

**ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
SCHOOL OF PUBLIC HEALTH**

**Utilization of HIV Counseling and Testing Service and predictors of
intention to use it among Teachers of Harari Region**

By

Shemshedin Omer, (B.Sc)

**A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY SCHOOL OF
GRADUATE STUDIES IN PARTIAL FULFILLMENT FOR THE DEGREE OF
MASTER OF PUBLIC HEALTH**

Addis Ababa, Ethiopia

July, 2009

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Abstract

Background: The HIV/AIDS pandemic remains one of the global health problems ever faced by mankind including Ethiopia. Cognizant of the problem, various interventions have been made among which HIV counseling and testing (HCT) is one of crucial intervention package in the country.

Objective: This study aimed to assess the utilization of HCT and predictors of intention to use it among teachers of Harari Region.

Methods: A cross sectional study design with analytic component was conducted among 566 teachers drawn from 20 selected schools of Harari Region from March to April 2009. Socio-demographic and other important data was collected using self administered questionnaire developed based on the theory of planned behavior. The data were entered and analyzed using SPSS version 16.0 statistical package. Logistic and multiple linear regressions were used to identify association among variables and assess predictors of utilization & intention to use HCT service. A p-value of <0.05 was considered significant.

Result: about half (46.3%) of the study population were tested for HIV. The odds of having tested for HIV increased with being female and age below 35 years. The result of multiple linear regression analysis indicate that subjective norm ($\beta = .31, p < 0.001$), perceived behavior control ($\beta = .25, p < 0.001$) and attitude toward using HCT service ($\beta = .19, p < 0.001$) were found to be the predictors of intended use of HCT service. The addition of perceived susceptibility increase the explained variance marginally by about 6 % ($p < 0.05$).

Conclusion and Recommendation: Large proportion of teachers in the region has been tested for HIV. The TPB variables were found to be significant predictors of intended use of HCT with subjective norm being the strongest followed by perceived behavioral control and attitude toward the use of HCT. when planning any program targeting increase uptake of HCT service among teachers, particular attention should be paid on their referents and changing their perception of control in order to strengthen their intention to use HCT service.

List of Abbreviations

AIDS:	Acquired Immunodeficiency syndrome
AOR:	Adjusted odds ratio
ART:	Antiretroviral treatment
BSS:	Behavioral Survey surveillance
C.I.	Confidence interval
COR:	Crude odds ratio
EFA:	Education for all
FMoE:	Federal Ministry of Education
FMoH:	Federal Ministry of Health
GAMET:	Global HIV/AIDS Monitoring and Evaluation Team
GoE:	Government of Ethiopia
HAPCO:	HIV/AIDS prevention and control office
HCT:	HIV counseling and testing
HIV:	Human immunodeficiency virus
MoE:	Ministry of education
NGO:	Non-governmental organization
PBC:	Perceived behavioral control
PLWHA:	People living with HIV/AIDS
PMTCT:	prevention of mother to child HIV transmission
SCM:	Social cognitive model
SN:	Subjective norm
SPSS:	Statistical package for social science
STD:	Sexually transmitted disease
TPB:	Theory of planned behavior
TRA:	Theory of reasoned action
VCT:	Voluntary HIV counseling and testing

1. Introduction

1.1 Background

The HIV/AIDS pandemic is a pressing problem which remains a major challenge to public health. In 2007 the total number of people living with HIV/AIDS worldwide was 33.2 millions. Adult above 15 years of age constitute 92 % of infection. The numbers of people newly infected and died from HIV/AIDS are 2.5 millions and 2.1 millions respectively. Sub Saharan Africa, which constitutes only 10 % of global population, remains the most seriously affected region by AIDS pandemic. More than two out of three (68%) adult and nearly 90% of children infected with HIV live in this region, and more than three in four (76%) AIDS deaths occurred in the same region (1).

The HIV/AIDS is unique in that it affects all sectors. The basic education sector which is vital to the creation of human capital is equally affected. Education has been called the social vaccine against HIV/AIDS, because education empowers individuals with appropriate skills to receive and act on knowledge including knowledge about HIV/AIDS. The global campaign for education estimates that some 7 millions HIV infections could have been prevented by the achievements of the Education for all (EFA) goals. But in an unkind paradox, HIV/AIDS is itself weakening the capacity of education systems to play this preventive role by reducing the supply of teachers, affecting demands for education, reducing quality of education and increasing costs significantly(2, 3).

HIV was first detected in Ethiopia in a stored sera collected in 1984 and the first two AIDS case were reported in 1986. According to the single point prevalence estimate the national adult prevalence in 2008 was 2.2 % (7.7% urban and 0.9% rural).

The estimated new HIV infection and AIDS death in 2008 were about 125,000 and 58,000 respectively. The number of people living with HIV/AIDS who are in need of ART is estimated to be 289,734. AIDS accounted for an estimated 34% of all young adult deaths in Ethiopia and 66.3% of all young adult deaths in urban Ethiopia (4, 5). Study of HIV/AIDS related mortality among primary and secondary school teachers (1998-2003) in Addis Ababa showed that HIV/AIDS related illnesses were the leading cause of death accounted for nearly half of all deaths (6).

In response to the epidemic the Federal Ministry of Health (FMoH) has undertaken various activities including HIV/AIDS policy formulation in 1998(4). This created an enabling environment for HIV/AIDS prevention and control such as provision of extensive voluntary HIV counseling and testing (VCT) service for the larger community and development of VCT guideline in 2000. The service is provided in public, private and NGO health settings and limited free standing and youth friendly services. The number of people up taking VCT annually increased from about 10,000 clients in 2002 to nearly 500,000 in 2005(7). The 2007 revised HIV counseling and testing guideline stated that HIV counseling and testing (HCT) is a crucial intervention component of HIV/AIDS prevention, care and support program and shall be promoted and made widely available, affordable and accessible for all individual and community (7, 8).

1.2 Statement of the problem

Although some information on HIV/AIDS and factors affecting acceptance and utilization of VCT on different target group are available, there is still scarcity of information on teachers in this regard. The 2005 behavioral surveillance survey of Ethiopia revealed that almost all teachers had heard about HIV while more than 60% knows the three programmatic prevention areas (9). However, teachers were less likely to accept HCT compared to other professionals for uncovered reasons (10). Therefore this study was proposed to fill this gap and contribute to the development of theory based educational program to increase the uptake of HCT services.

2. Literature Review

2.1 HIV/AIDS Impact on education sectors

HIV/AIDS has become one of the major obstacles to achieving education for all (EFA) by the target date of 2015. In addition to the general financial constraints that hinder the prospect of achieving EFA, HIV/AIDS adds very substantially higher costs. UNICEF estimates that global costs related to teachers' absenteeism, deaths and training, school programs and programs for orphans and vulnerable children might require as much as US\$ 975 million a year. HIV/AIDS affects education systems as described below (2):

Reduce the supply of teachers: HIV/AIDS affects education supply through increased absenteeism and increased teacher mortality. Over 30% of teachers in parts of Malawi and Uganda, 20% in Zambia, and 12% in South Africa have been estimated to be HIV positive. HIV/AIDS related mortality among primary and secondary school teachers (1998-2003) in Addis Ababa were the leading cause of death accounted for nearly half of all deaths. Study conducted by Ministry of Education (MoE) of Ethiopia in 2003 indicated a 5% increases in the deaths of teachers (2, 6, 11).

Reduce the ability of children to attend school: HIV/AIDS is rapidly increasing the number of children who are orphaned and lack the financial, emotional and social support to attend school: by 2010 there will be more than 18 million orphans in Sub-Saharan Africa. Schooling may also be interrupted for children who have to take care of sick parents and relatives. In Uganda 26% of older children of people living with AIDS said they had to stay at home because of increased responsibilities. Reports from FMoE of Ethiopia shows the schools drop out rate increased from 1996/97 to 2000/2001(2, 11).

Affect the management capacity and increase the costs of Ministries of Education (MoE):

Not only do Ministries have to establish HIV/AIDS secretariats; most of these have to train staff to handle tasks in addition to other roles that they play. Costs are increased by absenteeism of teachers and other education sector staff who become ill or have to take care of sick relatives and attend funerals. There are also costs of death benefits, training new teachers and adopting curricula to address HIV/AIDS prevention information (2, 11).

Affect the Quality of Education: The quality of education is being affected by the trauma, fear and powerlessness that teachers face due to HIV/AIDS. A quality is also affected through increased absenteeism as teachers become ill themselves or have to deal with illness and death in their families. Without adequate attention to the management education systems, and efforts to improve the overall quality of education, HIV and AIDS prevention and impact mitigation must be surely failed (2, 12).

2.2 National Response to HIV/AIDS pandemic

Since 1985 the government of Ethiopia (GoE) responded to the epidemics by formulating several guidelines (PMTCT, ART, IP, VCT etc) and strategic documents to create an environment conducive for the implementation of HIV prevention, care and treatment and support programs. In July 2003, the government adopted the policy of ARV drug supply and use, paving the way for additional initiatives that facilitates access to free and low cost ARVs. In January 2005 the government launched the free ARV treatment initiatives (4, 13).

The first HIV counseling and testing guideline were published in 2000 by FMOH and revised two times in 2002 and 2007.

The counseling and testing services were supposed to be given by trained health professionals previously. In the 2007 guideline non health personnel are promoted as counseling and testing counselors after adequate training. There are three types of HIV testing in the country. Client initiated or voluntary HIV counseling and testing, provider initiated counseling and testing and mandatory HIV screening. The service is provided in various sectors such as public, private, NGO health setting and youth friendly service (7, 8).

2.3 HIV counseling and testing

HIV counseling and testing allows individuals to determine their HIV status and serve as a gateway for both HIV prevention and early access to treatment, care and support (7). Various determinants that affect the acceptance and utilization of the service have been identified.

Socio-demographic factors: Different studies conducted in different setting indicated some of socio-demographic variables as determinant factors of HCT utilization. The Zimbabwe cohort study revealed that having secondary / higher education is predictor for using HCT in younger age group of less than 35 years (14). The study done among Tanzanian teachers to search for socio-demographic and socio-psychological correlate showed that about 20% of the participants had voluntary tested for HIV. Teacher aged between 21-30 years of age were significantly more likely to have tested for HIV (15). The study conducted among different professional in Gondar revealed 82% of the respondents were willing to accept VCT. The age group of 15-19years was the most receptive group where 91.2% opt to accept VCT while least acceptance was seen among those age 40 years and above (10).

Another study conducted in Gurage zone found that the majority (82.8%) of the VCT user was in the age group of 15 – 29 years and their main reason of HIV testing was for premarital purpose (16). There is contradicting result as to which sex is more likely use the service. The willingness to accept was claimed to be three times higher among males than their counterpart in the study conducted among high-school teachers of Addis Ababa while the study conducted in Butajira reported the increased VCT service utilization among female (17, 18). The former one indicates the future event while the later showed the real service utilization.

The service related factors such as availability and accessibility were indicated to affect the utilization of HCT. The Tanzanian study reported that teachers who had easy access to the HIV testing service were significantly more likely to be tested (15). The studies conducted among members of central military commands and armed force of Ethiopia reported that the easily accessibility to VCT centers and provision of ART free of charge influence positively VCT acceptance (19, 20). The Gurage zone study also revealed similar result (16).

