

**Assessment of Couples Voluntary Counseling
and Testing Service Utilization at Addis Ababa
Government Hospital VCT Sites**

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List of Abbreviations

AIDS	Acquired immuno deficiency syndrome
AOR	Adjusted Odds Ratio
BCC	Behavioral change communication
CDC	Center for disease control
CVCT	Couples voluntary counseling and testing
FGD	Focus group discussion
HC	Health Center
HIV	Human immuno deficiency virus
IEC	Information education and communication
IVCT	Individual Voluntary counseling and testing
OR	Odds Ratio
VCT	Voluntary counseling and testing
WHO	World Health Organization

Abstract

Background: Couples Voluntary Counseling and Testing (CVCT) is an effective HIV prevention strategy for couples who represent the largest risk group in Africa. In this region, less than 1% of couples tested for HIV. Of the estimated 100 infections per day in many African countries 70% occurs in cohabiting couples. In Ethiopia, there are only few couple based VCT studies conducted. Narrowing the gap of knowledge in these matters will help as a baseline for other studies. Furthermore it helps in forming strategies and specific interventions to deal with drawback of CVCT program.

Objectives: The aim of this study was to determine the magnitude of couples coming to VCT centers and to assess the factors associated with use and non-use of CVCT services in Addis Ababa.

Methods: A cross sectional study in 6 government hospital VCT sites in Addis Ababa city was conducted in the month of April, 2007.

Using quota sampling method, the 875 individuals who fulfilled the criteria who took VCT/CVCT service were included in the study consecutively until the required sample was obtained. Data was collected using standard interview questions. For supplementing the quantitative results, 4 Focus group discussions among VCT users were conducted. To explain the study population in relation to relevant variables, frequencies and summary statistics were used. Association between dependant and independent variable was assessed and presented using odds ratio and confidence interval. Logistic regression was used to control possible confounders.

Result: Out of all 771 study participants, 14.5% were couples. The HIV infection rate was 21%. Based on the adjusted regression, the respondents who were in the primary education(1-8) level were four times likely to use CVCT service than those respondents who never had a formal education with AOR(95%CI): 3.88 (1.22,12.30). Adjusted for the other variable, those study participants who used condom occasionally, during sexual intercourse with their regular partners, were five times more likely to use CVCT service than those who never used condoms with AOR (95%CI): 4.50 (1.33-15.31). Respondents who claimed to never heard

about CVCT service utilization were less likely to use CVCT service compared to those who did with AOR (95%CI) 0.29(0.13-0.65).The participants who had no history of HIV testing were less likely to use CVCT service than those who had with AOR (95%CI) 0.44(0.27-0.71).The knowledge of participants on HIV and other STIs had no significant association with CVCT service utilization. The most common reason claimed by the respondents for not using CVCT service during the study was because the partner already knew the result.

Conclusion and Recommendations: The prevalence of couples VCT service utilization in Addis Ababa VCT sites is low. Frequent, clear and accurate media-based information programs using multiple languages are needed to increase access to information on VCT, with particular attention to the importance of VCT for couples. And other Specific approaches to promote CVCT service is needed to be developed service through appropriate researches.

1. INTRODUCTION

1.1. Background

One intervention that has demonstrated effectiveness in reducing risk behavior and HIV incidence is a programme of voluntary counseling and testing service (VCT) (1). Couples Voluntary Counseling and Testing (CVCT) is an effective HIV prevention strategy for couples who represent the largest risk group in Africa. In this region, less than 1% of couples tested for HIV (2, 3). In VCT sites more than 70% of clients present as individuals, and most of these do not know the HIV status of their partners (4, 5). In Kenya, couples constitute 8-10% of all clients at a VCT centre at a major referral hospital (6). In Ethiopia as shown in a report on VCT centers in Addis Ababa (2002), 9.4% were couples (7).

While CVCT reduces stigma, and helps couples to plan their future in an informed manner, it is an important intervention because as many as 30% of couples in high HIV prevalence countries are sero-discordant or have one partner who is infected with HIV and one who is not (8). In the impact of VCT among couples, data from Zambia and Rwanda cohort studies showed that among HIV+/- discordant couples, HIV heterosexual transmission was decreased by 50%. In both HIV positive couples, gonorrhea and trichomonas rate was decreased by more than 50% and in both HIV negative couples, new infection reduced by more than 70% (2).

Stigma, fear of a HIV positive result, lack of treatment options and concerns about confidentiality are still major barriers to seeking VCT in all countries

studied. Motivations for seeking VCT services include planning to get married, perceived benefits of HIV testing, and perceptions of risk. The social meaning of HIV testing and what partners ascribe to these meanings are important barriers in the decision to undergo testing and whether to involve a partner in the testing experience (9).

Over 80% of adults living with HIV reside in sub-Saharan Africa, of which greater than 85% of adult HIV infections are due to heterosexual transmission and more than 80% of urban adults HIV positive are in steady cohabiting union and have children (10). Of the estimated 100 infections per day in many African countries, 70% occurs in cohabiting couples (1). Most HIV prevention programs in Africa focus on reducing the number of casual sexual partners, using condoms during casual sex, and increasing faithfulness among married partners. However most HIV infections in sub-Saharan Africa occur during heterosexual intercourse between persons in couple relationships, many of whom do not realize that only one may be HIV infected (1,10). Women, who are infected by HIV sero-positive partners, have high risk of infecting their infants in turn. For persons in an HIV-discordant relationship encouraging monogamy without safer sexual behavior will not decrease the risk of HIV transmission (1).

1.2. Rationale of the Study

Experiences in sub-Saharan Africa reveal that VCT and VCT for couples in particular have a great deal to offer current prevention efforts but numerous questions remain unresolved (11). Our understanding of sexual relations and risk reduction with sexual partners in sub-Saharan Africa has not improved. More research is needed on risk behaviors and risk prevention by men and women in couple relationships (11, 12). Factors associated with successes and failures of couples with HIV prevention need to be studied and clarified. Data on risk factors are commonly collected but very little is known about communications within couples. Learning from the experiences of couples over time will be essential for more effective VCT and support interventions for couples in sub-Saharan Africa. (11).

It is particularly important that social/behavioral research identify strategies that couples develop themselves for dealing with HIV risk and the knowledge of personal sero-status as well as the features that different couples share in common. Information of this kind would be most useful for ensuring that external prevention and support interventions reinforce strategies which, because developed by couples themselves, are more acceptable to them. Assessment of strategies for disseminating VCT information to and recruitment of couples to VCT, Operational research is needed to assess effective methods for disseminating HIV prevention information targeted to couples (11).

In Ethiopia, the fact that there are few studies conducted on why there are few number of CVCT clients and no strategies being tried to alleviate the problem, couples being high risk group, creates a gap in reaching the goal of Millennium development goal (MDG) to decrease HIV incidence.

Thus, this study tried to assess the extent of utilization of the service in Addis Ababa selected VCT sites and factors associated with use of VCT service as a couple or individual. Narrowing the gap of knowledge in these matters helps as a baseline for other studies. Furthermore it helps in forming strategies and specific intervention to deal with drawback of CVCT program.

2. LITERATURE REVIEW

2.1. Background

Despite their salience as social contexts for sexual activity and HIV infection, couple relationships have not been given adequate attention by social/behavioral research in sub-Saharan Africa. Increasingly, studies point to the value of VCT as HIV prevention tool (11, 13).

Over 80% of adults living with HIV reside in sub-Saharan Africa, of which greater than 85% of adult HIV infections are due to heterosexual transmission and more than 80% of urban adults HIV positive are in steady cohabiting union and have children. Of the estimated 100 infections per day in many African countries 70% occurs in cohabiting couples (1).

As analyzed in the study of the secondary data, according to the records of clients had their blood tested following pre-test counseling, of which 25% had test results that turned out to be HIV positive (14). Currently, the 2005-06 data showed that the prevalence HIV of Addis Ababa VCT clients is 11.7 % (15).

HIV prevalence of VCT clients varied by marital status. Ever married clients are more likely to be HIV+ than never married ones. HIV prevalence for never married clients was estimated at 17.6% as opposed to currently married 30.9%. A significantly higher prevalence was found among clients whose marriages ended by divorce/separation (42.9%) and death of partner (61.8%) (14).

Other findings reported that men, women, and couples who enrolled in the Voluntary Counseling and Testing efficacy study at the study site in Nairobi, Kenya, 21% tested at baseline were found to be infected with HIV. Among women, most likely to be infected were those in steady relationships enrolling as a couple member (40%seropositive). Those least likely to be infected were not married women enrolled in the study as a couple members (17%). Among men, those most likely to be infected were married men enrolled as a couple member (20% sero-positive), and those least likely to be infected were not married men enrolling as a couple member (0% sero-positive). Of the 258 couples who received VCT at baseline, 20 were sero-discordant (16).

Studies in Africa frequently reported that VCT is associated with reduced risk behaviors and lower rates of sero-conversion among HIV sero-discordant couples (11,17,18 and 19). Many of these studies point out that VCT has considerable potential for HIV prevention among other heterosexual couples, and recommend that VCT for couples be practiced more widely in Africa. However, follow-up in the area of VCT for couples has been extremely limited. Thus, current understandings from social/behavioral research on how couples in sub-Saharan Africa manage HIV risks as well as HIV prevention interventions to support couples' HIV prevention efforts have remained underdeveloped. It appears that important opportunities are being missed for preventing HIV infection, be it by heterosexual transmission or mother-to-child HIV transmission by mothers who have been infected by their partners (11).

Broad-based HIV/AIDS information programs, be they referred to as Information Education and Communication (IEC) or Communications for Behavior Change (BCC), and which use the electronic and (to a lesser extent) printed media to promote HIV/AIDS awareness and behavior change, have been common in sub-Saharan Africa since the mid - 1980s (11). Typically these programs are directed toward an undifferentiated public or categories of individuals that are identified as more inclined to engage in higher-risk sexual behaviors. Messages may, for example, encourage men as members of a gender category to use condoms with non-regular sexual partners, particularly female sex workers. Media messages are less likely to address details of condom use with the wives or other regular sexual partners. Media programs that depict two heterosexual partners together are more often concerned with the technicalities of safe sex (proper condom use) than with processes of communication and negotiation that affect HIV risk and prevention efforts by couples. While media-based programs may occasionally describe voluntary counseling and testing, they infrequently provide specific messages for couples and are characterized by unidirectional information flow. While media based efforts by national AIDS programs in sub-Saharan Africa have contributed to increased levels of HIV/AIDS awareness and some improvements in knowledge about HIV/AIDS, their impact on behavior change outside a few high-risk categories (e.g., female sex workers) has been much more reserved (20).

2.2. Magnitude and Significance of CVCT

In Africa, only less than 1% of couples tested for HIV (2). In Uganda, at VCT sites more than 70% of clients present as individuals, and most of these do not know the HIV status of their partners (4). In Kenya, Couples constitute 8-10% of all clients at a VCT centre at a major referral hospital (6). This is similar with the case of Ethiopia's as shown in a report on VCT centers in Addis Ababa that 9.4% were couples (7). In Mozambique's largest VCT sites only 5% were couples (21).

VCT is a key component in HIV prevention and care programs. The need for VCT is increasingly compelling as HIV infection rates continue to rise and; countries recognize the need for their citizens to know their sero-status as an important prevention and intervention tool. In the prevention aspect, VCT helps people to learn about how HIV is transmitted, practice safer sex, get HIV test and, depending on the result, take steps to avoid becoming infected or infecting others. With in the care and support programs, HIV test results and follow up counseling mean people can benefit from care and support services. It is emphasized that access to VCT is recognized as a critical strategy for responding to HIV/AIDS in low and middle-income as well as in high-income countries. VCT for HIV/AIDS is included as one of the strategies HIV/AIDS prevention approved national HIV/AIDS policy and was considered as one of the priority intervention areas with the general objective of serving as an entry point for HIV prevention by creating more personal awareness (11).

CVCT allows sexual partners to learn their HIV status together as a unit. It is offered at VCT sites but may also be offered in other settings as well, such as prenatal clinics. Counseling sessions focus on discussing risk issues and concerns, risk reduction, and linkages to care, treatment, and support. Pre- and post-test counseling sessions focus on recommending and offering the HIV test, obtaining informed consent, using the test results to make medical care decisions or recommendations, and providing appropriate referrals (11).

By comparison, the needs of married and cohabiting couples have been neglected despite the fact that, in generalized HIV epidemics, many infections occur within marital and cohabiting unions because of either prior infection by one partner or infidelity (22). Estimates of HIV transmission rates in African discordant couples who do not know their HIV results range from 20 to 25% per year. This fits well with a per heterosexual exposure transmission risk of 1/500 to 1/ 1000 multiplied by a frequency of sex of two or three times per week (23).

