ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES DEPARTMENT OF PSYCHOLOGY

DETERMINANTS OF OUTCOME OF COUNSELING HIV POSITIVE PEOPLE IN ADDIS ABABA

Fentie Ambaw Getahun

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A thesis submitted to the school of graduate studies of Addis Ababa University in partial fulfillment of the requirements for the degree of Master's in counseling psychology

June 2007

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Determinants of outcome of counseling HIV positive people in Addis Ababa

By

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Approved by the Board of Examiners

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The commitment my parents had for my betterment continues to maintain my momentum.

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Abstract

This cross-sectional survey was conducted on 191 HIV positive client's of age above 15 years (124 females and 67 males) at three counseling centers in Addis Ababa in May, 2007 to determine the effect of the client's background, the content of the counselor's message using the health belief model as a framework, and the counselor's approach using client-centered theory on the outcomes of counseling HIV positive people. The study has found out that female gender increases the risk of poor interaction with one's family after HIV diagnosis (OR=.38, 95%CI= .16- .9, p< .05) and male HIV positive clients were found to be less rejected by others after their HIV diagnosis (OR= .31, 95%CI= .126- .745, p= .009). Thirty-two (16.8%) of the respondents reported that the counselor's message was irrelevant to them, and irrelevant information was found to increase feelings of guilt (OR= 2.8, 95%CI= 1.2- 6.4, p< .05). Including the four key beliefs of the health- belief model (susceptibility of clients to negative outcomes, severity of negative outcomes, benefits of performing specific plans (behaviors), and barriers of performing specific plans) in the counselor's message minimizes specific negative outcomes. No statistically significant association was found between the counselor's congruence or respect of the client and the client's counseling outcome. But perceived loss of confidentiality was found to increase the major negative outcome depression (OR= 2.2, 95%CI=1.13- 5.86, P<.05). Interaction with family and friends was found to be supportive for above 80% of the HIV positive clients. These results indicate that counselor's must be very careful about the content of their message, client-centered approach should be investigated further, family counseling with consent from the specific client should be considered, and more focus should be given for female HIV positive clients.

Key terms: VCT, health- belief model, client- centered counseling

ACRONYMS AND OPERATIONAL DEFINITIONS

1. **AIDS**- Acquired Immune Deficiency Syndrome
2. **HIV**- Human Immunodeficiency Virus
3. **MOH**- Federal Ministry of Health of Ethiopia
4. **HAPCO**- HIV/AIDS Prevention and Control Office of Ethiopia
5. **Outcome**-The medium term result of one or several activities
6. **Counseling**- A confidential dialogue between a counselor and a client aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS.
7. **HIV Positive People**- People whose serostatus is positive for HIV
8. **VCT Center**- voluntary counseling and testing center for HIV
9. **Client** – HIV positive people visiting the counselor for help
10. **Message**-Important idea communicated
11. **Counselor**- A professional trained in some way to give counseling for HIV positive cases
12. **Sexual Partner** – People whose relationship includes sexual intercourse regardless to their marital status
13. **CDC**- Centers for Disease Control of America

CHAPTER- ONE

Introduction

1.1 Background

World wide HIV/AIDS has created enormous challenge on the survival of man kind. Since its recognition, the virus has infected close to 65 million individuals and over 25 million have already died due to AIDS (MOH, 2003). Despite evidence that prevention programs instituted some time ago are beginning to have an impact in some countries, the epidemic continues to grow. For example, the number of HIV infected people in 2005 was found to be double the number of HIV infected people in 1995 (Global Health Council, 2006).

In Ethiopia, the first cases of AIDS were detected in 1986. The national adult prevalence rate for 2005/2006 was estimated to be 3.5%, with a 10.5% urban rate and a 1.9% rural rate (MOH, 2006). The life lost to AIDS was an estimated cumulative total of 900,000 by 2003, and is projected to reach 1.8 million by 2008 if present trends continue. Adult deaths due to AIDS are expected to rise in the coming years, and AIDS already accounts for about one – thirds of all young adult deaths in the country (Global AIDS Program, 2004; MOH, 2004). The regional HIV/AIDS estimate for Addis Ababa for the year 2005/2006 shows 11.7% adult prevalence of HIV infection (MOH, 2006), 23,590 new AIDS cases, and 245,925 HIV positive cases (MOH, 2005). In Ethiopia, heterosexual transmission is responsible for the majority of infections followed by mother- to –child transmission route (HIV/AIDS Prevention and Control Office, 2003).

Possible impact analysis on different variables shows that HIV/AIDS has a visible effect and detrimental impact on Ethiopia's society and economy. For example, HIV/AIDS accounted for an estimated 38% (54,000) of all tuberculosis cases incidence in the year 2003; in this same year, HIV/ AIDS on the average was expected to reduce life expectancy in Ethiopia by 4.6%, there were 90,000 adult and 25,00 child deaths, and

539,000 AIDS orphans. The impact it has on trained workforce and the social services is gravy (MOH, 2004).

Diagnosis of HIV positive status results in immediate and powerful emotional responses in the individual and his families. HIV positive people may be distraught for weeks or months. Depression often occurs and thoughts of suicide are frequent (Stine GJ, 1996). Adjustment to living with a chronic viral condition, absence of a cure, limits imposed by a possible ill health, possible social, occupational and sexual rejection or treatment failures are usually the causes for depression. Interpreting HIV as a punishment, for example for being sexually promiscuous, and over anxiety caused to partner/ family can lead to sever guilt feeling. HIV positive people are usually in fear and anxiety of partner's reaction, infecting others, abandonment and stigma, as well as uncertain prognosis (Chippindle S. & French L., 2001).

The national strategic framework of Ethiopia focuses on the following intervention areas out of which counseling is the focus of this research: behavior change communication, condom promotion and distribution, blood safety, management of sexually transmitted infections (STI), prevention of mother to child transmission (PMTCT), universal precautions and post exposure prophylaxis(PEP), care, support and treatment of people with HIV/AIDS, main streaming, capacity building, conducting surveillance and research, and advocating the legal and human rights of people with HIV/AIDS (HIV/AIDS Prevention and Control Office,2003).

Counseling in HIV and AIDS has become a core element in a holistic model of health care, in which psychological issues are recognized as integral to patient management. HIV and AIDS counseling has two general aims: the prevention of HIV transmission, and the care and support of those affected by HIV and AIDS (Chippindale S. & French L., 2001). To fulfill its public health functions, HIV counseling must be **client-centered**, that is tailored to the behavior, circumstances, and special needs of the person being served. Risk- reduction messages must be personalized and realistic (The Center for AIDS Prevention Studies USA, 2003; Stine GJ., 1996). Counseling should be culturally

competent (i.e., program services provided in a style and format sensitive to cultural norms, values, and traditions that are endorsed by cultural leaders and accepted by the target population), sensitive to issues of sexual identity, developmentally appropriate (i.e. information and services provided at a level of comprehension that is consistent with the age and learning skills of the person being served), and linguistically specific (i.e. information is presented in a dialect and terminology consistent with the clients language and style of communication) (Stine GJ., 1996).

Counseling also requires time (the counselor should address the concerns of the client without rushing), acceptance (people with HIV/AIDS should feel that they are fully accepted irrespective of the life styles and their socioeconomic ethnic, and religious backgrounds), accessibility (easy to obtain; able to call on a counselor at any time; opportunity for subsequent meetings), consistency and accuracy of information, and confidentiality (it establishes trust between counselor and client and must be maintained at all times) (Cameroon Baptist Convention Health Board, 2004).

According to the **health belief model**, health related behaviors depend on four key beliefs that must be operating for a behavior change to occur: *perceived susceptibility* (personally vulnerable to the condition), *perceived severity* (belief the harm can be done by the condition), *perceived benefits of performing a behavior* (what they are going to get out of the change), and *perceived barriers of performing the behavior* (what keeps them from performing the behavior) (Washington state department of health, HIV/AIDS prevention and education services, 2006; The Communication Initiative, 2003)

Counselors can help the affected persons adopt new life styles, assist them to retain their identities, independence, privacy, social status, and self-worth. This can then reduce the risk of negative outcomes, re-infection, and transmission of infection to others. Negative reactions that follow learning positive HIV diagnosis, especially at 1st may include: depression, denial, anger, suicidal ideation, guilt and lowered self-esteem (Cameroon Baptist Convention Health Board, 2004).

The evaluation of effectiveness of HIV counseling has been impeded by a lack of adequate outcome instruments and concerns about the validity of self-reported behaviors as well as the breadth of the issue (Grinstead OA., 1997). In settings with low level of resources, through evaluation of the process and an assessment of the immediate outcomes may be the most appropriate evaluation strategy. As HIV counseling is of fundamental importance to regional, national or international HIV prevention efforts, its evaluation is a critical issue (Rugg DL et al., 1991).

Evidences that show effectiveness of VCT in reducing risk behaviors in HIV transmission, and cost wise acceptable are not few (WHO, 2004). What seems to be lacking, especially in Ethiopia, is a more focused local or regional study that can be practically used to get the maximum possible benefit from the available few services.

