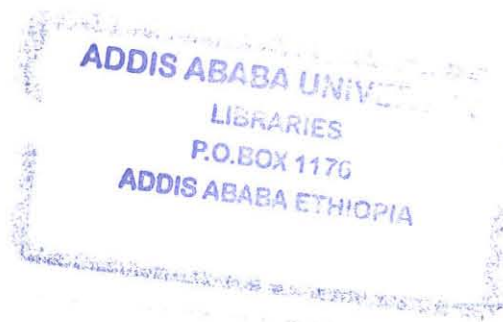


**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF PSYCHOLOGY**

**KNOWLEDGE, ATTITUDE AND PERCEIVED
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COUNSELING AND TESTING AMONG
SUDANESE WOMEN REFUGEES IN
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BY: ENISHAW TESHOME



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**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
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**PERCEIVED BARRIERS TO UNDERGO
VOLUNTARY, HIV COUNSELING AND TESTING
AMONG SUDANESE WOMEN REFUGEES IN
PUGNIDO REFUGEE CAMP**

BY: ENISHAW TESHOME

Approval of Board of Examiners

Tolu Fawda

Chair Person, Department

Tolu Fawda

Signature

25 July, 2008

Date

Seleshi Zeleke

Advisor (Name)

SWB

Signature

25 July 2008

Date

Messeret Asfo

External Examiner (Name)

Messeret Asfo

Signature

25 July 2008

Date

Dr. Desalegn Chalchisa

Internal Examiner [Name]

Desalegn Chalchisa

Signature

25 July 2008

Date

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Acronyms and Abbreviations

ARRA	Administration for Refugee-Returnee Affairs
ARV	Antiretroviral Drug
DICAC	Development Inter Church Association Commission
FGD	Focus Group Discussion
HIV	Human Immune Deficiency Virus
MOH	Ministry of Health
NGO	Non Governmental Organization
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
UNHCR	United Nations Higher Commissioner for Refugees

ABSTRACT

The major purpose of the study was to identify the significant perceived barriers of women refugees to undergo voluntary HIV counseling and testing (VCT). Additionally knowledge of the study participants about VCT and their attitude towards the potential benefits of VCT were explored. To collect data from the respondents, a structured questionnaire that comprised of knowledge, attitude and perceived barrier items was administered. To supplement the quantitative data gathered through the questionnaire, focus group discussion was held with 15 samples. Percentage, t-test and chi-square were used to analyze the quantitative data. Information obtained from focus group discussion was analyzed qualitatively. The results indicated that knowledge of women refugees about VCT was relatively insufficient to undergo the service as well as about its potential benefits and their attitude towards the services was inclined to negative. The important barriers among women refugees to undergo VCT were found multi-dimensional. Among these barriers, fear of stigma and discrimination from the refugee community was the principal problem. Also, negative attitude of the community towards HIV positive peoples was the other barrier. Moreover, unwillingness of partners to be tested together, absence of care and support services and antiretroviral medicine for HIV positive people were obstacles to undergo VCT. MTCT program in the camp, cultural barriers and limited male involvement in VCT service, absence of open discussion about HIV/AIDS and VCT in the refugee community, fear of worry, stress, and fear of rejection if the result is positive were also identified as barriers that hindered women refugees to undergo VCT. Based on the findings, recommendations were made.

Chapter One

Introduction

1.1 Background

World wide, millions of people who abandon their homes and communities because of drought, floods, earth quakes, war, or civil strife live in squalid conditions in foreign lands. They may end up in making shift camps where infrastructural facilities are rarely available, women and girls are abused, unsafe sexual harassment is common, and access to health services limited UNHCR (2000). In such situations, vulnerable people particularly women and girls face a serious risk of HIV infection

According to the U.S Committee for Refugees, globally more than 34 million people were living away from their homes at the end of 2000. Close to 15 million of them were refugees in foreign countries. More than 3 million were living in Africa (USCR, 2001).

A large portion of the global refugee population is found in sub-Saharan Africa. Women and children make up roughly 80 percent of people made refugees or displaced by conflict. Meanwhile, five of the top ten largest refugees' camps in the world originate from sub-Saharan Africa countries (USCR, 2001).

Ethiopia, as one of the sub-Saharan countries, has hosted large number of refugees from different neighboring countries. According to the research done by Aria, 288,000 Somalis, 76,000 Sudanese, 18,000, Djiboutian, and 8,671 Kenyan refugees are found in Ethiopia (Aria, 1998). Aria's research also showed that some 58,507 Sudanese were found in Western and South-Western Ethiopia in four camps. At the end of April 1998, they were distributed in the respective camps as follows: 11,920 in

Bonga, 7,644 in Dimma, 18, 482, in Pugnido and 20,461 in Sherkole. The research also described that the majority of the refugees were women, children, disabled and aged people (Aria, 1998).

Further displacement and the disruption of refugees' life often put women refugees at risk of unsafe sexual practices, sexual violence and HIV/AIDS. According to Collymore (2001), some of the factors which lead to increased risk from abuse behavior and susceptibility for HIV infection are limited access to prevention and care services, gender violence and sexual exploitation, population mixing, lack of safe blood supply, the destruction of families, deterioration of social structures and unraveling of social mores, loss of home, a income and commercial sex trade within refugee camps.

To minimize the risk taking behavior and susceptibility to HIV infection in refugee community, taking different preventive measures is essential. According to UNHCR report, different intervention strategies are designed and implemented in various refugee camps in Ethiopia (UNHCR, 2005). The report also showed that more emphases are given for prevention activities such as providing information about universal precautions, safe blood supply, condom distribution, voluntary counseling and testing, prevention of mother-to-child transmission, and treatment for sexually transmitted infections, comprehensive care for people with HIV/AIDS, and advocacy and communication with the host community.

One of the important intervention strategies in the effort to reduce the number of refugees infected and affected by HIV/AIDS is to encourage them to know their HIV sero-status (UNHCR, 2000). This strategy is voluntary counseling and testing (VCT).

Voluntary counseling and testing is a process by which an individual makes an informed choice about being tested for HIV. This decision is entirely the choice of the individual and he/she will be assured that the process is confidential (UNAIDS, 2002).

HIV voluntary counseling and testing is a vital intervention strategy that can help refugees whose HIV sero-status is either positive or negative. For people whose HIV test result is positive, VCT helps to get medical services, psychosocial support and to adopt a healthier HIV/ AIDS life style that improves their health status and slows down the progression from HIV infection to symptomatic disease and full blown AIDS (UNAIDS 2004). Knowing one is HIV negative similarly can serve the individual as a strong motivating factor to remain negative by reducing their various risk behaviors.

Available evidence in general depicts that VCT is an effective strategy to bring behavioral change among clients and in turn a pivotal strategy for HIV/AIDS prevention and control.

Despite the strong research support and widely acclaimed contribution of VCT in the prevention and control of HIV/AIDS, many individuals, especially those at risk for HIV infection are reluctant to undergo voluntary counseling and testing owing to various perceived barriers (Maria, 2006). This research will assess Sudanese women refugees' participation to take VCT and find out the possible factors which hinder them from utilization of service.

1.2 Statement of the problem

According to a joint publication of UNAIDS, UNFPA, UNIFEM (2004), globally there are about 17 million women between the age of 15 and 49

living with HIV/AIDS. The publication also indicated that there is a dramatic change in HIV infection rate among young women who now make-up over 60% of 15-24 years old living with HIV/AIDS and they are 1.6 times more likely living with HIV/AIDS than young men.

Women refugees and girls are more susceptible to HIV /AIDS due to gender and sexual violence, insufficient access to HIV prevention information and service, economical problem that leads to prostitution, inability to negotiate safer sex, mixing of population and lack of health facility (Spiegel,2006).

VCT, as an effective means of HIV prevention and control, plays a great role in safeguarding people from HIV infection. The potential benefits of VCT are many and varied. Evidence from UNAIDS shows that some of these benefits are prevention of HIV transmission, giving gate way to care and support services, prevention of mother to child transmission, entry point for social psychological support, entry point for on going emotional and spiritual support and decreasing HIV/AIDS stigma and discrimination (UNAIDS, 2000).

However, studies recommend that peoples' readiness to get the service is not encouraging compared to the seriousness of the problem and susceptibility of individuals for the virus (Maria, 2006).

The researcher initiated to conduct this research in Pugnido Refugee Camp situation because of two reasons. Primarily, he got the chance to observe women refugees' utilization of VCT service a year before in the Refugee Camp. Secondly there is knowledge gap, that is, no research has been conducted so far about perceived barriers to undergo women refugees in Ethiopia context.

Hence, the purpose of this study is to investigate perceived barriers to undergo HIV voluntary counseling and testing in the Camp. To accomplish these objectives; the study tries to answer the following basic questions:

- ❖ What are the perceived barriers to undergo HIV counseling and testing for Sudanese women refugees in Pugnido Refugee Camp?
- ❖ Do women refugees have positive attitude and awareness about VCT service?

1.3 Objectives of the study

General Objective

- To find out factors that hinder women refugees from undertaking VCT service.
- To contribute to the knowledge as to how to improve the current intake of VCT service.

The Specific Objectives are

- To explore those significant perceived barriers of Sudanese women refugees to undergo VCT services,
- To assess the attitude of Sudanese women refugees in Pugnido Refugee Camp towards VCT,
- To assess Sudanese women refugees' knowledge about VCT services,
- To offer suggestions on how to improve women refugees' participation in VCT programs.

1.4 Significance of the study

Taking voluntary counseling and testing services is very essential for the refugees' community since VCT is a good way to prevention, treatment and care services. It is a crucial tool in the effort to control HIV/AIDS

epidemic. VCT could be an effective intervention strategy in reducing risk behaviors among Sudanese women refugees who are at risk for HIV infection.

Knowing refugees' attitudes towards VCT and identifying the major perceived barriers which hinder them from accessing VCT services play a significant role in designing intervention programs related to VCT and this will contribute much in the prevention and control of the HIV epidemic among women refugees. In addition, the study can be used as a starting point to conduct further study in the area.

1.5 Delimitation of the study

The scope of this study is confined to Sudanese women refugees who are found in Pugnido Refugee Camp in Gambella region.

1.6 Definition of Terms

- **HIV testing** is the obtaining of a bodily sample for the specific purpose or performing a medical test to determine the HIV status of a person.
- **HIV counseling** - a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV /AIDS.
- **Perceived barriers** -reasons that women refugees consider as important for not taking HIV voluntary counseling and testing.
- **Voluntary counseling and testing (VCT)** is a process by which an individual undergoes counseling to enable him/her to make an informed decision about being tested for HIV and develop a risk reduction strategy.

Chapter Two

Review of Related Literature

2.1 Global Aspect of HIV/AIDS

According to UNAIDS report, since its emergence in the 1980s, HIV/AIDS has been the most challenging epidemic of modern times, its devastating spread affects the lives of 16,000 people each day (UNADIS, 2003). The epidemic has resulted in the death of 3 million people and 5 million acquiring HIV only in 2003, bringing the number of people living with the virus around the world to 40 million (WHO, 2004).

Sub-Saharan Africa remains by far the region worst affected by the epidemic. Although Africa accounts for only 10% of the world populations, 70% of the HIV positive cases were found in the region (UNAIDS 2005). The report has also confirmed that in 1999 alone, two million people were killed by HIV/AIDS in the region, as compared to the 200,000 who died each year from armed conflicts, giving the view that HIV/AIDS is the greatest undeclared war. Especially, the East, Central and Southern Africa including Ethiopia, Rwanda, and Burundi account for more than 50% of the world's burden of HIV/AIDS (Getachew, 2004).

According to MOH (2002), two million Ethiopian adults and 220,000 children are living with HIV/AIDS: 219,400 people have full-blown AIDS, the highest number following South Africa and India.

On the other hand, UNHCR publication on HIV/AIDS and internally displaced persons in eight priority countries revealed that at the end of 2003, Sudan's overall HIV prevalence was estimated at 2.3% with a low estimate of 0.7% and a high estimate of 7.2% (UNHCR, 2006). The publication has also asserted that three decades of conflict have resulted

in relative isolation of the southern provinces of the country. Consequently, little is known about the epidemiology of HIV infection in the region.

2.2 Women and HIV /AIDS

According to joint publication of UNFPA, UNAIDS and UNIFEM, globally there are about 17 million women and 18.7 million men between the ages of 15 and 49 living with HIV/AIDS. Since 1985, the percentage of women among adults living with HIV/AIDS has risen from 35 to 48 percent. There is a dramatic change in HIV infection among young women, who now make up over 60 percent of 15 to 24 year olds living with HIV/AIDS. Globally, young women are 1.6 times more likely to be living with HIV/AIDS than young men (UNAIDS, UNFPA and UNIFEM, 2004).

The report additionally confirmed that in Sub-Saharan Africa about 23 million adults aged 15 to 49 are infected, with 57 percent- 13.1 million of them women. Since 1985, there has been an increasingly disproportionate impact on women in this region. In 1985, roughly half a million women and half a million men were living with HIV/AIDS relative to men has increased every year, particularly affecting young women aged 15 to 24, who are now more than three times more likely to be infected than young men.

According to UNAIDS publication, HIV is spreading predominantly through heterosexual contact, which has increased the impact on women. This is seen most clearly in Southern Africa, where more than 20% of pregnant women tested were infected with HIV in most countries in the region, with prevalence rates among pregnant women in Botswana and Swaziland are almost 40% (UNAIDS 2005).