Recent studies have shown that VCT is a cost-effective intervention for reducing HIV-related risk behaviors, particularly when applied to at risk-couples (24). A study showed that VCT to be a very cost-effective intervention in urban East African settings. The cost analysis was based on client infection status, sex, and whether VCT was received as an individual or as a couple. VCT was estimated to avert 1,104 HIV-1 infections in Kenya and 895 HIV-1 infections in Tanzania during the year after receiving VCT. In addition targeting VCT to persons likely to be infected with HIV and couples significantly enhance cost effectiveness (25).

According to a study conducted from 1998-1999 G.C in Ethiopia, on HIV incidence among a cohort of study participants indicated that, HIV-VCT utilization decreases the incidence of HIV infection (14).

Even though individual level approach is useful; it may not adequately target or characterize the effects at the level of the sexually active couples. Providing HIV test results to couples during a joint counseling session has considerable benefits over individual counseling (1, 26). Of particular concern to the HIV epidemic in Africa, is the possibility of transmission within the context of an ongoing heterosexual relationship. Transmission rates in sero-discordant heterosexual couples can range from 2.3 to 10.7 per 100 person-years, depending on condom use and the direction of transmission (1).

In a record review of data on 2001 - 2004 in Addis Ababa, Kassanchis Health Center showed that sero-positivity for HIV was higher among married clients tested than those who were not married (14). Though an important component of VCT programs is encouraging clients to inform partners of their sero-status, yet many clients do not disclose results to partners according to a study done in Illubabor Zone, Southwest Ethiopia (27). Moreover, among those who tested and got results perceive that their partner also have the same result according to a study done in behavioral survey in Uganda (28). In the case of Ethiopia, it is very hard to know how much this problem contributes to the increment of the HIV prevalence and there are few studies conducted on the magnitude of the service.

2.3. Factors that Affect CVCT Utilization

Among people attending VCT at Bethzatha Clinic in Addis Ababa, it was reported that, the majority of respondents gave reasons for testing to know their status while about 10% sought the services for pre-marital check ups (14). A range of studies conducted in different settings indicated that sex, race, education, occupation and risk perception are the main determinant factors for seeking HIV testing (29, 30).

Out of the individuals who underwent civil marriage, about 55% reported having had pre-marital HIV testing. The main reason given for not having HIV testing was that the interviewees did not feel at risk of acquiring HIV/AIDS. Individuals of both sexes who had frank discussion as a couple about HIV were found to be more likely to have pre-marital HIV testing (31).

In the record review of data, at Kazanchis Health Center in Addis Ababa, socio-demographic and behavioral profiles were assessed together with the prevalence of HIV and its correlates. During the specified period, for about 27 months, a total of 6,599 clients have received VCT services from the Health Center. On average there were about 244 VCT clients per month or 12 clients per day.

Among the 6,599 clients, about 54% were females; about 70% were never married followed by currently married clients (14.4%). Among the married and never married clients, the number of males was found to be a little higher than

that of the females while among those separated, divorced and widowed, the proportion of female clients was higher than males, particularly among widowed clients (79.6%)(14). Although, the study tried to show the profile of VCT clients, it did not include how many utilized the service in couple.

In quantitative study conducted in Kenya, set out to establish factors that influence decisions to take-up VCT with or without sexual partner: Individual clients: 25% male, 13% female tested alone to bring partner later. 19% females and 4% male tested alone for fear of abandonment by partner. Couples, 22% male, 15% female tested with partner because of lack of trust. Almost 5 times as many women said they took the test with partner for fear of violence if they declined (32).

In other qualitative study conducted in Kenya, some factors were illustrated as predictors to get tested for HIV. For couples, the decision to test for HIV was usually initiated by a single partner, who in most cases was the male. Couples described testing as (i) preventive health measure that they used before unprotected sexual intercourse, marriage, or pregnancy. (ii) means to reaffirm one's commitment to the relationship and as a way to try to diagnose and treat other reproductive health problems and, (iii) that the church required them to be tested before marriage (33).

Perception of personal susceptibility to HIV infection seems to be the primary factor motivating women to overcome other barriers to HIV testing. Only a few men were motivated to undergo testing because they feared they were already infected as a result of sickness or past sexual behaviors (33).

The social meaning of HIV testing and what partners ascribe to these meanings are important barriers in the decision to undergo testing and whether to involve a partner in the testing experience. For both men and women, HIV testing implied lack of faith in the partnership, lack of trust in a partner's behavior, and an acknowledgment of their own risky sexual behaviors (32).

When discussing HIV testing with a partner, participants were afraid that communicating their desire to be tested could threaten the relationship. Several women presented HIV testing as another strategy the couple could use to try to understand the reproductive health problems they were having (32).

Another qualitative study was also done in Harare: the study revealed that, even though the study participants supported the idea of couple counseling and testing but provided an insight into some pertinent problems as follows: (a) they experienced difficulties with introducing the subject to their partners due to the uncommunicative nature of their relationships; (b) they expressed fear of discordant results which could lead to divorce; (c) they feared that results would reveal their partners or their own past, present and future infidelity; (d) they

thought HIV counseling and testing was not a high priority compared to other issues in their lives. Therefore, they were reluctant to commit their time to VCT; (e) their wives were often unavailable to come to an urban VCT center because they reside in rural areas; (f) the men reported that their wives assumed that they would be negative if the husbands HIV test results were negative; (g) lastly, the men thought that there was a lack of interactive communication between counselors and clients during pre-test counseling. They therefore often did not feel compelled to confide in the counselor about their feelings about couple counseling (33).

In couples VCT within prevention of mother to child transmission project in Addis Ababa, 2003, pregnant women were offered VCT in antenatal clinics in Addis Ababa, partners were willing to accept VCT offered in an antenatal setting but uptake was limited due to factors: women's unwillingness to disclose their results to their partners irrespective of their sero-status, and the men being unwilling to be tested even when they had been informed of their partners' results (34).

Even though the study done in Kasshanchis Health center in Addis Ababa doesn't show the motive to VCT service separately for couples and individual the reasons cited for seeking VCT services were diverse. The majority (23%) reported that they practiced risky behavior, followed by those who (8.5%) want to "plan for the future", 5.9% reported that they have "seen" symptoms of HIV/AIDS in their body, 5.2% did for visa application and 4.2% reported partner's risky behavior as a reason for utilizing the service (14).

When asked how they heard about CVCT in the study of Kigali, most "walk-in" couples reported that they had heard about CVCT from a couple previously tested at the center (55%) or from friends (25%). Pamphlet and radio announcements represented 16% and 13% of respondents respectively (2).

In the study of creating demand for VCT, Multivariate analysis showed that, using positive messages to target high-risk groups was an effective means of promoting VCT, and using mass-media was a key source (2,3,7 and 31).

3. OBJECTIVES

3.1. General objective

The main objective of this study is to determine the magnitude of couples coming to government hospital VCT centers and to assess the factors associated with use and non-use of CVCT services in Addis Ababa.

3.2. Specific Objectives

- To determine the magnitude of CVCT service utilization.
- To evaluate the sero-positivity rate among the couples and individuals.
- To assess the factors associated with of CVCT service utilization.

4. METHODOLOGY

4.1. Study Setting

Institutional based crossectional survey of VCT service users was selected because little was known on CVCT service utilization. To study the magnitude of CVCT use, secondary data analyses would have been preferable but since it was difficult to get well documented data, and the other objective of the study was to also dig into the socio-behavioral factors related with use and non-use of CVCT, to use primary data was found to be compulsory. The study was conducted from July 2006 to July 2007. It was conducted in Addis Ababa which is the capital city of Ethiopia. The study was undertaken in the six referral hospital VCT sites (Zewidutu Memorial, Ghandi Memorial, Minilk II, Yekatit 12, St Paul and St Peter Hospitals).

4.2. Population

4.2.1. Source Population

All VCT service users in all referral government hospital VCT sites found in Addis Ababa were considered source population for this study.

4.2.2. Study Population

The study population consisted of VCT service users of the selected VCT sites.

4.2.3 Criteria for Inclusion & Exclusion of Study Subjects

Inclusion criteria: All VCT service users, who took the service during the time of the study.

Exclusion criteria: Clients aged below 18 years were excluded from the study.

4.2.4. Sampling

Sample size was calculated using the formula: $\frac{(z)^2 p (1-p)}{d^2} = n$, with

assumption of prevalence of CVCT 9.4% (7), a confidence interval of 95% and 2% chance of error for detecting the prevalence, the calculated sample size was 818. Adding 10% non-response rate required sample size for the study was 900.

4.2.5. Sampling Procedure

All government hospital VCT sites were included in the study except those who give the service restricted to special group of people like the Military and Police Hospitals. Due to difficulties that were out of scope, only the six Hospitals were included in the study. Using quota sampling method, the individuals who fulfilled the criteria who were taking the VCT and CVCT service in the month of April were included in the study consecutively until the required sample was obtained.

4.3. Data Collection

4.3.1. Data Collection Tool

The instrument used was standard interview questions taken from Carletonville Study, August 1999. The language was translated from English to Amharic and back to English in order to maintain consistency.

It was piloted on VCT service users in Addis ketema Health center and the necessary modifications were incorporated. There were a total of 14 interviewers who were nurse counselors who worked at the selected hospital VCT sites and

two supervisors including the investigator. At the spot training was given for interviewers on administering the research tool and basic interviewing technique.

4.3.2. Variables

- Socio-demographic: Age, sex, ethnicity, education, religion, employment, source of income, marital status, occupation
- Behavior: Condom use, having sexual intercourse, having more than one partner at a time
- Sero-status, prior HIV testing as a couple or as individual, Where the partner lives, living with a partner
- Knowledge, attitude
- Reasons for couples to be tested for HIV
- Source of information of VCT users
- CVCT service utilization

4.3.3. Operational Definitions

Knowledge: Someone was considered knowledgeable if he or she answered, above the average number of questions of the interview in section four.

Sexual intercourse: Intercourse which involves penetrative vaginal or anal sex.

Partner: The person that the study participant said at the time of the study living with married to or committed to but may or may not be having a sexual relationship with.

Condom use: Consistent and appropriate use of male condom during sexual Intercourse.

Sero-Status: The absence or presence of antibodies for HIV antigen.

Casual Partner: The person that the study participant said who at the time of the study had relationship with other than the person he or she was living with married to or committed on casual bases.

CVCT: Processes by which couples undergo HIV testing and counseling in union, to enable them make informed choice and tested voluntarily for HIV.

CVCT Service Utilization: Couples coming to VCT service together and taking VCT including taking the results together.

IVCT Service Utilization: Using of VCT service with out a partner regardless of partners testing status before or after the test.

VCT: Process by which an individual undergoes counseling to enable him make informed choice about being tested.

HIV Discordant Result: When two individuals testing as a couple have a result of one HIV positive and one who is not.

4.3.4. Data Collection Procedure

The same instrument was used for both IVCT and CVCT users. Each member of the couples was interviewed separately with separate interview questions. The interview took place before the usual session of pre-test counseling. The trained nurse counselors in the VCT sites administered the questionnaire after obtaining an informed consent (verbally) as well as written from eligible clients. The interview contained 43 structured questions and approximately took about 25 to 30 minutes for a single interview.

4.4. Data Quality Control

Subsequent to training of the data collectors at the spot prior to starting interviewing, three times a week monitoring of the process by the supervisor anonymously and two times a week by the chief investigator were done. There were discussions on any kind of problem they faced in the process. Data was checked for completeness, consistency and soundness by the principal investigator. Data was entered, stored and analyzed into a computer using the SPSS version 13. For the qualitative data, every focus group discussion was transcribed on the day it was conducted.

4.5. Data Processing and Analysis

Data entry, data cleaning and coding was performed using the SPSS version 13 soft ware. To explain the study population in relation to relevant variables, frequencies and summery statistics were used. Associations between dependent and independent variables was assessed and presented using odds ratios and confidence intervals. Logistic regression was used to control possible confounders. In determining the factors associated with CVCT service use, purposefully only those study subjects who had partners at the time of the study and only, one member of each couple randomly selected were included.

4.6. Qualitative

In order to supplement the data that was obtained by the interview, four focus group discussions were held among clients that were not included in the interview. Two FGDs which consisted of 8 individuals who had partners, but who

used VCT service as individual were held. Two FGDs, which consisted of 8 CVCT service users in each group was conducted using a semi- structured and open ended questions in order to have more information on barriers to CVCT utilization and the factors that lead to use of CVCT. The members of each FGD were selected on purposive bases by the facilitators and the researcher. Focus group participants were individuals who were currently in relationship, individuals who had sexual partners, couples who were married, and couples who lived together and who were intending to get married. The discussion was moderated by the researcher with the assistance of note taker and tape recorder.

