ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

School Of Public Health

UTILIZATION OF HIV/AIDS VOLUNTARY COUNSELING AND TESTING SERVICE AND ASSOCIATED FACTORS AMONG GOVERNMENT HIGH SCHOOL ADOLESCENTS IN ADDIS ABABA, ETHIOPIA.

AN INSTITUTION-BASED CROSS SECTIONAL STUDY.

BY

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A thesis report submitted to the School of Public Health of Addis Ababa University as a Partial fulfillment for the completion of a Masters Degree in Public Health

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ACRONMYS

AIDS – Acquired Immunodeficiency Syndrome

ART – Anti Retroviral Therapy

CHW – Community Health Workers

EDHS – Ethiopian Demographic Health Survey

FMoH – Federal Ministry of Health

HAPCO - HIV/AIDS prevention and control office

HCT – HIV Counseling and Testing

HIV – Human Immunodeficiency Virus

MAC-E – Millennium AIDS Campaign - Ethiopia

MTCT – Mother to Child Transmission

PMTCT – Prevention from Mother to Child Transmission

PLWHA – People Living with HIV/AIDS

VCT – Voluntary Counseling and Testing

ABSTRACT

BACKGROUND: Voluntary Counseling and Testing (VCT) is a key component in the national HIV/AIDS prevention and control programs in sub-Saharan Africa. HIV/AIDS is the number one cause of death among adolescents in sub-Saharan Africa. Nevertheless, testing among adolescents remains very low. The 2016 EDHS shows in Ethiopia 74% of girls and 88% of boys aged 15 – 19 years have never been tested. However in Ethiopia HIV Counseling and Testing tends to be on the fall among adolesccents according to EDHS 2011 and 2016. The objective of this study is to determine the prevalence of Voluntary Counseling and Testing (VCT) of HIV/AIDS and associated factors among high school adolescents in Addis Ababa, Ethiopia.

METHODS: We carried out a cross-sectional study to assess the prevalence of VCT utilization and its associated faactors among high school adolescents aged 15 – 19 years in Addis Ababa, Ethiopia from February to April 2018. Our study participants were selected using simple random sampling technique. A self-administered structured and pre-tested questionnaire was used to collect data. Data was analyzed using SPSS 21. We used Descriptive statistics to describe the study population, bivariate analysis to determine the presence and strength of association and multivariable methods of data analysis to control for confounders; $p<0.05$ was considered statistically significant.

RESULTS: Our study participants constituted 400 adolescents; 44% male, 56% female with a mean age of 17.2±1.3 years. 20.2% of our study participants were sexually active with the mean age of first sexual intercourse 16.3±1.5 years. The prevalence of VCT utilization was 35.8% and the associated factors were; Ever had sexual intercourse [AOR=2.09 (1.03, 4.26)], Availability of VCT services in or around the high school [AOR=1.85 (1.07, 3.18)], time on foot to nearest VCT center [AOR=3.74 (1.17, 12.0)], perception of stigma and discrimination [AOR=3.0 (1.79, 5.014)].

CONCLUSION: VCT utilization among high school adolescents was low. Accessibility, perceived stigma and discrimination remain major barriers to VCT utilization for adolescents.

RECOMMENDATION: VCT services should be made available in schools and Campaigns to educate parents and adolescents on stigma and discrimination will improve VCT utilization.

CHAPTER 1: INTRODUCTION

1.1 Background

HIV voluntary counseling and testing over the last few decades has been identifies as a key entry point into HIV prevention, treatment and support service all in one. As an HIV prevention intervention, it provides individual HIV counseling; improving HIV knowledge and awareness and knowledge of ones HIV status, which could influence behavioral change and at the same timeit facilitates access to care, treatment and support service for those diagnosed HIV positive. However, testing and treatment for adolescents remain particularly low. Recent data shows only 13% of adolescent girls and 9% of adolescent boys in sub-Saharan Africa have ever been tested and received their results(1). Meanwhile, in Ethiopia, a staggering 74% of adolescents girls and 88% of adolescent boys aged 15 - 19 have never been tested, the highest compared to any other age group(2). This low prevalence of testing among adolescents results in late diagnosis and subsequently late entry into care which leads to high HIV related mortality in this age group.

HIV/AIDS is the leading cause of death among adolescents in sub-Saharan Africa, and only second to road traffic accidents globally in this same age group(3).Over 80% of the worlds HIV related deaths among adolescents occur among adolescents in sub Saharan Africa(4).Since 2000, interventions focusing on the reduction of HIV mortality and propagation have been successful with HIV related deaths markedly reduced in all age groups but for adolescents were HIV related deaths have almost increased threefold, rising from 18000 to 41000 adolescent deaths in 2015(1). Here 1 of every 6 deaths among adolescents is due to HIV, making up approximately 16% of all adolescent deaths in the region(5).

Despite the significant progress made in the reduction of HIV/AIDS worldwide among all age groups, HIV/AIDS among adolescents remain a global issue. Approximately 1 in every 3 new infections occurs in young people aged 15 – 24 emphasizing the significance of HIV prevention interventions targeting this age group(6). In 2016 there were approximately 2.1 million adolescents living with HIV worldwide, a significant 30% increase from 1.4 million recorded in 2005(1). In 2014 sub-Saharan Africa accounted for 79% of all new infections among young people with about two-thirds being girls (7). This could result in a reversal in the major gains made with programs like PMTCT.

In recent years, in an effort to improve on the progress in HIV/AIDS among adolescents, multiple programs such as Fast Track (2014), DREAMS; Determined, Resilient, Empowered, AIDS Free (2014), #ALL in to end adolescent AIDS (2015), Start Free Stay Free AIDS Free-super fast track (2016) have been launched to end adolescent AIDS by 2030. However, at the core of attaining the targets set in these programs is HIV counseling and testing. Through VCT as an entry point, more adolescents will be educated on behavioral changes necessary to prevent HIV, know their HIV status and seek treatment if need be.

1.2 Statement of the Problem

Adolescence is a transition period from childhood to adulthood therefore the health and wellbeing of adolescents ensures a transition into a health adult life. Thus, a healthy adolescence is vital for the growth and development of every society. According to economist, healthy thriving adolescents will increase productivity and improve the economy of the country, whereas poor health will result to a generational vicious cycle of poor health and socio-economic loss(8). With the rapid growth of the youth population especially in sub-Saharan Africa, new HIV infections among adolescents could rise from 250,000 – 400,000 between 2015 and 2030, if the status quo on emphasis put adolescent HIV prevention does not change(9).

In Ethiopia, adolescents represent approximately 25% of the population and according to EDHS between 2011 and 2016, HIV testing coverage has significantly dropped uniquely among adolescent boys and girls aged 15-19 (2, 10). This decrease in HIV testing coverage among adolescents could result in fewer adolescents who know their status and therefore result in increased risky sexual behavior among adolescents resulting an increase in new HIV infections in this age group and late entry into treatment for those HIV positive and thus, increase in HIV related morbidities and mortalities among adolescents with severe impact socially and economically to the community.

1.3 Significance of this Study

A previous study in 2011 assessing knowledge and attitude towards VCT utilization revealed a prevalence of VCT utilization of 62.2% among high school adolescents in Addis Ababa aged 15-19. This study however did not assess the factors associated with VCT utilization among high school adolescents. Since 2011, there has not been any follow-up study to assess the prevalence of VCT utilization among adolescents in Addis Ababa.

Therefore our study thus comes as a follow-up to assess the present prevalence of VCT utilization among adolescents in Addis Ababa, and assess the factor affecting VCT utilization among this age group. This study will therefore enable policymakers to assess the effectiveness of existing adolescent HIV prevention programs and properly tailor inclusive policies and interventions which cover all adolescents' needs. It will serve as a measure for organizations working on HIV/AIDS and VCT implementation to assess the progress made over the last 7 years and to determine the way forward.

CHAPTER 2: LITERATURE REVIEW

2.1 Definition and concepts of Adolescence

Adolescence is the period of developmental transition from childhood to adulthood. Dubbed as the healthiest period of one's life, this critical development period known to be the onset of puberty and social independence is also known to be the most rapid phase of human of development characterized by physical, psychological, emotional changes and sexual experimentation.

For many decades the delimitation of a specific age range to define adolescence has been and is still up for discussion due to variability in individual development, gender, culture and race. According to the Oxford English dictionary, the original definition of adolescence back as early as the 15th century was defined as the period between 14-25 for males and 12-21 for females, in the early 20th century it was defined by Hall as the period between 14 – 25 for both sexes. The definition over the years has undergone multiple modifications however present day definition according to WHO refers to adolescence as the period between 10 to 19 years of age and can be divided into 3 subgroups; Early adolescence (approximately 10-13 years of age), Middle adolescence (approximately 14-16 years of age), Late adolescence covers 17-19 years of age(11).

Adolescents make up a significant proportion of any population. Worldwide, there are about 1.6 billion adolescents, making approximately one-fifth of the world's population(8). In sub-Saharan Africa, adolescents make the up about 23% of the population, making it largest demographic on the continent. Similarly, in Ethiopia, the adolescent population makes up about 25% of the country's population. This emphasizes the significance of adolescent health in any society since adolescents are an integral part of any society's future labor force and economy, thus neglecting their health may result in very high social and economic costs.

2.2 Adolescents and HIV/AIDS

HIV/AIDS is the second highest cause of death among adolescents globally and the number one cause of death among adolescents in Africa. Despite multiple efforts and interventions put in place to stop the propagation of HIV, over the past decade, AIDS-related deaths have decreased in all age groups but have however increased among adolescents(1).

Adolescents and young people represent a growing share of people living with HIV worldwide. Despite efforts to reduce HIV transmission and mortality, adolescents remain the only age group with increasing rates of new infection. Between 2005 and 2015, the number of adolescents living with HIV increased by 28%. This increase can, however, be explained by a high number of children who acquired HIV through MTCT attaining adolescence.

Nevertheless, with the outstanding progress made in reducing MTCT worldwide, unprotected sex remains the next most frequent mode of HIV transmission among adolescents(1). Acquisition of HIV through unprotected sex among adolescents could be attributed to developmental changes associated with adolescence and the desire to explore peer relationships and their sexuality. However this remains a major problem, as not only acquisition can be attributed to this but also adolescents who contract HIV at an early age are more likely to transmit the virus since HIV risk behaviors are higher at younger ages and decreases with age(12). Nonetheless growing evidence shows this unprotected sex could be coerced especially among girls(13).

2.3 Adolescent Risky Behavior

Trimpop defined risky behavior as any consciously, or non-consciously controlled behavior with a perceived uncertainty about its outcome, and/or about its possible benefits, or costs for the physical, economic or psycho-social well-being of oneself or others(14). Risky behaviors such as substance abuse, sexual risky behaviors feature as a predictor for the top 10 causes of mortality among adolescents.

Adolescence comes with developmental changes, and with developmental changes comes the urge for self-discovery and experimentation. During this phase, adolescents experiment with new habits and even their sexuality with little attention to the fore coming consequences. As seen in multiple studies, adolescents have a high tendency of engaging in risky behavior, putting them at a great risk of pregnancy, STIs, and HIV. This includes an increased intake of alcohol, substance abuse, and smoking. These are all factors that impair and have been shown to be strongly associated with risky sexual behavior. This behavioral pattern in adolescents could be attributed to lack of adequate information, lack of experience, peer pressure and poor parental support. But as other studies have shown, healthy environmental and social factors like schools play a protective role resulting in them engaging less in risky behavior(15). Adolescent centered HIV

prevention interventions are therefore vital to curb this ever growing trend of HIV among this age group.

2.4 VCT Services Policies and Procedures

Voluntary Counseling and Testing for the last two decades has been a core component of HIV prevention strategies. As a multi-faceted intervention, it doesn't only enable one to know their HIV status, but also provides awareness and knowledge about HIV, influencing behavioral change through individual counseling on the prevention front and on the treatment front, facilitates acceptance and coping for those diagnosed positive as well as it facilitates access to treatment and if need be. On the community level, VCT also reduces HIV/AIDS stigmatization through increasing awareness(16).It is thus rightly at the core of the HIV prevention strategies put in place to achieve the UNAIDS fast track 90-90-90 target: 90% of all living with HIV will know their status, 90% of all living with HIV will receive anti-retroviral therapy, 90%of all receiving antiretroviral therapy will achieve viral suppression(6).

Alongside the practical benefits VCT services, is its cost-effectiveness, putting it at the center of the national HIV/AIDS programs of most low and middle-income countries.

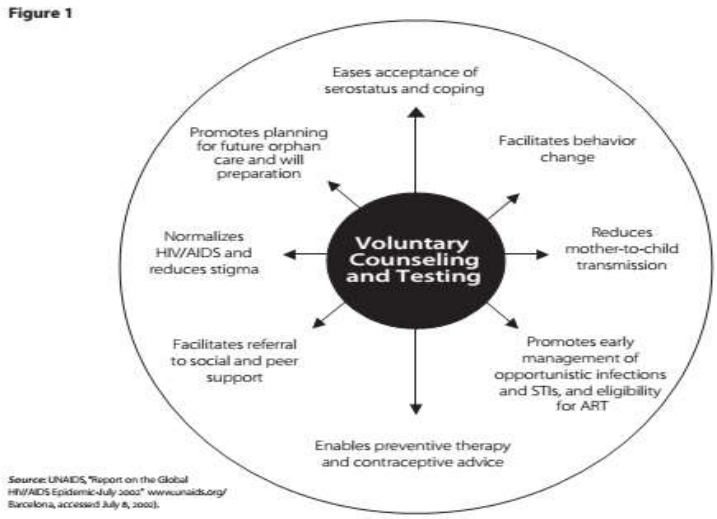

Figure 1: VCT as an entry point to HIV/AIDS prevention(17)

VCT procedures can be divided into 4 stages; Registration, pre-test counseling, HIV testing and result delivery and finally the post-test counseling.

Registration; It is done using identifiers or codes for confidentiality sake, so as to protect the client's identity.

Pre-test counseling; HIV counseling is a voluntary dialogue between a counselor and client, couple or a group of clients. It is a process of enabling clients to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning.

The relevant information that should be provided includes: The reasons why HIV testing and counseling is being recommended, the clinical and prevention benefits of individual and couple testing, the available services in the case of either negative or positive test result, including the availability of ART, the confidentiality of result other than the health care providers directly involved in providing services to the patient, ***the right to decline the offered test and declining an HIV test will not affect the patient's access to other medical services,*** the right of the client to ask the health care provider any concern or questions.

Informed consent should always be given as a verbal consent as individual or couple privately. According to the Ethiopian National Guidelines for Comprehensive HIV Prevention, Care and Treatment, ***persons aged 15 and above are considered mature enough to give informed consent for themselves.***

HIV testing; It is recommended to use rapid diagnostic tests to improve the quality of service delivery, acceptability, and uptake of VCT.

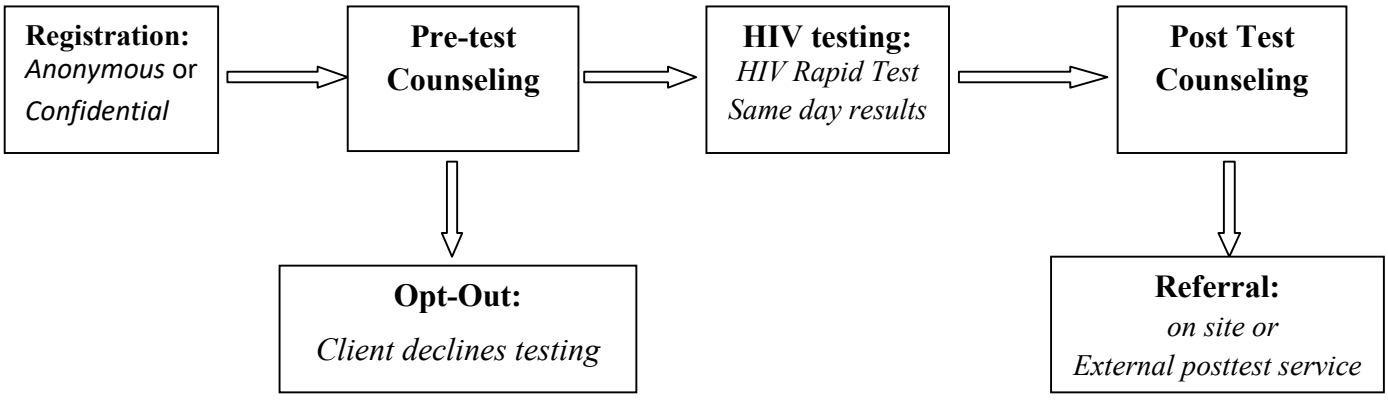

Figure 2: Schematic representation of VCT service chain

depends on the test result; for positives, sessions will focus on the meaning of HIV positive result, coping with the test result, importance of medical care and treatment, disclosure and partner testing, prevention messages and positive living referral for care and treatment.

