ADDIS ABABA UNIVERSITY COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES,

SCHOOL OF PSYCHOLOGY

IDENTIFYING FACTORS THAT AFFECT HELPING CLIENTS AT VCT IN BLACK LION HOSPITAL

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June, 2015

ADDIS ABABA ETHIOPIA

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Identifying factors that affect helping clients at VCT in Black Lion Hospital

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A Thesis submitted to Graduate school of psychology Addis Ababa University. In partial fulfillment of the requirement for the degree of master of counseling psychology.

ADDIS ABABA

June, 2015

ACKNOWLEDGMENT

I thank God above all, for being by my side throughout my study. I would like to express my deepest gratitude to my Advisor, Dr. Teka Zewdie for his constructive comments and guidance. I am also very much indebted to my husband, Waktola Mamo ,my sister Yimtu Bereda, and my sister husband, Yigremachu Doya, for the persistent moral and material supports they rendered me during the entire period of my study and for them commitment in tabulating the data.

Finally doctors and nurses of the selected hospital are acknowledged for their cooperation during data collection.

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Acronyms

AIDS- Acquired immune deficiency syndrome

ARV-Anti retroviral treatment

CSA-Central statistical Authority

HBM-Health Belief model

HIV-Human immunodeficiency virus

MDGs- Millennium Development Goals

MOH-Minister of Health

MSP-Multiple sexual partner

STD-Sexually transmitted disease

SPSS-Statically package for social sciences

OPD- Outpatient department

PLWHA-People living with HIB/AIDS

UNAIDS-United nation program on HIV/AIDS

VCT-Voluntary counselling and testing

WHO-World Health organization

Abstract

A cross sectional descriptive study was conducted in March 2015 among Black Lion Hospital young clients. The objective of the study was to identify factors that affect VCT services. Convenience sampling method was used to fill out 188 self administered questionnaires of which 180 were retuned complete, making the respondent rate of 95.7%. Among the respondents, 96 (53.3%) were males and 84(46.7%) were females. The mean age of the respondent was 16.25 and standard deviation 0.821 of both sex mix, 114(63.3%) of the respondents had sexual experience i.e. (31.1%) of the males and 32.2% of female. The majority 175 (97.2%) of them had heard about VCT services from different sources, but only 106 (58.9%) of the client had undergone VCT. 62.8% of the young were willing to undergo VCT in the future. A theoretical construct with the intention and willingness to undergo VCT was analyzed by asking client future plan to use VCT. Thus correlation analysis showed that willingness to VCT was significantly associated with perceived susceptibility, perceived barrier & perceived benefit. Even if majority of youth had high level of knowledge, still they were engaged in risky sexual behavior. About half of (44.4%) young's had low perception (didn't belief they are at risk of getting HIV) perception to ward acquiring HIV.Health institution and different media should advocate the benefits of VCT and HIV preventive message like VCT should emphasis personal susceptibility to HIV/AIDS. Other non health professionals, trained VCT counselor should be involved in counseling to increase the acceptance rate. Fear reduction of stigma and discrimination should be strengthened. Information, education and communication programs should be established and emphasis should be put on reproductive health in order to encourage the young to avoid unsafe sex.

CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND OF THE STUDY

HIV/AIDS is a major source of concern all over the world as it constitutes a major source of death and a threat to national development (WHO, 2010). HIV/AIDS is a global pandemic. As UNAIDS 2012, approximately 35.3 million people are living with HIV globally. Of these, approximately 17.2 million are men, 16.8 million are women and 3.4 million are less than 15 years old. There were about 1.8 million deaths from AIDS in 2010, down from 2.2 million in 2005 (UNAIDS, 2013).

In 2010 young people aged 15–24 accounted for 42% of new HIV infections in people aged 15 and older. Among young people living with HIV, Nearly 80% (4 million) live in sub -Saharan Africa (WHO, 2010).

Ethiopia is one of the countries in sub Saharan Africa (SSA) that have been affected by a generalized HIV/AIDS epidemic. The estimated adult HIV prevalence in 2009 was between 1.4% and 2.8%.Even though this prevalence is lower than in other SSA countries, Ethiopia has one of the largest population of HIV infected people in the World, with an estimate of 1.1million (MOH, 2010).
To combat the epidemic, the Ethiopia government has responded favorably ever since the first case of HIV was recorded in the country, using diverse approaches to mitigate the increasing and devastating effect of HIV/AIDS epidemic. The country started VCT for the larger community after the national HIV/AIDS policy was launched in 1998 (MOH, 2010).

VCT may have potential preventive effects on HIV transmission and serves as a gateway to most HIV/AIDS-related services (Denison, Orelly & Kennedy, 2008). The counseling component should be based on confidentiality and include information about HIV transmission and personal discussion about an individual's risk in order to enable people to make informed decisions about

testing and their own risk. Thus, expanding access to VCT services has both individual and societal benefits (WHO, 2003). For the individual, VCT enhances the ability to reduce one's risk of acquiring or transmitting HIV, to access HIV-specific treatment, care and support (MOH,2010), to manage one's health, and to plan for the future (WHO, 2003). VCT provide awareness of safer options in preventing vertical HIV transmission if pregnant women and their families use such services and learn about their sero-status (UNAIDS, 2000). For society, widespread knowledge of one's HIV status can lead to better community mobilization against the epidemic, and may reduce HIV related stigma and discrimination and support human rights (EDHS, 2005).

Despite the potential benefits of VCT, uptake is often poor regardless of the availability of the services. Several possible contributing factors could play an essential role in the uptake of VCT socio demographic characteristics, proximity to a clinic (Jereni & Muula, 2008) awareness/knowledge related to HIV/AIDS, perception being at risk of HIV infection, perceived benefits of VCT, the belief that knowledge of infection may accelerate disease progression, psychosocial actors such as HIV/AIDS related stigma and discrimination, and concerns about confidentiality (MOH, 2010).

Despite the various efforts made to implement HIV prevention activities, VCT uptake among adults has also been disappointingly low in Ethiopia. According to the 2005 Ethiopia Demographic Health Survey (EDHS) only 4% of women (aged 15-49 years) and 6% of men (aged 15-49 years) had ever been tested for HIV (EDHS, 2005). The Ethiopia government has therefore recently started routine HIV testing as well as integration of HIV counseling and testing with family planning and maternal, newborn and child health services. Studies from other SSA countries indicate that the introduction of routine testing has particularly increased testing experience among women through PMTCT program, whereas men are reluctant to come to the antenatal clinic with their wives to be tested. It thus seems that improvement of voluntary counseling and testing services may be needed to increase uptake of testing among men. VCT

places more emphasis on autonomy than routine testing, and is therefore better option from a human rights perspective too (Wondmagegn, 2004).

A review of the interventions recommends for more researches on effectiveness of VCT services aiming defining strategies of support for clients. VCT has just been introduced in Ethiopia; it is important therefore to improve the quality and effectiveness of the services. Studies may be extended to a broader population constituted by actual and potential users attending VCT services. Monitoring the quality of counseling may not only report the attendance, coverage and return rates of clients. Although good quality of service is reflected by clients' attendance, it is also important to ensure that effective counseling strategies have been provided (Baggaley, 2001). A comprehensive understanding of individuals' desires and motivations about their sexual life may enable policy makers to identify appropriate strategies to improve programs (Roiphe, 1997). Perception of personal susceptibility to HIV/AIDS infection is the main factor motivating clients to overcome barriers for seeking VCT (Wood, 2003).

The purpose of this study to describe sexual experience of the young client and to assess client perception (susceptibly, perceived, benefits and perceived barriers) towards HIV/AIDS and VCT. Finally to give possible suggestions for health institution.

1.2. STATEMENT OF THE PROBLEM

Young people aged 15-24 account for more than 50 present of all HIV infection worldwide (WHO, 2012). In Ethiopia VCT for HIV is included as one of the strategies for HIV/AIDS prevention in HIV/AIDS policy. Yet very little is known about what influence VCT services. The HIV/AIDS BSS report by 2002 showed that only 4% of in school youth said they had been tested for HIV, in the context, assessing the predictors that influence the youth not to undergo VCT is important (Abebe, Debela & Dejene 2005).

About 33% of the youth out of school youth and more than 25% of in school youth had sex by the time they were 15 years old. In addition, due to the lack of services, the youth are often less informed, less experienced and less comfortable, accessing reproductive health services including VCT (Boggaly, 2001), this study assessed young client perception of their susceptibility to ward HIV/AIDS and its severity as well as perceived benefits & barrier of VCT.

1.3. SIGNIFICANCE OF THE STUDY

This study intends to assess factor that affect for VCT in Black Lion hospital in Youths (female and male 15-24 years), the study can serve in the future and also helpful for improving the VCT services in Addis Ababa.

The results of this study would hopefully give information and direction for decision makers such as city administration, health office, health facilities and NGOs who are working in the medical environment to work on quality of services that can satisfy all clients.

1.4. OBJECTIVES

1.4.1.GENERAL OBJECTIVE

- The study has the main objective of identifying client helping and hindering factors towards VCT.

1.4.2.SPECIFIC OBJECTIVE

- To describe sexual experience of the client.
- To assess the perceived susceptibly and perceived severity towards HIV/AIDS.
- To assess the perceived benefits, perceived barriers, towards VCT.
- To forward some possible suggestions for health institution.

This study were attempted to answer the following research questions:

- What is the current status of sexual experience of the youth?
- Is there any relation between clients perceived susceptibly and perceived severity towards HIV and client willingness to undergo VCT?
- What are the roles of client perceived benefits and perceived barriers on client willingness to undergo VCT?
- Is there association between socio demographic data and client willingness to undergo VCT?

Operational definitions of terms

Perceive severity: Refers to subjective assessment of the sternness of a health problem and its potential consequences.

Perceive susceptibility: Refers to subjective assessment of risk of developing a health problem.

Perceive benefits: Refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behavior (VCT service) to decrease risk of disease.

Perceive barrier: Individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat.

Voluntary Counselling and Testing (VCT): Is the process by which an individual undergoes counseling to enable him/her to make an informed choice about being tested. For HIV usually involves two counseling sessions: one prior to taking the test known as "pre-test counseling" and one following the HIV test when the results are given, often referred to as "post-test counseling". Counseling focuses on the infection (HIV), the disease (AIDS), the test, and positive behavior change.

Counseling: Counseling is the activity of the counselor, a professional who counsels people (gives them assistance, advice and guidance), especially on personal problems and difficulties.

CHAPTER TWO

LITERATURE REVIEW

2.1. History of HIV/AIDS

The Human Immunodeficiency Virus (HIV) which causes the Acquired Immune Deficiency Syndrome (AIDS) was first discovered in the early 1980s. It has spread more rapidly than most diseases in recent history, having social-cultural, economical and moral repercussions on individuals, families, communities and threatening foundations of entire societies. Over the years, the link between HIV/AIDS and impoverishment has grown and even stronger as the disease is infecting and affecting the younger generation who are the productive labor force of every economy (MOH, 2007).

HIV infections are spreading quickly within the youth populations and what happens to them today will determine what becomes of them and their communities in the future. An estimated 11.8 million young people aged 15-24 are living with HIV/AIDS, and half of all new infections, over 6,000 daily, are occurring among them(UNAID,2013). The World Health Organization (WHO) has identified HIV/AIDS as one of the world's first health emergency and an urgent threat to global public health. It reveals that HIV/AIDS is the world second widely spread communicable disease and the sixth common cause of death globally. In international circles in recent years, it has received as much attention as other pressing global questions like war, terrorism, environmental degradation among others. According UNAIDS (2006), about 65 million people have been affected and more than 25 million people have died of AIDS related causes.

The situation is made even gloomier, with 29 million new infections estimated by 2020 if prevention and treatment are not accelerated. The United Nations Millennium Development Goals (MDGs) report for 2006, states that several countries report success in reducing HIV infections. However, the overall infection rate is on the rise. Sub-Saharan Africa (SSA) remains the highest

affected region. The WHO (2004) has classified HIV/AIDS as the main cause of adult mortality in Africa. It affirms that about 3.1% and 3.9% of all male and female deaths respectively are caused by AIDS related diseases. In the same vein, UNAIDS (2006) fact sheet states that 63% of the global HIV/AIDS infections are in Africa, South of the Sahara with the prevalence rate highest among the age group 15-49 years. It is the reason African heads of states declared AIDS as a state of emergency in the continent during the African development Forum (2000). This does not give a promising picture for the African continent because this age group constitutes youths and adults who are the most active and productive and should be leading the process of development and social change.

