ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF PSYCHOLOGY

# An Assessment of the VCT Services and Counseling Applications in Selected VCT Centers of Dire Dawa City

By:- Mesfin Dejene

June, 2007

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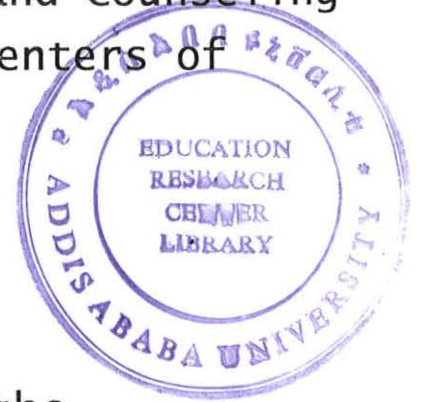




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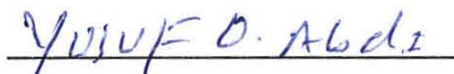

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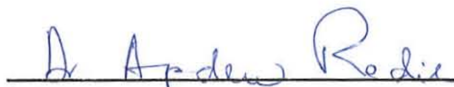

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# LIST OF ACRONYMS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **BCC** | Behavior Change and Communication |
| **CDC** | Center for Disease Control and Prevention |
| **CRDA** | Christian Relief and Development Association |
| **CSA** | Central Statistics Authority |
| **CSWs** | Commercial Sex Workers |
| **D.D** | Dire Dawa |
| **ELISA** | Enzyme Linked Immuno Sorbant Assay |
| **FDRE** | Federal Democratic Republic of Ethiopia |
| **FGAE** | Family Guidance Association of Ethiopia |
| **FHI** | Family Health International |
| **GAP** | Global AIDS program |
| **GRID** | Gay-Related Immune Deficiency syndrome |
| **HAPCO** | HIV/AIDS Prevention and Control Office |
| **HIV** | Human Immunodeficiency Virus |
| **IDP** | Integrated Development Plan |
| **IEC** | Information Education and Communication |
| **IFA** | Indirect Immuno Fluorescence Assay |
| **MOH** | Ministry of Health |
| **MOLSA** | Ministry of Labour and Social Affairs |
| **NACS** | National AIDS Council Secretariat |
| **NBCC** | National Board for Certified Counselors |

| | |
|---|---|
| **NGO** | Non-Governmental Organization |
| **NHI** | National Institute of Health |
| **OSSA** | Organization of Social Services for AIDS |
| **PCR** | Polymerase Chain Reaction |
| **PLWHA** | People Living with HIV/AIDS |
| **PMTCT** | Prevention of Mother-to-Child Transmission of HIV |
| **STI** | Sexually Transmitted Infection |
| **TB** | Tuberculosis |
| **UNAIDS** | Joint United Nations Program on HIV/AIDS |
| **USAID** | U.S Agency for International Development |
| **VCT** | Voluntary Counseling and Testing for HIV/AIDS |
| **WAO** | Women's Affairs Office |
| **WBA** | Western Blot Assay |
| **WHO** | World Health Organization |

## *ABSTRACT*

*HIV/AIDS has been seriously threatening the social, psychological, health and economic situations of the contemporary society, in order to pave the way to mitigate the expansion of the pandemic, different strategies have been designed. One of these strategies is the establishment of VCT Centers. Hence, the purpose of this study was to assess VCT services and counseling applications provided by selected VCT Centers of Dire Dawa City. More over, an attempt was made to explore whether the counselors skills demonstrated and contents discussed in counseling sessions were in accordance with UNAIDS and MOH VCT protocol. In order to assess VCT Services and counseling applications at the VCT Centers 3 sample VCT Centers were purposefully selected from Government Hospital, Private Hospital and NGO VCT Centers. In this study a total of 130 clients were selected using availability sampling techniques and 6 counselors and 3 coordinators were purposefully selected. In order to collect the relevant data, interview, Focus Group Discussion, observation and questionnaires were used. Questionnaire for clients were prepared based on VCT protocol developed by UNAIDS and MOH. Both quantitative (i.e., descriptive statistics) and qualitative data analysis methods were used to analyze the data. According to the finding of the study, counseling skills demonstrated by the counselors and contents of counseling discussed between the client and the counselor in the VCT Centers under investigation found to be in accordance with standards of VCT protocol. However, all counselors of VCT Centers did not apply counseling theories and techniques at all. Inadequate training for counselors, inadequate space for privacy and waiting area, workload on counselors, and lack of professional capacity to handle serious cases were the major problems. Thus, it could be reasonable to recommend intensive training by relevant professional persons for the VCT counselors. Finally, based on the findings, recommendations were forwarded to minimize the problem and help to effectively implement counseling.*

# CHAPTER ONE

## INTRODUCTION

All countries over the world are directly or indirectly affected by the pandemic. Its problem becomes one of the most global agenda. This is related to its serious health, social, psychological and economical problems causing to the contemporary society.

HIV/AIDS tragic effect is very severe in sub-Saharan African courtiers that doubled the problem with the backwardness and deep rooted poverty. Among sub-Saharan African countries Ethiopia is one of the most affected countries by the pandemic even in the world (MOH, 2002).

The problem of the pandemic has left various communities of Ethiopia with broken homes and broken economic ties that have resulted in exposure of many families to destitute life and illiteracy and the living standard of people afflicted with level even below (MOH 2002).

It is clear that counseling is a corner stone for early access to prevention as well as to care and support services. However, according to Yusuf (1996), the concept and tradition of modern counseling service in Ethiopia is fairly young, and the offering of counseling service in Ethiopia is limited mainly to the following settings; higher institutes, secondary schools, youth centers, Family Guidance Association of Ethiopia, counseling centers of HIV/AIDS and other settings such as rehabilitation centers and orphanages.

In light of this, HIV counseling began in Ethiopia in the late 1980s with services expanding throughout the 1990s. Usually counseling for HIV/AIDS is rendered in different settings. One of these is voluntary HIV counseling and testing center (MOH, 2002).

As there is no cure for HIV/AIDS, VCT remains a key strategy to control the spread of HIV and to provide support to those who are positive (MOH, 2003). Increasing access quality VCT can also be important in challenging stigma, promoting awareness and supporting human rights.

To accomplish all these, counseling is rendered in VCT Centers. Whether the counseling services indeed served the purpose it has been established for and whether the services consistently have helped in accomplishing these tasks has not been studied.

Hence, this study attempt to assess the VCT Service rendered in selected VCT Centers of Dire Dawa town and to analyze counseling applications in order to draw valid conclusions regarding the relevance of counseling services offered in the VCT Centers and recommend on ways of improving the qualities of VCT for better service delivery to clients.

## *1.1 Statement of the Problem*

The HIV/AIDS epidemics have become the source of health, economic, psychological, social and political problems which resulted in wide spread of fear and concern of nations and governments of all countries of the world. To date, there is no cure for HIV infection. The only means of protection of the spread of the epidemics is to use VCT Services.

In Ethiopia access to VCT Service is limited. The available ones are not also explored to improve the qualities of the services they offer. Assessing VCT Services tc ensure the qualities of the service they offer therefore is essential to create and increase the demand for VCT Service.

Moreover, according to the report of UNAIDS (2002), in almost all VCT Centers in Addis Ababa town; medical doctors, nurses, teachers, sociologists and other non-psychologist counselors are reported as "HIV Counselors".

Based on this rationale, the present study was undertaken to assess the status of VCT Services and analyze the counseling applications of selected VCT Centers of Dire Dawa town. To this end the researcher will focus on addressing the following questions: -

- Are the services given in VCT Centers go along with available standards?
- Do the counselors apply the basic counseling skills and follow the appropriate principles?
- Are the essential contents of pre and post-test counseling sessions covered?
- Are the VCT Centers physically and materially conductive to provide VCT services?
- What are the limitations that affect effective Counseling Services?

## *1.2 Objective of the Study*

### 1.2.1 General Objective

The general objective of this study is to assess the status of VCT Services and to analyze the application of counseling principles in selected VCT Centers of Dire Dawa town.

### 1.2.2 Specific Objectives

The study aimed to: -

- Assess the extent to which services given in VCT go along with the standards of VCT protocol.
- Identify whether the counselor apply the basic counseling skills and follow the appropriate principles
- Explore the content coverage of pre-test and post-test counseling sessions.
- Investigate whether the VCT Centers are physically and materially conducive or not to provide VCT Services.
- Identify the limitations that affect effective counseling Services?
- Suggest possible intervention mechanisms to improve the situations.

### 1.3 Significance of the Study

This study is expected to have the following contributions: -

- It will help to assess the services renders in VCT and improvement to be made
- It will help to identify the counselor's limitations to apply counseling principles effectively and suggest constructive comments on how counseling principles have been applied in HIV counseling.
- Since little has been done concerning this area in our country, this study can be a base for further research.

### 1.4 Delimitation of the Study

The scope of this study geographically was delimited to Dire Dawa city administration. Thus, the conclusions drawn, and the suggestions and recommendations made reflected what the situation looks like in the stated Region. And it was also delimited to only ten VCT Centers (1 government hospital, 1 private hospital, 6 government health centers and 2 NGO VCT Centers) available in Dire Dawa Due to time and financial constraints it is very difficult to generalize to all Ethiopian VCT Centers.

### 1.5 Limitation of the Study

Continuous counseling observation is a vital means in order to have first hand information about the counseling process. In this study however, due to confidentially considerations, direct observation or audio recording of the counseling sessions were difficult for the researcher.

In addition to this due to shortage of locally produced reference materials related to this study, the researcher has been forced to rely on certain foreign sources. Unwillingness of some clients to participate in the study was also

another problem faced during data collection. In-spite of these problems, the researcher attempted to make the study as complete as possible.

## 1.6 Operational Definition of Terms

- ***Counseling principles:-*** implies the legal and ethical considerations, the effective counselors characteristic, and counseling theories and techniques application while providing HIV counseling.(Dillon et.al.,2002)

- ***HIV Counseling:*** is a confidential dialogue between the client and counselor aimed at creating an enabling environment for person to cope with stress and to make personal decisions related to HIV/AIDS (WHO, 2002).

- ***Post-test Counseling:*** is an HIV/AIDS counseling given after HIV-test result made available (MOH,2003)

- ***Pre-test Counseling:*** is an HIV/AIDS counseling given before some one has HIV tests. (MOH,2003)

- ***VCT Protocol:*** standards used to guide counselor-client discussion in the process of providing VCT services. (UNAIDS,2000a)

- ***Voluntary Counseling and Testing (VCT):*** is the process by which an individual undergoes HIV/AIDS counseling and HIV blood testing by his/her own initiative. . (MOH,2003)

# CHAPTER TWO

# REVIEW OF RELATED LITERATURE

## *2.1 The Concept of Counseling*

Counseling is a process that enables a person to sort out issues and reach decisions affecting their life. It involves talking with a person in away that helps the person solve a problem or helps to create conditions that will cause the person to understand and/or improve his behavior, character, values or life circumstances (NBCC, 2001).

Counseling is often performed face-to-face in confidential sessions between the counselor and client's. However, counseling can also be undertaken by telephone, in writing and in these days of the internet by email or video conferencing.

Counseling can be done by psychologists, social workers, psychiatrists' physicians, nurses and other health workers, clergy, teachers and other to enable clients to cope with their problems. As Carl Rogers and Albert Ellis sited in Corey (1984), the attitudes and feelings of the counselor is more important than techniques and theoretical orientations. He further illustrates that; genuineness, unconditional positive regard and understanding the client are important personal characteristics of a counselors.

Rogers argues that if the above personalities are met, clients will become better integrated and able to function more effectively. On the other hand, Ellis believed that personal warmth, affection and caring are secondary and good counseling can be done without them. On the other hand, Corey (1984) and others pointed some important personal characteristics of an effective counselor:-

- ***Good will:-*** effective counselors are those who show interest to the welfare of others. They should respect, trust, care and value others.
- ***The ability to be present for others:-*** counselors should be emotionally present for clients (i.e.) to be with them in time of pain and joy.
- ***Acceptance of personal power:-*** effective counselors should recognize their personal power in a sense of building confidence.
- ***Ones own knowledge:-*** counselors should build counseling styles based on their own knowledge
- ***Risk taker:-*** counselors sometimes should be willing to take risks, trust their perceptions even when they are unsure of the outcomes, to be emotionally touched by others, to draw on their own experiences so that, they will sense the feelings and struggles of their clients.
- ***Self-respect and self-appreciation:-*** counselors in order to be effective, they should have a strong sense of self-worth that will relate them to others out of their strengths.
- ***Model for their clients:-*** counselors should be able to be good models by the way they try to help clients to help themselves.
- ***Admit mistakes:-*** accepting and learning from ones own mistake is the quality of a good counselor
- ***Growth oriented:-*** the most effective counselors remain open to the possibility of broadening their horizons instead of telling themselves that they have enough knowledge.

Counseling may take time to work, depending upon the nature and number of problems being presented by the client. Sometimes, a single or a few sessions are all that is needed. At other times, longer periods possibly months or up to a couple of years may be needed.

According to Corey (1984), the central responsibility of any counselor is to be genuinely concerned about the welfare of the client. This means that primary importance should be given to the need of the client and not to the counselor. According to MOH (2003), code of ethics serves as general guide to every day conduct of counselors. It is also a brief standard of ethical behavior for counselors in their professional relationships with clients, colleagues, employees, the community and the society at large.

***The following are some basic counseling ethics use by counselors*** (MOH, 2003).

- The counselor should maintain high standards of personal conduct.
- The counselor should accept responsibility for the quality and extent of the service that the individual assumes, assigns or performs.
- The counselor should protect participants from unwarranted physical or mental discomfort, distress, harm, danger and deprivation.
- The counselor should not engage in any action that violates or diminishes the civil or legal rights of clients
- The counselor should respect the privacy of the clients and hold in confidence all information obtained in the counseling sessions.
- The counselor should not participate in fraud, dishonesty or misrepresentation.
- The counselor should not misrepresent professional qualifications.
- The counselor should not exploit professional relationships for personal gains.
- The counselor should not practice any form of discriminations on the basis of race, age, sex, religion, national origin, political orientation, physical handicap, marital status or any other characteristics.

## *2.2 HIV Counseling*

AIDS pandemic, because of its total outcome or its being deadly disease, creates feelings of fear and resentment. Moral breakdown accompanied with ideas of guilt and punishment related to social norms or religious perspectives is the initial response to the disease. Stigmatization, ostracism, rejection and discrimination will exacerbate the already heavy stress that the victim has developed. As a result, counseling is considered as catchword associated with HIV infection (Bennett and Erin, 2001).

Many of these problems may be resolved or at least minimized through psychological help if it is properly given.

In the case of Ethiopia HIV/AIDS counseling and testing started at the end of 1987 with two social workers in the Ministry Of Health (MOH, 2003).

Later in line with high demand for the test, HIV counseling trainings for health professionals and social workers were given. According to NACS (2001), HIV counseling trainings were conducted by the Ministry of Health (MOH), Christian Relief and Development Association (CRDA) and Organization of Social Service for AIDS (OSSA) for nurses and social workers from all regions. The training manual was not standardized. Based on this, in the strategies of the National AIDS Council Secretarial (NACS) plan includes:-

- Standardizing the training in counseling methods
- Standardizing the HIV testing protocols in VCT Centers, according to national guidelines.
- Establishing new VCT Centers where they are needed
- Training of staff for counseling and testing and
- Establishing a referral system for care and support

To this effect in 2003, MOH prepared a standardized HIV/AIDS counseling training manual, standardized referral system and counseling protocol.

## 2.3 HIV Counseling Definitions

According to Hubley (2002), HIV counseling is as a helping relationship based on discussion between a counselor and the infected or potentially at risk individual. It is non-threatening, non-judgmental and unconditionally accepting relationship with the client. As stated by UNAIDS (2000), HIV counseling is defined as a confidential dialogue between a person and a care provider. Besides, according to MOH (2003), HIV/AIDS counseling is a confidential communication between a client and a care provider aimed at enabling the client cope with stress and take personal decisions relating to HIV/AIDS.

HIV counseling as a process is purposeful working relationship to help clients explore and clarify their concerns, find their resources and plan some actions to be taken. Regarding this Green and McCreaner (1989) argued that HIV counseling is about promoting and maintaining the physical and mental well being of all whose lives are touched directly or indirectly with HIV virus, people with AIDS, those with HIV infection, those at risk their lovers, family and other care givers. UNAIDS (2000) explained that counseling includes an evaluation of personal risk of HIV transmission and the emotional support of those who wish to consider HIV testing both to help them make a decision about whether or not to be tested, and to provide support and facilitate decision making following testing. Furthermore, UNAID (2000) indicated that counseling is aimed at enabling the person to cope with stress and make personal decision related to HIV/AIDS. Further Hubely (2002) explained that particularly pre and post-test counseling is to assist the person having the test accepts the possibility of and/or a positive diagnosis. The objective of counseling is on the other hand, to encourage people to be tested in order for them receive help, and start providing the care reserved for positive diagnosis. There served help for the positive diagnosis include medical care and food along with facilitating motivation, reducing the stressful impact of HIV/AIDS on the individual, transmission of HIV infection, understanding, problem solving and decision making.

## 2.4 History of HIV Test

Though no cure has been found for AIDS, many medical doctors have tried to make instruments to test the pressure of HIV in the blood before the disease (AIDS). In 1979 and 1980 doctors in US observed clusters of previously extremely rare diseases. The first case was among homosexual men. At that time the disease was called Gay-Related Immune- Deficiency Syndrome (GRID) (Stine, 2002; Kirton, 2001; Granich and Mermin, 2001).

However, the disease was not restricted only to homosexuals. It was seen also among others who were hemophiliacs and recipients of blood transfusions. Subsequently, the syndrome was identified among injecting drug users and infants born to HIV/AIDS mothers and used drugs. As a result, the disease has been renamed Acquired Immune Deficiency-Syndrome (AIDS) (Nichols, 2002; Stine, 2002; Kirton, 2001; Granch and Mermin, 2001).

In 1983, a group of researcher in France found a virus HIV in people with AIDS. However, the virus could only be found by using expensive tests (Stine, 2002; Kirton, 2001; Granch and Mermin, 2001).

