

Addis Ababa University
School of Graduate Studies
Department of Psychology

Knowledge and Attitude towards HIV/VCT
among military personnel: the case of cadets at
Major General Haylom Araya Military
Academy.

BY: Mulugeta Dagneu



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Abstract

An assessment was made mainly to describe the knowledge about and attitude towards HIV/VCT of cadets at the Major General Haylom Araya Military Academy. Subsequently, an attempt was made to see the effects of cadets' residence, marital status and education level on cadets' knowledge and attitudes towards HIV/VCT.

To attain this objective a sample of 193 male cadets was randomly selected from a population of 595 cadets and all the available female cadets' (16) were included. In addition, (18) cadets were purposefully selected for the Focus Group Discussion (FGD). The collected data were analyzed using SPSS soft ware.

Analysis of the qualitative and quantitative data indicated that the majority of the cadets have got good knowledge of HIV/VCT and showed a favorable attitude towards HIV/VCT, but with some reluctance to get the service.

Moreover, cadets didn't show significant knowledge differences on HIV/VCT across residence and education levels but marital status. No significant attitude differences was observed towards HIV/VCT across marital status and education levels except residence where urban raised cadets were seen with more favorable attitudes than rural raised cadets. Moreover, knowledge about HIV/VCT was not seen significantly correlated with attitude towards HIV/VCT.

It was concluded that cadets had good knowledge and attitude towards HIV/VCT despite some reluctance to test their anti bodies against HIV.

ACRONYMS

- ❖ **AAU** – Addis Ababa University
- ❖ **AIDS** – Acquired Immunity Deficiency Syndrome
- ❖ **ART**-Anti Retroviral Therapy
- ❖ **BCC** – Behavior Change and Communication
- ❖ **BSS** – Behavioral Surveillance Survey
- ❖ **CDC** – Center for Disease Control
- ❖ **CRDA** – Christian Relief Development Association
- ❖ **DU** – Defense University
- ❖ **DHS** – Demographic Health Survey
- ❖ **DPACT** – Disease prevention and Control Department
- ❖ **EHA**-Ethiopian Health Association
- ❖ **FHI** – Family Health International
- ❖ **FDRE** – Federal Democratic Republic of Ethiopia
- ❖ **FGDs** – Focus Group Discussions
- ❖ **HAPCO** – HIV/AIDS Prevention and Control Office
- ❖ **HIV** – Human Immunity Virus
- ❖ **IBG** – Imperial Body Guard
- ❖ **MGHA** – Major General Haylom Araya
- ❖ **MOD** – Ministry Of Defense
- ❖ **NAC** – National Aids Council
- ❖ **NGOs** – Non Governmental Organizations
- ❖ **PMTCT** – Prevention of Mother to Child Transmission
- ❖ **PLWHA** – People Living With HIV/AIDS
- ❖ **SPSS** – Statistical Package for Social Sciences.
- ❖ **STIs** – Sexually Transmitted Infections
- ❖ **UNAIDS** – United Nation AIDS
- ❖ **VCTs** – Voluntary Counseling and Testing Services
- ❖ **WHO** –World Health Organization
- ❖ **YRHE** – Young Reproductive Health Ethiopian

Chapter one

Introduction

1. Background

The first case of HIV/AIDS was clinically diagnosed in the USA in 1981 (UNAIDS, 2004). Within few years it reached Africa and victimized a huge number of its population. Sub-Saharan Africa with 10 percent of the world's population hosts more than 80 percent of the worlds HIV infection and AIDS cases (FDRE/MOH, 2004).

In Ethiopia, the first evidence of HIV-infection was discovered in serological samples in 1984. This was followed by the first reported case of AIDS diagnosed in a laboratory in 1986 (MOH/HAPCO, 2004). Since then, the devastating effect of HIV/AIDS has been getting worse. Its impact, if not controlled, will be highly destructive. It is expected to be the main cause of deaths among adults who are highly the productive members of the society WHO (2002).

According to the report of UNAIDS (2006) an estimated 38.6 million (33.4- 46.0 million) people world wide were living with HIV at the end of 2005; an estimated 4.1 million (3.4- 6.2 million) became newly infected with HIV and an estimated 2.8 million (2.4- 3.3 million) lost their lives because of AIDS. Sub-Saharan Africa, with only 10% of the world's population accounts 80% the worlds HIV infection and AIDS cases.

In the global share, Ethiopia hosts the third largest number of people living with HIV-AIDS, next to South Africa and Nigeria. As stated by MOH (1998) from every 13 Ethiopian adult one is found infected with the virus. In urban areas one out of every six adult is living with the virus.

According to the report of MOH (2005) Ethiopia ranked sixth in terms of HIV prevalence in that year. The 2005 DHS also indicated the prevalence rate in women 5.9% and for men 0.9%.

As is indicated by the latest report of HAPCO/MOH-2006 the national HIV-prevalence in 2005 was 3.5%, 3% among males and 4% among females. The estimated prevalence in urban areas was 10.5% (9.1% among males and 11.9% among females). The prevalence in rural areas was 1.9 % (1.7% among males and 2.2% among females). In

2005 the overall HIV-incidence was estimated at 0.6% which was projected to stay up to 2010. In that year, it was estimated that a total of 1,320,000 people were living with HIV/AIDS of which 634,000 were living in rural areas and 686,000, in urban areas. Of the total 590,000 were male and 730,000 were females. HIV/AIDS has left 744,100 orphans and 277,800 people in need of retroviruses medicine. The disease accounted for an estimated 34% of all young adult deaths in Ethiopia (MOH/HAPCO, 2006).

In the same year it was estimated that there were a total of 137,500 new AIDS cases, 128,900 new infections (353 a day) including 30,300 HIV positive births and 134,500 (368 a day) AIDS deaths. Among these 20,900 were children below 15 years of age. The cumulative number of AIDS patients was 1,267,000 by 2005 and is projected to reach 1.9 million by 2010. Adult deaths due to AIDS progressively increased. HIV/AIDS has had determinant socio-economic impacts on Ethiopia. Studies conducted at schools, work place and among all orphans indicate similar impacts. Up to 2005 they accounted for 35% of young adult (15-49) deaths and are expected to dramatically decline up to 2009 but rising again in 2010 as people on ART start dying (MOH/HAPCO,2006).

According to (MOH, 2006) HIV/AIDS reduced life expectancy by five years in 2005 and accounted for about 32% of the estimated 141,000 total TB cases in 2005. The effect of HIV on TB is expected to continue from 2005 through 2010.

Although, the overall HIV prevalence for the country is low due to large number of population, the absolute number of persons infected and affected by the disease is significant. It will ask many years and efforts to see significant declines in the prevalence incidence of the disease (MOH/HAPCO, 2006). Universal provision of prevention, care and treatment to the estimated 1.32 million PLWA and 744,500 AIDS orphans posse substantial challenges to the poorest country in the world. The loss of adults in their productive years of life will affect the countries overall economic out put (MOH/HAPCO, 2006).

According to the report of MOH/HAPCO (2004) the HIV prevalence rate in the military which was 2.6% in 1991 raised to 15.3 by 2004. The rapid increase of HIV prevalence in the military affects the civilian and the national security of nations. So it requires the active engagement of every citizen, government, military and civil society to control and mitigate the impact of HIV/AIDS epidemic in Ethiopia.

The pandemic has already taken roots and the nation has started feeling the all round impact on household's agriculture, firms, education security and health sectors. As a response to the pandemic and its all-round impact, most countries affected by HIV/AIDS developed a national program to fight against the epidemic. These programs include Behavior Change and Communication (BCC), voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT), care and support prevention of sexually transmitted infection and blood safety. But the emphasis given to these programs and their components varies from country to country. With the increase in HIV infection, the need for establishing a voluntary counseling and testing (VCT) center is growing especially in Africa. In line with this testing and knowing one's HIV status has become an important part of life. For example, testing has become a precondition for employment, educational opportunity, travel, migration, insurance in many institutions.

Therefore this research focuses on studying those variables which may limit the expansion of VCTs among soldiers, taking behavioral characteristics as determinant factors.

1.1. Statement of the problem

HIV/AIDS is expanding in an alarming rate through out the world. Accordingly, the society is facing massive problems of losing parents and relatives, breakdown of marriage and family, unemployment, decrease in income and loss of pride and respect due to stigma and discrimination.

Most people in Ethiopia who are HIV positive do not know that they are living with the virus. Fear of stigma is a common reason for most people for not wanting to know their HIV status since it is believed that the virus is largely transmitted by unsafe sexual practices. Others usually hesitate to go to VCT centers for lack of awareness about the existence of such services and benefits gained after getting VCT services. And others' reason could be the problem of availability and proximity of VCT centers. As stated in (HAPCO/MOH, 2004) HIV/AIDS is not only a socio economic problem but also security threat. So it is important to include HIV/AIDS in the general activities of the defense, militia, and police force at all levels. The military have a capacity of extending civic services to remote areas and unreachable segments of rural population. Thus it is

important to fight the epidemic first with their domain and mitigating the security impact of the disease and using them as agents to expand the services to remote areas.

As mentioned in FDRE/MOH strategic plan (2005) the military and the police forces could be used as the main instruments in the campaign against HIV/AIDS throughout the country. This is because the military and the police forces are parts of the problems of the disease and reach vast areas contacting different people. For this reason it is chosen to play its own role in fighting the spread of HIV/AIDS. So far the level of knowledge and attitude of the military and the police personnel towards the disease has not been studied. Upon the researchers experience the military and the police are the hardly affected members of the society by HIV/AIDS. Because they don't have the right attitude towards the disease and the VCT service, they hesitate to benefit from the voluntary counseling and testing. They might contribute to the spread of the disease rather than serving the campaign against the disease. Due to the nature of the service it renders, the military personnel are likely to have a number of sexual partners' wherever they march. This may have two effects one, the effect on the population and the other is the effect on the military itself and on the national security for it affects the skilled and proficient members that defend the sovereignty of the country. The MOH, (2006) identifies the military as one of the customers to commercial sex workers where HIV is more prevalent. According to the NAC/HIV prevalence estimate, the HIV prevalence rate of the military is 15.3% (MOH, 2003). As the study by Ibrahim (2006) which was conducted among Defense University students showed the highest number of students don't want to get VCT services despite their high knowledge about the nature, transmission and hazards of HIV/AIDS. So the main problem that needs concern is attitude or behavioral change. So it is quite important to focus on their attitudes. The BSS of(2005) done on nine regional states and on sample of uniformed services (defense and police forces), road construction workers, long distance truck drivers, inter-city bus drivers, teachers, in school youth, factory workers, pastoralists etc revealed that more than 98% of the study population were aware of HIV/AIDS except in pastoralists (80%). Almost all the study population knew at least one prevention method; about 86% knew two of the three preventive methods and nearly 55% knew all the three. But, as is shown by the study, misconception about HIV/AIDS is high irrespective of their level of

knowledge (FDRE/MOH, 2006). As indicated by the same study, one or more stigmatizing attitude prevailed in all most all target groups, particularly among bus drivers, military, and teachers.

It is evident that the military experiences stigma which hampers him not to go to VCT-centers. So, independent study of this and other variables in the military is crucial. This is because people have developed negative attitudes, especially fear and anxiety from government media, posters and films. This preventive actions had delivered, knowingly or unknowingly, wrong perceptions to people about HIV transmission, nature and characteristics. It is proposed that fear and anxiety to HIV/AIDS results in retreat of people from voluntary counseling and testing, this study will attempt to answer the following questions. g services. Another reason may be the accessibility of effective, efficient and permanent VCT centers. From personal observations of the researcher, it was possible to assess the availability of these centers at different levels of commandment, division, regiments and training centers. Since this also seems to affect the attitude of the military personnel, it is important to study the variables affecting their attitude towards HIV/AIDS, and consequently, their attitude to get voluntary counseling and testing services. By focusing on these problems

- What is the level of military cadet's awareness towards HIV/ VCT and its function?
- Is there any knowledge difference across residence, marital status and educational levels?
- What is the attitude of the military cadet's personnel towards voluntary counseling and testing?
- Is there any attitudinal difference across residence, marital status and educational levels?
- Is there any relationship between knowledge about HIV/ VCT and attitude towards HIV/ VCT among the cadets?

1.2. Significance of the study

Voluntary counseling and testing (VCT) is an important service for prevention and treatment of HIV/AIDS. It helps people to protect themselves from HIV and help people

living with the virus to get different services. Moreover, it helps people plan for their future, for example marriage, to have children, education etc. VCT also reduces the rate of stigma and discrimination if more people begin to know about the virus, transmission mechanisms, care and support given. In raising the level of knowledge and attitude towards HIV/AIDS, voluntary counseling and testing has served as effective and ethical public health tool (WHO, 2002). Along with other strategies and interventions, VCT is being implemented in Ethiopia in various parts and institutions of the country.

The Defense Ministry is one of the governmental institutions where the control and prevention of HIV/AIDS is given a due concern. To control the spread of the disease, it has focused on raising the awareness of members about HIV/AIDS and VCT by using posters, slogans etc. As is suggested by CRDA (1996), VCT services for the military should be developed with the support of the military command and should include the following.

- a .avoidance of blame and stigma
- b .developing comprehensive services for STIs
- c .promoting condom use
- d .promoting partner(spouse) referral
- e .referral for care and support for those infected

The UNAIDS (2006) report also recommends that governments incorporate awareness trainings in to operations of national uniformed services and international peace keepers.

Nevertheless the VCT centers haven't fully served their purposes due to attitudinal problems and problems associated with behavioral changes. The campaign against the spread of the disease in the military as well as throughout the country will be effective if the military itself has the right attitude towards the disease and VCT services.

Therefore, studying the attitude of the military cadets is expected to have the following contributions.

- Explores the knowledge and attitude of the cadets towards the voluntary counseling and testing and suggests possible strategies which will increase the level of knowledge and attitudes.

- Evaluate the attitudinal differences and their possible causes across the socio-demographic variables
- Suggest strategies that will be devised by the Ministry of Defense to control the spread of HIV/AIDS and raise their level of awareness and to minimize the differences, if any.
- Contribute as a starting point for researchers who want to study the problem across wider ranges in the military.

1.3. General objective

The overall aim of this study is to explore the knowledge and attitude of military personnel towards voluntary counseling and testing and its contribution and effort in preventing and reducing the impact of HIV/AIDS in the Defense Forces in general.

1.3.1. Specific objectives

- To assess the knowledge of cadets towards VCT services
- To assess the attitude of the cadets towards VCT services
- To identify factors that affect the uptake of VCT services in the Military Academy
- To identify benefits of VCT services to the cadets.
- To see the effect of education level on knowledge about HIV/AIDS and VCT
- To see the effect of education level on the attitude of cadets towards HIV/AIDS and VCT
- To see the educational level and attitude across, residence and marital status.
- To see the relationship between knowledge about HIV/VCT and attitude towards HIV/VCT

1.4. Delimitations

This study tried to measure the attitude of cadets towards VCT for HIV in MGHA Military Academy, the only cadet school in Ethiopia where members are trained both

academically and militarily for three years. Due to a number of factors that are beyond the control of the researcher it is found difficult to study large sample area.

The final analysis is based on data obtained from 187 persons. Even here, due to the difficulty of the service rendered in the military, the number of female cadets is too small to study sex as an independent variable. So it became difficult to conclude the result as a representative of the whole in the military.

1.5. Operational Definition of Terms

- **Attitude:** the favorable or unfavorable response to the benefits, the problems, sessions, counselors, etc. towards HIV voluntary counseling and testing among the urban/rural, married/unmarried across education levels (from 1st to 3rd years) of cadets in MGHA Military Academy.
- **Cadets:** military personnel at MGHA Military Academy who are taking academic and military science trainings for 3 years and will get the rank of lieutenant and will finally be awarded with a lieutenant ranks and diplomas in military management sciences.
- **VCT:** voluntary counseling and testing for HIV is an HIV prevention – intervention strategy initiated by the client on his own freewill, which provides the client an opportunity to confidentially explore and understand his/her HIV risks and to learn his/her infection status which in turn helps him/her minimize risks, plan for the future, adjust life, get care and support, with the help of the counselor.
- **Knowledge:** a living accumulated set of facts about the nature, causes, impacts, ways of transmission, controlling mechanisms, etc. of HIV/AIDS and about the meaning, benefits, problems, forms of HIV/VCT services among the cadets at the MGHA Military Academy.
- **Residence:** the living (growth) environment of the Cadets at MGHA before joining the military differentiated as urban (old big cities & small towns) and rural (environments out of and far from towns and cities).
- **Marital status:** the condition of cadets at MGHA military academy identified as married and non-married.

