ADDIS ABABA UNIVERSITY SCHOOL OF GRAGUATE STUDIES

KNOWLEDGE AND ATTITUDE OF PEOPLE TOWARDS VOLUNTARY COUNSELING AND TESTING FOR HIV: *THE CASE OF SHASHEMENE*

BY:

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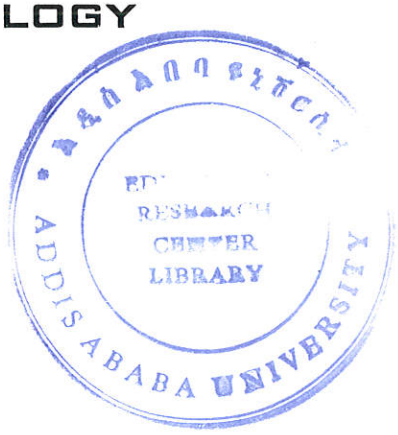
A THESIS SUBMITTED TO PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTERS OF ARTS IN COUNSELING PSYCHOLOGY



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Knowledge and Attitude of People towards voluntary counseling and testing HIV: *the Case of Shashemene*

By:

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Abstract

Voluntary counseling and testing (VCT) is potentially effective mechanism to prevent HIV infection and transmission by changing the knowledge and attitude of people. The main objective of the study was to examine the knowledge and attitude of people towards voluntary counseling and testing for HIV.

A cross-sectional survey aimed at assessing the knowledge and attitude of people towards voluntary counseling and testing for HIV was made. Shashemene woreda in western Arsi Zone was selected purposely for this study. From the woreda two kebeles (four and six) were selected as a sampling unit. Data regarding knowledge and attitude was collected from 200 households available in the kebeles which were selected by using systematic random sampling method.

The finding depicts that significant number of people had adequate knowledge and positive attitude towards voluntary counseling and testing for HIV. They are aware that voluntary counseling and testing is a key element in HIV prevention and care and it assists people to make informed decisions about the test of HIV. Moreover, results showed that stigma and discrimination, worrying about the test result and unavailability of the service hinders the use of voluntary counseling and testing.

The t-test value revealed that there is no significant knowledge and attitude difference towards voluntary counseling and testing for HIV between subjects belonging to sex groups of male and female. On the other hand one-way ANOVA result shows a significant attitude difference observed among subjects based on their education level. As education level increases attitude also increases.

It is concluded that the level of awareness regarding knowledge and attitude towards voluntary counseling and testing for HIV seems too high on the study community. However, there are still different factors which prohibit people in order not to use voluntary counseling and testing service. There fore, efforts should be made to change this high awareness to practice by reducing or if possible by eliminating those factors that prohibit the use of voluntary counseling and testing.

ACRONYMS

AIDS- Acquired Immune Deficiency Syndrome

CRDA- Christian Relief and Development Association

HIV- Human Immune Virus

MOH- Ministry of Health

NACS- National AIDS Control Secretariat

NGOs- Non-Governmental Organizations

OSSA- Organization for Social Support for AIDS

PLWHA- People Living With HIV/AIDS

UNAIDS- United Nations Program on AIDS

VCT- Voluntary Counseling and Testing

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CHAPTER ONE: - INTRODUCTION

1.1. Background

Voluntary counseling and testing (VCT) is one of the many different strategies stipulated in the policy and strategy documents, for the prevention and control activities that are planned to be carried out and currently undergoing at the national level (MOH, 1998). The role of voluntary counseling and testing can play on HIV/AIDS prevention and control is said to be multifaceted. Many indicated that VCT can be considered as entry point to prevention and care, medical care, for preventing mother to child transmission of HIV infection (PMCTC) interventions, for ongoing emotional and spiritual care and social support (UNAIDS, 2000). Hence, the need for expansion of voluntary counseling and testing service and stimulating its utilization is outlined as a priority intervention area and as an entry point for HIV prevention, through creating more personal awareness and care (NAC, 2001).

In view of the widely acclaimed and important contribution, voluntary counseling and testing can have in the prevention and control of HIV/AIDS, and the observed growing demand for the service (NAC, 2000), HIV testing may have far reaching implications and consequences for the person being tested. Although there are important benefits to knowing one's HIV status, HIV infection in many communities, is a stigmatizing condition and this can lead to negative outcomes for people following testing. Stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid to seek HIV service, because they fear stigma and discrimination from their families and communities (UNAIDS, 2000). Furthermore, fear and stigmatization associated with HIV testing can minimize public acceptance of the voluntary counseling and testing, dwarfing the role the service can play in prevention and control initiatives.

Apart from the social implication the HIV testing could have and the weakness observed in the existing service delivery points (NACS, 2000). Findings of the few studies conducted in Ethiopia revealed that, other factors like lack of awareness about the mode of transmission of the disease (HIV/AIDS), lack of perceived benefit for having the HIV test, limitation related with the economic and physical access to the service etc, are some of the factors that can contribute for the low utilization of the already available services (Michael, 2001). However, none of the very few studies conducted so far in the country tried to give a comprehensive overview about the attitude and knowledge of people towards VCT of which is a widely acclaimed but underutilized service.

Voluntary HIV counseling and testing (VCT) is then a process by which an individual undergoes counseling enabling him/her to make an informed choice about being tested for HIV. This process is also aimed at helping them to cope with stress and to make personal decisions related to HIV/AIDS (MOH, 2002). It means voluntary counseling and testing is important for the following reasons.

1. To provide information on the mode of HIV transmission and prevention.
2. To help those who wish to consider HIV testing make decision about whether or not to be tested and to provide support following the test.
3. To provide information on the increased risk of HIV transmission associated with other sexually transmitted infections (STIs) and give referral for STI examination and treatment.
4. To provide information on the increased risk of opportunistic infections including Tuber culosis (TB) associated with HIV infection.
5. To provide referrals to HIV positive and high risk HIV negative persons for necessary medical, preventive and psychosocial services and home based care in the community.

Hence, this study will be done with the main purpose of filling the knowledge gap in the knowledge and attitude of people towards voluntary counseling and

testing services in shashemene. Shashemene is located 250 km apart from Addis Ababa in the southern direction. Shashemene is one of the cities in 0romia region. The population living in this town is estimated to be 103,000. Shashemene is the commercial center and the joint place from four different directions: - Awassa from south, Addis Ababa from north, Arbaminch from west and Bale from east. This indicates that people come from different areas to the city. So there may be a high prevalence of HIV/AIDS in the area. Developing the awareness of people in this area towards VCT has great importance in reducing the transmission of HIV/AIDS. Therefore, this study asses the knowledge and attitude of people towards voluntary counseling and testing for HIV in Shashemene.

1.2. Statement of the problem

HIV/AIDS has become a prevalent disease and presents a global problem. Its impact if not controlled, will be profound and is considered to be highly distractive, fast spreading and expected to become the main causes of death among youth and middle age adults (highly productive and reproductive members of the society) (Assefa Befekadu, 1994).

UNAIDS estimate that globally there were 64.8 million HIV infected people, among them 24.8 million were died due to the disease and the remaining 40 million living with HIV/AIDS. The African continent particularly the Sub-Saharan African countries are the most affected regions of the world (of the total HIV infected people 42.5 million live in sub-Saharan African countries) holding about 65.6 percent of all HIV infected individuals (UNAIDS, 2001).

Ethiopia is one of these countries that are affected by this rapidly spreading Pandemic. The disease was known in the country in 1984 and now it is spreading at an alarming rate. The true number of AIDS cases since the beginning of the epidemic in Ethiopia is not known, but probably numbered about 400,000

(MOH, 2000). But after a while it is estimated that there are about 2.6 million people living with HIV/AIDS (2.4 million adults and 250,000 children). This number is expected to grow to more than three million by the year 2006 (MOH, 2000). In terms of absolute number of people infected, Ethiopia ranked third next to South Africa and Nigeria, which has about 4.2 and 2.7 million HIV, infected people respectively. As would be expected, HIV prevalence was low at its initial stage, in 1980's, and the increase has become rapid since the early 1990's.

This research is designed with in an intention of finding answer to the following questions

1. What is the level of community's awareness towards voluntary counseling and testing and its function?
2. What are the community's knowledge and attitude towards voluntary counseling as HIV control mechanism?
3. What are the obstacles that hinders in order not to use voluntary counseling and testing service?

1.3. Objective and significance of the study

The objective of the study is to make assessment on knowledge and attitude of the target population and establish baseline information which will be the basis for future evaluation and intervention. More specifically the objectives are:

1. To asses the level of awareness of the target population on voluntary counseling and testing.
2. To asses the knowledge and attitude of the community towards voluntary counseling and testing service.
3. To identify barriers related to voluntary counseling and testing and its use.

This study will contribute to the existing knowledge about this issue and is also expected to initiate researchers for further studies. Furthermore; it will give

insight for interested social workers and other concerned bodies as to how to design their strategies to help people with the purpose of alleviating HIV/AIDS by expanding and applying voluntary counseling and testing program.

1.4. Delimitation

This research will deal with the attitudes and knowledge of peoples towards VCT for HIV in shashemene, one of the zones in Ormia region. Of course shashemene is wider zone, which consists of rural and urban kebeles. But this study will focus on the urban part of the town.

To that end, the study will be conducted mainly with people living in the two kebeles of the city of shashemene.

1.5. Limitation

One limitation of the study is the small sample size. The analysis of the study is only based on data obtained from 200 people. The other limitation arises from the need to measure the actual behavior of people (respondents) toward voluntary counseling and testing. Thirdly it was not possible to measure the magnitude of knowledge and attitude according to the quality of voluntary counseling and testing for many reasons. Therefore, this study couldn't find out the relationship between attitude and the severity of voluntary counseling and testing.

1.6. Operational definition of terms

Attitude: - idea with emotional content, important belief, prejudice, biases, predisposing, appreciation and as a state of readiness.

Knowledge: - the understanding of the respondents about VCT as a prevention method, health promotive, psycho-emotional support and process of informed consent.

HIV Counseling: HIV counseling has been defined as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and to take personal decisions related to HIV/AIDS infection.

Voluntary Counseling and Testing (VCT): VCT is the process by which an individual undergoes counseling enabling him or her to make informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.

CHAPTER TWO: - REVIEW OF RELATED LITERATURE

2.1. Historical view

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

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

2.2. Voluntary Counseling and Testing in Ethiopia

In Ethiopia HIV counseling service began in the late 1980's with services expanding throughout the 1990s. In the early 1990s several national level training programs were conducted by MOH and other NGOs like Christian Relief and Development Association (CRDA) and Organization for Social Service for AIDS (OSSA) for nurses and social workers from all regional hospitals and Addis

Ababa. About 3000 "counselors" were trained; however, as to how many of the trainees are currently on the job is not known (NAC, 2000).

In addition to setting counseling services in health institutions, the Ministry of Health collaborates with other NGOs to provide social services for PLWHA. A situational analysis conducted in September 2000, regarding VCT service revealed that there are 80 institutions in the country providing either HIV testing or counseling or both. The assessment further identified that few of the health facilities have full time counselors, referral system for HIV positive individuals to care and support centers and to other institutions involved in the VCT service is not well developed, there is no system to monitor and evaluate VCT services and the majority of health facilities have shortage of test kits (NACS, 2000).

Further assessment reveals that demand for HIV testing is growing but service provision by government health facilities is limited due to shortages of physical facilities, test kits and trained manpower (NACS, 2000).

2.3. Construction and definition of Voluntary counseling and testing

To see the knowledge and attitude of people towards voluntary counseling and testing, it is better to define VCT in different perspectives. Because when we say knowledge and attitude, from what stand point (reference) did people became evaluated or identified. To do so, the following ideas have been reviewed from different literatures.