For negatives should include the meaning of test result, prevention message (risk-reduction plan to remain negative) and importance of partner testing(18).

2.5 VCT Services in Ethiopia

Voluntary HIV counseling and testing for the larger community started in Ethiopia after the National HIV/AIDS policy was launched in August 1998, and VCT guidelines were developed in 2000. The service is provided in public, private and NGO health settings and limited free standing and Youth friendly services. In the year 2000, there were only about 60 sites providing HIV counseling and testing, with most of them situated in Addis Ababa, and there was a severe lack of trained HIV/AIDS counselors. By March 2003 the number of VCT sites had increased to 279 and as of 2008, there were 968 functional HIV counseling and testing sites. The number of people up taking VCT annually increased from about 10,000 clients in 2002 to nearly 500,000 in 2005. Currently different international organizations are assisting the government in the expansion and scaling up of VCT services. However, most of the VCT sites remain concentrated in Addis Ababa and major towns of the country. In late 2006, the Millennium AIDS Campaign for Ethiopia (MAC-E) was launched targeting an accelerated increase in VCT uptake through an increase in the capacity of entry points and intense social mobilization(19).

2.6 Factors Affecting VCT Utilization

With respect to reproductive health, adolescents remain an underserved age group as many parents find discomfort in discussing reproductive health issues with them, while health workers and policymakers have failed to address the reproductive needs of this age group, limiting services and policies to people 18years of age and above(13). This among others contributes to VCT being alarmingly lower among adolescents compared to any other age group.

However, there are multiple factors which affect the uptake of VCT services by adolescents, which could either be enabling or deterring factors.

A systematic review to assess the factors affecting HIV testing in European countries found out barriers for HIV testing was centered around the low-risk perception of HIV; accessibility of health services, reluctance to address HIV and to offer the test; and scarcity of financial and well trained human resources(20). Another systematic review assessing enabling factors and deterrents of VCT uptake in sub-Saharan Africa revealed the major barriers to uptake of HIV testing included perceived low risk of HIV infection, perceived health workers' inability to

maintain confidentiality and fear of HIV-related stigma. Meanwhile, other factors like; gender inequality which inhibits women from making their own decisions also played a role in affecting the utilization of VCT services(21).

Knowledge of HIV was also found to be a vital predictor of utilization of VCT service by adolescents, as shown by a study carried out in Debre-Markos, North-West of Ethiopia among university students revealed, students who had good knowledge of HIV were 3.7 time more likely of using VCT services than students who did not. Knowledge and attitude towards VCT services were also found to be a predictor affecting the use of VCT services by adolescents (22).

Socio-demographic factors such as sex, age, level of education, family background have all been found to significantly influence the use of VCT services by adolescents. Studies carried out in Cameroon, Tanzania and Ghana all showed similar patterns of the influence of age sex and level of education on the use of VCT. These different studies observed adolescent girls were more likely to use VCT services than boys, VCT services were more likely to be used by older adolescents (>18) than younger adolescents and the higher ones level of education, the high the probability for them to use VCT services(23-25).

However in rural setting where VCT uptake is very low compared to urban settings due to socio-cultural differences and gender stereotype inhibits women from making decisions, these patterns could be reversed, as men are more likely to be tested than women and younger better educated men with more knowledge about HIV and VCT services are more likely to use VCT services than older uneducated men(26).

In Ethiopia assessing the factors affecting VCT utilization among students similarly concluded; the level of education, HIV knowledge, socio-demographic factors (sex, age, and level of education), risk perception of HIV, stigma and nearness to VCT site as the most recurrent factors affecting utilization in different areas in Ethiopia.

2.7 Conceptual Framework

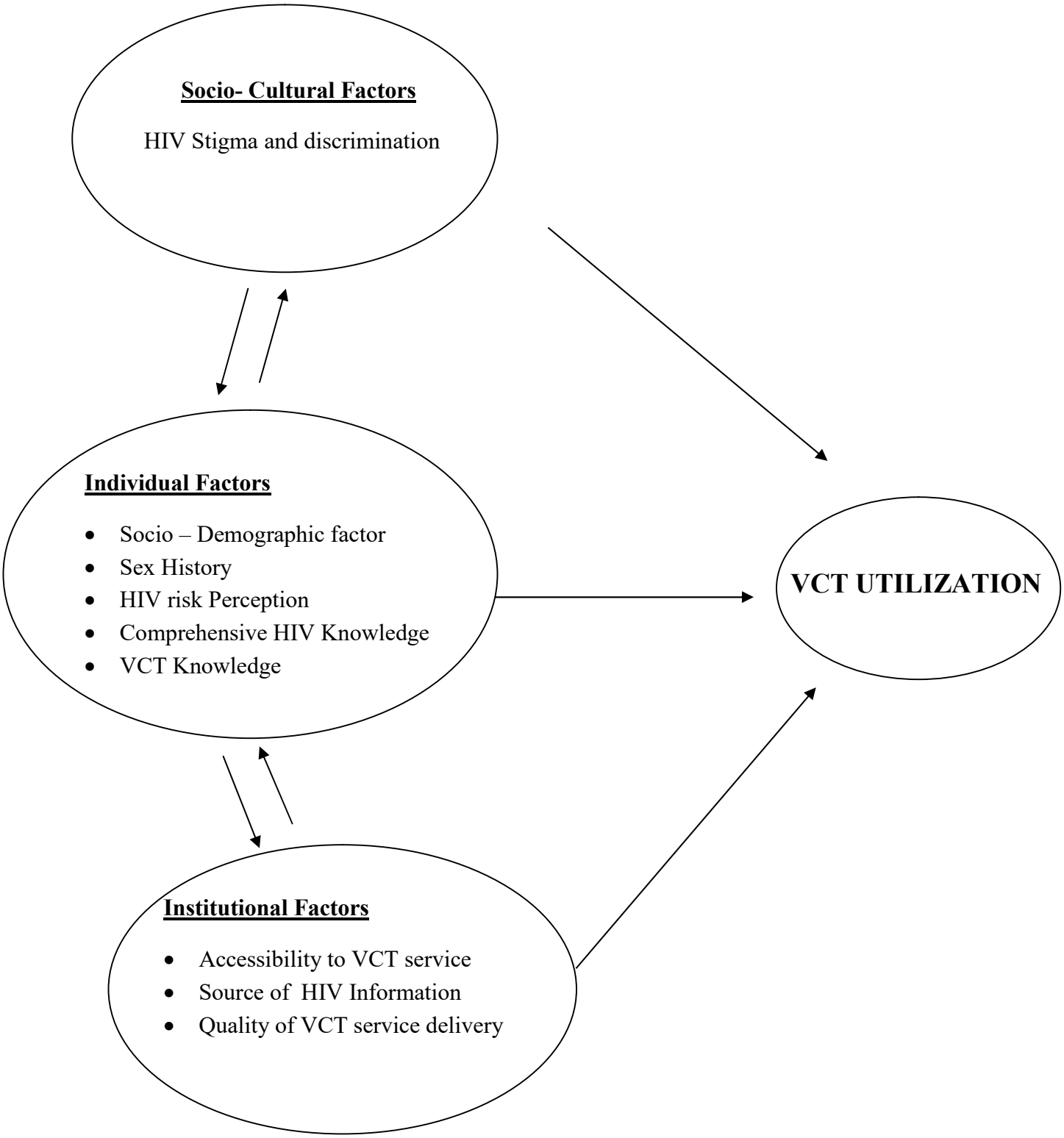

Figure 3: Schematic representation of Conceptual Framework

CHAPTER 3: OBJECTIVES

3.1 General Objectives

To determine the prevalence and associated factors affecting the utilization of HIV/AIDS Voluntary Counseling and Testing services among high school adolescents in Addis Ababa, Ethiopia.

3.2 Specific Objectives

1. To determine the prevalence of HIV/AIDS Voluntary Counseling and Testing service utilization among high school adolescents in Addis Ababa, Ethiopia.
2. To determine factors associated with HIV/AIDS Voluntary Counseling and Testing service utilization among high school adolescents in Addis Ababa, Ethiopia.

CHAPTER 4: METHODS

4.1 Study Area

Addis Ababa is the capital and the largest city in Ethiopia. It's the divided into 10 sub cities with a total of 100 kebeles under the Addis Ababa Administration. According to the 2017 census, it is home to about 3,384,569 people with an annual growth rate of 3.8% and an adolescent (10 – 19) population which is predominantly made up of girls, makes up about 23% of the Addis Ababa population. There are 66 government owned high schools (grades 9 – 12) in this city enrolling about 100,000 students. The number of high school students in Addis Ababa is also the largest in the country with the majority of enrollment being in government school(27).

4.2 Study Period

Our study was carried out over a 3 month period, from 1/02/2018 to 30/04/2018

4.3 Study Design

A cross-sectional institution-based design using quantitative methods was employed in this study to determine the prevalence of VCT utilization, as well as determine the factors affecting VCT utilization among adolescent high school students in Addis Ababa, Ethiopia.

4.4 Source Population

Our target population for this study was all adolescent high school students in Addis Ababa, Ethiopia.

4.5 Study Population

For the sake of this study, our study population was adolescents in government high schools in Addis Ababa with the following criteria;

Inclusion criteria;

All adolescents between the ages of 15 – 19 years inclusive,

All regular full time day adolescent students enrolled for the 2017/2018 academic year.

Exclusion criteria;

All incompletely filled questionnaires,

All high school adolescents who fulfill the above criteria but were absent during data collection.

4.6 Sample Size

To determine the sample size of our first specific objective, we used single population proportion formula, using the prevalence of VCT utilization among adolescents at 62.2% gotten from another study carried out on high school adolescents in Addis Ababa in 2011(28).

$n = \left[\frac{z_{\partial/2}}{d}\right]^2 . p(1-p)$

Where;

n = Sample Size

z = Desired Level of Confidence Interval = 1.96

d = Margin of Error = 0.05

p = proportion of VCT utilization among adolescents = 62.2%

Therefore;

$n = \left[\frac{1.96}{0.05}\right]^2 x\ 0.622(0.378)$

$= \underline{\mathbf{361}}$

We assumed an estimated a non- response rate of 10%

Thus our sample size= $\underline{\mathbf{397}} \approx \underline{\mathbf{400}}$

4.7 Sampling Procedure

Firstly, all government high schools were stratified into the 10 different sub-cities. Using lottery method we then selected 17 high schools, drawing from all sub cities based on the proportion of government high school in the sub-city. Likewise, the number of participants allocated for each sub-city was calculated using proportional sampling technique; the proportion of all enrolled students in each sub-city to the total number of enrolled students in the city multiplied by our sample size. From each school, we randomly selected our participants from grade 9-12. (See Figure 4)

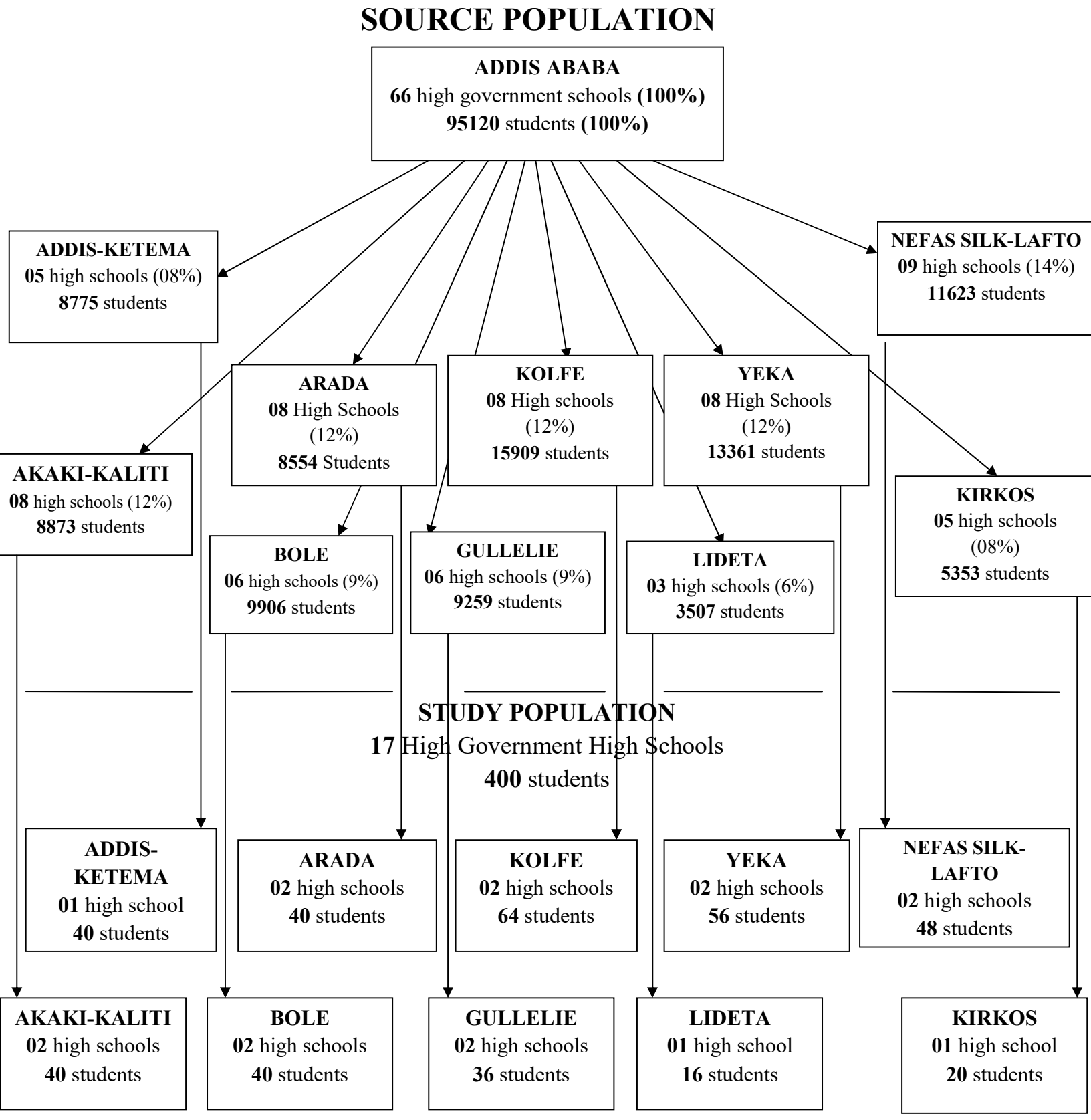

Figure 4: Schematic representation of sampling procedure

4.8 Data Collection Procedure and Quality Control

Data for this study was collected using a self-administered structured questionnaire adapted from a standardized BSS questionnaire to address all variables of the study. The questionnaires were translated from English to Amharic and back to English to ensure consistency. Data were collected using public health graduates.

We carried out a pretest on 40 high school adolescents, selected from 02 high schools not included in the study from 02 different sub-cities; Abyssinia high school in Addis Ketema and Beshale High school in Bole were used to test the usability and effectiveness of our questionnaire. From our pretest results, language on our questionnaires was adjusted to suite the understanding of our study participants.