- **Educational level:** the years of cadets' admittance in MGHA military academy for attending the academic and military science training which are identified by first, second and third year.

Chapter Two

2. Review of Related Literature

In this chapter a conceptual and empirical review of previous and related studies are assessed in accordance with the present study.

2.1. HIV/AIDS: Nature, ways of Transmission and its Impacts

AIDS: represents Acquired Immune Deficiency Syndrome. It is caused by human immune deficiency virus known as HIV. This virus attack and destroys the white blood cells that are crucial to the human body immune system, (CRDA, 1996). This virus attacks and destroys the capacity of the body in defending itself from other diseases like TB and cancer (UNAIDS 2005). HIV is dreadful, it attacks the very command center of the immune system and exposes the individual to other infectious disease such as cancer, and TB (UNAIDS, 2005). HIV is a virus that causes AIDS, infection with the disease causes AIDS. Hence, AIDS is a group of disease or conditions characterized by a defect in natural immunity and development of opportunistic infections that eventually lead the victim to the death (MOH, 2004, 2005, FHI, 2003). By nature HIV reproduces by using cytoplasm or host of cells in an animal or humans (Mahta and Sodi, 2004). That means, the virus can not multiply by its own. HIV belongs to group of viruses known as retrovirus, which integrated to the genetic material of the host, it made difficulty of finding any vaccine or cure to it (Quadango and Denny, 1992).

Today the disease is affecting the development of the country in many aspects. However, loss of young adults in their most productive years of life is certainly the major one. According to the report of the MOH (2002) the number of adults with HIV infection was 6.6% in 2001; the number was 7.3% of the total population of Ethiopia. Even though some stabilizing signs are shown, according to the report of FDRE/MOH (2006) the observed changes are not sufficient enough compared to the size of the population and the magnitude of damage already infected.

With such a fast spread of the disease the industrial and agricultural sectors of the economy will be the most affected sectors (MOH, 2000). As is indicated in the same

source, the widespread of the disease became a cause, not only for lose of millions of lives, but also brought economic, social and psychological effects at an individual, family and community levels. As reported by CRDA (1996) the military in Ethiopia represent a mobile high risk group that needed a primary attention. According to the 2003 NAC/HIV report prevalence rate of HIV/AIDS in the military was 15.3% (MOH, 2003)

In Ethiopia, there are four HIV-transmission mechanisms. These are sexual contact, prenatal transmission, blood transfusion and unsafe injection (MOH, 1998). Among these the major mode of HIV transmission is heterosexual relation, accounting for 87% of the infections. Another 10% of the infection occurs due to mother- to- child transmission. The remaining 3% of the infection is estimated to occur due to the utilization of unsafe, sharp and skin piercing instruments and blood transfusion (MOH/HAPCO, 2004).The HAPCO suggested a number of factors facilitated the spread of the disease. These are poverty, illiteracy, stigma and discrimination, high rate of unemployment, wide spread commercial sex work, gender disparity, population movement (rural to urban and urban to rural), harmful cultural and traditional practices. Garbus L (2003) added gender inequality, war displacement and big mobile military population in the country as direct causes of HIV spread.

In Ethiopia, the spread of HIV/AIDS started and was initially localized in urban areas connected to major roads and commercial routes (MOH/HAPCO, 2004). Currently, a steady rise of infection is seen in rural areas. Unless urgent attention and effective intervention is undertaken, the disease will become a threat to rural areas, where the majority of Ethiopians (78%) live and the country's economy relies on (MOH/HAPCO, 2006).

According to a caution by MOH (1997), failing to take any action is permitting the disease to paralyze the most productive members of society and the generation as well. The countries most affected by HIV/AIDS including Ethiopia, will fail to reach their millennium development goals of reducing poverty, hunger and child mortality (UNAIDS, 2006).

HIV counseling began in Ethiopia in the late 1980s and expanding its services throughout 1990s. Most of the time HIV counseling is undertaken in different settings. The most important of these is voluntary HIV Counseling and Testing center (FDRE/

MOH, 2002). Despite its necessity for behavioral changes, HIV counseling is the most neglected profession in Ethiopia (Yusuf, 2004).

2.2. VCT: Meaning and History

As is defined by FDRE/MOH (2002) VCT is the process by which an individual undergoes counseling which will help him/her to make an informed choice whether to test for HIV. The process was also aimed at helping them to cope up with stress and make personal decisions related to HIV/AIDS. This means the decision must entirely be the choice of the individual and assured for confidentiality. As defined in CDC (2003), VCT is an essential component of a comprehensive HIV/AIDS program. It is the base of prevention, care and support services.

The voluntary counseling and testing participants manual MOH (2003) defines VCT as an HIV prevention intervention which gives the client an opportunity to confidentially explore his/her HIV risks and encourage his/her partners, family members and friends to access to VCT.

As defined by Family Health International FHI (2003) VCT is an internationally recognized, effective, important strategy for both prevention and care of HIV/AIDS. It further describes VCT as a cost effective strategy to facilitate behavioral change and as an important entry point for care and support to those who tested positive.

The HIV prevention counseling what is known today as VCT is the result of years of research in many parts of the world. HIV counseling has its roots in the earliest days of HIV testing in the United States when a need arose to explain the test results. In early stages HIV testing was given by different bodies for different reasons. Blood transfusion centers, for example, perform HIV testing to differentiate an infected blood result; to aid in patient management to investigate the manifestations of HIV infection and surveillance program test for HIV and to determine the magnitude of the epidemic in a given risk group or geographic area (Allen S, 1999) . In those stages clients often received nothing more than explanation of the test results and some education from their counselors (CDC, 2003). This time HIV counseling was not effective in preventing new infections. Many years of experience with giving HIV anti-body test results led to a recommendation that encourages HIV test result to be given voluntarily and followed by detail explanation,

emotional support and practical recommendations. This view necessitated the establishment of VCT centers (Allen, 1999).

As HIV infection rate continued to rise, countries started to understand the importance of VCTs as HIV prevention and intervention tool (Solomon M, 2004). With the growing awareness of the scope and severity of the epidemic and the predictive value of positive test, HIV counseling and testing began to expand as of 1987. In many countries of the world counseling and testing are largely accepted as an important/compulsory component of their national HIV/AIDS prevention and control programmes (MOH, 2003). Today countries have understood the importance of early knowledge of HIV infection as a critical component to control the spread of the disease (CDC, 2001). Due to this, African countries have shown a dramatic increase in the demand of voluntary counseling and testing and thus, made the service accessible, affordable and secure to their people who wanted to know their HIV status. As is reported in UNAIDS (2006) the number of people using HIV testing and counseling services quadrupled in the past five years from 4 million in 2001 to 16.5 million in 2005. The increased access to care and treatment, decreased stigma and discrimination in many settings opened new opportunities associated with taking HIV test (WHO, 2002).

2.2.1. History of VCT in Ethiopia

It is more than two decades since HIV/AIDS virus is detected in Ethiopia. The rate of spread of the disease has become not only a cause for the death of millions of people but also brought economic, social and psychological effects at individual, family, community and national levels (FDRE/MOH, 1997).

The seriousness of the problem and its high prevalence rate necessitated the implementation of multi-faceted preventive activities and programs. One of such programs is implementation of voluntary counseling and testing services.

As one component of fighting HIV epidemic, the Ethiopian government implemented a voluntary HIV counseling and testing in the late 1980s and expanded its services throughout 1990s (MOH, 2002). In the beginning of 1990s, a number of national training programs were given for nurse-counselors and social workers in Addis Ababa from all regional hospitals by MOH and other non- governmental organizations.

As is indicated by MOH (2002) VCT started in Ethiopia at the end of 1987 with two social workers in the Ministry of Health for the purpose of surveillance. Up to 1998, HIV testing and counseling services were limited to government health institutions to screen out patients suspected of HIV infection and to check for visa applicants. After the declaration of National HIV/AIDS Policy in August, 1998, VCT services started to be implemented widely throughout the country. Since then the service was given mainly in public institutions, but later it expanded to private and NGO health settings (MOH, 2002).

Over the last 2 years (2004- 2006) the VCT centers have been growing rapidly. The number of VCT centers which stood at 170, three years ago, has jumped to 658 in 2006. There were 277 VCT centers in 2004. But the counseling and testing coverage is still low with only 5% of the general population 15-49 years of age being ever tested (MOH, 2006). At the end of 2005 the number grew to 525. On the contrary, the number of clients has fallen over the past two years. In 2004, 451,387 people were tested for HIV. Unpredictably, the figure in 2005 shows a marked decline from 451,387 to 231,166. The number in 2006 is also expected to be similar to 2005 (Lambadina, 2006). As indicated in the annual report of Ethiopian fiscal year 1998 a total of 564,351 VCT clients received counseling and testing services. The proportion of male and female was nearly equal. The 2005 DHS survey which conducted a survey on HIV/AIDS knowledge, attitude and behaviors including VCT behavior in the general population found that all women and men aged 15-49 were eligible for testing. A total of 11,050 adults (83% of the 7142 eligible women and 76% of the 6,778 women) were tested for HIV (FDRE/MOH 2006).

Despite the increasing number of VCT centers for the last three years, the number of users has shown a dramatic decrease. The report didn't mention the reason but UNAIDS (2006) indicated the impact of stigma and discrimination as still continuing in an alarming rate. To the researchers understanding and experience, this could happen due to less works done on changing the attitude of people towards the disease and voluntary testing and counseling services. Moreover, there are no efforts that can help and encourage the changes brought for it helps sustainability of the changes (FDRE/ MOH 1997). That is why this study is focused on identification of variables affecting people's attitude towards VCTs.

2.3. Importance of Taking VCT

The promotion of voluntary counseling and testing is an essential element in the response to HIV epidemic. According to UNAIDS (2002) the VCT can play an important role in HIV prevention and care. Based on this fact UNAIDS encourages countries to take VCT as part of their HIV prevention strategy. In the recently approved HIV/AIDS policy (1998) of Ethiopia, VCT is included as one of the strategies of HIV/AIDS prevention (MOH/HAPCO, 2004).

In short, HIV counseling can have two major goals; prevention of HIV infection by enhancing behavioral change and by giving psychological support to people who are infected and affected by the disease (FHI, 2003, Yusuf, 2004). Through VCT services individuals acquire knowledge on their HIV status. For those who are not infected with HIV/ VCT helps them in reducing their risks and can become ambassadors for prevention of the disease by encouraging partners, family members and friends to consult VCTs (FDRE/ MOH, 2003).

For those who are found infected by the disease, knowing their HIV status allows them as an entry point to take care of themselves and better protect their sexual partners. VCT also helps them to get HIV treatment and support of services and plan for their future. After knowing their HIV sero-status, they can also get access to continuous counseling, emotional and medical supports which help them treat and/or prevent HIV associated illnesses (FDRE/MOH,2003) According to UNAIDS (2000) the service of VCT is found to be relatively cost effective intervention in preventing in the transmission of HIV/AIDS.

As the study conducted in Uganda witnessed, people who used VCT brought responsible behavior by using condoms with casual sexual partners. Another study conducted on 3120 people in Kenya, Tanzania and Trinidad and Tobago reported decline of unprotected sexual intercourse by 35% among men and 39% among women. (FHI, 2003)

The availability of VCT can also contribute in the prevention of mother to child transmission of HIV by helping the sero-positive woman to make informed decision on having no child or bear a healthy child by modified infant feeding systems.

A study conducted on 640 residents of Addis Ababa showed the importance of having pre-marital VCT for the following reasons.

- a. to prevent hetro-sexual HIV transmission (93.6%).
- b. to plan for future life (87.5%)
- c. to plan to have a child (86.35) (MOH, 2003).

In general, in a situation where advanced therapies are not available in many developing countries, VCT can provide the following opportunities for individuals and couples (WHO, 2002).

- Knowledge of sero -status empowers individuals to make important life decisions.
- Individuals can be helped in developing individualized risk-minimizing plans depending on their HIV status and sexual relationship.
- Couples can understand their sero-status together and plan and discuss ways of dealing with similar or different infection status.
- Decide whether to have more children.
- Knowledge of HIV status gained in a psychologically and socially supportive environment motivates individuals and partners to initiate and maintain safe sexual behaviors.

The CDC training manual also summarized some benefits of visiting the VCT for the community (NACS, 2005). According to NACS, VCT

- helps to change the societal image of HIV/AIDS from illness, suffering and death to positive living,
- generates optimism as large number of people test HIV negative,
- reduces stigma and enhances development of care and support services,
- reduces transmission of the disease, and
- Enables access to preventive measures and antiretroviral therapy and clinical services.

According to NACS (2000) HIV Counseling operates at two levels of prevention:-

- a. primary prevention aims to keep people from becoming infected. Counseling plays a crucial role in helping people to identify their own risk behaviors,

explore options for reducing their risk and negotiate a risk reduction plan that is realistic and feasible.

- b. secondary prevention aims to prevent people infected with HIV from transmitting the virus further. With proper counseling, care and support people with HIV may avoid feeling alienated from society and therefore feel more accountable to it, adopting practice that minimize risk of infecting others.

As the researcher believes, people fail to know such uses and benefits gained from VCTs and this is true in the military. Thus, it is important to study knowledge as one variable that may have affected access to VCTs.

2.4. Challenges to the uptake of VCTs

2.4.1. Stigma and Discrimination

Despite the increasing number of VCTs in most of the developing and middle income countries, many people are still showing reluctance to be tested for HIV (UNAIDS, 2006). A number of factors affect the VCT not to play its role of prevention and care against the spread of HIV/AIDS. As is shown in many studies, HIV testing might have far reaching consequences for the person to be tested. Despite the benefits gained by knowing one's HIV status, HIV infection in many societies leaves negative impacts on the people who took the test. According to the FDRE/MOH, (2003) people with HIV are experiencing social rejection and discrimination. Many people are frightened to get the VCT service because they fear stigma and discrimination from their families, and communities. As a result of stigma, these people lose access to care and support and choices.

In some countries, people with HIV are subjected to discrimination at work and education. Unless these problems are protected by law, people are likely to remain reluctant in taking the voluntary counseling and testing (UNAIDS 2000). According to the UNAIDS (2006) the reports of civil society from over 30 countries indicated stigma and discrimination remaining pervasive.

A national survey of adults in USA by Herik and his associates found out that 38% of respondents worry about stigma, 44% indicated stigma influenced their decision to undergo VCT (Herek et.al, cited in Andargachew, 2006)

Another study in USA by Stall cited in Solomon (2004) on homosexual individuals showed that 66% of the respondents worried about AIDS related stigma.

The studies in Africa witnessed existence of similar problems. On a study on South African mine workers 1/3 of those who had visited VCT fear of testing positive for HIV, stigma, disease and death were identified as main barriers to test. A study carried out in Kenya and Uganda among the youth revealed the existence of stigma and discrimination together with other factors (Horizons, 2001). As a study in Bahir Dar indicated, significant number of respondents reported their worries about stigma and discrimination (Michael, 2001).

The study in the UK by Sheer et al, cited in WHO(2002) identified societal factors like stigma, partner violence, minimal male involvement, rejection of HIV positive women, helplessness, ignorance of educated men, condom use, quality of information and modes of prevention affecting the uptake of VCT services. Among the 18 patients who took VCT in Ghana 16 didn't inform their parents for fear of condemnation and none of them told their children (WHO, 2002).

2.4.2. Lack of Perceived Benefit

Another common barrier to the uptake of VCT is the lack of perceived benefit. In areas with few resources people develop a perception that little support will be available to them if they are found infected by the virus. This deters many people from knowing their HIV status. This shows the dependency of VCT on the communities by societal factors as well as by factors related to delivery of services. So, linking VCT service with care and support providing institution and establishment improves the acceptance of VCT. (Bagaley R.etal., 1998)

2.4.3 Gender Bias

In many cultures and countries women will become particularly vulnerable and face risks like rejection, violence, abandonment or loss of home and children if their HIV

status is known. Hence quite often women prefer to keep their HIV status anonymous and often don't go to VCT centers (WHO, 2002). According to UNAIDS (1999), there is some evidence, in highly stigmatized societies, that women who suspect themselves at risk of infection are less likely than low risk women to take testing.

2.4.4. Confidentiality

According to FDRE (2003) confidentiality allows no reference to or discussion about the client or his test result without the permission of the client. For VCT services to be acceptable, confidentiality must be guaranteed. According to UNAIDS (2000) many people are not ready to get HIV services because they are afraid of stigma and discrimination from their families and the community. VCT services, therefore, should always maintain the confidentiality of the clients test results. According to Baggaley, et al (1998) in circumstances where confidentiality is not respected, people feel more comfortable when they give pseudonyms during the uptake of VCT.

