliation:			3.276	.916
• Christian	91.5	80.2		
• Muslim	8.5	19.8		
Employment status:			12.038	.061
• Employed	73.2	63.2		
• Not employed	26.8	36.8		

As shown in Table 4.7, the large proportion of educated women (93.0%), Christian women (91.5%), and employed women (73.2%) were able to initiate discussion on sexual issues with their partners. However, none of these variables have shown significant association with the ability to initiate discussion on sexual issues with their partners say no to sexual intercourse on Pearson’s chi-square analysis.

4.2.4.2.3 Ability to initiate discussion on the risk of HIV transmission

Table 4.8 provides a summary of the bivariate analyses of the ability to initiate discussion on the risk of HIV transmission with a partner and the demographic variables.

Table 4.8 Bivariate analyses of the ability to initiate discussion on the risk of HIV transmission (N=357)

Variables	Ability to initiate discussion on the risk of HIV transmission with a partner:		Person Chi-square	P-value
	Yes (n=193) %	No (n=164) %		
Education level:			10.848	.093
• Educated	96.0	86.0		
• Not Educated	4.0	14.0		
Marital status:			19.711	.249
• Married	83.4	61.0		
• Not married	16.6	39.0		
Religious affiliation:			9.409	.309
• Christians	85.0	79.0		
• Muslim	15.0	21.0		
Employment status:			7.986	.239
• Employed	76.7	52.4		
• Not employed	23.3	47.6		

Table 4.8 showed that a large proportion of educated women (96.0%), married women (83.0%), Christian women (85.0%), and employed women (76.7%) were able to initiate discussion on the risk of HIV transmission with their partners. However, none of these variables have shown significant association with the ability to initiate discussion on sexual issues with their partners say no to sexual intercourse on Pearson's chi-square analysis.

4.2.4.3 Ability to use contraceptive without the consent of male partner

Table 4.9 provides a summary of the bivariate analyses of the ability to use contraceptive without the consent of the male partner and the demographic variables.

Table 4.9 Bivariate analyses of the ability to use contraceptive without the consent of the male partner (N=357)

Variables	Able to use contraceptive without the consent of the male partner:		Person Chi-square	P-value
	Yes (n=160) %	No (n=197) %		
Education level:			12.009	.445
• Educated	88.0	94.0		
• Not Educated	12.0	6.0		
Marital status:			19.711	.234
• Married	67.0	78.0		
• Not married	33.0	22.0		
Religious affiliation:			14.206	.583
• Christians	73.7	89.3		
• Muslim	26.3	10.7		
Employment status:			15.562	.212
• Employed	57.5	71.0		
• Not employed	42.5	29.0		

As indicated in Table 4.8, a large proportion of educated women (88.0%), married women (67.0%), Christian women (73.7%), and employed women (57.5%) were able to use contraception without the consent of the male partners. However, none of these variables have shown significant association with the ability to use contraception without the consent of the male partners on Pearson’s chi-square analysis.

According to finding from this study, 83.2% (n=351) of respondents accepted that as sexual intercourse discussion should be initiated by their partners. For this finding correlation statistics was performed with variables such as educational level, marital status, religious affiliation and employment status among respondents. Accordingly among these four variables, significant association was found between this finding and marital status ($X^2=18.199$, p-value=.020) of respondents at 95% significance level. On similar way, according to Harvey et al’s (2013:76) report, 16.4% of women who participated in study agreed that their partner has more power in decision making when compared with them. Similarly decisions regarding whether to use condoms and type of sexual activity, a larger percentage of women agreed that their partners should make decisions (Harvey et al 2013:76). This is in contrary to The Fourth World Conference on Women, as it said without the perspective of women at all levels of decision-making, the

goals of equality, development and peace cannot be achieved (UNDAW 2005:7). This further aggravates decision making gap between genders since underlying systemic discrimination against women is the maintenance of patriarchal power for the purpose of maintaining male privilege (UNESCO 2001:14). UNESCO 2001 Report was in line with feminist theories of patriarchy as men's presence and dominance of political institutions might be as a major obstacle to women's equality (UNDAW 2005:14).

Accordingly 60.9% (n=257) of them refused sexual intercourse for their partners due to suspect that partners might have sexual relationship with other women. On other hand about 39.0% of respondents would not refuse sex for their partner whatever they suspect. Similarly the relationship between this finding and educational level, marital status, religious affiliation and employment status of respondents were calculated. And consequently the finding showed significant correlation with religious affiliation ($X^2=12.530$, p-value=.014) among respondents at 95% significance level. In general the pattern of women's and men's roles and relationships in Africa puts women at greater risk. In this sense, polygamy, sexual coercion and violence against women all contribute to the distressing gender gap in HIV and AIDS (TEMAH 2007:5). Similarly a UNAIDS report indicated that masculinity encourage young men to view sex as a form of conquest (WHO 2003:2), thus it is difficult for women to refuse sexual intercourse whether they were interested or not.

The finding revealed that 52.8% (n=223) of respondents were as initiator for discussion on HIV risk within their partnership. Correlation between this finding and educational level, marital status, religious affiliation and employment status of respondents were explored. And unfortunately associations were non-significant found between these variables and current finding at 95% significance level. Despite their initiation, violence is not only a risk factor for HIV infection but also becoming increasingly clear result of the epidemic as 19% of HIV positive women were experienced violence from partner in Kenya (WHO 2000:11). Similarly, in a number of countries, harmful cultural practices also control women's sexuality and led to great suffering (United Nations' Programme of Action 1994:38).

Finding highlighted that 72.7% (n=307) of respondents agreed as condom is effective to protect HIV infection. Despite such good knowledge, not discussing on condom use with their partners were common among respondents due to they believe their partners

would think that the respondents were promiscuous worthy; the partner wouldn't like using a condom and the respondent is too afraid or embarrassed to raise the subject (Blanc & Wolff 2013:20). Accordingly about one third of study participants had never thought about discussing on condom use with their partners (Blanc & Wolff 2013:20).

The finding from this research also implied that 64.7% (n=273) of respondents told to their partners as they do not want to have sex without condom. The finding was some bite less than that of Roberts and Kennedy (2006:36) reported as 80.0% of women expressed their high intention to use condoms in the next sexual encounter. Consequently the reasons were given lack of trust in their lover's fidelity to use condom as the primary justification (Pillai et al 2012:17).

This study finding publicised that 55% (n=232) of respondents were in need of their partners' approval to use reproductive health services. On the same manner, correlation between this finding and educational level, marital status, religious affiliation and employment status of respondents were calculated. And accordingly values showed statistical non-significant association between these variables and current finding at 95% significance level. Coherently this finding is better than one reported by Kalipeni and Ghosh (2005:327) as 8.0% of women agreed that as there was nothing much they could do to change the mind of their partner once he refused the use of modern methods of child spacing. Similarly another study done in Kenya proved that the 50% respondents felt their spouse or partner would approve the use of family planning method; 23% of respondents thought their spouse or partners would not approve the use of family planning; and 26% respondents said that the feelings of their spouse or partner were unknown (Akelo et al 2013:4). In general, women still have to ask their male partner for permission to test for HIV or to access their health care services (Chersich & Rees 2008:8).

4.3 CONCLUSION

This chapter presented and discussed the findings of the first phase of the study. Both descriptive and inferential statistics were used to give more clarity on the findings. Descriptive statistics used to describe variable with respect to current study respondents. The aim for inferential statistics was to see association between variables with regard to independent decision-making ability and those variables related to HIV

vulnerability among recent respondents. The next chapter would present and discuss the results for phase 2 of the study.

CHAPTER 5

GUIDELINE FOR GENDER SENSITIVE HIV AND AIDS PREVENTION STRATEGIES

5.1 INTRODUCTION

This chapter discussed the development of guidelines on gender sensitive HIV prevention strategies. The processes for guidelines development were divided into sections and subsections. Conclusion of the chapter was also presented for this chapter.

5.2 GUIDELINES DEVELOPMENT PROCEDURE

This section discussed guidelines formulation courses, logical processes and the rationalisation of the development of guidelines.

5.2.1 Guidelines formulation courses

Two sequential stages were used to arrive at these guidelines. For stage 1, the researcher conducted quantitative study design with aid of structured data collection instruments after through checking for its validity and reliability. The result from phase one study was used to develop the draft guidelines for the study and the second phase involved qualitative research and its findings allowed the researcher to complete the development of the guidelines. The guidelines were then given to all the stakeholders for input, including supervisors of the project.

In general, the contributions for these guidelines were obtained from the findings of the first phase study, experts' views during second phase of the study as well as different literature appraisal to convene the issues so that smooth courses of pursuing of the development of these guidelines to be there. During focus group discussions with stakeholders, the draft guidelines were used as platform for discussion in the effort of enriching the draft guidelines. To sum up, researcher's goal to conduct focus group discussion was to gain a meaningful insight into the fact with aid of the people's

experience within the context as evidence provided by the participants was considered as experts' account (Squire 2007:2). As a result the feedbacks from focus group discussions were used to build up on the guidelines. Accordingly, aspects of the guidelines were modified in agreement with recommendations given during focus group discussion.