For data collection, adolescents were gathered in their respective classrooms during free period, the purpose and objective of our study was explained, we then randomly selected our study participants from those students willing to participate in the study. The selected students filled the questionnaire after reading and signing the consent form, and the questionnaires were collected in a box placed at the front of the class.

4.9 Study Variables

***Dependent Variable*;**

VCT utilization.

***Independent Variables*;**

Socio-demographic characteristics (age, sex, level of education, religion, ethnicity, family status),

Sexual History (age of first sexual intercourse, use of condoms, multiple sexual partners),

Comprehensive Knowledge about HIV,

HIV Risk Perception,

Knowledge and Accessibility to VCT service centers,

Perception and Willingness to have VCT,

Perception of HIV Stigma and discrimination.

4.10 Operational Definitions

VCT: A process where an individual actively or voluntarily seeks counseling and HIV testing to know his/her status.

Adolescent: An adolescent is any individual within the age range of 10 – 19 years as defined by WHO. However for the purpose of our study, taking into to account the policy on consent on children and youth testing, we will refer to adolescents as those aged between 15 – 19 years of age who are eligible to provide consent.

Knowledgeable: Respondents who scored at least 03 out of 04 regarding modes of HIV transmission and HIV prevention.

Less Knowledgeable: Respondents who scored less than 03 but knew at least one correct mode of HIV transmission and HIV prevention.

Not Knowledgeable: Respondents who didn't know one correct mode of HIV transmission and HIV prevention.

Stigma: Negative feeling or an intention to avoid one living with HIV/AIDS.

Media: Television, Radio, Internet

Time from the nearest VCT center was categorized as:
Near; Time to the nearest VCT center ≤ 30 minutes on foot
Far; Time to the nearest VCT center 31 – 60 minutes on foot
Very Far; Time to the nearest VCT center >60 minutes on foot

4.11 Data Management and Analysis

A strict daily supervision of the data collection process was maintained throughout the data collection period. We checked study sites and received filled questionnaires from the data collectors daily and check them for completeness. Completed questionnaires underwent a final check for accuracy of response and incomplete questionnaires were excluded from the study. Our data were then entered into the EPI info 7 software package for data cleaning then imported into to the SPSS 2.1 software package for data analysis. Descriptive statistics was done using frequency tables, charts and graphs to describe the characteristics of our study population.

Bivariate analysis was used to determine association between dependent variable and each independent variable using $p<0.05$ and Odds ratio with 95% Confidence Interval (CI).

Independent variable were tested for multi-collinearity and one variable was dropped from the multivariable analysis if the variable inflation factor (VIF) was greater than 10.

We then carried out multivariable analysis using a logistic regression model; using independent variables with significant association with the dependent variable on bi-variate analysis and those with marginally significant and none significant but with previous evidence from literature review indicating possible association with VCT service utilization were considered in the logistic regression model.

4.12 Ethical Consideration

For this study we obtained an ethical clearance from the Research and Ethics Committee of the School of Public Health, Addis Ababa University for ethical approval. Prior to data collection, we obtained permission to collect information from the students from the school administration of the selected high schools. During the data collection process, considering the national guidelines for HIV care stipulate; treatment and prevention stipulates adolescents 15 years and above can give consent for VCT(18), we obtained written informed consent from each respondent after explaining to them; the objectives of the study, the benefits of the study, and their right to voluntarily accept or decline to participate in the study. The participants were then notified there will be no compensation for participating in the study. To maintain anonymity, identifiers like names were not taken in the questionnaire. It was also clearly stated to the participants that the information they will provide whether orally or in writing will be for research purposes and strictly confidential. The data collectors were also trained to provide supplementary information to those in need.

4.13 Dissemination of Finding

These findings of this study will be communicated to the stakeholders through the following ways; the final result of the study will be submitted to Addis Ababa University, School of Public health and a copy will be available in the library.

Feed-back will be given to the Addis Ababa City Administration Health Bureau.

Finding will be disseminated to the relevant stakeholders including FMOH, HAPCO and other relevant institutions working in the area of health and to the public at large through seminars and conference presentation.

Publication of result will be carried out accordingly in reputable journal.

CHAPTER 5: RESULTS

A total of 400 self-administered questionnaires were distributed to 400 high school adolescents (grade 09 – grade 12) aged 15 to 19 years. Of these, 14 questionnaires were not properly filled thus, were excluded from analysis leaving us with 386 properly filled questionnaires making a response rate of 96.5%.

5.1 Socio-Demographic Characteristics

The participants of our study were made up of 170 (44%) male and 216 (56%) female high school adolescents.

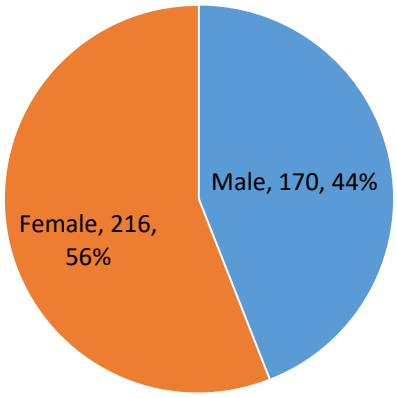

Figure 5: Distribution of study participants by gender, Addis Ababa, 2018

Our participants were recruited uniformly across the high school grades (9 – 12) within the age range of 15 – 19 years with age distribution being; 46(11.9%), 80(20.7%), 89(23.1%), 91(23.6%) and 80(20.7%) for the ages of 15, 16, 17, 18, and 19 years, respectively with a mean age of 17.2 years and a standard deviation 1.3 year. The majority of our study participants were from the Amhara ethnic group 153(39.6%) followed by Oromo 88(22.6%). Approximately, three quarters were Orthodox Christians 283(73.3%), meanwhile Muslims and Protestants made up 44(11.4%), 39(10.1%) respectively. Most of the parents of our participants were married 307(79.5%), with 46(11.9%) having only one living parent, 08(2.1%) had lost both parents and 25(6.5%) whose parents were divorced. (See Table 1).

Table 1: Socio-Demographic characteristics of our study participants, Addis Ababa, March 2018.

Socio-demographic characteristics	Frequency	Percent
Age		
15	46	11.9
16	80	20.7
17	89	23.1
18	91	23.6
19	80	20.7
Level of education		
Grade 09	96	24.9
Grade 10	97	25.1
Grade 11	96	24.9
Grade 12	97	25.1
Religion		
Orthodox Christian	283	73.3
Muslim	44	11.4
Protestant	39	10.1
Catholic Christian	18	4.7
other	1	.3
Ethnic group		
Amhara	153	39.6
Oromo	88	22.8
Tigray	86	22.3
Gurage	36	9.3
Other	23	6.0
Parent's status		
Married	307	79.5
Divorced	25	6.5
One parent dead	46	11.9
Both parents dead	8	2.1

5.2 Sexual History

Out of our 386 participants, 78(20.2%) have reported to have had sexual intercourse. Of these, 46(59.1%) were male and 32(41.0%) were female. We realized a trend in increase sexual activity with increasing age and level of education.

(See figure 6 and figure 7).

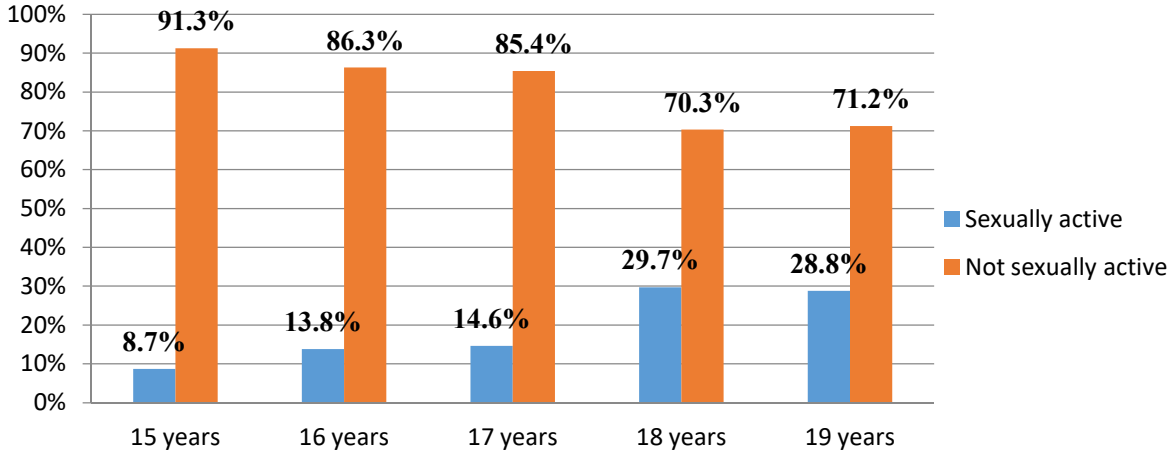

Figure 6: Percentage distribution of study participants' sexual activity by age, Addis Ababa, 2018

The mean age of first sexual intercourse was 16.3 years, with a standard deviation of 1.5 years. Of the 78(100%) sexually active adolescents, 35(44.9%) had previously had intercourse with multiple sexual partners. Sixty one and a half percent of the sexually active adolescents Always used condoms, with condom use higher among male adolescents 29(60.4%) compared to 19(39.6%) among the female adolescents.

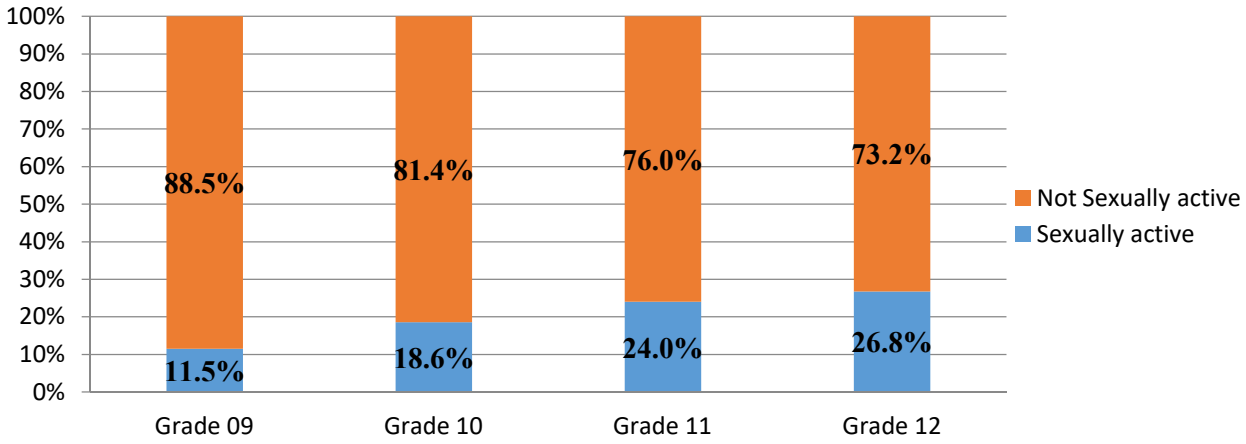

Figure 7: Percentage distribution of study participants' sexual activity by level of education, Addis Ababa, 2018

5.3 Source of information and knowledge of HIV

All 386(100%) respondents had heard about HIV/AIDS from various sources, with the majority having heard of it from school 336(84.1%) followed by media 296(73.9%) and family 273(68.3%) and the least being from neighbors with just 31(7.8%). (See figure 8)

Two hundred and thirty-seven respondents (61.4%) thought someone looking healthy could be infected by HIV/AIDS, 44(11.4%) thought a healthy person couldn't be infected and 105 (27.2%) didn't know.

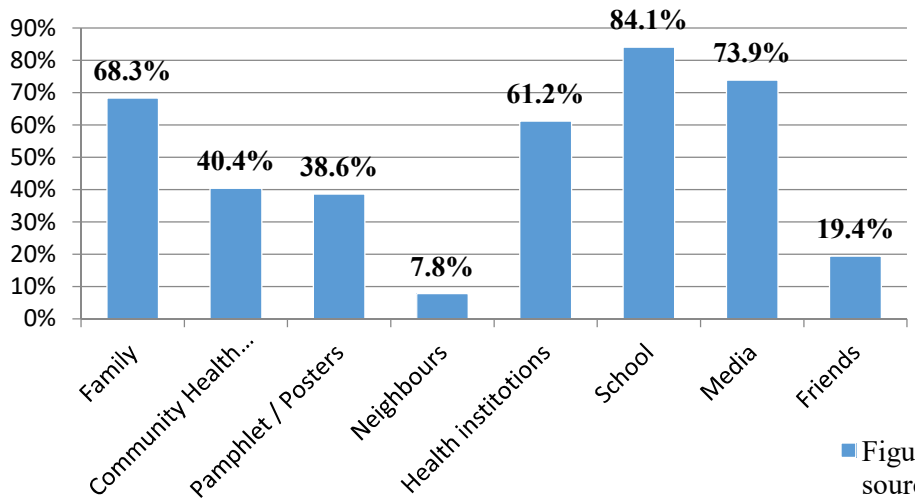

Figure 8: Percentage distribution of study participants' source of information on HIV Knowledge, Addis Ababa, 2018.

Out of 386(100%) participants in our study, 233(60.4%) and 231(55.2%) were knowledgeable about HIV transmission and prevention respectively while 121(31.3%) and 138(35.8%) were less knowledgeable on HIV transmission and prevention respectively. (See table 2)

One hundred and seventy-seven (45.9%) respondents had misconceptions about HIV/AIDS. 53(33.3%) of them believed HIV/AIDS was transmitted by mosquito bites, while 85(48%) of them believed HIV/AIDS could be diagnosed by simple physical examination by a health personnel.

However only 162 (41.9%) participants were comprehensively knowledgeable of HIV/AIDS transmission, prevention and had no misconceptions about HIV/AIDS.

Table 2: Representation study participants of HIV/AIDS knowledge, Addis Ababa, 2018

Characteristics	Frequency	Percentage
HIV Transmission Knowledge (n=386)		
Knowledgeable	233	60.4%
Less Knowledgeable	120	31.1%
Not Knowledgeable	30	8.5%
HIV Prevention Knowledge (n=386)		
Knowledgeable	213	55.2%
Less Knowledgeable	134	34.7%
Not Knowledgeable	39	10.1%
HIV Misconception (n=386)		
Present	177	45.9%
Absent	209	54.1%

5.4 HIV Risk Perception

The majority of our study participants 336(87.0%) did not think they were at risk of being infected by HIV/AIDS, with most of them 250(74.4%) citing abstinence from sex as their main reason, 60(15.5%) cited they had not share nor been injured with contaminated sharp objects, while 26(6.7%) thought they were not at risk because they had one faithful sexual partner.

Meanwhile, 20(5.2%) respondents thought they were at risk of being infected by HIV/AIDS, with 12(60%) of them citing having had sex without a condom, 07(35%) have had sex with more than one sexual partner and 01(5.0%) had sex with a commercial sex worker.

30(7.8%) didn't know if they thought they were at risk of being infected by HIV/AIDS or not.

