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Acceptability of Voluntary Counseling and Testing (VCT)

in Assosa Town, Western Ethiopia

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By

Michael Dejene, Dr.

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List Of Abbreviations

AIDS:	Acquired Immune-Deficiency Syndrome.
ANC:	Antenatal care.
BOH:	Bureau Of Health
CBOs:	Community Based Organizations
CSA:	Central Statistics Authority
CRDA:	Christian Relief and Development Association
DPPB:	Disaster Prevention and Preparedness Bureau
ELISA:	Enzyme Linked Immunosorbant Assay
FGD:	Focus Group Discussion
FHI:	Family Health international
HIV:	Acquired Immune Deficiency Syndrome
MOH:	Ministry Of Health
NAC:	National AIDS Council
NACS:	National AIDS council Secretariat
NGO:	Non-Governmental Organization
OSSA:	Organization for Social Support for AIDS
PLWHA:	People Living With HIV/AIDS
PHC:	Primary Health Care.
PMTCT:	Prevention of Mother to Child Transmission
RAS:	Regional AIDS Secretariat
RHB:	Regional Health Bureau
STDs:	Sexually Transmitted Disease
TB :	Tuberculosis.
UNAIDS:	United Nations Program on AIDS
USA:	United States Of America
UNICEF:	United Nations International Children's Fund
US, DHHS:	United States -Department of Health and Humanitarian Service
VCT:	Voluntary Counseling and Testing
WHO:	World Health Organization
WHO/GPA:	World Health Organization/Global Program on AIDS

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Abstract

A cross sectional survey was conducted in Assosa town of the Benshangul Gumze National Regional State on March 2002, to identifying factors that affect the acceptability of VCT services in Assosa town of the Benshangul Gumze National Regional State. Both quantitative and qualitative data collection methods were utilized to gather the required information. The collected data was analysed using bi variate and multivariate techniques and results were presented using tables and in the form of rates and proportions. The observed association between dependant variables and covariates was presented in the form of Chi-square and Odds ratio. Results of the Focus Group Discussions and in depth interviews were presented as excerpt and in the form of case studies

Six hundred ninety two respondents between the age of 15 and 49 years selected with using multistage sampling procedure were included in the study. The male female ratio of the study subjects was almost 1:1 with the mean age of 25.6 and standard deviation of $\pm$ 8.53 years.

More than 86 percent of the respondents are aware of HIV/AIDS and about 85 percent of them know whether one can check his/her HIV status through a blood test and three fourth stated that the service is available in Assosa town. Nearly eighty seven percent expressed willingness to use VCT service; and about equal proportion (86.1%) show intention to ask their partners for VCT, however, a lesser proportion (75%) expressed their readiness to declare the HIV test result. The bivariate analysis result showed a significant association between respondents that belief that People Living with HIV/AIDS need better care and support among those who intend to use VCT and with risk perception for HIV for those who expressed their readiness to declare the test result. The results of the multivariate analysis showed that sex employment status and respondents belief that People Living with HIV/AIDS need better care are significant predicators for the respondents readiness to request their partners for VCT. The VCT centre of Assosa hospital is found to be not functional on full time bases and getting the HIV test result can take up to two weeks time. Furthermore mechanisms are not in place that ensure People Living With HIV/AIDS could be provided with a continuous care and support from the concerned.

Intensive Information Education and Communication activities on VCT aimed at reducing stigmatising effects of AIDS and HIV positive result in Assosa town, strengthening the VCT centre of the Assosa hospital so as to enable it functional at full capacity and establishing other free standing VCT centres are the major recommendations of the study.

Chapter 1: Introduction

1.1 Statement Of The Problem

Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) has become a prevalent disease and present a global problem. Its impact if not controlled, will be profound and is considered to be highly destructive. It is fast spreading and expected to become the main cause of death among youth and middle age adults (Assefa, 1994).

Today, 20 years after the first case of AIDS was reported, globally about 16,000 people still become infected with HIV every day. At the end of 2000, more than 36 million people are living with HIV, nearly four times the number in 1990 (UNAIDS, 2000; FHI, 2001). The African continent particularly those Sub Saharan African countries are the most affected regions holding about 25.3 million or 70.1 percent of all HIV infected individuals of the world (UNAIDS, 2000a).

Ethiopia is one of these countries that are affected by this rapidly spreading pandemic. The true number of AIDS cases since the beginning of the epidemic in Ethiopia is not known, but probably was about 400,000 by the end of 1999. In the same year it is estimated that there are about 2.6 million people living with HIV/AIDS (2.4 million adults and 250,000 children). This number is expected to grow to more than three million by the year 2006 (MOH, 2000).

The devastating effect of HIV/AIDS is getting more and more visible through time. About 1.2 million Ethiopians are estimated to have lost their lives due to HIV/AIDS from the beginning of the epidemic to year 2000 and as a result life expectancy is said to have reduced from 50 years to 42 years. To day as much as 42 percent of the hospital beds of the country are occupied by AIDS patients; this drains the scarce resource allocated for the health sector, and lays additional burdens to the already over-stretched health services (increased workload and congestion of health facilities) and reduce the capacity of the health system to adequately respond to other health challenges. Added to this, by causing a progressive rise in the death of infants and children, AIDS has further threatened many of the recent gains of child survival programs. An increase in both proportion and absolute number of HIV related chronic and resource-draining disease like TB is also another observation made by some researchers (MOH, 2000; WHO/UNAIDS, 2000).

Apart from its effect on the health sector, AIDS would affect the economic development of the country in many ways. However, the loss of young adults in their most productive years of life is certainly the major one. With the continuing spread of the disease the industrial and agricultural sector of the economy will be the two most affected sectors of the country's economy (MOH, 2000).

Disruption of the family tie, increasing the number of orphan children (900,000 AIDS orphans are estimated to exist in the country by 2000), increase in the

number of street children, raising the burden of women and stress to the extended family, etc. are some of the observed social effect of this progressively increasing pandemic (MOH, 2000).

If it continues unchecked, HIV/AIDS will alter the path of the countries development by retarding growth, weakening human capital, discouraging investment, exacerbating poverty and inequality, and leaving the next generation increasingly vulnerable to the impact of the epidemic (NACS, 2000b; MOH, 2000).

Recognizing the seriousness of the problem, the government of Ethiopia has established a national HIV/AIDS control program under the Ministry of Health to coordinate intervention activities including the control programs undertaken by government, NGO's and other partners. Further, two medium term prevention and control plans were designed and implemented between 1987 and 1996. However, the efforts made through several intervention programs were reported to have low impact and the involvement of the public at the community level was found to be minimal. With the intention to strengthen the already initiated activities, the government's commitment towards fighting the spread of this deadly epidemic is further expressed with the formulation of the HIV/AIDS policy in August 1998 and the establishment of the National HIV/AIDS Prevention Council in April 2000 (MOH 1998, MOH 2000, NACS 2000b).

Voluntary Counseling and Testing (VCT) is one of the many different strategies stipulated in the policy and strategy documents, for the prevention and control activities that are planned to be carried out and is currently undergoing at the national level (NACS, 2000a; MOH 1998). Hence, the need for expansion of VCT service and spur its utilization is outlined as a priority intervention area and as an entry point for HIV prevention through creating more personal awareness and care (NACS, 2000a).

The rationale for considering VCT as having pivotal role in HIV/AIDS prevention and control activities is summarized as follows: (1). VCT is more than drawing and testing blood and offering a few counseling sessions. It is a vital point of entry to other HIV/AIDS services including prevention of mother-to-child transmission; prevention and clinical management of HIV related illnesses, tuberculosis control, and psychosocial and legal support. (2). There is demand (i.e. people want to know their HIV sero-status), or demand can be created when comprehensive services are made available. (3) VCT provides benefits for those who test positive as well as those who test negative. VCT alleviates anxiety, increases client's perception of their vulnerability to HIV, promotes behavioral change, facilitates early referral for care and support including access to anti-retroviral therapy and assists reduction of stigma in the community. (4). VCT offers a holistic approach that can address HIV in the broader context of peoples' lives, including the context of poverty and its relationship to risk practice (FHI, 2001; UNAIDS, 2000).

1.2 Rationale for the Study

In light of the above statements, however, none of the very few studies conducted so far in the region tried to give a comprehensive overview about the awareness of the community towards HIV/AIDS, the extent of acceptability of VCT and care and support for HIV/AIDS both in Benshangul Gumze regional state as well as Assosa town, and this has created a knowledge gap about the extent of the problem in the area.

Hence, the study has the main purpose of filling the knowledge gap in identifying the awareness level of the community about HIV/AIDS, care and support for people living with HIV/AIDS and factors that affect the acceptability of VCT services in the study population. Furthermore, there is a strong belief that the study will provide baseline information on the above-mentioned key issues related to prevention and care. So that all interested including government, NGOs (local, national etc), CBOs could design and implement intervention activities focusing on issues that require immediate action.

1.3 Objectives of the Study

The study has the main objective of identifying factors that affect the acceptability of VCT services in Assosa town of the Benshangul Gumze national regional State and the perception of the community towards care and support for People Living With HIV/AIDS.

The specific objectives are:

1. To assess the knowledge and attitude, of the community towards VCT services as well as their risk perception towards HIV/AIDS.

2. To identify barriers and concerns related to VCT service utilization.

3. To assess the awareness and perception of the study community regarding care and support on HIV/AIDS, and,

4. Based on the study findings to forward practicable recommendations for policy makers and service providers.

1.4 Background to the Study Area (Assosa Town)

Geography and Climate

Assosa town is the capital city of both Assosa Zonal administration and Benshangul Gumze National Regional State and is located 680 kms west of Addis Ababa.

The town has a plain topography and is situated at an altitude of 1560 meters above sea level. It has arid whether with a temperature ranging between 25 and 30- Degree Celsius and an average annual rainfall of 1300mm (Plan and Economic Development Bureau, 2000).

Transport, communication and trade

Assosa town is linked with Addis Ababa and other nearby outlets like Nekemte with all weather roads. There is also an air transport service that connects Assosa with Addis Ababa and other major towns like Jimma and Gambela. Postal service, digital telephone, clean water supply and eighteen hours electricity from diesel generators are also available in Assosa town.

According to the Trade, Industry, Transport and Communication Bureau of the region, there are 56 food and drink establishments (19 hotels, 4 pensions and

33 bars) with 329 hotel beds (Plan and Economic Development Bureau, 1999).

Population

Assosa town has four Kebeles, with an estimated population of 16,113 and sex ratio of 1.17. The four Kebels have a total of 4,443 households with 3.6 average household size, (Benshangul Gumze National Regional State Health Bureau, 2001). The age distributing of the population indicated that about 58.3 percent are in the age group 15-49 while female account for 42.8 percent of those in the mentioned age group. Oromo, Amhara, Jebelwi and Tigrawai are the four major ethnic groups accounting for 41.2%, 30.0%, 17.4% and 5.4% of the population respectively. Coptic Christianity, Islam and Protestantism are the dominant religions, with 55%, 30% and 15 % followers respectively, (CSA, 1998).

Education

There are two elementary, one junior high school and one senior secondary school in Assosa town with 4,860 enrolled student population and 134 teachers, (Plan and Economic Development Bureau, 2000).

Health

There is one hospital (with a 90-bed capacity) and one health center, two private clinics and seven drug-vending shops in the town. The health manpower distribution showed that there are about 13 physicians, 33 nurses, 26 health assistants and 101 support staff working in the two health facilities. Communicable disease like, malaria, intestinal helminthes, upper airway problems and diarrhea and dysentery are found to be the leading causes of the health facility visits (Regional Health Bureau, 2001).

The HIV/AIDS Profile of Assosa Town

Risk Factors for HIV/AIDS Transmission

The result of the population and housing census of 1994 showed that about 60% of the residents of Assosa town are in the age group 15-49 with a sex ratio of 1.17, while youth in the age group 15-24 account for 27.8 percent of the total population (CSA, 1998).

The assessment of the physical, social and economic situation of Assosa town carried out by the Regional Bureau of Plan and Economic Development in 1999 illustrates that, the population of Assosa town is rapidly increasing and this is particularly true for people in the young age group. This was mainly attributed for the influx of young adults from the neighboring regions and surrounding rural areas looking for job opportunities. Besides, the central

position the town holds in the livelihood of many traders who move frequently between the town and other nearby Woreda's, the existence of large student population (mainly coming from the nearby settlement villages for high school level education) and the presence of a military camp and a refugee compound near the town are indicated to be the major reason for the observed rapid population increase in the area.

Sexual practice at earlier ages and multi partner sexual contact is also said to be prevalent among the youth in Assosa town. For example, a study conducted in 1996 among high school students found out that a considerable proportion of them start to practice sex at early age (between 14 to 16 years) and a good number of them reported to have multiple sexual partners ranging from 2 to 5 (NACS, 2001).

Added to the above fact, the presence of large number of food and drink establishments (there are a total of 56 food and drink establishments; 19 hotels, 4 pensions and 33 bars) and an estimated 350 female sex workers (RACS, 2001) serves as a pointer to the existence of an undeniable and visible risk factors for HIV/ AIDS transmission in the area. In this regard, the findings of two sero surveys conducted in 1999 and 2000 in Assosa hospital affirmed that one in three patients visiting Assosa hospital and one in six adult population of the town are living with HIV/AIDS and HIV/AIDS is indeed a serious problem in Assosa town (Adugna et al. 1999 & 2000).

HIV/AIDS Related Health Problems

Diseases that are known to have association with HIV/AIDS like Tuberculosis, atypical pneumonia and typhoid fever are the major causes of hospital admission and deaths in the area. For example in the year 2001, the above-mentioned diseases accounted for 27.3 percent of all hospital admissions and 64.3 percent of all hospital deaths in Assosa and Metekel Hospitals (Regional Health Bureau, 2001). Many attributed this for the high prevalence of HIV/AIDS in the area.

HIV/AIDS Related Activities Taking Place In Assosa Town

An organized HIV/AIDS control activity in the region as well as in Assosa town is dated back to 1996 where an HIV/AIDS and Sexually Transmitted Infection (STI) Unit was established under the Department of Disease Control and Prevention of the Regional Health Bureau (RHB). The principal task of the unit was to organize HIV/AIDS/ STI prevention and control activities at various levels and to liaison with the Ministry Of Health, the Regional Council and other organizations. Social mobilization at regional, zonal and Woreda level each year, conducting in-service training for health workers and strengthening the capacity of laboratory services of the hospitals to carry out HIV test are indicated to be the main tasks the unit has accomplished since its establishment (Regional Health Bureau, 2001). In this regard it is possible to

see that till the establishment of Regional AIDS Council Secretariat (RACS) in January 2001 no major coordinated community level HIV/AIDS prevention and control activities were taking place in Assosa town as well as in the region.

The Regional AIDS Council Secretariat (RACS) was established as part of the national effort to strengthen the fight against AIDS initiatives. Since its establishment the RACS has organized various sub committees to coordinate activities focusing on issues like Information Education and Communication (IEC), social support, fund raising, institutional care and laboratory service. Furthermore RACS through its sector wide strategy has managed to initiate HIV/AIDS related activities in all sector offices of the regional government, five selected Woredas and other relevant community based and religious organizations (NACS, 2001).

At the time of this survey HIV/AIDS related control and prevention activities are well initiated and are underway in Assosa town. Anti AIDS clubs are established in Assosa senior secondary and Junior high schools, in the four Kebeles, among various Community Based Organizations (CBO) including self-organized out of school youths. The Ethiopian Orthodox, Muslim and Protestant religion leaders in the area are also actively involved in HIV/AIDS related teachings. In the past six months awareness raising activities are carried out through health education sessions, teaching materials like leaflets, broachers, stickers and youth newspapers (RACS, 2001).

Voluntary Counseling And Testing Service In Assosa Town

The HIV testing and counseling unit of Assosa hospital in its current form was established in November 2001. The unit is running in a room allocated for the purpose and situated near the administrative quarter of the hospital. There are three nurses and one physician trained to provide counseling service to patients as well as to others who volunteer for the test. However, all are working as counselors on part time bases. At the time of this study the center was providing service on Tuesday and Thursday afternoons.

The HIV test as well as the pre and post test counseling services are provided to the needy free of charge. People who volunteer for the test get a pretest counseling before blood is drown for the laboratory test and the HIV test is carried out in the hospital laboratory where spot test supplemented by Enzyme Linked Immunosorbant Assay (ELISA) is the standard HIV test procedure. Getting the test result can take from seven up to fourteen days. People who return for the test result are provided with posttest counseling, however, there is no mechanism that will ensure follow up counseling, support and care for those people who test positive and their partners.

Since its establishment in November 2001 the center provided service to a total of 228 volunteers (with a rate of 14 people per month) out of whom 40 turned out to be HIV positive giving a 17.6 percent HIV prevalence rate.

Couples who volunteer to check their HIV status before marriage; military personnel and youth are among the major users of the service.

Care and Support for People Living With HIV/AIDS and Their Families

Known AIDS patients as well as their families are treated in a similar way like other patients and patient families in Assosa hospital. Many indicated that, though strongly believe, that AIDS patients and their families need additional care and support, factors like lack of training on how to provide better care for People Living With HIV/AIDS and their families, shortage of resource required for proper patient handling and stigma associated with the disease including fear of contracting the virus from patients limited them in implementing such practice in the hospital.

Absence of referral mechanisms that link HIV positive people with organizations or responsible bodies providing care and support, the limited capacity of the existing organizations that provide care and support and unwillingness of patients to declare their HIV positive status are sited to be the main contributing factors for the existing gap in providing an organized care and support service for AIDS patients and their families.

According to the information obtained from the Regional Disaster Prevention and Preparedness Bureau, 60 children from Assosa town who are believed to

1.5. Literature Review

1.5.1 Voluntary Counseling and Testing

Historical Perspective

Publicly funded HIV antibody counseling and testing services were initiated in the USA in March 1985 to provide an alternative to the donation of blood as a means for high-risk persons to determine their HIV status. At that time, little was known about the prevalence and natural history of HIV infection. Counseling was considered as an essential adjunct to HIV testing. The counseling addressed the accuracy and consequence of test and was designed to help persons interpret the meaning of positive and negative results. HIV counseling was based on the recognition that learning HIV status may be difficult for certain clients (US/DHHS, 1994).

