The Utilization of Voluntary of HIV Counseling and Testing by Family Planning and Antenatal Care Service Attendees at Hossana Town (The Case of Nigist Elleni Mohammed Hospital and Hossana Health Station)

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Counseling Psychology

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Acronyms and Abbreviations

MOHSS	Ministry of Health and Social Service in Namibia
PMTCT	Prevention of Mother to Child Transmission
FP	Family planning
ANC	Antenatal Care
RH	Reproductive Health
MCH	Maternal and Child health
MTCT	Mother to child Transmission
ARV	Antiretroviral
UNAIDS	United Nation Jointed program on HIV/AIDS
USAID	United stated Jointed program On HIV/AIdS
PHC	Primary Health Care
PLWHA	People Living with HIV AIDs
VCT	Voluntary HIV Counseling and Testing
IEC	Information Education and Communication
MOH	Ministry of Health
UNFPA	United Nations Fund for Population Activities
STI	Sexually Transmitted infections
STD	Sexually Transmitted Disease
IPPF	International Planned Parent-Hood Federation
SRH	Sexual and Reproductive Health
WHO	World Health Organization
SNNPRG	Southern Nation Nationalities People's Regional Government
HZHO	Hadiya Zone Health Office
FHI	Family Health International

Abstract

This study was carried out among women of family planning and antenatal care attendants at Hossana town in Hadiya zone of South Ethiopia. Hadiya zone has decentralized the service to different government health stations. However, reports show that there was low utilization of services. The objective of this study was to assess the VCT utilization by women of family planning and antenatal care attends at Hossana town in Hadiya zone of South Ethiopia.

This cross sectional study was particularly conducted on the utilization of VCT in reproductive age women of FP and ANC attendees who were from 15-49 years. The proportional stratified random sampling technique was applied to involve 120 participants. However, excluding the non returned questionnaire a total of 110 participants were participated from the Nigist Elleni Mohammed Hospital and Hossana health Station at Hossana town. The Data were collected from the respondents using the questionnaire, in-depth interviews and focus group discussion.

The result indicated that greater number of the participants were found to be knowledgeable about HIV/ AIDS existence. The knowledge of the respondents on VCT services was also found sufficient and nearly 92% of them had favorable attitude in the benefits of VCT.

Over all, 49.1% of the study participants practiced or used the VCT services. The main barriers for refusal of the test in this study were found fear and followed by stigma associated with HIV/AIDS. Besides, the use of IEC approaches was poor that could not be applied in away that can lessen stigma and fear. This study has also shown that there was an integration of VCT with in the family planning and antenatal care .

Chapter One

Introduction

1.1 Background of the study

HIV/AIDS is one of the biggest social, economic and development challenges facing world today. As of the end of 2006, globally 39.5 million people are living with HIV/ AIDS, with 48% (17.7 million) among them being women. And more than half of the infected women (59%) are in sub-Saharan Africa. This number of new infections among women and girls is increasing every year, highlighting the vulnerability, increased risk and unequal power relations in many societies (UNAIDS/ WHO; 2006).

According to the country's analysis of family planning and HIV/AIDS - Ethiopia, 2006 report, in 2002, in Ethiopia HIV prevalence rate was at 7.6 percent. This translated into an infected population of 2.8 million. According to MOH, heterosexual contact (87 percent) and parental transmission are the primary methods fueling the epidemic (USAID, 2002). In spite of Ethiopia effort, the epidemic has expanded rapidly. The Virus is killing people in both their reproductive and most productive years, severely disrupting social and economic systems.

In Ethiopia, when we assess the young women and girls in particular, they are disproportionately affected by the epidemic. For instance, 55% of the 1.32 million people living with HIV are women and they also account for 53.2% of all new HIV infections. The 2005 Ethiopian Demography and Health statistics showed that HIV prevalence among women is twice that of men (1.9% compared to 0.9%).Numerous obstacles contribute to the vulnerability of young women and girls to HIV. These include cultural and religious factors which can

decrease respects for women legal rights and access to key services (USAIDS, 2003).

With in the larger global context of increasing access to HIV prevention, care, support and treatment, more and more women will learn their HIV serostatus. This is possible through various means, including voluntary counseling testing (VCT) and prevention of Mother to child transmission of HIV (PMTCT) programs.

It is widely accepted view that HIV counseling is a confidential dialogue between the client and the counselor. This aimed at creating an enabling environment for the person to cope with stress and to make personal decisions related to HIV/AIDS. But, when we deal with voluntary HIV counseling and testing it is the process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for HIV. This is because counseling helps him or her to cope with stress and to make personal decisions related to HIV/AIDS. According to MOH (2002), counseling and testing can benefit women who are or who want to become pregnant. Ideally, all women should be advised for and have access to VCT before they become pregnant so that they can make informed decisions about pregnancy and family planning. Counseling and voluntary testing services attached to reproductive health services are an important entry point to the continuum of care. But it must be understood that HIV related counseling is not the primary of these services. They unlikely to be able to provide as much follow up counseling or support as clients need. Counseling at reproductive health facilities should therefore provide referrals to support groups or other services of information about care and living positive with HIV (UNAIDS, 1999).

It is obvious that counseling and voluntary testing is needed for people in order to know their HIV status and not to be at risk in HIV infection in various situations. With respect to this, findings revealed that VCT is the entry point for medical, psychosocial, legal and sometimes material care and support for all those in need in relation to the antenatal setting. Thus, it is the entry point for

comprehension, long term care and support of pregnant women. This includes clinical care such as treatment and preventions for MTCT of HIV education, prevention of HIV/STI infection and infant feeding support and family planning.

We can see that a great effort has been made to expand the utilization of its quantity and quality of VCT. However, it has not been seen as a priority and not highly encouraged in HIV prevention care programs in many developing countries. And often it is not widely available. Even in areas where VCT services are available, the services provided are still poor. In favor of this idea, some literatures show that due to the inconvenient locations of many health facilities and the work load that exists in these facilities, people coming to VCT services, however do not get the service quickly and efficiently (MOH,2002) .

Moreover, the population information program center for communication program in population report (1987) shows that traditionally most family planning training concentrated on reproductive philosophy, family planning methods and technical skills. But, less attention was given to how to listen and respond to clients in an emphatic way. And less consideration was observed on how to help them make decisions, and how to inform and instruct clients in away that they will remember and follow. So, this suggests there is a gap between women who follow family planning and antenatal care service and the VCT practice in that there is some what knowledge about AIDS and STI. These however, do not necessarily mean that the population are well informed about the disease and hence are taking precaution measure to avoid getting AIDS.

When the HIV epidemic emerged in the 1980's, family planning organizations responded with some of the first HIV prevention projects in the developing world. However, a review of the contribution of sexual and reproductive health services to HIV prevention conducted in 2003 for WHO, found that integrating HIV prevention in to family planning services had not yet been implemented effectively except few cases (UNFPA, 2004).

It is known that family planning has a critical role to play in curbing the HIV / AIDS epidemic and strengthening links between family planning and HIV/ AIDS prevention. The care and treatment services provide an opportunity to make efficient and effective use of available resources to address client's dual risks of unintended pregnancy and HIV infection. Integrating HIV counseling into family planning services helps prevent HIV infection among women of reproductive age. Besides, integrating VCT as well helps identify infected women who can then receive targeted family planning counseling and services. Further more, integrating HIV counseling and VCT into antenatal services helps prevent infection among pregnant uninfected women and it can also identify pregnant women who are HIV infected (WHO, 2003)

In brief, the integration of VCT services into family planning programs provides an opportunity to increase access to HIV services among women of reproductive age. It addresses especially a population not easily reached by traditional HIV programs primarily targeting HIV risk care transmitter groups. Although referral between family planning and VCT services was common, family planning providers at only one facility offered comprehensive services including information, education, counseling and testing with in their counseling services.

In areas where VCT services are available, most of the time uptake of services is poor. This is due to poor IEC approaches, lack of funding and integration infrastructure, and trained and designated staff. Provided that VCT has been integrated with medical care, FP and ANC and effort is made to improve awareness, attitude and practice, it will help to reduce the challenges. It is clear that there is a high degree overlap between the population at risk for unplanned pregnancy and those at risk for HIV/AIDS. So, VCT has shown a progressive behavior changes and become part of a holistic approach to promote sexual and reproductive health among individual couple and the society as well.

In general some studies revealed that there was sufficient knowledge, favorable attitude and good practice among the mothers of reproductive ages. And they also in favor of there were linkage in between the VCT and MCH services that means (FP and ANC) in their facilities. However, other studies claimed that, even though girls and women are highly vulnerable to HIV infection, they know less than males about HIV /AIDS. For instance, as to the study globally more than 80% of the young women did not have "sufficient" knowledge about HIV/AIDS. Many had no idea how HIV is transmitted and little or no information on protection methods. More over, people coming to VCT services do not get the services quickly and efficiently. (UNAIDS/WHO, 2002)

Therefore as far as the various finding from different studies relation to VCT utilization is concerned, the researcher will try to assess the VCT utilization in MCH settings with the emphasis of FP and ANC attendees.

As major concern of this paper, the study assesses the situation of knowledge, attitude and practice of voluntary HIV counseling and testing among women who attend family planning and antenatal care service. It also tries to see is the VCT integrated with the services. And further what major factors affect VCT utilization among the family planning or ANC at Hossana town.

1.2 Statement of the Problem

It is known that health service settings are the places where that can provide treatment, education and prevention services concerning one's health related issues. In coordinating with the mentioned service, they are also believed to provide counseling for HIV/AIDS and testing, mainly by using VCT services. Besides, some health stations on clinics give health reproductive services, such as family planning with the help of counseling to use modern methods.

Counseling and voluntary testing for HIV have benefits beyond the prevention of transmission from mother to child. Indeed, HIV testing is often used as a diagnostic tool to confirm symptomatic AIDS. But a growing number of studies

assure to the value of counseling and voluntary HIV testing in largely healthy population. These services have been shown to contribute to an increase in a start behavior at the individual level and are likely also to reduce ignorance, fear and stigma associated with HIV infection in the population at large. However, according to UNAIDS (1999), counseling services have been slow to gain acceptance in any countries. It is especially which HIV is heavily stigmatized and access to services and support for HIV infected is limited. Specifically, with having strong evidence currently most women attending FP and ANC in areas of high HIV prevalence do not know their serostatus and have no access to VCT. It is true that FP and VCT service have similar aims of reaching sexually active people and promoting safe and healthy sexuality. And it also includes the prevention of HIV, sexually transmitted infections (STIs), and unwanted pregnancy. But the integrating HIV prevention, particularly VCT in to FP and ANC services had not yet been implemented effectively except few cases (WHO, 2003).

Therefore, this study will try to assess the knowledge, attitude, practices and factors in relation to the services.

Specifically the research will try to answer the following research questions

1. **What does the family planning and antenatal care service attendees' awareness/knowledge, attitude and the practice on VCT look like?**
2. **Are the VCT and family planning and ANC services integrated?**
3. **Are there any influencing factors that affect the VCT utilization by FP and ANC services attending women?**

1.3 Objectives

1.3.1 General objective

The general objective of this paper is to assess the attendees' knowledge, attitude and practice about VCT utilization by family planning and antenatal care service attendants.

1.3.2 Specific objectives

- To assess the knowledge, attitude and the uptake of VCT among the women.
- To find out whether there is integrative practice of VCT in MCH setting or not.
- To identify the major factors that affect VCT utilization by Family planning and antenatal care attending women.

1.4 Significance of the study

At present, HIV/AIDS is becoming an important issue all over the world. As a result, various attempts are being made to identify ways of preventing the dissemination of HIV/AIDS in population to public. Specifically, the MCH settings have likely better opportunity to reach the women of reproductive age with respect to HIV/AIDS services. Hence, the study is contributing in the following ways.

- It provides insight for the health service providers and other concerned bodies in their effort to facilitate, plan and implement the VCT services with the already existing duties in their facilities.
- It gives an insight to minimize the missed opportunities, that is the use of dual protection for both sexual and health related issues in MCH settings.

- Since almost not much research have been yet done, at least to the knowledge of the present researcher, regarding this area in our country, this research can contribute something for further research.

1.5 Delimitation of the Study

This study was first delimited to Hossana town. Then, it was delimited to Nigist Elleni Mohammed Hospital and Hossana Health Station where family planning and antenatal care service are given. And further it included only females in the reproductive ages (15-49) who are residents in the catchments area of the two health facilities.

1.6 Definitions of Terms

Acquired Immune Deficiency Syndrome (AIDS) A collection of symptoms and infection resulting from the depletion of the immune system

Counseling : an interaction in which the counselor give another person (s) time, attention, respect necessary to explore, discover and clarify ways of living more resource fully (WHO,2002).

HIV testing: The process by which blood or body fluids are analyzed for the presence of antibodies or antigens produced in response to HIV

Chapter Two

Review of Related Literature

2.1 Prevalence of HIV/ AIDS

In 2003, the global HIV epidemic killed more than 3 million people, 2.3 million of whom were in Sub-Saharan Africa. Women in the world and Africa in particular are experiencing a unique challenge as manifested by the high prevalence of HIV. The fast test growth in recent years has been in South Africa, where the prevalence of infection in adult women increased from 1% in 1990 to 25% in 2000 (Dabis, et al 2004). More than one in five pregnant women are HIV- infected in most countries, in Southern Africa, while else where in sub-Saharn Africa, median HIV prevalence in antenatal clinics exceeded 10% in few countries . HIV infection in East Africa had spread rapidly in the late 1970s and early 1980s. As a result, 15-30% of pregnant women are HIV positive in Uganda (Mendel, 2004). In many countries throughout Africa, HIV prevalence rates among pregnant women attending ANC clinics are the most reliable sources of data to monitor the epidemic and access the impact of interventions (Zaba, et al, 2000). According to the MOH, prevalence rates as of 2001 averaged from 4% in rural areas to 14 in cities (Ethiopia Aids Resource Centre, 2003).

When we see the reality in Ethiopia, it is one of the countries of the world that are most seriously affected by HIV/ AIDS. According to MOH 2004, nearly 60% of HIV positive individuals in the country are women.

2.2 Mother to Child Transmission of HIV (MTCT)

Mother to child transmission is the most common mode of human immuno deficiency virus (HIV) transmission in children. This can be vertically transmitted from HIV positive pregnant woman to her unborn baby during pregnancy, labour and delivery or through breast feeding. During 2001, UNAIDS estimated that world wide through mother to child transmission

approximately 800,000 children acquired HIV infection including 720,000 in Sub- Saharan Africa .

In developing countries, for instance in Namibia without any prevention of Mother to Child Transmission of HIV (PMTCT) intervention for every 300 children born to HIV infected women about 100 will become infected. Of those 100 children infected, about 0.16 would have acquired HIV during pregnancy, 50 during labor and delivery and 34 after delivery through prolonged breast feeding (MOHSS, 2004).

Therefore, the prevention of acquisition of infection in women and reduction of incidence of unwanted pregnancy in HIV positive women will help global prevention of Mother to Child Transmission of HIV (PMTCT) by decreasing the neonatal and maternal mortality rates.

2.3 Prevention of Mother to Child Transmission of HIV (PMTCT)

The developing countries have seen a continued rise in pediatric HIV cases. And most of them are through mother to child transmission of HIV (MTCT).