In the thematic analysis of the unpublished literature (Solomon V. et. al, 2004) the concept of voluntary counseling and testing is both multi-dimensional and complex, making it difficult to define or describe in any clear-cut way. Voluntary counseling and testing is made up of a number of different process elements. The main one's being voluntaries, counseling and testing. However, each of these process elements carry its own set of definitional issues, and when

these concepts are combined they allow for a number of different perceptions and standpoints on what it means to do voluntary counseling and testing. The following are some of the integrated but not separated definitions (Solomon V. et. al, 2004)

2.3.1. Voluntary counseling and testing as a prevention strategy

The first definition of VCT, and perhaps the most important in terms of the plan to reduce the impact of HIV/AIDS, is a definition that describes the role and function of VCT as primarily preventive. The role that voluntary counseling and testing can play on HIV/AIDS prevention and control is said to be multifaceted (UNAIDS 2000). This preventive function is described in two ways. Firstly, VCT is seen to preventive in terms of inhibiting and/or stopping the spread of HIV/AIDS between people. In this construction of voluntary counseling and testing, the primary and direct benefit of promoting HIV counseling and testing is its ability to prevent the spread of HIV. The second preventive function of VCT is the prevention of further illness in people who are diagnosed as HIV positive. This linked, and has been artificially separated here for the purposes of clarity. So counseling is both educational and informative; it also helps people to know their HIV status and means to prevent re-infection and spread of the epidemic.

Counseling is the means by which prevention education is communicated to both sero-positive and sero-negative individuals. Therefore, the training of counselors to successfully deliver quality counseling is a vital component to ensure VCT can play a role in prevention. In both views, however, there is an assumption that once people are made aware of their own risks and how these risks can be changed (either through counseling or through testing) then the spread of HIV should be substantially reduced.

Voluntary counseling and testing is seen to be the best current solution for containing the spread of HIV. It has become an alternative to medical treatment, a move that places VCT at the centre of any HIV strategy.

2.3.2 Voluntary counseling and as health promotive

The second definition or construction of VCT is that it is health promotive (Solomon V. et. al, 2004). Within this construction, VCT is described variously as health promotive, an entry-point into care and as an early detection service. Early detection of HIV infection means that preventive and other forms of treatment can begin immediately. This lengthens and improves quality of life HIV voluntary counseling and testing has been shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point to care.

Voluntary counseling and testing provides people with an opportunity to learn and accept their HIV sero-status in confidential environment with counseling and referral for ongoing emotional support and medical care. Voluntary counseling and testing is thus seen to promote "wellness" in people.

Obviously this early detection and health promotion message does feed back into the prevention message discussed above. If people can be persuaded to know their positive status this should not only improve their health, quality of life and prolong their life for years to come, it should also prevent the transmission of HIV and thus reduce spread. It could be surmised that this is why these two messages are often provided together creating a construction that VCT is not only for the benefit of others, but also for your own benefit as well. The advantages of early detection are highlighted throughout all the different types of literature. Many indicated that VCT can be considered as entry point to prevention and care, medical care, for preventing mother to child transmission of HIV infection (PMCTC) interventions, for ongoing emotional and spiritual care and social support (UNAIDS, 2000). This appears to be means of encouraging

One of the primary outcomes of the provision of support to HIV positive people and their families is the promotion of quality of life in patients as well as prolonging life through the generation of hope and the will to live. Support and care help overcome the psychological burden of coming to terms with one's status and of living with AIDS and in addition promotes healthy living, and "wellness" which leads to longer and better life.

However, despite the importance placed on care and support in defining what VCT is, there are some indications that the lack of such services in some areas is proving to be a discouragement to testing (Michael, 2002).

This lack of back-up services is also held to be a primary reason for repeat testing. People are not supported through the first positive result and are therefore going to be tested repeatedly with the hope of receiving a negative result. This form of denial is precisely the function of VCT described above, suggesting that while such services are seen to be important they have not been implemented well.

2.3.4 Voluntary counseling and testing as a process of informed consent

Across all of the literature, there is a common construction of VCT as being a process of informed consent, in that VCT is defined as a service that provides a complete package" of important information that equips the client to make an informed decision about whether or not they wish to go people to know and understand the process of testing and make decision about being tested.

> *VCT stands for voluntary counseling and testing. VCT is needed when a person chooses to undergo HIV/AIDS counseling so that they can make an informed decision about whether to be tested for HIV.VCT is a process of informed decision, support and confidentiality as part of a*

decision process of whether to take the test. It is more than just a test (Solomon V. et al, 2004)

Within this view, VCT is seen to be a means of facilitating decision making in clients themselves through the provision of knowledge and support about HIV and the testing process. Thus, the counseling aspect of VCT is primarily geared towards promoting decision making about testing. This conception of VCT as an informed consent process redirects attention away from the anticipated public health goals of VCT (prevention and support) and provides a much more practical and grounded view of the primary function of the VCT process. However, questions must again be raised about how this function of VCT might work in actuality. Although clients are provided with valuable information as to the testing process, one wonders if the client has not already made up his or her mind before approaching the clinic for a test. How much does the actual counseling process contribute to the testing decision? In addition, while the counseling focuses on the outcomes of VCT, does it actually explicitly explore this issue of whether or not people are ready to be tested?

The issue of voluntariness in HIV counseling is a two-part concept. Firstly, voluntary refers to the counseling process, which should enable an individual to make an informed choice about being tested for HIV. Secondly, voluntary refers to the manner by which people come to make use of VCT services. In many instances, people approach VCT services freely and without force.

In other circumstances, people are referred for HIV testing by health care workers for treatment and/or diagnostic purposes. Under these conditions, it is unlikely that persons coming for VCT have done so freely, and without coercion. Questions must be raised about this function of VCT in settings where people are referred for testing and are therefore not necessarily given an option as to whether they do or do not want to be tested at all. This definition of VCT places

voluntariness at the centre of the VCT process people must be informed so as to make their decisions on their own.

2.3.5 Voluntary counseling and testing and stigma reduction

A final construction of VCT has to do with the idea of "normalizing" HIV/AIDS as disease and there by reducing the stigma associated with being HIV positive. This should have the desired effect of lifting the associated fear and stigma that surrounds the disease making it more like other chronic and terminal illness.

> *The government is encouraging all of us to come forward to be tested for HIV. They believe that if many of us get tested, even though we may not be sick, this will help to lessen the amount of stigma associated with the HIV test. Widespread VCT contributes towards the destigmatisation of the disease (Solomon V. et. al, 2004)*

This idea of stigma reduction is linked to concepts of confidentiality and secrecy in the process of voluntary counseling and testing. Confidentiality is held to be a significant aspect in achieving the aim of drawing people in for testing with the aim of normalizing HIV/AIDS as a disease. Voluntary counseling and testing is defined in terms of a free and confidential HIV/AIDS service. However, some suggest that the confidentiality associated with the testing process is problematic, implying that if the secrecy attached to the disease were lifted then this should help to lift the stigma associated with HIV.

2.4 Knowledge of people about Voluntary counseling and testing

People need to have access to voluntary HIV testing and counseling so they can find out about their HIV status and thus make the most of interventions for prevention and care (WHO, 2002). HIV testing and counseling provide essential knowledge and support: they enable uninfected people to remain so and enable those infected with HIV to plan for the future and prevent HIV transmission to others. Those who are infected can also benefit from available care, treatment

and support services. Knowledge of HIV infection is a prerequisite to initiating antiretroviral therapy for the long-term treatment of people living with HIV. It is also the main entry point for interventions that prevent HIV infections in infants and young children.

HIV infected women who know their sero-status is able to make informed choices about their reproductive lives and, if pregnant, to access specific interventions, such as antiretroviral drugs and infant-feeding counseling and support, which can significantly reduce the risk of mother-to-child transmission of HIV. Currently, the majorities of HIV-infected people is unaware of their serostatus and are therefore unable to make informed decisions and receive the services they need. Knowledge is a key entry point to prevention and care of HIV.WHO aids@who.int.

Increased access to knowledge of sero-status is urgently required to serve new imperatives, such as the provision of specific services for people living with HIV/AIDS for their care, treatment and support, and for the prevention of HIV transmission to infants and young children. WHO is committed to public health policies that will foster the rapid expansion of HIV testing and counseling services while protecting the rights of those affected by HIV. At the consultative meeting held in December 2001, there was unambiguous endorsement of the standard VCT service delivery model as the way to meet certain needs such as an individual's desire for information about their HIV infection status before entering a new sexual partnership in certain settings such as free-standing VCT sites or sexual health clinics. The various aspects of the VCT model are important components of any HIV-testing process.

The configuration and emphasis of these components, however, may vary in different circumstances. The participants at the meeting called for innovative additional models for the provision of testing and counseling services,

recognizing that programmes need to be adapted to the populations to be reached, the service delivery settings and the main outcomes sought (such as HIV prevention in vulnerable groups, prevention of HIV transmission to infants, and access to care, treatment and support).

For ethical reasons, however, all models should ensure that informed consent is obtained before proceeding with HIV testing and that high-quality counseling is offered to all people who test positive. WHO will soon be conducting a wider consultation to define in more detail strategies for increasing access to knowledge of HIV status, to specify the essential requirements of the informed consent procedure, and to describe models of service delivery that meet current priorities (WHO, 2002)

HIV testing and counseling enable people to learn whether they are infected, understand the implications of their serostatus, and make more informed choices for the future. HIV testing is the process by which blood or body fluids are tested for the presence of antibodies or antigens associated with HIV infection. HIV testing of individuals should be undertaken only with their informed consent and should be entirely voluntary. In this context, HIV counseling is a confidential process that enables individuals to examine their knowledge and behavior in relation to their personal risk of acquiring or transmitting HIV infection that helps them decide whether or not they should be tested and that provides them support when they receive their test result.

2.4.1 Knowledge of HIV status

Wider access to knowledge of HIV status would enable individuals to (WHO, 002):

- Initiate or maintain behaviors to prevent acquisition or further transmission of the virus
- Gain early access to HIV-specific care, treatment and support

- Access interventions to prevent transmission from mothers to their infants
- Better cope with HIV infection
- Plan for the future enables communities to:
    - Reduce denial, stigma and discrimination that surround HIV/AIDS
    - Mobilize support for appropriate responses

At this time, the availability of testing and counseling services is very uneven, and only a small proportion of people living in developing countries know their serostatus. In most resource constrained settings with high HIV prevalence, investment in testing and counseling services is inadequate, medical and laboratory infrastructures remain insufficient, and trained staffs are scarce.

Furthermore, in areas where testing and counseling services are available, the uptake of these services has remained low, because of widespread denial, stigma and discrimination. Until recently, many people believed there were few benefits to knowing their serostatus. This is now hanging, due to improved access to antiretroviral drugs for treatment and for use in preventing mother-to-child transmission of HIV.

Demand for HIV testing and counseling services is now increasing in many places. The provision of these services will need to be scaled up dramatically in the future in order to reach the goals for prevention and care that have been set at the 2001 United Nations General Assembly Special Session on HIV/AIDS. **Purpose of the meeting** WHO is exploring innovative, ethical and practical ways to increase access to knowledge of serostatus in resource-constrained settings. To this end, WHO convened a small consultative meeting in December 2001, to discuss approaches to service delivery for different purposes and settings? The participants included experts in the following key areas: ethics, human rights, law, health systems and voluntary counseling and testing services.

2.4.2 Knowledge of Voluntary counseling and testing

Voluntary counseling and testing, or VCT, was developed in the mid-1980s as the standard of care for individuals seeking to know their infection status. Its core components have been codified in guidelines developed by various health agencies, including WHO. The voluntary nature of HIV testing ensures that the process is free from coercion. Counseling should be client-centre and focused on ensuring informed consent to testing, providing HIV-related information, assisting clients in developing a risk education plan, and discussing strategies for disclosure and social support.

The goals of testing are to ascertain the client's serostatus and to contribute to promoting motivation, increasing knowledge to support risk reduction, and planning for the future. Counseling has been closely linked to testing, to ensure that informed consent is achieved and to maximize the benefits of the intervention. The sequence followed is pre-test counseling, HIV testing and post-test counseling. The standard VCT model places a strong emphasis on its contribution to meeting HIV-prevention goals.

Nonetheless, the adoption of VCT has generally been slow in most developing countries, with a few exceptions notably Uganda and Thailand, where VCT has been successfully included as a key element of HIV prevention and care programmes. However, since the inception of VCT as a model of service delivery, the benefits of knowing one's HIV status have evolved, primarily through increased access to antiretroviral drugs for the treatment of HIV disease and for the prevention of mother-to-child transmission of HIV (WHO, 2002).