A study conducted by Mohammed in 2000 on a sample of 720 subjects indicated the VCT method they prefer most. The majority of participants (61%) preferred confidentially linked, 31.6% anonymous and 1.8% suggested getting the service openly or no confidentially. The study implies the fact that confidentiality should strictly be assured at VCT centers.

2.4.5 .Commodity Management

The availability of test kits and other commodities needed for efficient VCT services are critical to the success of VCT programs. Frequent stock outs of HIV test kits and other important commodities can deter clients from seeking VCT services at their local centers. Thus lack of commodities can negatively influence the client's perception on qualities of services given at VCT centers (Solomon M. 2004).

2.4.6. Quality of Counseling Services

As proposed the UNAIDS (2001) the uptake of VCT in communities relies on societal factors as well as factors that are associated with service delivery. Such a proposal

stresses on the counselors' attitude towards testing for it affects the uptake of VCT. In a study conducted in the United Kingdom by Sheer et.al, (cited in it WHO, 2002) was found out that professional skill and empathy of the counselor are societal factors affecting the demands of VCT services.

HIV counseling is a difficult and stressful job. It is not easy for counselors to maintain professional boundaries in their relationship with clients. Counselors have to deal with intense emotional issues with clients about life and death. The absence of medical treatment or cure to the disease is another headache that counselors are facing with (UNAIDS, 2000, WHO, 2002, NACS, 2005).

According to the studies of Liknaw and Solomon, counselors may not be effective enough in handling the stress of working with HIV positive patients. For him the problem of role confusion on the counselors is another problem to deal with. Counselors have to do the jobs of a therapist and of the educator. In addition to providing information and giving advice, counselors are expected to give support and care to the client, and such a dual role is hard to compromise because counselors are not trained for both kinds of services simultaneously (Solomon. M, 2004, Liknaw, 2006)

The study by Mohammed (2000) conducted to identify the people's preference on a counselor showed 51.9% choosing a physician, 29.1% trained counselor, 10.5% religious leader and 7.9 a nurse counselor. This may tell us the existence of problems in trained counselors due to the facts explained earlier. To the researcher's experience, these problems exist in VCT of the military and have affected the attitude of cadets to HIV/VCT. Thus it needs investigation.

2.5. Sessions of VCT

According to FHI (2003), the golden standard for VCT includes regiments of pretest counseling and post test counseling sessions. UNAIDS (2006) also proposed the ideal VCT counseling to consist at least the two sessions, pretest and post-test sessions. The FDRE/MOH (2003) also supports and recommends the presence of the two sessions. But it does not mean that more sessions couldn't be possibly offered before or after the test or during the time the client was waiting for the result.

2.5.1. Pretest Counseling

According to MOH (2003) pretest counseling is a part of counseling that is offered before an HIV test. At this session the counselor should assist the client to identify his/her risk of acquiring HIV and prepare for taking the test.

As is recommended by Solomon M. (2004) pretest counseling is a prerequisite to all clients who wanted to know their HIV status. In this session the counseling could be given individually, as a group or with a couple. The FHI (2003) suggested that pretest counseling should include offering reading materials before clients enter a group or private sessions with the counselor. At this session it is appropriate to ask the reason the client sought a test and about his past behaviors/experiences which he/she suspect for risk of HIV infection.

As is stated in MOH (2003) pretest counseling is useful in preparing a person to make an informed decision to take the test and consider the implications of the positive or negative results and how to live with it. This counseling also helps a person to consider behavioral changes as a means to prevent HIV infection and realize risk factors.

Moreover, the counselor should ascertain the clients understanding of HIV transmission and the meaning of the test result by (MOH, 2002, NACS, 2005).

- discussing the client's understanding of the risk for HIV/AIDS.
- discussing the nature of the virus and ways of its transmission.
- ensuring the benefits of the clients' awareness of the risk and knowing his/her HIV infection status.
- emphasizing on religion and culture.
- discussing on the meaning of the test result.

In addition to the above tasks the FHI (2003) suggests the inclusion of tasks, such as

- explaining the limitations of the test result.
- helping the client to think about the possible relations of the test result and whom to tell the result.
- discussing the importance of telling to one's sexual partners.

In general the components of the pretest counseling should include (CDC, 2003).

- establishing the reason for requesting the test
- assessing the clients existing knowledge of HIV/AIDS
- discussing misinformation and the myths
- assessing the risk
- risk reduction means's
- about testing and possible results with their meanings
- implications of testing on the clients life
- Preparation of the client to receive his/her results and to explore coping strategies.

The commonly recommended procedures in pre testing session are according to (CDC, 2001)

- introduction and orientation to the session
- assessment of risk
- exploration of options for reducing risk and
- preparation for the test(MOH,2002).

The absence of these information/tasks in pretest counseling session affects the attitude of clients towards VCT services.

2.5.2. Post- test Counseling

As we can understand from its name, post test counseling is a second intervention session given after the HIV test result is ready. What ever the test result is, post test counseling is mandatory.

According to MOH (2003) and UNAIDS (2006) post test counseling is offered to a client who is willing to receive and learn about the HIV test results. It helps to ensure if the person has understood the meaning of the result he/she has received and to provide emotional support necessary to cope with the results and promote behavioral changes and assess the necessity of care and follow up.

This session has two parts. These are post test counseling with HIV negative result and post test counseling with HIV positive result (FDRE/ MOH, 2003). In the case of HIV negative result the counselor should:

- provide HIV negative test result,

- negotiate on risk reduction plan,
- identify support for risk reduction,
- negotiate disclosure and partner referral
- consider the window period.

In the case of HIV positive result, the counselor should

- provide HIV positive test result,
- identify the sources of support,
- negotiate disclosure and partner referral ,and
- address risk reduction issues.

As a continuation of post-test counseling, on going counseling has to be provided for those whose test results are positive and for high risk negative clients. On going counseling helps clients (MOH, 2003, UNAIDS, 2001, CDC, 2003)

- to cope with HIV and to encourage positive living,
- to help them prepare future risk reduction plan, and
- to help them deal with HIV/AIDS related problems,

These are important components for HIV counseling that every VCT should incorporate in its counseling programs. Their absence is likely to affect people's attitude to VCT. But, as to the researcher's view, most VCT centers fail to undertake effective use of these elements forcing clients hesitate to come to VCT. So, it is important to study these variables in the military as their absence may have affected people's attitudes towards VCTs.

2.6. Forms of HIV Counseling in VCT Centers

According to the view of many scholars counseling could be given in many forms depending on the type of clients, location, communication medium and interaction process. But the selection of a specific form of counseling is based on the needs and preference of the client within the range of services available. For the purpose of HIV counseling VCT centers use individual and couple counseling as basic counseling forms. In VCT group counseling is often considered as educational session for it is a method by which clients with similar problems discuss, share experiences and help each other to overcome their problems (MOH, 2005).

2.6.1. Individual Counseling

This is a process by which an individual interested to take HIV test gets counseling services about HIV. After the disclosure of the test results, the individual is usually recommended to share his/her result with a partner and encouraged to bring partner to take a test (Solomon K, 2004, MOH, 2002, 2003,)

2.6.2. Couple Counseling

Is a form of HIV counseling where two individuals who intended to get married, have sexual relation, plan to have children or who need to reunite after divorce come together to take HIV counseling and testing. Here VCT is used to strengthen the relationship and promote mutual understanding. It helps the two individuals to share and learn more about HIV infection. They then plan joint strategies of supporting each other socially and psychologically by sharing their feelings, anxieties, concerns and worries about the disease. In addition to developing and promoting behavioral changing strategies, couple counseling helps the couple to identify factors that may predispose to HIV and, avoid infection with HIV, learn more about safety sex methods (MOH, 2003, WHO, 2002, Solomon K, 2004).

The presence or ignorance of these forms may affect people's attitude towards voluntary counseling and testing. And this in turn increases the spread of HIV/AIDS in the community.

Which form of HIV counseling is being given for the military is not studied yet. The researcher need to survey this issue for it may have influenced attitudes towards HIV counseling and testing.

2.7. The Status of HIV/AIDS in the Military

The studies of many countries showed that HIV- prevalence rate of the military is 2 to 3 times larger than the comparable civilian population Clingedael Institute, 2005 cited in Ibrahim (2006). As seen from the study of Radhika (2003) soldiers are the most vulnerable group of people in many countries. HIV infection rates are many times higher in the military than the civilians. For example in 2003, the Sierra Leonean Military

personal were the most risky and exposed group to STDs and HIV/AIDS. The infection rates of the armed forces increase especially at peace times.

In the 1995 survey study of Zimbabwean armed forces their HIV infection rate was found to be 3 to 4 times higher than in the civilian population. This is also confirmed by the latest studies in UK and USA. In this later study the military personal were found at the highest risk of HIV infection than equivalent civilian groups Protocol for Surveillance 2003 cited in Ibrahim (2006).

The HIV/AIDS information in the Ethiopian military is inadequate. Between 1985 and 1986 less than 0.1% (5265) Ethiopian military members were found infected by the virus. After five years (1991) the sero-prevalence rate of the same population increased to 2.6% (Essex and K, 1991). According to the report of MOH (2004) the HIV-prevalence rate of the military raised to 15.3. On the study of BSS (2005) the Ethiopian military was reported as one of the highly risky group.

Probably, one factor that led to high rates of HIV infection in the military is the deployment of military personnel far from their family and their accustomed community for a long duration of time. This might force soldiers to search for commercial sex working female (MOH, 2006). Another factor that led to high rates of HIV infection is the nature of the profession. The military professional ethos encourages risk taking in combats. This may lead them to develop unnecessary risk taking behaviors like unprotected sexual intercourses outside combats (Retta, 2001)

2.7.1. Impacts of HIV/AIDS in the Military

Radhika (2003) listed a number of ways by which HIV/AIDS can affect the security of nations. The spread of the disease in the military may deter the readiness of soldiers for combats. Military capabilities could easily be deteriorated if the pandemic spreads unchecked among soldiers. As is warned by many security analysts, soldiers' risk taking increases if HIV/AIDS remains rampant and if access to treatment remains low (Radhika, 2003).

Retta (2001) stated the destabilizing influence of HIV/AIDS on security affected nations. For him, the massive infection of military members may finally result in exhaustion of those forces, and loss of key leaders which will in turn cause social,

economic and political instability. Moreover, HIV/AIDS has become the main cause for loss of senior leadership and skilled members of the military. According to Retta, HIV/AIDS might also kill troop vigor, resulting in reduced military capability, discipline and moral values. This affects the civilian and the national securities of nations. This forced the FDRE Ministry of Defense to consider financial and policy issues in relation to prevention, care, strain on hospital services, and replacement of trained manpower, testing troops, and keeping medical records. The MOD Health Office has designed a strategy which helps to develop the necessary behavioral changes among its members (Retta, 2001). Whether strategies of the MOD have achieved their goals is not known. This is because of absence of studies that focused on the development of right behavioral changes like on attitudes and knowledge's. Even the undertaken studies focused simply on Defense University students which hardly represent the military. These students are simply recruited and allowed to join the university from their high schools and families. Even though they are required to take a six week military training before joining the university, they hardly know the actual hardships of military lives and experiences. The study of Ibrahim (2006) and EPHA (2003), as the researcher believed, failed to represent the actual military.

That is why the present study focuses on studying the knowledge and attitude of cadets at MGHA Military Academy who are recruited from the army after years of military services and experiences.

2.8. Knowledge and Attitude towards HIV-AIDS and VCT.

In order to halt the spread of the disease and its consequences, it is important to consider a number of variables. Of these variables is changing the knowledge and attitude of the people to wards the disease (Michael, 2001)

A global program on HIV/AIDS (UNAIDS, 2003) recommended the importance of education, information and counseling as key strategies in preventing the spread of HIV/AIDS. But, the only real prevention as suggested by FDRE/MOH (2006) is giving more concern to the knowledge and attitudes. According to MOH (1997) changing of attitudes can play important role in minimizing the effects of the disease.

In a campaign against HIV/AIDS, behavioral change remains the only means to prevent the spread of HIV. In this regard, it is agreed that, HIV/AIDS prevention is not mainly a problem of delivering knowledge; rather, it is a matter of changing attitudes and overt behaviors. Even on the existence of good knowledge and awareness of the virus, most people fail to change their behavior Mahta and Sodi (2004), Tilahun (2003) and Kelly (2001). The FDRE/MOH (2005) mentions lack of behavioral change as a main factor that dwarfed the campaign against HIV/AIDS in Ethiopia. According to VSO (2004) culture the role and position of women in the society, ideas of masculinity, migration, female circumcision etc are some of the factors that prevent behavioral change among people. Behavioral change, however, is not simple to achieve. For Helen (1992) one solution to bring behavioral change is by personalizing the risk. For her, knowledge is not the only important thing to bring appropriate behavioral change, but they have to watch and feel the risk of being affected by the virus.

Several models have been used to explain the importance of behavioral change in relation to HIV/AIDS. Among these models is the Health Belief Model that stresses on the role of individual's perception of susceptibility to the disease, seriousness of the disease and the benefits of health action. According to this model, sufficient knowledge of the disease is important, but not the only prerequisite for behavioral change (Lindan et.,al 1991, Pollak, 1992, cited in Solomon.K,2004).

Another model, the AIDS risk reduction model, also lists awareness on ways of transmission of the disease, belief in the severity of the disease and perceived risk of being infected and peer support for safer behavior as a means to bring behavioral change (Lindon et al ,1991,Living stone 1992, cited in SolomonK,2004).

The theory by Rebwt (1992) discussed by Helen stresses the positive correlation between exposing HIV/AIDS patients and prevention seeking behavior. This theory says that human beings need to touch shock of many deaths in order to awaken their senses and change their behavior. Many countries like Uganda and Tanzania who used these models reported to have benefited in creating a favorable attitude towards PLWHA among their people.

Favorable trends in incidence in several countries are related to changes in behavior and prevention programs UNAIDS (2006). So it is important for countries to focus on changing their people's behavior about the disease.

Unless people bring attitudinal changes, knowledge alone does little in minimizing the effects of the disease. This is proved in studies conducted in Northern Ethiopia and Addis Ababa. As is disclosed by these studies, high percentage of people, especially the youth, continue to experiment high risk behaviors, despite their knowledge of HIV/AIDS (Shitaye et.al, 2004, Beyene et al., 1997)

A cross sectional study on HIV/AIDS related knowledge and practice among students of Defense University found out that almost all of the students have good knowledge of HIV/AIDS and related issues, even though, it increases with the raise in education levels (EPHA , 2003). As found out by the same study of the 72.4 percent of students who were sexually active 22.2 percent were reported to have more than one sexual partner. In this group, only 55% percent reported regular use of condom and 45 percent to have shown irregularity on the use of condom. According to CRDA (1994), the military in Ethiopia represent the highly affected group of people by HIV/AIDS. The study of Kabtamu (2006) on 400 college students in Assela Town showed that knowledge about HIV/AIDS is not significantly related to undergo VCT services. As Beyene et.al (1997) stated in their studies knowledge of HIV/AIDS, even though important, is not the only factor to bring behavioral change. Knowledge must be translated into attitudinal change.

Most HIV/AIDS scholars believe that sufficient knowledge together with attitude and beliefs about HIV will take to positive behavior changes which are less risky and safer. However, studies indicate that increased knowledge to HIV/AIDS does not always bring positive behavior change, (CDC, 2003). Some studies undertaken in developing countries witnessed that VCT is successful in helping clients reduce risky behaviors (UNAIDS, 2001). In those studies subjects showed a decrease in risky sexual practice and increase in regular condom usage. But VCT hasn't brought a significant behavior change among participants who tested negative. A study in Uganda showed that individuals who used VCT reported safer sexual behaviors compared to those who didn't visit VCT, Here again, it was the HIV positive individuals who developed safer sexual behaviors than the

sero-negative (Muller et.al., cited in Solomon ,2004). Research finding that failed to support VCT facilitate behavior change in sero-negative individuals are persuaded by the assumption that increased condom use which is often used to measure behavior change may not be an appropriate outcome measure for sero-negative individuals. According to the study of Peltzer (2004), done on the attitudes of Indian, South African, USA, students, stigma reduces people's willingness to VCT services. In Peltzer's study there was a country differences regarding HIV test and attitude. The USA students had significantly more positive attitude towards HIV test and strong intentions to go for VCT than South African and Indian students. According to Peltzer in a certain groups of studies of couples, VCT knowledge was found effective in promoting behavioral change and reducing transmission.

The failure to use HIV/VCT by risky individuals is attributed to many factors both at individual as well as societal level. For example, among high risk individuals in the US reasons given for not to use VCT were

- failure to learn HIV positive (25%)
- belief that they are likely to have been exposed to HIV (18%)
- belief that they are HIV negative (13%)
- belief that they are HIV positive (8%)
- belief that they can do little if HIV positive (6%)

Other factors include stigma and discrimination, concerns of confidentiality etc. (Peltzer, 2004). Norman and Yitades (2001) who studied the knowledge and attitude of Jamaican University students reported that stigma, discrimination and confidentiality were mentioned as factors.