Prevention of Mother to child transmission of HIV includes four main strategies:

- Primary prevention of HIV in women of reproductive age.
- Prevention of unintended pregnancy in HIV infected women.
- Prevention of MTCT through the use of antiretroviral therapy (ARV) drugs and other practice.
- Provision of comprehensive care to HIV infected women, partners and children.

The corner stone of a successful PMTCT program is a high rate of HIV testing among pregnant women. This is to identify those who are positive and at risk of transmitting the virus to their babies. Therefore, evidences strongly suggest that routine voluntary counseling and HIV Testing should be integrated. The service should be integrated in to ANC, maternity or at any other opportunity. It should be to all pregnant women who accept to deliver effective PMTCT services

rather than being provided through a separate. In Ethiopia, VCT and treatment of STIs have been integrated with family planning in some organizations. Some programs have also incorporated treatment of opportunistic infections into their programs. A few organizations have integrated post abortion care PMTCT into other MCH and ANC clinics (Yared Mekonnen, 2004).

2.4. Voluntary HIV Counseling and Testing (VCT)

When the HIV test was developed in mid 1980's, testing tended to be accompanied by little HIV counseling. However, with the growing awareness of HIV infection and AIDS and the recent availability of ART, the scope and reasons for voluntary counseling and HIV testing have been broadened. VCT is a process by which an individual undergoes counseling to enable him or her to make an informed decision about being tested for HIV. Besides, it assesses their personal risk for HIV and develops a risk reduction strategy. VCT services are essential components of HIV prevention and care programs. It is known that the social conceptualization and representative-ness of HIV and HIV testing also have influence on HIV test up take rates. For instance, the association of HIV with immediate death and discrimination, belief that a person is out side rates in one's community. And also fear of being labeled and stigmatized by the significant others are factors hinder VCT utility. Moreover, the perception of the consequences of living with HIV, user friendliness of testing sites, symptom driven health seeking, lack of knowledge about available treatment are included. These and other some factors have been alleged to deter people from HIV testing (MOHSS, 2004).

Thus, UNAIDS identified various approaches to VCT services which included integration of VCT in to Antenatal Care (ANC), primary health care (PHC) services into hospital settings and the private sector.

2.4.1. VCT, Adolescent Girls and Women

Even though girls and women are highly vulnerable to HIV infection, they know less than males about HIV/ AIDS and how it is transmitted. In many societies,

including Ethiopia, both the discussion of and education about sexual matters is frowned upon. As a result, millions of people, especially girls and women remain ignorant about HIV/AIDS with potentially deadly consequences. According to studies the rising rates of HIV infection among girls and women require approaches to prevention that address their specific needs and realities. And these are linked with other reinforcing elements along abroad continuum of prevention, treatment and care (USAIDS, 2003).

Nine out of ten people living with HIV/AIDS do not know they are infected. Yet studies have shown that young people have a strong interest in knowing their HIV status. More than 75% of young people surveyed in Kenya, and about 90% in Uganda, indicated that they would like to be tested while still healthy (UNAIDS/WHO,2002). Despite the importance of VCT, in many countries fewer than 50% of young people know when they can be tested for HIV. For instance, in Cambodia only 16 percent of girls aged 15-19 know where to go for testing, in Zimbabwe only two out of five know where to be tested (UNAIDS/WHO,2002).

As the study showed in Sub-Saharan Africa, 53 percent of young women know that a healthy- looking person can be infected, compared to 64 percent of young men. For instance, in Ethiopia 39 percent of young women know that a healthy person may have HIV, compared to 54 percent of young men. Moreover, too few young people report condom use at last sexual encounter with a non-cohabiting partner, with young women reporting condom use less than young men (USAIDS, 2003).

Therefore, studies showed VCT can contribute to a decrease in un increase in condom use and more people choosing abstinence. Research in Kenya, Trinidad and Tobago and Tanzania found that VCT was more effective in reducing reported risk behaviors than just providing information on HIV transmission. Pilot projects in Coted' Ivoire indicated that integrating VCT in to sexual and

reproductive health services also reduces stigma associated with HIV/AIDS and increased utilization.

2.4.2. VCT as Part of MTCT Strategy

The World Health Organization (WHO) is promoting the pre-test initiative, which calls for HIV voluntary counseling as an entry point for access to care and prevention. Although globally, VCT services have been identified as an important strategy in managing HIV care and prevention programs, in many developing countries it has therefore not been widely available.

It is clear that since women are more vulnerable than male in the HIV infection, the young women, particularly young women who are pregnant and tested positive should be given due emphasis. That is to mean, they should be offered special care to safe guard their own health and minimize the risk of passing the virus to their baby.

As studies showed VCT is critical for reducing the numbers of infants born with HIV. MTCT is the primary cause of all HIV infections in children under 15. Yet in 2003, only 1 percent of pregnant women in countries heavily affected by AIDS had access to testing and treatment. That same year, more than 700,000 children were newly infected, mostly through MTCT. Ideally, VCT should not only allow women who are HIV positive to receive treatment that would prevent their children for becoming infected by PMTCT but also receive treatment from them.

However, according to Ethiopian journal of health development 2005 report, in the absences of VCT services, most women in Africa have no definite way of knowing their HIV status; that is, until they fall ill with identifiable symptoms of AIDS, or until they give birth to a baby who is diagnosed with the virus. They do not know their HIV status and eventually died from AIDS. For women identified as being HIV positive before or during pregnancy, test related counseling can help them plan for their future and the future of their families

(Korra, et al, 2005). Currently most women attending ANC in areas of high HIV prevalence don't know their serostatus and have no access to VCT . It is now urgent to promote and provide or improve access to VCT in areas where MTCT interventions are planned (UNAIDS, 1999).

2.5. Up-Take and Acceptance of VCT

According to data from the surveys globally, more than 80 percent of the young women did not have sufficient knowledge about HIV. Many had no idea how HIV/AIDS is transmitted and little or no information on protection methods. In Thailand, 98% of pregnant women accept HIV testing during the antenatal care visits. A cross sectional survey was used in Bushenyi District of Uganda to estimate the proportion of pregnant women who undertake VCT. The researchers found that thirty- eight (17%) of 219 people interviewed had ever undergone HIV testing. The factors influencing VCT for HIV are the following: the consequences positive test result, influence of a sexual partner, the cost of VCT, physical accessibility of VCT, awareness and risk of HIV infection (Nuwaha, et al, 2002).

In pilot study of the same day, VCT in six urban antenatal clinics in Lusaka, Zambia, 84% of pregnant women requested testing and a quarter of those women tested positive. In Nambia, a very low uptake of VCT (<10%) was recorded during the pilot PMTCT program. This was attributed primarily due to the lack of trained counselors in Namibia (MOHSS, 2004).

Misconception and inadequate knowledge of HIV transmission among the youth in Ethiopia are common. Also data on the rate of infection for youth aged 5-18 is almost non- existent, with few cases of HIV/AIDS having been officially reported for this age group. In addition to MTCT, a significant number of HIV infections may occur as early as 10 years of age for girls. Due to harmful traditional practices including early marriages few counseling services exist for youth particularly for young girls. Many people with HIV in Ethiopia do not

know they are infected up until now, only a small percentage of those with HIV/AIDS have had access to reliable VCT (MOH, 2002).

2.6 Factors that Affect Uptake and Acceptability of VCT in PMTC Services.

A number of varied and complex factors serve as barriers to the acceptance and uptake of VCT. These include both the service and client- related factors.

2.6.1. Service Related Factors

2.6.1.1 Accessibility and Availability of VCT Services.

Accessibility and availability of VCT services have generally not been seen as a priority in HIV care and prevention programs. In many areas of the world and specifically in developing countries, voluntary counseling and confidential testing (VCT) is not widely available or not available at all. In supporting the above idea WHO health service coverage (2004) showed that the percent of pregnant women offered VCT in PMTCT services was 8% for the world, 5% for sub- Saharan Africa.

In four year study, the introduction of PMTCT services within maternal and child health programs in Kenya and Zambia was examined. Here, more than 22,000 women who sought antenatal care as new clients received pretest counseling. But less than one- third went on to have an HIV+ test. Reasons for disproving VCT uptake at ANC/PMTCT sites through out Africa may include logistic barriers (e.g results are unavailable the same day or tests are expensive) and fears that test results will not remain confidential. Even when women are tested, a substantial number do not return for their results (Cartoux, M. 1998).

2.6.1.2. Confidentiality and Attitude of Health Workers

Voluntary screening programs for HIV may be either confidential or anonyms. A study investigating VCT uptake by pregnant women using focus group

discussion in South West Uganda showed that pregnant women were anxious about taking up VCT. This was due to the fear for confidentiality and fear that maternity status was known (Pool, et al. 2001). It is alleged that in some health facilities nurses disclose the HIV status of their clients in the public without informed consent. In addition, patients are said not to accept being counseled by counselors who are younger than themselves, which increases the pressure on the availability of counseling services (MOHSS, 2004).

In short, concerning problems not related to the client the several key factors may contribute to the poor and inconsistent utilization of maternal health care services for PMTCT. These are stigma and fear for HIV positive pregnant women to disclose their status to health workers. On the other hand, the quality of care (good or bad) received from a health facility during previous pregnancy or delivery can have an associated effect on her further utilization of the facility.

2.6.2. Client Related Factors

2.6.2.1. Knowledge, Attitude and Practice about HIV/AIDS and VCT

At least 90% of the 25.3 million people living with HIV/AIDS (PLWHA) in sub-Sharan Africa do not know that they are HIV positive (WHO HIV/AIDS, 2002). In a study conducted among pregnant women in southern India, the majority (86%) reported that they would agree to test for HIV. This group of women stated that they would consent to HIV testing in order to protect their unborn babies. Whereas, women who stated that they would refuse to test said they did not perceive themselves to be at risk for HIV or needed their husband's permission to undergo the test.

A study conducted to assess pregnant women's knowledge of HIV and AIDS awareness and attitude towards VCT uptake in a teaching Hospital in Northern Nigeria indicated the following. For instance, 65% had good knowledge, 24% had fair knowledge and 11% had poor knowledge of infection. Most respondents

were aware of VCT through health workers, mass media and friends (Iliyasu, et al 2005). On the other hand the literature revealed that at least 90% of the 25.3% million people living with HIV/AIDS in sub-Saharan Africa does not know that they have HIV positive (WHO, HIV/AIDS 2002).

When we consider the Ethiopian situation, many people in high prevalence are aware that VCT services are available at different sites such as hospitals and free standing VCT centers. However, a very small proportion of the population who knows about the availability of VCT has been tested for HIV. Among the reasons why many individuals may not seek HIV testing can be negative perceptions of testing services. Even such attitude was demonstrated as one of the barriers for high risk individuals in the Untied States (Andargachew Moges, 2006).

Another study conducted by Simeon Adebo, 2003 also revealed that although considerable proportion of respondents, 51% have heard of VCT. When it comes to the question whether it is useful or not, the vast majority, 79% of the sample population did not respond. Of those who responded only 4% held that it was useful. When they were asked whether they would take the test if the service were available only 13.8% answered in the affirmative and 59.6% said they were not sure. The rest expressed their unwillingness. It should be noted, however, that here too, 84% did not respond to the question.

Furthermore, many girls and women know very little about their bodies, their sexual and reproductive health or HIV/AIDS. In many societies, the discussion of and education about sexual matters is forbidden as taboo. As a result, millions of people, especially girls and women remain ignorant about HIV/AIDS with potentially deadly disease. Young women's more limited knowledge is evident in early every country surveyed with sex disaggregated data for both sexes. In some regions and countries, the gap is substantial (UNFPA, 2004).

As to the findings, the majority of respondents (89.9%) were aware that one could check his or her HIV status. If these attitudes of our people could be practical on the actual ground, it would be highly likely that the incidence of HIV would decrease in the country.

Thus, most pregnant women attending health services do not know their HIV status. Where as, those who do get VCT usually learn that they are HIV negative because they are faithful to their husbands and assume that their husbands are faithful to them. Also many believe that there is no point in knowing their HIV status when pregnant. This is because they believe that the baby will automatically become infected if the mother is HIV positive. Concerning this, studies showed that because women think there is no hope of protecting the baby from HIV infection. And also since there are no services of treatment available to them if they are HIV positive, these women can not see how they will benefit from taking the HIV test (Hareg project, 2004).

2.6.2.2. Age, Literacy and VCT

The studies held in Illesa, Nigerian on HIV VCT of pregnant women in primary health care centers showed significant difference. HIV infections were more common among pregnant woman who did not go to school or complete secondary school education. It agrees with the studies reported women with higher education have better knowledge of HIV transmission where as low level of females education promoted ignorance about HIV transmission and its prevention, especially to the unborn child.

The majority of women in many developing countries are illiterate which contributed to them not to understanding health related problems. A pilot study investigated factors related to uptake and acceptability of VCT for HIV. For example, among pregnant woman in Kigali, Rwanda found that woman whose partners had skilled and well-paid jobs were about four times more likely to accept HIV testing than women whose partners were unemployed. The

other study held in Ethiopia, especially at Kassanchis Health center showed that the prevalence is higher among older clients than younger ones.

Gender differences are confirmed with women living in rural settings. Illiterate women and older women appear less inclined towards the test than the other groups. Thus, supporting this idea, studies in Ethiopia, particularly in Awi and Gojjam(2002) showed that, with some cautions, the younger people and people with a higher level of education are better disposed towards the use of HIV prevention and testing.

2.6.2.3 Discrimination and Stigma

It is known that stigma is largely driven by social and family pressure. It is also driven by some cultural or religious norms and value as well as by fear of AIDS and secrecy.

A study conducted in Nigeria to determine the acceptability of VCT among pregnant women indicated that fifty- three subjects gave informed consent to HIV testing. Five clients (9.4%) did not turn up for their results and 3.8% consents did not want to know their sero status. In another study conducted in a teaching hospital in Nigeria, most women were aware of VCT through health workers, mass media and friends. Similarly most participants (81%) approved of VCT, (13%) disapproved of it and the remaining 6% was undecided. The main reasons for disapproval were fear for stigmatization, isolation, and effect on marriage security (Iliyasu, et. al 2005).

Many people with HIV are being discriminated. Once their HIV status is known, they can lose their jobs, friends, homes and even their families

In some settings, people with HIV have been disowned by their families, fired from jobs, victimized in their community and physically assaulted. In some settings, due to cultural taboos, pregnant women seeking an HIV test are

viewed as immoral and subject to shame, ridicule and gender violence (UNAIDS, 1999).

Women may ignore having HIV counseling and testing for the psychological and social problem. Regarding this, studies have shown in many African countries that women have refused testing. This is because HIV testing and subsequent knowledge of HIV status can bring emotional distress, stigma and abandonment. In many cases HIV positive women are told that they should not have children. This discriminatory treatment leads many such women not to disclose their status to health workers (UNFPA, 2004).

2.7. Voluntary HIV Counseling and Testing and FP and ANC Settings

It is widely supported by evidences that VCT programs have become a corner stone of expanded responses to the HIV/AIDS pandemic. Their importance is based on several factors. First, individuals have a right to know their serostatus in order to protect themselves and others from infection. Second, VCT may help individuals and couples cope with the anxieties associated with the uncertainty of not knowing their serostatus. Third, early detection of HIV infection allows people to gain access to source of support and a variety of treatments of HIV infection itself. And also gives information on preventing mother to child transmission of opportunistic infections associated with HIV and AIDS.