In 1987, with increased understanding about the scope and severity of the HIV epidemic and the predictive value of positive test, HIV counseling and testing were expanded. Persons seeking care for sexually transmitted infections, family planning, childbirth, or substance abuse were counseled and tested in an attempt to reduce their risk for HIV transmission (US DHHS, 1994). "The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their

risk of becoming infected and to assist infected individuals in avoiding infecting others".

The Benefits Of VCT

Voluntary Counseling and Testing is considered by many as entry point: to prevention and care, medical care, for preventing mother to child transmission of HIV infection (PMCTC) interventions, for ongoing emotional and spiritual care and social support (UNAIDS, 2000b). While HIV counseling and testing is not a substitute for behavioral change it is assumed to play a significant role in the prevention effort. As a diagnostic tool, testing enables those with HIV to initiate medical treatment that can enhance and promote life. As a health intervention, HIV counseling and testing provides an opportunity for personal risk assessment, education about HIV/AIDS, and the prospect of reducing high-risk behavior, thus slowing the spared of the epidemic (Ickovics et al 1994).

The need for expansion of VCT service and stimulating its utilization is outlined as a priority intervention area and as an entry point for HIV prevention, through creating more personal awareness, and care (NACS, 2000a). Indeed, HIV testing has often been used as a diagnostic tool to confirm symptomatic AIDS. **S**tudies also attest the value of counseling and voluntary HIV testing in largely healthy populations. These services have been

shown to contribute to an increase in safe behavior at the individual level, and are likely also to reduce the ignorance, fear and stigma associated with HIV infection in the population at large, VCT may also enable people to cope with anxiety, because early detection of HIV infection may lead to an effective psychological support (UNAIDS, 1999; VCT Efficacy Study Group, 2000).

Several studies carried out elsewhere in the world have also demonstrated that VCT can prevent HIV transmission among serodiscordant couples[1] (UNAIDS, 2000b). There have also been some studies showing significant behavioral change in individuals following VCT. A recent multi-site study conducted in Kenya, United Republic of Tanzania and Trinidad to assess the role of VCT in HIV prevention and its cost effectiveness as compared with other HIV prevention interventions has demonstrated that VCT significantly reduced sexual risk behavior - specifically, unprotected sex with non-primary partners, with commercial sex workers, and among couples who have been tested and counseled together. The study also showed that VCT could be cost-effective in terms of the cost per HIV infection averted (Sweat et al., 2000).

Uptake of VCT

Although VCT is becoming increasingly available in the developing and

1. Couples one of whom with HIV positive and the other with HIV negative sero status

middle-income countries, there appears to be wide variation in acceptance rate of HIV-counseling and testing services. For example acceptance rate of 79 percent was reported from a study done in STD clinic patients in South Carolina in 1989 (Jones et al. 1993). In a multi centered study carried out in London during 1995/96, uptake of antenatal HIV testing ranges from 3.4-51.2 percent (Diana et al.1998). Preliminary result from a large MCTC program in Botswana show a relatively low uptake of VCT during the first eight months of operation (Mazhani et al., 2000). Uptake of VCT in other operational settings varies considerably in the UNICEF/UNAIDS MCTC pilot sites (UNAIDS, 2001a).

A recent community based study conducted in Addis Ababa to assess factors influencing the use of VCT services revealed that the majority of the respondents expressed their intention to test but the practice was non-existent (Abeba, 2001). Another study conducted in Harar among the 15-49 years identified that 85 percent of the respondents have intention of having VCT (Fahmi, 2000). A much higher level (92 percent) of intention to use the service was reported from Dire Dawa (Michael, 2001a).

Studies conducted both in developed and developing countries demonstrated that factors that affect acceptance or refusal of VCT could be dependent on societal, demographic as well as factors associated with delivery of service (Baggaley et al., 1997, Valdierri 1999). Difference in testing schedules, maturity

of the epidemic, seroprevalence in the community and attitudes to and availability of VCT in the community are thought to be important. It is also proposed that counselors' attitudes towards testing at the sites may be a key factor in uptake (UNAIDS, 2001a).

The association of acceptance of routine HIV test (VCT) with age lower than 25 years and refusal of testing above the age of 35 is observed among pregnant women (Michael et al., 1991; Sorin et al, 1996; Simpson, et al, 1998). Significant association of acceptance of VCT was found with marital status, being single and level of education below grade twelve among pregnant women in Atlanta in 1989 (Michael et al., 1991).

According to a study carried out in Eastern Ethiopia (Fahmi, 2000), significant inverse correlation has been observed between males' attitude towards asking partners for VCT and age. It was also indicated that attitude towards asking partner for VCT had significant association with gender, marital status, employment status and previous sexual practice. Contrary to the above findings, a study conducted among Ethiopian factory workers (Tefera et al, 1999) demonstrated that Posttest Counseling Attendance did not differ by age, gender, or other attributes like HIV positive status. However, the same study demonstrates that factors independently associated with posttest counseling attendance in males differ with that of female.

Some studies also demonstrate that there may also be great differences in theoretical and actual uptake rates. For example in Lusaka when students were asked if they wished to be tested for HIV there was a very high rate of interest. When the service was provided initially, uptake was very low. However, with time, there has been increasing demand for VCT in Lusaka (Baggaley et al., 1997). Another study from Zambia examined the readiness to utilize the VCT services offered to 4812 participants from rural and urban sites. Although 37% initially expressed willingness to use VCT service only 3.6% actually came for the service (Rosenvard et al., 1998). A wider gap between intention to know the HIV result and actual uptake of posttest counseling and test result was also recorded in the study carried out by Tefera Sahlu and his colleagues in Addis Ababa (Tefera et al, 1999). The Addis Ababa VCT survey (Abeba, 2001) also revealed that though there is a general agreement on the importance of knowing ones HIV status among the study subjects, interest to test is not as high as people's belief on the importance.

A study conducted in Uganda showed that Interest in VCT is often "social", with clients showing interest in knowing their serostatus before getting married, embarking on a new relationship, or making plans for the future (UNAIDS, 1999b). The respondents association of testing with social and other medical factors like, "chronically sick and ordered by doctors to test", going aboard, marrying and getting pregnant is also frequently demonstrated

in studies carried out at different regions of Ethiopia (Abeba 2001, Michael 2001a&b).

Attributes such as good knowledge of HIV transmission, positive attitude HIV testing and high-risk sexual practice are also said to have influence on the acceptance of VCT (Fahmi 2000). For example, the association of attending posttest counseling with good knowledge of HIV/AIDS and the belief that medical treatment would improve the course of HIV infection was reported among male factory workers in Ethiopia (Tefera et al, 1999). Similarly the existence of significant positive association between knowledge about HIV/AIDS among male study subjects and having no previous sexual contact in both sexes with the intention to asking partner to get VCT was demonstrated in a study carried out in Harar (Fahmi, 2000)

Barriers for uptake of VCT

A common barrier for a better uptake of VCT is the lack of perceived benefit (Baggaley et al., 1995). According to UNAIDS, linking VCT with medical care, including improving medical services for people with HIV and offering interventions to prevent mother to child transmission (MCTC) can enhance utilization of VCT services (UNAIDS, 2000b).

Although there are important benefits to knowing one's HIV status, HIV is, in many communities, is a stigmatizing condition, and this can lead to negative outcomes for those tested. People with HIV may experience social rejection and discrimination (Karim et al, 1995). As a result stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid to seek HIV service and decline service because they fear stigma and discrimination from their families and communities. Societal attitude towards HIV can have a strong impact on individual choices. And if people known that to be HIV positive exposes them to face discrimination and stigma, VCT is unlikely to be a popular intervention (NACS, 2000a).

Stigma associated with HIV/AIDS and fear of isolation and discrimination surrounding the disease are found to be the major barrier for people to actively look for VCT service. This is attested in the findings of recent community-based studies conducted in Addis Ababa, Dire Dawa and Bahir Dar (Abeba , 2001; Michael 2001a&b).

The findings of some studies recommended that protection and support of vulnerable individuals who test seropositive must be considered when developing VCT services. In Zambia, women said that it was thought to be shameful to have HIV, and if they were known to be seropositive, they worried that they would suffer discrimination. Studies from Kenya have also shown that women may be particularly vulnerable following VCT and in some cases

have lost their home and children or have been beaten or abused by their husbands / partners if their status become known (Temerman et al. 1994). There is currently some evidence that, in societies where AIDS patients are highly stigmatized, women who believe themselves to be at high risk of infection are less likely than low risk women to choose to be tested for HIV infection or to come back for their test result, (UNAIDS, 1999a). In this regard, unless women and their partners fully understand the benefits of an HIV test, they are unlikely to choose to have one. A negative result allows an individual to act to avoid infection in the future. It will also allow women to breastfeed confidently which is in the best interest of for her child, (UNAIDS, 1999a).

1.5.2 Care and Support for people affected by HIV/AIDS

The need for more comprehensive and effective care and support for people affected by HIV has been ignored for far too long. Experience showed that improving access to HIV/AIDS care and support services help to distigmatize HIV, improve demand for HIV voluntary counseling and testing services, and allow for early management and prevention of infectious diseases, such as Tuberculosis and sexually transmitted infections (STIs), among both HIV positive and negative people. Providing these services, in turn, creates important opportunities for HIV prevention (FHI, 2001).

The needs of people living with HIV/AIDS and often their families have been identified in four interrelated domains: medical needs, such as treatment

information and treatment; psychological needs, such as emotional support; socioeconomic needs, such as helping hands and orphan support; and human right and legal needs, such as access to care and protection against violence and discrimination.

Within each community, region and country, there is an existing level of HIV care and support that needs strengthening. Though in the Ethiopian setting most of the HIV/AIDS related interventions are heavily focused on prevention than care and support activities, most of the care and support services given to people affected by HIV/AIDS is carried out by family members or the community at large (UNAIDS, 2001). For example the result of a community-based study conducted in Addis Ababa showed that people are willing to care for People Living with AIDS and most do know that one should practice basic precautions in caring for PLWA. However, it was pointed out that there are no sources of care meant for PLWA in the communities and no support groups for PLWA or their caretakers as well (Abeba 2001).

Apart from the absence of a well organized care and support services meant for AIDS patients and their care givers in many parts of the country, studies conducted in Dire Dawa and Bahir Dar (Michael, 2001a&b) revealed that lack of adequate knowledge about the diseases transmission and stigma associated with the disease are the factors that could hamper the care and support activities taking place at the community level.

1.6. Conceptual Framework

1.6.1 Theoretical Background:

According to a decade review of HIV testing and counseling practice in USA, factors that influence acceptance or refusal of VCT could be characterized as socio demographic, cognitive and behavioral, and organization of VCT service delivery (Valdierri, 1999).

The association of acceptance of routine HIV test (VCT) with age lower than 25 years and refusal of testing above the age of 35 is observed among pregnant women (Michael et al, 1991; Sorin et al, 1996). Significant association of acceptance of VCT was found with marital status, being single and level of education below grade twelve among pregnant women in Atlanta in 1989 (Michael et al., 1991).

According to a study carried out in Harar, Eastern Ethiopia (Fahmi, 2001), significant inverse correlation has been observed between males' attitude towards asking partners for VCT and age. It was also indicated that attitude towards asking partner for VCT had significant association with gender, marital status, employment status and previous sexual practice.

Various studies have also shown that acceptance of VCT is influenced by attributes such as good knowledge of HIV-transmission and prevention,

positive attitude towards HIV-testing and high risk sexual practice (Fahmi, 2001).

Ronald O. Valdierri reported that the organization of testing system described as the process one goes through to acquire testing services, the type of diagnostic test used, the process required to receive test results as well as the place where the test is offered can influence HIV test seeking behavior and test-receiving outcomes (Valdierri, 1999).

This study bases its assumption on the basic propositions of the Theory of Reasoned Action. The theory of reasoned action (Ajezen & Fishbein, 1980; Fishbein & Ajezen, 1975; Fishbein & Middlesadt, 1989) proposes that an individual's AIDS-preventive behavior is a function of his or her behavioral intention to perform a particular preventive act. Behavioral intentions, in turn, are assumed to be a function of individual's attitude toward performance of a particular preventive behavior, the individual's subjective norm or perception of what significant others wish the individual to do with respect to the behavior in question, or both.

The theory of reasoned action specifies the basic psychological underpinnings of the attitudinal and normative determinants of AIDS prevention as well. According to the theory, an individual's attitude toward performance of a particular AIDS preventive behavior is a function of the individual's beliefs

about the consequences of performing the behavior, multiplied by his or her evaluations of these consequences. In parallel fashion, the theory holds that an individual's subjective norm is a function of his or her perception of social support from specific reference others for performance of a preventive behavior, multiplied by his or her motivation to comply with these referents' wish (William et al, 1995). Furthermore, according to a recent UNAIDS report (UNIADS 1999c), HIV/AIDS preventive behavior depends not only on cognitive variables like awareness about HIV/AIDS but also on contextual factors like government policy, culture, socio- economic status, gender issues and spirituality

Taking the theory of reasoned action as a base: Acceptability of VCT, which is the dependant variable in this study, is translated as individual's AIDS-preventive behavior and is expressed as a function of the respondents behavioral intention to perform a particular preventive act i.e., willingness to utilize VCT service, intention to ask partner of getting VCT service and intention to declare the test result.

Based on the study findings conducted in the country and elsewhere as well as taking the basic theoretical propositions of the Theory Of reasoned Action, this study assumed that basic socio demographic variables like age, sex, marital status, religion etc as well as other cognitive and perception factors like awareness about HIV/AIDS, VCT and care and support and risk perception

towards HIV/AIDS can have an effect on the acceptability of Voluntary Counseling and Testing.

1.6.2. Expected Linkages of the Variables Outlined In The Conceptual Framework

Acceptability of VCT expressed by basic behavioral attributes like willingness to use VCT, intention to ask partner to receive VCT and intention to declare the test result is directly influenced by socio demographic variables like age, sex, marital status, religion and literacy status and employment status of the respondents.

The independent variables (socio demographic variables like age, sex, marital status, religion, literacy status and employment status of the respondents) acts trough the intermediate variables to affect the acceptability of VCT by the respondents. The linkage of the independent and intermediate variables with the dependant variable is further described in figure 1

Intensive and sustainable Information, Education and Communication (IEC) activities could play a great role in raising the awareness of the community about HIV/AIDS and promoting AIDS preventive behavior. In the conceptual framework depicted in figure 1, attempt is made to show how IEC could affect the dependant variable acceptability of VCT through the intermediate variables awareness and perception about HIV/AIDS/VCT/Care and Support. However,

due to the absence of well-organized and intensive IEC activities on HIV/AIDS in general and VCT in particular in the study area, effort is not made to look at how IEC could be associated with both the intermediate and dependant variables.

1.6.3 Definition Of the Major Variables Outlined In the Conceptual Framework

Age: Age refers to age in completed years as reported by the respondent

- The age of the respondents is further categorized into seven groups using a five years class interval: 15-19, 20-24. . . 40-44, 45-49.

Marital Statutes: Currently married includes both male and female who are in a formal as well as in an informal union and reported being in a marital union at the time of the survey.

- Never married includes those individuals who had never been legally married and are not in a formal as well as in an informal union at time of the survey

- Ever married refers both males and females who are either currently married or those who are divorced, widowed, or separated.

Literacy Status: Ability to read and write in a language that the respondents was familiar with.

Employment Status: The employment status of the respondent was determined by his/her participation in an income generating activities within 15 days prior to the survey

Awareness about people affected with HIV/AIDS: This sentence refers to respondents knowledge about the existence of a person/people who are living with HIV/AIDS or who died secondary to AIDS in the family or in the community.

Knowledge about VCT: Respondents knowledge about the availability of VCT service in Assosa town

Believe that PLWHA need better care and support: The respondents belief that People Living with HIV/AIDS require better care and support than other patients is considered as a measure of respondents knowledge about care and support.

Risk perception for HIV/AIDS: Respondents feeling of vulnerability for HIV/AIDS

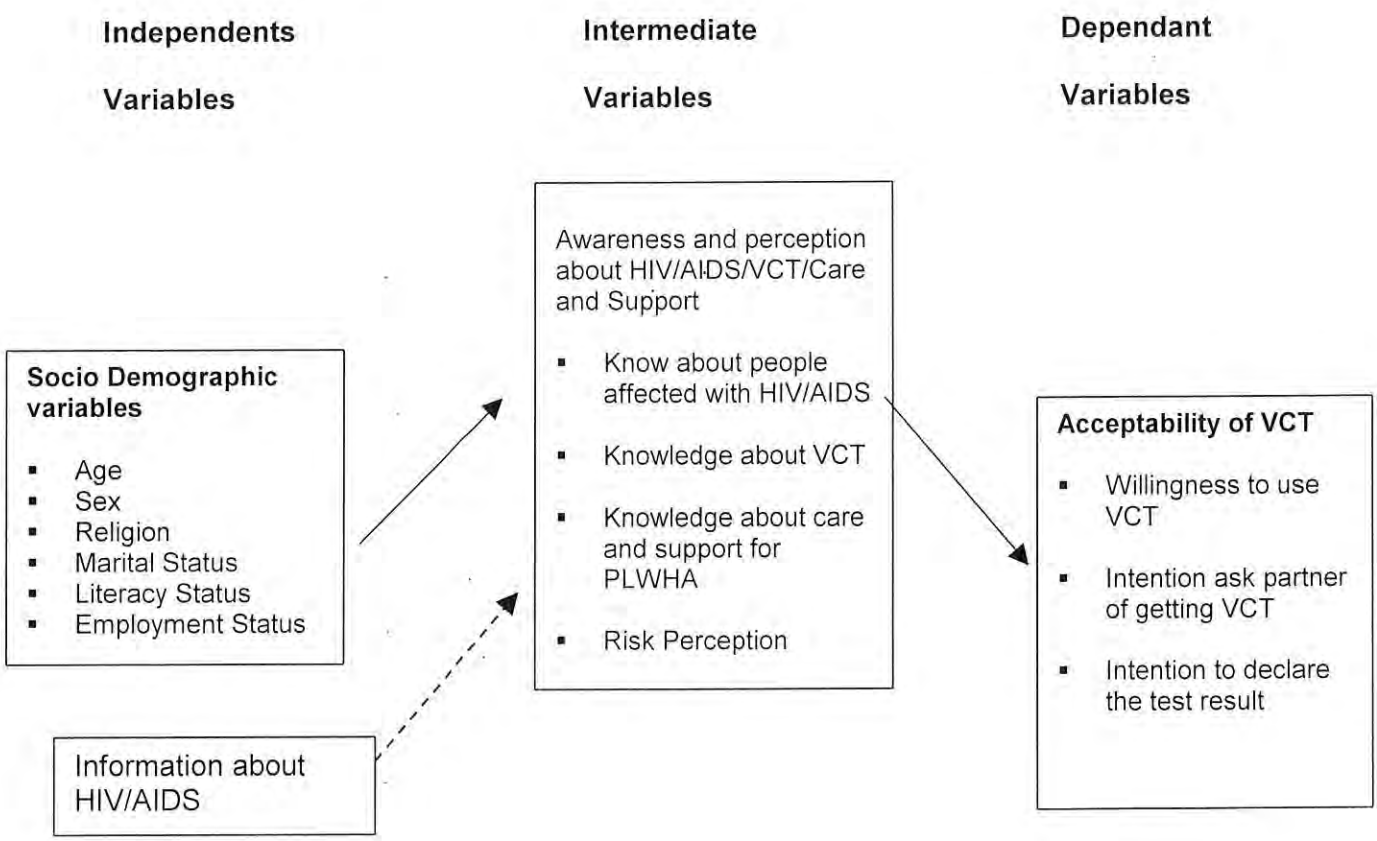

Figure 1: Conceptual framework for the Study of, "Acceptability of Voluntary Counseling and Testing (VCT) Services in Assosa Town, North Western Ethiopia (Developed by Michael Dejene, March 2002: Based on the Theory of Reasoned Action formulated by Ajezen & Fishbein, 1980; Fishbein & Ajezen, 1975; Fishbein & Middlesadt, 1989)

Note: The broken lines represent that IEC as independent variables affecting acceptability of VCT is not addressed in this study (For further explanation see page 29)

1.7 Hypothesis

Taking into consideration the above-mentioned interrelationship of the dependant and independent variables as a base, the following hypotheses are made:

The Null Hypothesis and alternative hypothesis used in this study are:

Ho: There is no difference in the use of VCT services among different socio demographic and cognitive variables.