5.2.2 Logical reasoning process

Reasoning is the processing and organising of ideas in order to reach a conclusion (Burns & Grove 2011:8). Similarly logical reasoning is used to break the whole into parts through inductive and deductive reasoning to understand and organise a condition under study (Polit & Beck 2008:13). For the purpose of these guidelines development, both inductive and deductive reasoning approaches were utilised.

The inductive reasoning is the process which starts with the specific aspect of the fact to come up with the general picture of the fact to give likely conclusion on the phenomenon (Babbie & Mouton 2001:643; Streubert Speziale & Carpenter 2003:10). For the current study, inductive reasoning was used particularly during the first phase of the study. As elucidation, separate findings on different variables from first phase of the study were utilised to know the pattern of decision-making among study population and eventually lead to the development of the guidelines.

The deductive reasoning starts with a general idea of the phenomena and goes to end with a particular conclusion (Burns & Grove 2011:9). For the current study, the deductive reasoning was employed for the guidelines development as overall findings from the first phase of the study was used to develop each guideline based on decision-making pattern of the study population. Similarly the focus group discussions were also made use of deductive reasoning approach to supplement on initially developed specific guidelines. In conclusion, the guidelines development processes were employed deductive reasoning process since development process of the guidelines were based on general outcomes from both phases of the study.

5.2.3 Rationalisation of the guidelines

Guidelines are statements of principles giving practical guidance (Hawkins 1990:358). It is systematically developed directions to assist in decisions making processes and related service provisions. Good guidelines can serve as quality improving tactic which bring together the best evidence and knowledge necessary for decision-making about management (University of Minnesota 2002:1). The guideline should be shared and well understood by relevant stakeholders to get full focus and to be implemented. Implementation of developed guideline needs appropriate planning, resources, organisational and administrative support to be effective. For the purpose of this study, current guidelines are assumed as practical guidance for policy makers and other implementing bodies on how to relate gender issues with the existing practices. These guidelines were solely developed based on evidence from both phases of the study.

According to the WHO (2008:1), guidelines may provide answers to questions about organisational or policy interventions in the hope of improving health care or health policy. Thus high-quality guideline could help by attracting attention for stakeholders through its indication of unrecognised aspects of gender focused health service provision. In order to get full attention by stakeholders, the guideline needs to be based on evidence. It was envisaged that these guidelines would provide strong evidence for stakeholders to focus on gender issues whenever they plan and implement the programmes so that gender equity in decision-making process should be there. These guidelines are crucial contribution from the researcher to the field of study as currently in Ethiopia, there is no guideline that focused on gender sensitive issues in particular related to HIV prevention strategies. The researcher also excited with these guidelines as they could address almost half proportion of population group in the country, further in the global level. Thus it is clear that the guidelines can be used anywhere in the world as gender issues are not fully addressed even in developed countries. Moreover, it advocates gender equity in health programming and health programmes' implementation for better addressing the needs of whole population regardless of individual's gender.

5.3 GUIDELINES FORMULATION ON GENDER SENSITIVE HIV PREVENTION

This section of the chapter revealed different sub sections of main issues addressed under these guidelines. The draft guidelines were developed based on main findings from the first phase of this study. Likewise, the guidelines enriched through incorporation of feedbacks from supervisors who guided each step through the processes in development of this study. Further, the document was enriched through focus group discussions. Summary of focus group discussions was used to amend the document with incorporation of these experts' account. Thus the guidelines focused on thematic areas based on scope of the study to address more inclusive issues on gender sensitive HIV prevention strategies.

5.3.1 Guideline on socio-economic determinants

This subsection focused on guidelines development based on common socio-economic variables which can significantly affect women decision-making patterns. Therefore, giving recommendations to be implemented could have added advantage on dealing with the setback.

5.3.1.1 *Guideline on women education*

This guideline supposed to concentrate on narrowing down education attainment difference between men and women due to their gender. Current study finding showed that majority of respondents were attained secondary schooling level or below. Although the respondents had better literacy, it is difficult for them to compute for better job and other professional marketing. For detail understanding, the respondents' educational achievements were presented under section 4.2.2 of this study.

Thus rationale for the implementation of this guideline is to create chance for women to access and reach higher educational levels. The researcher contemplated that list of actions, as proposal to be taken by concern bodies, would draw attention for policy makers and implementers during planning and implementing of their programmes/projects.

As a result the researcher would like to recommend the following action points:

- Equal education access for both male and female should be created.
- Women should understand the role of education and use all efforts to improve their educational achievements.
- Education institutions should address special needs for female students.
- Special awareness should be created among parents to treat female children as they do for male including fair education access.
- Educational institutions should design peer study programmes to facilitate interaction and knowledge sharing among students.
- Education policy makers should consider special passing rates for high school leaving examination among female students to improve their participation at college and university level schoolings.

5.3.1.2 *Guideline on culture*

This guideline's intention is to focus on cultural impact on gender roles and related women decision-making ability. Current study findings showed that religious affiliation and ethnic group belongings of the respondents. Ethnic group belongings and religious affiliation of respondents has impact on their roles in community as majority of religious teachings are declaring men superiority in every aspect of partnership. Similarly several ethnic groups have their own values and practices of which majority of the values give superiority to men. Both religion and ethnic group attitude and teaching are designed in favour of men's advantages. For detail understanding, religious affiliation and ethnic group belongings for the respondents were presented under sections 4.2.5 and 4.2.6 of this study respectively.

Thus rationale for the implementation of this guideline is to identify cultural related challenges and taking appropriate actions to gear the problems. Further identifying the problems would lead to solution through concrete action by concerned stakeholders.

Thus the following action points should be taken into action:

- Religious teachings should respect women's right and give similar handling for women as men.
- Oppressive and only men favouring cultural values should be amended to address women's need.
- Community should be taught to have positive attitude on women's roles in day to day practices of the society.
- Society should be educated to avoid unfair job allocation due to their genders as women can do whatever men can do.
- Household jobs/roles should be equally distributed regardless of gender.
- Policy makers should design policies and strategies to deal with gender issues without discrimination owing to religious and ethnic group values and practices.

5.3.1.3 *Guideline on marriage*

The guideline targeted at respondents' marital status on gender role and decision-making patterns. Marital status is factor which can affect independent decision-making ability for both men and women. This variable can affect both married and even non-married through imposing unfair treatment on aspects of people's life between male gender and female gender. Moreover those who are married whether living together or not also have different consequence on independent decision-making for their life planning. For detail understanding, marital status for the respondents was presented under sections 4.2.3 and 4.2.4 of this study respectively.

Thus rationale for the implementation of this guideline is to show marital status roles on independent decision-making to alleviate the challenges which are currently occurring due to gender variation. The guideline made clear number of actions to be implemented by concerned actors.

As a result the following proposals are needed to be implemented:

- Partners in marriage should respect each other dignity and thought.

- Health programmes should prepare programme targeting those who are in marriage to solve their health problems.
- HIV programme should give due emphasis for couples in marriage as marital status is not immunity for HIV risk.
- Policy makers should pay attention for those who are in marriage during their planning and implementing the programmes/projects.
- Community should be educated to identify about what is acceptable and unacceptable practices in their community with respect to the gender to come up with coordinated and agreed way out from the dare.

5.3.1.4 Guideline on employment

This guideline addressed issues related to employment in gender. Current employment pattern is somewhat biased in favour of men. At the moment, the employments for higher salary are mostly occupied by men. On other hand, lower salary and ordinary work mostly occupied by women. This can create more women dependence on men counterpart. The ultimate end result of this dependence could reduce or prevent women from independent decision-making. So this poses unequal access for employment between men and women due to their gender variation. Further this leads to maintenance of higher status quo for men and sustain women's dependence in decision-making on their counterparts. For detail understanding, employment status for the respondents was presented under section 4.2.7 of this study.

Consequently rationale for the implementation of this guideline is to indicate issues to be addressed to improve imbalance in employment between genders. This is to attract the attention from relevant organisations or bodies to implement this guideline to solve the challenge.

Accordingly the following suggestions are come out for the implementation:

- Women should improve their status through education to become competent enough to join better earning job.
- Industries who hire human resources should be impartial in gender line with wrong assumption on the types of job.

- Hiring industries should have clear policies and procedures which accommodate both genders in filling of employees in vacant posts.
- Women should be given affirmative action in employment process due to their historical disadvantage and current level of lower achievements when compared to men.
- Policy makers should place clear direction to promote women's status in job market through planned manner.

5.3.1.5 Guideline on income

The guideline aimed at respondents' income pattern. Majority of respondents were largely dependent on their partners' income. This could be further complicated with larger number of family size. It is clear from this point that once women are economically vulnerable and dependent to their partners, then majority of decision in household level dependent to their male counterpart. This complicates independent decision-making ability to women. It also gives for men to take any decision without consent of women. Economic dependence close for women ability to burgeon to issues which they are not ready to accept simply their male counterpart decide. For detail understanding, family size, number of people brings income and main source of income for the respondents was presented under sections 4.2.8, 4.2.9 and 4.2.10 of this study respectively.

Thus rationale for the implementation of this guideline is to propose points which can contribute in increasing better earning among women. For this reason the guideline viewed as advice for policy makers and implementers to be noted and concentrated on.

