DETERMINANT OF VOLUNTARY COUNSELING AND TESTING UTILIZATION AMONG YOUTH IN JIJIGA TOWN, ETHIOPIA.

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LIST OF ABBREVIATIONS

AAU	Addis Ababa university
AIDS	Acquired Immunodeficiency Syndrome
AOR	Adjusted Odds Ratio
BSS	Behavioral surveillance survey
CDC	Center for disease control
CI	Confidence interval
CSA	Central statistics authority
DHS	Demographic and health survey
FGAE	Family guidance association Ethiopia
FGD	Focus group discussion
FHI	Family health international
H/C	Health center
HIV	Human Immunodeficiency virus
MOH	Ministry of Health
OR	Odds ratio
PMTCT	Prevention of mother to child transmission
SD	Standard deviation
SPSS	Statistical package for social science
STD	Sexually transmitted Disease
UNIADS	United nation program on AIDS
VCT	Voluntary counseling and testing for HIV
WHO	World health organization

Abstract

Although VCT service is increasingly available in Ethiopia, there is still great reluctance for youth 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 care.

The study was conducted from August 2003 to May 2004 to identify factors influencing use of VCT service among 15-24 years old age group in Jijiga town using quantitative and qualitative methods of data collection.

The study design is unmatched case-control, where the cases are HIV tested and controls are untested youth. A total of 242 tested and 484 untested youth were included in the study. Of all the socio-demographic and sexual history variables, being female, older youth, educational level of secondary and above grade and sexually active youth were more likely to be tested [AOR (95% CI)=1.52(1.03,2.23)], [AOR (95% CI)=1.93 (1.30,2.87)],[AOR (95% CI)=2.29 (1.03,5.11)], [AOR (95% CI)=2.23(1.42,3.52)], respectively. The main reason for VCT utilization was to know self (61.6%) and have not had HIV test yet because they afraid to get the result.

Based on the finding, advocating HIV VCT with proper IEC activities through mass media and peer education for youth in general and male, illiterate, young and not sexually active youth in particular need to be addressed by involving all stakeholders and using local resources, improving training, testing equipment, condom promotion, STI treatment, supervision, referral system, feedback and network are recommended.

Dedication

This thesis work is dedicated to my lovely parents Ato Yimam Idris and W/ro Desta Ali who have been the source of inspiration through all my academic life.

1. INTRODUCTION

To day, some of 37.8 million people are living with HIV, of which 2.9 million died in 2004(1). An estimated 4.8 million people became newly infected with HIV and half of infection occurred among young people in 2003(1). Ethiopia is one of the countries hard hit by the HIV/AIDS epidemic and the highest prevalence was seen in the age group 15-24 years (2,3). In Jijiga town, Somali Region, about 52 percent of infection found at the age of 15-24 years (2).

HIV/AIDS counseling is “confidential communication between a client and a care provider aimed at enabling the client to cope with stress and to take personal decisions relating to HIV/AIDS. The counseling process including the evaluation of personal risks of HIV transmission, the facilitation of preventive behavior, and evaluation of coping mechanisms when the client is confronted with a positive results” (4).

There are several possible contributing factors that must be addressed if voluntary counseling and testing is to have an important role in HIV prevention and care. Factors that influence acceptance or refusal for voluntary counseling and testing could be characterized as socio-demographic, cognitive and behavioral, and organizational of the voluntary counseling and testing service delivery (5).

The proportion of adults needing voluntary counseling and testing verses who received it ranged from almost none in Southeast Asia, to seven percent in Sub Saharan Africa and one and half percent in Eastern Europe (1). Many people with HIV in Ethiopia do not know they are infected. Only small percentages of those with HIV/AIDS have had access to reliable voluntary counseling and testing service (4,6). According to Somali RHB report in Jijiga town voluntary counseling and testing services began in 2001 and

the utilization of the service is very low. As of 2003, only 5 percent of youth accepted one–on-one pretest counseling and had an HIV test. Why the youth are not using the service is unknown. Considering a variety of factors that place them at the center of HIV vulnerabilities, voluntary counseling and testing remains a key strategy to control the spread of HIV. Thus, there is a need to understand factors influencing HIV testing so as to increase utilization of VCT center by youth.

2. LITERATURE REVIEW

2.1 The rationale for VCT

Vulnerability, risk and the impact of AIDS coexist in a vicious circle. Vulnerability can be reduced by providing young people with schooling, supporting protective family environments and extending access to health and support services population wide (1).

HIV testing accompanied by prevention intervention has a place with a comprehensive range of measures for HIV/AIDS prevention, care and support (5). Voluntary counseling and testing is a vital entry point of preventive and other HIV/AIDS services including prevention of MTCT; prevention and clinical management of HIV related illnesses; tuberculosis control, and psychosocial and legal support, there is demand and VCT provides benefits for those who test positive as well as those who test negative. VCT alleviates anxiety, increases client's perception of their vulnerability to HIV, promotes behavioral change, facilitates early referral for care and support including access to anti retroviral therapy and assists reduction of stigma in the community (5,7,8,9,10).

One of the code of ethics in counseling is the counselor should retain ultimate responsibility for the quality and extent of the service that the individual assumes, assigns or performs (5). Exploring of risk allowed the counselor to help the client consider ways to reduce personal risk and commit to a single, explicit step to do so; effective at reducing high risk sexual behaviors and new STDs and cost-effective at preventing STDs in persons at increased risk for HIV (5,10,11,12).

Study from Rwanda and by the AIDS Information Center in Uganda showed increases in reported condom use, associated with VCT (8). In Uganda, widespread low-cost VCT provision with high quality post-test support service is thought to have contributed to the

stabilization of HIV-1 prevalence (8). Studies conducted in Kenya and Tanzania have conclusively shown the high degree of cost-effectiveness of VCT in reducing HIV transmission in those countries, especially in urban settings (8,13,14,15,16).

Current HIV prevention coverage is extremely low. Only fractions of people at risk of HIV exposure have meaningful access to basic prevention services. And an even smaller proportion of adults had access to VCT (1,6).

2.2 Determinants of VCT

Factors that influence acceptance or refusal for VCT could be characterized as socio-demographic; cognitive and behavioral, and organizational of the VCT service delivery (9). Young people usually seek an HIV test while they are healthy. Having HIV symptoms and feeling ill are seldom reasons that tested youth given (17,18). For finding out their serostatus the cited reason that tested youth gave for getting an HIV test was to know their HIV status in general, distrust of partners, being worried, exposure to HIV risk, pregnancy, service provider referral, decision by parent or Health workers, with out their knowledge and plan to marry(18,19,20,21).

The three reported barriers to the perceived usefulness of counseling are the type of counseling provided, how it is recommended, and the setting of the counseling. In setting where many clients are declining counseling, these barriers and others should be examined (5). Some of the challenges and obstacles that prevent youth from getting health care and VCT services were lack of money, fear-of-family, lack of trust on service providers, lack of confidence in the quality of counseling, physical inaccessibility, lack of information about the location of the services, fear of being identified by someone, lack of privacy and parents' attitude towards HIV-1 testing (1,6,18,19,22,23).

Acceptance of HIV testing is reportedly lower when client were tested previously and are fearful of their ability to cope with their test results (5). Study in South Africa showed that individuals who had not been tested for HIV and those tested but who did not know their results held significant more negative testing attitude than individual who were tested (14).

AIDS related stigma and discrimination directly hamper the effectiveness of AIDS responses. Stigma and concerns about discrimination constitute a major barrier to people coming forward to have an HIV test, and directly affect the likelihood of protective behaviors (1,15,19). Perceived risk of HIV infection had a major influence on VCT readiness among young people (24). The reason for not being willing to have an HIV test include not being ready to go VCT; could not cope with the results; do not have the courage to go; not need for testing as there is no cure for HIV/AIDS (6,22).

2.3 Addressing barriers to HIV testing

Knowledge of HIV infection status can benefit the health of individual persons and the community. Thus, HIV testing should be as convenient as possible to promote client knowledge of HIV infection status. Efforts should be made to remove or lower barriers to HIV testing by insuring that;

- Testing is accessible, available, and responsive to client and community needs and priorities.
- Anonymous and confidential HIV testing are available.
- The testing process considers the client's culture, language, sex, sexual orientation, age, and developmental level; and
- Confidentiality is maintained (5).

Quality assurance activities should address accessibility of service, compliance with written protocols for provision of service to an individual clients, Service and materials appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level, staff performance and preferences / proficiency, supervision, compliance with program guideline and performance standard, appropriateness of services to client needs and measured with client satisfaction tools (5).

Each counseling session should be tailored to address the personal HIV risk of the client rather than providing a predetermined set of information (5).The aim of supervision is to provide support to the counselors, so that they can establish and maintain a uniform standard of counseling (4). Several factors can prevent provision of high-quality HIV prevention counseling, including unavailability of trained prevention counselors at the setting in which the HIV test was conducted, client reluctance and low rate of client return for test results.

Recommended strategies for addressing these common barriers include

- Provision counseling on-site
- Enhancing client acceptance of counseling by examining and improving the counseling provided, and
- Considering alternate counseling methods (5).

Stand-alone sites are not associated with an existing medical institution and usually have staff fully devoted to VCT. The benefits are maximum coverage and quality attracts population groups that would not otherwise attend. Experience from Uganda, Thailand, Malawi and Zimbabwe has shown that stand-alone sites can meet increasing

demands. Studies have also indicated that young people & men do not access VCT services when they are located in medical facilities (8).

RATIONALE FOR THE STUDY

Youth between the age of 15 and 24 are both the most threatened. In Jijiga town about 52 percent of infection found at the age of 15-24 years.

Voluntary counseling and testing is one of the main intervention areas to fight against HIV/AIDS. In Jijiga only 5 percent of youth utilized the one-on-one VCT service. Why the youth are not using the services is unknown. There are several possible contributing factors that must be addressed if VCT is to have an important role in HIV prevention and care.

3. OBJECTIVE

3.1. General objective:-

To assess factors influencing VCT service utilization among 15-24 years old age group in Jijiga town.

3.2. Specific objectives:-

1. To identify factors influencing use of VCT Service.
2. To assess quality of VCT service in the town.

4. METHODS AND MATERIALS

4.1. Study area: - The study was conducted in Jijiga town, the capital of the Somali Regional State. Jijiga town is located some 638 kms east of Addis Ababa. The population of Jijiga town is projected to be around 89,531 in 2004, and has six Kebeles. There is land and air transportation, and telephone service in the town. The media facilities regularly available are radio, newspapers and television. VCT center in the town is available at Karamara hospital, Jijiga H/C and FGAE clinic.

4.2 Study design: - Population based unmatched case-control study.

4.3. Study population: -

The sample for the study was drawn from youth aged 15-24 years living in Jijiga town.

4.4. Study Subject: -

The study subjects were youth HIV tested and two randomly selected untested near by a tested youth in selected Kebeles and who have lived for at least six months in Jijiga.

Inclusion criteria

- Age 15-24 years
- Those who lived in the selected kebeles for at least six months

Exclusive criteria

- Youths who are unable to hear and mentally disabled.

4.5. Sample Size: - The Sample size for this study has been calculated using STATCAL of EPI info software.

Sample size was worked out for each variable to get a minimum sample size that would allow for 95% confidence level with 80% power for all study questions. If assuming that 13.3% of those that have tested for HIV had high risk perception compared to 6.5% risk perceived among untested youth obtained from previous BSS study (6), the minimum sample size that would allow to demonstrate this 7% difference using a 1:2 ratio between VCT: No VCT, would be 240/480.