H1: There is difference in the use of VCT services among different socio demographic and cognitive variables.

The following variables were used in the testing of the hypothesis:

Socio Demographic Variables:

Age, Sex, Marital status, Religion, Literacy status and Employment status

Cognitive Variables:

Knowledge about people Living with HIV/AIDS, risk perception for HIV/AIDS, awareness about people living with HIV/AIDS needs better care and support.

Chapter 2: Source Of Data And Methods of Analysis

2.0 Introduction

This is a community-based cross sectional survey with both quantitative (descriptive) and qualitative components. The study is carried out with the objective of identifying factors that affect the acceptability of VCT services and the perception of the community towards care and support for People Living With HIV/AIDS.

2.1 Source and Study Population, Sampling Units

People in the reproductive age group of the community (age group 15 to 49) who reside in Assosa town at the time of the survey are the source population for the study. While people in the specified age group, residing in randomly selected households who are willing to participate in the study were the study populations.

Households were the sampling units for the community-based (descriptive) study. Households of the four Kebels were utilized as a sampling frame for the selection of households that were included in the study. While two members of the sampled households (one male and one female) who are in the specified age category and are available in the house during the survey period were the subjects of study.

Youth (school and out of school youth), commercial sex workers, community and religious leaders, government employee, leaders of NGOs and health workers who are actively involved in HIV/AIDS prevention and control activities and People Leaving With HIV/ AIDS (PLWHA) who are residing in Assosa town were the sampling unit for the qualitative study.

2.2 Sample Size Determination

A sample size of 679 people age 15-49 was obtained using stat calc (EPI info version 6.3) for population survey/descriptive study using random sampling procedure (Dean et al., 1993). The following assumption were also utilized in the computation of the sample size:

- ***Size of the target population:***

Number of people age 15-49 years, leaving in Assosa town (N=9393)

- ***Expected frequency of the subject under study:***

Risk perception towards HIV/AIDS (22%), a figure obtained from the findings of a similar study

- ***Worst acceptable frequency of the subject under study:***

Risk perception towards HIV/AIDS (19%)

- 95% confidence level

2.3 Sampling Procedure

2.3.1 Household Survey

Households of the four Kebels were utilized as a sampling frame for the selection of households that were included in the study. Multistage sampling procedure, which is probability proportional to size, followed by systematic and simple random sampling techniques were employed to select the respondents who were included in the study.

The number of people that were included in the study from each of the four Kebels were determined using probability proportional to size sampling technique i.e., proportionate to the total eligible population residing in each Kebele. That is, out of the 9,393 people (projected population for year 2002) in the age category 15-49, 25.9% reside in Keble 01 and the remaining 28.8%, 27.7% and 17.5% reside in Keble 02, 03 and 04 respectively. Hence, the allocation of the 677 total sample size calculated for the study is made based on the proportion of eligible respondents from the four Kebels (see figure below).

Once the number of eligible groups to be interviewed from each Kebele is determined, the second procedure followed was to use systematic sampling techniques to identify the household to be interviewed. In this case the sampling interval (I) was obtained by dividing the total number of households

in each Kebele (H) by the number of households to be interviewed from each Kebele.

Where: I (Sampling Interval) = H (total number of households in each Kebele) / h (total number of households to be included in the survey)

For example, the sampling interval for Kebele 01 was obtained by dividing the total number of households in the Kebele i.e., 1,288 by the total number of households to be interviewed from the Kebele i.e., 88 and this gave the sampling interval of 15. This means that every 15 households in the Kebele were included in the sample.

The sampling intervals calculated for the three-remaining Kebele's were 12 for Kebele 02 and 13 for Kebele 03 and 04.

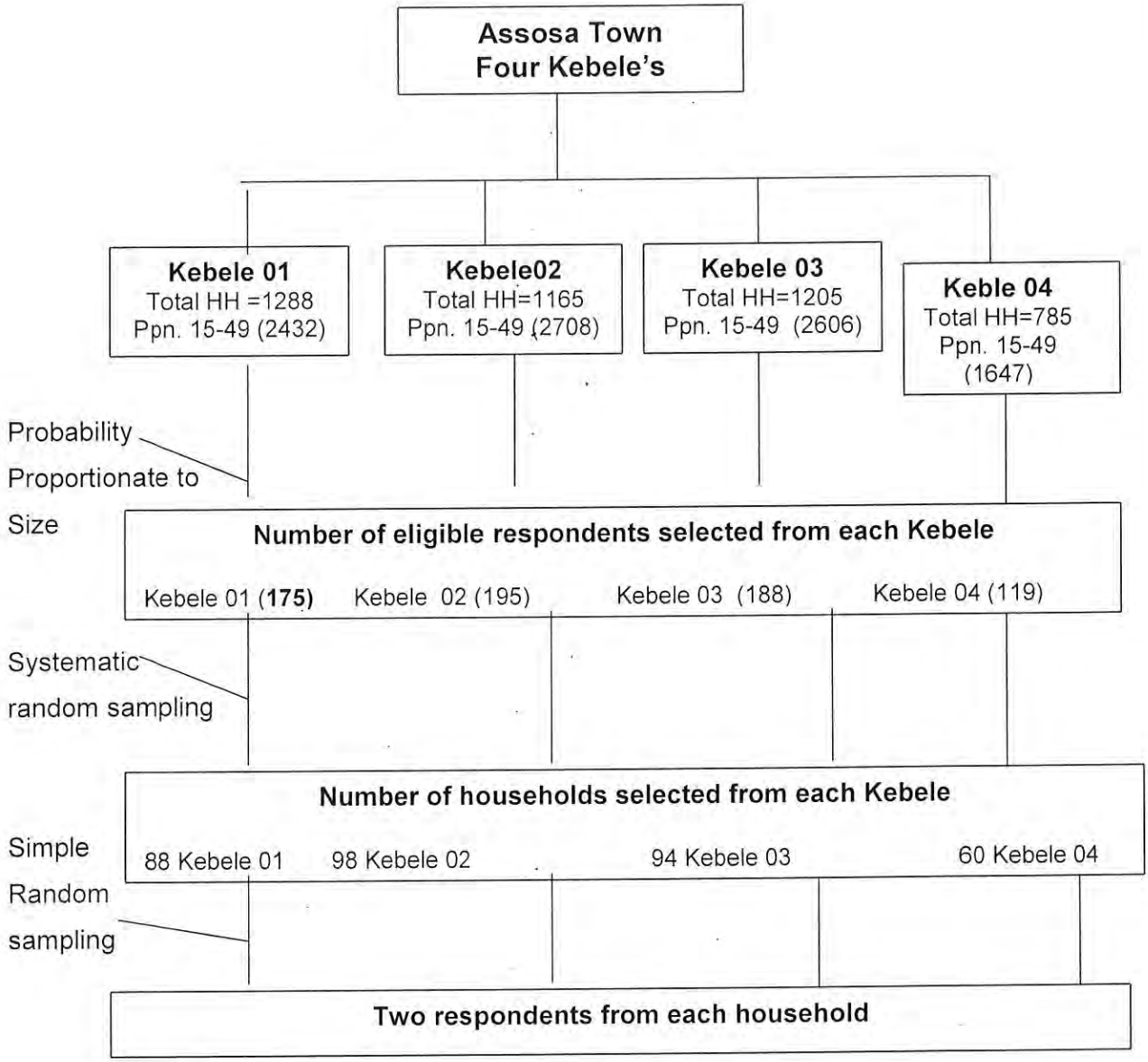

Figure 2. Sampling Procedure

Simple random sampling techniques using random number generated from a calculator was employed to select the first household interviewed. Once the first household was identified the next household was the I th (sampling interval) household in the right direction of the first sampled household. For example to select the first household interviewed from Kebele 01, the random

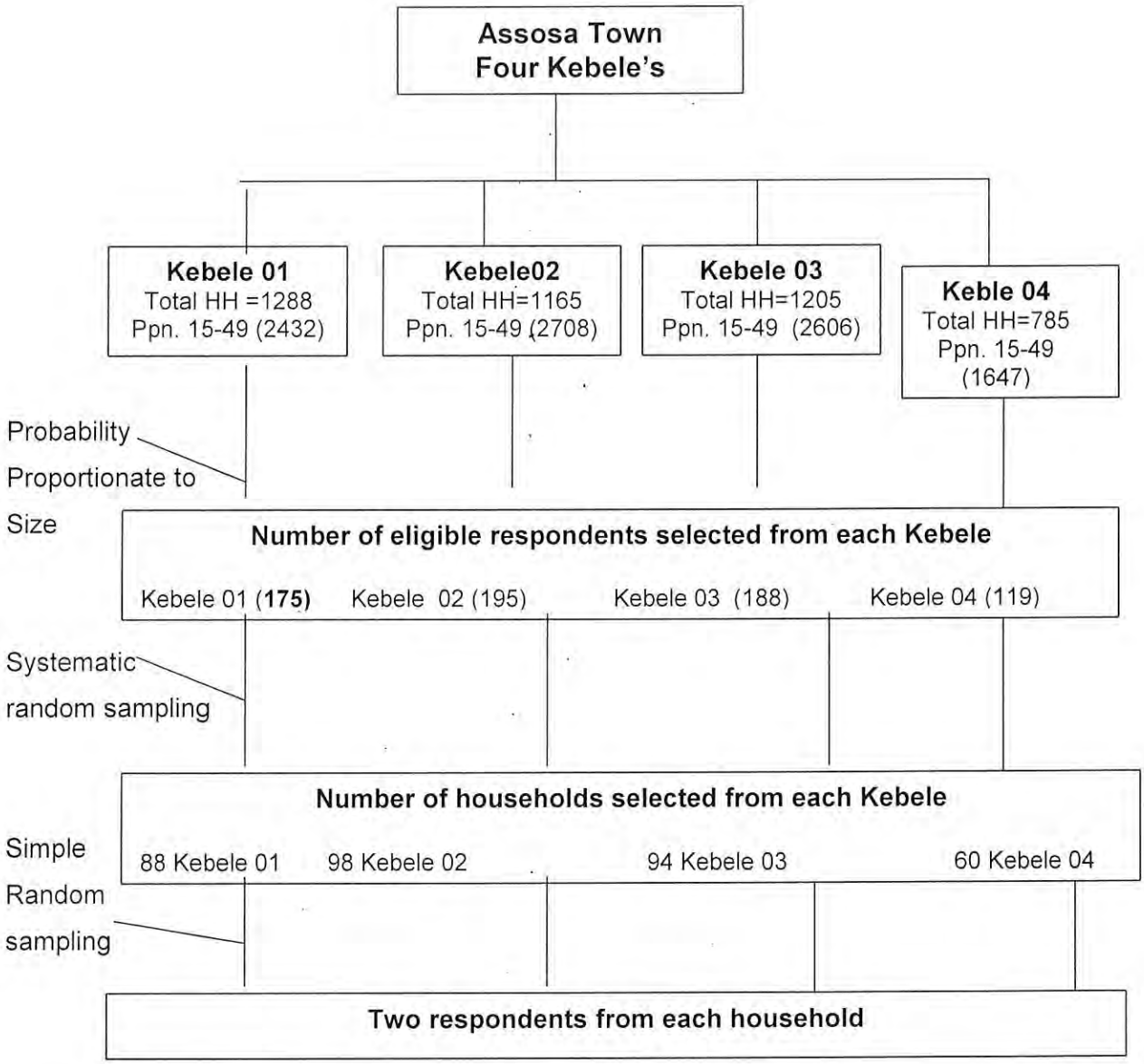

Figure 2. Sampling Procedure

Simple random sampling techniques using random number generated from a calculator was employed to select the first household interviewed. Once the first household was identified the next household was the I th (sampling interval) household in the right direction of the first sampled household. For example to select the first household interviewed from Kebele 01, the random

number generated from a calculator was taken to represent the first household interviewed from that Kebele and since the sampling interval calculated for the same Kebele was 15, the next household interviewed was the 15th household located in the right direction of the first household. This same procedure was followed in all the zones of the Kebele till the required number of respondents from the Kebele was obtained.

From each selected household two eligible respondents (One male and one female in the 15-49 age category) were interviewed. In situations where more than one respondents of the same sex were available in the household, selection of the respondent that was interviewed was made by lottery method. In conditions where eligible respondents were not available in the selected households, the house next to the selected household was taken as replacement.

2.3.2 Qualitative Data

The rationale for the qualitative study was to address certain issues that are not covered by the questioner survey and to get deep insight about the perception of the different section of the community and other stakeholders about VCT and care and support activities that are taking place in the area. For this purpose, a total of eight focus group discussions (two from in school youth, two from out of school youth, two from commercial sex workers, two

from community and religious leaders) were carried out. Furthermore, in-depth interviews were conducted with People Living With HIV/AIDS, Commercial Sex Workers, NGOs and CBO leaders and Government employees who are actively involved in coordinating activities related to care and support activities. The selection of the discussants of the focus group discussions and in-depth interviews was carried out using convenient sampling procedure.

Selection of the discussants for the focus group discussions and in-depth interviews as well as organization of the discussion sessions was made with the assistance obtained from the Regional AIDS Council Secretariat, The Regional Education Bureau and leaders of an anti AIDS club established by out of school youths.

The principal investigator conducted the qualitative survey (focus group discussions and in-depth interviews). Focus group discussion guide (topic guide) and tape recorders were utilized for the purpose.

2.4 Variables

2.4.1 Dependant variables

The following dependant variables are selected to assess the acceptability of VCT by the study population,

- Willingness to be tested
- Intention to ask partner of getting VCT service

- Readiness to declare test result

The questions asked in the questionnaire survey to address the above mentioned dependant variables were posed to the respondents as follows:

Willingness to be tested:

- *"If HIV blood testing and counseling service was offered free of charge, would you be willing to undergo the VCT?"*

-*"If the answer for the above question is No what is your reason?"*

Intention to ask partner of getting VCT service:

-*"If HIV blood testing and counseling service was offered free of charge, would you ask your sex partner to undergo the VCT?".*

-If the answer for the above question *is No* what is your reason?

Intention to declare the test result:

"If you decide to be tested for HIV, would you be willing to declare the test result? "

2.4.2 Independent Variables

Socio Demographic variables like Age, Sex, Marital Status; Religion, Education and labor force participation (involvement in income generating activities within 15 days prior to the data collection); knowledge variables like

Information about HIV/AIDS, VCT and condom; attitude, perception and practice variables like risk perception, perceived benefit about the service, attitude towards VCT, awareness about care and support services are the major independent variables.

Accessibility of VCT: Along with the acceptability issues, factors related with accessibility i.e., physical, financial and psychological access to the service, are known to have influence on VCT service utilization. However, in the setting where this survey is carried out, the service is provided free of charge and the site where the VCT center is located is within a maximum of one hour walking distance from almost all of the housing units of the town. Hence, considering accessibility variables as factors affecting utilization of VCT in Assosa town will not have a sound theoretical justification. Despite this verity, the study enquired whether the respondents were aware the existence of the service in Assosa town and whether or not it is provided free of charge.

2.5 Data Collection Instrument

A structured questionnaire prepared in English and later translated to Amharic was pre tested and standardized before use to collect the quantitative data. Hence, all the data collection took place using Amharic Language which is the working language for the area and spoken and understood by all the respondents.

The questionnaire has a total of eight four questions and is divided into six sections: The twelve questions included in section one of the questionnaire address the major socio demographic characteristics of the respondents like Age, sex, Marital Status, Religion, Educational status etc. Section two has twenty HIV/AIDS related Knowledge, Attitude and Practice questions. Section three is purely meant for never married respondents and includes six questions that ask about the sexual practice of the respondents. The main body of the questionnaire that address issues related to Voluntary Counseling and Testing has a total of 34 questions. Section five includes three key questions designed to address issues related with care and support for AIDS patients and the last section (section six) has seven questions that concentrate on condoms and their utilization. *For a detailed perusal, it is attached at the end of the thesis.*

Focus Group Discussion and in depth interview guides (topic guide) were utilized in the qualitative data collection. They are also included at the back of the thesis for referral.

2.6 Data Collection and Management

Twenty-four interviewers, twelve male and twelve female who are twelve grade complete and who have had previous experience in field data collection were recruited and trained for two days on the content of the questionnaire and interviewing techniques. Male interviewers interview male respondents,

while female interviewers interview female respondents. Two supervisors and the principal investigator closely followed the day-to-day data collection process. Questionnaires collected were revised and edited each night for completeness. For the few questionnaires found to be incomplete, revisits to the households were arranged on another day so as to make the necessary corrections.

