

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

**AN EVALUATION OF COUNSELING SERVICES IN VCT
CENTERS IN GO AND NGO AT DIRA DAWA TOWN**

**BY
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**Addis Ababa University
School of Graduate Studies**

**An Evaluation of Counseling Services in VCT
Centers in GO and NGO at Dira Dawa Town
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List of Acronyms

ART	Anti- Retro-Viral Therapy
AIDS	Acquired Immune Deficiency Syndrome
CAPS	Center for AIDS Prevention Studies
CDC	Center for Disease Control
DPCD	Disease Prevention and control Department
FDRE	Federal Democratic Republic Ethiopia
FHI	Family Health International
HIV	Human Immune Deficiency Virus
IEC	Information, Education and Communication
MOH	Ministry of Health
NGO	Non-Governmental Organization
GO	Governmental Organization
WHO	World Health Organization
UNAIDS	Joint United Nation Program on AIDS
VCT	Voluntary Counseling and Testing
DDDIPO	Dire Dawa Development and Improvement Project Office
FGA	Family Guidance Association

ABSTRACT

HIV voluntary counseling and Testing (VCT) is becoming the based for HIV prevention, control and care programmes. Although, it is crucial for all AIDS projects, very little work has been done to evaluate the quality of VCT services especially by professional counselor. An evaluation of VCT services in Dire Dawa Town was conducted to assess client and counselor situation/satisfaction, the quality of the services and to identify major problems encountered in providing the services. A cross sectional survey was carried out using tools adapted from UNAIDS 2000a and literatures, consisting of questionnaire, semi structured interviews and observations were made on 2 VCT centers. Half of the clients and counselors of the study have positive attitude towards counseling. All counselors were not self motivated to be a counselor; training for counselors is not adequate and standardized. There is no professional counselor at all. There is no adequate space for privacy and waiting area. In GO VCT center, there is no waiting area at all. Major problems in the VCT centers are work load, on counselors, lack of experience, lack of adequate training, lack of incentives of additional work particularly in GO VCT centers, lack of adequate waiting area, limited number of VCT centers (only two), Lack of adequate waiting area and conducive office, etc. These and other problems led to inefficient counseling services. The study identified areas where adequate the standardized trainings needs for counselors and suggested ways of improving the services. Moreover, the outcome of this study also suggest that increased awareness raising and access for VCT, focusing the positive consequences of VCT as well as offering high quality VCT services for beneficiaries. If we keep the quality of the counseling services, the number of clients may be increased. And has great contribution to reduce the prevalence rate of HIV.

CHAPTER ONE

1. INTRODUCTION

1.1. Back Ground of the Study

HIV/AIDS is come as one of the worst epidemics ever faced by mankind. Mostly because of its nature of spread in relation to man kind's sexuality as well as the fact the no one is still capable of finding the effective cure/vaccine/ to overcome the problem.

More than 40 million people are identified as having this deadly virus in the world, out of that 68%of the world's total victims are found in Africa particularly in the sub-Saharan country (MOH, 2003) Ethiopia is one among countries with the highest level of infection in Africa. Ethiopia has a projected population of 77.4 million of which 15% lives in urban areas. There are 1.5 million peoples are living with HIV/AIDS, among these 96,000are children (MOH, 2004).

Though the proportion of urban population affected by HIV/AIDS is larger than the rural. All areas and regions of the country are affected by the epidemic. The national prevalence rate of the virus is 4.4%. There are also 1.2 million orphans because of HIV/AIDS in Ethiopia (FDRE MOH, 2003).

HIV/AIDS is spreading and expected to become the main causes of death among youth and middle age adults who are highly productive and reproductive members' of the society are.

The devastating effect of HIV/AIDS is getting more and more visible over time. More than 80% of adults living with HIV reside in sub-Saharan African countries where the epidemic still continuous in progress. In the global scale Ethiopia hosts the 3rd largest number of people living with HIV/AIDS (PLWHA) and ranks 16th in terms of prevalence rate in the year 2005 (FDRE MOH, 2003).

Especially the east, central and southern Africa (including Ethiopia and Burundi) accounted for more than 50% of the world's burden of HIV/AIDS. It is known that 12 of the 14 countries with the heaviest burden of HIV/AIDS are in this region. HIV/AIDS is the worst disaster ever to afflict the sub-region and this region has been the epicenter of the epidemic (UNAIDS, 2000b).