A joint publication of UNAIDS, UNFPA, and UNIFEM (2004) has shown that the United Nations Secretary General's task force on women, girls and HIV/AIDS in Sub-Saharan Africa has identified three key factors that contributed to the greater vulnerability of the region women and girls to HIV infection, each of which must be addressed:

- ◆ The culture of silence related to sexuality,
- ◆ Exploitative transactional and intergenerational sex, and
- ◆ Violence against women within relationship.

According to the publication, all the three factors are understood in the context of the poverty and inequalities that define the daily lives of both women and men in the region.

2.3 Conditions that Lead Women Refugees to HIV Infection

There is a probability of greater HIV infection rate where there is social instability. Conflict, displacement and insecurity have the potential to make affected people particularly women and girls more vulnerable to HIV virus infection. The United Nations General Assembly special session on HIV /AIDS report remarked that refugees and internally displaced population particularly women and girls are at increased risk of exposure to HIV infection (UN General Assembly, 2001). Similarly, (Poul, 2004) in his study declared that conflict and displacement from the normal life is directly associated with an increase in HIV/AIDS transmission (Paul, 2004). His study also confirmed that women are more likely to contract HIV in a refugee camp than in the general populations out side of the refugee camp.

Different evidences asserted that sexual violence, prostitution in the refugee camp and around the camp, mixing of populations, blood

transfusion, lack of health infrastructures, lack of appropriate and organized education and service about reproductive health and HIV/ AIDS can be some of the factors that expose refugees particularly women and girls to HIV infection during conflict (Paul, 2004, Benjamin, 2001). The next part discusses the way how these factors expose women refugees to HIV infection.

2.3.1 Sexual Violence

According to Women Commission for Refugees (2006), many women and girls are at risk and their vulnerability to sexual violence has increased as a result of numerous human rights abuses coupled with services of protection failure during their search for safety-during flight, during displacement and during the return and reintegration processes. The Commission report also revealed that many displaced women and girls experience sexual violence at every stage of their journey. Moreover, failure to account for women's security and exposure to HIV infection can make a refugee camp hazardous for women and girls. Furthermore, the commission report pointed out the causes of sexual violence as (1) the high level of poverty among refugees, (2) limited monitoring of camp situations by international relief workers, and (3) cultural attitudes on the part of some relief work and refugee-led camp management.

Sexual violence on women and children can be one of the most important means for spread of HIV in the refugee camp. A joint publication of UNAIDS with University of Zambia School of Medicine stated that refugees are generally in a vulnerable position to virus. They may often be pressured into having sex or actually raped (UNAIDS, 1997). Similarly, Benjamin in his study about Women, War and HIV/AIDS in West Africa and the Great Lakes region has shown, sexual violence against women both during armed conflict and in camps for refugees or internally

displaced persons is an important risk factor for HIV/AIDS (Benjamin, 2001)

He has also suggested that the condition of sexual violence during conflict situation is offensive. Warriors often use rape as an expression of violence and revenge against those whom they consider to be their enemies. Rape and sexual violence do not necessarily end when women and children reach refugee camps. In Rwanda, women living in camps without adult males in their household were especially at risk. Men in the camps often pursued female refugees to latrines and water taps, taking advantage of these basic needs to subject women and girls to sexual coercion (Benjamin, 2001). A study in Rwanda revealed that 17% of women who had been raped tested HIV positive compared with 11% of women who had not been raped (UNAIDS and UNHCR, 2003).

Displacement may cause families and communities to split apart, destroying community structures and support system that traditionally serve to protect women and children. This may lead men and women to engage in risky sexual behaviors.

Sexual violence on women can be committed in different situation when they perform their day to day activity in the refugee camp. According to women's commission for refugees' publication, collecting fire wood for cooking is one of the major occupations for women and girls in the refugee camps. The most devastating and destructive sexual violence occurrence while gathering fire wood was the beating and /or rape of girls and women (WCR, 2005).

In general, all the above mentioned evidence revealed that sexual violence can be committed by different individuals, in every aspect of displacement and it can be one of the means of HIV infection for Women Refugees.

2.3.2 Prostitution and HIV Infection in the Refugee Camp

During displacement especially in the early stages of refugee life women's obligations and responsibilities may increase. At the same time, the disruption of normal life through displacement, family separation and the loss of property and home may severely affect women refugees psychologically, socially, emotionally and economically with little capacity to support each other and little or no income of their own.

Women and girls-headed households continued to be dependent on relief aids or their own assumed coping mechanisms such as prostitution. According to the joint publication of UNAIDS and University of Zambia School of Medicine indicated that, prostitution very often becomes established in or around refugees camps. It will inevitably involve both the refugee and host communities. Exchanging sex for money to buy food and other essential materials is therefore not uncommon (UNAIDS, April 1997). This implies that economical problem of women and girls leads to prostitution that can be the most important factors for the spread of the virus through out the refugee camp situations.

2.3.3 Mixing of Population

Refugee camps are often great melting pots in terms of where the inhabitants originally came from (Benjamin, 2001). Refugees who previously lived in urban settings may be well informed about the risks of HIV and have formulated their own ideas on self-protection. On the other hand, refugees in the same camps who lived in rural areas may not have had access to the same level of HIV prevention information.

Apart from different level of prior awareness of HIV in the camp, there can be huge difference between different groups in rates of actual infection.

People who have fled from areas where HIV was not common may be living side by side in a crowded camp with refugees from areas with much higher HIV rates.

Although living side by side with others poses no risk at all to anyone, sexual contact between different groups can quickly spread the virus among all the groups. In these situations, those who came from areas where HIV was uncommon may thus suddenly find themselves potentially exposed to a much higher HIV risk. If they also had little prior knowledge of HIV risks and prevention, they might be very vulnerable to infection.

2.3.4. Population Displacement

Conflict often prompts large number of people to flee the fighting, which uproots them from their usual areas of residence. When people move from low prevalence to high-prevalence HIV-settings, they inevitably face increased risk of HIV exposure. In addition, rapid population movements disrupt social networks and institutions that normally protect and support people. Furthermore, displacement frequently place people in chaotic circumstance in which access to condoms and other prevention tools may be scarce (Benjamin, 2001).

2.3.5 Other Situations that Exposes Women to HIV Infection

It is not only their presence in the refugee that exposes women's chance for HIV infection; they are biologically and socially highly vulnerable to the virus. According to Urassa, women experience HIV/AIDS differently than men do in a number of important respects especially in developing countries (Urassa, et al 2005)

In general, women refugees are at high risk for HIV infection through out their displacement life. Different prevention activities such as VCT

services are provided by different organizations to safeguard the life of these people (UNHCR, 2005). However, different evidences confirm that refugees are reluctant to undertake the service (Michael, 2001, Mengesha, 2006 and Maria, 2006). The next section covers the meaning, benefit of voluntary HIV counseling and testing and the barriers to undertake the service by women refugees.

2.4 Voluntary HIV Counseling and Testing

When the HIV test was developed in the mid 1980s, testing tended to be accompanied by little HIV counseling. However, with the growing awareness of HIV infection and AIDS and the recent availability of antiretroviral therapy (ART), the scope and reasons for voluntary HIV counseling and testing have broadened. UNAIDS define VCT as a process by which an individual undergoes counseling to enable her/him to make an informed decisions about being tested for HIV, assess their personal risk of HIV and develop a risk reduction strategy (UNAIDS, 2004).

VCT services are essential components of HIV prevention and care programs. People who tested positive for HIV infection can immediately seek appropriate information, treatment, support and people who test negative can keep their HIV negative status. However, many people were reluctant to be tested if care and treatment were not offered (Stringer, et al, 2003). Similarly, according to the joint publication of UNFPA, UNAIDS and UNIFEM (2004), the majority of people living with HIV/AIDS do not know their HIV status and most men and women who are at risk of infection have not been tested.

The social conceptualization and representation of HIV and HIV testing have influence on HIV test uptake rates. For instance, the association of HIV with immediate death and discrimination; the belief that a person is

outside the category of risk , lack of awareness or knowledge about rates in one's community; fear of being labeled and stigmatized by the significant others, perception of the consequences of living with HIV, user friendliness of testing sites, symptom driven health seeking, lack of knowledge about available treatment, are some of the factors that have been alleged to deter people from HIV testing (Moths, 2004).

2.5 Voluntary HIV Counseling and Testing Process

According to UNAIDS technical update, VCT process consists of pre-test counseling, the testing process, post-test counseling and follow-up counseling. HIV counseling can be adapted to the needs of the clients and can be for individuals, couples, families and children and should be adapted to the needs and capacities of the settings in which it is to be delivered. The content and approach may vary considerably for men and women and with various groups (UNAIDS, 2000).

Establishing good rapport and showing respect and understanding will make problem solving easier in difficult circumstances. The manner in which news of HIV sero-status is given is very important in facilitating adjustment to news of HIV infection. Counseling as part of VCT involves two sessions: pre-test counseling and post-test counseling.

2.5.1 Pre-Test Counseling

Pre- test counseling is the first VCT service that is offered before taking HIV test. The counselor in this stage prepares the client to decide to either undergo or cancel the HIV test by explaining what an HIV test is and the reasons for taking it. The counselor also discusses with the client his/her personal risk profile including sexuality, possible risky sexual practices, sexual abuse or drug related behavior that increases risk of HIV infection. Myths and misconceptions, if any, are also corrected in the pre-

test counseling session. Besides, discussions on the implications of knowing one's HIV status and ways to cope with that new information will be cleared out to the client during this session. Pre- test counseling in most HIV testing centers is a necessity before undergoing HIV test. Nevertheless, some people argue that people who don't want to undergo pre-test counseling shouldn't be prevented from taking a voluntary HIV test. For instance, people who have had VCT before any request testing but not wish to have further pre-test counseling but informed consent from the person to be tested should be a minimum ethical requirement before HIV test (UNAIDS, 2001).

Pre-test counseling ends with making an informed decision about taking HIV test. If the individual decides to undergo testing, a few drops of blood will be taken for the HIV test (UNAIDS, 2000).

2.5.2 Post -Test Counseling

According to UNAIDS, after the blood test which takes not more than 30 minutes, the client will receive his /her test result from the counselor during the post- test session. This session, depending on the test result, covers issues dealing with HIV positive or negative sero-status (UNAIDS 2000). The main goal of post-test counseling is to help clients understand their test results and initiate adaptation to their sero-positive or negative status. If the test result is positive, the counselor tells the client the result clearly and sensitively, providing emotional and psychological support by discussing how he/she can cope with the status. During this session, the counselor has to ensure that the person has immediate emotional support from a partner, a relative or a friend.

If the client is willing, the counselor may offer information on referral services that may help clients accept their HIV status and adopt a positive

outlook. Referral for medical treatment will also be given and the client will be provided with nutritional advice. Discussion is also made on how the client can change his/her life style to hinder others from infection and protect him/herself from other infections like TB.

Counseling is also important when the test result is negative. While the client is likely to feel relief, the counselor has to emphasize several points, mainly discussion on the need to change behavior that can help the client stay HIV- negative. Such discussion includes the need to have safer sex practices including condom use and other methods of risk reduction. "During the window period" (4-6 weeks), immediately after a person is infected, antibodies to HIV are not always detectable. As a result, in such cases a negative result received during this time may not mean the client is definitely uninfected; the client should consider taking the test again in 1-3 months (UNAIDS, 2000).

2.6 The Benefits of Voluntary Counseling and Testing

VCT has various benefits for the client whether the individual is HIV positive or negative. Some of its contributions are discussed as follows.

2.6.1 HIV Prevention

According to UNAIDS publication, voluntary HIV counseling and testing is an effective component of prevention approaches, which promote sexual behavior change to reduce HIV transmission (UNAIDS 2001). Voluntary HIV counseling and testing efficacy study group (2000) confirmed that people who attend VCT typically reflect deeply on their values and sexual practices and a diagnosis (whether negative or positive) are often associated with reduced risk behaviors. VCT offers couples a way of finding out each other's HIV status and plan accordingly. The existing

body evidence is especially strong for VCT as a tool to help HIV positive persons to reduce their high risk behaviors to avoid spreading the disease to uninfected ones.

2.6.2 An Entry Point for HIV Treatment and Care

VCT plays a great contribution as an entry point for appropriate medical and supportive services for people with HIV/AIDS. According to UNAIDS (2000), these services include the prevention of HIV related illnesses, psychological, social, legal and family support and comprehensive treatment with anti-retroviral therapy if it is available.

2.6.3 Prevention of Mother to Child Transmission

Currently, VCT services have been identified as an important strategy in managing HIV transmission from mother to child. VCT also assists women who want to become pregnant. For women who test positive, counseling can help them decide whether or not to have children, and helps to explore family planning options. For women who are already pregnant and whose tests are sero-positive, VCT can help them make decisions about terminating their pregnancy, if safe, or if they choose to continue with their pregnancy.

Maria, (2006) condensed the benefits of VCT for prevention of the virus from mother-to-child as follows:

- Primary prevention of HIV women of reproductive age
- Prevention of unintended pregnancy in HIV infected women,
- Prevention of PMTCT through the use of antiretroviral therapy (ARV) drugs and other practice
- Provision of comprehensive care to HIV infected women, partners and children.

- Ensure a safer hospital delivery attended by a qualified staff member.
- Helps to learn how to protect them from getting re-infected with HIV, care for their newborn baby while looking after their own health needs, consider carefully future family planning methods, discuss hopes and desires for more children, and learn where to get for support.

2.6.4 Getting Emotional, Spiritual and Social Support

Although the immediate emotional needs of people following testing may be met by the counseling service, some clients may require long term treatment and care. All services available for people who test positive like spiritual services, traditional medicine or support groups can be arranged (UNAIDS 2000). The other benefits of VCT are that it can serve clients with HIV to make plans for their future and the future of their dependents. Material and financial support can be requested for those who are unable to finance themselves and their family.