The principal investigator organized and carried out the qualitative data collection. FGD guides and tape recorder were used for the purpose. In situations where the discussants were not comfortable with the use of the tape recorder, assistant to the principal investigator helped with handwriting of the information. The overall data collection took eleven days.

2.7 Entry and Exclusion Criteria

One female and one male in the age group 15-49 years who are available in the sampled households during the survey period and who showed willingness to participate in the study were included in the study. While people who are not willing to participate in the study, who are sick or unable to communicate for different reasons were excluded from the study. However, except for three cases where individuals were not willing to participate in the survey due to personal reason, no obstacle was faced in identifying and interviewing the study subjects.

2.8 Ethical Considerations

Households and individuals were enrolled into the study after obtaining their prior informed consent. Information was provided to all on the objective of the study. Maximum effort was made to maintain privacy during interview and confidentiality of information were assured by omitting names of the study subjects from the questionnaire.

2.9 Ensuring Data Quality and Processing

The use of appropriately designed and pre tested questionnaire, administration of the questioner which is prepared in the language spoken and well understood by both the respondents and the data collectors, appropriate and adequate training of the data collectors as well as close follow up of the data collection and entry process has contributed for the good quality of the data and minimize the non sampling error that would be expected to be committed during the data collection and processing. In this regard, two supervisors and the principal investigator closely followed the day-to-day data collection process and ensured quality of the data as well as its completeness and correctness.

EPI INFO Version 6.3/ SPSS Version 9.0 statistical packages were applied for data entry and analysis.

Responses obtained from the open-ended questions were coded and organized before being entered into the computer while the remaining questions initially presented in a coded form were entered as they were.

After the data entry was completed and appropriate data cleaning was carried out, frequency distribution of all the variables under consideration was computed by sex of the respondents and the result was presented in the form of tables. In the second stage of data analysis, the dependant variables that address the major theme of the study, "Acceptability of VCT" were cross tabulated with the major demographic and intermediate variables and the observed degree/significance of association was presented in the form of Chi-square and Odds ratio. In this study a 95% significance level was taken as a cutting point to determine the significance of association between the dependant and independent variables.

In the third stage of the data analysis, multivariate analysis using logistics regression method was employed to see the effect of confounders on the observed association between the three dependant variables and the other variables that are assumed to have association with them.

2.10 The Model

In a study of determinants of acceptability of VCT, for example, the response variable may be willing to be tested or not willing to be tested or show readiness to request partner for VCT or not readiness to ask partner for VCT.

In a situation like this one, the standard multiple regression analysis becomes inappropriate, as the response and predicators cannot be related through a linear relationship. One important method that can be used in such a situation is logistic regression. Logistic regression has been widely used in a functional relationship where the response variables are categorical, often either a success or failure.

Suppose that y_i is a binomial random variable, with n_i trails, and with probability of success on any trail equal to P_i (with $0 \leq P_i \leq 1$, unknown).

In logistic regression, we model P_i as a functional form relating P_i to X_i known to be S shaped (Weisberg, 1985).

This can be done by using the logit transformation of P_i, defined to be

$$\text{logit}(P_i) = \ln [P_i / (1 - P_i)] \quad \text{---- 1}$$

The logit is the logarithm of the odds of success or occurrence, the ratio of the probability of success to the probability of failure. The properties of the logit function include:

i) as P_i increases, so does logit (P_i), and

ii) logit (P_i) varies over the whole real line, where as P_i is bounded between 0 and 1.

The logistic regression model can then be expressed in two equivalent ways. First, we can fit a linear model in a logit scale,

$$\text{logit}(P_i) = \beta_0 + \beta_i x_i \qquad \text{-----(2)}$$

Solving (2) for P_i, using (1), we get the formula

$$\epsilon(Y_i / N_i) = P_i = \text{Exp}(\beta_0 + \beta_i x_i) / [1+\exp(\beta_0 + \beta_i x_i)] \text{ --------- (3)}$$

Equation (3) expresses the model as S shaped curve in the original probability scale . It can be noted also that equation (2) and (3) are equivalent.

In logistic regression, the deviance is useful in some goodness of fit test. and changes in deviance between various models are used in significance testing. The deviance is defined as

$$\text{Deviance} = 2 \times \Sigma y_i \ln(Y_i / N_i P_i) + (N_i - Y_i) * \ln(N_i - Y_i / N_i - N_i P_i) \text{ -----(4)}$$

with N - 6 degrees of freedom, where 6 is the number of β's in the linear form and N is the number of binomials. To compare two nested models, change in deviance and degrees of freedom, are computed and the results are compared with the P value of the Chi Square distribution.

Chapter 3: Demographic and Basic HIV/AIDS Related Findings

3.1 Socio-Demographic Characteristics of the Study Population

The distribution of the respondents by basic socio demographic variables such as age presented in five years age groups, sex, marital status, religion, occupation etc. are presented in table 3.1.

In the study, out of a total number of 692 respondents in the age group 15-49 years, nearly an equal proportion i.e., 50.4 percent males and 49.6 percent females were reported.

The mean and standard deviation of the age of the respondents are 25.6 and 8.53 years respectively. The proportion of females declines with increasing age. The age distribution of males shows a similar declining patter with increasing age, however, the proportion of males in the age group 45-49 slightly predominates those in the preceding age group. A further analysis of the respondents' age by sex demonstrates that females slightly outnumber the males in the 15 to 24 years age category (54.4% vs. 51.0%) while males predominate in the age group 35 and above (19.8% vs.14.6%).

Of the study subjects 40.7 percent males and 4.7percent of females were heads of their respective households, and 30 percent were found to be either daughters or sons of the household heads. The respondents' history of marriage showed that 36.4 percent of the male and 56.6 percent of the female

respondents were ever married while more females than males were divorced widowed and separated.

Classification of the respondents by religious showed that followers of the Ethiopian Coptic Christianity predominate (61 percent) among the study groups, followed by those who follow other religious denominations such as Protestantism (18.9 percent) and Muslims (15.6 percent).

Nearly 84 percent of the respondents have formal schooling. The educational attainment of the respondents classified by sex further showed that males predominate both among those who have formal schooling and those who reported literacy (The literacy of the respondents in this study was determined by their ability to read and in any language they are familiar with). Of the men and women who attended school, about a third of the female and a quarter of the men reported to have primary level education. Almost twice as many men have reported above secondary level education.

Questions posed to the respondents to assess their labor force participation showed that 39.2 percent worked for salary or profit during the two weeks prior to the survey and slightly more than half of them (52 percent) were self-employed.

Table 3.1. Distribution of the Respondents by Sex Differentials of the Socio Demographic Characteristics of the Study Population, Assosa town, Benshangul Gumze National Regional State; March 2002

Socio Demographic Variables	Total		Male		Female	
	Number	Percentage	Number	Percentage	Number	Percentage
Age	N=692		N=349		N=343	
15-19	212	30.6	104	29.8	108	31.4
20.24	153	22.1	74	21.2	79	23.0
25-29	139	20.0	67	19.2	72	21.0
30-34	69	10.0	35	10.0	34	9.9
35-39	51	7.4	28	8.0	23	6.7
40-44	32	4.6	17	4.9	15	4.4
45-49	36	5.2	24	6.9	12	3.5
Relation to Head of H-Hold	**N=692**		**N=349**		**N=343**	
Head	158	22.8	142	40.7	16	4.7
Wife	162	23.4	-	-	162	47.2
Relative	106	15.3	62	17.8	44	12.8
Daughter/Son	207	29.9	120	34.4	87	25.4
Maid	34	4.9	14	4.0	20	5.8
Others	25*	3.6	11	3.2	14	4.1
Marital Status	**N=692**		**N=349**		**N=343**	
Never married	371	53.6	222	63.6	149	43.4
Married	263	38.0	111	31.8	152	44.3
Divorced	31	4.5	9	2.6	22	6.4
Widowed	20	28.9	4	1.1	16	4.7
Separated	7	1.0	3	0.9	4	1.2
Religion	**N=692**		**N=349**		**N=343**	
Orthodox	422	61.0	199	57.0	223	65.0
Protestant	131	18.9	70	20.1	61	17.8
Catholic	10	1.4	4	1.2	6	1.7
Muslim	108	15.6	65	18.6	43	12.5
Others	19**	2.7	11	3.2	8	2.3
Able to read and Write	**N=692**		**N=349**		**N=343**	
Read only	51	7.4	28	8.0	23	6.7
Can read and write	541	78.2	296	84.8	245	71.4
Can not read and write	100	14.5	25	7.2	75	21.9
Have formal education	**N=692**		**N=349**		**N=343**	
Yes	578	83.5	308	88.3	270	78.8
No	114	16.5	41	11.7	73	21.2
Grade Completed	**N=578*** **		**N=308**		**N=270**	
1-6	166	28.7	73	23.7	93	34.4
7-8	139	24.0	83	26.9	56	20.7
9-12	205	35.5	108	35.1	97	35.9
12+	67	11.6	44	14.3	23	8.5
Worked for salary/profit	**N=692**		**N=349**		**N=343**	
Yes	271	39.2	192	55.0	79	23.0
No	421	60.8	157	45.0	264	77.0

* Include respondents who do not have blood relation with the head of the household
** Those who said have no religion and follow traditional religion
*** 114 have never been to schools

3.2. Awareness and Behavior Related to HIV/AIDS and Source of Information

Table 3.2 shows awareness and behaviour related to HIV/AIDS and source of information by sex of the respondents. Knowledge of AIDS is high among the study group where the majority (86.6 percent) of the respondents know (ever heard) about HIV/AIDS. Of those 71.9 percent mentioned multiple sources like radio, television, health workers, anti AIDS clubs etc. as regular sources of information regarding HIV/AIDS. Sexual intercourse is the most frequently mentioned means of HIV transmission mentioned by 40.2 percent of those who claimed to be aware of HIV/AIDS. While nearly a quarter of them (23.5 percent) don't know how the virus spreads from person to person.

Limiting oneself to one trusted sexual partner is the most common measure of prevention of HIV infection mentioned by 5.8 percent of the respondents. While a combination of different measures like abstaining sex, not sharing sharp and cutting objects like blades and needles, using condoms, and avoiding unsafe injections are mentioned by 83.4 percent of the respondents.

More than 90 percent of the respondents from both sexes believe that HIV is preventable. About 81 percent believe that a healthy looking person can carry HIV. And over 90 percent said that HIV could pass from mother to child. Of those who said that HIV could pass from mother to her child, nearly a third (34.0 percent) mentioned two or more correct modes (periods) of transmission

while the remaining 65.8 percent mentioned only one mode (period) of transmission.

Three hundred eighty five (64 percent) of the respondents said they frequently discuss issues related to HIV/AIDS with the members of their family and about a quarter said that they know a person living with HIV/AIDS or one who died of AIDS in the family /neighborhood.

The results outlined above indicate that more males than females know about HIV/AIDS (93.1% Vs. 79.9%), believe HIV/AIDS is preventable (96.6% vs. 92.0%) and know a person living with HIV/AIDS (28.3 vs. 21.5%). Whereas, more females believe that HIV can pass from mother to child (92.0 % vs. 90.5%), and discuss with family members about HIV/AIDS (65.7% vs. 63.1%).

The result of the qualitative survey indicated that all participants of the focus group discussions and in-depth interviews are aware of HIV/AIDS. They consider the problem as a serious threat for communities. Most indicated that people from all sections of the community are affected and continue to be affected by HIV/AIDS. The death of many people at young age and the fact that many people are bedridden with chronic debilitating disease conditions are the frequently mentioned reasons for believing that AIDS is becoming a serious problem in the area. This is also confirmed by health professional interviewees who claim that patient visits for diseases like Tuberculosis which

are related to AIDS, is increasing and proven AIDS cases are on the increase and proven AIDS cases are on the rise in Assosa hospital.

Discussants of the various FGDs have described the extent of HIV/AIDS among their community as follows:

"The extent of the problem is immense; we have enough information that there are a lot of people affected by AIDS." Pope of the Orthodox Church and Head of the Regional Synod

"Few years ago AIDS was a story for us, we were hearing about AIDS on the radio and the television. But now AIDS is with us. We are seeing it. It is affecting our community." Imam of the Grand Mosque of the Region

"There is no question that many people are affected by HIV and are dying from AIDS. AIDS in our area is affecting all sections of the community haphazardly. It is common to hear that married and unmarried, educated and uneducated, young and old are dying from AIDS," Public Relation Officer Of The Regional Education Bureau, March 2002.

"The progressively growing number of orphans who are coming to our office looking for support could be a good indication of how much serious the problem of AIDS has become in the town." Official from the regional DPPB, March 2002.

Table 3.2. Awareness About HIV/AIDS Among The Study Population about HIV/AIDS, Assosa Town, Benshangul Gumze National Regional State, March 2002.

Awareness and Source of information on HIV/AIDS	Total		Male		Female	
	Number	Percent.	Number	Percent.	Number	Percent
Know (heard) about HIV/AIDS	**N=692**		**N=349**		**N=343**	
Yes	599	86.5	325	93.1	274	79.9
No	93	13.4	24	6.9	69	20.1
HIV/AIDS is preventable	**N=599***		**N=325**		**N=274**	
Yes	566	94.5	314	96.6	252	92.0
No	3	0.5	1	0.3	2	0.7
Do not know	30	5.0	10	3.0	20	7.3
Healthy looking person can carry HIV	**N=599***		**N=325**		**N=274**	
Yes	487	81.3	269	82.8	218	79.6
No	39	6.5	18	5.5	21	7.7
Do not know	70	11.7	38	11.7	32	11.7
HIV can pass from mother to her baby	**N=599***		**N=325**		**N=274**	
Yes	546	91.1	294	90.5	252	92.0
No	11	1.8	7	2.2	4	1.5
Do not know	42	7.0	24	7.4	18	6.5
Know when HIV pass from mother to her child	**N=546****		**N=294**		**N=252**	
During pregnancy	227	41.6	132	44.9	95	37.7
During delivery	41	7.6	14	4.8	27	10.7
Through breast milk	91	16.7	57	19.4	34	13.5
Multiple answer (2plus)	187	34.2	91	31.0	96	38.1
Discuss with family members about HIV/AIDS	**N=599***		**N=325**		**N=274**	
Yes	385	64.3	205	63.1	180	65.7
No	153	25.5	90	27.7	63	23.7
Do not know/No answer	61	10.2	30	9.2	31	11.3
Know PLWHA or those who die from AIDS	**N=599***		**N=325**		**N=274**	
Yes	151	25.2	92	28.3	59	21.5
No	317	52.9	184	56.6	133	48.5
Do not know	118	19.9	44	13.5	74	27.0
Others	13	2.1	5	1.5	8	2.9

* The 93 missing cases are those who are not aware of HIV/AIDS

** Out of those respondents who said HIV could pass from mother to her child

"I think that many people are affected by HIV/AIDS in Assosa town." A School Teacher Focus Group Discussant

"AIDS is not only affecting the urban community, it has spread to the rural areas. It is affecting every one." A Muslim community leader

3.3 Risk perception and behavioral changes related to HIV/AIDS

To ascertain the risk vulnerability of the respondents about HIV/AIDS, respondents who had heard of the infection were asked whether they feel at risk for HIV infection, whether they did change their behavior to avoid the risk of catching the virus and the type of behavioral changes they made to avoid the risk of infection. Table 3.3 shows the percentage of women and men who mentioned their risk vulnerability and the type of measures they took to avoid the risk of HIV infection. Accordingly, the level of perceived vulnerability to HIV/AIDS is very low among the study population. In this regard slightly more than a quarter (27.0 percent) of those who are aware of HIV/AIDS feel that they are at risk for HIV/AIDS. Of those who feel at risk, 90 percent said they have a moderate chance of catching the virus.

Despite the low level of perceived vulnerability to HIV/AIDS, 76 percent said that they have modified their behavior to avoid the risk of HIV, and out of them 66 percent did so a year ago. Abstaining from sex, avoiding sharp and piercing objects, limiting to one trusted sexual partner, and using condoms are the

most frequent behavioral changes made to avoid the risk of HIV infection mentioned by 28.4, 10.1, 9.0 and 8.1 percent of the respondents respectively.

The risk / vulnerability further cross classified by the basic demographic variables including sex, age, marital status, religion and literacy status of the respondents showed that almost equal proportion of males (26.8 percent) and females (27.0 percent) feel vulnerable to HIV/AIDS. However, those in the age group 20-24 (35.7 percent) and 25-29 (32.8 percent) feel more vulnerable than those at the beginning and the end of the age range i.e., 15-19(21.2 percent) and 35-49 (20.3 percent). Furthermore, larger proportion (41.0 percent) of divorced, widowed and separated respondents feel at risk than the never married (29.7 percent) and married (19.9 percent) respondents. A wider gap in the proportion who feel vulnerable is observed between those who can read and write/read only (28.2 percent) and those who cannot read and write (12.0 percent).

3.4 Sexual Practice of Never Married Respondents

Never married respondents were asked certain questions on sexual practice to assess their level of exposure to factors that can expose them to the risk of HIV infection. Table 3.4 shows that among the never married respondents 42.0 percent of males and 34.0 percent of females currently have sexual partners (boy/girl friend). Of those who currently have boy/girl friend 16.7 percent (21.5 percent males and 7.8 percent females) reported having more than one sexual partner and 79.9 percent (86.0 percent males and 68.6

percent females) admitted of ever having sex, however, only 38.9 percent of them disclosed ever using condoms during sexual intercourse.

Out of the 39 (35 male and 4 female) respondents who admitted ever having sex with a person other than their regular sexual partner/s, only 28.0 percent mentioned ever-using condom during the sexual encounter. The above findings indicated that, in Assosa town, unmarried males are more likely to be involved in relationship with the opposite sex, to initiate sex and be exposed to risky sexual behavior such as having multi partner sexual contact to have sex with persons other than their regular partner compared to unmarried females in the same area.

Table 3.3 Risk perception towards and behavioral changes made to avoid the risk of HIV/AIDS among the study population who are aware of HIV/AIDS in Assosa town, Benshangul Gumze National Regional State; March 2002.