There are studies that demonstrated the effect of educational status and income on the VCT utilization. The study conducted in Butajira and North Wollo showed that individual with educational status of secondary and above is more likely to utilize the service than those who had no formal education. Butajira's study also revealed the increased VCT service utilization among those with income greater than 1000 Eth. Birr per months. The study conducted among high-school teachers of Addis Ababa also reported increased willing to accept VCT among those with monthly income of greater than 800 Eth. Birr (17-18, & 21) .

Knowledge, attitude and other cognitive variable: The study conducted among different target group in Ethiopia indicated the high level of knowledge on HIV/AIDS. The 2005 behavioral surveillance survey of Ethiopia revealed that almost all (99.3%) teachers had heard about HIV while more than 60% knows the three programmatic prevention areas (9). Another study conducted among high-school teachers of Addis Ababa in 2004 reported that 97.3% and 72.6% have heard about HIV/AIDS and know the existence of VCT service respectively. According to this study the attitude of teachers toward HIV/AIDS was fair as seen in their willingness to share meal with PLWHA, to work with them and do some social activities with known HIV/AIDS patient. The majority (85.4%) of teachers has no misconception and their willing to accept the service was 69.9% (17). The study conducted in Addis Ababa on utilization of pre-marital HIV testing showed that 91.4% of the subject had heard about VCT while 76.4% said they were aware of the existence of the centers providing VCT service (22). The community based study in northwest Ethiopia in 2003 reported that 73.8% of respondents knew the availability of VCT service (23).

One of the reasons mentioned among non user in the Gurage zone study was having no information about VCT while community based study in Harar also indicated lack of knowledge about HIV testing among the major reasons mentioned why people refused HIV testing (16, 24). The study conducted among armed force reported that soldiers who knew a person infected with HIV or died of AIDS and those who were knowledgeable about the use of VCT were most likely to have undergone HIV testing (20). In contrast to the above findings, a number of studies reported the in significant effect of knowledge on VCT acceptance or utilization (10, 17-18 and 21-22).

The psycho-social aspects played a role in the HCT acceptance as well as utilization. The Tanzanian study indicated that the rate of having been tested for HIV was significantly associated with psycho-social perceptions including: absence of vaccine and cure for HIV/AIDS, risk of HIV infections and fear of dying quicker if tested for HIV and being told about positive results (15). Another study on Tanzanian teacher examined the applicability of TPB to predict the intended use of HCT service. This study reported that teachers' intention to use HCT service was primarily due to their perceived behavioral control and attitude while subjective norms had less weight. The TPB components accounts for explaining 30% of variance in intention to use HCT (25). The cohort study in Zimbabwe showed also the physiological deriving factors such as motivation, control, intention, self efficiency and attitude play role in the decisions to use HCT service (14).

The psycho-social aspects have been also reported from studies conducted in Ethiopia on different target group. Study conducted among different professionals in Gondar demonstrated the role of significant other such as religious leaders, community leaders, sexual partners, parents and friends on the acceptance of VCT. They increase the acceptance of the service by four folds (10). Based on the study conducted on the utilization of pre-marital HIV testing service and determinants of VCT in Addis Ababa, the reasons given for not having been tested were: not feeling at risk (57.8%), having never thought about it (23.9%), having had HIV testing for another reason (8.1%), fear of positive result (4.9%) and fear of stigma (4.6%) (22). A number of other studies also reported partner and/or self trust, fear of getting test result, fear of stigma related to HIV/AIDS and do not trusting the confidentiality as a reasons for not using HCT service (16, 20, 24).

According to the study done in Harar town among 15-49 years age group a high (85.4%) proportion of the study subjects had intention of having VCT. Salient belief about benefits of having VCT and subjective norms are predictors of intentions of having the service by the study subject (24). Similar study conducted in the same region but at different time among lactating mother showed that 69.9% respondents had intention to have VCT in the future. (26).

2.4 Conceptual framework

The theory of planned behavior (TPB) is an extension of theory of reasoned action (TRA). It constitutes a promising frame work for understanding and predicting behaviors and behavioral intentions. As shown in Figure 1 according to this theory human action is guided by three kinds of consideration: a belief about the likely outcomes of the behavior and the evaluation of the outcomes (behavioral beliefs). Belief about the normative expectations of others and motivation to comply with this expectations (normative beliefs), and beliefs about the presences of factors that may facilitates and impede performance of the behavior and perceived power of these factors (control beliefs). In their respective aggregates, behavioral beliefs produce favorable or unfavorable attitude toward the behavior; normative beliefs result in perceive social pressure or subjective norm; and control beliefs give rise to perceived behavioral control. The predictors of TPB influence subsequent behavior indirectly through behavioral intention However, perceived behavioral control may influence behavior directly if it reflects actual control and whenever the behavior in question is not under complete volitional control by the individual (27-29).

TRA/TPB has been applied to explain variety of behaviors including HIV and other STD prevention. The model has been applied in health related behavior in African context including Ethiopia. Its applicability was tested in predicting intended and self reported condom use in rural Ethiopian population, intended use of contraceptive among female adolescent of Ethiopia. It was also used to understand the motivation to learn about HIV/AIDS prevention among adolescent in Tigray (30-32).

In other African country it was used to predict intention to use condom and intention to use HCT service (25, 33-34). This theory was also used in the present study to predict intention to use HCT among previously untested teachers.

The theory of planned behavior is open to the inclusion of other variable if they increase the predictive utility (28). Hence perceived susceptibility and perceived severity from health belief model were added to the TPB model to test whether they increase the predictive ability of the theory.

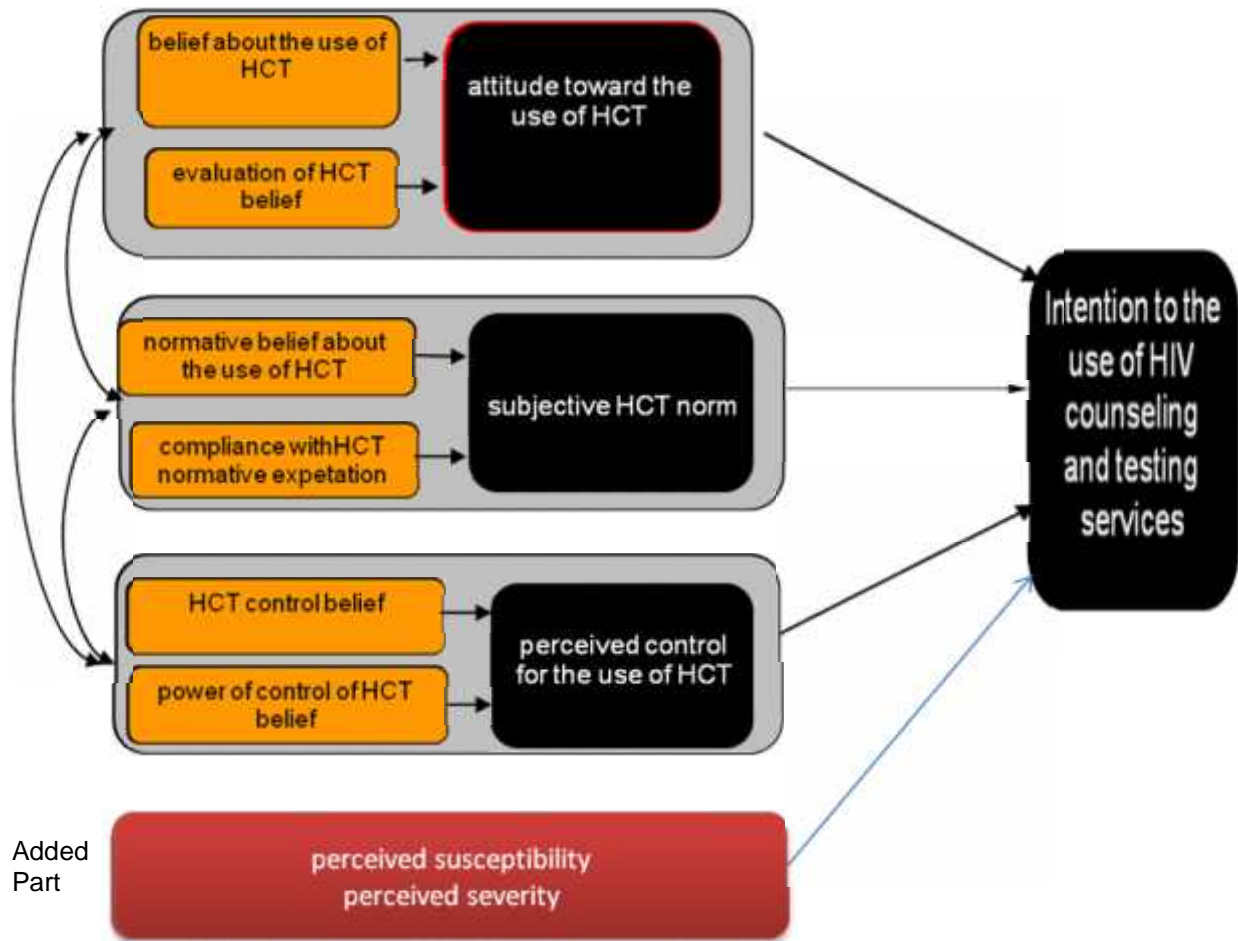


Figure1. The extended theory of planned behavior

3. Objective of the study

General objective

- To assess the utilization of HIV counseling and testing services and predictors of intention to use it among teachers of Harari Region, using theory of planned behavior.

Specific objectives

- To assess the prevalence of HIV counseling and testing utilization among teachers,
- To assess the factors that affect the utilization of HCT services among teachers,
- To assess the predictive capacity of TPB in explaining intention to use HCT service among teachers.

4. Methods and Materials

4.1 Study design: cross sectional design with analytical component was used to assess the utilization of HIV counseling and testing service and predictors of intention to use it using TPB among teachers in Harari region.

4.2 Study Area

The study was conducted in Harari Region. The capital of the region is Harar town which is found 525 KM East of Addis Ababa .The Region is divided into 9 administrative kebeles (6 urban and 3 rural). According to the 2007 population census, the population of Harari region was estimated to be 183,344. The major ethnic groups based on population size of the town are Amhara, Oromo, Harari, Gurage, Tigrae and Somalie(35). The total number of schools and teachers in 2008/09 were 57 (31 urban 26 rural) and 1,426 respectively. There were 4 hospitals, 5 health centers, 14 health posts and 22 private clinics in the region. All hospitals and health centers provide comprehensive HIV/AIDS services i.e HCT, PMTCT, ART and only two NGO clinics provide HCT service. According to the point prevalence estimate, the 2008 adult HIV prevalence is 3.3% which is higher than the country prevalence (2.2%). The estimate of total numbers of HIV positive population was 4,264 (5).

4.3 Data collection period: Data were collected from March to April 2009.

4.4 Source population: The source population was all primary and secondary school teachers in Harari region who were serving by their profession at the time of data collection.

4.5 Study population: All eligible teachers in the selected schools who were present at the time of data collection.

Inclusion criteria: All teachers in the regions who were serving in the selected schools at the time of data collection and who agreed to fill the self administered questionnaire.

Exclusion criteria: Teachers who have visual impairment were excluded.