Then, the researchers raced to make a cheaper test that could tell if people had HIV before they become sick with AIDS. Finally, in 1985 the Enzyme Linked Immuno Sorbent Assay (ELISA) test, Western Blot (WB) Assay and Indirect Immuno Fluorescence Assay, (IFA) were invented (Granich and Mermin, 2001; Nichols, 2002).

To day there are modern HIV/AIDS tests in the world and in Ethiopian too. In recent days, the pre-test counseling ends with making an informed decision about taking an HIV test.

If the individual decides to undergo testing, a few drops of blood will be taken for the rapid HIV test unlike the previous ELISA; HIV test which takes a week or more to know the result, the rapid HIV test determines a persons HIV status within a few minute with nearly 100% certainty (UNAIDS, 2000b).

After blood test, which takes not more than 30 minutes, the client will receive his/her test result from the counselor during the post test session. This session depending on the test result covers issues dealing with an HIV positive or negative sero-status (UNAIDS, 2000b).

Pre-test counseling in most HIV testing centers is a necessity before undergoing an HIV test. Nevertheless, some argued that people who don't want to under go Pre-test counseling shouldn't be prevented from taking a voluntary HIV test (for instance, people who have had VCT before may require testing but not wish to have further pre-test counseling).But informed consent from the person to be tested should be a minimum ethical requirement before an HIV test (UNAIDS, 2001).

### *2.5 Reasons for HIV Testing*

Nichols, J. (2002) stated that many people are reluctant to HIV testing. People fear the social, psychological and health consequences of being discovered HIV positive sero-status (Durham and Lashley, 2000).

Thus, whenever such people think to undergo HIV test, the question that springs to their mind are the question of health, social relations and the psychological impacts that may arise of being sero-positive. Regarding the reasons some people undergo HIV testing. The study conducted by Nichols, J. (2002) shows that most people make HIV test due to requirements, HIV/AIDS symptoms, awareness of personal risk and incidental to other complaints.

Some people take HIV test for their test results are needed for many purpose. The purposes of requirements includes:- employment, citizen (immigration), military service, etc (on line, http://travel,state.gov/HIVtestingrequs, htm/2003). An increasing number of countries require their foreigners to be tested for HIV prior to entry. According to these countries they measure, those who will be long term visitors, i.e. students and workers, or change in residence status, including citizenship applications should be HIV negative test. In case, if the applicants are HIV positive, he/she will be automatically decides for his/her application (on line, http://www.sfaf.org/aids101/hiv-testinghtm/ 2003). According to MOH (2003),in Ethiopia people are taking HIV test due to migration, due to AIDS symptoms and the individuals who cognizant of their risk of exposure, either through their high risk behavior or having contact with some one found to be HIV positive may be initiated to undergo the test. Moreover, Nichols, J. (2002) reported that HIV test could be done due to incidental to other complaints. Such people are not intentionally making HIV test for their suspiciousness contracting HIV/AIDS. Rather, they known their being infected by HIV in the course of being diagnosed for complaints not associated with HIV infection (UNAIDS 2002).

## *2.6 Voluntary Counseling and Testing (VCT) Historical Perspective*

The "HIV prevention counseling", component of what is known to day as VCT is the product of years of research and practice in many parts of the world. Concerns about the efficacy of HIV counseling have their roots in the earlier days of HIV testing in the United States when laboratories began returning Enzyme Linked Immuno Sorbant Assay (ELISA). This test-kit used to take a number of days to release test results. The results needed to be explained to clients who did not always return following the two-weeks processing time. Those who did return often received nothing more than an explanation of the laboratory results and some educational materials from their counselors (CDC, 2003). The Center for Disease Control and Prevention (CDC) had assessed the

counseling and testing practice in many of its partner centers in many countries. The assessment prevailed that the experience was land mark for all the health professionals concerned who identified interesting parallels and contrasts with the HIV counseling and testing. The result was that HIV counseling was not as effective as it could have been at preventing new infections and many people did not return for their test results. This was a clear indication that more work was needed to be done. In response, a group of experienced counselors developed the interactive HIV prevention counseling approaches aimed at risk reduction that has laid the groundwork for the VCT practices in many parts of the world today. The approach was first introduced as "client-centered" HIV prevention counseling in CDC's (1993) HIV counseling and Testing Guidelines. These guidelines recommended use of the new counseling approaches for all clients who had HIV testing in publicly funded test sites (CDC, 2003).

## *2.7 An Overview of Voluntary Counseling and Testing (VCT): -*

The changing face of the HIV/AIDS epidemic has resulted in new opportunities as well as new imperatives to increase access to HIV testing and counseling and to knowledge of HIV status. Increase access to care and treatment and decrease stigma and discrimination in many settings present important new opportunities associated with taking an HIV test (WHO, 2002).

In many countries, counseling and testing are widely accepted as a necessary component of the national HIV/AIDS prevention and care programs (MOH, 2003). Early knowledge of HIV infection is now recognized as a critical component in controlling the speared of HIV infection (CDC, 2001). Due to this, dramatic increase in demand for voluntary counseling and testing has been identified in most African countries when the services are made accessible, affordable and secure to those people who want to their own HIV status. The concept of counseling has several definitions depending on the theoretical and

professional background. Ministry of Health (MOH) and Centers for Disease Control and Prevention (CDC) in the voluntary counseling and Testing participants manual defines voluntary counseling and Testing (VCT) as an essential component of a comprehensive HIV/AIDS program. It is from the foundation of VCT that other prevention, care and support services emerge (MOH/CDC, 2003).

In Ethiopia the first evidence of HIV was found in 1984 and the first AIDS cases were identified in 1986 since then in urban areas, more than one out of six adults is infected. Ninety percent of the reported cases occur in the most economically productive age group that is between the ages of 20 and 49 years (MOH, 2000).

According to UNAIDS (2001), voluntary counseling and testing services is reported to have began in Ethiopia 1998. At that time there were much debate as to whether VCT should be offered in the first place, while we don't have enough trained counselors, trained lab-technicians and adequate HIV blood test equipments to offer the services to the multitudes of Ethiopians who are HIV positive or even to the millions of other "healthy" persons who want to undertake voluntary HIV blood testing services. Finally, there was a consensus among health Policy makers and medical professionals that VCT Services should be accessible and affordable to all.

According to Allen, Susan A. et al (1999) before the introduction of VCT, HIV testing has been carried out by different bodies for a variety of reason. Blood transfusion centers, for instance, physicians in health institutions use the test results to aid in patient management surveillance program test for HIV to determine the magnitudes of the epidemic in a given risk group or geographic areas. As Allen and his associates explained depending on the reasons for testing in mot cases were not linked to patient identifies and of linked, they may not be communicated to the individual.

Many years of experience with giving HIV antibody test results have led to the recommendation that if and when an HIV test result is given, it should be voluntary accompanied by a through explanation, emotional support and practical recommendations. This view necessitated the establishment of centers that provide VCT free of charge or with a small amount of payment (Allen et al., 1999).

Soon, however, debate arose about whether or not all programs that rendered HIV testing should give results to the individual. In order to resolve this problem, in 1987 the National Institute of Health (NHI) in America instituted a requirement that all participants in NHI funded studies had to be given their test results with appropriate counseling. The regulation instituted by NHI was based on the underlying assumption that giving HIV test results with appropriate counseling will provoke changes in behavior that will reduce the spread of HIV (Allen et al., 1999).

In Ethiopia, VCT began in the late 1980s with services expanding through at the 1990s and early 2005, in the early 1990s several national level training programs were conducted by MOH and NGOs like the CRDA and OSSA. Many Nurses and social workers from all regional hospitals and Addis Ababa were trained as HIV counselors (MOH, 2002).

To day, there are more than 282 VCT Centers in the country and new VCT Centers are getting established in many areas of the country (Irin, 2005).

In addition, the manual describes VCT as an HIV prevention intervention which gives the client an opportunity to confidentially explore his or her HIV risks and encourage partners, family members and friends to access VCT.
Family Health International FHI (2003) also defines Voluntary Counseling and Testing for HIV as an internationally recognized effective, important strategy for

both prevention and care. It is also a cost-effective strategy for facilitating behavior change and it is an important entry point for care and support for those who test positive.

According to Dillon (2002), VCT programs are designed to provide easy access to HIV testing for persons who wish to know their sero-status through an approach that emphasizes informed consent, pre and post-test counseling and referral to follow-up services.

Ministry of Health and Centers for Disease Control and Prevention (CDC) pointed some ***characteristics of effective VCT counselors:*** - (CDC, 2001)

- One should believe that HIV prevention counseling can contribute for preventing and controlling HIV for individual, family and community
- Uses active listening skills
- Should be comfortable, discussing specific HIV risk activities
- Interest in learning new counseling skills and approaches
- Able to remain focused on risk issues
- Should help the client to develop relevant risk reduction plan.
- Should stay, organized and should avoid counseling outside the protocols structure
- Should avoid collecting data about the client during the counseling sessions.
- Convey to the client that his or her confidentiality will be strictly protected.
- Speak to the client according to there level of understanding.

### 2.8 Voluntary Counseling and Testing (VCT) in Ethiopia

In Ethiopia HIV testing was started in 1987 in the Ministry of Health and expanded to 1990's. The service was focused on sero-survey of participants (CSWs and long truck drivers). Several national level training was also conducted in the above mentioned years to provide the service (MOH, 2003).

Following the issuance of the national HIV /AIDS Policy in 1998, the service (VCT) which was provided by public Health institutions were also started to be provided by private sectors as well as by non-government AIDS support organizations. The number of VCT or HIV testing centers or both increased to 80 in 2002. In 2000 VCT guideline which was revised in 2002 was prepared to help standardize the service in the country (MOH, 2002).

As situational assessment of VCT practice in Ethiopia revealed (MOH, 2002):-

- Health facilities have no separate rooms for HIV counseling
- The demand for HIV testing is growing but service provision by government faculties is limited for shorter of physical facilities, test kits and trained man power.
- In some places counseling and testing services were interrupted for months due to transfer of trained staffs.
- Referral system of HIV positive individuals to care and support and other institutions involved in VCT Service is not well organized.
- The majority of health facilities have shortage of test-kits and these are delivered to them with short shelf life.
- The facilities has kits which has expired or were about to expire
- Only one type of rapid test-kits was used in some facilities for both diagnosis and screening.

In a recently released document by the Ethiopian government namely strategic framework for the National Responses to HIV/AIDS in Ethiopia (2001-2005), VCT is under priority area number three after Information, Education and Communication (IEC) and after CONDOM promotions and distributions as basic strategies to prevent and reduce HIV/AIDS risks (HAPCO, 2003).

Regarding counseling service Yusuf says: -

> *"Though HIV counseling is a basic instrument in behavior change, prevention and control of the spread of HIV/AIDS it is the most neglected and least developed in Ethiopia. And yet there is a great need for counseling service in Ethiopia (Yusuf, 2004).*

## 2.9 The Process of VCT

In traditional VCT settings, VCT Services may be limited to three basic components:- ***pre-test counseling***, where we offer the person to prepare physically and psychologically to enable her/him to make "informed choice" for HIV blood test. Then we ***send the person to go to the laboratory for HIV blood test***. Then the result is received and we go to third component ***post-test counseling***. Here, we inform the person about the meaning of the HIV blood test result and offer him/her all the necessary support especially when the person turn up to be sero –positive

### 2.9.1 Pre-Test Counseling

In VCT, pre-test counseling is a pre-requisite to all clients intending to know their status. This can be done as an individual, couple or group session. FHI(2003) suggest that pre-test counseling include providing materials before clients enter a group or private sessions with a counselor and at this session the client may be asked why they want to be tested and about their behavior that they think that may put them at risk for HIV infection. Furthermore, FHI (2003) point out that if testing is warranted the counselor should: -

- Describe the test and how it is done
- Explain HIV/AIDS and the way HIV is spread
- Discuss ways to prevent the spread of HIV
- Discuss the meaning of possible test results
- Ask what impact the result will have on you
- Address the matter of whom to tell about your test results
- Ask what impact the result will have on you
- Address the matter of whom to tell about your test result
- Discuss the importance of telling your sexual partners if you are HIV positive.

Similarly according to MOH (2002), pre-test counseling should assist the client to identify her/his risk of acquiring HIV and prepare the client for taking the test. Furthermore, the counselor should certain the clients understanding of HIV transmission and the meaning of the test result by doing the following: -

- Discuss the client understanding of the risk for risk
- Discuss what the virus is and how it is transmitted
- Ensure the client understands the risk and benefits of knowing his/her HIV infection status
- Emphasis should be given to religion and culture
- Discuss what the test result mean

Generally, the above discussion indicate that the components of pre-test counseling include establishing the reason for requesting the test, existing knowledge of HIV/AIDS misinformation and myths, risk assessment, risk reduction, testing and possible results together with their meanings. The important parts in pre-test counseling include ensuring that the decision to test is based on information about implications of testing in the clients life and the preparation of the client to receive his/her results and to explore coping strategies.

### 2.9.2 Post-Test Counseling

As the name indicates, post-test counseling is offered after HIV test result is available and it should be always offered whether the result is positive or negative UNAIDS (2000b) and MOH (2002) suggest that the main goals of post-test counseling sessions are to help clients understand their test results and initiate adaptation to their sero- status.

Similarly MOH (2003) indicate that the aim of post-test counseling is to:-

- Provide emotional support
- Prevention of further transmission of HIV/AIDS

According to MOH (2002) in post-test counseling the counselor should: -

- Assure the test result and any other information the client provide remain confidential
- Provide HIV test results
- Interpret the HIV test results
- Ensure the client understand what the result mean
- Address immediate emotional concerns
- Reinforce the plan for reducing risk considering the clients HIV status.
- Discuss with the clients for additional medical and/or social services as appropriate.

UNAIDS (2000b) suggest that in post-test counseling when the blood test result is positive the counselor should: -

- tell the result clearly and sensitively to the client
- provide emotional support and discussed how to cope
- ensure the client has immediate emotional support from a partner, relative or friend
- offer information on referral services that may help clients accept their HIV status and adopt a positive outlook.
- ensure sharing a test-result with a partners or some one trusted is often beneficial

Furthermore, UNAIDS (2000b) point out that when the test result is negative the counselor need to: -

- Discuss changes in behavior that can help the client to stay HIV-negative, motivate the client to adopt and sustain new safer sex practices and provide encouragement for these behavior change.
- refer the client to on-going counseling support groups or specialized care services if necessary

In general, from the above discussion it is indicated that post-test counseling sessions include informing the client his/her results, check understanding of result, providing emotional support accordingly, exploring the clients concern and needs, discuss risk reduction strategies, exploring disclosure issues and discussing support system. Depending upon the result, the client may need to be helped with the need for a required and possible behavior change.

## *2.10 Voluntary HIV Counseling and Testing (VCT) Protocol*

VCT, which is the main gate to many other HIV preventions interventions, has the counseling and testing components. The counseling component is a tailored highly focused and relatively brief intervention (Dillon, 2002; Marlink, Jarantola and Ramanathank, 2002). It consists of two sessions' pre and post-test counseling sessions. Within each of these sessions there are several components that make up the prevention intervention (MOH, 2003; GAP, 2003 and Dillon, 2002).

One commonly used VCT protocol has the following components and each component builds on the previous one. The first four components of the protocol are including in pre-test counseling sessions. These are: -

1. Introduction and orientation to the sessions
2. Assess risk
3. Explore options for reducing risk
4. HIV test preparation
5. HIV testing

In post-test counseling session the emphasis of the protocol is based on HIV negative or HIV positive test results. With clients who have HIV negative test results, the following are emphasized: -

6. providing HIV negative test result
7. negotiate risk reduction plan
8. identify support for risk reduction
9. negotiate disclosure and partner referral

With clients whose HIV test result is positive, the following protocols are emphasized:-

10. providing HIV positive test result
11. Identify source of support
12. Negotiate disclosure and partner referral
13. Address risk reduction issue (Dillon, 2002 and GAP, 2003).

Skills that help to facilitate discussion in counseling sessions are also included in protocol. Techniques /skills are only means to ends. Some techniques are used by some and ignored by others (Yusuf, 1998).

As mentioned in Tools for Evaluating HIV Voluntary Counseling and Testing and National HIV/AIDS Counselors Training Manual UNAIDS (2000a) and MOH (2003), there are standards used to assess VCT Services. In this standard, there are competency-based and content-based elements which are computable with the counseling service protocol that the counselors trained to follow:-

A. ***Competency-Based Elements:*** - these refer to skills employed in HIV counseling sessions. They are grouped in to four based on their functions. Each of them has other elements that enable to assess the skills employed in counseling sessions.

***1. Interpersonal relationship:*** -

The counselor should perform the following skills: -

- greet and welcome clients warmly
- invite clients to seat

- introduce himself
- ask clients to introduce themselves
- establish rapport which makes clients engage in conversation
- listen actively

*2. Gathering information*

- seek clarification from clients about information he/she gives
- probe appropriately
- summarize main issues discussed

*3. Giving information*

- give information to clients in a clear and simple terms
- reinforce important information
- give time to absorb information, the result and respond
- check for understanding /misunderstanding

*4. Handling special circumstances*

- accommodate language difficulties
- talk about sensitive issue plainly and appropriate to the cultures
- use silence well to deal with difficult emotions
- manage clients reaction

***B. Content-based elements: -*** these are mainly divided in to two. They have different elements to guide the counselor-client discussions.

