



**ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
SCHOOL OF PUBLIC HEALTH**

**ASSESSMENT OF VOLUNTARY COUNSELING AND
TESTING UTILIZATION AMONG PREPARATORY
STUDENTS IN HAWASSA TOWN, SNNPR, ETHIOPIA.**

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Acronyms

AIDS:-	Acquired Immunodeficiency Syndrome
AOR:-	Adjusted Odds Ratio
ART:-	Anti Retroviral Therapy
BCC:-	Behavior change communication
BSS:-	Behavioral surveillance survey
CI:-	Confidence Interval
EPHA:-	Ethiopian public Health Association
FMHAPCO:-	Federal Ministry of health HIV/AIDS prevention and Control Office
HIV:-	Human Immunodeficiency Virus
IEC:-	Information, education, communication
ISY:-	In-School-Youth
MOH:-	Ministry of health
OR:-	Odds Ratio
PLWHA:-	People Living with HIV/AIDS
SNNPR:-	Southern Nations and Nationality peoples Region
STI:-	Sexually Transmitted Infections
UNAID:-	United nations program on HIV/AIDS
UNIGASS:-	United nations general assembly special session for HIV/AIDS
VCT:-	Voluntary Counseling and Testing

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Summary

Background:- HIV voluntary counseling and testing is an entry point to both prevention and treatment. Adolescents have to know their HIV sero status to enable them to seek appropriate treatment as well as to enable them to choose prevention strategies and adopt safe sexual behavior. For effective service delivery in an area and the country recent and local information is very important.

Objective:-Assessment of VCT utilization among preparatory students in Hawassa town.

Method:- The study was A cross-sectional quantitative study a total of 570 preparatory students were selected using a two-stage sampling proportional to size method.

Result:- Five hundred thirty (95.8%) of the study participants had good knowledge and attitude toward HIV/AIDS and VCT. Two hundred twenty three (40.3%) had VCT in the past 70(12.6%) females and 153(27.7%) males. With regard to service provision the majority preferred health professionals, integrated VCT center followed by self standing, face to face and weekends followed by after working hour as service provider, scheme, way to get HIV test result and convenient time. The finding showed that, not having history of previous sexual practice and self standing VCT service scheme preference had significant positive-associations while sidama in ethnic and married had significant negative- associations with VCT utilization.

Conclusions:- The finding reflects knowledge-practice gap and IEC/BCC should be provided in a way that inspire preparatory students, make them perceive the benefits and drive them to practice. It is also advisable to provide voluntary HIV counseling and testing services in self standing-VCT-center and youth-center and in extra regular working hours (weekends and after working hour).

1 Introduction

1.1 BackGround

HIV/AIDS is a serious public health problem globally 33 million people are living with HIV with 2.7 million new infections in 2007. Sub-Saharan Africa remains the most seriously affected region. AIDS has been the leading cause of death there. About 35% of HIV infection and 38% of AIDS death in 2007 occurred in sub-Saharan Africa. Sub-Saharan Africa is home to 67% of people living with HIV/AIDS globally. Young people aged 15-24 account for an estimated 45% of new HIV infection worldwide and 2 million less than 15 years children live with HIV almost 90% live in sub-Saharan Africa in 2007(1).

Ethiopia is one of the countries hard hit by the HIV/AIDS epidemic. Since the first two reported AIDS cases in 1986, the disease has spread at an alarming rate throughout the country. The point prevalence estimate in 2007 showed that, the number of people living with HIV/AIDS was 977,394 and of these 578,018 (59%) were females. The national adult HIV prevalence in the same year was estimated to be 2.1% of which 7.7 % was from urban and 0.9% from rural (2). According to the 2006 report of AIDS in Ethiopia, people between 15-24 years had the highest prevalence of HIV, 5.6% (3).

Voluntary counseling and testing (VCT) for HIV infection is a process for providing individuals or couples with HIV test. VCT consists of pretest counseling about whether to take an HIV test and what one's personal risks are for HIV infection. If the client decides to take the HIV test he or she then receives test results, during a post Test counseling session clients work with the counselor during the post test counseling session to develop life plans for behaviors that protect themselves and others from HIV transmission and they receive referrals for needed services(4).

Voluntary counseling and testing is much more than drawing and testing blood and offering a few counseling sessions. It is a vital entry point to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, tuberculosis (TB) control, psychosocial and legal support and prevention of mother to child transmission of HIV (5).

High quality VCT enables and encourages people with HIV to access appropriate care and is an effective HIV prevention strategy. VCT can also be an effective behavior-change intervention. VCT offers a holistic approach that can address HIV in the broader context of people's lives including poverty and its relationship to risk reduction practice (5).

There is demand for VCT (people want to know their HIV status). Demand can also be created when comprehensive services are made available and stigma is reduced (5). Experiences in several Sub-Saharan African countries reveal that youth actively seek and receive voluntary counseling and testing though many have expressed concerns about confidentiality, cost, access and lack of trust in their sexual partners (6).

Ethiopia responded to the HIV/AIDS epidemic as early as 1985. As part of this effort the federal ministry of health (FMOH) published the first counseling and testing guide lines in 1996, the second in 2002 and has a new version in 2007 (7), and Ethiopia implement VCT as one of the program for the road map accelerated access to HIV/AIDS prevention, treatment, care and support by 2010(7). In 2007 there were 1005 voluntary counseling and testing sites and 1.9 million people tested for HIV in the same year (8).

In Ethiopia currently most people remain UN aware of thiere HIV status due to various reasons. However, with the development of affordable and effective medical care for people living with HIV, testing is increasing rapidly, creating urgent need to increase access. The availability of HIV counseling and testing services in Ethiopia has been un even, and even when available, up take has been relatively very low. Many people are reluctant to learn thiere HIV status due to various reasons. When medical care for HIV related illnesses and psychosocial support does not exist, and in the absence of community support and legal protection when they face discrimination and social marginalization (7). There are studies that showed factors associated with VCT utilization in the general and specific groups of population in Ethiopia however there is no study that showed factors associated with VCT utilization among preparatory students in the country or specifically in Hawassa town. This study will assess VCT utilization among preparatory students in Hawassa town.

2 Literature Review

2.1 Global and national over view of HIV/AIDS

HIV/AIDS is a serious public health problem globally 33 million people are living with HIV with 2.7 million new infections in 2007. Sub-Saharan Africa remains the most seriously affected region. AIDS has been the leading cause of death there. About 35% of HIV infection and 38% of AIDS death in 2007 occurred in sub-Saharan Africa and Sub-Saharan Africa is home to 67% of people living with HIV/AIDS globally. Young people aged 15-24 account for an estimated 45% of new HIV infection worldwide and 2 million under 15 years children live with HIV almost 90% live in sub-Saharan Africa in 2007 (1).

Ethiopia is one of the countries hard hit by the HIV/AIDS epidemic. Since the first two reported AIDS cases in 1986, the disease has spread at an alarming rate throughout the country. The point prevalence estimate in 2007 showed that, the number of people living with HIV/AIDS was 977,394 and of these 578,018(59%) were females. The national adult HIV prevalence in the same year was estimated to be 2.1% of which 7.7% was from urban and 0.9% from rural (2). According to the 2006 report of AIDS in Ethiopia, people between 15-24 years had the highest prevalence of HIV, 5.6% (3). HIV infection is acquired predominantly through behavioral factors like UN protected sexual intercourse and multiple sexual partners and perinatal transmission from an infected mother to child is the other key way that the virus spread (9). Although some countries are on course to meet the 2010 targets in the declaration of commitment others are not. Many countries will not achieve universal access to HIV prevention, treatment, care & support by 2010 or begin to reverse the epidemic by 2015. To halt the epidemic effectively responses to HIV/AIDS should be tailored to local needs (10).

2.2 Over view of VCT

The high rates of HIV infection and the risky sexual behavior among youth make it crucial to find programs to prevent infection and mitigate the effects of HIV in this age group, because there is evidence that many adults benefit from VCT there is increasing interest in extending these services to young people (11).

Voluntary counseling and testing (VCT) for HIV infection is a process for providing individuals or couples with HIV test. VCT consists of pretest counseling about whether to take an HIV test and what one's personal risks are for HIV infection. If the client decides to take the HIV test he or she then receives test results during a post Test counseling session clients work with the counselor during the post test counseling session to develop life plans for behaviors that protect themselves and others from HIV transmission and they receive referrals for needed services. VCT counseling aims to help adolescents evaluate their own behavior and its consequences. A negative test result offers the opportunity to recognize vulnerabilities and develop risk reduction plans to adopt safe behaviors, young people who test HIV positive can receive referrals for care and have opportunities to discuss and understand and what their HIV status means and what responsibilities they have to themselves and others as a result (4).