Worldwide, the available literature shows that one of the most important positive out comes of effective VCT, *disclosure of serostatus* to others, most importantly to one's sexual partner has been found to be strongly influenced by stigma (Lie, 1994; Grinsteed OA. et al, 2001; Nyblade L. et al, 2003; WHO, 2004; Sethosa E. & Peltzer K., 2005), concerns about confidentiality (Lie, 1990; Sethosa E. & Peltzer K,2005; Jackson H., 2002), and in women fear of disruption of family relationships, blame, violence, and loss of support (WHO, 2004; Sethosa E & Peltzer K, 2005).

Sethosa & Peltzer (2005), on their study to evaluate VCT, self-disclosure, social support and sexual change in South Africa on 55 HIV-positive (41 women, and 14 men) participants interviewed 5 months after diagnosis, found out that 36% of the respondents had disclosed their results to their sexual partners, and 50% of the participants had had sex. In this African study, counseling context and content, and counseling satisfaction were not found to be related with HIV disclosure.

Another study conducted in four cities of the USA by Weinhardt LS. et al (2004) to assess HIV transmission risk behaviors among men and women on 3729 HIV positive people (1918 gay men, 978 women, and 827 heterosexual men) had shown that 75% of

the heterosexual men and women were sexually active in the preceding three months after diagnosis. 36.5% of women and 34% of heterosexual men were to practice unprotected sex. 68.6% of women and 62.9% of heterosexual men were found to have disclosed their status to their sexual partners before having sex.

Both in the African study with small sample size and in the American study with very large sample size, one finding is common: the number of HIV positive people who continue sex after diagnosis is significant, and the number of people practicing sex after HIV diagnosis is larger than the number of people disclosing their status allowing the transmission to continue underground.

WHO (2004) summary report indicates that rate of disclosure of HIV positive status for women is 16%-86% mean 52%) in developing countries, and 42%-100% (mean 71%) in the developed world. In the report, it has also been included that social support, sense of ethical responsibility, failing health, and the need to minimize stress associated with non disclosure motivate people to disclose their result.

A study conducted in Tanzania by Lie (1994) on 246 HIV/AIDS clients indicated that sever social depravation, depression, guilt, and anxiety are strongly associated with stigma, the progress of the disease and the ability to work. Lie has found that 23% of the subjects felt rejected and 29% felt misunderstood even by their closest family. Nyblade L. et al (2003), in their study ' disentangling HIV and AIDS stigma in Ethiopia, Tanzania, and Zambia' found that both men and women are stigmatized for breaking sexual norms, but gender-based power results in women being blamed more easily.

Kelly JA. et al (1993) in their study of factors associated with severity of depression and high risk sexual behavior diagnosed with HIV, they were able to demonstrate that high level of depression was predicted by lower perceived social support, attributions that health was influenced more by chance, high risk sexual behavior practices, and greater number of HIV illness symptoms.

AIDS Community Research Initiative of America (2004) estimated depression among people with HIV to range from 15%-60%. It has also described that depression may interfere with adherence to treatment, health care visits, participation in social activities, and personal relationships.

Health Belief Model: History and Orientation

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. It was one of the first models that adapted theory from the behavioral sciences to health problems, and it remains one of the most widely recognized conceptual frameworks of health behavior. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS (Glanz et al, 2002).

The key constructs of the HBM include:

- **Perceived Threat:** Consists of two parts: perceived susceptibility and perceived severity of a health condition.
- **Perceived Susceptibility:** One's subjective perception of the risk of contracting a health condition,
- **Perceived Severity:** Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).
- **Perceived Benefits:** The believed effectiveness of strategies designed to reduce the threat of illness.
- **Perceived Barriers:** The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.

- **Other Variables:** Diverse demographic, sociopsychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behavior (The Communication Initiative, 2003).

Client-Centered Counseling: History and Orientation

Client-centered counseling has its origins as person-centered counseling in the 1930s and 1940s works of Dr Carl Rogers, the American psychologist and therapist. The central truth for Rogers was that the client knows best. It is the client who knows what is hurting and in the final analysis it is the client who knows how to move for ward. The counselor's task is to enable the client to make contact with his own inner recourses rather than to guide, advise, or in some other way influence the direction the client should take. The approach lays primary stress on the quality of the relationship between counselor and client, and places high value on the experience of the individual as well as his subjective reality. It also challenges each person to accept responsibility for his life and to trust in the inner resources which are available to all those who are prepared to set out along the path of self-awareness and self acceptance (Boeree C. G., 2006; Mearns D. & Thorne B., 1988).

To be successful, a client -centered therapist must have the following special qualities: congruence, empathy, and respect (unconditional positive regard) (Boeree C.G., 2006; Nystul.M. S., 1999; Mearns D. & Thorne B., 1988). Properly trained client -centered counselors can constructively confront resistance to behavior change and help design alternatives to high risk behaviors in many clients who are resistant to changing risk behaviors (Brookman J., 1996). The client-centered counseling has also been shown to be an effective strategy in achieving sexual behavioral changes with in the carefully defined groups such as commercial sex workers, and post test counseling for those who receive a positive HIV test result. The process of HIV testing offers an opportunity to use a client-centered counseling approach to under take an individual risk assessment, discuss and develop individually tailored personal prevention strategies and consider the implications of positive HIV test result (Johnson A., & Imrie J.,2001).

According to CDC (2001), a large, randomized, controlled trial, reported client-centered approach to be:

- effective at reducing high-risk sexual behaviors and new STDs
- feasible to use even in busy publicly funded clinics;
- acceptable to clients, counselors, and health-care providers and
- cost-effective at preventing STDs in persons at increased risk for HIV

In response to mounting evidences of poor outcomes from VCT evaluation studies, the CDC revised VCT guidelines in 1993. The new guidelines instruct HIV counselors to employ the client -centered approach since 1993 (CDC, 2001; Sheon N., 2006)).

In Ethiopia, VCT uses **client- centered approach** and one of the main barriers of VCT is lack of perceived benefits of VCT among the general public (MOH Ethiopia, 2003).

1.2 Statement of the problem

Evidences now support that VCT is effective in changing undesirable behavior related to HIV transmission; it is the most important entry point for care and support of people already infected, and is able to decrease stigma finally in the community by "normalizing" the condition as significant number of people know their status and disclose it. CDC, after a large scale study, has recommended client-centered approach of counseling for VCT, and the ministry of health of Ethiopia has adopted this strategy. As it has been stated earlier, the focus of client-centered counseling is the inner resource of the client and his subjective reality, and the approach lays primary stress on the quality of the relationship between the client and the counselor.

However, other evidences are showing that in sub-Saharan Africa the extended family has been the most reliable source of social welfare and security for centuries, and becoming insensitive to local traditional values and imposing Western notions of individual counseling may worsen the problems than solve them (Jackson H., 2002). This discrepancy needs to be cleared by a local more focused study to maximize the achievement of the desired outcomes of VCT.

This project had been designed to get some insight regarding the issues raised by investigating the effects of the counseling approach, the client's perception of the counselor's messages, and the background of the client on the outcomes of counseling among HIV positive cases.

1.3 Significance of the study

HIV/AIDS prevention, and care and support to people with HIV/AIDS are essentially based on effective counseling. The outcomes of counseling can be determined by factors related to the client's background, the counselor's approach of counseling, or the message.

Finding out which factor determines which outcome in a specific socio-cultural context can help to predict to what extent the goal of the process can be achieved provided the client's background, counselor's approach and the message are given. The knowledge of determinants of counseling HIV positive people helps to design health education to the public, to train effective counselors and to strengthen counseling centers.

CHAPTER TWO

2.1 Objectives of the study

2.1.1 General objective:

The general objective of this study was to assess the effect of the client's background, the content of the counselor's message as perceived by the client and the counselor's approach of counseling determining outcomes of counseling HIV positive people in Addis Ababa counseling enters.

2.1.2 Research questions

A. Client related questions

1. Do older HIV positive clients have positive counseling outcomes than younger HIV positive clients?
2. Do female HIV positive clients experience negative outcomes of counseling more frequently than male HIV positive clients?
3. Do some ethnic and religious groups experience negative outcomes of counseling than others when they are HIV positive?
4. Does higher level of education, occupation, or household income result in positive outcome when counseling HIV positive people?
5. Do married HIV positive people experience positive outcomes of counseling more than others?
6. Do HIV positive people who have children experience more negative outcomes after counseling than those who have no children?

B. Message related questions

1. Do HIV positive clients who perceive the counselor's message as irrelevant to their needs, or not compatible with their cultural values, or not clear to them, experience the negative outcomes of counseling?

2. Do HIV positive clients who believe that the counselor's message does not include their susceptibility to negative outcomes, or severity of the negative outcomes, or benefits of performing specific plans, or barriers of performing specific plans tend to experience negative outcomes after counseling?

C. Counselor related questions

1. Do HIV positive clients who perceive that the counselor is not accepting them, or not confidential to them or genuine experience negative outcomes of counseling?

2. Do HIV positive clients counseled by a counselor of the same age, sex, ethnicity, or religion experience positive outcomes of counseling?