The international community has come to acknowledge that HIV/AIDS is not only a health problem. It is a developmental disaster of alarming proportions which will affect development goals at the human, financial and material levels. Although one of the Millennium Development Goals (goal 6) particularly addresses HIV/AIDS, an effective response will enhance the achievement of all other Millennium Development Goals. According to UNAIDS (2008, 13) no disease in history has prompted a comparable mobilization of political, financial and human resources and no development challenge has lead to such a strong leadership by communities and countries most heavily affected. By reducing life expectancy, increasing child mortality and proliferating the number of orphans, HIV/AIDS impoverishes individuals, communities and nations by eroding the capacities of socioeconomic systems through losses of human resources which is the most important resource for meaningful and sustainable development. The devastating effect of the HIV/AIDS pandemic especially on the young generation is therefore a major Impediment to development (UNAIDS, 2011).

South & south East Asia (a region with about 2 Billion people as of 2010 over 30% of the global population) has an estimated 4 million cases (12% of all people living with HIV), with about 250,000 deaths in 2010. Approximately 2.5 million of these cases are in India, where however the prevalence is only about

0.3% (somewhat higher than that found in Western and Central Europe or Canada). Prevalence is lowest in East Asia at 0.1 % (UNAIDS, 2013, P, 14).

In 2008 approximately 1.2 million people in the United States had HIV; 20% did not realize that they were infected. Over the 10 year period from 1999-2008 it resulted in about 17,500 deaths per year. In the United Kingdom, as of 2009, there were approximately 86,500 cases and 516 deaths. In Australia, as of 2009, there were about 21,171 cases and around 23 deaths. In Canada as of 2008 there were about 65,000 cases and 53 deaths. AIDS was first recognized in 1981 and by 2009 has led to nearly 30 million deaths (UNAID, 2011).

Young people in the United States continue to be at risk for HIV and AIDS. At the end of 2009, in 46 states and five U.S. dependent areas with confidential name-based HIV infection surveillance, 80,461 young people ages 13-29 were living with HIV, comprising ten percent of all people living with HIV. Thirty-nine percent of all new HIV cases are among young people ages 13-29, and from 2007-2010, ages 15-19 and 20-24 were the only age groups to experience an increase in the rate of diagnoses of HIV infection. Youth of color and young men who have sex with men continue to be most at risk (CDC, 2012). It is important to promote programs that help young people lessen risky sexual behaviors by encouraging condom use, delay in sexual initiation, partner reduction, and early HIV testing and treatment. But research has shown that even when risk behaviors are equal, minority youth are more at risk for HIV. As such it is essential that research and resources be directed toward addressing the underlying social determinants that contribute to these disparities and that policies and programs promote structural and social-economical changes to ameliorate these factors (CDC, 2011).

Sub-Saharan Africa is the region most affected. In 2010, an estimated 68% (22.9 million) of all HIV cases and 66% of all deaths (1.2 Million) occurred in this region. This means that about 5% of the adult population in this area is infected. Here, in contrast to other reigns, women compose nearly 60% of

cases. South Africa has the largest population of people with HIV of any country in the world, at 5.9 million (UNAIDS, 2013).

Ethiopia has a large and very vulnerable population, with an estimated 15 percent of the population living below the poverty line. HIV/AIDS is one of the key challenges for the overall development of Ethiopia, as it has led to a seven-year decrease in life expectancy and a greatly reduced workforce.

Ethiopia faces an epidemic among sub-populations and geographic areas, with an estimated overall HIV prevalence rate of 1.4 percent, based on testing a sample of 5,780 men and 5,300 women age 15 to 49 who gave informed consent (Demissie, 2004).

While previous estimations were higher, expansion of surveillance data and improved analyses resulted in significantly lower estimations for 2005. Based on the same survey, HIV prevalence has declined to about 3.2% to 4.7% percent in urban areas (Calvaerton, 2008).

Almost three quarters (72%) of all adult and child deaths in sub-Saharan Africa in 2005 have occurred due to AIDS (EDHS, 2005). The devastating effect of HIV/AIDS in Ethiopia has become more and more visible with time, and the life expectancy is estimated to have fallen from 50 years to 42 years. Today 42% of the hospital beds in the country are estimated to be occupied by AIDS patients, draining the scarce resources allocated to the health sector (Calverton, 2008). Voluntary counseling and testing (VCT) for HIV is acknowledged in the international an effective and pivotal strategy for HIV/AIDS in terms of prevention and care. Research conducted in Kenya, Tanzania, and Trinidad by family health international in collaboration with UNAIDS, WHO & the center for AIDS prevention studies (CAPS) at the University of California have shown that VCT is an effective strategy for facilitating change in behavior. VCT is also an important entry point for care and support. These findings have boosted interest and support for VCT as a valuable component of comprehensive HIV/AIDS programs among international organization, including the national AIDS programs of many countries and donors (MOH, 2000). VCT is more than

drawing and testing blood and offering a few counseling sessions. It is a vital point of entry to other HIV/AIDS services, including preventing mother- to-child transmission; preventing and clinically managing HIV-related illnesses, tuberculosis control, psychosocial and legal support (Alemayeehu, 2010).

2.2. Sexual Behaviors

Study shows young people 13-24 in the United State, 77 percent of HIV/AIDS diagnoses in young people aged under age 25 were in males, and 23 percent were in females (CDC, 2012).

Fewer than 2% of adolescents in the United State have had sex by the time they reach their 12th birthday. But adolescence is a time of rapid change. Only 16% of young have had sex by age 15, compared with one-third of those aged 16, nearly half (48%) of those aged 17, 61% of 18-year-olds and 71% of 19-year-olds (Finer & Philbin, 2013).

There is little difference by gender in the timing of first sex.On average, young people in the United State have sex for the first time of about age 17, but they do not marry until their mid-20s. This means that young adults may be at increased risk for unintended pregnancy and STIs for nearly a decade or longer (U.S. Bureau of the Census, *America's Families & Living Arrangements*, 2009).

Youngs are waiting longer to have sex than they did in the recent past. In 2006–2008, some 11% of never-married females aged 15–19 and 14% of never-married males in that age-group had sex before age 15, compared with 19% and 21%, respectively, in 1995 (Finer & Philbin, 2013).

Among sexually experienced Younges, 70% of females and 56% of males report that their first sexual experience was with a steady partner, while 16% of females and 28% of males report first having sex with someone they had just met or who was just a friend (Martinez, 2006–2010).

Youngs sex is increasingly likely to be described as voluntary. In 2006–2010, first sex was described as “unwanted" by 11% of young women aged 18–24 who had had sex before age 20, compared with13% in 2002. For young men in the same age-group, the share reporting first sex as unwanted decreased from 10% to 5% (Martinez, 2006–2010).

HIV prevention among youth is key to limiting the spread of the HIV epidemic. In 2011, 43% of young women age 15-24 and 74% of young men age 15-24 knew a condom source. Young women and men in urban areas are most likely to know a condom source (76% and 95%, respectively). In addition, more than 90% of young women and men with more than secondary education know a condom source.Only one-quarter of young women and one-third of young men have a comprehensive knowledge of AIDS,(CDC,2013) meaning that they know the two major methods for preventing HIV transmission, know that a healthy-looking person can be HIV-positive, and reject the two most common misconceptions about HIV/AIDS. Comprehensive knowledge increases dramatically with education, from only 7% of young women with no education to 54% of young women with more than secondary education. Since 2005(Santelli J, Sandfort T and Orr M, 2008).

Early sexual debut continues to be common in Ethiopia, especially among women. Eleven percent of young women age 15-24 and 1% of young men age 15-24 had sexual intercourse by age 15. Four in ten young women age 18-24 and 13% of young men age 18-24 had sexual intercourse by age 18 (FHI, USAID, 2004).

The study on sexual initiation and its determinants among youths in north east Ethiopia shows the median age for first youths sexual intercourse was 17 (16.54±1.9) and 18 (17.5 ±1.4) years for male and female, respectively (Islami, 1997). Of those who experienced sexual intercourse for the first time, only one third reported that they had used condom.active females carry the greatest risk of HIV infection in the country, with prevalence rates much higher than the average for both urban and rural areas as well as all women of reproductive

age. Girls are at a much greater risk at early ages because of both biological and cultural factors (Central Statistical Agency and ORC Macro, 2006).

Young girls in Ethiopia are more vulnerable to HIV than boys because of early age at sexual debut, early marriage, sexual abuse and violence, such as rape and abduction. Sexual mixing patterns are more important than the age at sexual debut in putting girls at higher risk of HIV than boys. As well,adolescent girls are at risk because they are unlikely to have had any training or experience in sexual negotiation skills, and are especially vulnerable in situations with older men where age, wealth, physical strength and other power dynamics put them at a disadvantage (FHI, USAID, 2004).

Sexual Practice of youth in Jimma shows Above a quarter, 267(26.9%) of respondents ever had sexual intercourse (32.5% of males and 12.7% of Females). Male respondents were about three times more likely to ever had sexual intercourse as compared to females (OR=3.31; 95%CI: 2.26, 4.86). The mean age at first sexual intercourse was 17.7±2.7 years (17.8±2.5 for males and 17.4±3.7 for females) similar among males and females (p=0.29). The median age at first sex was 18 years. Among those who ever had sexual intercourse, more than three-quarter, 121(75.6%) (79.0% males and 54.5% females) had their first sexual intercourse during their secondary school. Majority, 170(68.0%) of them had first sexual intercourse with boyfriend or girlfriend. Nearly half, 127 (48.1%) had their first sexual intercourse with individuals of the same age (50.9% for males and 30.6% for females) females were more likely to have first sex with individuals who were about five years or older than them (P-value =0.001) (Gurmesa, Fessahaye, & Sisay, 2012).

2.3 WHAT IS VCT

The Declaration of Commitment, which resulted from the United Nations General Assembly special Session (UNGASS) on HIV/AIDS in June 2001, gave special attention to the pressing need for countries to either develop or scale up VCT services (UNAID, 2013). VCT is the process by which an individual

undergoes counseling to enable him/her to make an informed choice about being tested .VCT is not only a key component of both HIV prevention and care programmers, but is the gateway to both prevention and care. In order to respond effectively to options for each, it is preferable for the individual to know his/her HIV status (UNAIDS 2011).

The development of increasing numbers of effective and accessible medical and supportive interventions for PLWHA means that VCT services are being more widely promoted and developed, and many developing countries are gradually institutionalizing VCT as part of their primary health-care package. VCT has also proven to be a cost effective HIV-prevention intervention. Many approaches to HIV prevention and care require people to know their HIV status. Individuals can learn to change behavior patterns, and VCT therefore has an important role in the HIV prevention and care in order to minimize risky behavior. The importance of VCT has brought about the wider promotion and development of VCT services. Though, lack of resources has meant that VCT is often still not widely available in some of the highest prevalence countries. However, UNAIDS recommends that activities with in this area are up-scaled in all countries (UNAIDS, 2011, P, 14-17).

2.4 Barriers for VCT

Thier are many study are done in barriers of VCT.The Voluntary HIV Counseling and Testing Centre (VCT) is among of HIV intervention measure with the purpose of giving education about living with HIV and avoiding infecting others, and to uninfected ones on how to maintain their sero negative status. It assist in early detection of the of HIV infection. It also assists individuals in accessing intervention and support services including management of infectious diseases. Moreover, it assists infected individuals in assessing their personal risks and adopting risk reduction behaviors. It does not work at individual level only, but also provides strength to prevention efforts particularly at the community level (UNAIDS.2006). The barriers young people face in terms of seeking VCT services; some youths did not believe if the

result were kept confidence, others wanted to avoid social stigma that other HIV positive people suffer, some did not think if the HIV positive result were accurate and reliable, others who wanted to undergo test did not know where to go for HIV testing and some did not want other people to know that they have undergone the test. Waiting time and cost- sharing, even though it is small amount of penny to adults, prohibits some youths from seeking HIV test, worries of the positive results to be informed to their sexual partners and or parents were among of the barriers in use of VCTs services (UNAIDS.2006).