To date there are no studies that have followed youth in the developing world to determine whether they reduce their HIV risk behaviors as a result of undergoing voluntary HIV testing and counseling. There are however such impact studies among adults in developing countries and among youth in industrialized countries (6). Studies among adults in developing countries reported behavioral change after VCT on a range of indicators, including condom use, reduction in number of partners and reduction in STI incidence (6). A multicenter VCT efficacy trial in Kenya, Tanzania and trinidad found a number of changes due to VCT (12). Studies of VCT impact among youth in the United States do provide evidence that some youth adopt safe behaviors after testing. Although the U.S studies often focus on high risk individuals such as drug users, run aways, and those in high prevalence areas. (6). Testing for HIV is the gate way to treatment care and prevention. To scale up treatment & prevention rapid increases in both the volume of testing and the ability to counsel those who are tested are needed (13).

In Ethiopia there are three types of HIV testing client initiated, or voluntary counseling and testing, provider initiated testing and counseling and mandatory HIV screening and voluntary counseling and testing is delivered in four models, through integrated services, stand alone, outreach and mobile services (7). Although additional efforts are needed to prevent new HIV infections and provide universal access to treatment, care and support, site expansion for access of services of HIV counseling and test (HCT), prevention of mother to child transmission (PMTCT) and ART has shown dramatic change over the last three years(8). HCT site expanded from 658 in 2005 to 1005 in 2007, ART site expanded from 192 in 2005 to 272 in 2007, PMTCT site expanded from 32 in 2005 to 458 in 2007. Number of people tested has increased from 564,000 in 2006 to 1.9 million in 2007 due to national AIDS campaign initiative and free ART provision has increased from 53,889 in 2006 to 72,600 in 2007(8).

2.3 The demand, determinant and practice of VCT

In many developing countries VCT has not been available to young people however, when young people are asked about whether they would like to be tested they often say they would like VCT to be more widely available and would like to be tested (6). Similarly a report from family health international showed that there is demand for VCT (people want to know their HIV Serostatus). Demand can also be created when comprehensive services are made available and stigma is reduced (5).

A Study conducted in the general population in Gondar town and the surrounding areas indicated that 93.8% reported their willingness to use VCT services if made available free of charge (14).

A study conducted in North & South Gondar administrative zones showed that the highest VCT acceptance was observed among 15 to 19 years where 91.2% opted to accept VCT (15). In a study done in Gondar among high school students, majority of the students have adequate knowledge about HIV/AIDS and VCT while their perception of HIV risk and practice of protected sex is low. Over 82% of respondents approved screening for HIV as prerequisite for marriage and 97.2 % agreed to have VCT service (16). Similarly 90.5% of respondents among out of school youth in Diredawa town said that they have desire for VCT (17).

Various factors have been identified for the low uptake of VCT. Un matched case control study on determinants of VCT uptake among pregnant women attending ANC in Addis Ababa City indicated that there was no statistically significant association between socio demographic variables (age, religion, marital status, educational status, occupation, perceived susceptibility, economic status, monthly income), women's knowledge about HIV/AIDS and PMTCT and up take of HIV testing, also sexual risk behavior such as perceived vulnerability to HIV /AIDS, condom utilization, sex with non regular partner had no statistically significant associations however perception on confidentiality of test results and ability to access continued medical cares were significantly associated with HIV testing uptake (18).

A study on utilization of premarital HIV testing services and determinates of VCT in Addis Ababa indicated that out of the total number of respondents (55.6%) had premarital HIV testing and the reasons given for not doing by those who did not have were reported to be not feeling at risk (57.8%), having never thought about it (23.9%), having had HIV testing for another reason (8.1%), fear of a positive test result (4.9%) and fear of stigma (4.6%). It also showed that socio demographic variables, previous sexual history, knowledge about HIV/HCT and self perceived susceptibility were not found to be significantly associated with having had pre-marital HIV testing. However discussions between partners about HIV and equally discussion between partners about VCT was strongly associated with premarital HIV testing (19).

In a study done among 15-49 years age group in Harar, intention of having VCT in males was more likely in condom users and in females who had no previous sexual contact and the never married ones. Males who had no previous sexual contact and have never been married were more likely to report intention of asking their partners to get VCT than their counter parts. Females whose age is greater than 25 years were less likely to intend to ask their partner for VCT as compared to the age group 25 years and younger (20).

In a study done in Afar among out of school youth respondents being female and being Christian were positively associated with willingness to take VCT services and adequate knowledge of the preventive methods and transmission of HIV among out of school youths were positive predictors of willingness for VCT services (21).

Another study on factors affecting acceptance of VCT among different professional and community groups in north and south Gondar administrative zone showed that the area of residence (rural or urban), sex, educational level, knowledge on HIV and susceptibility perception doesn't make difference in VCT acceptance (15).

Another study on determinants of knowledge of HIV status in south Africa Results from A population based HIV survey reported that from the total sample 27.6% ever & 7.8% new their HIV status in the past 12 months. In multivariate analyses being female, the age group 25-34 years old, higher educational level, being employed, urban residence, awareness of a place nearby where one could be tested for HIV, impacts of HIV on the house hold and having had two or more sexual partners in the past year were associated with knowledge of HIV status (22).

Also another study on survey of motivation for use of VCT services for HIV in a high risk area of Shenyang, China indicated that the major demographic characteristic among 2676 VCT clients were 41.1% were in the age range 20-30 years, 73.1% were males and 67.1 % had attained the level of junior high school education. The primary information source for VCT services was mass media like television and newspaper in 88.9%. 34.3% were afraid of the result of infection which was main barrier to accept VCT services and among 540 participants answering the provided question 75.2% were motivated by recently acquired knowledge about HIV (23).

Family health international VCT toolkit reported that availability and acceptance of VCT services including legal issues, waiting time, costs, pressure by health staff to notify partners, worries about confidentiality, in accurate risk perception, stigma, perceptions of consequences of living with HIV, inadequate response from the health care provider about prevention, care and support needs of youth were barriers to VCT services for young people (5).

According to Ethiopian behavioral surveillance survey 2006, 41.3% (43.4% of males and 39.2% of females) knew of a confidential HIV testing service in their community with regional variations 54.6% in the Harari region to only 20.8% in the Benshangul-Gumuz region. Only 9.3% of ISY had undergone an HIV test. The highest proportion of tested ISY was reported in the Harari (16.1%) and Tigray (15.3%) followed by Addis Ababa, Afar, Diredawa and SNNPR respectively (10.8%, 8.8%, 8.4% and 8.3%). It also reported

that HIV test was significantly different between males and females on bivariate analysis and VCT services had been used by less than 4% of youth reporting risky sex in the last year (9).

A study among youth in Diredawa indicated that 28.6% of the total respondents had undergone VCT test before (23.4% male and 34.5% female), 2.2% did not have any information about VCT and sex, age, marital status and sexual initiation had statistically significant associations with VCT utilization, females were more likely to be tested than males, older youth were more likely to be tested than younger youth and sexually active youth were more likely to be tested than non-sexually active youth while Education, ethnicity, occupation and income didn't show statistically significant associations with VCT utilization. In this study it was also shown that knowledge of VCT users was better than that of non-users. But there was no statistically significant association seen in stigma towards HIV/AIDS between VCT users and non-users (17).

A study among in-school youth in Butagira indicated that 18.5% (10.8% males and 7.7% females) had undergone VCT and VCT was affected by age, education and previous sexual experience. It showed that previous sexual experience and high susceptibility perception were associated with low willingness to undergo VCT. Regarding preference of professionals as counselor, it showed that 52% of the students preferred trained VCT counselors, followed by physicians (25.2%), HIV patients (10.5%) and religious leaders (5.8%) (24).

Another study among health care professionals in Tanzania indicated that 34.5% of the study population reported to have attended VCT center and as there was no statistically significant difference between VCT attendance with regard to gender, age groups and sexual exposure. It also showed that with regard to the preferred models of service provision, 72.5% reported that the service should be integrated in to youth programs and also 66.4 % reported that VCT services should not be mixed with adults. (25)

2.4 Rational of the study

Children and youth have unique vulnerability to HIV infection. Youth (15-24) years are particularly vulnerable to HIV because of strong influence of peer pressure and the development of their sexual and social identities which often leads to experimentation (7). Young people aged 15-24 account for an estimated 45% of new HIV infection worldwide in 2007 and in Ethiopia people between 15-24 had the highest prevalence of HIV, 5.6 % (3).