CHAPTER THREE

Methodology

3.1 Research setting: The research was conducted in three governmental counseling centers in Addis Ababa: Arada health center, Yekatit 12 hospital and Kasanches health center. Arada health center was established in late 1960s in the present Arada sub city. VCT services have been given in the health center since 2003. Yekatit -12 hospital was established in 1923 in the present Arada sub city. VCT services have been given in the hospital since 2005. Kasanches health center was established in early 1944 in the present Kirkios sub city. VCT services have been given in Kasanches health center since 2002.

The three sites were selected because they give a pre-test, post-test and ongoing counseling services, were able to provide a private office for the interview, and have an experience of at least one year. One year experience and ongoing service of the centers allowed adequate number of respondents at each counseling center for this study.

3.2 Research design: A cross-sectional survey was conducted from May10-25, 2007 in all the selected sites.

3.3 Source population: HIV positive people with age above 15 years and attending post test counseling services in Addis Ababa. People below 15 years were not considered in this study.

3.4 Study subjects (participants of the study): HIV positive cases with at least one post test counseling (which may be at the respective site or any other site as reported by the client) and found at the selected counseling center during data collection.

3.5 Sample size A total of 191 HIV positive cases were included in this study.

3.6 Sampling techniques: In this study convenience sampling method was used. The study subjects were recruited for the study immediately they left the counselor's office at the respective counseling centers after informed consent was obtained from them through their counselor (The counselors were asking the clients if they were willing to participate in a study which includes an interview in a private room very near to the counselor's office, and they were sending clients willing to be interviewed to the interviewing room). All the cases in the study period were taken until the required sample size was obtained.

3.7 Selections of variables: The study has included the following **dependant** and **independent** variables. The dependant variables are indicators of outcome of counseling. They are, there fore, classified into ***positive outcome indicators*** **and** ***negative outcome indicators*** (adapted from Cameron Baptist Convention health board, 2004).

- **Indicators of positive outcome are**:

A. *Disclosure of HIV status to partner*s-This was measured by directly asking clients whether they have disclosed their positive status to their sexual partners or not.

A. *Consistent use of condom or abstinence*: This was measured by interviewing clients whether they practice sex or not, and whether they use condom consistently if they were practicing sex after diagnosis.
B. *Compliance to treatment*: This was measured by asking the clients whether they were on ART, and asking those that were on ART whether they were taking the drugs regularly or not.
C. *Social interaction*: clients were interviewed about their interaction with their partners, families, and with their workmates or fiends.
D. *Carrying out responsibilities*: This variable was intended to measure whether there was loss of role functioning among HIV positive cases after diagnosis or not. Clients were asked whether they were carrying out the responsibilities they had at least as before diagnosis or not.

- **Indicators of negative out come of counseling**

A. Depression: In this study the clinical diagnosis of depression (*DSM iv* criteria) was not used because many HIV positive people might not meet the criteria for clinical diagnosis but have several symptoms of depression that can have a negative impact on their lives(AIDS Community Research of America ,2004). Hence, a screening two -question test of depression was used. The two-question test has a sensitivity of 96% and a specificity of 57% (Thomas H., 2006). Similar to depression, all other variables intended to measure negative outcomes of counseling were presented in very simple forms that can be understood by any of the respondents regardless of their socioeconomic status.

B. Anxiety: It was measured by two item interviews that stress on feelings of tenseness and intrusive worries.

C. Guilt feeling- This was measured by interviewing clients to respond whether there were things which they regret and bother.

D. Denial: This was measured by interviewing clients whether they define symptoms related to HIV infection as symptoms of other conditions.

E. Feeling of being rejected: This was measured by interviewing clients whether they feel misunderstood even by their closest families and others or not.

F. Suicide ideation: this variable was measured by interviewing clients whether they had been thinking of taking their lives.

The independent variables were related to the client, the message and the counselor.

- **client related variables include the client's**:
    - age, sex, religion, ethnicity,
    - educational level, occupation, monthly household income
    - marital status, number of children
- **Message related variables**: These variables measure the client's evaluation of the **culturally fitness** of the counselor's message. They include the client's perception of the message's
    - relevance to his/her needs
    - compatibility with his/her cultural values
    - clarity (understandability) to him/her

The remaining message related variables were content indicators from the health – belief model and they were to be measured as perceived by the client. The variables included:

- Susceptibility of client to negative outcomes
- severity of negative outcomes
- benefits of performing specific plans
- barriers of performing specific plans

- **Counselor related variables**: These variables include the clients' preference of counselor's general back ground – age, sex, ethnicity, and religion,(to be measured by interviewing the clients about their preference), and three basic characteristics of

an effective counselor according to the client-centered theory- confidentiality, congruence (genuineness), and acceptance (respect) to be measured as perceived by the client (by interviewing clients). Empathy was not included in this study because its equivalent Amharic, "lik endante/endanchi huno/huna chigrkin/shin yiredalhal/shal wey" was found to be confusing for the clients during the pilot study. Instead, confidentiality which was not among the three basic requirements in the client - centered counseling was included because evidences suggest that clients need strict confidentiality as they are fear of stigma, employment discrimination, and other forms of legal and human rights abuse (Esex M. et al, 2002).

3.8 Data collection techniques: Structured interview schedule was used to collect data from respondents. This technique was preferred because the level of education of the clients was expected to range from college level to illiterate. Pilot study was done before the main study on clients whose number was 15% of the sample size of the main study and who were not included in the main study to refine the instrument and to learn unforeseen obstacles. The lessons obtained from the pilot study included: clients need great privacy during the interview (they do not want to be seen interviewed), other techniques such as focus group discussions cannot be feasible because of similar concerns, clients were counseled by more than one counselor either because the clients change their counseling center or the institutions shift the counselors duty or both , therefore, trying to study the relationship between the counselor's background and the outcome of the counseling was found to be difficult. The other lesson was that including counselors at the respective sites as study subjects was not as such important because their number was very small.

The data was collected by three trained nurses, one at each site. Great care was taken during the training and supervision to avoid differences in interpreting the interview schedule

3.9 Data presentation and analysis: The data generated was analyzed using SPSS for windows (version 13). Binary logistic regression was used to see the effect of the independent variables on the dependent variables by controlling confounders. This

statistical method was used because the dependent variables were in categorical dichotomy. Statistical significance was evaluated at .05 levels. Descriptive statistics was also applied as necessary. Tables and bar graphs have been used to present data.

3.10 Data quality control: The following measures were taken to maximize the quality of data:

- Data collectors were given one day training; their recruitment was based on their experience on other studies.
- The purpose of data collection and the importance of the study as well as the significance of true information were told to the participants.
- Clients were told that their responses are extremely confidential at any circumstance.
- Participants were told that they could refuse if they wish to do so.
- Pilot study was done on 15% of the sample size on respondents that were not included in the main study.
- Supervisions were done every day during data collection
- Data were seen by the end of each day to get supervision needs for the next day work.

3.11 Ethical considerations: The following ethical considerations were made:

- Confidentiality of responses was maintained throughout the research process.
- Participants participated only voluntarily
- Counseling centers were asked for their permission using formal permission letters.
- Personal privacy and cultural norms were respected.
- The result of the research has been disseminated to the study institutions and Addis Ababa health bureau

3.12. Limitations of the study: The limitations of this study include:

- Sexual issues are sensitive and people may not report their true behaviors. There may also be a tendency to report in a socially acceptable way, example,

disclosure, abstinence, and consistent condom use may be overly reported as there is mass media influence.

- Totally depended on interview
- Cultural influences (some may be very conservative or shy).
- Instruments to measure negative outcomes of counseling may be overly sensitive and may have lower specificities.

CHAPTER FOUR

Result

1. Background of the respondents

Out of the total of 191 HIV positive respondents interviewed at the three study sites (Kassanches health center, Arada health center, and Yekatit 12 hospital), 124 (64.9%) were female and 67(35.1%) were male. 55(28.8%) of the respondents were 15-24 years old, 126(66%) of the respondents were 25-49 years old, and the remaining 10(5.2%) of the respondents were above 49 years old.101(52.9%) of the respondents were educated to the level of grade 7-12, 54(28.3%) of the respondents were educated to the level of grade 1-6, 27(14.1%) of the respondents had college level education, 7(3.7%) of the respondents were illiterate, and 2(1%) of the respondents could only read and write. The religious composition of the respondents was orthodox 12o (62%), protestant 36(18.8%), muslim 23(12%) and catholic 12(6.3%) (Table 1).

Table 1 Age, sex, educational status and religion of respondents.

characteristics		frequency	
		number	percent
sex n=191	male	67	35.1
	female	124	64.9
	total	191	100
age in years n=191	15-24	55	28.8
	25-49	126	66
	more than 49	10	5.2
	total	191	100
educational level n=191	illiterate	7	3.7
	read and write only	2	1
	grade 1-6	54	28.3
	grade 7-12	101	52.9
	college level	27	14.1
	total	191	100
religion n=191	orthodox	120	62.8
	protestant	36	18.8
	muslim	23	12
	catholic	12	6.3
	total	191	100

According to the self reports, 76(39.8%) of the respondents were Amhara, 61(31.9%) of them were Oromo, 24(12.6%) of them were Tigre, 24(12.6%) of them were Guragie, and 6(3.1%) of them were from other ethnic groups. 64(33.5%) of the respondents were married, 84(44%) of the respondents were single, 13(6.8%) of the respondents were widow, and 30(15.7)%) of the respondents were divorced The mean household income of the respondents was 661.34 Birr with median 400 Birr and range 4969 Birr. The respondents reported that 50(26.2) of them were merchant, 46(24.1%) of them were government or non government employees, 38(19.9%) of them were daily laborers, and 20(10.5%) of them were commercial sex workers. others such as housewives, students and the unemployed contributed for the remaining 37(19.4%) of the respondents. (table2).