5.5 Knowledge and Accessibility to VCT service centers

Three hundred and thirty-five (86.8%) adolescents from our study had ever heard of VCT. Among these, the most common source of information was from schools 249 (74.3%), followed by media 206 (61.5%) and health institutions 176 (52.5%) and from family members 45(13.4%). (See Figure 9)

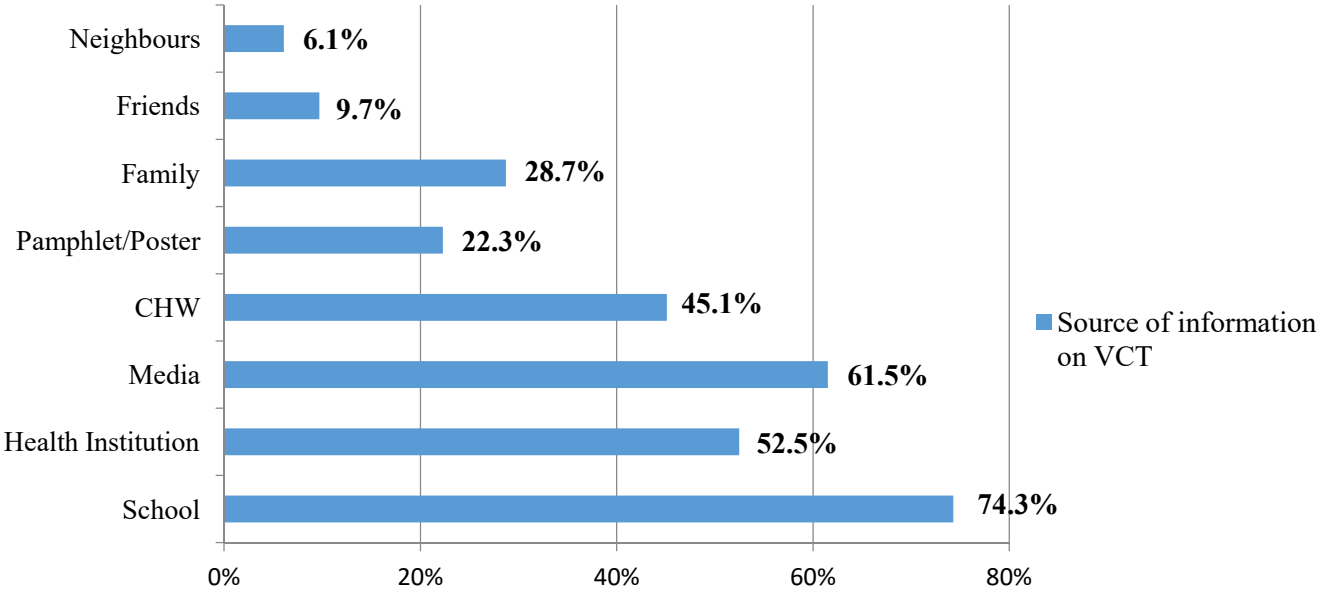

Figure 9: Percentage distribution of study participants' source of information on VCT Knowledge, Addis Ababa, 2018

Three hundred and eighteen (82.4%) respondents knew where to get VCT services; meanwhile 68 (17.6%) respondents didn't know where to get VCT services. Among those who knew where to get VCT services, 151(39.1%) cited they could receive VCT services from health centers, 114(29.5%) stated they could get VCT services from hospitals and the rest from private clinics 30(7.8%) and NGO's 23(6.0%).

219(56.7%) respondents knew VCT centers located in or around their schools.

We categorized the distance by foot to the nearest VCT center to "Near", "Far" and "Very far": 0-30mins, 31-60mins, and above 60mins respectively. One hundred and seventy-one (53.8%) respondents knew a VCT center near them, 126(39.6%) knew a VCT center which was far while 21(6.6%) knew VCT center that was very far. The Mean distance by foot to the nearest VCT center was approximately 43 minutes.

All 386(100%) study participants were knowledgeable about the advantages of VCT.

5.6 Perception and Willingness to Have VCT

Regarding the importance of counseling during HIV testing, three hundred and forty-one (88.3%) respondents thought counseling was important during HIV testing, while 25(6.5%) and 20(5.2%) thought counseling wasn't important during HIV testing and didn't know respectively.

Three hundred and two (78.2%) study participants thought both HIV positive and HIV negative persons benefited from VCT and when asked if VCT was important to prevent HIV/AIDS transmission, 355 (92.0%) participants agreed VCT is important to prevent the transmission of HIV/AIDS. (See Table 3).

Table 3: Distribution of study participants' perception of VCT, Addis Ababa, 2018.

Characteristics	Frequency	Percentage
Do you think counseling is important for HIV testing?		
Yes	341	88.3%
No	20	5.2%
Don't Know	25	6.5%
Who do you think benefits from VCT?		
HIV Positive person	38	9.8%
HIV Negative person	23	6.0%
Both HIV positive and HIV negative persons	302	78.2%
Don't Know	23	6.0%
Do you agree that VCT is important to prevent transmission of HIV/AIDS		
Agree	355	92.0%
Disagree	31	8.0%

When asked should one have an HIV test, the majority 362(93.8%) responded; "Anytime" 288(74.6%) followed by "before marriage" 52(13.5%) and "during illness" 22(5.7%).

Seven (1.8%) didn't know while the remaining 16(4.4%) were split between "before pregnancy", "during pregnancy", "when in doubt" and "to travel abroad".

On the subject of who should go for an HIV test, one hundred and ninety-five (50.5%) thought "anyone at risk", 78(20.2%) thought "anyone sexually active", while 22(5.7%), 23(6.0%), 27(7.0%), 37(9.6%) thought "those who are sick", "partners of sex workers", "sex workers" and "those to be married" respectively should go for an HIV test.

Three hundred and thirty-nine (87.8%) study participants were willing to have VCT whether or not they had had it before as opposed to 47(12.2%) who were not willing to have VCT.

5.7 VCT Utilization

Regarding the use of VCT 138(35.8%) respondents had used VCT services, among whom 61(44.2%) were male and 77(55.8%) were female high school adolescents, with most of them 107(77.5%) having used VCT services within the last year; 38(27.5%), 29(21.0%), 40(29.0%) used VCT services 3months, 6 months and 1year ago, respectively.

The majority of those who had used VCT services (63.7%) did to know their HIV status. (See Table 4).

Table 4: Distribution of study participants' VCT utilization and Reason for HIV testing, Addis Ababa, 2018

Characteristics	Frequency	Percentage
Have you ever used VCT services		
Yes	138	35.8
No	248	64.2
Reason for using VCT services (n=138)		
To know self status	88	63.7
To plan for future life	22	15.9
For marriage	7	5.1
For blood donation	21	15.2

One hundred and twenty (87.0%) of those who used VCT services received counseling while 115 (83.3%) of those who had used VCT services were satisfied with the service, with 47(42.0%), 38(33.9%), 17(15.2%) of them citing "warm reception", "Quick service" and "professionalism of the health workers" as the most common reasons for their satisfaction respectively.

Among the remaining 248 (64.2%) who had not used VCT services, the most common reason cited for not having used VCT services were "Not know where to get the service", "Afraid to get results", "Don't believe it will help" and "Fear of stigma", meanwhile "Partners refusal", "Cost of service" and "No nearby service" were the least cited reasons for not using VCT services. (See figure 10)

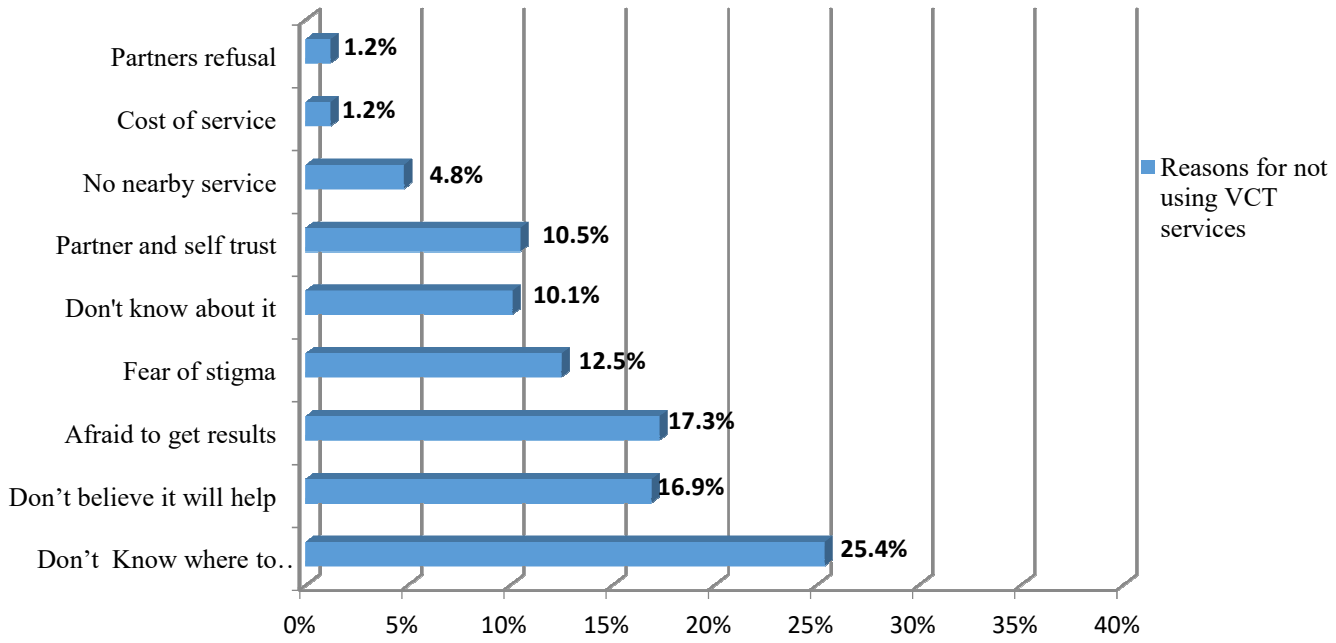

Figure 10: Percentage distribution of study participants reasons for not using VCT services, Addis Ababa, 2018.

5.8 VCT Preferences

Our study participants were also asked where they would prefer to go to receive VCT services, the majority of our respondents preferred to receive VCT services from government health institutions 251(65.0%), followed by Private health institution 74(19.2%) then Non-governmental institutions 61 (15.8%).

Most of our respondents preferred receiving counseling from medical doctors 200(51.8%), trained counselor 77(19.9%), Nurse 70(18.1%).
73.8% of our study participants preferred to receive their HIV results face to face from a health personnel while rest preferred to receive their results from their relative or sexual partner 42(10.9%), by telephone 41(10.6%) and by letter 18(4.7%).

Two hundred and seventy-six (71.5%) study participants were convenient with receiving VCT at anytime, while 69(17.9%) and 41(10.6%) preferred receiving VCT in the morning and in the afternoon, respectively.

5.9 Stigma and Discrimination

We asked our study participants to who will they disclose their HIV results in case they tested HIV positive and 244(63.2%) of them said they will tell their family, followed by 52(13.5%) who said they'll tell their religious leader while the rest indicated they'll tell "their relatives", "friends", "sexual partner" and "community leaders". (See figure 11)

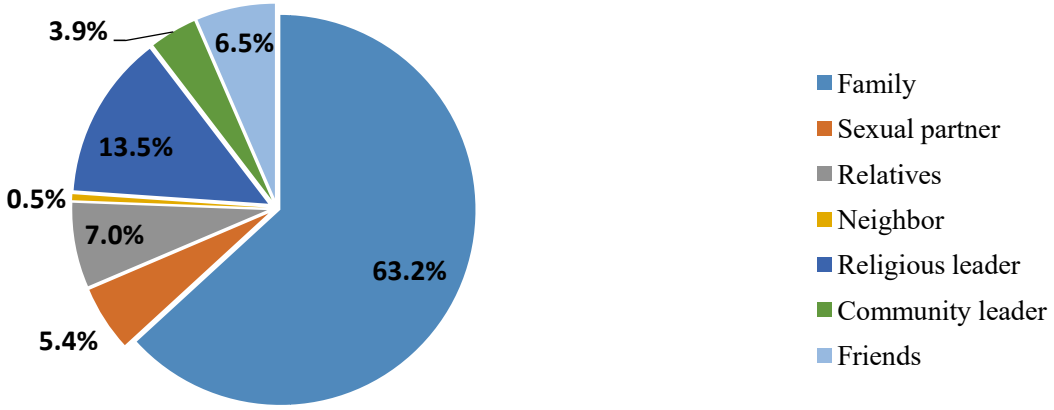

Figure 11: Percentage distribution of whom study participants' were willing to disclose results, Addis Ababa, 2018.

Regarding perception of stigma, our study participants were asked what will happen if they tested positive for HIV and decided to disclose their results, 175(45.6%) thought they will be neglected by their family, friends and sexual partners while 210(54.4%) thought they will be supported by their family, friends and sexual partners. (See figure 12)

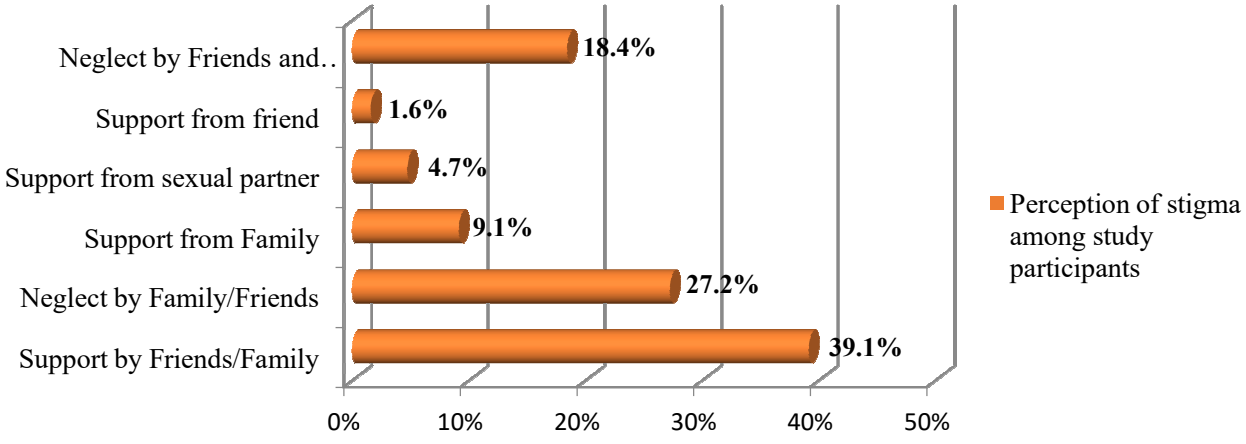

Figure 12: Study participants' perception of stigma, Addis Ababa, 2018

Assessing discrimination towards people living with HIV/AIDS (PLWA) among our study participants, 301(78.0%) of our study participants were willing to share a meal with someone who has HIV/AIDS. Three hundred and thirty-one (85.8%) were willing to let a student who has HIV/AIDS to continue attending school. 86.8% were willing to treat a relative with HIV/AIDS in their home. However, 345(89.4%) said if they had a family member with HIV/AIDS, they'll prefer to keep it secret. (See table 5)

Table 5: Distribution of study participants' attitude towards people living with HIV/AIDS, Addis Ababa, 2018.

Characteristics	Frequency	Percentage
Would you share a meal with someone who has HIV/AIDS? (n=386)		
Yes	301	78.0%
No	85	22.0%
If a student has HIV but not sick should he/she be allowed to attend school? (n=386)		
Yes	335	86.8%
No	51	13.2%
Would you be willing treat a relative in your home if he/she HIV/AIDS? (n=386)		
Yes	331	85.8%
No	55	14.2%
If a teacher has HIV but not sick should he/she be allowed to continue teaching? (n=386)		
Yes	342	88.6%
No	44	11.4%
Would you buy food from a shopkeeper who has HIV/AIDS? (n=386)		
Yes	280	72.5%
No	106	27.5%
If a member of your family is HIV/AIDS positive, would you want it to remain a secret? (n=386)		
Yes	345	89.4%
No	41	10.6%

5.10 Bivariate analysis of factors associated with VCT utilization

We carried out a bivariate analysis to assess if there was an association between VCT utilization and our independent variables.