4.7. Ethical Consideration

The research proposal was reviewed by Addis Ababa University Research Ethics Review Committees. Appropriate verbal as well as written consent were signed by the participants to enroll in the study. The interview of each study participant took place by the VCT counselors in the pretest room before they were given the pre-test counseling. Confidentiality was held, since there were no names in the data tool and the data collectors were the counselors that provided the VCT service.

4.8. Dissemination of the Result

The thesis will be presented to the department of community Health as partial fulfillment of Masters Degree in Public Health. The result of the study will be communicated to the Ministry of Health, Addis Ababa HIV/AIDS Prevention and Control Office (HAPCO) Addis Ababa Health Bureau, all government hospitals and other concerned bodies. The thesis will be submitted to reviewed journal.

5. RESULT

5.1. Description of the Study Participants

5.1.1. Socio-Demographic Characteristics of Study Participants

A total of 771 subjects (875 individuals, when the couples considered as two individuals, response rate, 85.6%) who came for HIV counseling and testing to six government hospital VCT sites were enrolled in the study according to the inclusion criteria set.

Among the 875 individual subjects enrolled in the study, 465 (53.1%) were females with over all average age of 26.1 years (S.D+/- 7.2), while that of the males is 31 years (S.D+/-9.3). About 546 (62.5 %) of all the respondents were single and 232 (26.6%) were married while the rest 64 (7.3%) were divorced and 31 (3.6%) widowed.

In terms of ethnic composition, the most common group was Amhara, with 52.2% (n=458). With regard to religion, the majority, 712 (81.4%) of the study participants were Orthodox Christians. The 346 clients (40%) were in the secondary education level and 213 (24.7%) in tertiary education level. The 320 (38.8%) of the study subjects had no monthly income. The majority, 449 (51.3%) of the study participants were employed or traders. The detailed description of the study participants is presented in Table1.

Table 1: General socio-demographic characteristics of the study participants in Addis Ababa, 2007 (n=875)

Characteristics	Frequency(n=875)	Percent
Age(years)(n=866)		
18 - 24	345	39.8
25 - 34	327	37.8
35 - 44	137	15.8
45 - 66	57	6.6
Sex(n=875)		
Male	410	46.9
Female	465	53.1
Marital status(n=873)		
Married	232	26.6
Single	546	62.5
Divorced	64	7.3
Widowed	31	3.6
Religion(n=875)		
Orthodox	712	81.4
Muslims	74	8.5
Protestant	74	8.5
Catholic	3	0.3
Others	12	1.4
Ethnicity(n=875)		
Gurage	86	9.8
Amhara	458	52.3
Oromo	217	24.8
Tigre	77	8.8
others	37	4.2
Education(n=864)		
No formal education	105	12.2
Primary(1 - 8)	200	23.1
Secondary(9 -12)	346	40.0
Tertiary (<12)	213	24.7
Occupation(n=875)		
Jobless	210	24.0
Employed/trader	449	51.3
House wife	54	6.2
Driver	30	3.4
Student	65	7.4
Others	67	7.7
Income(Birr)(n=825)		
No income	320	38.8
50 - 300	181	21.9
301 - 600	128	15.5
>601	196	23.8

5.1.2 Description of Study Participants by Health Institution

During the specified time of the study, 659 (86%) of the clients came without partners while 112 (14.5%) were couples. As shown in Table 2, CVCT was highest in Gandhi Memorial Hospital, followed by Minilik II Hospital 8 (19%) CVCT users and lowest in St. Peter Hospital which had only 1 (1.6%).

**Table 2: Distribution of study participants by health institution:
Addis Ababa, 2007 (n=771)**

Institution Name	VCT Service Used	
	Individual VCT	Couple VCT
Gandhi Memorial Hospital	96 (78.7%)	26 (21.3%)
Minilik II Hospital	34 (81.0%)	8 (9.0%)
ST Paul Hospital	70 (82.4%)	15 (7.6%)
St Peter Hospital	60 (98.4%)	1 (1.6%)
Yekatit 12 Hospital	36 (85.7%)	6 (14.3%)
Zewditu Memorial Hospital	363 (86.6%)	56 (13.4%)
Total	659 (85.5%)	112 (14.5%)

5.1.3 Magnitude of Couples VCT Service Users by Demographic Characteristics

As shown in Table 3, the majority, 46 (41.1%) of the CVCT service users were found in the age group of 25 - 34, 41 (36.6%) CVCT service users were in the age group of 18 - 24, while 21 (18%) were in the age group of 35 - 44 and

4 (3.6%) were over 45 years old. Most of the CVCT users, 76 (15.6%) were never married and 32 (16.8%) were currently married.

The majority 84 (75.7%) of the CVCT service users were Orthodox by religion and Amhara (n=55, 50%) by ethnicity. Only 5 (4.5%) had no formal education. The 25 (22.7%) CVCT users were found in the education level of primary while 45 (40.9%) and 35 (31.8%) had secondary and tertiary education level respectively. Among the CVCT service users, employed or traders were 64 (57.1%), while 19 (17%) had no occupation. The majority 34 (32.7%) CVCT service users had no monthly income. While 29 (16.9%) had monthly income more than 601 birr (Table 3).

Table 3: Magnitude of Couples VCT Users by Demographic Characteristics in Addis Ababa, 2007. (n=771)

Variable	Type of Service Used	
	CVCT	IVCT
Sex(771)		
Male	59(16.3%)	303(83.7%)
Female	53(13.0%)	356(87.0%)
Age(763)		
18 - 24	41(13.2%)	269 (86.8%)
25 - 34	46(16.2%)	238(83.8%)
35 - 44	21(17.5%)	99(82.5%)
> 45	4(8.2%)	45(91.8%)
Education(760)		
No formal education	5(5.2%)	91(94.8%)
1 - 8 (Primary)	25(14.5)	147(85.5%)
9 - 12 (Secondary)	45(14.3%)	270(85.7%)
>12 (Tertiary)	35(19.8%)	142(80.2%)
Religion(768)		
Orthodox	84(13.4%)	545(86.6%)
Muslims	11(17.5%)	52(82.5%)
Protestant	16(24.6%)	49(75.4%)
Others	0(.0%)	11(100.0%)
Ethnicity (763)		
Gurage	12(15.0%)	68(85.0%)
Amhara	55(13.8%)	343(86.2%)
Oromo	37(19.7%)	151(80.3%)
Tigre	5(6.9%)	67(93.1%)
Others	1(4.0%)	24(96.0%)
Occupation(771)		
No job	19(10.3%)	166(89.7%)
Employed/trader	64(16.2%)	330(83.8%)
House wife	8(17.4%)	38(82.6%)
Driver	6(20.7%)	23(79.3%)
Student	8(13.8%)	50(86.2%)
Others	7(11.9%)	52(88.1%)
Monthly Income(birr)(734)		
No income	34(12.1%)	248(87.9%)
50 - 300	21(12.6%)	146(87.4%)
301 - 600	20(17.7%)	93(82.3%)
>601	29(16.9%)	143(83.1%)
Marital Status(769)		
Married	32(16.8%)	159(83.2%)
Single	76(15.6%)	411(84.4%)
Divorced	4(6.6%)	57(93.4%)
Widowed	0(.0%)	30(100.0%)

5.2. Magnitude of HIV

5.2.1. Sero-Status of the Study Subjects

Among the study participants who had their blood tested, 187 (21%) turned out to be infected with HIV, of whom 116 (62%) were females. HIV sero-positivity increased from 41.8% in the age group 18 - 24 to 43.6% in the age group 45 and above (Table 4).

More than one quarter, 63 (29.4%), of the married study subjects were sero-positive. HIV infection rate was highest among the widowed (64.5%) and divorced (53.2%) and lowest among those who were never married (12.5%). Table 4 also showed that, among those who had never gone to a regular school, 35 (34%) were HIV positive, 57 (29.1%) were sero-positive among elementary completed, 94 (17.1%) were sero-positive among the secondary and above education level.

Similarly, Table 4 shows that government employees had higher proportion of sero positives followed by traders (31.7% and 29% respectively). An increase trend of sero-positivity was also observed with increasing income (Table 4). Of those who were IVCT users, 157 (24.5%) were sero-positive and 11 (10.3%) were sero-positive among couples. Among the couples enrolled in the study, 7 (6.6%) were sero-discordant.

Table- 2: Sero-status of the study participants: Addis Ababa, 2007. (n=875)

Characteristics	Sero-Status	
	Positive (n=187)	Negative (n=673)
Sex(n=869)		
Male	71 (17.5%)	334 (82.5%)
Female	116 (25.5%)	339 (74.5%)
Marital Status(n=858)		
Married	63 (29.4%)	151 (70.6%)
Single	67 (12.5%)	470 (87.5%)
Living together	3 (21.4%)	11 (78.6%)
Divorced	33 (53.2%)	29 (46.8%)
Widowed	20 (64.5%)	11 (35.5%)
Educational Status (n=849)		
No formal education	35 (34.0%)	68 (66.0%)
Primary	57 (29.1%)	139 (70.9%)
Secondary and above	94 (17.1%)	456 (82.9%)
Age(n=851)		
18 - 24	40 (11.8%)	300 (88.2%)
25 - 34	74 (23.1%)	247 (76.9%)
35 - 44	49 (36.3%)	86 (63.7%)
>45	24 (43.6%)	31 (56.4%)
Occupation(n=860)		
Jobless	66(31.6%)	143(68.4%)
Employed and trader	79(17.9%)	362(82.1%)
House wife	20(38.5%)	32(61.5%)
Driver	6(20.0%)	24(80.0%)
Student	2(3.2%)	61(96.8%)
Others	14(21.5%)	51(78.5%)
Monthly income(n=833)		
No income	74 (23.0%)	248 (77.0%)
50 - 300	36 (19.8%)	146 (80.2%)
301 - 600	37 (28.5%)	93 (71.5%)
>601	56 (28.1%)	143 (71.9%)
VCT utilization(n=749)		
CVCT	11 (10.3%)	96 (89.7%)
IVCT	157 (24.5%)	485 (75.5%)

5.3. Factors Associated with CVCT Service Utilization

5.3.1. Socio-Demographic Characteristics

As presented in Table 5, socio-demographic variables were analyzed if there were association with utilization of CVCT service. Based on the adjusted

regression, the respondents who were in the primary education (1 - 8) level were four times likely to use CVCT service than those respondents who never had a formal education with AOR (95%CI): 3.88 (1.22,12.30).

However, no significant associations were observed between, the variables occupation, monthly income and marital status with CVCT service utilization.

Table 5: Association of Selected Variables with CVCT Service Utilization Among VCT Service Users in Addis Ababa Government Hospital VCT Centers, 2007. (n=771)

Variables	Service used		Crude odds ratio(95%CI)	Adjusted odds ratio(95%CI)
	IVCT	CVCT		
Sex				
Male	303	59	1.00	1.00
Female	356	53	0.84 (0.55 - 1.29)	(0.55 - 1.72)
Educational Status(n=				
Never had a formal school	45	5	1.00	1.00
1 - 8	73	25	4.09(1.50-11.19)*	3.88 (1.22-12.30)*
9 - 12	143	45	1.33 (0.73-2.43)	1.43 (0.69-2.99)
12 =	77	35	1.44 (0.86-2.43)	1.72 (0.92-3.21)
Occupation(n=				
Jobless	66	19	1.00	1.00
Employed/trader	184	64	1.06 (0.39-2.84)	1.56 (0.33-7.44)
House wife	31	8	0.88 (0.36-2.14)	1.72 (0.62-4.83)
Driver	14	6	1.18 (0.37-3.72)	1.05 (0.19-5.94)
Students	25	8	0.71 (0.19-2.55)	1.34 (0.30-5.94)
others	23	7	0.95 (0.29-3.04)	1.88 (0.34-10.57)
Income(n=				
0	119	34	1.00	1.00
50 - 300	70	21	1.15 (0.65-2.03)	0.94 (0.23-3.93)
301 - 600	55	20	1.09 (0.58-2.09)	0.85 (0.38-1.88)
>601	88	29	0.91 (0.47-1.76)	0.82 (0.39-1.69)
Marital status(n=				
Married and cohabitants	146	32	1.00	1.00
Single	183	76	1.40 (0.43-4.59)	1.58 (0.46-5.47)
Divorced/widowed	13	4	0.74 (0.23-2.35)	0.86 (0.25-2.92)

*p<0.05

**1.00 indicates the reference group

***All variables are adjusted for sex, age, educational status, occupation income and marital status.

5.3.2. Risk Behavior Associated with CVCT

As presented in Table 6, risk behaviors and the living arrangements of respondents with their partners were assessed. Adjusted for the other variable, those study participants who used condom occasionally, during sexual intercourse with their regular partners, were five times more likely to use CVCT service than those who never used condoms with AOR (95%CI): 4.50 (1.33-15.31).