Voluntary counseling and testing is an important tool for preventing infection and it allows young people to evaluate their behavior and the consequences there of. Knowledge of HIV status is the gate way to behavioral change, treatment, care, support and has documented prevention benefits. However, current reach of HIV services is poor and up take is low largely because of fears of stigma and discrimination (26).

To scale up treatment and prevention rapid increases in both the volume of testing and the ability to counsel those who are tested are needed, the use of testing globally however is very low. Estimates on surveys in 12 high burden countries in sub-Saharan Africa indicated that a median of just 12 % of men and 10 % of women in the general population have been tested for HIV and received test results (13). And according to Ethiopian BSS only 9.3% of in-school-youth were tested for HIV in 2006 (9).

VCT services may have to be general or targeted depending on a range of factors including HIV prevalence, risky sexual behaviors, level of stigma, access to hard- to-reach groups and supportive legal and policy environment (5). Despite various factors have been identified for the low uptake of VCT globally and in the country among the general and special groups of population there is no study that showed what factors are associated with VCT utilization among preparatory students in the country or in Hawassa town so this study will provide important information for effective service delivery in preventing HIV/AIDS and in order to enhance the effective delivery of VCT services in the area and possibly the country by assessing VCT utilization among preparatory students in Hawassa town.

3 OBJECTIVES

3.1. General Objective

To assess VCT utilization among preparatory students in Hawassa town.

3.2. Specific objectives

To describe knowledge and attitude toward HIV/AIDS and VCT.

To assess the prevalence of VCT utilization among preparatory students.

To identify factors associated with VCT utilization among preparatory students.

4. Methods and Materials

4.1 Study Area

The study was conducted in Hawassa town. Hawassa town is the capital city of SNNPR located 275 km away from Addis Ababa.

It has 8 subcities and 32 kebeles. Hawassa town has a population size of 259,803, 133,637 males and 126,166 females. In the town 7 preparatory schools are found 1 governmental and 6 nongovernmental with a total of 3589 preparatory students. There are 1 governmental and 3 nongovernmental hospitals 48 nongovernmental clinics, 3 public health centers, 3 ART sites, 11 HCT centers, 12 health posts. In 2001, 42,188 people took VCT and 1595 were positive. The study is a cross sectional survey using quantitative method.

4.2 Study Population

4.2.1 Source of Population

All in-school youth in the age group 15-24 who were preparatory students in Hawassa town.

4.2.2 Study subjects

The study subjects were preparatory students in the age groups 15-24 sampled from the source population and fulfilled the inclusion criteria.

4.2.3 Inclusion and Exclusion Criteria

In-school youth, and who had lived for at least 6 months in Hawassa were included in the study. Youths who were unable to participate due to illness or mental problem were excluded.

4.2.4 Sample size

Sample size was determined using the formula for a single population proportion.

$$N = \frac{z^2 p (1-p)}{d^2} + 10\% \text{ non response rate}$$

$$\text{Total sample size} = 518 + 10\% = 570$$

Prevalence of VCT uptake for in-school youth for the country 9.3% (9), confidence level of 95 % and 2.5 % margin of error was taken and 10% was added to compensate for non response rate which is equal to total sample size of 570.

4.2.5 Sampling procedure

A two - stage sampling techniques was used to select the study participants. First from all 7 preparatory schools 30 classes were selected by using probability sampling proportional to size method, second the sample size was equally allocated to the selected classes and the study participants from the selected classes were selected by systematic sampling techniques.

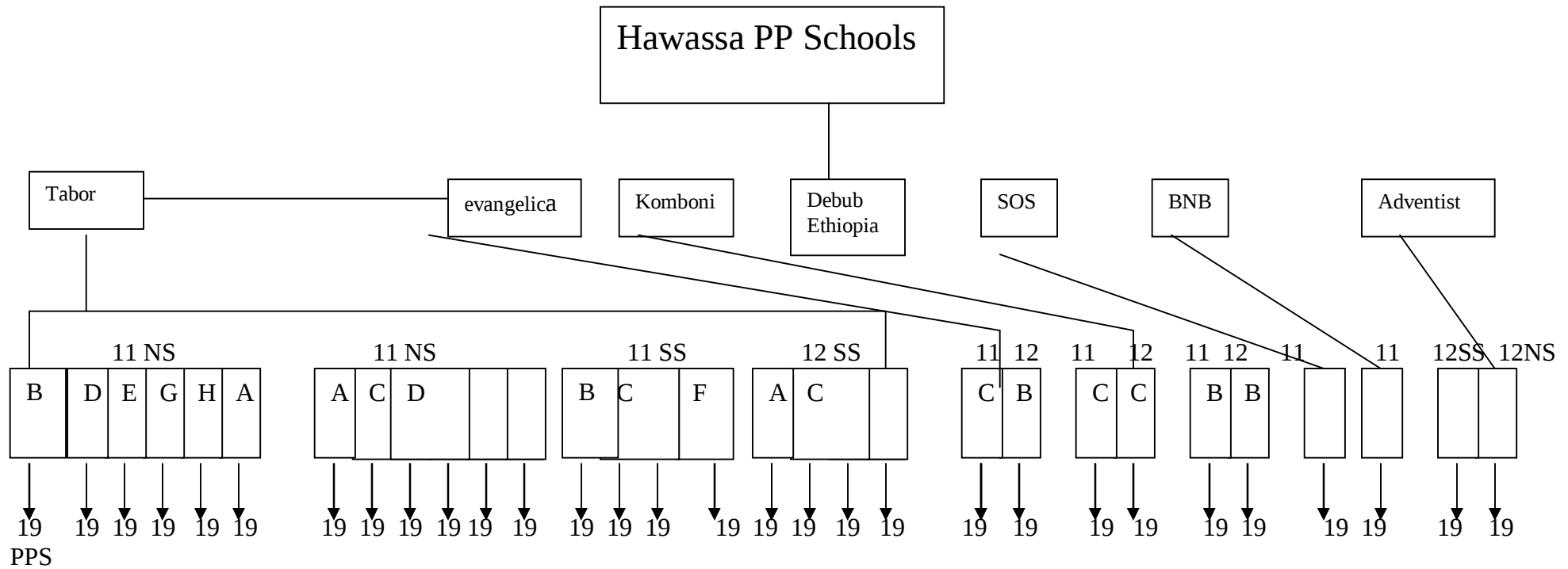


Fig 1 schematic presentation of sampling technique

Key

pp: -preparatory

pps: - preparatory students

NS: - natural science

SS: - social scienc

4.3 Data Collection tools and Procedure

4.3.1 Data collection procedure

Structured questionnaire was used to collect data. The questionnaire was derived from the ones used for conducting Behavioral surveillance survey of Ethiopia. It consisted of sections on socio demographic variable, sexual history and condom practice, knowledge of HIV and VCT and stigma. Pretesting of the questionnaire was carried out to verify clarity of the questions and based on the pretest questions were revised and edited. Data were collected by 1 supervisor and 4 data collectors who were Hawassa university graduating health science students. Two days of training was given for the supervisor and data collectors on the purpose of the study, study instruments and methods of data collection. Self administered data collection techniques was used to collect the data and the questionnaire was delivered by hand for each study participants, for about 19 study participants to fill at a time. Orientation was given on how to fill the questionnaire and the study participants were allowed to ask when they did have unclarity for the questions.

4.3.2 Study Variables

Dependent variable

VCT utilization

Independent variables

- 1 Socio demographic variables (age, sex, religion, ethnicity and marital status)
- 2 Socioeconomic variables (living arrangement, family income)
- 3 Knowledge and attitude toward HIV/AIDS and VCT
- 4 Susceptibility perception for HIV infection
- 5 Sexual history and condom use
- 6 Stigma towards HIV/AIDS
- 7 service factors

4.3.3 Operational definitions

VCT uptake- ever use of HIV testing service.

Sexual intercourse- refers only to penetrative vaginal sex.

Stigma-negative feeling toward PLWHA (toward serostatus disclosure.)

Good knowledge and attitude toward HIV and VCT – when the respondent correctly responded for 7 or greater than 7 of the provided 13 knowledge and attitude questions.