**1. Pre-test counseling contents:** - These are divided in to four sections

**1.1 Introduction/ orientation**: - in this session the counselor should: -

- orient a client about the counseling sessions
- describe to a client the testing procedure
- explain confidentiality
- assess clients reasons for coming in for service

**1.2 Risk assessments**

- explore recent sexual behavior of the clients
- ask why client feels that he is at risk for HIV

- ask the frequency of risk situation
- assess communication with sexual partner

### 1.3 Exploring options for risk reduction

- assess communication with others about HIV risk
- review previous risk reduction attempts
- assess successful experiences of practicing safer sex
- identify barriers to risk reduction
- assess experience of using ccndom

### 1.4 Partner disclosure /preparation for test

- explore clients understanding for the meaning of positive and negative results
- assess to whom a client had told to that he will go to VCT to be tested
- ask to whom they might want to tell/share their HIV status
- assess how a clients handles his sexual partners reactions, especially to a positive result
- obtain informed consent

**2. The post-test counseling session:** - This session is divided in to two sections: -

### 2.1 Informing the Result /emotional support

In this section the counselor should: -

- assess how the client has been feeling since he/she had the blood drawn
- tell to the client she/he is HIV infected simply and clearly
- ensure that the client has understood the meaning of HIV result
- clarify misconceptions between HIV positive result and AIDS
- discuss about positive living
- assess how a client is coping with the result

- discuss who client will inform the positive result
- assess the clients thought about asking his/her partner to be tested

**2.2 Risk Reduction Plan**

- assess clients plan to protect his/her partner from acquiring HIV
- examine how the client protects others from HIV
- identify barriers to risk reduction
- identify persons from family or friends to help the client through the process of dealing with HIV
- assess clients needs of support

## *2.11 Operational Aspects of VCT Service*

### 2.11.1 Site

#### 2.11.1.1 Counseling Room

There are no specific dimensions stipulated for a counseling room. However, a counseling room should be spacious enough to accommodate the counselor desk or table, filling cabinets, two chairs or more depending on the type of counseling offered in the site. Usually, it is recommended that a counseling room would have enough light as well as proper ventilation.

The counseling rooms should be situated in places that are not going to drawn attention from the public as this could further promote stigma to people seen entering such rooms. There is not need to identify them as HIV /AIDS counselors' rooms. The important thing is that the counseling rooms should provided the necessary privacy that clients require some one outside should not be able to tell who is inside and what is being said in there. According to CDC (1994), counseling rooms must be private to ensure confidentiality of the counseling sessions. Similarly UNAIDS (2000a) suggest that VCT to be carried

out correctly and effectively, privacy must be ensured. Discussing risk factors and sexual relations is part of VCT for HIV infection and key information essential to the process will not be elicited unless people can discuss these issues in private. According to Shertzer and Stone (1980), the counseling room should be comfortable and attractive. Counseling facilities should be designed for comfort and relaxation. Therefore, from the above discussion it is indicated that for effective counseling process private space is required. In addition to this to facilitate the counseling relationship, the counseling room should be comfortable and attractive.

#### 2.11.1.2 Proxemics

Hoasė and Dimattia as cited in Shertzer and Stone (1980) defined proxemic as the manner in which man regulates the spatial features of his environment and conversely the impact of that environment on his subsequent behavior. This means, the effect of physical distance between counselor and client, seating arrangement, furniture, and so on within the counseling office.

According to Yusuf (1998), a number of alternatives employed for the physical setting or arrangement within the office are suggested but the most effective seating arrangement is across the table. Similarly Hoase and Dimattia as cited in Shertizer and Stone (1980) suggest that the best seating position is across the corner of the desk to table.

In respect to distance between counselor and clients Shertzer and Stone (1980) suggest that people have a personal space within which they are comfortable in their interactions with another person. The same author's describe that the comfortable space or distance between two persons has been ascribed to cultural background, the relationship between the two parties, the sex of participants and their relative status.

### 2.11.1.3 Waiting Area

Clients must feel as comfortable and relaxed as possible during their stay in the VCT Centers. The counseling office should be easy to access and yet not in a busy place of any center where every passer-by knows that this is the counseling and testing for HIV. It is best if there is a waiting room or area. So that, clients have somewhere to sit out of the public gaze UNAIDS (2000a) suggest that in VCT Centers a well ventilated waiting area is important.

### 2.11.2 Confidentiality

Confidentiality forbids any reference to or discussion about client or a test result except with a professional relationship and only then with the consent of the client (MOH, 2003).

VCT Services to be acceptable, confidentiality must be guaranteed. In view of this UNAIDS (2000a) stated that many people are afraid to seek HIV services because they fear stigma and discriminations from their families and community. VCT Services should therefore always preserve individuals need for confidentiality.

According to MOH (2003), trust is one of the most important factors in the relationship between counselor and clients. It enhances their relationships and improves the chances that the client will act decisively on the information. Similarly UNAIDS (2000b) suggest that trust between the counselor and client enhances adherence to care and discussion of HIV prevention.

Furthermore, UNAIDS (2000b) stated that in circumstances where people who test sero- positive may face discrimination, violence and abuse. Hence, it is important that confidentiality be guaranteed.

According to UNAIDS (2000a) if it is not known that confidentiality will be respected the up-take of VCT will be low. Therefore, there must be a system to guarantee confidentiality. UNAIDS (2000) describe that in some settings it has been shown that people feel more comfortable about VCT Services if they can give a pseudonym. Also MOH (2002) suggest that in VCT settings, HIV testing and counseling could be either anonymous or confidential.

The above discussion generally implies the fact that confidentiality should be strictly assured because it enhances the counseling relationships and improves the chances that clients will act decisively on the information provided.

### 2.11.3 HIV Laboratory Test

Commonly used HIV test is based on the detection antibodies to the virus; most often, the body fluid that is tested is serum (Watery part of the blood). However, whole blood and newer test methods oral secretion are non available.

The use of HIV antibody testing to determine a persons HIV status is based on two assumptions:-

1. People who have been infected with produce detectable antibody against HIV
2. Those with detectable HIV antibody are infected with HIV.

***Types of HIV testing: -***

- Enzyme Linked Immuno Sorbent Assays (ELISA)
- Rapid Test (Blot Test)
- Western Blot
- HIV Antigen Test
- Polymerase Chain Reaction (PCR)
- Viral Culture

The most widely used screening tests are ELISAs and Rapid Tests. Rapid tests are simple to do, take up to 10 minutes. Most are dot-blot immuno assays or agglutination assays requiring no instrumentation.

***Interpretation of HIV test result***

1. Specimen that tested negative on the first test reported as "non reactive" or negative
2. Specimen that is positive in two tests (first and second) reported as reactive or "positive".
3. indeterminate result means the result is equivocal, i.e. neither positive nor negative it is a borderline result the test needs to be repeated after one month or using a different technique the person may be in the process of sero-converting.

***Testing Algorithm***

The test algorithm has thee steps

1. First test with sensitive kit (screening test)
    - Sample tested negative will be reported
    - Sample test positive (reactive) will be further tested with specific type
2. Second test with specific kit (confirmatory test)
    - Sample tested positive will be reported
    - If sample result with 2nd become negative will be subjected to third tie-breaker
3. Third or tie-breaker test highly specific
    - Sample tested the third time, if the results become positive or negative both are reportable. (MOLSA, 2002).

### 2.11.4 Linkages or Referral

In the context of HIV prevention, counseling and testing referral is the process by which immediate client needs for care and support services are assessed and prioritized and clients are provided with assistance in accessing services (CDC, 2001).

According to UNAIDS (2000a) VCT has been shown to be more effective when it is developed in conjunction with support services such as medical, psychological, social and the like. Similarly, MOH (2002) describe that referral is a key component of comprehensive HIV prevention services because not all facilities can address the variety of medical, psychosocial, environmental and structural issues that individual's ability to initiate and sustain behavioral change.

Referral services in general should be afforded to all clients who are infected or at increased risk for HIV to facilitate access to any necessary medical, nutritional, preventive and psychosocial support and faith-based services. In high prevalence area there should be a wide range of care and support activities in the community. Therefore, it will be important for counselors to be aware of these resources and to be able to make appropriate referrals (UNAIDS 2000a).

In regard to this MOH (2002) suggests that the client and counselor together should assess and prioritize the clients' referral needs. Clients often require referral for medical and on-going psychosocial support. Hence, a referral system should be developed in consultation with different Government and Non-Government organizations. From the above discussion it is indicated that there should be a linkage between VCT Centers and various organizations. Therefore, a process for routine referral should be established which results in the enhancement of VCT Services.

## *2.12 Benefits and Challenges of VCT*

High public awareness of HIV, increasing number of persons sick and dying with AIDS, and knowledge of personal risk behavior resulted in an increased desire to learn one's status which in turn prompted the increasing demand for VCT centers. Voluntary Counseling and Testing (VCT) is also a cornerstone for early access to prevention as well as to care and support services. In addition VCT is an important entry point to other HIV/AIDS services including prevention of mother to child transmission (PMTCT), prevention and management of HIV related illnesses, and social support. From a human rights perspective VCT can play a role in addressing stigma and discrimination. The benefits of VCT at various levels as stipulated by CDC's training manual are summarized as follows: -

**For the community**:-

- Changes the image of HIV/AIDS from illness, suffering and death to living positively with HIV
- Generates optimism as large numbers of persons test HIV negative
- Reduces stigma and enhances the development of care and support services.
- Reduces transmission
- Enables access to preventive measures and antiretroviral therapy where available and access to needed clinical services (antenatal clinics, STI and TB clinics, primary care clinics).

**For couples and families:-**

- Enables planning for the future (marriage, pregnancy, relationships, orphan care, financial and property arrangements)
- Enhances faithfulness
- Encourages family planning

**For the individual:-**

- Empowers uninfected persons to protect themselves from HIV
- Assists infected persons to protect others and live positively
- Supports adherence to anti-retroviral therapy (where available)
- Promote early uptake of care and support services for HIV positive clients

Parallel to the aforementioned benefits of VCT there are certain challenges which need to be acknowledged and addressed: -

- ***Stigma:-*** HIV is stigmatized every where resulting in those with the virus experiencing discrimination or rejection. Fear of rejection or stigma is a common reason for not wanting to know one's HIV status
- ***Lack of perceived benefit:-*** for people living in areas with few resources there may be a perception that little support will be available to them if they learn they are infected with HIV. This has resulted in deterring many people finding out about their status.
- ***Gender inequalities:-*** in many countries women are particularly vulnerable and may risk rejection, violence, abandonment, or loss of home and children if their HIV status becomes known. Hence, quite often women prefer to maintain the anonymity of their HIV status and often don't go to VCT Centers.
- ***Commodity management:-*** the availability of test-kits and other commodities needed for efficient VCT Services are critical to the success of VCT programs. Frequent stock-outs of HIV test kits or other essential commodities can deter clients form seeking VCT Services at their local facilities. The lack of commodities can negatively affect clients' perception of the quality of the complete VCT Service including counseling. So, the reputation of the entire service is at stake if commodities are not available and if sound and systematic commodity management system is in place.

### *2.13 The Role of Counseling in HIV/AIDS Prevention and Control*

HIV/AIDS counseling is a confidential process that enables individual's to examine their knowledge and behavior in relation to their personal risk of acquiring and transmitting HIV infection. HIV counseling helps clients to make decision on whether or not to be tested and provides them support when receiving the test results. The specific nature and scope of HIV/AIDS counseling depend on the situation in which it is being used. However, some general principles apply to all types of HIV/AIDS counseling (UNAIDS, 2000).

Every one is now encouraged to learn about his or her status. According to UNAIDS (2001), many approaches to HIV prevention and care require people to know their HIV status. HIV counseling allows access to treatment and support for those who are HIV positive and helps people who do not know their status to make informed decisions about whether to take an HIV test which is described as "Voluntary Counseling and Testing for HIV/AIDS (USAID, 2004). With this relation apart from individual counseling, couple counseling can have the advantage of allowing couples to support each other and to plan for the future.

Generally, HIV/AIDS counseling is a crucial component in the response to HIV/AIDS. It is an essential part of HIV testing, the entry point to prevention as well as to care and treatment. HIV/AIDS counseling also play a vital role in programs focusing on the prevention of mother-to-child transmission. Simply HIV counseling is said to help make people living with HIV/AIDS and every one else feel and live better, and grow personally (USAID, 2004).

## 2.14 Legal and Ethical Issues in HIV Counseling

### 2.14.1 Legal Aspect:-

Green and McCreaner (1989) put the legal aspects of HIV as suppose that a man is told that he is HIV positive. Embittered by this news, he decides that he will revenge himself on humanity by having unprotected sexual intercourse with as many partners as possible hoping that he will hereby infect others with the virus. Is the guilty of any crime? Crime of like rape, unlawful sexual intercourse with a girl under 16 or homosexual acts with a man under 21 also carries the risk of infecting the victim with HIV. The spread of HIV through purposeful transmission has given rise to many legal problems about which so far there has been time to give answers in the context of what has gone before and taking in to account recent judicial procedures (Green and McCreaner, 1889).

According to Ethiopian HIV/AIDS Policy (1998) no person should be forced to undergo mandatory HIV screening test for job recruitment purpose unless the nature of the job requires it, such as pilots-civil aviation and air force. However, if people living with HIV/AIDS (PLWHA) are irresponsibly involved in transmission to the community, they shall be imposed to punitive legal measure (MOH, 2003).

***Confidentiality from legal and ethical point of view:-*** confidentiality which is central to developing trusting and productive client-counseling relationship shows both a legal and ethical issues (Corey G. 2001). It enhances their relationships and improves the chance that the client will act decisively on the information. As indicated in MOH (2003), confidentiality forbids any reference to or discussion about a client except within the professional relationship and only with the consent of the client; counselors have an ethical responsibility to discuss the nature and purpose of confidentiality with their clients early in the

counseling process (Corey G. 2001; NACS, 2000). However, Corey G., (2001) argued confidentiality cannot be considered as an absolute. Hence, there are many circumstances in which confidential information must be divulged and there are many instances in which whether to keep or to break confidentiality becomes a cloudy issue. According to the same author, confidentiality must be broken and legally reported by counselors in the following circumstances: -

- ✻ When clients pose a danger to others or themselves
- ✻ When clients requires that their records be released to themselves or to the third party
- ✻ When the therapist believes a client under the age 16 is the victim of incest, rape, child abuse, or some other crime
- ✻ When the therapists determines that the client needs hospitalization
- ✻ When information is made an issue in a court action

In FDRE policy of HIV/AIDS (1998), it was states that PLWHA shall be encouraged through repeated counseling to accept the need to notifying his/her sero-status to others. However, in the case of altered state of conscious or of difficult cases where a person refuses to notify after adequate counseling and his partner is at risk of infection based on the circumstances the endangered partner shall have the right of direct access to the information regarding the sero-status of the partner. Furthermore, in almost similar way to Corey, G. (2001) MOH (2003) puts the following circumstances that forces a counselor to violate the confidential nature of counseling: -

- ✻ When a client presents a clear danger to himself or to other
- ✻ When a client communicates clear threat to cause physical harm to self or others
- ✻ When a client has a history of physical violence known to the counselor and the counselor responsibly believes that there is a clear danger the client will kill or cause serious physical harm to a reasonably identified persons

- ❋ When a counselor believes that a child under 18 yeas old or a person with disabilities is suffering from serious physical, sexual and emotional injury resulting from abuse or neglect.
- ❋ When physicians or counselors are committing misconduct due to court orders.
- ❋ When the client request the result

### 2.14.2 Ethical Aspect

Codes of ethics in providing counseling describe minimal standards of behavior and identify and prohibit those behaviors that are unethical.

According to Corey, G. (2001) there is a real difference between merely following the ethical codes and making a commitment to practicing with the highest ideas. The same author further indicated two levels of practicing counseling ethics:-

1st, Mandatory ethics, which entails a level of ethical functioning at which counselors simply act in compliance with minimal standards.

2nd Aspirational ethics is pertained to striving for the optimum standards of conduct. Counselors who are committed to aspiration ethics are primarily concerned with doing what is in the best interests of their clients. Furthermore, the same author recommended that because they are evolving documents that are modified over time. Some degree of flexibility is essential in applying them.

Generally, according to the author no code of ethics can delineate what would be the appropriate or best course of action in each problematic situation a professional will face HIV counselors are expected to view ethical responsibilities in various contexts and situations. Regarding this, some of the key codes of ethics that are expected of a counselor are summarized as follows (MOH, 2003; Corey G. 2001).

- Maintaining high standards of conduct
- Should be professionally competent and responsible
- Should not engage in any action that violates the legal right of clients
- Should respect the privacy of the clients
- Should not participate in condone or be associated with dishonesty, fraud, deceit, or misinterpretation
- Should not misrepresent professional qualifications
- Should not act inhuman or discriminatory practices against any person or group.
- Should not exploit professional relationship for personal gains.

In response to what should be the base to judge some act is ethically right or wrong in most moral problems and dilemmas encountered by counselor. Green J. and McCreaner A. (1989) put the major moral principles:-

1st: Beneficence and non-malfeasance which requires that good should be done and harm avoided to clients

2nd: Respect for autonomy (or self determination), which requires that the wishes as well as the interests of the client should be respected

3rd: Respect for justice which requires that the competing interests and wishes of different individuals should be judged fairly

Ideally all of these principles should be satisfied. The professional that should be well and avoid harm to the client in away which is in accordance with the letters, wishes and also is agreed to be fair to and by everyone else involved. If all of these conditions where satisfied, in deed there would no longer be a moral problem. However, unfortunately very often, it is not possible to satisfy all of these principles on the same accession (Green J. and McCreaner A. 1989).

## *2.15 Methods and Criteria used to Evaluate Counseling Service*

According to Shertzer and Stone (1980), evaluation is not intended to be threatening process; its purpose is to provide insight that will help counselors perform higher and more efficient levels. Further, they suggest that the major aim of evaluation is to ascertain the current status of counseling service within some frame of references and on the basis of this knowledge to improve its quality and efficacy. Evaluation is a vehicle through which it is learned whether counseling is doing what is expected of it.

After identifying some of the methodological problem related with evaluation, Van Eura 1983 as cited in Yusuf (1996) listed the following experimental designs which can be employed as they according to the kind of research intended: -

1. pre-test /post -test design
2. reversal experimental design
3. multiple baseline design
4. factorial design and
5. single "n" design

Furthermore, the author indicated that these five types of designs have each inherent difficulty. Shertzer and Stone (1980) suggested the use of supervisor ratings, peer ratings, Q-sort analysis and client rating to be criterion measure of effectiveness. In addition, it is suggested that most research in counseling can be classified as either process research or outcome research.

Process research focuses on what occurs as counseling proceeds and outcome research is directed towards assessing the final product of counseling. According to Yusuf (1998), in the Ethiopian context the evaluation of counseling service could be approached from two distinct but over lapping aspects, the two criteria namely macro-level and micro level-evaluation.