In taking these ideas into consideration, studies indicated that VCT is part of a holistic approach. This is to promote sexual and reproductive health among individuals and couples and with in the community at large. It makes sense, there fore, that such programs be integrated into family planning settings, especially in high prevalence countries. Research in progress suggests that highly sensitive counseling can be as effective as testing at encouraging behavior change. In such instances, family planning services may be more likely to continue to concentrate on contraceptive provision, while also making

women and men more of HIV, STIs through counseling services (UNFPA/ population council, 2002).

As some studies revealed attempts to introduce VCT and ARV provision in to the antenatal settings have been generally successful in Africa. Such provision also can be quite effective. VCT was shown to be both feasible and effective in ANC clinics in Zambia. In this pilot study of same day VCT in six urban ANC clinics in Lusaka, 84% women requested testing with a quarter of those women testing HIV positive. So, the effectiveness of this intervention led researcher to recommend that VCT in antenatal clinics be expanded to include couples (Bakari et al, 2000).

According to many studies, the VCT has also various advantages for those who are pregnant and attend the ANC clinics. Regarding this, the study supports that it is particularly important for pregnant women because diagnosis of HIV infection is the only way to ensure access to the growing number of interventions. This is possible in that it is designed to prevent the transmission of the virus to their newly born children, including access to drug therapies such as Zido vudine (AZT and nviroapine). Another important reason to integrate VCT programs in to antenatal clinics is the opportunity it provides for reaching husbands and male partners of pregnant women (UNFPA, 2002).

Many pregnant women are reluctant to accept VCT. However, most Antenatal Care /PMTCT sites throughout Africa have faced disappointing uptake of VCT from clients, at least in the early phases. Reasons may include logistics test (test results not available the same day), high cost of services and fears that test results will not remain confidential (Preble et al, 2003).

There are many ways to encourage women who attend antenatal clinics to enroll in VCT services. Some projects use videos or group counseling, or they include HIV counseling as part of midwives first interview. The goals of such services for pregnant women is to enable those who are HIV negative to remain

so and those who are positive to make informed decisions about their current pregnancy. This is done especially with regard to the PMTCT and to take care of their health. Counseling HIV positive women should also include providing them with information about avoiding re-infection with HIV and prevention of other STIs, and teaching them how to obtain care and support.

As studies showed in Rwanda, the PRIME II project has assisted the Ministry of Health to help prevent MTCT. This has been done by integrating HIV counseling, testing, and treatment in to antenatal care and obstetric services at Bynmba and kibuye district hospital (Nelson, 2003). In Guwahati Assam State of North East India where the HIV prevalence in antenatal clinics remains very low, the AIDS prevention society's year integrated Health service project for PMTCT of HIV. This includes integrating VCT services with MCH services during antenatal visits. This is being done to ensure that women "make informed decision about safer sex, having children and a healthy life style which will be linked to family planning services and prenatal and obstetric services" (AIDS prevention society, 2003).

2.7.1. Integrating VCT into FP and ANC Settings

A study presented on the integration of sexual and reproductive health services in Kuazulu Natal, South Africa shows that both providers and clients have positive attitudes towards integration. How ever, findings indicated that in order for service integration to work, health staff must be committed and well trained, and general sexual and reproductive health information needs to be made readily available to clients.

Another study on integration of VCT in to family planning, reproductive, and child health services in Tanzania indicates that integration is by itself not enough. But with appropriate training and community support, integration in this setting also attracted more women than stand- alone VCT clinics (UN conference report , 2006).

On the international conference held in Ethiopia in 2006, a paper was presented about the study in integrating VCT with in family planning clinics in South Africa. The paper revealed that compared to the cost of setting up a stand- alone VCT center, it is more cost- effective of fully integrate services with in an existing family planning setting. This should be done letting providers have time to provide VCT. However, partial integration may be more efficient if family planning providers are too busy to provide VCT and existing VCT centers are underutilized. For instance, as studies show in Ethiopia, integration saved an estimated $ 34 per every $ 1 spent.

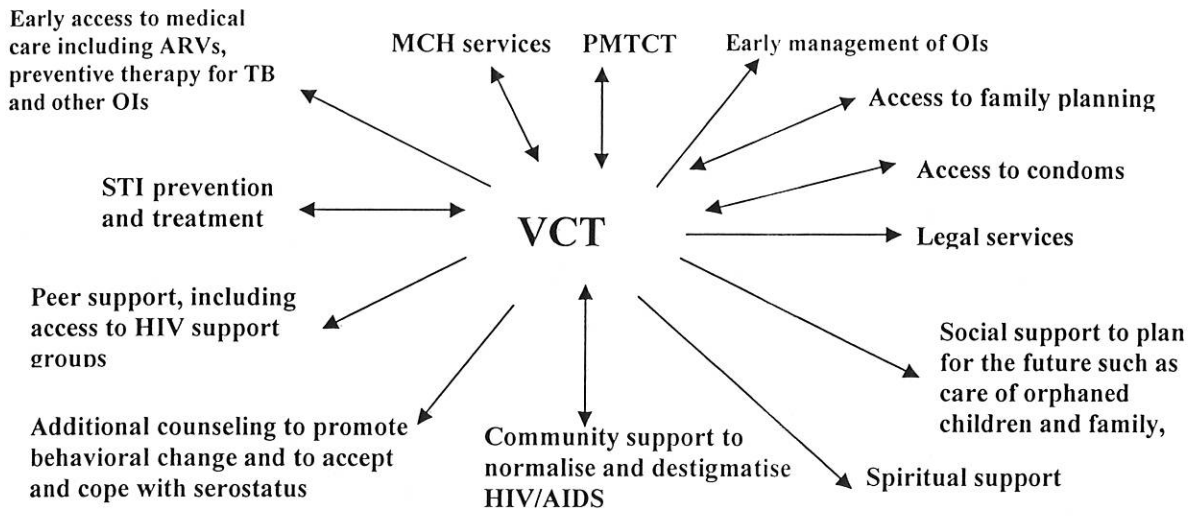
The study on integrating family planning services in VCT and PMTCT sites in Amhara- Ethiopia revealed that integration of family planning services into VCT/PMTCT settings can reduce missed opportunities and increase contraceptive uptake. In Amhara, 30% of VCT clients accessing sites with integrated services have now adopted a family planning method (UNAIDS, 2006).

The integration of contraception in to VCT services (VICS) in Ethiopia presented preliminary results of a base line survey conducted in 8 public facilities around Ethiopia. The study found that HIV- individuals received less counseling compared to HIV+ individuals, even though HIV- clients exhibit similar levels of risk behaviors. Clients who they were HIV + were less likely to desire more children; among those who desired more children, HIV+ individuals were more likely to desire a child sooner.

Finally, an assessment of the linkages between VCT and reproductive health services in Ethiopia shows that formal linkages exist between ANC and VCT centers, etc. However, such linkages are weak or non-existent between VCT and family planning service centers. VCT centers do not offer clients family planning services nor do they provide family planning referrals. There is an urgent need to strengthen linkages to reduce missed opportunities. Additionally, results

showed that integrated IEC/BCC materials need to be developed, improved up on, and widely distributed (Awoke Misganew, 2006).

VCT and its links to prevention, care support service



Adapted from UNAIDS (2002), HIV voluntary Counseling and Testing: Gateway to Prevention

2.7.2. How to Integrate VCT into RH

Recognizing that evidence on providing VCT in family planning settings remains limited, the concerning body has called for further research on the matter. Taking this situation in to account some literatures reflect concerns not only about how to introduce VCT in to family planning services but also about how to handle a broad range of needs of women who test positive. This is because it needs the capacity to identify women as HIV infected likely will generate additional responsibility for family planning providers. These include the need to ensure access to functioning and accessible referral clinics, regular supplies of drugs and other materials, strong supervision, and community level education (Askew I and Berer M, 2003).

According to USAID 2003, although some family planning program can promote or offer VCT, the degree to which VCT and other HIV services can or

should be integrated in to family planning services will depend on HIV prevalence, clients' needs and existing service capacity.

UNAIDS (1999b) has also produced a comprehensive guide for program managers and service providers seeking to establish high quality VCT services. Even though, specifically about VCT for pregnant women, this guidance includes curricula for counseling and types of lab tests. Besides, IPPF (with support from UNFPA) has produced two documents to guide those considering the addition of VCT to existing family planning, maternal and child health, STI service (UNFPA, 2004). The latter guide is a helpful contribution in that it broadly addresses how to determine an appropriate level of VCT service integration and how to plan and implement service based on that assessment. In terms of planning and implementation, it covers issues related to client targeting, orientation of (staff, other service providers, and stake holders) community education and mobilization. It also constitutes counseling and testing, care and support of infected individuals, monitoring and evaluation of VCT integration and resource requirements.

Therefore, literature specifically describing the integration of VCT services in to family planning services is scant. However, the experiences of four project sites two in the Ivory Coast and two in India piloted the integration of VCT in to existing reproductive health services, specifically family planning service. These are presented in the recent IPPF/UNFPA guide. Furthermore, it included the VCT integration experiences of three IPPF member associations in Kenya, Rwanda and Ethiopia.

New York based engenders health and FHI are collaborating to implement and evaluate comprehensive dual protection training in Ethiopia. Engender Health has developed filed tested a training protocol. It covers sexuality and gender, HIV and STI prevention, dual protection and integrated counseling skills. And it is using it to train staff at 5 primary health care facilities in three regions of Ethiopia. FHI will soon assess the training's impact on provider and client

knowledge and attitudes, provider counseling practices and client use of dual protection strategies (Wright K., 2003).

2.7.3 Challenges to Integrate VCT into FP and ANC

Tremendous progresses have been made with regard to expansion of service coverage for VCT services. However, the services have been limited in linking to other services including care and support systems.

As the findings suggest a significant proportion of providers of VCT operate in isolation or without prior knowledge of MOH. So, voluntary confidential and good quality HIV counseling testing and referral is lacking. As it is clearly observed, the key challenges in the provision of VCT services have included lack of adequate infrastructure and personnel, as well as stock out of HIV testing kits and reagents which have characterized the service in recent year.

USAID program guidance (2005), however, recommends that family planning counseling and services include the following activities. These are training family planning workers in HIV infection. It also includes promoting the use of barrier methods for prevention of STIs/HIV, and disposing and treating STIs. Furthermore, this guidance considers the establishment of referral links between VCT and family planning counseling services to be a core PMTCT intervention.

If they do not receive by referral women who have already been identified as HIV infected, family planning services face the challenge of integrating VCT services. That is to identify clients who are infected. Some maternal child health/ family planning programs have sought to integrate VCT as well as basic STI prevention and STI treatment. However, these effects have been limited and proper training and resources are lacking (Berer, 2003).

Where clients are not at high risk, family planning services that would be greatly burdened by delivering STI/HIV services on- site should establish ways

to make referrals when needed. Integrating VCT services may be too costly, for example, if the number of HIV positive tests is low (UNFPA, 2004)

2.7.4. Benefits of Integrating VCT into FP and ANC Services

Helping both non pregnant and pregnant women avoid HIV infection is critical to PMTCT. The most obvious services to target for PMTCT efforts focusing on HIV- uninfected pregnant woman are ANC services.

A comprehensive review commissioned by WHO found that efforts to integrate STI/HIV prevention activities with MCH /FP services had improved providers' attitudes and counseling skills, increased used satisfaction. In some cases, it resulted in higher levels of condom distribution and the use of other contraceptive methods. There is almost no evidence, however, that STI prevention among traditional family planning clients has reduced risk sexual behavior or increased condom use (O'Reilly et al; 1990; Askew and Maggiwa, 2002).

In relationship to HIV and pregnancy, VCT provides the opportunity for early access to prevention and care for mothers who know their serostatus. This has made the need for VCT more compelling in order to benefit from these interventions and other advantages of VCT. Women must first know and accept their HIV status PMTCT of HIV infection to infants is the major objective of introducing VCT services in to ANC but there are other significant benefits.

Studies have shown that when women learn they are not infected, not only is it a great relief for them, but it seems to make changes in their sexual behaviors to remain uninfected. Those who have used VCT services can also persuade their partners to be tested. Thus, it may be a highly effective intervention in preventing HIV transmission.

According to the study with VCT services, women who test seropostive in early pregnancy can make decisions about pregnancy. Therefore, they have the

option of terminating the pregnancy if their choices of abortion service are available and safe. Women who know their HIV status are in a better position to make decisions. This is about having further children following the current pregnancy and to plan for the further care of their dependents. Integrating VCT in antenatal and other health care settings may help "normalize" HIV infection (or at least testing) with in the community (UNAIDS, 1999).

Another study assured that integrated service for HIV prevention and maternal health can promote the following issues. These include condom use, manage STIs, and provide prenatal and post delivery care, safe delivery and counseling on infant feeding (UNFPA, 2004). So, the potential benefits of integrating VCT in to FP/ ANC has the following effects:

- increased access to and use of VCT services
- reduced stigmas associated with HIV
- increased awareness of healthy sexual behavior
- many HIV infected births averted by identifying infected women, then helping those who are not pregnant avoid unintended pregnancy or referring those who are pregnant for AR drug therapy.
- increasing knowledge of dual protection strategies to prevent both unintended pregnancy and HIV infection
- so, integration can enable FP and HIV service provides to reach more people with a broader range and services

Askew et al, (2002) noted that even for the limited objectives, there may be difficulties citing unfavorable experiences in Africa with the detection and treatment of (non-HIV) STIs in FP clinics. On the other hand, integration may be more feasible for certain activities such as PMTCT and VCT. Concerning this, on going research in Ethiopia and South Africa suggests that

> *"Integration is best cost effective and integrating such VCT in to FP or reproductive health centers may also increase testing among women (if not men) by providing amore secure*

environment for them than stand alone VCT services" (UNAIDS conference report,2006).

It has also been pointed out that many potential clients of VCT, in particular adolescent girls are also at risk of un-intended pregnancy. Such pregnancy might be reduced if FP information and contraceptives were offered in conjunction with HIV testing. In other words FP coverage and impacts may be strengthened by integration with HIV prevention programs.

Indeed a recent analysis of trends DHS data from 18 African countries (Cleland and et. al, 2003) documents a substantial rise in the use of condoms reported by young sexually active single women. And at least 60% of those using a condom at last sex said they did so many or partly to prevent pregnancy. These findings suggest that among this group promotion of condoms as a contraceptive device may be more effective than emphasizing the HIV/STI protection benefits. This is a further argument for integration of FP and HIV/STI prevention for this population, but not necessarily through existing net works which are not used by young single women. So there is need for regulation of socio-cultural and economic practices that increase the vulnerability of women and children. Thus, integration of HIV prevention in to other programs such as HIV/AIDS care and treatment of HIV/ AIDS from reproductive health is a missed opportunity. In short, it has advantages of integrating PMTCT messages and materials in to FP services, as well as and antenatal care services. This is the messages tend to be more acceptable and less stigmatizing when integrated in to existing reproductive health information (WHO, 2002).

In general, from the above literature review one can deduce that there has been ideas raised showing there is importance and utility of VCT with the exceptions of some influencing factors. It also addresses that the VCT integration is important and available in MCH settings. However, in one hand the findings of

some literatures argue against existence sufficient knowledge and positive attitudes towards the VCT and its practice. And the literature also reveals that the integration of VCT in MCH settings has not yet been effectively utilized.