4.3.4 Data Quality control

The structured questionnaire was adopted from the behavioral surveillance survey questionnaire. Its English version was translated in to Amharic version and again back to English so as to ensure its consistency. Training was given for the supervisor and data collectors on the purpose of the study, study instruments and methods of data collection, as self administered data collection techniques was used to collect the data the questionnaire was delivered by hand for each study participants, for about 19 study participants to fill at a time. Orientation was given by the data collectors on how to fill the questionnaire and the study participants were allowed to ask when they did have unclarity for the questions. The principal investigator and the supervisor checked the collected data for completeness and clarity throughout the data collection period.

4.4 Data processing and Analysis

Data were entered using the EPI INFO version 6.04 statistical package and were cleaned and analyzed using SPSS version 15 computer software package for different variables, frequencies, odds ratio (OR), 95% CI and P. value at 5% was computed, cross-tab was done for each covariates of VCT utilization and multivariate logistic regression analysis was done to assess the relative effect of various explanatory variables on VCT utilization. The result of the study was presented in tables for further descriptions and interpretation.

4.5 Ethical issues

Before collecting the data permission was secured from SNNPR education bureau, SNNPR health bureau, informed consent was obtained from each study participants for those 18 years and older and for those less than 18 years old informed consent from the parent (guardian) and ascent from each study participants was obtained after explaining the purpose of the study and confidentiality of the information was ensured. The study was conducted after approved and ethically cleared by the medical faculty of Addis Ababa University.

5-Result

5-1 Socio demographic characteristics

Of the total 570 study participants 553 study participants completed the interview which makes the response rate 97.01%, 332 (60%) of the study participants were males, 282 (51%) were grade 11, 540(97.6%) were not married and 491(88.8%) were in the age group 15-19. The mean age of the study participants was 18.38 years (± 1.01 SD). 154 (27.8%) were Sidama 131 (23.7%) were Amhara by ethnicity and 264 (47.7%) were orthodox, 242 (43.8%) were protestants, 14 (2.5%) were catholics and 16 (2.9%) were muslims by religion. With regard to living arrangement 294 (53.2%) live with mother and father 81(14.6%) live alone, 76(13.7%) live with relatives and 72(13.1%) live with father or mother only. 41(7.4%) had family income of >1000 birr, 31(5.6%) had <300 birr. (Table-1).

Table1- 1: Socio demographic characteristics of Hawassa preparatory students, Hawassa, SNNPR, Ethiopia, February, 2010 (n=553).

<i>variables</i>	<i>Frequency</i>	<i>Percent</i>
Sex		
male	221	40
female	332	60
Age		
15-19	491	88.8
20-24	62	11.2
Religion		
orthodox	264	47.7
muslim	16	2.9
protestant	242	43.8
catholic	14	2.5
other	17	3.1
Level of education		
Grade 11	282	51
Grade 12	271	49
Ethnicity		
amhara	131	23.7
oromo	83	15.0
gurage	75	13.6
sidama	154	27.8
other	110	19.9
Marrital status		
single	540	97.6
Divorce/separate	1	0.2
widowed	1	0.2
married	11	2.0
Family average monthly income		
<300	31	5.6
300-600	25	4.5
600-1000	35	6.3
1000+	41	7.4
Do not know/no response	421	76.1
Living with		
Father and mother	294	53.2
Mother only	54	9.8
Father only	18	3.3
relatives	76	13.7
alone	81	14.6
other	30	5.4

5-2 Sexual practice and condom use

A total of 95 (17.2 %) of the study population reported to have sexual intercourse prior to the survey, 84 (15.2%) males and 11(14.6%) females. The minimum ages of first sexual experience reported were 10 years for males and 15 years for females and the mean age of first sexual experience was 16.74 ($\pm 1.8SD$) years. For those who were married the minimum ages of first marriage were 17 for males and 13 for females and the mean age was 17.2 ($\pm 1.5SD$). Thirty nine (41.1%) of the study subjects practiced multi partner sex in the last year and the mean number of sexual partners reported was 3.23 and 9 (9.5%) male had sexual intercourse before the age of 15 but no female had sexual intercourse before the age of 15. Fifty eight (10.5 %) of the respondents reported that they practiced sex with their boy/girl friend and 35(60.3%) used condom, 13(22.4%) used HIV testing and 10(17.2%) used no action to prevent HIV.

Among the total 66 respondents who practiced sex in the last year 56 (84.8%) ever used condom in the last year and with regard to frequency of condom use 40 (71.4%) used condom consistently in the last year. Twenty five (64.1%) of those who practiced mutipartner sex in the last year used condom in their last sexual intercourse. 22(4%) perceive they are susceptible to HIV and for the question provided to know the presence of STI in the past year, 7 (1.3%) reported that they had STI in last year. (Table -2).

Table-2: Condom use and sexual practice among Hawassa preparatory students. Hawassa, SNNPR, Ethiopia, February, 2010.

<i>Variables</i>	<i>female</i> No (%)	<i>male</i> No (%)	<i>total</i> No (%)
Ever had sex(n=553)			
yes	11(14.6)	84(15.2)	95(17.2)
no	209(37.8)	244(44.1)	453(81.9)
Practiced sex in the last year(n=95)			
Yes	8(8.4)	58(61.1)	66(69.5)
no	3(3.2)	25(26.3)	28(29.5)
Ever used condom in the last year(n=66)			
no	3(4.5)	7(1.1)	10(15.2)
yes	4(6.1)	52(78.8)	56(84.8)
Pattern of condom use(n=56)			
Some times	2(3.6)	14(25)	16(28.6)
always	2(3.6)	38(67.9)	40(71.4)
Multi partner sex in the last year(n=95)			
yes	1(1.1)	38(40.0)	39(41.1)
no	8(8.4)	40(42.1)	48(50.5)
Condom use in last sex(n=39)			
no	1(2.6)	5(12.8)	6(15.4)
yes	1(2.6)	24(61.5)	25(64.1)
Sex with boy/girl friend(n=553)			
yes	9(1.6)	49(8.9)	58(10.5)
no	1(0.2)	32(5.8)	33(6.0)
HIV prevention method used(n=58)			
condom	4(6.9)	31(53.4)	35(60.3)
HIV testing	2(3.4)	11(19.0)	13(22.4)
nothing	3(5.2)	7(12.1)	10(17.2)
STI in the past year(n=553)			
yes	0(0)	7(1.3)	7(1.3)
no	204(36.9)	301(54.4)	505(91.3)
Susceptibility perception(n=551)			
no	207(37.6)	293(53.2)	500(90.7)
yes	6(1.1)	16(2.9)	22(4.0)
Age at first sex(n=95)			
<15	0(0)	9(9.5)	9(9.5)
15-18	9(9.5)	55(57.9)	64(67.4)
18-20	1(1.1)	8(8.4)	9(9.5)
Age at marriage(n=11)			
<15	1(9.1)	0(0)	1(9.1)
15-18	5(45.5)	4(36.4)	9(81.9)
18-20	1(9.1)	0(0)	1(9.1)

5-3 Knowledge, attitude and practice toward voluntary HIV counseling and testing

To assess the respondents knowledge and attitude toward HIV/AIDS and VCT 13 questions were provided and those who answered 7 and above were taken to have good knowledge and attitude and those who score less than 7 were taken to have poor knowledge and attitude according to this 530 (95.8%) had good knowledge and attitude and 23(4.2%) had poor knowledge and attitude. Two hundred twenty three (40.3%) of the study subjects ever had VCT in the past and 432 (82%) of those who heard of VCT had the desire to have VCT whether they had before or not. (Table-3).

Table -3: knowledge, attitude, practice and source of information, toward voluntary HIV counseling and testing among Hawassa preparatory students, Hawassa, SNNPR, Ethiopia, February, 2010.

	<i>Female</i>	<i>male</i>	<i>Total</i>
	N0 (%)	No (%)	No (%)
Ever heard of VCT(n=553)			
yes	210(38)	317(57.3)	527(95.3)
no	11(2.0)	15(2.7)	26(4.7)
Source of information about VCT(n=527)			
Mass media	142(26.9)	186(35.3)	328(62.2)
Health worker	90(17.1)	168(31.9)	258(49.0)
Friends	21(4.0)	55(10.4)	76(14.4)
Neighbors/Family	9(1.7)	27(5.1)	36(6.8)
other	14(2.7)	26(4.9)	40(7.6)
Agree that VCT is important(n=527)			
yes	208(39.5)	307(58.2)	515(97.7)
no	1(0.2)	7(1.3)	8(1.5)
Had the desire to have VCT(n=527)			
yes	172(32.6)	260(49.3)	432(82.0)
no	29(5.5)	43(8.2)	72(13.7)
Ever had VCT in the past(n=553)			
yes	70(12.6)	153(27.7)	223(40.3)
no	139(25.1)	163(29.5)	302(54.6)

Reasons identified for the feeling that voluntary HIV counseling and testing is important were 396(71.6%) to know HIV status, 347(62.7%) to protect oneself from being infected, 315(57%) if positive to get ART, 302(54.2%) to be free from stress, 296(53.5) if positive not transmit to others, 292(52.8%) to get care and support and 5(0.9%) mentioned other reasons. Reasons for voluntary HIV counseling and testing given by those who ever tested for HIV were 195 (87.4%) to know HIV status, 12 (5.4%) ordered by health workers, 9(4%) donation of blood, 1(0.5%) to travel abroad and 6(2.7%) for other reasons. Reasons identified by those who were not willing to had voluntary HIV counseling and testing in the future were 25(34.7%) fear of test result, 12(16.7%) lack of confidentiality, 5 (6.9%) long waiting time for service, 4 (5.6%) inconveniency of service delivery, 2 (2.8%) fear of parents or others and 24 (23.3%) had other reasons (Table-4).