According to the binary logistic regression, the participants who had no sexual intercourse during the six month prior to the study, were four times likely to use CVCT service than those who had sexual intercourse with OR (95%CI): 4.23 (2.66-6.68).

Those participants whose partners lived out side of town were less likely to use CVCT service than those who lived in the same town with OR (95%CI): 0.10 (0.01-0.79). The number of partners the participants had during the one year period prior to the study had no association with CVCT service utilization. Having more than one sexual partner at a time and living together with the partner had also no association with CVCT service utilization.

Table 6: Risk factors associated with CVCT service utilization among VCT service users in Addis Ababa government hospital VCT centers, 2007. (n=771)

Variables	Service used		Crude odds ratio(95%CI)	Adjusted odds ratio(95%CI)
	IVCT	CVCT		
Number of partners during the last year prior to Interview				
One	307	106	1.00	1.00
More than one	36	6	0.48 (0.19 - 1.18)	0.83 (0.14 - 5.01)
More than one sexual Partner at a time				
Yes	44	8	1.00	1.00
No	286	90	1.73 (0.79 - 3.81)	1.86 (0.31 - 11.07)
Sexual intercourse during the last month				
Yes	268	51	1.00	1.00
No	71	57	4.23 (2.66 - 6.68)*	VSN
Condom use with the regular partner				
Never used	154	27	1.00	1.00
Sometimes	53	10	1.79 (0.91 - 3.55)	4.50 (1.33 - 15.31)*
Always	54	17	1.67 (0.70 - 3.98)	1.16 (0.39 - 3.39)
The partner lives in				
In town	120	55	1.00	1.00
Outside of town	47	3	0.10 (0.014 - 0.79)*	VSN
Out side of the country	21	1	0.75 (0.07 - 7.59)	VSN
Living with partner or not				
Yes	127	31	1.00	1.00
No	201	66	1.35 (0.83 - 2.18)	VSN

*p<0.05

**1.00 indicates the reference group

****All variables are adjusted for the number of partners, more than one partner at a time, sexual intercourse, condom use, where the partner lives and living with partner

****VSN stands for very small number.

5.3.3. Knowledge Attitude and Practice Towards CVCT

As shown in Table 7, out of all the total respondents, 722 (82.6%) claimed to have heard about couples VCT. The major source of information for couples VCT

service mentioned was the media (n=431, 59.6%) followed by from other people like friends, neighbors and relatives. Only 16.7% of those who knew about CVCT service heard it from the health professionals.

Regarding where the CVCT service is provided, 779 (89%) mentioned government institution followed by the private, non-government health institution and PLWHAS associations respectively (Table 7). About 252 (34.9%) of the study participants mentioned one type of health institution as a place to get CVCT service as Table 7 shows. The 330 (45.7%) stated two types of health institutions as a place to get CVCT while 131 (18.2%) point out above three types of institutions.

As shown in Table 7 With regard to the attitude of the study participants towards CVCT, the great majority had positive attitude. The 851 (99.5%) of the study participants rated CVCT as very important for all types of couples. The 836 (97.5%) said that CVCT is very important for those couples who are intended to get married or intended to start sexual intercourse. While 818 (95.7%) said it is also very important for those couples who already got married or started sexual intercourse. Among the study participants, 371 (42.6%) were first time testers. A total of 167 (24.9%) individuals claimed to have been tested in couples prior to the time of the study. Among the 678 individuals who have never tested in couple, 194 (28.6%) claimed that they wanted to get tested together with their partner but couldn't.

Table 7: The Knowledge, attitude and practice towards CVCT among VCT service users in Addis Ababa government hospital VCT centers, 2007 (n=875)

	Freq	Valid Percent
Heard of CVCT(n=874)		
Yes	722	82.6
No	152	17.4
Heard about CVCT from family(n=719)		
Yes	75	10.4
No	644	89.6
Heard about CVCT from friends(n=719)		
Yes	175	24.3
No	544	75.7
Heard about CVCT from the media(n=719)		
Yes	431	59.9
No	288	40.1
Heard about CVCT from health professionals(n=719)		
Yes	121	16.8
No	598	83.2
CVCT service is provided in government health Inst.(n=875)		
Yes	779	89.0
No	96	11.0
CVCT service is provided in private health institute(n=875)		
Yes	473	54.1
No	402	45.9
CVCT service is provided in NGO health institute(n=875)		
Yes	151	17.3
No	724	82.7
CVCT service is provided PLWHAS association(n=875)		
Yes	62	7.1
No	813	92.9
The No. of types of CVCT service providers mentioned(n=722)		
0	9	1.2
1.00	252	34.9
2.00	330	45.7
3.00	76	10.5
4.00	55	7.6
Importance of CVCT (n=855)		
Very important	851	99.5
Some what important	2	0.2
Not important	2	0.2
Tested for HIV before(n=871)		
Yes	500	57.4
No	371	42.6
Ever tested for HIV in couple(n=870)		
Yes	167	19.2
No	703	80.8
Wanted to test in couple but couldn't(n=678)		
Yes	194	28.6
No	484	71.4

As shown in Table 8, respondents who claimed that they never heard about CVCT service utilization were less likely to use CVCT service compared to those who did with AOR (95%CI) 0.29 (0.13-0.65). The participants who had no history of HIV testing were less likely to use CVCT service than those who had with AOR (95%CI) 0.44 (0.27-0.71). The knowledge of participants on HIV and other STIs had no significant association with CVCT service utilization. Use of CVCT service prior to the study had also no association with CVCT service utilization.

Table 8: Knowledge, Attitude and Practice Towards CVCT Among Study Participants in Addis Ababa Government Hospital VCT Sites, 2007. (n=771)

	Service Used		Crude Odds Ratio(95%CI)	Adjusted Odds Ratio(95%CI)
	IVCT	CVCT		
Knowledge of participants(771)				
Unsatisfactory	337	53	1.00	1.00
Average	305	57	0.75 (0.17 - 3.33)	0.49 (0.11 - 2.23)
Enough	17	2	0.63 (0.14 - 2.79)	0.59 (0.13 - 2.68)
Ever heard of CVCT(770)				
Yes	520	103	1.00	1.00
No	139	8	0.29 (0.14 - 0.61)*	0.29 (0.13 - 0.65)*
Ever tested for HIV(767)				
Yes	352	81	1.00	1.00
No	303	31	0.45 (0.29 - 0.69)*	0.44 (0.27 - 0.71)*
Ever tested for CVCT(766)				
Yes	112	25	1.00	1.00
No	543	86	0.71 (0.44 - 1.16)	1.21 (0.71 - 2.05)

*p<0.05

**1.00 indicates the reference group

****All variables are adjusted for the number of partners, more than one partner at a time, sexual intercourse, condom use, where the partner lives and living with partner

5.3.4. Reasons for not Using CVCT Prior to the Study

A total of 167 (24.9%) individuals claimed that they have been tested in couples prior to the time of the study. Among the 678 individuals who have never tested in couple, 194 (28.6%) stated that they want to get tested together with their partner but couldn't. About 148 (27.7%) of those who came with out their partner wanted to get tested with their partner. As presented in Fig 1 the 52 (27.7%) respondents said the reason for them not to get tested even though they wanted, was their partners being not able to test as a result of being busy. The second common reason mentioned by 37 (19.7%) respondents was the unwillingness of the partner to get tested.

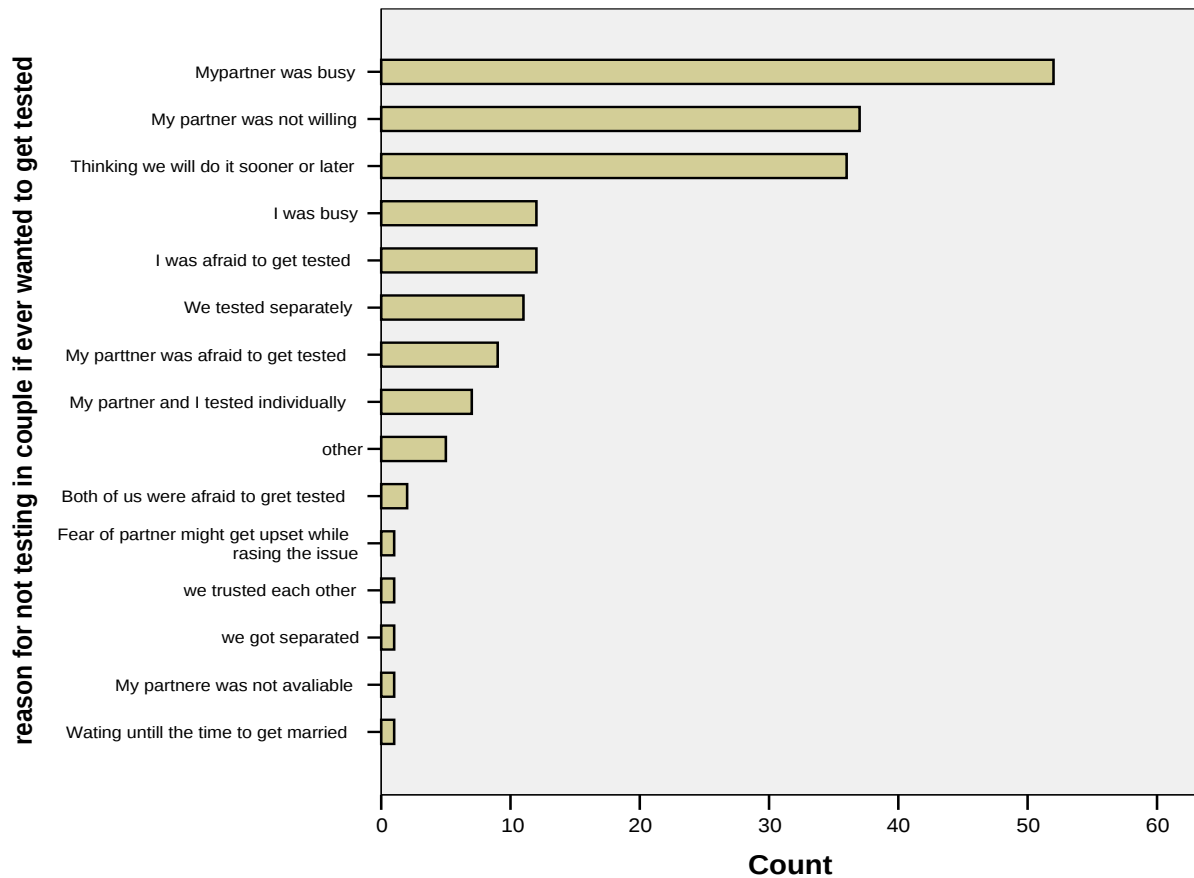


Fig 1 Mentioned reasons for not using CVCT service while having the desire prior to the study
In Addis Ababa, 2007

5.3.5. Reasons for getting Tested at the Time of the Study

The 345 (40%) study participants' reasons to get tested were the need to know their status. While 12% (n=104) of the study subjects tested for pre-marital purpose. The rest of the respondents gave different reasons for seeking HIV test. Among study participants who came as a couple, the majority, 70 (33%) were for pre-marital test. The second common reason was to know self (27.4%, n=58). The third common reason was the initiation of the idea of testing by the partner.