For fulfilment of the guideline, the following tips need to be take care of:

- Women should have right to access formal sectors employment instead of keeping them informal sector.
- Women should promote existing their educational level to higher level so that they can access better salary jobs.
- Relevant bodies should create additional opportunity for women to enhance their access for better income.

- Clear policies should be there for women occupation in better pay earning jobs through computation.
- Policy makers should propose transit strategy to accommodate women on certain better earning posts through allocative system.
- Income generating jobs should be created for those who are in informal sectors and also cannot take part in formal sectors due to their low level educational achievements.

5.3.2 Guideline on HIV vulnerability

This subsection of the chapter presented the guidelines related to HIV vulnerabilities. The subdivision also tried to show women's susceptibility to HIV and reproductive health service availability and its use. Similarly the component attempted to enlist recommendations related to sexual behaviour issues and women's attitude on health service utilisation. Complementarily information provision and wrong perception were addressed under this segment.

5.3.2.1 Guidelines for women's HIV susceptibility

The goal of this guideline is to address respondents' susceptibility to HIV. Majority of respondents had sexual intercourse. Even those who never had sexual intercourse justified their reason not having sex were wait until older, want to wait until marriage, to avoid sexually transmitted diseases, not have chance to have sex and against religion among as discussed under section 4.3.10. Similarly proportion of respondents was in position to not tell to someone about condom use to their sexual partner as indicated under section 4.3.19. Section 4.3.20 stated that significant number of respondents would not tell to someone as they do not want to have sexual intercourse. Moreover, about half of respondents use alcohol before sexual intercourse as presented under section 4.3.21. Further considerable numbers of respondents' friends were sexually active as indicted under section 4.3.22.

Thus rationale for the implementation of this guideline is to indicate action points to place in to attention to minimise liability women owing to their gender. The guideline has important implication for actions.

To this end the following recommendations were emphasised for their implementation:

- Women should practice safe sexual relationship.
- Women should freely discuss whether to agree or not on condom use with their partners.
- Women should have correct knowledge and attitude on why they do not carry out sexual intercourse at the moment.
- Women should be educated on risk factors which pose them to HIV risk including drug use and drinking alcohol so that they can protect themselves from HIV pandemic through acquiring correct knowledge on the matter.
- Women should possess accurate knowledge to keep themselves from peer influences which could lead to consequences in one's life.
- Community should acquire knowledge to help in reducing women vulnerability to HIV pandemic.
- Policy makers and HIV programme should identify risk factors possibly cause vulnerability to women and take corrective measures.

5.3.2.2 Guidelines on reproductive health service availability and use

This guideline intended to forward action points on reproductive health services availability and their uses to enhance reproductive health among women. In most cases, availability of reproductive health services is challenging which could lead women to more vulnerability to HIV and other health conditions. This confrontation is further aggravated by low uptake rate for those available reproductive health services to them. For current study use of birth control method/s was insufficient and significant number of respondents never used birth control method during previous sexual intercourse as indicated under section 4.3.2. Likewise high number of respondents never used condom for their sexual exposure as presented under section 4.3.3. In addition large number of respondents never used condom during sexual intercourses with their partner/s as revealed under section 4.3.5.

Thus rationale for the implementation of this guideline is to increase availability and use of reproductive health services through implementation of proposed action points. This would lead to pay attention for actions from stakeholders.

Consequently the following recommendations are forwarded:

- Reproductive health services and commodities should be available in right kind and quantity to respond these populations' need.
- Women should have full access to reproductive health services to protect themselves from several negative health outcomes.
- Reproductive health service should be located in reasonable distance for those who might use it to minimised geographical obstacle.
- Women should have full information and knowledge about reproductive health services use and their related advantages.
- Women should use those reproductive health services including condom in full potential.
- Role of condom on prevention of HIV should be clearly known by women and population in general.
- Policy makers should design free of charge access for reproductive health services to improve uptake rate through removing financial barrier for the access.

5.3.2.3 Guidelines on sexual behaviour

This guideline planned to point on sexual practices to bring down the magnitude of the problem through revelation of issues to be addressed. Unacceptable sexual relationships could lead to harmful consequences for both individual level and community level at large. This study reported that respondents had high frequencies of sexual intercourse practices even those who were unmarried as shown under section 4.3.1. Similarly considerable number of respondents had sexual intercourse with multiple partners during last 12 months including those who in marriage as specified under section 4.3.4. Further it is important to maintain current trend towards same sex sexual practice since none of respondents were engaged with it as observed under section 4.3.9.

The rationale for the implementation of this guideline is to propose positive action points to be executed to bring acceptable sexual practices among women through appropriate

implementation by concerned bodies. This would encourage and support stakeholders to right solutions and direct their action on it.

In view of the guideline, the following issues are suggested for action:

- Community should be aware of negative consequences of ill sexual practices.
- Teaching targeted on tackling unacceptable sexual practices should be designed and conducted for community to encourage youth and women to participate on less risky sexual behaviour.
- Women should know consequences of multiple sexual partnership and keep themselves away from such practices.
- Those married women should avoid extra-marital sexual practices.
- Society should understand the link between unacceptable sexual engagement and HIV risk.
- Policy makers and implementers should clearly differentiate issues guide to risk sexual behaviours and address accordingly.

5.3.2.4 Guidelines on HIV related information provision

This guideline made clear that the importance of information provision on HIV for women to improve their knowledge to protect themselves from HIV pandemics. The knowledge on HIV among study participants was not adequate to protect them from HIV infection. This study showed that insufficient knowledge about mosquito HIV transmission as shown under section 4.3.15. Equally considerable number of respondents had wrong perception about HIV transmission through meal sharing as revealed under section 4.3.16. Moreover, elevated numbers of respondents were unknowledgeable about HIV and AIDS as indicated under section 4.3.23. Furthermore, high proportion of respondents said people cannot protect themselves from HIV AND AIDS being abstaining from sexual intercourse as presented under section 4.3.24.

The rationale for the implementation of this guideline is to avail important information to be taken into account for better addressing HIV knowledge difference in gender. It is assumed to create good indicator for stakeholders to address gender issues during the planning and implementing programmes/projects.

The guideline would recommend the following points to be taken into account:

- Women should be knowledgeable about routes of HIV transmission.
- Women should not be ignorant to seek information related to HIV and AIDS.
- Communication medias should allocate time to provide participatory discussions about HIV and AIDS to raise awareness on disease.
- Health facilities should plan and conduct community education focused on HIV transmission.
- Health facilities, education facilities and people gathering locations should be furnished with written posters with tips to take note to protect one from HIV transmission.
- Policy pertaining to information on HIV transmission should be dictated and placed in transparent manner to increase public awareness on the matter.

5.3.2.5 Guidelines for knowing self HIV status

This guideline facilitated to increase HIV prevention service acceptance rates to tackle the problem. The knowledge on self HIV status is not complete and enough. This study revealed that considerable proportion of respondents was unknowledgeable about the location where HIV counselling and testing centre found as indicated under section 4.3.11. Moreover, high proportion of respondents never had testing for HIV as put under section 4.3.12. At the same time, about quarter of respondents had sexually transmitted infection as given under section 4.3.13.

The rationale for the implementation of this guideline is to improve knowledge in self HIV status through better access of information and resources among women. This would increase awareness among women on self HIV status and HIV service.

This guideline comes up with recommended solutions:

- Community should be informed about HIV counselling and testing services availability.
- HIV counselling and testing services should be with full consent and understanding from clients' side.
- The HIV counselling and testing sites should full supply and equipment.

- The time for counselling and testing should be reasonable.
- The location for counselling and testing should be at reasonable distance for clients.
- Women should use HIV counselling and testing to know their HIV status.
- HIV counselling and testing sites should address other common sexually transmitted diseases during clients' facility visit.
- Continuous monitoring and evaluation system for HIV counselling and testing services should be there to enhance suitability of the service.
- Policy makers should oversight the progress and amend existing HIV counselling and testing services based on new development from both nationally and internationally.

5.3.2.6 Guidelines on wrong perception on HIV

This guideline helped to correct respondents' wrong perception on HIV. Current study showed that the wrong perception among respondents on HIV was almost prevalent. There were proportion of respondents were not knowledgeable about how to protect themselves from HIV or AIDS as shown under section 4.3.8. As well as about half of respondents said having sexual intercourse with one uninfected faithful partner leads to HIV or AIDS as indicated under section 4.3.17. Moreover, significant number of respondents said healthy looking person cannot be infected with HIV or AIDS as seen under section 4.3.18. Further a proportion of respondents said that pregnant women cannot transmit HIV to unborn child as shown under section 4.3.25. Furthermore, significant number of respondents said that breast feeding cannot transmit HIV from infected mother to child as given under section 4.3.26.

The rationale for the implementation of this guideline is to forward concrete action points to be taken for better understanding of HIV transmission ways by women. This would increase knowledge on HIV transmission ways and help to keep them from HIV pandemic.