Thus, the researcher of this study tries to examine these arguable issues raised in different findings and wants to know where the recent finding lies in the study. As a researcher, he accepts that there is an indication of enough knowledge and positive attitude towards VCT among the study participants taking the evidence from the literature into consideration. However , there is still other study results which made the researcher to question the available results and to conduct the research. So, he further tries to assess whether there has been sufficient knowledge, favorable attitude and good practice of VCT and its integration as effectively as possible in the following chapters.

Chapter Three

Method

3.1 Research site

The place where the research was done is Hadiya Zone which is one of the 13 zones in the SNNPRG of Ethiopia. Its capital, Hossana is located 230 km south west of Addis Ababa. The zone is also characterized by high population growth and density of migration of men to bigger cities. As a result, HIV/AIDS prevalence in the town is estimated to be high. According to Hadiya Zone Health Office (2006) 3819 clients (1949 male and 1870 females) were tested for HIV/AIDS in 2006. Among them 286 were HIV positive (109 male and 177 female).

In short, the research was specifically conducted at Nigst Ellem Mohammed Hospital and Hossana Health station at Hossana town. The researcher preferred these organizations because of the availability of voluntary HIV counseling and testing services. There is also a possibility of getting women who are in active reproductive age and highly exposed to HIV infections. Thus, those females of clients in the MCH who are 15-49 Years in the catchments areas were included for the study.

3.2 Sample and sampling technique

The researcher used a proportional stratified random sampling technique to select appropriate sample attendees. At first, the probability proportion to size was used to allocate the required number of respondents from the hospital and health station. Based on this, sample size of 85 respondents from the hospital and 25 from the health station were taken.

Then, considering the proportion of the study subjects, 50 respondents from the FP service attendees and 60 respondents from ANC service were taken by using the convenient way of simple random sampling.

3.3 Research Instruments

In order to get the desired information about the utilization of VCT and its integration with FP and ANC on MCH settings, the study used the following instruments for data collection.

3.3.1 Questionnaire

First of all, a structured questionnaire was adapted from instruments used in previous studies which were formerly used from the standardized BSS questionnaire. Some of items were constructed by the author based on the literature review. The structured questionnaire had six parts. The first part of the questionnaire was intended to gather the socio demographic information about the respondents. The second part of the questionnaire was intended to gather the knowledge of the respondents regarding HIV/AIDS. It comprised of 10 items. The third part was designed to assess the knowledge on voluntary counseling and testing which has 11 items. The fourth was also designed to assess the respondents' attitude towards voluntary counseling and testing. The attitude scale was a five point Likert scale containing 10 items .The fifth part was intended to assess the respondents practices to voluntary counseling and testing with 12 items and the last part with seven items was concerning with pertaining the integration of VCT, FP and ANC (Appendices A & D).

3.3.2 In- depth interview

The in depth interview was conducted with 4(four) VCT, PMTCT and FP and ANC service providers in both service provision settings. The 1(one) voluntary counseling and testing counselor was asked how to perform the VCT experiences and work with family planning and antenatal care services. The 3(three) health care providers who are nurses from family planning and antenatal care were also interviewed. This was done to document their experiences and work relation to the HIV services such as VCT in a way that can promote dual protection among the women. A total of nine interview questions were presented to the health care services providers.

3.3.3 Focus group discussion

A set of 9 items were used as a guide for conducting Focus Group Discussion among 6(six) female clients who attended family planning and antenatal care in the settings. The discussion items mainly focused on assessing the attendees' knowledge, attitude and practice in relation to HIV/ AIDS and voluntary counseling and testing services. It also raised questions regarding how VCT is implemented together with FP and ANC services. As well as the factors those affect their VCT utilization of the FP and ANC attendees' in their MCH settings (Appendices C&F).

3.4 Data collection procedure

First, permission was obtained from the organization to conduct the study on attendees of family planning and antenatal care. Here, sixty items for 110 women respondents were administered by translating the English questions version into Amharic so that they can easily understood. The women were informed about the purpose of the study and were used as sources of information.

The pilot test of the questionnaire had been conducted on sample pilot study of 50 respondents in the hospital before the main study was done. The Cronbach alpha reliability showed the instruments were reliable that is, an α coefficient of 0.702 for knowledge on VCT item, 0.704 for the practice item and 0.802 for the attitude scale was computed respectively.

After some adjustments, the final study sample size of 110 women filled in the questionnaire which focused on socio demographic characteristics, knowledge on VCT attitude and practice towards VCT utilization and its integration with FP and ANC.

The researcher admits that item analysis was not done on the scales of this study either on pilot data or on final data. However, the reliabilities on the final

data were an α coefficient 0.71 for knowledge on VCT data, 0.89 for attitude data and 0.73 for practice data was computed.

To assure the quality of data and assist the respondents, five female data collectors also got a half day intensive training and orientations concern the objective of the study techniques of data collection and how to help the respondents.

3.5 Methods of data analysis

The analysis and interpretation of data was made as follows. First respondents' knowledge, attitude and practice towards voluntary HIV counseling and testing were analyzed on the basis of frequency and percentage. Lastly, the data collected through in-depth interview and focus group discussion were analyzed qualitatively.

Chapter Four

Results

4.1 Socio-demographic Characteristics of the Respondents

The socio-demographic characteristics of the sample are shown in table 1 below. The data indicate that the majority (57.3%) of the respondents fall in the age range 21-30 while about 28.2%, fall in the range 15-20 followed by those in the range 31-40(10.9%).

In terms of ethnic background, the sample includes Hadiyas (60.9%), Gurages (20.9%) , Kambatas (10%) and Amharas (3.6%) . Regarding the participants religious background, the data indicate that where as the majority (62.7%) are protestant Christians, Orthodox Christians (14.5%), Muslims (9.1%) and catholic Christians (8.2%) constitutes about a third of the sample.

The data further shows that about one-half (50.9%) of the participants have primary education (grades 1-8) whereas 22.8% have secondary education (grades 9-12). The remaining has either no education (10%) or can read and write (11.8%)

The data also shows that, more than half of the respondents were unemployed (63.7%) whereas by 36.4% were employed. Their current number of living children ranges from 1-2, 3-4 and no child with 38.2%, 17.3% and 26.4% respectively. According to the study participants, 71.8% of their husbands have no other wives whereas 17.3% have at least one other wife.

Table1.Socio-demographic Characteristics of the Respondents (N=110)

Socio-demographic characteristics	Number	Percent
Sex Female	110	100
Age		
15-20	31	28.2
21-30	63	57.3
31-40	12	10.9
41-49	4	3.6
Place of residence Town	110	100
Ethnic group		
Hadiya	67	60.9
Kambata	16	14.5
Gurage	23	20.9
Amhara	4	3.6
Religion		
Protestant	69	62.7
Orthodox	16	14.5
Muslim	10	9.1
Catholic	9	8.2
Others	4	3.6
No response	2	1.8
Educational level		
Illiterate	11	10.0
Read and write	13	11.8
1-4th grade	19	17.3
5-8th grade	37	33.6
9-10th grade	17	15.5
11-12th grade	8	7.3
Above 12 grade	5	4.5
Employment status		
Employed	40	36.4
Unemployed	62	56.4
Missing	8	7.3
Family size		
1-2	47	42.7
3-4	35	31.8
5-6	14	12.7
Above6	10	9.1
Omission	4	3.6
Current number of living children		
Do not have	29	26.4
1-2	42	38.2
3-4	19	17.3
5-6	11	10.0
Above 6	8	7.3
Omission	1	0.9
If currently married, does your husband have other wives?		
Yes	19	17.3
No	79	71.8
I do not know	4	3.6
No response	5	4.5
Omission	3	2.7

4.2 Knowledge about HIV/AIDS

The respondents' knowledge about HIV/AIDS was examined through items that ask whether, the participants have heard about HIV/AIDS and whether they are aware of the transmission of HIV from HIV positive mothers to their babies. The responses are summarized in table 2 below. The data indicate that except some few participants who have never heard about HIV/AIDS (0.9%) or who gave no response (4.5%), a great majority (94.5%) of the respondents have heard about HIV/AIDS.

The respondents were also asked about their sources of information about HIV/AIDS. In response, the respondents indicated television or radio (29.1%), health workers (20%), their own families (20%), and friends (15.5%) as source of information.

Furthermore, asked whether they are aware of the transmission of HIV positive mothers to their unborn babies, the majority (70.4%) answered in the affirmative. According to the data, the remaining participants are not aware of the points (20%) or did not give any response (3.6%). Similarly, the majority (81.8%) of the respondents indicated that they are aware that HIV positive mothers can transmit the virus to their babies through breast feeding.

The qualitative part of an interview result was also consistent with the above idea. For instance, all the 4 interviewed subjects replied that they made their clients aware of the HIV/AIDS. As the interview result assured, they told their clients about the transmission of HIV from HIV positive woman to their baby unless the woman takes care of her child. In supporting this view, the focus group discussants' response also showed that they were aware of HIV/AIDS and its seriousness. However, there were some discussants that were not sure of whether there is a transmission of HIV/AIDS virus from mother to child and prevention of mother to child transmission. In addition to this, some discussants, mentioned that a healthy looking person is HIV negative.

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Table 2 knowledge (awareness) of the respondents about HIV/AIDS

Item	Number	Percent
Awareness about the availability of HIV/AIDS		
Yes	104	94.5
NO	1	0.9
I do not remember	5	4.5
Sources of information about HIV/AIDS		
Family	22	20.00
Friend	17	15.5
Media, TV, radio	32	29.1
News paper	15	13.5
Health worker	22	20.0
Others specify	2	1.8
Awareness about the transmission of HIV virus to unborn baby from HIV positive women		
Yes	74	70.4
No	21	20
No response	15	13.6
The possibility of HIV positive mother to transmit the virus to her baby through breast feeding		
Yes	90	81.8
No	12	10.9
I do not remember	8	7.3
Do you think that using condom correctly at all times can protect from HIV/AIDS?		
Yes	81	73.6
Yes, but not 100%	21	19.3
No	8	7.3
Do you think that having one faithful partner can protect from HIV?		
Yes	92	83.6
No	7	6.4
I don't remember	11	10
Do you think that abstaining from sexual intercourse can protect from HIV?		
Yes	84	76.4
No	12	10.9
I do not remember	14	12.7
Do you think that a healthy looking person including you can be infected with HIV?		
Yes	58	52.7
No	29	26.4
I do not remember	23	20.9
Can a person who had HIV/AIDS be cured?		
Yes	41	37.2
No	69	62.8

4.3 Knowledge about VCT

Regarding ways of knowing HIV/AIDS status, the participants gave the following responses. As presented in Table 3 shows that more than half (51.8%) reported that one can check his or her HIV status by using VCT. 29.1% of the respondents said that one knows his or her status by physical examination where as a very small percent of them said they know simply by looking 5.5% and by going to traditional healers1.8%. The rest (1.8%) said that they do not know how to check their status.

According to the data the very large number (83.6%) of the participants heard the availability about VCT. The rest 5.6% and 10.8% of them responded to no and did not remember respectively. Government hospital (47.3%) and health stations (20%) were the common sites that many of the respondents identified as the places where one can get VCT services. In addition some few respondents (7.2%) indicated that private health institutions can be helpful to provide VCT service.

In relation to getting additional information about VCT through IEC systems, many of them (61.8%) reported that they did not hear about VCT through TV or radio in their health facilities or within the institutions. On the other hand, 31% of them said that they have watched programs about VCT through TV.

As the interview of the health service provider mentioned, they told their clients about the availability of VCT services, especially in their hospitals and health stations,. However, there were no information, education and communication strategies through TV or other Medias as the interviewed professionals mentioned. Moreover, the focus group discussants indicated that they did not hear about VCT from TV or other Medias in their MCH settings. But, they showed that there were HIV testing and counseling services in the government health facilities.

Concerning getting information about VCT, 82.7% of the participants replied that they have heard form the health service provider. Whereas, 12.7% did not remember that whether the health professionals told them and the others indicated they did not hear form the health service providers.

Table 3 knowledge (awareness) of the respondents about voluntary HIV counseling and Testing (N=110)

Items	Number	Percent
Ways of checking one's HIV status		
simply by looking	6	5.5
by physical examination	32	29.1
using VCT	57	51.8
go to traditional healers	2	1.8
do not know	2	1.8
no response	11	10
awareness about the availability of VCT services		
yes	92	83.6
no	6	5.6
I do not know	12	10.8
sites where one can get the VCT service		
government hospital	52	47.3
government health station	22	20
private health institution	8	7.2
do not know	21	19
others	7	6.4
getting information about VCT from the health service provider		
yes	91	82.7
no	5	4.5
no response	14	12.7
awareness through IEC materials (TV or media) about VCT		
yes	31	28.2
no	68	61.8
I do not know	11	10
The information told about VCT		
The service available here	61	55.5
The service available elsewhere	11	10
The use fullness of the service	38	37.6
What did you do if you have been informed about VCT?		
Will have HIV test	84	76.4
Will tell for others	20	18.1
Nothing	6	5.4
Awareness through tape or radio about VCT		
Yes	32	29.1
No	78	70.9
Awareness by reading printings about VCT		
Yes	33	29.9
No	77	70.1

4.4 Attitude towards VCT

The attitudes of the study participants toward VCT were examined through 10 items by asking them to rate each items on a, five-point scale. The data indicates that about 90% of the respondents either agreed or strongly agreed with the first three attitude items, (namely, knowing one's HIV status helps to avoid worry and stress; VCT plays a significant role in the prevention and control of HIV transmission; and knowing about one's HIV status through VCT helps to plan one's future life).

One can also see from the data in table 4 that the majority of the respondents (ranging form 51.9% to 88.2%) agreed or strongly agreed with the remaining seven items. Overall, it seems that the majority of the respondents have positive attitudes towards VCT and its benefits.

Taking the attitude of their clients about VCT into consideration the health service providers indicated that most of the clients (FP and ANC) had positive attitude. As they mentioned, the majority of women showed their willingness positively to get tested when the usefulness of VCT is explained. In addition to this, all the focus group discussants also agreed that they had favorable intention about VCT when the VCT is useful for them and PMTCT as well. However, all the discussants claimed that they would not prefer HIV testing provided that there is stigma among the society.

Table 4. Means and percentage distributions of women's responses to the attitude items (N=110)

Items	Response options					
	mean	SD	D	U	A	SA
Knowing one's HIV status helps to avoid worry and stress.	4.68	1.8	1.8	2.7	10	80.9
VCT plays a significant role in the prevention and control of HIV transmission.	4.68	2.7	1.8	3.6	14.5	76.4
Knowing about HIV status by VCT helps to plan ones future life.	4.65	3.6	2.7	3.6	10.9	78.2
VCT helps to prevent HIV transmission from HIV positive women to her baby.	4.62	1.8	6.4	9.1	11.8	50.9
VCT helps to arrange care and support services for people who tested positive.	4.22	4.5	2.7	6.4	15.5	72.7
In my belief people who need to get tested are those who practice unsafe sex.	4.56	3.6	7.3	8.2	12.7	64.5
VCT leads to earlier access to treatment.	4.29	3.6	5.5	9.1	11.8	67.3
I wish to get tested and know my HIV status.	4.37	1.8	9.1	4.5	17.3	66.4
I prefer not to know my HIV status, if there is stigma.	3.85	10.9	16.4	5.5	10.0	56.4
In my belief, people who are ready to get married should be tested.	3.40	20.0	19.1	5.5	6.4	45.5

Note that
SD= strongly disagree A = agree SA= strongly agree
D= disagree

4.5 Practices about VCT among the Respondents

The data obtained from the respondents about VCT related practices are shown in table 5. The data indicate that 49.1% of the respondents have undergone VCT in the past, whereas 50.9% have no experience at all.