In Uganda and Nairobi, Some youths argued that the positive results might easily lead to negative social and psychological consequences. Lack of information and misinformation was a barrier for youths accessing VCT services. Youths would like access to HIV testing and counseling services if the services are confidential, honest and inexpensive (Younde & Priscila M.2002).

In Malawi young people felt that they were not at risk then they did not see an importance of testing. Other did not want to be seen going to VCT centers, for people will know that their HIV positive and they were worried about the meaning totheir future. To some were ready to attend service whereby VCT service is free, the provision of result is rapid, if they are assured of privacy and anonymity and if they give enough time to have conversation with counselors

(WHO, 2007).

Also in Zambia confidentiality was among the reasons behind negative response to VCT services. Individuals preferred to attend services whereby they are not known by VCT service providers and privacy was assured. Worries of meeting anybody whom you know at the clinic were among the barrier to young people accessing VCT services (Horizon, 2002).

In a qualitative study conducted in rural areas of Uganda, some participants in FGD scommented on having counselors who were not residents of the area, for they were considered more credible and would offer a greater confidentiality than residents. They even gave their suggestion that counseling should take

place at neutral sites where confidentiality can be assured, for example, having private rooms. Few individuals thought that community centers like schools, churches homes, trading centers can be used to maintain anonymity (Kipp W, Kabarambe G, an Konde- Lule J. 2004).

Among other things found as barriers to access VCT services was poor perception of the health services marked as an obstacle to youth going for the health care. Easy access that was explained in two ways being among of the barriers, not only in distance but also easy to be visited by counselor that will make hard to maintain the anonymity. Even time spent when waiting for the result was among of the barrier for youths gong for VCT services (Fylkesnes K &Siziya S,).

In Mali disbelief in AIDS marked as barrier to the potential use of VCT Services. In a qualitative study conducted in Mali various reasons were given out as reasons for those who did not belief in the existence of HIV/AIDS. In one of the Focus group discussion, young men argued that, "I have heard about AIDS but I don't believe in it because I have never seen anyone ill with my own eyes. It is for this reason that I don't believe in it" [Bamako, man, 17 years old, trader, no education (Youth D)]. A similar comment was given by young woman who argued that, "In my opinion, AIDS is not a reality because they have not been able to find a treatment. For me, AIDS is a complication of another illness. If it gets to a very advanced stage, people say that it is AIDS [Bamako, woman, 20 years old, student, higher education (VCT, F)] (Castle ,146-55. 2005)

The low rate of youths attending VCTs services found in Tanzania has also been reported in other countries. In the Massachusetts survey, the HIV testing among sexually active adolescents was found not to be common. Adolescents who were interviewed were knowledgeable that they can contract AIDS and believed that the likeli hood of them being HIV positive was there; still they did not want to access VCT services and at a time of interview only 10% had pursued voluntary HIV testing (Samet ,2005).Therefore, this survey supports the observation that young people do not seek HIV testing regardless of them

knowing that they are at risk. Findings on why youths access or not access VCTs services including HIV testing are more or less the same to different countries with different social, cultural and economic backgrounds.

A team of South African researchers carried out a study on factors associated with participation in HIV Voluntary Counseling and Testing among TB patients in a rural South African hospital An investigation on the influence of self perception of HIV infection on youths attitude towards Voluntary Counseling and Testing services in Nigeria indicated that youths with low self perception were not inclined to reduce risky sexual behaviors or to seek HIV/AIDS counseling and testing. Similarly, another Nigerian study (Okpoto, 2009) on the attitude of the University of Ilorin undergraduates towards Voluntary HIV/AIDS Counseling and Testing. The study revealed that the students had negative attitude towards VCT and gender, age, religion, course of study and marital status had no significant influence on their attitude. The study recommended that VCT centers should be established to enable people access to the needed services. A similar negative attitude was noted amongst students of higher institutions in Ilorin towards use of antiretroviral agents (Jimoh, 2008).

A Ghanian study showed that 76% of the women reported no prior HIV counseling and 78% had never undergone for HIV testing. The study also indicated that the majority of the respondents were not accessing the available VCT services. It was also found that education, prior HIV testing and history of Sexually Transmitted Diseases (STDs) influenced respondents acceptance of VCT (Holmes, 2008).

Fear of Loss of Control Over Own Lives Because of a Positive Result is a common view taken by most at risk groups targeted for VCT. Fear of death, fear of a loss of control over their own destinies, or simply a fear of having to face more problems in their already Complicated lives due to a positive test result are powerful impediments to undergoing testing. These fears are especially exacerbated by the double stigma and discrimination from neighbors and

society at large that Continues to exist toward both HIV-positive people and Most-at-risk groups in Chinese society. An HIV-positive result is commonly seen to confirm that individual's membership in a group that participates in socially unacceptable behaviors. Far better then, they feel, not to know, rather than let their status be known. AIDS continues to be regarded by many as a deadly, incurable disease and hence a positive result equates to "waiting for death.

Fear of society's response if their HIV-positive status should become known is another powerful disincentive to testing. Examples were shared of HIV-positive people being ostracized by family members, friends, neighbors, colleagues, and even village clinicians. This fear was especially prevalent among those with the most to lose. those who were wealthy, had a higher social standing, or had good jobs. In such cases, the benefits of finding out their status would be far outweighed by the costs if the result was positive and their identity was revealed to colleagues, friends, or family (Okpoto,2009).

Fear of stigmatizations an important barrier to HIV testing and has negative consequences for AIDS Prevention and treatment. Intervention to reduce HIV related stigma are needed in order to foster voluntary HIV counseling and testing in South Africa (Holmes, 2008).

2.5 THEORETICAL FRAMEWORK

According to studies carried out by UNAIDS 2012, a lot has been done in order to determine the benefits of VCT. A majority of the studies reveal benefits following VCT leading to change of risky sexual behavior. Many of these studies have end points that rely on data, such as number of sexual partners or condom use and the results are not supported with more qualitative outcomes.

Though, some studies has revealed important lessons for groups interested in offering HIV counseling and testing services, based on many years of working with VCT, UNAIDS reveal recommendations that may affect the uptake of VCT (UNAIDS,1999)

If HIV/AIDS infected persons are being discriminated, or if there are no supportive services, it may not be appropriate to offer VCT. Anonymity and protection of confidentiality are critical. Persons going for testing need to feel that they will not be easily identified or stigmatized for entering the VCT service site. Effective counseling should be based on trust and requires a client-centered approach ongoing support helps HIV – positive and HIV-negative members adopt and maintain effective prevention behavior.

Why HBM is selected?

As it is known that since VCT is available, the acceptance has increased and the service was gradually wide spread but different studies show that for various reason the acceptance of VCT varied among selected population group in a wide range.

According to a decade review of HIV testing and counseling practices in USA, factory that influence acceptance or refusal of VCT could be characterized as socio demographic, cognitive and behavioral and organization of VCT service delivery.

There are a lot of model used in HIV/AIDS prevention derived from social psychology and concept of communication. For this particular study, this mainly assesses the intention toward a specific behavior and what are the possible factors that influence the development of the desired behavior, modified HBM was found to be appropriate. As behavior in this perspective is function of the subjective value of an outcome and of the subjective probability or expectation that outcome. Thus explanations for behavioral changes all focus on things that go on inside people's head their knowledge, belief, attitudes and perception of others.

In general it is now believed that people will take action if they regard themselves as susceptible and potentially damaging and also the anticipated barriers of taking action are outweighed by its benefit so to assess this the HBM is more appropriate than others.

2.6. Clint centered approach

Client centered approach is developed by psychologist Carl Roger in the 1940, and 1950, the goal of the theory is to provide client with opportunity to develop a sense of self where they can realize how their attitudes feelings and behavior are being negatively affected (Prochaska & Norcross, 2007) (Cooper & Hoeldamf, 2010). The necessary and sufficient conditions Rogers (1957; 1959) stated that there are six necessary and sufficient conditions required for therapeutic change:

- **Therapist–client psychological contact:** a relationship between client and therapist must exist, and it must be a relationship in which each person's perception of the other is important.

- **Client incongruence:** that incongruence exists between the client's experience and awareness.

- **Therapist congruence or genuineness:** the therapist is congruent within the therapeutic relationship. The therapist is deeply involved him or herself - they are not "acting" - and they can draw on their own experiences (self-disclosure) to facilitate the relationship.

- **Therapist unconditional positive regard (UPR):** the therapist accepts the client unconditionally, without judgment, disapproval or approval. This facilitates increased self-regard in the client, as they can begin to become aware of experiences in which their view of self-worth was distorted by others.

- **Therapist empathic understanding:** the therapist experiences an empathic understanding of the client's internal frame of reference. Accurate empathy on the part of the therapist helps the client believe the therapist's unconditional love for them.

- **Client perception:** that the client perceives, to at least a minimal degree, the therapist's UPR and empathic understanding.(Bower, P., Byford, S., Sibbald, B., Ward, E., King, M.,& Lloyd, R., et al. 2000).

2.7 THEORY OF REASONED ACTION

The theory of reasoned action is a model for the prediction of behavioral intention, spanning predictions of attitude and predications of behavior. The subsequent separation of behavioral intention from behavior allows for explanation of limiting factors on attitudinal influence (Ajzen, 1980). The Theory of Reasoned Action was developed by Martin Fishbein and Icek Ajzen (1975, 1980), derived from previous research that started out as the theory of attitude, which led to the study of attitude and behavior. The theory was "born largely out of frustration with traditional attitude-behavior research, much of which found weak correlations between attitude measures and performance of volitational behaviors" (Maiman, Marshall, Jone, &Robert, 1997).

2.8 TRANSTHEORETICAL MODEL

The conceptual roots for transtheoretical model come from Edwin B. Holt and Harold Chapman Brown's 1931 book theorizing that all animal action is based on fulfilling the psychological needs of "feeling, emotion, and desire". The most notable component of this theory is that it predicted a person cannot learn to imitate until they are imitated.

The transtheoretical model of behavior change assesses an individual's readiness to act on a new healthier behavior, and provides strategies, or processes of change to guide the individual through the stages of change to Action and Maintenance.

The transtheretcal model is also known by the abbreviation "TTM" and by the term "stages of change.. It is "arguably the dominant models of health behavior change, having received unprecedented research attention, yet it has simultaneously attracted criticism (Stretcher& Irwin, 1997).

SOCIAL COGNITIVE THEORY

The proposition of social learning was expanded upon and theorized by Canadian psychologist Albert Bandura. Bandura, along with his students and colleagues conducted a series of studies, known as the Bobo doll experiment, in 1961 and 1963 to find out why and when children display aggressive behaviors. These studies demonstrated the value of modeling for acquiring novel behaviors.

Social Cognitive Theory is a learning theory based on the ideas that people learn by observing others. These learned behaviors can be central to one's personality. While social psychologists agree that environment in which one grows up contributes to behaviors, the individual person (and therefore cognition) is just as important.

People learn by observing others, with the environment, behavior, and cognition all as the chief factors in influencing development in a reciprocal triadic relationship. For example, each behavior witnessed can change a person's way of thinking (cognition). Similarly, the environment one is raised in may influence later behaviors, just as a father's mindset (also cognition) will determine the environment in which his children are raised.

There are five core concepts associated with the SCT framework. These core concepts are observational learning/modeling, outcome expectations, self-efficacy, goal setting and self-regulation.

It is important to note that learning can occur without a change in behavior. According to J.E. Ormrod's general principles of social learning, while a visible change in behavior is the most common proof of learning, it is not absolutely necessary. Social learning theorists say that because people can learn through observation alone, their learning may not necessarily be shown in their performance (Bandura, 2001).

2.9 HEALTH BELIEF MODEL

The health belief model was developed in the 1950, by social psychologist at the U.S public health service and remains one of the most well known and widely used theories in health behavior research (Ajzen, Abbarracin, &Hornik 2oo7).

Health belief model is a psychological health behavior change model developed to explain and predict health-related behaviors, particularly in regard to the uptake of health services (Janz &Marshall, 1994)· The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior A stimulus, or cue to action must also be present in order to trigger the health promoting behavior (Rosenstock,1974).

The following constructs of the health belief model are proposed to vary between individuals and predict engagement in health-related behaviors (e.g., getting vaccinated, getting screened for asymptomatic diseases, exercising).