4.6 Sample size determination

Two previous study conducted in Harar town among different target group found that the intention to have VCT was 85% among 15-49years of age and 70% among lactating mothers (24, 26). Sample size for this study was calculated by taking the estimated prevalence of intention to be tested 77% which is close to the average of the two studies. Four percent margin of errors with 95% confidence of certainty of any outcome was used. Based on these assumptions, the sample size was calculated using the formula for single population proportion.

$$n = (Z_{\alpha/2})^2 P (1-P)/d^2$$

Where:

P= the estimated prevalence of intention of HCT among teachers (77%)

d= margin of error between the sample and population (0.04)

$Z_{\alpha/2}$ = critical value at 95% certainty (1.96)

Since sampling was from finite population of 1426 teachers, the finite population correction was considered (36). $n_f = n/(1+n/N)$, where: n is the sample size calculated from finite population (425). The calculated sample size (n) is 327. Considering 15% of non response rate and design effect (1.5), the overall sample size was 565.

4.7 Sampling procedure technique

Harari region was selected purposively. The total numbers of schools in the region were found to be 57(31 urban and 26 rural schools) and total number of teachers in the region was 1426 (60.5% male and 39.5% were female) in 2008/09. Of all teachers, 408 of them were serving in the rural schools while the rest 1018 were serving in urban schools. The schools were stratified into urban and rural. 12 schools from urban and 8 from rural were selected randomly using lottery method. Using cluster sampling technique, all teachers in the selected schools were invited to participate in the study. Finally, the data were collected from 566 teachers in the selected schools who were present and agreed to participate at the time of data collection. There were only 9 (5 from urban and 4 from rural schools) refusals and 28 absentees at the time of data collection.

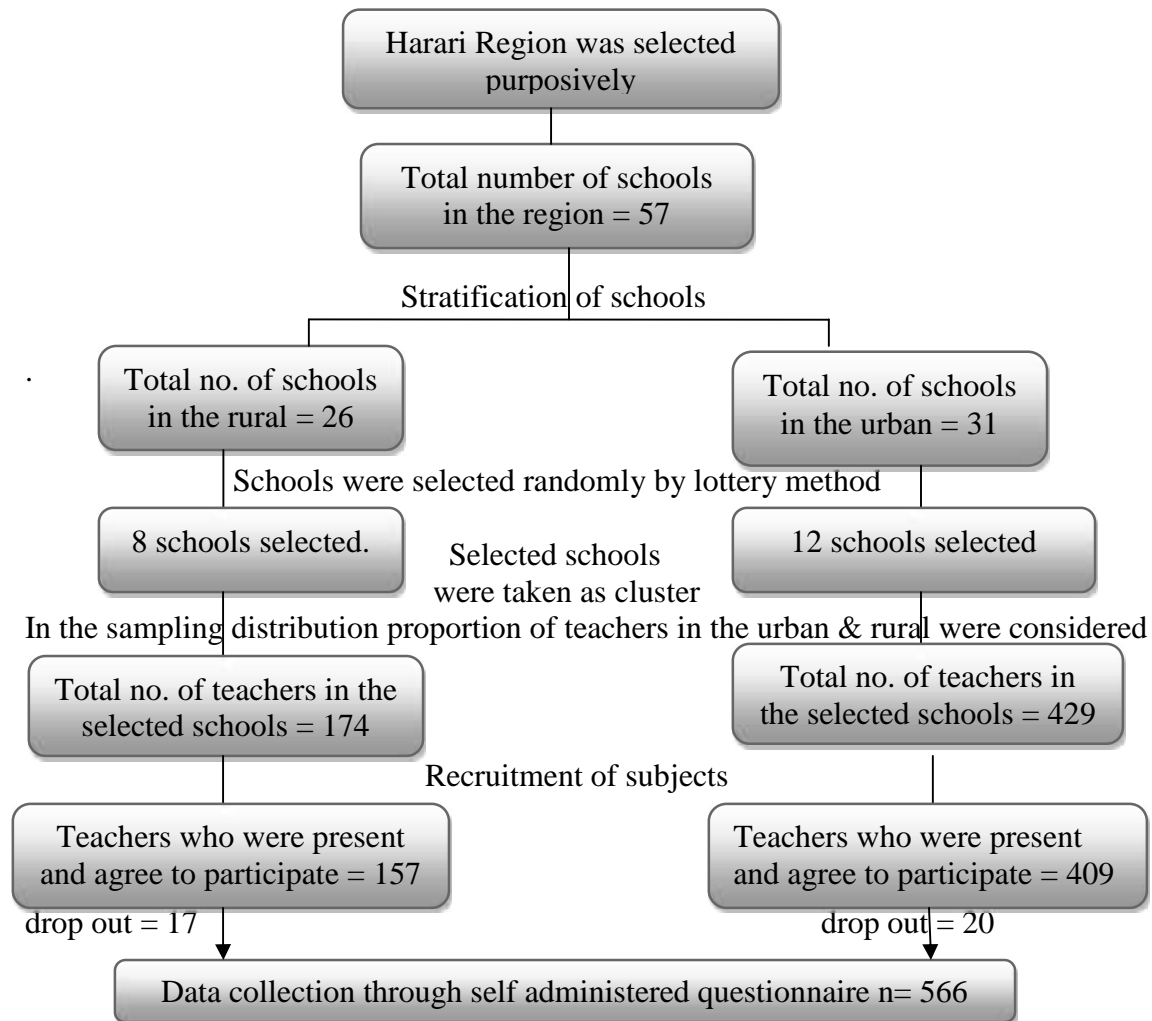


Figure 2 Schematic presentation of sampling procedure

4.8 Data collection Methods

Instrument: The self administered pre-tested questionnaire originally prepared in English language was used to measure the behavioral, normative and control belief. The questionnaire was adapted and modified from similar previous study and sample of questionnaire outlined by the founder of TPB. The questionnaire were translated to Amharic version and back translated to English language by another person to ensure that the meaning of questions did not change. In addition to the cognitive variable the questionnaire has covered socio-demographic information, information on HIV counseling and testing as well as sexual history.

Selection and training of data collectors

One supervisor and 6 facilitators with experience on data collection were recruited and trained for two days by the principal investigator prior to data collection. The training content comprised a briefing on the aim and content of the study, familiarization with and how to administer questionnaires. They were also introduced to research ethics, their responsibility and administrative issues including the work schedule.

Pre testing

Five days prior to the main fieldwork, a pre test was conducted on twenty school teachers from three schools that were not enrolled in the main study. These schools were characteristically similar to the participant schools. Following the analysis of the pilot study data, ambiguous or unclear questions were rephrased to make it more understandable.

Data quality

To assure the quality of data the following activities were accomplished.

- Individuals who have at least diploma were recruited as supervisor or facilitators. They were given adequate training. Beside this the data were collected under close supervision of principal investigators.
- The questionnaire was Pre-tested prior to the actual data collection. The result was analyzed and correction and changes were made on the questionnaire.
- Data were checked for its completeness and consistency by the principal investigator before data entry.
- The information entered was rechecked in 10% of randomly selected questionnaire.

4.9 Operational definition

Intention of having HCT: The individuals plan to use HIV counseling and testing in the near future (next two months).

Belief about the use of HCT: The extent to which an individual think the advantage of using HCT services.

Evaluation of HCT belief: The individual evaluation of the salient consequence resulted from using HCT in the near future.

Attitude toward the use of HCT: An individual predisposition to respond in favorable or unfavorable manner toward the use of HCT.

Normative beliefs towards HCT: The perception held by an individual whether significant others (important referents) think that s/he should use the HCT services.

Compliance with HCT normative beliefs: The individual's motivation to comply with the specific referents wishes about using HCT services.

Subjective HCT norm: The individual perception that significant others think him/her to use HCT services as a normative action.

HCT control beliefs: Belief about the presence of factors that might hinder or facilitate the use of HCT services.

Power of control of HCT beliefs: Perceived ability of individual to control factor that might hinder the use of HCT.

Perceived control for the use of HCT: The perceived easy or difficulty associated with the use of HCT.

Perceived susceptibility: A belief about likelihood of getting infected by HIV/AIDS

Perceived severity: Feeling about the seriousness of HIV/AIDS.

4.10 Variables

The following variables were used to fulfill the objective of the study:

Dependent variables

- utilization of HCT
- Intention to use HCT in the future (previously non tested individuals)

Independent variables

- **Socio demographic variables** (sex, age, marital status, ethnicity, religion, level of education, monthly salary)
- **Sexual history**
- **Cognitive variables:** The individual knowledge about HCT, belief about the use of HCT, evaluation of HCT beliefs, attitude toward the use of HCT, normative beliefs towards HCT, compliance with HCT normative beliefs, subjective HCT norm, HCT control beliefs, power of control of HCT beliefs and perceived control for the use of HCT, perceived severity and perceived susceptibility.

4.11 Data management and analysis

The data were entered and analyzed using SPSS statistical package version 16. Frequencies, proportion and summary statistics were used to describe the study population in relation to relevant variables. Chi-square analysis was used to identify any significant association with HCT utilization and selected variables. The Fisher exact test was used where the chi-square test was not applicable. To assess the relationship among TPB component and other selected variables Pearson's correlation was used. Cronbach's alpha which is a measure of internal consistency was examined before constructing scales. Assessment of the applicability of TPB model in predicting intention to use HCT service was done using multiple linear regressions.

In performing binary logistic regression the predictors were dichotomized into top two fifth and lower three fifth. The scores of construct developed from TPB ranges from 1-5 and score 3 indicated the neutrality of respondents. Therefore the upper two fifth indicate exposure to predictors while the lower three fifth indicate absence of exposure.

Each variable for the theoretical model was measured with the help of a five point Likert scale. The response options were in the five points likert scale ranging from strongly agree/very likely/very good to strongly disagree/not likely at all/very bad.

Intention to use HIV counseling and testing service was measured by three items namely a) How likely you intend to be tested, b) How likely you look for and request HCT service and c) How likely you accept HCT'. Responses ranged from (1) 'not likely at all' to (5) 'very likely'. A sum score (range 3-15) was constructed by adding the responses of the three items. The higher the score on the intention scale means the strong the intention formation.

Behavioral belief: was measured by six items by asking respondents to rate the extent to which they thought their use of HCT in the coming 2 months was likely to: a) decrease their chance of HIV infection, b) make it possible for them to avoid transmitting virus to their partner, c) result in happy life if test result is negative, d) help them plan for their future, e) improve their partner trust and f) help them to seek anti-retroviral therapy- timely if their test result is positive. Responses ranged from (1) 'strongly disagree' to (5) 'strongly agree'. Responses were summed to index score (range 6-30), the higher the score indicate favorable belief.

Out comes evaluation: Respondents were asked to evaluate the above mentioned six salient consequences resulted from using HCT services in the coming two months. Responses ranged from (1) 'very bad' to (5) 'very good'.

Attitude: Items of behavioral beliefs together with those of the outcome evaluation to compose the attitude scale. As recommended by Fishbein and Ajzen each behavioral belief item was multiplied by its corresponding outcome evaluation and the sum was used to compose attitude scale (29).

Normative belief: Respondents were asked the extent to which they thought their spouse/partner, close friends, fellow teachers, relatives, children/students and religious leader approve their use of HCT services in the next two months. Responses ranged from (1) 'strongly disagree' to (5) 'strongly agree'. Responses were summed to index score (range 6-30).

Motivation to comply: respondents rated the extent to which they would like to do what the above mentioned six salient referents thought they should do. Responses ranged from (1) 'strongly disagree' to (5) 'strongly agree'. Responses were summed to index score (range 6-30).