2.6.5 Alleviating HIV/AIDS Stigma and Discrimination

Besides its role in the prevention and control of HIV transmission as well as a gate way to care and support for those infected, VCT may also play a role in promoting greater social acceptance of the epidemic. It is argued that widespread uptake of VCT within communities can help to normalize HIV/AIDS, to reduce AIDS related stigma and to raise awareness of the epidemic (UNAIDS, 2001).

2.7. Barriers to Undergo Voluntary HIV Counseling and Testing

Although VCT plays a great role in both HIV prevention and for people with infection as an entry point for care and treatment, many people including women refugees still show great reluctance to be tested. There are several possible contributing factors that must be addressed if VCT is to have an important role in HIV prevention and entry point for care and treatment.

Different evidences asserted that some of the factors that hinder people from taking VCT service includes fear of stigma and discrimination, lack of accessibility, privacy, and appropriate knowledge, negative attitude about VCT, socio-cultural and personal factor (Michael, 2001 Mengesha, 2006 and Maria, 2006).

A study in the United Kingdom also shown that staff training (professional skills and empathy), minimal male involvement, partner violence and rejection of HIV positive women, condom use, quality of information and its mode of presentation were identified factors to take VCT (Sheer et al., cited in Getachew, 2004)

2.7.1 Stigma and Discrimination

Refugee women and girls suffer stigma and discrimination on a number of ways. According to UNHCR, they are often stigmatized just for being refugees by the society of their asylum due to their poverty and ethnicity (UNHCR, 2004). Also, refugees are falsely accused of bringing and spreading HIV within their country of refugee. On the other hand, returnees are accused of being infected when they repatriate to their home countries.

Fear of stigma and discrimination associated with HIV/AIDS can be one of the greatest barriers that prevent women refugees from getting adequate care, support, treatment and alleviating the overall impact of HIV/AIDS. HIV/AIDS related stigma can be described as a “process of devaluation of people either living with or associated with HIV/AIDS (UNAIDS 2003). Stigma and discrimination in the refugee camp situation can be triggered by many factors, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment and social fears (UNHCR 2004). Stigma and discrimination strengthen existing social inequalities-especially those of gender, sexuality, and race. It can deter women from getting tested, contribute to them infecting other and prevent people who are infected from receiving adequate care and treatment.

Stigma and discrimination in the refugee camp situation may come from the refugee community, host population, friends, and families. According to a study by UNHCR about HIV/AIDS in Kakuma Refugee Camp, misunderstanding and stigma continue to plague HIV positive refugees, among all of Kakuma’s 86,000 inhabitants; there is only one Ugandan man who has openly declared that he is HIV positive (Spiegel, 2004). The study also reported that even though the VCT centers offer education to relatives of HIV- positive refugees, families frequently asked “*why don’t the refugees authority take them some where isolated to die?*”. This idea implies that stigma and discrimination on HIV positive refugees is very serious problem even committed by family members of HIV positive people.

In his study, Michael likewise reported that about 23% and 23.1% of the respondents admitted that they are not willing to eat together and share drinking utensils with AIDS patients respectively. Besides, 12.8% don’t

want to have any type of contact with an AIDS patient and 12% believe that AIDS patients should be isolated from the society (Michael, 2001). Studies and experience in some regions in Namibia have shown that most women actually desire testing in order to protect their babies, but unfortunately they often fear stigma and rejection if they were to test positive (MOHSS, 2004).

In general, stigma and discrimination presents a great problem in the effort to expand access to voluntary HIV counseling and testing in different areas including refugee camp situations.

2.7.2 Confidentiality and Related Factors

Lack of confidentiality prohibits people from knowing their HIV status and related personal information as they fear stigma and discrimination. Alliance Frontiers Prevention Project defines confidentiality as, keeping a person's personal information private (AFPP, 2006).

Confidentiality is one of the issues that concern people when they think of knowing their HIV sero-status. Many researchers reported that clients in principle are not against VCT, but they have serious doubts and anxieties about the confidentiality of HIV test result. Fear of lack of confidentiality is therefore an important barrier that hinders many individuals from participating in VCT programs (Van Dyk and Van Dyk, 2003).

A qualitative study investigating VCT uptake by pregnant women using focus group discussion in south west Uganda revealed that pregnant women were anxious about taking up VCT due to the fear of confidentiality and fear that maternity staff might refuse to assess them when the time come to deliver if their status were known (Pool, et al. 2001). In addition, patients are said not to accept being counseled by

counselors who are younger than themselves, which increases the pressure on the availability of counseling services (MOHSS, 2004).

Regarding people who were not tested before, and didn't have a plan to be tested, Phillips and his colleagues found that participants especially women in stable relationship, black people, young people and those with a lower income were only willing to be tested if no one else could have access to their results (Phillips et al., cited in van Dyk and Van Dyk, 2003).

The problem of confidentiality in the refugee camps situation may be related with polygamy marriage style, they may think of lose of support from the camp authority, and fear of loss of partners if their result is positive.

2.7.3 Cultural Factors

The culture of a given society directly or indirectly has its won positive or negative impact on the belief, attitude, and practice of a given activity within a given time. The uptake rate of women refugees to take VCT service may be greatly influenced by the culture and norms of the society. According to Spiegel (2004), condoms are viewed by the Sudanese and Somalis as going against religion and culture. He also described that Sudanese are polygamous society and their wealth dictates how many wives they can have. For instance, when the number of wives increase there may be probability of lack of open discussion about HIV ,VCT or any sexual practices each other or with their husbands. Such cultural barriers can pose a special challenge in the prevention and control of HIV transmission by using different mechanisms including VCT. The same author also mentioned that in Rwanda, not even parents discuss sexual matters with adolescents and community educators and health care providers in the camps feel greatly constrained by such taboos.

2.7.4 Service Related Factors

In the refugee camps there may be high scarcity of health service such as awareness creation education about the potential benefits of VCT, condom (for both sexes), ART, PMCT program and voluntary counseling and testing service. In a survey of refugees settings world wide, UNHCR (2005) is found that voluntary counseling and testing is not available in most programs. Similarly the publication also revealed that PMTCT also do not seem to be universally applied, despite evidence suggested that it can be higher during complex humanitarian emergencies. Similarly, a joint report of UNAIDS, UNFPA, and UNIFEM (2004) has shown that VCT is available to only 12 percent of people who wants to be tested.

Accessibility and availability of the service may become more serious for refugees who displaced from their country. According to Spiegel (2004) in the refugee camp situation there was a very low up take of VCT program primarily due to lack of trained counselors and health expertise. Moreover, in many African refugee camps there is inadequate laboratory support for VCT, PMTCT program and for patients on ARV, rapid tests have not been incorporated.

According to WHO(2004), several key factors may contribute to the poor and inconsistent utilization of VCT service, such as lack of transport, low income, unemployment and low educational level. Research conducted in Namibia indicated that-return rates for HIV results are also (40-50%) similar to that of the region due to inherent delays in availability of results at least for two weeks or more (MOHSS,2002).

At the early stage of displacement and in refugee camps accessibility and availability of services for HIV prevention and treatment may be a problem. Monica Wemette, UNAIDS Planning Management Specialist gave

her witness about lack of access to condoms and health care service during the early stage of displacement as follows:

I arrived in Kigali during the Rwanda Genocide in mid-1994. Huge numbers of Rwanda refugees were continuing to pour into the camps in Zaire, Specifically in Goma. It was a great surprise for me to see that one of the first things many refugees did was to ask for condoms not food, not medicine, but condoms. Within two weeks, we were able to get two million condoms delivered through a collaborative WHO/UNHCR effort (UNHCR, 1997).

Structural barriers such as distance of service, inconvenient working hours and cost of services contribute significant contribution in prohibiting people from seeking VCT services. In an exploratory study among the Kenyan and Ugandan women cost, inconvenient working hours, distance and waiting time were reported by the respondents as important barriers for not accessing VCT services (Maria 2006)). Even though, refugees are found in a camp where health facilities more or less available, they may face the above mentioned problems during their displacement and when they go back home.

A study conducted in North western part of Ethiopia about factors affecting acceptance of VCT among different professional and community groups identified that lack of different care and support service including ART as a negative predictor of VCT acceptance.

Generally, the provision of different health services like ART, PMTCT and VCT in the refugee camp situation would have a significant effect in prolonging life and this would have an impact on the community in creating positive attitudes and acceptance towards the service.

2.7.5. Literacy and Acceptance of VCT

The majority of women in many developing countries are illiterate, which contributes to them not to comprehend health related problems. A research conducted in Dimma Refugee (Bethany Y.et al., 20003) indicated that in early 1992s, knowledge about AIDS and condom use was low among Sudanese women refugees. A study conducted to assess women's knowledge of HIV and AIDS awareness and attitude towards VCT uptake in Nigeria indicated that, 65% had good knowledge, 24% had fair knowledge and 11% had poor knowledge of infection. Most respondents were aware of VCT through health workers, mass media and friends (Iliyasu, et al., 2005).

Various studies undertaken in Ethiopia have shown that lack of perception of being at risk, no consideration for VCT services, fear of HIV positive results and fear of stigma are reasons for people not seeking pre-marital VCT. In another study, it was shown that having an educational status of secondary school and above, being female and being Christian were associated with willingness to take VCT (Mengesha et al, 2006). Since women refugees who come from rural areas may have low educational status or no education, this can be a barrier to undertake voluntary HIV counseling and testing.

According to Kowalczyk, et al. (2002) a pilot study that investigated factors related to uptake and acceptability of VCT for HIV among women in Kigali Rwanda found that women whose partners had skilled and well paid jobs were about four times more likely to accept HIV testing than women whose partners were unemployed.

2.7.6 Negative Attitude towards Testing Services

Many people in high HIV prevalence countries of Sub-Saharan Africa are aware that VCT services are available at different sites such as hospitals and free-standing VCT centers. However, a very small proportion of the populations who know about the availability of VCT have been tested for HIV. Among the reasons why many individuals may not seek HIV was demonstrated to be one of the barriers for high risk individuals in the United States. In a study of homosexual men and adults receiving sexually transmitted clinic services, individuals who viewed more positive and fewer adverse outcomes for HIV testing were more likely to have been tested as compared to those who don't (Stall et al., cited in Kalichman and Simbayi, 2003). However, the relationship between testing attitudes and seeking VCT is not a direct one.

2.7.7. Fear of Mental Distress and Depression

Together with other social and cultural factors, fear of mental distress and depression can be one of the factors that hinder women refugees from accessing VCT services. This problem can be more severe when the society's awareness is at the primary level and stigma and discrimination is common practice on the HIV positive people. A study by Macintyre and his associates, for instance, confirmed that feeling of mental distress and depression were reported by clients who believed that there is nothing they could do about being infected with HIV (Macintyre, Brown and Sosler, cited in van Dyk and Van Dyk, 2003).

The situation that women refugees are present by itself can also be a source of mental distress. For instance, they have no their won income, they are displaced from their country and home and their family is disintegrated. When the HIV and its associated problem added on these

individuals, the problem becomes more severe. Even though, evidence is unavailable in refugees situation, in their investigation on the consequences of announcing HIV sero-positive to women in African settings, Gaillard and his associates found that 15% of the HIV positive respondents felt that it would have been better not to have known their status, because they were depressed as a result of discovering their positive HIV status since there is no cure for the infection and hence nothing they could do about it (Gaillard, 2000).

A similar result was also reported in a study where the majority of sex workers in South Africa, who were willing to be tested monthly for HIV, didn't want a positive result disclosed to them. They believed that knowledge of a positive result would cause mental anguish that it would threaten their relationships with steady partners and that they would lose their clients and income (Van Dyk and Van Dyk, 2003). Likewise, the study confirmed that fear of mental distress and depression was an important barrier for people not to decide to get access to VCT. 86% of their research participants felt that it is not advisable for someone to know his/her HIV status or to go for VCT in the absence of any possibility of follow up, care and support as it causes depression, despair and death.

For women refugees to know HIV status in the context of their current refugee life situation, in a stigmatizing society and without any follow up and support services or treatment can be detrimental for their mental and physical wellbeing. So fear of mental distress and depression can be one of the factors that limit women refugees from accessing to VCT service in the refugee camp situation.

Chapter Three

Methodology

In this methodology part of the research, sample size and sampling techniques, data collection tools, procedure of data collection and data analysis are presented.

3.1 Sample Size and Sampling Techniques

According to the UNHCR (2008) report, a total of 18,959 Sudanese refugees are living in the camp. Among these 10545 are women and the remaining 8414 are men. The ethnic composition of the total women refugees from all age groups indicate that there are 4333 Nuer, 6091 Anuak, and 121 Dinkas in the camp. The total population of the study, that is, women aged 16-49 years covers about 4000. Based on the objective of this research; 10% of the total women refugees, (which is 400) were selected using stratified random sampling from each ethnic group. Considering the total number of each ethnic group, 169 Anuaks, 164 Nuer and 67 Dinkas were selected from a population of 4000 women refugees in the age group of 16-49 using stratified random sampling technique.

In addition to women refugees, the study has included a supervisor and a counselor from the VCT center in the camp as study participants. These were selected using purposive sampling technique.

3.2 Data Collection Tools

Data were collected using questionnaire, focus group discussion and interviews.

Questionnaire

The questionnaire incorporated socio-demographic characteristic of the study participants, items on knowledge of the respondents about VCT, attitude towards VCT and barriers to utilize VCT services. Items for the knowledge component of the questionnaire were adapted from previous studies related to VCT (Andargachew, 2006; Yohanes, 2007). These items were structured into a yes/no format, but for some items, respondents were given the opportunity to write additional information about the specific issue in order to accommodate more opinion.