When we compared VCT utilization across the age groups, we found there was a statistically significant association in VCT utilization with adolescents aged 19 years were 2.7 times more likely to use VCT services when compared to 15 year old high school adolescents. We also found our 11th grade respondents, when compared to adolescents in 09th grade were 2.3 times more likely to use VCT services while those in 12th grade when compared to the 09th graders were found to be 3 times more likely to use VCT services. However, we found no statistically significant difference in VCT utilization associated with Religion, Ethnic group or parent's status. (See table 6)

In this study, HIV transmission knowledge was found to be a significant factor associated with VCT utilization. Adolescents who were knowledgeable about HIV transmission were 4.7 times more likely to use VCT services than those who were not knowledgeable. Meanwhile those who were less knowledgeable were 3.9 times more likely to use VCT services compared to those who were not knowledgeable. Adolescents who were knowledgeable on HIV prevention were 3 times more likely to use VCT services compared to those not knowledgeable, while there was no statistically significant difference in VCT utilization when we compared those who were less knowledgeable on HIV prevention to those who were not knowledgeable. (See Tabe 7)

Our study respondents who were sexually active were 1.85 times more likely to use VCT compare to those who had never had sex.

Regarding accessibility, adolescents who had VCT service centers in or around their schools where 3.5 times more likely to use VCT services vis-à-vis those who didn't. Meanwhile adolescents who were Near a VCT service center were three times more likely to use VCT services compared to those who were Very Far from a VCT service center. However, compared to those who were Far from VCT service centers we didn't find any statistically significant difference in VCT utilization. (See table 7)

Table 6: Bivariate and Multivariable analysis of study participants' socio-demographic characteristics with VCT Utilization, Addis Ababa, 2018.

SOCIO-DEMOGRAPHIC CHARACTERISTICS	VCT				
	Yes	No	COR **(95%CI)**	AOR **(95%CI)**	p-*value* **(<0.05)**
GENDER (n=386)					
Male	61	109	1.01 (0.66, 1.54)		
Female	77	139	1		
AGE (n=386)					
15	12	34	**1**	1	
16	20	60	0.94 (0.41, 2.17)	0.79 (0.30, 2.07)	0.65
17	31	58	1.51 (0.69, 3.34)	1.55 (0.57, 4.21)	0.39
18	36	55	1.86 (0.85, 4.05)	0.95 (0.32, 2.87)	0.93
19	39	41	**2.70 (1.22, 5.94)**	1.20 (0.39, 367)	0.75
LEVEL OF EDUCATION (n=386)					
Grade 09	22	74	1	1	
Grade 10	30	67	1.51 (0.79, 2.86)	1.48 (0.58, 2.83)	0.541
Grade 11	39	57	**2.30 (1.23, 4.31)**	1.59 (0.65, 3.88)	0.308
Grade 12	47	50	**3.16 (1.70, 5.88)**	1.89 (0.72, 4.97)	0.197
RELIGION (n=386)					
Orthodox Christian	103	181	1		
Muslim	10	34	0.52 (0.25, 1.09)		
Protestant	18	21	1.51 (0.77, 2.96)		
Catholic Christian	07	11	1.12 (0.42, 2.97)		
other	0	1	0		
ETHNIC GROUP (n=386)					
Amhara	59	94	1		
Oromo	36	52	1.10 (0.65, 1.88)		
Tigray	26	60	0.69 (0.39, 1.21)		
Gurage	11	25	0.70 (0.32, 1.53)		
Other	6	17	0.56 (0.21, 1.50)		
PARENT'S STATUS (n=386)					
Married	108	199	1		
Divorced	8	17	0.87 (0.36, 2.07)		
One parent dead	18	28	1.19 (0.63, 2.24)		
Both parents dead	04	04	0.54 (0.45, 7.51)		

COR (Crude odds Ratio)

AOR (Ajusted Odds Ratio): Adjusted for age, level of education, sexual activity, HIV risk perception, HIV prevention/Transmission knowledge, availability of VCT center in/around school, time to nearest VCT center, perception of stigma.

* Independent variables significant on multi variable analysis

Study participants who thought they were at risk of being infected by HIV were three times more likely to use VCT services compared to adolescents who did not know if they were at risk of being infected by HIV or not. Nevertheless, when compared to adolescents who had no perceived risk being infected by HIV and those who did not know, we did not find any statistically significant difference in VCT utilization in the two groups.(See Table 8).

Table 7: Bivariate and Multivariable analysis of HIV knowledge, Accessibility to VCT service centers and sexual history with VCT Utilization, Addis Ababa, 2018.

CHARACTERISTICS	VCT				
	Yes	No	COR **(95%CI)**	AOR **(95%CI)**	p-*value* **(<0.05)**
HIV Transmission Knowledge (n=386)					
Knowledgeable	92	141	**4.73 (1.61, 13.9)**	2.45 (0.42, 14.8)	0.32
Less Knowledgeable	42	78	**3.90 (1.29, 11.8)**	5.29 (0.96, 29.4)	0.06
Not Knowledgeable	04	29	1	1	
HIV Prevention Knowledge (n=386)					
Knowledgeable	88	125	**3.22 (1.36, 7.62)**	1.84 (0.41, 8.21)	0.42
Less Knowledgeable	43	91	2.16 (0.88, 5.29)	0.97 (0.24, 3.93)	0.96
Not Knowledgeable	07	32	1	1	
HIV Misconception (n=386)					
Present	65	112	0.93 (0.61, 1.40)		
Absent	73	136	1		
Ever had sexual intercourse (n=386)					
Yes	37	41	**1.85 (1.11, 3.06)**	**2.09 (1.03, 4.26)**	**0.042***
No	101	207	1	1	
Is VCT available in or around your school? (n=386)					
Yes	104	115	**3.54 (2.23, 5.61)**	**1.85 (1.07, 3.18)**	**0.027***
No	34	133	1	1	
Time to nearest VCT service center on foot (n=318)					
Near (<30mins)	84	87	**3.09 (1.08, 8.81)**	**3.74 (1.17, 12.0)**	**0.026***
Far (31-60mins)	49	77	2.04 (0.70, 5.91)	1.51 (0.89, 2.55)	0.123
Very Far (>60mins)	5	16	1	1	

COR (Crude odds Ratio)

AOR (Ajusted Odds Ratio): Adjusted for age, level of education, sexual activity, HIV risk perception, HIV prevention/Transmission knowledge, availability of VCT center in/around school, time to nearest VCT center, perception of stigma.

* Independent variables significant on multi variable analysis

We also found perception of stigma and discrimination to be a significant factor associated with VCT utilization among our study participants. Adolescent who believed they would be supported by their family, friends and/or sexual partner(s) were twice more likely to use VCT services compared to those who thought they will be neglected. (See table 8)

Nonetheless we found no statistical significant difference in VCT utilization associated with our study participant's perception of VCT.

Table 8: Bivariate and Multivariable analysis of HIV risk perception, VCT perception and Perception of stigma with VCT Utilization, Addis Ababa, 2018.

CHARACTERISTICS	VCT				
	Yes	No	COR **(95%CI)**	AOR **(95%CI)**	p-*value* **(<0.05)**
Do you think you might be infected by HIV/AIDS? (n=386)					
Yes	11	09	**3.36 (1.02, 11.12)**	0.86 (0.18, 4.05)	0.852
No	119	217	1.51 (0.65, 3.49)	1.02 (0.36, 2.93)	0.793
Don't know	08	22	1	1	
Is counseling important for HIV testing? (n=386)					
Yes	121	220	1		
No	08	12	1.02 (0.44, 2.38)		
Don't Know	09	16	0.84 (0.25, 2.83)		
Who do you think benefits from VCT? (n=386)					
HIV Positive person	11	27	1		
HIV Negative person	05	18	1.58(0.52, 4.70)		
Both HIV positive and HIV negative persons	113	189	2.31(0.63, 8.47)		
Don't Know	09	14	1.08 (0.45, 2.56)		
Do you agree that VCT is important to prevent transmission of HIV/AIDS? (n=386)					
Agree	130	225	1.66 (0.72, 3.82)		
Disagree	08	23	1		
What would happen if you test positive for HIV?					
Support	93	120	**2.20 (1.43, 3.40)**	**3.0 (1.79, 5.014)**	**0.000***
Neglect	45	128	1	1	

COR (Crude odds Ratio)

AOR (Ajusted Odds Ratio): Adjusted for age, level of education, sexual activity, HIV risk perception, HIV prevention/Transmission knowledge, availability of VCT center in/around school, time to nearest VCT center, perception of stigma.

* Independent variables significant on multi variable analysis

5.11 Multi-variable logistic regression of factors associated with VCT utilization.

Using the independent variables which were significant on bivariate analysis; Age, Level of education, HIV transmission knowledge, HIV prevention knowledge, Ever had sexual intercourse, Availability of VCT in or around high school, Distance from VCT service center, HIV risk perception, perceived stigma and discrimination, we carried out multivariable logistic regression by including all the above mentioned variables to adjust for confounders.

After stepwise multiple logistic regression, we found study participants who sexually active to be two times more likely to have used VCT services as opposed to those who were not sexually active [AOR 95% CI: 2.09 (1.03, 4.26)]. (See Table 7)

We also found adolescents who had VCT service centers in or around their schools were 1.85 times more likely to have used VCT services [AOR 95% CI: 1.85 (1.07, 3.18)], meanwhile those who were Near a VCT service center were three times more likely to have used VCT services compared to those who were Very Far from a VCT service center [AOR 95% CI: 3.74 (1.17, 12.0)]. (See Table 7)

Perceived stigma and discrimination was also another factor which remained significantly associated with VCT utilization, with respondents who thought they would receive support from their family, friends and/or sexual partners were three times more likely to have used VCT services when compared to those who felt they would be neglected by their family and peers [AOR 95% CI: 3.0 (1.79, 5.014)]. (See Table 8)

However, some independent variables which were found to be significant on bivariate analysis; HIV transmission knowledge, HIV prevention knowledge, HIV risk perception, Age and level of education, were not found to be significantly associated with VCT utilization after stepwise multiple logistic regression.

CHAPTER 6: DISCUSSION

HIV Voluntary counseling and testing is a comprehensive HIV prevention intervention which educates and individual, enables them to know their HIV status and provide referral care and support if need be. We therefore set out to assess the prevalence and the factors associated with the utilization of VCT services among government high school adolescents aged 15 – 19 years. From this study, we found utilization of VCT among adolescents at 35.8% and the utilization of VCT services was associated with sexual exposure, physical accessibility to VCT service centers and the adolescents' perception to stigma.

In our study we had a response rate of 96.5%, similar to another study on factors affecting VCT uptake among Ambo secondary school students in West Shoa, Ethiopia which recorded 96.7% response rate. Our study participants were aged 15 – 19 years with a mean age of 17.2±1.3years with 44% being male and 56% being female all from grade 09 through grade 12, consistent with findings on a previous study on assessing Knowledge and attitude toward VCT utilization among high school adolescents in 2012(28).

The prevalence of HIV VCT utilization our study was found to be at 35.8%. This finding was significantly lower than the 62.2% found by Gatta et al in 2012(28). However is was consistent with findings in other studies by Sisay et al (2014) in Ethiopia and Van Handel et al (2016) in the United states of America(29, 30). Similar to previous studies (24, 28, 30), we found the number of girls who had used VCT services was comparatively high to the boys. However this difference wasn't statistically significant. This difference could be explained by low health seeking behavior associated with the male gender with respect to reproductive health services(31).

Among the majority of those who had not used VCT services, the reasons most cited by our study participants were; Fear of the outcome of HIV test results, the fear of stigma and no knowledge of where to get VCT services, remain major barriers to the uptake of VCT. This was consistent with findings from other studies carried out in Nigeria, Cameroon and Ethiopia (24, 30, 32) which reported similar reasons for the non uptake of VCT. With an extensive amount of research having been done on the effect of stigma and discrimination on the HIV/AIDS and the uptake of VCT, it still remains a major road block on the way to improve utilization of VCT among adolescents.

This was shown in our study, as the propensity to use VCT was twice more likely among those who believed they will be supported in case of an HIV positive result compared to those who thought they would be neglected. This could be a result of poor implementation of interventions geared towards reducing stigma and discrimination in this age group or the lack there of. However as shown by multiple studies, improving knowledge of HIV/AIDS transmission/prevention vastly affects ones perception of stigma and discrimination. Nevertheless a recent study in Hawassa, Ethiopia showed marked reduction in HIV/AIDS related stigma and misconception using IEC campaigns targeting adolescents in schools(33).

All our study participants had heard of HIV/AIDS, with the most common source of information being schools. Similarly among the 86.6% of our study participant who had heard of VCT, the majority of them 74.3% cited their respective high schools as their source of information followed by the media. This finding was consistent with a study carried out assess VCT uptake among high school students in the Tiko Health district in Cameroon, which found school and media as the main source of information of HIV and VCT(24). However our finding was in contrast with the findings of previous studies in where the majority of adolescents acquired information on HIV/AIDS and VCT from the media and health institutions(34, 35). This could be explained by the decreasing HIV media coverage(36) coupled with the increased implementation of school-based HIV/AIDS education policy where students can receive appropriate HIV/AIDS education in school simplifying the access to information on HIV/AIDS mean while expanding the reach to many more adolescents.

In this study, HIV transmission and prevention knowledge was 60.4% and 55.2% respectively for those who were found to be knowledgeable. This was comparable to the result found in other studies carried out in Addis Ababa and in west Shoa by T.Girma et al 2016, but yet lower than the 75% found in another study in Arusha, Tanzania. However, 91.5% and 89.9% of our study participants could identify at least one means of HIV transmission or prevention respectively.
In Ethiopia School-based HIV education policy has been the cornerstone of HIV transmission and prevention education. However recent studies show the methods of delivery of are becoming redundant as students tend to prefer peer education which better meets their needs. A study on the Effects of peer education intervention on HIV/AIDS related sexual behaviors of secondary school students in Addis Ababa, Ethiopia showed adolescents who received HIV education from

their peers demonstrated more comprehensive HIV knowledge, were more prone to reduce their risky sexual behavior and even go for HIV testing(37).

Approximately twenty percent of our study participants were sexually active, similar to the findings in another study in Gondar town, Ethiopia. We found adolescents who were sexually active were more likely to use VCT. This could be explained by the fact that adolescents who were sexually active had a higher perception for risk of HIV infection compare to those that weren't sexually active, thus they were more likely to seek reproductive health services and VCT. The mean age of first sexual intercourse was 16.3±1.5 years, similar to the mean age of sexual intercourse found in a study on high school adolescents in Cameroon and another in Debre-brehan town in Ethiopia(24, 30).

As established by multiple studies, low HIV/AIDS risk perception is a major barrier to VCT utilization. In this study, the majority of our study participants were not sexually active, most of them feeling they had a low risk to be infected by HIV/AIDS, citing Abstinence as the reason why they thought they weren't at risk of being infected by HIV/AIDS.

Assessing accessibility to VCT service centers, we found Accessibility to be a key factor associated with VCT utilization. Study participant who reported to have VCT centers in or around their schools were found to be about two times more likely to use VCT services compared to those who reportedly did not have VCT centers around their schools.

Likewise students who reported to have a VCT service center within a 30 minutes walking distance were also found to be over three and a half times more likely to use VCT service compared to those who had the nearest VCT center to them over an hour's walk away.

Consistent with findings in studies carried out in Ethiopia and around the world(20, 38), access has always been a major barrier to the uptake of VCT services, however over the years some progress has been made, with substantial increase in the number of VCT sites around the countries. Yet implementation of policies like outreach VCT centers in schools will go a long way to improve VCT uptake among adolescents.

CHAPTER 7: STRENGTH AND LIMITATIONS

7.1 Strengths

- High response rate
- Sample population was drawn from all 10 sub cities

7.2 Limitations

- Our study was a cross sectional study, so we couldn't establish causality
- Due to the sensitive nature of the questions, social desirability bias is unavoidable
- The responses in this study were dependent on the participants thus subject to recall bias
- This study was subject to selection bias as we only recruited regular students not night time high school students.
- This study cannot be generalized for all adolescents in Addis Ababa as our study population was drawn only from adolescents aged 15 – 19 and only those who attended Government High schools.

CHAPTER 8: CONCLUSION

In conclusion, HIV Voluntary Counseling and Testing among High school adolescents has decreased compared to the VCT service utilization prevalence found in the previous study on Knowledge and attitude towards VCT by Gatta et al in 2011(28).