## 2.16 Counselor Training

Counselors as well as their supervisors require adequate training and the training is not a one-time event ... It should be ongoing process (CDC, 1993).

According to UNAIDS (2000a), counselors in VCT Services will need continuous training which should consist of basic information on HIV transmission routes, risk factor, possible and available intervention and the role and process of pre-test post –test and on-going counseling.

Furthermore, UNAIDS (2000a) suggest there are several models of counseling training, a short course (usually 1-2 weeks) followed by practical work then a further (1-2 weeks) is a common time scale some models offer longer more in-depth training and there should be refresher courses and ongoing training and support.

According to Yusuf (2004), in Ethiopia there is acute shortage of trained counselors in VCT Centers where clients need psychological support. Hence, there is a need for professional counseling service. He further argues that at the present time standardized training program and uniform guidelines are lacking when counselors are trained for VCT Centers.

The fact is that there is a need to train "professionally competent counselors" who could work in HIV/AIDS prevention and risk reduction centers. Such professionally trained counselors would have standardized and uniform training programs for the delivery of efficient and effective counseling services. MOH (2002) suggest that any one selected to become a counselor should be given at least one month training on counseling.

According to IDP of Dire Dawa (2006), the current HIV/AIDS prevalence of urban and rural Dire Dawa is 10.9% and 1.3% respectively. On the other hand, the total positive population of Dire Dawa is currently estimated to be 17,035 in

urban and 707 in rural. Female and male HIV positive is expected to be 9,426 and 7,609 respectively. From the total HV positive population the higher share lies between the ages of 15-49 (15.93% positive people) which indicates that the active age population is highly affected by the epidemic of HIV/AIDS. Therefore, the relevance of VCT Centers with well trained counselors is very crucial.

Since no earlier research has been done on VCT in the Region, this study was initiated to investigate the present counseling services offered in VCT centers and to fill the gap.

# CHAPTER THREE

# METHODOLOGY

## *3.1 Design of the Study*

This study aimed at assessing the VCT Services and counseling applications offered in three selected VCT Centers of Dire Dawa Town (Dilchora Hospital, Bilal Hospital and D.D FGAE). To carry out the study, survey research methodology was employed.

## *3.2 Description of the Study Area*

This study was undertaken in Dire Dawa Town. Dire Dawa Administrative council is located between $9^0$ 27' N and $9^0$ 49' N latitude and $41^0$ 38' E and $42^0$ 19' E longitude. East Hararge Administrative zone of Oromiya regional state borders it in the south, south east and Shinele zone of Somali regional state in the north, east and west.

Dire Dawa city is accessible by airplane, train, and cars and is about 515Kms road distance to the east of Addis Ababa and 311Kms to the east of Djibuti port.

The total area of the region is about 128,802 hectare, out of these urban accounts for 2,684 hectare (2%) and the balance 98% is for rural. The total population of the town is 383,529. The increment in population size and the average annual population growth rate of the region generally shows a substantial population pressure facing against development efforts with limited resources and managing capacity in terms of spatial, environmental and technical aspects (IDP, 2006).

According to CSA (2004), there were 29.899 unemployed persons in Dire Dawa city, of which 21,232 are females with unemployment rate of 46.6% and 8,667 are males with unemployment rate of 19.8%. Total unemployment rate for Dire Dawa reaches 33.5%, which is higher than the National urban unemployment rate of 22.9 percent. The rate also ranks first from urban centers of Ethiopia, followed by Addis Ababa (29.1%), Tigray (22.1%) and Harari (22.1%).

The prevalence of HIV/AIDS of urban and rural of Dire Dawa is 10.9% and 1.3% respectively (IDP, 2006) Dire Dawa is one of the major towns expected to have high prevalence of HIV/AIDS.

Currently, Dire Dawa is becoming well known by its level of poverty and destitution, prevalence of high urban poverty, HIV/AIDS and related social evils are aggravated from time to time (IDP, 2006).

### *3.3 Subjects and Sampling Procedures*

In this study three groups of respondents were involved to provide data (clients, counselors and coordinators). Currently, a total of 10 VCT Centers providing VCT Service in Dire Dawa town (1 government hospital, 1 private hospital, 6 government health centers and 2 non-governmental organizations VCT Centers).

The researcher purposefully selected three VCT Centers out of 10 VCT Centers available in Dire Dawa town.

Clients were selected using incidental sampling/availability sampling techniques. That is, before selection all clients who came to VCT Centers were asked to participate in the study after pre-test and post-test counseling sessions and those who were willing to participate in the study were taken. Thus, a total of 130 clients (i.e. 60 from Dilchora Hospital, 54 from Dire Dawa FGAE and 16 from Bilal Hospital) were involved in the study.

Due to limited number of counselors and coordinators, all of them in the three selected VCT Centers participated in the study (i.e. 6 counselors both are females and 3 coordinators both are males).

***Table 3.1: Type and Number of Participants of this Study***

| **Subjects** | **Number** | | | **Total** |
|---|---|---|---|---|
| | **Dilchora hospital** | **FGAE** | **Bilal hospital** | |
| Clients | 60(46.15%) | 54(41.54%) | 16(12.3%) | 130 |
| Counselors | 2 | 2 | 2 | 6 |
| Coordinators | 1 | 1 | 1 | 3 |

## 3.4 Instruments

To obtain sufficient information for the study, four types of data collection tools were used including: - questionnaires, interviews, observations and focus group discussions. Questionnaire for clients were prepared based on the standards of VCT protocol developed by UNAIDS and MOH (2000a) and (2003) respectively.

### *A. Questionnaire*

Two sets of questionnaire were used to collect information from clients and counselors of the selected VCT Centers (see appendix A and B). The clients' questionnaire has four parts with 56 items that are close-ended and open-ended.

The first part was prepared to get personal information about clients. The second, third and fourth part was adapted from UNAIDS (2000a) Tools for evaluating Voluntary Counseling and Testing and MOH (2003) National HIV/AIDS Counselors Training Manual to get information about counseling skills of counselors, contents of pre-test counseling and contents of post-test

counseling sessions respectively. This adapted questionnaire for clients were translated to Amharic version by one Addis Ababa university 2nd year post-graduate student.

All the items in the initial questionnaire were pilot tested on 20 clients of kirkos sub-city Higher 18 Health center. The respondents who took part in the pilot study were taken through availability sampling method (i.e., all clients who come to the VCT Center and get the service were asked to fill in the questionnaire after pre-test and post-test counseling sessions by their willingness).

While providing the questionnaire to the respondents, they were told to note down any ambiguous words, phrases and sentences. As soon as they finished, discussion was held with these respondents and many of them had expressed their positive feeling about the items and pointed out items that are not clear to them. The questionnaire was also given to three experts in order to assess the content validity of the instruments. Except few modifications on two items (item number 6 of part two and item number 9 of part four) their feedback was positive towards the tools in general. And the final questionnaire was designed as a result of this test with minor modification made on two items (item number 6 of part two and item number 9 of part four) on clients' questionnaire. Computing coefficient of alpha using the data collected during the pilot survey assessed reliability of the instrument. Hence, the computation yielded reliability coefficients are counselor skills (0.71), pre-test counseling contents (0.77), and post-test counseling contents (0.79), and their variances are (10.77) , (9.01) and (9.99) respectively.

The counselors' questionnaire consists of one part having 15 items which are both close-ended (9 items) and open-ended (6 items). It was designed to obtain personal data of the counselor and to capture general information of the service.

***B. Interview***

In an attempt to collect data from counselors and coordinators, unstructured interviews were employed (see appendix C and D). The interview were mainly focuses on gathering information concerning: - the application of counseling principles, theories and techniques at VCT Centers, technical and emotional support provided to the counselors, the role and nature of coordinators, training supervision and facilities provided to counselors, referral and linkage with other organizations /VCT Centers, major challenges in rendering quality services and measure taken to overcome the problems.

***C. Observation***

In the present study a systematic observation was employed, point of observation was prepared to assess information regarding the overall setting of the VCT Centers (see appendix --E).

***D. Focus Group Discussion***

Wellington (1996) stated that a Focus Group Discussion among a member of small groups has been considered as a good instrument to capture versatile information. Moreover, Wamahiu and Karugue (1995) explained, "Focus Group Discussions are best suited for obtaining data on group attitudes and perceptions by initiating members for active participation". Because of this, I conducted intensive discussion with 6(six) purposefully selected participants assigned into one group. They are 3 counselors, one from each VCT Centers, (both are females), one higher expert from the Region's Health Bureau (male), one community representative (male) and one person from Tesfa Bisrat Miseker PLWHA Association (male) who were assumed to have adequate information about the study issues related to VCT Service. First, a Focus Group Discussion schedule was developed to conduct discussion among the selected participants.

It was designed to examine their common understanding about VCT Services, problems/ barriers to render the service and possible solutions to overcome the problem. It was also utilized to obtain stronger, well-discussed and useful information which can increase the reliability of the study. To make the discussion more interesting and resourceful, four (4) guiding questions were prepared (see, Appendix - F).

The FGD were recorded by tape recorder with the permission of the respondents in order to minimize lose of information during the discussion process. The researcher was chair the Focus Group Discussion based on the FGD guide.

### *3.5 Data Collection Procedure*

Before data collection began, letter of cooperation from Addis Ababa University Department of Psychology was submitted to Dire Dawa Health Bureau by the researcher. And the Health Bureau gave to the researcher a letter of cooperation requests the three VCT Centers to cooperate on the data collection process.

Four data collectors one female peer promoter and two male volunteer persons living with HIV virus who have been working with the two selected target VCT Centers and one male who can speak and listened Somalian and Oromian language with the age of 29, 33, 29 and 27 respectively were recruited. Both are completed grade 12 and have experience of data collection. A through training was given for the data collectors for half a day.

The entire questionnaires submitted by data collectors after administered were checked and be counter checked by the researcher for complete clarity and amendments each day.

The questionnaire developed to the counselors was administered by the researcher. Tow days were given to fill the questionnaire and return. Also focus group discussion, observation and interviews were conducted by the researcher.

### *3.6 Data Analysis*

The data obtained through different study tools were analyzed using both quantitative (i.e., descriptive statistics) and qualitative data analysis.

# CHAPTER FOUR

# RESULT OF THE STUDY

## *4.1 Data Analysis from Clients Questionnaire*

### 4.1.1 Socio Demographic Profile

A total of 130 VCT clients from three (3) VCT centers were involved in the final study analysis, of which 60(46.15%) clients were from Dilchora Hospital and 54(41.54%) clients were from FGAE and 16(12.31%) clients were from Bilal Hospital VCT centers. Among the respondents, those with the age of 20 years or less accounts 25(19.3%), 63(48.5%) were between the age of 21-30 years, 29(22.3%) were between the age of 32-40 years and 13(10.0%) were above the age of 40 years.

There were 70(53.8%) male and 60(46.2%) female client respondents. With respect to their educational level 19(14.6%) out of 130 were illiterate, 44(33.8%) were in primary school level, 27(20.8%) were 9-10$^{th}$ grade levels and 32(24.6%) were in 11-12$^{th}$ grade levels, and 8(6.2%) participants were in tertiary/college levels.

Regarding their occupation, students account for 28(21.5%) which was followed by Housewives, civil servants, unemployed, merchants and military in 23(17.7%), 20(15.4%), 16(12.3%), 15(11.5%) and 4(3.1%) respectively. 24(18.5%) of respondents were from other professions (i.e., 3 drivers, 4 daily laborers, 3 brokers, 2 prostitutes, 2 waivers, 2 were in pension, 2 were engaged in electronics work, 2 were NGO employed and 4 were engaged in private work). Regarding their marital status 70(53.8%) were married, 45(34.6%) were single (unmarried), 7(5.4%) were divorced and 8(6.2%) were widowed.

The socio demographic characteristics of clients shown in table 4.1 as follows:-

## *Table 4.1 Socio Demographic Characteristics of Clients/Respondents*

| Variables | Category | Responses | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Frequency | | | Percentage | | | Total | |
| | | Dilchora hospital | FGAE | Bilal hospital | Dilchora hospital | FGAE | Bilal hospital | Frequency | Percent |
| Sex | Male | 34 | 27 | 9 | 56.7 | 50.0 | 56.2 | 70 | 53.8 |
| | Female | 26 | 27 | 7 | 43.3 | 50.0 | 43.8 | 60 | 46.2 |
| Educational status /level | Illiterate | 10 | 7 | 2 | 16.7 | 13.0 | 12.5 | 19 | 14.6 |
| | Primary (1-8th) grade | 26 | 11 | 7 | 43.3 | 20.4 | 43.8 | 44 | 33.8 |
| | 9-10th grade | 4 | 20 | 3 | 6.7 | 37.0 | 18.8 | 27 | 20.8 |
| | 11-12th grade | 18 | 10 | 4 | 30.0 | 18.5 | 25.0 | 32 | 24.6 |
| | Tertiary (college level) | 2 | 6 | - | 3.3 | 11.1 | - | 8 | 6.2 |
| Age | 15 | 2 | - | - | 3.3 | - | - | 2 | 1.5 |
| | 18 | 6 | 2 | - | 10.0 | 3.7 | - | 8 | 6.2 |
| | 19 | 2 | 2 | - | 3.3 | 3.7 | - | 4 | 3.1 |
| | 20 | 6 | 3 | 2 | 10.0 | 5.6 | 12.5 | 11 | 8.5 |
| | 21 | 4 | 9 | - | 6.7 | 16.7 | - | 13 | 10.0 |
| | 22 | 2 | 2 | - | 3.3 | 3.7 | - | 4 | 3.1 |
| | 23 | 1 | 6 | 2 | 1.7 | 11.1 | 12.5 | 9 | 6.9 |
| | 24 | 3 | - | - | 5.0 | - | - | 3 | 2.3 |
| | 25 | 4 | 6 | 2 | 6.7 | 11.1 | 12.5 | 12 | 9.2 |
| | 26 | - | 2 | - | - | 3.7 | - | 2 | 1.5 |
| | 27 | - | 2 | 1 | - | 3.7 | 6.3 | 3 | 2.3 |
| | 28 | 2 | 3 | - | 3.3 | 5.6 | - | 5 | 3.8 |
| | 29 | 2 | 5 | 1 | 3.3 | 9.3 | 6.3 | 8 | 6.2 |
| | 30 | - | 4 | - | - | 7.4 | - | 4 | 3.1 |
| | 32 | - | 2 | - | - | 3.7 | - | 2 | 1.5 |
| | 33 | 4 | - | 1 | 6.7 | - | 6.3 | 5 | 3.8 |
| | 34 | 2 | - | - | 3.3 | - | - | 2 | 1.5 |
| | 36 | 4 | - | 2 | 6.7 | - | 12.5 | 6 | 4.6 |
| | 38 | - | 2 | 1 | - | 3.7 | 6.3 | 3 | 2.3 |
| | 39 | 3 | - | 1 | 5.0 | - | 6.3 | 4 | 3.1 |
| | 40 | 6 | - | 1 | 10.0 | - | 6.3 | 7 | 5.4 |
| | 42 | - | 4 | 1 | - | 7.4 | 6.3 | 5 | 3.8 |
| | 45 | 6 | - | 1 | 10.0 | - | 6.3 | 7 | 5.4 |
| | 78 | 1 | - | - | 1.7 | - | - | 1 | 0.8 |
| Occupation | Student | 12 | 16 | - | 20.0 | 29.6 | - | 28 | 21.5 |
| | Military | 4 | - | - | 6.7 | - | - | 4 | 3.1 |
| | House wife | 11 | 12 | - | 18.3 | 22.2 | - | 23 | 17.7 |
| | Civil servant | 4 | 11 | 5 | 6.7 | 20.4 | 31.3 | 20 | 15.4 |
| | Merchant | 6 | 5 | 4 | 10.0 | 9.3 | 25.0 | 15 | 11.5 |
| | Unemployed | 7 | 4 | 5 | 11.7 | 7.4 | 31.3 | 16 | 12.3 |
| | Others | 16 | 6 | 2 | 26.7 | 11.1 | 12.5 | 24 | 18.5 |
| Current marital status | Married | 28 | 30 | 12 | 46.7 | 55.6 | 75.0 | 70 | 53.8 |
| | Single (un married) | 22 | 21 | 2 | 36.7 | 38.9 | 12.5 | 45 | 34.6 |
| | Divorced | 5 | 1 | 1 | 8.3 | 1.9 | 6.3 | 7 | 5.4 |
| | Widowed | 5 | 2 | 1 | 8.3 | 3.7 | 6.3 | 8 | 6.2 |