Table 2 The ethnic, marital status, number of children, and occupational composition of respondents.

characteristics		frequency	
		number	percent
ethnicity (n=191)	amhara	76	39.8
	oromo	61	31.9
	tigre	24	12.6
	guragie	24	12.6
	others	6	3.1
	total	191	100
marital status (n=191)	married	64	33.5
	single	84	44
	widow	13	6.8
	divorce	30	15.7
	total	191	100
number of children (n=191)	no children	83	43.5
	1-3 children	91	47.6
	more than three	17	8.9
	total	191	100
occupation(n=19)	merchant	50	26.2
	government or NGO employee	46	24.1
	daily laborer	38	19.9
	sex worker	20	10.5
	others	37	19.4
	total	191	100

2. Clients' evaluation of the acceptability of counselor's information to them

According to the self reports, the information given to the client's by their counselors was relevant to their needs for 159(83.2%) of the respondents, compatible with their cultural and religious values for 188(98.4%) of the respondents, and clear (understandable) for 184(96.3%) of the respondents (table 3).

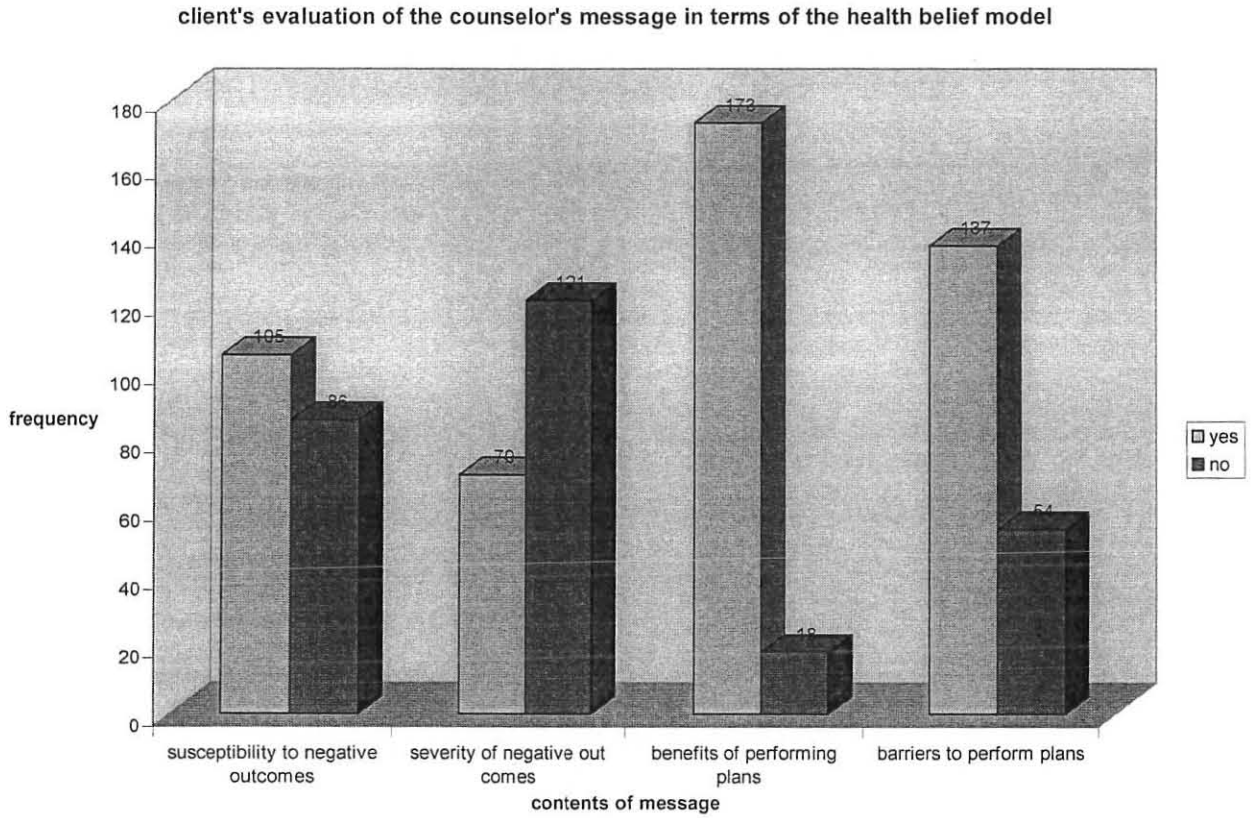
Table 3. Client's evaluation of the counselor's massage in terms of relevance, compatibility with values, and clarity.

characteristics		frequency	
		number	percent
information is relevant to my needs (n= 191)	yes	159	83.2
	no	32	16.8
	total	191	100
information is compatible with my cultural and religious values (n=191)	yes	188	98..4
	no	3	1.6
	total	191	100
information is clear (understandable) to me (n=191)	yes	184	96.3
	no	7	3.7
	total	191	100

3. Client's evaluation of the content of the counselor's message in terms of health belief model

out of the 191 respondents, 105(55%) reported that the counselor's message included their susceptibility to negative outcomes such as anxiety, depression, 70(36.6%) reported that the counselor's message included the severity of negative outcomes, 173(90.6% reported that benefits of performing counseling plans such as disclosure of status to partner, safe sex , medical follow up was included, and 137(71.7%) reported that the counselor's message included barriers of performing specific plans such as partner reactions, drug side effects and sigma (figure 1).

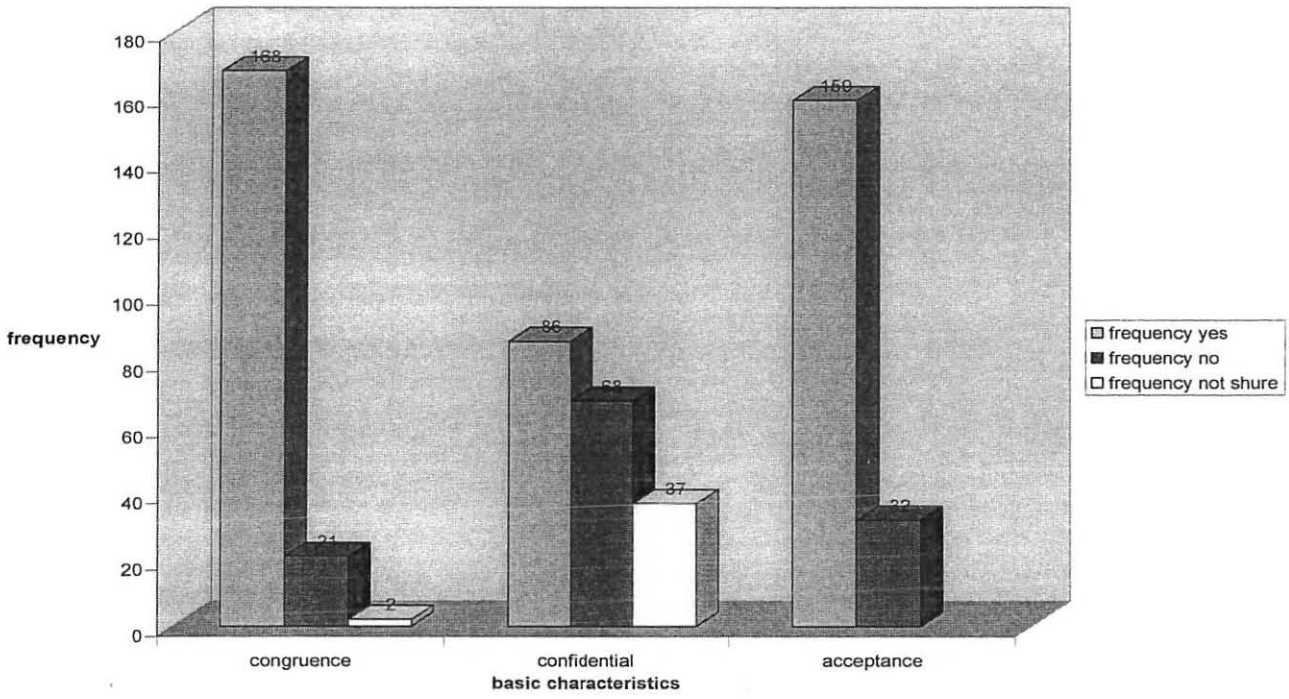
Figure1



4. Clients' evaluation of their counselors in terms of the three basic characteristics of effective counselor based on the client-centered theory

Assessment the three basic requirements in client-centered counseling: congruence (genuineness), confidentiality(keeping secrets of the client), and respect (accepting the client without any condition) has shown that 168(88%) of the respondents believe that their counselors are genuine (congruent), 86(45%) of the respondents believe that their secrets were kept, and 159(83.2%) of the respondents believe that their counselors accept them without any condition(respect) them. 21(11%) of the respondents believe that their counselor's were not congruent, 68(35.6%) of the respondents believe that their counselors do not maintain confidentiality, and 32(16(.8%) of the respondents do not believe that their counselors respect(accept them). similarly, 2(1%) of the respondents were not sure about the genuineness of their counselors, and 37(19.4%) of the respondents were not sure about the confidentiality of their counselors(figure 2)

Figure 2 clients' evaluation of their counselors in terms of congruence, confidentiality, and acceptance.



