Status Survey of Voluntary HIV Counseling and Testing and Posttest Services Provided by Mojo Municipality HIV/AIDS Committee

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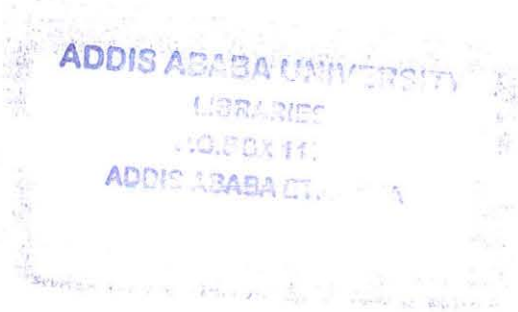

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Table of Contents

Contents **Page**

Acknowledgement ----------I

Table of contents ----------II

List of Tables ----------VI

Abbreviations and Acronyms----------VII

Abstract----------IX

CHAPTER ONE

1. INTRODUCTION

1.1. The Problem and Its Background ----------1

1.2. Statement of the Problem---------- 4

1.3. Objectives of the Study----------5

1.3.1 Specific Objectives----------6

1.4. Significance of the Study----------6

1.5. Delimitation of the Study----------7

1.6. Limitation of the study----------8

1.7. Operational Definition of Terms----------8

1.8. Organization of the Study----------8

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE----------9

2.1. The Impact of HIV/AIDS----------9

2.2. Voluntary HIV Counseling and Testing----------9

2.2.1 Definition of Voluntary HIV Counseling and Testing----------9

2.2.2. VCT Service Models----------10

2.2.2.1 Standalone VCT Centers ----------10

2.2.2.2 Integrated VCT Centers ----------10

2.2.3 Facilities of Voluntary HIV Counseling and Testing Center ----------11

2.2.4 Development of VCT and Posttest Services----------11
2.2.5. Voluntary HIV Counseling and Testing (VCT) Protocol------12
2.2.5.1 Pretest Counseling Session ----------13
2.2.5.2 Post test Counseling Session----------14
2.5.6 The Testing Component of VCT Service----------15
2.2.7 Counselor's Training----------16
2.3. Posttest Services----------16
2.3.1. Ongoing Counseling----------16
2.3.2 Psychosocial Support ----------17
2.3.3 Economic Assistance ----------19
2.3.4 Medical care ----------20
2.3.5. Home-Based Care ----------21
2.3.6. Legal and Ethical Services----------23
2.4. VCT and Posttest Services in Ethiopia----------24
2.4.1. VCT. Service in Ethiopia ----------24
2.4.2. Posttest services In Ethiopia----------25
2.5 VCT and Posttest Services in Mojo Town----------27
2.6 Sustainability of Care and Support Project----------28

CHAPTER THREE

3. METHOD AND DESIGN OF THE STUDY----------29
3.1. Method----------29
3.2. Study Area (site)----------29
3.3 Participants of the Study----------30
3.4. Tools of Data Collection / Instruments----------31
3.4.1 The Questionnaires----------31
3.4.2 Focus Group Discussion----------32
3.4.3 Interview----------32

3.5. Procedure of data collection----------33
3.6. Methods of Data Analysis----------34
3.6.1 Standards used to assess VCT service----------34
3.6.2 Standards Used to Assess Posttest Services----------38
3.6.3 Statistical Method Used----------40

CHAPTER FOUR

4. RESULTS ----------41

4.1 The characteristics of the participants of the study----------41
4.1.1 The Characteristics of the PLWHAs----------41
4.1.2. The Characteristics (Back Ground) of the Counselors---------43
4.2 List of Services----------43
4.3.Result of Data Collected on VCT Service----------45
4.3.1 Results of Data Collected from PLWHAs----------45
4.3.2 Result of data Collected from the VCT Counselors on VCT Service----------54
4.3.2.1 Problems Encountered by the Counselors---------57
4.4 Result of Data Collected on the VCT Center From the Implementers of the Project ----------58
4.5. Results of Data Collected on Posttest Services ----------60
4.5.1 Result of Data Collected from the PLWHAs on Posttest Services----------60
4.5.2 Result of Data Collected From the PLWHAs by Focus Group Discussion on Posttest Service ----------64
4.6 Result of Data Collected on Posttest Services from the Implementers ----------67
4.7. Result of Data Collected on Sustainability of Care and Support Project ----------70
4.7.1 Result of Data Collected on Sustainability from the PLWHAs ----------70

4.7.2 Result of Data Collected on Sustainability from PLWHA Group Discussants.----------72
4.7.3 Result of Data Collected from the Implementers on Sustainability of the Project.----------73

CHAPTER FIVE

5. DISCESSION OF THE RESULTS----------77

CHAPTER SIX

6. SUMMAY, CONCLUSIONS AND RECOMMANDATIONS--89

6.1 Summary ----------89
6.2 Conclusions----------94
6.3 Recommendations----------96
References ----------99
Appendix----------103

List of Tables

page

Table 3.1 Type and number of participants of the study ----------30

Table 4.1 Socio-demographic Characteristics of the PLWHAs. Mojo, Feb., 2006.---------- 42

Table 4.2 Responses of the PLWHAs Regarding Services Provided by the project. Feb., 2006.----------44

Table4.3 Responses of the PLWHAs to Items that Refer to VCT Center of the Project.----------45

Table 4.4 Responses of the PLWHAs Regarding the VCT Service Offered by the Project. Feb., 2006.----------46

Table 4.5 Responses of the PLWHAs Regarding the Counseling Skills Employed by the Counselors. ----------47

Table4.6 Responses of the PLWHAs Concerning Contents Discussed in Pretest Counseling Session.----------49

Table 4.7 Responses of the PLWHAs Regarding Contents Discussed in Posttest Counseling Session----------52

Table 4.8 Responses of the PLWHAs to the Financial Support----------61

Table 4.9 Responses of the PLWHAs to the Psychosocial support----------62

Table.4.10 Response of AIDS patients who are provided with Home-Based care to the Home-Based care they are Provided. Feb, 2006. (n = 26)----------63

Table 4.11. Response of the PLWHAs Concerning the Sustainability of the Project ----------70

Abbreviations and acronyms

AIDS	Acquired Immune deficiency syndrome
ANC	Antenatal Clinics
CDC	Center for Disease Control and Prevention
CRDA	Christian Relief and Development Association
FGD	Focus Group Discussion
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NGO	Non Governmental Organization
GO	Governmental Organization
OI	Opportuntic Infections
PLWHA	People Living With HIV/AIDS
PYO	Per year of Observation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nations Joint Program on HIV/AIDS
VCT	Voluntary HIV Counseling and Testing for
WHO	World Health Organization
SC	Save the Children USA
IOM	International Organization for Migration
EPHA	Ethiopian Public Health Association
TASO	The AIDS Support organization
FOCUS	Families Orphans and Children Under Stress.
OHAPCO	Oromiya HIV/AIDS Prevention and Control Office
ZAPSO	Zimbabwe AIDS Prevention and Support Organization
IGA	Income Generating Activities
CBO	Community Based Organization

FBO	Faith Based Organizations
GPA	Global AIDS Program
NAC	National AIDS Council
CHA	Community Health Agents
TBA	Traditional Birth Attendants
GIPA	Great Involvement of People Living with HIV/AIDS
GFRE	Government of the Federal Democratic of Ethiopia

Abstract

The main purpose of this study was to assess the status of Voluntary Counseling and Testing (VCT) and posttest services provided by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children USA. Moreover, 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. The study also focused on exploring whether the posttest services provided to the PLWHAs were in line with the standards formulated by Ministry Of Health (MOH) and agreed by the donor (SC) and the implementer (Mojo Muncipality HIV/AIDS Committee) .

A total of 100 purposefully selected subjects participated in the study. Among this participants 77, 3, 20, were PLWHAs, counselors and service providers respectively. Questionnaires were prepared based on VCT protocol and posttest services standards developed by UNAIDS and MOH. The questionnaires were administered to the selected PLWHAs and counselors. Interview and Focus Group Discussions were also held with selected service providers, key informants and PLWHAs.

According to the finding of this study, counseling skills demonstrated by the counselors and contents of counseling discussed between the client and the counselor in the VCT center under investigation found to be in accordance with standards of VCT protocol.

To the results of this study, financial support, psychosocial support and home-based care were provided by the project. However, on going counseling, medical care and legal and ethical services were not provided.

The financial support decreased by 10% than the two parties agreed to provide. This endangered the sustainability of the project. The Humanitarian support provided on monthly bases seems led the PLWHAs to developed dependency.

The psychosocial support provided in group helped PLWHAs to counter isolation and enabled them to developed self-confidence. According to the results of the study, home-based care provided raised the awareness of the community. Referral services, material distribution and providing support to the PLWHAs by training their own caregivers, were not given the necessary attention.

Finally, recommendations were forwarded to minimize the problems and help to effectively implement the project.

CHAPTER ONE

1. INTRODUCTION

This chapter focuses on the problem and its background. It includes statement of the problem, main and specific objectives of the study and significant of the study.

1.1 The Problem and Its Background

In the last two decades HIV/AIDS has been spread throughout the world. The cumulative number of HIV infected people world wide is estimated, about 64.8 million, death due to AIDS 24.8 million and people living with HIV/AIDS 40 million.

The cumulated numbers of sub-Saharan Africa is estimated as follows

- Infected by HIV 42.5 million
- Death due to AIDS 17.2 million (79% of the world death due to AIDS)
- Living with HIV/AIDS 28.1 million
- Death of children under 15 years of age is 2 million
- Orphans by AIDS at age of 14 years/younger 12.1 million
- New infection in a day 15,000/MOH, 2003 /

The cumulative number of people living with HIV/AIDS in 2003 in Ethiopia is 1.5 million out of which about 96,000 are children under 15 years. There were also 197,000 new infections. The estimated number of new AIDS cases in the adult population was 98,000 while the estimated new AIDS case in children was about 25,000. In the same year some 90,000 adults and 25,000 children had died of AIDS. Among ANC attendants 128,000 were HIV positives and 35,000 HIV positive children were born. There were also 537,000 children under 17 who were orphans by HIV/AIDS (MOH, 2004).

In response to this Voluntary counseling and testing (VCT) has been increasingly accepted as one and the first of the main prevention intervention strategies to curb the spread of HIV infection and related problems. This is because knowledge of HIV status is the only way that enables one to take measures to remain negative if his/her test result is negative or to be able to live longer and happier life with HIV if his/her test result indicates he/she is HIV positive. Thus VCT programs are designed to provide easy access to HIV testing through an approach that emphasizes informed consent pre and post test counseling and referral to (follow up) posttest services (Dillon, et. al. 2002). To adhere to these some VCT service providers organize posttest services and some others create linkage with organizations that provide services emphasizing the importance of being able to offer support to people, especially to those whose test results are positive which in turn attracts more clients (UNAIDS, 2000, and UNAIDS, 2002).

Such a support needs to be comprehensive and integrated (VCT along with posttest service) to satisfy the diverse and changing needs of persons living with HIV/AIDS (Marlink, Tarantala , and Ramanathan , 2002, & UNAIDS, 2000).

These comprehensive services include:

- Voluntary HIV counseling and testing
- Ongoing counseling
- Psychosocial support
- Medical care
- Financial support
- Home-base care
- Legal and Ethical support (MOH, 2002 & Marlink, Tarantala, and Ramanathan, 2002).

The importance of providing posttest services based on the VCT result was also emphasized by Helen Jackson. She says,

> *"... the services (VCT) provide a meaningful entry point to a continuum of care, and are not seen as an end in themselves. There is little point in testing people if they have no support to cope with infection or to remain negative. HIV positive and HIV negative people need opportunities for ongoing encouragement and support after being tested (2002).*

In Ethiopia the importance of these strategies was recognized and included in the HIV/AIDS policy of 1998 (FDRE, 1998) and the Five years Strategic framework for the national response to HIV/AIDS from 2001-2005 (NAC, 2001). In addition to setting up VCT centers, and providing posttest services in collaboration with other NGOs, MOH creates conditions that pave the way for the involvement of NGOs and private sectors to enable them provide these services. Several national level training were also conducted to increase their capacity of providing the services (MOH, 2000, & MOH 2003). VCT and Home-based care guidelines (MOH, 2002 & MOH, 2001) and VCT counselors training manual (MOH, 2003) were also prepared.

Given this intensity of activities, it was learnt that VCT is the least researched intervention areas related to HIV/AIDS. Of all (325) researches conducted on HIV/AIDS, Only 3.4% of them were focused on VCT, While 83 (25.60%) of them dealt with posttest services (care, support and treatment of PLWHAs). In order of priority, VCT was indicated as number one and posttest services were found to be fourth priority areas among researches related to HIV/AIDS. Of the total (11) VCT related researches none of them was conducted on status of VCT and posttest services (EPHA, 2005). Thus this survey study was designed

to assess the status of VCT and posttest services provide by Mojo Municipality HIV/AIDS Committee in collaboration with Save the Children/USA.

The project to be assessed is care and support project which has been implemented in Mojo town since 2003. It is part of SC/USA which aimed at reducing the transmission of HIV/AIDS along the Ethiopia/Djibouti transport corridors routes, which was identified as one of the principal sources for the spread of HIV/AIDS in African, by increasing HIV/AIDS Prevention practices as well as by increasing the demand, accessibility, availability and quality of the services to the project targets (commercial sex workers, truckers, trucking assistants, port workers, logistic staff, mechanics and others associated with the transport of goods and materials along the transport corridors).

1.2 Statement of the Problem

The HIV and AIDS epidemics have became the sources 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 epidemic is to use information, education and communication (IEC). When this (IEC) is backed up by VCT and other posttest services curbing the course of the epidemic becomes real.

In Ethiopia access to VCT service, which has linkage with posttest services, is limited. The available ones are not also explored to improve the qualities of the services they offer. Assessing VCT and posttest services to ensure the qualities of the service they offer, therefore, is essential to create and increase the demand for VCT service.

Based on this rationale, the present study was undertaken to assess the status of VCT and posttest services offered by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children USA. To this end the following research questions were raised.

1. Are skills demonstrated, contents discussed in VCT center organized by Mojo Municipality and Save the Children USA go along with the standards of VCT protocol?
2. Is the financial support provided in line with the agreement made between the donor and the implementer?
3. Is the psychosocial support up to the standards set by MOH?
4. Is the home-based care provided in accordance with the standard set by MOH?
5. Is ongoing counseling provided enough to enable the PLWHAs positively live with the virus?
6. Is the medical care provided enough to prevent diseases that hasten the progression of HIV to AIDS?
7. Are legal and ethical services provided to the PLWHAs up to the standards set by MOH?
8. Is the care and support project sustainable?

1.3 Objectives of the Study

The main objective of this study is to investigate the status of VCT and Posttest Services provided by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children USA.

1.3.1 Specific Objectives

1. To explore the extent to which counseling skills demonstrated and contents discussed at the VCT center organized by Mojo Municipality and Save the Children USA go along with the standards of the VCT protocol.
2. To investigate the extent to which the financial support provided is in line with the agreement made between the donor and the implementer.
3. To assess whether the psychosocial support is up to the standards set by MOH or not.
4. To examine whether the home based care provided is in accordance with the standard or not.
5. To investigate the extent to which ongoing counseling helped PLWHAs positively live with the virus.
6. To explore whether the amount of medical care provided is enough to prevent diseases that hasten the progression of HIV to AIDS or not.
7. To assess the extent to which legal and ethical services go along with the standards set by MOH.
8. To investigate the sustainability of the care and support project.

1.4. Significance of the Study

The rapid expansion of HIV/AIDS in sub-Saharan countries has a profound impact on the health sector as well as the socio-economic development of the region.

In Ethiopia impact surveys and different impact analyses indicated the existing grave situation that the HIV/AIDS epidemic contains to pose a threat to the development of the country (MOH, 2004).

The government of Ethiopia and its many partners are working hard to contain the pandemic. Accordingly, Save the Children USA is one of the NGOs, which strive to reduce the transmission of HIV/AIDS by providing care and support services to HIV infected persons, beginning from 2003 at Mojo Town.

As to the knowledge of the researcher this project is not assessed from the beginning to the present. Assessing of the outcome of a project is important for several reasons, including:-

- Assessing whether the contractor has truly completed the task
- Identifying the best practice for further projects.
- Identifying what resources are required for the future
- Identifying the needs for future projects. (Amdeberhan Gizaw, 2003)

Hence, this study may have the following contributions.

1. It may create suitable situation that enables Mojo Municipality HIV/AIDS committee and Save the Children to take measures that help them effectively implement the project.
2. No research has been done so far on the effectiveness of VCT Center, which has linkage with posttest services. This study, therefore, may help as a stepping-stone for those who may conduct study on similar topic.

1.5. Delimitation of the Study

The scope of this study is limited to the assessment of VCT and posttest services provided by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children. Thus, the conclusions drawn, and the suggestion and recommendations made refer only to the services provided by the same.

1.6. Limitation of the Study

Due to shortage of locally produced reference materials related to this study, the researcher has been forced to rely on certain abroad sources. Unwillingness of some key informants to participate in the study and repeated visit of offices of some others to meet them, were also other problems imposed limitation on data collection by reducing the number of the participants and producing time pressure. In spite of these problems the researcher attempted to make the study as complete as possible.