According to the FDRE MOH 2002 in Ethiopia the age groups between 20-49 years are mainly affected by this virus. This group is the most important group for both economic and parenting stand point. In this age group AIDS is now the leading cause of the death.

In our county (Ethiopia), the major mode of HIV transmission with heterosexual which accounts for 87% of infection, with another 10% of infection occur due to mother -to -child and transmission through unsafe blood transfusion and unsafe injection account for small percent of transmission (FDRE MOH, 2002).

As it is mentioned earlier, HIV/AIDS is one of the prominent global problems. The number of HIV/AIDS infected people is growing at an alarming rate. The rate of disseminating the virus is differ from country to country when we see the regional context within the country, it is clear that the prevalence rate is differ from region to region and it is found to be higher in urban than rural areas. Regions like Dire Dawa the problem is severe. The prevalence rate of the virus in the urban areas is 12.6% and 2.6% in rural areas (FDRE MOH, 2003).

Recognizing the seriousness of the problem and its high prevalence rate necessitates the implementation of multifaceted prevention activities and programs. One of such approaches is voluntary counseling and testing (VCT). The primary aim of VCT is to help people change their sexual behavior so as to avoid the transmission HIV to sexual partner and it can have in the prevention and control of HIV/AIDS, however, there are still many barriers to large scale

implementation VCT for effective implementation and uses are unknown. Knowledge of personal risk behavior and sero-stats is power (CDC, 2001).

HIV/AIDS counseling began in Ethiopia in the late 1980s with services expanding throughout the 1990s usually; counseling for HIV/AIDS is rendered in different situations. Voluntary HIV counseling and Testing (VCT) centers are among the major ones (FDRE MOH, 2002).

According to FDRE the definition of (2002) VCT is the process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for HIV. This process is also aimed at helping them to cope with stress and to make personal decisions related to HIV/AIDS.

The need for VCT is increasing as HIV infection rate continue to raise and countries recognize the need for their populations to know their serostatus as an important intervention tool. Those people who learn that they are seronegative can be empowered to remain HIV negative. For those HIV infected the development of less costly interventions to reduce mother-to-child transmission of HIV and HIV- associated infections takes on new importance. Further more, other medical and supportive care can help those living with HIV to live longer, healthier and prevent transmission to other.

In higher prevalence settings, many individuals tend to develop feeling of hopelessness, fear and helplessness and a sense that is too late for behavioral change. In these settings the power of positive behavioral change messages can be reinforced by effective and quality VCT services. In all settings, learning one's serostatus with prevention counseling can be powerful preventive and care strategy (CDC, 2001).

Many people with HIV in Ethiopia do not know they are infected; only a small percentage of those with HIV/AIDS have had access to reliable and quality VCT

services. As there is no cure for HIV/AIDS, VCT remains a key strategy to control the spread of HIV and to provide support to those who are positive (FDRE, MOH, 2002).

Additionally, as to UNAIDS (2000b) many approaches to HIV prevention and care require people to know their HIV status the importance of VCT in achieving this end has been acknowledged in the recent wider promotion and development of VCT services. VCT has paramount role in HIV prevention to help people make changes in their sexual behavior, so as to avoid transmitting HIV to sexual partners if positive, and to remain seronegative if they are negative. The other major role of VCT is in facilitating early and appropriate uptake of service for those people testing HIV positive and negative, including medical care, social and psychological support, legal advice and counseling for positive living. VCT is also essential if women and their families are to benefit from interventions to prevent mother-to-child transmission of HIV.

VCT is a corner stone for early access to prevention as well as care and support services. Higher public awareness of HIV, increasing number of person sick and dying with AIDS and knowledge of personal risk behaviors results in an increased desire to learn one's serostatus. The service is provided in VCT centers but whether the counseling services consistently have helped in accomplishing.

Therefore, VCT is an entry for many HIV/AIDS prevention, care and control program. In general, in Ethiopia in general and in regions like Dire Dawa in particular, in response to this critical problem, several intervention activities have been undertaken by government agencies, NGOs and other public centers with most intervening activities focused on VCT services.