Factors such as physical accessibility to VCT service centers, fear of stigma and discrimination, sexual exposure and low HIV risk perception are associated with VCT service utilization among adolescents.

CHAPTER 9: RECOMMENDATION

- We recommend to HAPCO:

✓ To increase HIV messaging through media outlets with themes attractive to adolescents so as to improve on their comprehensive HIV/AIDS knowledge.

✓ To use SBCC messaging on HIV and Discrimination targeted at secondary and high schools students to educate them at this early stage of their lives.

✓ To carryout regular VCT outreach in schools so as to eliminate the challenge of accessibility and improve VCT utilization.

- We recommend to the Addis Ababa Education bureau

✓ To revise the delivery of School-Based HIV education and encourage more peer HIV-education as adolescents prefer and respond better to their peer concerning HIV education.

- We suggest a similar study to be carried out on a nationwide scale to identify and address the needs of adolescents so as to improve their VCT service utilization.

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ANNEXES

Annexe 1: Ethical Clearance

ADDIS ABABA UNIVERSITY
College of Health Sciences
School of Public Health
Ethical Clearance Form

Version Feb .2018

Date: /____/____/____/
Ref. No. SPH/ /10

Project number: /____001____/

Date of approval: (D/M/Y) /__/ / /	
Project Title: Utilization of voluntary counselling and testing of HIV/AIDS and its predictors among high school adolescents in Addis Ababa, Ethiopia.	
Name of PI Lifanda Ebiama	Phone Number _____
Institution	School of Public Health
Department	
Decision of Research and Ethics Committee:	☑ Approved ☐ Approved with Recommendation ☐ Resubmission ☐ Disapproved
Valid until	Feb. 2018 – June 2018

Dean, School of Public Health
Signature _____
Date 16/02/18

A.A.U. College of H... Dean's Office School of Public...

Annexe 2: Support Letter to High School Administrators

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF REPRODUCTITVE HEALTH & HEALTH SERVICE MGT

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የሕብረተሰብ ጤና ት/ቤት
የስነተዋልዶ ጤናና የጤና አገልግሎት አመራር ትምህርት ክፍል

Ref.No/RHHM/ 100 / 2010
Date, February 20, 2018

To : _____

Addis Ababa, Ethiopia

Subject: Support letter

Lifanda Ebiama is an MPH student at the School of Public Health, Addis Ababa University. Currently He is working on a research proposal entitles ***Utilization of voluntary counselling and testing of HIV/AIDS and its predictors among high school adolescents in Addis Ababa, Ethiopia.*** Therefore, the school kindly requests all the necessary support and cooperation that he needs from your facility for the accomplishment of his work.

Best Regards,

Dr. Assefa Seme
Head Department of Reproductive Health
& Health Service Management

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Annexe 3: Information Sheet and Consent Form

Addis Ababa University
School of Public Health

Study on "Prevalence of VCT utilization and its associated factors among adolescent high school students in Addis Ababa, Ethiopia".

Greeting, first of all I would like to thank you for your time.

Dear respondents here are lists of questions with different sections, which are designed for research work to be conducted in partial fulfillment of master Degree in public health by Lifanda Ebiama Lifanda in collaboration with Addis Ababa University School of Public Health. The main purpose of the study is to determine *"**The Prevalence of VCT utilization and its associated factors among adolescent high school students in Addis Ababa, Ethiopia**"*. We are therefore inviting high school students, aged 15 – 19 to contribute to our study. You have been randomly selected among other student in your school to take part in the study. The study will not cause any harm to you except giving information.
I will ask you some questions about yourself. Responding to the questions will take about 30 minutes of your time. There are no anticipated problems but in case some questions make you feel uncomfortable; you are free to express your discomfort or decide not to respond. You are free to choose not to participate or stop responding if you choose to.

There are no direct benefits to you for choosing to participate in this interview. However, you will be helping program manager and others in future to develop better VCT. Also any question you have love to ask about VCT and or HIV, feel free to ask.

Your name will not be recorded and all the information you give will be kept strictly confidential and will be used only for the purpose of this study.

At this time, do you want to ask me anything about the study? If you have any questions at any time even after filling the questionnaire, feel free to ask. If you want to know more information you can contact Lifanda Ebiama at 0944110967 or drebiama@gmail.com.

Consent Form

This consent form has been read and explained to me and I have understood, and my questions have been addressed. I therefore willingly agree to take part in the study.

1, Yes; continue to the consent form
2, NO; skip to the next participant

Participant signature/ finger print _____

Name of High School _____

Data collector's name _____ signature _____

Date of interview _____Time started _____time finished _____

Supervisor name _____ signature _____

Annexe 4: English Questionnaire

ID. No._____ Date of Interview_____School _____

1. SOCIO - DEMOGRAPHIC CHARACTERISTICS

No	Questions and filters	Response categorization and coding	skip
101	Sex of the respondent	1. Male ☐ 2. Female ☐	
102	Age in year (completed year)	……..	
103	Level of education (grade)	1. Grade 9 ☐ 2. Grade 10 ☐ 3. Grade 11 ☐ 4. Grade 12 ☐	
104	Do your father and mother live together?	1. Yes ☐ 2. Divorced ☐ 3. One of them alive ☐ 4. Both of them not alive ☐	
105	What is your parents' educational status?	**A. Your father** 1. Never ☐ 2.Not completed Elementary school ☐ 3. Completed Elementary school ☐ 4. High school ☐ 5. University ☐ 6.Others ☐ **B. Your mother** 1. Never ☐ 2.Not completed Elementary school ☐ 3. Completed Elementary school ☐ 4. High school ☐ 5. University ☐ 99.Others ☐	
106	What is your family size with you?	_____	
107	What is your religion?	1. Muslim ☐ 2. Orthodox Christian ☐ 3. Protestant ☐ 4. Catholic ☐ 5. Others ☐	
108	To which ethnic group do you belong?	1.Amhara ☐ 2.Tigray ☐ 3. Oromo ☐ 4. Other ☐	

2. SEXUAL HISTORY

No	Questions and filters	Response categorization and coding	skip
201	Have you ever had sexual intercourse?	1. Yes ☐ 2. No ☐ if NO skip to ⟹	**301**
202	At what age did you have your first sexual intercourse?	----------	
203	Have you had sexual intercourse with multiple partners?	1. Yes ☐ 2. No ☐	
204	Did you use condom with multiple sexual partners?	1. Yes ☐ 2. No ☐	
205	How often do used condom with multiple sexual partners?	1. Always ☐ 2. Sometimes ☐	

3. HIV KNOWLEDGE AND RISK PERCEPTION

No	Questions and filters	Response categorization and coding	skip
301	Have you heard about HIV/AIDS?	1. Yes ☐ 2. No ☐	
302	From where did you hear about HIV/AIDS?	1.Radio/Television ☐ 2.Nighbours ☐ 3.Pamphlets/ poster ☐ 4.Community health workers ☐ 5.Health institutions ☐ 6.School ☐ 7.Family ☐ 8. Friends ☐	
303	Do you think that someone who looks healthy could have HIV/AIDS?	1.Yes ☐ 2. No ☐ 3. Do not know ☐	
304	What are the means of HIV transmission?	1.Through unsafe sex ☐ 2. From mother to baby ☐ 3. Sharing contaminated sharp instrument ☐ 4. Infected blood transfusion ☐ 5. Mosquito bite ☐ 6.Sharing meal ☐ 7.Breathing ☐ 8. Do not know ☐	

305	How people can avoid being infected with HIV/AIDS?	1. Abstinence from sex ☐ 2. Faith fullness to partner ☐ 3. Using condom ☐ 4.Avoid unscreened blood transfusion ☐ 5. Avoiding sharing of sharp materials ☐ 6.Avoid eating together ☐ 7.Protect from mosquito bite ☐ 8. Do not know ☐	
306	How can you know if you or someone has HIV/AIDS?	1. Simply by looking ☐ 2. By physical examination of health personnel ☐ 3. Go to traditional healer/wizard ☐ 4. Go to counseling and testing service ☐ 8. Do not know ☐	
307	Do you think you might be infected by HIV?	1. Yes ☐ 2. No ☐ 3. May be ☐	
308	Why do you think that you might be infected by HIV?	1. More than one Sexual partner ☐ 2. Have had sex without condom ☐ 3. Have had sexual intercourse with a commercial sex worker ☐ 4. Injuries with contaminated sharps ☐ 5. Blood transfusion ☐	
309	Why do you think that you might not be infected by HIV?	1.Have never made sexual intercourse ☐ 2. Have abstained from sex ☐ 3. One faithful partner ☐ 4 .Did not share needle for injection ☐ 5. I always use condom ☐	

4. KNOWLEDGE AND PERCEPTION AND UTILIZATION OF VCT SERVICES

No	Questions and filters	Response categorization and coding	skip
401	Have you heard of voluntary HIV counseling and testing?	1. Yes ☐ 2. No ☐ if NO skip to ⟹	**403**
402	From where did you get the information?	1.Neighbors ☐ 2.Friends ☐ 3.Relatives ☐ 4.Teachers ☐ 5.Media ☐ 6.Family (father, mother, siblings) ☐ 7.Health institutions ☐	
403	Is VCT available in your school or around?	1. Yes ☐ 2. No ☐	
404	Do you know where you can get the service other than your area?	1. Hospital ☐ 2. Health center ☐ 3. Family guidance ☐ 4. Private clinic ☐ 5. Don't know ☐	
405	How long in time did it take you to get to the service site by foot walk?	**----------Minutes**	
406	Have you ever had VCT?	1. Yes ☐ 2. No ☐ if NO skip to ⟹	**413**
407	When did you test for HIV?	1.Three Months ago ☐ 2.Six Months ago ☐ 3.One Year ago ☐ 4.Two Years ago ☐ 5.Three Years ago ☐ 6.Four Years ago ☐	
408	What was the reason for having HIV test?	1. Voluntary ☐ 2. Ordered by health worker ☐ 3. required for work ☐ 4. Required for visa ☐	
409	If voluntary for what reason?	1.To know self status ☐ 2. To plan future life ☐ 3. For marriage ☐ 4. Pregnancy ☐ 5. For blood donation ☐ 6. To start treatment ☐	

410	Did you have counseling during HIV test?	1. Yes ☐ 2. No ☐	
411	Were you satisfied for the services given?	1. Yes ☐ 2. No ☐ if **No** skip to ⟹	**414**
412	What was the reason for being satisfied?	1. Warm reception ☐ 2. Quick service ☐ 3. Confidentiality ☐ 4. Privacy ☐ 5. Professionalism of health care workers ☐ 6. Referral for care and support 7. Free service ☐ 8. Brief counseling ☐	
413	If **NO** for **Q 406** why have you never had VCT before?	1. Do not know where to get ☐ 2. Do not believe it will help ☐ 3. Partners and self trust ☐ 4. Afraid to get the result ☐ 5 .Do not know about it ☐ 6. Partner refusal ☐ 7. No near by the service ☐ 8. Fear of stigma ☐ 9. Cost of service ☐	
414	If **NO** for **Q411** why were you not satisfied?	1.No warm reception ☐ 2.Long waiting time ☐ 3.Lack of confidentiality ☐ 4.Lack of privacy ☐ 5.The counseling given was not clear ☐ 6.No referral for care and support ☐ 7. Professionalism of health care workers ☐	
415	If you have HIV test Which way do you prefer to obtain the HIV test result?	1. Face to face ☐ 2. Telephone ☐ 3. Secretary letter ☐ 4. Relative/ Partner ☐	
416	Do you think counseling is important for HIV testing?	1. Yes ☐ 2. No ☐ 3. Do not know ☐	
417	Who do you think benefits from testing?	1. HIV positive person ☐ 2. HIV negative person ☐ 3. Both HIV positive and negative persons 4. Do not know ☐	

418	Do you agree that VCT is important to prevent the transmission of HIV/AIDS?	1. Agree ☐ 2. Disagree ☐	
419	What are the advantages?	1. Prevention of partners/others ☐ 2. Knowing self ☐ 3. Self care for future life ☐ 4. Prevent mother to child transmission ☐ 5. Choosing partner ☐ 6. To plan future life ☐ 7. To start antiretroviral treatment ☐	
420	When does person should have a test for HIV?	1. Any time ☐ 2. During illness ☐ 3. Before marriage ☐ 4. During travel to abroad ☐ 5. In doubt ☐ 6. Before pregnancy ☐ 7. During pregnancy ☐ 8. Do not know ☐	
421	Who do you think should go for an HIV/ AIDS test?	1. Sex workers ☐ 2. Partner of sex workers ☐ 3. Those to be married ☐ 4. Any one at risk ☐ 5. Any one sexually active ☐ 6. Those with multiple partners ☐ 7. Those who are sick ☐ 9. Do not know ☐	
422	By whom do you prefer to get VCT counseling?	1. Physician (Doctor) ☐ 2. Nurse ☐ 3. Trained counselor ☐ 4. Religious leader ☐ 5. Community leader ☐ 6. HIV/AIDS positive people ☐ 7. No need of counselors ☐	
423	Are you willing to have VCT whether you had it before or not?	1. Yes ☐ 2. No ☐	
424	Where would you go?	1. Government health institution ☐ 2. NGOs health institution ☐ 3. Private health institution ☐	
425	In your opinion what time is convenient for VCT service delivery?	Morning from 8:30am-12: 30am ☐ After noon 1: 30pm- 5:30pm ☐ Any time ☐	

5. STIGMA AND DISCRIMINATION

No	Questions and filters	Response categorization and coding	skip
501	If your testis positive for HIV, would you tell for any of the following individuals about your test result?	1.Your family ☐ 2.Your sexual partner(s) ☐ 3.Your relatives ☐ 4.Your neighbor ☐ 5.Your religious leaders ☐ 6.Your community leader ☐ 7.your employers ☐ 8.Your friends ☐	
502	If your tests is positive for HIV and prefer to disclose your HIV test result, how likely is it that the following might happen to you?	1.Neglected by Family ☐ 2. Support from Family ☐ 3.Neglected by friends ☐ 4. Neglected by sexual partner ☐ 5. Support from Friends ☐ 6. Support from sexual partner ☐	
503	Would you be willing to share a meal with a person you knew had HIV?	1. Yes ☐ 2. No ☐	
504	If a relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household?	1. Yes ☐ 2. No ☐	
505	If a student has HIV but is not sick, should he or she be allowed to continue attending school?	1. Yes ☐ 2. No ☐	
506	If a relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household?	1. Yes ☐ 2. No ☐	
507	If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school?	1. Yes ☐ 2. No ☐	
508	If you knew a shopkeeper or food seller had the HIV virus, would you buy food from them?	1. Yes ☐ 2. No ☐	
509	If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret?	1. Yes ☐ 2. No ☐	

THANK YOU FOR YOUR TIME.