2.9.1 PERCEIVED SEVERITY

Perceived severity refers to subjective assessment of the severity of a health problem and its potential consequences. The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles. For instance, an individual may perceive that influenza is not medically serious, but if he or she perceives that there would be serious financial consequences as a result of being a bent from work for several days, then he or she may perceive influenza to be a particularly serious condition (Janz &Marshall, 1994).

2.9.2 PERCEIVED SUSCEPTIBILITY

Perceived susceptibility refers to subjective assessment of risk of developing a health problem. The health belief model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviors to reduce their risk of developing the health problem Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular illness Others may acknowledge the possibility that they could develop the illness, but believe it is unlikely. (11) Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviors. Individuals who perceive a high risk that they will be personally affected by a particular health problem are more likely to engage in behaviors to decrease their risk of developing the condition (Janz &Marshall, 1994).

The combination of perceived seriousness and perceived susceptibility is referred to as perceived threat. Perceived seriousness and perceived susceptibility to a give health condition depend on knowledge about the condition The health belief model predicts that higher perceived threat leads to higher likelihood of engagement in health-promoting behaviors (Carpenter, 2010).

2.9.3 PERCEIVED BENEFITS

Health-related behaviors are also influenced by the perceived benefits of taking action (Carpenter, 2010). Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behavior to decrease risk of disease. If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behavior regardless of objective facts regarding the effectiveness of the action For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer (Janz &Marshall, 1994).

2.9.4 PERCEIVED BARRIERS

Health-related behaviors are also a function of perceived barriers to taking action. Perceived barriers refer to an individual's assessment of the obstacles to behavior change. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behavior. In other words, the perceived benefits must outweigh the perceived barriers in order for behavior change to occur. Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a medical procedure) and discomfort (e.g., pain, emotional upset) involved in engaging in the behavior For instance, lack of access to affordable health care and the perception that a flu vaccine shot will cause significant pain may act as barriers to receiving the flu vaccine (Carpenter, 2010).

2.9.5 CUES TO ACTION

The health belief model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviors Cues to action can be internal or external. Physiological cues (e.g., pain, symptoms) are an example of internal cues to action. External cues include events or information from close others the media, or health care providers promoting engagement in health-related behaviors. Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened (Janz &Marshall, 1994).

2.9.6 SELF-EFFICACY

The Self-efficacy was developed by Albert Bandura. It was added to the four components of the health belief model (i.e., perceived susceptibility, seriousness, benefits, and barriers) in 1988 Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behavior. Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviors.

The model was originally developed in order to explain engagement in one-time health-related behaviors such as being screened for cancer or receiving an immunization. Eventually, the health belief model was applied to more substantial. Long-term behavior change such as diet modification, exercise, and smoking Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-efficacy was a key component of health behavior change (Galanz,Barbara,&Viswanath ,2008).

EMPIRICAL SUPPORT

The health belief model has gained substantial empirical support since its development in the 1950s. It remains one of the most widely used and well-tested models for explaining and predicting health-related behavior. A 1984 review of 18 prospective and 28 retrospective studies suggests that the evidence for each component of the health belief model is strong. The review reports that empirical support for the health belief model is particularly notable given the diverse populations, health conditions, and health-related behaviors examined and the various study designs and assessment strategies used to evaluate the model. A more recent meta-analysis found strong support for perceived benefits and perceived barriers predicting health-related behaviors, but weak evidence for the predictive power of perceived seriousness and perceived susceptibility. The authors of the meta-analysis suggest that examination of potential moderate and mediated relationships between components of the model is warranted (Janz &Marshall, 1994).

APPLICATIONS

The health belief model has been used to develop effective interventions to change health-related behaviors by targeting various aspects of the model's key constructs. Interventions based on the health belief model may aim to increase perceived susceptibility to and perceived seriousness of a health condition by providing education about prevalence and incidence of disease, individualized estimates of risk, and information about the consequences of disease (e.g., increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy various behaviors to reduce risk of disease, identifying common perceived barriers, providing incentives to engage in health-promoting behaviors, and engaging social support or other resources to encourage health-promoting behaviors. Furthermore, interventions based on the health belief model may provide cues to action to remind and encourage individuals to engage in health-promoting behaviors. Interventions may also aim to boost self-efficacy by providing training in specific health-promoting behaviors, particularly for complex lifestyle changes (e.g., changing diet or physical activity, adhering to a complicated medication regimen). Interventions can be aimed at the individual level (i.e., working one-on-one with individuals to increase engagement in health-related behaviors) or the societal level (e.g., through legislation, changes to the physical environment) (Stretcher& Irwin, 1997).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 THE STUDY AREA

The study was conducted in Addis Ababa, the capital city of Ethiopia which has an area of 530.14 square kilometers and is divided into 10 sub cities (Kefle Ketema). There are 28 hospitals in Addis Ababa city. Among those 7 are federal government hospitals, 6 are regional government hospitals and the remaining 15 private hospitals distributed in different Kifle Ketemas. Also there are 23 health centers and 376 private clinics in Addis Ababa (MOH, 2010).

For this study Black Lion Hospital were selected. The reason black Lion Hospital were selected it has high patient flow when compare to other hospital. The hospital provides a tertiary level referral treatment and is open 24 hours for emergency services. The hospital is administered by Addis Ababa University and is the largest teaching hospital among, providing teaching for about 300 medical students and 350 residents every year. Black Lion Hospital Office provides diagnosis and treatment services for approximately 370,000 - 400,000 patients a year. The hospital has 800 beds, with 130 specialists, 50 non-teaching doctors. The emergency department sees around 80,000 patients a year (MOH, 2007).

Black Lion Hospital (Tikur Anbesa in Amharic), located in the nation's capital Addis Ababa, is Ethiopia's largest general public hospital and one of only two University Hospitals in the country. In 1998 Black Lion Hospital, which is also the largest referral hospital in the country was organized under the medical faculty of Addis Ababa University (AAU) and acknowledged by the Ministry of Health (MOH) as its main teaching hospital. The faculty is the the largest among the health training institutions in the country, staffed with the most senior specialists (MOH, 2010).

3.1. STUDY DESIGN

Descriptive cross sectional study design was employed to conduct this study. This method is employed because of its important that it is fits to get detail of data from many respondents and it is appropriate to assess the status of the phenomena.

Regarding this method Bobbie, (1990), cited in Creswell (2003, p.154)

<<….descriptive study method includes cross sectional and longitudinal studies using questionnaires or structured interviews for data collection, with intent of generalizing from a sample to population also it enable to generalize from a sample to a population so that inference can be made about characteristic, attitude or behavior of that population>>.

3.2. SAMPLE POPULATION AND SAMPLING PROCEDURES

Young clients, who receive service on OPD, were participants of the study. As the study is Quantitative research type, non-probability sampling technique was use to select the participant. As stated by marshal and Rossmans(1999) during non probability sampling technique units are deliberately selected from the study population.

Participants were selected by using convenient sampling technique, because number of clients came to OPD fluctuated so it is difficult to determine the total population number. The total sample size was 188.

Participant for self administered questionnaire were selected with the help of OPD Nurses in the hospital with the following Inclusion criteria.

Inclusion criteria:-

- The study population was involved female and male young clients they age between 15-24 years.

- ❖ Young client who were able to communicate (conscious, free from mental illness)

- ❖ Young client who were voluntary to participate in the study.

3.3. DATA COLLECTION PROCEDURES

Quantitative data is collected using self-Administration structured questionnaire. The questionnaire items were prepared first in English and then translated in to Amharic by professional translator. The Amharic version of the questionnaire was pretested for clarity, acceptability and flow among the non study subjects. Based on the findings from pre testing the item that is difficult to answer is modified and the corrected questionnaire was distributed to collect the data. Data was collected by the researcher and 2 trained data collectors (BSC nurse). The data collection done after given one day training was given to the assistants. Practical exercise was made through peer review.

There were sets of items included in the questionnaire

- Socio demographic data
- Knowledge about HIV/AIDS.
- Perception about HIV /AIDS.
- Knowledge and Perception toward VCT.

The data collection mechanisms included closed end and open end questionnaires. For 188 participant 32 close-ended and 2 open-ended questionnaire were given and more expected answer were offered and the data was collected. Many scholars wrote about the important of using questionnaire to collect information from respondent.

Regarding this, key (1997) mentioned that << Questionnaire is a means of eliciting the feeling, beliefs, experiences, perception or attitudes of some sample of individuals>>

Sarantukos (2005, p.263) on his side stated the following about the use of questionnaire. Questionnaires are less expensive, consistent and uniform measures, free of variation. They after a considered and objective view of the issue, since responded can consult their files and since many subjects prefer to write rather than talk about certain issues. Questionnaire allows a wider coverage than other method. In addition, they offer less opportunity for bias or caused by the presence or attitude of the interviewers.

All close-ended and open-ended questionnaires were translated in to Amharic by researcher and given to language specialist and checked. The feedback from the language specialist was that, the translation was quite equivalent.

3.4. DATA QUALITY MANAGEMENT

During data collection, data were checked for completeness, and missing information at each point by both the principal investigator and data collectors. In addition, data were rechecked during data entry into the computer software before analysis.

3.5. SOURCES OF DATA

The data source of this study includes both the primary data and secondary data source. The primary data sources were the young client from black Lion hospital.

The secondary source of information for this study were available material related to research topic like ,journals, books, magazine ,related researches (articles) and electronic information. These were reviewed to show the views of different authors on the study problem and to connect the research with related literature. Official reports from the federal health ministry as well as from study organization were also reviewed to generate data related to VCT.

3.6. DATA ANALYSIS PROCEDURES

Quantitative analysis emphasizes how data fit together as a whole, bringing together context and meaning. It is also stated that after data collection is completed, following interrelated steps of data analysis process such as, reading, coding, displaying, reducing and interpreting is one of the appropriate methods to analyze the data. To this end the questioner were first transcribed carefully in to Amharic and translated in to English. Next to this, repeated reading of the question was under taken and central point of the data related to the research questioner were labeled or coded.

In this process 34 primary code emerged. Then code reduction through merging (categorizing) similar primary code undertaken by giving common title codes. Due to this the primary code reduced in to 28 condensed codes. The data after cleaned edited and coded enter in to computer via SPSS version 20 and analyzes and also frequency table, percentage and graph (pia and bar) were used.

Finally, the major finding in line with the research questions were presented mathematically and discussed in relation to secondary data the conceptual frame work of study.

3.7. ETHICAL CONSIDERATION

As this is an academic research, in conducting the study it is necessary to maintain the highest ethical standards of research. The research proposal was review and approved by representative of school of psychology, Addis Ababa University. A formal letter from the school of psychology was also obtained to continue the study, permission from the black lion hospital medical director and OPD unit head obtained to conduct the study and clarification about the objective of the study and rapport building was made with the staffs.

In order to minimize the risk of losing confidentiality of participant from accidental disclosure to the third parts, one isolated room for the data collection time was arranged by the head of OPD clinic.

To avoid any possible fear or negative effect on the participant by involving in the study pre-questioner, orientation about keeping the anonymity, confidentiality of the information and voluntarily participation explained for the participants.

Personal Identification of participants was not recorded in the study rather participant names change in to code. Any data obtained from the study participant also was not disclosed to anybody. Soft copies & hard copies of the study are kept in the researcher's personal computer and is a secure locked place respectively.

After providing full information to all study participants regarding the purpose of the research, the data collector were able to the consent of the respondents. Every patient was told the right to refuse participation in the research.

CHAPTER FOUR

RESULTS

4.1. Socio demographic characteristics

188 clients filled out the self administered questionnaires of which 180 returned the complete response, making a response rate of 95.7%. 8 clients returned incomplete questionnaires and were excluded from analysis.

Among the 180 clients who successfully completed, the questionnaires 96(53.3%) were males and 84(46.7%) were females out of which 72 (40.0%) were single 66(36.7%) were married, 18 (10.0%) were divorced and 23(12.8%) were includes in the category of other. The mean age of clients was16.25 with of SD#0.821. Majority of the clients 179 (99.5%) were single.

Ninety two clients (51.1%) were orthodox Christians 33 (18.3%) were Muslim, 36 (20.0%) were protestants, 12 (6.7%) were Catholics and 2 (1.1%) were no religion. The rest 5 (2.8%) were includes in the category of other.