With regard to obtaining the result of the test, 46.4% confirmed that they have received the test result out of the total. However, 95% of them (that is, 51 of the 54) who participated in testing have obtained their test results.

The responses of the interview result confirmed that HIV testing is available in the institutions.

As the result of the focus group discussion showed, there was the VCT utilization. However, many of them replied they did not get HIV testing though

the health service providers told them to get VCT service. According to the discussants, fear of positive test result, stigma and discrimination, and lack of test result confidentiality in some extent were the barriers that hinder their VCT uptake.

When they were asked about the reason why, they have been discouraged to practice and got their test result. 44.1% of the respondents reported they had fear followed by stigma and discrimination (30.6%). Sum of them replied that they had never practiced due to lack of privacy or confidentiality (15.3%).

Concerning the exposure of getting pretest counseling before they had HIV test, the majority (84.5%) of the respondents reported that they went through pretest counseling whereas a small number (5.4%) of them did not respond to the pre testing service. Regarding post test counseling services, of the 51people who received test results, 98% them replied they got the post counseling service.

Table 5. VCT Utilization by the respondents (N=110)

Item	Number	percent
Have you ever had VCT in the past		
yes	54	49.1
no	56	50.9
The factors that made them discourage to be tested		
fear of positive test result	49	44.1
stigma and discrimination	34	30.6
lack of privacy or Confidentiality	17	15.3
bad treatment of counselors	7	6.4
cost	4	3.6
Have you ever obtained test result		
yes	51	94.5
No	3	5.5
Total	54	100
The practice of getting pre test counseling		
yes	93	84.5
no	6	5.5
I do not know	5	4.5
no response	6	5.4
The practice of getting post test counseling		
yes	50	98
no	4	2
Total	54	100
The information told to go to VCT center		
yes	96	87.3
no	9	8.2
I do not remember	5	4.5
The information about test result confidentiality		
yes	66	60
no	44	40
Did you get the test voluntarily or provider initiated?		
voluntarily	53	48.2
provider initiated	41	37.3
do not remember	16	14.5
The preference to have HIV test and the counseling		
by physician	74	67.3
by nurse	11	10
by trained counselor	19	17.3
by religious leader	2	1.8
by HIV positive people	2	1.8
others specify	2	1.8
The preference to obtain the HIV test result		
face to face to face	78	70.9
secretive letter	22	20
partner	6	5.4
relative	4	3.6
When was your recent HIV test?		
this year	39	35.4
last year	28	25.5
1-2 years back	9	8.2
do not remember	34	30.9

4.6 VCT- FP and ANC Integration

As the data in table 6 below show, the respondents were asked about the availability of services in health facility. In addition to pretest counseling, 31.8% and 30.9% of the respondents indicated that they got the FP and ANC services respectively. The availability of HIV testing service was also endorsed by 35.4%. Additionally, the respondents were also asked what benefit they got from the facility. Concerning this, 32.7% of the respondents mentioned that they got methods of contraceptives and 25.5% of them replied that they got the prevention of mother to child transmission. Finally, 79% of the respondents showed their intention to use VCT and contraceptive methods together. But, 15.5% of them indicated that they do not use both at the same time.

Table 6 VCT-FP and ANC integration (N= 110)

Items	Number	Percent
The availability of activities other than the pretest counseling (multiple response is possible)		
FP service	34	30.9
STD prevention	4	3.6
ANC service	35	31.8
HIV testing	37	35.4
If so, the benefits they-ever got in their recent visits from the facility? (multiple responses)		
- contraceptive methods	36	32.7
- PMTCT	28	25.5
- HIV test result and post test counseling	27	24.4
- Prevention of communicable disease	11	12
- Others	8	7.2
The intention to use both modern contraceptives and VCT services together	87	79.1
yes	17	15.5
no	2	1.8
don't know	4	3.6
no response		
How is the integration of VCT With FP and ANC provided?		
The different health service providers in different rooms	64	58.2
The professional by changing the rooms every week	9	8.2
The same health professional in the same room	20	18.1
Do not remember	17	15.5

Chapter Five

Discussion

The purpose of this study was to assess the utilization of voluntary HIV counseling and testing by women attending family planning and antenatal care services. It was conducted at Hossana town, particularly in Nigist Elleni Mohammed Hospital and Hossana Health Station in Hadiya Zone. The research focuses on identifying the women's knowledge, attitude and practice about VCT and whether there is integration between the services. Moreover, the discussion part also tries to identify the major factors influence VCT utilization. Based on these objectives, the following major issues were identified during the analysis and are discussed as follows.

5.1 Knowledge about HIV/AIDS

The finding of this study revealed that 94.5% of the respondents have heard about HIV/AIDS. Only a small number have not heard about HIV/AID. According to the research done by Molla Yared and et al, (2005) about knowledge of HIV/AIDS on government employees in Seka, town, Jimma, the study revealed that almost all of the participants heard about HIV/AIDS. As to the study done by Mustafa Reshid (2006) there was high level of awareness about HIV/AIDS where 97% and 95% of them know the HIV transmission and prevention methods. Also, a large number of the respondents (76%) had knowledge on the transmission of HIV virus from a pregnant woman to her unborn baby.

Although knowledge of HIV transmission and prevention seems to be higher among the respondents, there are still misconceptions about ways of controlling HIV/AIDS in this study.

5.2 Knowledge about VCT

In relation to the existence of VCT knowledge among the FP and ANC service attending women, better knowledge was observed among the majority of the respondents. Various items were asked to check the VCT knowledge (the availability of VCT, ways of checking HIV status, knowing the information told by the health service provider and others). For these items, the majority of the respondents gave positive responses. That is, VCT is a more important way to check one's HIV status than using physical examination, simply looking or going to traditional healers. The reason behind having good knowledge might be due to the existing wide ranging of dissemination of VCT information these days.

The qualitative finding reveals the study participants had got knowledge concerning the existence, sources and the sites about VCT service mainly by the health professions. This study has also found that a large number of the respondent have sufficient knowledge. This is consistent with the finding a study done by Awoke Misganaw (2006) which showed that 52.8% of the study subjects had sufficient knowledge. The knowledge on VCT of this study participant was found to be better compared to the finding of study done in teaching hospital of Northern Nigeria which indicated 65% had sufficient knowledge (WHO, 2002). This study participants' knowledge was thus better. This could be the fact that more people can have more access and be addressed by VCT information after 6 years later. Another study on knowledge, attitude and practice on VCT and HIV/AIDS conducted in Gurage zone also confirmed that 99.5% had good knowledge (Tefera Balachew, 2005).

The sites at which VCT services are provided were mainly in government hospitals and health stations. The respondents are not well informed about private health institutions, VCT centers and other related service centers. Though the majority know government health stations as sites for checking one's HIV status, there are still underutilized service provision settings.

This implies that a lot of effort should be exerted by both the service providers and the clients and even the society as well. Concerning the utility of information, education and communication materials, such as TV and other media, the majority indicated that there were no services. Similarly, as health service providers' interview and focus group discussion result revealed, there was no TV and radio service in the MCH settings except the availability of the materials. This might indicate that there was low utilization of VCT through information and education strategy though it is helpful in minimizing the fear and discrimination.

According to UNAIDS (2002), VCT is now acknowledged as an effective strategy for HIV testing and essential for access to AIDS care. Knowledge of HIV status helps HIV negative individuals to make specific decision to reduce risk and increase safer sex practices so that they can remain HIV negative. For those who are HIV-infected, knowledge of their HIV status allows them to better protect their sexual partners, to access treatment for HIV disease and to plan for their future.

The health service providers told the women about the availability and the usefulness of VCT. According to the respondents report, more than half percent of them were told about the availability of VCT in the health settings while very small number mentioned that the service was available elsewhere. One can see that the health service providers stressed mainly government health stations and the study participants are aware of only one setting. This implies that the clients were not made to use wider opportunities to utilize VCT. This further indicates that the use of information dissemination by health service providers should be supported by information and education systems to make their clients more informed .Supporting this idea, 71.5% of the clients reported that they did not listen to tape or radio about HIV/AIDS test in their facility. Though

the majority of the respondents were relatively literate who can read and write and listen they could not use IEC materials because of their absence.

5.3 Attitude towards VCT

The majority of the respondents believe in the usefulness of VCT. For instance, they affirmed that VCT is useful in the prevention and control of HIV transmission and to avoid worry and stress. Similarly, 62.7% showed positive intention to VCT in replying that VCT helps to prevent HIV transmission from HIV positive woman to her baby. More than half had better intention towards VCT. This could be due to the fact that the respondents show their willingness towards something when it is helpful for the reduction of HIV risks. However, where as a need to get HIV test, this time the respondents did not show practical responses feeling fear for positive test result. For instance, about 77.2% and 52% respondents believed those who need to get HIV test are only those who practice unsafe sex and ready to get married respectively.

From the above description, one can learn that there is difference in attitude among the respondents when there is a need to get and show the benefit of VCT. The reason could be due to the fear and stigma which resulted from being positive when they get tested. The large number of the respondents showed their positive intention not to get tested if there is stigma. So, it was observed that the attitude that influences VCT seeking is related with stigma and discrimination, fear of test result and considering themselves as low risk for HIV were observed.

In general, the maximum percent of the study participants had favorable attitude towards VCT. This result is supported by the research work on HIV related knowledge in Jimma town which revealed 75% of the respondents had favorable attitude (Molla Yared et al, 2005)

As cited in the study by Awoke Misganaw, a community based study done in Jimma urban and its rural surroundings support this finding (90.4%). The other study done on the same town also shows (62.4%) of the participant had favorable attitude towards VCT. Moreover, significant percentages of the participants (81.2%) have favorable attitudes towards VCT. Thus, it suggests that the previous evidences together with this study finding confirm many people have better positive intention about the VCT usefulness (Awoke Misganew 2006).

It can be reasoned out that this study's participants are in a better position to get sufficient information from the health service providers as the finding suggests. This is because of having wider accessibilities disseminating VCT benefits these days. The qualitative section also confirms women had developed positive attitude regarding the usefulness and its benefits. But, they mentioned their unwillingness in relation to HIV risks followed by test results.

5.4 VCT practice among the women attending FP and ANC

As it is presented in the analysis, the practice in VCT utilization has shown something different finding unlike the knowledge and attitude. That is to mean, when the respondents were asked about their ever practice of the HIV test, the (49.1%) replied that they have under gone practice of VCT the VCT. Moreover, nearly all the participants who took the test have been returned to obtain test result.

From the above description, we can see that though there has been low utilization of VCT practice irrespective of their high percentage of knowledge

and attitude. It still shows the existence of good practice. This study finding is also supported by the study conducted in Butajira-SNNPR by Awoke Misganaw (2006). It revealed that 44.2% ever had HIV test.

The VCT uptake among the respondents of this study is better compared to the previous finding. The significant proportion of the women had ever had HIV test and the most recent VCT was taken within the past two years. This implies that there was relatively sufficient awareness about VCT utilization. It can also be justified that this study is done two years after the previous study which PMTCT is highly initiated. In addition to this, HIV/AIDS intervention activities are well coordinated and implemented in the health facilities and the participants of this study have frequent visits of this facility due to the availability of PMTCT these days.

The finding of this study reveals that fear and stigma were identified by majority of respondents as barriers to discourage women from HIV testing followed by lack of test result confidentiality. This study also agrees with other reports on assessment of voluntary counseling and testing done in Gurage which indicated the presence of stigma that isolates the residential areas of people living with HIV/AIDS (Tefera Belachew, 2005).

The other study done in PMTCT of HIV on pregnant women in Zimbabwe also supports that there is a need to have IEC activities to raise awareness and openness in discussing HIV infection and PMTCT interventions. It also used to lessen stigma and fear of positive test result surrounding HIV infection. Having this in mind, the intervention should be carried out through information sessions, and group meetings, using educational material and leaflets. It is also aimed at pregnant women, women of child bearing age, and includes men, community and social leaders and community members at village level (Perez F. et al, 2004).In line with findings of this study, similar results were observed in study conducted by other research works.

From the study subjects, about 615 (85%) had low VCT uptake. This is said because of the fact that many studies conducted else where in Africa have shown that uptake of VCT in communities is dependent on social factors associated with delivery of service. Moreover, there is a great difference in theoretical and actual acceptance rates of VCT from the study subjects in this study. This is consistent with other study which means the readiness to utilize the VCT services among the study group was 37% and only 3.6% actually came for VCT (Mustafa Reshid 2005).

5.5 VCT versus FP and ANC Service Integration

First and foremost, the MCH settings are expected to provide the FP and ANC services for their clients and of course they are performing their own duties. However, besides the former duties, they should also serve the clients with other health issue. The one and the burning issue is HIV/AIDS prevention through VCT services. In fact, we can say that almost all items in this study directly or indirectly were designed to assess the VCT on MCH settings. Based on this, the knowledge of the respondents about VCT is almost sufficient. Their favorable attitude towards VCT also was high and with nearly half percent of VCT practice.

The qualitative part of the study also showed there was provision of HIV counseling and testing service though there were times to miss because of some problems as they underlined. The greater number of the participants had been informed about VCT during their current visits by health care providers. This result contradicted by assessment of VCT utilization among delivery, ANC and FP attendees by Awoke Misganew (2006) who reported that 46.9% had been in formed about VCT by health service providers. This implies that people are getting information in a better way exposing themselves towards the health professionals and other opportunities through time changes. It further implies that there is relatively good integration in the MCH settings.

Apart from this, as it was identified in the integration section of analysis, the participants also replied that there was HIV testing together with other MCH services.

Moreover, the very large number of the participants showed their desire to use VCT and modern contraceptives together in the future. They really responded positively and knowledgeably to the dual protections. This might be due to the fact that they have got the health and sexual benefits at once so far in one setting.

The qualitative result of the work also revealed that the health service providers serve their clients by FP and ANC service as well as the VCT and PMTCT. Regarding the VCT service, they informed their clients about HIV, and then referred them to VCT .During their duty session, they give pretest counseling about the benefits of VCT, and then give the test service if they were volunteer. They also refer to VCT centers and told them to have a VCT as one strategy to PMTCT. So, these all evidences show there is integration.

Generally, to assess whether there is an integrative work in MCH settings or not, the FP and ANC service attendees were asked various questions. These include questions assessing their knowledge of existence of HIV test in the study facilities, VCT related information obtained from the health service providers, and availability of messages in the facilities about VCT.

Chapter Six

Summary, conclusion and recommendations

6.1 Summary

As far as the utilization of VCT is concerned on the MCH setting, the researcher has come across the following summary.

The study emphasized on women of FP and ANC attendees in Hossana town particularly in Nigist Elleni Mohammed Hospital and Hossana Health station. For the study purpose, a total of 110 women of reproductive age were taken from both settings.

To get data on the personal information, the socio-demographic items were used. Among these, the majority of the respondents were from 21-30 age level. Their literacy status was also divided in to seven levels based on the current educational level structure of the country. So, the greatest number was from 5-8 grade levels. The respondents' HIV related knowledge was high. As the finding of this study shows, almost all of them heard about the HIV/AIDS. They were informed about the disease through TV, family, friends and health workers. Among these sources, media or TV took the first position while both family and the health workers come in the second position followed by friends.