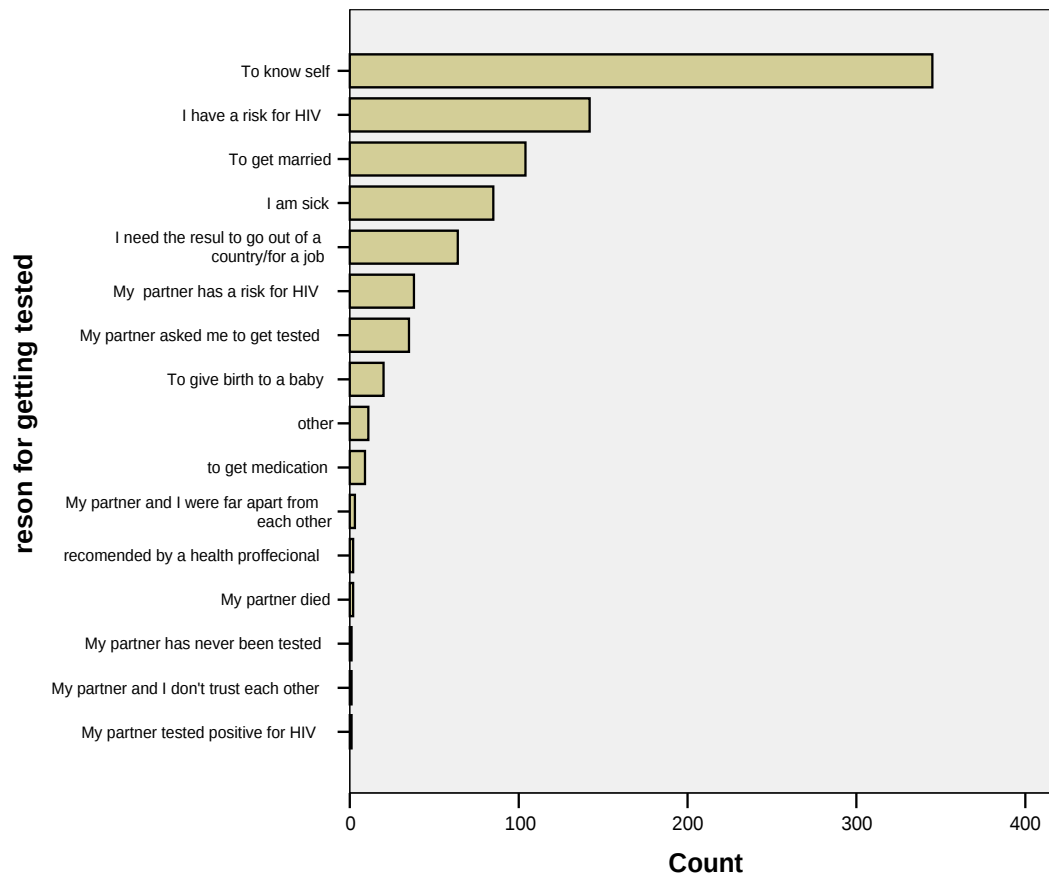


Fig 2. Mentioned reasons for getting HIV tested at the time of the study in Addis Ababa, 2007.

5.3.6. Reasons of Respondents for not coming with their Partner at the Time of the Study

As shown in Table 9, the reason most frequently mentioned by the respondents for coming without their partner was, their partners already knowing their results, followed by their partners being unavailable to come to the VCT center.

Table 9: Mentioned Reasons of Respondents for not Testing with their Partner at the Time of the Study, Addis Ababa 2007. (n=343)

	Frequency	Percent
My partner was not willing	48	14.0
My partner and I tested individually	16	4.7
My partner tested individually before	99	28.9
My partner was not available	70	20.4
I prefer to know my result first	35	10.2
I have a plan to be separated from my partner	4	1.2
I came to tested not deliberately	34	9.9
I had a risk for HIV	2	0.6
I have a fear my partner would get upset if questions raised on testing	2	0.6
I prefer to know my result only	7	2.0
I am sick	11	3.2
I suspect my partner of infidelity	1	0.3
I am the one who have reason to get tested	2	0.6
I trust my partner	1	0.3
Other	11	3.2
Total	343	100

5.3.7. Reasons for not Telling Partner the Plan to get Tested

Most of the study participants, 236 (66.1%), who had partners at the time of the study, did not notify their partners their plan to get HIV tested. However, among those 121 (33.9%) who notified their partners about their plan, about 90% stated to have their decision supported by them. The respondents' partners being unavailable at the time of the study was the most common reason mentioned for

not notifying the partner about the HIV testing plan. The other reason stated was the unintended choice made to get tested after coming to the VCT center.

Table 10: Reasons study participants mentioned for not letting know the plan of testing for their partner Addis Ababa 2007. (n=239)

Reason for not telling partner about HIV testing plan	Frequency	Percent
Fearing partner will tell others if tested positive	1	0.4
Fear of partner will suspect me of having sex with others	12	5.0
Partner is not willing to talk about testing	20	8.4
We are now on a fight	29	12.1
My partner is not around	67	28.0
I came not deliberately	65	27.2
I want to know my result first	29	12.1
I can know my partners result using mine	3	1.3
I am the one who got reason to get tested	9	3.8
Fear of he or she might get upset	1	.4
Other	3	1.3
Total	239	100

Among the respondents, 171 (19.8%) stated that they wouldn't share their results with anyone. About 14.2% (n=80) of those who had partners at the time of the study who came as individual, declared that, they wouldn't disclose their results to anyone. While 72.6% (410) said that they would share their results with their partners.

5.4. Summary of Results of Focus Group Discussions

Four focus group discussions were carried out among individuals who were in the process of taking the VCT service at Zewditu Memorial Hospital. Individuals were separated into groups of eight based on their sex and on whether they arrived individually or as a couple. Each focus group addressed the following three major issues: (a) knowledge of and attitude towards HIV; (b) knowledge of and attitude towards CVCT; (c) strategies for improving CVCT service utilization.

5.4.1. Knowledge of and Attitude on HIV

Knowledge of and attitude on HIV Participants were questioned on their understanding of HIV infection and AIDS. Many individuals made no distinction between the concepts of HIV sero-positivity and active AIDS, although they noted that HIV infection did not necessarily curtail one's daily activities. Notably, one individual, a 26-year-old female health professional who arrived with her fiancé for HIV testing, was able to clearly distinguish the concept an AIDS patient from that of an HIV positive individual showing neither signs nor symptoms.

Additionally, opinions were sought on the issue of HIV discordant couples. One 32-year-old male taxi driver who arrived for HIV testing as an individual acknowledged the existent of different HIV test results in married couples but stated that his partner was absent because she believed that knowledge of his result would be sufficient for both of them. Another participant, a male NGO worker who arrived for testing with his fiancé, shared the following story. "I know

two married people who live outside of Addis Ababa. The man is a medical doctor and the woman is a housewife. When the wife got sick and was tested for HIV, she was found to be positive, although her husband tested negative.”

A third individual, a 26-year-old woman who said that she lived outside of Ethiopia said, “I am now testing with my partner because I don’t know what he has been doing during my stay outside of Ethiopia. However, if two people are having unprotected sex, their HIV result will be the same, without a doubt.”

5.4.2. Knowledge of and Attitude towards CVCT

Most FGD participants were unfamiliar with CVCT exception of couples who recalled other couples being tested by parents and “Simagles” for their HIV test results before marriage. One 40-year-old male shared, “I am going to get married soon. I am going to marry my fiancé in a protestant church ceremony and they wouldn’t let us get married unless we show them the paper that certifies that we have been tested for HIV.”

Most FGD participants agreed on the importance of CVCT. One participant expressed the opinion that no one should be married without prior HIV testing. However, many individuals mentioned a partner’s unwillingness to be tested for HIV. A 22-year-old male Addis Ababa University student suggested that his partner’s lack of self-confidence was the cause for her unwillingness.

The other challenge mentioned by another participant, a 28-year-old male mechanic, was the issue of stigma and discrimination as an outcome of a

positive result. He said, “If my result is positive and my partner knows about it, she will tell others. Therefore, I would find out my status first and if it turns out to be negative, it is only then I would ask her to come with me to test together.”

5.4.3. Measures Suggested to be taken by Respondents to Improve Couples VCT Service Utilization

Many of the participants mentioned the media as a very good source of information. They said they had heard many times about the practice of getting HIV tested. However, they mentioned they have never heard about the use of CVCT in the media. So, they suggested that the media should play role in promoting the CVCT and while at the same time people coming for testing HIV be encouraged to get tested with their partner. Radio and television dramas shall aim why and how couples need to get tested for HIV together. They also appreciated that religious organizations require partners to get tested as a prerequisite for marriage.

6. DISCUSSION

CVCT is a cost-effective prevention program proven to reduce HIV transmission among African couples, where 70% of infections occur (1, 24). However, in Ethiopia, little is known about CVCT service users and the factors that are associated with the service utilization. Therefore, this study attempted to explore the present state of CVCT service utilization in Addis Ababa government hospital VCT sites and it also tried to point out the main factors that influenced couples to test jointly for HIV. During the time of the study which was carried out over the course of one month, 875 interviews and four focus group discussions were conducted.

In this regard, the socio-demographic, behavior and knowledge status of the study subjects have been described. In determining the factors associated with CVCT service use, purposefully only those study subjects who had partners at the time of the study and only, one member of each couple randomly selected were included.

During the study period, only 14.5% of participants were couples. This is slightly larger number when compared to the 9.4% report of VCT centers in Addis Ababa (7). It is also, greater than the 5% of couples testing in the case of VCT centers of Mozambique's largest VCT centers in 2005 (21). Nevertheless, VCT for HIV/AIDS has been one of the strategies for national HIV/AIDS prevention for years and is considered one of the priority intervention method (11). It is difficult

to say, the determined magnitude of CVCT in this study is a satisfactory achievement, while studies showing, as many as 30% of couples in high HIV prevalence countries are sero-discordant (8). And studies in sub-Saharan Africa produce evidence indicating, that VCT can be effective as an HIV-prevention tool, particularly when members of couples participate together in the VCT process (2,3, 5,9,11,12). It is possible to say that important opportunities are being missed for preventing HIV infection, be it by heterosexual transmission or mother-to-child HIV transmission from mothers who have been infected by their partners.

The prevalence of HIV infection in the study population was 21%. This is comparable to the analysis of the secondary data in Kasshanchis Health Center, according the records of clients who had their blood tested following pre-test counseling, of which 25% had test results that turned out to be HIV positive (14%). This figure is almost double the prevalence of HIV reported in VCT centers of Addis Ababa in 2005/06 (15). This is probably due to the fact that the study populations were from hospitals.

In this study, the majority of sero-positive study participants were females. This is a similar finding when compared to other studies conducted (14, 27). The HIV prevalence increased as the ages of the study participants increased. This is true also in other study done in Uganda (27) and in Socio-demographic characteristics and prevalence of HIV infection in VCT clients of Addis Ababa

(14). The majority of the study subjects whose marriage ended either because of divorces or deaths of their partners were found to be HIV infected, followed by those who were currently married. The individuals who never married took the lowest number in getting infected with HIV. This is also similar with the other study done in Addis Ababa (14). The fact that the individuals, who were married, divorced and widowed being the one more infected than the never married individuals, may make people aware that just because someone is married doesn't mean he or she is protected. A lot of the prevention messages in the early days would say things like, staying faithful would protect from HIV. However, it is no use if one of the couple members is not faithful. That's the big hurdle to overcome, in particular because women tend to have fewer partners outside of marriage than men (11).

In this study, the HIV infection rate was greater among those who came as individuals than those who came as couples. This in some cases is due to the reason that those who come as couples reported to have needed to get tested alone before testing with their partners. Some of the participants mentioned that getting tested as couples would only be possible on condition of finding out the HIV result individually prior to testing together as a couple. As a result, the magnitude of discordant results of couples may be underestimated. Still, the prevalence of the HIV discordant result is comparable with the finding in the recruitment and baseline characteristics of men, women, and couples who

participated in the Voluntary Counseling and Testing efficacy study at the study site in Nairobi, Kenya.

While there were no other socio-demographic characteristics associated with CVCT service utilization in this study, attaining primary education (1-8) level was associated with a greater likelihood of using the service than having no formal education. Eventhough, there are only few local studies that have been conducted emphasizing on CVCT; studies verify the role of education in utilization of VCT service in general (14, 27).

With regard to the respondents' sexual behavior, using condoms occasionally with a regular partner was significantly associated with the use of CVCT when compared to not using condom at all. As, the Uganda behavioral study and this study showed, there were people who don't have the awareness on the chance of only one partner being infected. So, they may consider prevention of HIV transmission to be inevitable if one of them were infected.

In this study, the couples who did not live in the same town were less likely to use CVCT service when compared with those who lived in the same town. This may be expected since the distance between them might have been a challenge for them to use CVCT jointly.

The respondents who claimed to have never heard about CVCT service utilization were less likely to use CVCT service when compared to those who had heard. Unlike the FGD participants, they claimed to have heard of it from the media.

In the study, having no sexual intercourse for 6 months prior to the time of the interview was significantly associated with CVCT service utilization. This is probably due to the fact that couples who came to test together may not begin sexual intercourse before getting tested for HIV. Those who had sexual intercourse with people other than the partners they were committed to, may not come to test without knowing their results first or may refuse to come at all.

Concerning the attitude towards CVCT service utilization, almost all of the participants had positive attitude. This is similar to the study in Rwanda in the assessment of knowledge, attitude and practice towards CVCT.

In the study, the most frequently stated reason among those individuals who wanted to get tested but couldn't was that their partner couldn't test as result of being busy. This is difficult to take as an explanation when comparing it to exposing oneself with HIV. This is similar to the qualitative study done in Harare, which stated one of the reasons for the couples not to test was that they thought HIV counseling and testing was not a high priority compared to other issues in their lives. Therefore, they were reluctant to devote their time to VCT (33). The most common reasons for women not to bring their partners to CVCT in the other

study done in Addis Ababa was the unwillingness of their partner and the women's' inability to disclose their results.