In the study of Tefera (2004) on the university students of Jimma over 97% of respondents have good knowledge and about 80% have favorable attitude towards VCT. The majority (82.6%) planned to get VCT services. Despite their knowledge and attitude, students are found as high risk sexual behaviors.

Such attitudinal problems can hamper people from knowing their HIV status, by going to VCT increase the spread of the disease and its impacts. To change this attitude it needs great psychological/counseling work (CRDA, 1996).

Chapter 3

Method

In this chapter, the design and subjects involved in the study, the data source, the tools used in collecting the data the procedures followed when collecting data and the methods of analyzing the data are presented.

3.1. Design

This study focuses on assessing the knowledge about HIV/VCT and the attitudes of cadets towards VCT in M.G.H.A Military Academy. The main objective of the study was to explore the knowledge and attitude of cadets towards HIV/VCT. It also assesses if factors like stigma, discrimination, confidentiality etc which affected the attitude of people towards HIV/VCT, also deterred the cadets from VCT services. The study was undertaken with first hand data generated from 193 independent sample groups divided across education level who were selected to fill the structured knowledge and attitude questionnaires and invited to FGDS. The final result of this study will be based on the information obtained by these situations. To undertake the study the approach followed was a descriptive survey method; for it is a preferable approach to describe the occurrence of current problems such as beliefs, attitudes, opinions, values and preferences. Moreover use of this approach helps to study the problem in a relatively manageable sample of large population.

3.2. The Study Area

This study was undertaken at Major General Haylom Araya Military Academy in Holleta Gennet Town, about 44 kilometers west of Addis Ababa. It was the first Military Academy in the Military history of Ethiopia. It was established in 1934 by emperor Hailesellaie I for the purpose of training modern Imperial Body Guards (IBGs). Even though closed after Italian occupation of the country from 1936 to 1941, it was reopened a year after the Italian defeat in 1942 by British support. It extended its services up to 1974 and through out the *Derg Regime*. From 1991 to 2004 it served as a training center for

senior military officers. In 2004 the MOD decided it to be used as a training of cadets and changed its name to Major General Haylom Araya training Academy after the death of the known general of ground forces.

3.3. Population and Sampling

The FDRE Ministry of Defense has only two military cadets Training centers; the Debre Zeit Air force cadet school and Major General Haylom Araya Military Academy. The subjects of this study were the 1st to 3rd year cadets of Major General Haylom Araya Military academy. The MGHA military academy was purposefully selected for the study because of the researcher's familiarity with the trainees as instructor and because of their actual military experiences in actual combats and military life compared to the air force cadets who are relatively in settled lives.

There were totally 595 cadets in the Military Academy. Among these 579 of them were male and 16 female trainees. From the total 595 population 260 were first year (245 male and 15 female), 229 were second year students (228 male and 1 female) and 106 were all male 3rd year students.

For there were no division on departmental bases they were studied according to their year levels (1 to 3) years. Simple random sampling was applied separately on each grade level to draw samples that would correspond to the proportional size of each level in the population. From the total of 8 sections for first year cadets four sections, section (2, 4, 6, 8) randomly selected using simple random sampling method. In each section 19 first year male cadets were randomly selected using simple random sampling method except, section 8 with 20 cadets.

For the second year cadets there were seven sections. Among these four sections (1, 3, 5 and 7) were randomly taken using simple random sampling method. In these sections 17 male cadets were randomly selected in each section using simple random sampling method and made to fill the questionnaire.

For the 3rd year cadets there were 3 sections. In these sections section 1 and 3 were randomly selected using simple random sampling method. In these sections 17 cadets were randomly selected in each class and made to fill the questionnaire.

Since the number of cadets across sections is fairly almost equal, the number of male cadets drawn from these sections is almost made to be equal. From these population 177 male were randomly selected and the whole available female, (16) totally 193 samples were selected and included in the study. Since percentage of female students/trainees was very small compared to male students, the available number was purposefully included in the study. These were 1 from second year and 15 from 1st year cadets.

Random sampling was used because it is very effective method in producing an adequate cross section of its population and that a random sample is usually an adequate representation of the population as the size of a sample gets larger.

On the other hand the FGD participants were purposefully selected from each year samples that filled the questionnaire. There were about 18 FGD participants divided into three groups according to their education level, six for each level. The purposeful sampling was made to represent members from each category of independent variables (education level, marital status and residence) from each level.

Table 1 summary of total population, sample population and their number in education level from 1st to 3rd years.

Grade level	Sample					
	M	F	T	M	F	T
1 st	245	15	260	77	15	92
2 nd	228	1	229	68	1	69
3 rd	106	-	106	32	-	32
Total	579	16	595	177	16	193

3.4. Tools

To collect enough information and substantiate the information collected, the study was conducted by using the following two types of tools.

Best and Kahan (1998) proposed the use of multiple data collection instruments in ones own research. But this may not be always practical for some psychological variables like attitudes, feelings etc are hardly quantified. Aronson et al as cited in Solomon

M.(2004) suggested the use of each instrument accordingly as far as it is appropriate to the purpose, size and situation under which the study is conducted. By taking Bests' and Kahans' suggestions, this study used the questionnaires and FGD as basic sources of information.

1. Questionnaire: Self report questionnaire was filled by the selected samples. The questionnaire, prepared and adopted (see the appendix for the English version) was intended to get first hand information from the students. Some of the adopted items were taken from Liknaw (2006) and Solomon M (2004). This questionnaire has got three parts. The first part of the questionnaire was prepared to get background information (age, sex, martial status, religion, military experience, and education level) about the respondents. The second part of the questionnaire (Yes or No type) was intended together information on the knowledge status of the cadets regarding, the nature, the ways of transmission, and prevention mechanisms of HIV/AIDS and knowledge of voluntary counseling and testing its benefits, elements and problems associated with. It consists of 21 items out of which 20 of them had a weight of 1 point each.

The third and the last part of the questionnaire were designed to measure the respondents' attitude towards voluntary counseling and testing. Thus it was prepared in rating scale form. A likart scale of 5 points with a continuum (Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree) were represented by numbers 1-5 consecutively.

The scale has got a total of 21 items in which the participants were asked to indicate their feelings to each statement that express/describe their stand on characteristics described in each item.

Each client has a score from 1 to 5 on each item, and a client's total score, representative of an over all attitude is the sum of the item scores. Likart scale was found advantageous because; first it gives respondents a variety of categories to select and second it helps the respondents provide answers anonymously when asked to rate their expressed opinion. It is quick and economical to administer and score. It also gives direct and reliable assessment of attitude and adapts easily to most attitude measurement situations.

2. Focus Group Discussion (FGD) :

This was the second mechanism used to collect qualitative data from the respondents. The purpose of the FGD was to obtain in depth information about the knowledge and attitude of cadets about VCTs services, hindering factors, benefits gained from having VCT. Eight inviting questions that elicit information about the nature, cause, ways of transmission and impacts of HIV/AIDS and that elicit information on the benefit, forms, sessions and problems associated with VCT service were prepared in English for 18 FGD (see appendix C - for the English version of the instrument) participants purposefully recruited from the sample in accordance with the education levels (6 from each level).

3.5. Pilot Test

The pilot test was found important for the following purposes.

- a. To collect data that would be used for screening the items.
- b. To find out if the wordings, the instructions and the response categories of the instrument as a whole were clear and comprehensible for the respondents.
- c. To check the validity and reliability of the items to attain such objectives. Before conducting a pilot test, the instrument was thoroughly read by one senior psychology post graduate student and two linguist instructors in AAU, if there are any ambiguities in language which may not have been noticed by the researcher. The entire questionnaire was translated to Amharic and administered to 54 (14 female and 40 male) military personnel attending their resource management training at Defense Resource Management College in Addis Ababa. The respondents were taken randomly in different offices. While administering the questionnaire, they were instructed to note down any difficult word.

Soon as they finished filling the questionnaire, discussion was held with these respondents and many of them expressed their agreement with most of the items. So no modification was made on knowledge related items.

After the attitude scales was administered, and returned; an item analysis was made to see how well each item discriminates between the respondents with most favorable

attitudes (top 25 percent) and those with least favorable attitudes (bottom 25 percent). Those items of a scale upon which the highest score and the lowest score are responded similarly, have been discarded, for they are assumed, they do not measure the same attitude as a scale as a whole.

Based on this 11 items were discarded out of 32 items prepared for the pilot test. The final scale (21 statements) was constructed from items that consistently elicit agreement from the most favorable pilot tested subjects and the vice versa. Using the data of the pilot test, the internal consistency of the knowledge and attitude instrument/scales/ was computed using Kuder Richardson (KR-21) for knowledge and coefficient alpha for attitude related items respectively. After the computation, the reliability coefficient of the knowledge related items was 0.74 and 0.63 for the attitude scale.

On the other hand the content validity of the instrument was confirmed after commented by two professionals at AAU and 2 post graduate students from the measurement and evaluation area.

3.6. Procedure

The researcher took a letter that asks the cooperation for concerned bodies from the AAU-Psychology Department and delivered it to the commander of the college. Then it was referred to the dean of students because it was his mandate to accept or reject such requests. Fortunately the researcher secured permission from the dean and came back home to administer the test 3 days later. This was because; he was told that the 3rd year students were on meeting for two days. Then, the researcher went 3 days later with 3 of his assistants who were experienced instructors in that college. The researcher was engaged in supervising and monitoring the process if it was being done according to the instruction. The questionnaire was administered in the morning session on regular class periods with no time limits.

After lunch, a focus group discussion that contained eight leading questions was forecasted for three groups given appointment while filling the questionnaire (6 cadets in each level). Grouping was stratified according to educational status and an attempt to be made to include gender, marital status and residence. Two groups were formed from each category. First the researcher informed participants about the objectives of the discussion,

the worth of the information gained from each participant and about the confidentiality of the information gained from the discussion. Then, discussion was started after full consent was secured from members. The researcher led the discussion in Amharic by probing each group. On average the discussion took 65 minutes. The researcher took notes through out the discussion session.

3.7. Method of Data Analysis

3.7.1. Scoring of the Instrument

For the knowledge items where the respondents were asked to choose from the given alternatives (Yes or No) those who had chosen yes for positive statements and those who had chosen no for negative statements were considered to have positive response and thus given one mark. Those who answered no for positive statements and who said yes for negative statements are taken to have negative response and given no marks. Then the responses of each individual on the knowledge items were summed across statements to get the total score of each individual on a scale. Finally the total score of each individual was entered in to SPSS₁₂ program to apply the descriptive and inferential statistics which will be used for further interpretations of the results.

In the attitude scale each response has five specific categories (5 = strongly agree, 4 = agree, 3 = undecided, 2 = disagree, 1 = strongly disagree). Here an individual's score was determined by the sum of the point values given for each item.

For attitude items those who opted for strongly agree and agree for positive statements were considered to have positive attitudes and given 5 and 4 points respectively. Those who chose neutral for both positive and negatively stated statements were considered to have neutral attitude and given 3 points. Those who chose strongly disagree and disagree for negative statements were taken to have positive response and given 5 and 4 marks respectively. And those who chose agree and strongly agree for negatively stated items were leveled to have negative responses and given 2 and 1 marks consecutively. Then the responses to all attitude items were summed across statements to get the total score of each individual on a scale. Finally the total score of each individual was entered in to SPSS₁₂ program to apply additional descriptive and inferential statistics which are important for further interpretations.

3.7.2. Data Analysis

In analyzing and interpreting the quantitative data collected from respondents the researcher applied both descriptive and inferential statistics.

To describe the level of respondents' knowledge and attitude on HIV/VCT descriptive statistics such as percentages, mean and standard deviation were used;

To see if there is significant mean difference in knowledge about HIV/VCT and attitude towards HIV/VCT across residence (rural, urban) and marital status (married – unmarried) an analysis of t-test was applied.

To see the effect of education on knowledge about HIV/VCT and attitude towards HIV/VCT, analysis of variance (one way – ANOVA) was used.

Finally Pearson product moment correlation was used to see the relation between knowledge about HIV/VCT and attitude towards HIV/VCT. The qualitative data obtained from FGD participants was analyzed and interpreted in accordance with the headings of the quantitative data and research questions.

As is, described in the limitation, it was not possible to analyze sex as an important variable for the number of female students in the academy was too small to compare with the male. This is because, the nature of the military service, training etc which makes the participation of female cadets very small.

Chapter Four

Results

The major objective of this study was to assess the knowledge about HIV/VCT attitude of respondents to wards HIV-Voluntary Counseling and Testing /VCT/ services.

The data collected have been analyzed with respect to the specific questions raised in chapter one followed by interpretations. The quantitative analysis of the data with regard to HIV/AIDS related knowledge and attitude questionnaires have been supplemented by the qualitative analysis of the information obtained through Focus Group Discussions.

4.1. Characteristics of Respondents

Table 2. Characteristics of respondents (N=187)

Grouping variable	Characteristics	Number	Percentage
1. Sex	1. Male	172	85
	2. Female	15	15
	Total	187	100
2. Education	1. 1 st year	91	48.7
	2. 2 nd year	64	34.2
	3. 3 rd year	32	17.1
	Total	187	100
3. Residence	1. Rural	46	24.6
	2. Urban	141	75.4
	Total	187	100
4. Marital Status	1. Married	63	33.7
	2. Non married	124	66.3
	Total	187	100
5. Religion	1. Orthodox	130	70
	2. Protest	39	21
	3. Muslim	12	6.4
	4. Other	06	0.3
	Total	187	100
6. Age	1. 20-25	44	24
	2. 26-30	128	68.4
	3. 31-33	8	4.2
	Total	187	100
7. Experience	1. 2-6	37	20
	2. 7-10	145	75.4
	3. 11-17	3	1.6
	Total	187	100

The age gap of respondents varies from 20 to 33 years. The majority 128 (68.4%) of them fall between 26 and 30 years. About 44 (24%) of them were from 20 to 25 years. Only 8 (4.2%) of the respondents are between 31 and 33 years of age. Here we can understand that the majority of cadets are with in the adult population.

A look at on the respondents experience shows that about 145 (75.4%) of the respondents have rendered a military service of 7 to 10 years. And about 37 (20%) of them have served for 2 to 6 years. Only 3 (1.6%) of them have service years of 11 to 17 years. So, most of them have enjoyed 7 to 10 years of the military lives.

With respect to religion, the majority 130 (70%) of the respondents are orthodox followers. The next majority 39 (21%) are protestants followed by Muslim 12 (6.4%) and other (Pagan, Bahullah, Jehovah etc) 6 (0.3%).

As to the education level, about 91 (48.7 %) were first year cadets, 64 (34.2%) second year and 32 (17.1%) third year cadets. As the data on marital status shows significantly the highest proportion 124 (66.3%) were unmarried and 63 (33.7%) were married cadets. The divorced and the widowed were non existent in the sample. As the analysis of respondents on residence shows more than two fold, 141 (75.4%), were reared in urban environments and 46 (24.6%) were reared in rural backgrounds.

However, only marital status, residence and education level will be analyzed as independent variables to see if they have effects on the knowledge and attitude of cadets toward VCT service and if there is a significant knowledge and attitude different between the levels.

4.2. Analysis of knowledge of respondents about HIV/VCT

4.2.1. Analysis of the descriptive statistics

Table 3. Descriptive Analysis of Knowledge about HIV/VCT (N=187)

<i>Knowledge about VCT</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Mean</i>	<i>Standard deviation</i>
Knowledge	12.00	20.00	17.09	1.64

Table 4. Table showing the frequency and percentage of respondents' on each score of knowledge about VCT.

	Frequency	Percent
12	1	0.5
13	5	2.7
14	8	4.3
15	19	10.2
16	24	12.8
17	46	24.6
18	45	24.1
19	34	18.2
20	5	2.7
Total	187	100.00

The major aim of this study was to assess the knowledge and attitude of cadets towards HIV/VCT. Moreover, the study is aimed at examining barriers to VCT and a possible relationship between knowledge and attitude to VCT among cadets.

As the above descriptive statistics shows, this analysis used a total of 187 respondents divided across education level, residence and marital conditions.

Assessment of the cadets HIV/AIDS and VCT knowledge shows in table (3) that the mean score of respondents for a scale of maximums, core 20 and minimum score 12 was 17.09 and standard deviation of 1.64. The majority of (90) percent laid one standard deviation above and below the mean. This proves the homogeneity of the sample population during data collection. The majority of respondents 70%) have answered more than 85% of the items. From this we can say that majority respondents have good knowledge about HIV/VCT. Only 3.2% of the respondents are about 2 standard deviation units below the mean. Since the minimum score is 12 more than half on a scale of maximum score of 20, it is not possible to say that they have low knowledge about HIV/AIDS and VCT.