To accomplish all the above tasks HIV/AIDS counseling is rendered in VCT centers. But whether the counseling services indeed serve the clients with

quality and effectively have not been studied with professional counselor or very little work has been done in Addis Ababa by others (non-counselor professionals).

Accordingly, the evaluation/ assessment of VCT services is relatively untouched area in Ethiopia particular in regions like Dire Dawa by researchers. Then, this study was initiated to assess the counseling services rendered in GO and NGO VCT centers in Dire Dawa town and it is hoped to draw valid conclusion regarding the effectiveness of counseling services offered in VCT Centers in the town, and recommend on points for improving the qualities of VCTs better service rendered to the clients.

1.2. Statement of the Problem

HIV/AIDS is recently becoming one of the most serious health, social, economic and political problems which created such as a wide spread fear and concern of national and governments of all countries of the world. Yet, there is no curative medicine for AIDS. The only real protection is to use information, education and counseling to influence the behavior of individuals or groups so as to curb the spread of HIV.

In countries many high prevalence, of countries VCT centers is not widely available and people are often afraid of knowing their serostatus because there is little care and support available following testing and also not effective/ low quality counseling services particularly in developing countries (FDRE, MOH 2003). Setting up VCT centers and ensuring qualities counseling services will increase demand.

Based on the above reasons, the research is designed to assess VCT counseling services offered by GO and NGO HIV/AIDS VCT centers in Dire Dawa town. Then, the study attempts to answers the following basic research questions:

1. Are VCT counseling services that are offered in VCT centers effective?
2. What are the limitations that affect effective counseling services and what should be the solutions to overcome such constraints?
3. How are VCT counselors selected? By whom?
4. Are the VCT counselors professional in counseling or are they other professionals with training in counseling?
5. Have VCT counselors' sufficient training to provide counseling services as its demands?
6. Do the VCT counselors apply the basic counseling skills
7. Do the VCT counselors get the necessary support and supervision?
8. Are the essential contents of pre- and post-test counseling sessions covered during counseling processes?
9. What kind of attitude do clients and counselors have towards VCT counseling services?
10. Is there any in service training for VCT counselors?
11. Is the physical organization of the counseling center conducive for effective counseling?
12. Is there a significance difference between the GO and NGO VCT centers in the services they rendered?

1.3. Objectives of the Study

1.3.1. General Objectives

The general objective of this study is to evaluate the counseling services offered in GO and NGO VCT centers of Dire Dawa town there by identify the problems encountered in rendering the services

1.3.2. Specific Objective

- To identify factors affecting the VCT centers in Dire Dawa town and suggest improvements needed to make the service more effective.
- To point out the weaknesses and strength of Dire Dawa VCT centers

- To examine the attitude of clients and counselors towards the VCT counseling services.
- To assess how VCT counselors are selected to handle the service.
- To evaluate the content coverage of pre-test and post-test counseling sessions.
- To investigate the supervision and support that provided to the counselors.
- To evaluate the counseling skill of VCT counselors.
- To explore about the nature and type of training given to the counselors.
- To investigate whether the VCT centers are physically conducive or not to provide VCT services.

1.4. Application of the Results/Significance of the Study

HIV/AIDS counseling in VCT centers has many roles in both prevention of HIV infection and care for AIDS cases. Thus, it is vital to assess the services that delivered in different counseling centers. Accordingly, this study is expected to have the following contributions:-

- It tries to highlight the role of VCT services in both aspects of prevention and care.
- It investigates the major problems encountered in provision of services in different centers and suggesting as to how the services will be more effective.
- It provides highlight on theoretical frameworks by indicating the extent to which counseling is utilized and integrated with the national HIV/AIDS counseling guide line.
- It will serve as one of the vital attempts to enhance the quality of counseling services in VCT centers
- It indicates the strength and weakness of VCT services Dire Dawa town for HIV/AIDS prevention and control programme office.

- It will give insight for GOs and NGOs as to have design their strategies to provide VCT services with the purpose for prevention control and care particularly for Dire Dawa town, Ethiopian in general.
- It serves as a starting point for interested group for further and in depth studies on the problem to come up better and viable solutions especially in region like Dire Dawa.