Risk Perception and Behavioral Changes	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Feel at risk for HIV/AIDS	**N=599***		**N=325**		**N=274**	
No (No chance)	350	58.4	209	64.3	141	51.5
Have moderate chance	135	22.5	77	23.6	57	20.8
Have big chance	27	4.5	10	3.1	17	6.2
Do not know	82	13.7	27	8.3	55	20.1
Others	4	0.7	2	0.6	2	0.7
Changed behavior to avoid exposure to HIV infection	**N=599***		**N=325**		**N=274**	
Yes	455	76.0	262	80.6	193	70.4
No	127	21.2	52	16.0	75	27.4
Do not know/no answer	17	2.8	11	3.4	6	2.2
Duration since changed behavior	**N=455****		**N=262**		**N=193**	
Within six months	51	11.2	24	9.1	27	14.0
Six to twelve months	29	6.4	17	6.5	12	6.2
Before a year	300	65.9	199	75.9	101	52.3
Do not remember the specific duration	75	16.5	22	8.4	53	27.4
Types of behavioral changes made	**N=455****		**N=262**		**N=193**	
Multiple answers (more than one answer)	189	41.5	107	4.1	82	42.5
Abstain from sex	129	28.4	85	32.4	39	20.0
Avoid sharing sharp objects	46	10.1	15	5.7	31	16.1
Limit to one trusted partner	41	9.0	25	9.5	16	8.3
Use condoms	37	8.1	25	9.5	12	6.2
Avoid unsafe injection	18	4.0	5	1.9	13	6.7

* The difference from the total sample are those who are not aware of HIV/AIDS

** The difference from the total sample refer to those who reported no behavioral change to HIV infection

3.5 Knowledge and Practice Related to Condom and Its Utilization

Promotion of the use of condoms is cited among the important components of AIDS prevention programs. It is an ascertained fact that knowledge about condom and its proper utilization can play an important role in preventing the transmission of HIV/AIDS and Sexually transmitted infections. Table 3.5 gives sex differential in terms of respondent's knowledge and utilization of condoms.

Out of the 692 respondents who participated in the study 76.4% reported ever hearing about condoms, of which 85.3% disclosed ever seen a condom. Hiwot trust is the brand of condom most commonly mentioned by about half of the respondents from both sexes. Furthermore slightly more than a third (35 percent) of those who mentioned ever seeing condoms reported used condom too.

A little more than a fifth (22.0 percent) and 5 percent of the respondents who know about condoms believed condoms could protect from HIV/AIDS and STD's respectively, and a further 44.9 percent gave a combination of correct answers like condoms could protect from HIV/AIDS/STD's and pregnancy. However, about 18 percent gave non-specific answers like condom is useful for health and could protect from diseases.

When the sex differentials of the awareness and utilization of condoms is compared, the proportion of males is higher among the groups who admitted ever hearing about condom (85.3% vs. 67.3%), ever seeing a condom (91.3% vs. 77.5%), and ever using a condom (37.9%vs. 29.6%).

Table 3.4. Sexual practice of never married people, Assosa Town, Benshangul Gumze National Regional State; March 2002.

Sexual Practice of Never Married Respondents	Total		Male		Female	
	Number	Percent.	Number	Percent.	Number	Percent
Currently have boy (girl friend (lover))	**N=371***		**N=222**		**N=149**	
Yes	144	38.8	93	41.9	51	34.2
No	227	61.2	129	50.1	98	65.8
Ever had sex with boy/girl friend	**N=144****		**N=93**		**N=51**	
Yes	115	79.9	80	86.0	35	68.6
No	29	20.1	13	14.0	16	31.4
Ever used condom during sexual intercourse	**N=144****		**N=93**		**N=51**	
Yes	56	38.9	43	46.2	13	25.5
No	33	22.9	20	21.5	13	25.5
Do not know (no answer)	55	38.2	30	32.3	25	49.0
Have more than one partner	**N=144****		**N=93**		**N=51**	
Yes	24	16.7	20	21.5	4	7.8
No	120	83.3	73	78.5	47	92.2
Ever had sex with persons other than the regular partner	**N=115*****		**N=80**		**N=35**	
Yes	39	33.9	35	43.8	4	11.4
No/No answer	76	66.1	45	56.2	31	88.6
Ever used condom with non regular partner	**N=39******		**N=35**		N=4	
Yes	11	28.0	8	22.8	3	75.0
No	28	62.0	27	77.1	1	25.0

* Excludes the ever married respondents

** It excludes those who are ever married and currently have no boy/girl friend

*** Excludes those who have had no sexual intercourse with non regular partners

**** Respondents who ever had sex with other persons other than the regular partner

Table 3.5. Knowledge and practice about condom among the study population, Assosa Town, Benshangul Gumze National Regional State; March 2002.

Knowledge and Practice About Condom	Total		Male		Female	
	Number	Percentage	Number	Percentag	Number	Percentage
Ever heard about condom	**N=692**		**N=349**		**N=343**	
Yes	529	76.4	298	85.3	231	67.3
No	140	20.2	41	11.7	99	28.9
No response	13	1.9	10	2.9	3	0.9
Ever seen condom	**N=529***		**N=298**		**N=231**	
Yes	451	85.3	272	91.3	179	77.5
No	72	13.6	20	6.7	52	22.5
Do not know (no answer)	6	1.1	6	2.0	-	0
Ever used condom	N=451**		N=272		N=179	
Yes	156	34.6	103	37.9	53	29.6
No	295	65.4	169	62.1	126	70.4

* Excludes those who never heard about condoms

** Excludes those who never seen and never heard about condom.

3.6 Awareness About and Attitude Towards Care and Support for People Living with HIV/AIDS (PLWHA)

Respondents who are aware of HIV/AIDS were asked a number of questions in order to assess their awareness about care and support activities and attitude about care and support for HIV/AIDS. Of the respondents who are aware of HIV/AIDS, 93.7 percent believe that AIDS patients need better care than other patients. They should be provided with all types of care they need; better care than other patients, psychosocial support, medical care, food, clothing and money etc. are the types of care respondents believe PLWHA should get.

The results of the focus group discussions and in depth interviews carried out with the various representatives of the community revealed that all the discussants know at least one person who is living with HIV or has developed AIDS. Most of the discussants have further indicated that there are many people who are bed ridden after falling sick with AIDS, and believe that many more are infected by the virus.

The discussions further attested that HIV is a stigmatizing disease in the area and PLWHA are not well treated and cared for by their community. The two HIV positive individuals interviewed during the survey have indicated that some people treat them well while most do not reflect good attitude towards them. Both have a feeling that they are rejected by friends and

excommunicated by the community they belonged to. They further said that the social pressure is so intense that it cost their job and destabilized their family life.

When describing what she faced after declaring her HIV status to the public, a woman living with HIV said, *"Some people considered me that I am mad, others looked at me as if I am a new creature. Even my friends gradually avoided me. Previously I used to earn my living through working as a petty trader selling "Gesho" in a local market. After I declared my HIV positive status and started teaching others, people started to come to where I am, just to look at me, they gossip about me and point their fingers at me. They even went further and took my photo while I am sitting in a market place. Even if the society treated me badly, I tried to maintain my business for about two months, but when I reached to a point where no body was buying my commodity, I decided to stop the business from which I used to earn my living. What other choices do I have except to get out of the business when no body is willing to buy the commodity I used to sell?"* For details of the what PLWHA feel about testing for HIV and care and support activities taking place in Assosa town, see case studies in Annex 2.

The following are some of the measures the discussants said would take if they found out that are HIV positive:

"If I get tested and found out that I carry the virus, I will start to teach others." Youth FGD Participant

"I will commit suicide." A commercial sex worker and a youth FGD participant

"If the government can support me I will stop my work at the bar." Commercial Sex Worker

"I will change town and start another work." Commercial Sex Worker

" I will not do anything." Student FGD discussant

Despite the consensus reached by most discussants that HIV/AIDS is a stigmatizing disease in the area, many of the participants of the qualitative study tried to emphasize that people ostracize PLWHA due to lack of awareness about how the virus is transmitted from one person to the other. In this regard an official of the Women's Affairs Bureau of the Region said, *"I do not think that most members of the community have enough information and awareness about HIV/AIDS. They still isolate AIDS patients." Representative of the Women's Affairs Bureau of the Region*

However, irrespective of the poor community attitude towards PLWHA, efforts are being made to change the observed stigma associated with the disease. According to the religious and community leaders, people are frequently asked to be compassionate to PLWHA. Caring for AIDS patients is also taken as a major discussion issue during the religious and community gatherings.

"Providing economic, social and spiritual support for the needy is part of our religious obligation and because of this we encourage our followers to provide all the needed support for AIDS patients and their families." A Muslim religious leader

"It is a must that a good Christian should help the poor, the sick and the starved so there is no reason why AIDS patients should be discriminated. We teach our followers to give due attention to AIDS patients." An Orthodox Church priest

Caring for People Living With HIV/AIDS

According to the result of the questioner survey, slightly more than a quarter (25.9 percent) of the respondents said that caring for PLWHA is the responsibility of the respective communities in which the patients live. Government (14.2 percent), family members (10.9 percent) and health workers (8.0 percent) are the other bodies frequently mentioned by the respondents as having the responsibility of providing the required care and support for PLWHA. However, 12.9 percent were not sure who should be responsible for such undertaking.

When asked whether they will be willing to provide care and support for people living with HIV/AIDS (family members), a great majority of the respondents 87.6 percent reported positively. The feeling that the patients need care and support till they die (43.1 percent) and family obligation (25.0 percent) are the two most frequently mentioned reasons forwarded by the respondents. The willingness of respondents further cross-tabulated by selected demographic variables indicated that as compared to the Muslims and those with no formal education, relatively larger proportion of Christians and those who have formal education show willingness to care for PLWHA i.e., (90.8% Christians vs.

79.8% Muslims) and (90.2% with formal education vs. 67.7% with no formal education).

Regarding the level of care AIDS patients should get, about 79 percent of the respondents reported that they should be provided with a better level of care than other patients receive but less than a tenth (8.5 percent) said that AIDS patients should be treated less well than other patients.

Although many of the focus group discussants and in-depth interviewees believe that the task of caring for PLWA is the responsibility of the government, the community and family, most AIDS patients in Assosa town are cared for by members of their respective families and their close relatives. Most agree that the community and the government have contributed little in caring for AIDS patients.

Patients' unwillingness to declare their HIV status and failure to seek support were believed to be the main reason for the observed poor government support for AIDS patients.

Low awareness of the community about the mode of transmission of the virus, the stigma attached to the disease, lack of NGOs and Community Based Organizations (CBOs) working in the area of care and support are cited as

having contributed for the overall low commitment of the community in caring for AIDS patients.

When describing the care and support activities taking place in the area, different representatives of the community forwarded the following:

"We did not do enough to provide care and support for AIDS patients. But now we plan to work in that area." A Muslim religious leader

"If we get sick of AIDS no body will come near to us. I do not think that the community will support us. May be we can help each other." Commercial Sex Worker
"We should not discriminate AIDS patients, they are part of our society We should be able to support them with every thing we can." A community leader

Chapter 4: Voluntary Counseling and Testing (VCT)

4.1 Awareness and Attitude Related to VCT

Voluntary Counseling and Testing is considered by many as entry point: to prevention and care, medical care, for preventing mother to child transmission of HIV infection (PMTCT) interventions, for ongoing emotional and spiritual care and social support. In this study, respondents were asked a number of questions in order to assess their awareness and attitude about VCT. Table 4.1 shows that about 85 percent of the study population (88.9 percent males and 79.6 percent females) who are aware of HIV/AIDS know whether it is possible to check ones HIV status through a blood test. Out of these, 74.9 percent stated that the service is available in Assosa town, while 93.9 percent believe that the service is available elsewhere in the country. Assosa hospital is the place mentioned by 89.5 percent of the respondents as a site where one can get the testing service. When asked to state the other (additional) services they know and provided in the hospital with the HIV test, nearly 40 percent said that no other service is available while 43.7 percent, 4.0 percent and 2.1 percent mentioned pretest counseling, care and support, and post test counseling, respectively.

Of the 380 respondents who know about the availability of VCT service in Assosa town, 81.0 percent know that the service is provided free of charge

and 78.0 percent said that it takes less than 30 minutes to reach the VCT center.

Out of the respondents who know that people can check their HIV status, 88.3 percent expressed their willingness to pay for the service. When asked to state the amount they can afford, about 19.7 percent mentioned an amount ranging between 25 cents and 10 Birr. However, nearly a third (32.7 percent) of them could not state a specific amount of money.

According to the results of the qualitative survey, all the focus group discussants and in-depth interviewees are aware of the availability of HIV blood test in Assosa. Assosa hospital is sited by the entire respondent as a site where one can check his/her HIV status. Furthermore, except for the in school youth and some of the CBO and religious leaders, the other focus group discussants know that the service is provided to the needy free of charge. However, the discussants' awareness about the time needed to get the test result varies. Some indicated that they are not sure about how long it will take to get the test result, but most pointed out that it will take from two weeks up to six weeks.

Regarding the actual utilization of the available testing service, three of the youth focus group discussants and the two PLWHA that claimed having been tested for HIV, testing for HIV is not difficult in Assosa hospital. However, the youth and one of the people living with HIV stated that getting the test result

could sometimes be delayed up to two weeks. The counselors of Assosa Hospital VCT center confirmed the discussants claim about the long waiting time required to get the test result and attributed it to the testing procedure that is followed by the hospital laboratory, which is a rapid test followed by ELISA. According to the counselors, running ELISA test would only be cost effective when as many as required samples are available for the test, and in situations where the number of people who volunteer for the test are few the center will be forced to extend the time up to two weeks.

All the 507 respondents who are aware of the HIV blood test believe that VCT service has some benefits. Checking ones HIV status 75.8 percent, avoiding the risk of HIV 4.6 percent, contributing for prevention activities 4.8 percent and knowing HIV status before marriage 3.0 percent are some of the benefits of VCT listed by the respondents.

Eighty-two (14.1 percent male and 19.0 percent female) respondents feel that VCT is something scary. The belief that the test can affect life, fear of positive result, stigma associated with positive result and social rejection are the most frequently reported reasons for having a negative feeling for HIV test.

When asked about the attitude of the community towards those who seek the service, about 19.4 percent said that people would think he/she has AIDS and 15 percent said the person would be considered as promiscuous.

Nearly 50 percent of the respondents feel that people should be tested for HIV anytime. However, 27.7 percent and 25.0 percent said the HIV test is only necessary when somebody is feeling sick or just before marriage, respectively.

Table 4.1. Awareness of the study population about VCT services, Assosa town, Benshangul Gumze National Regional State, March 2002.

Awareness about VCT	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Know that a person can check his/her HIV status	**N=599***		**N=325**		**N=274**	
Yes	507	84.6	289	88.9	218	79.6
No	24	4.0	14	4.3	10	3.6
No answer	68	11.4	22	6.8	46	16.8
Know about the availability of VCT service in Assosa town	**507****		**N=289**		**N=218**	
Yes	380	74.9	213	73.7	167	76.6
No	127	25.0	76	26.3	51	23.4
Know about the availability of VCT service elsewhere in the country	**507****		**N=289**		**N=218**	
Yes	473	93.3	274	94.8	189	86.7
No	44	8.7	15	5.2	29	13.3
Sites where VCT services are available in Assosa town	**N=380*****		**N=213**		**N=167**	
Hospital	340	89.5	185	86.9	155	92.8
Health center	7	1.8	4	1.9	3	1.8
Hospital/Private clinic/health post	20	5.3	14	6.6	6	3.6
Others	13	3.4	10	4.7	3	1.

* Excludes respondents who are not aware of HIV/AIDS
** Excludes those who do not know **about the HIV blood test**
*** **Excludes those who do not know about the availability of VCT service in Assosa town**

For the question, "who do you think is the section of the society that needs the VCT service most?" Almost one in every three (32.3 percent) said every one need to be tested, while 8.5 percent indicated that HIV test is necessary for those who suspect themselves of having the virus and those who are sick.

Many of the focus group discussants and in-depth interviewees believe that people who are at risk of HIV need the HIV test most. However, for most of them, the definition of "risk group" varies. For example for most of the in-school youth; commercial sex workers and the jobless are at risk for HIV/AIDS and needs the test most. The commercial sex workers' definition of risk group for HIV/AIDS is however different from that of the youth. According to them, the youth, married individuals particularly men; military personal and they themselves are at greater risk for HIV and need to be tested. On the other hand, the religious, and CBO leaders and health workers interviewed have said that all people irrespective of age, social and economic status are at risk for HIV and need to be tested.

"For me commercial sex workers, students and married people are at risk of HIV/AIDS." Commercial sex worker,

"For me students are relatively at higher risk for HIV, because they mostly and frequently have sex without condom." Commercial sex worker,

Table 4.2. Attitude and perception of the study population towards VCT services, Assosa Town, Benshangul Gumze National Regional State, March 2002.

Attitude and Perception towards VCT	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Willing to use VCT service (if made available free of charge)	**N=507***		**N=289**		**N=218**	
Yes	437	86.5	246	85.1	191	87.6
No	24	4.8	15	5.2	9	4.1
Do not know (No answer)	44	8.7	26	9.0	18	8.3
Others	2	0.4	2	0.7	-	
Reason for volunteering for HIV test	N=437**		N=246**		N=191**	
To make sure of HIV status	184	42.1	70	28.6	114	59.7
To make sure of negative status	139	31.8	96	39.0	43	22.5
If positive to be careful for self and partner	29	6.6	14	5.7	15	7.9
Because it is provided free of charge	21	4.8	11	4.5	10	5.2
Others	88	20.1	64	26.0	24	12.6
Allow partner to use VCT service (if service is free of charge)	**N=507***		**N=289**		**N=218**	
Yes	443	87.4	248	85.8	195	89.4
No	17	3.4	11	3.8	6	2.8
Not sure	24	4.7	20	6.9	4	1.8
Do not know/No answer	23	4.5	10	3.5	13	6.0
Ask partner to use VCT service	**N=494*****		**N=281**		**N=213**	
Yes	426	86.2	233	82.9	193	90.6
No	32	6.5	23	8.2	9	4.2
Not sure	36	7.3	25	8.9	11	5.2
Reason for not asking partner to use VCT service	**N=32******		**N=23**		**N=9**	
I believe her	12	37.5	7	30.4	5	55.6
I am not tested	5	15.6	4	17.4	1	11.1
She might think I suspect her	8	25.0	7	30.4	1	11.1
Do not want to ask her	5	15.6	3	13.0	2	22.2
Other	2	6.3	2	8.7	-	
Allow child to be tested (if service is made available free)	**N=507***		**N=289**		**N=218**	
Yes	179	35.3	143	49.5	136	62.4
No	60	11.8	59	20.4	1	0.5
Do not know/No child	168	33.1	87	30.1	81	37.2

*Out of the respondents who **know that a person can check his/her HIV status**

** Multiple answers

*** Excludes missing cases

**** Excludes those who showed readiness to request partner for VCT

4.2 Intention to Use, Allow and Ask Partner for VCT Service and Declare the Test Result

Table 4.2 shows the percentage of women and men who have heard of HIV/AIDS by their awareness, attitude and perception towards VCT. Accordingly, out of those respondents who know about the possibility of checking ones HIV status, 86.5 percent expressed their willingness to use the service if made available free of charge. In this case almost similar proportion of females and males expressed their readiness to be tested. The desire to know the HIV status and ensuring the HIV negative status are the two main reasons given by 42.1 percent and 31.8 percent of the respondents respectively, for being ready to be tested. However, except for those people who believe that People Living With HIV/AIDS need better care and support (X^2 =16.5 and P<0.0000) none of the socio demographic variables are found to have significant association with the respondents' willingness to be tested table 4.3, on page 78.