The clients were dominantly Amhara that consisted of 58(32.2%) followed by Oromo, Gurage, Tigre and other which comprised 36(20.0%),28(15.6%), 25(13.9%) and 33 (18.3%) respectively.101 (56.1%) came from urban areas and the other 79(43.9%) were from rural city.

The clients were dominantly high school students 70(38.9%). 38(21.1%) were 5-8 grade, 18 (10.0%) were below grade 4, 18 (10.0%) were unable to write and read, 12 (6.7%) certificate and 24(13.3%) were with diploma level of education and above **(See table 1)**

Table 1; Distribution of clients by their socio demographic characteristics, in Black Lion hospital, Addis Ababa, March 2015

Socio – demographic Variables		Number(180)	Percent
Sex	Male	96	53.3
	Female	84	46.7
Age	<15	26	14.4
	15-19	72	40.0
	>20	69	38.3
	I don't know	13	7.2
Marital Status			
	Single	72	40.0
	Marred	66	36.7
	Divorced	18	10.0
	Other	23	12.8
Religion			
	Orthodox	92	51.1
	Muslim	33	18.3
	Protestant	36	20.0
	Catholic	12	6.7
	No religion	2	1.1
	Other	5	2.8
Area of Residence			
	Urban	101	56.1
	Rural	79	43.9
Ethnicity			
	Gurage	28	15.6
	Amhara	58	32.2
	Tigre	25	13.9
	Oromo	36	20.0
	Other	33	18.3
Educational Status			
	Unable to write and read	18	10.0
	Below grade 4	18	10.0
	5-8 grade	38	21.1
	High School	70	38.9
	Certificate	12	6.7
	Diploma and Above	24	13.3

4.2. Knowledge about HIV/AIDS

A total of 10 questions were to assess the knowledge status of the clients about HIV/AIDS way of transmission and prevention.

154 (86.0%) client responded that it could be transmitted by unsafe sex.45 (25.0%) said it could be transmitted by mosquito bite. For the questions assessing knowledge of MTCT, correct response on the transmission of the HIV, 122 (67.8%) replied it can be transmitted to the infant before birth, about 146 (81.1%) answered that it can be transmitted from the mother to the new born during delivery, 146 (81.1%) said it could be transmitted during breast feeding to the infant. Majority of the clients 163 (90.6%) responded that shaking of hands couldn't transmit the virus .158 (87.8%) said feeding together with HIV infected person could not transmit the virus.

154 (85.5%) reported regular and proper use of condom could prevent HIV infection. while 26 (14.4%) of the respondents didn't agree that regular and proper use of condom protects HIV infection .138(76.7%) said abstinence could prevent the transmission of HIV. Majority of the clients 154 (85.6%) believed being faithful to one partner could prevent the transmission of the virus. **(See table 2)**

Table 2 Knowledge of clients on the modes of HIV transmission and prevention in Black Lion Hospital, Addis Ababa, March 2015

Knowledge on HIV	Male	Female	Total
Unsafe sex transmit HIV			
Yes	80 (44.7%)	74(41.3%)	154(86.0%)
No	15 (8.4%)	10(5.6%)	25(14.0%)
Mosquito bite transmit HIV			
Yes	27(15.0%)	18(10.0%)	45(25.0%)
No	69(38.3%)	66(36.7%)	135(75.0%)
Pregnant mother transmit HIV to the fetus before birth			
Yes	64(35.6%)	58(32.2%)	122(67.8%)
No	32(17.8%)	26(14.4%)	58(32.2%)
Pregnant mother transmit HIV to the fetus during delivery			
Yes	76(42.2)	70(38.9)	146(81.1)
No	20(11.1)	14(7.8)	34(18.9)
Pregnant mother transmit to the fetus by breast feeding			
Yes	78(43.3%)	68(37.8%)34EW	146(81.1%)
No	18(10.0%)	16(8.9%)	34(18.9%)
Shaking of hand transmit HIV			
Yes	8(4.4%)	9(5.0%)	17(9.4%)
No	88(48.9%)	75(41.7%)	163(90.6%)
Taking meal together with HIV positive individual transmit HIV			
Yes	11(6.1)	11(6.1)	22(12.2)
No	85(47.2)	73(40.6)	158(87.8)
Regular & proper use condom protect HIV			
Yes	78(43.3)	76(42.2)	154(85.5)
No	18(10.0)	8(4.4)	26(14.4)
Abstinence from sex protects HIV			
Yes	70(38.9)	68(37.8)	138(76.7)
No	26(14.4)	16(8.9)	42(23.3)
Being faithful to partner protects HIV			
Yes	82(45.6%)	72(40.0%)	154(85.6)
No	14(7.8)	12(6.7)	26(14.4)

4.3. Knowledge on condom and sexual behavior.

Significant numbers of the clients 175 (97.2%) were aware of the presence of male condom. Majority of the clients 139 (77.2%) knew the correct use of male condom, out of which 75 (41.7%) were male and 64 (35.6%) were females. Out of 180 respondents, 114 (63.3%) reported that they previous history of sexual contact. Among these respondents 56 (31.1%), 58 (32.2%) were males and females respectively.

The majority of the respondents 61 (53.5%) started sexual intercourse between year of 15-19 age, 3 (2.6%) stared when they were leasthan15 years and 45 (39.5%) greater than 20 years.

Out of those who had previous history of sexual contact, 55 (30.6%) were males &52 (28.9%) of female responded that they had sexual in intercourse in the last 12 months.

Out of those who responded that, they had sexual contact in the last 12 months 38 (33.3%) used condom consistently, 50 (43.9%) used condom occasionally and 21 (18.4%) did not use condom. **(See table 3)**

Table 3 - Knowledge of clients about condom & sexual behavior in Black Lion Hospital, Addis Ababa, March 2015

Condom use related knowledge	Male	Female	Total
Heard of Male condom			
Yes	95 (52.8%)	80(44.4)	175(97.2)
No	1(0.6%)	4(2.2)	5(2.8)
Know the correct use of condom			
Yes	75(41.7)	64(35.6)	139(77.2)
No	21(11.7)	20(11.1)	41(22.8)
Ever had sexual intercourse			
Yes	56(31.1)	58(32.2)	114(63.3)
No	40(22.2)	26(14.4)	66(36.7)
Ever used a male condom while doing sex in			
Yes /always	19(16.7)	19(16.7)	38(33.3)
Yes/Occasionally	25(21.9)	25(21.9)	50 (43.9)
Never	10(8.8)	11(9.6)	21(18.4)
No response	2(1.8)	3(2.6)	5(4.4)
Age start sexual Intercourse			
>15	1(0.9)	2(1.8)	3(2.6)
15-19	25(21.9)	36(31.6)	61(53.5)
<20	29(25.4)	16(14.0)	45(39.5)
I don't know	1(0.9)	4(3.5)	5(4.4)
Had sexual intercross during the last 12 Month			
Yes	55(30.6)	52(28.9)	107(58.3)
No	41(22.8)	32(17.8)	73(40.6)

With regard to knowledge on voluntary counseling and testing, 175(97.2%) of clients either knew or had heard of VCT from different sources .Health intuition was the main source of information access in 79(44.9%) of the respondents,22.2% from television, 18.8% from Radio, 6.3% from magazine ,4.0% from friends and 2.3% from neighbor.

Clients were asked whether VCT was important or not and 159 (88.3%) of respondents believed that VCT is important, while 21 (11.7%) sated that it is not.

Regarding preference of professionals as counselors majority 95(52.8%) of the clients preferred physicians, followed by 54 (30.0%) who preferred nurses, 13 (7.2%) showed their preference for HIV patients and 17 (9.4%) religious leaders.

(See figure 1)

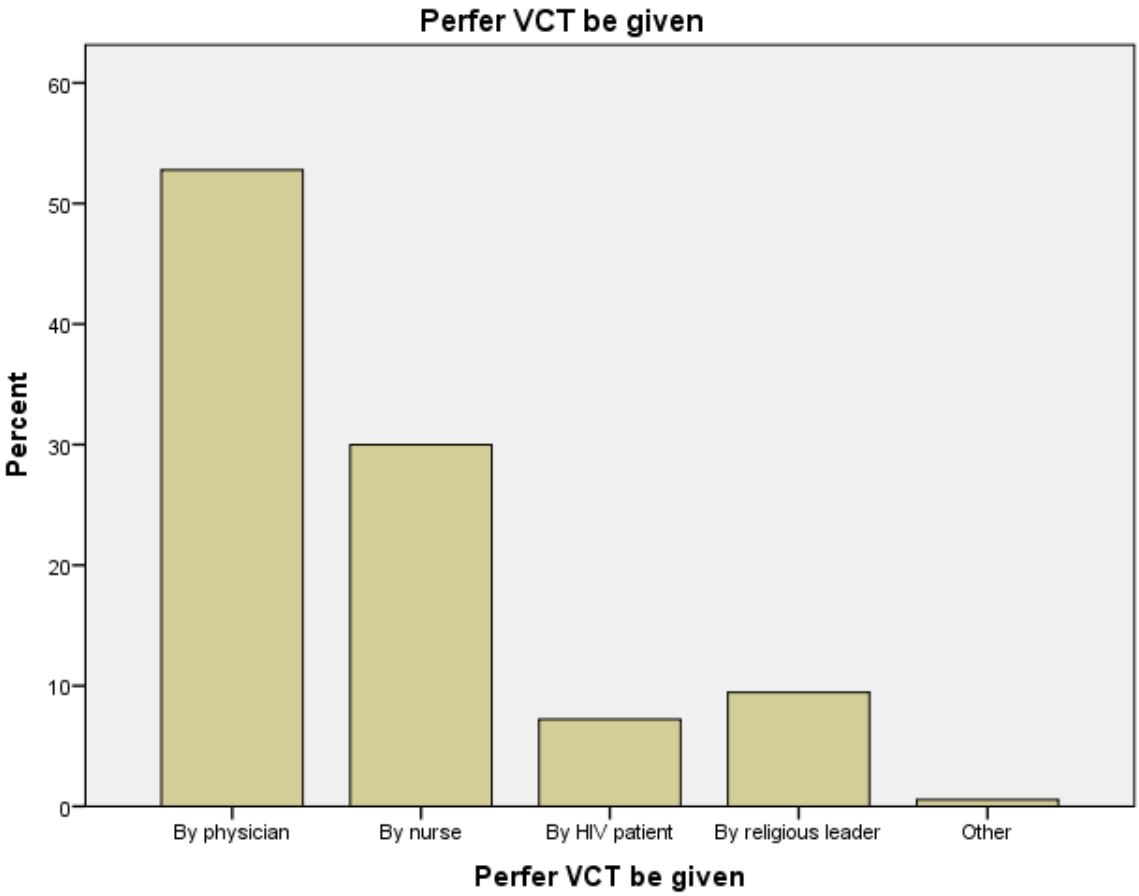

Fig 1. Client preference of professionals as VCT counselors

Regarding their attitude and practice towards VCT, 106 (58.9%) used VCT services of those who underwent VCT counted 29.4% and 29.4% males and females respectively. Majority of the respondents 90(54.5%) stated that they underwent VCT to just know their current health status, 21(12.7%) visited the VCT center for marriage. **(See Figre2)**