1.7.Operational Definition of Terms

1. **Status**–state of affairs of VCT and posttest services provided by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children among the PLWHAs when this study was conducted
2. **Posttest services**- care and support service provided to PLWHAs by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children
3. **VCT Protocol**- Standards used to guide counselor-client discussion in the process of providing VCT service.
4. **Sustainability**- The continuation of providing care and support services by the project at the same rate or level of activities with out any problem

1.8. Organization of the Study

This paper consists of six chapters. The first chapter deals with the problem and its background. The second chapter refers to review of related literature. The third chapter contains the methodology of the study. The fourth chapter presents the results of the study. Chapter five presents discussion of the findings. Chapter six contains summary, conclusions and recommendations of the study.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

This chapter focuses on review of related literature and research findings up on which the present study based on.

2.1. The Impact of HIV/AIDS

HIV/AIDS has become global problem and the people of sub-Saharan Africa countries continue to bear a disproportionate 70% of the global burden of HIV infection (Stein, et. al, 2002). In the worst affected countries, the pandemic has reversed the developmental gains of the past few decades (MOH, 2004).

In Ethiopia it has been recognized that it has, demographic, health care economic and social impacts which negatively affect our development efforts (MOH, 2003). Different measures have been taken to alleviate the impacts of the pandemic. Providing VCT and posttest services are also included in the measures taken to prevent and control HIV/AIDS transmission (FDRE, 1998 & NAC, 2001).

2.2. Voluntary HIV Counseling and Testing

2.2.1 Definition of Voluntary HIV Counseling and Testing

"Voluntary counseling and HIV testing (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 (Dillon, et. al., 2002).

2.2.2. VCT Service Models

There are two basic models for VCT in Africa "stand alone and integrated VCT centers"

2.2.2.1 Standalone VCT Centers

Stand-alone or freestanding VCT centers were pioneered in Uganda and replicated in Malawi, and Zimbabwe. (Lallemant and Le Coeur, 2002). As experiences from the above countries indicated stand alone VCT centers have:

- The ability to attract clients who are not yet ill.
- Confidentiality in these sites is more easily maintained than in an integrated sites
- Staff at stand alone sites devote their working hours to deliver VCT service,
- Stand Alone sites, however, are almost always heavily dependent on external donor funds, and the long term sustainability of these programs is uncertain (Lallemant and Le Coeur, 2002).

2.2.2.2 Integrated VCT Centers

- Integrating VCT services within existing health facilities is believed to improve likelihood that these services will be sustained over the long term
- Thought to improve HIV infected clients access to other medical services
- Over time they may allow HIV testing to become an increasingly routine medical procedure, rather than a service distinct from other public health services.
- Unfortunately, in many African countries health facilities are inadequate to meet the urgent medical needs to other than HIV patient. This may make the workers in this sites devote only few

minutes to each sick person. This in turn makes the abilities of these institutions to attract more VCT clients with no urgent medical problems, and to provide adequate risk reduction and counseling sessions a major concern (Dillon, et. al., 2002).

2.2.3 Facilities of Voluntary HIV Counseling and Testing Center

A voluntary HIV counseling and testing center is expected to have waiting and counseling rooms which make clients feel at ease, and also feel the discussion and testing conducted confidential.

Experiences form south Africa, Zambia and Zimbabwe indicated that efforts are made to make VCT centers as attractive as possible. The centers provide a walk in services and no appointments are necessary. In one of VCT centers ZAPSO, for example, trained receptionists well come all clients and take them through the waiting room where cold drinks are available. A counselor meets the client in the waiting room and takes them to counseling room. The counseling room is designed to make the atmosphere as relaxing as possible with easy chairs and no desk to act as a barrier between counselor and client (UNAIDS, 2002).

One proposed VCT site design suggests that the clinic flow systems should be client (centered) focused, and the waiting rooms to be two. The first waiting room is a room where a client stays before pretest counseling session is conducted, and the other one is a room where a client stays until his/her test result is provided (Global AIDS program, 2003).

2.2.4 Development of VCT and Posttest Services

HIV testing method was developed and implemented in 1985 in America for the prevention of the blood supply form HIV infected donors. The

availability of the test for detecting HIV infection raised the possibility of various uses of the test (Ven Devanter, 1991, Ng Weshemi and Walvaven, 1997). Several years of these test results led to the recommendation of voluntary HIV counseling and testing through an approach that emphasizes informed consent, pre and post test counseling and referral to posttest (care and support) services (Dillon et.al., 2002, and Molla, Yohanes and Melese, 2005).

In Uganda where VCT was initiated for the first time in Africa, the new infection rates have declined about 50%. At one urban antenatal clinic, for example, rate dropped form 29.5% in 1992 to 13.4% in 1998 (UNAIDS, 2001,). Experiences form Uganda (UNAIDS, 2000 & Jackson, 2002) South Africa, Zambia and Zimbabwe indicate VCT service providers emphasize the importance of being able to provide other supports to people, especially to those whose test result is positive if they were to attract more clients since clients, who feel that they will be cared for after testing may be more willing to determine their HIV status (Dillon et. al., 2002, & UNAIDS 2002). Over time as the awareness of people on HIV infection and the role of VCT increased, and especially, as more back up support and services became available, attendants of VCT center has increased enormously (Jackson, 2002).

2.2.5. Voluntary HIV Counseling and Testing (VCT) Protocol

VCT, which is the main gate to many other HIV prevention interventions, has the counseling and testing components. The counseling component is a tailored highly focused and relatively brief intervention (Dillon, et. al., 2002, & Marlink, Tarantotal and Ramnathan, 2002). It consists of two sessions pre and posttest counseling sessions with in each of these sessions there are several elements (components) that make up the prevention intervention (MOH, 2003, GAP, 2003 & Dillon, et. al., 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 included in pretest counseling session. These are (1) Introduction and orientation to the sessions (2) Assess risk, (3) Explore options for reducing risk, and (4) HIV test preparation. This is followed by the (5^{th}) Protocol which is HIV testing.

In posttest counseling session the emphasis of the protocol is based on HIV negative or HIV positive test result. With clients who have HIV negative test results the following are emphasized, (6) Providing HIV negative test result and followed by (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 issues ((Dillon, et al., 2002 & GPA, 2003).

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

As mentioned above these protocols___series of questions that direct counselor-client discussion, are discussed in pre and posttest counseling sessions.

2.2.5.1 Pretest Counseling Session

This session takes form 30-90 minutes depending on the knowledge base of test taker (VanDevanter, 1991). 15-30 minutes (UNAIDS, 2002), 10-20 minutes (GAP, 2003).

It is a session which is provided to each client before HIV testing. The purpose of this counseling session is to assist the individual to make an informed choice about testing and prepare him/her for the test outcome. To make an informed choice, the person seeking testing should be fully aware of the meaning and implication of the test results. These require the assessment of individual's personal risk of HIV infection, which is central to the decision-making process (VanDevanter, 1991, & MOH, 2003).

2.2.5.2 Post test Counseling Session

The posttest counseling session is provided after the blood test is made available and the relative emphasis of this session differs based on the clients test result.

The posttest counseling session for HIV negative clients focuses on the prevention of HIV Infection, with an emphasis on establishing a realistic and specific risk reduction plan, while the focus of posttest counseling session for HIV positive client is on coping and support issues, partner disclosure and medical follow up, since HIV counseling is tailored to the individual needs.

> *"The post test counseling will vary according to the clients needs' which in turn depends on the stage of the infection and context of the test as well as on the individual's personal coping style and life situation (Jackson , 2002)*

On receiving a positive result, the reactions of the clients are entirely unpredictable. Commonly encountered emotional reactions after positive result are shock, denial, anger, fear, guilt and disbelief (MOH, 2003). Individuals may become agitate, feel faint, cry or with draw (VanDevanter 1991). In this emotional state clients may not even want emotional support, but just to be alone, or perhaps to talk latter (Jackson, 2002).

According to VenDevanter;

> *".... Fears of death and dying, guilt, fear of exposure of life-style, fear of contagion loss of self esteem, loss of body image , loss of sexual freedom, fear of losing physical attractiveness, and loss of freedom to reproduce with out worry of infecting an unborn child are commonly experienced feelings of HIV sero-positive persons.*
> *It will be difficult to absorb information in such an emotional state----." (1991).*

It is after the culmination of this emotional state of the client that posttest counseling is going to be discussed. In addition to this, the HIV sero- positive individual should be able to repeat the basic information, establish priority and select appropriate supports at the end of the posttest counseling session (VanDevanter , 1991).

All the above mentioned activities are expected to be completed in 20-25 minutes in our case.(GAP,2003). In some other countries the length of posttest counseling session is 60-90 minutes it may also last longer (VanDervanter, 1991). In some sub-Saharan Africa countries the length of this session is 20-30 minutes but particularly those who tested positive require longer time, which may extend for up to two hours (UNAIDS, 2002).

2.2.6. The Testing Component of VCT Service

Testing algorithm: traditionally, HIV testing algorithm have been a serial approach, with one test being conducted first and a second test being conducted only to conform positive results. These days some sites are using a "parallel" approach in which screening and confirmatory tests are simultaneously conducted on every sample from those testing positive and partly to increase public confidence in VCT. (Dillon, et.al., 2002).

Assuring quality of testing is another component of HIV testing by subjecting random blood samples by additional testing. In addition to this, all VCT sites must conduct rigorous and regular review of record keeping system to avoid recording errors (Dillon, et.al., 2002, MOH, 2002, & MOH,2002).

2.2.7. Counselor's Training

Any one who has very limited formal education does counseling or with more professional training he/she can be an excellent counseling provider, but he/she must complete training in general HIV/AIDS counseling service.

The most important qualities of a VCT counselor are empathy, compassion and commitment to help prevent HIV. In counseling service quality determines outcome. Consistent and systematic application of quality assurance measures and on ongoing supervision is crucial for effective counseling. Adherence to the counseling protocol and the use of appropriate counseling skills are critical (Dillon, et al., 2002, and MOH, 2003).

2.3. Posttest Services

2.3.1. Ongoing Counseling

Ongoing counseling is a continuation of posttest counseling. In posttest counseling session the client's reaction to the positive test result is unpredictable. As the result of this the client may not be able to absorb information provided. In addition to this ensuring his/her understanding of the difference between HIV and AIDS, and his/her capacity to deal with HIV and related problems become difficult (VanDevanter, 1991).

HIV/AIDS is a chronic disease, with chronic diseases the patients life irreversibly changed and crisis inevitably occur.

There are three periods that crises frequently occur with HIV/AIDS, when part of the continued support of a counselor needs to be available. According to Jackson Helen, the major crises periods are:

- When clients first learn of an HIV or AIDS diagnosis in themselves.
- The first onset of HIV related diseases.
- Life threading illness, death and bereavement.

In a crisis situation the counselor should help clients to regain sense of control by helping them to:

- Express their anxiety and fear
- Feel more secure by being warm and maintaining a calm presence
- Explore exactly what it is that seems overwhelming
- Subdivide the problems into manageable aspects and set priorities.
- Develop an action plan for coping with the most pressing issues (2002).

Ongoing counseling is also required

- For the optimal delivery of anti retroviral therapy to ensure adherence
- To prevent the development of drug resistance, and
- To provide patient care in the event of antiretroviral treatment failure (Dillon, et. al., 2002).

2.3.2. Psychosocial Support

To be told one has HIV/AIDS can cause a shock even when a person is prepared for it. Since AIDS generates fear, stigma, intolerance, and discrimination mainly because their association with topics such as sex, sexual orientation and death and dying, topics that are taboo in many cultures including cultures in Africa (TIOU, 2002). Intense negative

psychological reactions such as anxiety, helplessness, hopelessness, depression, guilt ,anger, and loss of self esteem commonly occur (MOH,2003). According to Straw, for those person who have tested positive, the following reactions are possible.

1. Feeling of contamination and unrealistic concern about infecting others through casual contact, including simply being around other people.
2. Fear of refection and abundant "Whom can I tell" becomes a primary concern
3. Fear of illness and loss of control. This reaction is a time bomb effect
4. Break down of denial and loss of invulnerability (1991).

To over come these problems it is necessary to:-

- Provide adequate information about HIV/AIDS according to their needs
- Assist them to recognizing their own decisions and put decisions in to practice that create new meaning to life.
- Help them to explore the coping strategies they use
- Encourage them to solve their problems rather than waiting for others to solve.

Regarding social support; they need emotional support that makes them feel accepted and loved. They also need specific assistance with day to day tasks.

To prevent suicidal behavior it is necessary to turn hopelessness into hope. It is necessary to provide skill that enables PLWHAs live positively with the virus and supplement counseling services by providing spiritual support (MOH, 2003). An important goal of social support includes enabling affected people to live with out fear and to continue functioning as normal member of society

"Family members representatives of religious communities, health care providers and counselors are important 'sources of psychological and spiritual support for coping with HIV infection" (UNAIDS, 2000).

Associations of people living with HIV/AIDS are good examples of community mechanism that provide psychological and social support (UNAIDS, 2000 & UNAIDS, 2002).

It was also believed that when PLWHAs feel safe enough to be open about their HIV infection, they involve in the fight against the pandemic which in turn enables them to bring first hand experience to AIDS action that help others, including policy makes, face up to the reality of the epidemic (UNAIDS, 2000).

2.3.3 Economic Assistance

The economic assistance provided to HIV infected, AIDS patients and affected people differ from one organization to another based on their objectives. Some organization provide the economic assistance in the form of loan to enable infected and affected ones generate their own income to help them from entering permanent destitution. Ones a signs of recovery appeared relief support can be gradually replaced with mitigation support for longer term needs (UNAIDS,1999). Some organizations provide economic assistance as a grant which may also be specific to the infected ones. In this case AIDS puts increased demand on welfare provision as it drives more families into poverty as the breadwinner die, creating immunes psychological problems. Some times it creates unbearable strain on the families and draw funding away from development (UNAIDS, 1999 and Jackson, 2002).

In a high prevalence countries however, the impact of AIDS is believed to be mitigated through intensified development strategies (UNAIDS, 2000).

2.3.4. Medical Care

Provision of medical care for HIV positives manly focused on treatment of opportunistic infections which includes tuberculosis and sexually transmitted diseases

In Sub Saharan Africa, TB is the leading cause of death among people with HIV infection, and world wide, it accounts for about one third of AIDS death (UNAIDS, 2000 & Maynaja, and Ridzan, 2002).

The impact of HIV on rates of TB is greatest where the two infections occur together, which currently is in Sub Saharan Africa. Out of the estimated 3 million of infected people world wide with TB and HIV, almost 80% reside in Africa (De Cock,1994). Hospital data from Africa show that up to 40% of HIV infected patients have active tuberculosis (UNAIDS, 2000,). In Ethiopia the incidence rate of TB was found to be 42. 3 among HIV-1 positives compared only to 6.9 per year of observation (PYO) among HIV negatives (EPHA, 2005).

The major problems attributed to the co-infection of TB and HIV are, increase in the number of TB patients, low cure rate of TB patients, high mortality during treatment, high rate of TB recurrence, and increase of TB drug resistance (MOH, 2004).

TB is transmissible to both persons with and with out HIV infection. This rises TB rates in Africa and affects the public health of the population as will as the health of the individual. This indicates that, in Africa, HIV infection and TB cases are integrally linked. Thus prevention and control efforts, aimed at each disease must take the other into consideration (Mayanja, and Riudzon , 2002).

Sexually transmitted diseases:- Studies indicated that HIV epidemic and sexually transmitted diseases interact and reinforce with each other.

Progress has been also made in understanding the determinants of HIV transmission and the role of STDs in enhancing both the acquisition and infectiousness of HIV (Aitken, and kapiga, 2002).

As estimated by World Health Organization more than 33 million new cases of syphilis, Gonorrhea, Chlamydia and trechomoniosis occur globally each year. The estimated annual incidence rates are highest in Sub Saharan Africa, where they range form 12 to 120 per 1000. Adults age 15 to 49 years (Aitken, and Kapiga, 2002). This contributes in fueling HIV epidemic (UNAIDS, 2000) In Ethiopia it was indicated that the prevalence of HSV-2 is as high 87% among patients presenting with STIs (EPHA;2005) Syphilis prevalence among ANC attendants in 2003 was 1.8% (MOH, 2004).

The presence of STIs not only increases the risks of HIV transmission, but also makes the treatment of STIs themselves more difficult and costly. When people have an STI, the immune system is highly active fighting off the infection and this may increase rates of replication of HIV in the blood (Jackson, 2002).

The prevention and control of sexually transmitted desease has thus become a major public health priority and critical components of HIV intervention programs (Aitken, and Kapiga, 2002). Recent data also point to the enormous potential of using improved health care for sexually transmitted infections could reduce the rates of HIV and other sexually transmitted infections (UNAIDS, 2000).

2.3.5. Home-Based Care:

The people of sub Saharan African continue to bear a disproportionate 70% of the global burden of HIV infection. This made many health care facilities report a dramatic raise 70% to 80% in bed occupancy for

persons with HIV related conditions. The additional demand on inadequate health care infrastructure together with the declining number of care providers, presents a major challenge for health care delivery (Setein, et. al., 2002). As HIV infection progresses, medical needs change, and there may be increasing financial burden, spiritual needs and other requirements for spiritual counseling.