4.6. Sampling procedure

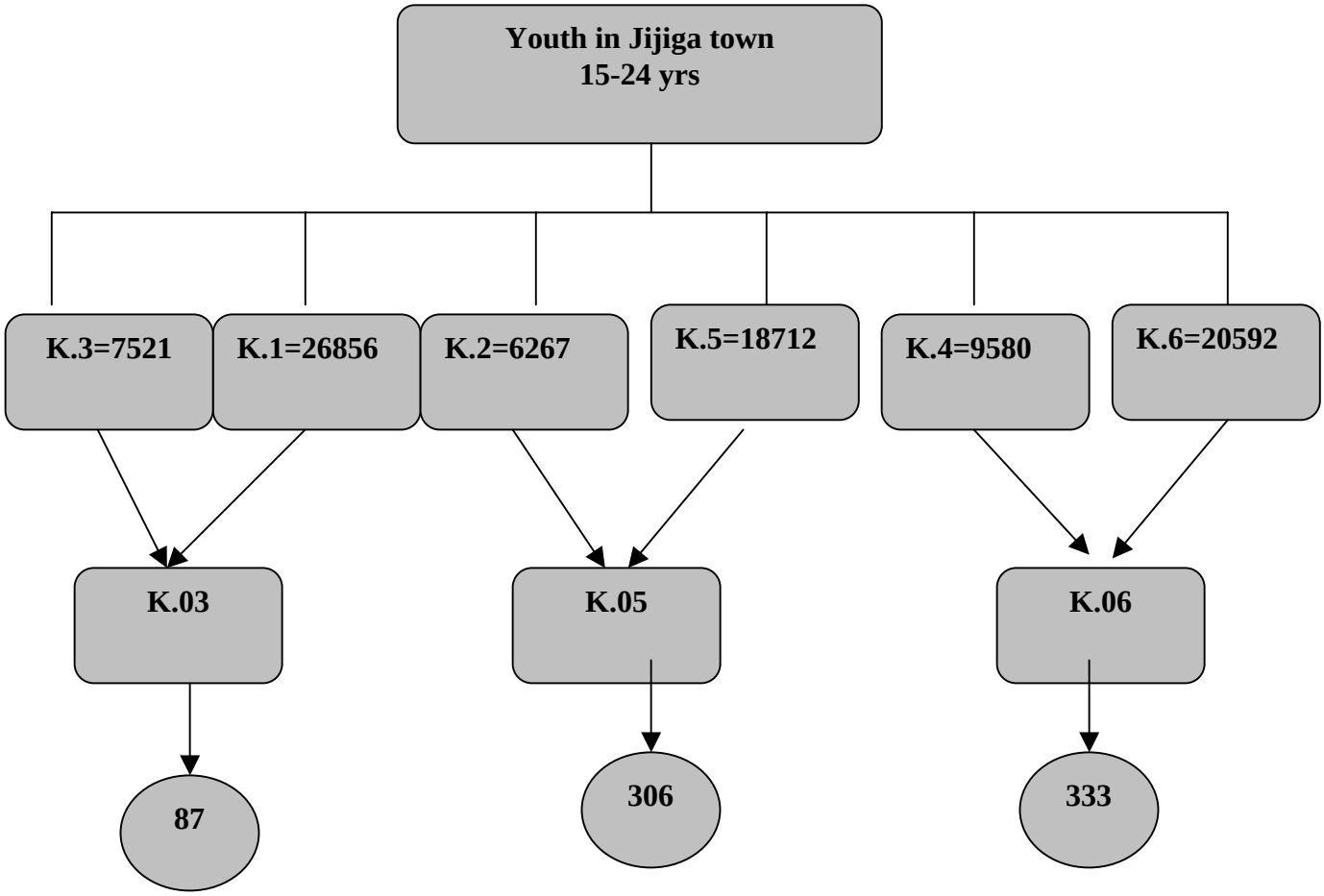
First stage: - Six Kebeles stratified in to three groups according to their dominant ethnic back group.

Second stage: - From each group, one Kebelle selected randomly.

Third Stage: - For each selected Kebele, tested study subjects were allocated proportional to their kebele population size and two near by untested youth were selected to act as controls. The two untested youth were selected by lottery method.

From each selected Kebele the first household was selected by spinning pen at the center of the Kebele and following the pen direction until the allocated sample size completed. The rest tested youth were only filled in survey format.

Figure: -1 Schematic presentation of the sampling procedure.



4.7. Data collection

In this study quantitative and qualitative methods were used. Pre-coded and structured questionnaire adopted from a standard questionnaire from BSS and WHO were used to collect data. The questionnaire was initially prepared in English and then translated in to Amharic and Somali. But due to four different dialects in Somali language in the town, Amharic was preferred at the end. Three supervisors and twelve data collectors from both sexes, who were experienced, 12^{th} grade complete and speak both languages fluently were recruited and trained for three days by the principal investigator. The Amharic version was again translated back to English to check for any inconsistencies. Pre-testing of the questionnaire for its clarity, understandability, completeness and reliability was conducted prior to actual data collection in kebele 01, 02 and 04 that were all outside the actual study area. After getting verbal consent, they were interviewed in their home. When there was a known youth not present during data collection the interviewer revisited the house at different time intervals. Strict daily supervision of the data collection process was maintained throughout the data collection period. One supervisor was responsible for each Kebele. Supervisors checked study sites at least twice a day and received filled questionnaires from the data collectors daily and checked for completeness. Principal investigator checked study sites daily. Completed questionnaires were submitted to the principal investigator for final check. Incomplete questionnaires were returned to the specific data collector to be corrected by revisiting.

For qualitative study

Semi structured open-ended focus group discussion (FGD) and in-depth interviews were used to guide the discussions. All the FGDs and in-depth interviews were conducted after the survey was completed so as to supplement the quantitative study and to address issues which could be determinant factors and were not mentioned by quantitative and observational method. Each session was tape-recorded after getting consent from the FGD participants. Three In-depth interviews were made with VCT service providers from the three health institutions. Four FGD among youth by sex and ethnic groups were conducted. Each group consisted of eight members selected on convenient bases by principal investigator. Participants should live in the area for at least six months before the data collection. Assisted with note takers, the principal investigator and an experienced female nurse facilitated the females groups discussion while two experienced males (HIV/AIDS coordinators) facilitated the males groups discussion.

The quality of the service could be one of the determinant factors. Hospital, FGEA clinic and H/C were observed by the principal investigator. Five observations for each institution were made by using the National VCT guideline tool.

Independent variables: - Socio-demographic characteristics, Sexual behavior, HIV risk perception, quality of counseling, stigma & discrimination, knowledge about HIV & VCT.

Dependent variables: - Cases: - Tested youth for HIV.

Controls: - Untested youth for HIV.

4.8 Operational definition

Youth: - Those who are in the age group 15-24 years.

Younger youth: - Those who are in the age group 15-19 years.

Older youth: - Those who are in the age group 20-24 years

VCT: - Process by which an individual undergoes counseling to enable him/her make informed choice about being tested voluntarily for HIV.

Cases: - VCT users or Who went to VCT site and tested for HIV.

Controls: - Non-VCT users or untested for HIV.

Risk perception of youth: - Youth attitude towards perceiving themselves as susceptible to HIV infection.

Comprehensive knowledge: - Knowledge of the three prevention methods and absence of misconception about HIV transmission.

Confidential HIV testing: - Client's identifying information is linked to testing information.

Anonymous HIV testing: - Client's identifying information is not linked to testing information.

Free standing VCT site: - Facilities that serve only VCT service.

Integrated VCT site: - VCT as an integral part of other ongoing health service

4.9 Data Analysis

Data were entered and cleaned using Epi-info version 6 soft ware and analysis was carried out using SPSS soft ware for different variables frequencies. Crude odd ratios were computed to assess the presence and degree of association between socio demographic, cognitive and behavioral variables with VCT utilization, and also compare results between tested and untested youth. Logistic regression was done to assess the relative effect of socio demographic, cognitive and behavioral variables on VCT utilization.

Knowledge of VCT was measured by the correct responses given for each knowledge variable. Correct response for a given variable was given a value of “2”; response didn’t Know was given a value of “1” and incorrect response “zero”. The overall correct responses were aggregated and the mean knowledge score was used. Respondents who obtained mean score and above were considered knowledgeable while those who obtained lower mean score were considered non- knowledgeable.

By observing the operational aspects of VCT sites and counseling processes the essential counseling elements were identified.

The recordings of the FGDs were transcribed and main concepts identified. Main concepts of In-depth interviews were identified too.

ETHICAL CONSIDERATION

Before the study began ethical clearance was obtained from the ethical committee of AAU. Official permission was secured from different authorities of the Somali Region. The respondents were informed about the objective and purpose of the study and verbal consent was obtained from each respondent. Confidentiality of the information was assured and collected anonymously. Information and contact with service providers and other organizations were facilitated for youth who need the service or other information.

COMMUNICATION OF THE RESULTS

The results of this study will be disseminated or communicated to the Ministry of Health, the Regional Health Bureau, local institutions and other concerned bodies through reports and publication on an appropriate journal.

5. Result

5.1.1 Description of surveyed youth in the study population

Overall, a total of 6804 households with a total population of 44,766 were surveyed. Two thousand and five hundred sixty two youth were eligible (15-24 yrs) for the study. One thousand and ninety nine (42.9%) were males, the mean age of eligible youth was 19.1 with a SD of ±2.66 years, one hundred and eighty seven (7.3%) were illiterate, fifty six (2.2%) eligible youth refused to participate in the study. The reasons for not participating were 27(48.2%) youth reported that they don't have time, followed by not their problem 12(21.4%) and study doesn't bring change 10(17.9%). Three hundred and thirty seven (13.2%) of youth were tested for HIV. The majority of youth were tested voluntarily 289 (85.8%), followed by ordered by health workers 26(7.7%), requested for visa 14(4.2%), required for work 4(1.2%) and screened upon blood donation 4(1.2%). (Table1).

5.1.2 Socio-demographic comparison of youth accepted VCT and not accepted.

A total 726 study subjects, 242 tested and 484 untested youth participated in this study. Females are more likely to be tested than males [AOR (95%CI)=1.52 (1.03, 2.23)]. Older youth are more likely to be tested than younger youth [AOR (95% CI)=1.93 (1.30, 2.87)]. Youth with secondary and above education were more likely to have utilized VCT service than illiterate [AOR (95%CI)=2.29(1.03, 5.11)]. Sexually active youth were more likely to be tested than non-sexually active youth [AOR (95% CI)=2.23 (1.42, 3.52)] (Table 2).

Table 1: - Description of surveyed youth in the study population, Jijiga town, December 2005.

Characteristics		HIV VCT		
		Yes N=337(%)	No N=2225 (%)	Total N=2562(%)
Sex				
	Male	124(36.8)	975(43.8)	1099(42.9)
	Female	213(63.2)	1250(56.2)	1463(57.1)
Age				
	15-19	120(35.6)	1319(59.3)	1439(56.2)
	20-24	217(64.4)	906(40.7)	1123(43.8)
Educational status				
	Illiterate	15(4.5)	172(7.7)	187(7.3)
	Primary	32(9.5)	380(17.1)	412(16.1)
	Secondary and above	290(86.1)	1673(75.2)	1963(76.6)
Willingness to participate				
	Yes	337(100.0)	2169(97.5)	2506(97.8)
	No	-	56(2.5)	56(2.2)
Reason for VCT for HIV				
	Voluntarily	289(85.8)		
	Ordered by health worker	26(7.7)		
	Requested for visa	14(4.2)		
	Requested for work	4(1.2)		
	Blood donation	4(1.2)		
Reason for not participating				
	No time		27(48.2)	
	Not my problem		12(21.4)	
	Study doesn't bring change		10(17.9)	
	No use		4(7.1)	
	Others		3(5.4)	

Table 2: - VCT utilization versus socio-demographic variables of youth in Jijiga, December 2005.