5. Client's preference of counselor's background

Out of the 191 HIV positive respondents, 11(58%) reported that they prefer a counselor above their age, 15(7.9%) reported that they prefer to use a counselor of their age, and 4(2.1%) reported that they prefer a counselor younger than themselves. 50(26.2%) of the respondents preferred counselors with the same sex as them selves, 59(30.9%) of the respondents preferred opposite sex counselors, and 82(42.9%) of the respondents did not have preferences for counselor sex. While 45((23.6%) of the respondents preferred a counselor with ethnicity the same as themselves, 146(76.4%) of the respondents did not have preferences for the ethnicity of their counselors. Similarly, 91(47.6%) of the respondents reported that they prefer counselors of their religion; but, the remaining 100(52.4%) of the respondents did not have any preferences for the religion of the counselors (table 4).

Table 4 Client's preferences to the age, sex, religion, and ethnicity, of their counselors.

client's preference of counselor's background		frequency	
		number	frequency
age (n=191)	less than my age	4	2.1
	the same as my age	15	7.9
	above my age	111	58.1
	any age	61	31.9
	total	191	100
sex (n=191)	same sex	50	26.2
	opposite sex	59	30.9
	any sex	82	42.9
	total	191	100
ethnicity (n=191)	the same as mine	45	23.6
	any ethnicity	146	76.4
	total	191	100
religion (n=191)	the same as mine	45	23.6
	any religion	146	76.4
	total	191	100

6. Positive outcomes of counseling

6.1 **Disclosure of HIV status to sexual partner**: Out of 191 respondents, 139(72.8%) reported that they have disclosed their sero-status at least to someone other than the counselor or health care provider; 52(27.2%) of the respondents never disclosed their status to anyone other than the counselor or the health care provider. out of those who disclosed their results, 60(43.2%) disclosed to their sexual partners, 31(22.3) disclosed to a sibling, 22(15.8%) disclosed to their parents, 20(14.4%) disclosed to a friend, and the other 6(4.3%) disclosed to other significant-others such as uncles or other relatives. The proportion of HIV positive cases who disclosed their status to their sexual partner is only 31.4%. Out of the 139 HIV positive respondents who disclosed their sero-status, 116(83.5%) disclosed with in one month of knowing their status, 12(8.6%) delayed disclosure after diagnosis for 1-6 months, 2(1.4%) delayed disclosure for 7-12 months, and 9(6.5%) delayed disclosure for more than 12 months(table 5).

Table 5 Rate of disclosure of sero-status of HIV positive cases, time lapsed before disclosure and their primary confident of disclosure.

characteristics		frequency	
		number	percent
disclosure of sero-status (n=191)	yes	139	72.8
	no	52	27.2
	total	191	100
primary confidant of disclosure (n=139)	partner	60	43.2
	sibling	31	22.3
	parents	22	15.8
	friends	20	14.4
	other	6	4.3
	total	139	100
time lapsed before disclosure (n=139)	less than one month	116	83.5
	1-6 months	12	8.6
	7-12 months	2	1.4
	more than 12 months	9	6.5
	total	139	100

The rate of disclosure of sero-status was higher among HIV positive cases whose reason for the test was sickness than whose reason for the test was to know status(OR=6.79, 95% CI= 3.1-15, P= .ooo), and those who perceive their general health as worse than before their diagnosis disclose their sero-status more frequently than those who perceive their general health at least as before diagnosis(OR= 2.3, 95% CI= 1.5- 5.4, $p<.05$). However, the client's background, the counselor's congruence, acceptance of the client by the counselor, and the client's perception of confidentiality (basic requirements in **client centered counseling**) or the perceived content of the counselor's message according to **the health belief model** did not have a statistically significant association with disclosure of sero-status in HIV positive people.

6.2 Consistent use of condom or sexual abstinence

Of the 191 HIV positive respondents, 62(32.5%) reported that they are sexually active after they know their diagnosis, and the remaining 129(129(67.5%) reported no sexual experience after they know their HIV status. 58(93.5%) of those who practice sex after their diagnosis reported condom use during sex; but only 42(72.4%) of them reported consistent (regular) use while the other 16(27.6%) did not use condom consistently (regularly).4(6.5%) of those who practice sex after their diagnosis never used condom during sex postpositively(table 6).

Table 6 Sexual practice and consistency of condom use among HIV positive clients.

characteristics		frequency	
		number	percent
sexual practice (n=191)	yes	62	32.5
	no	129	67.5
	total	191	100
condom use (n=62)	yes	58	93.5
	no	4	6.5
	total	62	100
consistent condom use (n=58)	yes	42	72.4
	no	16	27.4
	total	58	100

Post diagnosis sexual practice is predicted by perceived general health of the client (OR=.22, 95% CI = o.1-o.44, p= .000): HIV positive people who perceive their health as worse than before diagnosis practice sex less frequently than others. The binary logistic regression model was not significant to test predictors of condom use in HIV positive people(X^2 =29.66, 38df, p=.83).

6.3 Compliance to ART treatment and role fulfillment (functioning)

Out of a total of 191 HIV positive respondents, 130(68.1%) were ART users, and the other 61(31.9%) were not ART users. 120(92.3%) of the ART users reported that they are taking their drugs regularly as prescribed, but the other 10(7.7%) of the ART users reported that they had missed at least once. 96(50.3%) of the respondents reported that their role performance (functioning of roles and responsibilities) is at least as before

diagnosis, and the remaining 95(49.5%) of the respondents reported that they are performing less than before diagnosis(table 7).

Table 7 Compliance to ART, and role fulfillment (functioning) status of HIV positive clients.

characteristics		frequency	
		number	percent
ART use (n=191)	yes	130	68.1
	no	61	31.9
	total	191	100
regular use of ART (n=130)	yes	120	923
	no	10	7.7
	total	130	100
role performance (n=191)	less than before diagnosis	95	49.7
	at least as before diagnosis	96	50.3
	total	191	100

6.4 Interaction with others

Out of the 191 HIV positive people included in this study, 87(57.6%) reported that their interactions with their sexual partners were less than that of before diagnosis, and 64(42%) of the respondents reported that their interaction with their partners were at least as before diagnosis. 36(18.8%) of the respondents reported their interactions with their families were worse than before diagnosis, and another 155(81.2%) of the respondents reported their interactions with their families were at least as before diagnosis. Similarly, 37(19.4%) of the respondents reported that their interactions with their workmates or fiends were worse than before diagnosis, and the remaining 154(80.6%) of the respondents reported that their interactions were at least as before diagnosis (table 8).

Table 8 Interactions of HIV positive clients with their partners, families, and workmates or friends.

characteristics		frequency	
		number	percent
interaction with partner (n=151)	worse than before diagnosis	87	45.5
	at least as before diagnosis	64	33.5
	total	151	100
interaction with family (n=191)	worse than before diagnosis	36	18.8
	at least as before diagnosis	155	81.2
	total	191	100
interaction with workmates or friends(n=191)	worse than before diagnosis	37	19.4
	worse than before diagnosis	154	80.6
	total	191	100

Interaction with partner in HIV positive people is found to be strengthened when the counselor includes susceptibility of the client to poor interactions during the counseling session (OR = 2.8, 95%CI = 1.14- 7.03, p<.05), and interaction with family is worse than before diagnosis for the female HIV positive clients than for the male ones (OR= .38, 95% CI=.16-.9), p<.05).

7. Negative outcomes of counseling HIV positive cases

7.1 *Depression-* Out of the total of 191 HIV positive respondents, 85(44.5%) reported that *they had been bothered feeling down, depressed, or hopeless*, and 70(36.6%) reported that *they had been bothered by little interest or pleasure in doing things*. The over all sum of score shows that 64 (33.5%) of the HIV positive clients were depressed. Clients were found to feel down, depressed, or hopeless when they perceive their counselors are not confidential (OR= 2.2, 95%CI= 1.13-5.86), p<.05), and they perceive their general health status as less than before diagnosis (OR= 3.3, 95%CI= 1.8-6, p=.000). HIV positive clients who hadn't been informed by their counselors that they are susceptible to be bothered by little interest or pleasure in doing things (depressed) will suffer more from the problem than informed others (OR= 3, 95%CI= 1.28-7.35, p<.05). The client's background such as age, sex, marital status, household income, ethnicity, and

religion were not found to have a statistically significant association with depression variables.