Due to the limitation of formal health infrastructure, a number of alternative models of providing care at home have evolved to improve access to care by bridging the gap between the service available and the health care needs of persons living with HIV AIDS. (Marlink, Tarantota and Ramanatha , 2002). To provide optimal home based care, referral systems linking the home with clinic and hospital facilities, social services and transportation for home based care providers are essential. To make the program sustainable and effective, models of the home based care service must be in accordance with the capacity of the family and community to provide home based care, and develop support form formal medical services

Among home based care programs, the programs began by The AIDS support organization (TASO) in Uganda and FOCUS (Families Orphans and Children under Stress) in Zimbabwe are example of home based care programs which became effective (Stein, et, al., 2002).

Home based care at its best, helps patients live through their illness and die in some dignity and comfort in families surroundings with their families around them (Jackson, 2002). It can also contribute to breaking down the silence about the epidemic and reducing stigma and discrimination. At its worst, home care equates home neglect. Many patient die miserable painful deaths, and yet the cultural problems is

usually not so much the disease itself as poverty (UNAIDS, 1999. and Jackson, 2002).

There is increased evidence from Uganda, South Africa, Zimbabwe and Zambia successful result can be obtained by providing posttest services following VCT service.

Experiences of ZAPSO in Zimbabwe, and The TB/HIV pilot project in South Africa also indicated that support groups may not always successful and can run into problems and may be stopped or dissolved (UNAIDS, 2002).

Regarding the kind and amount of support provided there is no prefect or universally applicable formal. Since 1997 UNAIDS advocated that communities, along side stakeholders should be involved in developing standards for HIV care and support (UNAIDS, 2000).

Provision of care and support is not universally optimal even in the favoured part of the world. People who are prescribed with Anti-retrovirus therapy may not get enough help to device practical ways of adhering to drug regimens (UNAIDS,2000).

2.3.6. Legal and Ethical Services

With regard to legal and ethical issues it is critical for VCT programs to emphasize and preserve the voluntary nature of these services and to maintain strict confidentiality and avoid the misuse of test. (Dillon, et. al., 2002, and MOH,2002).

Furthermore, public efforts to prevent and control the spread of HIV/AIDS are more likely to succeed when policies and programs promote and protect human rights.

The right of the people to be protected emerge from three successive epidemic as constituting world wide public health emergency are:-

- The epidemic of infection with HIV
- The epidemic of AIDS itself, and
- The global epidemic of social, economic, political, and cultural reactions and persons to AIDS and HIV infection (Ballayd, 1991).

Numerous declaration, charters, policy statements were made. "Valuable as they are in establishing care values and frame work, they mean little if they do not lead to practical action and outcomes on the ground (Jackson, 2002). Because of this those who are involved in policy and decision making as well as implementers should be aware of the need to mobilize the community by advocating the consequences of the epidemics.

2.4. VCT and Posttest Services in Ethiopia

2.4.1. VCT. Service in Ethiopia

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

Following the issuance of the national AIDS policy in 1998, the service/VCT/ which was provide by public health institutions was also started to be provided by private scoters as well as by non-government AIDS support organizations. The number of VCT or HIV testing centers or both increased to 80 in 2002 and to 488 in 2006. In 2000 VCT guideline, which was revised in 2002, was prepared to help standardize the service in the county. (MOH, 2002 and AIDS Resource Center, 2006).

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 shortage of physical facilities, test kits and trained manpower.
- In some places counseling and testing services were interrupted for months due to transfer of trained staff.
- 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.

Among the prevention strategies designed to respond to the pandemic, VCT was given the third priority, following IEC/BCC and condom promotion and distribution (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." (2004).

2.4.2. Posttest services In Ethiopia

The importance of providing care and support as HIV/AIDS prevention strategy is recognized and mentioned in HIV/AIDS policy issued in 1998. It is also prioritized in the strategic plan of 2001-2005.

MOH in collaboration with other NGOs has been engaged in providing social services (MOH, 2002) Country exercises of CHBC were also indicated the need to respond to the medical, psychological and social economic needs of the infected and affected is an urgent task that deserves attention (MOH, 2001).

Care and support initiatives which range from clinical management and nursing care to psychological, social and economic support has been conducted by few NGOs, but communities have been building on local caring. PLWHA support groups are also emerged. Iders are also engaged in helping the sick, combining its traditional role around funerals with traditional caring and helping the poor with food and other resources. They are also helping to establish income generating projects and to explore other needs of families affected by AIDS (Jackson, 2002, Sitting Gebre Egziabher).

One indigenous NGO founded by PLWHAs, in Addis Ababa has begun to train home-based care providers. It has also developed education, counseling and social support programs and advocates the PLWHAs to come forwarded to be helped (Lindtjorn et.al., 2003).

WHO collaborative study conducted in 2001, that summarized information on 8 of 20 projects in different communities reported that 1,300 AIDS patients were benefited from the projects. The caregivers were physicians, nurses, neighbors, health assistances, CHAs, TBAs and others from the community members.

The care provided were well received by the patients and resulted in decreased social stigma in the project areas, but they felt short of

meeting basic needs, including food, material requirements and treatment of infections. (Yeneneh, Ali & Habtegiorgis, 2001).

2.5. VCT and Posttest Services in Mojo Town

Provision of VCT and posttest services for PLWHAs were directely connected to the establishment of Mojo Municipality HIV/AIDS committee. High Risk Corridor Initiative (HRCI) of Save the Children established the committee in the first half of 2003. Mojo Municipality HIV/AIDS committee and Save the Children developed a proposal that enable them work together.

According to this proposal which was entitled "care and support project at Mojo Town" the two parties agreed to start implementing the project on 09/05/2003, end on 08/05/2004, and to run the project by matching fund 10% from the community and 90% from Save the Children.

The goal of the project was: to reduce the transmission of HIV by launching care and support project.
The objectives of the project related to PLWHAs were: -

1. To provide care and support for 35 HIV infected persons for one year
2. To provide care and support to 15 AIDS patients for one year.

   Regarding project monitoring, the two parties agreed to monitor the project by:-

   A. Routine monitoring - to review the project progress as work plan, review financial management, and to provide technical assistance as needed.
   B. Assessment visit- to assess the average project accomplishments, on which the following year's action plan could be developed.

They also agreed that monitoring of the project to be accomplished by SC/USA/MOH/OHAPCO/staff.

2.6. Sustainability of Care and Support Project

Whenever a project is thought, the sustainability and means of scaling up of the project should be included in the project proposal developed. How a project can be sustainable even when the project owner phases out should also be clearly stated. 'Strategy for scaling up access and sustainability of VCT and posttest programs should be part of the initial planning...' (Jackson, 2000).

In planning care and support project the following points should be taken into consideration:-

- The needs the community for services and the available resources should be identified.
- Possible avenues by which relief support can be replaced by mitigating support should be prepared (UNAIDS, 1999)
- The ways and means of enabling the community to participate in the program should be considered.

Sustainability also depends on how well the knowledge, attitude and practice and technology have been introduced take root in the communities. Communities may participate at different levels. At first in program benefit, followed by participation in activities latter in implementation. Those who are more evolved and committed may participate in monitoring and evolution and perhaps go on to take part in planning (Ng' Weshemi, & Walraven , 1997).

CHAPTER THREE

3. METHOD AND DESIGN OF THE STUDY

This chapter deals with the study method, sampling procedure, tools of data collection and method of analyzing the results.

3.1. Method

This study is designed to assess the voluntary counseling and testing service and posttest services offered by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children, as well as pointing out problems encountered in providing these services. In order to accomplish this assessment descriptive survey method was employed. Because it is an appropriate method to collect several kinds of data related to the problem under investigation.

3.2. Study Area (Site)

The area selected for this study is Mojo town, which is 70 km away form the capital to the south east, in East Shewa Zone of Oromiya National State. It was selected for the following reasons.

The main reason for selection of this town is the availability of VCT center that has linkage with posttest services. And also the researcher's connection with PLWHAs, service provides of these PLWHAs, NGO and GO representatives as the result of his previous engagement in different HIV related activities.

The other reason is that Mojo town is a meeting ground for many routes the-route that leads to Shenkora Yohanis where patients, including AIDS patients go to be cured by the holly water available there, the route that leads to Moyale Kenya, to south and south west of the country; the route

that leads form Addis Ababa to Djibouti which is one of the roads known as High Risk Corridors in Africa-meet at Mojo town. This made the town a place where highly mobile people meet, which is considered to be fertile ground for high transmission of HIV.

3.3 Participants of the Study

As indicated in table 3.1 below, the participants of this study were broadly divided into two groups. The beneficiaries /PLWHAs/ are in one group and services providers /implementers/ of the project run by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children USA at Mojo town are in the other group.

Table 3.1 Type and number of participants of the study

No.	Type of Participants	Number
1.	Clients /PLWHAs	77
2	Service providers/implementers	
	2.1. Counselors	3
	2.2. Committee member, Home-based care providers and key informants	20
	Total	100

The beneficiaries were 77 PLWHAs, who are the main group that can provide first hand information about HIV/AIDS. Since enumerating of the entire population of persons who are HIV positives is not possible random sampling of those who have positive results is also impossible to draw. For this reason convenient sampling method was employed to select the area of this study. All HIV positives that were the beneficiaries (census) of the project at Mojo were taken to be the participants of this study.

All service providers /implementers/ who were participated in the study were purposefully selected. Accordingly,

- All the three VCT counselors of the VCT center were made to be the participants of this study.
- Twenty service providers were also deliberately selected for Focus Group Discussion and to be key informants. Those PLWHAs who were selected for FGD were among those who filled the questionnaire, based on their active participation in HIV/AIDS related activities and the number of years they stayed in the project.

3.4. Tools of Data Collection /Instruments

Three kinds of instruments were employed to collect data in this study. Questionnaires to collect data from PLWHAs and counselors, Focus group discussion to collect data from beneficiaries and service providers. Non-structured interview to collect data from some service providers other than those who participated in focus group discussion, GO and NGO officials to supplement the information obtained from the PLWHAs.

3.4.1 The Questionnaires

Two questionnaires were mainly prepared based on National HIV/AIDS Counselors Training Manual (MOH, 2003) and Tools for Evaluating VCT (UNAIDS, 2000). The questionnaire prepared for PLWHAs was pilot tested on 30 subjects for clarity and relevance and also to determine its reliability of the counseling content part of the questionnaire. Four MA program counseling psychology students commented on the questionnaire. Finally the Reponses of the participants were scored and its reliability was assessed by computing Cronbach Alph and proved to be reliable with œ.72.

The final, revised and refined, questionnaire prepared to collect data form the target group has both close ended and few open-ended question and also the following parts.

- Part one deals with the demographic data of the participants.
- Part two focuses on VCT facilities, skills and contents of counseling
- Part three deals with posttest services.
- Part four refers to the sustainability of the project

This questionnaire was first prepared in English and translated into Amharic again back to English.

The second questionnaire was prepared to collect data from VCT counselors. Two MA Program counseling psychology students commented on it. This questionnaire was prepared in English. It has the following parts.

- Part one deals with the demographic data of the counselors
- Part two refers to the facilities of the VCT center, skills employed and contents discussed in counseling sessions.
- Part three focuses on the problem counselors encountered in the provision of VCT service.

3.4.2 Focus Group Discussion

Two Focus Group Discussions were carried out with PLWHAs and some service providers to explain some of the findings obtained from the questionnaire.

3.4.3 Interview

Interview was used to collect data from GO and NGO officials and service providers other than those participated in Focus Group Discussion. A

guideline for both focus group discussions (FGDs) and for interview was prepared to collect data from key informants and from group discussion participants.

3.5. Procedure of Data Collection

Before data collection began letter of cooperation from Addis Ababa University was submitted to all concerned bodies and participants. Their informed consent was secured.

Six Melekete-Lumee Anti-Aids club members were selected to collect data based mainly on the trust they developed among PLWHAs. All of them had got training on different topics related to HIV/AIDS and, also assume responsibly in the club. Regarding their educational level one of them has completed grade 12, two of them are preparatory class students, and three of them 10th graders. Before they start collecting data, discussion was held with them on the questionnaire for the sake of clarity. They were also oriented not to impose their believes and opinions on the participants but instead help the participants understand the questions correctly.

The participants (PLWHAs) were consulted first on the occasion of their social gathering program. They were oriented on the advantages and disadvantages of participating in the study and their consent was secured. The consent of those who did not attend in the program was secured at their respective homes. The addresses of the participants were registered to make an easy access for collecting data and also to check against the payrole that the PLWHAs sign when they receive the financial support. This is done to be able to collected data only from the selected group.

Data collection process was a bit cumbersome task and took several days. This happened because the majority of the PLWHAs, were emotionally unstable in the process of filling the questionnaire.

In the process of collecting data the over all activity was supervised and coordinated by the researcher to ensure the accuracy of data collected.

The VCT counselors completed the questionnaire at Mojo Health Center, where the VCT center is located.

The interviews were conducted at the key informants respective offices or homes.

The Focus Group Discussion (FGD), which was conducted with service providers held at Meleke-Lumee HIV/AIDS clubs office. While Focus Group Discussion held with PLWHAs carried out in one of the PLWHAs house. The researcher moderated all focus group discussions.

Two 'trained' research assistances provided support during Focus Group Discussions. One of them tape-recorded the discussions and the other took note on the discussions.

3.6. Methods of Data Analysis

3.6.1. Standards Used to Assess VCT Service

To assess contents discussed and skills employed in counseling sessions, the following standards were adopted mainly from Tools for Evaluating HIV Voluntary Counseling and Testing, and from National HIV/AIDS Counselors Training Manual (UNAIDS, 2000, & MOH,2003).

These standards have competency-based and content-based elements which are computable with the counseling service protocol that the counselors trained to follow.

1. Competency-based elements:- these refer to skills employed in HIV counseling sessions they are grouped into four, based on their functions. Each of them has other elements that enable to assess the skills employed in counseling sessions

   1.1. Interpersonal relationship the counselor should perform the following skills:-
   - Greet and welcome clients warmly
   - Invite clients to seat
   - Introduce him self
   - Ask clients to introduce themselves
   - Establish rapport, which makes clients engage in conversation
   - Listen actively

   1.2 Gathering information:-
   - Seek clarification from clients about information he/she gives
   - Probe appropriately
   - Summarize main issues discussed

   1.3 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

   1.4 Handling special Circumstances:-
   - Accommodate language difficulties

- Talk about sensitive issue plainly and appropriate to the culture
- Use silence well to deal with difficult emotions
- Manage clients' reaction

2. Content-based elements:- these are mainly divided into two. They have different elements to guide the counselor-client discussion.

2.1 Pretest counseling contents are divided in to four sections

2.1.1. 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

2.1.2. Risk assessment:-
- 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

2.1.3. 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 condom

2.1.4. 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 client handles his sexual partner's reaction, especially to a positive result.
- Obtain informed consent

2.2 The posttest counseling session is divided into two sections

2.2.1 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 misconception between HIV positive results 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

2.2.2 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

3.6.2 Standards Used to Assess Posttest Services

Regarding posttest services, there is no perfect or universal applicable formula but developed by the involvement of the community (UNAIDS 2000, and MOH, 2002).

Because of this the standards used to assess the posttest services rendered by the project is the agreement signed between the two parties, based mainly on the posttest services indicated in HIV/AIDS policy of 1998, and also by Ministry of Health of Ethiopia (MOH; 2002). This includes:-

1. Ongoing Counseling

   Ongoing Counseling is provided:-

   - To help clients to cope with HIV and encourage positive living
   - To Consolidate future risk reduction plan
   - To help clients deal with HIV related problems

2. Psychosocial support:-

   - To provide information according to clients needs
   - To enable clients to recognize their decisions and put decisions in to practice
   - To help clients to explore their aspirations, priorities and goals, and assess the coping strategies they use.
   - To encourage clients to solve their problems rather than wait for others to solve.
   - To provide emotional support and specific assistance that can make them feel accepted and loved.

- To address thoughts of suicide to change hopelessness in to hope (MOH, 2003).

3. Food support- in the form of money

   For nutritional preventive (MOH, 2002) to reduce the progression of HIV to AIDS

4. Medical Care

   To prevent diseases that hasten the progression of HIV to AIDS like that of TB. STI, OI

5. Home Based Care

   AIDS patients are desperate and need care and support by care providers who solicit back up from spiritual leaders and trained counselors.

   5.1 They need medical and nursing care for conditions such as:-
   - Persistent diarrhea
   - Loss of appetite
   - Skin problems
   - Bed Sores

   5.2 They need spiritual and pastoral support to take care of the emotional and psychological aspects of the problems such as isolation, rejection, guilt, and hopelessness.

   5.3 Educating and training of care givers in the home:-
   - To improve the quality of care given to patients
   - To enable the care givers prevent transmission of HIV and other infections within the home environment

   5.4 Material and financial assistance to cover needs such as food, blanket, bed sheets, soap

   5.5 Appropriate referral service

   Effective implementation of referral system plays a pivotal role in the quality of care where the patient is started on treatment, and health professional at institution the link between the home based care provider should be extremely

effective to serve the needs of the patient to the best possible level (MOH, 2001)

6. Legal and Ethical Supports:-
   - To ensure informed consent
   - To maintain confidentially of counseling and testing
   - To assure PLWHAs equal access to all basic social services and human rights (MOH, 2001).