	Cases N =242	Control N=484	Crude OR	95% CI	Adjusted OR	95% CI
Sex						
Male	80	194	1		1	
Female	162	290	1.35	(0.97,1.90)	1.52	(1.03,2.23)**
Age						
15-19	74	28	1		1	
20-24	168	203	3.14	(2.24,4.42)*	1.93	(1.30,2.87)**
Marital status						
Unmarried	158	389	1		1	
Married	84	95	2.08	(1.52,3.13)*	1.02	(0.59,1.74)
Educational status						
Illiterate	13	27	1		1	
Primary	25	84	0.85	(0.40,1.81)	1.26	(0.63,2.52)
Secondary and above	242	368	1.56	(0.76,3.24)	2.29	(1.03,5.11)**
Currently in school						
Yes	85	280	1		1	
No	157	204	2.54	(1.82,3.54)*	1.62	(0.63,4.15)
Monthly income (in Birr)						
No income	185	420	1		1	
≤100	14	15	2.12	(0.94,4.75)	0.69	(0.14,3.33)
101-200	6	9	1.51	(0.47,4.72)	0.43	(0.09,1.90)
≥200	37	40	2.10	(1.27,3.48)*	0.27	(0.06,1.24)
Religion						
Orthodox	155	291	1		1	
Muslim	69	148	0.88	(0.61,1.25)	1.26	(0.65,2.44)
Other Christian	18	44	0.77	(0.41,1.42)	0.92	(0.38,2.21)
Ethnicity						
Amhara	140	271	1		1	
Somali	49	91	1.04	(0.68,1.59)	1.89	(0.88,4.07)
Others	53	122	0.84	(0.56,1.25)	0.88	(0.47,1.63)
Presently live						
With family	171	400	1		1	
A lone	30	28	2.51	(1.40,4.47)*	0.66	(0.35,1.24)
Others	41	56	1.71	(1.08,2.72)*	0.62	(0.28,1.37)
Ever had sex						
Yes	160	182	3.24	(2.31,4.54)*	2.23	(1.42,3.52)**
No	82	302	1		1	

5.1.3 Sexual behavior of the study subjects

The age of sexual debut, HIV risk perception and substance use (alcohol, shisha and khat) were not significantly associated with utilization of VCT services (Table 3).

5.1.4 Reasons for being tested for HIV testing by tested youth

Out of the total 242 tested youth, the most commonly cited reason that cases given for getting an HIV test was to know their HIV status in general. This reason was given by 149(61.6%), followed by to plan for future 29(12%), plan to marry 18(7.4%), ordered by health workers 18(7.4%), pregnancy 14(5.8%), requested for visa 7(2.9%), required for work 4(1.7%), donate blood 2(0.8%) and to get ARV treatment 1(0.4%). (Figure2).

5.1.5 Factors preventing controls from having an HIV test

Out of the total 484 untested youth, 87(18.0%) have not had HIV test yet because they afraid to get the result, followed by Still thinking about it 83(17.1%), partner and self trust 82(16.9%), don't know where to get the service 59(12.2%), self trust 47(9.7%), don't believe it will help 21(4.3%), lack of money 21(4.3%) and no near by service 18(3.7%) and others (no sex, religious, fear of injection, parental consent, etc…) 66(8.8%). (Figure3).

Table 3: - Risk behavior versus VCT utilization of youth, Jijiga town, December 2005.

	Cases N=242	Control N=484	Crude OR	95% CI	Adj. OR	95% CI
Age in years at first Sexual intercourse						
10-14	10	8	1		1	
15-19	118	147	0.64	(0.22,1.83)	0.50	(0.18,1.42)
20-24	26	19	1.09	(0.32,3.77)	0.65	(0.20,2.16)
Mean ±SD	17.7± 2.15	17.3± .84				
Risk perception						
Yes	17	24	1		1	
No	225	457	0.70	(0.35,1.38)	0.84	(0.38,1.89)
Alcohol consumption						
Yes	191	420	1		1	
No	50	62	1.77	(1.15,2.73)*	0.85	(0.48,1.50)
Khat consumption						
Yes	90	129	1		1	
No	152	355	0.61	(0.44,0.86)*	0.98	(0.55,1.75)
Shisha smoking						
Yes	24	32	1		1	
No	216	451	0.64	(0.36,1.15)	1.15	(0.53,2.49)

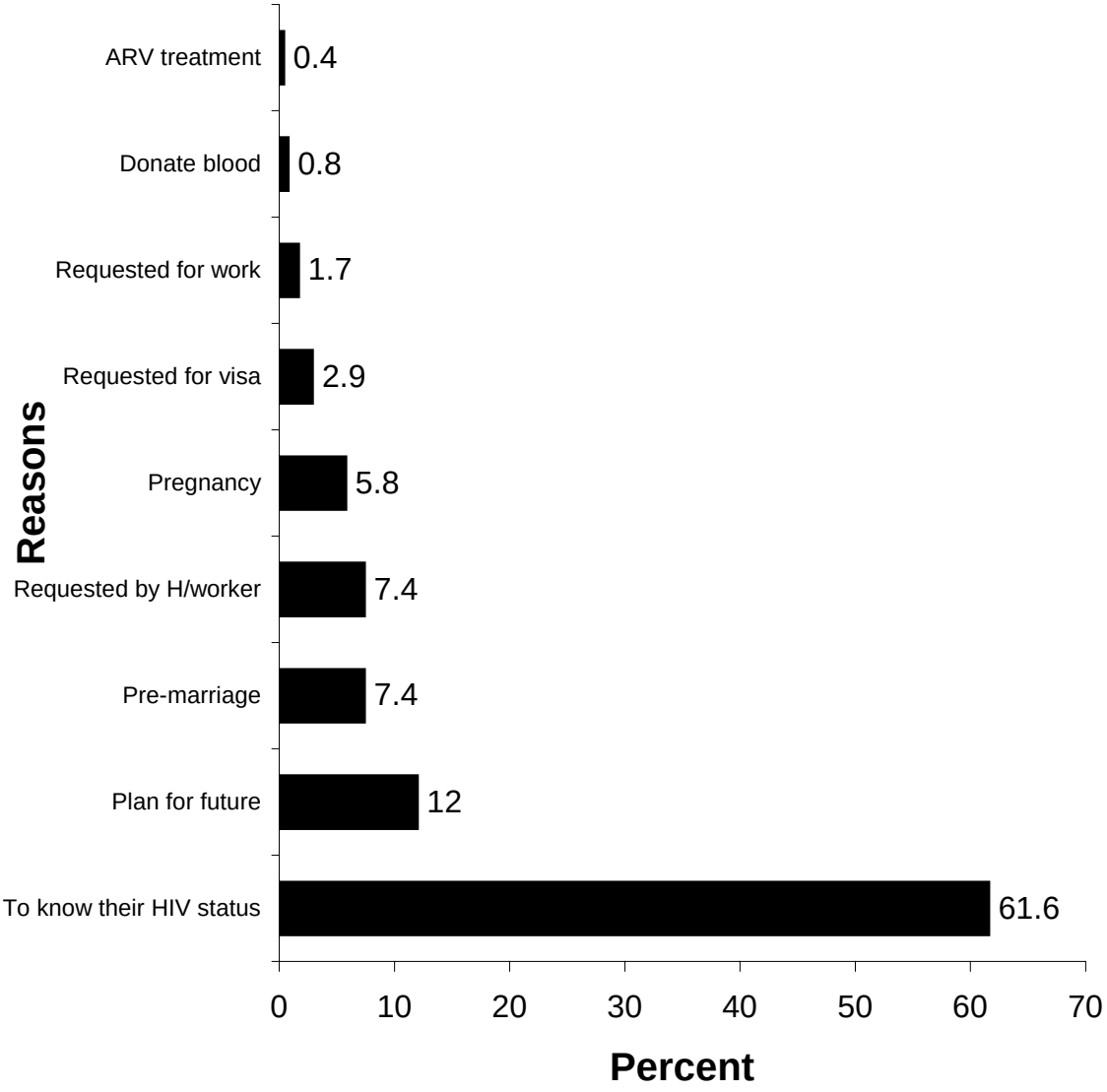


Figure 2: - Reasons for being tested for HIV testing by tested youth, Jijiga town, December 2005.

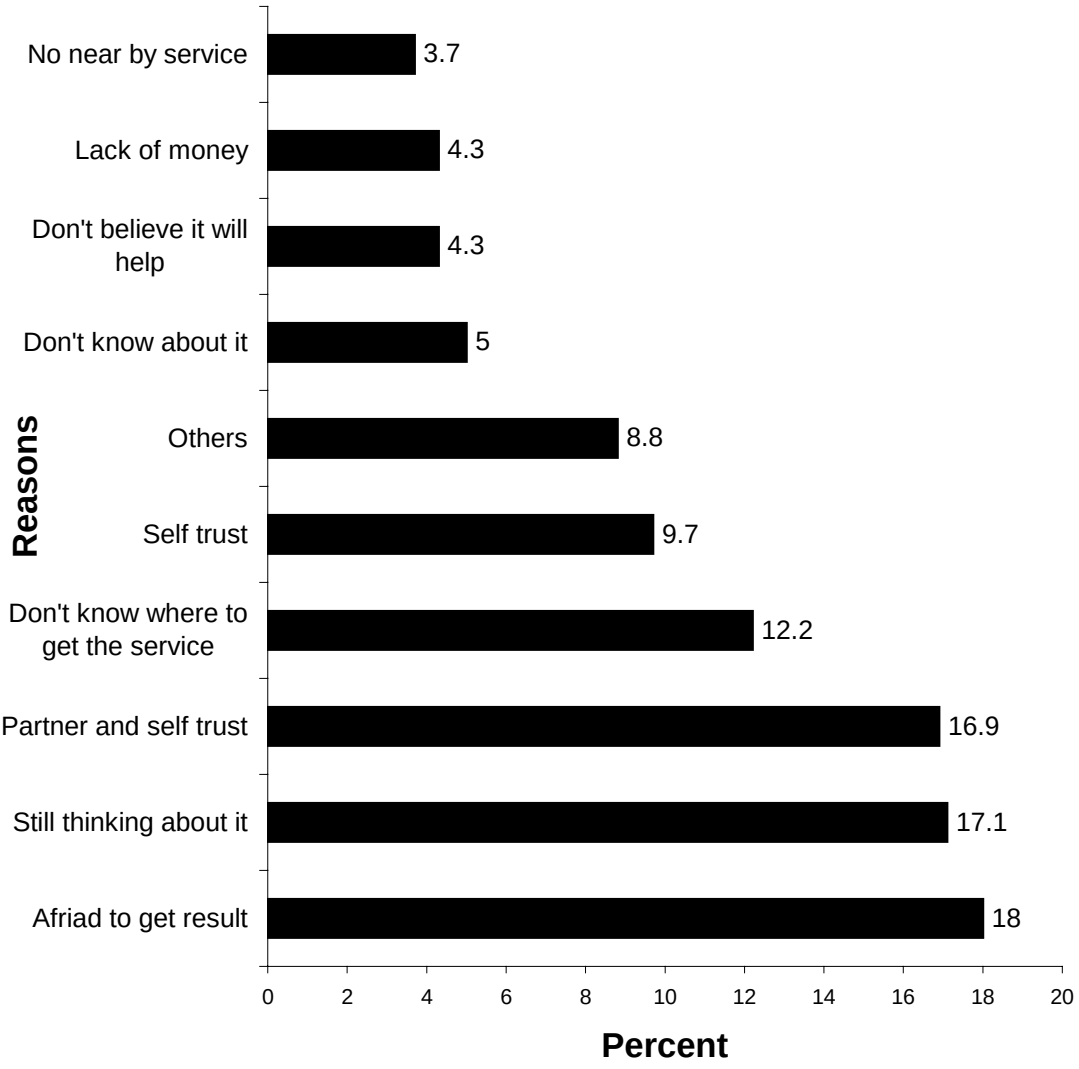


Figure 3: - Reasons for not having an HIV test among controls, Jijiga town, December 2005

5.1.6 Source of information about VCT of the study subjects

The Majority of study subjects 715(98.5%) have heard about VCT and mass media was cited more frequently source of information 707(98.9%), followed by peers 651(91.0%), youth center 615(86%), health institutions 570 (79.7%) and teachers 561(78.5%). (Table 4).