1.5. Delimitation of the Study

VCT services are given in all Regional states of Ethiopia. But the scope of this study is geographically delimited to the Dire Dawa Administrative council, because to manage the study easily and to investigate the problem deeply. Additionally, there was time and financial constrains to cover other regions. Hence, conclusion to be reached reflected what the situation looks like in the stated region in the study. The region was selected for this study because the researcher has background knowledge of the areas as the researcher was working in the area for years ago and the researcher has developed an interest to assess the status of VCT services in the town.

Additionally, the researcher selected VCT centers for the study with a rationale that VCT service is one of the most important strategies for prevention of HIV/AIDS. According to Federal Democratic Republic Ethiopia (FDRE) MOH (2003) VCT is becoming increasingly available in Ethiopia but many people are still reluctant to be tested. This may be because of the quality of the services. Therefore, the researcher developed, among other things a real concern for some of the counseling problems in VCT centers, which in time led to a decision to assess the situation at the VCT centers in Dire Dawa town.

1.6. Limitation of the Study

One of the limitations of the study is small sample size. In addition to this, due to shortage of reference materials related to the study, the researcher has been

forced to rely on certain foreign sources. Clients' lack of willingness to participate in the study was also another problem faced during data collection. In spite of these, the researcher has attempted to make the study as complete as possible.

1.7. Operational Definitions

Voluntary Counseling and Testing:- is the process by which an individual by his/her own initiative or voluntarily undergoes HIV/AIDS counseling and HIV testing.

Pre-test Counseling:- is an HIV/ AIDS counseling before someone has HIV tests.

Post-test counseling:- is an HIV/AIDS counseling after HIV-test result is made available.

Burnout:- refers to emotional exhaustion that results when a counselor has reached his/her limit to deal with HIV and its related emotional stress.

Confidentiality:- refers to the prevention of any reference to, or discussion about client or a test results.

HIV/AIDS counseling:- is a confidential dialogue between a client and a counselor to enable the person to cope with stress and to make personal decisions related to HIV.

Effective VCT Service:- contains adequate counseling room, waiting area, trained, professional counselor, supervisors, keeping confidentiality, covering major pre and post-test counseling session and the linkage of referral system.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. What is Counseling?

Various psychologists/counselors have described the word counseling in differently. It also defined differently based on its objective. According to McLead (1993) counseling and denotes a professional relationship between a trained counselors a client. This means a purposeful relationship in which one person helps another to help himself/herself. The relationship is designed to help clients to understand and clarify their view, and learn to reach their self-determined goal through meaningful, well informed choice and through resolution of problems of an emotional or inter personal relationship. It is also a helping people to find and use their own resources for coping with difficult resolutions.

It is generally defined as a direct source of help in enabling people to explore and understand their world more fully and therefore adopt more effectively. It is also a vehicle for making choice about others sources of direct help and treatment (Davis, 1994).

Edwin cited in Shertzer and Stone (1980) had defined counseling as a process by which client is helped to feel and behave in a more personally satisfying manner through interaction with the counselor, who provides information and reaction which stimulate the client to develop behavior that enable the client to deal more effectively with him/her self and his/her environment. Then, there are general definitions of counseling. However, it should be noted that the following are the key elements in the definitions:

- Its aimed at helping people to make choices and act on them.
- It is helping the person with the problem make sense of clarity his/her problem.

- It is getting the person with the problem accept the responsibility for the problem and the resolution.
- It usually leads to the resolution of the problem.

Similarly, according to Hoppock who is a well known career counselor (1967, cited by Yusuf, 1998), counseling is not:-

- Recruiting clients for occupation
- Diverting clients from occupation for which the counselor believes them to be qualified or of which he/she the counselor disapproves.
- Encourage the bright student to go to college and low students to go to work.
- Substituting the values, ideas, ambitions or judgment of the counselor for those of the client, no matter how strongly the counselor may feel that knows the best.
- Make decisions for the client or even to being to the point of decisions himself.

From these arguments we can understand that in counseling services, no one has the right to tell the clients what is best for them. Then, counseling is an interaction and process between a client and a counselor that takes place in private, through confidential dialogue. The basic ideas of the above explanations are:

- Counseling is a relation based on discussion. It should not be directly/ordering type of relationship rather it is through a two way dialogue that the client will arrive at solutions/decisions.
- It is non-judgmental relationship. That means accepting the client as he/she is without an attempt of value judgment by the counselor.