3.6.3. Statistical Method Used

The data was processed using SPSS version 12.00 for windows. Both qualitative and quantitative methods were employed to analyze the obtained data. Specifically, percentage was used to analyze the quantitative data.

CHAPTER FOUR

4. RESULTS

In this chapter the characteristics of the participants of the study and list of services are presented first, and then results of data collected from:- the beneficiaries [PLWHAs] and implementers (VCT counselors, Focus group discussants and key informants) on VCT service, posttest services and sustainability of the project were presented

4.1 The characteristics of the participants of the study

4.1.1 The Characteristics of the PLWHAs

Out of 87 PLWHAs intended to be involved in this study; 79 of them filled the questionnaire and returned, out of which two of them were discarded. Eight PLWHAs who were included at the initial plan to be the participant of this study did not participate because three of them died, two of them are under the age of 18 years, and three of them were not around when the questionnaire was filled. The demographic data of the participants in the study was as follows

Table 4.1 Socio-demographic Characteristics of the PLWHAs. Mojo, Feb., 2006.

Variables	Responses	
	Frequency	Percent
Age		
15-24	12	15.60
25-34	42	54.50
35-44	16	20.80
45 and above	7	9.10
Sex		
Male	19	24.70
Female	58	75.30
Marital status		
Single	15	19.50
Married	17	22.10
Divorced	18	23.40
Widowed	27	35.00
Educational status		
Can't read and write	16	28.80
Can read and write	7	9.10
Grade 1-6	27	35.10
Grade 7-12	21	27.30
Omission	6	7.50
Is there any one among your family members who has an income?		
Yes	4	5.20
No	54	83.10
Omission	9	11.70
The house in which you live in is ---		
Your own possession.	2.1	2.60
Rented from Kebele	12	15.60
Rented from individuals	56	72.70
Other	5	6.50
Omission	2	2.60

As can be seen form table 4-1, nearly three fourth (75.30%) of the participants were females and the rest one fourth (24.70%) of them were males giving a sex ratio (male to female) of 1:3. The mean age of the participants was 32.7 with standard deviation of 8.21 years, which ranges from 18-55 years.

Regarding their educational status, 73.00% of the participants attended primary (1-6) grades or below. Information collected on their family sized indicated that the mean size of their families (other than themselves) was 3.17 with standard deviation of 1.83 which ranges from 0—9. According

to the majority (83.10%) of the participants there is no one among their family members who has his own income, 77.9,these families have either father or mother, and 72% of the participants live in houses rented from individuals.

4.1.2. The Characteristics (Back Ground) of the Counselors

There were two males and one female VCT counselors at Mojo Health Center. All of them filled the questionnaire. They were nurses and permanent workers of Mojo Helth Center before they became counselors. They have work experiences that range from 4 to 19 years. Two of them have four years and one of them has two years of experience in HIV counseling. They were selected for training on HIV counseling by the organization in which they are working now. Two counselors have got training twice by OHAPCO and by IOM in collaboration with Save the Children USA. The third counselor trained once by IOM and Save the Children.

All of them indicated that their training was based on the manual prepared by IOM and Save the Children. One of them who was trained twice indicated that his second training was based on the manual prepared by MOH, and the other one who was trained twice said that his second training was based on the manual prepared by CRDA. All of them indicated that they feel they need more training on counseling.

4.2 List of Services

The participants were provided with list of services that are expected to be provided to PLWHAs and they were required to identify those care and support services they are provided with. The following result was obtained

Table 4.2 Responses of the PLWHAs Regarding Services Provided by the project. Feb., 2006.

Type of Services	Responses		
	Category	**Frequency**	**Percent**
Voluntary HIV Counseling and testing	Yes	76	98.70
	Omission	1	1.30
Financial support	Yes	76	98.70
	No	1	1.30
Psychosocial support	Yes	54	70.10
	No	22	28.60
	Omission	1	1.30
Ongoing Counseling	Yes	26	33.80
	No	49	63.60
	Omission	2	2.60
Medical Care	Yes	16	20.80
	No	60	77.90
	Omission	1	1.30
Legal and ethical Care	Yes	4	5.20
	NO	63	81.80
	Omission	10	13.00
Home-based Care	Yes	26	33.80
	No	49	63.60
	Omission	2	2.60

As indicated in table 4.2, the majority (98.70%) of the participants reported that they received VCT services and financial support, and 70.10% of them also said that they have been provided with psychosocial support.

Regarding ongoing counseling, 63.60% of the respondents indicated that they were not provided this service out of the rest of the respondents 33.80% reported that they were provided with ongoing counseling. Out of the total respondents, 81.80% and 77.90% of them also reported that they were not provided with legal support and medical care respectively. Sixteen (20.80%) of the rest of the respondents reported that they were provided with medical care.

4.3. Result of Data Collected on VCT Service

4.3.1 Results of Data Collected from PLWHAs

Results of data collected from the PLWHAs on VCT service, skills and contents of HIV counseling are presented as follows.

Table4.3 Responses of the PLWHAs to Items that Refer to VCT Center of the Project.

Items on VCT service	Response		
	Category	Frequency	Percent
Have you been provided voluntary HIV counseling and testing service by Mojo Municipality HIV/AIDS committee in collaboration with SC?	Yes	76	98.70
	No	-	-
	Omission	1	1.30
If yes, is there a separate room at the VCT center to ensure Counseling sessions to be private?	Yes	69	89.60
	No	6	7.80
	Omission	2	2.60
Did the arrangement of the counseling room make one feel at ease?	Yes	53	68.80
	No	20	26.00
	Omission	4	5.20
How do you rate the attempts counselors made to secure confidentiality?	Very Good	16	20.80
	Good	38	49.40
	Not good	14	18.20
	I do not know	8	10.40
	Omission	1	1.30
Is there a waiting room?	Yes	5	89.60
	No	69	6.50
	Omission	2	3.90

As presented in table 4.3, almost all (98.70%) of the participants reported that they were provided with VCT service by Mojo Municipality HIV/AIDS committee in- collaboration with Save the Children. Regarding the facilities of the VCT center the majority (89.60%) of them said that there is a separate room to ensure counseling session to be private, 68.80% the participants said that the arrangement of the counseling room made them feel at ease. According to the rating of nearly half [49.40%] of the participants the attempts made by the counselors to secure confidentiality was good, and to 20.80% of them it was very good. The majority (89.60%) of the participants reported that there is no waiting room at the VCT center.

Table 4.4 Responses of the PLWHAs Regarding the VCT Service Offered by the Project. Feb., 2006.

VCT Service	Responses		
	Category	Frequency	Percentage
Did you get VCT service freely?	Yes	**76**	98.10
	No	**1**	3.70
Who informed you the availability of VCT service at Mojo Health center?	Other PLWHAs	20	26.00
	Medical personnel	6	7.80
	Home-based care provider	5	6.50
	Friends	24	31.20
	Others	18	23.40
	Omission	4	5.20
Which of following reasons forced you to go to the VCT?	Need to know HIV status	62	80.50
	Need to get care and support	5	6.50
	To prepare for marriage	1	1.30
	Other	9	11.70
Did you get the service on the first day you went to the center to be tested?	Yes	62	80.50
	No	13	16.90
	Omission	2	2.60

As can be seen from table 4.4, almost all of the participants reported that they were provided with the VCT service freely by the project. As reported by 26% and 31.20% of the respondents they were informed the availability of VCT services by the project by other PLWHAs and their friends respectively. The rest [23.40%] of the respondents said that others informed them about the availability of the VCT service freely at the VCT center of the project. Among those who were informed by others only three of them said they have got the information form a notice posted in Mojo Health Center. The remaining ones said that they heard the information form their spouses, sisters and other relatives. According to the majority (80.50%) of the PLWHAs the main derive that made them tested was the drive they have to know their HIV status. Sixty two [80.50%] of the respondents reported that they were provided with the service on the first day they went to the VCT center.

Table 4.5 Responses of the PLWHAs Regarding the Counseling Skills Employed by the Counselors.

Function	Skills	Responses		
		Category	Frequency	Percentage
Interpersonal Skills	Greeted and welcomed me warmly	Yes	60	77.90
		No	17	22.10
	Invited me to seat	Yes	69	89.60
		No	8	10.40
	Introduced himself first	Yes	68	88.30
		No	9	11.70
	Asked me to introduce myself	Yes	47	61.00
		No	29	37.70
		Omission	1	1.30
	Established rapport which made me engage in conversation	Yes	66	85.70
		No	11	14.30
	Listened actively	Yes	73	94.80
		No	4	5.20
Information gathering skills	Sought clarification about information given.	Yes	67	87.00
		No	10	13.00
	Probed appropriately	Yes	68	88.30
		No	8	10.40
		Omission	1	1.30
	Summarized issues discussed	Yes	63	81.80
		No	14	18.20
Information giving skills	Gave me information in clear and simple terms.	Yes	61	79.20
		No	16	20.80
	Reinforced important information.	Yes	65	84.40
		No	12	15.60
	Gave me time to absorb information and to respond.	Yes	66	85.70
		No	11	14.30
	Checked for understanding /misunderstanding.	Yes	68	88.30
		No	9	11.70
Handling special circumstances	Accommodated language difficulty	Yes	63	81.80
		No	14	18.20
	Talked about sensitive issues plainly and appropriate to the culture.	Yes	61	79.20
		No	16	20.80
	Used silence well to deal with difficult emotions.	Yes	70	90.90
		No	7	9.10
	Managed clients reactions.	Yes	71	92.20
		No	4	5.20
		Omission	2	2.60

As table 4.5, makes plain, out of the respondents who responded to interpersonal skills employed by the counselors, Sixty [77.90%) of them reported that they were greeted and welcomed by the counselors. Sixty nine [89.60%] of the respondents said that they were invited to seat by

the counselors. Sixty eight [88.30%] of the respondents indicated that the counselors introduced themselves, and forty seven [61.00%] of the respondents said that they were asked to introduce themselves. Sixty six [85.70%] of the respondents assure that the counselors established rapport which made them engage in conversation. Seventy three [94.80%) of the respondents said that the counselors listened to them actively.

To the skills employed by the counselors for gathering information, sixty seven [87.00%] of the respondents said the counselors sought clarification about information given. Sixty eight [88.30%] of the respondents indicated that the counselors probed information appropriately, and sixty three [81.80%] of the respondents indicated that the counselors summarized the main issues discussed.

With regarded to information giving skills employed by the counselors, Sixty one [79.20%] of the respondents said that the counselors gave them information in a clear and simple terms, and sixty fife [84.40%] of them also indicated that the counselors reinforced important information. Of all the respondents sixty eight [88.30%] of them indicated that the counselors checked for understanding /misunderstanding of information provided.

The responses of the respondents to the skills that the counselors employed to handle special circumstances were as follows. Sixty-three [81.80%] of the respondents said that the counselors accommodated language difficulties, and sixty one (79.20%) of the counselors talked about sensitive issues plainly and appropriate to the culture. Seventy [90.90%] of the respondents said that the counselors used silence to deal with difficult emotions, and seventy one [92.20%] of the respondents assured that the counselors managed their reactions.

Table4.6 Responses of the PLWHAs Concerning Contents Discussed in Pretest Counseling Session

	Contents	Responses		
		Category	Frequency	Percentage
Introduction/ orientation	Orientation about the counseling sessions	Yes	68	88.30
		No	9	11.70
	Describing about the test procedure	Yes	55	71.40
		No	22	28.60
	Explanation on the confidentiality of the test	Yes	69	89.60
		No	7	9.10
		I do not remember	1	1.30
	Reason (S) that made you visit VCT to get the service	Yes	72	93.50
		No ~~I do not remember~~	4	5.20
		I do not remember	1	1.50
Risk Assessment	Your recent sexual behavior	Yes	57	74.00
		No	20	26.00
	Why you feel that you are at risk	Yes	65	84.40
		No	11	14.30
		I don't remember	1	1.30
	Frequency of risk situation	Yes	54	70.10
		No	23	29.90
	Communication with partner about HIV risk	Yes	53	68.80
		No	23	29.90
		I don't remember	1	1.30
Risk Exploring Options for Risk reduction	Communication with others about HIV risk	Yes	47	61.00
		No	30	39.00
	Previous risk reduction attempts	Yes	56	72.70
		No	21	27.70
	Your successful experiences of practicing safer sex.	Yes	58	75.30
		No	19	24.70
	Identifying barriers to risk reduction	Yes	61	79.20
		No	14	18.20
		I don't remember	1	1.30
		Omission	1	1.30
	Your experience of using condom	Yes	56	72.70
		No	21	27.30
Preparation for the test /plan partner disclosure	Ensuring your understanding of each of possible test results	Yes	72	93.50
		No	5	6.50
	To whom you had told that you were going to VCT to be tested	Yes	51	66.20
		No	26	33.80
	Who to tell your HIV status to if HIV positive	Yes	57	74.00
		No	20	26.00
	How to handle your partner's reaction, especially to a positive result	Yes	53	68.80
		No	23	29.90
		I don't remember	1	1.30
	Possibility of refusing the test	Yes	53	68.80
		No	23	29.90
		Omission	1	1.30

As presented in table 4.6, Sixty eight [88.30%] of the participants said that they were oriented on counseling sessions, 89.60% of them reported

that explanation was given to them on the confidentiality of the test. Seventy two [93.50%] of the participants also reported that the reason as to why they visited the VCT center to be tested was discussed. And 71.41% of them indicated that the HIV testing procedure was described to them.

With regard to the content related to risk assessment, the participants reported the following. Fifty seven [74.00%] of all the participants said that their recent sexual behavior was discussed and 84.40% of the respondants said that they discussed with the counselors on their feeling that made them feel that they were at risk. Fifty four [70.10%] of them reported the frequency of their risk situation was discussed, and 68.00% of them said that their communication with their sexual partner was assessed by the counselors.

Regarding contents grouped under exploring options for risk reduction, 61.00% of the participants reported that their communication with others about HIV risk was discussed. Fifty six [72.70%] of them indicated that they had discussed with the counselor on their previous risk reduction attempt. And 75.30% of them said that their successful experiences of practicing safer sex were assessed. Sixty one [79.20%] of the respondents said that they discussed with the counselors to identify barriers to the risk reduction, and 72.70% of the participants indicated that their experiences of using condom was assessed.

In the discussion held on preparation for the test/plan partner disclosure, 93.50 % of the respondents reported that the counselors raised issues to ensure their understanding of each of the possible test results. Fifty one [66.20%] of them reported that they were asked to whom they had told to that they were going to be tested. Fifty seven [74.00%] of the respondents said that discussion was held on who to tell

if their test results indicate HIV positive. Fifty three [68.80%] of the participants said that they discussed with the counselor on how to handle their partners' reaction, especially to a positive result. Fifty three (68.80%) of them confirmed that they had been asked their informed consent.

Table 4.7 Responses of the PLWHAs Regarding Contents Discussed in Posttest Counseling Session

	Contents	Response		
		Category	Frequency	Percentage
Informing the result/ Emotional Support	How have you been feeling since you gave the blood sample	Yes	61	79.20
		No	13	16.90
		I don't Remember	2	2.60
		Omission	1	1.30
	Told you that you are HIV infected simply and clearly	Yes	76	98.70
		Omission	1	1.00
	Ensuring whether you have understood the meaning of positive result or not	Yes	70	900
		No	6	7.80
		Omission	1	1.30
	Clarifying misconception between positive result and AIDS	Yes	57	74.00
		No	17	22.10
		I don't Remember	2	2.60
		Omission	1	1.30
	Examine how you should deal with the changes that occurred to you because of positive result	Yes	71	92.20
		No	5	6.50
		Omission	1	1.30
	Assessing to know how you are coping with positive result	Yes	68	88.30
		No	7	9.10
		Omission	2	2.60
	How to in from to your sexual partner	Yes	52	67.50
		No	20	26.00
		I don't remember	2	2.60
		Omission	3	3.90
	Your thought about asking your sexual partner to be tested	Yes	52	67.50
		No	22	28.60
		I don't remember	2	2.60
		Omission	1	1.30
	Who to tell your HIV test result	Yes	52 54	67.50
		No	24	31.20
		Omission	1	1.30
Risk reduction plan	How to protect your sexual partner from HIV risk	Yes	64	83.10
		No	8	10.40
		I don't Remember	3	3.90
		Omission	2	2.60
	How to protect others from HIV risk	Yes	62	80.50
		No	14	18.20
		Omission	1	1.30
	How to identify barriers to risk reduction (Alcohol and other addictive drugs)	Yes	62	80.50
		No	12	15.60
		I don't Remember	1	1.30
		Omission	2	2.60
	Identifying person from family members or friends who can help you through the process of dealing with HIV	Yes	55	71.40
		No	20	26.00
		I don't Remember	1	1.30
		Omission	1	1.30
	Your needs to referral services	Yes	68	88.30
		No	8	10.40
		Omission	1	1.30

As presented in table 4.7, contents of posttest counseling session related to informing the result/providing emotional support section, sixty one (79.20%) of the participants reported that the counselors asked them how they have been feeling since they gave their blood to be tested. Seventy six [98.70%] of them said that the counselors told them simply and clearly that they were infected with HIV. And 90.90% of them reported that the counselors discussed with them to ensure whether they have understood the meaning of positive result or not. Fifty seven [74.00%] of the participants indicated that discussion was carried out with the counselors to clarify any misconception between positive result and AIDS, and 92.20% of them was reported that the counselors discussed with them to examine how they should deal with the changes that occur to them because of positive result. Sixty-eight [88.30%] of the participant said that discussion was held to assess how they were coping with the positive results. Fifty two [67.50%] of the participants reported that discussion was held on how to inform to the their sexual partners, 67.50% of the participants said that their thought about asking their sexual partners to be tested was explored. To whom to tell their HIV positive result was also probed as reported by 67.50% of the participants.