Similarly, 8 items were adopted from past investigations pertaining to VCT (Andargachew 2006; Yohanes 2007) while the remaining 12 were developed by the author. Each question is organized in to a five point scale (Likert scale) that ranges from strongly agree to strongly disagree, five representing strongly agree and one strongly disagree. Some items for the attitude scale were negatively phrased. Reverse scoring was used for these items (that is, one for strongly agree and five for strongly disagree).

As there was no previously validated instrument for assessing the perceived barriers of people about VCT, the component used to measure refugees' perceived barriers to undergo VCT was developed by the author. Finally, the questionnaire was given to two graduate students and for UNHCR HIV/AIDS Monitoring and Evaluation Officer in Addis Ababa for the purpose of avoiding redundancies and evaluating the relevance of each item for the intended purpose. Based on the comments, the items were increased from 25 to 30 and some ideas were incorporated on the interview and focus group discussion items. The 30 items were then structured into a five point scale as follows: 5=very important, 4=important, 3 undecided, 2= less important and 1= not important.

Focus Group Discussion (FGD) Guide

To complement the information gained through the structured questionnaire, a focus group discussion was held with 15 purposefully selected women refugees from the Women's Association of the Refugee Community. The author thought that these women may have better experience in recognizing women's problem in their day to day women's affair activities in the refugees' camp situation. Representative of all the three ethnic groups (that is, Nuer, Agnewak, and Dinka) participated in the focus group discussion. From each group, five women were selected to participate in the FGD. The FGD participants were excluded from filling out the questionnaire.

Interview Guide

To get additional information about barriers to undergo VCT among refugees semi structured interviews were conducted with one supervisor and one counselor of the VCT center in the camp. This was done because the author believes that they have better experience in their day to day activity related to the objective of the study.

3.3 Procedure of Data Collection

In obtaining the necessary information, the author first contacted and discussed about the purpose of the research with UNHCR HIV/AIDS Monitoring and Evaluation Officer in Addis Ababa. This was a great help in getting the necessary support such as transportation from Gambella to Pugnido, formal permission from ARRA and related information about the current situation about the project area.

In the camp, the author first contacted and discussed the objective of the research with the Authority of the Camp. This communication has facilitated the author's work of getting formal letter to establish contact

with the HIV/AIDS supervisor, counselor and record and documentation officer of the camp. The data collection process was started by collecting list of women refugees from the record office. The principal of the Pugnido Refugee Camp Secondary School and Anti-AIDS Club from refugee camp were contacted in order to select trainees that would administer the structured questionnaire. Based on their educational performance, especially in English together with the school principal the author selected the best students of the school from grade 10 consisting of both males and females. With the help of Development Inter Church Aid Commission (DICAC) office of the camp, the author gave a short training for the assistants on how to administer the questionnaire.

Before administering the instrument, to screen out the final version of the structured questionnaire, a pilot study was conducted on 50 randomly selected female refugees whose ages were greater than 16 years. These were students from the Pugnido Refugees Camp Secondary School. Both the attitude scale and perceived barrier items were administered at the same time. The internal consistency of both the attitude and perceived barrier scales were then computed. The results indicated that the scales have acceptable reliability with alpha (α) coefficients of 0.76 for the attitude scale and 0.77 for the perceived barriers scale. After completing training of the assistants, the structured questionnaire was administered on refugees from randomly selected houses. Assistants who belong to their ethnic group have administered the questionnaire.

The interviews were conducted with the Supervisor of HIV Prevention and Control Officer of the camp and counselor of the center. Unfortunately, the author was able to contact only one counselor. The remaining two were participating in a workshop in Dimma Refugee Camp for a month. After taking an appointment with the interviewees, the interviews were

conducted. Finally, the FGD was conducted with 15 women refugees organized in to three groups and 6 hours were required to conduct it.

3.5 Data Analysis

The main purpose of the study was to identify perceived barriers of women refugees to access VCT. As a subsidiary objective, the knowledge and attitude of the participants towards VCT were explored. Both quantitative and qualitative methods of data analysis were employed. To analyze the data obtained from the structured questionnaire, both descriptive and inferential statistics were employed. The descriptive statistics used included means, standard deviation and percentage distributions. Chi-square and one sample t-test were also employed. A significance level of $P \leq 0.01$ was used for the study. Data generated from the focus group discussion and semi structured interview were analyzed qualitatively.

Chapter Four

Results

This chapter presents the results of the study. Socio-demographic characteristics of the participants, knowledge about VCT, attitudes towards VCT, and factors or barriers to uptake VCT are presented. Descriptive statistics (mean standard deviation, percent, and frequency distribution) and inferential statistics (t-test) used to analyze the results. Data gained from focus group discussion and interviews are analyzed qualitatively.

4.1 Socio-Demographic Characteristics

The socio-demographic characteristics of the study participants are shown in Table 1 below. Except those who gave interviews, all the study participants were women. Most of the participants were in the age range 21-25 (26.5%) and 26-30(29%).

The marital status of the study participants shows that the majority of women (41.8%) were married and living with their husband, 108 (27%) were never married, 81(20.3%) were married but did not live with their husbands and 44(11.0%) were divorced.

The ethnic composition of the study participants shows that 169(42.3%) are Anuake, 164(41.0%) are Nuer and 67(16.8%) are Dinkas. One hundred and sixty eight (42%) of the study participants lived in the Pugnido refugee camp for more than four years, whereas 111 (27.8%) of them were in the camp for 3-4 years. With regard to religion, 392 (98.0%) were Christians whereas the remaining 8(2.0%) were Muslims.

Table 1 Socio Demographic Characteristics of the Study Participants (N=400)

		Frequency	%
1	Age distribution of study participants		
	↓ 16-20	41	10.3
	↓ 21-25	106	26.5
	↓ 26-30	116	29.0
	↓ 31-35	70	17.5
	↓ 36-40	40	10.0
	↓ 41 or above	27	6.8
2	Marital status		
	↓ Married, live with husband	167	41.8
	↓ Widowed	81	20.3
	↓ Divorced	44	11.0
	↓ Single never married	108	27
3	Educational level		
	↓ No education	156	39
	↓ Grades 1-4	107	26.8
	↓ Grades 5-8	65	16.3
	↓ Grades 9-10	56	14.0
	↓ Grades 11-12	16	4.0
4	Ethnic group		
	↓ Nuer	164	41.0
	↓ Anuak	169	42.3
	↓ Dinka	67	16.8
5.	Duration in the camp		
	↓ Less than one year	57	14.3
	↓ 1-2 years	64	16.0
	↓ 3-4 years	111	27.8
	↓ More than four years	168	42.0
6	Religion		
	↓ Christian	392	98.0
	↓ Muslims	8	2.0

4.2. Respondents' Knowledge about VCT

As shown in Table 2 below, out of the 400 women refugees, 315(78.75%) have identified sexual intercourse as the main way of contracting HIV/AIDS while 200 (50%) said that HIV is transmitted from mother to child and 187 (46.75%) of them through blood contact. The remaining (15.25%) mentioned other methods of HIV transmission such as a person having an open wound coming in contact or touching an infected blood during accidents, delivery and sharing blades with an infected person.

With regard to ways of knowing one's status, the majority (65%) stated that HIV testing is the only way to check one's HIV status. Fifty five (13.75%) of the respondents also mentioned that getting sick for a long period of time is one means of knowing one's HIV status. Forty five (11.25%) said that looking some symptoms would help to check one's HIV status. 40 (10%) replied that looking one's physical appearance help them to identify one's HIV/AIDS status. Out of the total study sample 287 (71.75%) reported that they were aware of the availability of VCT service in the Refugee Camp. Similarly, all the FGD participants confirmed that they have prior information about the presence of a VCT center in their camp. But 113(28.25%) of them indicated that they didn't know the availability of the service in the camp.

Concerning the experience of discussion with friends or families about VCT, 212 (53%) of the respondents indicated that they discussed with friends or families about VCT whereas 188 (47%) of them admitted that they didn't discussed with friends, family or other people. In the same way, almost half of the FGD participants indicated that there was no open discussion about VCT and related issues in their families.

According to the data in Table 2, health institutions in the refugee camp, family, friends and radio were the main sources of VCT information for the majority of the respondents. Similarly, almost all FGD participants reflected that the health institution in their camp is the main source of information about VCT.

Only a small number of the respondents indicated that they get information about VCT from television (17%), refugees' publications (3.75%), and newspaper (2%). Thus, only a small proportion of the respondents used these media as source of VCT information. In the same manner, all FGD participants affirmed the absence of television, refugee publication, newspaper, which could have been sources of information about HIV and VCT.

Respondents listed church education, social gatherings, coffee ceremony organized by ZOA and UNHCR as other sources of information about VCT. Apparently, a small number of the research participants (14.5 %) had prior HIV testing experience. However, the majority, (85.5%) reported that they didn't undergo VCT before. Similarly, all the FGD participants admitted that they had no prior HIV testing experience.

Table 2, Knowledge of the respondents about VCT (N=400)

No	Items	Frequency	%
1**	Knowledge about the way how a person gets infected with the HIV virus - By sexual intercourse - From infected mother to child - Through blood contact - Others	315 200 187 61	78.75 50 46.75 15.25
2	Method of checking one's HIV status - Undergoing HIV testing - Getting sick for a long time - Looking one's physical appearance - Looking symptoms	260 55 40 45	65 13.75 10 11.25
3	Awareness about the availability of VCT center in the camp -Yes -No	287 113	71.75 28.25
4**	Sites where one can get the VCT service - Free standing VCT centers - Private hospital and clinics out side the refugee camp - Private and government hospitals in their country - In the refugee camp clinics - No knowledge of VCT sites	156 66 240 285 35	39 16.5 60 71.25 8.75
5	Experience of discussing about VCT with friends /family/other people -Yes -No	212 188	53 47
6**	Sources of information about VCT -Radio -Television -News paper/magazines -Refugees publication -Friends -Heath institution in the camp -Family -Other sources -No source	200 68 8 15 200 277 212 24 18	50 17 2.0 3.75 50 69.25 53 6 4.5
7	Previous HIV testing experience - Yes - No	58 342	14.5 85.5

** Multiple Response Items

4.3 Attitude towards Voluntary HIV Counseling and Testing

The attitude inventory shows that almost half of the study participants agreed that VCT helps refugees to get care and support services (49.39%), to plan one's own future life (44.8%) and has significant contribution in the prevention and control of HIV transmission (52.8 %).

Likewise, 35.8% of the respondents agreed that getting tested for HIV helps people feel better. On the other and, more than half of the respondents (54.3%) thought that knowledge of one's HIV status makes one to worry and be under stress. Because of fear of stigma and discrimination against themselves and their families if the test result turns out to be positive, 67.3% of the respondents did not prefer to undergo HIV test.

The study participants were asked about the attitude of the community towards HIV positive people. In response, 70.3% of the respondents thought that the refugees' community had no positive attitude towards HIV positive people. Similarly SSI the interviewees indicated that the community had negative outlook about HIV positive people. They stated that if a woman is HIV positive she is considered as already dead. In the same manner, the majority of the FGD participants reflected that most of the refugees community have negative attitude towards HIV positive people. A significant number of the respondents (64.8%) also stated that if their result is positive they feel that no body would provide them with care and support services.

Availability of different health services such as ART and PMTCT and participants' readiness to be tested show positive relationship. They reported that if antiretroviral treatment is available in the camp, they are ready to be tested. For example, 49.8% of the respondents indicated that

they are ready to undergo VCT test. The responses of the interviewees also showed that there were no antiretroviral treatment, PMTCT, and mobile VCT service in the camp. When the study participants were asked about their attitude towards VCT services that were provided in the camp, only 32.3% of them felt that there was sufficient facility for VCT service in their camp.

Finally, concerning readiness for utilization of the services, 66.3% of the respondents agreed that they do not like to know their HIV status since HIV has no medicine. In the same way, more than half of the FGD participants stated that they are not ready to undergo VCT. Only 35.8% percent of the respondents have agreed that elderly refugees encourages women to undergo VCT and 54% of the study participants believed that a positive test result may affect their relationship with religious leaders. Most of the FGD participants agreed that religious leaders have positive attitude towards women's utilization of VCT service. Moreover, they reflected that on Sundays after liturgy there is education about HIV/AIDS that is provided by the religious leaders. On the other hand, most participants consented that elderly people have shown relatively negative attitude towards women utilization of VCT service.

In determining whether the participants' attitude towards VCT is negative or positive, one sample t-test was computed as shown in the Table 3 below.

Table 3: t-test for Significance of Mean Difference for the Attitude

Inventory

N	400
Test value	60
Mean	51.77
SD	11.4
t	-14.47
P value	< 0.01

Note SD=standard deviation

The data in Table 3 show that the participants' attitude towards VCT (mean=51.77,SD=11.4 is significantly less than the test value (that is,60).That is women refugees who participated in this study tended to have relatively negative attitude towards voluntary HIV counseling and testing. Frequency distribution, mean, standard deviation and percentage result of refugees' response for attitude inventory are presented in appendix F.

4.4 Major Barriers to Undertake VCT among Women

Refugees

As presented in Table 4 below, mean of the responses of the participants to the perceived barriers items shows that among the total 30 factors hypothesized to prevent women refugees from having VCT, thirteen (12) items were rated as " important" and/or "very important" by the majority of the respondents.

On the other hand, the other three items (fear of rejection from local people, absence of privacy during VCT service and fear that positive test result affect relation with religious leaders) are nearly above average and the rest fifteen (15) items were rated by several respondents as less important or not important at all.