The knowledge scale was supplemented by FGD items related to knowledge about VCT, its uses and problems associated with VCT services. The results on the FGD also

showed that the respondents have good knowledge of HIV/VCT. In the qualitative data obtained from the observations of FGDs, participants were seen actively discussing on each issue raised about HIV/AIDS and related facts. Almost all of them answered or gave suggestions and constructive ideas throughout the discussions.

Almost all FGD participates proudly mentioned the following benefits of VCT services:-

- a valuable prevention and intervention strategy
- as tool to psycho-emotional support
- to take measures before physical exhaustion
- to have access to care and support.

On the problems side, the FGD participants raised:-

- absence of permanent VCT centers at each training center, command, division regiments etc,
- stigma and discrimination, lack of confidentiality of test results.
- absence of ethical and professional counselors
- compulsory and forced HIV testing in the military
- absence of pretest and post test elements/sessions of VCT. In most cases, they reported, they are not counseled, even informed whether the blood was taken for HIV-tests. At the end they used to receive their results publicly, identified by their first names.

4.2.2. Analysis of sources of knowledge

Table 5. Frequency and percentage of respondents on their source(s) of knowledge about VCT.

Source of Information	Yes	
	N ^o	%
1. Mass Media	172	91.5
2. Health personnel	145	77.1
3. Colleagues /Friends	113	60.1
4. Command center/Division	107	56.9
5. Family Guidance Association	86	45.7
6. Teacher/Trainer	54	28.7
7. Other	9	4.8

*N ≥ 187 since respondents may have answered to more than one source.

As the analysis of the data on sources of knowledge in table (5) shows mass-media has played the leading role in delivering information to cadets about HIV/VCT. The majority (91.5%) of cadets indicated mass media as their basic source of knowledge. The next source of knowledge was health personnel chosen by 145 (77.1%) of the respondents. The third source of knowledge was friends and/or colleagues. About 113 (60%) of the respondents' reported to have got information from their colleagues /friends. The military command center and departments having 44% of respondents is indicated as the fourth source of knowledge. This shows that HIV/VCT is not still taken as a major issue of concern at different levels. Teacher/Trainer has become the sixth source of knowledge about HIV/VCT. Only 28.7 % have got their information from their teachers/trainers.

4.3 Difference in knowledge about HIV/VCT as a function of residence, marital status and education level

4.3.1. Residence

The second question in the present study was “Do cadets show differences in knowledge about HIV/VCT across residence, marital status and education level”? While the analysis of t-test was used to compare means for residence (urban, rural) and marital condition (married, unmarried), one way ANOVA was employed see the effect of education level. Summary of t-test and ANOVA across each independent variable is shown as below.

Table 6. Summary table of t-test on cadets' knowledge about HIV/VCT by residence

<i>Variable</i>	<i>Residence</i>	<i>No of respondents</i>	<i>Mean</i>	<i>St. deviation</i>	<i>df</i>	<i>t</i>
Knowledge about HIV/VCT	Rural	46	17.30	1.63	185	1.015
	Urban	141	17.02	1.64		

As the results of t-test (Table 6) shows knowledge about HIV/AIDS scores do not differ due to the residence of cadets ($t=1.015, P>0.05$). This means that there is no statistically significant difference between rural and urban cadets in terms of their knowledge about HIV/VCT. To see if cadets' knowledge about HIV/VCT shows

significant difference as a function of marital status, analysis of t-test was made and shown as follows.

4.3.2. Marriage

Table 7. Summary table of t-test on cadet's knowledge of HIV/VCT by marriage

<i>Variable</i>	<i>Marital condition</i>	<i>N</i>	<i>mean</i>	<i>Std. deviation</i>	<i>df</i>	<i>t</i>
Knowledge on HIV/VCT	Married	63	17.42	1.30	185	2.228
	Un married	124	16.91	1.76		

As shown in Table (7) Cadets have shown significant difference on scores of knowledge about HIV/VCT by marital condition. ($t=2.228$, $df=185$, $p=0.045$). In this comparison married cadets were found more knowledgeable on HIV/VCT than unmarried cadets. A comparison has also been made to see if cadets differ by knowledge of HIV/VCT across education levels.

4.3.3. Education level

Table 8. One way ANOVA test on students' knowledge to VCT by education level.

	<i>Sum of squares</i>	<i>Df</i>	<i>Mean square</i>	<i>F</i>	<i>Sig.</i>
Between Groups	13.841	2	6.920	2.61	0.07
Within Group	487.614	184	2.650	1	
Total	501.455	186			

As indicated in the above table (8) there was no significant effect of education ($F_{(2,184)}=2.611$, $p>0.05$). This means cadets do not differ in their knowledge about HIV/VCT across their education level, i.e. the 1st, 2nd and 3rd year cadets do not show statistically significant difference in their knowledge about HIV/VCT/ among themselves.

4.4. Descriptive analysis of cadets' attitude towards VCT

Table 9. Descriptive statistics on attitude towards HIV/VCT (N=187)

	Minimum	Maximum	Mean	Std. Deviation
Attitude towards VCT	52	92	75.12	6.44

Table 10. Frequency and percentage of respondents on each attitude score from the minimum to maximum

	<i>Frequency</i>	<i>Percent</i>
52.00	1	.5
55.00	2	1.1
56.00	1	.5
57.00	1	.5
59.00	1	.5
62.00	1	.5
64.00	1	.5
65.00	5	2.7
66.00	1	.5
67.00	5	2.7
68.00	6	3.2
69.00	6	3.2
70.00	10	5.3
71.00	5	2.7
72.00	12	6.4
73.00	14	7.5
74.00	6	3.2
75.00	8	4.3
76.00	16	8.6
77.00	17	9.1
78.00	9	4.8
79.00	7	3.7
80.00	12	6.4
81.00	12	6.4
82.00	10	5.3
83.00	8	4.3
84.00	3	1.6
85.00	2	1.1
86.00	3	1.6
87.00	1	.5
92.00	1	.5
Total	187	100.0

As it can be seen from the table above, out of 105 marks given for the attitude scale the minimum and maximum scores are 52.0 and 92 consecutively. The mean score of the respondents was 75.12. About 134 (80%) of the respondents' score lay between one standard deviation unit above and below the mean. This shows the concentration of majority of respondents around the mean. This indicates that the majority of respondents showed their favorable attitude towards HIV/VCT. This is because they showed their agreements to the majority, (75%), of the items which ask respondents' stand on HIV/VCT.

In table (7) only 3.2% of the respondents are below two standard deviation units from the mean. These are respondents who scored between 52 and 59. Even for these respondents who scored above half of the total marks, it is hard to conclude their stand as unfavorable to VCT.

The results of the FGD show that the cadets' attitude towards VCT was positive. Almost all of them underlined VCT as an important strategy to reduce HIV transmission to get care and support and plan for future life like having a family. But when I asked them to test their blood by then, the majority didn't agree rationalizing that they were not ready to withstand stigma and discrimination from the community, and to receive a positive result. Some agreed if confidentiality is guaranteed.

4.5. Difference on attitude towards HIV/VCT across residence, marital condition and education level

4.5.1. Residence

From the descriptive statistics of attitude towards HIV/VCT it was observed that the majority of cadets have shown favorable attitudes. But whether these cadets differ as a function of residence, marital condition and education level needs examination. An assessment of attitude difference on HIV/VCT between these independent variables is shown below.

Table 11. Summary table of t-test on attitude of cadets towards HIV/VCT by residence.

Variable	Residence	N	Mean	St- deviation	df	t	P
Attitude towards HIV/VCT	Rural	46	73.39	6.07	185	2.119	0.03
	Urban	141	75.68	6.47			

Attitude of HIV/VCT differs among cadets ($t=2.119$, df , 185, $p=0.035$) From the Table (11), it is seen cadets of urban origin show more favorable attitude than the rurally raised cadets. The results from above comparison witness a significant difference of attitude between cadets as a function of their residence.

Difference on attitude to HIV/VCT among cadets was also examined as a function of marital status.

4.5.2. Marital Status

Table 12. Summary tables of t-test on cadets' attitude towards VCT as a function of marital status

<i>Variable</i>	<i>Marital status</i>	<i>N</i>	<i>Mean</i>	<i>Std. deviation</i>	<i>df</i>	<i>t</i>	<i>P</i>
Attitude towards HIV/VCTT	Married	63	76.11	5.92	185	1.500	0.13
	Unmarried	124	74.62	6.65			

As it can be seen from the table above, married and unmarried cadets do not differ in attitude ($t=1.50$, df , 185, $p>0.05$) towards HIV/VCT. In other words, there is no statistically significant difference among the married and unmarried cadets.

Finally the effect of education on attitude towards HIV/VCT was assessed by using one way ANOVA test.

4.5.3. Education level

Table 13. Summary table of one way ANOVA to test the effect of education on attitude towards HIV/VCT

<i>Attitude towards HIV/VCT</i>	<i>Sum of Squares</i>	<i>Df</i>	<i>Mean square</i>	<i>F</i>	<i>Sig.</i>
Between groups	27.381	2	13.69	0.328	0.72
Within groups	7690.79	184	41.798		
Total	7718.17	186			

As the result from one way ANOVA test shows, there is no significant effect of education level ($F_{(2,184)}=0.328$, $P>0.05$) on the cadets attitude towards HIV/VCT.. In other way, the first, second and third year cadets do not differ in their attitude towards HIV/VCT.

4.6. The relationship of variables used in the study

The fifth research question raised was “Is there any relationship between knowledge about HIV/AIDS and attitude towards HIV/VCT?”

Pearson product moment coefficient correlation was used to see the interrelationship between knowledge about HIV/VCT and attitude towards VCT. The correlation value indicated in table (14) showed no statistically significant relationship (0.16) between the two dependent variables. According to this study knowledge about HIV/VCT has very small (no) contribution for attitude towards VCT.

Table 14. Bivairate correlation between knowledge about VCT and attitude toward VCT)

Variables	Knowledge about HIV/VCT	Attitude towards HIV/VCT
Knowledge about HIV/VCT	1	0.16
Attitude towards HIV/VCT	0.16	1

Chapter Five

Discussion

In this Chapter the results of the present study will be discussed in the light of previous findings. Discussion on this chapter will be done on the following headings.

1. Knowledge status of cadets about HIV/AIDS and HIV/VCT.
2. Difference between cadets' knowledge about HIV/VCT as a function of residence, marital status and education level.
3. Attitude of cadets towards HIV/VCT
4. Difference among cadets on attitude towards HIV/VCT as a function of residence marital status, and education level
5. Relationship between knowledge about HIV/VCT and attitude towards HIV/VCT

5.1. Knowledge status of cadets about HIV/AIDS and HIV/VCT

One of the major objectives of this study was to assess the knowledge status of cadets about HIV/AIDS and HIV/VCT.

As could be observed from the descriptive statistics, table (3) cadets are found to have high knowledge on HIV/AIDS and VCT.

The mean score of 187 respondents on this scale was 17.09 a standard deviation of 1.64. The majority of the respondents, 130 (70%) have scored above the mean score.

In addition to the quantitative data obtained from structured questionnaires the responses on FGD participations showed that cadets have sufficient knowledge about the meaning of HIV/AIDS, ways of transmission and preventive mechanisms. Cadets were also observed to have good knowledge about VCT, its importance, its elements and problems encountered by the VCT services. This result may be due to the fact that the study included large number of military members who spent years of military services receiving HIV/AIDS and VCT related education, communication and information in the military. On the other hand attributed to the wide spread HIV/AIDS campaigns of MOD through education, communication etc.

The result of the present study is similar with the findings of Ibrahim, (2006) and EPHA (2003) on Defense University students, which reported the high level of awareness

of students on HIV/VCT, though EPHA reported some differences with the rise of education levels. Both studies found out that almost all Defense University students have good knowledge about VCT. The present finding was also congruent with the studies of Kabtamu-(2006, Liknaw (2006), Andargachew (2006). Other studies conducted by Kelly, (2001), Tilahun (1997) on university students confirms with the present finding. Kabtamu's study on college students of Assela reported that the majority of students have high knowledge of HIV/VCT. Kelly's study on Africa University students reported that tertiary level students have got high level of knowledge about HIV and related intervention programmes, despite their failure to bring desirable behavioral changes. Andargachew (2006) in his study of knowledge and attitude towards VCT, on the Bahir Dar university students, show that the majority of students have good knowledge of HIV and VCT. Tilahun (1997) and Tefera (2001) who studied university students in Gondar and Jimma respectively reported that the majority of their samples have got high knowledge on HIV/VCT and related issues. The reports of MOH/ HAPCO (2006), UNAIDS (2005) were also in agreement with the present study.

As the analysis of the sources of knowledge about HIV/VCT indicates mass media was found to be the first source of disseminating information about HIV/AIDS and VCT. About 172 (91.5%) of the cadets reported it as their source of information. The second source of information health personnel, was selected by 145 (77.1%) of cadets. Teacher /trainer were the last selected source of knowledge about HIV/VCT for cadets. This shows that HIV/VCT is still less communicated in classes and training centers. Moreover, the fact that command centers and divisions are found as the fourth source of information indicates HIV/VCT is still found with less concern in the military commands.

So we can conclude that mass media played a key role in dissemination information about HIV/AIDS and VCT in the military. The reason that military members are not mostly allowed to leave out of their camps, training centers and forts may have restricted them from access to other information sources. About 60% of cadets have got information from colleagues (friends). This shows that there is good communication of HIV/VCT among cadets.

At the study of Ibrahim (2006) mass media was the first information source for DU students. In the BSS of (2005), mass media was the first source of information for the study population that included the military.

In the studies of Cyaziow (2005), who studied the knowledge and attitude of university students in Nigeria Kabtamu (2006) who studied the knowledge and attitudes of college students in Assela Town and Andargachew (2006), who studied the knowledge and attitudes of Bahir Dar university students, mass media was also reported as the first selected source of information about HIV/AIDS and VCT.

5.2. HIV/VCT knowledge differences among cadets as a function of residence, marital status and education level.

5.2.1. Knowledge differences across residence.

In this study the analysis of t-test on knowledge of cadets about VCT shows rurally-raised cadets do not show a significant difference from urban-raised cadets in terms of their knowledge about HIV/VCT.

In the result of the FGD, most of the respondents argued that urban raised children are fast in accepting change but the rural ones are better in making decisions for HIV/VCT.

The result may be influenced by the military environment, discipline and military ethos which require the equal participation competence and homogeneity of members regardless of their beliefs, cultures and residence etc. this may help members to develop the attitude of competency in all issues and information including knowledge to HIV/AIDS and VCT.

Thus, it is encouraging to say that the causes, consequences, benefits and problems of HIV/AIDS and VCT are equally recognized by all cadets regardless of their residence. Hence this study indicates that difference across residence, knowledge is not the main problem of HIV/AIDS and VCT in the military. All of them may be used as HIV/VCT ambassadors to fight the spread of the disease in the community. This result is inconsistent with the reports of MOH|DPCD (2004), where uniformed services were included and rural residents reported with less knowledge of HIV/AIDS and related strategies.

5.2.2. Knowledge differences across marital status

The second variable in which knowledge difference was assessed was on marital status. It is obvious that marriage can contribute a lot to the knowledge of HIV/AIDS and VCT by discussing with the partner, limiting the individual's movements and by settling his/her sexual desires. It enables the couple share and learns more information of HIV infection; share their feelings, anxieties, concerns and worries about the disease (MOH, 2003)

As the result of this study shows cadets are found to differ in their knowledge about HIV/VCT across the marital status. Here the married cadets are found better in their knowledge about VCT than their unmarried counterparts. This implies that marriage is found helpful in raising the awareness of the military members towards HIV/AIDS and VCT.

5.2.3. Knowledge differences as a function of education level

According to the suggestions of MOH/HAPCO (2004) illiteracy was mentioned as one of the many factors that hastened the spread of HIV/AIDS. It is reasonable to assume that difference on education has its influence in receiving and/or comprehending to a certain issue and there by reaction to the issue. The same seems true with HIV/AIDS and VCT. But do really formal education help to overcome the problems of HIV/AIDS was one issue of this study. Eleni (1998) cited in Solomon K (2004) who studied the knowledge, attitude and behavior among long distance bus drivers underlined education as the most determinant factor for knowledge. For such reason knowledge about HIV/VCT was studied in line with the educational level of cadets. As the result of the present study reveals education has not any significant effect on cadet's knowledge of HIV/AIDS and VCT. There was not any difference of knowledge observed among cadets with the increase in their education levels and military trainings.