In the section of posttest counseling session that requires discussion on how to plan risk reduction plan, 83.10% of the participants indicated that they discussed with the counselor on how to protect their sexual partners from HIV risk, and 80.50% of the participant said that they also discussed on how to protect others from HIV risk, Sixty two [80.50%] of the participants reported that they discussed on how to identify barriers to risk reduction. As to 71.40% of the respondents discussion was held with the counselors to identity persons who can help them through the process of dealing with HIV, and 88.30% of them reported that their needs to referral services were discussed.

4.3.2 Result of data Collected from the VCT Counselors on VCT Service

The councilors reported that they began providing HIV counseling service in the VCT center under investigation and said that VCT service is provided feely. All of them responded negatively to the item that says. "Do all client get the service on the first day they come to be tested?" The reason as to why they do not get the service on the first day they come as mentioned by the counselors, is that the demand for the VCT service has increased. Since there is one counseling room the VCT center can provide service only for 8-10 clients in a day. Everyday the number of clients is more than 10. Because of this there are some Clients who do not get the service. Two counselors indicated that they used to refer HIV positive clients to posttest services provided by Mojo Municipality HIV Committee in collaboration with Save the Children. One of them said that there is no any organization to which counselors refer clients for posttest services.

Regarding skills and contents of counseling sessions the following result was obtained from the counselors. They also reported that there is no waiting room in VCT center.

With regard to skills demonstrated in counseling sessions that refer to inter personal skills, all of them reported that they greet clients warmly and invite them to seat. They also said that they introduce themselves. Two of the counselors said that they ask clients to introduce themselves, while one of them said that he/she does not employ this skill. The counselors reported that they establish rapport that make a client engage in conversation and they listen to clients actively.

Regarding the skills employed for gathering information, the counselors indicated that they seek clarification on the information given by clients probe the information appropriately, and summarize the main issues discussed.

Concerning information giving skills they employ, the counselors said that they give information in clear and simple terms and reinforce the important ones. The counselors also said that they give time for the client to absorb and to respond to the information. Finally they said that they check for the clients understanding of the information provided.

Information obtained from the counselors on the skills they employ to handle special circumstances, two counselors said that they accommodate language difficulties, while one of them said that he/she couldn't accommodate language difficulties.

The counselors said that they discuss on sensitive issues plainly and appropriate to the culture. They indicate that they use silence to deal with difficult emotions and also said that they manage clients' reaction. In connection to contents of pretest counseling session related to introduction/ orientation section, all the counselors said that they orient clients on the counseling sessions. Two of them reported that they describe the testing produce, while one of them indicated that he/she does not describe about the testing procure. All of them reported that they discuss with clients on the confidentiality of the counseling sessions and on reasons that made the clients visit the VCT center to get the service.

Regarding contents included in risk assessment, the counselors said that they discuss on clients recent sexual behavior, on reasons as to why the clients feel that they are at risk, and the frequency of risk situation. Two

of the counselors said that they discuss with clients on their communication with friends, while one of them responded negatively to this item.

Concerning Contents included in exploring options for risk reduction, the counselors said that they discuss on communication of clients with their partners about HIV risk, on their previous risk reduction attempts, on their successful experiences of practicing safer sex, and also on identifying barriers to risk reduction. All of them said that they discuss on the clients experience of using condom and assess clients understanding of each possible test results.

With regard to contents related to plan parents disclosure/ preparation for testing the counselors said that they discuss with clients to whom they told to that they were going to VCT to be tested. All the counselors reported that they discuss on who to tell their HIV status if they find it positive and how to handle their partners' reactions, especially to positive result. Two of them said that they discuss with the clients on the possibility of refusing the test if they want, while one of them indicated that he does not discuss on the possibility of refusing the test.

Regarding contents of posttest counseling session, which are included in informing the result /emotional support, all the counselors reported that they discuss on the feelings of the clients from the time he/she gave blood for the test till he/she come back to hear the result. They also indicated that they discuss on the meaning of positive result, to clarify misconceptions between positive result and AIDS; on the capacity of the clients to cope with positive results and to plan for the future. All of them also said that they discuss on how to tell to their sexual partners, and also on the clients thought about asking their sexual partners to be tested,

With regard to contents related to risk reduction plan of posttest counseling session the counselors said that they discuss with clients on how to protect their sexual partners and others from HIV risk, and also discuss on how to identify barriers to risk reduction, on identifying persons who can help them through the process of their dealing with HIV, and also on their needs of support services.

Two of the counselors reported that they have invited clients to comeback for on going counseling, and one of these counselors estimated that the clients who comeback can be about 25%, while the other one said that about 75% of the clients comeback for the ongoing counseling. One of them said that he/she never invited counselees to comeback for ongoing counseling. The counselors were asked to rate the usefulness of ongoing counseling. One of them said its use is high, the other one said medium, and the third one said that is undecided.

4.3.2.1 Problems Encountered by the Counselors

Counselors were asked whether they had encountered with some problems in their counseling work and then to indicate those problems they faced among those presented in a list. All the counselors said that lack of access to refer clients for care and support service is the problem they encountered at the VCT center.

Two of them reported that workload in providing additional services in another department and lack of supervision were the problems they faced. One of them indicated that lack of administrative support, burn out and lack of waiting room are the problems he/she encountered in the VCT center.

Regarding supervision and support they are provided with, all of them reported that they have an access to counseling supervision. Concerning

ongoing support two of them said they are provided once in a year, which includes refreshment course.

4.4 Result of Data Collected on the VCT Center From the Implementers of the Project

According to the participants of the study unavailability of VCT center in Mojo town was identified when available recourses and gaps was assessed to plan for care and support project. Since using VCT service as an entry point to care and support program is essential, the donor /SC/ agreed to fulfill this prerequisite service for implementation of the program.

Oromiya Health Bureau and Save the Children agreed, and established integrated VCT center at Mojo Health Center.

- All necessary equipments, other than prepared previously, formats, record books, and reagents were provided by Save the Children
- Training on HIV counseling was also provided to those who were previously trained by Oromiya Health Bureau. A room for counseling was arranged and providing VCT service was started. There is no a waiting room from the beginning to the present and there is no any change made to scale up the provision of the service.

Since people were not coming to the VCT center to get the service, it was planned to collect information from different sources the addresses of those terminally sick individuals and give these addresses to home based care providers to enable them meet in person.

Home-based care providers were oriented and directed to visit terminally sick persons in the community and give to them information on the

importance and usefulness of HIV test, the availability of the VCT service at Mojo and also the availability of care and support services if their test result is found HIV positive.

Regarding the confidentiality of the service the respondents said in addition to precautions made by the counselors, in the training provided by Save the Children it is the counselor himself who is required to draw blood from the clients for HIV test, this by itself made the service provided in this VCT center highly confidential.

Regarding to referral service, particularly when the VCT center began providing service, this was provided by two (male and female) Home-based care providers trained by Save the Children. These Care providers used to go house to house to visit patients and refer them to this VCT, and also used to consult the VCT center to refer those HIV positives to the care and support project run by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children, to be provided with care and support services. Since district HAPCO was not established yet, at the beginning of the project it was in this way that referral services were provided. At present patients are referred to Adama Hospital for Antiretroviral treatment by Mojo health center.

The problems that the VCT center encountered currently are two. According to the implementers of the project.

1. Shortage of rooms to increase the accessibility of the service. First of all there is no a waiting room, in the second place there is great change regarding the demand of VCT service. In the last two and half years the demand of VCT service has increased. On the average about 30 clients visit the VCT center per day in need of the service. There is only one counseling room. A counselor is required to provide the service for 8 or maximum 10 clients per day. Because of

this about 20 clients go back without being provided with the service.

2. The other problem is lack of access to referral services, particularly service related to ongoing counseling to create psychosocial adjustment, which is necessary service for all who are provided with VCT service. Because simply testing clients and let them go back to the community without helping them accept the reality, may not enable us to reduce the transmission of the virus.

4.5. Results of Data Collected on Posttest Services

4.5.1 Result of Data Collected from the PLWHAs on Posttest Services

The participants were asked first to know whether they know about social gathering program or not and some questions related to their participation. The majority (86.60%) of them reported that there is a social gathering program organized by Mojo Municipality HIV committee, while 7.80% of them said they did not know about the program and 71.40% of them reported that they usually participate in the program, while 20.80% of them did not. Out of those who participate in the program, 67.50% of them complained that the social gathering program has not been conducted timely. According to nearly half (51.90%) of the participants there are discussions program on HIV/AIDS occasionally (table is not presented).

Table 4.8 Responses of the PLWHAs to the Financial Support

Financial support	Responses		
	Category	Frequency	Percent
Are you provided with financial support?	Yes	76	98.70
	No	1	1.30
Which from of economic support you have been provided?	- Cash in the form of grant to support your living.	76	98.70
	-Cash in the form of loan to enable you generate your income.	-	-
	Omission	1	1.30
The amount of support in birr is per/month.	135	76	98.70
	Omission	1	1.30
Is the financial support provided to you timely?	Yes	9	11.70
	No	66	85.70
	Omission	2	2.60
The financial support you are provided is enough to satisfy your primary needs at ------- level.	Low	55	71.40
	Medium	18	23.40
	High	2	2.60
	Omission	2	2.60

Almost all (98.70%) of the participants reported that they are provided with financial support in birr as a grant. The same percent (98.70%) of them also indicated that the amount of support in birr is 135 per month. Out of all the participants 85.70% of them complained that the financial support is not provided on time.

Regarding the extent to which the amount of money satisfies their primary needs, 71.40% of the respondent said that it is only enough to satisfy their primary needs at low level.

Table 4.9 Responses of the PLWHAs to the Psychosocial support

Type of psychosocial Support	Respons		
	Yes	No	Omission
	# %	# %	# %
Support that enabled me to over-come, psychological problems such as depression, helplessness, guilt, hopelessness.	49[63.60]	15[19.50]	13[16.90]
Support that enabled me to explore my aspiration	37[48.10)	27[35.10]	13[16.90]
Support that enabled me to cope with HIV/AIDS related problems	50[64.90)	14[18.20]	13[16.90]
Specific assistance like that of clearing house, washing clothes, preparing food, when I feel ill	21[27.30)	43[55.80]	13[16.90]
Support that enabled me to share experiences, exchanged ideas, laugh or cry together	54[70.10)	10[13.00]	13[16.90]
Support that helped me to establish priorities.	32[41.50]	32[41.60]	13[16.90]
Support that encouraged me to set goals	34[44.10]	29[37.70]	14[18.20]
When you rate the satisfaction you got from supports provided through the social gathering program, it is----------	Low Moderate High I don't know Omission	37.70 24.70 13.00 7.80 16.90	

As presented in the above table, regarding the psychosocial support provided through social gathering program, 63.60% of the respondents reported that they were provided with support that enabled them to over come their psychological problems. Fifty [64.90]% of the respondents reported that they were provided with support that enabled them cope with HIV/AIDS, and ~~of all~~ 70.00% of the respondents also said that hey were provided with support that enabled them to share experiences exchange ideas, laugh or cry together. Thirty seven [48.10%] and Thirty [44.10%] of the respondents said that they were provided with the support that enabled them to explore their aspiration and support that encouraged them to set goals respectively. 55.80% and 41.60% of the respondents said that they were not provided, with specific assistances like cleaning house, when they feel sick and support that enabled them establish priorities respectively.

According to the rating of 37.70% of the respondents, the satisfaction they have got from the social gathering program is law, while to 24.70% of them it is moderate.

Table.4.10 Response of AIDS patients who are provided with Home–Based care to the Home–Based care they are Provided. Feb, 2006. (n = 26)

Care Provided	Responses		
	Category	Frequency	Percent
Medical care for conditions such as persistent diarrhea lose of appetite, skin problems and bed sores	Yes No	22 4	84.60 15.40
Spiritual and postural support to take care of the emotional and psychological aspects of your problems	Yes No	25 1	96.20 3.80
Educating and training of care givers in the home, such as your family member neighbors and volunteers	Yes No	16 12	61.50 38.50
Appropriate referral services	Yes No	12 14	46.20 53.80
Material assistance to cover your needs such as soap, bed sheets	Yes No	16 12	61.50 38.50
Are you provided with medical care whenever you need?	Yes No	11 15	42.30 57.70
When you rate the home-based care you are provide with, it is _____.	The least satisfactory Moderately satisfactory More satisfactory	26	100

As indicated in table 4.2, on page 44 in which list of services were presented, out of the total respondents, 26 (33.70%) indicated that they were provided with home based care (this service is provided only for those who are AIDS patients). The patients were asked to indicate to specific home-based care they are provided among the care/support presented in the above table (table, 4.10). The majority (84.60%) of them reported that they are provided with medical care for conditions such as persistent diarrhea, lose of appetite, skin problems, and bed sores. The majority (96.20%) of them also reported that they are provided with spiritual support to take care of the emotional and psychological aspects of their problems. Sixteen [61.50%]of these respondents reported that

persons who can provide care for them were educated and trained. Sixteen (61.50%) of respondents were also reported that they are provided with material support such as bed sheets, soap. With regard to appropriate referral services and the availability of medical care, the majority (53.80%) and 57.70%) of the respondents indicated that they were not provided with these services respectively. According to the rating of all (100%) the patients who are provided with home base care, the care provided to them is the least satisfactory.

4.5.2 Result of Data Collected From the PLWHAs by Focus Group Discussion on Posttest Service

According to some of the discussants, it was by home-based care providers they were informed the availability of VCT and other posttest services. As to some of the discussants they heard about the services from friends who were provided with the service. It was very difficult for them to decide for the test because of fear of positive result which implies immediate death, discrimination and rejection by others, including family members. By repeated visits of the home-based care provides and encouragement, they decided to be tested and referred by care givers to the VCT center for the service, and to the committee for other services. According to the PLWHA discussants, VCT service was the first support that they were provided freely.

One of the PLWHAs said,

> *"I thought again and again and lastly I said to myself that I am a sick person that can not work and earn my living, why not I get tested and receive the support till I die. Then I decided and went for the test."*

As indicated by the beneficiaries in August 2003 the first 9 HIV infected person who were tested in the newly established VCT center, were

provided with financial support. This changed hopelessness to hope, and made them feel that they can live.

Among the discussants one PLWHA said:

> *"I was tested my blood and informed my HIV status at the end of 2003. The number of PLWHAs at that time was about 45. I was invited to participate in the social gathering program. It was hard for me to believe when I see infected persons talking together as if noting happened to them. This made me feel a sense of security and hope to live than I felt when I was Provided with the financial support."*

Another PLWHA said:

> *"I would have died long a ago and forgotten, if I was not provided care and support by the committee established by save the children. I was in bed, frustrated and was waiting for my death, when I was informed the availability of free VCT service that will be followed by other services if my HIV test result found positive. At that time I was not well aware of the pandemic, but I did as I was told. I became one of those persons who received financial support on August 24, 2003 for the first time. This date is a day which I consider as my second birth day, but it is a day that gives me more meaning than my real birthday."*

The beneficiaries reveled that the amount of money they were provided was birr 100.00 first. This was increased to birr 150.00 per month. The provision of financial support was scheduled at the beginning of the project year, but gradually delaying became frequent. Delaying was not exaggerated at first even if occurred, Mojo Municipality used to provide the financial support till the budget was released. This is not possible these days, and the delaying of the budget has also increased. This particularly made the lives of those who are bedridden very difficult. The amount of financial support provide was also decreased from 150.00 birr to 135.00 birr. Due to inability of the committee to mobilize the community to enable them contribute the matching fund.

Regarding Home-Based care the beneficiaries said, it is one of the services provided for those who are AIDS patients. It is provided from the beginning to the present. Among those who are provided home-based care some of them died with their dignity being among their family members, some others have recovered from their illness, and still there are some who are provided with the service. It is very useful and necessary service. Due to the disproportionate numbers of caregivers to those who need their care provideing adequate care for the patients was not possible.

According to the discussants, the social gathering program is a program through which psychosocial support is provided to the PLWHAs. It is by which

- An interaction between infected and uninfected was observed
- Information on how to:
    - Deal with problems associated with HIV/AIDS and,
    - Care of themselves was released
- Relation among PLWHAs was strengthened, and
- Spiritual support was provided, this enabled PLWHAs counter isolation reduce feelings of rejection increased their self-confidence.
- Training opportunities provide for some of them produced dissatisfaction to some others. And the number of PLWHAs who participate in social gathering program decreased. This program was previously conducted twice or once in a month, these days it is conducted once in two or more months.