The most common reason mentioned by those individuals in the study for not coming as a couple was that their partners already knew their result. Even if we could say for sure that their partners have been tested before, they are still missing the opportunity of knowing their HIV status together as a unit, and planning ways of risk reduction with the help of a counselor.

The majority of the individuals who had partners at the time of the interview didn't let their partners know about their plans to get tested. This is because their partners were not around at the time of the decision. The second common reason mentioned was that the study participant came to the VCT center not specifically to test for HIV. Effective protective action against HIV/STD infection within couple relationships requires communication, agreement, and above all, cooperation between couple members (11). So, these factors should be given more attention by social/behavioral research and prevention interventions.

7. STRENGTHS AND LIMITATIONS OF THE STUDY

Strengths

- CVCT is more effective than IVCT in prevention of HIV transmission. However, CVCT has been given little attention and almost no related studies have been conducted. Therefore, this study can be taken as a baseline for other studies.
- Pre-testing of the questionnaire and correcting accordingly and supervision of the data collectors through all possible means by the researcher and supervisors was conducted

Limitations

- Utilization of health professional data collectors (nurses) may create bias as they might direct the respondents during the interview.
- The study participants may create social desirable bias during the interview.
- Shortage of literature, particularly studies on similar topics, could be mentioned as a imitation.
- The major VCT centers were included in the study.

8. CONCLUSION

- The prevalence of couples VCT service utilization in Addis Ababa government hospital VCT sites was 14.5%.
- In this study Age, marital status, income and occupation had no relation with Couples VCT service utilization.
- Among the study participants, educational level was found significantly associated with CVCT service utilization.
- In this study, condom use during sexual intercourse with regular partner was significantly associated with CVCT service utilization.
- In this study, having sexual intercourse prior to HIV testing was significantly associated with using CVCT service.
- How far apart couples live from each other was significantly associated with CVCT service utilization, in this study.
- There was positive attitude towards CVCT service among the study participants.
- Premarital testing was the most important reason couples in the study used CVCT service.
- Previous history of testing of a partner individually was the most important reasons mentioned by the study participants for not using the CVCT service.
- The majority of individuals didn't involve their partners in the decision of HIV testing.

9. RECOMMENDATIONS

- Based on the research findings, the following recommendations can be made.
 1. Frequent, clear and accurate media-based information programs in multiple languages are needed to increase access to information on VCT, with particular attention to the importance of VCT for couples for both preventing heterosexual and mother to child HIV transmission.
 2. Other specific approaches to promote CVCT service use is need to be developed through appropriate studies.
 3. VCT clients should be provided with basic information towards CVCT, by training of nurse counselors.
 4. Further evaluation of factors that hinder couples not to use VCT service jointly should be conducted.

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**Annex - 1. Focus Group Discussion participant Description Addis Ababa,
Zewiditu Memorial hospital VCT site, 2007**

Characteristics				
Group	Sex	Age	Service used	Duration of Discussion
1	Females	21 - 35	CVCT	45min
2	Males	24 - 40	CVCT	60min
3	Females	20 - 48	VCT	60min
4	Males	20 - 42	VCT	55min

Annex - 2. Interview Questions

Assessment of utilization of couples Voluntary counseling and testing at VCT centers of Addis Ababa, 2007

Contents:

- Written Consent

Section 1. Socio-demographic factors

Section 2. Risk behaviors of the study participants

Section 3. Knowledge on HIV and others STIs

Section 4. Knowledge, attitudes and practice towards CVCT

Written Consent

We are doing a research to assess the utilization of CVCT in Addis Ababa VCT centers. Its purpose is to identify factors that are associated with the use or non use of CVCT. So, I'm going to ask you some very personal questions that some people find difficult to answer and your result after tested will be put. Your test result and answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand about couples VCT utilization in the city. We would greatly appreciate your helping. Would you be willing to participate? If Yes, _____ (1) Continue. No _____ (2) Stop.

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

(Signature of the respondent agreeing to the interview.) _____

Introduction: My name is _____. I'm working for _____.
_____. We are interviewing people here in _____
_____ (name of the site) about couples Voluntary HIV Counseling and testing service utilization.

Interviewer Name _____ **Signature** _____

Date of interview _____

Date _____

N0	Questions	Answers	Skip
1	Type of service	1 IVCT 2 CVCT	
2	Result code		
3	Sero-status	1positive 2negative	
4	Couples code		

Socio-Demographic Characteristics

Circle the choice of the respondent answered or write the answer in the blank space

No.	Questions and filters	Coding categories	Skip to
1	Sex of the respondent	1. Male 2. Female	
2	Age of the respondent	_____years	
3	Level of education completed		
4	What religion are you?	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. other	
5	To which ethnic group do you belong?	1. Gurage 2. Amhara 3. Oromo 4. Tigre 5. Others	
6	What is your current occupation?	1. Job less 2. Merchant 3. Government employee 4. House wife 5. Driver 6. Others (specify)	
7	What is your monthly income?	• Birr per month _____ • No income	
8	Marital status	1. Married 2. Committed but not living together 3. Single 4. Separated/divorced 5. Widowed	

Section 2. Risk Behaviors of the Study Participant

No.	Questions and filters	Coding categories	Skip to
9	How many partners did you have in the last 12 months?	1. None 2. One 3. Two 4. Three 5. Four and above	Q 16
10	Have you ever had more than one partner at a time?	1. Yes 2. No	
11	In the last 12 months, what kind of partner/s did you have?	1. Regular partner 2. Mistresses, 3. Sex workers 4. Casual partners 5. Others	
12	For how long did you have the relationship with your recent partner?	1.	
13	How old is your recent partner?		
14	Do you usually live together in the same House/compound?	1. Yes 2. No	Q16
15	[IF NO]Where does he/she usually live:	1. Same place 2. Another place 3. Abroad	
16	Did you have sex in the last six months?	1. Yes 2. No	Q 21
17	If yes, With what kind of sexual partner did you have penetrative sex with?	1. Regular partner 2. Mistresses, 3. Sex workers 4. casual partners 5. Others	
18	Do you use condoms with this regular partner?	1. Never 2. Sometimes 3. Always	Q20
19	IF ALWAYS OR SOMETIMES] Why do you use condoms?	1. To avoid pregnancy 2. To avoid HIV transmissions 3. To avoid other STIs 4. Pressure from partner 5. Other	Q21

20	[IF NEVER OR SOMETIMES] What was the main reason that you never or do not always use a condom with this regular partner?	1. Not available 2. Too expensive 3. Partner objected 4. Don't like them 5. Made a decision not to 6. Using another form of contraception 7. Other.	
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Section 3. Knowledge STDs and HIV

21	As far as you know can a person get a disease or infection through sexual intercourse?	1. Yes 2. No	→ Q. 23
22	From what you've heard or read, what are some common signs and symptoms of such diseases? 1. Vaginal discharge 2. Abnormal vaginal bleeding 3. Vaginal itching 4. Warts/lesions/sores 5. Pelvic pain 6. Pain during intercourse 7. Painful urination 8. Discharge from penis 9. Other	Mentioned, Not	
23	How long can a person infected with HIV remain without showing any sign and symptoms?		
24	What would be the result of a partner of one who already knows his or her HIV status?	1. The same 2. Different 3. May or may not be the same 4. Don't know	

Section 4. Knowledge, Attitudes and Practice towards CVCT

No.	Questions and filters	Coding categories	Skip to
25	Have you heard of couples Voluntary HIV Counseling and Testing?	1. Yes 2. No	► Q. 27
26	If yes where did you get this information?	1. Family 2. Friends 3. Neighbors 4. Mass media 5. Health workers 6. (Institutions) 7. Other 8. (Specify)	
27	What kind of places is CVCT services provided?	1. Government health institutes 2. Non-government health institutes 3. Private health institute 4. PLWHAS association 5. Don't know 6. Other	
28	How important do you think CVCT is?	1. Very important 2. Important 3. Somewhat important 4. Not important	
29	How important do you think CVCT is for married couples and for couples who are started sexual intercourse?	1. Very important 2. Important 3. Somewhat important 4. Not important	
30	How important do you think CVCT is for non-married couples and for couples who have no sexual intercourse?	1. Very important 2. Important 3. Somewhat important 4. Not important	
31	Have you ever tested for HIV?	1. Yes 2. No	
32	Have you ever tested with a partner(any kind)	1. Yes 2. No	► Q. 35
33	With whom did you receive the results?	1. Together 2. Alone 3. other	

34	If yes to Q 32 what was the reason for having CVCT?	1. Ordered by health worker 2. Requirement for marriage 3. Voluntary to know self 4. Other purpose (visa, marriage, employment etc) 5. Asked by partner 6. Other (specify)	→ Q. 37
35	Did you ever have the desire to take CVCT service?	1. Yes 2. No	→ Q 37
36	If yes, what was the reason for not taking the service?	1. He or she was not willing 2. We tested separately 3. He or she tested before 4. thinking we would get tested sooner or later 5. he or she couldn't make it because of his or her occupation 6. Because I couldn't make it because of my work 7. Because I was afraid to get tested 8. because he or she was afraid to get tested 9. other	
37	What is the main reason for you to get tested now?	1. Your own past sexual behaviors 2. Your partner's past sexual behaviors. 3. Your primary partner told you to come in and get tested. 4. Your partner (former or current) is sick or died. 5. Your exposure to HIV at work 6. You had a blood transfusion 7. You are taking care of people with HIV/AIDS. 8. You just wanted to know your serostatus. 9. You are sick. 10. Your workplace requires testing, so you came here first. 11. You are planning to get married	

		12. Premarital testing required by the church. 13. You are planning on having children. 14. You are planning for the future 15. You fear you may have been injected/ injected yourself or cut with a contaminated instrument (needles, blades, shaving instruments). 16. You fear you may have been bewitched. 17. Other, specify:	
38	(If the client came as individual while having a partner) what was the reason for him or her to come with out his her partner?	1. He or she was not willing 2. We tested separately → 3. He or she tested before 4. other	Q 41
39	(If the client came with his /her partner) Which way do you prefer to obtain the result?	1. Together 2. Alone → 3. other	Q.44
40	If you are going to receive the result individually, what is the reason?		
41	Does you partner know you have decide to test?	1. Yes 2. no →	Q.43
42	If yes How did your partner feel about your decision to come for HIV testing? (check all that apply)	1. He was supportive of my decision 2. He was unsupportive of my decision → 3. He did not care if I came for HIV testing 4. He did not tell me how he felt about my decision 5. He is the one who told me/asked 6. Me to come for testing 7. Other, specify: 8. Declined 9. Don't know	Q.44

43	If not why not?	1. Fearing he or she may tell others if my result turn out to be positive 2. In order not suspect me with infidelity 3. He or she is not willing to have a conversation on HIV testing 4. We are on a fight for the time being 5. He or she is not around 6. I came to the VCT center not deliberately 7. I want to know mine prior to telling him or her 8. My result will show his or hers 9. I am the one who have got reason to test 10. Other	
44	If you were infected with HIV who would you disclose to?	1. Tell no one 2. I will tell to my regular partner 3. Relatives 4. Others	

Annex 3 - Structured Amharic Interview Questions Version

የፈቃደኝነት ማረጋገጫ ቅጽ

ጤና ይሥጥልኝ! እኔ አቶ/ወሮ/ወሪት/ሲር ----- እባላለሁ።

በአሁኑ ሰአት ጥንዶች በጋራ የሚያደርጉትን በፈቃደኝነት ላይ ተመስርቶ የሚደረግ የኤች አይ ቪ የምክር እና የምርመራ አገልግሎት ላይ አዲስ አበባ ዩኒቨርሲቲ ጥናት እያደረገ ይገኛል። የጥናቱ ዋና አላማ ጥንዶች በጋራ የሚያደርጉትን በፈቃደኝነት ላይ ተመስርቶ የሚደረግ የኤች አይ ቪ የምክር እና የምርመራ አገልግሎት ላለመውሰዳቸው ወይም ለመውሰዳቸው ተጽኖ ሊያደርጉ የሚችሉ ምክንያቶች ለማወቅ እና መፍትሄዎችን ለመጠቀም ነው።

ስለዚህ ከአስራ አምስት እስከ ሃያ ደቂቃ ያህል የሚወስዱ ጥያቄዎች እጠይቃለሁ። ወጤቶንም ከደረሰኝ በኋላ በመጠይቅ ገጹ ላይ አስፍረዋለሁ። ነገር ግን ይህ ሲሆን ስሞትም ሆነ ማንነቱ ሊገለጽ በማይችልበት በመሆኑ ሚሲጥራዊነቱ እንደተጠበቀ ነው። መመለስ ፈቃደኛ ያልሆኑት ማንኛውም ጥያቄ አልመልስም ማለት ይችላሉ። በማንኛውም ሰአት የጥያቄ እና መልሱን ሂደት ማቋረጥ ይችላሉ። ነገር ግን ለሚጠየቁት ጥያቄ የሚሰጡን እወነተኛ የሆነ ምላሽ በአዲስ አበባ ያለውን የጥንዶች በጋራ የሚያደርጉትን በፈቃደኝነት ላይ ተመስርቶ የሚደረግ የኤች አይ ቪ የምክር እና የምርመራ አገልግሎት አጠቃቀም ላይ የበለጠ መረዳትን ይሰጠናል።

በዚህ ጥናት ላይ መሳተፍ ፈቃደኛ ነዎት?