As was observed from the FGDs, most participants agreed that the increase in education level do little contributions or do not concede with knowledge of HIV/VCT and AIDS. By referring their experiences in a civilian as well as a military society most of them reported their observations of educated people dying of HIV/AIDS knowingly. This

may be attributed to the very narrow gap that exists between the levels of education among cadets. The result of this study is consistent with the finding of Kabtamu (2006) done college students of Assela town, across education level. In his study, education level was found to have no effects on students' knowledge about HIV and VCT. But the result of this study was found inconsistent with the findings of the 2005 BSS which indicated the increased knowledge among uniform service, youth and long distance drivers with increase education level. This study was also inconsistent with the study of EPHA, (2003) which reported the knowledge increment of Defense University students with the increase in their level of education. Kelly's study (2001) conducted on higher institution students in Southern Africa. In his study, Kelly (2001) found out that tertiary level students of South Africa seem to have better knowledge of HIV/AIDS and related issues. Another study undertaken to understand the impact of education on the knowledge of HIV/AIDS/VCT among young Ethiopians revealed that young men/ women who have primary education were 4 to 7 times greater in knowledge about HIV/VCT than those with no education (YRHE, 2003).

One possible explanation seems to be the knowledge about HIV/AIDS is determined by a minimum level of education to facilitate the information and bring the desired changes. But the cadets have already gained the minimum knowledge to comprehend information about HIV/AIDS.

The second possible explanation for the obtained results of the present study seems to be the contribution of anti AIDS-campaigns given at all levels. The efforts made through preparing leaflets, posters booklets, dramas and discussions in every level seem to have contributed better for equally high level of knowledge about HIV/VCT and related issues irrespective of educational levels. So HIV education seems better contributed than formal educations.

5.3. Assessment of cadets attitude towards HIV/VCT

As many findings argue HIV/VCT plays a key role by helping people aware of HIV/AIDS, its nature, ways of transmission etc. It is also obvious that VCT play a major role as intervention and prevention mechanism, to care and support, to minimize stigma and discrimination, etc.

The present study disclosed that cadets' attitude towards HIV/VCT service was favorable.

Assessment of the cadets HIV/VCT attitude shows that the mean score is 75.12 for 187 respondents with a scale of maximum score 92 and standard deviation 6.44 (table 9). The majority of the respondents' score 134 (84%) is concentrated around the mean which by itself is pulled towards the maximum score (92).

Thus one can surely say that the cadets' attitude towards HIV/VCT is favorable /positive/. On the other hand, it is observed that the majority of respondents have shown their agreements with most items that ask their stand about many issues on HIV/VCT.

The analysis of FGDs also confirms this fact. In the FGDs participant cadets in all the four groups were observed being actively involved in the discussion about the benefits of VCT, processes one can pass through VCT and problems associated with VCT services.

The majority of respondents replied that VCT is important to reduce HIV transmission, care and support for life adjustments. This findings on one hand may be a result of overall representation of numbers that are all above secondary education levels and on the other hand may be the results of strengthen HIV/AIDS control and mitigation efforts of the MOD that help them to gain high attitude among members.

But when they were asked to be tested at that time, most group members expressed their unwillingness reasoning that they have to get ready for it. Only some group members were ready to consult VCT that moment.

As it was reported by the FGD participants, stigma and discriminating attitude is not an issue in the military. Today HIV positive members in the military are treated well, assigned to easy tasks, but they observed their HIV positive colleagues experienced such attitudes from the civilian society. The communities don't rent houses for HIV positive military personnel and unwilling to interact in any issue. Moreover, there were no any permanent VCT centers, services and counselors at all places where the military were deployed.

The other issue confirmed by the FGDs was a problem of confidentiality, counselor skills and ethics. In military there is a situation where HIV testing becomes forced and accidental. One cadet, for example, raised an incident where he and most of his friends were forced to give their bloods accidentally. That was not the problem, as he says. They heard the result in assembly identified by their first names. In that situation, some

members with HIV positive result have drunk a poison and committed suicide. Those with normal physical appearance got shrunk within short days and got sick. And some were reported to be mentally ill. For this reason members prefer to test outside in public or government health institutions.

According to the FGDs, pretest and post-test counseling sessions are non-existent in the military. According to the military discipline, orders are inviolable; members accept whatever the discipline asks.

From this, it is possible to say that HIV/VCT is not well undertaken in the military, and counselors are not ethical, well trained and well equipped.

As the overall analysis of both the FGD and the descriptive statistics shows, cadets still favor HIV/VCT despite the presence of some problems. The present study is congruent with the study of Ibrahim (2006) on the Defense University students where he reported the students showed favorable attitude towards HIV/VCT. Andargachew, (2006) who studied the knowledge and attitude of BahirDar University students reported that most of his respondents have favorable attitudes to HIV/VCT. Liknaw (2006) even though on different settings, has reported the favorable attitude of most of his respondents in Shashemene Town. But the study is not consistent with the study of EPHA (2003) where the majority of Defense University students were reported to have unfavorable attitude towards VCT despite their high level of awareness about HIV/VCT. The second BSS (2005) which included 50.8% of military members indicated also the presence of one or more stigmatized attitudes among respondents despite their high level of knowledge on preventing methods.

5.4. Differences in attitude towards HIV/VCT

5.4.1. Attitudinal differences on HIV/VCT across residence

Many psychologists agree that human behavior may be influenced by environment and early child hood experiences. This may be different from place to place and from culture to culture. It is obvious that children of rural areas grew up from traditional, backward and conservative families. So it is an observed fact that they resist changes, at least for short period of time.

More over, in Ethiopia context, one can propose that people in rural areas lack up-to-date information about what is happening currently in the world. They are also in short of education, communication and technology. On the other hand, most people in rural areas are strongly devoted to their belief and cultures. For such a reason, most of them are suspicious of new information and are also change resistant. So it seems difficult for them to bring attitudinal changes easily with in a short period.

The present study disclosed that cadets of rural background were found to be relatively with less favorable attitudes towards HIV/VCT. Here the urban raised cadets showed more favorable attitudes than the rurally raised cadets. A significant mean difference was observed between rural and urban cadets.

The implication of this seem to be that urban areas are relatively susceptible to new information's, new things and technologies which in turn lays a ground for easy attitudinal changes.

This was also observed in the FGDs where most of the participants agreed on the change resistant but decision making quality of rural cadets on HIV/VCT than urban raised ones.

This study is consistent with the report of MOH/HAPCO (2006) where most rural areas of Ethiopia were found to be difficult for easy behavioral changes and thus more affected by the damages of the disease, on contrary to rural areas where the prevalence of the epidemic is declined.

5.4.2. Attitude differences on HIV/VCT as a function of marital status

As is observed from the t-test summary in Table (12), cadets do not show any significant difference of attitude towards HIV/VCT in line with their marital status. Here marriage is not found to add a lot in changing cadets' attitude towards HIV/VCT. This may be attributed to the implementation of behavioral changing programmes equally for both groups and members by the MOD. The fact that couples are more/equally suffering from infections on HIV/AIDS and the fact that many HIV orphaned children exist in the military may imply less contribution of marriages for behavioral/attitudinal changes towards HIV and VCT (MOH/HAPCO, 2006).

5.4.3. Attitude differences as a function of education level.

Attitude scores of cadets towards HIV/VCT were examined in line with their education level. Unlike residence, education level is not found to bring significant statistical difference on attitude towards HIV/VCT among participants of the present study. The result may be affected by different factors such as the proximity/narrow gap between the education levels, which may not significantly cause wide ranges of behavioral changes. The result of this study is in agreement with BSS (2005), which reported the absence of attitude difference with increase in education levels among the participants including military members. In the study of EPHA (2003) DU students didn't show any attitude differences at any levels but knowledge differences.

But this result is inconsistent with the findings of Liknaw (2006) who studied the attitude of people in Shashemenie town on HIV/VCT in line with education level and revealed a significant difference among his groups. According to Liknaw (2006) result, as education level increases peoples attitude towards VCT and related issues becomes positive.

A possible explanation for the inconsistency of this result with Liknaw's would be the fact that the participants of this study had a narrow gap between their levels of education (between 1st, 2nd and 3rd year) But Liknaw's study used wide differences in levels of education (illiterate, secondary and tertiary levels).

Another possible explanation may be the fact that an equal access to behavior changing information, education and communication is delivered by anti HIV clubs in the military academy and by the Health Bureau Ministry of Defense. Another possible reason for the absence of difference can also attribute to similarity of attitude towards VCT, all positive, according to the scores on the descriptive statistics.

5.5. The relation between knowledge about HIV/VCT and attitude towards VCT

In order to know the relationship between the two independent variables, knowledge about HIV/VCT and attitude towards VCT, computation of Pearson product moment coefficient (bivariate) correlation was employed. As the bivariate correlation matrix (Table 14) shows, there was no any statistically significant relationship observed between

knowledge about HIV/AIDS and attitude towards VCT. The correlation coefficient of 0.16 showed a very weak and insignificant relation between the two variables. From the observation of FGDs, a similar opinion was observed. Most of them shared their experiences of observing more educated people dying from HIV/AIDS and experiencing sexually risky behaviors. One member for example, remembered his experience of observing a teacher discussing a condom as useless and not fluid proof and narrating HIV as a man made disease. Another member also remembered his experience of 2002 hearing from commercial sex working females that educated foreigners making sex with out condoms. As most of the FGD participants agree knowledge does not necessarily bring attitudinal changes.

The findings of this study are incongruent with the commonly accepted assumption that values the necessity of knowledge for people's need and readiness for VCT services. Some previous studies of EPHA (2003), BSS (2005), Ibrahim (2006), Tilahun (1997), Kabtamu, (2006) and Kelley, (2001) agree with this study. In the study of EPHA (2003) the majority of Defense University students were reported practicing high risk sexual behaviors despite their high level of awareness about HIV/AIDS and related preventive mechanisms. Ibrahim's study on 236 Defense University students also showed high level of student's awareness and favorable attitude towards HIV/AIDS and VCT. But students showed unwillingness on testing their blood. In the study of BSS (2005), the military were also indicated practicing one or more stigmatizing attitudes, unlike their high knowledge about HIV/AIDS and VCT. Tilahun (1997) who studied the AIDS related knowledge and sexual behavior of medical college students in Gondar reported that AIDS related knowledge was generally high among the students but their knowledge was not consistent with their sexual behavior.

As Kelley (2001) reported, knowledge about the disease and related intervention programmes didn't help students to bring necessary behavioral change.

This finding also seem consistent with the "Health belief model" cited in Helen (1992) which says "sufficient knowledge of the disease is important but not the only prerequisite for behavioral change" In the study of Kabtamu (2006), on college students of Assela Town, knowledge about HIV/AIDS is not related to their readiness to undergo VCT services.

One possible reason for the absence of relationship between HIV-related knowledge and attitude towards VCT seem to be the wrong symbolization and exaggerated presentation of HIV related education and information. Some of the HIV related information broadcasted and disseminated by the mass media may have led people to develop fear of stigma towards HIV/AIDS and keep them away from visiting VCT centers. Another possible reason as reported by BSS (2005) was the existence of still low comprehensive knowledge and persisting misconceptions in the military and other study groups, where more than 40% in each group responded. As is seen from FGDs another possible reason seems to be the trend HIV testing is given in the military.

The way the test result was publicized without the consents of the tested was criticized by all of the FGD members. As one member reported, one of his colleagues at Bure, a place at Ethio-Eritrean border, has suffered from psychological and emotional problems and died within 2 months when his positive results was publicized in an assembly.

All these and other reasons may probably have kept HIV/AIDS related knowledge not to be related with the attitude towards VCT services.

Chapter Six

Summary, Conclusions and Recommendations

6.1. Summary

The core objective of the present study was to examine/assess the knowledge and attitude of military cadets towards voluntary counseling and testing for HIV.

In order to accomplish this objective the following basic questions were formulated.

- What is the level of the military's awareness towards voluntary counseling and testing?
- What is the military's attitude towards HIV/VCT?
- Is there any difference of knowledge about VCT among cadets across the three socio-demographic variables, namely residence, marital status and education level?
- Do cadets show difference in attitude towards VCT in line with the above independent variables?
- What is the relationship between knowledge about HIV/VCT and attitude towards VCT?
- What are the possible factors that hinder the cadets from voluntary counseling and testing?

To find responses for the above questions about available 16 female 177 male sample cadets were selected from a total of 595 cadets who are attending their military and academic trainings at Major General Haylom Araya Military Academy in Holeta Town. Simple random sampling of male cadets was undertaken and the available female cadets were included.

To get the relevant information for the study, a structured questionnaire was used as the main instrument of data collection. To supplement the information collected by the questionnaire, leading questions (about eight) were prepared for focus group discussions (FGD). These focus groups were formed from 18 sample cadets six in each year.

The structured questionnaire was administered to 193 cadets (16 female and 173 male) at their regular class time. But, only 187 cadets (16 female and 171 male) samples returned the questionnaire and their responses were used in the final data analysis. The collected

data were analyzed quantitatively and qualitatively. For the quantitative data both descriptive (mean and standard deviation) and inferential statistics (t-test, one way ANOVA and Pearson product moment correlation) were employed. All the required information was analyzed using SPSS₁₂ program.

- Percentage was used to identify the proportion of respondents categorized under certain conditions
- Mean and standard deviation were used to describe the concentration and deviation of respondents scores around the mean
- T-test was used to find out the significance of differences in knowledge and attitude among cadets as a function of residence and marital status.
- One way ANOVA was employed to examine the significance of differences among cadets based on their educational levels.

Analysis of the overall data provided the following results

- It was found out that the majority of the respondents had good knowledge about HIV/AIDS, HIV/VCT and related issues. It was observed that more than 70 percent of the respondents have answered more than 85% of the HIV/VCT knowledge items.
- Knowledge about HIV/VCT didn't show significant difference with reference to residence. The rural and urban-raised cadets were almost equally knowledgeable about VCT and related issues.
- With respect to the marital status, the married cadets had more knowledge than their unmarried counter parts. Their difference was statistically significant.
- In line with education level, there was no statistically observed significant difference among the first, the second and third year students with respect to their knowledge about HIV/VCT.
- It was possibly seen that the significant majority of the cadets had shown positive attitudes towards HIV/VCT and related issues.
- A comparison of the means on the cadets' score of attitude scales in line with residence resulted in statistically significant difference between the rural and urban cadets. Here, those cadets who grew in urban environments showed more favorable attitudes than rurally grown cadets.

- There was no significant effect of education observed on attitude towards VCT. All the three levels had shown similarities in their attitude towards HIV/VCT.
- Knowledge about HIV/VCT and attitude towards HIV/VCT are not significantly related. They showed a very weak (0.16) of the correlation coefficient value.

As observed from the analysis of FGDS, it was found out that:-

- Cadets showed variation only in their attitude towards VCT as a function of residence. Other wise they were observed equally and actively participating through out the session at all the issues.
- VCT centers are rare in most Military Centers (command, division, regiments and training centers).
- Stigma and discrimination from the community, forced HIV-testing, absence of confidentiality, counselor skill and ethics were mentioned by participants of the FGD as problems of VCT services in the military.
- VCT-was also mentioned as key strategy to prevention, a tool to psycho-emotional support, access to get care and support by FGD participants.

6.2. Conclusion

From the results of the present study it is possible to draw the following conclusions:-

- Cadets have got a reasonably high knowledge about HIV/VCT services and related issues. Here it is possible to conclude that knowledge about HIV/VCT is not a problem of cadets and the military personnel.
- The absence of difference of knowledge between the rural and urban cadets implies the equal importance of both groups for serving as agents to HIV/AIDS campaigns in the community.
- Cadets' knowledge with respect to their marital status has shown a difference. Married cadets are found with higher knowledge than the single ones. This may indicate that married cadets get additional information and knowledge on HIV/VCT probably by discussing with their wives. Here the researcher suggests the Ministry of Defense to reconsider its code of conduct which prohibits members from marriage before rendering seven years of military service.