4.6 Result of Data Collected on Posttest Services from the Implementers

According to the informants and the discussants, as the result of PLWHAs' fear of rejection and discrimination, including by their own family members, providing services to them was very difficulty. Regarding this one of them said,

> *"At the very beginning of the project year, we were not expecting the PLWHAs to come to us, but instead we, service providers, were made ourselves ready to go where the PLWHAs were. Beause of this a home-based care provider and I went to one of the PLWHAs home to deliver the financial support. As soon as we arrived there, the PLWHA became disturbed, shocked and also was unable to talk with us. Although there was variation in the intensity of fear that was produced by the PLWHAs, 9 of them were not feel at ease when we arrived at their respective homes."*

The implementers of the project indicated that as soon as the social gathering program [coffee ceremony as some of them call it] of the PLWHAs became operational, fear of rejection, isolation and discrimination were reduced. Since this program created opportunities to provide to PLWHAs with necessary information, psychosocial and spiritual supports that enabled them to reduce feelings of loneliness, hopelessness, and also to develop self –confidence. The program also enabled the PLWHAs to stand in the face of rejection and discrimination. According to the informants and group discussants, the social gathering program also provided an opportunities for those who were members of the donor organization /SC/ to observe and understand what was being done to curb the course of the pandemic.

At the beginning of the project almost all of the PLWHAs, used to participate in the social gathering program and was conducted twice or once in a month. These days it is conducted once in two or more months.

Almost all the implementers said that, the other support provided for PLWHAs is financial support. The donor and the implementer agreed to provide birr 100.00 (One hundred) per month for each PLWHA supported by the project and did as they agreed.

By the second cycle of the project year the amount of money was increased from birr 100.00 to birr 150.00 and the number of PLWHAs supported increased from 50-87 persons. Starting about seven months ago the amount of money provided to the PLWHAs decreased from birr 150.00 to birr 135.00. Previously the financial support was provided as scheduled by the project. Even if occasionally the budget was not released on time, Mojo Municipality used to arrange means that enabled the committee to provide the support on time. At present delaying of the budget become frequent, and means that enable to provide the support on time is not available.

The majority of the PLWHAs even those who can work don't try to work and improve their living condition. This indicates dependency which is an 'Unintended' outcome of the project

As indicated by the implementers of the project, Home-Based care is also one of the services provided by the project. It is provided for AIDS patients to improve their lives. It was also used as an entry point to increase awareness among the community. The interaction and casual body contact that took place between PLWHAs and care providers increased the awareness of family members of the PLWHAs and the community at large that HIV does not transmitted this way.

In order to indicate the change obtained a care provider said,

> *"As the result of fear of rejection and discrimination by neighbors and relatives including family members. PLWHAs were used to warn us to visit them without having kits.*

He continued to indicate the extent of rejection and discrimination by telling history of a sick lady he came across at the beginning of the provision of the service:

> *"I was informed the address of a sick lady and went to visits her. After greeting and introducing myself, I asked a women that I met/probably the mother of the sick lady/ she hesitated at first and asked me some questions. Then she ordered a boy to show me the room where the sick lady/was in. When the room was opened I saw dishes and cups scattered here and there. I tried to great her, but unable to get any response. As I approached to her I found her dead. Then I began thinking for a moment about what to do. I went out of the room and asked that women to put on the light telling her that the room is too dark. As soon as we entered in to the room. I put on gloves and begun touching the dead body telling to the women that the sick lady was dead. These days we can visit any of the PLWHAs at any time, at any corner of the town having the kits with us".*

With regard to the contribution of Home based care one of the discussants said;

> *"Provision of home-based care, not only helped patients develop sense of being accepted and loved by others, but also indicated that HIV/AIDS cannot be transmitted through infected-uninfected interaction and casual contact".*

All the discussants and the informants assured that the number of care givers which was sometimes two or three even at the some other time is one, was not enough to provide adequate care for the patients as needed. This made the lives of patients very difficult.

Materials, particularly bed sheets, were not distributed to all PLWHAs . Because the number of bed sheets provided by the donor never equates to the number of PLWHAs who were provided support. This creates dissatisfaction particularly among AIDS patients

4.7. Result of Data Collected on Sustainability of Care and Support Project

4.7.1 Result of Data Collected on Sustainability from the PLWHAs

There were some questions in the questionnaire that refer to the sustainability of the project and the following result was obtained.

Table 4.11. Response of the PLWHAs Concerning the Sustainability of the Project

Items on sustainability	Response		
	Catagory	Frequency	Percentage
Is there any written agreement between SC/USA/ donor/ and Mojo town HIV/AIDS committee /the implementer/?	Yes No I do not known Omission	8 11 52 6	10.40 14.30 67.50 7.80
Who covers the expense? It is covered by -----	The donor matching fund (the donor and the implementer) - other - Omission	60 11 5 1	77.90 14.30 6.50 1.30
Is there any change in the amount of money you are provided?	Yes No Omission	71 1 5	92.20 1.30 6.70
If the amount of money is decreased, from what amount to what amount?	15 150,130 150-135 Omission	1 2 70 4	1.30 2.60 90.60 5.20
Are there CBOs or FBOs or AIDS patient family members who were trained and educated at home level nursing and provide voluntary services to PLWHAs?	Yes No I do not know	23 40 14	29.90 51.90 18.20
Is there any condition that allows to pass to (transfer to) the financial support of the PLWHA to his family members when he passed away?	No If his children are below age of 18 Omission	74 2 1	96.10 2.60 1.30
In your opinion, will the care and support project be sustainable if Save the Children terminates donation?	No I don't know Omission	64 4 9	83.10 5.20 11.70

As presented in the above table, table 4.11, the majority [67.50%] of the participants said that they do not know whether there is an agreement between SC/USA and Mojo Municipality HIV/AIDS committee or not. Sixty [77.90%] of them said that the donor covers the expense. Seventy (92.90%) of them reported that as there is change in the amount of money they are provided, and 90.90% of them indicated the change in the amount of money was from 150 birr to 135 birr. There was an open-end question in the questionnaire that says "why for the amount of money is decreased if any?" Out of the total participants only 51.90% responded to this item, out of which 82.50% of them reported that they do not know as to why that happed, while 17.50% of them said that inability of the committee to mobilize the community to contribute 10% of the matching fund. Forty [51.90%] of the respondent said that they do not know whether there are voluntary home based care providers who were trained and educated at home level nursing to provide care for PLWHAs, or not, 96.10% of the respondents reported that it is not possible at all to pass to the financial support of the PLWHAs to other family members. The respondents were asked their opinion on the sustainability of the project if the donor terminates donation. Sixty-four [83.10%] of them said that the project would not be sustainable. This question was flowed by an open-ended question that says "what measure will you take if the donor terminates donation?

Only twenty six (33.80%) of the participants were responded to this item. Their responses were the following ones.

"I don't want to think about this "	2 (8%)
"God knows"	3 (12%)
"I will not be able to do any thing except waiting for my death being in my sleeping place"	6(24%)
"I will resume commercial sex work"	2(8%)

" I will be a daily laborer until my health condition allows me to work"	4(16%)
" I will start begging"	2(8%)

4.7.2 Result of Data Collected on Sustainability from PLWHA Group Discussants.

According to the discussants sustainability of the project is not asured. Since a committee, which is unable to mobilize the community to contribute the matching fund (10%), cannot accomplish tasks that make the project sustainable. If the committee were strong enough to mobilize the community, it would have been possible to make the project sustainable.

The IGA program, which was organized by Save the Children, was not also succeeded. Because of this the sustainability of the project with out support of save the children, is not visible.

All PLWHA discussants confirm that except those who are bedridden, the rest of the them are 'healthy' people, who can work and can be productive if they are provided with proper guidance and training, and also with financial support that enable them start working a work which does not affect their health condition. According the PLWHAs , this is one of the means that enable PLWHAs, to support themselves and their family, and also be out of the care and support program.

4.7.3 Result of Data Collected from the Implementers on Sustainability of the Project.

According to this group of participants, individuals were invited from different social group were provided with training on how to plan care and support program on a community level. Following this the needs of

the community were assessed. Available resources and the gaps were identified. According to the result of this assessment lack of access to VCT and posttest revises were the main gaps identified to engage in activities that reduce the transmission of HIV/AIDS. Based on this SC/USA agreed to establish a VCT center integrated in Mojo Health center that fulfills VCT protocol. They also agreed to provide posttest services, and a project proposal was also developed.

The participants of the workshop were organized in such a way that enables them to carry out different activates believed to be supplement and compliment the program to make up the prevention intervention. Accordingly, the group became the general assembly of Mojo Municipality HIV/AIDS committee, which has;

An executive committee, and four sub-committees, namely:-

1. Care and support sub-committee
2. Fund raising sub-committee
3. Orphan support sub-committee
4. Youth and prevention sub- committee

Based on this guideline, both the donor and the implementer embarked on activates designed to implement the program. As it was made plain by the respondents, preparation to implement the project was started.

Accordingly, on the part of the donor:-

- Two nurses were trained on HIV counseling and became counselors of the VCT centers to be established at Mojo Health center
- Two anti- AIDS club members were trained on how to provide Home-based care and became home based care providers.
- Integrated VCT center was established at Mojo Health center and
- The budget was released.

The committee on its part:-

- Obtained the initial contribution of the matching fund from Mojo Town Municipality.
- Discussed and planned on how to encourage the public particularly terminally sick persons to go to the VCT to get the service. Home-based care providers were assigned to visit terminally sick persons and provide information on the availability of services.

Regarding the matching fund almost all of the participants indicated that the purpose of contributing 10% of the matching fund from community members was to create and develop sense of ownership of the project at initial stage, and through time to make the community ready to cover the cost of the project. With this, to lay down the foundation of the sustainability of the project.

Based on the same understanding another proposal was developed which was to be implemented from 10/10/2004-09/10/2005. As mentioned there the numbers of PLWHAs to be provided posttest service increased from 50 persons to 87 persons and the amount of financial support increased from birr 100.00 to birr 150.00.

Organizing IGA program was one newly introduced activity in the action plan. To put this into practice 10 persons i.e. 4, PLWHAs (two females and two males, 4 Orphans (female students) and 2 sex workers were selected, trained and budget was also allotted and released but did not succeeded.

According to the informants from SC, using VCT service as an entry point to provide care and support for 50 infected persons, without

discrimination, for a year was the strategy used to break the silence about HIV. Since it was a right strategy at that time the course of the epidemic has changed.

These days this strategy became a strategy that encourages dependency. Almost all PLWHAs are waiting for the financial support considering it as a salary.

- Community members and home-based care providers were not willing to provide the service. This decreased the quality of the service.

- Networking that was expected to enable us to provide integrated service for PLWHAs, was not well developed. As the result of this the support provided became limited.

According to informants other than those from SC, and discussants, some committee members were unwillingness to participate in the committee from the very beginning of the program, some others were also terminated participating, because of this it became difficult to mobilize the community to contribute 10% of the matching fund. Due to this reason the financial support provided to the PLWHAs was reduced by 10%.

Regarding the willingness of the community to contribute the matching fund, all the discussants and informants assured that the community is willing and ready to contribute as agreed. This was observed whenever meetings were organized and conducted on the pandemic.

One of the main committee members said,

> *"Once a meeting of Idir leaders was organized and conducted by this committee, I think some of you remember that meeting. Before the meeting was started a young lady dweller of this town*

was appeared before the participants and read a poem, finally she informed them that she is a PLWHA. It was very difficult for most of the participants to believe what she said. Some of them were crying. It was decided to pay 3 birr per head of members from the deposit they have first and then to continue the contribution after discussing on the issue with their respective Idir members some of them did as promised while most of them did not"

According to the discussants and informants measures were taken recently with an intention of strengthening the committee, so those who did not participate actively and those terminated participated were replaced by others. The PLWHAs were also included in the committee. However, the active involvement of Mojo town administrators is essential to facilitate the involvement of the community in HIV/AIDS related activities and to contribute the matching fund, so that to ensure the sustainability of the project.

CHAPTER FIVE

5. DISCESSION OF THE RESULTS

In this chapter the discussion made on the major findings of the study are presented.

Preventing HIV transmission is the main reason 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 result in misunderstanding and even resistance to behavior change. In order to provide quality service an integrated VCT center should have counseling room and a 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. The counselor needs to perform skills and discuss contents included in pre and post counseling sessions 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 et.al., 2002). Thus, the counselor- client relationship and interaction are vital elements in counseling process, which in turn determined by the skills that the counselor possesses.

VCT service, when used as entry point to care and support services, attracts potential users of the service from the community.

. Skills Employed by the Counselors

The result of this study, regarding the interpersonal skills of the counselors, indicated that the clients were greeted and welcomed by the counselors and also invited to seat by the same. The counselors introduced themselves first and then asked the clients to introduce themselves. The counselors establish rapport, which made clients engage in conversation. Clients who said that the counselors were listened to them actively were as high 94.80%. Concerning information gathering skills that the counselors employed, the result of this study indicated that the counselors sought clarification about information given. Sixty eight (88.30%) of the clients assured that the counselors probed the information given appropriately. The counselors also summarized the main issues discussed.

With regard to information reserving skills employed by the counselors, the result of this study revealed that the counselors gave 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. The counselors checked for understanding /misunderstanding of the information they provided and 90.90% of the clients revealed that the counselors summarized the main issues discussed.

With respect to skills employed by the counselors to handle special circumstances in counseling session, 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 emotional reactions. Seventy one (92.20%) of the clients said that the counselors managed their reactions.

Almost all of the counselors confirmed that they demonstrated the skills of counseling whenever they offer HIV counseling.

This study indicated that the skills demonstrated by the counselors of the VCT under investigation go along with the standards of the VCT protocol.

. Contents Discussed in Pretest Counseling Session

The results of this study made plain that all pretest counseling contents discussed in the counseling session. As reported by of the clients contents grouped under introduction /orientation were discussed in the counseling session. Accordingly, counselors oriented the clients about the counseling session. They also described the testing procedure. The counselors explained the confidentiality of the test, and also asked the clients the reasons that made them visit the VCT center to get the service.

Concerning contents grouped under risk assessment, the clients recent sexual behavior and as to why they feel that they were at risk were discussed. The frequencies of risk situation of the clients and the communication that they have with their sexual partners were also discussed.

The counselors also discussed on contents grouped under exploring options to risk reduction. Accordingly, they discussed on the communication that the clients have with others about HIV risk, on previous risk reduction attempts, on clients' experiences of safer sex, on identifying barriers to risk reduction, and on clients' experiences of using condoms.

Concerning contents related to preparation for the test /plan partners disclosure group of the pretest counseling session, they discussed to ensure the clients understanding of possible test result, to identify to whom the clients told that they were going to VCT to be tested. The counselors (with the clients) also discussed on who to tell if their test results indicate that they are HIV positive. And finally they discussed on the possibility of refusing the test if they don't want to be tested.

The findings of this study indicated that the majority of the clients reported that almost all the contents of pre test counseling were covered.

The counselors also revealed that almost all the pretest counseling session contents were almost covered in the VCT center under investigation. This indicates that counselor – client discussion on contents of pretests counseling session accord with the VCT protocol.

. Contents Discussed in Posttest Counseling Session

As the result of this study indicated, the majority of the PLWHAs reported that in posttest counseling session they were asked how they have been feeling since their blood was drawn for the test, and they were told that they were HIV positives simply and clearly. Their understanding of the meaning of the positive result was checked. The misconception between positive result and AIDS clarified, the way that they (PLWHAs) deal with the changes occurred due to HIV positive result was examined. How the clients will cope with HIV positive result, how to inform to their sexual partners, their thought about asking their sexual partners to be tested and who to tell their positive HIV test result were assessed.

The results of this study indicated that, the majority of the clients reported that issues about how to protect their sexual partners and others as well, how to identify barriers to risk reduction, how to identify persons that provide them support and their referral needs were explored. These indicate discussions held on contents of posttest counseling session go along with the standards of the protocol.

The counselors also conformed that the contents of posttest counseling session prepared to be discussed with positive clients were covered.

. VCT Services

As reported by 98.70% of the PLWHAs and also by other participants of the study, VCT Service is one of the services provided freely by the project. As indicated by group discussants and key informants it was through personal contact that individuals were referred to the VCT center. PLWHAs also reported that they were informed the availability of free VCT service at Mojo by other PLWHAs who were provided with the service, friends, relatives, spouses. In this way the demand of the VCT service increased and became more than the center can provide in a day. With this the silence about HIV/AIDS was broken in relatively short period of time. This was observed in Uganda and Kenya low response similar to the one investigated among potential clients was observed (Jackson, 2002). This study conformed that VCT is an effective prevention intervention, particularly, when it is used as an entry point to provide posttest services.

As the results of this study indicated there were three counselors that offer counseling services. There is a counseling room to ensure privacy. Since the counselors draw blood from the clients for testing, confidentiality was maintained.

According to the counselors and other implementers the VCT center is integrated in a Health institution. Counselors of the center are permanent workers of the health center.

As to the same group of respondents, there is only one counseling room and a counselor is required to counsel 8-10 persons in a day. Because of this it is not possible to offer the service for all clients who come in need of the service as needed.

.Financial Support

The result of this study revealed that almost all (98.70%) of the PLWHAs were provided with 135.00 per month while this research was conducted. It was upon the receiving of this support that the clients felt that they can live longer with the virus.