Annexe 5: Translated Information Sheet and Consent Form

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ስኩል ኦፍ ፐብሊክ ሄልዝ

በፈቃደኝነት ላይ የተሞረተ የምርና የምርሙራ አገልግሎት እና አጠቃቀም አስሜክቶ በአዲስ አበባ ከፍተኛ 2ኛ ደረጃ ት/ቤቶች ተሜሪዎች ላይ የሚካሄድ ጥናት

በቅድሚያ የከበረ ሰላምታዬን አቀርብላችኋለሁ፡፡

የተከበሩ ሜላሻችን ከዚህ ቀጥሎ የተለያዩ ጥያቄዎችና የተለያዩ ክፍሎች የያዙ የሚኙ ሲሆን ከአዲስ አበባ ዩኒቨርስቲ ስኩል ኦፍ ፐብሊክ ሄልዝ ለድህረ- ምረቃ ወይም ማስተርስ ሚሃ ግብር ሞሟያ ፅሁፍ የሚሆን ጥናት በሊፋንዳ እብሃማ ሊፋንዳ የሚከሄድ ጥናት ሚሆኑን ልገልጽላችሁ እውዳለሁ፡፡ የዚህ ጥናት ዋነኛው ዓላማ በአዲስ አበባ ኢትዮጵያ ከፍተኛ ሁለተኛ ደረጃ ተሜሪዎች ዘንድ በፍላጎት ላይ የተሞረተ የምርር እና የምርሙራ አገልግሎት አጠቃቀም አስሜከቶ ወጣት ተሜሪዎች ያላቸውን አሜላካከት ለሚዳት ነው፡ በሚሆኑም ዕድሜያቸው ከ15-19 የሆኑ ተሜሪዎች በዚህ ጥናት ላይ እንዲሳተፉ የጋበዝናቸው ሚሆናችንን እየገለፅን ከሌሎች ት/ቤታችሁ ተሜሪዎች ሞካከል በዕጣ ሚጥናችሁ ሚሆናችን እንድታውቁ እንወዳለን፡፡ ከዚህ ጥናት ጋር ተያይዞ ስለሰጣችሁን ሚጃ ጋር በተያያዘ ምንም አይነት ጉዳት የሜይደርስባችሁ ሚሆኑን አሳውቃችኋለሁ፡፡

በሚሆኑም ስለራሳችሁ አንዳንድ ጥያቄዎችን እጠይቃችኋለሁ፡፡

ይህ ቃለ-ሞጠይቅ 30 ደቂቃ ያህል የሜፈጅ ይሆናል፡፡ ምንም እንኳን በዚህ ሞጠይቅ ውስጥ ላሌ አይነት ችግር የሜያስከትልባችሁ ጥያቄ የሌለ ሚሆኑን እየገለፅኩላችሁ ነገር ግን በሜዘል የሜይስሞቹሁ ወይም ነፃነታችሁን የሚ ፍግ ስጜ ካደረባችሁ ወይም ሜልሱን ላለመሞላስ ከፈለጋችሁ በማናኛውም ጊዜ ሜቋረጥ የምትችሉ ሚሆኑን አሳውቃችኋለሁ፡፡

በዚህ ቃለ-ሞጠይቅ ውስጥ ስለተሳተፋችሁ ምንም አይነት በቀጥታም ሆነ በተዘዋዋሪ የምታገኙት ጥቅማጥቅም የሌለ ሚሆኑን ከወዲሁ ላሳውቃችሁ እፈልጋለሁ፡፡ ይሁን እንጂ ለወደፊት በፈቃደኝነት ላይ የተሞረተ የምርና የምርሙራ አገልግሎት በተሻለ ሁኔታ ለሞቅረፅ በሚሞጹ የሚሃ ግብሩ ስራ አስኪያጅ ወይም በዚህ ስራ ላይ የሚሳተፉ ሌሎች ሰዎችን በረዳትነት አግዛችሁ እንድትሰሩ ሊደረግ ይችላል፡፡ እንዲሁም ስለ ፈቃደኝነት ላይ የተሞረተ የምርር አገልግሎትና ምርሙራ አስሜክቶ ወይም ስለ ኤችአይቪ ሞከየቅ የምትፈልጉት ማናኛውም ጥያቄ ሞከየቅ ትችላላችሁ፡፡

በዚህ ቃለ-ሞጠይቅ ውስጥ ስለተሳተፋችሁ ስሞችሁ የሜይሞገብ ሚሆኑን የሰጣችሁት ሚጃ በሚስጢር የሚያዝና ለዚህ ጥናት አላማ ብቻ የሚውል ሚሆኑን ላስረዳችሁ እውዳለሁ፡፡ በዘ ህ ጊዜ ስለጥናቱ አስሜክቶቶ ጥያቄ ካላችሁ ሞከየቅ ትችላላችሁ፡፡ እንዲሁም ሞጠይቁን ከሞላችሁ በኋላ በአእምሮአችሁ የሚሞላስ ጥያቄ ካደረባችሁ በማናኛውም ጊዜ ሞከየቅ ትችላላችሁ፡፡ ለተጨሜሪ ሚጃ በስልከ ቁጥር 0944110967 ወይም በኢሜይል አድራሻ፡ drebiama@gmail.com ሊፋንዳ ኢቢዓማ ሞገር ትላላችሁ፡፡

2. **የስምምነት ቅጽ፡**

ይህ የስምምነት ቅፅ አስፈላጊ የሆኑ ሚጃዎች ተነቦልኝ ከተረዳሁ በኋላ ሞልሶቹን ሰጥቻለሁ፡ ፡

በሚኦም በዚህ ጥናት ላይ ለማሳተፍ ፈቃደኛ ሚሆኔን እስማማለሁ፡ ፡

1. አዎን ይቀጥሉ ወደ የስምምነት ቅጽ ይቀጥሉ
2. የለም ፈቃደኛ አይደለሁም ወደ ሌላ ቀጣይ ማሾች ይለፉ

ማሹ /ተሳታፊው ፊርማ ወይም የጣት አሻራ _____

የጤፍ ተቋሙ ስም _____

የጢያቂው ስም _____ ፊርማ _____

ቃለ-ማኪይቁ የተካሄደበት ቀን፤ _____ የተጀሚበት ሰዓት _____ የተጠናቀቀት _____

የተቆጣጣሪው ስም _____ ፊርማ _____

Annexe 6: Translated Questionnaire

ማጠይቅ

ሚቁ _____ ቃለ ማጠይቁ የተካሄደበት ቀን፡ _____ ት/ቤት _____

1. የ ማህበረሰብ ብዛት ሚረጃ

ቁጥር	የ ማጣራት ጥያቄዎች	የ መልሶቹ ምድቦች እና ኮድ የ ማስጠት	ወደ.. ይለፉ
101	የ መላ ሹ ጾ ታ	1. ወንድ ☐ 2. ሴት ☐	
102	ዕድሜበ ዓ መት (ያጠናቀቀዉ/ች ዓ መት)	.....	
103	የ ትምህርት ደረጃ (ክፍል)	1. 9ኛ ክፍል ☐ 2. 10ኛ ክፍል☐ 3. 11ኛ ክፍል☐ 4. 12ኛ ክፍል☐	
104	አባትዎ እና እናትዎ አብረዉ ይኖራሉ ?	1. አዎን ☐ 2. የ ተፋታ ☐ 3. አንዳቸዉ በሕይወትሉ ☐ 4. ሁለታቸዉም በሕይወት የ ሉም☐	
105	የ ወላጆችዎ የ ትምህርት ሁኔ ታ ምን ይመስላል ?	**ሀ . አ ባ ት ዎ** 1. በ ፍጹ ም ☐ 2.የ አ ንደኛ ደረጃ ትምህርት አ ላጠናቀቁ ም ☐ 3. .የ አ ንደኛ ደረጃ ትምህርት አ ጠናቅቋል ☐ 4. ከ ፍተኛ ደረጃ ትምህርታቸዉን ☐ 5. የ ዩ ንቨርሲቲ ትምህርት ☐ 99.ሌሎች (ገ ልጽ)_____ **ለ . እ ና ት** 1. . በ ፍጹ ም ☐ 2.የ አ ንደኛ ደረጃ ትምህርት አ ላጠናቀቁ ም ☐ 3. .የ አ ንደኛ ደረጃ ትምህርት አ ጠናቅቋል ☐ 4. ከ ፍተኛ ደረጃ ትምህርታቸዉን ☐ 5. የ ዩ ንቨርሲቲ ትምህርት ☐ 99.ሌሎች (ገ ልጽ)_____	
106	የ ቤተሰ ባቸዉ ብዛት ስንት ና ቸዉ?	_____	
107	አ ይማኖትዎ ምን ድነ ዉ?	1. ሙሲሊም ☐ 2. የ ኦ ርቶዶክስ ክ ሪስቲ☐ ን 3ፕ ሮተስ ታን ት ☐ 4. ካ ቶሊክ ☐ 5. ሌላ ከሆነ ይገ ለፅ ☐	

108	ብሔር ዎ ምን ድ ነ ዉ?	1.አ ማራ ☐ 2.ት ግ ሮ ☐ 3. አ ☐ 4. ሌላ ይ ግ ለ ፁ----------	

2. የ ግ ብረ ስ ፓ ግ ን ኙ ነ ት ታ ሪ ክ

ተ.ቁ	**የ ማጣሪ ያ ጥ ያ ቄ ዎ ች**	**የ ሚ ል ሶ ቹ ም ድ ብ እ ና ኮ ድ አ ሰ ጣ ት**	**ወ ደ .. ይ ለ ፉ**
201	ከ ዚ ህ በ ፊ ት የ ግ በ ረ ስ ፓ ግ ን ኙ ነ ት ፈ ጽ ሙ ያ ውቃ ሉ?	1. አ ዎ ☐ 2. የ ለ ም☐ ከ ለ ሌ ላ ወ ደ ⇨	**301**
202	ለ መ ጀ መ ሪ ያ ጊ ዜ የ ግ ብ ረ ስ ፓ ግ ን ኙ ነ ት የ ተ ፈ ፀ ሙ በ ስ ን ት ዓ መ ት ዎ ነ ዎ?	----------	
203	ከ ተ ለ ያ ዩ የ ግ ብ ረ ስ ፓ ግ ን ኙ ነ ት አ ፓ ሮ ች ፓ ር ፈ ጽ ሙ ያ ውቃ ሉ ?	1. አ ዎ ☐ 2. የ ለ ም☐	
204	የ ግ ብ ረ ስ ፓ ግ ን ኙ ነ ት ከ ተ ለ ያ ዩ ሰ ዎ ች ፓ ር በ ፈ ፀ ሙ በ ት ጊ ዜ ኮ ን ዶ ም ይ ጠ ቀ ማ ሉ?	1. አ ዎ ☐ 2. የ ለ ም☐	
205	ከ ተ ለ ያ ዩ አ ፓ ሮ ች ፓ ር የ ግ ብ ረ ስ ፓ ግ ን ኙ ነ ት በ ሚ ፈ ጽ ሙ በ ት ጊ ዜ በ ምን ያ ህ ል ጊ ዜ ኮ ን ዶ ም ይ ጠ ቀ ማ ሉ?	1. ሁ ል ጊ ዜ ☐ 2. አ ን ዳ ን ድ ጊ☐	

3. ስለኤችአይቪ ያልዎት እውቀት እና የስጋቱ ዕይታ

ተ.ቁ	የ ማጣሪያ ጥያቄዎች	የ መልሶቹ ምድብ እና ኮድ አሰጣት	ወደ.. ይለፉ
301	ስለኤችአይቪ/ኤድስ ሰምተው ያውቃሉ?	1. አዎ ☐ 2. የለም☐	
302	ስከኤችአይቪ/ኤድስ ከየት ሰሙ?	1.ሬዲዮ/ቴሌቪዥን ☐ 2.ከጎረቤት ☐ 3.ከበራሪ ወረቀቶች/ፖስተሮች ☐ 4.ከማህበረሰብ የጤና ሰራተኞች ☐ 5.ከጤና ተቋማት ☐ 6.ከትምህርት ቤት ☐ 7.ከቤተሰብ (አባት ፣ እናት ፣ እህት ፣ ወንድም ፣ ከልጆች) ☐ 8. ከጓደኞች ☐	
303	ጤና ማየ ሚመስሉ ግለሰቦች ኤችአይቪ/ኤድስ ይኖርባቸዋል ብለው ያስባሉ?	1.አዎ ☐ 2. የለም ☐ 3. አላውቅም ☐	
304	ኤችአይቪ/ኤድስ የሚተላለፉባቸው መንገዶች ምንድን ናቸው?	☐ 1.ጥንቃቄ ያልተደረገበት የግብረስጋ ግንኙነት ☐ 2. ከእናት ወደልጅ 3. የተበከሉ ስለታማቁሳቁሶችን ተጋርቶ በመጠቀም ☐ 4. የተበከለ ደምበመለገስ ☐ 5. በወባ ትንኝ ☐ 6.ምግብ አብሮ በመማ ብ ☐ 7.በትንፋሽ ☐ 8. አለውቅም ☐	
305	በኤችአይቪ/ኤድስ እንዳይጠቁ ሰዎች እንዴት መከላከል ይችላሉ?	1. በመታቀብ ☐ 2. በሙተማመን ☐ 3. ኮንዶምበመተቀም ☐ 4.የተበከለ ደምከመጠቀምበመቆጠብ ☐ 5. ስለታማቁሳቁሶችን ከመጋራት በመቆጠብ ☐ 6.አብሮ ከመብላት መቆጠብ ☐ 7.ከቀባ ትንኝ ራስን በመከላከል ☐ 8. አላውቅም ☐	
306	አንድሰውኤችአይቪ/ኤድስ ካለው በምን ሊያውቁ ይችላሉ?	1. በቀላሉ በማየት ☐ 2. በጤና ባለሙያዊች አካላዊ ምርመራ በማድረግ ☐ 3. በባህላዊ ህክምና ☐ 4. በማማከር አገልግሎት እና ምርመራ ☐	

		በ ማድረ ግ 5. ሌሎች	
307	በ ኤች አ ይ ቪ ተ ጠቅ ቻለ ሁ ብለ ው ያ ሰ ባ ሉ?	1. አ ዎ ☐ 2. የ ለ ም ☐ 3. ምን አ ልባ ት ☐	
308	በ ኤች አ ይ ቪ ተ ጠቅ ቻለ ሁ ብለ ው የ ሚያ ስ ቡት ምክ ን ያ ት ምን ድ ነ ው?	1. ከ አ ን ድ በ ላ ይ የ ግብረ ስ ጋ ግ ን ኙ ነ ት አ ጋ ☐ ስ ለ ነ በ ሩ ኝ 2. ያ ለ ኮ ን ዶ ም የ ግ በ ረ ስ ጋ ግ ን ኙ ነ ት ☐ ስ ለ ፈ ፀ ምኩ ኝ 3. ከ ሴ ተ ኛ አ ዳ ሪ ዎ ች ጋ ር የ ግብረ ስ ጋ ☐ ግ ን ኙ ነ ት ስ ለ ፈ ፀ ኩ ኝ 4. በ ተ በ ከ ለ ስ ለ ታ ማ ቂ ሳ ቂ ስ ስ ለ ተ ቆ ረ ☐ ኩ 5. ደ ም ል ገ ሳ ስ ለ ተ ጠ ቀ ምኩ ☐ 6. ሌ ሎ ች	
309	በ ኤች አ ይ ቪ አ ል ተ ጠ ቃ ሁ ም ብለ ው የ ሚያ ስ ቡት ለ ምን ድ ን ነ ው?	1.ምን ም ዓ ይ ነ ት የ ግ ብስ ጋ ግ ን ኙ ነ ት አ ድ ር ጌ ☐ ስ ለ ማ ላ ውቅ 2. ከ ግ ብ ረ ስ ጋ ግ ን ኙ ነ ት ስ ለ ቆ ጠ ብ ኩ ኝ ☐ 3. በ ሙ ተ ማ መ ን ስ ለ ቆ የ ው ☐ 4 .ለ ማ ን ኛ ው ም ሞ ር ፌ ስ ላ ል ተ ጠ ቀ ምኩ ኝ ☐ 5. ሁ ል ጊ ዜ ም ኮ ን ዶ ም ስ ለ ም ጠ ቀ ም ☐ 6.ሌ ሎ ች	