The need for voluntary HIV testing is growing in a number of settings. There is often the presumption that VCT is a package that must always be provided in a uniform way (whether the HIV test is sought in free-standing centers, in antenatal care or in clinical care settings). In practice, however, diverse models

because they wanted to know their results, but because they wanted to be part of another, research study (Kipp et. al, 2001: ID186).

This subtle coercive element - which may operate in any research conducted at public health care setting or where health care professionals are held in high regard has already been noted by other researchers. It is well documented that patients relinquish autonomy to professional medical authority in medical settings and it is therefore not surprising that informed consent sought under such circumstances may be less than voluntary. In such contexts, not returning for test results may be the only polite way for many women to decline testing.

Furthermore, uptake of VCT in communities is said to be dependant on societal factors as well as factors associated with delivery of service.

2.6 Advantages of Voluntary counseling and testing service

HIV voluntary Counseling and testing have been shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point for care. VCT provides people with an opportunity to learn and accept their HIV status in a confidential environment with counseling and referral for ongoing emotional support and medical care. People who have been tested sero-positive can benefit from earlier appropriate medical care and interventions to treat and /or prevent HIV associated illnesses. Pregnant women who are aware of their sero-positive status can prevent transmission to their infants. Knowledge of HIV serostatus can also help people to make decisions to protect themselves and their sexual partners from infection. A recent study has indicated that VCT may be a relatively cost effective intervention for the prevention of HIV transmission (UNAIDS, 2000).

Voluntary counseling and testing can prevent HIV transmission among sero-discordant couples. There have also been some studies showing significant

behavior change in individuals following VCT. A recent multi-site study conducted in Kenya, United Republic of Tanzania and Trinidad has provided data on the role of VCT in HIV prevention and its cost effectiveness compared with other HIV prevention interventions. This study demonstrated that VCT Significantly reduced sexual risk behavior - specifically, unprotected sex with non-primary partners, with commercial sex workers, and among couples who have been tested and counseled together. The study also showed that VCT could be cost-effective in terms of the cost per HIV infection averted. For example, the cost per client for VCT was $29 in the United Republic of Tanzania and $27 in Kenya, and was more cost-effective when targeted to HIV-positive persons, couples, and women. (Sweat ML et. al, 2000).

However, Counseling services have been slow to gain acceptance in many countries, especially where HIV is highly stigmatized and access to services and support for HIV infected individuals is limited. Indeed, HIV testing has often been used as a diagnostic tool to confirm symptomatic AIDS. But a growing number of studies attest to the value of counseling and voluntary HIV testing in largely healthy populations. These services have been shown to contribute to an increase in safe behavior at the individual level, and are likely also to reduce the ignorance, fear and stigma associated with HIV infection in the population at large (UNAIDS, October 1999).

2.7 Factors affecting the demand of voluntary counseling and testing

Although VCT is becoming increasingly available in the developing and middle-income countries, there is still great reluctance for many people to be tested. There are several possible contributing factors that must be addressed if VCT is to have an important role in HIV prevention and care. In this regard studies showed that HIV testing might have far reaching implications and consequences for the person being tested. Although there are important benefits to knowing

one's HIV status, HIV infection, in many communities, is a stigmatizing condition and this can lead to negative outcomes for people following testing. People with HIV may experience social rejection and discrimination (Karim Q., Karim S., Soldan K., Zondi M. 1995). As the result stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid to seek HIV service and decline service because they fear stigma and discrimination from their families and communities. Societal attitude towards HIV can have a strong impact on individual choices, and if people known to have HIV face discrimination and stigma, VCT is unlikely to be a popular intervention (UNAIDS, 2000).

The findings of studies outlined that protection and support of vulnerable women who test sero-positive must be considered when developing VCT services. In Zambia, women said that it was thought to be shameful to have HIV, and if they were known to be sero-positive, they worried that they would suffer discrimination. Studies from Kenya have also shown that women may be particularly vulnerable following VCT and in some cases have lost their home and children or have been beaten or abused by their husband's partners if their status becomes known (Temerman M. et. al, 1994).

There is currently some evidence that, in highly stigmatized societies, women who believe themselves to be at high risk of infection is less likely than low risk women to choose to be tested for HIV infection or to come back for their test result (UNAIDS, 1999). In this regard, unless women and their partners fully understand the benefits of an HIV test, they are unlikely to choose to have one. A negative result allows an individual to act to avoid infection in the future. It will also allow a woman to breastfeed, confident in the knowledge that it is the best for her child (UNAIDS, 1999).

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In some countries people with HIV are subject to discrimination at work or education. Unless legislation is in place to prevent this, some people will be reluctant to undergo VCT (UNAIDS, 2000). Even in areas where VCT services are available, uptake of services is often poor. A common barrier for VCT is the lack of perceived benefit (Baggaley R, et al, 1995). If VCT is linked with medical care, and effort is made to improve medical services for people with HIV, this will help to reduce this barrier to testing. Offering interventions to prevent MCTC (mother to child transmission) can also be recognized as a major benefit of VCT (UNAIDS, 2000).

Similarly, preliminary result from a large MCTC program in Botswana shows a relatively low uptake of VCT during the first eight months of operation. This was said to be due to fear of sero-positive result, lack of facilities where partners can receive counseling and testing, worry about partners' reaction about the lack of effective treatment available for infected women and themselves (Mazhani L. et al, 2000). Uptake of VCT in other operational settings varies considerably in the UNICEF/UNAIDS MCTC pilot sites. Difference in testing schedules, maturity of the epidemic, sero-prevalence in the community and attitudes to and availability of VCT in the community are thought to be important. It is also proposed that Counselors' attitudes towards testing at the sites may be a key factor in uptake (UNAIDS, 2001). Generally the factors can be grouped in to two major categories (Solomon V. et al, 2004).

2.7.1 Internal factors

A. Access

A key barrier to successful VCT implementation is inadequate access to VCT service centers. There are certain communities, which have been traditionally neglected in terms of health care and support service delivery. Thus, new government policies have focused particularly on this issue in an attempt to redress the imbalance in the provision of services. However, even though the

policy decisions are in place, until such redresses have been dealt with they still constitute a significant barrier to the use of VCT services. Many people who want to be tested either cannot or will not travel to VCT facilities either due to lack of time, lack of motivation or lack of funds.

B. Demand vs. Quality

Another barrier to effective VCT service delivery, has to do with service quality where often the need to keep up with the demand for HIV/AIDS service results in a compromised quality of service. For example, there is some concern that more attention and effort is spent establishing new VCT sites, than in improving the quality of services or upgrading resource at existing sites. In addition, the monitoring and evaluation processes seen to be vital to effective VCT functioning are generally not implemented or the information not used. Thus, there is no feedback of information about quality that can be used to improve the service delivery.

C. Human factors

HIV/AIDS counseling is a difficult and stressful job. It is often not easy for counselors to maintain professional boundaries in the relationships that develop between them and their clients. Counselors have to deal with intense emotional issues of dealing with people living with a life threatening disease, severe illness and death. The lack of a medical treatment for HIV/AIDS patients is an added frustration that counselors are faced with. Relationship one should or should not have with a client impacts directly on the nature of the counseling that is performed and the quality of care the patient receives. Counselors' may generally not be suited to handling the stress of working with HIV positive patients and this kind of personality trait is often not detected in the short training period.

The confusion that most counselors' experience as to their relationship with their client is further exacerbated by a tension between counseling roles that the

counselor has to negotiate through. Counselors have to perform dual roles of therapist and educator. Counselors are expected not only to provide basic information and advice, but also to provide support and care to a client. This kind of dual role is hard to negotiate and counselors are not always trained to handle both kinds of counseling simultaneously.

There is recognition that often the VCT system does not take into account the fact that counselors bring their own issues into any counseling situation with them. For example, the personality or values of the client may clash with those of the counselor and counselors are often not taught to deal with those situations either.

D. Service delivery factors

There are a number of service delivery factors that can be seen as barriers to effective VCT service delivery, because they are factors which impact on exactly how the process of VCT gets to take place. For the most part, these factors result from the tension between the medical and the non-medical components of VCT. For example, because the HIV test is a medical test, only a trained medical person can do it. As a result, this means that most VCT is done in medical rather than non-medical settings as the problems of finding trained medical people to work in non-medical sites is prohibitive.

In addition, the fact that only a medically trained person can do the test means that either the counseling or testing components of VCT must be split between two people or a nurse must be made to do both of these components. Neither of these solutions is ideal as typically nurses cannot do the counseling due to an overload of clients and yet having two people do one test is illogical and creates problems with clients as well as between medical and non-medical staff especially in terms of roles, functions and responsibilities.

A major problem is the fact that HIV counseling is a non-medical service often performed by lay and non-professional people that takes place in a medical setting, which is occupied by professional doctors. This particular problem impacts on the delivery of the complete VCT services. Ideally, VCT sites should have sufficient people trained in counseling and in testing that do not have to undertake any other medical duties as well. However, such a system does not seem probable.

E. Resources

Another major apparent problem related to effective VCT service delivery is an apparent inconsistency between strategic objectives and service delivery realities. It is clear that VCT objectives cannot be met in reality due to inadequate resources such as testing kits, finances, infrastructure or even basic medication. This is a quality of care issue and there have been reports of extremely poor VCT service delivery for a variety of reasons.

Common negative experiences of care in general clinics where victimization of HIV positive users, callous treatment from health providers, poor confidentiality, overcrowding, long waiting times, limited hours of service and shortage of drugs. In some senses staff cannot perform their duties effectively and yet they are also not supervised properly through the process.

Strategies need to be reviewed and effectively implemented with regards to duty allocations and in particular performance outputs to ensure VCT services are delivered effectively to the public as originally intended. However, better resource allocation and management is also needed to ensure the resources needed to run a good quality VCT service are made available to those working in VCT sites. It cannot be forgotten that a major part of quality improvement is improved resources. With so much attention now given to improving health service performance and reducing costs, there is a danger of neglecting the care and prevention demands generated by HIV infection.

2.7.2 External factors

A. Survival issues

This category includes aspects of poverty that govern the poor person's perception of knowing their HIV status or even caring about it. Whether they are HIV-positive or negative is of little consequences for them. It might just mean the realization that they will not be able to support themselves or their families, when they become sick. Often they would rather not know.

HIV/AIDS preventive mechanisms have little impact. Many women with low socio-economic status have no choice regarding their sexual behavior. They are governed by their partner's demands. Voluntary counseling and testing has a greater chance of success in more developed and sophisticated communities. Socio-economic development strategies need to be put into place before VCT can reach its full potential.

The programmatic response fails to take account of the social context that influences behavior. Thus, messages to promote safe behavior are often inappropriate and ineffective. The issue has to be addressed beyond its biomedical features and solutions. Social factors that drive behavior must equally be recognized and addressed.

The information in this supplement provides most of what we know already about HIV/AIDS. However, many more people have died of AIDS in Africa than in countries like America or Britain or other so-called "first world" countries. This has caused our leaders to begin asking questions about why so many Africans die as a result of AIDS. Questions that seem easier to answer in America or Europe about the HIV Virus are harder to answer when we think about Africa.

B. Partner violence

A barrier in the prevention role that VCT tries to perform is that many women are scared to reveal their HIV-positive status to their partners in fear of a violent

reaction. Especially women have no control whether to be tested or not; this decision is made by their partners.

An important component of HIV voluntary counseling and testing VCT programs is encouraging clients to inform partners of their serostatus. Many women lack autonomy to make decisions about HIV testing. Disclosure to partners by HIV-positive women has increased over time but is still significantly less than that for HIV negative women. Partner violence is a serious problem among female VCT clients. A small proportion of women who disclosed their serostatus to partners reported a negative reaction. Women's HIV status is strongly associated with partner violence.

C. Stigmatization

The fear of being rejected by one's own family, community, workplace, schools and even church is a major factor preventing people from coming forward and finding out their HIV/AIDS status. One of the objectives of VCT is to make people aware that people living with HIV/AIDS are as normal as any other person living with a life threatening disease (UNAIDS, 2001).