Based on the result from the percentage (that is) items which have higher percentage of response for important and very important and items which have the calculated mean values greater than or equal to 3.50, are taken as a barrier to undertake VCT service among the study participants. Percentage distribution of refugees' response for the barrier items are presented in the appendix part. Next mean, standard deviation, rank order of the items and the hypothesized items are presented.

Table 4 Means, Standard Deviations and Rank Order of Refugees' Responses to the Perceived Barrier Items

Item	Mean rating	Standard deviation	Rank order
Fear of stigma and discrimination from the refugee community	4.15	1.21	1
Unwillingness of partners to be tested together	4.01	1.33	2
Fear of rejection of one's partner and family members	3.86	1.24	3
Absence of open discussion about HIV/AIDS and VCT	3.85	1.28	4
Lack of care and support services for HIV positive people	3.77	1.38	5
Fear of worry and stress if the result is positive	3.73	1.43	6
Unwillingness of family members to accept positive result	3.72	1.36	7
Absence of antiretroviral medicine and PMTCT program	3.7	1.43	8
Absence of organization that support HIV positive people	3.65	1.43	9
Negative attitude of the community towards HIV positive peoples	3.56	1.44	10
Feeling HIV negative because they were not exposed to HIV infection	3.54	1.52	11
Lack of interest to think about HIV and being HIV positive	3.54	1.2	12

4.5 Qualitative Data

As indicated before interview and FGD were used to gather additional information about the perceived barriers to undertake voluntary counseling and testing among women refugees. Both interview and FGD were conducted after the structured questionnaires were completed so as to supplement the qualitative study and to address issues which could be determinant factors and were not mentioned by quantitative study.

4.5.1 Interview with Supervisor and Counselor

To complete data gathered from structured questionnaire, interview were conducted with a supervisor and counselor who work in the VCT center of the Pugnido refugee Camp. To avoid redundancy the two interviews result were presented here together.

The response of the supervisor and counselor on the general status and establishment of VCT service in the camp revealed that it was established almost one year and six months before by the help of Gambella Region Health Bureau collaborated with different NGOs which work in the camp. The service center have provided service for both the refugees' community and local people integrated with different organizations such as ZOA, UNHCR, and ARRA.

According to the interviewees the attitude of women refugees on the use of VCT shown that women participation to take the service is low compared with the total number of women refugees in the camp.

The response of the interviewees about the availability of the necessary facilities and equipments that help to provide complete VCT services in the camp indicated that the VCT center has all the equipments, facilities and human power to render complete and appropriate VCT service in the

camp. But both the supervisor and counselor described that there were no antiretroviral treatment and PMTCT service in the camp. Both the interviewees list out their opinion about the factors that hinder women refugees to under take VCT in the refugees' camp situations as follows:

- ❖ Fear of stigma and discrimination by the refugee community as well as local people,
- ❖ Fear of rejection by their partners, as they follow polygamy marriage style,
- ❖ Lack of awareness about the potential benefits of VCT,
- ❖ Cultural factors, for instance in Anuak culture, if a husband tested and his result is positive he is obliged to pay compensation for his wife and her families in the form of cattle, money etc.
- ❖ Lack of facilities such as ART and PMTCT program in the refugees' camp situation,
- ❖ Low utilization of VCT service by male refugees, and
- ❖ Negative attitudes of the community towards HIV positive people can be taken as a factor for the reluctance of women refugees to take VCT services.

According to the interviewees, the community has negative outlook about HIV positive people. If a woman is HIV positive she is considered as already dead. Generally the above ideas mentioned both by the supervisor and the counselor are some of the factors that hinder the participation of women in taking VCT service.

According to the supervisor, working hard is the important remedy to bring behavioral change, to scale-up the use of VCT service and ultimately to alleviate the spread of HIV/ AIDS.

In response to a case that might be reported on rape and sexual abuse problem, the supervisor confirmed that there are some rape cases which are reported officially and now the cases are being processed through the court. He also stated that rape is common especially in Nuer ethnic group. Such violence is practiced due to the influence of their culture. In Nuer community the male should give 40 cattle to get married. Those who are economically poor and couldn't marry committed different gender violence including rape.

4.5.2 Focus Group Discussion (FGD) with Women Refugees

To complement data from structured questionnaires focus group discussion were conducted with purposefully selected 15 women refugees. The FGD participant women were assigned in to three groups. The purpose of FGD was to investigate the perceived barriers that affect women refugees from taking VCT

➤ Focus Group Discussion Proceedings

While all focus group discussion the researcher acted as chairperson having consent from the group members. The topic "Factors Affecting Taking VCT" was accepted by the groups as a point of discussion and the author told the group members that they were given the right to communicate freely without any reservation. During the discussion, supplementing idea, disagreeing on the point raised, reflecting new information etc. were possible. The main ideas related to objective of the study that reflected from FGD from the entire groups were summarized and presented here.

Reflected ideas from all groups and the whole participants indicated that women refugees have basic knowledge about the meaning of VCT. For instance, a participant from Nuer Ethnic group reflected her idea as follow: "*I know about VCT. It is the method that helps to check up whether*

a person is infected or free from HIV virus or not". This and similar reflected ideas of FGD participants implies that they have some basic concept about the concept of VCT. Next they discussed the potential benefits of VCT. Here, even though almost half of participants were not actively participate on the issue discussion, the remaining actively involved and they were able to reflect different helpful ideas about the potential benefits of VCT. Some of these were,

- ❖ VCT helps to plan once future life
- ❖ VCT helps to know the HIV status of the individual
- ❖ VCT helps to get care and support if the individual is HIV positive etc...

But majority of the participants have no idea about the potential benefits of VCT in the prevention of mother to child transmission of the virus. This implies that the knowledge of women refugees is not complete and inclusive for that reason awareness creation education is essential.

Here the FGD participants talked comprehensively about the factor that obstruct women refugees from taking VCT service and many ideas were forwarded and discussed with the other group members. Almost comparable ideas were reflected from different groups. Based on this, some of the major factors that were reflected by the participation condensed as follows:

- ❖ Absence of antiretroviral medicine for the refugee community,
- ❖ Lack of organization that support HIV positive people in the refugee camp,
- ❖ Culture of the community is not encouraging to take the service,
- ❖ Low participation of husbands to be tested,
- ❖ Fear of stigma and discrimination,
- ❖ Lack of sufficient awareness creation education for the refugee community,
- ❖ Negative attitude of the community for HIV positive people.

For instance, in Nuer ethnic group if a woman is HIV positive she is considered as already dead. This and related cultural and sociological factors can impose great challenge on women refugees participation to take VCT service. One FGD participant from Anuak ethnic group reflected her idea about the factors that limit women from taking VCT as follow:

“ In my opinion the main reasons that hold back our community from taking VCT service are our culture, negative attitude of the society for HIV positive people, and in my case I fear death through AIDS, I want to live for my children”.

This and other similar reflection imply that factors that affect women’s participation in VCT services are multidirectional. That means the factor might originate from the individual him/her self, from the environment or from their family. The other participant from the other group described her idea; focus on their marriage style as follow:

“My husband has other two wives. If I want to take VCT first I have to get consent from him. Otherwise if I tested alone and my test result is positive he will reject me. On the other hand, he is not charitable to be tested with me.”

These ideas indicate that even if women understand the potential benefits of VCT and want to be tested they face great dispute from their partner. It is clear that both religious leaders and elderly people might have positive or negative impact on the day to day activity of the society. Most of the FGD participants agreed that religious leaders have positive attitude towards women’s participation in VCT service. Moreover, they reflected that on Sundays, after liturgy there is education related to HIV /AIDS that provided by the religious leaders. This and similar reflections of the

participant can implies that the positive attitude of the spiritual leaders towards participation of women in VCT service.

On the other hand, most participants consented that elderly people have no positive attitude about women participation in VCT service. When they reason out, elderly people said that “*there is no HIV/AIDS at all*” and when people sick by AIDS they gave traditional medicine that were prepared from local materials. However, there were also few participants who said elderly people have positive attitude towards women’s participation in VCT service.

Concerning the attitude of the refugee community towards VCT, different ideas were reflected by different groups and individuals. According to the participants, some people have positive attitude and most of the refugees community have negative attitude about VCT. Some of the reasons that were forwarded by FGD participants were absence of medicine, fear of stigma and discrimination, people’s belief like “*no HIV at all*” etc. Among the FGD participants one of them said that,

“It is observable that our society hasn’t good attitude towards HIV/aids. However, it is possible to change by providing awareness creation education for women and their husbands, working with different NGOs, providing care and support services for HIV positive people etc.”

Finally different individuals from different groups forwarded most important solutions to improve the participation of women refugees to take VCT service. Some of these were:

- ❖ Appropriate facilities like medicine, care and service are essential,
- ❖ Alleviate men superiority on women and maximize male participation in the VCT service utilization by providing awareness creation education for both sexes,
- ❖ Mass mobilization and community conversation are essential,
- ❖ Provision of service like PMTCT and ART for the refugee community,
- ❖ Avoidance of stigma and discrimination on the HIV positive people,
- ❖ Increase the number of mobile VCT center in the camp.

CHAPTER FIVE

Discussion

This chapter discusses the main findings pertaining to knowledge attitude and the major barriers in undertaking VCT services among Sudanese women refugees in Pugnido Refugee Camp.

5.1 Socio-Demographic Characteristics of the Respondents

All the study participants except the supervisor and the counselor of the VCT center were women refugees. With regard to age, (73%) of the participants were from 21-35 years of age. This implies that most of the study participants were in the reproductive age group.

The educational status of the study participants shows that 39% of them were illiterate and 26.8% were from grades 1-4. Thus, the majority of women refugees could face problem to get the necessary information from different publication about the benefits of VCT and how to protect themselves and their families from HIV/AIDS. In addition, this may hinder them from getting information from different media and publications.

Due to different factors, (being widow, single and divorced) more than half of the study participants were not living with their husbands. Their marital statuses suggest that most women refugees may be exposed to different sexual violence that could lead to HIV infection.

5.2 Knowledge of the Study Participants about VCT

The study generally shows that knowledge of the respondents about the way HIV transmitted is relatively good. The current study revealed that 78.75 % of the respondents identified sexual intercourse as the main rout

of contracting HIV and 50% mentioned that HIV can be transmitted from mother to child, and 46.75% stated that blood contact. Generally, the result implies that women refugees had relatively better knowledge about the way HIV is transmitted.

Women refugees had relatively low level awareness about way of checking one's HIV status. A Significant number of the respondents still believes that being sick for a long time, looking symptoms and one's physical appearance as correct means of checking one's HIV status. In addition, the finding revealed that a significant number (28.25%) of respondents did not know about the availability of the center in their camp.

The qualitative data obtained from the focus group discussion and interview held with the study samples show that the study participants' knowledge about VCT was not sufficient. The majority of the participants did not have any idea about the potential benefits of VCT in the prevention of mother to child transmission of the virus. Similarly, both the supervisor and the counselor reflected that women refugees, especially those who came from rural areas did not have the necessary awareness about VCT. This problem may be linked to the refugees' low level of education and low level of awareness about the epidemic.

A study conducted in Kigali, Rwanda that investigated factors related to uptake and acceptability of VCT for HIV among pregnant women found that women who were educated and who had well paid jobs were about four times more likely to accept HIV testing, than uneducated and unemployed (Kowalczyk, et al cited in Marria 2006).

Concerning open discussion about VCT and issues related to HIV, almost half of the study participants (47%) didn't have any kind of discussion with friends, family or other people in any occasion. From this, it is clear

that there is a serious problem associated with discussing VCT among the participants. This is therefore, one factor that limits women refugees' utilization of VCT services. In addition, the result indicates that the majority of the participants did not have access to information sources such as TV, refugee publications and newspaper/magazines mainly because of lack of accessibility and their educational background.

Even though most refugee women had relatively good knowledge about the way how HIV is transmitted, a significant number of respondents had no clear information about ways of checking one's HIV status, the availability of VCT service in their camp, and the potential benefits of utilization of VCT. This can be due to different factors primarily low level of awareness about the potential benefits of VCT.

5.3 Attitude of Women Refugees towards VCT

The present study found that only half of the study participants agreed that VCT helps to get care and support services, plan one's own future and prevention and control of HIV transmission. However, a study in Bahir Dare University revealed that almost all the study participants agreed that VCT is helpful to acquire care and support services, plan one's own future and prevention and control of HIV transmission. This result implies that most of women refugees' attitude towards the potential benefits VCT is negative. Similarly, interviews with, the counselor and the supervisor suggested that the attitude and practice of women refugees are generally unfavorable characterized by lack of awareness about the potential benefits of taking VCT services.

In this study more than half of the women (54.3%) replied that knowledge of one's HIV status makes one's to worry and be under stress. This result implies that a significant number of women refugees have fears about a

positive result and problems associated with positive test result. According to UNAIDS (2000) report in high HIV prevalence countries of sub-Saharan Africa, many people are aware of VCT services that are available at different sites such as hospitals and free-standing VCT centers. However, small proportions of people know about their HIV status because of worry and stress. Similarly, only 35.8% of the study participants agreed that getting tested for HIV helps people feel better. This suggests that fear of a positive result and associated outcomes develop negative attitude towards VCT service among the majority of the study participants.

The main reason for the negative attitude of women refugees could be linked to fear of a positive test result and stigma and discrimination in the community. The current study revealed that 67.3% of women refugees agreed that they prefer not to know their HIV status because of fear of stigma and discrimination if the test result is positive. Stigma and discrimination in the refugee camp situation could come from the local community, refugee community as well as family members. Stigma and discrimination from their husbands can also be one of the serious problems since polygamy is a common form of marriage.