This guideline leads to the following recommendation:

- Women should know how can protect themselves from HIV and AIDS through appropriate means of communications.
- Women should be knowledgeable about having sexual intercourse with uninfected faithful partner cannot transmit HIV as long as he is free from HIV.
- Women should be clear that someone should be tested to say whether he acquire HIV or not, thus it is wrong to judge someone's HIV status just looking at his physical appearance.
- Women should be well-informed about possibility of pregnant women can transmit HIV to foetus before his birth.
- Women should obtain correct understanding about possibility of HIV transmission through breast feeding.
- Media should play significant role in improving wrong perception through broadcasting targeted information for the public.
- Policy makers should identify knowledge gaps and act accordingly to recover the phenomenon.

5.3.2.7 Guidelines on HIV prevention means

This guideline entitled to address HIV prevention for women despite their gender. Current study implied lack of appropriate knowledge on HIV prevention methods. This study revealed incomplete knowledge on source of condom to use during their sexual practices as shown under section 4.3.6. Still proportion of respondents was not fully knowledgeable about how to use condom during sexual intercourse as indicated under section 4.3.7.

The rationale for the implementation of this guideline is to let know women about all spectrum of HIV prevention methods through actions by relevant bodies. It can also give list of recommendations to be taken into action by stakeholders to bring better understanding among women.

Consequently the researcher will give the following action points to be converted into action:

- Information for HIV prevention methods should be available for those who need it.
- The source for HIV prevention methods should be known by everybody to use in case he needs it.
- Correct knowledge to use HIV prevention methods is mandatory to protect oneself from HIV pandemic.
- Communication means should be designed to make public knowledgeable on aware on HIV prevention methods.
- Women should ask health professionals about how they can protect themselves from HIV.
- List of HIV prevention methods should be available for public knowledge through media, community organisation, schools, health facilities and stakeholders working at community level.
- HIV policy should well know where the knowledge gap laying and take appropriate solution for the problem.

5.3.2.8 *Guideline on women's attitude on available health services*

This guideline tried to advice about women's attitude on available health services to tackle HIV vulnerability among women due to their gender. On other hand, it is challenging to get better attitude from women on reproductive health services. As justification, current study found that a number of respondents believed that condom cannot protect from HIV infection as expressed under section 4.3.14.

The rationale for the implementation of this guideline is to identify list of recommendations which need appropriate action by concerned bodies. This would lead direction for action by relevant bodies.

Therefore, the following action points are recommended:

- Community norms which affect women's attitude on acceptance of reproductive should be attended.

- Women should know advantage of reproductive health services and use them properly.
- Behavioural change communication should be designed to educate women on reproductive health services to get positive attitude on the service.
- The issues which block positive attitude should be identified and removed for betterment of scenario.
- Policy should be formulated to progress in positive direction on reproductive health service uptake.

5.3.3 Guidelines for decision-making pattern

Decision-making pattern in gender is crucial issue to be addressed. The aim of guidelines under this subsection is to enhance women's current level of decision-making on all aspect of their living to positive direction. It is true that women should have autonomy in decision-making whether related to sexual behaviour or other components of self-lif5. It is also important for women to have right for free movement including seeking health services at health facilities. For that reason, male partners should understand this right of women and should allow their female partners to choose health services without interference by their male partners.

5.3.3.1 *Guideline on sexual decision-making*

This guideline branded for sexual related discussion initiation and free decision-making pattern among women in partnership. Sexual and other decision-making is mainly controlled by male counterparts. This monopoly of decision-making by men is tool for them to oppress women's ability. Even several cultural settings are considered men as superior and provider for family. This attitude of society is helping in maintaining privilege for main to control everything with use of this power. This fact is more aggravated by women's silent acceptance of this oppression at right for men to make decision in all level of societal structure. Majority of current study respondents agree that sexual intercourse discussion should be initiated by their partners as shown under section 4.4.1. At the same time, sizeable proportion of respondents said that they would never refuse sexual intercourse for their partner as long as he needs it as reported under section 4.4.2.

The rationale for the implementation of this guideline improves decision-making ability for women through appropriate implementation of proposed action points by policy makers and implementers. It is believed that the guideline could show the way for performance.

Hence, the following are recommended:

- Women should understand their right to initiate sexual discussion in the household.
- Couple should be transparent to each other on sexual discussion.
- Women should know their right to refuse for sexual intercourse for their partner through discussion and understanding each other.
- Any decision related to sexual matter between partners should share and decide by both parts.
- Culture should give equal authority for both men and women in their role on sexual matter.
- Oppressive cultural norms should be flexibly modified for mutually benefit of both gender.
- Women status should be enhanced through education and better earning to reduce issue contribute to perpetuated dependence on male counterpart.
- Women affair division and other stakeholder should work on the matter to shrink down the magnitude of the problem.

5.3.3.2 Guidelines on HIV risk discussion

This guideline interested in improving HIV risk discussion among people in partnership to break cultural and other challenges posing hindrance on their understanding of the reality around HIV pandemics. In most cases, sharing information about HIV among people who are in partnership is limited. This fact is further revealed from this study finding since about half of current study respondents said their partners have been initiating discussion on HIV risk as stated under section 4.4.3.

The rationale for the implementation of this guideline is to give tips on HIV risk discussion to be given through attention by stakeholders. This tips believed to accelerate narrowing down the prevailing condition in HIV risk discussion in partnership.

For that reason, the researcher would like forward following issues:

- Women should know about relevance of discussion about HIV risk with partner an family.
- Women should understand connotation of hiding HIV related information to each other.
- Women should take lead in HIV related issue discussion in family to improve their decision-making ability.
- Partners should understand the role of women in decision-making and encourage to participate and lead decision-making process.
- Women's decision-making ability should be promoted through education and acquiring experience at higher administrative level.
- Women exemplar leaders should be involved in policy and implementation process of women role on HIV issues.

5.3.3.3 Guideline on reproductive health service visit decision-making

This guideline proposed to enhance women's free decision-making to visit reproductive health facilities to seek reproductive health services without external barriers. In practice, it is difficult for women to visit health facilities without consent from their partners. Majority of respondents from this study agreed that it is against cultural norm to use and visit reproductive health services without consent of male partner as indicated under section 4.4.6. This unacceptable attitude among women would maintain the problem for longer.

The rationale for the implementation of this guideline is to suggest action points to enhance freedom to use reproductive health services with full right, free choice and autonomy among women. This would aid in addressing this miserable situation for women through taking concrete action by stakeholders.

So, the researcher would like to contribute the following points:

- Women should have fully right to visit health facilities to use available health services.
- Community should understand women's right to seek health service without hindrance by cultural norms.
- Women should be treated as men in their roles in the community.
- Government and other stakeholders should understand women's role in better use of reproductive health services.
- Policy enhancing women role should be clearly formulated to minimise dependence of women to use health services including HIV prevention services.

5.3.3.4 Guideline on improving in women bargaining power

This guideline emphasised on modifying of bargaining power for women to increase their roles in decision-making in different levels of community and administrative structures. Despite women contributes almost half population size in the country, women's voice is almost silent in decision-making even those decisions can directly affect them. The finding from this study showed about quarter of respondents said that they do not agree on condom effectiveness to protect HIV infection as shown under section 4.4.4. On other account, about one third of respondents were unwillingness to use condom due to they do not want to bargain with their partners as given under section 4.4.5.

The rationale for the implementation of this guideline is to put relevant action points to be implemented to promote women's bargaining power on the different aspects of decision-making. It is believed to improve women's participation in decision-making process.

Then, the researcher would like to underline the following indicators:

- Policy makers should work to improve women bargaining power.
- Cultural norms should be addressed so that they can facilitate for women to be able to bargain.

- Religious taught should be directed to work in power sharing for religious issue leadership instead of men monopoly of the institute.
- Women education should get high attention to fully equipped with knowledge and skill to know current situation in global thinking in gender perspective.
- Job should be fairly distribute for both gender.
- Women's employment status should be enhanced to increase confidence and earning for women.
- Women should occupy higher administrative powers to build up their capability.

5.3.4 Guidelines for joint actions

Gender issues are crosscutting issues hence it needs joint action to responded its demand. As a result partnership is crucial to bring available resources together to address the subject. In addition to that collaboration among agencies to take care of the matter has great value to progress forwards on gender issues. Of course, to reach gender goals within different sectors, coordination and integration of gender activities have maximum contribution to see the desired outcomes from the efforts which were put by several stakeholders.

5.3.4.1 Guidelines for partnership among organisations on gender issues

This guideline highlighted on the role of partnership on gender issues among organisations to take common stand on the problem. Despite the importance of partnership among different organisations, current actions are segregated and interrupted to solve existing difficulty. Possible reason for this dilemma could be due to lack of clear policies, strategies and guidelines to bring different partners in to pipeline. The problem further aggravated due to lack of ownership to pull organisations together.

The rationale for the implementation of this guideline is to attract partnership among organisations to put their efforts on gender issues. This could bring resources and attention for gender issues.

In that case, the researcher separated the following points:

- Clear policy to bring partnership among stakeholders on gender should be there.
- Gender issues should be taken as crosscutting issue during formulation and implementation for policies.
- Adequate resources should be allocated to deal with gender issues to bring fair treatment in gender.
- Women should play significant roles in gender issue advocacy and promotion.
- Human right organisations should adopt gender issues as one of their focus area to upgrade it.
- Clear mechanisms for partnership on gender should be there.
- Head of agencies should target gender issue as one of indicator for their progress.
- Global organisations such as United Nations' organisations should propose recommendations to be implemented by specific countries.