- There was no any knowledge difference observed in the three education levels. Here we can conclude that difference in education level is not a factor for the spread of HIV/AIDS and for not getting VCT services in the military. There may be other possible factors.
- Cadets are found to have shown (developed) relatively favorable attitude towards voluntary counseling and testing but their behavior is not on a scale that leads them to get VCT services. This implies that, attempts made by the Health Bureau of the MOD and anti HIV clubs in the MOD haven't reached to a scale that helps cadets bring maximum behavioral changes.
- With respect to residence urban cadets were more favorable than rural cadets. This implies that rurally raised cadets still resist attitudinal changes and need special treatments.
- With respect to marriage: there was no any attitudinal difference observed among cadets. Here it is possible to conclude that marriage has better contribution in raising level of knowledge about HIV/VCT and less in changing attitudes among cadets.
- Educationally there was no significant attitudinal difference across the grade levels. It can be concluded that narrow differences across education levels are less probable in bringing attitudinal changes with in the military.
- Knowledge about HIV/VCT and attitude towards HIV/VCT of cadets is not related according to this study. Here it is possible to conclude that high or less level of knowledge about HIV/VCT is not a pre-requisite for attitudinal changes in the military.
- Even though VCT is mentioned as a key strategy to care, prevention, psychological support, it is rarely instituted in most of the military commandments, divisions, regiments and training centers. Forced HIV testing, absence of confidentiality, less counselor skill and ethics, stigma and discrimination were other problems found with in the military. These are the main variables that restricted the military from getting VCT services.

6.3. Recommendations

Based on the findings of the study, the researcher would like to forward the following suggestions.

- The results of the study indicated that there was high knowledge and positive attitude towards VCT, despite their reluctance to use VCT services. Thus, it is advisable to the MOD scale up multi-faceted behavioral changing models, encouraging and supportive policies.
- Since marriage is found to be an influential variable in the study in increasing the knowledge about HIV/VCT, the MOD is better advised to allow marriages and increase female members in the institution.
- By creating a linkage with MOH and other HIV funding organizations, the military could serve as instruments of fighting HIV/AIDS at national level.
- The MOD may strengthen its efforts of fighting HIV/AIDS by encouraging anti-HIV clubs, HIV positive members and promoting ranks or incentives for members who work for it.
- The MOD would rather stop forceful and situational HIV-testing trend and displaying the results openly and publicly. It is better to have confidential voluntary HIV-testing with Pretest and post test counseling sessions.
- HIV related competitions, dialogues and debating programmes have to be designed and organized among the trainees so that they could bring significant behavioral changes.
- From personal observations of FGDs and raw data, it was observed that VCT centers are only situated to MOD referral hospitals, some command centers and few divisions. So it is better for MOD to institute permanent VCT centers and services at every training centers, commandment, division, regiments and academic centers.
- Even the existing VCT counselors in the military are found with problems of ethics and professional skills. So the MOD would rather take measures that increase their

efficiency and prepare scheduled trainings for VCT counselors. Moreover, every VCT center is advised to have professional counselors.

- In this study, knowledge about HIV/VCT and attitude towards HIV/VCT are found unrelated. The researcher would like to recommend, further studies if there might be other factors that affect the relation of these variables.

References

- Allen S. (1999). *The evolution of voluntary testing and counseling as an HIV prevention strategy*: in Laura Gibnary, R.J. Declemetete and sten H vermund (Ed.) New york: Kliwer Academic plenum publishers.
- Andargachew Moges. *Percieved Barriers to undergo HIV/VCT among Bahirdar University students*: MA Thesis, June, 2006, Addis Ababa
- Baggaley R. Kelly M, et.al, (1998). *HIV counseling and Testing in Zambia*: The Kara counseling experience: Zambia.
- Beyene Petros, Solomon Belayneh and Yared Mekonnone, (1997) *AIDS and college students in Addis Ababa. A study of knowledge, attitude and behavior*, Ethiopian Journal of Health Development, (11),115-123
- Best, J., and Kahan, J. (1989). *Research in Education*, 7th ed. Prentices Hell, Eglewood Cliffs, New Jersay.
- CDC (2001): *Revised guidelines for HIV counseling, testing and referral CDC, 2001*
- CDC (2003). *Voluntary counseling and Testing (VCT) Trainers manual*:
- Ceyaziw (2005) *Assessing Nigerian University Students Knowledge about HIV/AIDS*. *Journal of social science* 11(3).207-213
- CRDA (1996). *Study Tour Reports on HIV/AIDS/STDs programmes in Kenya, Uganda and Tanzania*.
- CSA(2005). *Ethiopian Demographic Health Survey The 2005 Report* Addis Ababa.
- Ethiopian Demographic Health Survey (EDHS)-2000 and 2005 Reports Addis Ababa.
- EPHA (2003). *Ethiopian Health Association*, Addis Ababa.
- Essex David and Kalergayi. *Mobwar* (1991). *AIDS in Africa*, Raven Press Ny.
- FHI (2003). *Voluntary counseling and Testing for HIV/FHI*: (available online <http://www.fhiorglen/hiv aids/publication/factsheets/vctforhiv.htm>)
- FMOH/HAPCO (1997). **የኤች. ኤይ. ቪ/ኤድስ ወረርሽኝ ለመከላከልና ለመቆጣጠር የሕዝብ ንቅናቄ ማቀጣጠያ ስትራቴጂ ታህሳስ 1997 ዓ.ም አዲስ አበባ**
- Garbus.L (2003). *HIV/AIDS in Ethiopia*: AIDS Research Institute, AIDS policy Research center: Univ-california.

- HAPCO/MOH (2006). *AIDS in Ethiopia, 6th report*: September, 2006: Addis Ababa, Ethiopia
- HAPCO/MOH (2005). *Behavioral surveillance survey 2005 reports*: Addis Ababa, Ethiopia
- HAPCO/MOH (2005). *Behavioral Surveillance Survey*: Institute AIDS security, Democracy: Addis Ababa
- Hellen J. (1992). *AIDS Action Now information prevention and support in Zimbabwe*:
- Horizons (2001). *HIV voluntary counseling and Testing among youth*: Results from an exploratory study in Nairobi, Kenya and Kampala and Masaka ,Uganda: New York population council [http:// heapol – oxford Journal – org/](http://heapol-oxfordjournal.org/)
- Ibrahim Yimer, (2006). *A comparative study of knowledge, attitude and practice about HIV/AIDS and VCT among Defense University College students*: MA Thesis, Addis Ababa University.
- Kabtamu Ayele (2006). *Knowledge about HIV/AIDS, Risk Reduction behavior and Readiness to undergo voluntary counseling and Testing*: the case of college students in Arisi Zone: Unpublished MA Thesis: AAU.
- Kelly M. (2001). *Challenging the challenger: understanding and expanding the response of universities in Africa to HIV/AIDS*: Washington: ADEA working group on higher education.
- Lambadina (2006). *In pursuit of youth empowerment*: a private news paper Vol. 1 No 12 June 2006, Addis Ababa
- Liknaw Ayenew (2006). *Knowledge and attitude of people towards voluntary counseling and Testing for HIV*: the case of Shashemene: Unpublished MA Thesis, AAU, June, 2006.
- Mahta,S and Sodi,K (2004). *Understanding AIDS; myths, efforts, and achievements*. Apm. Publishing corporation:New Delhi.
- Michael Dejene (2001). *Barriers and concerns for VCT services among youth and antenatal care followers in Bahir Dar Town, North West Ethiopia*:- FGAE

- Mohammed F. (2000) Factors related to HIV/VCT among 15-19 year old Urban Community: *MA Thesis Department of Community Health.*
- MOH/HAPCO (2004). *Ethiopian strategic plan for intensifying multi-sectoral HIV/AIDS Response, 2004 – 2008:* Addis Ababa, Ethiopia.
- MOH/DPCD (2004). *AIDS in Ethiopia, fifth Report Addis Ababa,* Ethiopia, June 2004
- MOH (2005). *Guidelines for implementation of antiretroviral therapy in Ethiopia:* DPCD Addis Ababa
- MOH (2003). *National HIV/AIDS counseling training manual DPCD:* Addis Ababa.
- MOH (2005). *Guidelines for voluntary HIV counseling and testing in Ethiopia. Unpublished manual:* Addis Ababa
- MOH (1998): *AIDS in Ethiopia: Background projection, Impact and intervention:* second edition, epidemiology and AIDS Department Addis Ababa
- MOH (2002). *National guidelines for voluntary HIV counseling and Testing in Ethiopia:* Addis Ababa.
- MOH (2004). *AIDS in Ethiopia:* Disease Prevention and Control Department: Addis Ababa.
- NACS (2005). *National guideline for voluntary HIV: counseling and testing service in Ethiopia,* Addis Ababa.
- NACS (2000). *National guideline for voluntary HIV: counseling and testing service in Ethiopia,* Addis Ababa.
- Normal R. and Ytades Gebre (2005). *HIV Testing an analysis of university students in Jamaica:* Madcape General Medicine, 7(1) <http://www.medcape.com/view/article/498954>
- Peltzer A. (2004). Attitude towards HIV antibody testing and people with AIDS among University Students Indian, South African and United States. *Indian Journal of Medical and Science* (58) No.3 pp.95-108. <http://www.Bioline.org.br/ims>.
- Quadango, D. and Denny, N (1992). *Human Sexuality* (2nd edn.) Mosby Year Book Inc: Boston.
- Rahihika Sorin (2003). *The enemy within: AIDS in the military*

- Retta Ayele (2001). *CAP related to HIV/ among the military*: unpublished Thesis, School of Health Science; Addis Ababa.
- Shitaye Alemu, Nuru Abseno, Getu Degu, Yared Mekonnen and Solomon Amsalu (2004). *Knowledge and attitude towards VCT for HIV Community based study in North West Ethiopia*. Ethiopian Journal of Health Development, (18)2 pp. 82-88
- Solomon Kebede (2004). *Knowledge and attitude of AAU female students towards HIV/AIDS: with particular reference to preparatory students*; MA Thesis. Addis Ababa University
- Solomon Mekonnen (2004). *An assessment of counseling services in voluntary counseling and testing centers: the case of Addis Ababa* unpublished MA Thesis: Addis Ababa University.
- Tefera Belachew, (2001). *Knowledge attitude and practice about HIV/AIDS and VCT among students of Jimma University*, Ethiopian Journal of Health science (14)Special issue, PP-43-52
- Tilahun Teka (1997). *AIDS related knowledge and behavior among college students: Gonder, Ethiopia*.
- UNAIDS (1999). *Counseling and voluntary HIV Testing for pregnant women in Highly HIV prevalence countries: Elements and issues*, UNAIDS Best practice collection.
- UNAIDS (2006). *Report on the global AIDS epidemic: Exclusive summary: ANAIDS 10th anniversary special edition*, Geneva, Switzerland
- UNAIDS (2005). *Report update on the global HIV/AIDS epidemic*, December 2005. <http://www.org/bangkok2005/report.html>
- UNAIDS (2004). *The 2004 Report on the global AIDS epidemic UNAIDS*: Geneva, Switzerland.
- UNAIDS (2000). *Voluntary counseling and Testing (VCT): UNAIDS Technical update* Geneva, Switzerland.
- UNAIDS (2001). *The impact of voluntary counseling and Testing: A global review of the benefits and challenges*

- VSO (2004). *VSO Ethiopia: HIV/AIDS Mainstreaming manual unpublished manual*, VSO: Addis Ababa.
- WHO (2002). *Increasing Access to HIV Testing and counseling*: Geneva Switzerland.
- WHO (2002). *Increasing access to HIV testing and counseling*. Report of WHO consultation, November 19-21. Geneva, Switzerland.
- YRHE (2003). *Young Reproductive Health Ethiopia: Family Guidance Association Ethiopia (FGAE) Addis Ababa*.
- Yusuf O. Abdi (2004). *HIV/AIDS counseling: The Ethiopian experience. A pledge to reverse the present statuesque*: AAU, Department of Psychology /memo/

Appendixes

Appendix A
ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF PSYCHOLOGY
COUNSELING UNIT

Objectives: This questionnaire is aimed to collect information on the knowledge and attitude of cadets about voluntary counseling and testing services.

The study can accomplish its tasks, if and only if you are honest and frank to help in filling the questions. I assure you to feel free for:-

1. The information obtained through the questionnaire will be used (is sought) only for research purposes.
2. All your responses are to be kept in absolute confidentiality and never affect you in one or the other way.
3. You are not responsible what ever the research out come is.
4. If you find any ambiguity in the statements you are welcomed to ask.
5. There is no need to write your names in the questionnaire.

Thank you in advance for your cooperation

Part I

Personal Information

For the following items, you are required to fill your background information in two ways. For items with blank spaces, you are to fill with your answers and for items with options, you are to encircle the number of your choice.

- | | |
|---------------------------------|---|
| 1. Age _____ | 4. Military experience _____ |
| 2. Religion _____ | 5. Sex 1. Male 2. Female |
| 3. Command (<i>Eiz</i>) _____ | 6. Year/level 1. 1 st 2. 2 nd 3. 3 rd |
| 7. Birth Background | 1. Rural 2. Urban |
| 8. Marital status | 1. Married 2. Unmarried |
| | 3. Divorced 4. Widowed |

Part II – Voluntary counseling and Testing and HIV (AIDS) knowledge related questions

1. HIV is a name given for the virus that causes the disease called AIDS
1. Yes 2. No
2. Today HIV/AIDS is a little concern of human life than war, drought and hunger
1. Yes 2. No
3. There is no need to worry for HIV/AIDS as far as condoms are available
1. Yes 2. No
4. Rare sexual experience means no HIV infections
1. Yes 2. No
5. Physical appearance can help to distinguish people with HIV infections
1. Yes 2. No
6. It is important to know one's own HIV status
1. Yes 2. No
7. There is a situation when voluntary counseling and testing for HIV is given forcefully
1. Yes 2. No
8. Voluntary counseling and testing for HIV is helpful for the infected to manage their habits and live positive lives
1. Yes 2. No
9. Access to support services is possible after if one has passed through voluntary counseling and testing services
1. Yes 2. No
10. For people who attended the pre-test counseling, it is mandatory to test for HIV
1. Yes 2. No
11. Voluntary counseling and testing helps the HIV positive people make mental and psychological adjustments
1. Yes 2. No
12. Access to VCT helps to take measures that prevent the transmission of HIV from the mother to child during pregnancy
1. Yes 2. No

13. Stigma and discrimination decreases as knowledge of people to VCT increases

1. Yes 2. No

14. One who tested negative for HIV antibodies, is free from the virus for the past 3 months

1. Yes 2. No

15. Individuals who had sexual experiences with commercial sex workers should better visit VCT services than others

1. Yes 2. No

16. I know there is a full equipped VCT service in the military/college

1. Yes 2. No

17. I know VCT services in the military lack proper facilities

1. Yes 2. No

18. Having a meal with an HIV positive individual can transmit the virus to an infected person

1. Yes 2. No

19. I know counselors in the military VCT centers are well equipped, and skillful

1. Yes 2. No

20. I know the counselors in the military are ethical

1. Yes 2. No

21. Where did you get information about the presence of voluntary counseling and testing services? Rank in order.

- a) Mass Media
- b) Health personnel
- c) Colleagues
- d) Command centers/division
- e) Family Guidance Association
- f) Teachers/instructors

No	Questions related to attitude towards HIV and voluntary counseling and Testing	5	4	3	2	1
1	One should better die from battles than/with HIV/AIDS					
2	Since man is mortal, no need to bother for HIV infections					
3	HIV/AIDS is a global issue, so one better focus on his/her own private matters					
4	One can better keep away from having HIV voluntary testing and counseling as far as he is sure of being free from the virus.					
5	I don't want people laugh (stare) at me by visiting VCTS and receiving a positive blood result					
6	One needs to have voluntary counseling and testing when he has get some health problems					
7	I hesitate to visit VCTs for their long and boring sessions					
8	I am afraid of dealing with people who live with HIV virus					
9	I don't know what to do, if my blood test is positive					
10	The service given in voluntary counseling and testing is a threatening situation than the result is					
11	VCT centers should better be located a part from main roads and populated areas					
12	HIV positive people can live long if they get appropriate VCT services					
13	One has to check/test his blood for VCT can give opportunities to live longer					
14	Stigmatizing and discriminating HIV infected people hastens the spread of HIV/AIDS by minimizing people who need for VCTS					
15	HIV counseling should better given individually for it preserves confidentiality					
16	Knowing one's HIV status is possible after voluntary counseling and testing.					
17	Knowing ones own HIV status benefits the tester.					

18	Counseling and testing helps people change their negative attitude towards HIV virus and people live with the virus.					
19	Voluntary counseling and testing is joyful it given properly					
20	Any professional can give voluntary counseling and testing					
21	Voluntary counseling and testing may help positive individual to correct/adjust his behavior and adapt positive living.					

Appendix B.