ምላሹ አዎ ከሆነ ----- (1) መቀጠል ይችላሉ

ምላሹ ፈቃደኛ አይደለሁም ከሆነ ----- (2) ጥያቄውን ያቁሙ

መለሹ ጥያቄዎችን ለመመለስ ፈቃደኛ መሆኑን በቃል መግለጹን የየሚያረጋግጥ የጠያቂው ፊርማ -----

መለሹ ጥያቄዎችን ለመመለስ ፈቃደኛ መሆኑን መግለጹን የየሚያረጋግጥ የተጠያቂው ፊርማ --

የጤና ተቋሙ ስም

መጠይቁ የተሞላበት ቀን -----

መጠይቁ የተሞላበት ሰዓት-----

ክፍል 1.

ተ.ቁ	ጥያቄ	መልስ	ይታለፍ
1	የተጠያቂው አመጣጥ	1.በነጠላ 2.በጥንድ	
2	የተጠያቂው የወጤት ኮድ	-----	
3	የተጠያቂው ወጤት	1 ፖዜቲቭ 2 ኔጌቲቭ	
4	የጥንዶች ኮድ	-----	

ክፍል 2. አጠቃላይ የግለሰብ መረጃ

መልሱን ከተሰጠው ምርጫ ያክብቡ ወይንም ከተሰጠው ክፍት ቦታ ይጻፉ

ተ.ቁ	ጥያቄ	መልስ	ይታለፍ
1	ፆታ	1. ወንድ 2. ሴት	
2	እድሜ	1. በአመት ይገለጽ ----- 2. በትክክል መግለጽ ካልቻሉ በግምት---	
3	መደበኛ ትምህርት ከተማሩ ያጠናቀቁት የክፍል ደረጃ	1. -----	
4	የምን እምነት ተከታይ ኖዎት?	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ አይነት ከሆነ ይገለጽ-----	
5	የምን ብሄረሰብ ተወላጅ ኖዎት?	1. የጉራጌ 2. አማራ 3. ኦሮሞ 4. ትግሬ 5. ሌላ አይነት ከሆነ ይገለጽ-----	
6	መደበኛ ስራዎ ምንድን ነው	1. ሥራ የለኝም 2. ነጋዴ 3. የመንግስት ሰራተኛ 4. የግል ተቀጣሪ 5. የቤት እመቤት 6. ሹፊር 7. ወዛደር 8. ሌላ አይነት ከሆነ ይገለጽ-----	
7	አማካኝ ወርሃዊ ገቢዎት ስንት ነው?	1 በወር ብር -----	
8	በአሁኑ ሰዓት ያለው የጋብቻ ሁኔታ	1. ያገባ 2. ያላገባ 3. ጓደኛ ያለው/ያላት ያለህጋዊ ትስስር አብረው የሚኖሩ 4. የፈታ/ች 5. የሞተበት/የሞተባት	

ክፍል 3. ለኤች አይ ቪ ሊያጋልጡ የሚችሉ ባህሪዎች

ተ.ቁ	ጥያቄ	መልስ	ማስታወሻ
9	በአለፉት 12 ወራት ሥነት ፍቅረኛ/የወሲብ ቅደኛ ነበረዎት?	1. ምንም  2. አንድ 3. ሁለት 4. ሶስት 5. አራት እና ከዛ በላይ	ወደ ጥያቄ ቁ 16
10	በአለፉት 12 ወራት ከአንድ በላይ የወሲብ ቅደኛ /ፍቅረኛ በተመሳሳይ ጊዜ ኖሮት ያዉቃል?	1. አዎ 2. አያውቅም	
11	በአለፉት 12 ወራት ምን አይነት የወሲብ ቅደኛ ነበረዎት? (ሁሉንም ምርጫ ያንብቡላቸው)	1. በትዳር የተሳሰሩት/ቋሚ ቅደኛ አዎ--- አይደለም--- 2. ወሽማ አዎ --- አይደለም--- 3. ሴተኛ አዳሪ አዎ--- አይደለም--- 4. ጊዜያዊ ቅደኛ አዎ--- አይደለም --- 5. ሌላ ካለ ይገለጽ -----	
12	ከአሁኑ/ዋ ወይም የመጨረሻ ክብሮት የወሲብ/የትዳር ቅደኛ ጋር ምን ያህል ጊዜ በትዳር/ቅደኝነት ቆይታችኋል?	1 -----	
13	የአሁኑ/ዋ ወይም የመጨረሻ የክብሮት የትዳር አጋርዎ/ወሲብ ቅደኛዎ እድሜ ስንት ነው?	1 በአመት-----	
14	በአሁኑ ሰአት ከትዳር አጋርዎ/ወሲብ ቅደኛዎ አንድ ቤት ውስጥ ይኖራሉ?	1. አዎ  2. አይደለም	ወደ ጥያቄ ቁ 16.
15	አብረው የማይኖሩ ከሆነ በአሁኑ ሰአት የትዳር አጋርዎ/ወሲብ ቅደኛዎ የሚኖሩት የት ነው?	1. አንድ ከተማ ውስጥ 2. ሌላ ክፍለሀገር 3. ከአገር ውጭ	
16	ባለፈው ስድስት ወራት ግብረሰጋ ግንኙነት ፈጽመዋል?	1. አዎ 2. አልፈጸምኩም 	ወደ ጥያቄ ቁ 21
17	የግብረሰጋ ግንኙነቱን ከፈጸሙ ከምን አይነት የወሲብ ቅደኛ ጋር ነው የፈጸሙት? (ሁሉንም ምርጫ ያንብቡላቸው)	1. በትዳር የተሳሰሩት/ቋሚ ቅደኛ አይደለም--- አዎ--- 2. ወሽማ አይደለም---አዎ --- 3. ሴተኛ አዳሪ አይደለም---አዎ--- 4. ጊዜያዊ ቅደኛ አይደለም --- አዎ--- 5. ሌላ ካለ ይገለጽ -----	
18	ከትዳር የተሳሰሩት/ቋሚ ቅደኛ ጋር እስከዛሬ በነበረው ግብረሰጋ ግንኙነት ኮንዶም ተጠቅመው ያውቃሉ?	1. ተጠቅመን አናውቅም  2. አልፎ አልፎ 3. ሁልጊዜ	ከሆነ ወደ ጥያቄ ቁ. 20
19	እስከዛሬ በነበረው ግብረሰጋ ግንኙነት ከትዳር የተሳሰሩት/ቋሚ ቅደኛ ጋር ኮንዶም ተጠቅመው ከሆነ ምክንያቱ ይገለጽ?	1. እርግዝና ለመከላከል 2. ኤች.አይ.ቪ ለመከላከል  3. ሌሎች ያባላዘር በሽታዎችን ለመከላከል 4. እሱ/እሷ ስለምትፈልግ 5. ሌላ ምክንያት	ከሆነ ወደ ጥያቄ ቁ 21
20	እስከዛሬ በነበረው ግብረሰጋ ግንኙነት ከትዳር የተሳሰሩት/ቋሚ ቅደኛ ጋር ኮንዶም ተጠቅመው የማያውቁ ከሆነ ምክንያቱ ይገለጽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ማግኘት አስቸጋሪ ስለሆነ 2. ውድ ስለሆነ 3. እሱ/እሷ አትፈልግም 4. ኮንዶምን አንመርጠውም 5. እንዳንጠቀም ስለወሰንን 6. ሌላ የወሊድ መከላከያ ስለምንጠቀም 7. ስለምንተማመን 8. ሌሎች	

ክፍል 4 የመላሽ በኤች ኤይ ቪ እና በሌሎች በአባላዘር በሽታዎች ላይ ያላቸው ግንዛቤ

ተ.ቁ	ጥያቄ	መልስ	ይታለፍ
21	በግብረሰጋ ግንኙነት የሚተላለፍ የሚያወቁት በሽታ አለ?	1. አዎ 2. አላወቅም 	ከሆነ ወደ ጥያቄ ቁ 23
22	በግብረሰጋ ግንኙነት የሚተላለፍ የሚያወቁት በሽታ ካለ ምን አይነት የዚህ በሽታ ምልክቶች ያወቃሉ? (ለምሳሌ ግዜ ይስጡ፡ የተሰጡትን ምላሾች ከተሰጡን ምርጫ ጋር ካለ ምልክት ያርጉበት)	1. ምንም አላወቅም 2. ያልተለመደ የብልት ፈሳሽ 3. ብልት ማሳከክ 4. ቁስል 5. ከእንብርት በታች ህመም 6. በግብረሰጋ ግንኙነት ግዜ ህመም 7. በመሽናት ግዜ ህመም 8. የብልት ፈሳሽ (የወንድ) 9. ሌሎች	
23	ከቫይረሱ ጋር የሚኖር ሰው ለኤች ኤይ ቪ ከተጋለጠበት ግዜ ጀምሮ በአማካኝ ለምን ያህል ግዜ የህመም ምልክት ሳያሳይ ሊቆይ ይችላል ብለው ያስባሉ?	1. -----	
24	አንድ ሰው ኤች ኤይ ቪ ምርመራ አድርጎ ወጤቱ ቢታወቅ የወሲብ ንደኛ /ሚስት/ባል ውጤት ምን ሊሆን ይችላል?	1. ተመሳሳይ ወጤት ይኖራቸዋል 2. የተለያየ ወጤት ይኖራቸዋል 3. ተመሳሳይ ወጤት ወይም የተለያየ ወጤት ይኖራቸዋል 4. ሌላ -----	

ክፍል 5 - የመላሽ በጥንዶች በፈቃደኝነት ላይ ተመስርቶ የሚደረግ የ ኤች ኤይ ቪ የምክር እና ምርመራ አገልግሎት ላይ ያለው ግንዛቤ አመለካከት እና ተግባር

ተ.ቁ	ጥያቄ	መልስ	
25	ስለ ጥንዶች በፈቃደኝነት ላይ ተመስርቶ የሚደረግ የኤች.አይ.ቪ ምርመራ እና ምክር አገልግሎት ስምተው ያወቃሉ?	1. አዎ 2. አላወቅም 	አላወቅም ከሆነ ወደ ጥያቄ 27
26	ከየት ነው ይህን መረጃ የሰሙት?	1. ቤተሰብ 2. ንደኛ 3. ጎረቤት 4. መገናኛ ብዙሃን 5. ጤና ባለሙያ (ጤና ተቋም) 6. ሌሎች -----	
27	የጥንዶች በፈቃደኝነት ላይ ተመስርቶ የሚደረግ የኤች.አይ.ቪ ምርመራ እና ምክር አገልግሎት በምን አይነት ቦታዎች ይሰጣል?	1. የመንግስት ጤና ተቋማት 2. የግል ጤና ተቋማት 3. መንግስታዊ ያልሆኑ ጤና ተቋማት 4. ከየኤች.አይ.ቪ ጋር የሚኖሩ ሰዎች በአቋቋሙት ማህበራት 5. አላውቀውም	