Patterns as cited in Shertzer and Stone (1980), has defined counseling by exclusion, or by designating what a thing is not. He said counseling not:

- Giving information, though information may be useful for counseling;
- Giving advice, suggestion or recommendation.
- Influencing attitudes, beliefs or behaviors by means of persuading leading/convincing, no matter how indirectly, subtly or painlessly.
- Influencing behavior by admonishing, warning threatening or compelling without the use of physical force/coercion.
- A personal work
- Selection and assignment of individuals of various job/activities.
- Interviewing although interview is an important tool in counseling.

Accordingly, one can understand on the above points, that no one has the right to tell clients what is best of them. So, the client has to decide what is good for him/her.

In addition Patterson further described the nature of counseling is to be found in the following characteristics:

- Counseling is concerned with influencing voluntary behavior change on the client/clients wants to change and seeks counselor's help to change.
- The purpose of counseling is to provide conditions which facilitate voluntary change (conditions like the individuals right to make choices, to be independent)
- As in all relationship limits are imposed on counselee.
- Conditions facilitating behavioral change are provided through interview.
- Listening is present in counseling but not all counseling is listening.
- The counselor understands clients qualitatively.
- Counseling is conducted in privacy and discussion is confidential.
- The counselor understands clients qualitatively.

From this point of discussion it is clear that counseling is an interaction and a process between client and a counselor that take place in private, through

confidential dialogue, through which clients/counsels are helped to define goals, make decisions and solve problems related to psychological, social, educational, personal, ... concerns.

2.2. The Purpose of Counseling

Hoppock as cited in Yusuf (1998), the main purpose of counseling is to help the client to know or recognize his/her own needs, values, to see how these affect the goals/visions that he/she seeks to reach, to identify these goals and to discover the possible courses of action which may bring him/her closer to the goals he/she wants and to anticipate as accurately as possible the results or each course of action in terms of his/her own goals.

In other words, Yusuf (1998), professional counselors agree that counseling provide relationship between the counselor and the client, the most prominent understanding and in the course of action open to the client; that counseling provides for some degree of intervention with the client's conditions and his/her relationship with significant others and provide leadership in developing a "health" psychological environment for his client.

Accordingly, the purposes and definitions of counseling presented above shows that counseling is "a therapeutic and growth process" through which individuals are helped to define goals, make decisions, recognize potentials and identities and solve problems that related in different dimensions personal, social, educational, psychological career/concerns and etc.

However, the ultimate goal of counseling should be decided by the counselor and the client with together. Many theorists don't agree on the goals of counseling (MOH, 2003). Statements of goals are often too general, vague and saturated with implications.

Although, there are variations between scholars on the goals of counseling, the following major goals that are discussed by (MOH, 2003) are accepted by many practitioners and researchers. These are:-

1. **Facilitating behavioral change:** to enable the client to live a more productive and satisfying or a happy life.
2. **Enhancing coping skills:** learning behavior patterns that are efficient and effective. Helping individuals learn to cope with new and demanding situations, to be assertive and to be less anxious in various conditions.
3. **Promoting decision-making:** enabling the client to make critical decisions. The client should know why and how the decisions are made. He/she learns to estimate the probable consequences of personal sacrifices, time, energy and money, risk and so on.
 - Counseling helps individuals obtain information and interpret it to understand emotions and attitudes, etc. It stimulates the individual to evaluate, make, minimizing dependence on his/her physical and social environment.
4. **Improving relationships:** skills in interpersonal and social skills are developed. Issues of poor self-image, too much defensiveness and inadequate social skills are focused. The counselors usually work toward the client's authenticity, being-genuine of self in relation to others and overcoming alienation and meaninglessness.
5. **Facilitating client potential:** providing opportunities to learn, ways to use abilities and interests to the maximum. It is improving personal effectiveness in meeting the demands of life expected at a given development stage:
 - For example, helping clients to learn how to overcome smoking, drinking, sexual dysfunction, addiction, anxieties, etc. It is development of skills, attitudes and perceptions of social reality fit for the healthy growth development of the person.

6. ***Facilitating the spontaneity and trust on self***: clients being free, self-confidence, flexible and open to experience and reduction of rigidity.

2.3. What are the Relationship between Counseling and Other Helping Professions?

Helping is usually defined as aiding, assisting, doing well to and relieving of distress of others (MOH, 2003). It is the notion of working along-side people. Counselors, social workers, teachers, physicians, nurses, psychiatrists, and community workers are engaged in helping/caring professions and relationships.