5.1.7 Practices on voluntary counseling and testing by clients and VCT Service preference by study subjects.

Out of the total tested study subjects, 101(41.7%) were tested in Jijiga branch FGAE, followed by else where 75(31.0%) and at Jijiga Karamara hospital 66(27.3%). Out of tested else where, 31(4.1%) tested in Addis Ababa, followed by in Harar 19(2.6%), Dire Dewa 16(2.2%). All cases have received their test results. Pre and post- test counseling were received by 189(78.1%), followed by only pre-test counseling 37(15.3%), didn't receive any counseling 13(5.4%) and only post- test counseling 3(1.2%). (Table5).

Out of the total tested study subjects, 220(90.9%) were satisfied with the service and 218(99.1%) were because of warm reception, followed by, confidentiality 216(98.2%), health worker competency 212(96.4%), privacy 210 (95.5%) and quick service 202(91.8%). Out of unsatisfied cases, 18(81.8%) were because of counseling given was not clear, followed by , lack of privacy 14(63.6%), no warm reception 14 (63.6%), no care and support 11(50.0%), long waiting time 10(45.5%), lack of confidentiality 5(22.7%) and expensive 3(13.6%) (Table5).

Out of the total study subjects, the majority of youth (99.2%) agreed that VCT is important and 577(80.6%) were in order to know self, followed by to plan for future 66(9.20%), self-care 50(7.0%) and prevention of partners or others 23(3.2%). The

majority of youth had recommended an HIV testing to their peers 610(84.0%). Youth would like to be tested in the future 706(98.1%). 65.5% of youth preferred Government health institution, followed by private 71(29.7%) and NGOs 19(7.9%). (Table6).

Out of the total study subjects, Three hundred and thirty five (42.1%) preferred HIV testing to be given in hospital followed by youth center 275(37.9%) and clinic 54(7.4%). (Table6). Study subjects were asked for when did a person should test for HIV, 522(72.7%) reported that at any time, followed by pre-marriage 147(20.5%), when there is doubt 39(5.4%) and illness 9(1.3%).

Out of the total study subjects, five hundred and thirty three (74.3%) of youth preferred to have confidential testing. four hundred and forty sex (61.4%) youth preferred physician to get VCT service, followed by trained counselor 221(30.4%). Concerning the preferred ways of obtaining HIV test result, the majority 620(86.1%) of youth preferred face-to-face, followed by confidential letter 94(13.1%), through partners 4(0.6%) and through relatives 2(0.3%). (Table6). Regarding convenient time for VCT service delivery, 388(53.9%) youth preferred at any time, followed by morning 230(31.9%) and afternoon 93(12.9%). Youth were asked about their willing to pay a reasonable fee for VCT service, 244(33.6%) youth were willingness to pay. Among youth who were willingness to pay, 100(41.0%) reported that 6-10 Birr is a reasonable fee, followed by 1-5 Birr 59(24.2%).

Table 4: - Source of information about VCT of the youth, Jijiga town, December 2005

Characteristics	Cases N=242 (%)	Control N=484 (%)	Total N=726 (%)
Source of information			
Mass media	238(98.3)	469(99.2)	707(98.9)
Peers	220(90.9)	431(91.1)	651(91.0)
Youth center	209(86.4)	406(85.8)	615(86.0)
Health institution	212(87.6)	358(75.7)	570 (79.7)
Teacher	186(76.9)	375(79.3)	561(78.5)
Other relatives	171(70.7)	322(68.1)	493(69.0)
Mother	135(55.8)	266(56.2)	401(56.1)
Father	134(55.4)	263(55.6)	397(55.5)
Spouse	69(28.5)	78(16.5)	14720.6)
Partner	66(27.3)	73(15.4)	139(19.4)

NB. Percents will not add up 100, as multiple responses are possible

Table 5: - practices on voluntary counseling and testing service by clients, Jijiga town, December 2005.

Variables	Number (242)	Percent
Tested place		
Karamara hospital	66	27.3
FGAE Jijiga branch	101	41.7
Else where	75	31.0
Counseling received		
Pre-test counseling	37	15.3
Post-test counseling	3	1.2
Both pre and post-test counseling	189	78.1
No counseling at all	13	5.4
Tested youth satisfied with the service?		
Yes	220	90.9
No	22	9.1
What tested youth liked about the service*	**Number (220)**	**Percent**
Warm reception	218	99.1
Confidentiality	216	98.2
Health worker competency	212	96.4
Privacy	210	95.5
Quick service	202	91.8
Free service	115	52.3
Referral for care and support	83	37.7
Youth friendly	52	23.6
What tested youth didn't like about the service*	**Number (22)**	**Percent**
Counseling given was not clear	18	81.8
No warm reception	14	63.6
Lack of Privacy	14	63.6
No referral for care and support	11	50.0
Long waiting time	10	45.5
Lack of Confidentiality	5	22.7
Expensive	3	13.6
Time taken to get test results	**Number (242)**	**Percent**
One and less than one hour	11	4.5
1:05-2:00 hrs	19	7.9
2:05-12:00 hrs	138	57.0
12:05-24:00 hrs	37	15.3
More than 24 hrs	37	15.3

* NB. Percents will not add up 100, as multiple responses are possible

Table 6: - Comparison between tested and untested youth on service preference, Jijiga town, December 2005.

Characteristics	Cases N=242 (%)	Control N=484 (%)	Total N=726 (%)
VCT Method preferred			
Confidential	176(73.0)	357(75.0)	533(74.3)
Anonymous	65(27.0)	119(25.0)	184(25.7)
Recommend HIV test to peers			
Yes	223(92.1)	387(80.0)	610(84.0)
No	19(7.9)	97(20.0)	116(16.0)
Desire to be tested in the future			
Yes	239(98.8)	467(97.7)	706(98.1)
No	3(1.2)	11(2.3)	14(1.9)
Institution preference to get an HIV test			
Government health institution	148(61.9)	328(70.2)	476(67.4)
Private	19(7.9)	29(6.2)	48(6.4)
NGOs	71(29.7)	107(23.0)	178(25.2)
Other	1(0.4)	2(0.4)	
Preference on convenient place to get an HIV test			
Hospital	100(41.3)	235(48.3)	335(46.1)
Youth center	103(42.6)	172(35.1)	275(37.9)
Clinic	17(7.0)	37(7.6)	54(7.4)
Others	22(9.1)	40(8.3)	62(8.5)
Desired counselor qualification			
Physician	148(61.2)	298(61.3)	446(61.4)
Trained counselor	78(32.2)	143(29.5)	221(30.4)
Others	6(6.6)	43(8.9)	59(8.1)
Way of getting HIV test result			
Face to face	214(88.4)	406(84.9)	620(86.1)
Confidential letter	26(10.7)	68(14.2)	94(13.1)
Partner	1(0.4)	3(0.6)	4(0.6)
Relative	1(0.4)	1(0.2)	2(0.3)

5.1.8 Knowledge and Attitude toward HIV/AIDS and VCT

The majority 609(83.9%) of youth would like to share their results with their parent, followed by their sisters 558(76.9%) and brothers 5.6(69.7%). (figure 4). The study subjects were asked about what happens if they were positive for HIV and preferred to disclose their HIV test result, 570(78.5%) responded that increase emotional support from health workers, followed by increase emotional support from families or relatives 532(73.3%), increase emotional support by peers 380(52.3%) and neglected by peers 322(44.4%). (Figure 5). Average score of knowledge on VCT was taken after coding from total score of 26. Youth with score of average and above were considered knowledgeable. There was no statistical significant difference between cases and controls. Study subjects were asked about their reaction for possible positive test result, 313(43.1%) responded by saying would like to disclose their test result, followed by hopelessness 104(14.3%) and revenge 27(3.7%).

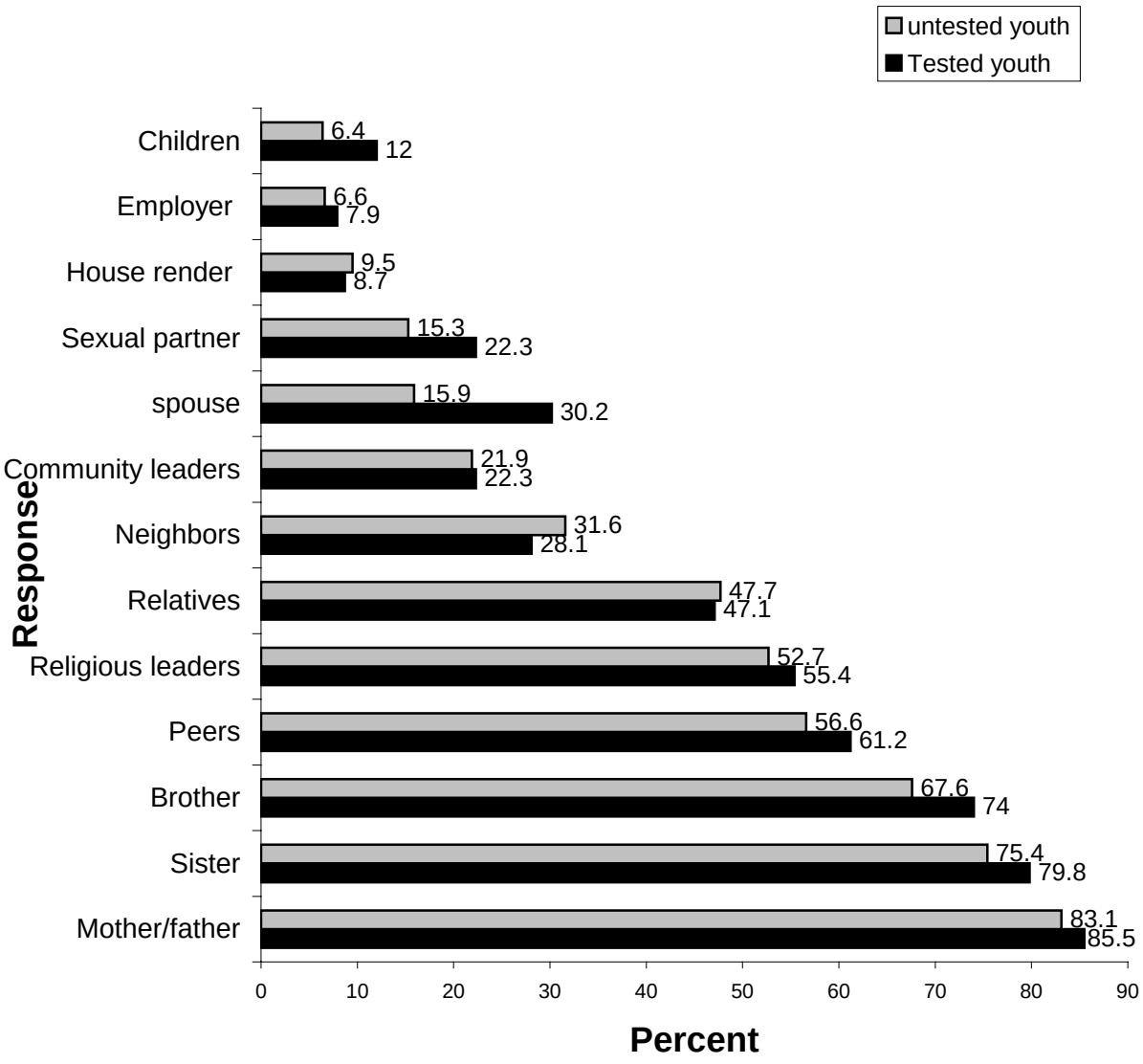


Figure 4: - With whom youth share test result of study subjects, Jijiga, December 2005.