Not feeling at risk of HIV/AIDS, fear of social rejection and positive result, are the frequently mentioned reasons given by the respondents who expressed unwillingness to be tested.

Attempts made to further assess what representatives of the community feel about VCT showed that most of the youth group discussants would volunteer for the test. But so far, they did not get tested because they do not feel at risk

of HIV. However, three of the male out of school youth mentioned that they have been tested and confirmed that they are free from the virus. The commercial sex workers, on the other hand, indicated that they have no intention of testing because they are afraid of a positive result. They frequently are heard saying "what would happen to me if the result turned out to be positive?" They further noted that exchanging sex for money is the source of their livelihood and nobody will be willing to sleep with them if they identified themselves with the virus.

When giving the reason for not being ready to be tested for HIV some commercial sex workers said:

"There is quite a high possibility that I can have the virus and what will happen to me if told that I am HIV positive? I would rather get tested after falling sick?"

"If I got tested and people heard that I have the virus nobody will get near me? This will drive me out of business and I would be staved to death."

"Till the government gives me another job, I will not be willing to be tested."

"I will get tested only when I have enough economic capacity to support myself."

"Once my sexual partner asked me to be tested but I refused, because there is a possibility that I could have the virus in my blood."

Table 4.3. Willingness to be tested for HIV among the study population, Assosa town, Benshangul Gumze National Regional State; March 2002

Socio Demographic Variables	Willing to be tested		X^2	P-Value
	Number	Percentage		
	N=437	%(86.5)		P<0.05
Sex				
Male	246	85.1	.649	NS
Female	191	87.6		(.420)
Age				
15-19	146	88.5	2.189	NS
20-34	240	86.0		(.335)
35-49	51	80.9		
Marital Status				
Never married	260	87.2	.676	NS
Ever married*	177	84.7		(.411)
Have formal education				
Yes	404	86.9	.404	NS
No	33	78.6		(.135)
Religion				
Christian	374	85.8	.447	NS
Muslim	63	88.7		(.504)
Worked for salary/Profit				
Yes	189	84.7	.694	NS
No	248	87.3		(.405)
Feel at risk for HIV/AIDS				
Yes	125	86.8	.063	NS
No	312	86.0		(.166)
Know PLWHA				
Yes	116	86.6	.021	NS
No	321	86.1		(.884)
PLWHA needs better care				
Yes	413	87.9	16.5	.000**
No	17	60.7		

* The ever-married group includes those who are currently married, widowed, divorced and separated.

** Significant at P<0.05

NS= Not Significant at P<0.05

PLWHA: People Living With HIV/AIDS

The religious and community leaders who commented on this issue said that, they are teaching their followers to be tested and suggested that if one is sure of his deeds, she/he should not be afraid to undergo test.

"We teach the importance of the HIV test. We did this because it has no harm. It will only tell them who they are." An Ethiopia Orthodox Church priest

"We are telling our followers to be tested for HIV. We promised to give every support for the people who will volunteer for the test" Imam of the Grand Mosque of the Region.

Readiness to allow partners (would be partners) to utilize VCT service is high i.e., above 86 percent of respondents from both sexes indicated that they would be willing to allow their partners or would be partners for HIV test. A further analysis revealed that as compared to those without formal education and believe that PLWHA do not need better care and support, respondents with formal education and who believe that PLWHA need better care and support have shown a better inclination to allow their partners for VCT (89.5%vs. 76.2%) and (93.3% vs. 80.5%) respectively (Table 1, Annex 1).

Similar to the observation made in the respondents' willingness to allow their partner/s for VCT, about 86 percent of them expressed their readiness to request their partners for VCT. However, in both cases females predominate (86.1 % vs. 90.7%) and (82.9 % vs. 90.6%). The bivariate analysis result

showed a significant association between the respondents readiness to request their partners and covariates sex, age, employment status and respondents feeling that PLWHA needs better care and support than other patients (Table 4.4). The logistics regression analysis made to ascertain whether the observed association will hold true after controlling the effect of confounders is presented in section 4.6, on page 87.

Despite the observed high level of intention to use the service, allow and ask partner for VCT, about a third (33.1 percent) of the respondents said that they are not ready to announce their decision to have the HIV test. When we further see the respondents' readiness to declare the decision to be tested with the basic demographic variables, no major variation in proportion is observed between male and females, between the higher and lower age category, never married and ever married, Christian and Muslim or between who have formal education and not educated (Table 2, Annex 1).

Fear of social rejection due to stigma following HIV positive result, uncertainty about the outcome of the result, and fear of rumors are the frequent reasons given for not being willing to tell the decision to be tested.

The observed reluctance to declare the decision to be tested is also observed in the respondents' readiness to tell the outcome of the result where slightly more than a quarter (27.2 percent) of the respondents are not ready to tell the outcome of the test result.

Fear of social rejection, stigma associated with HIV positive status and poor expectations from others with regard to care and support, are the main reasons given by the respondents for the observed reluctance to tell the HIV test result. Further analysis made on this dependant variable showed that apart from those who feel at risk for HIV/AIDS (X^2 4.378, P< .036), all the socio demographic and cognitive variables are found to have no significant association with the respondents' readiness to declare the HIV test result (Table 4.5).

When asked about what measures they would take if identified as having HIV in their blood, 10.9 percent said they would teach others, 5.3 percent would abstain from sex, while nearly half (51.7 percent) gave a combination of answers including abstinence, avoiding pregnancy, using condoms and seeking medical care. Whereas, 28.1percent and 24.4 percent respectively of the respondents say people who identify themselves as having the AIDS causing virus in their blood should reveal their status, or look for medical care.

Respondents were asked about the measures they would take if their partner tested positive for HIV and accordingly, a third (32.9 percent) said they would check their own blood or take care of their partner or both. However, 25.5 percent said they would seek a divorce.

Table 4.4 Readiness to request partner to be tested for HIV among the study population, Assosa town, Benshangul Gumze National Regional State; March 2002

Socio Demographic Variables	Yes Number	Yes Percentage	X^2	P-Value
	N=426	%(86.2)		P<0.05
Sex				
Male	233	82.9	6.039	.014**
Female	193	90.6		
Age				
15-19	143	89.9	6.770	.034*
20-34	238	86.2		
35-49	45	76.3		
Marital status				
Never married	256	88.3	2.465	.116
Ever Married	170	82.5		
Religion				
Christian	367	86.1	.217	.641
Muslim	59	88.1		
Literate				
Yes	378	87.1	2.237	.135
No	48	80.0		
Worked for salary/profit				
Yes	175	80.6	10.186	.001**
No	251	90.6		
Feel at risk for HIV/AIDS				
Yes	121	87.1	.108	.742
No	305	85.9		
Know PLWHA				
Yes	110	83.3	1.252	.263
No	315	87.3		
PLWHA needs better care				
Yes	403	87.8	14.434	.000**
No	16	61.5		

* Significant at P< 0.05
** Significant at P<0.01

Table 4.5 Readiness to tell (declare) the HIV test result among the study population, Assosa town, Benshangul Gumze National Regional State; March 2002

Socio Demographic Variables	Ready to declare the test result		X^2	P-Value P<0.05
	Number	Percentage		
	N=367	%(72.8)		
Sex				
Male	206	72.0	.208	.648
Female	161	73.9		
Age				
15-19	124	74.7	.445	.801
20-34	199	71.8		
35-49	44	72.1		
Marital Status				
Never married	217	72.3	.088	.767
Ever married	148	71.8		
Religion				
Christian	311	71.7	1.360	.244
Muslim	55	78.6		
Have formal education				
Yes	337	72.9	.045	.833
No	30	71.4		
Worked for salary/profit				
Yes	157	71.4	.417	.518
No	210	73.9		
Feel at risk for HIV/AIDS				
Yes	94	66.2	4.378	.036*
No	273	75.4		
Know PLWHA				
Yes	98	72.1	.047	.829
No	268	73.0		
PLWHA needs better care				
Yes	347	73.8	3.254	.071
No	15	57.7		

* Significant at P< 0.05

4.3 Logistics regression

The statistical analysis made to test the association of the three dependant variables i.e., willingness to be tested, readiness to declare the test result and readiness to request partner for VCT with basic socio demographic and cognitive variables, (Tables 4.3,4.4 and 4.5) necessitated that further analysis be made using logistic regression model only on one of the dependant variables i.e. the respondents' readiness to request partner for VCT.

Table 4.6 presents the parsimonious model for the determinants of readiness to request partner for VCT for respondents who showed willingness to ask their partners for VCT services. Four variables were found to influence the respondents readiness to request partners for VCT after holding the other explanatory variables constant and at significant level $P< 0.01$. Accordingly, the respondents' readiness to ask their partner for VCT is significantly associated with socio demographic and cognitive variables such as sex, employment status of the respondent and the belief that PLWHA needs better care and support. However, none of the other socio demographic variables were found to be significantly associated with the respondents' intention to ask their partners for VCT.

The observed association between the demographic variable sex with that of the dependant variable utilized in the model showed that males are 98 percent more likely to request their partners for VCT than their female counterparts.

The association of the social and cognitive variables with respondents' intention to ask partner for VCT showed that employed people are 2.2 times more likely to intend to ask their partners for VCT than the unemployed. However, respondents who believe that PLWHA need better care and support are 83.2 percent less likely to request their partner for VCT.

Table 4.6 Logistic Regression Model predicting agreement to respondents' readiness to request partner for VCT and socio demographic and cognitive variables

Covariates	B	SE	Significance	Odds Ratio Exp (B)
Sex				
Male	.686	.316	.030*	1.986
Female [RC]				
Age				
15-19	-.828	.439	.060	.437
20-34	-.562	.367	.147	.588
35-49 [RC]				
Worked for salary/profit				
Yes	.791	.290	.006**	2.205
No [RC]				
PLWHA needs better care				
Yes	-1.784	.453	.000**	.168
No [RC]				

Variables entered in the Logistics Regression Model: Sex, Age, Marital Status, Religion, Literacy, Employment Status, Risk Perception for HIV/AIDS, Care and Support and Awareness about People Living With HIV/AIDS.

B= Regression coefficient

S.E = Standard error

RC = Reference category

Sig. T. = Significance of P

* ≤ 0.05

** ≤ 0.01

Exp (B) = Exponent of B (Odds Ratio)

Chapter 5: Discussion

This study utilized both descriptive and qualitative data collection methods and was carried out with the aim of identifying factors that affect the acceptability of VCT among the study community and their perception towards care and support for People Living With HIV/AIDS. A further assessment was also made on the awareness of the study community about HIV/AIDS and their risk vulnerability towards HIV infection.

Knowledge of HIV/AIDS is fairly high among the study subjects (86.5 percent) with females less likely to have heard about HIV (79.9 percent vs., 93.1 percent) than males. However, higher rates are reported in various studies conducted elsewhere in the country, for example awareness about HIV/AIDS was 96% for males and 85% for females in Demographic and Health Survey of Ethiopia (CSA & ORC Macro, 2001), 95.0 percent in an urban and rural comparison risk perception study (Fikru 2000), 92.7 percent and 97.0 percent in VCT studies conducted in Bahir Dar and Dire Dawa respectively (Michael 2001). As compared to the findings of the other studies, the relatively lower reported rates of awareness about HIV/AIDS in this study could be attributed to the fact that an organized HIV/AIDS awareness raising program is only initiated in Assosa town in the past two years and hence it might not have been extensive enough to reach the whole community.

Nearly two thirds of the respondents (64.3 percent of males and 65.7 percent of females) who have heard about HIV/AIDS discuss the issue of HIV/AIDS with members of their family. Similarly the 2000 Demographic and Health Survey report showed that 24.4 percent for males and 54.6 percent for of the females who are currently married or cohabitating with their partners in Benshangul Gumze region discuss the prevention of HIV/AIDS with their spouse or partners (CSA & ORC Macro, 2001), A recent survey conducted in Dire Dawa showed a relatively lower rate of discussion on HIV/AIDS among youth (47.5 percent) and antenatal care followers (54.0 percent), (Michael 2001a). The higher level of reported discussion on HIV/AIDS with family members in this study could have resulted from the felt severity of HIV/AIDS in the area combined with the effect of the Information, Education and Communication activities initiated by all concerned bodies including the community and religious leaders.

The results of this study showed that about three fourth of the respondents know about condoms and nearly a fifth indicated ever using one. An awareness level of 68 percent for men and 35 percent for women at the national level and 63.8 percent for men and 32.1 percent for women for Benshangul Gumze region was reported in the Demographic and Health Survey (CSA & ORC Macro, 2000). Similar level of awareness but a higher level of ever use of condom was reported in a study carried out in Bahir Dar (Michael, 2001b). A 33 percent of ever use of condoms is also reported

among the 15-49 years old in Harar (Fahmi, 2000). As compared to the national and the Benshangul region figures, the awareness of the respondents about condoms is high, this could be due to the fact that the findings in our study refers only to the urban area where information and access to condoms is better. The findings of a study carried out in Harar showed that preventive behaviors including the use of condoms and not having previous sexual contact were independent predictors of intention of having VCT (Fahmi 2000), significant association between willingness for VCT and use of condom is observed by Knut and his colleagues (Knut 1999).

About 85 percent of the study population who are aware of HIV/AIDS also know that a person can check his/ her HIV status through a blood test, and three fourth of them stated that the service is available in Assosa town while only 43 and 2 percent of them know that the HIV testing is accompanied by pre and post test counseling, respectively. The findings of both the descriptive and qualitative studies further showed that there is a high level of awareness about where the service is available in Assosa town. However, the discussants awareness about the time needed to get the test result varies. The level of awareness of the study community about the HIV blood test in this study is almost similar to the findings of two community-based studies conducted in Dire Dawa and Bahir Dar, where 86 and 83 percent of respondents respectively are aware about the HIV blood test in their respective locality (Michael 2001a&b). However, the respondents' lack of awareness about the

type of services available together with the blood testing is an indication of the fact that many people in the area are not well informed about what is included in the VCT package, what they should expect from the service if they would volunteer for the test and how long it would take to get the test result.

The survey finding further showed that getting the HIV test result in Assosa hospital would take up to two weeks time. This has resulted from the testing procedure followed by the hospital laboratory that demanded rapid test followed by ELISA for each blood sample. It was further ascertained that the VCT center in Assosa hospital is operational only two afternoons during a week and there is no mechanism that ensures those tested for HIV in the hospital VCT center get a follow up for appropriate care and support services. Though making the evaluation of the activities of the VCT center of Assosa hospital is beyond the scope of this study, the simple observations made and facts gathered during the survey indicated that both the testing procedures and lack of integration of counseling and testing services with care and support activities did not go with what is outlined in the National Guidelines for Voluntary Counseling and Testing in Ethiopia (NACS, 2000a) which demanded the test algorithms that require the use of rapid test to be implemented in health facilities like Assosa hospital. There are studies that show the feasibility of on-site HIV testing, preferred by clients, and resulted in significant improvement in the number of persons learning their serostatus, without increasing the cost or decreasing the effectiveness of counseling and

testing (Kassler, 1997). This shows that the attempt that is going to be made to improve the awareness of the residents of Assosa town with regard to VCT and associated services require the setting up of the service in a way proved to be effective by other studies in increasing the service utilization without compromising its value to address the issue.

Willingness to pay for the service in this study (88.3%) is higher and is found to be similar with what is observed in other studies conducted in Dire Dawa and Bahir Dar (Michael, 2001a&b) and Harar (Fahmi, 2000). Though the observed high willingness to pay for the service as an expression of readiness to use the service is an encouraging finding of the study, it should be interpreted with greater caution as nearly a third of those who mentioned their willingness could not mention the specific amount.

The tendency to relate HIV testing with 'falling sick/ill' or 'marriage' is found to be prevalent in this study. The association of testing with social and other medical factors like, "chronically sick and ordered by doctors to test", going abroad, marrying and getting pregnant is also frequently demonstrated in studies carried out at different regions of Ethiopia (Abeba, 2001, Michael, 2001a&b). A study conducted in Uganda showed that Interest in VCT is often "social", with clients showing interest in knowing their serostatus before getting married, embarking on a new relationship, or making plans for the future (UNAIDS, 1999b).

The level of perceived vulnerability to HIV/AIDS is very low among the study population. In this regard slightly more than a quarter (27.0%) of the respondents who are aware of HIV/AIDS between the sexes consider themselves at risk of HIV/AIDS. A similar level of perceived vulnerability is reported in a nationwide community based vulnerability study (Fikru, 2000), while a much higher level was reported from a study in Dire Dawa and Bahir Dar where 46 percent of ANC followers and 50.2 percent of women and youth feel vulnerable for HIV/AIDS (Michael, 2001a&b).