Subjective norm: Items of normative beliefs together with those of motivation to comply compose the subjective norm scale. As recommended by Fishbein and Ajzen each normative belief item was multiplied by its corresponding item of strength of compliance and the sum was used to compose subjective norm scale (29).

Control belief: Respondents were asked to rate the extent to which they thought that making decision to be tested is difficult: if their partners were not in favour of their use of HCT service, for fear of hearing HIV positive result, for fear of stigma if tested positive, if they suspect that the service providers could not keep their HIV test result confidentially, it was not easy for them to disclose their HIV positive test result. Responses ranged from (1) ‘strongly agree’ to (5) ‘strongly disagree’.

Power of control: The respondents rated the extent to which they thought they could use the HCT service in the coming two months given the five control belief statements. Responses ranged from (1) ‘strongly disagree’ to (5) ‘strongly agree’.

Perceived behavioral control: Items of control beliefs together with those of power of control items compose the perceived behavioral control scale. As recommended by Fishbein and Ajzen each control belief item was multiplied by its corresponding power of control and the sum was used to compose perceived behavioral control (29).

Perceived susceptibility was assessed by one single item: ‘I feel that it is likely for me to get HIV infection’. The response scale ranged from (1) ‘strongly disagree’ to (5) ‘strongly agree’.

Perceived severity was assessed by two items: a) If I get infected with HIV I will die immediately, b) I would rather have other terminal illness than HIV/AIDS’. Responses ranged from (1) ‘strongly agree’ to (5) ‘strongly disagree’.

4.12 Ethical consideration

- Ethical approval was obtained from the ethical review committee of the AAU, School of Public Health and FoM.
- Institutional consent was obtained by communicating to Regional education Bureau before conducting the study.
- The school masters were briefed about the study before meeting with teachers.
- Specifically, participants were informed about the objectives of the study and their participation was purely voluntary and their right not to answer any part of the question was respected.
- Each individual was presented with information sheet and consent paper presented in Amharic.
- Responses were anonymous and kept confidential.
- At the end of data collection, the study participants were updated on the current HCT guideline and any questions raised were entertained.

4.13 Dissemination of the result

The finding of this study after defense at Addis Ababa University will be submitted to School of public health and EPHA, the funding agent. As deemed necessary it will be communicated at scientific conferences and will be submitted for publication in relevant scientific journal.

5. Result

A total of 566 school teachers sampled from 20 selected schools in Harari region participated in this study. Of these, 58 participants did not return the questionnaire. 497 participants filled the questionnaire properly and returned them making the response rate of 87.8%.

5.1 Socio-demographic characteristics

As displayed in Table 1, out of 497 respondents, 494 (99.4%) filled question regarding their age. The age of respondents ranged from 18 to 61 years and the overall mean was 34.68 years with standard deviation of ± 9.9 . The majority of the respondents, 326 (66.0%), fall in the age category of 25-44 years. As to their sex, 309 (62.2%) were male while the rest 188 (37.8%) were female.

The proportion of teachers whose religion was orthodox, Islam, Catholic and protestant were 293 (59%), 132 (26.6%), 59 (11.9%), and 4 (0.8) respectively. Regarding ethnicity, around half 255 (51.3%) of study participant were Amhara. The rest were Oromo 158 (31.8), Harari 34 (6.8%), Tigre 20 (4.0%), Gurage 19 (3.8) and others 11 (2.2%).

Slightly over half (54.1%) of them were married and 192 (38.6%) were single. The rest were either divorced/separated (5%) or widowed (2.2%).

About half (51.7%) of the study participant had diploma, 132 (26.6%) had certificate while the remaining 108 (21.7%) had their 1st degree at the time of the interview. With regard to the location of the schools, most (72%) were from urban school while the rest 28% were from rural schools.

Out of the total respondents around 98% of them responded to question regarding their monthly income. The proportion of teachers who had monthly salary below 1000 Birr, 1001-2000 Birr and above 2000 Birr were 43%, 52.9% and 4.1% respectively.

Table 1: Socio-demographic characteristics of respondents by gender in schools of Harari Region, March-April, 2009.

Variables	Male	Female	Total
	Freq. (%)	Freq. (%)	Freq. (%)
Age category (n= 494)*			
15 – 24	47(15.3)	18(9.8)	65(13.2)
25 – 34	134(43.6)	70(37.4)	204(41.3)
35 – 44	66(21.5)	56(29.9)	122(24.7)
45 - 54	41(13.4)	40(21.4)	81(16.4)
55 – 64	19(6.2)	3(1.6)	22(4.5)
Religion (n = 497)			
Islam	105(34)	27(14.4)	132(26.6)
Orthodox	163(52.8)	130(69.1)	293(59)
Catholic	30(9.7)	29(15.4)	59(11.9)
Protestant	3(1)	1(.5)	4(.8)
Other	8(2.6)	1(0.5)	9(1.8)
Ethnicity (n = 497)			
Amhara	134(43.4)	121(64.4)	255(51.3)
Oromo	116(37.5)	42(22.3)	158(31.8)
Harari	22(7.1)	12(6.4)	34(6.8)
Tigre	13(4.2)	7(3.7)	20(4.0)
Gurage	15(4.9)	4(2.1)	19(3.8)
Other	9(2.9)	2(1.1)	11(2.2)
Marital status (n = 497)			
Single	141(45.6)	51(27.1)	192(38.6)
Married	153(49.5)	116(61.7)	269(54.1)
Divorced/separated	12(3.9)	13(6.9)	25(5.0)
Widowed	3(1)	8(4.3)	11(2.2)
Educational status (n = 497)			
12+1/10+1	72(23.3)	60(31.9)	132(26.6)
Diploma	150(48.5)	107(56.9)	257(51.7)
1 st degree	87(28.2)	21(11.2)	108(21.7)
Location of school (n = 497)			
Urban	217(70.2)	141(75)	358(72)
Rural	92(29.8)	47(25.0)	139(28)
Salary category (n = 488)*			
400 – 1000 Eth. Birr	130(42.6)	80(43.7)	210(43.0)
1001 – 2000 Eth. Birr	157(51.5)	101(55.2)	258(52.9)
2001 – 3000 Eth. Birr	18(5.9)	2(1.1)	20(4.1)

*sample size varies due to missing response.

5.2 Knowledge, source of information and utilization of HCT

As depicted in Table 2, nearly all (98.6%) have heard about the confidential HIV counseling and testing service. Their sources of information were mass media 419 (85.3%), health professional 276 (56.2%), close friends 118 (24%) and partners 45 (9.2%).

Likewise the vast majority (98.4%) know from where they can get HCT service in their locality. Most of them mentioned the existence of confidential HCT service in government hospital (63.2%) and family guidance associations (FGAE) clinics (60.9%). Only about one quarter (26.2%) of them mentioned the existence of service in health center.

The proportion of study participants who ever tested for HIV was 230 (46.3%). Of these the majority of them were tested within one year prior to the data collection. The remaining 89 (38.7%) were tested before 2year prior to the data collection.

Table 2: Knowledge, Source of Information and Utilization of HCT Service among Teachers of Harari Region by Gender, March-April, 2009

Variable	Male	Female	Total
	Freq. (%)	Freq. (%)	Freq. (%)
Have you heard about HCT (n = 497)			
Yes	302(97.7)	188(100)	490(98.6)
No	7(2.3)	0(0.0)	7(1.4)
Source of HCT information (n = 490)			
Health professional	174(57.4)	102(54.3)	276(56.2)
Mass media	265(87.5)	154(81.9)	419(85.3)
Close friends	79(26.1)	39(20.7)	118(24.0)
Partners	36(11.9)	9(4.8)	45(9.2)
Do you know from where you can get HCT (n=497)			
Yes	302(97.7)	187(99.5)	489(98.4)
No	7(2.3)	1(0.5)	8(1.6)
From where you can get HCT service (n = 489)			
Government hospital	200(66.2)	109(58.3)	309(63.2)
Health center	84(27.8)	44(23.5)	128(26.2)
FGAE clinic	173(57.3)	125(66.8)	298(60.9)
Private clinic	22(7.3)	20(10.7)	42(8.6)
Have you ever tested for HIV (n = 497)			
Yes	127(41.1)	103(54.8)	230(46.3)
No	182(58.9)	85(45.2)	267(53.7)
When did you get tested (n = 230)			
In the past 3 month	37(29.1)	39(37.9)	76(33)
In the past 12 month	36(28.3)	29(28.2)	65(28.3)
Before 2 years	54(42.5)	35(34)	89(38.7)

5.3 Sexual experiences of study participants

Table 3 display the sexual experience of respondents. The prevalence of premarital sexual intercourse among never married respondents was above half (54.9%). Among unmarried respondent who ever had sexual intercourse, 67(66.3%) of them were sexually active in the last 12 months prior to the data collection. The proportion of all respondents who had more than one sexual partner 12 months prior to the data collection were 44(13.7%).

Table 3: Sexual Experience among Teachers of Harari Region, March-April 2009

Variable	Male	Female	Total
	Freq. (%)	Freq. (%)	Freq. (%)
Ever had sexual intercourse (n = 184)**			
Yes	75(56.6)	26(53.1)	101(54.9)
No	60 (44.4)	23(46.9)	83(45.1)
Sexual intercourse in the last 12 months (n=101)**			
Yes	48(64.9)	19(70.4)	67(66.3)
No	26(35.1)	8(29.6)	34(33.7)
How many partner in the last 12 months (n= 322)*			
One	144(71.3)	79(65.8)	223(69.3)
More than one	26(12.9)	18(15)	44(13.7)
I did not have	32(15.8)	23(19.2)	55(17.1)

***This question was asked for respondents who were single by their marital status (n= 192). There were 8 non response*

**This question was asked to all respondents (n=497). Due to sensitivity of the question the non response to this particular question was So high. Therefore it was excluded from further analysis*

5.4 Predictors of using HIV counseling and testing service

As shown in Table 4, bivariate and multivariate analysis were done to assess factors predicting utilization of HIV counseling and testing service. Among the socio demographic variable being female is shown to be significantly associated with having tested for HIV (COR = 1.74; 95%CI =1.20 to 2.50). Being age group above 35 years also increases the likelihood of testing for HIV (COR = 1.55; 95% CI =1.085 to 2.22). After controlling for selected variables both sex and age remained significant (AOR = 1.59; 95%CI=1.05 to 2.41), (AOR = 2.25; 95%CI= 1.41 to 3.6) respectively. The other socio demographic variable such as educational status, marital status, location of the school, religion and ethnicity were not significantly associated with utilization of HCT service.

On the bivariate analysis, having monthly salary of less than 1,500 Ethiopian Birr was significantly associated with testing for HIV (COR = 1.81; 95%CI = 1.1, 2.98). After controlling for possible confounders this association was found to be insignificant (AOR = 1.39; 95% CI= 0.73 to 2.65).

Knowledge on HCT and knowing the existence of HCT service in their locality did not show significant association with the utilization of HIV testing.