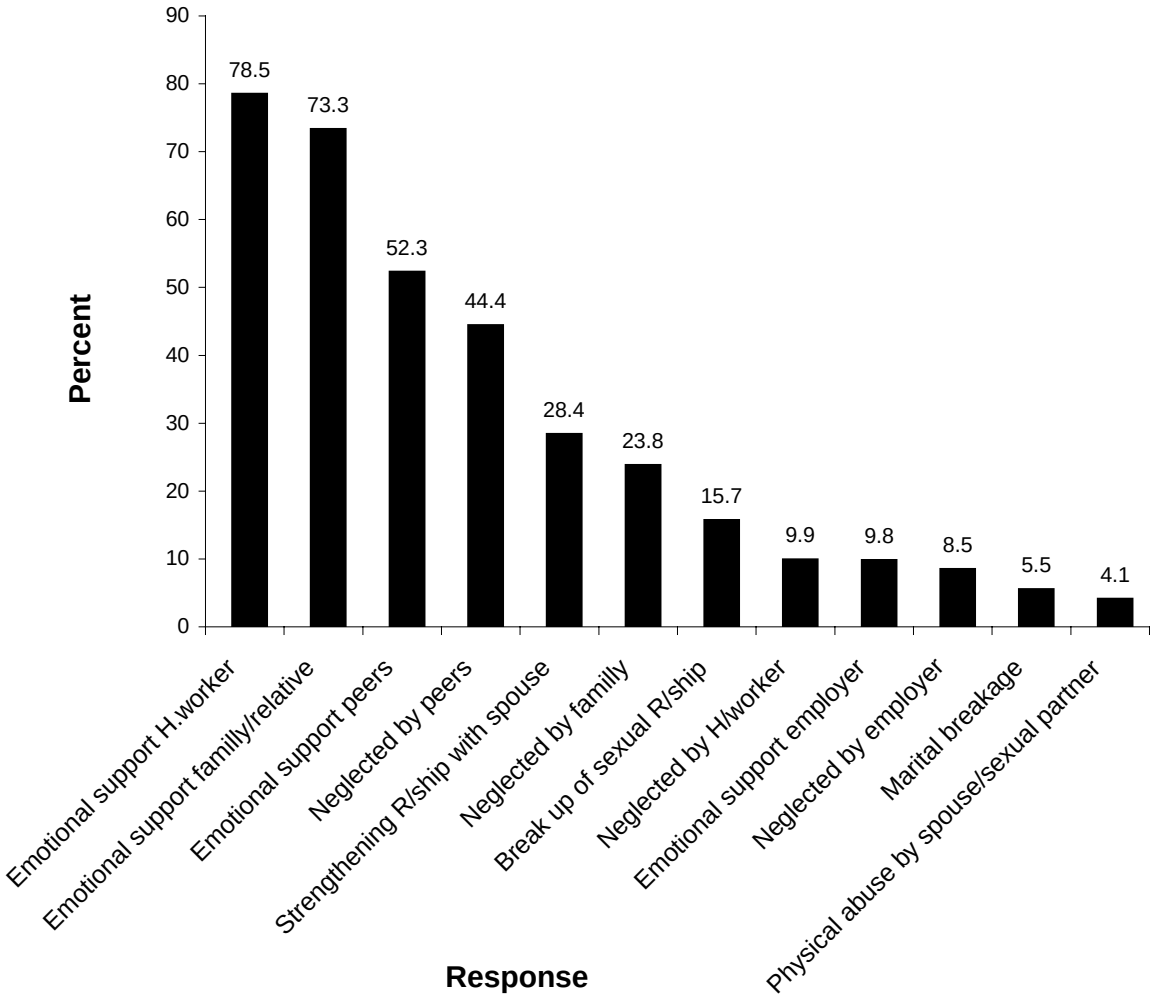


Figure 5: - Consequences of disclosing positive test result of study subjects, Jijiga town, December 2005.

5.2.1 Observational Assessment of VCT sites

Several factors can prevent provision of high-quality HIV prevention counseling, including unavailability of trained prevention counselors at the setting in which the HIV test was conducted and recommended strategies for addressing this common barrier including enhancing client acceptance of counseling by examining and improving the counseling provided.

In all health institutions they used series algorithm, rapid test and test performed by laboratory technicians. There is no ongoing counseling, care and support in all institutions. In FGAE clinic and H/C there are rooms for the service provisions but in hospital the room was used by other services and was not quiet. Only FGAE clinic gives treatment for STI, condom provisions, youth friendly service and referral to HAPCO and hospital.

The cost of the test in FGAE clinic for youth was five birr and for those who have letter from youth center was free but in hospital and H/C it was free for all. There are shortages of equipments in H/C like refrigerator. Despite the presence of trained counselors in hospital, the counseling was given by PMTCT counselors, and in H/C the service provider didn't take any counseling training at all.

Assessment during counseling process

In FGAE clinic describing the role of counseling, explain confidentiality and assessing partner's risk were not mentioned in all observations. Exploration of HIV/ STD risks was not mentioned in two out of five observations. In hospital, exploration of HIV/ STD risks was mentioned in two out of five observations and during post-testing counseling identifying source of support, negotiating disclosure and partner referral on addressing

risk reduction issues were not mentioned at all. In H/C, there was no counseling at all. In all institutions explore options for reducing risk was not mentioned.

5.2.2 Summary result of in-depth interview

5.2.2 .1 The major goal of the institutions with regard to VCT.

The service providers in hospital and H/C mentioned that the institutions paid more focus on PMTC program. VCT was done so as to give Nevirapine.

"Our main goal is for youth but still we involve adults".

(Service provider, FGAE clinic).

5.2.2.2 Service providers' attitude toward youth

When the service providers were asked about their attitude towards youth, one of the service providers noted that it is difficult to discuss about sexual issues as many of them do not easily open up.

"Most youth are not free to discuss sexual issues". (Service provider, FGAE clinic).

5.2.2.3 Service providers experience in the utilization of VCT service and parental consent.

The service providers in hospital and H/C reported that VCT service was more utilized by pregnant mothers. But FGAE service provider reported that;

"VCT is more utilized by less than 25 years and 90% of youth came to know their HIV status". (Service provider, FGAE clinic)

All service providers felt that HIV tests should be provided with parental consent for those less than fifteen years.

5.2.2.4 Service providers experience in utilization of guideline, feedback, supervision and periodic training update.

All service providers reported that counseling was not supported by ongoing counseling service and supervision. Except the service provider in H/C, all mentioned that they used National VCT guideline. The service providers in hospital and H/C reported that there were no update training and the services are not delivered in accordance with the need of the youth.

"There is nothing especial for the youth as to our services".

(Service provider, Karamara hospital).

5.2.2.5 Service providers experience in cost of VCT service for the youth and record keeping .

The service providers in hospital and H/C mentioned that VCT service is free for all.

But FGAE clinic provider said that there is especial consideration for youth.

"Our institution gives free service for youth unable to afford as approved by a letter from youth center".

All service providers mentioned that records are kept by coding and sent to RHB on quarterly bases.

5.2.2.6 Service providers' suggestions to enhance further utilization of VCT service for youth.

"Advocacy should be done by actively involving parents and religious leaders".

(Service provider, FGAE clinic).

"*Nika is a marriage ceremony in Islam with good opportunity for the religious leaders to encourage youth to be tested".* (Service provider, FGAE clinic).

"There is language barrier during counseling so that there should be more training for those speaking Somali language". (Service provider, Karamara hospital).

"There should be continuous health education". (Service provider, H/C).

5.2.3 Summary result of FGD

5.2.3.1 Knowledge about HIV/AIDS and VCT

All youth have stressed about the severity of HIV and AIDS.

"If the father dies of AIDS, no one takes care of you. The mother couldn't manage everything as before, thus you may enforce to drop out from school and assist your mother by selling injera or washing cloths. Particularly in our area, when parents die, the burden goes to grand mothers". (22yrs, female, Amhara)

Most youth mentioned that they should be tested anytime for HIV.

"Re-testing is necessary on a second marriage like marrying his brother after the death of the husband." (18yr, male, Somali)

Majority of female youth mentioned that female circumcision is common in their community that makes it one way of HIV spread in their area.

"Female circumcision in our area is common and they share unsterile instruments, so, this may be one way of HIV spread in our community". (22yr, Female, Somali)

5.2.3.2 Attitude toward VCT

When we asked about the importance of counseling, to cope with the results was the most common response.

"*It stabilizes your emotions and actions"* (19, male, non-Somali)

"Before testing I used to consider HIV is a killer disease but after counseling I realized that one can live longer." (22yr, female, non-Somali, tested)

"A girl may be infected in child hood during circumcision so that testing is very important" (21 yrs, female Somali).

When we asked about encouraging peers for HIV test, the majority were in favor of it considering oneself tested at first to be accepted by others. A 20-year non-Somali female expressed her fear to encourage her boy friend:

"It is difficult to me to encourage my boyfriend because he may push me to do sex if we are both negative."

"Take the test your self and then initiate others" (23yr, male, non-Somali)

5.2.3.3 Youth experience in their parental attitude on HIV testing.

When youth were asked about the consequence of parents knowing their desire to be tested, arising of suspicion for secretive sex was the most common response.

"Although the family suspects you of secretive sex when you want to be tested, it is good to be tested to know your self." (20yr, female, Somali)

"Parents are different in opinion. While some of them encourage testing, others suspect you for secretive sex." (19yr, male, non-Somali)

5.2.3.4 Youth preference for convenient place, counselor and cost issue for HIV testing.

The majority of youth preferred hospital and youth center for HIV test. They also expect cautious, well-mannered, same sex and age mate or elderly counselors.

Concerning the cost of VCT service, the majority suggested the test to be free of charge.

"As all persons may not afford, it is better that the test be free or have very low cost." (22yr, male, Somali)

5.2.3.5 Religious/cultural setting to promote VCT

Most of youth mentioned that there should be parents and religious leaders' active involvement in HIV testing.

"Religious leaders, elders, parents and authorities should be tested to be an example for the community." (22yr, female, Somali)

To encourage youth to be tested, most youth suggested increasing the number of mini-media, sensitization work to be done by youth and tested youth to be a model to encourage others.

"According to the custom in our area, if some one is tested, others are initiated to be tested especially if they are friends. So, awareness should be done widely".

(19yrs, female Somali)

6. DISCUSSION

This study has attempted to look into several possible contributing factors for VCT utilization by youth. The quality of the service is one of the determinant factors in this study. The observational method tried to address the main elements of counseling to look at the quality of the services so all the quality assurance assessments were not done. The study includes all tested youth who undergone voluntary counseling and testing because of direct or indirect pressure by some body or some thing.

Females, older youth, educated at least to the level of secondary school and sexually active had statistically significant association with VCT utilization. The majority of tested youth came voluntarily to know their HIV status. This is also supported by qualitative study and is in line with other study (10,17). Females were more likely to utilize VCT service than males. This may be due to females were tested for their pregnancy or more involved on Anti-AIDS activities.

Older youth utilized VCT service more than younger youth. Older youth might have more sexual experience and risk exposure than younger ones. This indicates infected younger youth can transmit HIV infection with out knowing their HIV status or if not infected they may acquire it from others. We need to cover the younger youth with VCT for effective prevention.

Youth with educational status of secondary and above have more utilized VCT service than illiterates. Youth in this educational level might have had better information and awareness about VCT and are more likely to utilize VCT. This is also similar to other studies done in Ethiopia and Uganda (20,25).

Sexually active youth were more tested than not sexually active ones. This may be due to their previous exposure of risk and they perceived HIV transmitted through unsafe sexual intercourse.

The fact that Mass media and peers are a key source of information about HIV testing highlights the potential to use media and peer networks to promote youth VCT service.

Regarding knowledge of HIV prevention and misconception this study didn't show statistical difference between tested and untested youth. One hundred and eighty four (25.4%) of youth had comprehensive knowledge about HIV/ AIDS. Although most youth (99.6%) have heard of HIV and AIDS, they are mostly (67.9%) unable to recognize three misconceptions about HIV. This is also in line with the findings of other studies in Ethiopia (1,10,26). Access to AIDS information alone is no guarantee of behavioral change, but education does have an impact (1).

Risk perception of youth was very low (5.7%). This finding goes with the other finding in the country (5,26). Study showed that in Rwanda self-perceived risk leads to more reception to intervention correlates with testing behavior (21,23,26,27,28).