When the study participants were asked about the attitude of the community towards HIV positive people, 70.3% of the women refugees thought that the refugees' community had no positive attitude towards HIV positive people. This implies that women refugees can be greatly influenced by the negative attitude of the community to take VCT service. More than half of the respondents (64.8%) also replied that if their result is positive no body would give care and support to them.

In the refugee camps, there may be high scarcity of health services such as awareness creation education about the potential benefits of VCT,

condom (for both sexes), ART, and PMCT program (Spiegel 2004). Similarly, in the Pugnido Refugee Camp both the counselor and supervisor confirmed the absence of antiretroviral treatment and PMTCT services. In the present study almost half of the women refugees (49.8%) replied that if antiretroviral treatment were available in the camp, they could have been ready for the test.

Close to 60.3% of women refugees responded that the availability of care and support service encourages people to undergo VCT. With regard to VCT service in the camp, only 32.3% of them felt that the service was satisfactory. The provision of health services would have a significant effect in prolonging life and this would have an impact on the community in creating positive attitude and therefore use of VCT service. For instance, if ART is available and awareness creation education is provided in the camp, the VCT acceptance of the refugees' community may increase.

Concerning women refugees' readiness to undertake VCT service, 66.3% of the women refugees agreed that they didn't want to know their HIV status. Some of the reasons that were given by the FGD participants were fear of stigma and discrimination, lack of organization that supports HIV positive people, unwillingness of husbands and friends to be tested, fear of worry and stress if tested positive.

Similarly, only 35.8% of the respondents agreed that elderly refugees encourage women to undertake VCT service and 61.3% of the study participants believed that positive test result may affect their relation with religious leaders respectively.

Generally, the attitude of women refugees and their readiness to undergo VCT was found to be influenced by lack of awareness about its potential

benefits, negative attitude of the society towards HIV positive people, fear of stigma and discrimination from the refugees' community if tested positive, and lack of care and support like ART and PMTCT services.

5.4 Perceived Barriers to Undertake Voluntary HIV

Counseling and Testing

Although VCT plays a great role in both prevention and for people with infection as an entry point for care and treatment, many people including women refugees still show great reluctance to be tested (Maria, 2006). In this study, it was found that among the participants; only 14.5% had prior-HIV testing. This shows that the majority of women refugees were reluctant to undertake voluntary HIV counseling and testing. Similarly, research conducted on accessibility of VCT for pregnant women in Namibia revealed that women show reluctance to utilize the VCT service because of different factors such as fear of stigma and discrimination, lack of accessibility, lack of privacy, lack of awareness and lack of confidentiality (Maria, 2006). Similarly, the present study indicated that among the 30 items hypothesized to explain women refugees' unwillingness to access voluntary HIV counseling and testing 12 of them were found to be significant problems.

❖ Stigma and discrimination associated problems

Fear of stigma and discrimination can be one of the reasons for women refugees' failure to use VCT service. Eighty two point eight percent of the respondents stated that fear of stigma and discrimination by refugees' if tested positive was found the most important reason for the failure to use VCT service. According to a study conducted by UNHCR (1995), about

HIV/AIDS in Kakuma Refugee Camp in Kenya among 86,000 inhabitants, only one Uganda man openly declared his HIV status.

Similarly, most of the study participants in the FGD reflected that stigma and discrimination is one important factor that affects them from accessing VCT services. In addition, the supervisor and the counselor mentioned stigma and discrimination as the most important factor that hinder women's refugees from undertaking VCT services. A study carried out in Namibia has shown similar result: most pregnant women desire testing in order to protect their babies, but they often fear stigma and discrimination if they were tested positive (Maria, 2006). Fear of stigma is known to discourage individuals from being tested for HIV and from disclosing their HIV status to sexual partners, families and friends.

In the current study, 40.8% and 30.3% of the participants responded that fear of rejection from their partners including their husbands while undergoing for VCT hinder them from undertaking VCT. In addition, the FGD participants also stated that fear of rejection from their partner is one of the main reasons that hinder them from undertaking. One of the FGD participants reflected her experience as follows:

“My husband has two wives. If I want to take VCT first I have to get his willingness. Otherwise, if I undertake the test and my test result is positive, he will reject me. On the other hand, he does not volunteer to be tested with me”.

This response and other similar reflections of the FGD participants imply that even if women refugees were concerned to be tested, they faced great challenge from their partners. In addition to the negative attitude of the community towards people living with HIV/AIDS, rejection of family members was stated as an influential factor to undergo VCT. In this study, unwillingness of family to accept positive result was found

significant factor or reason for the refugees' women not to undertake VCT. During the FGD women refugees described similar reason to take the service especially for adolescents and young people who may not have their own source of income and other related necessities.

On the other hand, more than half of the study participants responded that fear of discrimination from the local people and fear of loss of day to day support from the camp authority if tested positive were not important or less important factors.

In conclusion, fear of stigma and discrimination from refugees' community and local population and fear of rejection from their families especially from their partners were found to be factors that hindered women refugees from knowing their HIV status.

❖ **Social and Cultural Related Factors**

The attitude and practice of a given phenomenon in a particular group may be influenced by beliefs, values and culture of the community. The negative attitude of refugees' community towards HIV positive people might have great impact for the reluctance of women refugees to take the service. To this factor 61.58% of the respondents said that refugees show negative attitude towards HIV positive people. Similarly, interviewees reflected that in Nuer ethnic group if a woman is HIV positive she is considered as already dead. This and related cultural and sociological factors can impose great pressure on women refugees' to undertake VCT services.

For instance, one FGD participant from Anuak ethnic group reflected her thought about the factors that limit women from taking VCT as follows:

“In my opinion, the main reasons that hinder our community from taking VCT services is our culture-negative attitude of the society for HIV positive people, and fear of death due to AIDS”.

These results imply that women refugees' participation to take the service can be affected by the culture and attitude of the society towards HIV positive people. Also, most FGD participants shared their view that elderly people do not support women's participation in VCT service. When they reason out, elderly people said that "*there is no HIV/AIDS at all*" and when people are sick by AIDS, they give traditional medicine. However, there were also few participants who said elderly people have positive attitude towards women's participation in VCT service.

The interviewees stated that the community has negative outlook about HIV positive people. If a woman is HIV positive, she is considered as already dead. Generally, the above ideas mentioned by the counselor and by the supervisor states the seriousness of stigma and discrimination in the refugee life situation. This is one of the factors that prohibit women refugees from using VCT service.

Similarly, a study by Maria (2006) indicated that 87% of the participants said that the attitude of community was negative due to fear of contracting the virus from positive people. The study has also shown that people were isolated, rejected and discriminated, they were gossiped, laughed at, and accused people of living with HIV as were looking for the disease. The study also revealed that some people, as they see them speak badly about them. Some HIV positive people were even physically abused and beaten as a result that some are in such despair that they committed suicide.

Both the FGD and the interview results have made known that the absence of open discussion within the community towards VCT and HIV/AIDS might have significant contribution for the reluctance of women refugees to take VCT service. On the other hand, factors such as "VCT is out of my religion doctrine" and "taking VCT may affect relation with religious leaders if tested positive" were responded by most of the women

refugees as not important and less important for their lack of interest to take the VCT services.

❖ **Service Related Factors**

In the refugee camps there may be high scarcity of health service such as ART, PMTCT and VCT services. According to a joint report of UNAIDS, UNFPA, and UNIFEM (2004), VCT is available to only 12 percent of people who want to be tested. In a survey of refugees' settings world wide, UNHCR (2005) found that voluntary counseling and testing is not available in most programs. On a similar publication PMTCT do not seem to be universally applied, despite evidence suggests that it can be higher during complex humanitarian emergencies.

However, in Pugnido refugee camp two clinics were found at the center of the camp. In addition mobile VCT centers provided service for the refugees' community. Concerning whether distance from home-to-VCT center is a factor or not only 27.3 % respondents replied as important factor for their reluctant to undertake the services. This result indicates that distance from VCT center was not as such a serious problem for the majority of the study participants. Similarly, almost the same result was observed for the factors inconvenient hours of VCT service and whether physical environment wasn't convenient to take the service.

The response of the supervisor and the counselor on the general status of VCT service in the camp revealed that two VCT centers were established almost one year and six months before by the help of Gambella Region, Health Bureau, with the collaboration of different NGOs. Currently, three counselors are providing counseling services in the centers. The service centers have provided service for both the refugees' community and local

people integrated with different organizations such as ZOA, UNHCR, and ARRA.

The response of the interviewees about the availability of the necessary facilities and equipment that help to provide complete VCT services in the camp indicated that the VCT center had all the equipment, facilities and human power to render complete and appropriate VCT service in the camp. However, both the supervisor and the counselor described that there were no antiretroviral treatment and PMTCT services in the camp.

Lack of care and support services for people who test positive is a decisive factor determining women refugees' reluctance to undergo VCT services. In the present study 69% percent of the respondents considered this factor as important barrier. Similarly, during the FGD with women refugees, this factor was one of the common responses. Lack of care and supports service for HIV positive people, absence of organization that support these people and absence of services like ART, PMTCT were said to be decisive factors that made them become reluctant to undergo VCT services. These results imply that lack of these services can affect women refugees from accessing the VCT services.

In principle, it is recommended that when private, government and non-governmental organizations establish VCT services, they have to try to integrate care and support services. In line with this finding in a study by Vann Dyk and Van Dyk (2003), 86% of the participants reported that knowing one's HIV status or going for VCT is not advisable for someone if there are no treatment options available. The respondents felt that to know one's HIV positive status with out any possibility of follow up, care and support services would only cause depression, despair and death. Similarly, a study conducted by Mengesha (2006), identified lack of

different care and support services including ART as a negative predictor of VCT acceptance.

❖ **Confidentiality and Privacy Related Factors**

Lack of privacy and confidentiality prohibits people from knowing their HIV status and related personal information as they fear stigma and discrimination. Confidentiality is one of the issues that concern people when they think of knowing their HIV sero-status. In the current study participants (36.3 and 28.3%) indicated that lack of privacy and confidentiality were important factors for not taking VCT service.

Similar to this finding, other researches have indicated that clients in principle are not against VCT, but they have a serious doubts and anxieties about the confidentiality and privacy of their HIV test result. Fear of lack of confidentiality and privacy are therefore important barriers that hinder many individuals from participating in VCT programs (Vann Dyk and Van Dyk, 2003).

A qualitative study investigating VCT uptake by pregnant women using focus group discussion in South West Uganda revealed that pregnant women were anxious about taking up VCT due to fear of confidentiality and fear that medical staff might refuse to treat (follow up) them during delivery, if their positive status were known (Pool et al., 2001).

❖ **Fear of Positive Result and its Associated Outcomes**

One of the reasons for women refugees' failure to undergo VCT services was fear of worry and stress. The majority of the respondents replied that fear of worry and stress if tested positive made them fail to undergo VCT service. Of course, stress and feeling of worry are common experiences of many clients who attend VCT programs. This experience is clearly

observed before and after an individual undergone the services. This is particularly intensified if the person's HIV status is positive.

For instance, a study by Macintyre (2003) confirmed that feeling of mental distress and depressions were reported by clients who believed that there is nothing they do about being infected with HIV. A woman during FGD reflected her feeling for the question "why don't you take VCT?" as:

"My current situation in the Refugees' Camp is full of stress and tension, I displaced from my home, my family is broken, my husband killed by the ACPLA armed forces, our property was looted by worriers, it is impossible to be quite sure what happened tomorrow. I don't want to add another stress in my life".

Together with unstable life and lack of confidentiality in their current situation, many refugees may develop such feeling and this can be one of the obstacles for refugees' unwillingness to take VCT service. In the present study, 40.3 and 21.3 percents of the respondents rated this barrier as "very important" and "important" respectively. Stigmatizing attitudes towards people with AIDS and absence of cure for the epidemic may help them develop a feeling of hopelessness. So the feeling "if I tested positive, I will not have hope for the future" develops and gradually influence the refugees' life.

On the other hand, a significant number of people feel as if they were HIV negative because they thought that they were not exposed to risk factors for HIV infection. In this study, a significant number of respondents (61.1%) revealed that they were not exposed to risk factors for HIV infection. According to Alexandra (2006), women who tested that they would refuse to test said they either didn't perceive themselves to be at risk for HIV or required their husband's permission to undergo the test.

Other personal related barriers such as being displaced from home and country ;not wanting to be tested in current situation ,being not pregnant ,using condom and husband/ friend being HIV negative responded by majority of the respondent less important factors to be reluctant to take VCT service by most of the respondents.

Other barrier stressed by many participants during the FGD and during interview includes:

- ❖ fear of rejection by their partners, as they follow polygamy marriage style,
- ❖ lack of awareness about the potential benefits of VCT,
- ❖ lack of organization that supports HIV positive people in the refugee camp,
- ❖ low participation of husbands to be tested,
- ❖ cultural factors, for instance in Agnuak culture, if a husband tested and his result is positive he obliged to pay compensation for his wife and her families,

In response to a case that might be reported on rape and sexual violence problem, the supervisor confirmed that currently there were two rape cases which were reported officially and now the cases are being processed through the court. He also stated that rape is common especially in Nuer ethnic group. Such violence is practiced due to their culture influence. In Nuer community the male should give 40 cattle to get married. Those who are economically poor and couldn't marry commit different gender violence including rape.

Chapter Six

Summary, Conclusion and Recommendation

6.1 Summary

The primary objective of the study was to assess the major obstacles (barriers) of women refugees in using VCT services. This study is therefore initiated to explore potential barriers towards poor utilization of VCT services. As a subsidiary objectives knowledge and attitude of the study sample towards VCT were explored. The target population for the study was women refugees in Pugndo refugee camp which comprised of those from the three ethnic groups whose age ranges from 16 to 49 years. From a total of about 4,000 women refugees, 400 samples were selected randomly and included in the study.