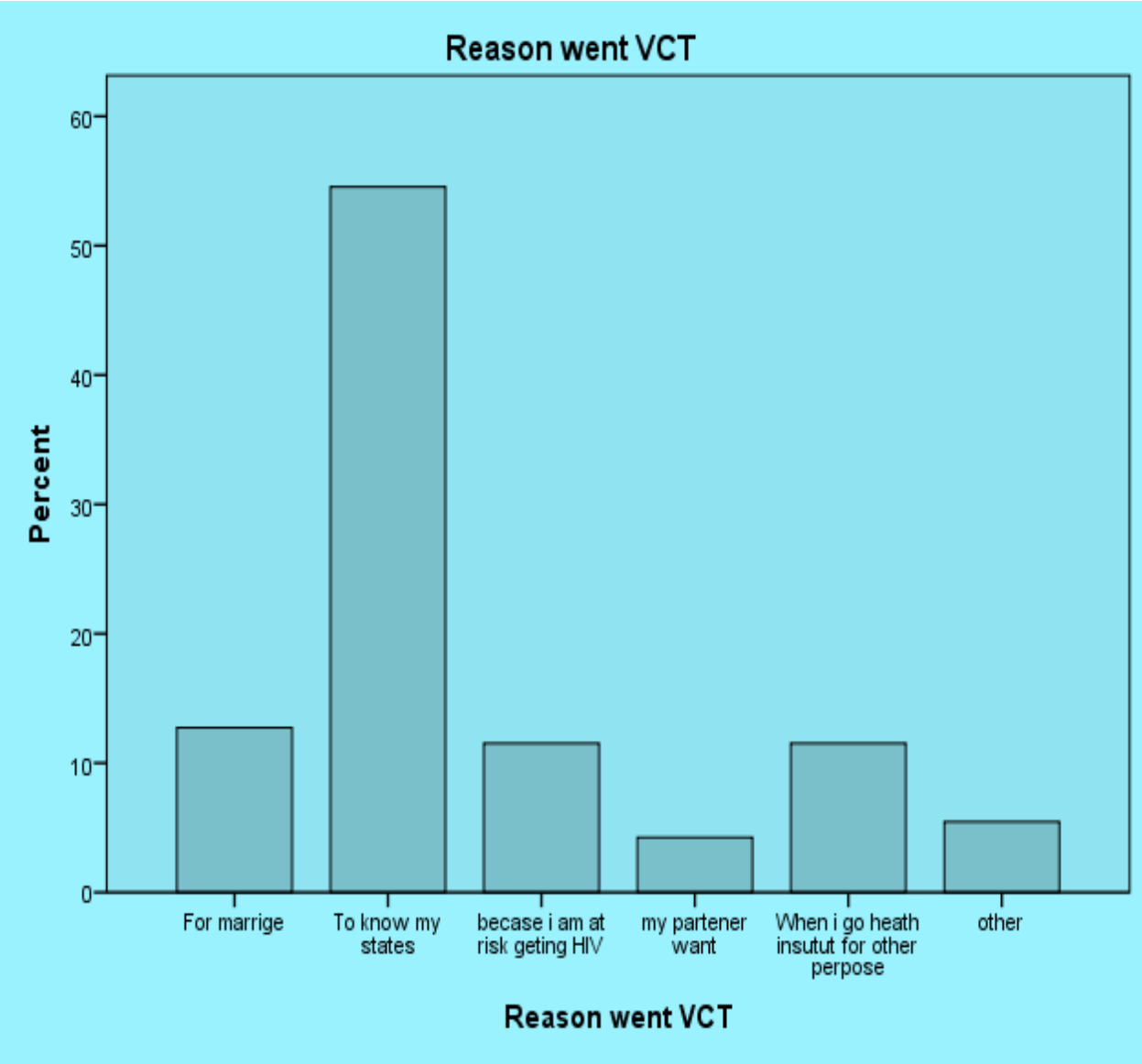

Fig.2 the reason of clients for VCT

Client willingness to undergo VCT was assessed. Accordingly 113 (62.8%) of the respondents responded that they were willing, while the rest 67(37.2%) were not. The reason for not undergoing VCT was for fear of anxiety following the result 19(27.9%), for fear of stigma by the society 18(26.5%),for lack of confidence 11 (16.2%), lack of knowledge 6(8.8%), 9(13.2%) had no sexual intercourse experience & 2(2.9%) had not had any VCT service. **(See Figure 3)**

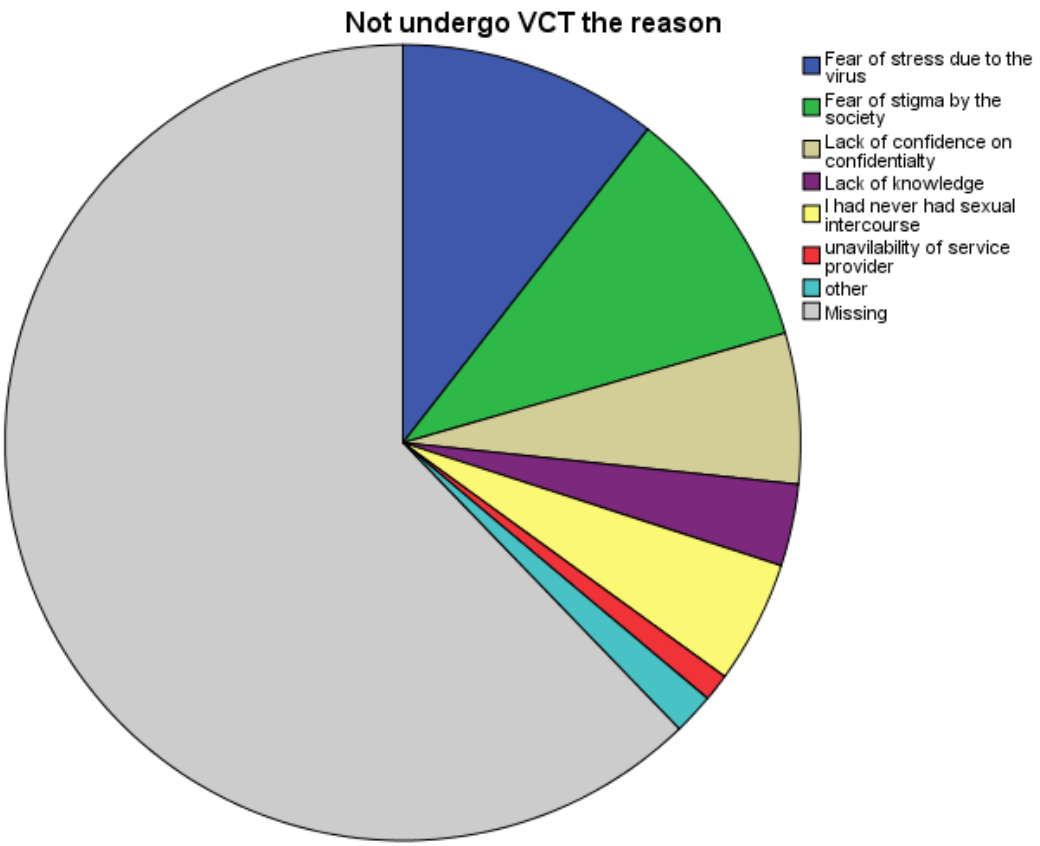

Fig.3 the reason of clients Not undergo VCT

Table 4 Knowledge and attitude of clients towards VCT, March 2015

Characteristics	Male	Female	Total
Heard of voluntary HIV counseling and testing			
Yes	93 (51.7)	82(45.6)	175(97.2)
No	3(1.7)	2(1.1)	5(2.8)
Feel that VCT is necessary			
Yes	81(45.0)	78(43.3)	159(88.3)
No	15(8.3)	6(3.3)	21(11.7)
Source information VCT			
Radio	16(9.1)	17(9.7)	33(18.8)
Televise	20(11.4)	19(10.8)	39(22.2)
Magazine	4(2.3)	7(4.0)	11(6.2)
Health Institutions	47(26.7)	32(18.2)	79(44.9)
Friend	3(1.7)	4(2.3)	7(4.0)
Neighbor	1(0.6)	3(1.7)	4(2.3)
Other	3(1.7)	0(0.0)	3(1.7)
Last went VCT			
Before 1 year	30(16.7)	22(12.2)	52(28.9)
1-2 year	9(5.0)	11(6.1)	20(11.1)
2-4 year	8(4.4)	13(7.2)	21(11.7)
4 year back	6(3.3)	7(3.9)	13(7.2)
I, don't undergo	38(21.1)	24(13.3)	62(34.4)
I, don't know	5(2.8)	7(3.9)	12(6.7)
Reason went to VCT			
For marriage	13(7.9)	8(4.8)	21(12.7)
To know my states	45(27.3)	45(27.3)	90(54.5)
I am at risk	7(4.2)	12(7.3)	19(11.5)
My partner want	2(1.2)	5(3.0)	7(4.2)
When I go health institution	15(9.1)	4(2.4)	19(11.5)
Other	6(3.6)	3(1.8)	9(5.5)
Willing to undergo VCT			
Yes	53(29.4)	60(33.3)	113(62.8)
No	43(23.9)	24(13.3)	67(37.2)
Reason do not want to VCT			
Fear of stress due to the virus	10(14.7)	9(13.2)	19(27.9)
Fear at stigma by society	12(17.6)	6(8.8)	18(26.5)
Lack of confidence	8(11.8)	3(4.4)	11(16.2)
Local at knowledge	3(4.4)	3(4.4)	6(8.8)
Never had sexual Intercourse	7(10.3)	2(2.9)	9(13.2)
Unavailability of Service	1(1.5)	1(1.5)	2(2.9)
Other	3(4.4)	0(0.0)	3(4.4)

4.4. Perception about HIV/AIDS and VCT

Perceived susceptibility

Clients attitude towards perceiving themselves as susceptible to HIV infection was assessed and the result indicated that 73 (40.6%) of them replied as having low perception of acquiring the infection. The remaining 107(59.4%) of them responded that they could have high possibility of getting HIV/AIDS.

80 (44.4%) of the clients perceived they were at risk of getting HIV, the other 100 (55.6%) were not.

Perceived Severity

One hundred five (58.3%) of the respondents had high perception towards severity of HIV/AIDS. While 75 (41.7%) had low perception.

Perceived Benefit

One hundred seven (87.2) of the respondents agreed that VCT is an effective way for preventing HIV/AIDS.

Perceived Barrier

One hundred fifty five (88.3%) of the clients had high level of perception on barriers of VCT and 21 (11.7%) were not **(See Table 5)**

Table 5 Perception of client to words HIV/AIDS and VCT in Black Lion Hospital, March 2015

		Male	Female	Total
Risk getting HIV	Yes	47 (26.1)	53(29.4)	100(55.6)
	No	49(27.2)	31(17.2)	80(44.4)
HIV destroy feature				
	Yes	48(26.7)	54(30.0)	102(56.7)
	No	48(26.7)	30(16.7)	78(43.3)
Possible get HIV				
	Yes	55(30.6)	52(28.9)	107(59.4)
	No	41(22.8)	32(17.8)	73(40.6)
HIV death sentence				
	Yes	55(30.6)	50(27.8)	107(58.3)
	No	41(22.8)	34(18.9)	75(41.7)
VCT necessary				
	Yes	81(45.0)	78(43.3)	159(88.3)
	No	15(8.3)	6(3.3)	21(11.7)
VCT help alleviate anxiety				
	Yes	88 (48.9)	76(42.2)	164(91.1)
	No	8(4.4)	8(4.4)	16(8.9)
VCT methods tackle HIV				
	Yes	81(45.0)	76(42.2)	107(87.2)
	No	15(8.3)	8(4.4)	23(12.8)

4.5. Association of socio-demographic variables and theoretical variables *(Perceived susceptibility, Severity, Benefit and Barrier*) with willingness for VCT.

- Socio demographic variables, theoretical variables were analyzed if there were association with willingness to VCT. By applying correlation the following variable showed statistical association with willingness to VCT.
- Age groups 15-19 and 20 years and above were more likely to undergo VCT.
- Clients with live in urban area were more likely to show willingness to VCT than those live rural area.
- Clients with educational status increase were more likely to show willingness to VCT than those lower class students.
- Clients who had sexual intercourse were less likely to show willingness to VCT than to those who did not have.
- Those clients who had high perceived susceptibility were highly likely having intention for willingness VCT than those having low perception.
- Clients who had high perception on barriers were highly likely to have intention to willingness for VCT than to those having low perception.
- Clients who had highly perceived on Benefit were highly likely to have intention to willingness to VCT than to those having low perception.

  (See Table 6)

Table 6 Association of Socio demographic, theoretical variables and practices with willingness for having VCT among clients in Black Lion Hospital, Addis Ababa, March 2015

Variable	Willingness To		Correlation
Age	Yes	No	(Pearson's R Correlation)
<15	16	10	
15-19	44	28	0.490
>20	43	26	
I don't know	10	3	
Area of residence			
Urban	63	38	
Rural	50	29	0.900
Education status			
unable to write and read	10	8	
below 4 grade	10	8	
5-8	25	13	0.973
High school	49	21	
certificate	6	6	
Diploma & above	13	11	
Had sexual intercourse			
Yes	105	9	0.797
No	8	58	
Use condom			
Yes	81	7	
No	19	2	0.520
No response	5	0	
Perceived susceptibility			
Low	36	44	
High	77	23	0.394
Perceives severity			
Low	33	42	
High	80	25	0.00
Perceives Benefit			
Low	11	12	
High	102	50	0.113
Perceives barrier			
Low	4	4	0.447
High	109	63	

CHAPTER FIVE

Discussion

The HIV/AIDS pandemic that started over twenty years ago is still extremely active and growing worldwide. Young people (15-24 years old) account for half of all new infections according to UNAIDS, 2004 report.