4. በፈቃደኝነት ላይ የተመሰረት የምክር እና ምርመራ አገልግሎት እውቀት አመልካከት እና አጠቃቀም

ተ.ቁ	የ ማጣሪያ ጥያቄዎች	የ መልሶቹ ምድብ እና ኮድ አሰጣት	ወደ.. ይለፉ
401	ስለኤችአይቪ ፈቃደኝነት ላይ የተመሰረተ የምክር እና የምርመራ አገልግሎት ሰምተውያውቃሉ?	1. አዎ ☐ 2. የለም ☐ የለምከሆነ ወደ	**403**
402	መረጃውን ከየትነበር የሰሙት ?	1.ከጎረቤቶቼ ☐ 2.ከትዳር አጋሬ ☐ 3.ጓደኞቼ ☐ 4.ዘመዶቼ ☐ 5.መምህራን ☐ 6.ብዙሃን መገናኛ ☐ 7.ቤተሰብ (አባት፣ እናት፣ እህት፣ ወንድም፣ ልጆች) ☐ 8.ከጤና ተቋማት ☐	
403	በፈቃደኝነት ላይ የተመሰረተ ምክር እና ምርመራ አገልግሎት በትምህርት ቤታችሁ ወይምበአካባቢያችሁ ይኖራል?	1. አዎ ☐ 2. የለም ☐	
404	ከአከባቢዎ ውጪአገልግሎቱን ከየት ማግኘት እንደሚችሉ ያውቃሉ?	1. ከሆስፒታል ☐ 2. ከጤና ጣቢያ ☐ 3. ከቤተሰብ መምሪያ ☐ 4. ከግል ክሊኒክ ☐ 5. አላውቅም ☐	
405	አገልግሎቱ የሚሰጥበት ቦታ ለመድረስ በእግር ጉዞ ምን ያህል ሰዓት ይፈጅብዎታል?	**----------ሰዓት**	
406	ከዚህ በፊት በፈቃደኝነት ላይ የተመሰረተ የምክር እና ምርመራ አገልግሎት አግኝተውያውቃሉ?	1. አዎ ☐ 2. የለም ☐ ዮምከሆነ ወደ	**413**

407	ከዚህ በፊት ስለኤችአይቪ ምርመራ ያደርጉት መቼ ነው?	1.ከሶስት ወር በፊት ☐ 2. ከስድስት ወር በፊት☐ 3.ከአንድ ዓመት በፊት ☐ 4.ከሁለት ዓመት በፊት ☐ 5.ከሶስት ዓመት በፊት ☐ 6.ከአራት ዓመት በፊት ☐ 7.አላውቅም	
408	የኤችአይቪ ምርመራ ያደረጉት በምን ምክንያት ነው?	1. በፈቃደኝነት ☐ 2. በጤና ባለሙያ ታዝዤ ☐ 3. ለሥራ ተፈልጎ ☐ 4. ለቪዛ ተፈልጎ ☐ 5. ሌሎች (ይግለፁ)	
409	በፈቃደኝነት ላይ ተመስርቶ ከሆነ ለምን ምክንያት ?	1.ስለራሴ ለማወቅ ፈልጌ ☐ 2. ለወደፊት ሕይወቴ ለማቀድ ☐ 3. ለጋብቻ ☐ 4. እርግዝና ☐ 5. ለደመልገሳ ☐ 6. ሕክምና ለመጀመር ☐ 7.ሌላ (ይግለፁ)	
410	የኤችአይቪ ምርመራ ባደረጉበት ጊዜ አስፈላጊውን የምክር አገልግሎት አግኝተዋል?	1. አዎ ☐ 2. የለም ☐	
411	በአገልግሎቱ ረክተዋል?	1. አዎ ☐ 2. የለም ☐ የለምከሆነ ወደ ⇨	**414**
412	የረኩበት ምክንያት ለምንድን ነው?	1. አቀባበላቸው ☐ 2. ፈጣን አገልግሎታቸ☐ 3. የሚስጥር አያያዛቸ☐ 4. የግል ጉዳይ አያያዛ☐ው 5. የጤና ባለሙያዎቹ ሙያዊ አገልግሎት ☐ አሰጣጥ ☐ 6. ላደረጉልኝ እንክባከቤ እና ድጋፍ 7. ነፃ አገልግሎት በማግ☐ 8. የምክር አገልግሎቱ ጊዜ አጭር በ☐ነ	

413	ለጥያቄ ቁ 406 መልስ የለምከሆነ ከዛ በፊት ምንምዓይነት ፈቃደኝነት ላይ የተመሰረተ የምክር እና የምርመራ አገልግሎት አግኝተውአያውቁም?	1. የት እንደሚሰጥ ስለማላውቅ ☐ 2. ይረዳል ብዬ ስለማላምንበት ☐ 3. በአጋሬ እና በራሴ ስለምተማመ☐ 4. ውጤቱን ለወቅ ስለምፈራ ☐ 5 .ስለጉዳዩ ስለማላውቅ ☐ 6. አጋሪ ፈቃደኛ ባለመሆናቸው ☐ 7. አገልግሎት የሚሰጥበአቅራቢያ ስለ☐ይገኝ 8. መገለል በመፍራት ☐ 9. የአገልግሎቱ ወጪ ☐	
414	ለጥያቄ ቁ 4011 መልስዎ የለምከሆነ ለምን በአገልግሎቱ አልረኩበትም?	1.አቀባበላቸው መልካም ስላ☐ን በረ 2.ብዙ ጊዜ ስለሚያስጠብቅ ☐ 3.ምንምሚስጥር ስለማይጠብ☐ 4.የግል ጉዳይአያያዘውስለ☐ይረባ 5. የሚሰጠውየምክር አገልግሎት ግልጽ ☐ ስላልነበረ 6.ምንምዓይነት እንክብካቤና ድጋፍ ☐ ስላልነበረው 7. በጤና ሰራተኞቹ ሞያዊ አገልግሎት ☐ ምክንያት	
415	የኤችአይቪ ምርመራ አድርገውከሆነ ስለኤችአይቪ ምርመራ በየትኛውን አማራጭማግኘት ይፈልጋሉ?	1. ፈትለፊት ቀርቦ የሚሰ☐ው 2. በስልክ ☐ 3. በሚስጥራዊ ደብዳቤ☐ 4. ዘመድ/አጋር ☐	
416	ለኤችአይቪ ምርመራ የምክር አገልግሎት ጠቃሚነውብለውያስባሉ?	1. አዎ ☐ 2. የለም ☐ 3. አላውቅም ☐	
417	ከምርመራውተጠቃሚየሚሆነውማነው ብለውያስባሉ ?	1. ኤችአይቪ ያለበት ሰው☐ 2. ኤችአይቪ የሌለበት ሰ☐ 3. ሁለቱምኤችአይቪ ያለባቸውእና የሌለባቸውሰዎች ተጠቃ☐ይሆናሉ 4. አላውቅም ☐	
418	ስለኤችአይቪ/ኤድስ ስርጭት ለመቆጣጠር እና ለመከላከል በፍቃደኝነት ላይ የተመሰረተ የምክር እና ምርመራ አገልግሎት ጠቃሚነውብለውይስማማበታል?	1. እስማማለሁ ☐ 2. አልስማማም ☐	
419	የሚያስገኛቸውጥቅሞች ምንድን ናቸው?	1. ከአጋሮች/ሌሎች ለመካለከል ☐ 2. ራስን ለማወቅ ☐ 3. ለቀጣይ ሕይወት ጥንቃቄ ለማድረግ☐ 4. ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላ☐ል ☐	

		5. የ ት ዳ ር አ ጋ ር ለ መ ም ረ ጥ 6. ለ ወ ደ ፊ ት ሕ ይ ወ ቴ ለ ማ ቀ ድ ☐ 7. የ ኤ ች አ ይ ቪ ዕ ድ ሜ ማ ራ ዘ ሚ ያ መ ድ ሐ ኒ ት ለ መ ጀ መ ር ☐	
420	አ ን ድ ግ ለ ሰ ብ የ ኤ ች አ ይ ቪ ምር መ ራ ማ ድ ረ ግ ያ ለ በ ት መ ቼ ይ መ ስ ል ዎ ታ ል ?	1. በ ማ ን ኛ ው ም ጊ ዜ ☐ 2. ሲ ታ መ ም ☐ 3. ከ ጋ ብ ቻ በ ፊ ት ☐ 4. ወ ደ ውጪ በ ሚ ዝ በ ት ወ ቅ ት ☐ 5. በ ጥ ራ ጣ ሬ ወ ስ ጥ ሲ ሆ ኑ ☐ 6. ከ እ ር ግ ዝ ና በ ፊ ት ☐ 7. በ እ ር ግ ዝ ና ወ ቅ ት ☐ 8. አ ላ ው ቅ ም ☐	
421	የ ኤ ች አ ይ ቪ/ኤ ድ ስ ምር መ ራ ማ ድ ረ ግ ያ ለ በ ት ማ ን ነ ው ብ ለ ው ያ ስ ባ ሉ ?	1. ሴ ተ ኛ አ ዳ ሪ ዎ ች ☐ 2. የ ሰ ተ ኛ አ ዳ ሪ ዎ ች አ ጋ ሮ ች ☐ 3. ለ ት ዳ ር የ ሚ ዘ ጋ ጁ ☐ 4. ማ ን ኛ ው ም በ ስ ጋ ት ላ ይ ያ ለ ☐ ሰ ብ 5. ማ ን ኛ ው ም ለ ግ ብ ረ ስ ጋ ግ ን ኙ ነ ት ብ ☐ የ ሆ ነ ☐ 6. የ ተ ለ ያ ዩ የ ግ ብ ረ ስ ጋ ግ ን ኙ ነ ት አ ጋ ሮ ች ያ ላ ቸ ው 7. የ ታ መ ሙ ግ ለ ሰ ቦ ች ☐ 9. አ ላ ው ቅ ም ☐	
422	በ ፈ ቃ ደ ኝ ነ ት ላ ይ የ ተ መ ሰ ረ ተ የ ምክ ር እ ና የ ምር መ ራ አ ገ ል ግ ሎ ት እ ን ዲ ሰ ጡ ት ይ ፈ ል ጋ ሉ ?	1. በ ዶ ክ ተ ሮ ች/ሐ ኪ ሞ ች ☐ 2. በ ነ ር ስ ☐ 3. ስ ል ጠ ና በ ወ ሰ ዱ የ ም ክ ር አ ገ ል ግ ☐ ሰ ጪ 4. በ ሐ ይ ማ ኖ ት መ ሪ ☐ 5. በ አ ገ ር ሽ ማ ግ ሌ ☐ 6. ኤ ች አ ይ ቪ/ኤ ድ ስ በ ደ ማ ቸ ው የ ሚ ገ ☐ ሰ ዎ ች 7. ም ን ም ዓ ይ ነ ት የ ም ክ ር አ ገ ል ግ ሎ ት አ ያ ስ ፈ ል ግ ም ☐	
423	ከ ዚ ህ በ ፊ ት ወ ስ ደ ው ቢ ሆ ን ም ባ ይ ሆ ን ም በ ፈ ቃ ደ ኝ ነ ት ላ ይ የ ተ መ ሰ ረ ተ የ ም ክ ር እ ና የ ምር መ ራ አ ገ ል ግ ሎ ት ለ ማ ግ ኘ ት ፈ ቃ ደ ኛ ነ ዎ ት ?	1. አ ዎ ☐ 2. የ ለ ም ☐	
424	ይ ት ቢ ሄ ዱ ይ ሻ ል ዎ ታ ል ?	1. በ ፈ ቃ ደ ኝ ነ ት ላ ይ የ ተ መ ሰ ረ ተ የ ም ክ ር እ ና የ ምር መ ራ አ ገ ል ግ ሎ ት የ ሚ ሰ ጥ በ ት የ መ ን ግ ስ ት የ ጤ ና ተ ቋ ም ☐ 2. በ ፈ ቃ ደ ኝ ነ ት ላ ይ የ ተ መ ሰ ረ ተ የ ም ክ ር እ ና የ ምር መ ራ አ ገ ል ግ ሎ ት የ ሚ ሰ ጥ በ ት መ ን ግ ስ ታ ዊ ☐	

		ባልሆኑ የጤና ተቋም 3. በፈቃደኝነት ላይ የተመሰረተ የምክር እና የምርመራ አገልግሎት የሚሰጥበት የግል የጤና ተቋም ☐	
425	በእርስዎ አስተያየት በፈቃደኝነት ላይ የተመሰረተ የምክር እና የምርመራ አገልግሎት በስንት ሰዓት አካባቢ ቢያገኙ አመቺ ነውይላሉ?	ጠዋት ከ2:30-6: 30 ሰዓት ☐ ከሰዓት በኋላ 7: 30 - 10፡ 30 ሰዓት ☐ በማንኛውም ጊዜ ☐	

5. መገለል እና መድሎ

ተ.ቁ	የማጣሪያ ጥያቄዎች	የመልሶቹ ምድብ እና ኮድ አሰጣት	ወደ.. ይለፉ
501	የምርመራ ውጤትዎ የኤችአይቪ በደም ውስጥ የሚገኝ መሆኑን ቢያረጋግጥ ለሚከተሉት ግለሰቦች ውጤቱን ያሳውቃሉ?	1.ለቤተሰብ ☐ 2.ለግብረስጋ ግንኙነት አጋርዎ ☐ 3.ለዘመዶችዎ ☐ 4.ለጎረቤትዎ ☐ 5.ለሐይማኖት መሪዎ ☐ 6.ለአገር ሽማግሌዎች ☐ 7.ለአሰሪዎ ☐ 8.ለጓደኞችዎ ☐	
502	የደም ምርመራ አድርገውየምርመራ ውጤቱ ኤችአይቪኤድስ በደምዎ ውስጥ የሚገኝ መሆኑን ቢያረጋግጥ እና ይህንንምቢያሳውቁ ቀጥሎ ከተዘረዘሩት የትኛውሊያጋጥመኝ ይችላል ብለውይሰጋሉ?	1.በቤተሰብ መገለል ☐ 2.በግብረስጋ ግንኙነት አጋሬየሚደርስብኝ አካላዊ ጥቃት ☐ 3.በጓደኞች የሚደርስ መገለል 4.ከቤተሰብእና ዘመዶች የስነልቦና ድጋፍ የሚደረግልኝ መጨመር ☐ 6. .ከእኩዮቼ እና ከግብረስጋ አጋሮቼ የስነልቦና ድጋፍ የሚደረግልኝ መጨመር ☐ 8.የግብረስጋ ግንኙነት መቋረጥ ☐	
503	ኤችአይቪ/ኤድስ እንዳለበት ከሚያውቁ ግለሰብጋር ገበታዎን ይጋራሉ?	1. አዎ ☐ 2.የለም ☐	
504	የእርስዎ የስጋ ዘመድ የሆነ ግለሰብ በኤችአይቪ/ኤድስ ቢታመምበቤተሰብዎ ውስጥ ግለሰቡን በአግባቡ ለመንከባከብ ፈቃደኛ ነዎት ?	1. አዎ ☐ 2. የለም ☐	
505	አንድ ተማሪ ኤችአይቪ ቢኖርበት ነገር ግን ታመሚ ባይሆን ትምህርትን/ትምህርቷን መቀጠል ይኖርበታል/ይኖርባታል?	1. አዎ ☐ 2. የለም ☐	
506	የእርስዎ የስጋ ዘመድ የሆነ ግለሰብ በኤችአይቪ/ኤድስ ቢታመምበቤተሰብዎ	1. አዎ ☐ 2. የለም ☐	

	ውስጥ ግለሰቡን በአግባቡ ለመንከባከብ ፈቃደኛ ነዎት ?		
507	አንድ መምህር ኤችአይቪ በደሙውስጥ ቢኖር እና ባይታመም መምህሩ በማስተማሩ ሥራ መቀጠል ይኖርበታል?	1. አዎ ☐ 2. የለም ☐	
508	አንድ የሱቅ ባለቤት ወይም የምግብር መደብር ሻጭ ኤችአይቪ ቫይረስ እንዳለበት ቢያውቁ ከእርሱ ለምግብ የሚጠቀሙትን ይገዛሉ?	1. አዎ ☐ 2. የለም ☐	
509	ከቤተሰብዎ አባላት አንዱ የኤችአይቪ ተጠቂ ቢሆን ይህንን በሚስጥር ትጠብቀዋለህ?	1. አዎ ☐ 2.የለም ☐	

ይህንን ቃለ መጠይቅ በመመላስ ስላሳለፉ ምስጋናችን ላቅ ያለ ነው