Helping relations means a situation where at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning and improved coping with life of the others.

Helping enables those who are helped to recognize, feel, know, decide and choose to change. It is facilitating positive ways of improving through interviewing, discussions, counseling, psychotherapy, etc.

According to C.H. Patterson as quoted by Shortzer and Stone (1980) the following points are some of the major characteristics of a helping relationship.

- The relationship is meaningful. It is valued by the client, the counselor and relevant others.
- Some affect is evident emotions are revealed and the self is expressed.
- Integrity is present participations intended to be intellectually and emotionally honest with other. Presentation and deceit are avoided and honesty with each other prevails.
- Takes place by mutual consent of the individuals' involved-consent (agreement) is given explicitly by choice and/or by tradition.

- The client needs information, instruction, advice, assistance, understanding and treatment from the helper-help is needed in the domains of knowledge, skill competence and emotional areas.
- Is conducted through communication and interaction-verbal and non-verbal communications affect both parties. Each person talks, reacts, conveys and influences the other.
- Structure is evident; some working arrangements such as beginning and ending of sessions, time and place for the relationship exist.
- Collaborative effort make the relationship participants work together, they express views and suggest solutions.
- The helper is approachable and secure person. He/she exhibits steadiness and stability.
- Change is the main objective of the relationship the participants learn from each other and the change occurs in perceptions, attitudes and skills.

Many authors recommended that “care givers”/helpers need the following skills:-

- The ability to observe, collect and record information
- Understand and evaluate relevant professional language.
- Distinguish between comments, opinions and facts.
- Use time and other resources constructively
- The ability to listen-pay attention and understand.
- Hear what is said and not what is left unsaid.
- Pick up emotionally significance-the significance factors related to the environment (particularly the social environment).

It is clear that helping professionals such as psychology, medicine, psychiatry, social work and theology are very broad and complex, fields. Even the sub-fields of counseling could be divided in to educational, vocational, personal, HIV/AIDS counseling and so on. We will be limiting ourselves to the general

fields of personal/social counseling in general and HIV/AIDS counseling in particular.

From the above discussions, we can understand that there are difference between counseling and other helping professionals. For instance, on content areas focused, depth and duration of training, criteria used to determine outcomes and assumptions concerning the determinants of behavior are different.

For example, HIV/AIDS education/health education provides information and discussion on public health needs such as on prevention of HIV transmission, discouraging stigma and discrimination and provision of care to the affected and the infected ones. It is not confidential/ has no privacy.

Most counseling situations don't involve giving advice and impositions of ones values. But, in many African countries including Ethiopia, giving advice is a common way of providing help to other people (MOH, 2003). Elders, priests, teachers, family members tend to give advice on how to behave, choices to make and on the future life.

Since provision of advice has some value imposition, promotes, dependence on the advice and takes away the responsibility from the client, it is highly recommended that counselors refrain from providing direct advice to their clients.

Clients (those person seeking of counselor/help, parents, teachers, counselors, physicians, government and non-government agencies and religious institutions have different expectation /outcome/ perceptions of counseling.

2.4. Counselor Selections and Training

2.4.1. Counselor Selection

There appears to be very little published research on the selection of applicants for training in counseling. A problem in counselor education /training/ is selecting those who are to become competent counselors.

According to Shertzer and Stone (1980) selection for counseling is viewed as a continuous process that takes place not only at the point of admission to the program but throughout the training. And the individual's initial decision to seek admission to counselor education involves self-selection and purely voluntary. The same author further argues that if serious weaknesses become evident, however, some where along the line a decision to reject him or her as a counselor candidate must be made by the preparation institution.

Redfering and Biasco as Cited in Shertzer and Stone (1980) suggested that there should be actual criteria in selection and elimination of candidates for counselor preparation program.

These are

1. Grade point average
2. Interview
3. Test score
4. Letter of recommendation
5. Personal knowledge of candidate
6. Work experience
7. Under graduate study

According to McLead (1993), the best way in selection of counselors involve taking one or two days to put candidates through an "assessment center" procedure, in which they are interviewed on different topics by different selectors, observed in group discussion and counseling role play situations, and asked to complete tests that tap relevant aspects of personality, intelligence and counseling aptitude.