5.3.4.2 Guideline on collaboration among organisations on gender issues

The guideline accentuated significances of organisational collaboration on gender issues to speed up the implementations of gender related projects/programmes among parts. Even though strong link between different parts on implementing gender initiatives is very crucial, the existing situation dictates that the bond is too loss to solve the problem. The problem becomes persistent due to even those who undertaking the initiative also not strong enough to create collaboration among elements. This gives open door for the problem to maintain its pressure on the problem.

The rationale for the implementation of this guideline is to show initiatives to give pay attention by stakeholders. Hopefully, this could underscore the relevance of focus on the gender issues through collaborative effort.

Subsequently, the following issues come out for attention:

- Every organisation should collaborate on gender issues as gender issues are responsibility for all organisation.

- Organisations should sign memorandum of understanding to ensure commitment
- Proposed collaboration should enable organisations to share resources and good practices without threatening of the autonomy and internal functioning of organisations
- The organisations should explicitly define area of interest to set boundaries for action
- Regular meetings between organisations should be conducted to monitor and follow up progress of the plan implementation

5.3.4.3 Guideline on coordination of gender related activities among organisations

This guideline called attention to issues related to coordination activities on gender among different organisations. Every organisation recognised and created gender unit within their administrative structure, though this does not integrated gender related activities to bring bigger picture at national level. This situation would help in perpetuation the problem without contributing to bigger picture. This also keeps wastage on available resources including financial and human resources.

The rationale for the implementation of this guideline is to encourage coordination of planning on gender activities among multiple agencies to alleviate the problem. Coordinated planning on gender activities would help focus on bigger picture and achievement by different agencies.

Afterward, the following recommendations come through:

- Every activities on gender should be identified and shared among concerned bodies.
- Joint planning on gender issues should be there.
- Adequate resources should be allocated for implementation.
- Joint periodical monitoring and evaluation on gender related activities should be there.
- Strong commitment for advocating of gender issues should be there.
- Gender policies should be reviewed based on existing practice if needed.

5.7 CONCLUSION

The chapter elaborated on the guidelines development procedure including their logical development. It was also presented rational at the back of the development of the guidelines. Similarly the developed guidelines presented under this chapter. Each guideline was fastened on emerged evidence, rational behind the development of the guideline and finally concluded with list of recommendations to be accounted by concerned bodies. Then next chapter presented conclusions, recommendations and limitations for the study.

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

6.1 INTRODUCTION

Under this chapter conclusions were drawn based on findings from both phases of the study. Similarly recommendations for future researches were made to deal with the gender issues. Further limitations were identified and presented in view of enhancing validity and credibility of study outputs. Furthermore the chapter was ended with overall conclusion remark for the study.

6.2 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this study was to explore and describe the role of gender in the spread of HIV among women of reproductive age in Ethiopia with the view of proposing guidelines on gender-sensitive HIV and AIDS prevention strategies. And specific objectives of this study were to

- explore and describe the status of independent decision-making ability among reproductive age women regarding sexual and reproductive health issues.
- determine the association between HIV vulnerability and the status of independent decision-making ability among reproductive age women regarding sexual and reproductive health issues.
- develop guidelines that could be used by health professional to formulate gender-sensitive HIV prevention strategies for reproductive age women in Ethiopia.

6.3 RESEARCH DESIGN AND METHODS

This study was used quantitative and qualitative paradigm in sequentially mixed manner with first and second phases respectively. Study design for first phase was facility based descriptive cross-sectional study to explore and describe the role of gender in the spread of HIV among women in Ethiopia. For the first phase of the study, interviews

were conducted for respondents with structured data collection instrument which was pre-tested to observe its reliability and validity. During this phase of the study, the data was statistically analysed with aid of SPSS version 16.0. And then the findings from this phase of the study were presented under Chapter 4 of this thesis.

The second phase of the study employed focus group discussion among representatives of clinics, women affairs, HIV programme managers, non-government organisation and policy makers. Actual focus group discussions were done after draft guidelines developed based on first phase of study to make complete and quality in the contents of the guidelines. Finally agreed outcomes from focus group discussion were used to enrich and revise the draft guidelines. After capturing of feedbacks from audiences and supervisors, the final guidelines were embraced in this thesis as Chapter 6.

In general, the researcher took due attention on ethical issues throughout the process so that possible reliability and validity of the findings could be amplified. Similarly the researcher also deemed to maximise the execution through building confidence for implementers owing to its high level ethical soundness.

6.4 THE STUDY WITH RESPECT TO THE THEORY

This study used Liberal feminism theory to guide this study as this theory is concerned with the criticism of a historical consciousness of gender imbalances between dominant patriarchal systems and subservient females. This theory guided every step during the development of this study. Literature review process was also used this theory as indicator to access sources of data and refinement of information from available literature from the field. Similarly methodological development for this study perfectly used this theory to use appropriate method with in framework of the theory.

The presentation of findings also surely followed the guidance by this theory. Every finding discussed according to this theory. Hence the theory guided all steps in this study starting from particular idea to the development of the chapters of the document to show guided and accurate flow of the ideas.

This theory clearly also guided the development of the guidelines as the main aim for the guidelines was to recover unfair treatment in gender through appropriate implementation by concerned bodies. The theory shaped every steps of the guidelines' development starting from wording to completed document. The main purposes for the guidelines were to increase women's independent decision-making abilities in different aspects of their living as directed by this theory. The overall goals for the guidelines were to bring better future for women decision-making pattern including freedom for health services utilisation. Thus every progress under this report guided by this theory to make sure proposed study to be in line with chosen theory with correct momentum in the gain.

6.5 CONCLUSION FOR EACH PHASE OF THE STUDY

Under this section, conclusions were drawn based on findings from first and second phase of the study. A detailed discussion on conclusions for the findings presented under further divided subsections of this section to provide with clear picture on outcomes of each phase of the study. On the same way, overall conclusion for the study was presented under section 7.8 of this chapter.

6.5.1 Conclusion from first phase of the study

This subsection presented conclusions based on selected findings of the study as follow:

- Majority of the respondents were belongs to Christianity, thus religious group teaching and attitude on gender issues better reflected.
- Economic dependent nature for women has negative consequence on their ability to make independent decision on their own life and family, this is also revealed from this study findings as majority of respondents dependent on their partners in terms of household income.
- Current study population is in miserable situation in uptake of condom during sexual intercourse as majority of them was never used condom during sexual exposure.
- It was found unaccepted sexual behavior among respondents as almost one third of respondents had multiple sexual partners.

- It is important to intervene for sexual transmitted infections as current finding indicated that high proportion of the population had history of sexually transmitted infection.
- National HIV and AIDS programme should work hard to correct wrong perception among women on HIV transmission routes as more than one third of respondents believe mosquito can transmit HIV.
- Current study respondents were using alcohol or drug before sexual intercourse so it needs work from relevant bodies to address the problem as this type behavior is enhancing factor for HIV incidence.
- Knowledge for current respondent is incomplete as considerable proportion of respondents lack correct knowledge whether pregnant and breast feeding women can transmit HIV to their child.
- Respondents were not fully understand their roles in initiation of sexual discussion as significantly high proportion of current population agreed that their partners should initiate sexual intercourse discussion in their relationships.
- Majority of respondents agreed that it is against cultural norm to use reproductive health service without partner's consent thus this position of respondents would persistently affect the effort to address gender related violence and unacceptable practices in communities.
- Marital status of respondents was affecting initiation of sexual discussion.
- Religion affiliation had impact on whether the respondents to refuse sex to their partners.
- Marital status of respondents was highly affected number of sexual intercourses through increasing number of sexual practice for those who in marriage.
- Religious affiliation of respondents was directly influenced number of sexual practices positively or negatively.
- Employment patterns for respondents were forced sexual behavior through increasing vulnerability to those who unemployed or earn lower pay for high sexual intercourse practices to generate money for their survival.

6.5.2 Conclusion from second phase of the study

During second phase of study, the guidelines were developed to answer third objective of the study. This phase of the study made use of findings from first phase of study as

input to draft the guidelines. The draft guidelines further developed through focus group discussions with stakeholders. Finally these guidelines are contribution from this study to be implemented to address issues on gender. At the end, these guidelines should be implemented to address gender issues through which women could make independent decision to change wrong belief and practices in community and policy making levels.

6.6 RECOMMENDATIONS

The recommendations were suggested based on the conclusions drawn from the findings of the study. Thus this subsection took into account future researches and developed guidelines.

6.6.1 Recommendations for future research

The findings of the present research pointed out a number of areas for future studies. Areas need to investigate are:

- Male partners' attitude on freedom of women in decision-making to bring real picture of the problem to take appropriate measure to solve bottlenecks on independent decision-making among women.
- Investigation on empowerment strategies necessary for gender equity.
- Improvement strategies for cultural values with high level of resistance to bring women empowerment in decision-making as identification of resistant cultural values would lead to action.
- Identification of organisational challenges in the provision of support for gender issues.
- Same types of the study should be taken place in different study settings to validate the evidence generated from this study.
- The same type study with stronger study design (experimental design) should be conducted to have more strong evidence for the practice so that the evidence could change policy and practice.