**በአዲስ አበባ ዩኒቨርሲቲ
በሥነ-ትምህርት ፋካሊቲ
ድህረ-ምረቃ መርሃ ግብር**

ዓላማ- የዚህ መጠይቅ ዓላማ ዕጩ መኮንን/ኗ በፈቃደኝነት ላይ የተመሰረተ የኤች አይ ቪ. ኤድስ ምክክርና ምርምር አገልግሎት ያለውን እውቀትና አመለካከት በተመለከተ ጥናታዊ መረጃ ለመስጠት የተዘጋጀ ነው። ይህ ጥናት የታቀደለትን ግብ ሊመታ የሚችለው እጩ መኮንን/ኗ መጠይቁን በታማኝነትና በቅንነት ለመሙላት ሲተባበሩ ብቻ ነው። መጠይቁን በሚሞሉበት ጊዜ ፍጹም ነጻ ሊሆኑ ይገባል።

ምክንያቱም፡-

1. በዚህ መጠይቅ የተሰበሰበው መረጃ ከጥናትና ምርምር ውጭ ለምንም ዓላማ የሚውል አይደለም፤
2. የሚሰጡት መረጃ በከፍተኛ ደረጃ ሚስጥርነቱ የተጠበቀ ከመሆኑም በላይ መረጃ ሰጪውን በአንድም ሆነ በሌላ መንገድ የሚጎዳበት ምንም መንገድ የለውም፤
3. የጥናትና ምርምሩ ውጤት ምንም ይሁን ምን መረጃ ሰጪውን ተጠያቂ አያደርገውም፤
4. መጠይቁን በመሙላት ሂደት ውስጥ ማንኛውም ግልጽ ያልሆነ ነገር ካጋጠመዎ መረጃ ሰብሳቢውን መጠየቅ ይችላሉ፤
5. በመጠይቁ ላይ ስምዎትን መጻፍ አያስፈልግዎትም።
ለትብብርዎ አስቀድሜ ምስጋናዬን አቀርባለሁ።

ክፍል አንድ

ግለሰባዊ መረጃዎች

የሚከተሉት ጥያቄዎች የግል መረጃዎትን በሁለት ዓይነት መንገድ እንዲሞሉ የሚጠይቁ ናቸው። ባዶ ቦታ ለተተወላቸው ቦታዎች ትክክለኛ መረጃዎችን እንዲጻፉ የሚጠየቁ ሲሆን ምርጫ ለቀረበላቸው ጥያቄዎች ደግሞ እርስዎን የሚገልጸውን ቁጥር ያክብቡት።

1. እድሜ _____
2. ጾታ 1. ወንድ 2. ሴት
3. ኃይማኖት _____
4. የነበሩበት ዕዝ _____
5. በውትድርና ሙያ ላይ ያገለገሉበት ዘመን _____
6. በእጩ መኮንን አካዳሚው የትምህርት ዓመት 1. 1ኛ 2. 2ኛ 3. 3ኛ
7. ወደ ውትድርና ሙያ እስከገቡበት ጊዜ ድረስ የኖሩበት ወይም ያደጉበት ቦታ
1. ገጠር 2. ከተማ
8. የጋብቻ ሁኔታ
1. ያገባ 2. ያላገባ 3. የፈታ/ች 4. ባል ወይም ሚስት በሞት የተለየበት/ባት

ክፍል ሁለት

በፈቃደኝነት ላይ የተመሰረተ የምክክርና ምርመራ አገልግሎትና ኤች አይ ቪ. ኤድስን ጠቅላላ ዕውቀት ወይም ግንዛቤን የሚመለከቱ መጠይቆች፡-

1. ኤች አይ ቪ. ኤድስ ተብሎ የሚጠራውን በሽታ ለሚያመጣው ህዋስ/ቫይረስ መጠሪያ ስያሜ ነው። 1. አዎ 2. አይደለም

- 2. አሁን ኤች አይ ቪ. ኤድስን ክድርቅ፣ ከጦርነትና ከረሃብ ብዙም አስበልጠን የምናይበት ዘመን ላይ አይደለንም። 1. አዎ 2. አይደለም
- 3. ኮንዶም እስካለ ድረስ ብዙም ስለ ኤች አይ ቪ. ኤድስ መጨነቅ አያስፈልግም። 1. አዎ 2. አይደለም
- 4. የጥቂት ጊዜ ግብረ-ሥጋ ግንኙነት ልምድ ያለውን ሰው ከኤች አይ ቪ. ኤድስ ነጻ ነው ማለት ይቻላል። 1. አዎ 2. አይደለም
- 5. ኤች አይ ቪ. ኤድስ ያለበትን ሰው የሰውነት ገጽታውን ወይም አቋሙን በማየት መናገር ወይም መለየት ይቻላል። 1. አዎ 2. አይደለም
- 6. አንድ ሰው ኤች አይ ቪ. ኤድስ እንዳለበትና እንደሌለበት ማወቁ ለራሁ ይጠቅመዋል።

1. አዎ 2. አይደለም

- 7. የኤች አይ ቪ. ኤድስ ምክክርና ምርመራ አገልግሎት በግዴታ ላይ የተመሠረተ የሚሆንበት ወቅት አለ። 1. አዎ 2. አይደለም
- 8. በፈቃደኝነት ላይ የተመሰረተ የምክርና ምርመራ አገልግሎት ኤች አይ ቪ. ቫይረስ በደማቸው የተገኘባቸው ሰዎች የተሳሳተ ልምድ/ባህሪያቸውን አስተካክለው ከቫይረሱ ጋር የሚኖሩበትን ዘዴ እንዲቀይሱ ይረዳቸዋል። 1. አዎ 2. አይደለም
- 9. ማንኛውንም ኤች አይ ቪ.ን በተመለከተ እርዳታና አገልግሎት ለማግኘት የሚቻለው በፈቃደኝነት ላይ በተመሰረተ የምክክርና ምርመራ አገልግሎት ሂደት ውስጥ ከታለፈ በኋላ ነው።

1. አዎ 2. አይደለም

- 10. የቅድመ ኤች አይ ቪ. የምክክርና ምርመራ አገልግሎት የወሰዱ ሰዎች ሁሉ ደማቸውን የግድ ለምርመራ መስጠት ይጠበቅባቸዋል። 1. አዎ 2. አይደለም

- 11. የኤች አይ ቪ. የምክክርና ምርመራ አገልግሎት ቫይረሱ በደማቸው ውስጥ ያለባቸው ሰዎች የተሳሳተ አመለካከታቸውንና ሥነ ልቦናቸውን ለማስተካከል ይረዳቸዋል።

1. አዎ 2. አይደለም

- 12. በፈቃደኝነት ላይ የተመሰረተ የኤች አይ ቪ. የምክክርና ምርመራ ማድረግ ለነፍስ ጡር እናቶች ቫይረሱ ከእናቷ ወደ ጽንሱ እንዳይተላለፍ የሚረዱ ጥንቃቄዎችን ለማድረግ ይረዳቸዋል። 1. አዎ 2. አይደለም

- 13. በፈቃደኝነት ላይ የተመሰረተ የምክክርና ምርመራ አገልግሎት እየተስፋፋ መሄድ መድሎና መገለል እንዲቀንስ ያደርጋል። 1. አዎ 2. አይደለም

- 14. አንድ ሰው የኤች አይ ቪ. ምርመራ አድርጎ ከቫይረሱ ነጻ ከሆነ ግለሰቡ ላለፉት ሶስት ወራት ከቫይረሱ ነጻ መሆኑን ያመለክታል። 1. አዎ 2. አይደለም

- 15. ከሌተኛ አዳሪዎች ጋር ግብረ ስጋ ግንኙነት ያደረጉ ሰዎች ከሌሎች ይልቅ ለእነርሱ በፈቃደኝነት ላይ የተመሰረተ የምክክርና ምርመራ አገልግሎት ያስፈልጋቸዋል።

1. አዎ 2. አይደለም

- 16. በሰራዊቱ ውስጥ የተሟላ የምክክርና ምርመራ አገልግሎት መስጫ ተቋም አለ። 1. አዎ 2. አይደለም

- 17. በሰራዊቱ የሚገኘው የምክክርና ምርመራ መስጫ ተቋም በአቅርቦት በኩል የተሟላ አይደለም። 1. አዎ 2. አይደለም

- 18. የኤች አይ ቪ. ቫይረስ ካለበት ሰው ጋር አብሮ መመገብ ቫይረሱን ለጤነኛው ሰው ሊያስተላልፍ ይችላል። 1. አዎ 2. አይደለም

19. በሰራዊቱ የምክክርና ምርመራ ተቋማት ውስጥ ያሉ የምክር ሰጭ ባለሙያዎች በሙያው በቂ እውቀት አላቸው። 1. አዎ 2. አይደለም
20. በሰራዊቱ የምክክርና ምርመራ መስጫ ተቋማት ውስጥ ያሉ የምክር ሰጭ ባለሙያዎች ተገቢ የሙያ ሥነ-ምግባርን የተላበሱ መሆናቸውን አውቃለሁ። 1. አዎ 2. አይደለም
21. ስለ ኤች አይ ቪ የምክክርና ምርመራ መስጫ ተቋም መኖር መረጃ ያገኙት ከሚከተሉት በየትኛው መንገድ ነው።
- 22.1. ከመገናኛ ብዙኃን 1. አዎ 2. አይደለም
 - 22.2. ከጤና ባለሙያ 1. አዎ 2. አይደለም
 - 22.3. ከባልደረቦቹ 1. አዎ 2. አይደለም
 - 22.4. ከዕዝ/ከክፍለ ጦር/ከሬጅመንት 1. አዎ 2. አይደለም
 - 22.5. ከቤተሰብ መምሪያ ተቋማት 1. አዎ 2. አይደለም
 - 22.6. ከአሰልጣኝ/ከመምህራ 1. አዎ 2. አይደለም

ክፍል ሦስት:

ስለ ኤች አይ ቪ ኤድስና በፈቃደኝነት ላይ የተመሰረተ የምክክርና ምርመራ አገልግሎት አመለካከትን የሚመዘኑ/የሚለኩ ጥያቄዎች

የሚከተሉት ጥያቄዎች በኤች አይ ቪ ኤድስ ምክክርና ምርመራ አገልግሎት ላይ ያለህን/ሽን አመለካከት የሚለኩ ናቸው። በሠንጠረዥ ላይ የተመለከቱት ቁጥሮች የሚከተለውን ይወክላሉ።

- 5. አጥብቄ እስማማለሁ፤
- 4. እስማማለሁ፤
- 3. አልወሰንኩም፤
- 2. እቃወማለሁ፤
- 1. አጥብቄ እቃወማለሁ።

በእያንዳንዱ ዓ/ነገር ፊት ለፊት የአንተን/ችን አመለካከት የሚወክለውን ቁጥር በሳጥኑ ውስጥ የ (✓) ምልክት አስቀምጥ/ጭ።

ተ. ቁ	የኤች አይ ቪ ኤድስ ምክክርና ምርመራ አገልግሎት አመለካከት (Attitude) የሚመዘኑ ጥያቄዎች	5	4	3	2	1
1	በኤች አይ ቪ ኤድስ ከመሞት ይልቅ በውጊያ ላይ መሞት ይሻላል።					
2	የሰው ዘር ሁሉ ሚች ስለሆነ በኤች አይ ቪ ቫይረስ ስለመያዝ መጨነቅ አያስፈልግም።					
3	ኤድስ ዓለም አቀፋዊ ጉዳይ ስለሆነ አንድ ሰው በግል ጉዳዩ ላይ ቢያተኩር የተሻለ ነው					
4	አንድ ሰው ከቫይረሱ ነጻ ስለመሆኑ በራሱ ከተማመነ የኤች አይ ቪ ምክክርና ምርመራ ማድረግ አያስፈልግም።					
5	የደም ምርመራ አድርጎ ቫይረሱ ቢገኝብኝ የሰው					

	መጠቋቋሚያና መሣሰቂያ መሆን አልፏልግም።					
6	አንድ ሰው የኤች አይ ቪ ኤድስ ምክክርና ምርመራ ማድረግ ያለበት በጤንነቱ ላይ አንዳች ችግር ሲያጋጥመው ነው።					
7	ወደ ሰራዊቱ የምርመራ ማዕከላት ለመሄድ የማመነታው በረጅምና አሰልፎ አገልግሎታቸው ምክንያት የተነሳ ነው።					
8	የኤች አይ ቪ ቫይረስ ካለባቸው ሰዎች ጋር መሆንም ሆነ መወያየት ያስፈራኛል።					
9	ተመርምሮ የኤች አይቪ ቫይረስ በደሜ ቢገኝብኝ ምን እንደማደርግ አላውቅም።					
10	በእኔ እምነት ከውጤቱ ይልቅ የሚያስፈራው የምክክርና ምርመራ አገልግሎቱ ነው።					
11	በእኔ እምነት የምክክርና ምርመራ መስጫ ማዕከላት ሰው በሚበዛባቸውና መንገድ ዳር ላይ ቢሆኑ ይመረጣል።					
12	ቫይረሱ በደማቸው ውስጥ የተገኘባቸው ሰዎች አግባብ ያለው እንክብካቤና አገልግሎት ካገኙ ለረጅም ጊዜ በሕይወት መቆየት ይችላሉ።					
13	በፈቃደኝነት ላይ የተመሰረተ የኤች አይ ቪ ምክክርና ምርመራ ማድረግ አንድ ሰው ለረጅም ጊዜ የሚኖርበትን እድል ያመቻችለታል።					
14	ከቫይረሱ ጋር የሚኖሩ ሰዎችን ማግለልና መድልዎ ማድረግ ሰዎች መገለልና መድልዎን ፈርተው ከቫይረሱ እንዲጠነቀቁ ያደርጋል።					
15	የኤች አይ ቪ ምክክርና ምርመራ አገልግሎት በግል መሰጠቱ ምስጢርን ስለሚጠብቅ ተመራጭነት አለው።					
16	ማንም ሰው ከቫይረሱ ነጻ ስለመሆኑ እርግጠኛ መሆን የሚችለው በፈቃደኝነት ላይ የተመሰረተ ምክክርና የደም ምርመራ ካደረገ በኋላ ነው።					
17	ሰዎች ምን ይበሉ ምን አንድ ሰው ራሱን አውቆ መኖሩ					

	ለራሱ ይጠቅመዋል።					
18	የኤች አይ ቪ ምክክርና ምርመራ አገልግሎት ሰዎች ስለ ቫይረሱና ከቫይረሱ ጋር አብረው ስለሚኖሩ ሰዎች ያላቸውን የተሣሣተ አመለካከት ይቀንስላቸዋል።					
19	በአግባቡ ከተከናወነ የምክክር ምርመራ አገልግሎት ሂደት አስደሳችና የሚስብ ነው።					
20	ማንኛውም የተማረ ሰው የምክክርና ምርመራ አገልግሎቱን ቢሰጥ ችግር የለውም።					
21	የኤች አይ ቪ ምክክርና ምርመራ አገልግሎት ማግኘት ቫይረሱ ለተገኘበት ሰው መረጋጋትና የሥነ-ልቦና እርዳታ እንዲያገኝ ይረዳዋል።					

Appendix C

Focus Groups Questionnaire

About eight FGD questions were prepared and administered to eighteen participants in three groups in order to elicit in depth information from respondents. The discussion was led by a moderator or facilitator who introduced the topic, asked specific questions, controlled digressions and stopped break away conversations. He made sure that no one person dominated the discussion, whilst trying to ensure that each of the participants made a contribution.

1. Every one agrees that it is important to know one's own HIV-status. What is the importance? What would be your reaction if you are asked to do it yourself now?
2. Most people disfavor VCT services. What do you think their reasons may be? Why?
3. Are all members in the military happy to get tested for HIV?
4. Stigmatizing and discriminating people who tested positive for HIV hinders the campaign against HIV and keeps people away from VCT services. Do you agree? What do you do if a member/s among you gets such condition?
5. As the studies of most researches showed, people are still experiencing (showing) high risk HIV behaviors despite their knowledge of HIV/AIDS. What do you think the problem is? Do you agree that attitudinal change is not a matter of knowledge? Or knowledge is a precondition for attitudinal changes?
6. Education is reasonably a necessary condition for change of behavior. What's your reaction? Do you think that people with higher education level may have more positive reaction to HIV/AIDS and to HIV/VCT?
7. It is a well established argument that human behavior is influenced by early child hood experiences. In our country child rearing practices differ from place to place and from culture to culture. For example, those with rural background are reared in more traditional, backward and conservative cultures even late chances to basic education. So they tend to resist change of certain behaviors. What if for example, for HIV/AIDS and VCTs? Which one of them do you think are easy for change? Those with urban or rural backgrounds? Why?
8. What is AIDS? What is HIV? Is there any difference between AIDS and HIV? What is the main ways of HIV transmission? As mot people think, AIDS is God's punishment, came as a result of man's sin? Do you agree?

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

Name: MULLHGETA DAGNEW

Signature: 

Date: 09/8/2007

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

Name: Dr. Sa

Signature: _____

Date of Approval: _____