Table 4: Factors Predicting the Utilization of HIV Counseling and Testing Service among Teachers of Harari Region, March – April 2009

Variable	HIV testing		COR(95% C.I)	AOR(95% C.I)
	Yes	No		
Sex				
Male	127	182	1	1
Female	103	85	1.74(1.20, 2.50)*	1.59(1.05, 2.41)*
Age category				
15-34	138	131	1.55(1.09, 2.22)*	2.25(1.41, 3.6)*
35-64	91	134	1	1
Salary category				
<1,500 Eth.birr	199	208	1.81(1.10, 2.98)*	1.39(.73, 2.65)
>= 1,500Eth.birr	28	53	1	1

**significant at p<0.05*

5.5 Descriptive Statistics of Cognitive Variables

Table 5 depicts the descriptive statistics of the salient beliefs which is applied for 267 respondents who never had HCT. The study group had strongly favorable behavioral belief and outcome evaluation of using HCT services. They also perceive normative pressure positively. Their perceived susceptibility was very low because 220(82.7%) of individual perceive that they were not susceptible to HIV infection. The proportion of respondents who had intention to be tested for HIV in the coming two months was 45.9%.

Table 5: Descriptive Statistics of the Cognitive Variable (n = 266)

Components	Item	Mean ^a	SD
Behavioral belief	6	4.31	0.80
outcome evaluation	6	4.48	0.81
Normative belief	6	3.6	1.00
Motivation to comply	6	3.54	1.11
Control belief	5	3.35	1.09
Power of control	5	2.96	1.11
Perceived susceptibility	1	2.29	1.28
Perceived severity	2	3.46	1.25
Intention	3	3.38	1.25

^ascale range = 1-5. n = 266 because this cognitive variables were computed for previously untested respondents which was 267. There was only one non response

5.6 Partial Correlation among the Components

Partial correlation coefficient among TPB variables, perceived severity, perceived susceptibility and total monthly income were done. All TPB components correlated significantly with behavioral intention. Subjective norm ($r=0.45$, $p<0.001$) demonstrated the highest correlation followed by perceived behavioral control ($r=0.42$, $p<0.001$) and attitude ($r=0.33$, $p<0.001$). Since they correlated positively an increase in the value of one TPB component is accompanied by an increase in intention. Perceived severity ($r= -0.14$, $P<0.001$) was also negatively correlated with behavioral intention. This indicates that as the perceived severity of individual increase their intention to be tested decreases. Perceived susceptibility($r=0.25$, $p<0.001$) was also positively correlated with intention. However total monthly salary did not correlate significantly with any of the TPB component. The internal consistency in terms of Cronbach's alpha was 0.92, 0.71, 0.89, 0.93 and 0.67 for intention, attitude, subjective norm, perceived behavioral control and perceived severity respectively.

Table 6: partial correlations (pearson's r) among the components of planned behavior, perceived severity, perceived susceptibility, monthly salary and intention

Variables	1	2	3	4	5	6	7
1. Attitude	-						
2. Subjective norm	0.30***	-					
3. Perceived behavioral control	0.09	0.31***	-				
4. Perceived severity	-0.10	-0.12	0.01	-			
5. Perceived susceptibility	0.11	0.05	-0.02	-0.41***	-		
6. Monthly salary	-0.02	-0.02	0.04	0.04	-0.02	-	
7. Intention	0.33***	0.45***	0.42***	-0.14**	0.25***	-0.01	-

*Significant at * $p<0.05$, *** $p<0.001$; controlled for age, location and educational status*

5.7. Testing the empirical model

Multiple linear regression analysis was performed to predict intention to use HCT among untested respondents. Demographic variables (i.e age, sex, educational status and location of school) were entered in the first step accounting for 3.5% of explainable variance in intention. Attitude and subjective norms were entered in the second step and accounted for 25% of variance in intention. The perceived behavioral control was entered in the third step and increases the explained variance by 6.5%. The perceived susceptibility was entered in the fourth step and increase explained variance by 6.1%. Finally perceived severity was added but no additional explained variance observed. From the statistically significant predictors emerged in the final step, subjective norm ($\beta = 0.31$, $p < 0.001$) was found to be the strongest predictor followed by perceived behavioral control ($\beta = 0.25$, $p < 0.001$), perceived susceptibility ($\beta = 0.22$, $p < 0.001$), attitude ($\beta = 0.19$, $p < 0.001$) and age ($\beta = -0.13$, $p < 0.05$) in descending order.

Table 7 Standard beta coefficients when intention to use HCT is regressed upon the TPB components and perceived susceptibility (PSU) (n = 266)

Components entered	Adj.r ²	ΔR^2	F-change	p-value	Standardized regression coefficient			
					A	SN	PBC	PSU
Demographic variable ^d	.032	.035	9.436	P<.05				
A + SN	.28	.25	82.64	P<.001	0.21*	0.40*	-	
A+ SN+PBC	.33	.065	22.89	P<.001	0.21*	0.33*	0.24*	
A+ SN+PBC+PSU	.37	.061	23.61	P<.001	0.19*	0.31*	0.25*	0.22*

^dSocio-demographic variable entered: sex, age, educational status, location and total monthly income .
A=attitude; SN= subjective norm; PBC = perceived behavioral control; β = standardized regression coefficient. * $p < 0.001$.

5.8 Intention to use HIV counseling and testing service

Table 8 displays the relationship between intention to be tested for HIV with age, sex and theoretical construct. The socio-demographic variables, age and sex have shown significant association with utilization of HCT by both bivariate and multiple logistic regression model. However they are not significantly associated with intention to be tested. Similarly perceived severity did not show significant association with intention to be tested on bivariate analysis. School location (COR = 0.71; 95% CI = 0.48 to 1.05) also did not show significant association with intention to be tested. (Not displayed in the table)

On bivariate analysis perceived susceptibility was significantly associated with intention to use HCT service (COR = 5.61; 95% CI= 2.65 to 11.89). After controlling for selected variable, it increase the likelihood of intention to be tested by greater than 3 folds (AOR = 3.79; 95% CI = 1.61 to 8.92).

Behavioral belief was also significantly associated with intention to be tested for HIV (COR = 3.01; 95% CI = 1.6 to 5.67). This association was not sustained in multiple logistic regression model (AOR = 1.44; 95% CI = 0.65 to 3.23). Similarly those who have desirable evaluation of consequence of using HCT was significantly associated with intention to be tested on bivariate analysis (COR = 3.75; 95% CI = 1.65 to 8.53). However this association was not retained after adjustment (AOR = 1.87; 95% CI = 0.69 to 5.08).

On bivariate analysis both normative belief (COR = 6.39; 95%CI = 3.73 to 10.94) and motivation to comply (COR = 5.08; 95%CI = 2.97 to 8.64) was significantly associated with intention to be tested. However, after adjustment only normative belief sustained the association (AOR = 3.01; 95%CI = 1.48 to 6.11). This implies that those who perceived normative pressure more positively had intention to be tested for HIV more than three folds than who perceive normative pressure negatively.

Similarly Control belief (COR = 2.51; 95%CI = 1.52 to 4.14) and power of control HCT (COR = 6.57; 95%CI = 3.5 to 12.33) were significantly associated with intention to perform the behavior on bivariate analysis. After adjustment for possible confounders control belief was not significant while the power of control remained significant. Individual who had high level of control (perceive easy associated with the use of HCT) had more than three folds intention to perform the behavior than who perceived difficulty associated with the use of HCT (AOR = 3.81; 95%CI = 1.84 to 7.89).

Table 8 Relationship between intention to be tested for HIV with age category, sex and theoretical construct among untested respondents (n = 266)

Variable	Intention to be tested for HIV		Crude odd ratio COR 95% C.I	Adjusted odd ratioAOR95%C.I
	Yes	no		
Age category (n= 264)¹				
<35	66	65	1.35(0.83, 2.20)	1.22(0.70, 2.14)
>=35	77	56	1	1
Sex (n = 266)				
Male	98	83	1.0(0.60, 1.68)	1.03(0.61, 1.76)
Female	46	39	1	1
Perceived susceptibility (n= 266)				
Yes	36	10	5.61(2.65, 11.89)**	3.79(1.61, 8.92)*
No	86	134	1	1
Perceived severity (n = 265)¹				
Yes	58	61	1.25(0.77, 2.04)	0.65(0.36, 1.19)
No	63	83	1	1
Behavioral belief (n = 266)				
Good	106	99	3.01(1.6, 5.67)*	1.44(.65, 3.23)
Bad	16	45	1	1
Evaluation of consequence(n=266)				
Desirable	114	114	3.75(1.65, 8.53)**	1.87(.69, 5.08)
Undesirable	8	30	1	1
Normative belief (n = 266)				
Yes	81	34	6.39(3.73, 10.94)**	3.01(1.48, 6.11)*
No	41	110	1	1
Motivation to comply (n = 266)				
Yes	71	31	5.08(2.97, 8.67)**	1.35(0.64, 2.84)
No	51	118	1	1
Control belief (n = 266)				
No	64	44	2.51(1.52, 4.14)**	1.38(0.76, 2.53)
Yes	58	100	1	1
Power of control (n = 266)				
High	55	16	6.57(3.5, 12.33)**	3.81(1.84, 7.89)*
Low	67	128	1	1

*1= sample size vary due to non response. **significant at p<0.001, *significant at p< 0.01*

6. Discussion

HIV counseling and testing service is a very important component of HIV/AIDS prevention. The proportion of teachers who had been tested for HIV was 46.3% (54.8% for female, 41.1% for male). This figure is in conformity with the proportion of tested armed force which is 46.9% (20). But it is better when compared to the finding of 2005 HIV behavioral surveillance survey of Ethiopia suggesting a two fold increase in utilizing HCT service. It is also relatively better than proportion of HIV tested teacher of Tanzania i.e 46.3% versus 20% (9, 15). Of all tested individual the majority (61.3%) of them were tested one year prior to the present study. These could be due to the introduction of provider initiated counseling and testing (PIHCT) service at the end of 2005 and launching of Millennium AIDS campaign for Ethiopia (MAC-E) in the late 2006 which lasts for a year. Both PIHCT and MAC-E increased the uptake of HCT service substantially (8).

Interestingly another important finding in this study was the differential in sex and age. Female were more likely to be tested for HIV than their counterpart. This is in line with the 2008 HIV/AIDS Ethiopian epidemiological synthesis and study conducted in Butajira (8, 18)). This finding could be explained by the fact that women in the reproductive age group are offered the HCT service while they visit health facility for antenatal checkup (37).

Being age less than 35 years was positively associated with the utilization of HCT. The HIV prevalence in Ethiopia is higher among 15-24 year age group (4).

Therefore individual who falls in this category might be more eager to know their HIV sero-status than older age group. Besides this, young individuals are more likely to be tested for HIV before marriage. Different study conducted in Ethiopia and other African country support this finding. One study conducted in Gonder reported high acceptance for HCT among 15-19 age group (10). Another study in Gurage zone reported that the vast majority of VCT clients were younger age group of 15-29 years and their main reason was for pre-marital testing (16). Prospective study in Zimbabwe revealed those who are in the age group less than 35 years were found to be predictors of testing. Similarly the study conducted among Tanzanian teachers has showed those who were age between 21 and 30 years were more likely to have been voluntarily tested for HIV (14-15). These indicate that being younger age group was predictor for HIV testing.

Although being female and age less than 35 years were more likely to have had HIV testing, this association was not demonstrated in the intention to have HCT. The tested group might be characteristically different from the untested group which could be the reason.

The major source of HCT information identified was mass media. According to this study 98.6% of respondents heard the availability of HCT service which is comparable with the finding from pre-marital HIV utilization study in Addis Ababa (22). But it is higher than the result obtained for community based study in northwest Ethiopia which is 73.5% (23).