The stigmatization barrier affects HIV victims and many of the HIV/AIDS workers, who are at times ostracized for the work they do. The question arises: do people want to know their status? Knowing one's sero-status means not only living with a terrible secret and facing rejection but also knowing that there is no available HIV/AIDS treatment. An element of distrust about counseling confidentiality might explain why some counseling services have been slow to get off the ground. People infected with HIV find themselves increasingly marginalized due to the public's ignorance about the disease, despite the fact that the virus was first diagnosed as long as the early 1980s. "People who are infected and affected by HIV live in isolated world without any hope, a world ruled by fear of being rejected once they disclose they are living with HIV/AIDS or are related to someone who is HIV positive.

In addition disclosure may not be what people wish to do if there is no treatment available counseling services have been slow to gain acceptance in many countries, especially where HIV is heavily stigmatized and access to services and support for the HIV-infected is limited.

D. Fear of results

The VCT goal is often defeated when people do not come back for testing after receiving initial pre-test counseling. The fear of having to face being HIV-positive contributes to people not coming forward voluntarily for testing. Testing often only takes place when the victim starts showing signs of being ill. This factor inhibits the VCT objectives of promoting prevention and healthy lifestyles.

People are scared to come to the counseling centre voluntarily; they come when they start showing symptoms. Some when they discover their partners have been promiscuous or when people close to them die. Pre-test counseling is an important part of the work. Clients are unable to cope with the results of positive tests.

E. Cultural factors

One can realize the impact that traditional medicine has on the health system in our country. Traditional health care is an integrated and influences the lives of people. Many people would rather make use of them than attending the local VCT clinic. An option for VCT planning could be to possibly examine the traditional health system to establish its popularity and to incorporate some ideas and even traditional health workers into the HIV/AIDS prevention system.

Traditional medicine represents the largest indigenous resource base for caring for the people of Africa. It is the oldest art of healing on this continent and is therefore integrated in the socio-cultural and religious worldviews of many of our people.

CHAPTER THREE: RESEARCH METHODS

3.1 Study method

The approach selected for this study was survey method, since it gives the description of the statuesque of the phenomenon. This phenomenon in the study was to identify the attitude and knowledge of people towards voluntary counseling and tasting for HIV/AIDS. The use of this method aims at assessing an issue in a relatively manageable number of respondents (sample) takeout from large population.

3.2. Sampling

Purposive sampling technique was used to select the population included in the study. The town of shashemene was selected as a target population for the study.

As to the sampling design a probability sampling technique was used to carry out the questionnaire survey to generate data, which was used in this study. For the purpose of selecting representative kebeles, from the existing seven (7) kebeles in the town simple random sampling scheme was used, with this method two kebeles (six and four) were selected as a sample.

Households in these kebeles were enumerated to know the available house holds in each kebeles. Code was given for each household in the two kebeles. From all households in these kebeles only representative samples was selected using systematic random sampling scheme.

In kebele four out of the total 1014 households 10 percent that are 101 eligible people in different age, education level, and religion filled the questionnaire. From kebele six out of the total 902 households 11 percent household's 99 eligible representatives were selected and filled the questionnaire. Therefore, the total numbers of respondents from each household were 200 samples. The

respondents are designed to be equal number of males and females as one sample from a household.

The rational for selecting samples male and female in different households were primarily to obtain diverse information from households. Secondly, comparison of women and men knowledge and attitude towards voluntary counseling and testing may vary because of variation in their level of education, occupation etc, they have than comparing women and men of the same households who share common experience in their life.

3.3. Data gathering instruments

This study has employed quantitative data collection approach. A questionnaire was used as the main instrument. A structured questionnaire of three parts was administered. The first part of the questionnaire was intended to gather background information about the respondents. The second part of the questionnaire was intended together the knowledge base of the respondents regarding to voluntary counseling and testing. It comprised of 21 items each item weighs one point. The third part was designed to assess the respondent's attitude towards voluntary counseling and testing issues. A three point Likert type attitude scale with a continuum "Agree", "Uncertain" and "disagree" was constructed.

The scale consists of 25 items and the participants were asked to indicate their agreement with each statement using a three-point attitude scale. The given scale value were 3 = agree, uncertain = 2 and disagree = 1 to the positively stated items.

In the items that were negatively stated the scoring was reserved as, 1 = agree, 2=uncertain, and 3=disagree. The maximum possible score for the attitude scale would be seventy five (75).

3.4 Pilot study

Before implementation, the questionnaire was translated in to Amharic and administered to those twenty four (24) households that live in kebele seven. To make the pilot study comprehensive the researcher includes educational level, age, sex and religion in to consideration.

The kebele, which is found far from the sample kebeles, was purposely selected as the center for the pilot study so as to avoid test contamination. Coefficient Alpha and kuder–Richardson (KR–20) was used to see the internal consistency of attitude and knowledge items (scales) respectively. After calculating the internal consistency of the items, the reliability coefficient of attitude scale was .67 and the reliability coefficient of knowledge related items was .76 for the remaining quality items.

3.5. Data collection procedure

Contact has been made with different persons who found in different responsibilities. This has been done for the purpose of getting information about the worda's HIV/AIDS condition and the relevance of voluntary counseling and testing. Moreover, the researcher found out whether related research was made or not in the worda.

For the purpose of collecting information the researcher made strong relation with different associations of youths regarding to HIV/AIDS prevention and education. With having such relationship, the researcher has selected among those members for the purpose of enumeration and data collection. The activity of selection among those members of the association who have better knowledge and willingness to participate were made with the help of the coordinator of the association.

The first step was training enumerators for the survey. Half day training on the survey questionnaire and how to approach households has been given for five enumerators. Coordinators closely supervised the fieldwork. The supervision was designed in such a way that as to closely monitor the data collection activities, facilitate the data enumeration process and ensure that the data collection takes place according to the instruction.

After the questionnaire returned from the field, manual editing for completeness, accuracy & homogeneity and coding was undertaken on survey items to enhance data entry in to the computer. Information then entered and statistical tables were produced and analyzed by using SPSS-10 program.

CHAPTE FOUR: DATA ANALYSIS

Analysis of findings

In the first section of this chapter, the general information about the sample subjects has been presented. After the description of sample subjects, data collected were analyzed based on the specific research questions raised in the first chapter of this study. The result was presented using percentage. In the third section comparison of the results was conducted to see whether there is statistically significant difference between male versus female subjects. Moreover, analysis was made on the education level of the respondents. Respondents were grouped in to four groups based on their education level as: - illiterate (who were not entertained in the formal education, primary (whose education level was from 1-8 grade), secondary (whose education level were from 9-12/10 grades) and tertiary (whose education level were above 10/12 grade).

4.1. Characteristics of respondents

Table 1. Characteristics of respondents

	Characteristics	Number	Percentage
1. Sex	Male	100	50
	Female	100	50
	Total	200	100
2.Education level	Illiterate	15	7.5
	Primary(1-8 grade)	28	14
	Secondary(9-10/12 grade)	128	64
	Tertiary (above 10/12 grade)	29	14.5
	Total	200	100

As indicated in methods (data gathering instrument) of chapter three the study was analyzed quantitatively. The quantitative data were generated through a survey prepared for households of 200 samples.

Seventy five percent of the respondents fall in 20 years and above. This indicates that they belong to adult group and the remaining 24.5% falls bellow 20 years which they belong to adolescent stage. Data gathered on the marital status of the respondents show significantly high proportion 57.5% were unmarried and those (37.5%) of respondents were married while (9.5%) of the respondents were divorced and 2.5% were widowed.

The other section of respondent's characteristics was analyzed based on educational level. Data gathered on the educational background of the respondent's show a significant high population (64%) was 10/12 complete. Respondents with tertiary education level constitute (14.5%) and primary educated respondents constitute (14%) where as the respondents with no formal education constitute (7.5%).

Furthermore, data obtained on the respondents profile show that (62%) of the respondents were employed in their own business where as (10%) and (6%) were employed in NGO's and government organizations respectively. The analysis of gender and level of education here, aim at examining the possibilities of differences in community knowledge and attitude towards voluntary counseling and testing services.

4.2 Knowledge of people towards HIV/AIDS

Table2. Frequencies and percentage of respondents to the knowledge of HIV/AIDS:-Based on sex and education level

Items	Sex (N=200)						Education Level (N=200)							
	Male		Female		Total		Illiterate		Primary		Secondary		Tertiary	
	No	%	N	%	N	%	N	%	N	%	N	%	N	%
1. No experience of sexual intercourse means someone is free from HIV/AIDS														
Yes	16	16	7	7	23	11.5	4	27	4	14	18	14	6	21
No	84	84	93	93	177	88.5	11	73	24	86	110	86	23	79
2. Using condoms serves no purpose to prevent HIV/AIDs														
Yes	18	18	9	9	27	13.5	2	13	10	36	18	14	6	21
No	82	82	91	91	173	86.5	13	87	18	64	110	86	23	79
3. A person who seems healthy might be infected with HIV/AIDS														
Yes	12	12	10	10	22	11	8	53	5	18	25	19.5	1	3.6
No	88	88	90	90	178	89	7	47	23	82	103	80.5	28	96.4
4. One should check his/her HIV status voluntarily														
Yes	93	93	92	92	185	92.5	13	86.7	24	85.7	121	94.5	27	93
No	7	7	8	8	15	7.5	2	13.3	4	14.3	7	5.5	2	7

It is vital that people protect themselves from HIV/AIDS, for this they should have adequate knowledge about the prevention and transmission mechanism of the virus.

In table 2 most respondents (88.5%) on item 1 replied that no experience of sexual intercourse means some one is not free from HIV/AIDS. While only (11.5%) answered that no experience of sexual intercourse means one can be free from HIV/AIDS. The above figure shows respondents have the knowledge base regarding the way of transmission of HIV/AIDS. Respondents list the ways in which HIV/AIDS transmitted from one person to other was:-unsafe sexual intercourse, common use of sharp materials, blood contamination and from mother to child during birth.

Regarding the use of condom as one way of preventing HIV/AIDS, most respondents (86.5%) believed that it helps to prevent HIV/AIDS, while only (13.5%) were responded use of condoms serves no purpose to prevent from HIV/ AIDS.

For the purpose of identifying a person who has been infected by HIV/AIDS (89%) respondents replied that one couldn't identify a person who has been infected by HIV/AIDS simply by observing. The remaining (11%) said that, it is possible to identify a person who has been infected by HIV/AIDS simply by observing. HIV status ca be known through blood test and it should also be done voluntarily. To this point most, (92.5%) respondents agreed. Meaning HIV test should be entirely voluntary and with in the consent of the person, while only (7.5%) answered HIV test should not be in the consent of the person who was intended to be tested.

The researcher analyzed whether there is a difference in the knowledge of HIV/AIDS transmission and prevention between sexes and education level. Females had greater knowledge in each of the above concepts. This idea was also

analyzed in terms of education level. To the concept of no sexual experience as an indication of being free from HIV/AIDS, most respondents at all education level had similar understanding. That means respondents in all education level understand that HIV/AIDS can be transmitted through different mechanisms in addition to sexual intercourse. The same analyses were made on concept of voluntary counseling and testing of HIV, the response of the respondents show no difference on the result.

4.3 Analysis of respondent's source of knowledge to voluntary counseling

Table3. Frequencies and percentages of respondents the source of information on the availability of VCT

Item			Yes		No		No Answer		Total	
			No	%	No	%	No	%	No	%
I got information on the availability of VCT from	1	Health personnel	137	68.5	37	18.5	26	13	200	100
	2	Mass media	179	89.5	13	6.5	8	4	200	100
	3	Friends	120	60	51	25.5	29	14.5	200	100
	4	Neighbors	84	42	86	43	30	15	200	100
	5	School	102	51	70	35	28	14	200	100
	6	FGA	100	50	68	34	32	16	200	100

This table (table 3) described the information center that respondents get awareness about the presence of VCT in their area. As shown above respondents got information through different sources. Most (89.5%) respondents get information about VCT through mass media, the second access to information about VCT was from Health personnel (68.5%), and the third was from friends (60%).

As indicated above communities have access to information from different sources. This access is encouraging, because, as the source of information increases, people will have the chance to get the required knowledge. However,

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	3	Friends	120	60	51	25.5	29	14.5	200	100
	4	Neighbors	84	42	86	43	30	15	200	100
	5	School	102	51	70	35	28	14	200	100
	6	FGA	100	50	68	34	32	16	200	100

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respondents got information from their neighbors were less than the other sources. This indicates that the community is still in favor of not dealing with HIV/AIDS. This further leads researcher to see that one who has HIV/AIDS in the community will not be helped from his/her neighbors. But changes in the knowledge of the community may come when discussion among neighbors existed.