Table-4 Reasons for voluntary HIV counseling and testing and for non willingness to had voluntary HIV counseling and testing among Hawassa preparatory students, Hawassa, SNNPR, Ethiopia, February, 2010.

<i>Reasons</i>	<i>Frequency</i>	<i>Percent</i>
Reason for VCT(n=223)		
to know HIV status	195	87.4
ordered by health workers	12	5.4
donation of blood	9	4.0
to travel abroad	1	0.5
other	6	2.7
Reason for non willingness to had VCT(n=72)		
fear of test result	25	34.7
lack of confidentiality	12	16.7
long waiting time for service	5	6.9
inconveniency of service delivery	4	5.6
fear of parents or others	2	2.8
other	24	33.3

With regard to service preference 290 (55%) preferred week-ends and 93 (17.6%) after working hour as their convenient time and 122 (23.1%) preferred self-standing-VCT-center and 96 (18.2%) youth center as scheme of VCT service. (Table-5)

Table-5: voluntary HIV counseling and testing service preferences among Hawassa preparatory students, Hawassa, SNNPR, Ethiopia, February, 2010.

<i>Preferences</i>	<i>Frequency</i>	<i>Percent</i>
Preferred scheme		
Integrated VCT center	145	27.5
Self standing center	122	23.1
Youth center	96	18.2
mobile	57	10.9
In-school	56	10.6
Home to home	23	4.4
other	13	2.5
Preferred service provider		
Health professionals	299	56.7
Peer counselor	116	22.0
People living with HIV/AIDS	53	10.1
Any counselor	54	10.2
other	5	1.0
Preferred way to get test result		
Face to face	378	71.8
Secretive letter	104	19.7
telephone	11	2.1
Relative/partner	9	1.7
Do not know	25	4.7
Preferred convenient time for VCT		
Week ends	290	55.0
Usual working hour	130	24.7
After working hour	93	17.6
other	14	2.7

5-4 Stigma about HIV/AIDS

To know the respondents attitude of stigma about HIV/AIDS a one item question was provided and according to this 192 (34.7%) had stigmatizing attitude i.e. if a member of their family become ill with HIV they want it to remain secret. The reasons they gave for their stigmatizing attitude were 108 (56.3%) fear of discrimination, 61(31.8%) fear of stigma 39(20.3%), since difficult to tell, 6(3.1%) mentioned other and 7 (3.6%) no response. For the question asked whom they will tell their HIV test result if they test positive for HIV 204(36.9%) said to family, 169 (30.6%) to sexual partner , 148 (26.8%) to friends, 88(15.9%) to religious leaders, 69 (12.5%) to spouse and 52(9.4%) said to others.

5-5 Association of factors with voluntary HIV counseling and testing utilization

In the univariable logistic regression analysis age, religion, educational level, family monthly income, living arrangement, ever use of condom in last year, multi partner sex in last year, condom use in last sexual intercourse, pattern of condom use, stigma and risk perception were not found to have significant associations with VCT and sex, ethnicity, marital status, history of sexual practice and knowledge and attitude toward HIV/AIDS and VCT and VCT service scheme preference were found to have significant associations while in multivariate logistic regression analysis of variables that have significant association in the univariable logistic regression analysis or with p.value <0.1, sex, living arrangement, knowledge and attitude had no significant associations and ethnicity (sidama in ethnic) (AOR=0.44 95%CI 0.26,0.76), marital status (AOR=0.11 95%CI 0.02, 0.61), history of sexual practice(AOR=2.03 95%CI 1.19, 3.45) and VCT service scheme preference (AOR=2.03 95%CI 1.19, 3.47) had significant associations with VCT utilization. (Table-6)

Table-6: Factors associated with having been tested for HIV among Hawassa preparatory students, Hawassa, SNNPR, Ethiopia, February, 2010.

<i>Variables</i>	<i>HIV ever tested</i>		<i>Crude OR</i>	<i>Adjusted OR</i>
	<i>Yes</i>	<i>No</i>	<i>(95%CI)</i>	<i>(95%CI)</i>
Sex				
Female ^R	70	151	1.00	1.00
Male	153	179	0.54(0.38,0.78)	0.76(0.49, 1.17)
Ethnicity				
Amhara ^R	44	87	1.00	1.00
Oromo	34	49	0.73(0.41, 1.29)	0.64(0.34, 1.20)
Gurage	17	58	1.73(0.9, 3.31)	1.56(0.78, 3.12)
Sidama	84	70	0.42(0.26, 0.68)	0.44(0.26, 0.76)
Other	44	66	0.76(0.45, 1.23)	0.68(0.38,1.20)
Marrital status				
Single ^R	212	328	1.00	1.00
Married	9	4	0.12(0.03,0.54)	0.11(0.02, 0.61)
Ever practiced sex				
yes ^R	53	42	1.00	1.00
no	170	288	2.14(1.37,3.34)	2.03(1.19, 3.45)
Living with				
Father and mother ^R	111	183	1.00	1.00
With mother only	18	36	1.21(0.68, 2.24)	1.17(0.60, 2.28)
Father only	10	8	0.49(0.19, 1.27)	0.55(0.20, 1.51)
Relatives	37	39	0.49(0.39, 1.06)	0.64(0.36, 1.12)
Alone	36	45	0.76(0.46, 1.25)	0.76(0.43, 1.30)
Other	11	19	1.05(0.48, 2.28)	1.75(0.63, 4.90)
Knowledge and attitude toward HIV and VCT				
Poor ^R	4	19	1.00	1.00
Good	219	311	0.30(0.1, 0.9)	0.32(0.09, 1.19)
Preferred VCT service scheme				
Integrated ^R	69	76		1.00
Self standing	42	80	1.73(1.05, 2.84)	2.03(1.19, 3.47)
Mobile/home to home/ other	45	48	0.97(0.58, 1.63)	1.13(0.64, 2.00)
Youth center/in-school	65	87	1.22(0.77, 1.92)	1.17(0.71, 1.91)

R-Reference

CI-confidence interval

OR-odds ratio

AOR-adjusted odds ratio

6- DISSCUSSION

Two hundred twenty three (40.3%) of the study participants ever had VCT in the past and the observed VCT uptake was slightly higher compared to other studies (9,17,24,25) this rise in magnitude could be explained by the possibility that the nationwide AIDS campaign initiative in 2007, contributed for this. However, in terms of the benefits of VCT and in terms of meeting targets to combat against HIV/AIDS it is still low. This study observed factors associated with VCT as follow.

In the un adjusted logistic regression analysis age, Religion, education level, family monthly income and living arrangement had no significant associations with VCT utilization, the finding is similar with the study in Addis Ababa on determinants of VCT uptake and the study in Gondar on factors affecting acceptance of VCT, but it contradicts with the study in Butagira which showed willingness for VCT was affected by age and education (18, 15, 24).

Sex (being male) had negative association with VCT utilization but lost its association in the multivariate regression unlike many other studies that reported being female were positively associated with VCT utilization (9,17,21,22). Ethnicity (being sidama) in ethnic and marital status (being married) had significant negative associations with VCT uptake. The lower rates of VCT uptake in the married ones was also explained by the study in Harar which reported VCT uptake was higher in the never married but it contradicts with the study in Addis Ababa on VCT uptake among pregnant women (20,18). The lower VCT uptake in the married might be because they think they were on the safe side and were not susceptible to HIV.