7.2 *Anxiety-* out of the total of 191 HIV positive respondents, 117(61.3%) reported that *they felt tense*, and 151(79.1%) reported that *they experienced intrusive worries*. the over all sum scores show that 115 (60.2%) of the respondents were suffering from anxiety. Clients who were not informed by their counselors about the *barriers* that may be encountered when performing plans experience intrusive worries 4.55 times more than informed others (OR= 4.55, 95%CI = 1.22-17), p<.05).

7.3 *Guilt-* Out of a total of 191 respondents, 99(51.8%) reported that *there were things they regret and bother*. HIV positive clients who perceive the information they are getting from their counselors as *irrelevant to their needs* were found to be about three times more likely to experience guilt than others (OR=2.8, 95%CI= 1.2-6.4, P<.05).

7.4 *Suicide-* Out of a total of 191 respondents, 44(23%) reported that *they had been thinking of taking their lives*. Effective interaction with partner reduces suicidal ideation significantly (OR=.142, 95%CI=.04-.52, p = .003).

7.5 *Denial-* Out of a total of 191 HIV positive respondents, 52(27.2%) reported that *they defined symptoms related to HIV as symptoms of other conditions*. HIV positive people who were not informed well about the benefits of plans necessary to promote and maintain health deny HIV related symptoms more frequently than others, indicating, ineffective coping strategy (OR=6.88,95%CI= 2-23.6, p=.002).

7.6 *Feeling of rejection-* Out of a total of 191 HIV positive respondent, 36(18.8%) reported that *they felt misunderstood even by their closest family*, and 40(20.9%) reported that *they felt rejected by others.* The over all sum scores show that 30 (15.7%) of the respondents suffer the feeling of rejection. HIV positive clients who did not disclose their sero-status were found to feel less misunderstood by their closest families (OR= .127, 95%CI= .029- .551, p=.000), and male HIV positive clients were found less rejected by others than female HIV positive clients (OR= .31, 95%CI= .126- .745, p= .009).

Generally, this study has shown that those who did not disclose their results felt less rejected by others than those who did so (OR= .246, 95%CI= .083- .73, P<.012). Negative outcomes of counseling HIV positive clients are presented on table 9 below.

Table 9 Negative out comes of counseling HIV positive clients: depression, anxiety, guilt, denial, suicidal ideation, and feelings of rejection

characteristics		frequency	
		number	percent
feeling down, depressed or hopeless (n=191)	yes	85	44.5
	no	106	55.5
	total	191	100
little interest or pleasure in doing things (n=191)	yes	70	36.6
	no	121	63.4
	total	191	100
feeling tense (n=191)	yes	117	61.3
	no	74	38.7
	total	191	100
experiencing intrusive worries (n=191)	yes	151	79.1
	no	40	20.9
	total	191	100
regretting or bothering for things (n=191)	yes	99	51.8
	no	92	48.2
	total	191	100
thought of taking life (n=-191)	yes	44	23
	no	147	77
	total	191	100
defining symptoms of HIV as other conditions (n=191)	yes	52	27.2
	no	139	72.8
	total	191	100
feeling of being misunderstood by closest family (n=191)	yes	36	18.8
	no	155	81.2
	total	191	100
feeling of being rejected by others (n=191)	yes	40	20.9
	no	151	79.1
	total	191	100

CHAPTER FIVE

Discussion

1. Background of the study subjects:

In this study, it has been found that the number of female HIV positive respondents was greater than the number of male HIV positive respondents (64.9% females, and 35.1% males). This finding matches with the 2005/2006 report of MOH on the number of people living with HIV in Addis Ababa (63.5% females, and 36.5% males). In this study the age proportion of HIV positive respondents was 28.8%, 66% and 5.2% for the ranges 15-24 years, 25-49 years, and above 49 years respectively. According to the 1994 population and housing census of Ethiopia, these age groups make 28.83%, 30.86%, and 8.57% of the Addis Ababa population (Central Statistics Authority, 1994). This indicates that the highest burden is in the 15-24 years age group, matching with the national distribution of HIV (MOH, 2003). The educational status of most of the respondents was found to be in the ranges of grade 7-12 and grade 1-6, contributing for 52.9% and 28.3% of the participants. This was because , in the general population of Addis Ababa those who are in grade 7-12 make 50.18%, and in grade 1-6 make 36.46% (Central Statistics Authority, 1994).

In this study, most of the respondents were found to be orthodox (62.8%) in religion followed by protestant, (18.8%), muslim (12%), and catholic (6.3%). Similarly, most of the respondents were found to be amhara in ethnicity (40%), followed by oromo (32%), tigre (12.6%), and guragie (12.6%). The report of Central Statistics Authority (1994) shows that orthodox makes 82%, muslim makes 12.7%, protestant makes 3.9% and catholic makes only 0.8% of Addis Ababa population. The present finding does not agree with the 1994 census report in terms of religious composition. The probable reason may be the change in the composition of religions in Addis Ababa over the 10 years period or some religious groups choose other options when they become HIV positive, e.g. Wholly water. This needs another investigation. The ethnic composition of the present finding seems to agree with the ethnic composition of Addis Ababa. The Central Statistics Authority (1994) reported that there was a trend in the rise of the proportion of oromo

and tigre in Addis Ababa from 1984 to 1994 and a decrease in the proportion of guragie. The trend might be continued and resulted in the present finding.

This study has found out that participants were 44% single, 33.5% married, 15.7% divorce, and 6.8% widow. The 1994 census report shows the composition of Addis Ababa in marital status is 60.3% single, 29.4% married, 5.6% divorced, and 4.4% widow. The marked difference between the present study and the census report is that the proportion of singles in the census report is 60.3% where as the proportion in the present study is 44%. The major reason for the difference is that this study included singles above 15 years only but the census report included singles above age 9. A slight rise in the proportion of the married may be explained by absence of premarital screening for HIV infection. The proportion of respondents with no children (43.5%) is similar to the proportion of people who are single, and can be explained the same way as the explanation for the single.

The 1994 census report describes occupation in terms that do not match with the category in this study. But occupation in this study was not found to be associated with outcomes of counseling HIV positive people probably because the effect of the stigma is strong enough to affect people in all occupations

The mean household income of the respondents, 661.34 Birr with a range of 4969 Birr and median 400 Birr may mean that people from lower and middle classes are using the VCT services.

2. The client's perception of the counselor's message

Regarding the acceptability of the counselor's information to the clients, 98.4% of the participants evaluated their counselor's message as compatible with their cultural and religious values, 96.3% evaluated their counselor's messages as understandable (clear), and 83.2% of the participants evaluated the counselor's information as relevant to their needs. But 16.85% of the study participants reported that the information they were getting from their counselor's was not relevant to their needs. These respondents may represent a special group of HIV positive people such as adolescents, elderly people or other segments of the population who should be approached quite in a different way. Further study is strongly recommended.

The client's evaluation of the counselor's messages in terms of the health- belief model shows that 105 (55%) were made clear that they are susceptible to develop any of the negative outcomes such as depression, anxiety, interaction problems, 70 (36.6%) were made clear about the severity of the negative outcomes, 170 (90.6%) were made clear about the benefits of performing the specific plans such as disclosure of HIV positive status to sexual partner and others, safe sex, medical follow up, and 137 (71.7%) were made clear about the barriers of performing specific plans such as partner reactions to disclosure, drug side effects, and stigma. These factors were found to be *strongly associated with the outcomes of counseling* the participants (HIV positive clients). According to the health- belief model, those participants who were not made clear about any of the four key beliefs (susceptibility to the specific condition, severity of the specific condition, benefits of performing the specific plans, and barriers of performing the specific plans) experience more negative outcomes such as depression, guilt, suicidal ideation, impairment of social interaction and role performance (Washington state department of health, HIV/AIDS prevention and education services, 2006). The Ministry of Health of Ethiopia reports that one of the main barriers of VCT is lack of perceived benefits of the service among the general public (MOH, 2003). The findings indicate the strong need for proper counselor training.

The assessment of the participants' (HIV positive people) evaluation of the counselors in terms of the client-centered theory has shown that 168 (88%) of the participants believe their counselor's were genuine (congruent), 86(45%) of the participants believe their counselor's confidential, and 159 (83.2%) of the participants believe that their counselors accept (respect) them. Others reported that either they were not sure or their counselors did not maintain congruence, confidentiality and respect. In this study confidentiality was found to be strongly associated with negative outcomes. Different researchers found out that the issue of confidentiality in HIV/AIDS where stigma and discrimination are attacking has a determinant effect on the outcome of counseling (Lie, 1990; Sethosa E, & Pelter K., 2005; Jackson H., 2002). This can show the demand for proper counselor training and organization of the services to enable them maintain confidentiality.

3. **Client's preference to counselor's background:**

The assessment of the clients' preference to the counselor's age shows that significant number of clients want to be counseled by a counselor above their age. This result agrees with a finding in Tanzania (Lie, 1990). This may be due to the tradition that the elderly know better and even asked advices in times of crisis. This study has shown most of the participants do not mind about the sex, religion, and ethnicity of their counselors.