## 4.1.2. Skills of Counselors

***Table 4.2: Responses of Clients on the Counseling Skills employed by the Counselors***

| Function | Counselors skills | Category | Responses | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Frequency | | | Percentage | | | Total | |
| | | | Dilchora hospital | FGAE | Bilal hospital | Dilchora hospital | FGAE | Bilal hospital | Frequency | Percent |
| Interpersonal skills | Greets me | Yes | 44 | 48 | 9 | 73.3 | 88.9 | 56.3 | 101 | 77.7 |
| | | No | 16 | 6 | 7 | 26.7 | 11.1 | 43.8 | 29 | 22.3 |
| | Introduce self | Yes | 50 | 42 | 13 | 83.3 | 77.8 | 81.3 | 105 | 80.8 |
| | | No | 10 | 12 | 3 | 16.7 | 22.2 | 18.8 | 25 | 19.2 |
| | Engages me in conversation | Yes | 46 | 49 | 14 | 76.7 | 90.7 | 87.5 | 109 | 83.8 |
| | | No | 14 | 5 | 2 | 23.3 | 9.3 | 12.5 | 21 | 16.2 |
| Information gathering skills | Listen actively both verbally and non verbally | Yes | 52 | 52 | 14 | 86.7 | 96.3 | 87.5 | 118 | 90.8 |
| | | No | 8 | 2 | 2 | 13.3 | 3.7 | 12.5 | 12 | 9.2 |
| | Is supportive and non judgmental | Yes | 55 | 51 | 15 | 91.7 | 94.4 | 93.8 | 121 | 93.1 |
| | | No | 5 | 3 | 1 | 8.3 | 5.6 | 6.3 | 9 | 6.9 |
| | Use appropriate balance of open and closed questions | Yes | 32 | 42 | 11 | 53.3 | 77.8 | 68.8 | 85 | 65.4 |
| | | No | 28 | 12 | 5 | 46.7 | 22.2 | 31.3 | 45 | 34.6 |
| | Use silence well to allow self expression | Yes | 50 | 52 | 14 | 83.3 | 96.3 | 87.5 | 116 | 89.2 |
| | | No | 10 | 2 | 2 | 16.7 | 3.7 | 12.5 | 14 | 10.8 |
| | Seeks clarification about information given | Yes | 51 | 49 | 13 | 85.0 | 90.7 | 81.3 | 113 | 86.9 |
| | | No | 9 | 5 | 3 | 15.0 | 9.3 | 18.8 | 17 | 13.1 |
| | Avoid premature conclusion | Yes | 53 | 46 | 14 | 88.3 | 85.2 | 87.5 | 113 | 86.9 |
| | | No | 7 | 8 | 2 | 11.7 | 14.8 | 12.5 | 17 | 13.1 |
| | Probes appropriately | Yes | 56 | 50 | 16 | 93.3 | 92.6 | 100.0 | 122 | 93.8 |
| | | No | 4 | 4 | - | 6.7 | 7.4 | - | 8 | 6.2 |
| | Summarizes main issues discussed | Yes | 50 | 48 | 13 | 83.3 | 88.9 | 81.3 | 111 | 85.4 |
| | | No | 10 | 6 | 3 | 16.7 | 11.1 | 18.8 | 19 | 14.6 |
| Information giving skills | Give information in clear and simple terms | Yes | 54 | 54 | 15 | 90.0 | 100.0 | 93.8 | 123 | 94.6 |
| | | No | 6 | - | 1 | 10.0 | - | 6.3 | 7 | 5.4 |
| | Give me time to absorb information and to respond | Yes | 57 | 52 | 14 | 95.0 | 96.3 | 87.5 | 123 | 94.6 |
| | | No | 3 | 2 | 2 | 5.0 | 3.7 | 12.5 | 7 | 5.4 |
| | Has up to data knowledge about HIV | Yes | 46 | 48 | 13 | 76.7 | 88.9 | 81.3 | 107 | 82.3 |
| | | No | 14 | 6 | 3 | 23.3 | 11.1 | 18.8 | 23 | 17.7 |
| | Repeat and reinforce important information | Yes | 50 | 54 | 15 | 83.3 | 100.0 | 93.8 | 119 | 91.5 |
| | | No | 10 | - | 1 | 16.7 | - | 6.3 | 11 | 8.5 |
| | Summarize main issue | Yes | 42 | 52 | 15 | 70.0 | 96.3 | 93.8 | 109 | 83.8 |
| | | No | 18 | 2 | 1 | 30.0 | 3.7 | 6.3 | 21 | 16.2 |
| Handling special circumstances | Accommodate language difficulty | Yes | 48 | 52 | 14 | 80.0 | 96.3 | 87.5 | 114 | 87.7 |
| | | No | 12 | 2 | 2 | 20.0 | 3.7 | 12.5 | 16 | 12.3 |
| | Talk about sensitive issues plainly and appropriate to the culture | Yes | 22 | 45 | 11 | 36.7 | 83.3 | 68.8 | 78 | 60.0 |
| | | No | 38 | 9 | 5 | 63.3 | 16.7 | 31.3 | 52 | 40.0 |
| | Use silences well to deal with difficult emotions | Yes | 36 | 52 | 12 | 60.0 | 96.3 | 75.0 | 100 | 76.9 |
| | | No | 24 | 2 | 4 | 40.0 | 3.7 | 25.0 | 30 | 23.1 |
| | Priorities issues to cope with limited time in short contacts | Yes | 30 | 46 | 10 | 50.0 | 85.2 | 62.5 | 86 | 66.2 |
| | | No | 30 | 8 | 6 | 50.0 | 14.8 | 37.5 | 44 | 33.8 |
| | In innovative in overcoming constraints | Yes | 40 | 46 | 11 | 66.7 | 85.2 | 68.8 | 97 | 74.6 |
| | | No | 20 | 8 | 5 | 33.3 | 14.8 | 31.3 | 33 | 25.4 |
| | Manage clients distress/ reaction | Yes | 38 | 52 | 15 | 63.3 | 96.3 | 93.8 | 105 | 80.8 |
| | | No | 22 | 2 | 1 | 36.7 | 3.7 | 6.3 | 25 | 19.2 |
| | Flexible in involving partner or significant others | Yes | 36 | 44 | 12 | 60.0 | 81.5 | 75.0 | 92 | 70.8 |
| | | No | 24 | 10 | 4 | 40.0 | 18.5 | 25.0 | 38 | 29.2 |

Four main areas of counseling skills, (i.e., inter-personal skills, information gathering skills, information giving skills and handling special circumstances) were taken. Under each main area of counseling skills, different items were presented and asked clients whether they agree or disagree on the coverage in counseling sessions.

As presented in table 4.2, out of the respondents who responded to interpersonal skills employed by the counselors 101(77.7%) of them responded that they were greeted by the counselors. 105(80.8%) of the respondents indicated that the counselors introduced themselves, 109(83.8%) of the respondents assure tat the counselors established good relationship which made them engage in conversation.

With regard to information gathering skills employed by the counselors, 118(90.8%) of the respondents said that the counselors listened to them actively. 121(93.1%) of the respondents assure that the counselors were supportive and non judgmental. 85(65.4%) of the respondents reported that the counselors used appropriate balance of open and closed questions during the counseling sessions. 116(89.2%) of the respondents said, the counselors used silence well to allow self expression. 113(86.9%) of the respondents said, the counselors sought clarification about information given. 113(86.9%) of the respondents assure that the counselors were avoid premature conclusion during the counseling sessions. 122(93.8%) of the respondents indicated that the counselors probed information appropriately and 111(85.4%) of the respondents indicated the counselors summarized the main issues discussed.

To the skills employed by the counselors for giving information, 123(94.6%) of the respondents said that the counselors gave them information in clear and simple terms, of all the respondents 123(94.6%) of them indicated that the counselors gave time to absorb information and to respond. 107(82.3%) of the respondents assure that the counselors had up-to date knowledge about HIV.

119(91.5%) respondents indicated that the counselors repeat and reinforced important information and 109(83.8%) of them also indicated that the counselors summarized the main issues discussed.

The responses of the respondents to the skills that the counselors employed to handle special circumstances were as follows:- 114(87.7%) of the respondents said that the counselors accommodated language difficulties, and 78(60.0%) of the counselors talked about sensitive issues plainly and appropriate to the culture, 100(76.9%) of the respondents said that the counselors used silence to deal with difficult emotions, 86(66.2% respondents indicated that the counselors were priorities issues to cope with limited time in short contacts. 97 (74.6%) of respondents assured that the counselors were innovative in overcoming constraints and 105(80.8%) of the respondents assured that the counselors managed their reactions, and also 92(70.8%) of the respondents assured that the counselors were flexible in involving partner or significant others.

### 4.1.3 Pre-test Counseling Contents

***Table 4.3: Responses of Clients Concerning Contents discussed in Pre-Test Counseling Sessions***

| Function | Pre-test counseling contents | Category | Responses | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Frequency | | | Percentage | | | Total | |
| | | | Dilchora hospital | FGAE | Bilal hospital | Dilchora hospital | FGAE | Bilal hospital | Frequency | Percent |
| Introduction / orientation | Reason for attending discussed | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Knowledge about HIV and modes of transmission explored | Yes | 60 | 52 | 16 | 100.0 | 96.3 | 100.0 | 128 | 98.5 |
| | | No | - | 2 | - | - | 3.7 | - | 2 | 1.5 |
| | Misconception corrected | Yes | 60 | 44 | 15 | 100.0 | 81.5 | 93.8 | 119 | 91.5 |
| | | No | - | 10 | 1 | - | 18.5 | 6.3 | 11 | 8.5 |
| | Information concerning the process of HIV testing given | Yes | 60 | 50 | 16 | 100.0 | 92.6 | 100 | 126 | 96.9 |
| | | No | - | 4 | - | - | 7.4 | - | 4 | 3.1 |
| Risk assessment | Assessment of personal risk profile carried out | Yes | 60 | 50 | 16 | 100.0 | 92.6 | 100.0 | 126 | 96.9 |
| | | No | - | 4 | - | - | 7.4 | - | 4 | 3.1 |
| | Discussion of possible test results and meaning of HIV positive and negative result | Yes | 60 | 48 | 15 | 100.0 | 88.9 | 93.8 | 123 | 94.6 |
| | | No | - | 6 | 1 | - | 11.1 | 6.3 | 7 | 5.4 |
| Risk exploring options for risk reduction | Capacity to cope with HIV positive results discussed | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Discussion of potential needs and available support | Yes | 58 | 46 | 14 | 96.7 | 85.2 | 87.5 | 118 | 90.8 |
| | | No | 2 | 8 | 2 | 3.3 | 14.8 | 12.5 | 12 | 9.2 |
| Preparation for the test/plan partner disclosure | Discussion of personal risk reduction plan | Yes | 58 | 47 | 15 | 96.7 | 87.0 | 93.8 | 120 | 92.3 |
| | | No | 2 | 7 | 1 | 3.3 | 13.0 | 6.3 | 10 | 7.7 |
| | Time allowed to think through issues | Yes | 60 | 48 | 15 | 100.0 | 88.9 | 93.8 | 123 | 94.6 |
| | | No | - | 6 | 1 | - | 11.1 | 6.3 | 7 | 5.4 |
| | Informed consent /dissent given freely | Yes | 60 | 45 | 15 | 100.0 | 83.3 | 93.8 | 120 | 92.3 |
| | | No | - | 9 | 1 | - | 16.7 | 6.3 | 10 | 7.7 |
| | Follow-up arrangements discussed | Yes | 60 | 42 | 14 | 100.0 | 77.8 | 87.5 | 116 | 89.2 |
| | | No | - | 12 | 2 | - | 22.2 | 12.5 | 14 | 10.8 |
| | Adequate time for question and clarification given | Yes | 60 | 48 | 15 | 100.0 | 88.9 | 93.8 | 123 | 94.6 |
| | | No | - | 6 | 1 | - | 11.1 | 6.3 | 7 | 5.4 |

Four main functions/areas of per-test counseling contents, (i.e., introduction/ orientation, risk assessment and risk exploring options for risk reduction, and preparation for the test/ plan partner disclosure) were taken. Under each main function of pre-test counseling contents, different items were presented and the respondents asked in such away that they agree or disagree on coverage of the contents of the pre-test counseling sessions.

As presented in table 4.3,out of the respondents who responded to introduction/ orientation function 130(100%) reported that reason for attending the sessions was discussed.128(98.5%) of the respondents assured knowledge about HIV/AIDS and its mode of transmission was explored. 119(91.5%) respondents reported that misconception about HIV/AIDS was corrected. And 126(96.9%) of them indicated that the process of HIV testing was described to them.

With regard to the content related to risk assessment, the participants reported the following:-126(96.9%) of participants said that personal risk behaviors were explored during the pre-test counseling sessions. Of all respondents 123(94.6%) respondents said that they were discussed with the counselors on possible test results and meaning of HIV positive and negative results.

Regarding contents grouped under exploring options for risk reduction, all participants reported that capacity to cope with HV positive result was discussed. Among all respondents, 118(90.8%) responded, issues concerning potential needs and available support was raised during the pre-test counseling sessions.

In the discussion held on preparation for the test/plan partner disclosure, 120(92.3%) respondents responded positively to personal risk reduction plan. 123(94.6%) participants responded that adequate time was allowed to think through issues and for questions and clarifications. 120(92.3%) participants responded that informed consent given freely. In respect to follow-up arrangements 116(89.2%) participants responded that the issue was discussed.

### 4.1.4 Post-Test Counseling Contents

*Table 4.4: Responses of clients regarding contents discussed in post- test counseling sessions*

| Function | Post-test counseling contents | Category | Responses | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Frequency | | | Percentage | | | Total | |
| | | | Dilchora hospital | FGAE | Bilal hospital | Dilchora hospital | FGAE | Bilal hospital | Frequency | Percent |
| Informing the result | Result given simply and clearly | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Time allowed for the results to sink in | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Checking for understanding | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Discussion of the meaning of the result for me /partner | Yes | 59 | 40 | 13 | 98.3 | 74.1 | 81.3 | 112 | 86.2 |
| | | No | 1 | 14 | 3 | 1.7 | 25.9 | 18.8 | 18 | 13.8 |
| | Discussion of personal, family and social implications including who, if any to tell | Yes | 58 | 53 | 16 | 96.7 | 98.1 | 100.0 | 127 | 97.7 |
| | | No | 2 | 1 | - | 3.3 | 1.9 | - | 3 | 2.3 |
| Risk reduction plan | Discussion of a personal risk reduction plan | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Dealing with immediate emotional reactions | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |
| | Checking availability of immediate support | Yes | 58 | 48 | 14 | 96.7 | 88.9 | 87.5 | 120 | 92.3 |
| | | No | 2 | 6 | 2 | 3.3 | 11.1 | 12.5 | 10 | 7.7 |
| | Discussion of the HIV/AIDS policy | Yes | 48 | 45 | 14 | 80.0 | 83.3 | 87.5 | 107 | 82.3 |
| | | No | 12 | 9 | 2 | 20.0 | 16.7 | 12.5 | 23 | 17.7 |
| | Discussion of follow-up care and support | Yes | 60 | 52 | 16 | 100.0 | 96.3 | 100.0 | 128 | 98.5 |
| | | No | - | 2 | - | - | 3.7 | - | 2 | 1.5 |
| | Options and resources identified | Yes | 58 | 52 | 15 | 96.7 | 96.3 | 93.8 | 125 | 96.2 |
| | | No | 2 | 2 | 1 | 3.3 | 3.7 | 6.3 | 5 | 3.8 |
| | Immediate plans, intentions and actions reviewed | Yes | 58 | 52 | 15 | 96.7 | 96.3 | 93.8 | 125 | 96.2 |
| | | No | 2 | 2 | 1 | 3.3 | 3.7 | 6.3 | 5 | 3.8 |
| | Follow-up plan discussed | Yes | 60 | 46 | 14 | 100.0 | 85.2 | 87.5 | 120 | 92.3 |
| | | No | - | 8 | 2 | - | 14.8 | 12.5 | 10 | 7.7 |
| | Referrals discussed when necessary | Yes | 60 | 54 | 16 | 100.0 | 100.0 | 100.0 | 130 | 100.0 |
| | | No | - | - | - | - | - | - | - | - |

The post-test counseling session content is divided in to two functions/areas, informing the result and risk reduction plan.

As presented in table 4.4, contents of post-test counseling sessions related to informing the result/providing emotional support section, 130(100%) of the participants reported that HIV test result was given simply and clearly and all respondents reported that enough time was allowed for the HIV test result to sink is. And all of them reported that the counselors discussed with them to ensure whether they have understood the meaning of positive and negative result or not. 112(86.2%) respondents reported that the meaning of the result was made clear. 127(97.7%) of all respondents reported that discussion to personal, family, and social implication was made and discussion was held on how to inform to their sexual partners.

In the section of post-test counseling session that requires discussion on how to plan risk reduction, all of the participants indicated that discussion was made with regard to personal risk reduction plan. All respondents reported that emotional reaction to test result news was entertained. 120(92.3%) respondents reported availability of immediate support was checked. 107(82.3%) of the participants reported that they discussed with the counselors about the HIV Policy issues. 128(98.5%) of the participants reported that discussion was made about follow-up, care and support.125(96.2%) of respondents reported, identification of options and resources, and immediate plans, intentions and actions was reviewed. 120(92.3%) of participants reported, discussion was made about follow- up plan of all the respondents. And all of them reported that their needs to referral services were discussed.

## *4.2 Data Analysis from Counselors Questionnaire*

### 4.2.1. Socio Demographic Characteristics of Counselors

*Table 4.5 Socio Demographic Characteristics of Counselors*

| Variables/ characteristics | Category | Responses Number | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Dilchora hospital | | FGAE | | Bilal hospital | | Total | |
| | | Counselor 1 | Counselor 2 | Counselor 1 | Counselor 2 | Counselor 1 | Counselor 2 | No | Percent |
| Sex | Male | | | | | | | - | - |
| | Female | 1 | 1 | 1 | 1 | 1 | 1 | 6 | 100.0 |
| Age | 26 | | | 1 | | | | 1 | 16.7 |
| | 28 | | | | 1 | | | 1 | 16.7 |
| | 35 | 1 | | | | | | 1 | 16.7 |
| | 42 | | | | | 1 | 1 | 2 | 33.3 |
| | 45 | | 1 | | | | | 1 | 16.7 |
| Profession | Nurse | | 1 | | | | | 1 | 16.7 |
| | Health assistance | | | 1 | 1 | 1 | | 3 | 50.0 |
| | Health officer | | | | | | | - | - |
| | Sociologist | | | | | | | - | - |
| | Psychologist | | | | | | | - | - |
| | Physician | | | | | | | - | - |
| | Other | 1 | | | | | 1 | 2 | 33.3 |
| Educational level | Primary | | | | | | | - | - |
| | Secondary | 1 | | | | | | 1 | 16.7 |
| | Tertiary (Diploma & above) | | 1 | 1 | 1 | 1 | 1 | 5 | 83.3 |
| | Others | | | | | | | - | - |
| Years of experience in VCT counseling | Less than one year | 1 | | | | | | 1 | 16.7 |
| | One year | | | | | | 1 | 1 | 16.7 |
| | Two years | | | 1 | | | | 1 | 16.7 |
| | Thee years | | 1 | | | 1 | | 2 | 33.3 |
| | More than 3 years | | | | 1 | | | 1 | 16.7 |
| Working days per-week | Five days | 1 | 1 | 1 | 1 | | | 4 | 66.7 |
| | Six days | | | | | | 1 | 1 | 16.7 |
| | Seven days | | | | | 1 | | 1 | 16.7 |
| How many clients do you counsel per day? | 5 and less than | | | | | 1 | 1 | 2 | 33.3 |
| | 6-10 | | | 1 | 1 | | | 2 | 33.3 |
| | 11-15 | 1 | | | | | | 1 | 16.7 |
| | 16-20 | | 1 | | | | | 1 | 16.7 |
| | More than 20 | | | | | | | - | - |
| Dose the VCT provide feely? | Yes | 1 | 1 | | | | | 2 | 33.3 |
| | No | - | - | 1 | 1 | 1 | 1 | 4 | 66.7 |

A total of 6(six) counselors participated in this study (2 counselors in each VCT Centers). As presented in table 4.5 there were 6 (six) female counselors. The age of counselors ranges from 26 to 45 years with respect to their profession, 3(50%) were health assistance, 1 nurse, 1 laboratory technologist and 1 was not professional but took two weeks training of HIV/AIDS counseling. 5(83.3%) of them were at tertiary educational level and, 1(16.7%) was at secondary educational level. In respect to counseling experience, 1 of the respondents had less than 1 years of experience, 1 had one years of experience, 1 had two years of experience and 2 respondents had 3 years of experience and the remaining 1 counselor had 5 years of experience. Among the 6 respondents 1 counselor work the whole week (7 days), one counselor work 6 days per week and 4(66.7%) of counselors work 5 days per week. Regarding the number of clients counseled per-day by the counselors, among the 6 counselors 2 of them reported that they counseled 5 and less clients on average per-day, and 2 counselors counseled 6 to 10 clients on average per-day, 1 counselor counseled 11 to 15 clients on average per-day and 1 other counselor reported that she counseled 16 to 20 clients per day on average.