Taking that in to considerations, a cross sectional study among Black Lion Young Clients was conducted, which tried to assess information on knowledge of HIV transmission, prevention, sexual behavior and different issues on VCT. Even if majority of the clients had sufficient knowledge, significant proportions of clients were engaged in risky sexual practice.

In this study 63.3% of the study subjects of which 31% male clients and 32.2% of female client had sexual experience; this figure is low as compared to other studies in *USA and Canada*, which were 46-72% for boys and 24-72% for girls. (Finer & Philbin, 2013.) In Europe it was between 18.9-78% for boys and 17-45% for girls.

In North West Ethiopia Kolla Diba it was 31.9% for both sexes (Ismail,1997), In Jimma 32.5% for males and 12.7% for Females (Gurmesa Tura, Fessahaye Alemseged, & Sisay Dejene, 2012),and in Addis Ababa it was 5.6% for girls, 39.8% for boys (Eshetu,1997).This figure is lower than the report from BSS, which were 19.3% and 12.8% for male and female respectively. This might indicate that young people might be able to abstain from sexual intercourse to prevent being infected from HIV. This might be as a result of the different interventions programs designed and being implemented on avoidance of pre marital sex in becoming effective.

Regarding to the age start first sexual intercourse, the majority of the respondents (53.5%) starts sexual intercourse between 15-19years of age, (2.6%) starts leasthan15 years and (39.5%) after 20 years.

In United State fewer than 2% of youth had sex by the time they reaches their 12th birthday. Only 16% of young have had sex by age 15, compared with one-third of those aged 16, and nearly half (48%) of those aged 17, 61% of 18-year-olds and 71% of 19-year-olds. (Finer & Philbin , 2013.) In Nigeria it was 17 years for males (Kelly, 1998). In Addise Ababa, especially among women,11% of young women ages 15-24 and 1% of young men ages 15-24 had sexual intercourse by age 15. Four in ten young women ages 18-24 and 13% of young men ages 18-24 had sexual intercourse by age 18. (FHI, USAID, 2004) . The study of sexual initiation and its determinants among youths in north east Ethiopia shows the median age for first youths sexual intercourse was 17 (16.54±1.9) and 18 (17.5 ±1.4) years for male and female, respectively (Central Statistical Agency and ORC Macro,2006)

Males started sexual intercourse earlier than females which is demonstrated in other studies. But a study done among school adolescent in Oromia showed female student had sexual intercourse earlier than male (G.Selassie, 1996).
As to their knowledge on preventive measure 85.6% remaining faithful to be partners.Majority of the study subjects know the presence of male condom and where it is available. Nearly one fourth of the study subjects didn't know the proper use of male condom. This finding showed that still there is knowledge gap in there preventive method.

Significant proportion of the study subjects (97.2%) knew the presence of VCT from different sources. The main source being Health intuition (44.9%), majority of them (62.8%) were willing to undergo VCT for HIV.

In this study of the study subjects of which 53.3% of males and 46.6% of females had undergone VCT, these figures are higher than that of BSS 2002 report, which was 4.5% for male and 3.4% for females. This showed the acceptance rate of expansion of VCT.

Although majority of the respondents prefer to be counseled by physician & any trained nurse, but some of them had preference for religious leaders and

HIV patients. These findings highlight that religious leaders and HIV patients had better been involved in VCT to increase the acceptance rate. Study done in Uganda and Tanzania showed that involving traditional leader and religious leader in HIV counseling showed significant result to expand VCT services (Rachel & Jaques, 1997).

Clients were increase grade 9and above had showed more willing to undergo VCT than those below. Youth in this educational level might have had better information and awareness about VCT and are more likely to show willingness VCT. This might be the level, of awareness will increase about the Importance of VCT. This is also similar to other study done in Ethiopia and Uganda (Wondimagegn, 2004).

Similarly clients at higher age were more likely to willing be for VCT, this might be again as age advance the status of their knowledge might increase.

Those clients who ever had sexual experience, replied that they did have high perceived susceptible were less likely to have intention for willingness to VCT. This might be due to the fact that they were afraid that they could get the HIV infection and might be engaged in unprotected sexual intercourse.

Fear of positive result, stigma and discrimination attached with HIV in the public were the major reason mentioned by the respondents for their unwillingness for VCT. Similar finding in many developing country were reported by UNAIDS emphasizing that a property curried out program could help to break the vicious circle of fear and stigma.

Strength and limitation of the study

Strength

- There is high response rate, which is about 95.7%
- This study is applicable and widely used.

Limitations

- Since some questions include sensitive issues, responses may reflect desirability bias.

Conclusion

- Clients had high level of knowledge about HIV/AIDS but were engaged in unprotected sexual intercourse that was demonstrated by 1ow utilization of condom & lack knowledge and un proper use of male condom.
- The perception of majority of the young towards acquisitions of the infection was low.
- There is high willingness to undergo VCT.
- Majority of Clients had high perception on barriers of VCT.
- Client's perception on the benefit of VCT was high.
- Statistically significant association was seen between respondent of having high and low perception on perceived susceptibility, barrier and benefit with willingness to VCT.
- Fear of stigma and discrimination by the society were the main reason for not undergoing VCT.

Recommendations

- Health institution and different media should advocate the benefits of VCT. Fear reduction of stigma and discrimination should be strengthened.
- Information, education and communication programs should be established and emphasis should be put on reproductive health in order to encourage the young to avoid unsafe sex.
- HIV preventive message like VCT should emphasis personal susceptibility to HIV/AIDS.
- Other non health professionals, trained VCT counselor should be involved in counseling to increase the acceptance rate.

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ANNEX I- English Version Questionnaire

ADDIS ABABA UNIVERSITY SCHOOL OF EDUCATOION AND BEHAVIOURAL STUDIES, COUNSLLING PSYCHOLOGY MA PROGRAM.

Questionnaire for Data Collection on Client helping and hindering factors in HIV counseling Verbal consent form before conducting interview.

Hospital/health center/ clinics _____ Code _____

Ward/OPD _____

Hello, my name is _____ I am working in the research team of Addis Ababa, Ethiopia. I would like to ask you few questions about your experience and opinion on HIV counseling. The objective of this study to assess client helping and hindering factors on HIV counseling. I would like to appreciate your participation and my questionnaire takes about 10 -15 minutes. Your answer will remain confidential and also I will not take your name & address. Your participation is voluntary and you are not obliged to answer any question you do not want to answer. Your participation is valuable. Do I have your permission to continue?

Yes _____

No _____

1. If yes. continue to the next page
2. If no, ask the reason and skip to the next respondent.

Date of data collection __/ ____/_____ times of interview: started ___ end _____

Data collector name and signature _____

Guide Line – 1. Please tick (√) to select your answer.

2. Read each question carefully and given answer

Section I. Socio – demographic Characteristics.

101	Sex	☐ Male ☐ Female	
102	Age	----------year	
103	Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Other (specify)	
104	Occupation	_____	
105	Area of residence	☐ Urban ☐ Rural	
106	Religion	☐ Orthodox ☐ Muslim ☐ Protestant ☐ Catholic ☐ No religion ☐ Other Specify	
107	Ethnicity	☐ Gurage ☐ Amhara ☐ Tigre ☐ Oromo ☐ Other Specify --------	
108	Educational Status	☐ Unable to write and read ☐ Below 4th grade ☐ 5th – 8th Grade ☐ High school ☐ Certificate ☐ Diploma & above	

Section II – Sexual behavior and knowledge of HIV/AIDS

Instruction – chose one of the given choices to answer the Sexual behavior and knowledge of HIV/AIDS of a client.

Scale – strongly Agree – **5** Agree – **4** Not agree – **3**

Disagree -**2** strongly Disagree – **1**

Ways of HIV transmission

201	Doing unsafe sexual intercourse Can transmit HIV.	**SDA= 1**	**DA= 2**	**NA= 3**	**A= 4**	**SA= 5**
202	HIV Can be transmitted by mosquito bite.					
203	HIV Can be transmitted from pregnant mother to the fetus before birth.					
204	HIV Can be transmitted from pregnant mother to the fetus during delivery.					
205	HIV Can be transmitted from pregnant mother to the infant by breast – feeding.					
206	Shaking hands Can transmit HIV.					
207	Taking meal together with HIV positive individual Can transmit HIV.					

Ways on HIV prevention

208	By using condom regularly and	**SDA=**	**DA=**	**NA=**	**A=**	**SA=**

	properly.	**1**	**2**	**3**	**4**	**5**
209	By abstaining from sexual intercourse.					
210	By being faithful to partner.					
211	Have you heard of male condom?	☐ Yes ☐ No				
212	Do you know the correct use (when, how to insert and discard) condom?	☐ Yes ☐ No				
213	Have you ever had sexual intercourse?	☐ Yes ☐ No				
214	How old were you when you started sexual intercourse?	☐ Less than 15 ☐ 15-19 ☐ Gertherthan 20 ☐ I don't no				
215	Have you had sexual intercourse during the last 12 month?	☐ Yes ☐ No ☐ No response				
216	Have you ever used condom while doing sex.	☐ Yes, usually ☐ Yes, occasionally ☐ No ☐ No response				

Section III. **Perception about HIV/AIDS Infection**

Instruction – Choose one of the given choices to answer perception about HIV/AIDS Infection

Scale – strongly Agree – 5 Agree – 4 Not agree – 3 Disagree -2 strongly Disagree – 1

301	You are at risk of getting HIV/AIDS.	**SDA= 1**	**DA= 2**	**NA= 3**	**A= 4**	**SA= 5**	
302	It is possible that you will get HIV/AIDS.						
303	It is likely that you will get HIV /AIDS.						
304	Getting HIV a sure death sentence.						

Section IV – Knowledge & perceptions related to VCT

401	Have you ever heard of voluntary HIV counseling and testing?	☐ Yes ☐ No	
402	What is the source of information if the answer is yes?	☐ Radio ☐ Television ☐ Magazine ☐ Health institution and profession ☐ Friend ☐ Neighbor ☐ Other Specify--------	
403	Do you feel that VCT is necessary?	☐ Yes ☐ No	
404	When was the last time you underwent VCT?	☐ Before one year ☐ 1-2 year ☐ 2-4 year ☐ 4 year back ☐ I don't undergo	

		☐ I don't know	
405	If you underwent VCT, what was your reason?	----------	
406	By whom do you prefer VCT be given?	☐ By physician ☐ By nurse ☐ By HIV patient ☐ By religious leader ☐ Other Specify-------- ☐ I don't know ☐ No response	

Instruction – chose one of the given choices to answer the Knowledge & percaption related to VCT

Scale – strongly Agree – **5** Agree – **4** Not agree – **3**

Disagree **-2** strongly Disagree – **1**

407	If anyone considers him/her self as vulnerable for HIV/AIDS exposure, such thought may has influence on VCT service to be delivered to such person.	**SDA= 1**	**DA= 2**	**NA= 3**	**A= 4**	**SA= 5**	
408	An opinion concerning HIV/AIDS has positive influence over VCT service provision.						
409	VCT is one among the methods to tackle HIV/AIDS.						
410	The knowledge of VCT service provider concerning HIV/AIDS has influence on acceptance of service delivery.						

411	Knowledge of concerning counseling methods by VCT service provider has positive influence on such persons counseling service.						
412	Does VCT help you to alleviate your anxiety?						
413	Are you sure to use VCT in the future?						
414	If your answer is no for the above question what is your reason for not want in to VCT?	----------					

Thank you!!!