Table 4: Frequencies and Percentages of respondents' preference to VCT site

Item			Yes		No		No Answer		Total	
			No	%	No	%	No	%	No	%
I preferred to have VCT service in	1	Hospital	161	80.5	17	8.5	22	11	200	100
	2	Health Center	142	71	28	14	30	15	200	100
	3	Private Clinic	108	54	61	30.5	31	15.5	200	100
	4	FGA	105	52.5	62	31	33	16.5	200	100

Table 4 tried to discuss the preferable site for the respondents to have voluntary counseling and testing. Based on the information, most (80.5%) respondents select hospital, the second preferable site was health center (71%), the third t preferable site was private clinic (54%) and the fourth was family guidance and association. Here, most respondents choose more than one site for their HIV testing.

4.4 Knowledge of respondents to voluntary counseling and testing

4.4.1 Knowledge of respondents towards the benefit of voluntary counseling and testing

Table 5: Frequencies and percentage of the benefits of VCT as perceived by the respondents

Item	Based on Sex (N=200)						Based on Education (N=200)							
	Male		Female		Total		Illiterate		Primary		Secondary		Tertiary	
	No	%	No	%	No	%	No	%	N0	%	No	%	No	%
1. VCT is an entry point in to care and an early detection service														
Yes	98	98	99	99	197	98.5	15	100	27	96.4	127	99.2	28	96.5
No	2	2	1	1	3	1.5	0	0	1	.3.6	1	.5	1	3.5
2. VCT prolong the life of HIV infected people by providing mental support														
Yes	79	79	89	89	168	84	13	86.7	24	85.7	108	84	24	82.7
No	21	21	11	11	32	16	2	13.3	4	14.3	20	16	5	17.3
3. Knowledge of HIV/Aids can be gained through VCT														
Yes					187	93.5								
No	92	92	95	95	13	6.5	15	100	27	96.4	117	91.4	27	93
	8	8	5	5			0	0	1	3.5	11	8.6	2	7
4. As more people are knowledgeable about HIV/AIDS Stigmatization will reduce														
Yes	90	90	85	85	175	87.5	14	93.3	25	89	111	86.7	24	82.7
No	10	10	15	15	25	12.5	1	6.7	3	11	17	13.3	5	17.3
5. VCT assist people to make informed decision to make HIV test.														
Yes	90	90	91	91	181	90	14	93.3	24	85.7	119	93	23	82
No	10	10	9	9	19	10	1	6.7	4	14.3	9	7	5	18
6. Adequate knowledge on VCT contribute to di-stigmatization of the infected person														
Yes								86.7		78.6		75.8		72.4
No	79	79	74	74	153	76.5	13	13.3	22	21.4	97	24.2	21	27.6
	21	21	26	26	47	23.5	2		6		31		8	
7. VCT is a key element in HIV prevention and care program														
Yes	89	89	91	91	180	90	14	93.3	23	82	117	91.4	26	89.7
No	11	11	9	9	20	10	1	.6.7	5	18	11	8.6	3	10.3

The first idea raised on table 5 was the concept of VCT as an entry point into care and early detection service. Most (98.5%) of the sample population answered that the idea was correct. That means almost all the sampled respondents have the required knowledge regarding VCT as an early detection service for HIV care program. Most respondents (84%) replied that getting VCT services prolong the life of infected persons by providing mental support and resistance. The remaining (16%) said that getting VCT could not prolong the life of infected persons.

Here, when we see the above concept in terms of sex and education level, there is no much difference in the knowledge of VCT as an entry point and early detection service. The percentage of respondents to this concept for female and male was (99%) and (98%) respectively. The same concept regarding education level was also analyzed. Respondents at different education level: - illiterate, primary, secondary and tertiary level educators had responded (100%), (96.4%), (99.2%) and (96.5%) respectively, which indicates illiterate and secondary respondents have almost the same level of knowledge or information and primary and tertiary respondents respectively.

Most (76.5%) respondents answered that adequate knowledge on VCT to people reduce the stigmatization occurred on those HIV/AIDS infected individuals. Female and male respondents have different (79%) and (74%) information with this idea. This was also analyzed in terms of education level.

The response given by the respondents to adequacy of knowledge on VCT was analyzed as 86.7%, 78.6%, 75.8% and 72.4% for illiterate, primary, secondary and tertiary level education respectively.

The other idea raised to the respondents about the benefit of VCT was, VCT assist people to make informed decision to seek HIV test. Most (87.5%) respondents replied that the concept is correct while only (12.5%) respondents

answered negatively (incorrect). Large number of male and female (90%) and (91%) respectively favor to the idea. So there is no knowledge gap between sexes. When the result was analyzed in terms of education level as illiterate, primary, secondary and tertiary, it showed that 93.3%, 85.7%, 93% and 82% respectively answered as correct. This analysis indicates that illiterate and secondary education level respondents had the same knowledge. Primary and tertiary education level respondents replied 85.7% and 82% respectively.

Voluntary counseling and testing is a key element in HIV prevention and care program. To this idea most respondents (90%) answered VCT is a key element in HIV prevention and care program, while only (10%) answered it is not a key element. Both female and males had the same level of information regarding this concept. There was a difference in the response of the respondents within different education level. Most illiterate persons (93.3%), primary educated people (82%), secondary educated persons (91.4%) and tertiary educated persons (89.7%) were responded VCT is a key element to prevent HIV/AIDS. It shows a difference between these respondents having different education level. Responses to these items were further examined by sex and level of education.

Table 6:- T-test results on the knowledge of VCT benefit by sex

N			M		Sd		df	t-value	t-critical
M	F	T	M	F	M	F			
100	100	200	6.19	6.29	2.07	1.8	198	.39	1.960

*Note alpha level of 0.05 was used to test the significance

As it can be seen from the above table (table 6) the mean score difference between subjects belonging to male and female was very low. There was a slight variation in deviation score between the two groups. This implies there is no significant knowledge difference among subjects belonging to the sexes identified for the purpose of this study.

The t- critical alpha 0.05, df (N-2) =200-2=198 is 1.960. Hence t-calculated is less than t-critical; the observed difference is not statistically significant. Therefore, it can be said that, there is no statistically significant variation in knowledge on the benefit between subjects belonging to different sex as identified in the study.

Table 7: One-way ANOVA tests on the knowledge of the benefit of VCT

Items	Source of variance	Sum of squares	df	Mean square	F	Sig.
1	Between Groups	2.079E-02	3	6.930E-03		
	With in Groups	3.899	196	1.989E-02		
	Total	3.920	199		.348	.790
2	Between Groups	.171	3			
	With in Groups	27.384	196	5.692E-02		
	Total	27.555	199	.140	.407	.748
3	Between Groups	.256	3			
	With in Groups	11.899	196	8.530E-02		
	Total	12.155	199	6.071.E-02	1.405	.243
4	Between Groups	1.768	3			
	With in Groups	21.587	196	.589		
	Total	23.355	199	.110	5.352	.001
5	Between Groups	6.483E-02	3			
	With in Groups	8.530	196	2.161E-02		
	Total	8.595	199	4.352E-02	.497	.685
6	Between Groups	.141	3			
	With in Groups	35.814	196	4.704E-02		
	Total	35.955	199	.183	.257	.856
7	Between Groups	.585	3			
	With in Groups	17.415	196	.195		
	Total	18.000	199	8.885E-02	2.195	.090

*Note- *items are listed in the same order as in table 5*

Table 7 presents the analysis of the benefit of voluntary counseling and testing as perceived by the respondents based on education level. As shown in the table the calculated F-value of item 1, "voluntary counseling and testing is an entry point to care and an early detection service", item 2, "voluntary counseling and testing prolong the life of HIV infected people by providing emotional support", item 5,

"voluntary counseling and testing assist people to make informed decision about the test" and item 6, "adequate knowledge of voluntary counseling and testing contribute to the destigmatisation of the infected person" were .348, .487, .497and .257 and the table value of those items were .790, .748, .685, and .856 respectively. There fore, there is no statistically significant difference among illiterate, primary, secondary and tertiary educated respondents on these concepts.

On the other hand table 7 shows a significant difference among groups on item 3 "knowledge of HIV/AIDS can be gained through voluntary counseling and testing", item 4 "as people are knowledgeable about HIV/ AIDS stigma will reduce" and item 7 "voluntary counseling and testing is a key element in HIV prevention and care program" where their F (calculated) value 1.405, 5.352, and 2.195 was greater than their table value .243, .001, and .090 respectively. This shows there is a statistically significant difference among groups on the raised issues. The difference shows that illiterate people are more knowledgeable on the benefit of voluntary counseling and testing than others.

4.4.2 Knowledge of respondents to the problems associated with voluntary counseling and testing

Table 8: Frequencies and percentages of respondent's knowledge towards the problems associated with VCT.

Items	Sex (N=200)						Education level (N=200)							
	Male		Female		Total		Illiterate		Primary		Secondary		Tertiary	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
1. VCT found in our area gives adequate service to the clients. Yes	28	28	47	47	75	37.5	10	66.7	9	32.2	42	32.8	13	45
No	72	72	53	53	125	62.5	5	33.3	19	67.8	86	67.2	16	55
2. Adequate attention is not made on VCT services Yes	69	69	56	56	125	62.5	7	46.7	17	60.7	85	66.4	18	62
No	31	31	44	44	75	37.5	8	53.3	11	39.3	43	33.6	11	38
3. Even if VCT services are available, the uptake of the service is very low because of stigma and denial. Yes	69	69	73	73	142	71	8	53.3	23	82	94	73.4	15	51.7
No	31	31	27	27	58	29	7	46.7	5	18	34	26.6	14	48.3
4. VCT is not much important for those who have low socio-economic status. Yes	38	38	39	39	77	61.5	2	13.3	10	35.7	50	39	16	55.2
No	62	62	61	61	123	38.5	13	86.7	18	64.3	78	61	13	44.8

In table 8 most respondents (71%) were responded that the up take of VCT service is very low due to denial and stigma. The remaining (29%) however, responded that they disagree with this concept. The analysis based on sex shows that 69% male and 73% female agree with idea raised. Meaning denial and stigma decreases the use of voluntary counseling and testing. This idea was also analyzed based on the respondents' education level. Illiterate persons (53.3%), primary educated persons (82%), secondary educated persons (73.4%) and tertiary educated persons (51.7%) respectively favor with stigma and discrimination hinders the use of voluntary counseling and testing service.

A key barrier to successful voluntary counseling and testing implementation is the inadequate access to voluntary counseling and testing service centers for the client. Most (62.5%) of the respondents know that voluntary counseling and testing service is not available and unable to give the adequate service to their area, while only (37.5%) respondents replied that voluntary counseling and testing in their area provide adequate service. To this idea, there was a difference between male and female respondents. Most male respondents (72%) and (53%) female respondents answered that voluntary counseling and testing did not give adequate service in their area.

Educational level as a factor is also analyzed and hence illiterate respondents of 66.7% replied that the voluntary counseling and testing center found in their area would give the adequate service. While those primary, secondary and tertiary levels educated respondents 67.8%, 67.2% and 55% of the respondents respectively replied that the voluntary counseling and testing service in their area would not give the adequate service.

Most (61.5%) respondents answered economic status couldn't be a barrier to the use of voluntary counseling and testing. But the remaining 38.5% respondents replied that economy become a barrier to the service or not.

Analysis regarding to this idea was made based on sex and education level. There is no difference in the response of male and female respondents. Sixty one percent male and sixty two percent female respondents replied that socio-economic status affect the up take of voluntary counseling and testing. Those (86.5%) illiterate, (64.3%) primary, and 61% secondary level educated respondents replied that socio-economic status did not affect the use of voluntary counseling and testing while (54%) of the tertiary educated level respondents replied that the need to voluntary counseling and testing can be affected by socio-economic status.

Table 9: T-test results on the knowledge of VCT associated problems by sex.