Out of 3 VCT centers only Dilchora Hospital VCT Center is provided VCT Service freely. The rest Bilal Hospital VCT Center and FGAE VCT Centers have received 10 Birr and 5 Birr /client respectively for the service.

Do all clients get the service on the first day they come to be tested? All counselors responded that all clients have got the service on the first day they come. As stated by respondents, the organizations that provide HIV counseling training for VCT counselors under the study were FGAE, MOH and CDC.

As stated by VCT counselors of the VCT Centers under the study, the following organization are the organizations that counselors wee refer HIV positive clients for care and support services. These were OSSA, Tesfa Bisrat Association, woredas HIV/AIDS offices, and Shama Birhan Association of PLWHA.

### *4.3 Data Analysis from Counselors Interview*

To supplement additional information on data gathered by different information gathering tools at VCT Centers, totally six counselors were interviewed from 3 VCT Centers. The first question was about the professional background they think more effective at VCT Centers in providing counseling .2 respondents responded that medical background professionals who are trained in HIV/AIDS counseling skill should give it These respondents were asked to justify for their response, and they replied that the problem of HIV/AIDS is the health matter and in order to address clients needs a person with medical background should be handle it.

The other 3 respondents replied that any person who is trained in HIV/AIDS counseling can provide Counseling services with the justification that following the counseling protocol which is standardized by MOH is not as such difficult since most people who come to VCT with prior information and readiness. The rest one respondent replied that it should be psychologists. And she justified that the problem of HIV/AIDS causes a great psychological problem and thus the one who serve as counselor should have the concept of counseling. Thus, since it is sometimes difficult to handle some psychological problems particularly in the case of HIV positive clients, those who are trained in psychology should handle.

The second question was asked whether they have ever been faced challenging cases in rendering HIV/AIDS counseling, four(4) counselors of the VCT Centers under the study responded that they faced clients who deny accepting the positive test result and the rest two respondents said that they had faced difficulty to handle difficult psychological problems. All of these respondents used referral system to the Regions health bureau, kebele HAPCO and different PLWHA associations.

Based on the challenging cases stated above the interviewer asked the respondents, what limitations they could observe on themselves in applying counseling principles for HIV/AIDS counseling, Most of the respondents said that they felt less to handle clients' case that is more of psychological problem.

And the respondents were asked for any suggestions regarding the application of counseling principles for HIV counseling, all of them commented that the HIV/AIDS counseling training given to them were not intensive and sufficient to provide the necessary counseling and to apply counseling principles effectively, and thus, the training should be intensive and extended.

The 3rd, 4th, 5th and 6th questions were asked whether they apply counseling theories and techniques during pre-test and pot-test counseling sessions, all of the respondents responded that they did not apply theoretical perspective and techniques while providing counseling except following the counseling protocol standardized by MOH.

The 7th question was asked whether they have been encountered with problems in the process of rendering VCT Service, and four respondents responded that the number of clients of which they provide counseling per-a day is more than their capacity. They said that some times they provide counseling for about 15 clients' per-day. Moreover, some respondents responded that they play double role that makes them over loaded, since the service they rendered were integrate with other services and joint medical treatments. The 8th question was asked whether their work is supervised and whether the counseling director provides them the necessary support like budget, training facilities, technical and emotional support. Among 6 counselors 4 of them responded that they did-not get any in-service training. While, the remaining 2 counselors responded that they have got in-service training and refreshment courses. Moreover, 4 respondents said that their work has never been supervised. While, the remaining two counselors responded that their work were supervised at least

one times per month. However, almost all respondents said that they have got pre-service training but the pre-service training was not adequate and they feel that they need more training in the area of burnout management, implementation of antiretroviral therapy, handling serious psychological problems, information gathering techniques and managing clients emotional reaction.

The 9th question was about an access to get HIV/AIDS counseling manuals, guidelines and HIV/AIDS policy. Almost all respondents responded that they have an access to get if they need it. However, out of the 6 counselors only two of them said that the above materials are already on their hand and they used on it as necessary.

### 4.4 Data Analysis from the Coordinators Interview

In order to get some detailed information on the study under taken at VCT Centers, totally 3 coordinators were interviewed from 3 VCT Centers. The first question was about the significant role of coordinators in their VCT Centers. All of them reported that they facilitates and supervised the work of counselors and coordinate programs and give guidance for counselors. Regarding the support that provide for the counselors, respondent from FGAE VCT Center reported, that his VCT Center provides a new and up-to-data information from internet, basic and refreshment trainings and equipment facilities for the counselors. On the other hand, respondent from Dilchora hospital VCT Center said that his VCT Center provide additional payment for counselors as an incentive and they had an access to discuss problems that they faced during the counseling sessions in their continuous two weeks meeting period. The respondent from Bilal hospital VCT Center reported that the support given to the counselors' have more of management dimension and less technical and emotional support. Even if the support have management dimension, the coordinator reported that he always willing to provide any kinds of support per

the request of the counselors. Moreover, the coordinator reported that he needs more training on counseling and supervision to do so. In general all coordinators assured that the support given to counselors by coordinators was not adequate.

In respect to in-service training, only one respondent from FGAE reported that in-service training was given for the counselors. While, the remaining coordinators said that in-service training have never been given to the counselors. With regard to linkage with other VCT Centers and organizations, coordinator from Dilchora Hospital reported that they have formal referral paper for HIV positive clients and send them to different responsible organizations. With this respect, they have good linkage with other VCT Centers and organizations. Respondent from FGAE reported that they have good linkage with all VCT Centers since, they have common goals. Respondent from Bilal Hospital said that their linkage was only at the Hospital level and he confirmed that there is not at all well organized linkage.

Regarding the constraints that the counselors faced in rendering quality service in VCT Centers, the major constraints faced by counselors as reported by coordinators were lack of adequate training, work load, in adequate technical and emotional support and lack of medical equipments particularly test-kits.

With regard to facilities, coordinator form FGAE said that his VCT Center is a model VCT Center in the city with full standards and facilities. On the contrary, the remaining coordinators reported that there are no adequate facilities in their VCT Centers in different dimensions.

All coordinators reported that they have an access to get HIV /AIDS counseling manuals, guidelines and HIV/AIDS Policy.

- Increasing number of professionals in the area
- Continuous training of Para counselors

- Providing continuous basic and refresher training for the already existing counselors
- Creating access to get adequate test-kits and drugs were suggestions given by the coordinators for the betterment of counseling services in their respective VCT Centers.

Almost all coordinators commented that the numbers of beneficiaries were alarmingly increasing time to time which hindered them to provide quality service for their beneficiaries.

### *4.5 Data Analysis form Focus Group Discussion (FGD)*

In order to back up the information obtained by other instruments and to fill the gap, one focus ground discussion were held. Three counselors, one community representative, one higher expert from Health Bureau and one person from PLWHA association were participated in the Focus Group Discussion.

In FGDS pointed out that their service was mainly focus on HIV/AIDS and every individual who come to VCT Centers to get voluntary counseling and testing was their target group.

All participants of the FGDs mentioned that they were not quite sure that the whole community is aware of the HIV/AIDS VCT Services. Since, minimum or least attention was given to promotion.

The counselors in the FGD also reported that lack of on-going training, lack of up-to-date information regarding new findings and lack of sufficient technical and emotional support are also challenging they faced. In order to resolve the above problems, participants of the FGD suggested that frequent in- service training would solve the problem. And also the on-going training also minimizes the shortage of up-to-date information.

Counseling supervision training to coordinators and supervisors would help to maximize the technical and emotional support provided to the counselors. All counselors in the FGD reported that they required training on treating difficult psychological problems with applying different psychological theories and techniques.

### *4.6 Data Analysis form Observation of Facilities*

With regard to the place of VCT or counseling rooms in the compound, as the observation revealed that they didn't have special attention at all sampled centers. Dilchora Hospital VCT Center counseling rooms are placed at the place where people are crowded which is not helping to keep privacy and confidentiality of clients. With regard to the size of the counseling room, two VCT Centers (Dilchora and Bilal hospital VCT Centers) have three by three meters sized counseling room. When we compare them, FGAE VCT Center has relatively wide and better counseling room. With regard to the seating arrangement, the observation revealed that the seating arrangement was a typical office seating arrangements.

With respect to arrangement of psychological settings, the observation revealed that there are two types of VCT Centers. The first type is VCT Center that has separate waiting, counseling and laboratory rooms and the second is the VCT Center that has no separate waiting, counseling and laboratory rooms.

The observation revealed that there was a waiting area in two VCT Centers (Bilal and FGAE VCT Centers). In these centers the waiting area was good and adequate. However, the waiting areas were not used only for VCT clients but also other patients who come to medical examinations and for other reproductive health services. While, there is no any waiting area in Dilchora Hospital VCT Center, and counselors used the same room for counseling and blood testing by using rapid test tools/kits the name called "determine". In this

VCT Center there was high observed distraction like distraction from people who are waiting for TB and ARV treatment as well as those who are waiting for pre-test or post-test counseling. The counselors in the two VCT centers (Bilal and FGAE) play double role. When a content of the counseling protocol is observed, a content of counseling principles standardized by MOH is not fully applied for all VCT Centers.

With regard to ensuring confidentiality, all counselors had used coding system to keep their clients confidential.

# CHAPTER FIVE

## DISCUSSION OF THE RESULT

This part of the research is pertaining to discussing the implication of the main findings with the review of related literature or prior findings.

Preventing HIV transmission is the main reasons for people to learn their HIV status, uninfected people are counseled to help them remain negative and infected people are counseled to help them to avoid acquiring further-virus and to avoid transmission of the virus to others. This is determined by the quality of the counseling service provided. Poor quality counseling can resulting misunderstanding and even resistance to behavioral change, in order to provide quality service, VCT Centers should have counseling room and waiting room. Privacy must be ensured and confidentiality should be maintained to elicit information necessary for counseling. There must also be at least a counselor who is trained on HIV counseling. As the result of this study indicate that all of the counselors took training on HIV counseling skill and they believed to be effective to provide the counseling. It is also requires a lot of work and experience to provide good counseling. Hence, the result of this study indicates that the experience of counselors ranges form less than a year to five years and the majority of counselors (5 counselors) experience in counseling in this study was between 6 months to three years.

This indicates that the majority of counselors are not well experienced. As responded by counselors, they are required to counsel 5-15 people in a day on average which hinder to give good counseling.

The counselor- client relationship and interaction are vital element in the counseling process. The counselor needs to perform skills and discuss contents included in pre and post-test counseling session adequately to provide good

quality of HIV counseling. To this end adherence to the counseling protocol and the use of appropriate counseling skills are critical (Dillon, 2002).

As the result of this study regarding interpersonal skills of the counselors indicated that the clients were greeted by the counselors, the counselors introduced themselves and engage clients' conversation. Clients who said that the counselors were listened to them actively were as highly (90.8%). Concerning information gathering skills that the counselors employed, the result of this study indicated that the counselor sought clarification about information given. 122(93.8%) of the clients assured that counselors probed the information given appropriately and the counselors summarized the main issues discussed.

With regard to information giving skills employed by the counselors, the result of this study revealed that the counselor give information in clear and simple terms and reinforced important ones. It was also indicated that the counselors gave time for the clients to absorb information and respond. 107(82.3%) of the clients assured that the counselor have up-to-data knowledge about HIV and 109(83.8%) of the clients revealed that the counselor summarized the main issues discussed.

With respect to skills employed by the counselors to handle special circumstances in counseling sessions, the counselors accommodated language difficulties and also talked about sensitive issues plainly and appropriate to the culture. The counselors also used silence well to deal with the clients difficult emotions/reactions. 105(80.8%) of clients said that the counselors managed their reactions. Hence, this study indicated that the skills demonstrated by the counselors of the VCT Centers under investigation go along with the standards of the VCT protocol. The process VCT counseling consists of at least two sessions, pre-test and post-test counseling. With each session, there are several elements that make up the prevention intervention (MOH, 2003)

Pre-test counseling offered before HIV testing. Ideally the counselor prepared the clients for the test by explaining HIV/AIDS and its modes of transmission, what HIV test is and its importance as well as myth and misconception about HIV/AIDS. The counselor also discuss the clients personal risk profile and HIV prevention methods, the implications of knowing ones sero-status, the way to cope with HIV test results and potential needs and available support. As the findings of this study indicated, the majority of clients reported that almost all the issues or contents of pre-test counseling sessions were covered in all VCT Centers. This indicates that counselor-client discussion on contents of pre-test counseling sessions were according with the VCT protocol.

As the result of this study indicated, the majority of clients reported that in post-test counseling sessions they were asked whether the counselors give test result simply and clearly, allowed time for the result to sink in, check the understanding of test result, explain the meaning of test results, discuss the implication of test results, deal with personal risk reduction plan, manage clients immediate emotional reaction, checking availability of support, discussion about the HIV policy with relation to test results, discuss follow-up care and support and discuss about referral when necessary. The findings of this study indicated that almost all of post-test counseling contents were covered in all VCT Centers. These indicate that discussion held on contents of post-test counseling sessions go along with the standards of the VCT protocol.

As some participants responded to interview questions, they argued that the matters of HIV are related with problems arisen of medical problems and it is relevant that the counseling should be given by health professionals. While, other respondents argued that the issues to be addressed through counseling are more of psychological and whatever the root causes for the problems may be, it needs psychological help. So, the counseling should be given by psychologist. However, majority of counselors responded that any person who took HIV/AIDS counseling training can be VCT counselor. The counselors also

interviewed whether they faced challenging cases ad whether they apply any counseling theory and techniques in order to handle their clients cases, all of the respondents responded that they have little concept about counseling theories and techniques and thus they couldn't apply it.

The responses to interview question that asks the counselors to tell the limitation they had observed to serve as VCT counselor had also showed that they had faced difficult to handle the psychological problems of their clients. Hence, these indicate that the counselors at VCT Centers are professionally not enough to apply counseling principles appropriately particularly counseling theories and techniques.

As all participants of coordinators interview responded that, the major constraints that the counselors faced in rendering quality service and needs to be resolved were lack of adequate training, workload, inadequate technical and emotional support and lack of medical equipments (test-kits). Increasing number of professionals in the area, training of Para counselors, providing basic and refresher trainings for counselors and creating access to get adequate test -kits and drugs were major suggestions given by coordinators of the VCT Centers under the study. Moreover, as reported by Focus Group Discussion (FGD) participants', lack of on-going training, lack of up-to-date information regarding new findings and lack of sufficient technical and emotional support were the major challenges that the counselors faced. And on-going in -service training, counseling supervision training and training on treating difficult psychological problems with applying different psychological theories and techniques were the major suggestions given by FGD participants to solve the above mentioned challenges.

VCT to be carried out correctly and effectively, privacy must be ensured. Hence, the observation of the VCT Centers revealed that all VCT Centers have separate rooms for counseling but, even if they have separate rooms the place where the

counseling rooms are located was not adequate and conducive to ensure privacy. In addition to separate counseling room, a well ventilated waiting area is important in VCT Centers. The observation of the VCT Centers revealed that two VCT Centers have a waiting area despite it is not only for VCT clients.

HIV infection is still a stigmatized condition in many areas. So, counselors and all the staffs involved must be maintaining confidentiality. Lack of confidentiality will result in reduction of clients who seek the service. The observation of the VCT Centers revealed that in all VCT Centers discussion was made how confidentiality is ensured and this is usually done coding system/anonymous testing to keep their clients confidentiality/keeping clients secret.

Seating arrangement is the other factor that affects effective counseling. The observation of the VCT Centers revealed that in all VCT Centers the arrangement was typically an office arrangement. According to Yusuf (1998) different seating arrangement have their own benefits and draw backs. However, the most effective is across the corner of the table. Hence, this study indicated that effects in seating arrangement were observed in all VCT Centers.

## CHAPTER SIX

## SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter pertains with summarizing the major points of each chapter, providing its conclusion and recommending the possible solutions based on the research findings.

### *6.1 Summary*

Human beings are suffering of many complicated man made and nature caused problems. Above all, the problem of HIV/AID is severe particularly to sub-Saharan countries. As one of the intervention strategies, many countries have designed VCT to control and prevent the expansion of the pandemic. Counseling which is the major activity of most VCT Centers has been given to person who seeks HIV test. This service has given by different persons from different educational background.

As found in this research all of the counselors of the VCT Centers under the study are medical persons. However, from the professional point of view, providing counseling service for people who manifested psychological problems needs the skill to apply counseling theories and techniques. This is mainly important in the case of handling HIV/AID related cases.

Therefore, the major purpose of this study was to assess VCT Services and counseling applications at VCT Centers. More explicitly the present study was conducted with the following specific purposes: -

To assess the basic skills of counselors, the content of pre and post-test counseling, the counseling environment, to find out problems that exist in

rendering the services and to suggest possible intervention mechanisms to improve the situations.