6.6.2 Recommendations for the guidelines

The guidelines need committed stakeholders to their applicability to change unacceptable practice in gender issues. Accordingly the following points are recommended:

- The guidelines could be adapted and tested in places other than study area to make more confident on the applicability of them on other settings.
- The guidelines and the findings of the study should be broadly disseminated to several audiences through meetings, seminars, workshops and publications.
- The guidelines should be incorporated in to policy documents to be enforced for implementation.
- The guidelines should be implemented through relevant bodies to address unacceptable current gender related decision-making patterns.
- Partnership in implementation of guidelines should be there.
- Collaborative effort in guidelines implementation crucial to achieve gender needs with full expenses of effort of activities related to gender.

6.7 LIMITATIONS OF THE STUDY

The following limitations have been identified:

- This study was based on contribution from health facility visitors, thus the findings could be different if study settings were different sites such as community, military training sites, prison population, etc.
- The study did not include men's view during data collection thus it may lead to some extent of respondent selection bias.
- Current study was used cross sectional descriptive type of study design but it might be good if randomised control types of design were used to minimise possibility of bias due to types of study design.
- It was difficult to know exactly whether those who visited health facilities during study period and included in the study as respondents may differ in view and practice from those who were not visited health facilities during study period.

- Those who refused not to be part of study could affect creditability of the findings due to their possible difference in decision-making pattern.
- Researcher's limited financial capacity posed financial suffering to the researcher to conduct smoothly this study.

6.8 CONCLUSION

The identification of factors affecting gender roles is crucial first step to address gender issues by relevant organisations. And then developing the guidelines based on those variables which increasing vulnerability to gender including HIV prevention would have added value for future action on the matter through availing tools to be implemented. Further implementation of the guidelines would ensure direct actions on the matter with intention of adjusting the problems to the direction which favour positive gender treatment. At the end this would improve the quality of independent decision-making process in gender without interference of external parts. Furthermore, partnership and collaboration among organisations would confirm the success in implementation of these guidelines. At the bottom, the next sections presented bibliography and annexes for current study.

REFERENCES

- Ahlburga, DA, Jensenb, ER & Perezc, AE.1997. Determinants of extramarital sex in the Philippines. *Health Transition Review:Supplement*.
- Akelo, V, Girde, S, Borkowf, CB, Angira, F, Achola, K, Lando, R, Mills, LA, Thomas, TK & Lecher, SL. 2013. Attitudes toward family planning among HIV-positive pregnant women enrolled in a prevention of mother-to-child transmission study in Kisumu, Kenya. *PLoS ONE* 8(8):e66593. doi:10.1371/journal.pone.0066593.
- American Society for Microbiology.2015. Current concepts in HIV/AIDS.:22(6); 3-6.
- Araoye, MO. 2003. *Research methodology with statistics for health and social sciences*. Ilorin: Nathadex Publishers.
- AUC, UNECA, AfDB and UNDP. 2012. Assessing progress in Africa toward the millennium development goals: MDG Report 2012. African Union, Addis Ababa, Ethiopia.
- Babbie, E & Mouton, J. 2009. *The practice of social research*. South African edition. Cape Town: Oxford University Press.
- Baral, YR, Lyons, K, Skinner, J & Van Teijlingen, ER. 2010. Determinants of skilled birth attendants for delivery in Nepal. *Kathmandu Univ Med J* 8(31)1-329.
- Basavanthappa, BT. 2007. *Nursing research*. 2nd edition. New Delhi: Jitendar.
- Blanc, AK & Wolff, B. 2013. *Gender and decision-making over condom use in two districts in Uganda*. Women's Health and Action Research Centre.
- Booyesen, FR & Summerton, J. 2002. Poverty, risky sexual behaviour, and vulnerability to HIV infection: Evidence from South Africa. Centre for Health and Population Research. *J Health Popul Nutr*.287.

Bourg, MC.2003. *Gender Mistakes & Inequality*. An unpublished doctoral dissertation: Stanford University, UK.

Burns, N & Grove, SK. 2011. *Understanding nursing research: Building evidence based practice*. 5th edition. Texas: Elsevier/Saunders.

Campbell, H. 2005. *The principles of beneficence in applied ethics*. Oxford: Blackwell.

CDC. 2006. Racial and ethnic disparities in HIV/AIDS, sexually transmitted diseases, and tuberculosis among women. *Journal of Women's Health*. Mary Ann Liebert, Inc. Atlanta, Georgia.

Central Statistical Agency. 2012. *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia.

Chersich, MF & Rees, HV. 2008. *Vulnerability of women in southern Africa to infection with HIV: biological determinants and priority health sector interventions*. Wolters Kluwer Health: Lippincott Williams & Wilkins.

Do, M. 2008. Multiple sex partners and perceived risk of HIV infection in Zambia: attitudinal determinants and their gender differences. Tulane University SPHTM.

Dworkin, SL. 2005. Who is epidemiologically fathomable in the HIV/AIDS epidemic? Gender, sexuality, and intersectionally in public health? *Culture Health and Sex*: 7(6), 615-623.

Durojaiye, M & Kammerer, C. 2012. Religious and gender dimension of HIV/AIDS risk among women. Brandeis University, Nigeria.

Federal Demographic Republic of Ethiopia Population Census Commission. 2008. *Summary and Statistical Report of the 2007 Population and House Census: population by age and sex*. Addis Ababa, Ethiopia.

Federal Ministry of Health. 2007. *Single HIV prevalence estimation*. Addis Ababa, Ethiopia.

FHAPCO. 2010. *Report on progress towards implementation of the UN Declaration of Commitment on HIV/ AIDS*. Addis Ababa, Ethiopia.

FMOH and Federal HAPCO. 2007. *Guidelines for HIV counseling and testing in Ethiopia*. Addis Ababa, Ethiopia.

FMOH/HAPCO. 2006. *AIDS in Ethiopia, sixth report*. Addis Ababa, Ethiopia.

Fiske, ST.1998. Stereotyping Prejudice & Discrimination. *Journal of Personality & Psychology*. 63:877-889.

Gatta, AA & Thupayagale-Tshweneagae, G. 2012. Knowledge of, and attitudes towards, Voluntary HIV Counseling and Testing services amongst adolescent high school students in Addis Ababa, Ethiopia', *Curationis* 35(1):26.

Gay, LR, Mills, GE & Airasian, P. 2006. *Educational research: Competencies for analysis and application*. 8th edition. Upper Saddle River: Prentice Hall.

Gender Team. 2005. *Gender and HIV/AIDS in sub-Saharan Africa: Putting gender on the MAP*.

Haber, J & Lobiondo-Wood, G. 2006. *Nursing research: methods and critical appraisal for evidence-based practice*. 6th edition. St Louis: Mosby.

Hamid, S, Stephenson, R & Rubenson, B. 2011. *Marriage decision-making, spousal communication, and reproductive health among married youth in Pakistan*. Global Health Action: Gorgia.

Handicap International. [s.a.]. *Research findings on the knowledge, attitude, practice and access to HIV and AIDS information and services amongst persons with disability*. Dimitir Taylor/Handicap International.

Handcock, MS & Gile, KJ. 2011. On the concept of snowballing. *Sociological Methodology* 41(1):367-371.

Harvey, SM, Bird, ST, Galavotti, C, Duncan, EAW & Greenberg, D. 2013. *Relationship power, sexual decision-making and condom use among women at risk for HIV/STDs*. London: Routledge.

Hassen, F & Deyassa, N. 2013. The relationship between sexual violence and Human Immunodeficiency Virus (HIV) infection among women using voluntary counseling and testing services in South Wollo Zone, Ethiopia. *BMC Research Notes*:6:271.

Hawkins, JM. 1990. *The Oxford Paperback Dictionary*. Oxford: Oxford University Press.

Herzog, T. 1996. *Research methods in the sciences*. New York: Harper Collins.

Higgins, JA., Hoffmann, S & Dworkin SL. 2010. Rethinking Gender, heterosexual Men, and Women's vulnerability to HIV/AIDS. *American Journal of Public health*.100(3), 435-445.

Holloway, I & Wheeler, S. 2010. *Qualitative methods for health research in nursing and health care*. 3rd edition. Oxford: Wiley-Blackwell.

Jat, TR, Nawi N & Sebastian, MS. 2011. Factors affecting the use of maternal health services in Madhya Pradesh state of India: a multilevel analysis. *International Journal for Equity in Health* 10:59.

Jukes, M, Simmons, S & Bundy, D. 2008. *Education and vulnerability: the role of schools in protecting young women and girls from HIV in southern Africa*. Wolters Kluwer Health: Lippincott Williams & Wilkins.

Kader, P. 2006. *Nursing research: principles, process and issues*. 2nd edition. New York: Palgrave Mecomillan.

Kalipeni, E & Ghosh, J. 2005. Women in Chinsapo, Malawi: vulnerability and risk to HIV/AIDS. *Journal of Social Aspects of HIV/AIDS*:327-329.

Kambewa, P, Nagoli, J & Hüsken, SMC. 2009. Vulnerability of female fish traders to HIV/AIDS along the fish market chain of the south-eastern Arm of Lake Malawi. Analysis report. Regional Programme Fisheries and HIV/AIDS in Africa: Investing in Sustainable Solutions. The World Fish Center. Project Report 1979.