N			M		Sd		df	t-value	t-critical
M	F	T	M	F	M	F			
100	100	200	3.04	2.17	2.09	3.05	198	.37	1.960

*Note, alpha level of 0.05 was used to test the significance

As it can be seen from table 9 the mean score difference between male and female subjects were very low. There was a slight variation between deviation score of the two groups. This implies that there is no significance knowledge difference among subjects belonging to the sex level identified for the purpose of this study.

T-calculated is less than t-critical; the observed difference is not statistically significant. Therefore, it can be said that, there is no statistically significant variations in knowledge on problems associated with voluntary counseling and testing between subjects belonging to different sexes identified in the study.

Table 10: One -way ANOVA on the knowledge of problems associated with VCT.

Items	Source of variance	Sum of squares	df	Mean square	F	Sig.
1	Between Groups		3			
	With in Groups	.174	196			
	Total	46.946	199	5.785E-02		
		47.120		.240	.242	.867
2	Between Groups		3			
	With in Groups	.532	196			
	Total	46.588	199	.177		
		47.120		.238	.746	.526
3	Between Groups		3			
	With in Groups	8.781E-02	196			
	Total	42.307	199	2.927E-02		
		42.395		.216	.136	.939
4	Between Groups		3			
	With in Groups	.439	916			
	Total	46.916	199	.146		
		47.355		.239	.612	.608

***Note**- *items are listed with the same order made in table 8*

The level of education was the other factor examined to analyze the knowledge of problems associated with voluntary counseling and testing. Results (table 10) show there was a significant difference with item 2, "adequate attention is not made on voluntary counseling and testing services" and item 4, "voluntary counseling and testing is much important for those who have low socio economic status". Here the calculated (F-value) of item 2 and 4 were .746, and .612 respectively, which is greater than the table (p-value) at critical alpha 0.05. The knowledge of respondents to problems associated with voluntary counseling and testing in these items show there is a significant difference among groups of different education level even if the pattern was indeterminate

On the other hand in item 1, "voluntary counseling and testing found in their area provide adequate service to the clients" and item 3, " even the use of the

available services were low due to denial and stigma" showed no statistically significant difference among the respondents at different education level.

4.5 Attitude of respondents towards voluntary counseling and testing

Table 11: Frequencies and Percentage of respondent's attitude towards HIV/AIDS

	Items		A	U	D	Total
1	Share a meal with an individual who is positive for HIV/AIDS transfer the virus to uninfected person.	F	19	25	156	200
		%	9.5	12.5	78	100
2	Purchasing food items from a shop worker who is HIV positive transfer the virus to the uninfected person.	F	4	41	155	200
		%	2	20.5	77.5	100
3	It is important to keep mysterious, if some one in the family member will be HIV positive.	F	43	31	126	200
		%	21.5	15.5	63	100
4	I think HIV/AIDS is God's punishment to man.	F	53	77	70	200
		%	26.5	38.5	35	100
5	It is not necessary to abstain from sexual intercourse until one gets married.	F	52	20	128	200
		%	26	10	64	100
6	Willingness to discuss freely about HIV/AIDS in the family is important.	F	172	7	21	200
		%	86	3.5	10.5	100
7	It is embarrassing to buy condom from shop or other places.	F	83	25	92	200
		%	41.5	12.5	46	100
8	I think HIV/AIDS is the disease of "sinners".	F	25	57	118	200
		%	12.5	28.5	59	100

*Note A=Agree U= Uncertain D= Disagree

One of the functions of voluntary counseling and testing is to make people aware of HIV/AIDS mode of transmission and prevention. As clearly shown on the above table (table-11) the researcher raised questions, which diagnose the respondent's attitude towards HIV mode of transmission and prevention.

Most respondents on item 1, 2 and 3 which was 78%, 77.5% and 63% respectively disagree with the idea raised. That means respondents on all these items had positive attitude towards HIV infected individuals. They replied that sharing of a meal, and purchasing of food items from HIV positive individual couldn't transmit the virus and it is not important to be mysterious to talk about HIV.

On the other hand, 38.5% of the respondents became uncertain whether HIV/AIDS is God's punishment or not. Sixty four percent of the respondents disagree with the concept that abstain is not necessary until one gets married. Eighty six percent of the respondents agree with the idea that free discussion on HIV/AIDS should be existed in the family. Further analysis was made based on sex and education level.

Table 12: T-test results on the attitude of HIV/AIDs by sex

N			M		Sd		df	t-value	t-critical
M	F	T	M	F	M	F			
100	100	200	14.42	15.63	6.37	6.75	198	.40	1.960

*Note Alpha level of 0.05 was used to test the significance

The T-test result on table-12 show there is a little difference within the male and female groups, with the stated ideas. The calculated t- value =0.40 is less than the table value of t=1.960 at critical alpha level of 0.05. This shows that there is no statistically significant difference within the group used in the study towards the attitude of HIV transmission and prevention mechanisms.

To see the above concept with other grouping method (educational level) the following one-way ANOVA was used.

Table 13: One-way ANOVA test on HIV attitude by the level of education

	N	M	Sd	F	Sig.
Illiterate	15	16.07	6.30		
Primary education	28	14.92	6.30		
Secondary education	128	14.52	6.15		
Tertiary education	29	14.79	6.48	10.358	2.778

*Note, alpha level of 0.05 was used to test the significance

As it can be seen from table 13, the mean score difference among subjects belonging to illiterate, primary, secondary and tertiary were very high. There was a consistent decrease in the mean response with increase in educational level except tertiary education level. It shows there is statistically significant difference among the groups, since the calculated (F-value=10.358) is greater than the table value (p=2.778). It shows that as education level increases, the attitude towards HIV decreases among illiterate, primary and secondary education level.

4.6. Attitude towards Voluntary counseling and testing

4.6.1 Attitude towards the benefit of voluntary counseling and testing

Table 14: Frequencies and Percentage of respondent's attitude towards the benefit of VCT

	Items		A	U	D	Total
1	HIV/AIDS patients should invite voluntary counseling and testing center to get help from the center	F	147	23	30	200
		%	73.5	11.5	15	100
2	Voluntary counseling and testing service is used to adjust the life style of the individual after test	F	124	35	41	200
		%	62	17.5	20.5	100
3	Getting voluntary counseling and testing help those HIV infected persons to get psycho-emotional support.	F	119	44	37	200
		%	59.5	22	18.5	100
4	Voluntary counseling and testing help individual to make informed decision about the test.	F	144	25	31	200
		%	72	12.5	15.5	100
5	The presence of voluntary counseling and testing shape the attitude of people to HIV/AIDS.	F	141	29	30	200
		%	70.5	14.5	15	100
6	Voluntary counseling and testing provides information on the increased risk of opportunistic infections of sexually transmit diseases.	F	72	55	73	200
		%	36	27.5	36.5	100
7	Getting voluntary counseling and testing is necessary to take care of partners from HIV/AIDS.	F	82	61	57	200
		%	41	30.5	28.5	100
8	Voluntary counseling and testing help infected women, who know their sero-status, are able to make informed choices about their reproductive lives.	F	88	49	63	200
		%	44	24.5	31.5	100

Getting voluntary counseling and testing has various advantages to the needy. To this concept table 14 were analyzed with different interrelated ideas.

As shown on the above table (table 14) most respondents 73.5%, 62%, 77%, and 70.5% on item 1, 2, 4 and 5 were agreed up on the stated items. They favor the benefit of VCT in which it is advisable to people to invite the center. In the same case VCT has the advantage of adjusting the life style, shapes the attitudes of people towards HIV/AIDS and HIV positive people.

Moreover, 59.5%, 41% and 44% of the respondents considerably agree with the advantages stated in the same table on item 3, 6 and 8 respectively, VCT help to make psycho-emotional support, take care of partners and for those mothers need to have birth after been infected. On item 6 respondents have equal level of response on the item agree and disagree, 36% and 36.5% respectively. Uncertain response of the respondents on item 6 and 7 (27.5% and 30.5%) respectively were also considerable.

Table 15: T-test results on the attitude of the benefit of VCT by sex

N			M		Sd		df	t-value	t-critical
M	F	T	M	F	M	F			
100	100	200	18.60	18.70	6.35	6.36	198	.11	1.960

*Note, alpha level of 0.05 was used to test the significance

As it can be seen from table 15, the mean score difference between subjects belonging to male and female is very low. There is a slight variation in deviation score between the two groups.

The t-critical alpha 0.05, df (N-2) =200-2=198 is 1.960. Hence, t-calculated value is less than t-critical; the observed difference is not statistically significant. Therefore, it can be said that there is no statistically significant variation in attitude towards the advantage of VCT between subjects identified in the study

Table 16: Summery of one-way ANOVA tests on the benefit of VCT by education level.

	N	M	Sd	F	Sig.
Illiterate	15	17.40	6.37		
Primary education	28	18.70	6.13		
Secondary education	128	18.73	6.39		
tertiary education	29	19.19	6.10	7.745	3.768

*Note, alpha level of 0.05 was used to test the significance

The above table shows the analysis of one way ANOVA to see whether there exist a significant difference with the attitude of respondents among the group of illiterate, primary, secondary and tertiary education level.

The result shows there is significant difference, since the calculated (F=7.745) value is greater than the table value (p=3.768) in the mean rating of items with the difference in the level of education attained by the responses. It is interesting to note that the education factor that contributes to the difference in attitude toward the benefit (advantage) derived from voluntary counseling and testing for HIV. Hence, more educated people are more aware of the benefits that can be drawn from voluntary counseling and testing services.

4.6.2 Attitude towards problems associated with voluntary counseling and testing

Table17: Frequencies and percentage of respondent's to the problems associated with VCT.

	Item		A	U	D	Total
1	Voluntary counseling and testing is necessary for those specific people who are expected to be HIV positive	F	24	10	166	200
		%	12	5	83	100
2	People who went to voluntary counseling and testing have certain health problem.	F	20	32	148	200
		%	10	16	74	100
3	Stigma and discrimination threatened me in order to reveal the result after test	F	94	57	49	200
		%	47	28.5	24.5	100
4	Since I worry a lot about HIV test result, I will never be voluntary to go to the counseling and testing service	F	71	35	94	200
		%	35.5	17.5	47	100
5	Although going to the center of VCT to get blood test is easy, taking the result is threatening.	F	81	29	90	200
		%	40.5	14.5	45	100
6	Staying without HIV test is better than being tested.	F	69	20	111	200
		%	34.5	10	55.5	100
7	Adequate and available information is not given by those institutions, which provide VCT service.	F	51	21	128	200
		%	25.5	10.5	64	100
8	Getting of VCT service makes no change in the way of life for those tested individuals.	F	44	79	77	100
		%	22	39.5	38.5	200
9	Since there is no much help for those tested people after testing I hesitate to go to the VCT service	F	76	64	60	200
		%	38	32	30	100

Table 17 focused on people's attitude toward the problems associated with voluntary counseling and testing service.

As shown in the table above, 83% and 74% of the respondents on item 1 and 2 respectively disagree. They perceived that people who went to the service are not

HIV positive or those who have certain health problem. Sixty four percent of the respondents were favoring their attitude to VCT in that the center found in their area gives adequate service. Fifty five percent of the respondents disagree with staying with out test is better than being tested for HIV.

Moreover, 47% and 38% of the respondents on item 3 and 9 respectively disagree with the stated ideas. They favor that stigma and discrimination and no much help after the test would not affect the uptake of VCT. Thirty nine percent of the respondents were uncertain with the concept VCT service make no change in the way of life as one problem of taking VCT services

Table 18: T-test results on the attitude of respondents to problems associated with VCT

N			M		Sd		df	t-value	t-critical
M	F	T	M	F	M	F			
100	100	200	17.10	18.01	7.21	7.62	198	.84	1.960

*Note, alpha level of 0.05 was used to test the significance.

As it can be seen from table 18, the mean score difference between subjects belonging to male and female is very low. There is a slight variation in deviation score between the two groups. It implies that there is no statistically attitude difference between these groups. Here, the calculated (t=. 84) value is less than the table value at critical alpha of 0.05, which is 1.960.

Table 19: Summery of one-way ANOVA tests on the problem associated with VCT by education level.

	N	M	Sd	F	Sig.
Illiterate	15	19.14	7.39		
Primary education	28	17.66	7.74		
Secondary education	128	17	6.99		
Tertiary education	29	16.66	7.2	14.501	3.266

*Note, alpha level of 0.05 was used to test the significance.