In the present study the vast majority of the respondent 489(98.4%) know the existence of confidential HCT service in their locality. This is by far higher than the 45.4% finding of 2005BSS-E (9). It is also higher than the finding of study done on high-school teachers of Addis Ababa in 2004, where 72.6% knew the existence of the service (17). This could be explained by the accelerated expansion of the HCT service done in recent years through increased advocacy and social mobilization of the existence of service (8). At least 60% of them mentioned the existence of service in the government hospital and/or Family Guidance Association clinics. Although all health center in the region provide the service, only about quarter (26.2%) of the teachers knew the existence of the service in the health center suggesting that the existence of HCT service in the health center was not known by the majority of the respondents.

In this study Knowing about HCT was not significantly associated with utilization of HCT. This is in line with other study that showed knowledge about HIV/AIDS does not necessarily guarantee behavioral change (9, 17-18 and 21-22).

Behavioral intention tells us the likelihood of the person to engage in given behavior (in this study behavior is testing for HIV). Based on previous study done in the same study area the proportion of individual who have intention to be tested was between 85.4 and 69.9% for general community and lactating mothers respectively (24, 26). However this was not the case in the present study the intention to engage in similar behavior was lower (45.9%) than previous studies. Similar result was also reported by the study conducted in northwest Ethiopia which showed high-school teachers' lower acceptance for VCT than other professionals (10).

Previous studies have used the TRA and TPB to predict the intention to perform certain behavior. For example, the Study conducted to predict intention to use condom among Ghanaian university students using TRA; and the study conducted among Tanzanian high-school students using TPB showed that the theories were explainable to 33% and 42% of variances in students' intention to perform the behavior respectively (33-34). Another study conducted on Tanzanian teachers also reported that 30% of variance in intention was explained by TPB (25). The study conducted in rural Ethiopia to predict intention to use condom using TPB demonstrated that the TPB components along with descriptive norm was able to explain 36% of variance in intention to use condom (30). Another study conducted in female adolescent in Ethiopia showed that this theory to explain 29% of variance in their intention to use contraceptives (31). In this study, the TPB components (i.e attitude, subjective norm and perceived behavioral control) explained 31.5% of variance in intention to use HCT which is in conformity with previous studies conducted in Africa including Ethiopia.

From standardized regression coefficient, the result of this study indicate that teachers' intention to use HCT services was primarily due to subjective norms and their perceived behavioral control while attitude has less weight but still being significant predictor. This finding tells us that teachers' intention to use HCT depend on how they perceived the significant others think them to use HCT service as normative action and perceived easy or difficulty associated with the use of HCT service. Though it has less weight, the belief they held in term of advantage and disadvantages associated with the use of HCT service are also important.

The founder of the theory pointed out that, the relative importance of attitude, subjective norm and perceived behavioral control in the prediction of intention is expected to vary across behavior and situation (28). Study among rural Ethiopian have shown attitude to be more important predictors of intention than the other components. Another study focusing on contraceptive use had shown that subjective norms were more important predictors (30-31). There were also studies that showed perceived behavioral control as the most significant predictors (25, 34). In this study subjective norms were more important predictors than the other component of TPB which indicate that significant others have great role to play in the use HCT service. Therefore in order to promote the use of HCT service among teachers attention should be paid to the significant other such as partner, other family member, friends and religious leader. Beside this enhancing perception of control so as to strengthen intention to use HCT also need to be addressed.

The addition of other variable was shown to increase the predictive utility of the model in the previous study (25, 30 and 34). In this study perceived susceptibility was added and found that it contributed significantly to the explained variance in intention to use HCT service. But the addition of perceived severity did not contribute significantly to the explained variance. Using multiple items for each scale is recommended to reduce measurement error and to increases the probability of including all relative components of each construct (38). In current study perceived susceptibility was measured only by one item. Hence it was prone to measurement error.

Review of the health belief model studies indicated that perceived susceptibility was strong predictors of preventive health behavior while perceived severity was the least powerful predictors (38). This study also finds the perceived susceptibility as predictor of intention to use HCT service while perceived severity did not.

To assess which salient belief are strong predictors of intention, binary logistic regression analysis was performed. Unlike community based study conducted earlier in Harar town which found the salient belief about the benefit of having VCT as predictors of intention, in this study belief about the advantage of using HCT service and the evaluation of the consequence was not found to be predictors of intention (24).

The study conducted among different professional revealed the importance of significant other as reinforcing factors toward the acceptance of VCT (10). Similarly in this study normative belief was found to be strong predictors of intention to use HCT service. Normative belief generally focus on what an individual believes other people, especially influential people, expect him or her to do. However, in this study motivation to comply with the expected norm was not different among intender and non intender. This implies that when planning any program targeting the uptake of HCT service among teachers, it would be helpful to target and enhance teachers' perception that their significant referents consider it appropriate for them to be tested for HIV rather than convincing them to comply with the wishes or advice of their referents.

The power of control was found to be predictor of intention to be tested for HIV. This implies that the following condition from which control belief was computed:

fear of hearing positive result, fear of disclosing positive result to other, fear of stigma related to HIV, suspecting about confidentiality were powerful in inhibiting individual decision to be tested for HIV. Therefore, when planning any program targeting the uptake of HCT service among teachers it is important to reduce the social and psychological barrier related to the use of the service.

7. Strength and limitation of this study

7.1 Strength

- ♣ The study used the theory that outlines how to measure the components explicitly.

- ♣ It used the pre-tested self administered questionnaire which reduces facilitators' bias.

- ♣ It has reproducible result in different context.

7.2 Limitation

- ♣ The study employed cross sectional study design therefore whether teachers intention is translated to actual use of behavior cannot be established from this study. It also has the other limitation of cross sectional survey.

- ♣ There were little control as how and when the questionnaire was completed which might affect the quality of information.

- ♣ The study was conducted in urban dominated area which can affect the generalizability of the finding from the study.

8. Conclusions

According to the finding of this study,

- ♣ Almost all respondents knew the existence of confidential HCT service in their locality. The majority of them mentioned the existence of service in the government hospital and FGAE clinics while the existence of service in health center was not known by the majority of them. The major source of HCT information was mass media.
- ♣ Large proportions of teachers have been tested for HIV which is more than two times that of BSS 2005. The majority of them were tested one year prior to the data collection indicating that uptake of HCT has increased.
- ♣ Being female or age below 35years was significantly more likely to have had HIV testing.
- ♣ The theoretical components of TPB provide fairly accurate description of intention formation process of HCT use among teachers of Harari region.
- ♣ TPB was applicable in predicting intention to use HCT. This call for the importance of normative expectation of others, perceived psychological constraint and the belief in terms of advantage and disadvantage held with the use of HCT.
- ♣ The inclusion of perceived susceptibility into the regression equation though marginally has increased the explained variance significantly.

9. Recommendation

- ♣ The intervention to increase the uptake of HCT among teachers should focus on developing teachers' ability to resist norm that oppose the use of HCT and change community held norms against HCT.
- ♣ In order to promote HCT among teachers attention should also be paid in enhancing perception of control so as to strengthen behavioral intention.
- ♣ There should be awareness creation for teachers on the existence of HCT service in the health centers in the region through educational radio program.
- ♣ HCT related message should capitalize on the susceptibility of every citizen since the epidemic can affect anyone and therefore it is necessary to promote the utilization of HIV.
- ♣ Further studies, with more representative sample as well as employing elicitation phase and using prospective approach are needed to be conducted in Ethiopian context to know whether intention is translated to actual behavior.

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Annex I
General information

**Assessment of predictors of intention to use HIV counseling and testing services
among teachers of Harari Region**

Dear teacher,

My name is Shemsedin Omer. I am a master of public Health student at Addis Ababa University, Faculty of Medicine, School of Public Health. I am here to study the practice of HIV counseling and testing (HCT) and predictors of intention to use it among school teachers and you are chosen to participate in this study. The choice was done randomly. The purpose of this study is to generate behavioral information necessary for the development of appropriate and possible work place intervention.

In order to attain this goal, I request your honest and genuine participation. I will provide you a questionnaire containing several intimate and private life questions concerning the study. There is no need to put your name on the questionnaire. No individual response will be passed to a third person; it is used only for the purpose of this study. It is your full right not to participate, to discontinue or to participate in the study. If you do not like to participate you are not obliged to fill the questionnaire. There will be no negative impact on you whatever your decision is. But your honest participation will have contribution to generate information that can be used in the fight against HIV/AIDS pandemic. So, please take a few minute to answer the questionnaire. If you have question or complaints don't hesitate to ask me using my private address.

Shemsedin Omer

Tele: 0911712777

Mail: shemsu_o2006@yahoo.com

If you wish to participate in this please indicate your willingness by ticking the following options and fill the consent form in the next page.

Yes I want to participate

No, I do not want to participate

Annex II
Consent form

I the undersigned have read and understood that the purpose of this particular research project is to find out predictors of intention to use HIV counseling and testing among teachers. I have been informed that the information I give will be used only for the purpose of this study; my identity, the information I give will be treated confidentially. I have also been informed that I can refuse to participate in the study, not to respond to question I am not interested or stop responding to question at any time in the process. Based on the above information I agree to participate in the research voluntarily.

Signature of the participant: _____

Date: _____

Annex III. English version questionnaire

PART I. Socio demographic Characteristics

Number	Question	Coding categories	Skip to
101	Sex	Male..... 0 Female.....1	
102	Age in complete years	_____	
103	What is your current marital Status? (circle the response)	Single..... 1 Married.....2 Divorced.....3 Widowed..... 4 Separated..... 5	
104	Educational status	12+1/10+1..... 1 Diploma.....2 First degree.....3 Second degree.....4	
105	What is your religion?	Islam.....1 Orthodox Christian.....2 Catholic Christian.....3 Protestant Christian.....4 Others (specify)5	
106	Ethnicity	Oromo.....1 Harari.....2 Amhara.....3 Guragae.....4 Tigre.....5 Others (specify).....6	
107	Occupation	Primary school teacher.....1 Secondary school teacher...2 Preparatory school teacher...3	
108	Total Monthly income	_____ Eth. Birr	
109	Location of your schools	Urban..... 1 Semi urban.....2	

Part II. Sexual history, Knowledge and practice of HIV counseling and testing . read the question carefully and circle the number of your choice.

Number	Question	Coding categories	Skip to
201	Have you ever had sexual intercourse	Yes.....1 No2	If 2 skip to Q 204
202	Have you had sex in the past 12 months	Yes..... .1 No2	If 2 skip to Q 204
203	How many sexual partners did you have in the last 12 months	One.....1 More than one.....2	
204	Have you ever heard of HIV counseling and testing?	Yes..... 1 No 2	If 2 Skip to Q
205	From where did you hear? (more than one answer is possible)	From health professionals.....1 From mass media.....2 From friends..... 3 From sexual partner.....4 Others (specify)_____ 5	
206	Do you know from where you can get confidential HIV counseling and testing?	Yes.....1 No.....2	
207	Which facilities do you know that provide HIV counseling and testing services?	Gov. Hospital..... .1 Health center.....2 FGAE clinic.....3 Private clinic4 Others(specify).....5	
208	Have you ever tested for HIV?	Yes.....1 No.....2	If no skip to Q 300
209	When did you get tested?	The last three months.....1 The last 12 months.....2 Before 2 years.....3	

Remark:

- ✓ **Those of you who have been tested before you have completed the questions intended for you**

The following questions are only for those who did not tested for HIV

Part III. The following questions ask you your belief about the likely outcome of using VCT services and the evaluation of the outcomes; make a tick () in the box provided according to your degree of agreement to the statement.