Lizárraga, MSA, Baquedano, MSA & Cardelle-Elawar, M. 2007. Factors that affect decision-making: gender and age differences. Arizona State University West, USA.

Magadi, MA. 2010. Understanding the gender disparity in HIV infection across countries in sub-Saharan Africa: evidence from the DHS, Department of Sociology City University, London.

MacDonald, A. 2013. Feminism, Concepts and Analysis. *Gender Studies*:1, 1-6.

Maial, C, Guilhem, D & Freitas, D. 2008. Vulnerability to HIV/AIDS in married heterosexual people or people in a common-law marriage. National Counsel of Technological and Scientific Development: Scientific Initiation.

Morrone, C, Myer, L, Mlobeli, R, Gutin, S & Grimsrud, A.2007. *Dual protection among South African women and men: perspectives from HIV care, family planning and sexually transmitted infection services*. Cape Town: Women's Health Research Unit.

Moyo, P & Plessis, GD. 2009. Factors influencing the attendance of voluntary counseling and HIV-testing (VCT) among women in Glen View High Density Suburb in Harare Zimbabwe. University of South Africa, Pretoria.

Muula, AS. 2008. HIV infection and AIDS among young women in South Africa. *Croatian Medical Journal* 49(3):423-435.

Myers, B, Kline, TL, Browne, FA, Carney, T, Parry, C, Johnson, K & Wechsberg, WM. 2013. *Ethnic differences in alcohol and drug use and related sexual risks for HIV among vulnerable women in Cape Town*. South Africa: Implications for interventions.

Oyewale, TO. 2008. HIV and AIDS knowledge and attitude among teachers in Abuja, Nigeria. Unpublished dissertation. Pretoria: UNISA.

Parker, W & Borwankar, R. 2012. *HIV prevention among adult women in Namibia: Opportunities for social and behaviour change communication*. Washington, DC: C-Change Project/FHI 360.

Parahoo, K. 2006. *Nursing research: Principles, process and issues*. 2nd edition. New York: Palgrave Macmillan.

Pathfinder International. 2008. *HIV prevention among vulnerable populations: The Pathfinder International Approach: Technical Guidance Series Number 6*. Watertown, USA.

Pera, SA & Van Tonder, S. (ed). 2011. *Ethics in health care*. Kenwyn: Juta.

Pillai, P, Bhattacharjee P, Ramesh, BM & Isaac, S. 2012. Impact of two vulnerability reduction strategies – collectivization and participation in savings activities - on HIV risk reduction among female sex workers, KHPT.

Polit, DF & Beck, CT. 2012. *Nursing research: Generating and assessing evidence for nursing practice*. 8th edition. Philadelphia: Lippincott Williams and Wilkins.

Ramjee, G & Daniels, B. 2013. Women and HIV in sub-Saharan Africa. *AIDS Research and Therapy* 10:30

Rea, ML & Parker, AR. 2000. *Research methodology*. Sao Paulo: ABDIR.

Reeves, H & Baden S. 2009. *Gender and Development: concepts and Definitions*. BRIDGE.

Robert, R & Ralph, LR. 1984. *Essentials of behavioral research: methods and data analysis*. New York: McGraw-Hill.

Roberts, ST & Kennedy, BL. 2006. *Why are young college women not using condoms? Their perceived risk, drug use, and developmental vulnerability may provide important clues to sexual risk*. California: Elsevier.

Rottach, E, Schuler, SR & Hardee, K. 2009. *Gender perspectives improve reproductive health outcomes: New evidence*. USA: Population Reference Bureau.

Santhya, KG, Jejeebhoy, SJ & Ghosh, S. 2008. *Early marriage and sexual and reproductive health risks: Experiences of young women and men in Andhra Pradesh and Madhya Pradesh, India*. New Delhi: Population Council.

Seloiwe, E & Thupayagale-Tshweneagae, G. (In press). The intersection of HIV and AIDS risk behaviours and gender-based violence among youths in Botswana, *AJPHRD*.

Shayo, EH, Norheim, OF, Mboera, LEG, Byskov, J, Maluka, S, Kamuzora, P & Blystad, A. 2012. 'Challenges to fair decision-making processes in the context of health care services: a qualitative assessment from Tanzania'. *International Journal for Equity in Health* 11:30.

Sibanda, M. 2008. The characteristics of pregnant women attending the prevention of mother to child transmission of HIV (PMTCT) programme at Bulawayo City Clinics, Zimbabwe. Unpublished dissertation. Pretoria: UNISA.

Sinikka, E & Umberson, D. 2008. The performance of desire: gender and sexual negotiation in long-term marriages. *Journal of Marriage and Family* 70(2):391-406.

Smith, MK. 2002. Gender, poverty and intergenerational vulnerability to HIV and AIDS. *Gender and Development* 10(3):1-12.

Smith, HW. 1991. *Strategies of social research*. 3rd edition. St Louis: University of Missouri.

Squire, C. 2007. *HIV in South Africa: Talking about the big thing*. London: Routledge.

Streubert Speziale HJ & Carpenter, DR. 2011. *Qualitative research in nursing: advancing the humanistic imperative*. 4th edition. Philadelphia: Lippincott Williams & Wilkins.

Sultana, T, Das, A, Sultana, MM, Samuels, F & Zarazua, MN. 2010. Bangladish: CARE.

Temah, CT. 2007. Gender inequality and HIV and AIDS epidemic in sub-Saharan Africa. Université d.Auvergne: CERDI.

The Global Coalition on Women and AIDS. 2008. Geneva, Switzerland: World Health Organization.

The International HIV and AIDS Alliance. 2010. *What's preventing prevention: Campaign policy briefing*. From: www.aidsalliance.org (accessed 12 June 2014).

Thomas, BE, Suresh, C, Watson, B, Jamuna, M, Vijayalakshmi, R & Swaminathan, S. 2013. What do we need to know about sexual risk vulnerability among married HIV positive individuals in serodiscordant relationships? A study from South India. *Africa Journal*:9-13.

Tong, R. 2009. *Feminist thought: A more comprehensive introduction*. USA: University of North Carolina, Charlotte, Westview Press.

UNAIDS. 2009. *Gender dimensions of HIV and AIDS in Kenya. Health Rights Advocacy Forum*. Geneva, Switzerland: UNAIDS.

UNAIDS. 2012. *Global report: UNAIDS report on the global AIDS epidemic*. Geneva, Switzerland: UNAIDS.

UNAIDS. 2013. *Progress Report on the global plan: towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*. Geneva, Switzerland: UNAIDS.

UNAIDS/UNFPA/UNIFEM. 2004. *Women and HIV and AIDS: Confronting the crisis*. Geneva, Switzerland: UNAIDS/UNFPA/UNIFEM.

UNAIDS/WHO. 2012. *HIV and hormonal contraception*. Geneva, Switzerland: UNAIDS/WHO.

UNESCO. 2001. *Gender and HIV and AIDS: A report of the international workshop on the development of empowering educational HIV and AIDS prevention strategies and gender sensitive materials*. Nairobi, Kenya: UNESCO.

UNFPA. 2000. *Gender and HIV and AIDS: leadership roles in social mobilization*. Addis Ababa, Ethiopia.

UNICEF. 2002. *HIV and AIDS Education: A gender perspective: Tips and tools*. New York, USA: UNICEF.

UNISA. 2007. *Policy on research ethics*. Pretoria: University of South Africa.

United Nations. 2013. *The millennium development goals report*. New York: United Nations.

UNDAW. 2005. *Equal participation of women and men in decision-making processes, with particular*. New York: UNDAW.

United Nations' Programme of Action. 1994. Adopted at the International Conference on population and development in Cairo, New York.

University of Minnesota. 2002. *Evidence-based health care*.
From: <http://evidence.ahc.umn.edu/> (accessed 22 July 2014).

WHO. 2000. *Violence against women and HIV and AIDS: Setting the research agenda*. Geneva, Switzerland: WHO.

WHO. 2003. *Gender and HIV and AIDS*. Geneva, Switzerland: WHO.

WHO. 2006. *Defining sexual health: Report of a technical consultation on sexual health*. Geneva, Switzerland: WHO.

WHO. 2008. *Indicators for assessing infant and young child feeding practices. Part 1 Definitions*. Geneva, Switzerland: WHO.

Annexure A: Ethical Clearance Certificate of UNISA to grant proposal approval



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

HS HDC/214/2013

Date: 15 October 2013 Student No: 4508-547-1
Project Title: Guidelines for gender-sensitive HIV and AIDS prevention strategies among women of reproductive age in Ethiopia.
Researcher: Abraham Alemayehu Gatta
Degree: D-LITT et PHIL Code: UPCHS04
Supervisor: Dr M Gongo Limanda
Qualification: PHD
Joint Supervisor: Prof GR Thupayagale-Tshweneagae

DECISION OF COMMITTEE

Approved

Conditionally Approved


Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE


Prof MM Maicela

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES



Annexure B: Permission letter from Family Guidance Association to conduct study



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Family Guidance Association of Ethiopia (FGAE)

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		www.fgaet.org

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 ቀን
 Date 20/11/13

**Addis Ababa Higher Model Clinics
FGAE, Addis Ababa Area Office
Addis Ababa**

Mr. Abraham Aslemayehu Gatta has requested permission letter to conduct his study in our clinic on the title Guidelines for Gender Sensitive HIV and AIDS prevention Strategies among women of reproductive age in Ethiopia at University of South Africa.