A structured questionnaire comprises of knowledge, attitude and perceived barriers items related to VCT was administered. To complement the quantitative data, semi structured interview with supervisor and counselor and focus group discussion was held with 15 sample participants assigned into 3 groups. After collecting the data, they were tabulated, analyzed and interpreted. Both descriptive and inferential statistics were used to analyze the data. The information gathered through focus group discussions and interviews were analyzed qualitatively.

The major findings of the study are:

- 13.75% of the study participants said that getting sick for a long period of time is one means of knowing one's HIV status,
- 65% of the study participants stated that HIV testing is the only way to check one's HIV status,

- 47% of them said they didn't discuss about VCT before with family, friends etc. and only 14.5% had prier HIV testing experience.
- Slightly more than half of women refugees have no positive attitude towards VCT,
- 67.3% of the study participants do not prefer to under go VCT.
- 70.3% of them thought that the refugee community had no Positive attitude towards HIV positive people and 64.8% of the Participants stated that if their result is positive they feel that no body would provide them with care and support services.
- The major barriers to access VCT service among Sudanese women refugees were:
 - ❖ Fear of stigma and discrimination from the refugee community,
 - ❖ unwillingness of partners to be tested together,
 - ❖ fear of rejection from partner and family members,
 - ❖ absence of open discussion about HIV/AIDS and VCT among the refugee community,
 - ❖ lack of care and support services for HIV positive people,
 - ❖ fear of worry and stress if the result is positive,
 - ❖ unwillingness of family members to accept positive result,
 - ❖ absence of antiretroviral medicine and PMTCT program in the camp,
 - ❖ absence of organization that support HIV positive people,
 - ❖ negative attitude of the community towards HIV positive peoples,
 - ❖ feeling HIV negative because they were not exposed to HIV infection
 - ❖ lack of interest to think about HIV and being HIV positive, and
 - ❖ cultural barriers and limited male involvement in VCT service.

6.2 Conclusion

Based on the findings of the study, the following conclusions are drawn.

- ❖ Even though 71.75% reported that they were aware of the availability of VCT service in their camp only 14.5% had prior HIV testing experience.
- ❖ Slightly more than half of women refugees had no positive attitude towards VCT.
- ❖ Because of lack of adequate knowledge and negative attitude towards VCT, many refugees were unable to know their HIV status and gain potential benefits that obtained from taking VCT service.
- ❖ Fear of stigma and discrimination, unwillingness of partners to be tested together, fear of rejection, absence of open discussion about HIV/AIDS and VCT, lack of care and support services, fear of worry and stress if test result is positive, absence of antiretroviral medicine and PMTCT program were some of the major factors that hinder women refugees utilization of VCT services.

6.3 Recommendations

1. NGOs should provide culture based awareness creation education for both sexes about the overall condition of HIV/AIDS and the potential benefits of VCT service utilization.
2. Concerned organizations should cooperate and collaborate to provide care and support services, antiretroviral medicine and PMTCT program to safeguard the lives of the refugees and to increase VCT services utilization.
3. VCT post-test clubs should be established to minimize the negative attitude of the community towards HIV positive people and to alleviate the level of stigma and discrimination.

4. Mobile VCT centers should be established to avoid some structural barriers like distance and inconvenient working hours.
5. Counseling interventions need to be intensified to reduce stigma and discrimination to strengthen the HIV positive people confidence. As a result of this, they can resist the challenges that are prevailing in the refugee community.
6. Participatory education and open discussion like coffee ceremony, peer education that incorporate both sexes should be encouraged.
7. Concerned organizations should design and implement different mechanisms to protect women refugees from sexual violence that could be a means of HIV infection.
8. Different information and communication sources like radio, television, refugees' publications leaflets etc. should be accessible in the camp to increase the awareness level of the refugee community about HIV/AIDS and the importance of VCT utilization.

REFERENCES

- AFPP (2006) *Let's Talk about HIV Counseling and Testing*. Alliance Frontiers Prevention Project. Available at: www.adisalliance.org.
- Alexandera R. (2006). HIV Related Knowledge, Attitudes, Perceived Benefits and Risk of HIV Testing among Pregnant Women in Rural Southern India. AIDS Patient Care and STDS volume 20, November 11, 2006. Wake Forest University, Mary Ann Liebert, Inc.
- Andargachew Moges (2006) *Perceived Barriers to Undergo Voluntary HIV Counseling and Testing Among Bahirdar University Students*. Unpublished MA thesis in Addis Ababa University.
- Aria C. (1998) *A Case Study on African Refugees in Ethiopia With Particular Emphasis on Dimma Refugees' Camp*. Unpublished BA Thesis Addis Ababa University.
- Bethany Y. (2003). *Planning STI/HIV Prevention among Refugees and Mobile Populations: Situation Assessment of Sudanese Refugees*. Blackwell Publishing, 9600 Garsington Road, Oxford UK and 350 main streets, Malden, MA 02148, USA.
- Collymore Y.(2001)*Uprooted People and HIV/AIDS in Africa*. Responding to the risk. Available at, <http://www.pepfar.gov/>.
- Getachew Kebede (2004) *Factors Associated with VCT Utilization in Guraghe Zone SNNPR, Ethiopia*. Unpublished MPH thesis in Master of Public Health. Addis Ababa University.
- Goosen C.(1996) *The South African Women Health book*. Cape Town: Oxford University press.
- Horizons R. (2001) *HIV Voluntary Counseling and Testing among Youth*. Results from an Exploratory study in Nairobi, Kenya and Kampala and Masaka,Uganda New.

- International Rescue Committee (2003) *Protecting the Future, HIV Prevention, Care and Support among Displaced and War Affected Populations*. United States of America.
- Iliyasu, Z.; Kabir, M.; Galadanci, H.S; Abubakar, I.S and Alyu, M.H .(2005).The Clinical Challenge of the HIV Epidemic in the Developing World. *Medical Journal* 1. Jan- march: 14(1):27-32.
- Kelly M.(2000)*Challenging The Challenger: Understanding and Expanding The Response of Universities in Africa to HIV/AIDS*. Washington :ADEA Working Group on Higher Education.
- Khan M. (2000) *Operational Research Project on HIV/AIDS*. Health and Population Extension Division Center for Health and Population Research Working paper P: 131
- Kowalkzyk J.; Jolly P; Karita, Enibarere, JA. and Solihe H. (2002). Acquired Immune Deficiency Syndrome. *African Medical Journal*. Dec: 31 (4):408-15
- Maria R.(2006).*Factors Affecting Voluntary Counseling and HIV Testing Among Pregnant Women in Tsumeb District, Oshikoto Region, Namibia*. Published MA Thesis in public health, University of the Western Cape.
- Mengesha Admasu, Yohannis Fitaw (2006) Factors Affecting Acceptance of CT among Different Professional and Community Group in North and South Gondar Administrative Zones, North West Gondar Ethiopia. *Ethiop.Journal Health* Dec. 2006:20(1).
- Ministry of Health (2002) *National Guidelines for Voluntary HIV Counseling and Testing in Ethiopia*. MOH Disease Prevention and Control Development. Addis Ababa .
- Micheal D.(2001)*Study on Factors Affecting Accessibility of Voluntary Counseling and Testing Service for HIV/AIDS in Bahir Dar Town, North Western Ethiopia*. Family Guidance association of Ethiopia (FGAE) North Western Branch.

- Micheal D.(2001)*Study on Factors Affecting Accessibility of Voluntary Counseling and Testing Service for HIV /AIDS in Bahir Dar Town, North Western Ethiopia.* Family Guidance association of Ethiopia (FGAE) North Western Branch.
- Ministry of Health and Social Science (2004) *Guidelines for the Prevention of Mother to Child Transmission of HIV.* 1st edition Windhoek: Namibia.
- Otsuki J.(2007) Refugee Women, Girls in Sub-Saharan Africa Among Hardest Hit by HIV/AIDS Crises: working to empower. Available at <http://www.workingtoempower.org/>
- Peltzer et al.(2004) Attitudes towards HIV-Antibody Testing and People with AIDS among University Students in India, South Africa and United States. *Indian Journal of medical sciences.*J. 58, 3, 95-108.
- Pood R. (2001) AIDS Care: Care and Support for People with HIV/AIDS in Resource Poor Settings. *East African Medical Journal.* Oct; 13(5)605-15
- Spiegel P.(2004) *HIV/AIDS among conflict –affected and displaced population: Dispelling Myths and Taking action:* United Nations Higher Commissioner of Refugees (UNHCR), over seas development institute. Geneva Switzerland.
- UNAIDS(2001) *The Impact of Voluntary Counseling and Testing: A global Review on the Benefits and Challenges.* Available at, <http://www.unaids.org>.
- UNAIDS,UNFPA and UNIFEM (2004) *Women and HIV AIDS: Confronting the Crisis.* Geneva Switzerland Available at www.unaids.org, www.unfpa.org, www.unifem.org.
- UNAIDS (1997) *Refugees and AIDS /UNAIDS Best Practical Collection Point of View:* The University of Zambia School of medicine. Available at, <http://www.unhcr.org>.

- UNAIDS (2000) *Gender and HIV/AIDS: Taking Stock of Research and Programmes*. Best Practical collection. Available at: www.unaids.org.
- UNAIDS (2000) *Voluntary Counseling and Testing: UNAIDS best Practical Collection*. Geneva Switzerland, Available at <http://www.unaids.org/>.
- UNAIDS (2001) *The Impact of Voluntary Counseling and Testing: A Global Review on the benefits and challenges*. Available at, <http://www.unaids.org>.
- UNAIDS (2005) *Strategies to support the HIV related needs of Refugees and host populations*. Available at <http://www.unaids.org>.
- UNAIDS.UNFPA and UNIFEM (2004) *Women and HIV AIDS: Confronting the Crisis*. Geneva Switzerland Available at: www.unaids.org, www.unfpa.org, www.unifem.org
- UNAIDS (1997) *Refugees and AIDS /UNAIDS Best Practical Collection Point of Review: The University of Zambia School of medicine.Lusaka Zambia*.
- UNHCR (1995) *Sexual Violence against Refugees: Guidelines on Prevention and response: Switzerland Geneva*. Available at www.unhcr.org
- UNHCR (2003) *Refugee Protection in International Law*. UNHCR's Global Consultations on International Protection. Cambridge University Press.
- UNHCR (2005) *United Nation Higher Commission for Refugees (UNHCR) Strategic Plan on HIV and AIDS 2005- 2007, 16 February 2005*. UNHCR, Geneva Switzerland.
- UNHCR (2005) *United Nation Higher Commission for Refugees (UNHCR) Strategic plan on HIV and AIDS 2002- 2004, 16 January 2005*. UNHCR, Geneva Switzerland.
- UNHCR (2000) *The State of the World's Refugees 2000*. Fifty years of Humanitarian Action. Oxford University Press Great Clarendon Street, Oxford OX2.

U.S Committee for Refugees (2001) *World Refugee Survey*, Immigration and Refugee Services of America. Washington DC.

Van Dyk, Altac, and Van dyk, Peet J. (2003) Psychosocial Barriers to HIV/AIDS Voluntary Counseling and Testing Programmes in South Africa. *South Africa journal of Psychology* January 33, 2,118-125

WHO (2004) *Investing in a Comprehensive Health Sector Response to HIV/AIDS Scaling up Treatment HIV/AIDS scaling up treatment and accelerating Prevention*. Geneva Switzerland.

Women's Commission for Refugees (2006) *Displaced Women and Girls at Risk: Risk factors, protection solutions and Resource Tolls*. Women's Commission for Refugee Women and Children. New York. Available at www.womenscommission.org

World Bank (2004) *Crafting institutional responses to HIV/AIDS: Guidelines and Responses for different institutions in sub-Saharan Africa*. Washington DC African Region Human Development

Appendix A
Addis Ababa University
College of Education Department of Psychology

Dear Refugees,

This questionnaire is to be completed by Sudanese women refugees, supervisors, and counselors in Pugnido refugee camp. The purpose of this questionnaire is to collect data on problems of women refugees to undertake voluntary HIV counseling and testing. The information obtained from the questionnaire is believed to have a valuable contribution in the prevention and control of HIV transmission among the refugee community. So you are kindly requested to provide your genuine responses to the questionnaire.

Note that

- * Your response will be kept confidential
- * There is no need to write your name

Thank you in advance for your cooperation!!

Part I Socio-Demographic Characteristic of the study participants

Complete the following information by using a "X" mark

1. Age

- 16-20 21-25 26-30
31-35 36-40 41 or above

2. Marital Status

- Married, lives with husband
Married, does not live with husband
Divorced
Single, never married

3. Educational level

- No education Grades 1-4
Grades 5-8 Grades 9-10
Grades 11-12 other, please specify.....

4. Ethnic group

- Nuer Agnuwake Dinkas
Other, please specify.....

5. Duration in the camp

- Less than one year
1-2 Years
3-4 Years
More than four years

6. Religion _____

Part II

The following items are presented to assess women refugees' awareness about voluntary HIV counseling and testing. Read each item carefully and provide your own response to each question.