In this study 95 (17.2%) of the participating preparatory students practiced sex previously and the mean ages of sexual initiation was 16.7 and the mean ages of marriage was 17.2. Sexual exposure had significant negative association with VCT utilization. Preparatory students who had not practiced sex previously were two times more likely to be tested for HIV than those who were sexually active despite cause-effect association could not be established, the possible explanations could be VCT enabled the users to delay sexual exposure or the sexually exposed had fear of test result to be tested. This

finding is similar with the study in Harar which reported intention of having VCT were more likely in females who had no previous sexual contact and the study on in-school-youth in Butajira (20,24).

39(41.1%) of the study participants who ever had sex had practiced multi partner sex, 56(84.8%) used condom in the last year, 40 (71.4%) of those who ever used condom used condom consistently and 25 (64.1%) of those who practiced multi partner sex used condom in their last sexual intercourse. In this study multi partner sex, condom use in the last year, pattern of condom use and condom use in last sexual intercourse had no significant associations with VCT utilization, this finding is consistent with the study in Addis Ababa city on determinants of VCT uptake among pregnant women attending ANC but contradicts with the study in Harar in which intention of having VCT in males was more likely in condom users and a population based study in south Africa in which having had two or more sexual partners in the past year were associated with knowledge of HIV status(18,20,22).

With regard to perception of risk for HIV on the unadjusted bivariate logistic regression analysis, susceptibility perception had no significant association with VCT utilization. This finding is consistent with the study in Gondar and studies in Addis Ababa (15, 18, 19). However it contradicts with the study in Butagira which showed high susceptibility perception was associated with low willingness to undergo VCT (24).

Knowledge and attitude toward HIV/AIDS had significant negative association with VCT utilization in the unadjusted bivariate analysis but not in the multivariate logistic regression analysis. This finding is consistent with other studies, with the Study in Gondar which showed knowledge on HIV does not make difference in VCT acceptance and the study in Addis Ababa where knowledge on HIV/AIDS was not significantly associated with VCT uptake (15,18) but contradicts with the study in south Africa , China and Diredawa which reported positive associations (22,23,17). The observation from this finding is the existence of knowledge practice-gap.

192 (34.7%%) of the study participants had stigmatizing attitude toward PLWHA and the reasons they gave for their stigmatizing attitude were 108 (56.3%) fear of discrimination, 61(31.8%) fear of stigma, 39(20.3%), since difficult to tell, 6(3.1%) mentioned other and 7 (3.6%) no response. Stigma was not associated with VCT uptake

in the un adjusted bivariate logistic regression analysis the study in dire dawa had also such finding unlike the report from family health international (17, 5).

Self-standing-VCT- center had significant positive associations with VCT utilization but VCT service provider and time for VCT had no associations with VCT uptake however significant numbers of study participants had varied needs and this reflects the importance of meeting such varied needs as were also reported in another studies (24, 25).

7-Strengths and limitations of the study

Strengths

- This study used structured questionnaire adopted from WHO, BSS.
- Use of probability sampling proportional to size sampling method enabled to include all the 7 preparatory schools in the town.

Limitations

- Cross-sectional nature of study, difficult to show causal associations with VCT utilization

8-conclusions

Knowledge regarding HIV/AIDS and VCT and willingness for VCT was high and VCT utilization was still low which reflected willingness-practice (knowledge-practice) gap and the study showed that Sidama in ethnic, married had significant negative-associations while not having previous sexual exposure and self-standing-VCT-center had significant-positive associations with VCT utilization. The study also showed that the majority preferred health professionals, integrated-VCT-center, weekends and face-to-face with regard to preference of service provider, VCT service scheme, convenient time and way of getting HIV test result respectively.

9-Recomendations

- The higher willingness-practice (knowledge-practice) gap reflects there was a gap in perceived benefits of VCT and IEC/BCC should be provided in a way that inspires preparatory students and enable them understand the benefits and drive them to practice.
- Service provision should consider preparatory students with varied service needs by accessing self-standing and youth-center VCT service.
- The majority of preparatory students preferred weekends and after working hour as their convenient time rather than the usual working hour for the service and this should also be considered to meet the need.
- Further study that assess the quality of the service provided and the consistency of VCT up take need to be conducted.

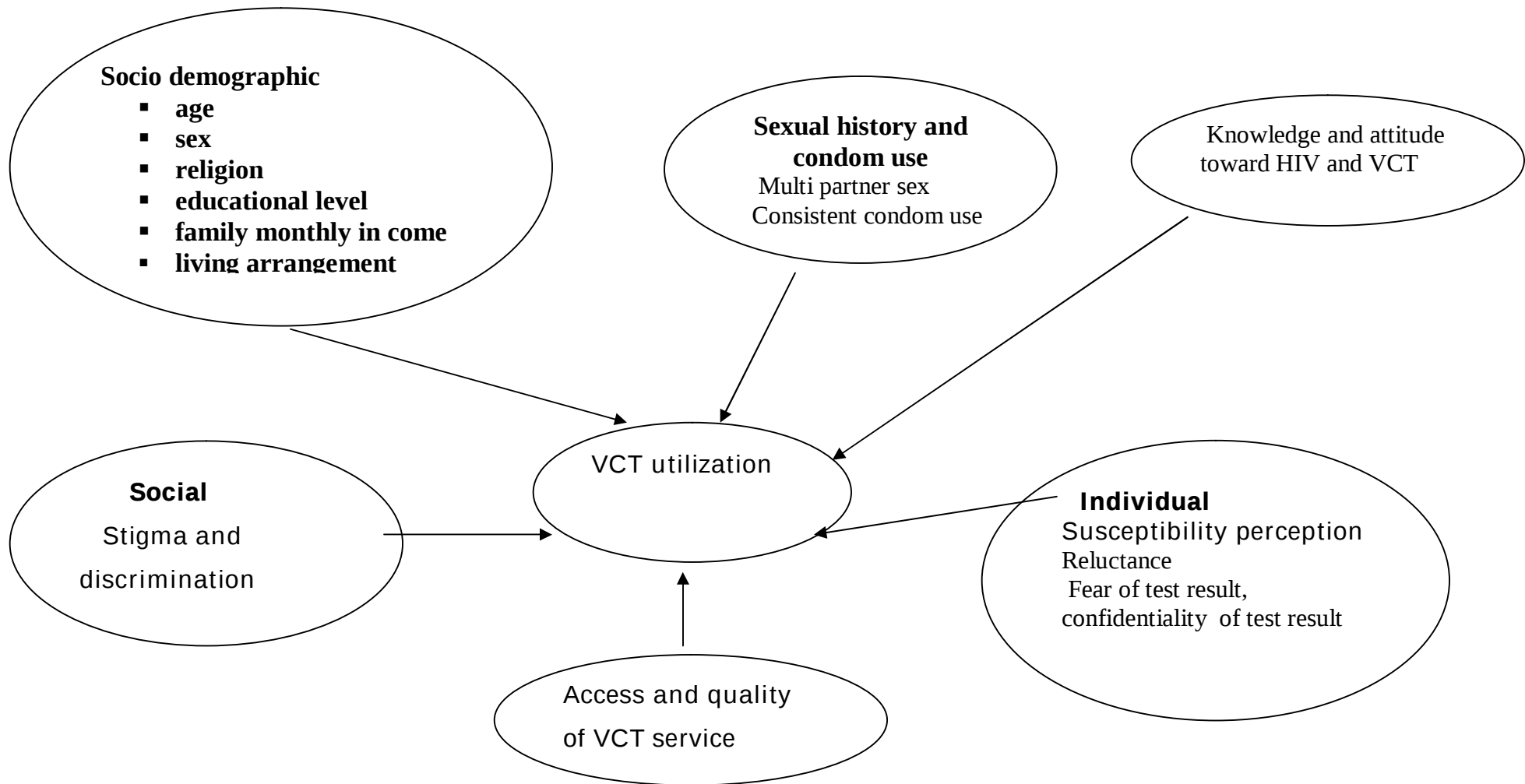
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11- Annex: Conceptual Frame Work



Conceptual frame work for VCT utilization

STRUCTURED QUESTIONNAIRE ENGLISH VERSION

Information sheet for study participants of age 18 years or older

Dear student we are conducting a study in Hawassa town that is to run by Addis Ababa University School of public health. The study assesses voluntary counseling and testing utilization among re preparatory students in Hawass town. The purpose of the study is to assess the prevalence of VCT utilization and to identify factors associated with VCT utilization among preparatory students in Hawassa town. The study will be conducted though self administrated questionnaire.