የአማርኛ መጠይቅ

የአዲስ አበባ ዩኒቨርስቲ የድህረ ምርቃ ጥናት ካውንስሊንግ ሳይኮሎጂ ማስተርስ ዲግሪ ተማሪ፡፡

በመንግስት ጤና ተቋማት በፍቃደኝነት ላይ የተመሰረተ የሚሰጥ የኤችአይቪ የማማከር እና የምርመራ አገልግሎት ለሚጠቀሙ ደንበኞች የተዘጋጀ መጠይቅ፡፡

ሆስፒታል _____ መለያ ቁጥር_____

ታካሚዎች በጥናቱ ለመሳተፍ ፍቃደኛ ስለመሆናቸው የሚገልፁበት፡፡

እንደምን ሰነበቱ? የእኔ ስም_____ ይባላል፡፡ በአዲስ አበባ ዩኒቨርስቲ በሚደረገው በዚህ ጥናት ውስጥ ተሳታፊ ስሆን እርስዎ ስለ ኤችአይቪ የማማከር አገልግሎት ያለዎትን አመለካከት ለመገንዘብ ጥያቄዎች አድርግልዎታለሁ፡ ለአላማው መሳካት የእርስዎን ትብብር እሻለሁ፡፡ የእርስዎ ስምም ሆነ አድራሻ በመጠይቁ ውስጥ አይካተትም እንዲሁም የእርስዎ ማንነትዎ ሆነ የሰጡትን ምላሽ የእርስዎ ስለመሆኑ በምንም ሁኔታ አይገለጽም፡፡ በዚህ ጥናት እንዲሳተፍ ፍቃድዎን ስንጠይቅ ያለ ምንም አስገዳጅነት ሲሆን ፍቃደኛ ካልሆኑ መጠይቁን ከመጀመርዎ በፊት ሆነ ከጀመሩ በኋላ ማቋረጥ ይችላሉ፡፡

በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነዎት? አዎ ☐ አይደለም ☐

ፍቃደኛ መሆናቸው ካረጋገጡ በኋላ መጠይቁን ይጀምሩ፡፡

ፍቃደኛ ካልሆኑ ምክንያቱ ይገለፅ _____

በመቀጠል ወደ ሚቀጥለው ህመምተኛ ይሂዱ፡፡

መጠይቁ የተደረገበት ቀን _____ የተጀመረበት ሰዓት _____

ያለቀበት _____

መረጃውን የሰበሰበው ሰው ስም እና ፊርማ _____

ክፍል አንድ

እርስዎን በተመለከተ የተዘጋጀ መጠይቅ

ትዕዛዝ፡- እባክዎን መልስዎን ለመምረጥ ☑ ይህንን ምልክት ይጠቀሙ

101	ፆታ	☐ ሴት ☐ ወንድ
102	እድሜዎ ስንት ነው?	_____ ዓመት
103	የትዳር ሁኔታ	☐ ያላገባ ☐ ያገባ ☐ የተለያየ/የተፋታ ☐ ሌላ ካለ ይግለፁ
104	ስራዎ ምንድ ነው?	_____
105	የሚኖሩበት አካባቢ	☐ ከተማ ☐ ገጠር
106	ሐይማኖትዎ ምንድ ነው?	☐ ኦርቶዶክስ ☐ መስሊም ☐ ፕሮቴስታንት ☐ ካቶሊክ ☐ ሐይማኖት የሌለው ☐ ሌላ ካለ ይገለጽ _____
107	ብሔሮ ምንድ ነው?	☐ ጉራጌ ☐ አማራ ☐ ትግሬ ☐ ኦሮሞ ☐ ሌላ ካለ ይገለጽ _____

108	የትምህርት ደረጃዎ	□ መፃፍ እና ማንበብ የማይችል □ ከ4ኛ ክፍል በታች □ ከ5ኛ - 8ኛ ክፍል □ 2ኛ ደረጃ ትምህርት □ በሰርተፍኬት የተመረቀ □ ዲኘሎማ እና ከዚያ በላይ ያለው፡፡

ክፍል ሁለት፡-

ይህ መጠይቅ የተዘጋጀው በኤችአይቪ ዙሪያ ያሉትን እውቀት እና በሰነ ፆታ ዙሪያ ያሉትን ባህሪ ለማወቅ ነው፡፡

ትዕዛዝ፡- እባክዎን ከታች ለተዘረዘሩት መጠይቆች የሚስማማቸውን መልስ እንደሚከተለው በመምረጥ ይህንን ☑ ምልክት ያስቀምጡ፡፡

1. በፍፅም አልስማማም
2. አልስማማም
3. ተስማምቻለሁ
4. በጣም እስማማለሁ
5. እጅግ በጣም እስማማለሁ

የኤች አይቪ መተላለፊያ መንገዶች

201	ልቅ የሆነ የግብረ ስጋ ግንኙነት ኤችአይቪ ያስተላልፋል፡፡	1	2	3	4	5
202	በወባ ትንኝ ኤችአይቪ ከህመምተኛ ሰው ወደ ጤነኛ ሰው ይተላለፋል፡፡					
203	የኤችአይቪ ቫይረስ በእርግዝና ወቅት ከእናት ወደ ፅንስ ይተላለፋል፡፡					
204	የኤችአይቪ ቫይረስ በወሊድ ወቅት ከእናት ወደ ልጅ ይተላለፋል፡፡					
205	የኤችአይቪ ቫይረስ ጡት በማጥባት ከእናት ወደ ልጅ ይተላለፋል፡፡					
206	ኤችአይቪ በእጅ በመጨባበጥ ይተላለፋል					
207	ኤችአይቪ ከተያዘ ሰው ጋር አብሮ መመገብ ቫይረሱ ከህመምተኛው ወደ ጤነኛ ሰው እንዲተላለፍ ያደርጋል፡፡					

በኤችአይቪ ቫይረስ መከላከያ መንገዶች

ይህ መጠየቅ የተዘጋጀው ስለ ኤችአይቪ በሽታ መከላከያ መንገዶች ያለህን ግንዛቤ ለመረዳት ነው::

208	የግብረ ስጋ ግንኙነት በሚፈፀምበት ጊዜ ኮንዶም በመጠቀም ኤችአይቪን መከላከል ይቻላል::	1	2	3	4	5
209	ከግብረ ስጋ ግንኙነት በመታቀብ ኤችአይቪን መከላከል ይቻላል::					
210	ለትዳር/ለፍቅር ጋደኛ ታማኝ በመሆን ኤችአይቪን መከላከል ይቻላል::					
211	ስለ ወንድ ኮንዶም ሰምተዋል	☐ አዎ ☐ አልሰማሁም				
212	ስለ ትክክለኛ የኮንደም አጠቃቀም (መቼ እንደምንጠቀም፣ እንዴት እንደሚደረግ እና እንዴት አውልቆ እንደሚጣል) ያውቃሉ::	☐ አዎ ☐ አላውቅም				
213	የግብረስጋ ግንኙነት አድርገው ያውቃሉ?	☐ አዎ ☐ አላውቅም				
214	ከላይ ላለው ጥያቄ መልስዎ አዎ ከሆነ የመጀሪያ የግብረ ሥጋ ግኙኝነት ያደረጉበት እድሜ ስንት ነው?	☐ ከ15 አመት በታች ☐ ከ15-19 ☐ ከ20 አመት በላይ ☐ አላውቀውም				
215	ባለፉት 12 ወራቶች የግብረሥጋ ግኙኝነት አድርገው ያውቃሉ?	☐ አዎ ☐ አላውቅም ☐ መልስ አልሰጡም				
216	የግብረ ሥጋ ግኙኝነት ሲያደርጉ ኮንዶም ተጠቅመው ያውቃሉ?	☐ ሁልጊዜ እጠቀማለሁ ☐ አንዳንዴ እጠቀማለሁ ☐ ተጠቅሜ አላውቅም ☐ መልስ አልሰጡም				

ክፍል ሦስት:-

ይህ መጠይቅ የተዘጋጀው የእርስዎን ስለ ኤችአይቪ ያለዎትን አመለካከት ለመገንዘብ ይሆናል።

ትዕዛዝ፡- እባክዎን ከታች ለተዘረዘሩት መጠይቆች የሚስማማችሁን መልስ እንደሚከተለው በመምረጥ ይገለፅ።

1. በፍፅም አልስማማም
2. አልስማማም
3. ተስማምቻለሁ
4. በጣም እስማማለሁ
5. እጅግ በጣም እስማማለሁ

301	በኤችአይቪ ቫይረስ የመያዝ እድሌ ሰፊ ነው ብለው ያስባሉ?	1	2	3	4	5
302	የኤችአይቪ ቫይረስ በደሜ ውስጥ አለ ብለው ያስባሉ?					
303	የኤችአይቪ ቫይረስ በደምዎ ውስጥ ቢገኝ የወደፊት ተስፋዎ የጨለመ ያህል ይሰማዎታል?					
304	በኤችአይቪ መያዝ ማለት የሕይወት መጨረሻ ነው።					

ክፍል አራት፡-
ይህ ክፍል የተዘጋጀው በፍቃደኝነት ስለሚሰጠው የኤችአይቪ የምክር አገልግሎት (ቪሲቲ) ያለዎትን እውቀት እና ግላዊ አመለካከት ለማወቅ ነው።

401	ስለ ቪ.ሲ.ቲ ሰምተው ያውቃሉ?	☐ አዎ ☐ አላውቅም
402	መልስዎ አዎን ከሆነ ከየት እንደሰሙ ይግለፁ።	☐ ከሬዲዮ ☐ ከቴሌቭዥን ☐ ከመፅሄት ☐ ከጤና ተቋማት እና ከጤና ባለሞያዎች ☐ ከጓደኛ ☐ ከጉረቤት ☐ ሌላ ካለ ይጥቀሱ።
403	የቪ.ሲ.ቲ አገልግሎት ጠቃሚ እንደሆነ ያስባሉ?	☐ አዎ ☐ አይ
404	ለመጨረሻ ጊዜ ወደ ቪ.ሲ.ቲ አገልግሎት የሄዱት መቼ ነው?	☐ ከአንድ ዓመት ወዲህ ☐ ከአንድ-ሁለት ዓመት ☐ ከሁለት-ሦስት ዓመት ☐ ከአራት ዓመት በላይ ☐ እኔ አላውቅም ☐ አላስታውሰውም

405	ወደ ቪ.ሲ.ቲ አገልግሎት እንዲሄዱ ያደረጉት ምክንያት ምንድን ነው?	_____
406	የቪ.ሲ.ቲ አገልግሎት በማን ቢሰጥዎ ይመርጣሉ?	☐ በሐኪም ☐ በነርስ ☐ በኤችአይቪ ህመምተኛ ☐ በሐይማኖት መሪ ☐ ሌላ ካለ ይጥቀሱ

ትዕዛዝ፡- እባክዎን ከታች ለተዘረዘሩት መጠይቆች የሚስማማቸውን መልስ እንደሚከተለው በመምረጥ ይህንን ☑ ምልክት ያስቀምጡ፡፡

1. በፍፅም አልስማማም
2. አልስማማም
3. ተስማምቻለሁ
4. በጣም እስማማለሁ
5. እጅግ በጣም እስማማለሁ

407	አንድ ሰው በኤችአይቪ ቫይረስ (የመያዝ እድሉ ሰፊ ነው) ብሎ የሚያስብ ከሆነ በሚሰጠው የማማከር አገልግሎት ላይ ተዕእኖ ሊፈጥርበት ይችላል፡፡	1	2	3	4	5
408	ስለ ኤችአይቪ ያለን አመለካከት (ከባድነት/ቀላልነት) በማማከር አገልግሎት ላይ አዎንታዊ ተፅዕኖ ሊፈጥር ይችላል፡፡					
409	የኤችአይቪን መዛመት ከምንገታበት መንገድ አንዱ ቪ.ሲ.ቲ ነው፡፡					
410	የቪ.ሲ.ቲ ባለሙያ ስለ ኤችአይቪ ያለው የእውቀት መጠን ለሚሰጠው አገልግሎት ተቀባይነት ከፍተኛ ሚና ይጫወታል፡፡					
411	የቪ.ሲ.ቲ ባለሙያ ስለ ማማከር አገልግሎት ያለው እውቀት እና ችሎታ ለሚሰጠው አገልግሎት አዎንታዊ ተጽእኖ አለው፡፡					
412	የቪ.ሲ.ቲ አገልግሎት ከኤችአይቪ ጋር ተያይዞ ያሉ ጭንቀቶችን ለማቃለል ይጠቅማል፡፡					
413	ለወደፊት የቪ.ሲ.ቲ አገልግሎት ይጠቀማሉ፡፡					
414	ለላይኛው ጥያቄ መልሱ አይ ከሆነ ምክንያቱ ምንድን ነው?	_____				

አመሰግናለሁ!!