One can see from table 19 that the mean score difference among subjects belonging to illiterate, primary, secondary and tertiary education level is very high. The results show significant difference, since the calculated (F=14.501) value is greater than the table (p=3.266) value at critical alpha 0.05.

There is a consistent decrease in the mean response with increase in education. It is interesting that as education level increases the attitude towards problems associated with VCT decreases.

CHAPTER FIVE: - DISCUSSION OF THE RESULT

5.1 Knowledge of respondents towards HIV/AIDS

Wider access to knowledge of HIV status would enable individuals to gain early access HIV specific care, treatment and support and access to intervention (WHO, 2002). It is vital that people protect themselves from HIV/AIDS. For this they should have adequate knowledge about the prevention and transmission mechanisms of the virus.

To see the knowledge of respondents how to prevent HIV from spread, different prevention related questions were raised. Eighty eight percent from the total respondents replied that sexual intercourse is not the only way that HIV virus can transmit from HIV infected to uninfected persons. But common use of sharp materials, blood contamination and from mother to child during birth was other mechanisms. Most respondents know that condom is one way of preventing the transmission of HIV.

People thought that HIV infected persons are thinner than those uninfected one's. Eighty nine percent of the respondents disprove this perception. To this end it is difficult to differentiate a person who has been infected by observing.

There was a difference in the knowledge of respondents based on their sex. The difference was statistically significant. Females had greater knowledge on HIV/AIDS transmission and prevention mechanisms. But one-way ANOVA shows that there was no statistically significance difference among subjects based on their education level.

5.2 Knowledge of respondents to voluntary counseling and testing

People need to have access to voluntary counseling and testing so they can find out about their HIV status and thus make the most of intervention for prevention

and care. That is why voluntary counseling and testing is considered as an entry point to care and early detection service. Ninety eight percent of the respondents had the knowledge towards this idea. Meaning they know voluntary counseling and testing is an early detection service for HIV care program. Female and male groups had similar knowledge to this point. One-way ANOVA also show no significant difference among groups on their education level.

Moreover, most respondents argued that adequate knowledge on voluntary counseling and testing reduce stigma and voluntary counseling and testing assist people to make informed decision to make HIV test.

Voluntary counseling and testing is a key element in HIV prevention and care program. To this idea most respondents (90%) answered voluntary counseling and testing is a key element in HIV prevention and care program. Both female and male had the same level of information regarding this concept. There was a difference in the response of the respondents within different education level. Most illiterate persons (93.3%), primary educated people (82%), secondary educated persons (91.4%) and tertiary educated persons (89.7%) were responded voluntary counseling and testing is a key element to prevent HIV/AIDS. One-way ANOVA shows there is statistically significant difference among subjects knowledge on their education level.

Although voluntary counseling and testing is becoming increasingly available in developing and middle-income countries, there is still great reluctance for many people to be tested. There are several contributing factors that must be addressed if voluntary counseling and testing has an important role in HIV prevention and care. In this regard, this study showed that HIV testing might have far reaching implications and consequences in the person being tested. Although there are important benefits of knowing HIV status, HIV infection in many countries is a stigmatizing condition and this can lead to negative out comes for people

following testing. In this regard most respondents (71%) were responded that the up take of VCT service is very low due to denial and stigma. The remaining (29%) however, responded that they disagree with this concept. The analysis based on sex shows that 69% male and 73% female agree with idea raised. Meaning denial and stigma decreases the use of voluntary counseling and testing. This idea was also analyzed based on the respondents' education level. Illiterate persons (53.3%), primary educated persons (82%), secondary educated persons (73.4%) and tertiary educated persons (51.7%) respectively favor with stigma and discrimination hinders the use of voluntary counseling and testing service. To this concept the difference between male and female subjects are not significant. Moreover, the difference among groups in education level was also not significant.

This analysis shows that illiterate and tertiary educated have the same knowledge base regarding stigma and discrimination as hindrance of taking voluntary counseling and testing service. Those primary educated individuals however, supported that denial and stigma are the most important factor that hinder voluntary counseling and testing service. Secondary educated people were in between the above groups. It showed that the level of awareness of respondents based on education level was unpatterned. It may be due to other factors.

A key barrier to successful voluntary counseling and testing implementation is the inadequate access to voluntary counseling and testing service centers for the clients. Most (62.5%) of the respondents know that voluntary counseling and testing service is not available and unable to provide the adequate service, while only (37.5%) respondents replied that voluntary counseling and testing in their area gave adequate service. To this idea, there was a difference between male and female respondents. Most male respondents (72%) and (53%) female respondents answered that voluntary counseling and testing did not give adequate service in their area.

Educational level as a factor was also analyzed and hence illiterate respondents of 66.7% replied that the voluntary counseling and testing center found in their area would provide the adequate service. While those primary, secondary and tertiary levels educated respondents 67.8%, 67.2% and 55% of the respondents respectively replied that voluntary counseling and testing service in their area would not give the adequate service. The difference observed between female and male subjects and among groups at different education level is not significant.

Lack of perceived benefit was also the other common barrier to voluntary counseling and testing. In poorer high prevalence areas, many people did not want voluntary counseling and testing service. Because they may afraid that little help will be available to them if they are infected and there fore, it is better not to know their serostatus. Therefore, people may perceive that voluntary counseling and testing is not much important for those who have low socio-economic status. Most (61.5%) respondents answered economic status couldn't be a barrier to the use of voluntary counseling and testing. But the remaining 38.5% respondents replied that economy become a barrier to the service or not.

Analysis regarding to this idea was made based on sex and education level. There was no difference in the response of male and female respondents. Sixty one percent male and sixty two percent female respondents replied that socio-economic status affect the up take of voluntary counseling and testing. Those (86.5%) illiterate, (64.3%) primary, and 61% secondary level educated respondents replied that socio-economic status did not affect the use of voluntary counseling and testing while (54%) of the tertiary educated level respondents replied that the need to voluntary counseling and testing can be affected by socio-economic status. Analysis made on sex shows that there was no significance difference on their knowledge towards problems associated with

voluntary counseling and testing. But there is significant difference among subjects in their education level as shown in the analysis table.

5.3 Respondents' attitude to HIV/AIDS

As indicated in different research and findings voluntary counseling and testing is used to make people, aware of HIV/AIDS mode of transmission and prevention, function and problems associated with voluntary counseling and testing.

Most respondents disagree with idea raised like sharing a meal, with HIV infected individuals and purchasing food items transfer HIV/AIDS. Respondents have good attitude towards how HIV/AIDS could be transmitted from infected to uninfected persons. This also can be gained through voluntary counseling and testing services.

On the other hand the respondent's attitudes towards HIV prevention mechanisms, 64% of them agree that abstain from pre-marital sex is important and 46% of the respondents disagree with buying condom from shop or other place is embarrassing. This indicates that respondents have good attitude towards the use of HIV preventing mechanisms.

In addition, 38.5% of the respondents were uncertain that whether HIV/AIDS is God's punishment or not. This indicate people may have a perception HIV/AIDS is a disease of sinners. It is a great problem, which creates negative image in the mind of the respondents towards people, who are living with HIV/AIDS. Moreover, 86% of the respondents agree that free discussion on HIV/AIDS in the family is necessary.

A t-test was used to see whether there is an attitude difference between male and female subjects with the above stated ideas. But the result did not show any

significant different between groups towards the HIV/AIDS prevention and transmission mechanism.

One-way ANVOA test was also used to see whether there is an attitude difference among groups of respondents. There was a statistically significant difference among groups. The difference show attitude towards HIV/AIDS decreases as education level increases except tertiary education level.

5.4 Attitude towards voluntary counseling and testing

Until recently, many people believed there were few benefits to knowing their serostatus. But Voluntary counseling and testing have various advantages to the needy. To this end voluntary counseling and testing service is used to adjust the life style of tested people, for psycho-emotional support, to make informed decision about HIV test, was raised. To these questions 62%, 59.5% and 72% of the respondents respectively agreed. From this we can understand that respondents' attitude towards voluntary counseling and testing service and its advantage is better the study community.

Moreover, 44% of the respondents replied that voluntary counseling and testing is advantageous for infected women, who know their sero-status, to make informed choices about their reproductive lives. Further, voluntary counseling and testing provide information on the increased risk of opportunistic infections of sexually transmitted diseases.

Further analysis on the advantage of voluntary counseling and testing was made based on sex and education level. The t-test analysis shows that there was no statistically significant difference between groups of male and female subjects in their attitude towards the advantages of voluntary counseling and testing services.

One-way ANOVA was used to see whether there is an attitude difference among groups based their education level. The result showed that there was a significant difference among the groups in their attitude towards the advantages of voluntary counseling and testing services. That is as education level increases, the attitude towards the benefits of voluntary counseling and testing also increases.

In addition to the above discussions, various questions related to problems associated with voluntary counseling and testing was raised and the result has been analyzed. Seventy four percent of the respondents disagree with People who went to voluntary counseling and testing have certain health problem. This indicates that even people had no problem of health they have to go to the service to check their HIV status or for other reason.

Stigma and discrimination threatened people in order not to reveal test result. Here, forty seven percent of the respondents agree with the idea. Mostly people are not voluntary to go to voluntary counseling and testing, because they worry a lot about HIV test result. Forty seven percent of the respondents did not worry about their HIV test results. The two concepts above seem to have opposite response. People fear stigma and discrimination but they were not worry about the test result. This idea generates the concept that most people fear not the test result but the stigma and discrimination after the test; such attitude towards voluntary counseling and testing may reduce the use of the service.

The other problem related to the attitude of respondents towards voluntary counseling and testing was fear of taking test result. But 45% of the respondents disagree while 40.5% the respondents agree. Seventy four percent of the respondents disagree that voluntary counseling and testing institutions in their area provide adequate service to clients. Thirty eight percent of the respondents hesitate to go to the voluntary counseling and testing service, because the service provided after test is not sufficient. This may hinder people from seeking

voluntary counseling and testing services because of their economic problem. Fifty five percent of the respondents disagree that staying without test is better than being tested.

With the attitude of people towards problems associated with voluntary counseling and testing further analysis was made on sex and education level. There was no statistically significant difference between male and female subjects. But one-way ANOVA showed that there is significant difference among groups at different education level. The analysis showed as the education level increases, there is a consistent decrease in the attitude of respondents to the problems associated with voluntary counseling and testing.

CHAPTER SIX: SUMMERY, CONCLUSION AND SUGGESTION

6.1 Summery

The main objective of the present study was to examine the knowledge and attitude of people towards voluntary counseling and testing for HIV.

In light of this objective, three specific questions were formulated for investigation. These are:

- What is the level of community's awareness towards voluntary counseling and testing and its function?
- What are the community's knowledge and attitude towards voluntary counseling and testing as HIV/AIDS control mechanism? and
- What are the obstacles that hinder in order not to use voluntary counseling and testing services?

This study was conducted in Shashemene of the Oromia Region. The study area was selected basically for two reasons. Firstly, from the researcher experience high prevalence of HIV/AIDS may exist, since it is a joint place from four different directions. Secondly there is no formal and systematic research done in the area on the same concept

Subjects were selected using systematic random sampling scheme. From randomly selected Kebles (Keble four and Kebele six) 99 and 101 subjects were included in the study.

The collected data was analyzed using percentage, t-test and one-way ANOVA. The percentage was used to identify proportion of subjects who are in favor of voluntary counseling and testing under certain conditions (i.e. benefit and problems associated with VCT). The t-test was employed to examine the significance of the difference in knowledge and attitude between subjects based

on their sex. One-way ANOVA is used to examine the significance of the difference among subjects based on education level.

Analysis of the data indicate the following-

- It was evident that significant percentages of respondents are in favor of voluntary counseling and testing on account to different factors. It was observed that most respondents had the knowledge on the benefits of voluntary counseling and testing for HIV/AIDS.

- Subjects acquire knowledge to influence their attitude towards voluntary counseling and testing through different information sources, in which they have positive attitude towards the benefits of voluntary counseling and testing services.

- Females have better knowledge than males but not significantly different. Subjects at all level of education had similar knowledge towards HIV prevention and transmission mechanisms.

- It was observed that people got information about the presence of voluntary counseling and testing through different sources. Among the available sites where VCT provided its services, most respondents prefer hospital than other sites.