Thus, we believe that the study is important for our clinic and we want you to collaborate him to collect data for the study. Attached please find the ethical clearance he gained from the university.

Regards,

Mohammed Yimer
A.A Area Manager

**CC. SRH Program Specialist
Addis Ababa Area Office
Addis Ababa**

From choice, a country of possibilities



FGAE is registered as Ethiopian Resident Charitable Society with registration No.0475 in Ethiopia and as Accredited Member Association of the International Planned Parenthood Federation (IPPF).

Annexure C: Letter to notice intent to submit thesis for Examination

NOTICE OF INTENT TO SUBMIT A DISSERTATION OR THESIS FOR EXAMINATION

SURNAME AND INITIALS: Gatta AA

STUDENT NUMBER: 45085471

DEGREE: Doctor of Literature and Philosophy in Health Studies

FINAL TITLE OF THE DISSERTATION / THESIS UNDER WHICH IT WILL BE SUBMITTED
(please print and ensure that the correct wording is used)

Guidelines for develop gender-sensitive HIV and AIDS prevention strategies among women of reproductive age in Ethiopia

I HEREBY GIVE NOTICE THAT I INTEND TO SUBMIT MY DISSERTATION /THESIS FOR EXAMINATION WITH A VIEW TO THE GRADUATION CEREMONY TO BE HELD DURING
(please mark with X)

APRIL / MAY 2015	or	SEPTEMBER 2015
X		



25 June 2014

SIGNATURE

DATE

Annexure D: Letter to seek consent from respondents

RESPONDENT INFORMATION SHEET

Hello, my name is _____ I am working as data collector for the research project titled “the guideline to develop gender sensitive HIV and AIDS prevention strategies among reproductive age women in Ethiopia”.

The purpose of this study is to conduct research for thesis paper of Doctoral Degree in Health Studies at UNISA, Department of Health Studies to explore and describe the role of gender in the spread of HIV among women of reproductive age in Ethiopia with the view of proposing guidelines that may be used to develop gender-sensitive HIV and AIDS prevention strategies.

Reproductive age women are the foci for this study to explore and describe the role of gender in the spread of HIV among women in Ethiopia. A total of 422 participants will be interviewed. I will ask the socio demographic characteristics, personal HIV vulnerability and decision-making pattern in partnership between male and female. Interview may take a maximum of 30 minutes.

The benefit of this study: the results of the study will help responsible parties to identify the weaknesses and strengths of HIV and AIDS program in terms of gender to take corrective action in places where there are problems. The findings from this study will help to put effort on strengthening gender sensitive components of HIV and AIDS program for positive achievements of gender issues while implementing the program. There is no financial or in kind item to be provided for you up on participating in this study.

Risk: There will not be any type of risk that may come on you or others up on providing information in this study.

Confidentiality: All information obtained from you will be kept strictly confidential and your name will not be written in this form. The information you tell us will never be exposed other parties that means it will be used only in connection with this study.

Free participation and withdrawal: Your participation is voluntary and you are not obliged to answer any questions you don't want to respond. You may also withdraw from the study at any time and you would not be penalized for your decision to withdraw.

Contact information:

1. Name of principal investigator: Abraham Alemayehu Gatta

Federal Ministry of Health, Ethiopia

Cell phone: +251912165699

Email: 45085471@mylife.unisa.ac.za

Addis Ababa, Ethiopia

CONSENT FORM

I understood all the above provided information and I entered the study after complete understanding of the objective, confidentiality, risks and benefits of the study and my participation is also completely voluntarily.

Signature of respondent _____

Date _____

Signature of data collector _____

Date _____

Contact information:

1. Name of principal investigator: Abraham Alemayehu Gatta

Federal Ministry of Health, Ethiopia

Cell phone: +251912165699

Email: 45085471@mylife.unisa.ac.za

Addis Ababa, Ethiopia

ANNEXURE E: QUESTIONNAIRE

INSTRUCTIONS TO THE INTERVIEWER

During your visit, please greet and make the respondent at ease. Ensure privacy of the respondent as possible. You can use a separate room or a quite place during interview for each respondent. Then notify to the respondent that this study is being carried on in the area, with the objective to explore and describe the role of gender in the spread of HIV among women of reproductive age in Ethiopia with the view of proposing guidelines that will be used to develop gender-sensitive HIV and AIDS prevention strategies, so as to help policy makers to obtain the necessary information to develop measures to solve the problem.

You should assure the respondent that the information to be given by her will be kept strictly confidential and no one, other than the interviewer, will discover it at any time. Tell the respondent that her name will not be written. Inform the respondent about participation in the study is only voluntary and guarantee the right to withdraw if she feels uncomfortable anytime within interview. Also inform the respondent about the right of not answering on questions that she does not want to answer. Inform the respondent that reliability and accuracy of any given information is highly necessary to achieve the objectives of the study.

After you discussed the above information with the respondent and obtained her full consent as confirmed by her signature on separate consent form, continue to complete the questionnaire. For each question make a circle around the number that corresponds to the answer and also circle and specify others when chosen by respondent as specified by respondent. Carefully read each question one by one for respondents until all questions are finalised.

In general this questionnaire has three sections (Demographic and socio-economic, HIV vulnerability and Decision-making pattern). Please do not write under official use column.

SECTION 1: DEMOGRAPHIC AND SOCIO-ECONOMIC DATA

No.	Questions	Responses	Official use
1.	How old are you in year?		
2.	What is your highest level of education? (Circle one category)	1=Never been to school 2=Primary level 3=Secondary level 4=College/University level	
3.	What is your Marital Status (Circle one category)	1=Single 2=Married 3=Divorced 4=Widowed 5=Separated	
4.	What is your Religious affiliation? (Circle one category)	1=Muslim 2=Orthodox Christian 3=Protestant Christian 4=Catholic Christian 5=Other (specify): _____	
5.	What is your ethnic group? (Circle one category)	1=Oromo 2=Amhara 3=Guraghe 4=Tigre 5=other (specify) _____	
6.	What is your employment status? (Circle one category)	1=Unemployed 2=Employed on job for pay 3=Self-employed	
8.	How many people live in your household?		
9.	Who is main bread winner in your household? (Circle one category)	1=Your partner 2=Yourself 3=Others (specify) _____	

SECTION 2: HIV VULNERABILITY

	Sexual behaviour		
1.	Have you been sexually active in the last 12 months? (Circle one category)	1=Yes 2=No	
2.	If sexually active in the last 12 months, how many people have you had sexual intercourse with? (Circle one category)	1=one person 2=more than one	
3.	If sexually active in the last 12 months, did you drink alcohol or drugs before sexual intercourse?	1=Yes 2=No	
4.	If sexually active in the last 12 months, how often did you or your partner use a condom when you had sexual intercourse? (Circle one category)	1=Never 2=Seldom 3=Always	
	Knowledge and attitude regarding HIV transmission		
5.	Have you ever heard about HIV and AIDS? (Circle one category)	1=Yes 2=No	
6.	Can HIV be transmitted through mosquito bites? (Circle one category)	1=Yes 2=No	
7.	Can HIV be transmitted by sharing meal with someone who is HIV positive? (Circle one category)	1=Yes 2=No	
8.	Can pregnant woman with HIV infection or AIDS infect her unborn child? (Circle one category)	1=Yes 2=No 3=I do not know	
9.	Can a woman with HIV infection or AID infect her new born child while breastfeeding? (Circle one category)	1=Yes 2=No 3=I do not know	
10	Can health-looking person be infected with HIV? (Circle one category)	1=Yes 2=No	
	Knowledge and attitude regarding HIV transmission		
11	Do you know where to get tested for HIV infection or AIDS?(Circle one category)	1=Yes 2=No 3=I do not know	
12	Have you ever tested for HIV infection or AIDS?(Circle one category)	1=Yes 2=No	
13	Condom use can reduce the risk of contracting HIV:	1=Yes 2=No	
14	Sexual abstinence can reduce the risk of contracting HIV:	1=Yes 2=No	
15	Being faithful to one uninfected partner can reduce the risk of contracting HIV infection:	1=Yes 2=No	

SECTION 3: DECISION-MAKING PATTERN

No.	Questions	Coding Variables	Official use
1.	Are you able to say no to sexual intercourse without condom?	1=Yes 2=No	
2.	Are you able to decide when to have sexual intercourse with a partner?	1=Yes 2=No	
3.	Are you able to initiate discussion on sexual issues with a partner?	1=Yes 2=No	
4.	Are you able to initiate discussion on the risk of HIV transmission with a partner?	1=Yes 2=No	
5.	Are you able to use contraceptive without the consent of the male partner?	1=Yes 2=No	

To be filled by the interviewer

Name of the interviewer-----

Signature of the interviewer-----

Date of the interview-----

To be filled by the coordinator

Name of the coordinator-----

Questionnaire Complete-----

Incomplete-----

Incorrect parts -----

Corrections to be made-----