		6. ሌላ-----	
28	በጥንድ የኤች.አይ.ቪ ምርመራ ማድረግ ምን ያህል አስፈላጊ ነው ብለው ያስባሉ?	1. እጅግ በጣም አስፈላጊ ነው 2. በጣም አስፈላጊ ነው 3. በመጠኑ አስፈላጊ ነው 4. አስፈላጊ አይደለም	
29	ግብረሰጋ ግንኙነት ለጀመሩ ወይም ትዳር ለመሰረቱ ጥንዶች የኤች.አይ.ቪ ምርመራ በጥንድ ማድረግ ምን ያህል አስፈላጊ ነው ብለው ያስባሉ?	1. እጅግ በጣም አስፈላጊ ነው 2. በጣም አስፈላጊ ነው 3. በመጠኑ አስፈላጊ ነው 4. አስፈላጊ አይደለም	
30	ግብረሰጋ ግንኙነት ላልጀመሩ ወይም ትዳር ላልመሰረቱ ጥንዶች የኤች.አይ.ቪ ምርመራ በጥንድ ማድረግ ምን ያህል አስፈላጊ ነው ብለው ያስባሉ?	1. እጅግ በጣም አስፈላጊ ነው 2. በጣም አስፈላጊ ነው 3. በመጠኑ አስፈላጊ ነው 4. አስፈላጊ አይደለም	
31	ከዚህ በፊት በፈቃደኝነት ላይ ተመስርቶ የማደረገውን የኤች አይ ቪ ምርመራ እና ምክር አገልግሎት ወስደው ያውቃሉ?	1. አዎ 2. ወስጄ አላውቅም	
32	ከዚህ በፊት በጥንድ በፈቃደኝነት ላይ ተመስርቶ የማደረገውን ምርመራ እና ምክር አገልግሎት ወስደው ያውቃሉ?	1. አዎ 2. አላውቅም →	ወደ ጥያቄ ቁ.35
33	በጥንድ በፈቃደኝነት ላይ ተመስርቶ የማደረገውን ምርመራ ካደረጉ የኤች.አይ.ቪ ውጤቱን ከማን ጋር ነበረ የተቀበሉት?	1. በጋራ 2. በግል 3. ሌላ ካለ ይገለጽ -----	
34	በጥንድ የኤች.አይ.ቪ ምርመራ ለማድረጋችሁ ምክንያቱ ይገለጽ	1. በጤና ባለሙያ ተነግሮን 2. ለመጋባት ስለምንፈልግ 3. እራሳችንን ለማወቅ 4. ሌላ ምክንያት (ለቪዛ፣ ስራ ለመቀጠር 5. ሌሎች	ወደ ጥያቄ ቁ 37
35	ለጥንዶች የሚሰጠው ኤች.አይ.ቪ የምርመራ አገልግሎት ከዚህ በፊት መወሰድ ፈልገው ያውቃሉ ?	1. አዎ 2. አላውቅም →	ወደ ጥያቄ ቁ.37
36	ፍላጎቱ ከነበረ ምርመራ ያላደረጋችሁበት ምክንያት ምንድን ነበረ?	1. እሱ/እሷ ፈቃደኛ አልነበረም/ችም 2. ለየብቻ ተመርምረን ነበረ 3. እሱ/እሷ ከዚህ በፊት ምርመራ አድርጋ/ጎ ነበረ 4. ዛሬ ነገ ስንል 5. በስራ ምክንያት እሱ/እሷ ስላልተመቻች 6. በስራ ምክንያት እኔ ስላልተመቻኝ 7. እኔ መመርመር ስለፈራሁ 8. እሱ/እሷ ስለፈራ/ች 9. ሌላ ምክንያት ካለ ይገለጽ -----	
37	በአሁኑ ሰዓት ለምርመራ የመጡበት	1. ከዚህ በፊት ለኤች.አይ.ቪ	

	ምክንያት ምንድን ነው?	ሊያጋልጠኝ የሚችል አጋጣሚ ስለነበረ ነው። 2. ከዚህ በፊት የትዳር አጋራ/የወሲብ ንደኛዬ ለኤች.አይ.ቪ ሊያጋልጠው የሚችል አጋጣሚ ሥለነበረ ነው። 3. የትዳር አጋራ/የወሲብ ንደኛዬ ኤች.አይ.ቪ እንድንመረመር ሃሳብ ስላመጣ/ች ነው። 4. በስራ ላይ ሊያጋልጠኝ የሚችል አጋጣሚ ስለነበረ ነው። 5. ከዚህ በፊት ደም ተለግሼ ስለማውቅ ነው። 6. ከኤች.አይ.ቪ ጋር የሚኖር ስውን ተንከባክቤ ስለማውቅ ነው። 7. የኤች.አይ.ቪ ወጤቱን ለማውቅ 8. ሀመም ስለተሰማኝ ነው። 9. የኤች.አይ.ቪ ምርመራ ለስራ/ለውጪ ጉዳይ ስላስፈለገኝ ነው። 10. ትዳር ለመምስረት የኤች.አይ.ቪ ምርመራ ስላስፈለገኝ ነው። 11. ትዳር ለመምስረት በቤተክርስቲያን/ሽርያ ፍርድ ቤት ስለጠየቀ ነው። 12. ልጄ ለመወለድ ዕቅድ ስላለኝ ነው። 13. ሌላ ምክንያት ካለ ይገለጽ	
38	(በአሁኑ ሰአት መላሹ የትዳር አጋር/ተቃራኒ ጾታ ንደኛ እያለው ከሆነ በነጠላ የመጣው) ምክንያቱ ይገለጽ	1. እሱ/እሷ ፈቃደኛ አልነበረም/ችም 2. ለየብቻ ተመርምረን ነበረ 3. እሱ/እሷ ከዚህ በፊት ምርመራ አድርጋ/ጎ ነበረ → 4. ሌላ ምክንያት ካለ ይገለጽ	ወደ ጥያቄ ቁ 41
39	በአሁኑ ሰአት መላሹ ከትዳር አጋር/ተቃራኒ ጾታ ንደኛ ጋር ከሆነ የመጣው) ወጤቱን ከማን ጋር ነው የሚቀበሉት?	1. በጋራ → 2. በግል 3. ሌላ ካለ ይገለጽ -----	ወደ ጥያቄ ቁ 44
40	የኤች.አይ.ቪ ወጤቱን በየግል የምትቀበሉ ከሆነ ምክንያቱ ይገለጽ	1. እሱ/እሷ ፈቃደኛ አልነበረም/ችም 2. እኔ ፈቃደኛ አይደለሁም 3. የኤች.አይ.ቪ ወጤቱን ከሰማን በኋላ ለመነጋገር ስለተስማማን ነው። 4. ሌላ ምክንያት ካለ ይገለጽ-----	
41	የትዳር አጋርዎ/የተቃራኒ ጾታ ንደኛዎ የየኤች.አይ.ቪ ምርመራ አንደሚያደርጉ ያወቃሉ?	1. አዎ 2. አያውቅም/አታውቅም →	ወደ ጥያቄ ቁ 43
42	አዎ ከሆነ ምላሹ የኤች.አይ.ቪ ምርመራ	1. የየኤች.አይ.ቪ ምርመራ የማድረግን	

	ማድረግ የትዳር አጋርዎ/የተቃራኒ ጾታ ጓደኛዎ ምን ተስማማቸዋል?	ወሳኔ ደግፎልኛል/ለች 2. የየኤች.አይ.ቪ ምርመራ የማድረግን ወሳኔ አልደገፈውም/ችውም 3. የየኤች.አይ.ቪ ምርመራ የማድረግን ወሳኔ ላይ ምንም አስተያየት አልነበረውም/ትም 4. የየኤች.አይ.ቪ ምርመራ የማድረግን ወሳኔ ላይ ተቃውሞም ወይም ድጋፍ አልነበረውም 5. የምርመራ ሃሳቡን ያቀረበው/ችው የትዳር አጋሪ/ተቃራኒ ጾታ ጓደኛዬ ነው/ነች 6. ሌላ ካለ ይገለጽ	ወደ ጥያቄ ቁ 44
43	ለትዳር አጋርዎ/የተቃራኒ ጾታ ጓደኛዎ የየኤች.አይ.ቪ ምርመራ አንደሚያደርጉ ካልተናገሩ ምክንያቱ ይገለጽ	1. እሱ/እሷ ውጤቱን ለሌላ ሰው እንዳይነግር/ትነግር 2. ከእሱ/እሷ ወጪ ግብረሰጋ ግንኙነት አድርገዋል/ሻል ብሎ/ላ እንዳይጠረጥር 3. በምርመራ ጉዳይ ላይ መነጋገር ፈቃደኛ አይደለም/ችም 4. ለጊዜው በጸብ ላይ ስለሆንን 5. ከእሱ/እሷ በአቅራቢያ ስለሌለ/ች 6. በአጋጣሚ ስለመጣሁ 7. መጀመሪያ የራሴን ማወቅ ስለፈለኩ 8. የኔ መመርመር የሱንም ውጤት ስለሚገልጽ 9. የመመርመር ምክንያት ያለኝ እኔ ስለሆንኩ 10. ሌላ ካለ-----	
44	ኤች.አይ.ቪ በደምዎት ቢገኝ ለማን ይናገራሉ?	1. ለማንም አልናገርም 2. ለባለቤቴ/ፍቅረኛዬ/ወሲብ ጓደኛዬ 3. ለዘመዴ/ቤተሰብ 4. ሌላ ካለ ይገለጽ	

ጥያቄዎችን ለይስለቹ በመመለስ ስለተባበሩን እጅግ በጣም እናመሰግናለን፡፡

ጠያቂ ስም-----

ፊርማ-----

Annex – 4

Focus Group discussion Protocol

Tentative Program Topic Guide

Focus Group Discussion Protocol

Good morning (afternoon), Thank you for your coming here

- My name is _____
- My colleague besides me is called _____
- We came from AAUMF

This will be read for them

- We will conduct brief introduction and will talk about several different issues.

We will ask you some questions about your general experience with the current disease HIV/AIDS in your locality and issues of couples Voluntary HIV Counseling and Testing (VCT).

We will end the session by asking you for your suggestions on how couples VCT program can be improved and strengthened in your community in the future.

- Potential use of Data

The information we are going to gather in relation to couples VCT program will be utilized to improve the program in a better way.

• Issues of Confidentiality

Please be certain that any information collected here is completely confidential. The research team or other participant will not directly share the gathered information in away that would reveal an individual's personal identify.

Consent for participation and Tape – recording

It is necessary that we obtain your comment for to conduct the session. Please understand that this is more for your protection than any thing else.

Read Consent form loud to the group

- Your remaining in this session indicates that you are volunteer and agreed to participate for the discussion you have the right to refuse to answer any questions and end the discussion if you find it necessary to do so. For the sake of accuracy and efficiency, we will tape-record the sessions, unless there is objection.
- Responsibility of Note taker/Moderator.

The moderator will facilitate the discussion. The moderator will keep truck of the discussion along the main issues. The moderator will not give any indication (Verbal/physical) that encourages certain types of comments or discourage other types of comments. Generally, the moderator will guide the session if necessary, but taking care not to lead the discussion. Our role will be facilitation and your role will be telling us what you think.

The note Taker will be responsible to capture the session as accurately as possible. This will includes not only participants' responses, but also nonverbal actions, physical environment, atmosphere of the session as well as other important peculiar manifestations of that particular session.

Importance of Total Group/Responses

In this group and session every body should feel free and talk freely. Each and every option/idea/ is important and wanted. It is vital that all the group participants get a chance to express their idea (opinion).

In this session there are no wrong or right answer. Everybody can express the opinion or attitude pertinent to him/her. When you express your opinion idea, you are encouraged to be honest in your view of HIV/AIDS prevention and VCT service program. We want you to focus your comments on the program and not toward each other or member of the group.

Focus Group Discussion: - Topic Guide

Parts I: - Introduction

At this moment, we would like you to introduce yourself to the rest of the group.

Let's start with the research team.

- Name
- Age
- Education
- Work experience...etc (in short)

Part II: - Ice breaking Question/Warming up/

To show concern about people, start by asking them how they cope with life, their jobs, health, etc.

Next we would like to hear a little about your experience or knowledge about HIV/AIDS.

1. What do you think the result of sexual partner of somebody who is HIV infected will be, if tested?
2. We would like you to tell us the difference between HIV and AIDS?

Probes:

1. Would you explain further?
2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there any thing else?

Part III. Voluntary HIV Counseling and testing program

Now we would like to ask you about voluntary HIV counseling and testing (VCT) service.

1. Have you heard of couples Voluntary Counseling and Testing?
2. What do you think about testing and counseling for HIV/AIDS as a couple?
 - Is it good or bad?
 - Pleasant or unpleasant?
 - Easy or difficult?

3. What are the usual reasons people go for CVCT in this area? Where do people go for CVCT service?
4. What are the benefit and harms of CVCT?
5. To whom do you think people comply to accept HIV testing and counseling as a couple?
6. You have the intention to ask your partner for VCT?
 - Why?
 - Why not?
7. Is there any cultural and religious practice in the area that could promote/prevent CVCT service utilization? Example? Is it acceptable? Why?
8. Is there any service delivery related problem that could prevent VCT service utilization?

Recommendation /Suggestion/

Up to now we have talked about one of the preventive programs of HIV/AIDS; CVCT. We would like to ask you what other things could be done to make this program (CVCT service) better acceptable in the community?

Thinking about the issues we have discussed, what recommendations/suggestions would you make on VCT program?

Probes: -

1. What do the rest of you think?
2. Would you explain further?
3. Would you give me an example?
4. Is there any thing else, remained?

We thank each of you for your time and cooperation and we do appreciate all your suggestions and ideas. At this point is there any thing we forgot to ask or any thing you would like to mention before we close the session?