1. How does a person get infected by the HIV virus?
 - a. by sexual intercourse
 - b. from infected mother to child
 - c. through blood contact
 - d. Other, please specify.....
2. How do you think one checks whether or not he /she is infected with HIV?
 - a. Undergoing HIV testing
 - b. If he/she gets sick for a long time
 - c. By looking his/her physical appearance
 - d. When he/she observes some symptoms
 - e. Other, please specify.....
3. Do you know the availability of VCT service in the refugee camp?
 - A. Yes
 - B. No
4. Among the following institutions which one do you think provide(s) VCT services? Indicate your response by encircling "Yes" or "No". You can give more than one response.

a. Free standing VCT centers,	Yes	No
b. Private hospitals and clinics outside the refugee camp	Yes	No
c. Private and government hospitals and clinics in your own country	Yes	No
d. In the refugee camp clinics	Yes	No
e. I don't know where VCT services are provide	Yes	No

5. Do you make discussion with friends, family members or any other person about VCT? A. Yes B. No

6. Which source(s) of information do you use to gain knowledge about VCT? Show your response by encircling "Yes" or "No". You can give more than one response.

- | | | |
|---|-----|----|
| a. Radio | Yes | No |
| b. Television | Yes | No |
| c. News paper/magazines | Yes | No |
| d. Refugees' publication | Yes | No |
| e. Friends | Yes | No |
| f. Health institutions in the refugee camps | Yes | No |
| g. Family | Yes | No |
| h. Other, please specify | | |
| i. I don't have any source of information about VCT | Yes | No |

7. Have you had HIV test before?

A. Yes

B. No

Part III

Below there are 22 statements that reflect women refugees' attitudes towards VCT. For each item the following five alternatives are provided, choose only one and put "X" in front of each item.

- Strongly agree - Agree -Undecided - Don't agree
- Strongly disagree

	Attitude Items	Strongly Agree	Agree	Undecided	Dis-agree	Strongly disagree
1	I think VCT helps refugees to get care and support services for those whose test is positive.					
2	I think Knowing one's HIV status helps to plan one's future life.					
3	I think VCT plays a significant role in the prevention and control of HIV transmission.					
4	I fear discrimination and stigma, so I will not take HIV test.					
5	If my HIV status becomes positive, I don't want to disclose to anyone.					
6	If antiretroviral treatment is available in the camp, I will be tested.					
7	I think VCT plays a significant role in the prevention and control of HIV transmission from mother to child.					
8	I prefer not to know my HIV status since HIV has no medicine.					
9	I prefer not to know my HIV status because of fear of stigma on my family members.					
10	I think if I am positive for HIV no body gives me care and support service.					

11	Knowledge of one's HIV status makes one to worry and be under stress.					
12	I feel that the refugee community has positive attitude towards HIV positive people.					
13	I think elderly refugees encourage when women go to VCT center.					
14	Taking VCT service is important whether the result is negative or positive.					
15	I feel there is well facilitated VCT service in our camp.					
16	I think positive test result may affect relation with religious leaders.					
17	Getting tested for HIV helps people feel better.					
18	I feel the availability of care and support service encourages people to be tested.					
19	I think VCT is essential for every body.					
20	I feel if my test result is positive, I will lose my partner.					

Part IV

Below perceived barriers that women refugees feel important for not accessing VCT services are presented. Read each item carefully and rate whether they are very important, important, undecided, less important and not important. Show your response by putting "X" on the space provided after each item that corresponds to the given alternatives.

- **Very important - Important - Undecided - Less important**
- **Not important**

	Barriers	Very important	Important	Undecided	Less important	Not important
1	I think I am HIV negative because I was not exposed to risk factors for HIV infection.					
2	Fear of loss of day to day support from the camp authority if tested positive.					
3	Fear of stigma and discrimination by refugees' community if tested positive.					
4	I don't want to be tested because I have no detail information about the importance of VCT.					
5	I don't want to be tested because there is no organization that supports HIV positive people.					
6	I don't want to be tested in my current situation because I displaced from my home and my country,					
7	I couldn't be tested because of cultural factors.					
8	I don't want to be tested because I doubt the confidentiality of VCT service in the refugee camp.					
9	I don't want to be tested unless my husband/friend is tested with me.					

10	I don't want to be tested because there is no antiretroviral medicine in the refugee camp for HIV positive people.				
11	Fear of worry and stress if tested positive.				
12	I don't want to be tested because I fear discrimination from local people.				
13	Fear of getting hopeless if tested positive.				
14	I don't want to be tested because I am not pregnant.				
15	Since there is no care and support services for people tested positive.				
16	I couldn't to be tested because of inconvenient hours of VCT services.				
17	I don't want to think about HIV/AIDS or being HIV positive.				
18	I don't want to be tested because my family members are not willing to accept a positive result.				
19	I don't want to be tested because the society has negative attitudes towards HIV positive people.				
20	I don't want to be tested since the counselors are younger than me.				
21	Absence of open discussion about the importance of VCT in the refugee camp.				
22	Fear of rejection by partner if tested positive				
23	I don't want to be tested because the social environment around the center isn't convenient to take the service.				
24	I don't want to be tested because the physical environment isn't convenient to take the service.				
25	There is no privacy during VCT service.				
26	VCT center is far from my residence.				
27	I don't want to be tested since VCT is out of my religion doctrine.				
28	I don't need to be tested because my husband is HIV negative.				
29	I don't need to be tested because I always use condom.				
30	I don't want to be tested because if the result is positive, it may affect my relation with religious leaders.				

Appendix B

Addis Ababa University

College of Education Department of Psychology

Focus Group Discussion Guide for Women Refugees

I am happy that you could allot sometime for the FGD, I am carrying out a study entitled "Perceived Barrier to Undertake VCT among Sudanese Women Refugees in Pugnido refugee camp". The objective of the study is to identify problems, to improve and expand VCT services among the refugees.

I would like to appreciate your cooperation!!

1. Do you know about VCT? If so, what is it?
2. What do you feel about the importance of VCT for people like you?
3. Do people in the refugee camp utilize the VCT service available in the camp?
4. What are the problems that prevent you and people like you to undertake VCT in the refugee camp?
5. In your view, what do you suggest to bring women refugees to voluntary HIV counseling and testing?
6. How do you describe the attitude and feelings of religious leaders and elderly people towards the importance of VCT for women refugees in the camp?
7. Can you tell me about the attitude of the refugees in the camp towards people who are living with HIV/AIDS?
8. What do you suggest to alleviate the problem?

Appendix C

Addis Ababa University

College of Education Department of Psychology

Semi Structured Interview Guide for Supervisors

I am happy that you could allot some time to me. I came from the Department of Psychology Addis Ababa University. I come here to assess barriers to undertake voluntary HIV counseling and testing (VCT) among Sudanese women refugees in your camp. You have been purposefully selected to participate in this interview because I believe that, you are the key member of the refugee camp community and that you have vital information and experience to share with me on the subject. I would like to say feel free to say anything concerning the topic of discussion.

Thank you very much!!

1. Can you tell me the general status and the establishment of VCT service in the Pugnido refugee camp?
2. Do you think you have all the necessary equipment for VCT services?
3. Do you think you have enough human power to provide the service appropriately?
4. Do you provide appropriate care, support and medication for HIV positive individuals in the refugee camp?
5. How do you describe the number of women refugees who have taken VCT service in the refugee camp compared to the total number of women refugees in the camp?
6. In your opinion, what are the major problems that hinder women refugees to undertake VCT in the refugee camp?
7. In your view, how can utilization of VCT services be enhanced (improved) for refugees in general and women refugees in particular?
8. How do refugees feel about VCT in general?

9. How do you feel about sexual abuse (rape) and its frequency the camp?
Is it non-existent?
11. How frequently are sexual abuses or rape officially reported in the camp?
12. How do you describe the importance of VCT services for refugees in the camp?
13. How do you describe the utilization of VCT services by refugees in the camp?

Appendix D
Addis Ababa University
College of Education Department of Psychology

Interview for the counselor

I am happy that you could allot some time to me. I came from Addis Ababa University in the Department of Psychology. I am now come here to assess barriers to undertake voluntary HIV counseling and testing (VCT) among Sudanese women refugees in your camp. You have been purposely selected to participate in this interview because I believe that, you are the key member of the refugee camp community that you have vital information and experience to share with me on the subject. I would like to say feel free to say anything concerning the topic of discussion.

Thank you very much!!

1. Can you tell me generally about VCT services in this refugee camp?
2. What do you think about the attitude of the refugees community when women refugees undertake VCT?
3. Do you think the service center has all the equipment and facilities that help to provide complete VCT service in the camp?
4. Do you provide appropriate pre-and post- test counseling for individuals who use VCT service in the camp?
5. How do you describe the number of women refugees who have taken VCT service in the refugee camp compared to the total number of women refugees and the seriousness of HIV problem in the refugee camp?
6. In your opinion, what are the main problems that hinder women refugees to undertake voluntary HIV counseling and testing in the refugees' camp?
7. Do you have any experience (positive or negative) in relation to VCT service in the refugees' camp?

Appendix E

Table -Means, Standard Deviations and Percentage Distribution of Refugees' Responses to the Perceived Barrier Items

No	Scale	Item																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	Not important	13.8	43.3	6.5	44.3	9.3	49.0	39.5	41.5	9.0	9.3	8.8	27.5	19.0	46.0	9.0	34.5	14.5
2	Less important	19.0	21.8	8.5	26.3	22.0	24.3	22.3	25.0	10.8	20.8	15.5	34.8	17.5	23.0	17.0	27.3	19.3
3	Undecided	6.3	3.5	2.3	3.3	4.8	3.8	6.0	5.3	2.0	4.3	8.3	2.5	9.5	7.0	5.0	5.8	4.8
4	Important	21.3	16.8	28.8	16.0	22.8	14.0	15.3	18.0	26.8	22.3	29.3	19.3	18.5	11.0	26.0	20.0	21.3
5	Very important	39.8	14.8	54.0	10.3	41.3	9.0	17.0	10.3	51.5	43.5	38.3	16.0	35.5	12.3	43.0	12.5	40.3
	Mean	3.54	2.38	4.15	2.22	3.65	2.10	2.48	2.31	4.01	3.70	3.73	2.62	3.34	2.20	3.77	2.49	3.54
	SD	1.201	1.525	1.212	1.413	1.433	1.376	1.54	1.422	1.334	1.434	1.434	1.462	1.559	1.428	1.38	1.447	1.521

Item													
18	19	20	21	22	23	24	25	26	27	28	29	30	
9.0	11.0	36.0	3.5	5.0	42.5	44.3	30.5	35.0	34.0	39.0	41.3	32.8	
16.0	21.3	23.5	21.5	15.5	21.8	17.0	28.5	29.0	27.3	29.8	25.5	29.5	
8.0	6.0	9.8	4.8	8.5	2.5	1.0	4.8	8.8	8.8	5.8	4.0	4.0	
28.5	24.8	17.3	27.3	30.3	19.0	21.5	20.3	20.5	17.5	13.3	14.0	11.8	
38.5	37.0	13.5	43.0	40.8	14.3	16.3	16.0	6.8	12.5	12.3	15.3	22.0	
3.72	3.56	2.49	3.85	3.86	2.41	2.49	2.63	2.35	2.47	2.30	2.37	2.61	
1.356	1.44	1.46	1.278	1.24	1.527	1.597	1.488	1.322	1.43	1.41	1.50	1.567	

Appendix F

Means, Standard Deviations and Percent Distribution of Refugees Response to the Attitude Inventory

	Scale	Item																			
		1		2		3		4		5		6		7		8		9		10	
		Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%
1	Strongly disagree	145	36.3	147	36.8	123	30.8	65	16.3	75	18.8	138	34.5	171	42.8	63	15.8	88	22.0	80	20.0
2	Disagree	54	13.5	55	13.8	60	15.0	41	10.3	69	17.3	41	10.3	88	22.0	45	11.3	43	10.8	45	11.3
3	Undecided	4	1.0	19	4.8	6	1.5	10	2.5	19	4.8	22	5.5	25	6.3	27	6.8	0	0	16	4
4	Agree	40	10	28	7.0	57	14.3	64	16.0	83	20.3	56	14	59	14.8	65	16.3	41	10.3	29	7.3
5	Strongly agree	157	39.3	151	37.8	154	38.5	220	55.0	154	38.5	143	35.8	57	14.3	200	50	228	57	230	57.5
6	Mean	3.03		2.95		3.15		2.17		2.57		3.06		2.36		2.27		2.31		2.29	
7	Standard Deviation	1.80		1.78		1.74		1.55		1.57		1.74		1.49		1.54		1.70		1.67	

	Scale	11		12		13		14		15		16		17		18		19		20	
		Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%	Frq.	%
1	Strongly disagree	94	23.5	194	48.5	174	43.5	199	49.8	171	42.8	216	54	218	54.5	107	26.8	148	37.0	101	25.3
2	Disagree	21	5.3	87	21.8	72	18.0	72	18.0	92	23	81	20.3	30	7.5	38	9.5	31	7.8	92	23.0
3	Undecided	15	3.8	16	4	11	2.8	29	7.3	8	2.0	3	0.8	9	2.3	14	3.5	3	0.8	24	6.0
4	Agree	53	13.3	68	17	70	17.5	59	14.8	56	14	21	5.3	78	19.5	72	18.0	64	16.0	50	12.5
5	Strongly agree	17	54.3	35	8.8	73	18.3	41	10.3	73	18.3	79	19.8	65	16.3	169	42.3	154	38.5	133	33.3
6	Mean	2.31		2.16		2.49		2.18		2.42		2.17		2.36		3.40		3.11		3.05	
7	Standard Deviation	1.67		1.40		1.60		1.43		1.57		1.58		1.64		1.69		1.80		1.64	

Declaration

I declare that this thesis is my original work, has not been presented for a degree in any university and that all sources of materials used in this thesis have been duly acknowledged.

Name: **Enishaw Teshome**

Signature: 

Date: 25 July 2008

This thesis has been submitted for examination with my approval as a university advisor.

Dr. Seleshi Zeleke (Ass. Prof)

Signature: 

Date: 25 July 2008