Using VCT services in the coming two months is likely to:		Strongly Agree	Agree	neutral	Disagree	strongly disagree
300.1	Decreases my chance of HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300.2	Help me not transmit the HIV virus to my partner if I found to be positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300.3	Result in happy life if my result is negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300.4	Help me to plan for my future life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300.5	Improve the trust b/n me and my partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300.6	Help me to seek timely the ART services if my test result is positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you evaluate using HCT in the coming two months?		very good	good	neutral	bad	very bad
301.1	For me knowing that I am HIV negative is...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
301.2	For me knowing that I am HIV positive & Safeguarding my partner to acquire infection from me is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
301.3	For me knowing that I am HIV negative and lead happy life is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
301.4	For me knowing my HIV status and planning my future life is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

301.5	For me knowing my HIV status and Improving the trust b/n me and my partner is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
301.6	My being HIV infected and starting ART early is..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part IV. The following questions ask your beliefs about the normative expectation of others and your motivation to comply with their expectation. Please read the question carefully and Make a tick () in the box provided according to your degree of agreement to the statement.

The following individual would approve my getting tested for HIV in the next two months		Strongly Agree	Agree	neutral	Disagree	strongly disagree
400.1	My spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.2	My close friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.3	My fellow teachers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.4	My relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.5	My children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.6	My religious leader	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
“I would like to do what.....”		Strongly Agree	Agree	neutral	Disagree	strongly disagree
401.1	My spouse/partner think that I should	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.2	My close friend(s) think that I should	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.3	My fellow teachers think that I should	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.4	My relatives think that I should	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.5	My children think that I should	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.6	My religious leader think that I should	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part V. The following questions ask your beliefs about the presence of factors that may facilitate or impedes the use VCT services and the perceived power of these factors.

Please read the question carefully and Make a tick () in the box provided according to your degree of agreement to the statement.

It will be difficult for me to be tested for HIV in the coming 2 month...		Very likely	likely	neutral	somewhat unlikely	not likely at all
500.1	If my spouse do not want me to be tested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
500.2	Because I fear to hear HIV positive result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
500.3	Because I fear to be stigmatized if my result is positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
500.4	B/c I doubt the counselor might disclose my result to other person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
500.5	Because disclosing HIV positive result will be difficult for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will be tested for HIV in the coming two months even if...		completely certain	certain	neutral	uncertain	completely uncertain
501.1	my spouse do not want me to be tested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.2	I fear to hear HIV positive result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.3	There is possibility of stigmatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.4	I am in doubt that the counselor might not keep my result confidentially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.5	I know it will be difficult for me to disclose my result if I am tested positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part VI. The following question asks you about your intention of using HIV counseling and testing in the coming two months. Please read the question carefully and Make a tick () in the box that best describe your opinion.

In the coming two months...		Very likely	likely	neutral	somewhat unlikely	not likely at all
600	How likely you intend to be tested?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
601	How likely you look for and request The HIV counseling and testing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
602	How likely you accept HIV counseling and testing services if you visit health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part VII Perceived susceptibility and severity of HIV/AIDS

700		Strongly Agree	Agree	neutral	Disagree	strongly disagree
700.1	I feel that it is likely for me to get HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
700.2	If I get infected with HIV/AIDS I will definitely die consequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
700.3	I would rather have any terminal illness than AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you so much for your cooperation in filling this questionnaire!!!

Annex IV Amharic version questionnaires

የመምህራን የኤች አይ ቪ/ኤድስ የምክርና የደም ምርመራ አጠቃቀምና ለወደፊት ለመመርመር ያላቸው ፍላጎትን የሚወስኑ ነገሮችን ለማወቅ የተዘጋጀ በመምህራን የሚሞላ መጠይቅ።

የተከበሩ መምህር/(ት)፤ እንደምን አደሩ/(ዋሉ)? እኔ በአዲስ አበባ ዩኒቨርሲቲ ህክምና ፋካሊቲ የሕብረተሰብ ጤና ት/ቤት የሁለተኛ ዲግሪ ተማሪ ነኝ። የዚህ ጥናት አላማ የመምህራን የኤች አይ ቪ/ኤድስ የምክርና የደም ምርመራ አጠቃቀምና ለወደፊት ለመመርመር ያላቸውን ፍላጎት በማጥናት ጠቃሚ መረጃን ሰብስቦ ለወደፊት አግባብ ያለው ትግበራ ለመንደፍ እንድረዳ ሲሆን እርሶም የተመረጡት በዕጣ/በአጋጣሚ ነው።

መጠይቁ የተለያዩ ሚስጥራዊና የግል ህይወትዎን የተመለከቱ ጥያቄዎችን ያካተተ ነው። የጥናቱን አላማ ለማሳካት እርስዎ ለጥያቄዎቹ የሚሰጡት ትክክለኛና ቀና መልስ ወሳኝ ሚና አለው። በመጠይቁ ላይ ስምም ሆነ ሌሎች የእርስዎን ማንነት የሚገልፅ ነገር አይጻፍም። የግል ምላሽ ሪፖርት የማይደረግ መሆኑን ከወዲሁ እንገልጻለን። መጠይቁን የሚሞሉት እርሶ ፍቃደኛ ስሆኑ ብቻ ነው። መጠይቁን ለመሙላት ፍቃደኛ ከሆኑ በኋላም ቢሆን መመለስ ያልፈለጉትን ጥያቄ አለመመለስ መብቶ ነው። ነገር ግን ሁሉም ጥያቄዎች ካልተሞሉ የጥናቱን አላማ ሙሉ በሙሉ ለማሳካት አስቸጋሪ ስለሚሆን መጠይቁን በሙሉ እንድሞሉልን በማክበር እንጠይቃለን ። ጥናቱ ላይ ላለመሳተፍ በመወሰንዎ ወይም በማቋረጥዎ ምንም የሚደርስበት ጉዳት የለም።

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት?

- 1. () አዎ
- 2. () አይደለሁም

አመሰግናለሁ

ማስታወሻ: በጥናቱ ለመሳተፍ ፍቃደኛ ከሆኑ በሚቀጥለው ገፅ ወዳለው የስምምነት ማረጋገጫ ቅፅ ይላፉ።

የስምምነት ማረጋገጫ ቅፅ

ከታች ፊርማዎን ያኖርኩት የጥናቱን አላማ አንብቤ በሚገባ ተረድቻለሁ። እኔ የምሰጠው መረጃ ለዚህ ጥናት አገልግሎት ብቻ የሚውል መሆኑንና በሚስጥር እንደሚጠበቅ እንዲሁም ማንነቴ እንደማይገለጽ ተነግሮኛል። በተጨማሪም በጥናቱ መሳተፍ አለመሳተፍ ወይም በማንኛውም ጊዜ ከጥናቱ ተሳታፊነት አቋርጬ መውጣት እንደምችል ሙሉ መብት እንዳለኝ ተረድቻለሁ። ስለዚህ ይህን መጠይቅ ለመሙላት ፍቃደኛ መሆኔን በፊርማዬ አረጋግጣለሁ፡

ፊርማ _____

ቀን _____

ክፍል አንድ፡ ማህበራዊና ዲሞክራሲያዊ ሁኔታዎች፡፡ መልስዎን ቁጥሮችን በማክበብ ይግለጹ

ቁጥር	ጥያቄ	መለያ ቁጥሮች	እለፍ/ፊ
101	ጾታ	ወንድ 0 ሴት1	
102	ዕድሜ	_____ ዓመት	
103	በአሁኑ ጊዜ የጋብቻ ሁኔታ	ያላገባ/ች..... 1 ያገባ/ች.....2 የተፋታ/ች.....3 ባል/ሚስት የሞተባት.....4 የተለያዩ.....5	
104	የትምህርት ሁኔታ	12+1/10+1.....1 ዲፕሎማ.....2 የመጀመሪያ ድግሪ.....3 የሁለተኛ ድግሪ..... 4	
105	ሐይማኖት	እስላም.....1 ኦርቶዶክስ ክሪስቲያን.....2 ፕሮቴስታንት ክሪስቲያን.....3 ካቶሊክ ክሪስቲያን.....4 ሌላ(ይግለጹ)5	
106	ብሔረሰብ	ኦሮሞ..... 1 ሐረሪ.....2 አማራ.....3 ጉራጌ..... 4 ትግሬ.....5 ሌላ(ይግለጹ)..... 6	
107	የሥራ ሁኔታ	የመጀመሪያ ደረጃ መምህር.....1 የሁለተኛ ደረጃ መምህር.....2 የፕሪፓራቶሪ መምህር3	
108	አጠቃላይ ወርሃዊ ገቢዎ	_____ ብር	
109	የት/ ቤቱ አድራሻ	ከተማ..... 1 ገጠር.....2	

ክፍል ሁለት፤ ስለኤች አይ ቪ/ኤድስ የምክርና የደም ምርመራ አገልግሎት እውቀትና አጠቃቀም

ቁጥር	ጥያቄ	መለያ ቁጥሮች	እለፍ/አለፊ
201	የግብረ ስጋ ግንኙነት አድረገው ያውቃሉን? (ያላገቡትን ብቻ ይመለከታል)	አዎን.....1 የለም.....2	መልሱ የለም ከሆነ ወደ ጥያቄ 204 ይለፉ
202	ባለፉት 12 ወራት ውስጥ የግብረ ስጋ ግንኙነት ፈፀመዋል?	አዎን.....1 የለም.....2	
203	ባለፉት 12 ወራት ውስጥ ስንት የወሲብ አልጋ የተጋሩት ጓደኛ ነበሮት?	አንድ.....1 ከአንድ በላይ.....2 ምንም አልነበረኝም.....3	
204	ስለ ኤች አይ ቪ/ኤድስ የደም ምርመራ ስምተው ያውቃሉን?	አዎን ስምቻለው..... 1 አልሰማሁም.....2	መልሱ አልሰማሁም ከሆነ ወደ ጥያቄ 208 ይለፉ
205	ከየት ነው የሰሙት? (ከአንድ በላይ መልስ መመለስ ይቻላል)	ከጤና ባለሙያ.....1 ከብዙሃን መገናኛ.....2 ከጓደኛ.....3 ከወስብ ጓደኛ.....4 ሌላ ካለ(ይግለጹ).....5	
206	የኤች አይ ቪ/ኤድስ የምክርና የደም ምርመራ አገልግሎት የሚሰጥበት ቦታዎችን ያውቃሉ ?	አዎን አውቃለሁ.....1 አላውቅም.....2	መልሱ አላውቅም ከሆነ ወደ ጥያቄ 208 ይለፉ
207	በአካባቢዎ የኤች አይ ቪ/ኤድስ የምክርና የደም ምርመራ አገልግሎት የሚሰጠው የትኛው ተቋም ነው ?	የመንግስት ሆስፒታል.....1 ጤና ጣቢያ.....2 የቤተሰብ መምሪያ ክሊኒክ.....3 የግል ክሊኒክ4 ሌላ ካለ(ይግለጹ)..... 5	
208	የኤች አይ ቪ/ኤድስ የደም ምርመራ አድርገው ያውቃሉን?	አዎን.....1 አላደረሁም.....2	መልሱ አላደረሁም ከሆነ ወደ ጥያቄ 300 ይለፉ
209	መቼ ነበር የተመረመሩት?	ባለፉት ሶስት ወራት.....1 ባለፉት 12 ወራት.....2 ከሁለት ዓመት በፍት.....3	