The further attempts made to assess the respondents' feeling of vulnerability and their willingness to be tested and ask their partners for VCT reveal no significant association with the major socio demographic and cognitive variables utilized in this study. However the result of the Focus Group Discussions came up with a combination of results in which groups who feel at risk for HIV/AIDS (commercial sex workers) lack of willingness for the test. However, the response obtained from the youth group discussants showed that their low tendency to express their willingness to be tested for HIV has resulted from their general feeling of lack of vulnerability for HIV. The association between lack of risk perception and respondents unwillingness to be tested was reported in a study conducted in South Carolina where groups that refused testing were at significant risk of HIV infection than those accepting (Jones, 1993). The feeling that, 'I am less likely to catch HIV' as a

reason for not volunteering for VCT was reported from a survey conducted in rural Tanzania (Killewo et al 1998). Contrary to these findings another study conducted among obstetric care follower in New York States identified that being the sexual partner of an Intra venous Drug User (IDU) or bisexual roughly doubles the likelihood of a women to accept HIV testing (Sorin 1996). The unwillingness to be tested among the groups who feel at risk for HIV/AIDS (commercial sex workers) in this study could have resulted not only from fearing of the positive result, but also from fear of stigma associated with the positive HIV result and being labeled as an 'AIDS' patient and uncertainty about availability of economic and other supports once tested HIV positive. Hence, any attempt to raise the awareness of the study community towards HIV/AIDS and VCT should give emphasis, among others, to practical risk reduction strategies and to the implementation of post test care and support activities.

In this study, although all the respondents who know about the HIV blood test believe about its benefit, nearly a sixth of them feel that VCT is frightening. The belief that the test can affect life, fear of positive result, stigma associated with positive result and social rejection are the most frequently reported reasons for having a negative feeling for HIV test. The findings of the focus group discussions and in-depth interview have also shown that for most of the discussants being an AIDS patient or having an HIV positive result is a highly stigmatizing condition. Lack of perceived benefit as a common barrier for a

better uptake of VCT, as well as, the stigma associated with the HIV positive result and the negative outcomes for those tested are reported in studies conducted in Zambia (Baggaley et al., 1995) and South Africa (Karim et al 1995). Studies from Kenya have also shown that women may be particularly vulnerable following VCT and in some cases have lost their home and children or have been beaten or abused by their husbands / partners if their status became known, (Temerman et al. 1994). Stigma associated with HIV/AIDS and fear of isolation and social rejection surrounding the disease as the major barrier for people to actively look for VCT service is indicated in findings of recent community-based studies conducted in Addis Ababa, Dire Dawa and Bahir Dar, (Abeba, 2001; Michael 2001a&b). In this study as all the respondents who are aware of the HIV test believe that testing for HIV has some benefit; lack of perceived benefit cannot be cited as a barrier for volunteering for VCT in Assosa town. However, fear of stigma and social isolation/rejection that will follow a positive result is indicated to be the major barrier for the respondents' fear of the HIV blood test. Lack of awareness among the study community about the mode of transmission of the disease and the importance of providing care and support for PLWHA could be cited as a reason for the observed negative attitude for the test as well as for people who tested positive.

Acceptability of VCT, as expressed by the respondents' willingness to be tested for HIV and to declare the test result, is found to be high in this study.

The two most frequently reported reasons for accepting testing were that respondents wanted to know their HIV status because of concern about their health and because they did not want to pass the virus to their partners if found out positive for HIV. Jones and his colleagues made similar observations in a study carried out among STD patients in South Carolina (Jones et al, 1993). However, the high level of intention to be tested observed in this result needs to be interpreted with much caution, as there are evidences that show great differences in theoretical and actual uptake rates. For example in Lusaka when students were asked if they wished to be tested for HIV there was a very high rate of interest. When the service was provided initially, uptake was very low. However, with time, there has been increasing demand for VCT in Lusaka (Baggaley et al., 1997). Another study from Zambia showed that among the 37 percent study subjects who initially expressed willingness to use VCT service only 3.6 percent actually came for the service (Rosenvard et al., 1998). A wider gap between intention to know the HIV result and actual uptake of posttest counseling and test result was also reported by Tefera and his colleagues in their study carried out among factory workers in Akaki (Tefera et al., 1999). A recent community based survey carried out in Addis Ababa also revealed that though there is a general agreement on the importance of knowing ones HIV status among the study subjects; interest to test is not as high as people's belief on the importance (Abeba, 2001).

The bivariate analysis proved the existence of significant association between the respondents' belief that People Living With HIV/AIDS need better care among the intenders to accept VCT and risk perception for HIV for those who expressed their readiness to declare the test result. This association was observed between the covariates including socio demographic and cognitive variables and the two dependent variables considered in this study, i.e., willingness to utilize the VCT service and readiness to request partners for VCT. However, none of the other socio demographic and cognitive variables are found to have significant association with the two dependant variables. The result of this study is however contrary to what was observed in other studies where significant associations were observed between socio demographic variables and respondents willingness to be tested. For example in a VCT study conducted in Harar Fahmi Mohamed reported the association of demographic variables like ethnicity among males and marital status and employment status among females with intention for VCT (Fahmi, 2000). The association of respondents' willingness to be tested with certain demographic variables like age and race is also reported from a study conducted among obstetric patients in USA (Sorin, 1996) and the existence of significant associations between the actual acceptance of VCT with socio demographic predictors like marital status, being single and level of education below grade 12 among pregnant women in Atlanta (Michael, 1991). However contrary to some of these findings, another study conducted among STD patients in

South Carolina showed that there is no statistically significant difference in the refusal rate for HIV testing by gender and race (Jones, 1993).

The result of the bivariate analysis, showed the existence of a significant association between the third dependant variable utilized as predictor of intention for VCT in this study i.e., readiness to request partner for VCT, and the socio demographic variables, sex, age and employment status as well as the cognitive variable care and support for PLWHA. In an effort to determine the important predictors of acceptability of VCT when the potentially confounding effects of other variables were controlled, logistics equations predicting readiness to request partner for VCT were estimated (fitted). Age as a measure of the intention in asking partner to get VCT that was observed to be a significant in the bivariate analysis failed to sustain its significance. Hence, based on results of the logistics regression model, the likelihood of being intender to ask partner for VCT is found to be higher among males and employed respondents. On the other hand, those respondents who believe that PLWHA need better care and support are less likely to request their partners for VCT. Association of socio demographic factors like gender, marital status, employment status and previous sexual contact, with the respondents intention towards asking partner for VCT was reported in VCT study conducted in Harar (Fahmi, 2001). The high likelihood of males to request their partners for VCT observed in this study is a likely finding in a male dominating society where awareness about HIV/AIDS and HIV test is

high among males than females. The fact that more males are reported employed and heads of their respective household can explain the reported high likelihood of readiness to request partner for VCT among the employed than the non-employed respondents. In this study females predominate among those who said that PLWHA needs better care and support, furthermore in most Ethiopian societies caring for sick patients is a socially and culturally accepted role females are expected to play and the same applies to caring for PLWHA. Hence, the less likelihood of intenders to ask partners among those who said people living with HIV/AIDS need better care and support can be explained both by the social and scientific (mathematical) facts explained above.

The analysis made on the applicability of the propositions of the theory of reasoned action that was used as a basic theory in formulating the conceptual framework in this study come up with the following basic findings. According to the theory, (Ajezen & Fishbein, 1980; Fishbein & Ajezen, 1975; Fishbein & Middlesadt, 1989) an individual's attitude toward performance of a particular AIDS preventive behavior is a function of the individual's beliefs about the consequences of performing the behavior, multiplied by his or her evaluations of these consequences. Furthermore, the theory holds that an individual's subjective norm is a function of his or her perception of social support from specific reference others for performance of a preventive behavior, multiplied by his or her motivation to comply with these referents' wish (William et al,

1995). In our study, respondents expressed their unwillingness to be tested (refusal to perform a particular AIDS preventive behavior) mainly because they are afraid of a positive result (consequences of performing the behavior), know about stigma associated with positive result and know that if found to be HIV positive could face social persecution and rejection (evaluations of these consequences). While those who expressed readiness to be tested for HIV (acceptance to perform a particular AIDS preventive behavior) did so because of concern about their health and because they did not want to pass the virus to their partners if found out positive for HIV. Hence, we can fairly conclude that the basic theoretical underpinnings of the theory of reasoned action are applicable in our study.

Furthermore, the findings of our study showed that HIV/AIDS preventive behavior (in our case willingness to be tested, to request partner for VCT and readiness to declare the test result) depends not only on cognitive variables like awareness about PLWHA needs for better care and support and risk vulnerability for HIV but also on contextual factors like economic status (measures by having personal source of income or employment) and gender issues.

Chapter 6: Conclusion and Recommendations

6.1. Concussion

Knowledge of HIV/AIDS is high among the study subjects. However, the rates are found to be lower as compared to the findings of other surveys carried out in different regional capitals of the country.

The level of perceived vulnerability for HIV/AIDS is low among the study population.

A considerable proportion of the respondents who know about HIV/AIDS also know that a person can check his/her HIV status through a blood test, and most of them stated that the service is available in Assosa town. However, the majority of the respondents are not aware that blood-testing service is accompanied by pre and post test counseling services.

The VCT center of Assosa hospital is not providing service on full time bases and the test procedure followed by the hospital laboratory does not follow the national guideline for HIV testing.

Acceptability of VCT, as expressed by the respondents' willingness to be tested for HIV and declare the test result is found to be high among the study population. However, this observed high level of intention to be tested needs

to be interpreted with caution as, there are evidences that show great differences in theoretical and actual uptake rates.

The predictive value of socio demographic variables in assessing the respondents' willingness to be tested and declare the HIV result is found to be irrelevant from the findings of this study. However, unlike that of the demographic variables, intention to undergo VCT and declare test result is predicated by cognitive variables like knowledge about care and support and risk vulnerability respectively.

Intention to ask partner for VCT is predicated by the socio demographic and cognitive variables: Sex, Employment status and knowledge about care and support.

Risk vulnerability among the risk groups and lack of risk vulnerability among the 'felt non risk groups' are the frequently mentioned reasons for the expressed unwillingness to be tested.

The belief that the test can affect, stigma associated with positive result, fear of positive result and social rejection is found to be the most frequently reported reasons for having a negative feeling for HIV test.

6.2. Recommendations

1. HIV/AIDS related awareness raising programs that are initiated at various levels in Assosa town should be strengthened so as to reach the various section of the community. In this regard schools, religion and community based organizations as well as NGOs and government institutions could play a great role in addressing the issues and sustaining the program.

2. Intensive Information, Education and Communication programs on VCT should be initiated and implemented in Assosa town. The participation of religious and community leaders as well as prominent personalities and local Community Based organizations like "Edir" in IEC activities and in caring for PLWHA can contribute much in reducing the stigmatizing effects of AIDS and HIV positive results.

3. The existing VCT center of Assosa hospital should be strengthened with the required manpower, material and supplies so as to make it functional on full time bases. In doing so, following the national guidelines for HIV testing and creating a link between the services of the center with agencies that provide care and support for PLWHA should also be strengthened.

4. Measures that will be taken to enhance the awareness of community members about VCT and promote the utilization of the VCT center of Assosa

hospital, should be accompanied with the expansion of other free standing VCT centers where people can get the service in places of their preference.

5. Attention should be given to relate the services of the VCT center with other activities focusing on care and support for PLWHA.

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List Of Annexes

Annex 1: Tables

Annex 1-Table 1: Willingness to allow partner to be tested for HIV among the study population, Assosa town, Benshangul Gumze National Regional State; March 2002

Socio Demographic Variables	Ready to allow partner to be tested	
	Number	Percentage
Sex	**N=443**	**%(87.7)**
Male	248	86.0
Female	195	90.7
Marital Status		
Never married	266	90.2
Ever married	177	85.9
Religion		
Christian	380	88.2
Muslim	63	89.9
Have formal education		
Yes	411	89.5
No	32	76.2
Worked for salary/profit		
Yes	191	86.0
No	252	90.3
Know the service is Provided free of charge **	N=380	
Yes	277	93.3
No	103	80.5

Annex 1-Table 2. Readiness to tell (declare) the decision to be tested for HIV among the study population, Assosa town, Benshangul Gumze National Regional State; March 2002

Socio Demographic Variables	Ready to declare the decision to be tested **Number**	**Percentage**
	N=339	**%(66.9)**
Sex		
Male	192	66.4
Female	147	67.4
Age		
15-19	112	67.5
20.24	85	68.0
25-29	70	64.8
30-49	72	67.3
Marital Status		
Never married	201	66.8
Ever Married.	138	66.9
Religion		
Christian	285	65.2
Muslim	54	77.1
Have formal education		
Yes	311	66.9
No	28	66.7

Annex 2: Case Studies

Case Study One

Ayelech is a 30 old petty trader living in Assosa town. She had tested for HIV some months ago following a teaching on HIV/AIDS by a religious leader. She had no problem in convincing herself to take the test. However, the test result was not what she expected. It turned out to be positive. When describing what had happened to her when she learned her positive status Ayelech said, "I went to the hospital to prove that I am HIV negative status, however the reverse happened. Immediately after receiving the result, I felt an irreversible change is going on in my life. I had a vision to establish a family and lead a happy life. But I am unfortunate to get what I dreamt for. Initially I was extremely stressed however with the help of my faith and the counseling and support I got from the hospital staff I overcome the stress I lived within the first few weeks of the incident ".

Soon after learning her HIV positive status Ayelech decided to teach others about the disease and become the first and only women in Assosa town to openly talk about her condition. When explaining how she reached on the decision she said, " My motive in doing so is saving the young generation who could be affected by the virus due to lack of awareness". Soon after declared her HIV positive status, Ayelech called her siblings who are living in Addis Ababa and informed them about her situation but asked them not to tell their

mother. " I told my sisters and brothers that I am HIV positive, but I decided not to tell our mother because of the effect it would have on her".

To Ayelech, the response of the community to her open declaration of her situation was dreadful. She lost her business and feels rejected by her community. When describing what has happened to her following openly talking about her HIV positive status Ayelech said, "Some people considered me that I am mad, others looked at me as if I am a creature new to them. Even my friends gradually avoided me. Previously I used to earn my living through working as a petty traders selling "Gesho" in a local market. After I declared my HIV positive status and started reaching others, people started to come to where I am, just to look at me, they gossip about me and point their fingers at me. They even gone further and took my photo while I was sitting in a market place. Even if the society treated me badly, I tried to maintain my businesses for about two months, but when I reached to a point where no body is buying my commodity. I decided to stop the business from which I used to earn my living. What other choice do I have except getting out of the business when no body is willing to buy the commodity I used to sell?

"My decision to openly tell my HIV positive status did not only affect my life but also affected the life of my brothers who are still young and living with me. People point fingers at them and their friends rejected them. In order to relive the distress they are forced to live with, I decided to live away from them in a

separate house. It is not the virus that is affecting me more but the stigma attached to it. I wish that our community would accept us. I wish they could understand me that I did not choose to be infected with the virus.

At present I am dependant on the regular financial support I get from the Regional Disaster Prevention and Preparedness Bureau. I also earn some amount of money as allowance whenever I teach the public about HIV/AIDS. But that is not enough. I have still to pay house rent, and cover all living expenses to myself and my two brothers who are dependant on me. Furthermore, When I feel sick sometimes I have to buy the drugs prescribed by physicians that are not usually available in the hospital pharmacy.

Ayelech has a strong belief that the HIV/AIDS related education that is being given in Assosa town is not strong enough to reach the community at a grass root level and bring the desired behavioral change. "People are not well informed about the disease. In many occasions I come across people who are not willing to hear about HIV and I heard many people denying about the existence of the problem in our area. There are people who will go to the extent of plugging their ear with their fingers whenever they hear about the disease; you cannot believe how much people are in a denial the fact. Even there are people who are well informed about HIV/AIDS but are involved in risky behavior".

When describing what she feels about the situation of HIV/AIDS in Assosa town Ayelech said," though not proven by blood test, we all know that there are a lot of people who are sick from HIV and confined to bed. In one Kebele here in Assosa I know that there are more than 20 children who lost both parents from AIDS. Imagine what would happen after two years."

Ayelech further said that, lack of awareness about the disease makes AIDS a stigma in her community. She noted that because of the fear of catching the disease people are not willing to enter into the house where an AIDS patient sleeps and it is common to observe that as much as possible people avoiding making any contact with people have the virus. When she describe what has happened to her, Ayelech said, "People are cool inside; they are not as friendly as before. You can observe and feel that they are not the same people you know in the past. People, who previously were hugging me when we meet, are not willing even to shake my hand. This is traumatizing."

"For me, those who distance themselves from PLWHA are those who are not well informed about the way the virus is transmitted. This way I do not believe that they have enough knowledge to be protected from AIDS. "

"I can tell you that people are not only afraid of being HIV positive but they are also afraid of the name AIDS. Even when they are sick with malaria, they are not willing to give their blood for malaria test. They are afraid of positive result.

Seeing what is happening to others, I have a strong feeling that many people in Assosa will not be willing to be tested and know their HIV status. When you ask them why they do not do volunteer for HIV test, many people would tell you that they would rather die without taking the test."

"The fear that strap our society emanates from our ignorance of the situation, in this regard we have to teach people about the situation and tell them that they have to contribute for the containment of the dissemination of the virus. People have to be informed that they should not ostracize PLWHA. "

For Ayelech, caring for PLWHA is everybody's responsibility; "It is difficult to say that this body is responsible for providing care and support for PLWHA. As to me if everyone takes the responsibility of providing the needed care and support for PLWHA, we can avoid the act of carelessness and revenge which we are observing from people who are affected by the virus.

Case Study Two

Kibru is a young man in his early 30's and a divorcee. He was almost certain that he has virus when he decided to be tested for HIV some six months ago. Describing his situation before the test he said, " I regularly go to the local church and attend teachings of religious fathers. When AIDS and the importance of giving care and support for AIDS patients is discussed during and after religious teachings, the feeling of checking my HIV status crossed my mind, but took me some days to reach at a decision to be tested. When finally I decided and went to the hospital for the test I had no doubt that my test result would be positive. This is because I had unprotected sex with many women and the woman who was my wife for some years had also similar experience. Furthermore, for sometimes before the test, I had frequent bouts of illnesses which I could not give explanation for. For these reasons, when the counselor told me that I am HIV positive, I was not surprised rather calm".

When explaining what he did after he knowing about the result Kibru said, "First I wanted to confine my situation only to one person and informed the result to my close friend. He helped me with every thing. Latter when I learned that other people are aware of my situation, I decided to make my HIV positive status open to the public and play a leading role in teaching my community members about HIV/AIDS".