- There was statistically significant difference in knowledge among illiterate, primary, secondary and tertiary level educated subjects towards the benefits of voluntary counseling and testing service. On the contrary, there was no significant difference between male and female subjects towards the same idea.

- It was observed that stigma and discrimination and unavailability of the service around the subjects' area were considered as the major factors, which affect the uptake of voluntary counseling and testing. Both male

and female subjects know this fact, while there was unpatterned difference among subjects at different education level.

- It becomes clear that more people had positive attitude towards individuals who had been infected with HIV/AIDS. Of course statistically significant difference was existed among subjects of different education level while no difference on attitude of male and female subjects towards the same idea.

- It becomes clear that most people had positive attitude towards the benefit of voluntary counseling and testing. Significant numbers of tertiary educated people favor their attitude towards voluntary counseling and testing. To this idea there was no significant difference between male and female subjects.

- Unlike the respondent's knowledge of voluntary counseling and testing service, their attitude to factors which affect voluntary counseling and testing was positive. Significant number of illiterate people favor that factors would not prohibit individuals from using voluntary counseling and testing service.

6.2 Conclusion

HIV voluntary counseling and testing (VCT) has been shown to have a role in both HIV prevention and for people with HIV infected as an entry point for care. Voluntary counseling and testing provide people with an opportunity to learn and accept their HIV status in a confidential environment with counseling and medical care (UNAIDS 2000). In this fact, people should protect themselves from HIV/AIDS when they have good knowledge and positive attitude to the transmission and prevention mechanism through voluntary counseling and testing.

According to the result of the cross-sectional survey, there was high level of awareness that no experience of sexual intercourse means some one is not free from HIV/AIDS and use of condoms serves much purpose to prevent HIV/AIDS. Respondents approve that HIV can transmit through other means than sexual intercourse and condom is one of the mechanisms used to prevent HIV.

Knowledge of voluntary counseling and testing and its use can be gained through different sources like mass media, health personnel, friends, neighbors. This leads the researcher to conclude that having such wide ranges of information on voluntary counseling and testing people are aware and knowledgeable to voluntary counseling and testing.

Further more, voluntary counseling and testing is an entry point in to care and early detection service. It confirms with different literature (V.solomon et. al, 2004). Moreover, respondents are highly aware and knowledgeable to the function of voluntary counseling and testing as to make informed decision to test HIV.

It can be concluded that voluntary counseling and testing services are used for HIV infected persons to adjust their living style and reduce the stigma and discrimination. In this concept, knowledge and awareness of respondents was encouraging. They advocate that voluntary counseling and testing do have good influence.

Although voluntary counseling and testing is becoming increasingly available in developing and middle-income countries, there is still great reluctance for many people to be tested. Factors considered for these are stigma and discrimination, inadequate access of voluntary counseling and testing services, worrying about test results and fear of taking test results.

It also concluded that respondents have better attitude towards voluntary counseling and testing on account of different factors. The attitude of respondents towards the benefit of voluntary counseling and testing is also encouraging. Moreover they have favorable attitude towards problems associated with voluntary counseling ands testing.

6.3 Suggestion

On the basis of the findings the researcher forwards the following suggestions.

- The result indicates that numerous numbers of people are aware of the advantage and problems associated with voluntary counseling and testing. But the practicability or using of voluntary counseling and testing was very low due to different factors that prohibit individuals in order not to use the service. Therefore, sensitivity program on the issue of voluntary counseling and testing and its physical, psychological and social benefit to people should be advocated by responsible bodies like government, non-government and civil societies

- More specifically, stigma and discrimination are the most significant factors which affect the use of voluntary counseling and testing. Therefore, exhaustive education, workshop for significant people like religious leaders, youth associations who are working in the area of HIV and other influencing bodies should be given to increase people's awareness on the negative consequences of stigma and discrimination.

- Institutions, which give voluntary counseling and testing service, should be available and equipped with necessary materials to give the adequate service needed by people. Moreover, these centers should have professionally trained counselors and "counselors" who are found in the institutions should get the appropriate training in order to treat clients empathetically.

- In addition, worrying about HIV test and fear of taking the test result affects the attitude of people towards voluntary counseling and testing. So to solve such types of problems, counselors should give the appropriate pre-test counseling for clients. This helps to make decisions on HIV test and taking the result with out hesitation. Moreover, post–test counseling should also be given for the purpose of emotional and social stability of HIV infected persons.

- Eventually, further research should be conducted on the basis of other factors, since there could be different factors, which were not included in this study.

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Addis Ababa University
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The aim of this questionnaire is to gather information on knowledge and attitude of peoples about voluntary counseling and testing service issues.

The questionnaire may try to explore some very personnel information about you but the information obtained form you is very essential to complete this study successfully. You have been selected as a respondent and it is believed that you could give all the necessary information frankly and honestly.

Your response will be kept in absolute confidentiality & will never affect you and the people related to you.

Thank you very much for your coc peration.

Instruction: - *No need of writing your name*
Please fill your answer in the blank space or encircle the number of your Choice or make thick mark (✓) for the question from part one to part three.

Part I. Background information

1. Age
   1. Below 20 year old.
   2. 20-30years old
   3. 31-40 year old
   4. Above 40 year old

2. Sex
   1. Male
   2. Female

3. Religion
   1. Orthodox
   2. Muslim
   3. Catholic
   4. Protestant
   5. Other, specify_____

4. Marital condition
   1. Married
   2. Un married
   3. Divorced
   4. Widowed

5. Level of education
   1. Illiterate
   2. 12/10 complete
   3. College diploma
   4. Above

6. Job occupation condition
   1. Private business
   2. Government employee
   3. Private employee
   4. NGO'S employee

7. Monthly total income for the family
   1. Below 300 birr
   2. 300 – 600 birr
   3. 600 – 900 birr
   4. Above 900 birr

Part II. Voluntary counseling & testing knowledge related Questions

1. No experience of sexual intercourse means, he/she is free from AIDS.
   1. Yes 2. No

2. Using condom serves no purpose to prevent for HIV/AIDS.
   1. Yes 2. No

3. It possible to differentiate by observing infected person from uninfected one With HIV/AIDS.
   1. Yes 2. No

4. One should check his/her HIV status voluntarily.
   1. Yes 2. No

5. Voluntary counseling and testing is an entry point into care and an early detection service.
   1. Yes 2. No

6. Knowledge of voluntary counseling and testing help individuals who have been infected HIV/AIDS to provide mental adjustment.
   1. Yes 2. No

7. Understanding of how to support people who live with HIV/AIDS can be gained through voluntary Counseling & testing.
   1. Yes 2. No

8. As more people became knowledgeable about voluntary Counseling & testing stigma and discrimination will decrease.
   1. Yes 2. No

9. Knowledge of HIV infection is a pre-requisite in initiating anti- retroviral therapy for long-term treatment of people living with HIV.

   1. Yes 2. No

10. HIV taste of individuals should be undertaken only with their informed consent and should be entirely voluntary.
    1. Yes 2. No

11. Adequate knowledge of voluntary counseling and testing contribute towards distigmatization of the disease
    1. Yes 2. No

12. Voluntary counseling and testing is a key element of HIV prevention and care program.
    1. Yes 2. No

13. Voluntary counseling and testing provides adequate service in our area
    1. Yes 2. No

14. Adequate attention and is not made on voluntary counseling and testing services.
    1. Yes 2. No

15. Even if testing and counseling services are available, the up take of the service is very low, because of denial & stigma.
    1. Yes 2. No

16. Voluntary counseling and testing is not much important for those who have low socio-economic status.
    1. Yes 2.No

17. I got information about the availability of voluntary counseling and testing from

17.1 Health personnel	1. Yes	2. No
17.2 Mass media	1. Yes	2. No
17.3 Friends	1. Yes	2. No
17.4 Neighbors	1. Yes	2. No
17.5 School	1. Yes	2. No
17.6 Family guidance association	1. Yes	2. No

18. The preferred location for voluntary counseling and testing is

11.1 Hospital	1. Yes	2. No
11.2 Health center	1. Yes	2. No
11.3 Private sector	1. Yes	2. No
11.4 Family guidance association	1. Yes	2. No

19. Which way do you know about the transmission of HIV/AIDS form infected to uninfected person?
    1. Blood transfusion
    2. From infected mother to child
    3. Sharp instruments used by the infected person
    4. Unprotected sexual intercourse
    5. All I know

20. What are the majors adapted to prevent HIV/AIDS form spreading.
    1. Absenteeism 3. Taking voluntary counseling & testing
    2. Being faithful 4. Condom use 5. All

21. How one can told that some one is free from HIV/AIDS?
    1. By blood testing 3. By urine examination
    2. By stool examination 4. All

Part III. Questions related to attitude of HIV and voluntary counseling & testing

No	Questions	Alternatives		
		Agree	Uncertain	Disagree
1	Share a meal within an individual who is positive for HIV/AIDS transmit the virus to uninfected person			
2	Purchasing food items from a shop worker who is HIV positive transfer the virus to the uninfected person.			
3	It is important to keep mysterious, if some one in the family member is positive for HIV AIDS			
4	I think HIV/AIDS is God's punishment to man.			
5	It is not necessary to abstain from sexual intercourse until one gets married.			
6	Willingness to discuss freely about HIV/AIDS in the family is necessary.			
7	It is embarrassing tc buy condom from shop or other place.			
8	I think HIV/AIDS is the disease of "sinners".			
9	HIV/AIDS patients should invite voluntary counseling and testing to get help for them selves			
10	Voluntary counseling and testing service used to adjust the living style of peoples after the test.			
11	Getting voluntary counseling and testing helps those HIV infected persons to get psycho-emotional support.			
12	The presence of voluntary counseling and testing help individuals to make informed decision about the test.			
13	The presence of voluntary counseling and testing shapes the attitude of individuals towards HIV/AIDS			

14	VCT provides awareness on the increased risk of opportunistic infections			
15	Getting voluntary counseling and testing is necessary to take care of partners from HIV/AIDS.			
16	Voluntary counseling and testing help HIV positive women who know their serostatus are able to make informed choices about their reproductive lives.			
17	Voluntary counseling and testing is necessary for those specific people who are expected to be HIV positive			
18	People who went to voluntary counseling and testing have certain health problem			
19	Stigmatization and discrimination threatened me in order not to reveal the result after test			
20	Since I worry a lot about HIV test result, I will not be voluntary to go to the counseling and testing service			
21	I think voluntary counseling and testing service is used for only those people who get the service.			
22	Although going to the center of voluntary counseling and testing to get blood test is easy, but taking the result is threatening.			
23	Adequate and available information is not provided by those institutions, which provide voluntary counseling and testing.			
24	Getting of voluntary counseling and testing service make no change in a way of life for the tested individual.			
25	Since there is no much help for those tested people after the result, I hesitate to go to the voluntary counseling and testing service.			

14	VCT provides awareness on the increased risk of opportunistic infections			
15	Getting voluntary counseling and testing is necessary to take care of partners from HIV/AIDS.			
16	Voluntary counseling and testing help HIV positive women who know their serostatus are able to make informed choices about their reproductive lives.			
17	Voluntary counseling and testing is necessary for those specific people who are expected to be HIV positive			
18	People who went to voluntary counseling and testing have certain health problem			
19	Stigmatization and discrimination threatened me in order not to reveal the result after test			
20	Since I worry a lot about HIV test result, I will not be voluntary to go to the counseling and testing service			
21	I think voluntary counseling and testing service is used for only those people who get the service.			
22	Although going to the center of voluntary counseling and testing to get blood test is easy, but taking the result is threatening.			
23	Adequate and available information is not provided by those institutions, which provide voluntary counseling and testing.			
24	Getting of voluntary counseling and testing service make no change in a way of life for the tested individual.			
25	Since there is no much help for those tested people after the result, I hesitate to go to the voluntary counseling and testing service.			

Declaration

I, the under designed, declare that this thesis is my original work, has not been presented for a degree in any other University and all source of materials used for the thesis have been dully acknowledged

Name Likinaw Atenew

Signature _____

Place Addis Ababa

Date of Submission _____

This thesis has submitted for examination with my approval as a university advisor.

Name R. VENKATACHALAM

Signature _____