The majority of the respondents reported that they had knowledge on the transmission of HIV virus from the pregnant women to her unborn baby. However, the greatest number of respondents believed that condom can protect from the HIV risk at all times when it is properly used. This might of course be a misconception about the prevention of HIV/AIDS.

As the findings confirm most of the respondents know the right way to find out their HIV status that is, using VCT. And a great number of them were well informed about the existence of VCT service in their settings, especially in the hospitals and health stations. However, the study participants were observed

there is lack of knowledge on the availabilities of other sites such as VCT centers, private health institutions. Similarly, the information communication strategies were not successfully used. To put it in a simple way, the IEC (information, communication and education) through TV, radio, and reading materials were very low in the MCH settings where the study was conducted.

The high percent of knowledge, attitude and VCT acceptance was observed among those study subjects.

Although, there was low VCT practice irrespective of the maximum percent of sufficient knowledge and favorable attitudes towards VCT, relatively there has been better VCT practice compared to other findings. The majority of the respondents mentioned that fear of positive test result and stigma were the reasons why they did not practice VCT successfully.

The VCT service is integrated with family planning and antenatal care services. This is though the women primarily come for family planning and antenatal care; there was HIV service together with the already known duties. In general, the study participants had sufficient knowledge and favorable attitudes and relatively good practice.

In short,the major findings of this study are

- **The vast number of women have adequate knowledge on VCT**
- **The very maximum percent of women have positive attitude towards VCT**
- **The VCT practice of the study participants is low compared to their knowledge and attitudethough it is good compared to some other studies.**
- **The dual (health and sexually related) services, that is the HIV services are integrated in maternal and child health settings**
- **The major barriers that affect VCT utilization are:**
  - **Fear of positive test result**
  - **Stigma and discrimination and followed by lack of test confidentiality**

6.2 Conclusion

This study has shown that participants from both the hospital and health station had sufficient knowledge concerning VCT.. Considerable proportions of the study participants showed positive attitudes to VCT services. In other words, very large number of (90%) the participants had favorable attitudes towards the benefit of the services.

Nearly half percent of respondents were ever having had HIV test and lower than the tested participants were returned to obtain the test. The VCT service link with the FP and ANC services in the health facilities was existed. Though the large number of them were informed about VCT by the health services providers the small number were tested.

The VCT clients were not referred to the family planning and antenatal clinics at the VCT centers in the facilities. The fear of positive test result and stigma were mainly identified as barriers that made the respondents discourage to get HIV test practice. Generally, even though the study participants had sufficient knowledge and favorable attitudes, there was low utilization of VCT. Some challenge such as lack of trained man power, in adequate space, work load on health services providers and lack of HIV testing kits were found in the VCT centers and MCH units. The use of information communication strategies that is IEC approaches to link those services was not satisfactory relating with the practice.

This study has tried to assess the overall knowledge, attitude and practice about VCT the by FP and ANC attendants in MCH settings. Based on the discussion and summary of the study, the following basic conclusions are made.

- ⇨ Nearly all the study subjects were informed about the existence of HIV/AIDS.
- ⇨ Though the greater number of the participants had better knowledge on HIV AIDS, there are still some women who had miss conception about HIV/AIDS transmission and prevention.
- ⇨ The maximum percent of the FP and ANC services attending women in MCH setting at Hossana Government Health Institutions had sufficient knowledge on VCT.
- ⇨ Large number of the study subjects had favorable attitude towards VCT.
- ⇨ The VCT practice of the women was found to be relatively good.
- ⇨ The information, education and communication (IEC) strategies on HIV/AIDS and VCT related service were very poor.
- ⇨ The integration of VCT in the MCH setting of Hosanna Health Institutions was found to be relatively good.
- ⇨ The fear of positive test result, stigma and discrimination were identified as barriers that hinder VCT utilization.
- ⇨ The shortage of trained man power, inadequate space, and inadequate HIV testing kits were also identified as challenges to integrate the HIV services together with sexual matters of women.
- ⇨ The work load on the health service providers, the need for short and long term training on how to implement the integrative service was also found through qualitative study.

6.3 Recommendations

Taking the result of this study into consideration, the following recommendations are forwarded.

- There is a need to have a continuous counseling and follow-up to maximize a practice of VCT working on reproductive age women and community as well.
- The health service providers and the coordinators in the health stations emphasize to work on IEC approaches so as to lessen stigma and fear of test positive result.
- The Ministry of Health (MOH) should facilitate the health workers' training how to integrate the VCT services in MCH settings in order to increase the dual (sexual and health) services and minimize the missed opportunities.
- The federal and regional concerned bodies should increase more trained health personnel and the necessary HIV testing kits to alleviate high work loads experienced by current health workers.
- Though the maximum percents of the study participants were knowledgeable on VCT, there should be further work by health service providers and other concerned bodies in the health stations to make the women get wider opportunities of VCT service sites effectively and efficiently.
- The health institutions coordinators give emphasis on facilities such as adequate rooms, health workers training and other relevant issues should be upgraded to accommodate new services brought about by integration.
- The strengths, weakness, opportunities and threats analysis should be done in service provision settings that already exist.
- Further research on cost effectiveness and partial versus full integration is required in the integrated programs.

Appendices

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Appendix A

Addis Ababa University

School of Graduate Studies

Department of Psychology

INTRODUCTION

The aim of this study is to assess VCT services utilization among the women who attend family planning and Antenatal care. It also aims to see the major challenges that hinder the service.

INFORMED CONSENT

For the selected mother read the following

To help our study, we would like to ask you some questions which may take about--------minutes. As your participation is very important to the outcome of the study, we kindly request you to give us your sincere and truthful answers. All your response will be kept fully confidential and you need not mention your name.

Do you agree to participate in the interview?

Yes I agree / / NO, I don't agree / /

If you agree, please try to use (X) for the answers you provide in the space provided.

Section I Socio-demographic characteristics

1. Age

   15-20 ☐

   21-30 ☐

   31-40 ☐

   41-49 ☐

2. Place of residence

   Town ☐

   Rural village ☐

No response ☐

3. your religious affiliation

Protestant ☐

Orthodox ☐

Muslim ☐

Catholic ☐

Other , please specify _____

4. Ethnic group

Hadiya ☐

Kambata ☐

Amhara ☐

Gurage ☐

Silte ☐

Other ☐

5. Marital status

Single ☐

Currently married ☐

Divorced ☐

Widowed ☐

6. Educational Level

Illiterate ☐

Read and write ☐

Grades 1-4 ☐

Grades 5-8 ☐

Grades 9-10 ☐

Grades 11-12 ☐

Above 12th grade ☐

7. If currently married, does your husband has other wives?

Yes ☐ No ☐ Don't know ☐

8. Family size

1-2	☐
3-5	☐
5-6	☐
More than 6	☐

9. Current number of living children

No child	☐
1-2	☐
3-4	☐
5-6	☐
More than 6	☐

10. Employment status

Employed	☐
Unemployed	☐

Section II- HIV/AIDS knowledge and Attitude questions

11	Have you ever heard of HIV/ADIS?	Yes ☐	No ☐	Don't know ☐	No response ☐
12	From where did you hear about HIV/AIDS?				Yes
		Family			☐
		Friend			☐
		Mass media (TV, Radio)			☐
		News paper			
		Health worker			☐
		Others specify----------			
13	Do you think that using condom correctly at all times can protect from HIV/AIDS	Yes ☐	No ☐	Don't know ☐	No response ☐
14	Do you think that abstaining from sexual intercourse can protect from HIV?	Yes ☐	No ☐	Don't know ☐	No response ☐
15	Do you think that having on faithful partner can protect from HIV?	Yes ☐	No ☐	Don't know ☐	No response ☐
17	Do you think mother who use antiretroviral can prevent HIV transmission to her unborn child?	Yes ☐	No ☐	Don't know ☐	No response ☐
18	Do you think HIV positive mother can transmit the virus to her born child through breastfeeding?	Yes ☐	No ☐	Don't know ☐	No response ☐

19	Do you think that a healthy looking person including you can be infected with HIV?	Yes ☐	No ☐	Don't know ☐	No response ☐
20	Can a person who has HIV/AIDS be cured?				

Section III - VCT knowledge related questions

21	How can a person find out if he/she has HIV/AIDS? (multiple response is possible)	Yes Simply by looking ☐ By physical examination, ☐ of health personnel ☐ using VCT ☐ Go to Traditional healers ☐ Don't know ☐ Other specify----------
22	Have you heard of voluntary HIV counseling and testing?	Yes ☐ No ☐ Don't know ☐
23	If yes, to Q 22 Which one was the source of information? Put your responses according to the priority by ranking 1,2,3 and so on (Multiple response possible)	-Family ---------- -Friends---------- -Neighbors---------- -Radio or TV---------- -Printed articles ---------- -Health workers ---------- institutions---------- -Others specify ----------
24	If yes, to Q 22 where did you find the service in your vicinity? (Multiple response possible	Government Hospitals ---------- Government Health station ---------- Private institutions ---------- Others specify---------- Do not know----------
25	Have you ever been informed about VCT during your current visits by the health service provider?	Yes ☐ No ☐ Don't know ☐
26	If yes to Q 25 what was the information about? (multiple response possible)	The service available here ---------- The service available elsewhere ---------- The service is useful ---------- Other specify ---------- Don't remember----------
27	If No, Q 25, If you have been informed, what would you do?	Will have HIV test ---------- Will tell for others ---------- Nothing ---------- Others specify----------
28	Have you ever watched TV about VCT during your current visits in this health facility?	Yes ☐ No ☐ Don't know/remember ☐
29	Have you ever listened to Tape/Radio about HIV/AIDS test during your current visits in this health facility?	Yes ☐ No ☐ Don't know/remember ☐

30	Have you ever read printed materials about HIV/AIDS test during your current visits in this health facility?	Yes ☐	No ☐	Don't know/remember ☐
31	Did the health service provider attending you, counsel you to have HIV test?	Yes ☐	No ☐	Don't know/remember ☐

Below are 10 questions (statements) that reflect the attitudes of women attending FP/ANC in the hospital or health clinic towards VCT. There are five alternatives for each question or statement. Then, select only one alternative for each item and put (x) mark on the answer you choose.

1. Strongly disagree
2. disagree
3. undecided
4. agree
5. strongly agree

		Strongly agree	**Agree**	**undecided**	**disagree**	**strongly disagree**
	Attitude statements					
32	Knowing one's HIV status helps to avoid worry and stress					
33	VCT plays a significant role in the prevention and control of HIV transmission					
34	Knowing about HIV status by VCT helps to plan ones' future life					
35	VCT helps to prevent HIV transmission from HIV positive women to her baby					
36	VCT helps to arrange care and support services for people who tested positive					
37	In my belief people who needs to get tested are those who practice unsafe sex					
38	VCT leads to earlier access to treatment					
39	I wish to get tested and know my HIV status					
40	I prefer not to know my HIV status if there is stigma					
41	In my belief, people who are ready to get married should be tested					

Section Five practice related questions

42.	If yes, to Q 31 during counseling did he/ she tell you to go to VCT center?	Yes ☐ No ☐ Don't know/remember ☐
43	Were you explained about the test's confidentiality	Yes ☐ No ☐ Don't know/remember ☐
44	Don't tell me the result, but have you ever had VCT in the past?	Yes ☐ No ☐ Don't know/remember ☐
45	If yes, Q 41 have you got the test voluntarily or provider initiated	Voluntarily ---------- Provider initiated ---------- Don't know ----------
46	If yes Q 41 don't tell me the result, but did you obtain the test result?	Yes ☐ No ☐ Don't know/remember ☐
47	If yes, Q 41 when was your recent HIV test?	Last year---------- 1-2 years back---------- 2-4 years back ---------- before four years ---------- Don't know ----------
48	If no, to Q 41 what do you think discourage?	-fear ---------- - stigma ---------- -lack of privacy or confidentiality--------- -bad treatment of counselor ---------- positive test result ---------- -any other ----------
49	If yes, Q 41 before you had HIV test, did you get pre-test counseling?	Yes ☐ No ☐ Don't know/remember ☐
50	If yes, Q 41 while you were receiving the HIV test result, did you get post-test counseling?	Yes ☐ No ☐ Don't know/remember ☐
51	If No, Q 41 do you have the desire to have VCT in the future? As you didn't have it before	Yes ☐ No ☐ Don't know/remember ☐
52	By whom do you prefer to have HIV test and the counseling? (multiple response possible	Physician---------- Nurse---------- Trained counselor ---------- Religious leaders---------- Community leaders---------- HIV/AIDS positive peoples ---------- Others specify----------
53	By which way do you prefer to obtain the HIV test result?	Face to face---------- Secretive letter---------- Partner---------- Relative---------- Others specify---------- Do not know----------

Section Six VCT - Family Planning and antenatal care service Integration Questions

54	If you came for FP, which FP method you received (multiple response is possible)	Pills ---------- Injectable ---------- Condom ---------- Norplant ---------- IUCD ---------- No response ----------
55	In addition to pretest counseling, what other services did you get? (multiple response is possible)	FP service ---------- STD prevention ---------- ANC service ---------- HIV testing ---------- Other ----------
56	What benefit have you ever got in the in your visit from this health facility? (multiple response possible)	- Contraceptives methods ---------- PMTCT ---------- - HIV test result and post test counseling ---------- - Prevention of communicable diseases - Others specify ----------
57	If you get contraceptive methods other than VCT, which one do you prefer	condoms---------- pills---------- injectables ---------- IUCD---------- ST diagnosis/ treatment ----------
58	If you prefer condom, why do you prefer condom	Prevents unwanted pregnancy - Prevention of HIV - Protect against STD ---------- - Rare side effects ---------- - Can be easily obtained---------- - Prevents both unwanted pregnancy and HIV ----------
59	Do you have intention to use modern contraceptives together with VCT in the further?	Yes ☐ No ☐

60	How do you use VCT and FP and ANC in integrated way?	- With different health service providers in different rooms ☐ - Health service providers changing the rooms every week ☐ - With the same health service providers in the same room ☐ - No answer ☐ - Others specify ☐

Appendix B

Interview Questions for FP, ANC and VCT Service providers

Interview guide

The aim of interview is to assess the knowledge attitude and practice about VCT Utilization of family planning and antenatal care attendees. And also to identify what activities they do to develop their behavioral change. If further aims of assess the VCT service integration with FP and ANC and identify what challenges you have encountered during the integration. And finally it recommends the necessary suggestions and the formation will be confidential and not be used to any other purpose except for this research work. Here, you are kindly requested to prove the necessary information which kindly requested to provide the necessary information which is very essential to the quality and validity of the research. Thank you very much for your genuine response

1. What do you think are the main health concerns of women?
2. Do you have IEC on HIV/AIDS and VCT? If so, do you use IEC materials to provide information?
3. What are the activities you perform to prevent a woman with HIV/AIDS virus from passing it to her baby?
4. Do you refer clients for VCT?
5. Do you think that women come for VCT to your hospital or clinic?
   - If yes, what did they encourage them to come?
   - If no, what do you think would discourage them to come?
6. Could you tell me how VCT service is linked with FP/ANC?
7. In your view, what are the advantages of linking VCT to FP/ANC service?

8. What are the main challenges you face while you are linking your service with MCH services?

9. What do you suggest to make VCT more accessible to women in general and those coming for FP/ANC in particular?

Appendix C

Focus group discussion Guide for the clients

1. What do you think are the main health concerns or problems of women people (like you)?

   For instance, what about sexually transmitted infection? what about HIV/ADIS?