We are asking you for a little of your time to help us in this study by responding the provided questions. The information you gives us will not have any risks to you but could help to design appropriate VCT programs for youth. We would like to assure you that your answers are completely confidential your name will not be written on this form and will never be used in connection with any of the information you tells us rather a code number will be used your responses to any of the questions will not be given to anyone else and no report of the study will ever identify you, if a report of results is published only information about the total group will appear.

Informed consent for study participants of age 18 years or older.

I understand the purpose, the benefits of the study described in the information sheet, also as it has no risk to me, my role in the study, as confidentiality of the data will be ensured and I agree to participate in the study.

Signature of participant

date

Information sheet for study participant of age less than 18 years old

Dear (parent/guardian) we are conducting a study in Hawassa town that is to run by Addis Ababa University School of public health. The study assesses voluntary counseling and testing utilization among preparatory students in Hawass town. The purpose of the study is to assess the prevalence of VCT utilization and to identify factors associated with VCT utilization among preparatory students in Hawassa town. The study will be conducted though self administrated questionnaire.

We are asking you to allow your (child/ward) to share us a little of (his/her) time by responding the provided questions. The information (he/she) gives us will not have any risks to you or your (child/ward) but could help to design appropriate VCT programs for youth. We would like to assure you that your (child/ward) answers are completely confidential (his/her) name will not be written on this form and will never be used in connection with any of the information (he/she) tells us rather a code number will be used (his/her) responses to any of the questions will not be given to anyone else and no report of the study will ever identify (him/her), if a report of results is published only information about the total group will appear.

Informed consent for participants of age less than 18 years old.

I understand the purpose; the benefits of the study described in the information sheet also as it has no risk to my (child/ward), his/ her role in the study, as confidentiality of the data will be ensured and I agree to allow my child /ward to participate with his/her assent.

Signature of parent/Guardian

date

I understand what I must do in this study and I want to participate in the study

Signature of child/ward

date

Section –I Socio Demographic characteristics

No	Questions and Filters	Response coding categories	Skip to
101	Sex	Male.....1 Female.....2	
102	Age in year	_____year	
103	Religion	1. orthodox 2. Muslim 3. protestant 4. catholic 5. other	
104	Level of education	1. grade 11 2. grade 12	
105	Ethnicity	1. amhara 2. oromo 3. gurage 4. sidama 5. other(specify)	
106	Marital status	1. single 2. divorce/separate 3. widowed 4. married	
107	Family average monthly income	1. no in come 2. 50-150 3. 151-300 4. 301-600 5. 600-1000 6. 1001-1550 7. 1551+ 88 Don't know 99 No response	

108	Whom do you currently live with	1 With father & mother . .2 with father only 3 with mother only 4 With relatives 5 live alone other (specify)_____	
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Section II sexual history & condom use

No	Questions and Filters	Response coding categories	Skip to
201	Have you ever had sexual inter course	Yes.....1 No.....2 No response99	
202	If, yes at what age you had sex first	Age in year_____ Don't know88 No response.....99	
203	If you are married at what age had you first married	_____years	
204	Have you had sexual intercourse on the past one year?	Yes1 No..... 2 No response..... 99	
205	If yes have you ever used condom?	Yes1 No2	
206	If yes how often you have used condom when you have sexual intercourse in this one year	Always1 sometimes..... 2	
207	Did you practice multi partner sex in the last	Yes.....1 No 2	

	year.	No response.....99	
208	If yes with how many different people had you sex during the past one year?	_____ Number	
209	have you practiced sex with non regular partner	Yes.....1 No.....2 No response..... 99	
210	If yes was that in the last 12 month	Yes1 No.....2 Do not know99	
211	If yes have you used condom in your last sexual intercourse	Yes.....1 No2 No response.....99	
212	If you have a boy/girl friend do you ever have sex with your friend?	Yes1 No.....2	
213	If yes to Q 212 what was the action to prevent HIV	Condom.....1 HIV testing.....2 Nothing3 Other (specify)_____	
214	Did you have any STIS in the past one year	Yes1 No.....2 No response.....99	

Section III HIV/AIDS and voluntary counseling and testing

No	Questions and Filters	Response coding categories	Skip to
301	Do you have information on HIV/AIDS(check all that apply)	Yes.....1 No2	
302	From where did you hear about HIV/AIDS(check all that apply)	Health worker/facility.....1 Mass media(radio ,TV,news paper)2 Friends 3 Neighbors 4 Other(specify)_____	
303	How is HIV/AIDS transmitted? (check all that apply)	Sexual inter course1 Mother to child2 Transfusion of infected Blood..... 3 By sharing sharps.....4 Do not know.....88 Other(specify)	
304	Do you think you can get HIV/AIDS	Yes.....1 No2 No response.....99	
305	Can HIV transmitted with mosquito bite?	Yes.....1 No2 Do not know.....88	
306	Can a person get HIV by sharing a meal with some one who is infected	yes1 No.....2 Do not know88	
307	Can people protect them selves from HIV by having	yes1 No.....2	

	one uninfected faithful sex partner?	Do not know.....88	
308	Can people protect themselves from HIV by using a condom correctly every time they have sex?	Yes.....1 No2 Do not know.....88	
309	Do you think that a healthy looking person can be infected with HIV?	yes1 No2 Do not know88	
310	Have you ever heard of voluntary counseling and testing	yes1 No 2 Do not know.....88	
311	What was your first source of information about this service?	Health worker/facility1 Mass media(radio ,TV,news paper)2 Friends3 Neighbors/family4 Other(specify)_____	
312	Do you agree that VCT is important	Yes.....1 No2 Do not know88 No response.....99	
313	What are the reasons for the feeling that VCT is important (multiple response is possible needs probing)	To know the HIV status1 To protect one self from being infected.....2 If positive not to transmit to others..... 3 To get care and support.....4 If positive to get ART5 To be free from stress6 Other specify_____	

		I don not know 88 No response 99
314	Do you agree that any one should check his/ here HIV sero statuses	Yes -----1 No -----2 I don't know88 No response99
315	Do you have the desire to have VCT whether you have it before or not?	Yes -----1 No -----2 I don't know88 No response99
316	If no, what was your reason	Fear of parents or others1 Lack of confidentiality2 Inconveniency of service delivery.....3 Long waiting time for service4 Fear of test result5 Other (specify) _____
317	Who can benefit more from VCT (multiple response is possible)	Health workers.....1 Accidentally exposed persons -----2 Pregnant mothers3 People with history of un protected sexual intercourse4 Those with multiple sexual partners5
318	At which time should one be tested for HIV (multiple response is possible)	When one become sick.....1 Before marriage2 If only has had multiple sexual partners- 3 If only had history of un protected sexual inter course.....4 At any time5 other (specify) _____ I do not know.....88 No response -----99

319	Which scheme of VCT testing you preferred	Integrated VCT center ----- 1 Self standing center ----- 2 Mobile -----3 Home to home -----4 Youth – center -----5 In school -----6 Other (specify) _____ No response -----99
320	Whom do you prefer to be youth VCT provider	Health professionals -----1 peer counselor ----- 2 People living HIV/ AIDS -----3 Any counselor could be -----4 Other (specify) _____
321	Which way do you prefer to obtain the HIV test result	face to face1 Telephones2 Secretive letter.....3 Relative/ partner.....4 Other /specify _____ Do not know88
322	Which time do you think it is convenient for youth VCT service	In the usual working hour ----- 1 After working hours -----2 Weekends3 Other (specify) _____
323	Have you ever had VCT in the past	Yes1 No.....2 No response99
324	If yes what was your reason for VCT	Ordered by health workers ----- 1 Donation of blood ----- 2 just to know HIV status ----- 3 Premarital.....4

		To travels abroad ----- 5 Other (specify-----
325	If a person is with positive HIV status what should be the next action (check all that apply)	Inform partners and family -----1 Tell to no one -----2 Have protected sex -----3 Have unprotected sex 4 Stop having sex for life -----5 No response -----99
326	Do you know a person living with HIV/AIDS	Yes -----1 No -----2
327	Do you have a friend who received VCT service	Yes -----1 No -----2
328	Do you advice others to use VCT service	Yes -----1 No -----2
329	Do you ever used to discuss with your parents on HIV matters	Yes -----1 No -----2

Section IV Stigma and Discrimination about HIV/AIDS

No	Questions and filters	Response coding categories	Skip
401	If a member of your family become ill with HIV, the virus that causes AIDS would you want it to remain secret	Yes -----1 No -----2 Don't know -----88 No response -----99	
402	If yes, can you specify the reason?	Fear of discrimination...1 Fear of stigma ----- 2 Since no change----- 3 Since difficult to tell -- 4 No response ----- 99 Other (specify)-----	
403	If you test positive for HIV for whom do you tell the HIV result	Your spouse.....1 Your family.....2 Your sexual partner.....3 Your friends4 Your religion leaders..... 5 Other (specify)_____	