The study also made plain that the financial support satisfies PLWHAs primary needs at low level. The result obtained from this study also indicated that the PLWHAs, infected and AIDS patients, started considering the humanitarian support as a salary and waiting for it rather than looking for other options. This was an 'unintended' out come of the project that seems led the PLWHAs to develop dependency.

This study also revealed that the financial support provided to the PLWHAs decreased by 10% than they were provided previously. This is 10% below than the donor and the implementer agreed upon to provide. This was conformed by the majority of the implementers of the project.

. Psychosocial Support

As this study made clear the psychosocial support provided through the social gathering program helped 63.00% of the PLWHAs to get relief from some psychological problems such as helplessness, hopelessness, guilt, and to 64.90% of them this support helped them to deal with HIV related problems and also helped 70.10% of them to use the program as an outlet of their emotional feelings. In this case the social gathering program, like that of support groups of PLWHAs, which were formed to counter social isolation and enable members to share experiences, and cope with stigma and discrimination, provided for the PLWHAs opportunities to exchange ideas, share views and opinions, discuss on similar problems (UNAIDS, 2000). It also provided opportunities to recognize the presence of others who have similar problems and interact with uninfected that could made them feel loved and accepted.

On the other hand the result of this study indicated that the social gathering program through which psychosocial support is provided was not adequate means to enable PLWHAs to explore their aspirations, establish priorities and set goals. These issues require ongoing counseling, which is provided to help clients to cope with HIV and encourage positive living (MOH, 2003). HIV counseling is also client centered and highly tailored to the individuals unique needs (Dillon et.al., 2002). The individual needs of PLWHAs cannot be dealt in depth by approaching them in-group. This indicates that unlike support groups in South Africa, Zambia, and Zimbabwe (UNAIDS, 2002) the social gathering program does not provide ongoing counseling. This indicts that ongoing counseling is not given the necessary attention it deserves.

As the result of this study indicated, the social gathering program provided opportunities to equip PLWHAs with the necessary information, psychosocial and spiritual supports. This shows that emphasis is not given to make PLWHAs participate actively in the program to apply the principle of GIPA stated by UNAIDS.

As to why some (7.80%) of the PLWHAs deny the availability of the social gathering program, and some others (20.80%) do not participate in the programs are issues that require further assessment.

.Home-Based Care

The result of this study indicated that patients were provided with medical care for conditions such as persistent diarrhea, lose of appetite, skin problems and bedsores.

They were also provided (as indicated by 96.20% of the patients) with spiritual and pastoral support of take care of the emotional problems such as isolation, rejection, fear and psychological problems such as guilt, hopelessness aspects of their problems.

The results of this study also revealed that the number of patients who were not provided support by training and educating their caregivers at home level nursing is not few to be neglected. Twelve (38.50%) of the patients did not get this support. It is an important support for many reasons. In the first place it enables family members of patients to provide appropriate care for the patients, in the second place, it helps family care givers protect themselves from HIV and other infections, in the third place it enables the technology used by the donor to take root in the community.

More than half (53.80%) of the patients did not provided with appropriate referral services. Effective two - way referral service that is from home to health institution at all levels and back to home is important to provide care for the patients. Lack of appropriate referral service indicates that the provision of the service is not well organized (MOH, 2003)

As the result of this study indicates, material assistance is not provided to 38.50% of the patients. For patients who suffer from persistent diarrhea, skin problems, and bed sores, materials like soap, bed sheet, are very essential to keep the body and the material the patients use as clean as possible.

The result of this study also indicated that 57.70% of the patients were not provided with medical care whenever they need. This is one of the indicators of less effective home-based care (MOH, 2003). Unless patients are provided with medical care whenever they need and helped to alleviate the pain they feel, the quality of the service becomes poor.

.Ongoing Counseling, Medical Care and Legal and Ethical Services

This study indicated that ongoing counseling medical care and legal and ethical services are not provided by the project under investigation. All of them are important posttest services that enable PLWHAs to lead happier and healthier lives, both physically and psychologically.

The number of PLWHAs who indicated that they were provided with ongoing counseling coincides to the number of PLWHAs who are provided with home-based care. There are also some (20.80%) who said that they

are provided with medical care. This indicates the need for further assessment to make these areas more clear.

Seen from the perspective of prevention intervention ongoing counseling has the greatest contribution. Since it enables to prevent the transmission of the pandemic at primary and secondary levels of prevention (MOH, 2003). Preventing HIV transmission is a critical reason for people to learn their HIV status. HIV negative people should be counseled to help them stay negative. HIV positive people should also be counseled to avoid acquiring further virus that hasten their progression to AIDS (Jackson, 2002)

Due to the irreversible changes that occur as the result of this chronic disease different goals are set at different stages of HIV/AIDS that are accompanied by crisis (Jackson, 2002). Anti retroviral treatment also requires counseling (Dillion et. al., 2002).

These all can be useful when they are provided on an appropriate time whenever the support is needed. Due to these reasons and the opportunity that ongoing counseling gives to discuss again and again contents discussed in posttest counseling session, ongoing counseling is known as the continuation of posttest counseling session. (VenDventer & MOH, 2003). Due to all the above reasons ongoing counseling session is an important posttest service, which is in separable from VCT service to curb the spread of HIV/AIDS.

.Sustainability of Care and Support Project

Regarding the sustainability of the project, it was revealed that 67.50% of the PLWHAs do not know whether the two parties (donor and implementer) have written agreement or not, and 14.30% of the rest of

them said that here is no agreement between the two parties. The majority of the PLWHAs reported that the financial support is not allowed to pass (transfer) to their family members when they pass away and 83.10% of them have of the opinion that the project cannot continue if the donor terminates donation.

The discussants and the informants (except those informants from SC) revealed that the matching fund (10% of the total fund), which was agreed upon to contribute from the community, with an intention of creating sense of ownership of the project among the community members and to lay foundation of the sustainability of the project, is not contributed at present. Because of this, the financial support provided to the PLWHAs decreased by 10%.

As mentioned by group discussants and key informants the main cause of the problems encountered to the project implementation were associated to unwillingness or inability of committee members to accomplish activities that they were assigned for. This problem is the outcome of lack of monitoring as agreed. If proper monitoring were conducted on time, the contribution of the matching fund would have not stopped.

When the financial support provided examined based on the objective of the program, it is a relief support and specific to the PLWHA.

The PLWHA utilizes the financial support together with his family members. Information obtained on the family members of the PLWHAs' indicated that they have on the average 3.17 family size, 77.90% of them have either father or mother. Fifty four (83.10%) of the family members do not have their own income, and 71.00% of them live in houses rented from individuals. This implies that the majority of the family members of the PLWHAs are dependent on relief support dependent persons. The

support that contributed to curb the spread of AIDS may at the same time contribute to increase the number of affected people that need more relief support when the breadwinner die, as mentioned by Jackson (2002).

The findings of this study indicated that the sustainability of the project is not assured. Mainly due to lack of advocacy and lack provision of ongoing counseling. If the project was adequately advocated among the community the matching fund expected on the part of dwellers was not stopped. And also there is no an earthly reason that makes the PLWHAs do not know what is going on in the community, leave alone issues advocated that refer them.

If the PLWHAs were provided with adequate ongoing counseling they would have been able to set goals that include their family members than to be dependent on relief support.

CHAPTER SIX

6. SUMMAY, CONCLUSIONS AND RECOMMANDATIONS

In this section of the study, the summary of the findings of the study, conclusions drawn on the basis of the findings and recommendations that are assumed to be useful to alleviate the problems are presented.

6.1 Summary

The main purpose of this study was to assess the Status of Voluntary HIV Counseling and Testing and Posttest Services provided by Mojo Municipality HIV/AIDS Committee in Collaboration with the Save the Children – USA.

To meet this purpose, the following research questions were raised.

1. Are skills demonstrated, contents discussed in VCT center organized by Mojo Municipality and Save the Children USA go along with the standards of VCT protocol?
2. Is the financial support provided in line with the agreement made between the donor and the implementer?
3. Is the psychosocial support up to the standards set by MOH?
4. Is the home-based care provided in accordance with the standard set by MOH?
5. Is ongoing counseling provided enough to enable the PLWHAs positively live with the virus?
6. Is the medical care provided enough to prevent diseases that hasten the progression of HIV to AIDS?

7. Are legal and ethical services provided to the PLWHAs up to the standards set by MOH?
8. Is the care and support project sustainable?

To answer these questions, survey research methodology was employed. Eighty-seven (87) PLWHAs respondents were purposefully selected. Out of these 77 of them participated in the study. A questionnaire was administered to these participants. Among these 7 PLWHAs were purposefully selected for Focus Group Discussion to elicit information regarding issues that require clarification. All the three counselors working at Mojo VCT center were purposefully selected and participated in the study. They filled the questionnaire.

Interviews were conducted with 13 purposefully selected service providers. Focus Group Discussions were also held with 7 service providers other than those who were interviewed, to supplement the information collected by the questionnaire from PLWHAs.

The data collected was analyzed using the standards adopted for this purpose from Tools for Evaluating Voluntary Counseling and Testing prepared by UNAIDS, and National HIV/AIDS counselors Training Manual. The data was processed using SPSS 10.0 for windows. The major findings of the study are presented below.

❖ The Major Findings of the Study

-Skills employed by the counselors

The analysis of the data collected both from the PLWHAs and the counselors indicated that the counseling skills demonstrated by the counselors in the VCT center under investigation were in accordance with the standards of the VCT protocol. Because the PLWHA

respondents confirmed that the counselors demonstrated the skills in the counseling sessions. Accordingly, the majority of PLWHAs of participants indicated that the counselors demonstrated the interpersonal skills, information gathering skills, information giving skills and skills to handle special circumstances.

-Contents Discussed in Pretest Counseling Session

According to the majority of respondents contents of pretest counseling session, which are grouped in to four groups, namely: introduction/ orientation, risk assessment, exploring options for the risk reduction and preparation for test/partner disclosure were discussed. This was inline with the VCT protocol.

-Contents Discussed in Posttest Counseling Session

The findings of this study indicated that the contents of posttest counseling session discussed in the VCT center under investigation was also in accordance with the standards of the VCT protocol. Accordingly, the majority of the PLWHAs disclosed that posttest counseling contents grouped in to two groups namely: providing the result/emotional support and risk reduction plan covered by the counselors.

-Voluntary HIV Counseling and Testing Services

As the findings of this study made plain VCT is one of the services provided freely by Mojo Municipality HIV/AIDS Committee in collaboration with Save the Children. The free provision of the VCT service was assured by the majority (98.70%) of PLWHA respondents, and also conformed by all the participants of the study.

The findings of this study also indicated that, all the Focus Group Discussion participants in both groups and informants, it was by personal contact of care givers that the PLWHAs referred to the VCT at

the beginning of the provision of the service. However, at present the demand of the service outpaced the capacity of the VCT center of providing the service.

-Financial Support

The findings of this study indicated that Mojo Municipality HIV/AIDS Committee in collaboration with Save the Children provides financial support. Almost all (98.70%) of the PLWHA respondents revealed that they are provided financial support on monthly bases. Almost all of the Focus Group Discussion Participants and informants confirmed what the PLWHAs said.

Almost all of the Focus Group Discussion participants and the majority of informants from service providers revealed that the financial support provided to the PLWHAs decreased by 10% than the two parties agreed upon to provide. As the finding of the study indicated the decrease in financial support was attributed to the unwillingness of individuals expected to participate in the committee and mobilize the community to contribute the matching fund. The findings of the study also revealed that the PLWHAs considered the humanitarian support provided on monthly bases as a salary, which seems led to develop dependency. This was an unintended outcom of the project.

-Psychosocial Support

As the findings of the study indicated, the three groups of respondents (PLWHAs, discussants and informants) indicated that the psychosocial & spiritual supports were provided and information was also released by the project through the social gathering program. This enabled PLWHAs to reduce fear of rejection, discrimination, and feelings of loneliness, this program also helped them to develop self-confidence. The majority of the participants, except the VCT counselors, revealed that this program was

previously conducted twice or once in a month. At present it is conducted once in two or more months time. As the findings the study indicated the majority of the PLWHAs said that the social gathering program was effective in providing support that helped them to counter isolation, helplessness and also helped them to develop self-confidence.

Since psychological support is provided in-group issues that need individual assistances that enable PLWHAs to explore aspiration, establish priorities and set goals were not fully addressed.

-Home-based care

As the findings of this study demonstrated, home-based care is one of the supports provided to AIDS patients by Mojo Municipality HIV/AIDS Committee in collaboration with Save the Children. According to the majority of the group discussants and informants the provision of Home-Based care helped to raise the awareness of the community that HIV does not transmitted by casual body contact by simply being together.

The majority of group discussants and informants revealed that the number of caregivers was not proportional to those who need their care. This has made the lives of the patients very difficult. On the other hand the majority of the patients indicated that they were provided with medical care, spiritual and pastoral support.

Twelve (38.50%) of the patients were not provided support by training and educating their caregivers at home. And more than half (53.80%) of the patients did not get appropriate referral services.

The findings of this study indicated that the patients (38.50%) were not provided with material assistance that helps them keep their body clean.

-Ongoing Counseling, Medical Care and Legal and Ethical Services

The majority of the participants revealed that ongoing counseling, medical care and legal and ethical supports were not provided by the Mojo Municipality HIV/AIDS in collaboration with Save the Children.

-Sustainability of Care and Support Project

The findings of this study demonstrated that the sustainability of the care and support project is not assured. As the group discussants and informants from service providers revealed that the agreed upon matching fund (10% of the total), which was believed to be the foundation of sustainability of the project, was not contributed by the community. As the result of this the financial assistance provided on monthly bases to the PLWHAs decreased by 10%.

As the two groups of participants, namely informants from service providers and group discussants indicated, as thc result of inability of the committee to mobilize the community to participate and contribute the agreed up on matching fund (10%) the financial support provided to the PWHAs was deceased.

As the findings of this study indicated, there is no tangible attempt made to gradually replace the relief support by mitigating support.

6.2 Conclusions

Based on the major findings of the study the following conclusions can be drawn.

1. Skills demonstrated and contents of counseling discussed in counseling sessions in the VCT center under investigation go along with the standards of the VCT protocol.

2. Mojo Municipality HIV/AIDS Committee in collaboration with Save the Children provides VCT service freely. At the beginning of the provision of the VCT service, it was by personal contact of care givers that individuals were encouraged to go to the VCT to get the service. These days the demand for VCT outpaced the capacity of the VCT center of providing the service.

3. Mojo Municipality HIV/AIDS Committee in collaboration with Save the Children provides financial support. The amount of money provided to the PLWHAs has decreased by 10% than the two parties agreed upon to provide, since the matching fund is not contributed from the community. It is not also paid on time as previously done. In addition to this the PLWHAs considered the humanitarian support provided on monthly bases as a salary. This seems led the PLWHAs to develop dependency, which was an unintended outcome of the project.

4. The PLWHAs were provided with psychosocial support. This support was effective and enabled the PLWHAs to overcome, helplessness, hopelessness and to counter isolation, loneliness, and also to reduce fears of rejection and discrimination. It also changed hopelessness into hope and helped the PLWHAs develope self-confidence. The psychosocial support is provided in group. It was not provided individually as the result of this issues that need individual assistance were not adequately addressed. The social gathering program through which psychosocial support is provided was previously carried out twice or once in a month. At present it is carried out once in two or more months. This indicates that the provision of the service does not accord to the standards that the two parties agreed to provide.

5. Home-Based Care is one of the posttest services provided to AIDS patients. It increased awareness among the community members that HIV does not transmitted by casual body contact. Appropriate referral service was not provided to all and material support distributed didn't equate to the number of patients. Thus the Home-Base care services do not accord to the standards set by the Ministry of Health.

6. Ongoing counseling, medical care, and legal and ethical supports are not provided by the project.

7. Ten percent (10%) of the matching fund agreed upon to contribute on the part of the community is not contributed at present. Replacing the relief support by mitigating support was not also given the necessary attention by the project. Because of this the sustainability of the project is endangered.

6.3 Recommendations

Based on the findings of the study the following recommendations were forwarded:

1 Short Term Recommendations

- The committee must advocate the project and strive to be able to mobilize the community to contribute the matching fund as agreed.

- At present the demand for the VCT service outpaced the capacity of the VCT center of providing the service. To scale up the provision of the VCT service arranging additional counseling rooms becomes

necessary, at least, to enable the three counselors provide HIV counseling.

- There must be schedule in order to provide the financial support on time as it was done previously.

- Appropriate monitoring should be conducted.

- Ongoing counseling should be provided to the PLWHAs. To this end the donor should train Para Counselors to provide the service

- Psychosocial support provided to the PLWHAs should consider the changing and divers needs of the PLWHAs and should be strongly based on their salient needs.

- The social gathering program should be provided on time as previously done.

- Materials provided to the PLWHAs should equate to the number of the patients.

- Two-ways referral service, which is the main reason that necessitates home-based care, must be arranged by the project owners to provide maximum possible care to the patients.

- The donor should train volunteer caregivers at home level nursing to improve the qualities of the service and protect the caregivers from HIV and other infections.

2 Long Term Recommendations

- In order to assure the sustainability of the project. In addition to the criteria used to select (assign) committee members individuals should be consulted to be sure that they are willing to spend their spare time to participate in such activities.