When describing how the society accepts the news that he is HIV positive Kibru said "My first encounter with the public was when I went to teach commercial sex workers about the HIV/AIDS. When I told them that I am HIV positive, some of them cried and were very supportive. In many occasions I had difficulties, many believed that I am lying. Some wrote me a letter to stop teaching about HIV. Few people have further gone to telling my landlady to evict me from the house she has rented me, which she refused to do so. I have also faced one worst incident in which people told my friends to isolate me because I can contaminate them with the virus. Though not totally rejected me, my friends are not treating me properly; they consider me as a different person. I know that they are slowly distancing themselves from me".

Kebru has a feeling that HIV/AIDS education that is being place in Assosa town is not adequate to bring about a proper awareness and behavioral change among community members. " There are people who believe that there is no AIDS. Some people say that the condom itself has HIV. Still others are not well aware of the ways the virus is transmitted. Members of our community do not differentiate between AIDS patients and People Living With HIV. For example, they considered me as an AIDS patient."

"Many of my friends died due to illness that looks like HIV/AIDS but a completely different reason is given by families. In this regard I can say that people are not comfortable to openly talk about AIDS."

Kibru believes that if people started to show their kindness and give care and support for those affected by the virus and to AIDS patients, then, others will be willing to be tested, declare their HIV status and contain the epidemic. He also indicated that, openly talking about the virus and teaching people how the virus is transmitted and could be prevented as well as making AIDS an open agenda would help people to reveal their HIV status.

For Kibru teaching about the virus is saving his community from HIV/AIDS and is a priority. When describing what he is aimed at, he said, " I am not worried about myself, because, already contracted the virus and I promised to God not to be the cause for the suffering of others. But, worried for those who are affected by the disease due to lack of adequate information."

To attain his wish, Kibru is working with other concerned people to establish Association for people living with HIV/AIDS in Assosa town. According to him, the association will help to perform an organized prevention and support activities in Assosa town. " We have to work hard so as to bring behavioral change and control the dissemination of the virus. I believe that, if we all work together we can contain the virus."

Annex 3: Focus group Discussion Protocol

Introductory Remarks

Good morning/Good afternoon, thank you for coming and for your willingness to participate in this discussion.

My name is_____and my colleges name is _____

I am a postgraduate student in demography at the Addis Ababa University, and currently conducting a study on Voluntary Counseling and Testing services in Assosa. The main objective of the study is identifying factors that affect the acceptability of VCT services in Assosa town and the perception of the community towards care and support for People Living With HIV/AIDS.

In an attempt to ensure the high quality of the study the information is being carried out using two approaches from the residents of Assosa town. The first is a household survey using questionnaires, and for which trained data collectors have already started filling the questionnaires by going from house to house. The other is by discussing important issues in the area with selected members of the community. This session is thus the part of the second approach of the supposed information gathering

The Benefit of the Study

The information obtained from this discussion will give us better insight about what is happening in Assosa town on issues like HIV/AIDS, Voluntary Counseling and Testing and Care and Support for People Living With HIV/AIDS. Though a limited forum, it will allow participants to share ideas and exchange information about the current burning issues like HIV/AIDS, and at the same time could create a common understanding for further action, which is much needed among community members. Furthermore, the conclusions and recommendations that would be drawn from the study will help the regional government and other involved parties on how to improve the HIV/AIDS teachings, the utilization of VCT services and care and support activities for PLWHA.

Confidentiality

We would like to assure you that the information you would be providing us will not be made public or shared with anyone in a way that would reveal identity. So we cordially ask you to give us your view on the issues under discussion with full confidence and without reservation of any kind.

Discussion rule

As there is no right or wrong answer for the questions that would be posed or issues raised, please feel free to forward anything you would like to say about the topic under discussion. The views of every discussant are equally valid, so all have equal right to forward his/her opinion, comment and suggestion. If any of the participants opposes your view or comments, please do not take it personal. If the questions we are going to pose are not clear, please do not hesitate to ask for clarifications.

To make sure that every body has equal chance to participate in the discussion, we will take the lead role in facilitating the discussion.

- Do you know about the virus that causes AIDS or HIV?
- From where do you frequently hear about HIV/AIDS? What do you think the reasons for this are?
- How do you see the extent of HIV/AIDS among the residents of Assosa town?
- In Assosa town, which organizations or individuals are involved in teachings about HIV/AIDS?

Voluntary Counseling and Testing for HIV

- Is there any way that a person can check whether he/she has the virus in his/her body?
- Is there any place in Assosa town where a person can check his/her HIV status? Can you specifically tell me where the place is?
- Have you heard about Voluntary Counseling and Testing (VCT) service in Assosa town?
- Is the service provided on payment or free of charge? How long does it take?
- Do you know people who volunteer for the test and get tested?
- In you view, which sections of the population need the test most? Why?
- If many people are not volunteering for the test can you tell me the reason?
- Is getting tested difficult? Have you heard about problems people face in getting the test?
- Can you tell me the benefit of having the test?
- Do you have a plan to be tested in the near future? If yes when? If no, why not?

Care and Support for People living with HIV/AIDS

- Do you know that there are people who are living with HIV/AIDS in Assosa town?
- Do you think many people are affected by the problems (the virus/ the disease)?
- From where did you get the information?
- How are people who are known to have AIDS treated in their community?
- Who provide the PLWHA with care and support they require?
- From your perspective whose responsibility is providing care and support for PLWHA?

General

- Do you have any question to ask me related with the issues under discussion?
- If you have any recommendations or suggestions related to the HIV/AIDS teachings, VCT service and care and support activities, please for ward it.

Organizational involvement in HIV/AIDS

- How is your organization involved in HIV/AIDS related activities that are being taking place in Assosa town?
- Are you involved in care ad support activities for PLWHA?

Annex 5: Focus Group discussants and in-depth interview Participants

Source , number of participants, place of discussion and time taken to conduct each discussion

	Participants	Number of participants	Place	Duration
	Focus Group Discussion			
1	Commercial Sex Workers (Group one)	Eight	Anti AIDS club office	70 Minutes
2	Commercial Sex Workers (Group two)	Six	Anti AIDS club office	85 Minutes
3	In school youth (Male group)	Nine	Assosa Junior School	55 Minutes
4	In school youth (Female group)	Nine	Assosa Junior School	65 Minutes
5	Out of school youth (Male group)	Ten	Anti AIDS club office	70 Minutes
6	Out of school youth (Female group)	Nine	Anti AIDS club office	70 Minutes
7	Community and religious leaders (group one)	Eight	Compound of the Orthodox church Synod	45 Minutes
8.	Community and religious leaders (group one)	Eight	Compound of the Regional Muslim Council	75 Minutes
	In-depth Interview			
1	People living with HIV/AIDS	Two	Anti AIDS club office	45 Minutes each
2	Commercial Sex Worker	One	Hotel	50 Minutes
3	Leader of an NGO	One	Hotel Compound	60 Minutes
4	Government employee/officials	Five	Office of education bureau and Regional DPPC	45 minutes each
5.	VCT center staff of Assosa hospital	Two	Assosa Hospital VCT center	60 minutes

Annex 6: Questionnaire

Questionnaire for the study "Accessibility and Acceptability of VCT Service in Assosa Town, North Western Ethiopia"

	Name of the data collector Name of the supervisor			
	BACKGROUND INFORMATION			
No		**Coding Categories**		**Skip To**
01	Address of the respondent	Kebele: _____ House Number: _____		
02	Sex	Male 1 Female 2		
03	Age	_____ Years		
04	Relation with the head of the household	Head .1 Wife .2 Relative .3	Son/Daughter. 4 Housemaid. 5 Other, Specify	
05	Current Marital Status	Never Married.1 Married. 2 Divorced.3 Widowed.4	Separeted.5 Other, Specify	
06	Religion	**Orthodox .1** **Protestant. 2** **Catoholic.3**	Muslim .4 Other Specify. 5	
07	Do you know how to read and write in any language?	Yes.1 No .2		
08	Have you ever attended school before?	Yes.1 No.2		
09	If the answer for question 08 is yes,	1-6 grade.1 7-8 Grade.2 9-12 grade.3 12+.4 Other, Specify		
10	Have you or are you working for pay or profit in the last two weeks?	Yes.1 No. 2		
11	If the answer for question 10 is yes, specify the type of work you are involved in?	Government .1 employee Student .2 Self employed .3	Employee of. 4 private firm Driver. 5 If other specify	
12	If the answer for question number 10 is no, why not?			
13	Do you have a functional radio at home?	Yes 1 No 2		

KNOWLEDGE OF AIDS

14	Have you ever heard of a disease called HIV/AIDS?	Yes 1 No 2	**If the answer is no skip to Q # 34 for unmarried & c # 69,a to Married**
15	From which sources of information do you mostly hear about AIDS? Any other sources? RECORD ALL MENTIONED	Radio .1 Television .2 Newspapers/magazines .3 Pamphlets/posters .4 Health workers .5 Churches .6 Mosques .7 Schools/teachers .8 Community event .9 Friends .10 Parents/family .11 Work place .12 Drama/performance .13 World AIDS day .14 Other (specify)	
16	How is HIV transmitted from one person to another?	Sexual intercourse 1 Sharing sharp objects like blade and needles 2 Mother to child 3 Mosquito bites 4 Shaking hand with People Living With HIV/AIDS Kissing 6 Sharing toilets. 7 If others, specify	
17	Is there anything a person can do to avoid getting infected with HIV, which is the virus that causes AIDS?	Yes 1 No 2 Don't know 3	**If no Skip to Q # 19**
18	What can a person do? Anything else? RECORD ALL MENTIONED	Abstain from sex 1 Use condoms 2 Limit sex to one partner/stay faithful to one partner 3 Limit number of sexual partner 4 Avoid sex with prostitutes 5 Avoid blood transfusion 6 Avoid injection with unclean needles 7 Avoid kissing .8 Avoid mosquito bite .9	

		Avoid sharing razors/blades .10 Other (specify)	
19	Is it possible for a healthy looking person to have the AIDS virus?	Yes .1 No .2 Don't know .3	
20	Can the virus that causes AIDS be transmitted from a mother to a child?	Yes .1 No .2 Don't know .3	**If no Skip to Q # 22**
21	If you say yes to Question 20, when can the AIDS virus be transmitted from a mother to her child? Any other times? RECORD ALL RESPONSES	During pregnancy 1 At delivery 2 During breast feeding 3 Other times 4 Don't know 5	

RISK PERCEPTION, BEHAVIOR CHANGE AND ATTITUDES TO PERSONS WITH HIV/AIDS

22	Do you know someone personally who has the virus that causes AIDS or someone who died from AIDS? Either in the family or in the community,	Yes 1 No 2 Not sure 3	
23	What are the chances that you might catch HIV? Would you say there is no chance, a moderate chance or high chance?	No chance 1 Moderate chance 2 High chance 3 Don't know 4 Already infected 5	
24	Have you personally made any changes in your sexual behavior to avoid HIV transmission?	Yes 1 No 2	**If no, skip to Q # 26**
25	If you have made changes, When did you start making these changes? Within the last 6 months or before?	Within 6 months 1 6-11 months 2 Before twelve months .3	
26	Would you be willing or not willing to take care of a family member with AIDS?	Willing 1 Not willing 2 Don't know 3	
27	If the answer for question 26 is 1&2 is Why?		
28	Have you ever talked about ways to prevent getting the AIDS virus with your family/parents?	Yes 1 No 2 Don't know 3	
29	Have you ever talked about on how to prevent getting the AIDS virus with your sexual partner? (If married or has sexual partner)	Yes 1 No 2 Have no sexual partner/not married 3	
30	In your community how are people living with HIV or AIDS patients treated?		
31	Should persons who know they are infected with HIV be entitled to keep this fact secret from the community	Entitled to keep secret 1 Should be revealed 2	

	where they live or should this information be revealed?	Do not know 3	
32	Should persons with HIV who work with other people, such as in a factory or an office, be allowed to continue their work or not? (**In your opinion**)	Allowed 1 Not allowed 2 Don't know 3	
33	Should persons with AIDS receive less, the same or more health care than other seriously ill persons?	Less .1 Same .2 More .3	

QUESTION NUMBER 30 TO 33 IS TO BE ASKED FOR NEVER MARRIED RESPONDENTS

34	Do you have a boy/girl friend?	Yes .1 No ..2	
35	Have you ever had sexual intercourse with him/her ?	Yes. 1 No. 2	
36	If yes for Question 35, do you use condo during the intercourse?	Yes. 1 No. 2	
37	Do you have more than one sexual partner?	Yes. 1 No. 2	
38	Have you had sex with other people other than your regular sexual partner?	Yes. 1 No. 2	
39	If yes for Question 38, do you use condo during the intercourse?	Yes. 1 No. 2	

VOLUNTARY COUNSELING AND TESTING (VCT)

VCT is getting HIV testing service voluntarily, with pre-test and post-test counseling

40	Do you know that a person can check whether or not he/she has the AIDS causing virus in his/her blood?	Yes. 1 No. 2	
41	Is such a service is available in Assosa town?	Yes. 1 No. 2	
42	Do you know that the service is available elsewhere in the country?	Yes. 1 No. 2	
43	If yes to Question 41, can you tell me where specifically the service is available in Assosa town?	Hospital.1 Health center.2 Health Station .3 Private clinic .4 I do not know .5	
44, a	How long will it take to reach the nearest center where the service (VCT service) is available ?	In Hours_____	
44, b	How far should you travel to reach the nearest VCT center?	In Kms. _____	
45	From the information you have, how much (time) will it take to have the test result?		
46	Is the service provided free of charge or on payment bases?	Free of Charge .1 On payment bases.2 I do not know .3	

47	If you say, on payment bases for question 46, how much does it cost to have the test?	In Birr_____	
48	What other services are provided to the people together with the HIV test?	Pre test counceling.1 Post test coucenling.2 . Care and support. 3 If other, Specify	
49	In your opinion is it necessary to test a persons blood for presence of the AIDS causing virus?	Yes, it is necessary 1 No, it is not necessary 2	
50	If you think it is necessary, what would be the importance?	To know if a person is infected 1 To be careful in future 2 Other (specify 3	
51	If you think the service is not necessary, what is your reason? Can you specify the reason?		
52	When should a person be tested for the HIV?	Any time 1 During sickness 2 Before marriage 3 Other (specify)	
53	If HIV blood testing and counseling service was offered free of charge, in your opinion what kind of people should be tested first (get the priority for VCT?) Who else? RECORD ALL ANSWERS	All people .1 Commercial sex workers .2 Drivers .3 Students .4 Pregnant women .5 Adult men .6 Children .7 People preparing for marriage .8 Other (specify)	
54	What should a person do if the test result indicates there is HIV in the blood? What else? RECORD ALL ANSWERS	Abstain from sex .1 Avoid pregnancy .2 Avoid marriage .3 Get divorced .4 Use condoms .5 Seek medical care .6 Other (specify).7	
55	What should the sexual partner (spouse) do? What else? RECORD ALL ANSWERS	Abstain from sex .1 Avoid pregnancy .2 Avoid marriage .3 Get divorced .4 Use condoms .5 Seek medical care .6 Get HIV testing .7 Give care and support .8 Other (specify)	
56	What would yourself do if your test result indicates there is HIV in your blood? What else? RECORD ALL ANSWERS	Abstain from sex .1 Avoid pregnancy .2 Avoid marriage .3 Get divorced .4 Use condoms .5 Seek medical care .6 Other (specify).7	

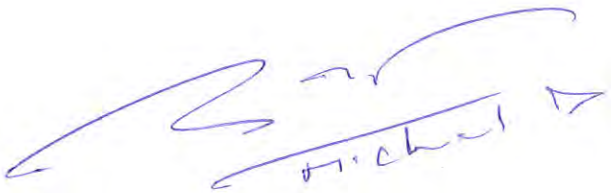
57	What would you do if your sexual partner (spouse) turns HIV positive? What else? RECORD ALL ANSWERES	Abstain from sex .1 Avoid pregnancy .2 Avoid marriage .3 Get divorced .4 Use condoms .5 Seek medical care .6 Get HIV testing .7 Give care and support .8 Stop all relationships .9 Other (specify) .10	
58	If HIV blood testing and counseling service was offered free of charge, would you be willing to undergo the VCT.	Yes .1 No .2	
59	If the answer of question number ***58 is No*** what is your reason?		
60,a **60,b**	If HIV blood testing and counseling service was offered free of charge, would you allow your sex partner to undergo the VCT. What about your child? Your maid? Your friend?	Yes 1 No 2 Child_____ Maid_____ Friend_____	
61	If HIV blood testing and counseling service was offered free of charge, would you ask your sex partner to undergo the VCT.	Yes 1 No 2	
62	If the answer of question number ***61 is No*** what is your reason?		
63	If HIV blood testing and counseling service were offered for a small amount of charge, would you be willing to pay the cost and undergo the VCT.	Yes 1 No 2 If the answer is no	**If no skip to Q. 65**
64	If you would be willing to pay for VCT, how much would you pay?	Birr_____.	
65	If you are not willing to pay for the service what is your reason?		
66	Do you think that testing for HIV is something scary?	Not scarring 1 Scarring 2 Very scarring 3	
67	Can you tell me the reason why you said that testing for HIV is scary?		
68	When people hear that some body has decided and gone to be tested for HIV, what would be their reaction?		
	Care and Support for PLWHA		
69	Do you believe that people Living With HIV/AIDS require special care and support?	Yes .1 No .2 I do not know .3	
70	What type of care and support service people with HIV/AIDS require?		
71	In your opinion, who is responsible for providing such care and support service for People Living With HIV/AIDS?		

CONDOMS			
72,a	Have you ever heard of a condom?	Yes 1 No 2	
72,b	What type of condoms have you heard off?		
73,a	Have you ever seen a condom?	Yes 1 No 2	
73,b	What type of condoms have you seen of?		
74,a	Have you ever used condoms?	Yes 1 No 2	
74,b	What type of condoms have you used of?		
75	What do condoms do?		

DECLARATION

I, undersigned declare that this thesis is my original work, has not been present for a degree in any other university and that all sources of materials used for the thesis been duly acknowledge.

Name: Michael Dejene Bejiga

Signature: 

Place: Addis Ababa

Date of Submission: 27 June 2002

Dr. Tesfay Teklu		July 1, 2002
Advisor	**Signature**	**Date**