STRUCTURED QUESSSIONNAIRE AMHARIC VERSION

መግቢያ

ዕድሜያቸው 18 ዓመት እና ከዛ በላይ የሆኑ የጥናቱ ተሳታፊዎች

ርዕስ:- የአዋሳ ወጣት መስናዶ ተማሪዎች የበጎ ፈቃደኝነት ላይ የተመሰረተ የኤች ኤይ ቪ

የምክርና የምርመራ አገልግሎት አጠቃቀም

አጥኚ:- ሲሳይ ፉጂጋ

ቦታ:- አዋሳ

ውድ ተማሪ በአዲስ አበባ ዩኒቨርሲቲ በህብረተሰብ ጤና ትምህርት ቤት ስር በአዋሳ ጥናት እየሠራን ነው። ጥናቱ የአዋሳ ወጣት መስናዶ ተማሪዎች የበጎ ፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት አጠቃቀም ይዳስሳል። የዚህ ጥናት ዓላማ በአዋሳ ወጣት መስናዶ ተማሪዎች ላይ በጎ ፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ስርጭት ማወቅ፣ በፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ላይ አስተዋፅኦ ያላቸው ነገሮችን ለይቶ ማወቅ ነው። ጥናቱ የሚከናወነው አንበው በሚመልሱት መጠይቅ ሲሆን ለዚህ ጥናት የተወሰነ ጊዜዎን በማጋራት ለቀረቡት ጥያቄዎች መልስ በመመለስ እንዲተባበሩን እንጠይቅዎታለን።

የሚሰጡን መረጃ እርስዎ ላይ ምንም ዓይነት ጉዳት አይኖረውም ግን ትክክለኛ የሆነ የበጎ ፈቃደኝነት ላይ የተመሰረተ የኤች ኤይ ቪ ምክርና የምርመራ አገልግሎት ለወጣቶች ለመተግበር ይረዳል። የእርስዎ መልስ ሚስጢራዊነቱ በሚገባ የተጠበቀ ሲሆን ስምዎም እዚህ ላይ አይጠቀስም። የሚሰጡም መረጃ በመለያ ቁጥር ነው የሚጠቀሰው ለየትኛውም ጥያቄ የምትመልሷቸው መልሶች ለማንም አይሰጥም የትኛውም የጥናቱን መግለጫ እርስዎን አይለይም። የጥናቱ ውጤት ለህትመት ቢበቃ ለአጠቃላይ ውጤቱ ብቻ ነው የሚቀርበው።

ዕድሜያቸው 18ዓመት እና ከዛ በላይ ለሆኑ የጥናቱ ተሳታፊዎች በጥናቱ ለመሳተፍ ፍቃደኝነት፡-

በመግቢያው ላይ የተገለፀው ጥናት ዓላማው፣ጥቅሙ እንደዚሁም እኔ ላይ ምንም ዓይነት ጉዳት የሌለው መሆኑ፣የእኔ አስተዋፅኦ በጥናቱ ላይ፣ የምሰጠው መልስ ሚስጥራዊነቱ በሚገባ የሚጠበቅ መሆኑን ተረድቼአለሁ እናም በጥናቱ ለመሳተፍ ፍቃደኛ ነኝ፡፡

የተሳታፊው ፊርማ

ቀን

መግቢያ

ዕድሜያቸው ከ18 ዓመት በታች ለሆኑ የጥናቱ ተሳታፊዎች

ርዕስ:- የአዋሳ ወጣት መሰናዶ ተማሪዎች የበጎፈቃደኝነት ላይ የተመሰረተ የኤች አይ ቪ

የምክርና የምርመራ አገልግሎት አጠቃቀም

አጥኚ:- ሲሳይ ፉጃጋ

ቦታ:- አዋሳ

ውድ (ወላጅ/ጠባቂ) በአዲስ አበባ ዩኒቨርሲቲ በህብረተሰብ ጤና ትምህርት ቤት ስር በአዋሳ ጥናት እየሠራን ነው። ጥናቱ የአዋሳ ወጣት መሰናዶ ተማሪዎች የበጎ ፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት አጠቃቀም ይዳስሳል። የዚህ ጥናት ዓላማ በአዋሳ ወጣት መሰናዶ ተማሪዎች ላይ በጎ ፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ስርጭት ማወቅ፣ በፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ላይ አስተዋፅኦ ያላቸው ነገሮችን ለይቶ ማወቅ ነው። ጥናቱ የሚከናወነው ተነቦ በሚመለስ መጠይቅ ሲሆን (ልጅዎ /ተጠባቂዎ) የተወሰነ ጊዜውን/ ጊዜዋን ለቀረቡት ጥያቄዎች መልስ በመመለስ ሊያጋራን እንዲፈቅዱለት እንጠይቅዎታለን።

የሚሰጡን መረጃ እርስዎ ወይም /ልጅዎ/ተጠባቂዎ/ ላይ ምንም ዓይነት ጉዳት አይኖረውም ግን ትክክለኛ የሆነ የበጎ ፈቃደኝነት ላይ የተመሰረተ የኤች አይ ቪ ምክርና የምርመራ አገልግሎት ለወጣቶች ለመተግበር ይረዳል። /የልጅዎ/የተጠባቂዎ/ መልስ ሚስጢራዊነቱ በሚገባ የተጠበቀ ሲሆን (ስሙ/ስሟ) እዚህ ላይ አይጠቀስም። (የሚሰጠን/የምትሰጠን) መረጃ በመለያ ቁጥር ነው የሚጠቀሰው ለየትኛውም ጥያቄ (የሚመልሳቸው/የምትመልሳቸው) መልሶች ለማንም አይሰጥም፤ የትኛውም የጥናቱን መግለጫ (እሱን/እሷን) አይለይም። የጥናቱ ውጤት ለህትመት ቢበቃ ለአጠቃላይ ውጤቱ ብቻ ነው የሚቀርበው።

ዕድሜያቸው ከ18 ዓመት በታች ለሆኑ የጥናቱ ተሳታፊዎች በጥናቱ ለመሳተፍ ፈቃደኝነት፡-

በመግቢያው ላይ የተገለፀው ጥናት ዓላማው፣ጥቅሙ እንደዚሁም (ልጅ/ተጠባቂዬ) ላይ ምንም ዓይነት ጉዳት የሌለው መሆኑ፣የእሱ/እሷ አስተዋፅኦ በጥናቱ ላይ፣ የሚሰጠው/የምትሰጠው መልስ ሚስጥራዊነቱ በሚገባ የሚጠበቅ መሆኑን ተረድቼአለሁ እናም (ልጅ/ተጠባቂዬ) በፍቃደኝነቱ እንዲሳተፍ ፈቅጃለሁ፡፡

_____	_____
የወላጅ/የጠባቂ ፊርማ	ቀን

በዚህ ጥናት ላይ ምን ማድረግ እንዳለብኝ ተረድቻለሁ እናም በጥናቱ ለመሳተፍ እፈልጋለሁ፡፡

_____	_____
የልጅ/የተጠባቂ ፊርማ	ቀን

ክፍል 1:- አጠቃላይ የግለሰብ መረጃ

ተ.ቁ	ጥያቄ	መልሶች	ይለፍ
101	የታዎ ምንድነው?	ወንድ1 ሴት2	
102	ዕድሜዎ ስንት ነው?	_____ ዓመት	
103	ሐይማኖትዎ ምንድነው	ኦርቶዶክስ.....1 ሙስሊም.....2 ፕሮቴስታንት.....3 ካቶሊክ4 ሌላ ካለ ይጠቀስ.....5	
104	የትምህርት ደረጃዎ	ክፍል 111 ክፍል 122	
105	ብሄረሰብዎ ምንድነው	አማራ1 አሮሞ2 ጉራጌ3 ሲዳማ4 ሌላ ካለ ይጠቀስ.....	
106	በአሁኑ ወቅት የጋብቻ ሁኔታ	ያላገባ1 የተለያየ.....2 የሞተበት3 ያገባ.....4	
107	የቤተሰብዎ ወርሃዊ አማካኝ ገቢ ስንት ነው?	ገቢ የላቸውም1 50-150.....2 151-300.....3 301-600.....4 601-1000.....5 1001-1550.....6	

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Declaration

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

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This thesis has been submitted with my approval as university advisor

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