To meet these purposes, the following research questions were raised

- Are the services given on VCT Centers go along with available standards?
- Do the counselors apply the basic counseling skills and follow the appropriate principles?
- Are the essential contents of pre and post-test counseling sessions covered?
- Are the VCT Centers physically conducive to provide VCT Services?
- What are the limitations that affect effective counseling services?

To answer these questions survey research methodology was employed. Both quantitative and qualitative data collection instruments were used to obtain adequate information.

To get the appropriate data on the above questions, 3 VCT Centers were purposefully selected. From all VCT Centers a total of 130 voluntary clients were taken using availability /incidental sampling method, (i.e. 60 clients from Dilchora Hospital VCT Center 54 clients from FGAE VCT Center and 16 clients from Bilal Hospital VCT Center). A pilot tested questionnaire was administered to these participants /clients. All the 6 counselors working at the sampled VCT Centers were participated in the study. They filled questionnaire and interviewed.

Interview was also conducted with 3 coordinators of each VCT Centers under the study. FGD also held with 6 purposefully selected participants to supplement the information collected by other instruments.

Observation was conducted for each VCT Center in order to asses the physical and psychological environment while undergoing counseling sessions. The data collected from clients was analyzed using the standards adopted for this purpose from Tools of Evaluating VCT prepared by UNAIDS and National

HIV/AIDS counselors training manual. The data were tabulated for analysis which includes statistical application involving frequency counts and percentage.

The result of the questionnaire administered to the clients indicated that the counseling skills demonstrated by the counselors in the VCT Centers under investigation were in accordance with the standards of the VCT protocol. Because, the client respondents confirmed that the counselors demonstrated the skills in the counseling sessions. Accordingly, the majority of client respondents indicated that counselors demonstrated the inter-personal skills, information gathering skills, information giving skills and skills to handle special circumstances.

According to the majority of client respondents, contents of pre-test counseling sessions, which are grouped under introduction orientation, risk assessment, exploring options for the risk reduction and preparation for test/ partner disclosure were discussed. This was inline with the standards of VCT protocol.

As the findings of this study indicated that the contents of post-test counseling sessions discussed in the VCT Centers under investigation was also in accordance with the standards of the VCT protocol. Accordingly, the majority of client respondents disclosed that post-test counseling content grouped under providing the result/emotional support and risk reduction plan were covered by the counselors.

As the information obtained from counselors indicated that some of the counselors are less experienced in counseling and all counselors are medical persons. The majority of counselors have got a few weeks pre- service training. As the result of interview administrated for coordinator revealed that the participations of counselors in in-service training was not adequate, in which case the result indicated that the majority of counselors have never been participated in in-service training.

As the result of interview administered for counselors revealed that the majority of counselors have never got technical and emotional support, and the majority of the counselors confirmed that their works have never been surprised. However, it has been stated in the VCT guideline of MOH (2002), the work of counselors should be supervised to ensure the quality of the service. In view of this fact the practice with respect to supervision was not adequate to ensure the quality of counseling services.

Counselors reported that the existence of work load, lack of on going training, lack of incentives, lack of supervision, inadequate referral system to the clients were the main problems that hinder the effectiveness of the service.

The result of the interview administered for coordinators revealed that the majority of the coordinators work was more of management dimension than technical and emotional support because, they didn't get adequate training in counseling and supervision. As the result of the FGD revealed that lack of ongoing training, lack of up to data information regarding new findings and lack of sufficient technical and emotional support were challenging that the counselors faced.

The observation revealed that there are, inadequate waiting area, lack of privacy and confidentiality for clients, shortage of time for counseling sessions, seating arrangement was like a typical office seating arrangement, narrow counseling rooms were observed.

### 6.2 Conclusion

Based on the major findings of this study the following conclusion can be made

- Skills demonstrated and contents of counseling discussed in counseling sessions in the VCT Centers under the study is go along with the standards of the VCT protocol.
- All of the counselor respondents were from health professions, they also trained in HIV counseling skill by health professionals. In addition the national HIV counseling training manual content gives more emphasis to the medical aspect of HIV/IADS. Besides, the training time which is 2 weeks on average is not enough to cover the basic counseling concepts, principals, theories and techniques
- Though nature can have its own contribution to determine personal quality of a counselor, developing counseling skills through training and experience is very important. As found in this study all counselor respondents were ineffective in applying counseling theories and techniques to handle psychological problems of clients during counseling sessions. This to some extent could be ascribed to the insufficient training and experiences in counseling skills
- There is inadequate space for privacy and waiting area for counseling and also a typical office seating arrangement in the counseling rooms.
- The presence workload on counselors and coordinators, lack of incentives, lack of emotional and technical support for the work of counselors, lack of on-going training for counselors and coordinators, lack of medical equipments (test-kits). Inadequate supervision on the work of counselors' is problems that hinder the provision of effective counseling.
- In addition to this Dilchora Hospital VCT Center provide VCT service freely. These were encouraged clients to go to the VCT Center to get the service. These days the demand of VCT out-paced the capacity of the VCT Center of providing the service

## 6.3 Recommendations

Based on the findings and conclusion made the researcher would like to forward some valuable recommendations as follows: -

***Short-term Recommendations***

- As found in this study all counselors were from health professions and trained by non-professional counselors. Thus, professional counselors should provide the training in intensive.

- Dire Dawa Health bureau should provide comprehensive and standardized counselors training program.

- Counselors should get incentives for their additional work and should get emotional and technical support from coordinators.

- At present the demand for the VCT Centers out paced the capacity of the VCT Centers. Hence, Dire Dawa Health bureau should be responsible in increasing the number of trained counselors and VCT Centers.

- There should be given space for privacy and confidentiality, adequate waiting room and medical equipments in the VCT Centers.

- Counseling sessions needs to be monitored or supervised to ensure that they are of high quality.

***Long-term Recommendations***

- Skills demonstrated and pre and post-test counseling session contents discussed were in accordance with the VCT protocol. However, improving the VCT Service is essential. Because of this coordinators of each VCT Centers should provide additional training and should also create opportunities that the counselors be able to share experiences with other counselors.

- The national HIV/AIDS counseling training manual focuses on the care and support or medical aspects. Thus, the Department of Psychology is responsible to revise the manual and in such away that it gives more emphasis to counseling principles, theories and techniques.

- Counselors need adequate on-going in-service training and supervision to ensure that they give good quality counseling. Here, Dire Dawa HAPCO and the Health bureau should be responsible.

- Coordinators should get training in counseling supervision

- Attention should be given on promoting VCT Services.

- A referral system should be developed in consultation with different Governmental and Non-Governmental Organizations.

- Exhaustive research should be undertaken on the area of VCT.

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# APPENDICES

# Appendix (A)

**Addis Ababa University**
**Post Graduate Studies**
**Department of Psychology**

**Code (01)**

**(Questionnaire for Counselees)**

**Objective:** This study is aimed at assessing the counseling services rendered in selected VCT centers of Dire Dawa town. The purpose of this questionnaire is to obtain information about counseling skills of counselor, counseling contents and problem faced by clients to get the service.

**N.B.**

- The information to be obtained through the questionnaire is going to be used only for the study undertaken.
- All information you provide will be treated as confidential.
- You will not be responsible for the research outcome, so you are requested to complete the questionnaire as genuinely as you can.
- Do not write your name on the questionnaire,

Therefore, the cooperation of clients of giving genuine information is highly valuable to complete the study.

***Thank you in advance for your cooperation***

## Part One - Personal Data

1. Name of the VCT center_______________________
2. Age ______________________
3. Sex (tick one) Male ☐ Female ☐
4. Educational status (tick one) Illiterate ☐ Primary level ☐ (1-8th grade) 9-10th grade level ☐ 11-12th grade level ☐ Tertiary level ☐ (College level)

5. Occupation (tick one)

Student ☐ Military ☐ House wife ☐

Government employee (civil servant) ☐ Merchant ☐

Unemployed ☐ Other (please specify)________________

6. What is your current marital status (tick one)

Married ☐ Divorced ☐

Single ☐ Widowed ☐ Others (please specify)________________

## Part Two - Counselors' Professional Skills

**Instruction:** Please put tick mark (✓) where your response with a respect to each statement in only one of the two (i.e Yes and No) choices.

| No. | Skill | Response | |
|---|---|---|---|
| | | **Yes** | **No** |
| 1 | Greets me | | |
| 2 | Introduce self | | |
| 3 | Engages me in conversation | | |
| 4 | Listens actively both verbally and non verbally | | |
| 5 | Is supportive and non judgmental | | |
| 6 | Uses appropriate balance of open and closed questions | | |
| 7 | Uses silence well to allow for self expression | | |
| 8 | Seeks clarification about information given | | |
| 9 | Avoids premature conclusion | | |
| 10 | Probes appropriately | | |
| 11 | Summarizes main issues discussed | | |
| 12 | Gives information in clear and simple terms | | |
| 13 | Gives me time to absorb information and to respond | | |
| 14 | Has up-to-date knowledge about HIV | | |
| 15 | Repeats and reinforce important information | | |
| 16 | Summarize main issue | | |
| 17 | Accommodate language difficulty | | |
| 18 | Talks about sensitive issues plainly and appropriate to the culture | | |
| 19 | Uses silences well to deal with difficult emotions | | |
| 20 | Priorities issues to cope with limited time in short contacts | | |
| 21 | Is innovative in overcoming constraints | | |
| 22 | Mange clients distress/reaction | | |
| 23 | Flexible in involving partner or significant other | | |

## Part Three - Counseling Contents

**Instruction:** Indicate your responses with a tick mark (✓) on the space provided

**Pre-test counseling** (During the session the following occurred)

| No. | Items | Response | |
|---|---|---|---|
| | | Yes | No |
| 1 | Reason for attending discussed | | |
| 2 | Knowledge about HIV and modes of transmission explored | | |
| 3 | Misconceptions corrected | | |
| 4 | Information concerning the process of HIV testing given | | |
| 5 | Assessment of personal risk profile carried out | | |
| 6 | Discussion of possible test results and meaning of HIV positive and negative results | | |
| 7 | Capacity to cope with HIV positive results discussed | | |
| 8 | Discussion of potential needs and available support | | |
| 9 | Discussion of personal risk reduction plan | | |
| 10 | Time allowed to think through issues | | |
| 11 | Informed consent/dissent given freely | | |
| 12 | Follow-up arrangements discussed | | |
| 13 | Adequate time for question and clarification given | | |

## Part Four: Post test counseling

**Instruction:** Indicate your responses with a tick mark (✓) on the space provided

**Post-test counseling** (During the session the following occurred)

| No. | Items | Response | |
|---|---|---|---|
| | | Yes | No |
| 1 | Result given simply and clearly | | |
| 2 | Time allowed for the results to sink in | | |
| 3 | Checking for understanding | | |
| 4 | Discussion of the meaning of the result for me/partner | | |
| 5 | Discussion of personal, family and social implications including who, if any to fell | | |
| 6 | Discussion of a personal risk reduction plan | | |
| 7 | Dealing with immediate emotional reactions | | |
| 8 | Checking availability of immediate support | | |
| 9 | Discussion of the HIV/AIDS policy | | |
| 10 | Discussion of follow-up care and support | | |
| 11 | Options and resources identified | | |
| 12 | Immediate plans, intentions and actions reviewed | | |
| 13 | Follow-up plan discussed | | |
| 14 | Referrals discussed when necessary | | |

15. Other issues discussed (if yes, please specify)

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

# Appendix (A)

## በአዲስ አበባ ዩኒቨርሲቲ
## የድህረ ምረቃ ትምህርት መርሐ ግብር
## ሳይኮሎጂ ትምህርት ክፍል

## መጠይቅ

## ኮድ (01)

በፈቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ አገልግሎት ለማግኘት በመጡ የአገልግሎቱ ተጠቃሚዎች የሚሞላ፤

**ዓላማ:-** የዚህ መጠይቅ ዋና ዓላማ በድሬዳዋ ከተማ በሚገኙና ለናሙና በተመረጡ በፍቃደኝነት ላይ የተመሠረተ የምክር (የካውንስሊንግ)ና የምርመራ አገልግሎት መስጪያ ጣቢያዎችን የምክር (የካውንስሊንግ) አገልግሎት አሰጣጥ ሂደት፣ የካውንስለሩን የካውንስሊንግ አገልግሎት አሰጣጥ ክህሎቶችን (counseling skills)፣ የካውንስሊንግ አገልግሎቱን ይዘት (counseling contents) እና የካውንስሊንግ አገልግሎቱ ተጠቃሚዎች አገልግሎቱን በማግኘት ረገድ የሚያጋጥማቸውን ችግር ለማጥናት የሚያስችል መረጃ ለመሰብሰብ ነው::

- ይህ ጥናት ስኬታማ ሊሆን የሚችለው ሁሉም የመጠይቁን ጥያቄዎች በቅንነትና በግልፅነት ሲመልሱ ብቻ ነው::
- በዚህ መጠይቅ አማካኝነት የሚወሰደው መረጃ ሁሉ ለዚህ ጥናት ሥራ ብቻ የሚውል ይሆናል:: ስለዚህ መልሶቻችሁን በግልፅነትና በታማኝነት እንድትሰጡ እጠይቃለሁ:: የምትሰጧቸው መልሶች በሙሉ በሚስጥርነት ይያዛሉ::
- ለምርምሩ ውጤት ደግሞ ተጠያቂ አይሆኑም::
- ስማችሁን በየትኛውም የመጠይቁ ገፅ ላይ መፃፍ አያስፈልግም::

በቅድሚያ ስለትብብራችሁ በጣም አመሠግናለሁ::

## ክፍል አንድ - የግል መረጃ

**መመሪያ:-** ከዚህ በታች ስለግልዎ አጠቃላይ መረጃ የሚጠይቁ ጥያቄዎች ተዘርዝረዋል:: ለተወሰኑት ጥያቄዎች አስፈላጊውን መልስ በተሰጠው ክፍት ቦታ ላይ ይምሉ፤ በምርጫ መልክ ለቀረቡት ጥያቄዎች ደግሞ መልስዎን ትክክለኛ ነው የሚሉትን አማራጭ ፊደል በማክበብ ይመልሱ::

1. በፍቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ አገልግሎት መስጫ ጣቢያው ስም ____________________
2. ዕድሜ____________________
3. ፆታ ሀ/ ሴት ለ/ ወንድ
4. የትምህርት ደረጃ ሀ/ ያልተማረ/ች ለ/ የመጀመሪያ ደረጃ (ከ1ኛ - 8ኛ ክፍል) ሐ/ ሁለተኛ ደረጃ (9-10, 11-12) መ/ በኮሌጅ ደረጃ

5. ሥራ ሀ/ ተማሪ ለ/ የመንግሥት ተቀጣሪ/ሠራተኛ ሐ/ ወታደር
መ/ ነጋዴ ሠ/ የቤት እመቤት ረ/ ሥራ አጥ
ሰ/ ሌላ ከሆነ ይግለፁ______________

6. የጋብቻ ሁኔታ
ሀ/ ያገባ/ች ለ/ ያላገባ/ች ሐ/ በፍቺ የተለየ/ለየች
መ/ በሞት የተለየ/የች መ/ ሌላ ከሆነ ይግለፁ______________

## ክፍል ሁለት

***መመሪያ:-*** ከዚህ በታች በፍቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ አገልግሎት ሰጪውን ሙያዊ ክህሎት (professional skills) የሚመለከቱ አረፍተ ነገሮች ተዘርዝረዋል:: እርስዎም አርፍተ ነገሮቹን በጥሞና ካነበቡ በኋላ በተሰጠዎት አገልግሎት ወቅት ከዚህ በታች የተዘረዘሩት ተገልፀው/ተንፀባርቀው ከሆነ በግል ሃሳብዎ መሠረት ከተሰጡት ሁለት አማራጮች መካከል ትክክለኛውን ይምረጡ:: ምርጫዎንም በዚህ (✓) ምልክት ያሳዩ::

| ተ.ቁ | የካውንስለርን ሙያዊ ክህሎት የሚገልፁ አረፍተ ነገሮች | መልስ | |
|---|---|---|---|
| | | አዎ | አይደለም |
| 1 | ከመቀመጫ በመነሳት እጅን በመጨበጥ በአክብሮት መቀበል | | |
| 2 | ስለራስ ማንነት በግልፅና በሚገባ ማስተዋወቅ | | |
| 3 | እኔን በማረጋጋት ወደ ውይይቱ እንድገባ ሁኔታዎችን ማመቻቸት | | |
| 4 | የሰውነቴን እንቅስቃሴ በንቃት መከታተልና በጥሞና ማዳመጥ | | |
| 5 | በኔ ጉዳይ ራሴ እንድወስን ማበረታታትና በኔ ውሣኔ ላይ ጣልቃ ያለመግባት | | |
| 6 | በውይይታችን ወቅት ከቀረቡልኝ ጥያቄዎች ውስጥ ምርጫ ያላቸውና ምርጫ የሌላቸው ጥያቄዎች በቁጥር ተመጣጣኝ ነበሩ:: | | |
| 7 | ራሴን የመግለፅ ዕድሉ እንዲኖረኝ ጊዜ መስጠትን እንደአማራጭ ዘዴ መጠቀም | | |
| 8 | ለተሰጠኝ መረጃዎች ተጨማሪ ማብራሪያ መስጠት | | |
| 9 | ቸኩሎ ድምዳሜ ላይ ያለመድረስ | | |
| 10 | እንድናገርና ሃሳቤን ያለፍርሃት እንድገልፅ ማደፋፈር/ማነሳሳት | | |
| 11 | የተወያየንባቸውን ቁልፍ ነጥቦች በማጠቃለል ግልፅ ማድረግ | | |
| 12 | የተሰጡኝን መረጃዎች በግልፅ እንድረዳ በሚገባኝ ቋንቋ በግልፅ ማስረዳት | | |
| 13 | የተሰጠኝን መልዕክት/መረጃ በሚገባ ተረድቼ መልስ እንድሰጥ በቂ ጊዜ መስጠት | | |
| 14 | ስለኤች አይ ቪ/ኤድስ በቂ መረጃና ግንዛቤ/እውቀት አለው/አላት | | |
| 15 | ጠቃሚ የሆኑ መረጃዎችን ደጋግሞ መናገርና ማበረታታት | | |
| 16 | የውይይቱን ፍሬ ሃሳብ በተመለከተ ማጠቃለያ መስጠት | | |
| 17 | የቋንቋ ችግር እንዳይኖርና መግባባት እንዲፈጠር ለቋንቋ ልዩ ትኩረት መስጠት | | |

| ተ.ቁ | የካውንስለርን ሙያዊ ክህሎት የሚገልፁ አረፍተ ነገሮች | መልስ | |
|---|---|---|---|
| | | አዎ | አይደለም |
| 18 | ለባሕላዊና ኃይማኖታዊ ጉዳዮች ጥንቃቄ ማድረግና በግል ጉዳዮች ላይ የሚደረጉ ውይይቶች ሙያውን ያገናዘቡ መሆን | | |
| 19 | አስቸጋሪና ስሜታዊ የሆኑ ጉዳዮች ሲያጋጥሙ በትዕግሥት ለመፍታት መሞከር | | |
| 20 | ቅድሚያ የሚሰጣቸውን ጉዳዮች የግንኙነት ጊዜን በማሳጠር ቶሎ ለመፍታት መሞከር | | |
| 21 | ችግሮችን ለመፍታት እንዲቻል አዲስ አማራጭ የማመንጨት ችሎታ | | |
| 22 | አለመረጋጋት ሲፈጠር ባፋጣኝ የተፈጠረውን ችግር ለመፍታት ጥረት ማድረግ | | |
| 23 | እንደአስፈላጊነቱ ጠቀሜታ ሊኖራቸው የሚችሉ ግለሰቦችንም ሆነ አካላትን በጉዳዩ ውስጥ ለማካተት ፍቃደኛ መሆን | | |