2. What is HIV/AIDS? How is it transmitted? What are the ways that it can be prevented?

3. Facts about MTCT. Can a woman pass the AIDS Virus to her baby? How? When ?

   Is there any thing that can be done to prevent a woman with HIV virus from passing it to her baby? What ?

4. How do you think people could find their HIV status if they are infected with HIV?

5. Where people can get an HIV test?

6. What do you think would be the advantages of knowing whether or not you are infected with HIV virus?

7. Do you think women (like you) would go for VCT?

   - What do you think would encourage women to go for VCT?
   - What do you think would discourage women to go for VCT?

8. What about your partner/husband? Do you think they would go for VCT? Why or why not?

9. If you are FP or ANC client, do the service providers give you VCT services ?

Appendix D

በአዲስ አበባ ዩኒቨርስቲ
የድህረ ምረቃ ት/ቤት
ስነ-ትምህርት ኮሌጅ
የሳይኮሎጂ ትምህርት ክፍል

የኤች አይ ቪ/ አድስ ምርመራ ምክር አገልግሎት
የጥናት መጠየቂያና የፍቃደኝነት መረጋገጫ ቅፅ

የዚህ መጠይቅ አላማው በኤች አይ ቪ ምርመራና ምክክር ዙሪያ አገልግሎት አጠቃቀም መረጃ ለመሰበሰብና ያለውን አገልግሎት ለማሻሻል እንዲረዳ ማስቻል ነው::

የፍቃደኝነት ማረጋገጫ

ለጥናታችን ይረዳን ዘንድ አንዳንድ ጥያቄዎችን ልጠይቅዎት እፈልጋለሁ:: ይህም ምን አልባት የተወሰኑ ደቂቃዎች ሊወሰድ ይችላል:: የእርስዎ በዚህ ጥናት መሳተፍ በጣም ጠቀሜታ ስላለው ለሚቀርብልዎት ጥያቄ የሚያውቁትን በግልፅና በትክክል መልስ እንደሚሰጡኝ ተስፋ አለኝ:: የሚሰጡኝ መልስ በሚስጢር እንደሚያዝና ስምዎም እዚህ መረጃ መሰበሰቢያ ላይ እንደማይሰፍር አረጋግጥልዎታለሁ::

ሰለዚህ በዚህ መጠይቅ ለመሳተፍ ፈቃደኛ ነዎት?

☐ አዎ

☐ አይደለሁም

መልስዎ አዎ ከሆነ ከቀረቡት አማራጮች ለጥያቄው መልስ የሆነውን በተሰጠው ቦታ «X» ምልክት በማድረግ ምላሽ ይስጡ

ክፍል I. አጠቃላይ የግለሰቧ መረጃ

ለዚህ ጥናት የሚጠየቁት ለቤተሰብ ምጣኔና ለቅድመ ወሊድ ክትትል ወደ ጤና ድርጅት የሚመጡ እናቶች ብቻ ናቸው

1. ዕድሜ

15-20	☐
21-30	☐
31-40	☐
41-49	☐

2. የመኖሪያ ቦታ (ምርጫው ይነበብ)

- ከተማ ☐ - አላውቅም ☐

- ገጠር ☐ - የለም ☐

3. ኃይማኖትሽ ምንድን ነው? (ምርጫዎች ይነበብ)

- ኦርቶዶክስ ክርስቲያን ☐ - ሌላ ይገለፅ ----------
- እስልምና ☐ - አላውቅም ☐
- ፕሮቴስታንት ☐ - መልስ የለም ☐

4. ብሔርሽ ምንድን ነው?

-ሃድያ ☐ -ከምባታ ☐
- ጉራጌ ☐ - ትግሬ ☐
- አማራ ☐ - ሌላ ይገለፅ ----------
- ስልጤ ☐ - መልስ የለም ☐

5. የጋብቻ ሁኔታ

- ያላገባች ☐ - የተፋታች ☐
- አግብታ አብረው የሚኖሩ ☐ - ባለቤቷ የተሞተባት ☐
- አግብታ ግን በምክንያት ተለያይተው የሚኖሩ ☐

6. የትምህርት ደረጃ

ያልተማረች ☐
ማንበብና መፃፍ ይችላሉ ☐
1ኛ-4ኛ ክፍሎች ☐
5-8ኛ ክፍሎች ☐
9-10ኛ » ☐
11-12ኛ » ☐
ከ12ኛ ክፍል በላይ ☐

7. ባልሽ ሌሎች ሚስቶች አሉትን?

- አዎ ☐ - አላውቅም ☐
- አለም ☐ - መልስ የለም ☐

8. የሥራ ሁኔታ

የመንግስት(ድርጅት) ተቀጣሪ ☐
ሥራ የለም ☐

9. የቤተሰብ ብዛት

1-2 ☐
3-4 ☐
5-6 ☐
ከ6 በላይ ☐

10. ባሁን ጊዜ በሕይወት ያሉ ልጆች ብዛት

ምንም የለም ☐

1-2 ልጆች ☐

3-4 » ☐

5-6 » ☐

ከ6 በላይ ☐

ክፍል II. ስለ ኤድስ በሽታ እውቀት አስተያየት እና አመለካከት በተመለከተ የቀረቡ ጥያቄዎች

11. ኤድስ የተባለ በሽታ ወይንም ኤች.አይ ቪ እንዳለ ሰምተሻል?

ሀ) አዎን☐ ለ) አልሰማሁም☐ ሐ) አላስታውስም☐

12. ስለ ኤች አይ ቪ ኤድስ ከየት ሰማሽ?

ሀ) ከቤተሰብ ☐ ሐ) ከቴሌቪዥን/ሬዲዮ ☐

ለ) ከጓደኛ ☐ መ) ከፅሁፋዊ መረጃዎች ☐

ሠ) ከጤና ባለሙያ ☐ ረ) ሌላ ይገለፅ----------

13. ሰዎች በግብረ-ስጋ ግንኙነት ወቅት ኮንዶም ሁል ጊዜና በአግባቡ በመቀጠም ራሳቸውን ከኤድስ አምጪው ሕዋስ መከላከል ይችላሉ?

ሀ) አዎን ☐ ለ) አዎን ሆኖም ከ100 % በታች ☐ ሐ) አላስብም ☐

መ) አላውቅም ☐

14. ሰዎች በግብረ-ስጋ ግንኙነት ጓደኛ በመወሰን ራሳቸውን ከኤች አይ ቪ መከላከል ይችላሉ? (ለሎች ሕዋሱን ሊያስተላለፉ የሚችሉ ሁኔታዎችን፣ በደም መስጠትና ስለት ባለው መሳሪያ ክሌሎች ጋር መጠቀምን ሳይጨምር)

ሀ) አዎን ☐ ለ) አላስብም ☐ ሐ) አላውቅም (አላስታውስም) ☐

15. በኤች አይ ቪ አምጪ ህዋስ የተያዘች እርጉዝ ሴት በማህፀንዎ ላለ ፅንስ ህዋስ ልታስተላልፍ ትችላለች?

ሀ) አዎን ☐ ለ) አላብም ☐ ሐ) አላውቅም ☐ መ) መልስ የለም ☐

16. ሰዎች ከግብረ-ስጋ ግንኙነት ተአቅቦ በማድረግ በኤች አይ ቪ ከመያዝ ይከላከላሉ? (ሌሎች ሕዋሱን ሊያስተላልፉ የሚችሉ ሁኔታዎች በደም መስጠት ሰለት ባለው መሳሪያ ከሌሎች ጋር መቀጠምን ሳይጨምር)?

ሀ) አዎን☐ ለ) አላስብም☐ ሐ) መልስ የለም ☐

17. ከ ኤች አይ ቪ አምጪ ህዋስ የተያዘች እርጉዝ ሴት በማህፀንዎ እንዳይተላለፍ ምን መደረግ አለበት? (ዝርዝሩ አይነበብ ከአንድ በላይ መልስ ለሰጥ ይችላል

1. የቫይረስ መከላከያ መጠቀም ☐
2. ማስወረድ ☐
3. የጤና ባለሙያ ማማከር ☐

4. ምንም ማድረግ አይቻልም ☐

5. ሌላ ይገለፅ ☐

18. በቫይረሱ የተያዘች ሴት ጡት በማጥባት ወደ ተወለደው ህፃን ህዋሱን ማስተላለፍ ትችላለችን?

ሀ) አዎን ☐ ለ) አላስብም ☐ ሐ) አላውቅም ☐ መ) መልስ የለም ☐

19. አንድ ጤናማ መስሎ የሚታይን ሰው በኤች አይ ቪ ቫይረስ ተጠቅቶ እንደሚሆን ታሰቢያለሽ ?

ሀ) አዎን ☐ ለ) አላስብም ☐ ሐ) አላውቅም ☐ መ) መልስ የለም ☐

20. ኤች አይ ቪ ኤድስ በሽታ ያመመው ሰው ሊድን ይችላል ብለው ያስባሉ?

ሀ) አዎን☐ ለ) አላስብም ☐ ሐ) አላውቅም ☐ መ) መልስ የለም ☐

ክፍል ሦስት. <u>የኤች አይ ቪ የምክርና የምርመራ አገልግሎት እውቀትን በተመለከተ የቀረቡ ጥያቄዎች</u>

21. አንድ ሰው የኤች አይ ቪ ቫይረስ በደሙ ውስጥ እንዳለ ወይም በሽታው እንደያዘው እንዴት ማወቅ ይቻላል?

ሀ) በቀላሉ በማየት ብቻ ☐

ለ) በጤና ባለሙያዎች በሚደረግ አካላዊ ምርመራ ☐

ሐ) በኤች አይ ቪ ላብራቶሪ ምርመራ ☐

መ) በባህላዊ መድሃኒት አዋቂዎች ☐

ሠ) አላውቅም ☐

ረ)መልስ የለም ☐

ሰ) ሌላ ይገለፅ ----------

22. ሰለ ኤች አይ ቪ ምርመራና ምክክር አገልግሎት ስምተሽ ታውቂያለሽ?

ሀ) አዎን☐ ለ) አልሰማሁም☐ ሐ) አላውቅም/አላስታውስም ☐

መ) መልስ የለም ☐

23. አዎ ከሆነ መልስሽ መልዕክቱ ከየት ደረሰሽ? ተጨማሪ ጥያቄ (የመልዕክቱን ምንጭ በቅደም ተከተል 1፣2፣3 ደረጃ በመስጠት መመላት ይቻላል)

ሀ) ከቤተሰብ ☐ ሠ) ፅሁፋዊ መረጃዎች ☐

ለ) ከጓደኛ ☐ ረ) የጤና ሙያተኞች ☐

ሐ) ከጎረቤት ☐ ሰ) ሌላ ይገለፅ ☐

መ) ሬዲዮ ወይም ተሌቪዥን☐ ሸ) አላስታውስም/ አላውቅም ☐

ቀ) መልሰ የለም☐

24. አዎ፣ ከሆነ መልስሽ አገልግሎቱ ከየት ማግኘት ይቻላል?

ሀ) ከመንግስት ሆስፒታል ☐

ለ) ከመንግስት ጤና ጣቢያ ☐

ሐ) ከግል ጤና ድርጅት ☐

መ) አላስተውስም/አላውቅም ☐

ሠ) መልስ የለም ☐

ረ) ሌላ ይገለፅ ----------

25. እዚህ ጤና ድርጅት አሁን ባለሽ ክትትል ስትመላለሺ ስለ ኤች አይ ቪ ምርመራ በጤና ባለመያዎች ተነገሮሽ /ተምረሽ ታውቂለሽ?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላውቅም ☐ መ) መልሰ የለም ☐

26. አዎን ከሆነ መልስሽ ምን ተነግሮሽ ነበር?

ሀ) አገልግሎቱ እዚህ እንደለ ☐ መ) ሌላ ይገለፅ ☐

ለ) ሌላ ቦታ እንዳለ ☐ ሠ) አላስታውስም ☐

ሐ) ጠቃሚ እንደሆነ ☐ ረ) አላውቅም ☐

27. አልተነገረኝም ከሆነ መልስሽ ተነግሮሽ ቢሆን ምን ታደርጊ ነበር?

ሀ) እመረመር ነበር ☐

ለ) ለሰዎች እነግር ነበር ☐

ሐ) ምንም አላደርግም ☐

መ) አላውቅም ☐

ሠ) መልስ የለም ☐

28. ከዚህ ጤና ድርጅት አሁን ባለሽ ክትትል ስትመላለሽ ስለ ኤች አይ ቪ ምርመራ በተመለከተ በቲቪ መልዕክት ተላልፎ ያውቃል?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

29. ከዚህ ጤና ድርጅት አሁን ባለሽ ክትትል ስተመላለሽ ስለ ኤች አይ ቪ ምርመራ በሬዲዮ ወይም በቴሌ መልዕክት ተላልፎ ያውቃልን?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

30. ከዚህ ጤና ድርጅት አሁን ባለሽ ክትትል ስትመላለሽ ስለ ኤች አይ ቪ ምርመራ ምክር አገልግሎት በተመለከተ ፅሁፎች አንብበሻል?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

31. ኤች አይ ቪ ምርመራ እንድታደርጊ ክትትል የሚያደርጉልሽ የጤና ባለሙያዎች መክረውሽ ያውቃሉ?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

ክፍል አራት፡- የኤች የምክርና የምርምራ አገልግሎት አስተያየት ወይም አመለካከትን በተመለከተ የቀረቡ ጥያቄዎች

ከዚህ በታች የተዘረዘሩት ዐ/ነገሮች በሆሳዕና ከተማ በንግስት እሌኒ መሐመድ የመታሰቢያና በሆሳዕና ጤና ጣቢያ የሚመጡ የቅድመ ወሊድ ክትትልና የቤተሰብ ምጣኔ የሚከታተሉ እናቶች በፈቃደኝነት ላይ ስለተመሰረተ የኤች አይ ቪ የምክርና የምርመራ አገልግሎት ያላቸውን አመለካከት ለመረዳት የቀረቡ ናቸው፡፡ እያንዳንዱን ዐ/ነገር በጥንቃቄ ካነበባችሁ በኋላ የራሳችሁን አስተያየት ከቀረቡት አምስት አማራጮች አንዱን ብቻ በመምረጥ «X» ምልክት በማድረግ ምላሽ ይስጡ፡፡