መግለጫ:-

- ክፍል ሦስት ቀጥሎ ያሉትን ጥያቄዎች ምላሽ መስጠት ያለባቸው ከዚህ በፊት ተመርምረው የማያውቁ ግለሰቦች ብቻ ናቸው።
- ክፍል ሦስት፣ አራት እና አምስት ውስጥ ያሉት ጥያቄዎች ምንም እንኳ ብመሳሰሉም አንድ አይደሉም። ከላይ የተጠቀሱትን ክፍሎች ከመሙላትም በፊት ጥያቄዎቹን ሙሉ በሙሉ ያንብቡ።

ክፍል ሦስት: ከዚህ በመቀጠል በፊቃደኝነት ላይ የተመሰረተ የደም ምርመራ ማድረግ ሊጠቅመኝ ይችላል ብለው የሚያስቡትን ነገሮች ለማወቅ የተሰጡ መጠይቆች ሲኖሩ እነዚህን መጠይቆች የርሶን በፊቃደኝነት ላይ የተመሰረተ የኤች አይ ቪ ቫይረስ የደም ምርመራ በሚቀጥሉት ሁለት ወራት ውስጥ ለማድረግና ላለማድረግ ያሉትን ፍቃደኝነት ለማወቅ ይረዳል። ስለዚህ መጠይቆቹን በመንተራስ በተቀመጡት ሳጥን አቅጣጫ ያሉትን ምርመራዎች በማየት የርሶን አስተሳሰብ የሚወክለው ሳጥን ውስጥ የራይት() ምልክት ያስቀምጡ።

በሚቀጥሉት ሁለት ወራት የኤች አይ ቪ/ኤድስ የደም ምርመራ ባደርግ ለሚከተሉት ይጠቅመኛል ብዬ አስባለሁ		በጣም እስማማለሁ	እስማማለሁ	ገለልተኛ	አልስማማም	በጭራሽ አልስማማም
300.1	የኤች አይ ቪ ቫይረሱ በደሜ ውስጥ ባይገኝ ለወደፊት የመያዝ አጋጣሚን ይቀንስልኛል ብዬ አስባለሁ					
300.2	የኤች አይ ቪ ቫይረሱ በደሜ ውስጥ ቢገኝ ወደ ጓደኛዬ እንዳላስተላልፍ ይረዳኛል ብዬ አስባለሁ					
300.3	የኤች አይ ቪ ቫይረሱ በደሜ ውስጥ ባይገኝ ደስተኛ ኑሮ እንድኖረኝ ይረዳኛል ብዬ አስባለሁ					
300.4	በኔና በባለቤቴ/በፍቅር ጓደኛዬ መተማመንን ያመጣል ብዬ አስባለሁ					
300.5	የወደፊት ሕይወቴን በዕቅድ እንድመራ ያስችለኛል ብዬ አስባለሁ					
300.6	የኤች አይ ቪ ቫይረስ በደሜ ውስጥ ቢገኝብኝ በጊዜ የፀረ ኤች አይ ቪ/ኤድስ መድሃኒት እንድጀምር ያስችለኛል ብዬ አስባለሁ					

በሚቀጥሉት ሁለት ወራት የኤች አይ ቪ/ኤድስ የደም ምርመራ በማድረግ የሚከተለው ጥቅም/ጉዳቱን እንዴት ያዩታል	በጣም ጥሩ ነው	ጥሩ ነው	ጥሩም መጥፎ አይደለም	መጥፎ ነው	በጣም መጥፎ ነው
301.1 በኤች አይ ቪ/ኤድስ የመያዝ አጋጣሚን ከመቀነስ ጥቅም አንፃር					
301.2 ቫይረሱን ለሌላ ሰው አንዳይተላልፊ ከማድረግ ጥቅም አንፃር					
301.3 ቫይረሱ በደምት ውስጥ ባይገኝ ከሚሰጠት ጥቅም አንፃር					
301.4 በእርሶና በባለቤቶቻችን/እኛችን መካከል ያለውን የመተማመን ሁኔታ ከመለወጥ አንፃር					
301.5 የወደፊት ሕይወትዎን በዕቅድ እንደመሩ ከማስቻል ጥቅም አንፃር					
301.6 የኤች አይ ቪ ቫይረስ በደምዎት ውስጥ ብገኝ በጊዜ የፀረ ኤች አይ ቪ/ኤድስ መድሃኒት እንድጀምሩ የማስቻል ጥቅም አንፃር					

ክፍል 4፤ ከዚህ በመቀጠል ለርሶ ቅርብ የሆኑት ሰዎች እንድፈሰሱት ከሚጠብቁት ነገሮችና የማበረታቻ ሐሳብ ናቸው ተብለው የሚታሰቡ መጠይቆች ተቀምጠዋል።ጥያቄዎችን በጥሞና ካነበቡ በኋላ የእርሶን የስምምነት ደረጃ የሚያሳይ ሳጥን ውስጥ የራይት() ምልክት ያስቀምጡ።።

“ከዚህ በታች የተዘረዘሩት ሰዎች በሚቀጥሉት 2 ወራት ውስጥ የኤች ኤይ ቪ የደም ምርመራ እንዳደርግ ያስባሉ”		በጣም እስማማለሁ	ገለልተኛ አልስማማም	በጭራሽ አልስማማም
400.1	ባለቤቴ/የወሲብ ጓደኛዬ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.2	የቅርብ ጓደኞቼ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.3	የስራ ባልደረቦቼ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.4	የስጋ ዘመዶቼ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.5	ልጆቼ/ተማሪዎቼ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
400.6	የሃይማኖት መሪ/አባቴ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
እርስዎ የሚከተሉት ሰዎች የሚጠብቁበትን ይሰራሉ ብንል ምን ያህል ይስማማሉ		በጣም እስማማለሁ	ገለልተኛ አልስማማም	በጭራሽ አልስማማም
401.1	ባለቤት/የወሲብ ጓደኛዎ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.2	የቅርብ ጓደኞችዎ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.3	የስራ ባልደረቦችዎ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.4	የስጋ ዘመዶችዎ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.5	ልጆችዎ/ተማሪዎ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
401.6	የሃይማኖት መሪ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ክፍል 5፤ ከዚህ በመቀጠል እርሶ በፊቃደኝነት ላይ የተመሰረተ የደም ምርመራ አገልግሎት ተጠቃሚ እንዲሆኑ ሊያበረታቱ ወይም እንቅፋት ሊሆኑ ይችላሉ የተባሉ ሐሳቦች ተቀምጠዋል። ጥያቄዎችን በጥሞና ካነበቡ በኋላ የእርሶን የስምምነት ደረጃ የሚያሳይ ሳጥን ውስጥ የራይት() ምልክት ያስቀምጡ።

በሚቀጥሉት 2 ወራት የኤች ኤይ ቪ የደም ምርመራ ለማድረግ መወሰኑ ያስቸግረኛል		በጣም እስማማለሁ	ገለልተኛ	አልስማማም	በጭራሽ አልስማማም	
500.1	ባለቤቴ/የወሰኑ ባለቤት ማመርመሪያን ካልፈለጉ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
500.2	ምክንያቱም ቫይረሱ በደም ውስጥ አለ የሚለውን ውጤት መስማት ስለምፈራ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
500.3	ምክንያቱም ማግለልና መድሎን ስለምፈራ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
500.4	ምክንያቱም የምክርና ምርመራ ሰጭ ባለሙያ ውጤቴን ለሌላ ሰው ልናገር ይችላል የሚል ስጋት ስላለኝ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
500.5	ቫይረሱ በደም ውስጥ አለ ብዛል ውጤቴን ለሌላ ሰው መናገር ስለምፈራ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
በሚቀጥሉት 2 ወራት የኤች ኤይ ቪ የደም ምርመራ ማድረግን ምን ያህል እርግጠኛ ኖት?		በጣም እርግጠኛ ነኝ	እርግጠኛ ነኝ	ገለልተኛ	እርግጠኛ አይደለሁም	በጭራሽ እርግጠኛ አይደለሁም
501.1	ባለቤጉ/የወስኑ ባለቤት ማመርመሪያን ባይደግፉ እንኳን	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.2	ቫይረሱ በደም ውስጥ አለ የሚለውን ውጤት መስማት ብያስፈራዎትም	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.3	መገለልና መድሎ ሊገጥምዎት እንደምችል ቢያውቁ እንኳን	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.4	ምስጥሪዎ ልጠበቅልዎት ባይችል እንኳን	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
501.5	ቫይረሱ በደም ውስጥ ቢገኝ ለሌላ ሰው ለመናገር ብያስፈራዎት እንኳን	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ክፍል 6 ከዚህ በመቀጠል ደግሞ እርሶ በሚቀጥሉት ሁለት ወራት ውስጥ ለኤች አይ ቪ/ኤድስ የደም ምርመራ የማድረግ ፍላጎት ያሳያሉ የተባሉ መጠይቆች ተቀምጧል። ጥያቄዎችን በጥሞና ካነበቡ በኋላ የእርሶን የስምምነት ደረጃ የሚያሳይ ሳጥን ውስጥ የራይት() ምልክት ያደርጉት።

በሚቀጥሉት 2 ወራት ውስጥ ለኤች አይ ቪ ቫይረስ ...	በጣም አስባለሁ	አስባለሁ	ገለልተኛ	አላስብም	በጭራሽ አላስብም
600.1 ምን ያህል ለመመርመር ያስባሉ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
600.2 የ ኤች/አይ ቪ/ኤድስ የምክር አገልግሎት እና የደም ምርመራ ያለበት ጤና ተቋም ሂደ ለመጠቀም ምን ያህል ያስባሉ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
600.3 የጤና ተቋም ብትጎቦች እና ባለሙያዎ የ ኤች/አይ ቪ/ኤድስ የምክር አገልግሎት እና የደም ምርመራ እንድታደርጉ ብጠይቆት የአገልግሎቱ ተጠቃሚ ለመሆን ምን ያህል ዝግጁ ነኝ ብለው ያስባሉ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ክፍል 7. ከዚህ የሚከተሉት አረፍተ ነገሮች ስለኤች አይ ቪ/ኤድስ ተጋላጭነትና አስከፊነት ያሉትን አመለካከት ለመረዳት የሚጠቅም ስሆን የተሰጡትን አረፍተ ነገሮች ካነበቡ በኋላ የእርሶን አስተሳሰብ የምወክለው ሳጥን ውስጥ የራይት () ምልክት ያደርጉት።

	በጣም አስማማለሁ	አስማማለሁ	ገለልተኛ	አልስማማም	በጭራሽ አልስማማም
700.1 በኤች አይ ቪ/ኤድስ ለመያዝ የተጋለጥኩ ነኝ ብዬ አስባለሁ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
700.2 በኤች አይ ቪ/ኤድስ ከመያዝ ይልቅ በሌላ ገዳይ በሽታ ብያዝ እመርጣለሁ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
700.3 እኔ በኤች አይ ቪ/ኤድስ ከተያዝኩ ወድያውኑ የምሞት ይመስለኛል	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ጊዜዎን ወስደው መጠይቁን በመሙላት ስለተባበሩን ክልብ አመሰግናለሁ።

DECLARATION

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

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

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