## ክፍል ሶስት

***መመሪያ:-*** ከዚህ በታች በፍቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ አገልግሎት ለማግኘት በሚሄዱበት ጊዜ በቅድመ ምርመራ የምክር አገልግሎት (pre-test counseling) ወቅት በምክር አገልግሎት ሰጪው ሊነሱ የሚገባቸው ጉዳዮች ተዘርዝረዋል፡፡ እርስዎም አረፍተ ነገሮቹን በጥሞና ካነበቡ በኋላ በቅድመ ምርመራ የምክር አገልግሎቱ ወቅት ጉዳዮቹ መነሳት ያለመነሳታቸውን ከተሰጡት ሁለት አማራጮች መካከል በዚህ (✓) ምልክት ያሳዩ፡፡

| ተ.ቁ | በቅድመ ምርመራ የምክር አገልግሎት ወቅት ሊካተቱ የሚገባቸው ጉዳዮች | መልስ | |
|---|---|---|---|
| | | አዎ | አይደለም |
| 1 | ወደ ደም ምርመራው ሊመጣ የሚቻልባቸውን ዋና ዋና ምክንያቶች በማንሳት ውይይት ተደርጓል፡፡ | | |
| 2 | ስለኤች አይ ቪ/ኤድስና የመተላለፊያ መንገዶቹ ውይይት ተደርጓል፡፡ | | |
| 3 | ስለኤች አይ ቪ/ኤድስ የተዛቡና የተሳሳቱ አመለካከቶች ማስተካከያ ተደርጐባቸዋል፡፡ | | |
| 4 | ስለኤች አይ ቪ/ኤድስ የምርመራ ሂደቶች በቂ መረጃ ተሰጥቷል፡፡ | | |
| 5 | ለኤች አይ ቪ ቫይረስ ሊያጋልጠ የሚችሉ ባሕርያትን ለይቶ ለማውጣት ተሞክሯል፡፡ | | |
| 6 | የደም ምርመራው ውጤት ምን ሊሆን እንደሚችልና ኤች አይ ቪ ፖዘቲቭና ኤች አይ ቪ ኔጌቲቭ ማለት ምን ማለት እንደሆነ ተብራርቷል፡፡ | | |
| 7 | ኤች አይ ቪ ፖዘቲቭ/ኔጌቲቭ ውጤትን ለመቀበል የሚያስችል አቅምን በተመለከተ ውይይት ተደርጓል፡፡ | | |
| 8 | ሊኖሩ ስለሚችሉ ድጋፎች ማለትም የጤና፣ የማህበራዊ፣ የሥነ ልቦናዊና የኢኮኖሚያዊ ድጋፎች ማብራሪያ ተሰጥቷል፡፡ | | |
| 9 | ያሉትን ሥጋቶች/አደጋዎች ለመቀነስ የሚያስችል የግል ዕቅድ ማውጣትን በተመለከተ ውይይት ተደርጓል፡፡ | | |
| 10 | በጉዳዮቹ ዙሪያ በጥልቀት ማሰብ እንዲቻል በቂ ጊዜ ተሰጥቷል፡፡ | | |
| 11 | የደም ምርመራ ውጤቱን በተመለከተ በምን መልኩ ሲነገር እንደሚያስፈልግና ለማን ሊነገር እንደሚፈለግ በግልፅ ውይይት ተደርጓል፡፡ | | |
| 12 | ከደም ምርመራ ውጤቱ በኋላ ሊኖር ስለሚችል የክትትልና ግንኙነት ሥርዓት ንግግር ተደርጓል፡፡ | | |
| 13 | ለጥያቄና ለተጨማሪ ማብራሪየ በቂ ጊዜ ተሰጥቷል፡፡ | | |

## ክፍል አራት

***መመሪያ:-*** ከዚህ በታች በፍቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ (post-test counseling) አገልግሎት ካገኙ በኋላ ውጤቱን ለመስማት በሚሄዱበት ጊዜ በድህረ ምርመራ የምክር አገልግሎት ወቅት በምክር አገልግሎት ሰጪው ሊነሱ የሚገባቸው ጉዳዮች ተዘርዝረዋል፡፡ እርስዎም አርፍተ ነገሮቹን በጥሞና ካነበቡ በኋላ በድህረ ምርመራ የምክር አገልግሎቱ ወቅት ጉዳዮቹ መነሳት ያለመነሳታቸውን ከተሰጡት ሁለት አማራጮች መካከል በዚህ (✓) ምልክት ያሳዩ፡፡

| ተ.ቁ | በድህረ ምርመራ የምክር አገልግሎት ወቅት ሊካተቱ የሚገባቸው ጉዳዮች | መልስ | |
|---|---|---|---|
| | | አዎ | አይደለም |
| 1 | የደም ምርመራ ውጤቱ ግልፅ በሆነና ሊገባ በሚችል መልኩ ተነግሯል፡፡ | | |
| 2 | የደም ምርመራ ውጤቱ በሚሰማበት ወቅት መረጋጋት እንዲቻል በቂ ጊዜ ተሰጥቷል፡፡ | | |
| 3 | የደም ምርመራ ውጤቱን ምንነት በሚገባ መረዳቴን ለማረጋገጥ ጥረት ተደርጓል፡፡ | | |
| 4 | በደም ምርመራ ውጤቱ ምንነት ትርጉም ዙሪያ ከእኔ፣ ከቤተሰቤና ከፍቅር ጓደኛዬ ጋር ውይይት ተደርጓል፡፡ | | |
| 5 | የደም ምርመራ ውጤቱ በግል፣ በቤተሰብና በማህበረሰቡ ላይ ሊያሳድር የሚችለውን ተፅዕኖ እንዲሁም የደም ምርመራ ውጤቱ ለማን እንዲነገርልኝ እንደምፈልግና የመነገሩን ጠቀሜታ በተመለከተ ውይይት ተደርጓል፡፡ | | |
| 6 | ያሉትን አደጋዎች መቀነስ እንዲቻል ሥጋቶችንና አደጋዎችን መቀነስ የሚያስችል የግል ዕቅድ ማውጣትን በተመለከተ ውይይት ተደርጓል፡፡ | | |
| 7 | በድንገት የሚፈጠሩ የስሜት መቀያየርና መረበሽን ለመፍታት ጥረት ተደርጓል፡፡ | | |
| 8 | በወቅቱ ያሉትን የድጋፍ አማራጮችን ለማጣራት ጥረት ተደርጓል፡፡ | | |
| 9 | ስለኤች አይ ቪ/ኤድስ ፖሊሲ መረጃ እንዲኖረኝ ተደርጓል፡፡ | | |
| 10 | ወደፊት ሊኖር ስለሚችል ክትትል፣ ድጋፍና እንክብካቤ ውይይት ተደርጓል፡፡ | | |
| 11 | ያሉ የድጋፍ አማራጮች ተለይተዋል ያሉት ድጋፎችም ምን ዓይነት ድጋፎች እንደሆኑም ተለይቷል፡፡ | | |
| 12 | ዕቅዶች፣ ዕቅዶችን የማስፈፀም ሂደቶችና ሊከናወኑ የሚገቡ ተግባሮች ተፈትሸዋል፡፡ | | |
| 13 | የክትትል ዕቅድና በተመለከተ ውይይት ተደርጓል፡፡ | | |
| 14 | እንዳስፈላጊነቱ ከጉዳዩ ጋር አግባብ ካላቸው ግለሰቦችም ሆነ አካላት ጋር እንዴት መገናኘት እንደሚቻል ውይይት ተደርጓል፡፡ | | |

15. ከላይ ከተገለፁት ውጪ ውይይት የተደረገባቸው ጉዳዮች ካሉ ይገለፁ፡፡

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# Appendix (B)

## Addis Ababa University
## Post Graduate Studies
## Department of Psychology

## Code (02)

**For Counselors:**

**Objective:-** This study is aimed at assessing the counseling services rendered in selected VCT centers of Dire Dawa Town.

The information to be obtained here is going to be used only for the study undertaking. Therefore, your cooperation by giving genuine information is highly valuable to complete the study. All information you provide will be treated as confidential.

***Thank you in advance for your cooperation***

### Personal data

1. Name of VCT center ____________________

   Woreda ______________ Kebele ______________

2. Age ________

3. Sex ________

4. What was your profession before you become a counselor (tick one).

   Nurse ☐ Health assistance ☐ Health officer ☐

   Sociologist ☐ Psychologist ☐ Physician ☐

   Other (please specify) __________________________

5. What is your educational background? (tick one)

   Primary ☐ Secondary ☐ Tertiary ☐

   Other (please specify)____________________________________

6. Total years of experience in serving as VCT counselor? (tick one)

   Less than one year ☐ Two years ☐

   One year ☐ Three years ☐

   - If more than three years please specify__________________________

7. How many days per week do you do counseling? (tick one)

One day ☐ four days ☐ seven days ☐

Two days ☐ five days ☐

three days ☐ six days ☐

8. Do all clients get service on the first day they come?

Yes ☐ No ☐

9. If "No" is your answer for question number "8" please mention the reason

______________________________________________

______________________________________________

10. Does the VCT service provide freely?

Yes ☐ No ☐

11. How many clients do you see per day? (in average)

5 and less than ☐ 6 – 10 ☐ 11 – 15 ☐ 16 – 20 ☐

If more than 20 please specify______________________________

12. Have you ever been trained in HIV counseling?

Yes ☐ No ☐

13. If your answer is "yes" for question number "12" name the organization that provide you the training______________________________

______________________________________________

14. Do you have an access to refer HIV positive clients to care and support services?

Yes ☐ No ☐

15. If your response is "yes" for question number "14" please list down the names of the organization to which you refer HIV positive clients for care and support services

______________________________________________

______________________________________________

______________________________________________

# Appendix (C)

## Interview for counselors

## Interview Guide

## Code (03)

1. Which professional background do you think is very helpful to apply counseling principles at VCTs? Why?
2. Have you ever been faced challenging cases in rendering HIV/AIDS counseling?
    - If "Yes" what kind of case you have encountered?
    - Have you handled the case?
    - What limitation do you think that you have in applying counseling principles for HIV/AIDS counseling?
    - Any suggestion regarding the application of counseling principles for HIV counseling?
3. Do you apply counseling theories and techniques?
4. If "Yes": which counseling theory do you usually apply for HIV/AIDS counseling?
5. The specific techniques of the theory you usually use?
6. The reasons for your choice of the theory along with it's specific technique?
7. Have you been encountered with some problems in your counseling work? If yes mention those problems you faced in the process of rendering VCT service?
8. Do you have an access to a counseling Director/Supervisor to provide you the necessary support like budget, training facilities, technical and emotional support and supervise your work? How often?
9. Do you have an access to get HIV/AIDS counseling manuals, guidelines and HIV/AIDS policy?

# Appendix (D)

## Interview for VCT Director/Coordinator

## Interview Guide

## Code (04)

1. What is your significance role in VCT?
2. Would you mention the support that you provide for the counselor? Do you think the support is adequate? If not what do you think could be improved?
3. Would you briefly discuss about in-service/training that you gave to your counselor?
4. Describe the linkage that you have with other VCT centers?
5. What are the constraints the counselors faced in rendering quality services in your VCT center?
6. Do you think that your VCT center have adequate facilities like budget, equipment, vehicles, etc? Mention the facilities that have in your VCT center?
7. Do you have an access to get HIV/AIDS counseling manuals, guidelines and HIV/AIDS policy?
8. What do you suggest for the betterment of counseling services in your VCT center?
9. Would you comment about the counseling services in your VCT center?

# Appendix (E)

## Observation of the VCT centers

## Point of observation

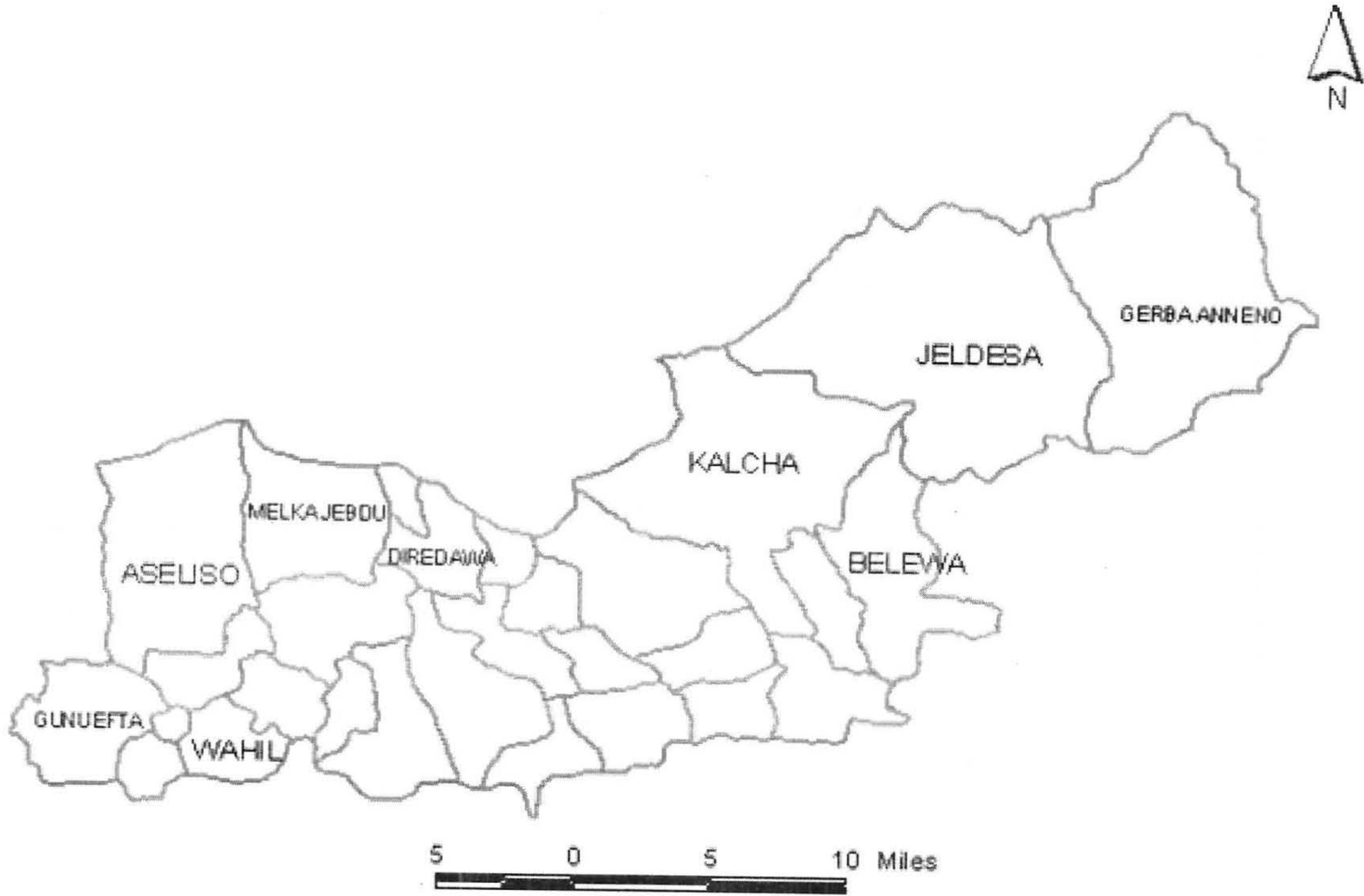
## (Code 05)

1. Place of the counseling room in the compound
2. The size of the counseling room
3. Sitting arrangement
4. Arrangement of psychological setting (destructors) from in and out of the room.
5. Contents of the counseling protocol.
6. Ensuring confidentiality (filing and keeping records)

# Appendix (F)

## Focus group discussion guide
## (Code 06)

1. What are the major HIV/AIDS counseling activities? Who are the target groups of HIV/AIDS counseling?
2. Do you think the community knows the availability and accessibility of the VCT service of your organizations?
3. What are the major problems encountered by the VCT counselors? How could these problems be resolved?
4. What are the prospects of the VCT counseling service?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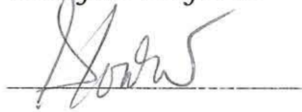
## *DECLARATION*

*I the undersigned, declare that this Thesis is my original work and has not been presented for a Degree in any other universities and that all sources of materials used for the Thesis have been duly acknowledged.*

*Name:* Mesfin Dejene

*Signature*



*Date of submission* 09/07/07

*This Thesis has been submitted for examination under my approval as a research advisor.*

*Name* YUSUF O. Abdi

*Signature*

*Date* July 9/2007