የአማራጮቹ መግለጫ እንደሚከተለው ነው፡፡

5. በጣም እሰማማለሁ
4. እሰማማለሁ
3. ለመወሰን እቸገራለሁ
2. አልስማማም
1. በጣም አልስማማም

ተ.ቁ	ሰለ ኤች አይ ቪ የምክክርና የምርመራ አስተያየት	በጣም እስማማለሁ	እስማማለሁ	ለመወሰን እቸገራለሁ	አልስማማም	በጣም አልስማማም
32	የራስን የኤች አይ ቪ ሁኔታ (የምርመራ) ውጤት ማወቅ ከሃሳብና ከጭንቀት ለመላቀቅ ይጠቅማል					
33	የኤች አይ ቪ የምክርና የምርመራ አገልግሎት የቫይረሱን ስርጭት ለመቀነስ እንዲሁም ለመግታት ከፍተኛ ጠቀሚታ አለው					
34	የኤች አይ ቪ የምክክርና የምርመራ አገልግሎት ማድረግ ራስን ለማወቅና ለወደፊት ሕይወት አስፈላጊ ጥንቃቄ ለማድረግ ይጠቅማል					
35	የኤች አይ ቪ የምክክርና የምርመራ አገልግሎት በሽታው ከእናት ወደ ህፃን የሚተላለፈውን ስርጭት ለመከላከል ይረዳል					
36	የኤች አይ ቪ የምክክርና የምርመራ አገልግሎት በቫይረሱ ለተጋለጡ ተገቢ ጥንቃቄና አንክብካቤ ለማድረግ ይረዳል					
37	እንደ እኔ እምነት የምርመራ አገልግሎት ማድረግ ያለባቸው ልቅ የግብረ ስጋ ግንኙነት የሚያደርጉ ስዎች ናቸው					
38	የኤች አይ ቪ የምክክርና የምርመራ አገልግሎት የስጋት ሕይወትን (ኑሮን) ይቀንሳል					
39	የኤች አይ ቪ የደም ምርመራ በማድረግ ራሴን ለማወቅ ፍላጐት አለኝ					
40	በህብረተሰቡ መገለል የሚደርሰብኝ ከሆነ የኤች እይ ቪ የደም ምርመራ አላደርግም					
41	እንደኔ እምነት የምርመራ አገልግሎት ማድረግ ያለባቸው ለትዳር እየተዘጋጁ ያሉ ተጋቢዎች ናቸው፡፡					

ክፍል አምስት፡ የኤች አይ ቪ ኤድስ የምክርና የምርመራ አገልግሎት ልምምድን በተመለከተ የቀረቡ ጥያቄዎች

42. የጤና ባለሙያዎቹ እንድትመረመሪ ሲመክሩሽ ወደ ኤች አይ ቫይረስ ምርመራ ክፍል ሂጂ ብለውሽ መክረውሽ ነበር?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

43. በአካባቢያችሁ ሰዎች ምስጢራዊ የኤድስ ቫይረስ ምርመራ ማድረግ ይችላሉ? (ምስጢራዊ ማለት ሌሎች ሰዎች አንቺ ካልፈቀድሽ በቀር ውጤቱን የማያውቁበት ሁኔታ ማለት ነው)

ሀ) አዎን ☐ ሐ) አላስተውስም/አላውቅም ☐

ለ) አይችሉም ☐ መ) መልስ የለኝም ☐

44. ውጤቱን አትንገሪኝ ግን የኤድስ ቫይረስ ምርመራ አድርገሽ ታውቂያለሽ?

ሀ) አዎን ☐ ለ) የለም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

45. አዎን ከሆነ መልሱ በፍቃድኝነት ነው የተመረመርሽው ወይስ ምርመራ እንድታደርጊ ተጠይቀሽ ነበር?

ሀ) በፍቃደኝነት ☐ ሐ) አላስተውስም /አላውቅም ☐

ለ) ተጠይቄ ☐ መ) መልሰ የለኝም ☐

46. ለእኔ አትንገሪኝ ነገር ግን ለራስሽ ውጤቱን አውቀሻልን?

ሀ) አዎን ☐ ለ) አላወኩም ☐ ሐ) አላስታውስም ☐ መ) መልስ የለም ☐

47. በቅርብ ወይም ለመጨረሻ ጊዜ የኤች አይ ቪ ምርመራ ማረጋገጫ ያደረግሽው መቼ ነው?

ሀ) በዚህ ዓመት ☐ ሠ) ከአራት አመት በፊት ☐

ለ) ባለፈው አመት ☐ ረ) አላስታውስም/አላውቅም ☐

ሐ) 1-2 አመት በፊት ☐ ሰ) መልስ የለም ☐

መ) 2-4 አመት በፊት ☐

48. የኤች አይ ቪ የምርመራ አገልግሎት እንዳታደርጊ የከለከለሽ ምንድነው?

- ፍርሃት ☐
- መገለል ☐
- የምርመራ ምስጢራዊነት ስለማይጠበቅ ☐
- የባለሙያዎቹ ተገቢ ጥንቃቄ ስለማይደረግ ☐
- ፖዘቲቭ የምርመራ ውጤት ☐
- ሌላ ካለ ይገለፅ ----------

49. የኤች አይ ቪ ምርመራ ከማድረግሽ በፊት ቅድመ ምርመራ የምክክር አገልግሎት አግኝተሻልን ?

ሀ) አዎን ☐ ሐ) አላስተውስም/አላውቅም ☐

ለ) የለም ☐ መ) መልስ የለኝም ☐

50. የኤች አይ ቪ ምርመራ አድርገሽ ውጤት ስትቀበይ የምርመራ ምክር አገልግሎት አግኝተሻልን?

ሀ) አዎን ☐ ሐ) አላስተውስም/አላውቅም ☐

ለ) የለም ☐ መ) መልስ የለኝም ☐

51. ከአሁን በፊት ካልተመረመርሽ ወደፊት ለመመርመር ፍላጎት አለሽ?

ሀ) አዎን ☐ ሐ) አላውቅም ☐

ለ) የለኝም ☐ መ) መልሰ የለም ☐

52. መልስሽ አዎን ከሆነ በማን የምርመራ ምክክር አገልግሎት እንዲሰጥሽ ትፈልጊያለሽ?

ሀ) በሀኪም ☐ ሠ) በማህበረሰብ መሪ ☐

ለ) በነርስ ☐ ረ) በቫይረሱ በተጋለጠ ☐

ሐ) በሰለጠነ አማካሪ ☐ ሰ) ሌላ ይግለፁ ☐

መ) በሀይማኖት መሪ ☐ ሸ) መልሰ የለም ☐

53. መልስሽ አዎን ከሆነ የምርመራ ውጤቱ በምን አይነት መንገድ ልታውቂ ትፈልጊያለሽ ?

ሀ) ፊት ለፊት በመነጋገር መ) በዘመድ

ለ) በሚስጢር ደብዳቤ ☐ ሠ) ሌላ ይገለፅ ☐

ሐ) በትዳርና መስል ጓደኛ ☐ ረ) አላውቅም ☐

ክፍል ስድስት. <u>የኤች አይ ቪ ኤድስ የምክር የምርመራና የቤተሰብ ምጣኔ ጣምራ አገልግሎት በተመለከተ የቀረቡ ጥያቄዎች</u>

54. የመጣሽው የቤተሰብ ምጣኔ አገልግሎት ከሆነ ምን ዓይነት የመከላኪያ ዘዴ ተሰጠሽ?

- የሚዋጠው እንክብል ☐ - ኮንዶም
- በመርፌ የሚሰጠው ☐ - ክንድ ላይ የሚቀበረው ☐
- በማህፀን ውስጥ የሚቀመጠው ☐ - መልሰ የለም ☐

55. ከቅድመ ምርመራ ምክክር በተጨማሪ ምን አገልግሎት ተሰጠሽ?

የቤተሰብ ምጣኔ አገልግሎት ☐

- በግብረ ሰጋ ግንኙነት ሰለማተላለፉ በሽታዎች መከላከያ ☐
- የቅድመ ወሊድ ክትትል ☐
- የኤች አይቪ የደም ምርመራ ☐

56. ወደዚህ የጤና አገልግሎት ሲመጡ ምን የተለየ ጥቅም አገኙ?

- ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴዎች ☐
- የኤች አይቪ ቫይረስ ከእናት ወደ ህፃን እንዳይተላለፍ የመከላከያ ዘዴ ☐
- የኤች አይቪ የደም ምረመራና ከምርመሪ በኋላ የምክር አገልግሎት ☐

☐

- የተላላፊ በሽታዎች መከላከል ዘዴ

- ሌላ ካለ ይገለፅ ----------

57. ከኤች አይቪ የምክርና የምርመራ አገልግሎት በተጨማሪ የወሊድ መቆጠቢያ የምትወስጂ ከሆነ ምን አይነት ዘዴን አብልጠሽ የምትጠቀሚው

- ኮንዶም ☐ - በመርፌ የሚሰጠው ☐
- የሚዋጠው እንክብል ፍሬ ☐ - በማህፀን ወስጥ የሚቀመጠው ☐
- ክንድ ላይ የሚቀበረው ☐

58. ኮንዶም ይበልጥ የሚመርጡ ከሆነ ለምን ይመስልዋል?

- ያልተፈለገ ርግዝና ስለሚከላከል ☐
- ኤች አይ ቪ ቫይረስን ስለሚከላከል ☐
- የሚያስክተለው ጉዳት አነስተኛ ስለሆነ ☐
- በቀላሉ ስለሚገኝ ☐
- ያልተፈለገ እርግዝና ኤች አይቪን ስለሚከላከል ☐

59. ወደ ፊት ዘመናዊ የወሊድ መቆጣጠሪያዎን ከኤች አይቪ የምክርና የምርመራ አገልግሎት ጋር አጣምረው ለመጠቀም ፍላጐት አሎት?

- አዎ ☐ አልፈልግም ☐ አላውቅም ☐ መልስ የለም ☐

60. የቅድመ ወሊድ ወይም የቤተሰብ ምጣኔ አገልግሎት በፈቃደኝነት የተመሰረተ የኤች አይቪ የምክክርና የምርመራ አገልግሎት በቅንጅት የሚሰራ ከሆነ አገልግሎቱ እንዴት ይሰጣል?

በተለያዩ ባለሙያዎች በተለያየ ክፍል ☐

ባለሙያዎቹ ክፍሎቹን በየጊዜው በመቀያየር ☐

በተመሳሳይ ባለሙያዎች በተመሳሳይ ክፍል ☐

አላውቅም ☐

ሌላ ካለ ይገለፅ ----------

Appendix E

ለቤተሰብ ምጣኔና የቅድመ ወሊድ አገልግሎት ሰጪ ለሆኑ የጤና ባለሙያዎች የቀረቡ የቃለ መጠይቅ ጥያቄዎች

1. የቤተሰብ ምጣኔ እና የቅድመ ወሊድ አገልግሎት ተከታታይና የሌሎችም እናቶች ዋና ዋና የጤና ችግሮች ምንድናቸው?
2. የቤተሰብ ምጣኔ እና የቅድመ ወሊድ አገልግሎት ተጠቃሚዎችን ስለዚሁ አገልግሎትና ስለ ኤች አይቪ ኤድስ ግንዛቤ የምታሰጭብጡት እንዴት ነው?ለምሳሌ የመረጃና የትምህርት ማሰራጫ ሚዲያዎች ትጠቀማላችሁ?
3. በኤች አይቪ ቫይረስ የተያዘች እናት በሽታውም ወደ ህፃን እንዳይተላለፍ ምን ምን ተግባሮች ይከናወናሉ?
4. የቤተሰብ ምጣኔ እና የቅድመ ወሊድ የሚከታተሉ እናቶች በፈቃደኝነት ላይ የተመሰረተ የኤች አይቪ የደም ምርመራና የምክር አገልግሎት እንዲያገኙ ታደርጋላችሁ/ታበረታታላችሁ?
5. እናቶች ወደ ጤና ድርጅታችሁ ሲመጡ በፈቀደኝነት ላይ የተመሰረተ የአች አይቪ ምርመራና የምክር አገልግሎት ተጠቃሚ ይሆናሉ ብለው ያምናሉ?
   አዎን ከሆነ እንዲመረመሩ የገፋፋቸው ነገር ምንድነው? የማይጠቀሙስ ከሆነ ችግሩ ምን ይመስላል?
6. የቤተሰብ ምጣኔ እና የቅድመ ወሊድ አገልግሎት በፈቃደኝነት ላይ ተየመሰረተ የኤች አይቪ የደም ምርመራና የምክክር አገልግሎት ጋር እንዴት አቀናጅተው እየሰሩ እንደሆነ ቢነግሩን ?
7. በእርስዎ አሰተያየት የቤተሰብ ምጣኔን እና የቅድመ ወሊድ አገልግሎትን በፈቃደኝነት ላይ ከተመሰረተ የኤች አይቪ ኤድስ የደም ምርመራና የምክክር አገልግሎተ አቀናጅተው መስራት ምን ምን ጠቀሜታ አለው ብለው ያምናሉ?
8. የእናቶችና የህፃናት ጤና አገልግሎቶችን በፈቃደኝነት ላይ ከተመሰረተ የኤተ አይቪ ምክክርና የምርመራ አገልግሎት ጋር አቀናጅተው ሲሰሩ ምን የጋጥማችሁ ችግር አለ?
9. ለእናቶች በፈቃደኝነት ላይ የተመሰረተ የኤች አይቪ የምክክርና የምርመራ አገልግሎት በተለይም ለቤተሰብ ምጣኔ እና ለቅድመ ወሊድ ተከታታዮች ይበልጥ እንዲዳረስ ምን መደረግ አለበት ይላሉ?

Appendix F

የውይይት ጥያቄዎች ለተወሰኑ ቅድመ ወሊድ ወይም ለቤተሰብ ምጣኔ አገልግሎት ተከታታዮች

1. የብዙ እናቶች (የአናንተም ጭምር) ዋና ዋና የጤና ጉዳዩች ወይም ችግሮች ምንድናቸው? ለምሳሌ ኤች አይ ቪ ኤድስ፣ በግብረ ስጋ ግንኙት የሚተላለፍ ሌሎች በሽታዎች እና ሌሎችም
2. ኤች አይ ቪ ኤድስ ምንድነው? እንዴት ይተላለፍል? የመከላከያ መንገዶቹስ?
3. አንዲት እናት ስለኤች አይ ቪ ኤድስ ቫይረስ ከተጋለጠች በሽታውን ለህፃናት (ኗ) ልታስተላለፍ ትችላለች ? እንዴት መቼ? ቫይረሱ ከእናት ወደ ህፃን እንዳይተላለፍ የመከላከያ መንገድ አለ? አዎ ከሆነ ለምሳሌ ምን ምንድናቸው?
4. አንድ ሰው ወይም እናት በኤች አይቪ ቫይረስ መጋለጥ ወይም አለመጋለጥን የምታወቂው እንዴት ነው?
5. ሰዎች ኤች አይቪ ኤድስ ቫይረስ ምርመራ የሚያገኙት ከየት ነው?
6. አንድ ሰው (እናት) በኤች አይቪ ኤድስ ቫይረስ መጋለጥ ወይም አለመጋለጡን በምርመራ ማወቅ ምን ጠቀሜታ አለው ብለው ያምናሉ?
7. ሴቶች እናንተንም ጨምሮ ወደ ኤች አይ ቪ የምክርና የምርመራ አገልግሎት ድረስ ይመጣሉ ብለው ያምናሉ?

   የሚመጡ ከሆነ ወደ ኤች አይቪ የምክርና የመርመራ አገልግሎት እንዲያገኙ የረዳቸው ምንድን ነው የማይመጡሰ ከሆነ ምን የከላከላቸው ይመስላል?
8. ባለቤቶቻችሁ ወይም የትዳር ጓደኞቻቸውሰ? ወደ ምርመራ አገልግሎት ይሄዳለሁ ብላችሁ ታስባላችሁ? አይደለም ከሆነ ምክንያቱ ምን ይመስላችኋል?
9. እናንተ የምትከተሉት የቅድመ ወሊድ ወይም የቤተሰብ ምጣኔ ከሆነ የጤና ባለሙያዎቹ የኤች አይ ቪ የምክርና የምርመራ አገልግሎት ይሰጣሉ?

Declaration

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

Name Demissie Semeko

Signature

Date 15 July 2008

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

Seleshi Zeleke		15 July 2008
Advisor	signature	Date