4. **Positive outcomes of counseling**

In this study 139 (72.8%) of the study subjects reported that they have disclosed their results to some one other than the counselor. But only 60 (31.4%) of the total participants were found to disclose their results to their sexual partners. yet 62 (32.5%) of the respondents were found to practice sex after diagnosis. This allows transmission of the virus even after post test counseling if clients do not use condom properly and consistently. WHO (2004) reports that rate of disclosure of women in developing countries is 16%- 86%. A study in South Africa found out rate of disclosure among HIV positive people to be 36% (Sethosa & Peltzer, 2005). Both results agree with this study. Out of those who disclosed their results, 22.3% disclosed to their siblings, 15.8% disclosed to their parents, and 14.4% disclosed to their friends (making 52.5% of those who disclosed their results). In addition to that 83.5% of those who disclosed their serostatus disclosed it with in one month after diagnosis. This can be a reliable source of security and social welfare just from the time of immediate crisis. Strict Western client-centered counseling should be questioned strongly, and even the importance of counseling the family with consent from the client should be considered to strengthen the client's support system.

The rate of disclosure of serostatus was higher among HIV positive cases whose reason for the test was sickness, and among those who perceive their general health status as worse than before diagnosis. However, the client's background, the counselor's congruence, the client's acceptance by the counselor, and the client's perception of confidentiality or the perceived content of the counselor's message according to the health -belief model did not have a statistically significant association with disclosure of

serostatus in HIV positive people. This finding agrees with a study conducted in South Africa in which counseling context and content, and counseling satisfaction were not found to be related with HIV disclosure (Sethosa & Peltzer, 2005). The probable explanation can be fear of stigma outweighing benefits of disclosing HIV positive status. Sickness leads to disclosure probably because the signs and symptoms become evident or when sick clients go to health services with others or support is needed when they get weak. WHO (2004) reports that social support is a motive to disclosure.

Out of the 62 (32.5%) HIV positive respondents who were sexually active after their HIV diagnosis, 58 (93.5%) reported that they were using condom. But 16 (27.6%) of those who reported condom use were not using it regularly (consistently). Abstinence from sex is strongly associated with perceived health: those who perceive their health worse than before diagnosis practice sex less than others. This may mean transmission continues when health is restored with medical and other supports if ongoing counseling is not strengthened.

In this study, 135 (68.8%) of the respondents were tested because they were sick and the remaining 56 (31.2%) were tested to know their status. One hundred thirty (68.1%) of the participants were on ART. This indicates that many people seek the service after their general health has markedly declined. it is for the same reason that 95 (49.7%) of the respondents were performing their roles less than before diagnosis. One hundred twenty (92.3%) of the ART users take their drugs regularly.

Significant proportion of the study participants reported that their interaction with their families, and friends was at least as before diagnosis (81.2% and 80.6% respectively). This strengthens the conclusion that family and close friends can be important sources of support for people living with HIV. While the proportion of female HIV positive people outweighs the proportion of male HIV positive people, interaction with family was lower for female HIV positive participants than for the male ones. Nyblade L., et al (2003) reported the same finding from a study in Ethiopia, Tanzania, and Zambia: women are stigmatized and blamed more. Interaction of the respondents with their sexual partners

was found to be less than before diagnosis for 87 (57.6%) of them and at least as before diagnosis for 64 (33.5%) of them. The probable cause for *interactions less than before diagnosis* may be blaming each other for infidelity. This study has found out that the problem can be minimized when the counselor discusses the possibility of negative interactions (susceptibility of client) from partners during the counseling process.

5. Negative outcomes of counseling

In this study 33.5% of the HIV positive respondents were depressed. AIDS Community Research Initiative of America (2004) estimates depression among people living with HIV to range from 15% to 60%. The main factors to be associated with depression were perceived absence of confidentiality, declining perceived health status, and when the susceptibility of the clients to negative outcomes was not included in the counselor's message. The findings indicate the need to train counselors properly and to find ways of improving confidentiality.

Similarly, 62% of the respondents had anxiety, and 51.8% of the respondents had felt guilt. The study has shown that anxiety was experienced more in respondents who were not made clear about the possible barriers for specific plans during their discussion with the counselor, and guilt was experienced more by respondents who perceive the counselor's information as irrelevant to their needs. These findings strengthen the suggestion that proper counselor training and intelligent application of the health belief model can minimize negative outcomes in HIV positive people.

A significant proportion of respondents (23%) reported suicidal ideations after their diagnosis, and 27.2% of the respondents were experiencing denial. Suicidal ideation was found to be associated with poor interactions with partner, and denial was found to be more common in clients who were not informed about the benefits of performing plans. Both denial and suicidal ideation are determinant to life. Stigma is a very strong factor standing against the counselor's effort (Lie, 1994; Nyblade L., et al, 2003).

In this study 15.7% of the respondents reported that they felt rejected, and this was found to be more common among the respondents who disclosed their results. Lie (1994) has

found out that 23% of the Tanzanian HIV positive respondents felt rejected. The findings indicate that counselors should be able to help clients to disclose their results without significant harm by including the process of disclosure in the discussion, not just the importance of disclosure.

CHAPTER SIX

Conclusion and recommendation

The study has resulted in the following conclusions:

1. The most important client's background negatively influencing the outcome of counseling HIV positive people is female gender. Marital status, number of children, educational level, occupation, average household income, ethnicity, and religion were not found to cause a statistically significant difference on the outcomes of counseling HIV positive people.
2. There are some parts of the HIV positive people who find the information they are getting from the counselor irrelevant to their needs, and hence experience negative outcomes more frequently than others.
3. Strengthening the four key beliefs of the **health -belief model** in the client: perceived susceptibility to negative outcomes, perceived severity of the negative outcomes, perceived benefits of performing specific behaviors, and perceived barriers of performing the specific behaviors decreases negative outcomes such as depression, anxiety, and denial in HIV positive people.
4. Interaction with family and friends after HIV diagnosis is positive for more than 80% of the HIV positive people. Complete sticking to the **client-centered** approach may result in the inefficient use of this resource.
5. Significant proportion of HIV positive clients want to be counseled by a counselor of age above them. This age preference was not found to be associated with the client's age, sex, ethnicity, religion, and educational level.
6. Disclosure of HIV status was found to be strongly associated with perceived health status of the client: HIV positive people tend to disclose their serostatus when they perceive that their health is declining.
7. Confidentiality is a strong factor determining outcomes such as depression.

Recommendations

Depending on the study findings, the following recommendations have been made:

1. Counselors should consider the extra psychological trauma of women- the extra blame, the extra stigma, the extra responsibility for the family dignity. To manage this problem, they should collaborate with health care providers, educators, policy makers, religious leaders, and elders of communities or any other responsible bodies.
2. Counselors should be trained for special groups of the population, such as adolescents, as their needs are usually different from adults.
3. Counselors should make clear to their HIV positive clients about their susceptibility to negative outcomes, the severity of the negative outcomes, the benefits of performing specific plans, and the barriers (obstacles) to perform the specific plans.
4. The family is important source of support for HIV positive people. Counselors should consider this resource and Western type individual client-centered counseling should be investigated further, and family counseling should be considered.
5. Preferably HIV counselors should not be very young.
6. Counselors should discuss the process of disclosure with their clients, not just the importance only; they should also make sure that the client has acquired the skills to disclose, the importance of disclosure and the problems with disclosure for the specific client.
7. Confidentiality should be maintained at all times. But, the client should be encouraged to disclose either himself or with the help of his counselor with full consent from the client.

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Annex

Interview schedule for the counselee

1) Age in years_____
2) Sex _____
3) Religion _____
4) Ethnicity_____
5) Educational level_____
6) Occupation _____
7) Marital status_____
8) Household income(monthly average)_____
9) Number of children_____
10) Please rate the **appropriateness** of the information you are getting from your counselor in terms of the following points.