The commonly cited reason for not being testing among youth was fear to get result. This is also in line with study finding in Tanzania, Kenya and Uganda (10,23). Most youth have a strong interest in knowing about their HIV status. This indicates they would like to be tested in the future. But studies have shown that the intention and actual practice of HIV are not the same (29). Even though health institutions accepted those fifteen to eighteen years old of age group, there is no legal background or supportive policy. Experience from Kenya and Rwanda showed that there is special consideration for those fifteen to eighteen years pregnant, married and mentally matured youth (15).

Most tested youth were tested in FGAE Jijiga branch, Followed by else where and Jijiga Karamara hospital. Twenty two (9.1%) tested youth were not satisfied with the service mainly due to unclear information given and most of them tested from Karamara hospital. This is also supported by qualitative study but study finding in Tanzania, Kenya and Uganda had shown that youth mainly get satisfied by Advice/information given (10).

The most commonly cited reason that cases gave for getting an HIV test was to know their HIV status voluntarily. This is also supported by qualitative study is consistent with study finding in Tanzania, Kenya and Uganda and Pre-marital testing is the main cited reason in other research findings in the country (10,20,21,23).

Regarding preference of most convenient place to get an HIV test, VCT method, counselor qualification and way of receiving HIV test result, there was no statistical difference between tested and untested youth. The majority preferred Hospital, confidential testing, physician, face-to-face way of receiving HIV test result. This is also supported by the qualitative study and is consistent with other research findings in the country (20,21,30,31). There is statistical difference between tested and untested youth regarding peers encouragement; tested youth encourage their peers more than untested youth.

Majority of youth were willing to share their results with their parents. This might be due to youth expecting support from their parents or close cultural relationship between parents and youth. But study in Kenya showed that youth less likely to share their test result with their parents because of fear of rejection by their family (15).

Assessment of HIV VCT centers from various angles is important in order to improve service to clients and provide accountability to stakeholders. All VCT providers should

conduct routine periodic assessment for quality assurance to ensure that the counseling being provided included the recommended, essential counseling elements (5,32).

Based on the observational assessment of VCT sites, all institutions lack essential counseling elements, on going counseling, feedback, and follow-up supervisions. While the hospital lacks appropriate room for VCT service, STI treatment, condom access, youth friendly service, follow-up training and referral system, the H/C additionally lacks basic training and equipments like refrigerator. This is also supported by in-depth interviews.

HIV prevention counseling should focus on the client's own unique circumstances and risk, and should help the client set and reach an explicit behavior-change goal to reduce the chance of acquiring or transmitting HIV (5).

Ongoing HIV prevention counseling aimed at personal risk reduction might be useful for youth who have continuous HIV risk. Youth with ongoing risk behaviors might benefit from ongoing counseling. Supervision updates the counselor's knowledge and skills, and enables counselors to look at their work in more objective, dispassionate and judicious way (5).

Lack of VCT room, equipments, STI treatment and condom access can affect the quality of service. Basic training and follow-up training are recommended to ensure high-quality VCT service (4). Referral can help youth access to relevant medical, preventive, and psychosocial support service to reduce their risk for transmitting or acquiring HIV infection (5).

VCT service providers and focus group discussants stressed the need for active involvement of parents and influential people in VCT promotion program. This is also in line with study finding in Tanzania, Kenya and Uganda (10).

7. STRENGTH AND LIMITATIONS

Strength

- The design of the study is trying to cover most of youth population by considering ethnicity distribution.
- Structured questionnaire adopted from a standard questionnaire from BSS and WHO.
- Questionnaire was pre-tested and necessary modification was made, the principal investigator and supervisors were supervising the daily data collection activity.
- The study used triangulation method.

Limitation

- Respondents might not give their exact attitude towards a given question. The study, therefore, could be confounded by social desirability biases.

8. CONCLUSION

- Females, older youth, educated at least to the level of secondary school and sexually active were more likely utilization VCT services.
- The study revealed that tested youth were mainly tested in order to know their HIV status and untested youth were mainly not tested because of afraid to get the result.
- There is no supportive policy for those fifteen to eighteen years to be tested with out parental consent.
- The study showed that tested youth have more willingness to encourage their peers to be tested.
- Most of the youth have desire to be tested in the future.
- The study revealed that majority of the youth preferred confidential testing, physician as a counselor and face-to-face receiving the test result.
- The study showed that the majority of tested youth preferred youth center for HIV testing while the majority of untested youth preferred Hospital.
- All institutions lack essential counseling elements, on going counseling, feedback, and follow-up supervisions. While the hospital lacks appropriate room for VCT service, follow-up training, STI treatment, condom access, youth friendly service and referral system, the H/C additionally lacks basic training and equipments like refrigerator.
- VCT service providers and focus group discussants emphasized on the need for active involvement of parents and influential people in VCT promotion program.

9. RECOMMENDATIONS

- Proper IEC activities on HIV VCT should be promoted through mass media and peer education for youth in general; males, illiterates, young and not sexually active youth in particular need to be addressed by involving all stakeholders and using local resources.
- The existing VCT services should be strengthened by training, regular supervision, necessary equipment, STI treatment, condom provision, referral system and feedback, and infra structure.
- The policy should be considered for those fifteen to eighteen years old age group to be tested with out parental consent.
- Health institutions are recommended to start HIV VCT as an outreach at youth centers by making network.
- Hospital, health center and FGAE should form network to better address the need of youth in VCT service.
- Parents and other influential people in the community should be actively involved in VCT promotion activities.
- All stakeholders, particularly the health sector, should give priority to address barriers of VCT utilization for youth.
- Further study needs to be conducted to evaluate the effectiveness of VCT among youth.

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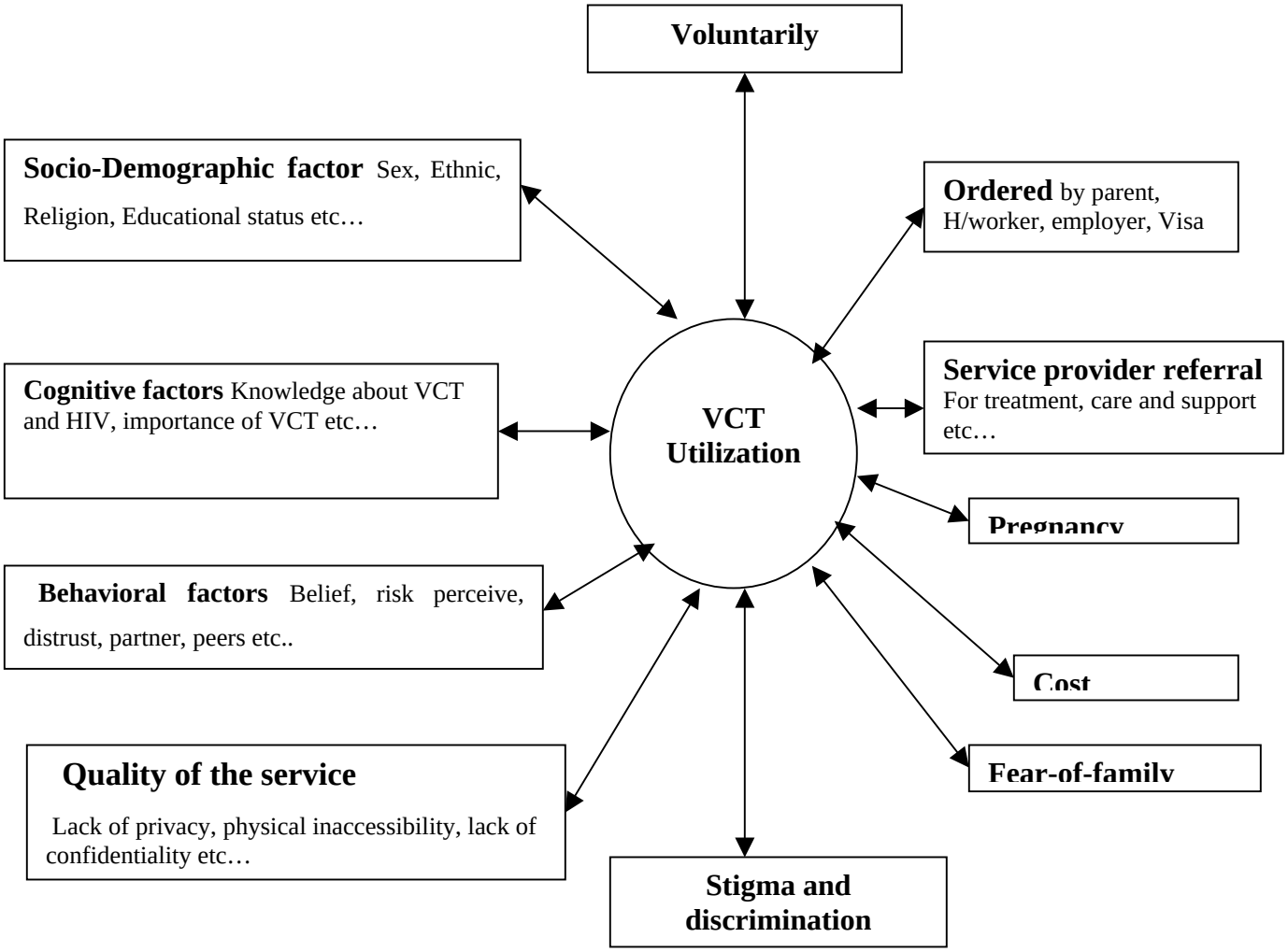
ANNEX. I

CONCEPTUAL FRAMEWORK



Annex-2 MAP OF SOMALI REGION

ANNEX:-3 DESCRIPTION OF FGD AND IN DEPTH INTERVIEW PARTICIPANTS

FGA participants

Characteristics					
Sex	**Ethnicity**	**No of participants**	**Place**	**Duration of session**	**Date**
Male	**Somali**	**8**	**Red cross office**	**85 min**	**30/03/97**
	Non-Somali	**8**	**Red cross office**	**60 min**	**30/03/97**
Female					
	Somali	**8**	**Red cross office**	**60 min**	**30/03/97**
	Non-Somali	**8**	**Red cross office**	**70 min**	**30/03/97**

***all participants were youth(15-24yr)**

IN-DEPTH INTERVIEW PARTICIPANTS

Sex	**Place**	**Duration of session**	**Date**
Female	**Hospital**	**60 min**	**22-23/03/97**
Female	**FGAE**	**60 min**	**20-21/03/97**
Female	**H/C**	**60 min**	**25,27/03/97**

ANNEX: -4

VCT study in Jijiga: Survey formate for Kebele_____

HH No	Eligible Yes=1 No =2 (15-24yrs)	Eligible code No in the house hold 1= 1st elder youth 2=2nd elder youth	Age	Sex 1=Male 2=Female	Education 1=Illiterate 2=Read & write 3= Grade 1-6 4= Grade 7-8 5= Grade 9-12 6= >12 grade	**HIV test ever** Yes=1 No =2	Willing to participate in the study Yes =1 No =2	If t tes 1=Y 2=(wo 3=I 4=r 5=I 6=(

ANNEX-5

QUESTIONNAIRE

Factors Associated with VCT utilization in Jijiga Town, Somali Region, Ethiopia,2004

Ser. No _____

Time at the beginning of interview [____/_____]

001 Questionnaire identification number_____

002 Kebele _____ 1. Kebele =1 2. Kebele =2 3. Kebele =3

003 House number _____

004 Study participant _____ 1 = VCT users
2 = Non-VCT users

Introduction: - my name is _____. I'm working for Somali Regional Health Bureau. We are interviewing 15-24 age groups, those already tested for HIV and those not tested yet in order to identify influencing factors for Voluntary HIV counseling and testing service utilization among youth to improve the program and plan for the future.

Confidentially and content:- I'm going to ask you some general and in-depth personal questions. Your answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand for our study objective and for future action. We would greatly appreciate your helping. Would you willing to participate? If Yes, _____(1) continue. No _____(2) stop.