- The donor and implementer should also reconsider the proposal to device means and ways of replacing the relief support by mitigating support.

- The project owners should strive to provide medical care at least by integration with other NGOs.

- Legal and ethical services should be provided. To provide these services the committee should be able to assign volunteers among the community members that can provide this support to the PLWHAs.

- The donor should train additional caregivers to be able replace whenever one gives up due to burnout or some other reasons.

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

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APPENDIX 1

QUESTIONNAIRE

1.1 Questionnaire for the Beneficiaries (Q1)

Instructional on how to fill the questionnaire

1. Do not write your name
2. For items which have options tick (✓) one of the options or encircle the latter that represents your choice.
3. For those items which to not have options write your responses in the space provided.

Thank you in advance for your cooperation

PART ONE

1. Age _____
2. Sex A. Male B. Female
3. Marital Status A. single B. Married
   C. Divorced D. widowed
4. Educational Status
   A. Can't read and write C. Grade 1-6
   B. Can read and write
   D. Grade 7-12 E. If any other mention _____
5. Family size is _____
6. Is there any one who has his own income among your family members?
   A. Yes B. No
7. The house in which you live in is _____
   A. your own possession B. rented from Keble
   C. Rented from individuals
   D. If any other mention _____

PART TWO

2.1 Facilities of the VCT Center

1. Have you been provided voluntary HIV counseling and testing service by Mojo Municipality HIV/AIDS committee in collaboration with SC.

   A. Yes B. No

2. If yes, is there a separate room at the VCT center to ensure counseling sessions to be private?

   A. Yes B. No

3. Did the arrangement of the counseling room make one feel at ease?

   A. Yes B. No

4. How do you rate the attempts counselors made to secure confidentiality?

   A. Yes B. No

5. Is there a waiting room

   A. Yes B. No

2.2 Which of the Following Activities were Done by the Counselor in Counseling Sessions?

No	Activities /Skills	Options		
		Yes	No	I don't Remember
1	Greeted and welcomed me warmly.			
2	Invited me to seat.			
3	Introduced himself first.			
4	Asked me to introduce myself.			
5	Established rapport which made me engage in conversation.			
6	Listened actively.			
7	Sought clarification about information given.			
8	Probed appropriately.			
9	Summarized issues discussed.			
10	Gave me information in a clear and simple terms.			
11	Reinforced important information.			
12	Gave me time to absorb information and to respond.			
13	Checked for understating/misunderstanding.			
14	Accommodated language difficulty.			
15	Talked about sensitive issues plainly and appropriate to the culture.			
16	Used silence well to deal with difficult emotions			
17	Managed clients reactions.			

2.3 Which of the Following Contents were Discussed in the pretest Counseling Sessions?

No.	Content discussed	Responses		
		Yes	No	I don't remember
1	Orientation about the counseling sessions			
2	Describing about the test procedure			
3	Explanation on confidentiality of the test			
4	Reason(S) that made me visit VET to get the service			
5	Your recent sexual behavior			
6	Why you feel that you are at risk			
7	Frequency of risk situation			
8	Communication with partner about HIV risk			
9	Communication with others about HIV risk			
10	Previous risk reduction attempts			
11	Your successful experiences of practicing safer sex			
12	Identifying barriers to risk reduction			
13	Yours experiences of using condom			
14	Ensuring your understanding of the meaning of each possible test a result			
15	To whom you had total that you were going to VCT to be tested			
16	Who to tell your HIV status of if HIV positive			
17	How to handle your partner's reaction, especially to a positive result			
18	Possibility of refusing the test			

2.4 Which of the Following Contents were Discussed in the Posttest Counseling Session

No	Contents	Options		
		Yes	No	I don't remember
1	How you have been feeling since you gave the blood sample			
2	Told you that you are HIV infected simply and clearly			
3	Ensuring whether you have understood the meaning of positive result or not			
4	Clarifying misconception between positive result and AIDS			
5	Assessing to know how you are coping with positive result			
6	Ensuring your understanding of possible HIV test results			
7	How to inform to your sexual partner			
8	Your thought about asking your sexual partners to be tested			
9	Who to tell yours HIV test result			
10	How to protect your sexual partner from HIV			
11	How to protect others from HIV			
12	How to identify barriers to risk reduction (Alcohol and other addictive drugs)			
13	Identifying persons from family members or friends who can help you through the process of dealing with HIV			
14	Your needs referral service			

PART THREE

3. Services Provided

3.1 Have you received any service provided by Mojo town HIV/AIDS prevention and control committee? Yes No

3.2 If your answer to item No 3. 1. is yes, which of the following services and/or care you have been provided?

No	Service/Care Provided	Options	
		Yes	No
A	VCT service		
B	Ongoing counseling service		
C	Psychosocial support		
D	Financial support		
F	Medical care		
E	Home-based care		
G	Legal and ethical service		

3.3 Who referred you to the committee for care and support service?

A. the VCT counselor B. Home-based care provider

C. If any other mention here _____

3.2 A VCT Service

1. Did you get VET service freely /with out being charged/ at Mojo health center.

   A. Yes B. No

2. Who informed you the availability of VCT service at Mojo Health center?

   A. Other PLWHAs B. Medicinal personnel

   C. Home-based care providers D. If any mention here _____

3. Which of the following reasons forced you to go to the VCT Center to get blood tested?

   A. need to know my HIV status C. to get married

   B. need to get care and support services

D. If any other mention here _____

4. Did you get the service on the first day you went to the center to be tested?

A. yes B. No

3.2. B. Ongoing Counseling

1. Have you ever gone back to the VCT counselor for ongoing counseling session.

A. yes B. No

2. If your answer to the item No. 1. Is yes, how many times?

A. ones B. twice C. three times D. more than three times

3. Have you been provide with ongoing counseling by an individual others than the VCT counselor? A. Yes B. No

4. If your answer to item No. 3. Is yes, who is the one that provide you the ongoing counseling? _____.

3.2 C Psychosocial Support

1. Is there and social gathering program organized by Mojo municipality AIDS committee? A. Yes B. No

2. Do you usually participate in the social gathering program organized by Mojo Municipality HIV/AIDS committee? A. yes B. No

3. If you say 'yes' to the item No.1. Were the supports provided through the social gathering delivered on time A. Yes B. No

4. Is there any discussion program conducted on HIV/AIDS?

A. Yes B. No C. I do not know

5. **Which of the following supports you have been provided through the social gathering program.**

No	Support Provided	Option	
		Yes	No
1	Support that enabled me to over come psychological problems, such as depression, hopelessness, guilt		
2	Support that enabled me explore me aspiration		
3	Support that enabled me to cope with HIV/AIDS related problems		
4	Specific assistances like that of cleaning house, washing clothes preparing food and when I feel ill		
5	Support that enabled me to share experiences exchange ideas, laugh or cry together.		
6	Support that helped me establish priorities		
7	support that encouraged me to set goals		

6. In general when you rate the satisfaction you got from supports provided through the social gathering program, it is _____

   A. The last satisfactory B. moderately satisfactory

   C. Satisfactory D. More satisfactory E. Most Satisfactory

3.2. D Financial Support

1. Are you provided with financial support?

   A. yes B. No

2. Which form of economic support you have been provided?

   A. Cash in the form of grant to support your living

   B. Cash in the form of loan to enable you generate your won income

3. The amount of money in birr is _____

- Implementing A. Yes B. No

20. Do activities carried out according to the agreement?

A. Yes B. No

21. If your answer to question no 20 is "No", what was the gap created?

_____

22. Is there any connection between the VCT center and Mojo Municipality HIV/AIDS committee? A. Yes B. No If there is any connection, in what way? _____

PART TWO

2. Facilities of the VCT center and counseling sessions

1. Is there a separate room to ensure counseling sessions to be private?

A. Yes B. No

2. Is there a waiting room? A. Yes B. No
3. Do you think that the arrangement of the counseling room make clients feel at ease? A. Yes B. No
4. Is there any table (desk) between you and client in the counseling room
5. How do you rate the attempt made to secure confidentially?

A. very good B. good C. not good D. undecided

2.2 Which of the following contents are discussed in pretest counseling session?

No	Topics Discussed	Option Yes	No
1	Orientation about the counseling session		
2	Description of the testing procedure		
3	Explanation on the confidentiality of the sessions		
4	Reason(S) that made the client to visite VCT to get service		
5	Clients recent sexual behavior		
6	The reason as to why the client feels that he/she is at risk		
7	Frequency of risk situation		
8	His/her communications with friends about HIV risk		
9	His/her Communication with his/her sexual partner about HIV		
10	His/her previous risk reduction attempts		
11	His/her successful experience of practicing safer sex		
12	Identifying barriers to risk reduction		
13	How to address barriers		
14	His/ her experience of using condom		
15	To whom he/she had told that he/she was going to VCT to be tested		
16	How to tell some one if he/she is positive		
17	Who to tell his/her HIV status if HIV positive		
18	How to handle his/her partner reaction, especially to positive result		
19	possibility of refusing the test		
20	If any other specify_____.		

2.3 Which of the following contents are discussed in posttest counseling session?

No	Topics discussed	Option Yes	No
1	How the client has been felling since he/she gave his/her blood for the test		
2	Discussing to assess the clients Understanding of the meaning of positive result		
3	Clarifying any misconception between HIV positive result and AIDS		
4	Discussion to assess the capacity of the client to cope with positive result		
5	How to plan for the future		
6	How to tell /inform to his/her sexual partner		
7	The thought of the client about asking his/her sexual partner to be tested		
8	Who to tell his/her test result		
9	How to protect his/her sexual partner form HIV		
10	How to protect others form HIV		
11	How to identify barriers to risk reduction (Alcohol. and other addictive drugs)		
12	identify person form family member or friends who can help him/her through the process of dealing with HIV		
13	His/her need of support services		

2.1 lists of expected counseling skills are given here under. Which of them are employed by you in counseling sessions/

No	Skills	Option	
		Yes	No
1	Greeting a client warmly		
2	Invite him/her to seat		
3	Introducing self		
4	Asking clients to introduce himself/her self		
5	Establishing report which make clients engaged in conversation		
6	Listening activity		
7	Seeking clarification on the information given		
8	probing appropriately		
9	summarizing main issues discussed		
10	giving information in a clear and simple terms		
11	reinforcing important information		
12	giving time for the client to absorb information and to respond		
13	checking for understanding/misunderstanding		
14	accommodating language difficulty		
15	discussing on sensitive issues plainly and appropriate to the culture		
16	using silent to deal with difficult emotions		
17	managing clients reaction		

4. Is the financial support provided to you timely?

A. Yes B. No

5. The financial support you are provided enough to satisfy your primary needs at the ____ level.

A. Low B. Moderate C. High

3.2 E Medical Care

1. Which of the following health problems you had faced after you have started receiving care and support services?

No	Care/support Provided	Option	
		Yes	No
1	STSs		
2	TB		
3	OIS		
4	Throat Infection		
5	Skin Problem		
6	Skin Problem		
7	Skin Problem		

3.2 F Homc-based Care to be filled only by those who are provided with Home based core

No	Care/ support Provided	Option	
		Yes	No
1	Medical care for conditions such as persistent diarrhea, lose of appetite. Skin problems and bed sores		
2	Spiritual and pastoral/support to take care of the emotional and psychological aspects of the problem		
3	Educating and training of care givers in the home such as family members, neighbors and volunteers		
4	Appropriate referral services		
5	Material assistance to cover your needs such as blankets. Soap, bed sheets.		
6	Are you provided with medical care whenever you need/		
7	When you rate the home based care you are provide with, it is__		

PART FOUR

Sustainability of the Project

1. Is there any written agreement between the donor/save the children USA/ and project implementer/Mojo municipality HIV/AIDS committee?

   A. yes B. No

2. If yes, does it include the following

   A. Planning A. Yes B. No

   B. Implementing A. Yes B. No

   C. Monitoring and evaluation A. Yes B. No

3. Who covers the expense?

   A. the donor

   B. By matching found (the donor and the Mojo town dwellers

   C. If any other mention _____.

4. Is there any change in the financial support you are provided?

   A. Yes B. No

5. If the financial decreased, from what amount to what amount _____.

6. Why for the amount of money is decreased _____.

7. Are there CBO or FBO or AIDS patient family members who were trained? A. Yes B. No

8. Is there any condition that gives room (allows) to pass the financial support of the PLWHA to his family members when he passed away?

   A. Not B. If there is one among his family members who is infected with the virus

   C. If the children are below age 18

9. In your opinion, will the care and support program be sustainable if save the children USA discontinue donation?_____

10. What measure will you take if the donor discontinue donation?

APPENDIX 2

Questionnaire

I thank you very much for your willingness to share your precious time to give me with the necessary information to be used in the study which is going to be conducted.

The purpose of this questionnaire is to collect data that will be used to investigate the status of VCT and Posttest Services provided by Mojo Municipality HIV/AIDS committee.

Instruction:

1. Do not write your name.
2. Put a tick (✓) mark or encircle the latter that represents your choice for items which have options .
3. write your answers in the Space provided for those items which do not have options.

1.Age_____ 2. Sex _____

3. What was your profession before you become HIV Counselor?_____

4. Total years of Work experience_____

5. years of service as a counselor_____

6. How did you become a counselor?

A .Self motivated B. selected by the organization in which you were working C. If any other mention

7. Are you a permanent government employee? A. Yes B. No

8.Have you ever been trained in HIV counseling? A. Yes B. No

9. Have you got training on HIV counseling more than once?

A. yes B. No

10. If yes, please list them down here including the name(s) of the organization(s) that gave you training _____

_____

11. Which of the following manual was employed when you were trained as HIV counselor? (It is possible to indicate more than one manuals)

A. the manual prepared by CRDH

B. the manual prepared by MOH

C. the manual prepared by WHO

D. If any other mention_____.

12. Do you feel that there is any area that you need more training on counseling? A. Yes B. No

13. Did You start providing HIV counseling in the VCT center located at Mojo Health center? A. Yes B. No

14. Does the (VCT) service provide freely ? A. Yes B. No

15. Do all clients get service on the first day they come to get the service? A. Yes B. No

16. If "No" is your answerer for item no 16, would you please mention the reason (s)

_____

17. Do you have an access to refer HIV positive clients to care and support services? A. Yes B. No

18. If yes would you please list down the names of the organization(s) to which you refer HIV positive clients for care and support services.___ -

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19. Is there any written agreement between the Mojo Health center and the organization you motioned above? A. Yes B. No

If yes, does the agreement include?

- Provision of reagents and the like. A. Yes B. No
- Planning A. Yes B. No

2.4 Ongoing Counseling

1. Have you ever invited clients to come back for ongoing counseling?

   A .Yes B. No

2. If yes, according to your own estimation the number of counselees who came back for the ongoing counseling can be about ------

A. 25% B. 50% C. 75% D. 75% and above

3. How do you rate the usefulness of ongoing counseling?

   A. Low B. Medium C. High D. Undecided

3. Problem encountered and support provided to the counselors

1. Have you been encountered with some problems in your counseling work? A. Yes B. No
2. If yes, problems that may occur in the process of rendering VCT service are listed here under. Indicate those problems you faced in your counseling work (It is possible to indicate more than one)

No	Problem	Option	
		Yes	No
1	Work load in another department		
2	Lack of ongoing training		
3	Shortage of counseling room		
4	Lack of confidentiality		
5	Lack of administrative support		
6	Lack of supervisions		
7	Lack of technical support		
8	Lack of privacy		
9	Burn out		
10	Turn over of counselors		
11	Lack of waiting room		
12	Shortage of reagents		
13	Shortage of organization to whom you refer clients for care and support		

3. Do you have an access to a counseling supervisor to provide you with the necessary support and supervise your work?

A. Yes B. No

4. How often you were provided with ongoing support by the supervisor(s)

A. once in every quarter of a yea B. once in every year

C. if any other mention here._____

5. Did the support you were provided include training? A. Yes B. No
6. How do you rate the supervision work?

A. Very good B. good C. not good D. undecided

7. Is there any other alternative where you can get technical and emotional support as a counselor? A. Yes B. No
8. What is your opinion about the sustainability of the VCT service?-----

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Appendix 3

Interview and Focus Group Discussion Items

1. What is your specific role in the service provided by Mojo Municipality HIV/AIDS committee?
2. When, how, why and by whom the committee was established?
3. If the committee has bilateral relationship, do the two parties have written agreement/proposal?
   What is the objective of the program?
   What is the role of each parties?
   Who provides the fund of the program according their agreement?
4. Would you please list and explain the services provided by Mojo Municipality HIV/AIDS committee in collaboration with Save the Children/USA?
5. Does the program is being carried out according to the agreement reached by the two parties?
6. If not, what is missing/the gap/ and what measures were taken to Carry out the program?
7. What is the main reason that necessitates to contribute (if any)? the matching found?
8. What is being done on the part of the community? PLWHA to secure the sustainability of the program if the donor terminates donation?
9. What do you personally think about the sustainability of the project.
10. If you have any other issue related to the case at hand, please mention if here.

Declaration

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

Name Mewaie Wedajench

Signature [signature]

Date of Submission June 30/2006.

Place: Department of Educational Psychology

A.A.U

Addis Ababa

This Thesis has been submitted for examination by approval as a university advisor (Advisor).

Name _____

Signature _____

Date of Submission_____