	Yes	No
The information I get from the counselor is relevant to my needs		
The information I get from the counselor is compatible with my cultural and religious values		
The information I get from the counselor is understandable (clear) to me		

11. Please rate the **content** of the information you are getting from your counselor in terms of the following points.

	Yes	No
The information I get from the counselor include my **susceptibility** to negative outcomes such as depression, anxiety, guilt and loss of functioning		
The information I get from the counselor include the **severity** of the negative outcomes		
The information I get from the counselor include the **benefits** of performing plans of care		
The information I get from the counselor include **barriers** of performing specific plans of care		

12. Please rate your counselor in relation to the following points.

	Yes	No	Not sure
My counselor is genuine			
My counselor maintains confidentiality of my information			
My counselor respects me			

13. What age do you prefer your counselor to be? less than my age/ the same as my age/ above my age/ any age

14. What sex do you prefer your counselor to be? the same as my sex/ opposite to my sex/ any sex

15. What ethnicity do you prefer your counselor to be? the same as my ethnicity/ other ethnicity/ any ethnicity

16. What religion do you prefer your counselor to be? the same as my religion/ other religion/ any religion

17. Please rate the following experiences /feelings as it applies to you.

Experiences	Yes	No
I have been bothered by feeling down, depressed or hopeless		
I have been bothered by little interest or pleasure in doing things		
I feel tense		
I experience intrusive worries		
There are things which I regret and bother		
I had been thinking of taking my life		
I define symptoms related to HIV infection as symptoms of other conditions		
I feel misunderstood even by my closest family		
I feel rejected by others		

18. How well are you performing in your role/ responsibilities after your diagnosis? less than before diagnosis/ at least as before diagnosis

19. How do you rate your interaction with others including your partner, family, neighbors and work mates?

	Less than before diagnosis	at least as before diagnosis
Partner/ spouse		
Family		
Neighbors		
Work mates or friends		

20. Are you making sexual relationships? Yes/ No
21. If your answer is yes to question number 20above, do you use condom? Yes/ No
22. If yes to question number 21above, how frequently do you use condom? Sometimes / Always
23. Are you taking ART? Yes/ No
24. If your answer to question number 23 is yes, how often do you take your drugs? Sometimes / always as prescribed
25. Have you disclosed your HIV status to others? Yes/ No
26. If your answer to question number 25 is yes, when was it? Month_____Year_____
27. For who have you told your HIV status? _____
28. When was your diagnosis? Month_____Year_____
29. Number of counseling sessions_____
30. Reason for getting HIV test: to know status/ sickness
31. Perceived general health of client: at least as before diagnosis /less than before diagnosis

የምክር አገልግሎት ተጠቃሚዎች መጠይቅ

1. እድሜ---------- 2. ፆታ ---------- 3. ሃይማኖት----------

4. ብሄር ---------- 5. የትምህርት ደረጃ----------

6. ሥራ ---------- 7. የጋብቻ ሁኔታ ----------

8. ወርሃዊ የቤተሰብ ገቢ በብር ----------

9. የልጆች ብዛት ----------

10. የሚከተሉት ጥያቄዎች እርስዎ ከካውንስለሩ (ከምክር አገልግሎት ሰጭው) የሚያገኙትን መረጃ ተስማሚነት ይመለከታሉ። ተስማሚነትታቸውን ለእርስዎ እንደሚመስለዋት ከሚከተሉት ነጥቦች አንጻር ይመልሱ።

	አዎ	አይደለም
ካውንስለሩ የሚሰጠኝ መረጃ የእኔን ልዩ ፍላጎት የተመለከተ ነው		
ካውንሰለሩ የሚሰጠኝ መረጀ ከእኔ ባህልና ሃይማኖት ጋር አይጋጭም		
ካውንስለሩ የሚሰጠኝ መረጃ ለእኔ ግልጽ ነው		

11. የሚከተሉት ጥያቄዎች እርስዎ ከካውንስለሩ የሚያገኙትን መረጃ ይዘት ይመለከታሉ። ይዘታቸውን ለእርስዎ እንደሚመስለዎት ከሚከተሉት ነጥቦች አንጻር ይግለጹ።

	አዎ	አይደለም
ከካውንስለሩ የማገኘው መረጃ ድብርት፣ ጭንቀት፣ ብቸኝነትና ሥራን በአግባቡ ያለማከናውን ችግሮች ሊያገጥሙኝ እንደሚችሉ ያጠቃልላል።		
ከካውንስለሩ የማገኘው መረጃ፣ ድብርት፣ ጭንቀት ብቸኝነት፣ ሥራን በአግባቡ ያለማከናወንና የመሳሰሉት ችግሮች አሰከፊ መሆናቸውን ያጠቃልላል።		
ከካውንስለሩ የማገኘው መረጃ እራሴን ለመንከባከብና ለመጠበቅ የተነደፉ እቅዶችን ጠቀሜታ በዝርዝር ያጠቃለላል።		
ከካውንስለሩ የማገኘው መረጃ እራሴን ለመንከባከብና ለመጠበቅ የተነደፉ እቅዶችን ለመተግበር ሊያጋጥሙኝ የሚችሉ መሠናክሎችን በግልጽና በዝርዝር ያጠቃልላል።		

12. የሚከተሉት ጥያቄወች የምክር አገልግሎት የሚሰጥዎትን ባለሙያ ይመለከታል። ከሚከተሉት ነጥቦች አንጻር እንደሚመስለዎት ይመልሱ።

	አዎ	አይደለም	እርግጠኛ አይደለሁም
የእኔ ካውንስለር ሀቀኛ (እውነተኛ) ነው/ ናት			
የእኔ ካውስለር ሚስጥሬን ሙሉ በሙሉ ይጠብቅልኛል/ለቸ			
የእኔ ካውስለር ያከብረኛል/ታክብረኛለቸ			

13. የምክር አልግሎት የሚሰጠዎት ባለሙያ እድሜ ምን ቢሆንም ይመርጣሉ?

ከእኔ እድሜ በታች/ የእኔ እድሜ እኩያ/ ከእኔ እድሜ በላይ/ ማንኛውም ዕድሜ

14. የምክር አገልግሎት የሚሰጠዎት ባለሙያ ጸታ ምን ቢሆን ይመርጣሉ?

ተመሳሳይ ጸታ/ ተቃራኒ ጸታ / ማንኛውም ፆታ ቢሆን ግድ የለኝም

15. የምክር አገልግሎት የሚሰጠዎት ባለሙያ ብሔር ምን ቢሆን ይመርጣሉ?

ከእኔ ተመሳሳይ/ ሌላ/ ማንኛውም ብሔር

16. የምክር አገልግሎት የሚሰጠዎት ባለሙያ ሀይማኖት ምን ቢሆን ይመርጣሉ?

ከእኔ ተመሳሳይ/ ሌላ/ ማንኛውም ሀይማኖት ቢሆን ግድ የለኝም

17. የሚከተሉት ጥያቄዎች የእርስዎን የግል ስሜቶች ይጠይቃሉ። እንደሚሰማዎት አዎ/ አይደለም በማለት ይመልሱ።

	አዎ	አይደለም
የበታችነት፣ የሀዘንና ተስፋ የመቁረጥ ስሜት ይሰማኛል		
ሥራዎችን የመሥራት ብዙም ፍላጎትና ደስታ የለኝም		
ወጥረት ይሰማኛል		
ሳላስበው የሚመጣ ጭንቀት ይረብሸኛል		
የእሚያስፀፅቱና የሚያሳስቡኝ ነገሮች አሉ		
እራሴን ለማጥፋት አስባለሁ		

ከቫይረሱ ጋር ተያያዥነት ያላቸውን ምልክቶች እንደ ሌላ ምልክት እተርጉማለሁ		
የቅርብ ቤተሰቦቼ ሳይቀር የሚረዱኝ (የሚገነዘቡኝ) አይመስለኝም		
ሰዎች ሁሉ የተውኝ ይመስለኛል		

18. የዘወትር ተግባርዎን የቱን ያህል ያከናውናሉ?

ከበፊቱ ቀንሻለሁ / ቢያንስ እንደበፊቱ

19. ከሰዎች ጋር ያለዎት ግንኙነት እንዴት ይመስለዎታል?

	ከበፊቱ ቀንሷል	ቢያንስ እንደበፊቱ ነው
ከትዳር/የፍቅር ጓደኛዎ ጋር		
ከቤተሰብዎ ጋር		
ከጎረቤትዎ ጋር		
ከሥራ ባልደረቦችዎ ጋር ወይም ከጓደኞችዎ ጋር		

20. የግብረ ሥጋ ግንኙነት ያደርጋሉ? አዎ/ አላደረግም

21. ለተራ ቁጥር 20 መልስዎ "አዎ" ከሆነ ኮንዶም ይጠቀማሉን?

አዎ/ አልጠቀመም

22. ለተራ ቁጥር 21 መልስዎ "አዎ" ከሆነ መቼ መቼ ነው የሚጠቀሙ?

አንዳንድ ጊዜ/ አብዛኛውን ጊዜ/ ሁልጊዜ

23. የእድሜ ማራዘሚያ መድሀኒት እየወሰዱ ነው?

አዎ/ አይደለም

24. ለተራ ቁጥር 23 መልስዎ "አዎ" ከሆነ መድሃኒቶችን እንዴት ነው የሚወስዷቸው?

አልፎ አልፎ/ በአብዛኛው/ ሁልጊዜ

25. ከቫይረሱ ጋር እንደሚኖሩ ለሰው ነግረው ያውቃሉ?

አዎ/ አልነገርኩም

26. ለተራ ቁጥር 25 መልስዎ "አዎ" ከሆነ መቼ ነበር?

ወር---------- ዓ.ም----------

27. ለተራ ቁጥር 25 መልስዎ "አዎ" ከሆነ ለማን ነበር የነገሩት?----------

28. ከቫይረሱ ጋር እንደሚኖሩ ያወቁት መቼ ነበር

ወር ---------- ዓ.ም----------

29. ስንት ጊዚ የምክር አገልግሎት አገኙ?

30. የተመረመሩበት ምክንያት ህመም/ እራሴን ለማወቅ

31. አጠቃላይ የጤንነት ሁኔታ፡ ቢያንስ እንደበፊቱ/ ከበፊቱ ቀንሷል

DECLARATION

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

Name: Fentie Ambaw

Signature _____

Date _____ July 2007

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

Name: Dr Teka Zewdie

Signature: _____

Date of approval_____