005 Result Code_____1=Completed. 2=Refused 3=partially completed 4. Other

006 Interviewer Name _____ Signature _____

007 Date of interview [____/_____/_____]
Checked by supervisor: Signature _____ Date _____

I) Socio-Demographic Characteristics

No	Questions and Filters	Response Coding categories	Skip to	
101	Sex of the respondent	Male…… ……=1 Female …….. …… =2		
102	Age in years (completed year)	Year _____ Do not know…… =8 No response ……. …… =99		
103	What is your Marital status	Single ……. ……. =1 Married …..…….. =2 Widowed …….. =3 Separate or divorced ….……..=4		
104	If married, how many wife do you have?	Single…… …… . =1 Multiple…… …… =2		
105	Level of Education	Illiterate …….. ..=1 Read and write ……. …… =2 Grade 1-6…… …….=3 Grade 7-8…… ……..... =4 Grade 9-12…..…… ……... =5 Above grade 12……..... =6 No response …… ……. =99		
106	Currently in school?	Yes …….. =1 No ……... =2		
107	What is your current occupation	Student …… …… =1 Job less …… =2 Merchant ……. =3 House wife …… ..=4 Driver …… =5 Gov't employee ……=6 Other(specific)_____ =7		
108	In the last 12-month have you been away from home for more than one month?	Yes ……..…. =1 No …… ……..… =2 Don't know …… ……. =88 No response ……..……..=99		
109	If you have a job, What is your average monthly income?	_____birr per month Do not know …… ……..=88 No response …… ……=99		
110	What religion are you?	Muslim ……..…. =1 Orthodox Christian …….=2 Protestant …… ……..….=3 Catholic …… =4 No response ……. ….. =99		
111	To which ethnic group do you belong?	Somali …….. =1 Amhara …… …. =2 Oromo ……..…… =3 Gurage …… …... =4 Hareri ……..……..… …….=5		

		Tigray ……..…….=6 Other_____ =7		
112	Do you presently live:-	A lone …… =1 With family …….. =2 With employer …… =3 With peer/friend/coworkers/student= 4 Wife/partner ……...…..=5 Others (specify)_____ =6 No response ……=99		

II) Sexual history

No	Questions and Filters	Response Coding categories	Skip	Code
201	Have you ever had sexual intercourse?	Yes ..... .=1 No ……. =2 → No response …… = 99		**Q. 301**
202	If yes, at what age did you first have sex?	Age in year _____ Don't know ……. =88 No response …….. =99		
203	If yes, with how many different people have you had sex during the past one-year?	_____ Number		
204	Have you had sexual intercourse with non-regular partner?	Yes …….. =1 No ……. =2 → No response……..… =99		**Q.301**
205	If yes to Q 204 was that in the past 12 months?	Yes……..=1 No ……..=2 Don't know……..……=88		

III) Knowledge and attitude towards and risk perception about HIV/AIDS

No	Questions and Filters	Response Coding categories				Skip	
301	Have you heard about HIV/AIDS?	YES …… =1 No ……. =2 →					**Q. 311**
302	If yes for Q 301 From where did you hear about HIV/AIDS? (multiple response is possible)		Yes	No	DN	NR	
		302.1 Family	1	2	88	99	
		302.2 Friend	1	2	88	99	
		302.3 Neighbors	1	2	88	99	
		302.4 Mass media	1	2	88	99	
		302.5 Health workers	1	2	88	99	
		302.6 others (specify)	1	2	88	99	
303	How much of a threat do you think	No threat at					

	HIV/AIDS is to your community? Would you say (read out codes)	all ……..…….... =1 Some threat …… =2 Serious threat ……... =3		
304	Do you think that a healthy looking person can be infected with HIV?	Yes ……. =1 No……... =2 Do not know……. =88		
305	How is HIV transmitted? (multiple response is possible)	Yes No DN NR 305.1 Un safe Sexual intercourse 1 2 88 99 305.2 Mother to child 1 2 88 99 305.3 transfusion of infected blood 1 2 88 99 305.4 Sharing of sharps with some one is infected 1 2 88 99 305.5 Inhalation 1 2 88 99 305.6 Body contact greeting 1 2 88 99 305.7 Eating together 1 2 88 99 305.8 Mosquito bite 1 2 88 99 305.9 Others (specific) 1 2 88 99 305.10 Don't know 1 2 88 99		
306	How can you find out if you have HIV/AIDS? (multiple response is possible)	Yes No DN NR 306.1 Simply by looking 1 2 88 99 306.2 By physical examination, of health personnel 1 2 88 99 306.3 Go to Traditional healer/wizard 1 2 88 99 306.4 Go to counseling or testing service 1 2 88 99 Other(specify)_____ 1 2 88 99		
307	How can people protect themselves from getting HIV/AIDS? (multiple response is possible)	Yes No DN NR 307.1 Abstinence 1 2 88 99 307.2 Avoiding multiple sexual partners 1 2 88 99 307.3 Always condom use 1 2 88 99 307.4 Avoiding sharing sharps 1 2 88 99 307.5 Using sterile needle 1 2 88 99 307.6 Avoiding Mosquito bite 1 2 88 99 307.7 Avoiding physical contact 1 2 88 99 307.8 Avoiding Eating together 1 2 88 99 307.9 Avoiding Living together 1 2 88 99 307.10 Others (specify)_____ 1 2 88 99		
308	Do you think you might be infected by HIV?(are you afraid of getting HIV/AIDS)	Yes …… =1 No ……..=2 May be ……..……..=3 No response……. =88		
309	If yes, for Q 308 why at risk?	More than one sexual partner ……... =1 Have had sex with out condom…… =2 Have had sexual intercourse with CSWs…..… =3		

		Injuries with contaminated sharps……=4 Blood transfusion ……=5 Others (specify) _____ =6		
310	If No, for Q 308 why not at risk?	Have never made sexual intercourse…… =1 I have abstained from sex…….. =2 One faithful partner……..…….... = Did not share injection……. =4 I always use condom……..=5 Others (specify) ……..=6		
311	Have you had any STD's in the past one-year?	Yes …….. .=1 No…….. .=2 No response…… =3		
312	During the last four weeks how often have you had drinks containing alcohol? Would you say… Read out circle one.	Every day ……..=1 At least once a week ……..… =2 Less than once a week …… ……=3 Never …… =4 Don't know …… ……. =88 No response ……...… =99		
313	Some people have tried a range of different type of drugs. Which of the following, if any, have you tried? Read list	Yes No DN NR Khat 1 2 88 99 Shisha 1 2 88 99 Benzene 1 2 88 99 Heroin 1 2 88 99 Cocaine 1 2 88 99		
314	If yes,for Q 313, During the last four weeks how often have you taken those drugs? Read list. 1= dialy 2=at least once a week 3= less than once a week 4= Never 88= Don't know 99= No response	1 2 3 4 88 99 Khat 1 2 3 4 88 99 Shisha 1 2 3 4 88 99 Benzene1 2 3 4 88 99 Heroin 1 2 3 4 88 99 Cocaine 1 2 3 4 88 99		

IV) Voluntary Counseling and Testing

No	Questions and Filters	Response Coding categories	Skip	
401	Have you heard of voluntary counseling and testing?(if No, tell her/him about VCT)	Yes …… =1 No…….. =2		
402	If yes, from what source did you learn where to get tested for HIV? (multiple response)	Yes No DN NR 402.1 Peer 1 2 88 99 402.2 spouse 1 2 88 99 402.3 Partner 1 2 88 99 402.4 Mother 1 2 88 99 402.5 Father 1 2 88 99 402.6 Other relatives 1 2 88 99 402.7 Teacher 1 2 88 99		

		402.8 Mass media 1 2 88 99 402.9 Youth center 1 2 88 99 402.10 Health institution 1 2 88 99 402.11 Others (specify) 1 2 88 99		
403	(Please do not tell me the result) Have you ever had VCT in the past?	Yes ……=1 No ……=2 → Q413 No response ……..…….. =99		
404	If yes to Q 403, What was the reason for having VCT? **(only for tested or cases)**	Voluntarily ……..……....=1 Ordered by health worker……..… =2 Required for visa) ……..=3 Required for work ……..=4 Others (specify)_____..... =5		
405	If Voluntarily, for what reason?	To know self ……=1 To plan for future ……..=2 Marriage……..……=3 pregnancy……..=4 Blood donation ……=6 Treatment ……..……..……=7 Others (specify)_____ = 8		
406	(Please do not tell me the result) Where were you tested? **(only for tested or cases)**	Karamara Hospital..... =1 Jijiga FGEA VCT center ……..….. =2 Others (specify)_____..... =3		
407	(Please do not tell me the result) Did you receive the result?**(only for tested or cases)**	Yes…….. =1 No …….. =2 No response ……... = 99		
408	(Please do not tell me the result) Which part of Counseling did you received? **(only for tested or cases)**	Pre-test counseling ……. =1 Post-test counseling ……..…… =2 Both pre and post test counseling ….……=3 Didn't receive counseling…… =4 Don't know……. =5		
409	Were you satisfied with the service? **(only for tested or cases)**	Yes……=1 No……=2		
410	If yes, for Q 409 what was the reason?	Warm reception……...=1 Quick service……..……..=2 Confidentiality……..……=3 Privacy……=4 Free service ……..=5 Youth friendly ….……=6 Professionalism of health care worker…….=7 Referral for care and support……..……..=8 Others (specify)…….=9		

411	If No, for Q 409 what was the reason	No Warm reception…… =1 Long waiting time…...……=2 Lack of Confidentiality..……..=3 Lack of Privacy……..……..=4 Expensive… ……=5 Counseling given was not clear……. =6 No Referral for care and support……=7 Others (specify)……..=8		
412	How long in time did it take to get your result? **(only for tested or cases)**	_____ hours		
413	If No to Q 415**,** what is the reason you did not have VCT before? **(only for untested or control)**	Do not know where to get …… =1 Do not believe it will help …… =2 Partners and self trust …… =3 Afraid to get the result ……...……. =4 Do not know about it ..…….=5 Lack of money …….. =6 Partner refusal ……...=7 Fear of stigma ……=8 No near by the service …….. =9 Others (specify)……...…….=10		
414	Do you agree that VCT is important?	Yes ……. =1 No …… =2 Do not know …… =88 No response ……... = 99		
415	If yes, to Q 412 what are the advantages?	Prevention of partners/others…… =1 Knowing self …….. =2 Self care for future .....……...……=3 To plan future life ……..……=4 Prevent mother to child transmission ……....=5 Choosing partner ……=6 Others (specify)_____…….…… =7 Do not know ……..…… =88		
416	Have you recommended an HIV test to any of your peers?	Yes……. =1 . No ……. =2		
417	Do you have the desire to have VCT whether you have it before or not?	Yes……. =1 No ……..=2 Don't know ……...……...=3 No response…… =99		
418	If yes to Q 417, where would you go?	Gov't Health institution having VCT center ……. =1 NGOs Health institution having VCT center…… =2 Privet Health institution having VCT center…….. =3 Others (specify)…… =4 Do not know……..…….. =88		
419	Generally, who should go for an HIV/AIDS test?	Yes No DN NR		

	(multiple response is possible)	418.1 Sex workers 1 2 88 99 418.2 Users of sex workers 1 2 88 99 418.3 Drivers, Soldiers, Traveling sales persons 1 2 88 99 418.4 Any one at risk 1 2 88 99 418.5 Those with multiple partners 1 2 88 99 418.6 Any one sexually active 1 2 88 99 418.7 Those who are sick 1 2 88 99 418.8 Any one 1 2 88 99 418.9 Others 1 2 88 99		
420	When does a person should test for HIV?	Any time ……. . =1 During illness …….. .=2 Before Marriage ……... =3 During travel to a broad …… =4 In doubt ……5 Others (specify) _____ =6 Do not know……...…… =88 No response …… =99		
421	Where would it be the most convenient for you to get an HIV test?	Clinic …….. =1 Hospital……... =2 Youth center ……..=3 School …… =4 Mosques……..=5 Church ……... =6 VCT center ……. =7 Others (specify)……. =8 Don't know ……..=88 No response ……..……..=99		
422	Which method of testing do you prefer if both methods are available?	Confidential , liked testing……..=1 Anonymous, lionked testing …….. =2 Others (specify) ……...……=3		
423	By whom do you prefer to get VCT Counseling?	Physician (Doctor) ……..…… =1 Nurse ……..…….. =2 Trained counselor …… =3 Religious leader ……. =4 Community leaders……..…… =5 HIV/AIDS positive people……... =6 No need of counselor ……..…….=7 Others (specify) ……...… =8 Don't know ……..=88 No response ……..….=99		
424	Which way do you prefer to obtain the HIV test result?	Face to face……. =1 Secretive letter…….. =2 Partner ……...……... =3 Relative…… =4 Others(specify) _____ =5 Do not know ……...……=88		

		No response ……=99		
425	What time convenient for VCT service delivery?	Morning from 8 am-12 am …… =1 Afternoon from 1pm- 5pm……..=2 Any time ……=3 Others(specify) _____ =4 Do not know ……=88 No response ……..…… =99		
426	Are you willing to pay a reasonable fee for VCT service?	Yes ……=1 No …… =2		
427	If Yes, What do you think is a reasonable fee for VCT services?	_____Eth.Birr		

V) Stigma and Discrimination

No	Questions	Yes (1)	No (2)	Not applicable (33)	No response (99)
428	If you test positive for HIV, would you tell any of the following individual about your HIV test result? (please read all the options that apply)				
	a) Your sexual partner/spouse				
	b) Both parents	1	2	33	99
	c) mother,	1	2	33	99
	d) father,				
	e) siblings/cousins	1	2	33	99
	f) Your relatives	1	2	33	99
	g) peers	1	2	33	99
	h) Your neighbors	1	2	33	99
	i) Your religious leaders	1	2	33	99
	j) Your community leaders	1	2	33	99
	k) Your employers	1	2	33	99
429	If you positive for HIV and prefer to disclose your HIV test result, how likely is it that the following might happen to you? (please read all the options that apply)				
	a) neglected by family	1	2	33	99
	b) Marital breakage	1	2	33	99
	c) Physical abuse by spouse/sexual partner	1	2	33	99
		1	2	33	99
	d) Neglected by friends	1	2	33	99
	e) Increased emotional support from family/relatives	1	2	33	99
	f) Increased emotional support by peers	1	2	33	99
	g) Strengthening of relationship with spouse/sexual partners	1	2	33	99
	h) Increased emotional support from health professionals	1	2	33	99
		1	2	33	99
	i) Break up sexual relationship				
	j) Increased emotional support from religious leaders	1	2	33	99
		1	2	33	99

	k) Increased emotional support from community leaders	1	2	33	99
	l) Discrimination by health professionals	1	2	33	99
	m) Discrimination by religious/ community leaders	1	2	33	99
	n) Hopelessness	1	2	33	99
	o) Revenge				
	p) Disclose the RESULT				

This is the end of our questionnaire. Thank you very much for taking time to answer these questions. We appreciate your co-operation.

Time at the end of interview_____

ANNEX-6

Observer checklist, in-depth and FGD interview protocol.

Observer checklist

Introduction and Orientation		
Key counselor tasks	Task addressed?	Comments and recommendations
Introduce to client		
Describe your role as counselor		
Explain confidentiality		
Review the rapid test process: o If negative, not infected as of 12 weeks earlier o If positive, infected with o Accurate, same day test results		
Outline content of session: o Exploration of HIV/STD risks o Address options for risk reduction o Discussion of testing and meaning of results o Provide test and results o Develop risk reduction and support plan		
Review “map” of client stops/activities during this counseling and testing visit		
Address immediate questions and concerns		
Assess Risk		
Assess client’s reason for coming in for services.		
Assess client’s level of concern about having/acquiring HIV		
Explore most recent risk explore/behavior o When o With whom o Under what circumstances		
Assess client’s level of acceptable risk		
Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident) o Number of partners o Type of partners o Frequency of new/different partners o Condom use		

Identify risk triggers, vulnerabilities and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		
Summarize and reflect back client's story and risk issues o Risk pattern o Prioritize risk issues o Risk triggers and risk vulnerabilities		
Explore Options for Reducing Risk		
Review previous risk reduction attempts		
Identify successful experiences with practicing safer sex		
Identify obstacles to risk reduction		
Explore triggers and situations which increase the likelihood of high risk behavior		
place risk behavior in the larger context of client's life		
Assess Condom skills		
Identify entire range of options for reducing risk		
Role play, skill build, problem solve		
Address examples when client's beliefs and behavior are at odds or when feeling are mixed about changing behavior		
Summarize risk reduction options and discussion		
HIV Test preparation		
Discuss client's HIV test history and behavioral changes in response to results		
Address client's feelings about testing for HIV		
Explore with whom client has shared his/her decision to come for VCT services. o Partners, family and friends		
Discuss the client's understanding of the meaning of positive and negative HIV test results Clarify client's misunderstanding about the meaning of HIV test results.		
Assess client's readiness to be tested and receive the test results o Response to positive results o Response to negative results		
Assess who will provide the client support if he/she were HIV infected		
Discuss positive living o Staying well living longer o Obtaining support o Medical care and follow-up		
Weigh and discuss the benefits of knowing your serostatus		

(knowledge is power) preparing for the future		
Determine client's test decision		
Identify and address examples when beliefs and behavior are at odds or when feeling are mixed about being tested and dealing with the results.		
If the client elects to be tested, describe the tests and the interpretation/reading of the test		
Direct client to lab to receive test and instruct him or her to return to the counselor or where to wait should the counselor be with another client.		
Provide HIV Positive Test Results		
Inform client that the test results are available		
Provide results clearly and simply		
Review the meaning of the result		
Allow the client's understanding of the result		
Explore the client's understanding of the result		
Assess how client is coping with the results		
Acknowledge the challenges of dealing with an initial positive result		
Discuss living positively. (If the client is not prepared for this discussion, provide him or her with a pamphlet)		
Identify Sources of Support		
Assess who client would like to tell about his or her positive test results		
Identify person, family member, or friend to help the client through the process of dealing with HIV		
Identify current health care resource		
Address the need for health care providers to know client' test result		
Explore client's access to medical services		
Identify needed medical referrals		
Discuss situations in which the client may want to consider protecting his or her own confidentiality		
Discuss options of support groups (i.e. post test club)		
Provide appropriate referrals		
Negotiate Disclosure and Partner Referral		
Explore client's feelings about telling partners about his or her HIV positive test result		
Remind client that his or her result does not indicate the partner's HIV status		
Identify partners that are at risk and need to be informed o their risk for HIV infection		
Discuss possible approaches to disclosure of serostatus to partners		

Anticipate potential partner for reactions		
support client to refer partner for testing		
Practice and role-play different approaches to disclosure		
Provide the client with support		
Address Risk Reduction Issues		
Assess client's plan to reduce risk of transmission to current partners		
Explore client's plan for reducing the risk of transmission to future partners		
Address disclosure of HIV status to future partners		
Encourage the client to protect others from HIV		
Anticipate potential partner reactions		
Support client to refer partner for testing		
Practice and role-play different approaches to disclosure		

Observer checklist

1. Test kit available always ? 1= Yes ☐ 2= No ☐

2. Type of test kit? 1= Rapid 2= ELISA 3=Others (specify)_____

3. Type of Rapid test 1=Determin 2=capilles 3= Serocard 4= Others (specify)_____

4. Test algorithm? 1= Series 2= Parallel

5. Is there room for VCT service provision? 1= Yes ☐ 2= No ☐

6. Is there privacy maintained? 1= Yes ☐ 2= No ☐

7. Is there care and support? 1= Yes ☐ 2= No ☐

8. Is there Referral System? 1= Yes ☐ 2= No ☐

9. If yes, where and for what purpose? _____

10. What is the number of trained counselor? _____-

11. Blood test done by_____

12. Cost for the test? _____

13. Ongoing testing is available? 1= Yes ☐ 2= No ☐

Topic Guide for In-depth interview

I am happy that you could make time to me. My name is _____. I came from AAUMF. I am carrying out a study called determinants of VCT service utilization among youth with the support of UNICEF. The study is aimed to improve and expand VCT utilization among youth. We would like to identify based on your knowledge and experience, ways to improve quality and utilization, and to expand VCT service for youth.. you have vital information and experience to share with me on this subject. Free to decide on whether or not to participate in the discussion. I also encourage to feel free to say anything concerning the topics. I appreciate your co-operation. (The facilitator may ask the participants to introduce him/her at this stage, giving a bit of his/her back ground and work/experience related to VCT).

1. Town_____
   Position of Respondent_____

   Name of Respondent_____

2. What is the major goal of your institution with regard to VCT?
   Probe - objective
   - ❖ Which type of counseling and which one is more emphasis is given, working days and time?
   - ❖ Plan, integration like medical care and psychosocial Support, budget and referral system?
3. How is your attitude toward youth?
   Probe – Problems
4. VCT service is more utilized by whom?
   Probe – why?
   - ❖ Your client proportion
5. Youth experience on parental consent?
6. Are counselors supported by their supervisors?
   Probe – how?
7. Are supervisors familiar with the curriculum?
   Probe - Which curriculum?
8. . Is there ongoing, periodic observation of counselors with immediate feedback by knowledgeable supervisors?
9. Is there periodic training update?
10. Is there additional risk reduction counseling service that could be applied for HIV-negative persons with on-going HIV risk?
    Probe – How?
11. Is the service delivering in accordance with a need of the youth?
    Probe- How? , Like youth-friendly etc…
12. How is record keeping?
13. How about the Cost of VCT service for the youth?
14. In what ways do you think VCT service utilization can be enhanced further for youth?

Topic Guide for FGD

You are all welcome. We are happy that you could make time to us. We are a team selected from Somali Regional health Bureau and from Addis Ababa university department of community health (Individual says own Name). We are carrying out a study called determinants of VCT service utilization among youth with the support of UNICEF. The study is aimed to improve and expand VCT utilization among youth. We would like to identify- based on your knowledge and experience- ways to improve quality and utilization, and to expand VCT service for youth. The result could be useful to individuals, families, or community and the country at large by highlighting ways in which together we can drastically curtail the epidemic through enhanced local actions. You have been purposely selected to participate in this exercise because we believe that, as youth, the key member of your community, you have vital information and experience to share with us on this subject. Individuals are free to decide on whether or not to participate in the discussion. We also encourage members to feel free to say anything concerning the topics of discussion. Thank you very much. (The facilitator asks participants to introduce themselves at this stage).

1. Please tell me about how much of a threat do you think HIV/AIDS is to your community?
2. Can you tell me about VCT services in this area?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?
3. When youth will be tested for HIV test and not tested for HIV? Especially in this area?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?

4. How about encouraging peers for HIV testing?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?
5. How about importance of counseling?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?
6. What is the indication in this area if youth tested for HIV?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?

7. What will be the consequence if parents who know their child wants an HIV test?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?
8. How about the cost issue for HIV testing?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?
9. Where will be the convenient place for HIV testing?
   Probe:-
   - Would you explain further?
   - Would you give me an example?
   - Is there any thing else?
10. What you expect from counselor in particular and VCT service in general?
    Probe:-
    - Would you explain further?
    - Would you give me an example?
    - Is there any thing else?
11. Is there any cultural and religious practices in the area that could promote/prevent VCT Service utilization?
    Probe:-
    - Would you explain further?
    - Would you give me an example?
    - Is there any thing else?
12. What could be done to encourage youth go for VCT service?
    Probe:-
    - Would you explain further?
    - Would you give me an example?
    - Is there any thing else?

We thank each of you for time and cooperation and we do appreciate all your suggestions.