Reports of counselor selection have indicated that this process is often inadequate (Miller and Casey, 1997). Counselors are often selected by managers who have little understanding of the needs and responsibilities of counselor but counselor selection should consider the person's attitude towards counseling, HIV/AIDS and peoples infected and affected by HIV/ AIDS (Lie and Biswalo, 1994)

According to FDRE MOH (2002) counselor should be either

- influential and respected person of a community
- dedicated school teachers
- motivated health workers
- peer counselors/ volunteers
- People living with HIV/AIDS (PLWHAS).

Then, the above discussion indicates that counselor selection should be purely voluntary and in addition there should be some actual criteria to select counselors.

2.4.2. Counselor Training

Counselor as well as their supervisors, require adequate training and the training is not a one-time-event... it should be on going process (CDC, 1993).

According to UNAIDS (2000a) counselors in VCT services will need continuous training which should consist of basic information on HIV, transmission routes, risk factor, possible and available interventions and the role and process of pre-test, post-test and on going counseling.

Furthermore, UNAIDS (2000a) suggest that there are several models of counseling training, a short course (2 weeks) followed by practical work. Some

models offer longer more in-depth training and there should be refresher courses and on-going training and support.

According to Yusuf (2004) in Ethiopia there is acute shortage of trained counselors in VCT centers, where clients need psychological support. Hence, there is a need for professional counseling service. He further argues that at the present time standardized training program and uniform guideline are lacking when counselors are found for VCT centers for the delivery of efficient and effective counseling services.

The fact that there is a need to train “professionally competent counselors” who could work in HIV/AIDS prevention and risk reduction centers. Such professionally trained counselors would have standardized and uniform training programs for the delivery of efficient and effective counseling services.

FDRE MOH (2002), suggest that any one selected to become a counselor should be given at least one month training on counseling.

2.5. Who should be a Counselor?

Counseling can be carried out by counselors, psychologists, psychiatrists, physicians, nurses; sociologists and social workers. These and other Para counselors who have been trained in counseling can provided counseling services.

The following are some of the major personal characteristics of an effective counselor that is mentioned by Yusuf.

According to Yusuf (1998: 32-33), the major personality characteristics of an effective counselor are:

- ❖ Maturity (personally and professionally)

- ❖ Understand self and other (e.g. client)
- ❖ Respect for self and others
- ❖ Empathic and understanding of client (neither “sympathetic” nor “apathetic”)
- ❖ Sensitive to the problems
- ❖ Responsible and dependable-can be trusted stands for truth.
- ❖ Emphatic- it is able to put himself on other’s place. Takes others’ perspective into consideration.
- ❖ Emotionally responsive
- ❖ Ethical and could be trusted.
- ❖ Intelligent, flexible and healthy both physically and psychologically.
- ❖ Show congruence and transparency manifests open and honest reactions are flexible and willing to change and adapt.
- ❖ Has positive regarded to self and others respects the dignity of self and others.
- ❖ Able to show acceptance and caring to others understanding, loving and respecting the clients in a non-judgmental ways.
- ❖ Has intellectual competence to comprehend social and personal problems.
- ❖ Has social relationship skills-warm, interacting and understanding person.
- ❖ Has interest in working with and helping people.
- ❖ Free from any type of bias and prejudice such as tribal, religious or political and so on.

Generally, a counselor should know:

- The self
- The client
- The socio-economic and political environment

2.6. Counseling Processes, Techniques and Skills

Elements required for effective counseling counselors are usually to comprehend the model and elements that facilitate counseling relationship. Such elements are basic not only in the initial counseling relationship but they are essential in the entire counseling process.

According Yusuf (1998: 54-55) there are two kinds of facilitating conditions that influence counseling outcomes. These are external and internal facilitating conditions.

Major external conditions which influence counseling are:-

- Greeting
- Physical set up (e.g. room) where counseling takes place
- Proximity (seating arrangements)
- Privacy (free from interference, noise, etc
- The use of note taking, tape recording, during interview.
- Counselor's attitude and beliefs which may influence counseling out come.
 - ✓ Counselors are human beings and they have their own beliefs, attitudes, needs and emotions. Culture, personality, skill and so on could influence his/her counseling relationship. The counselor is the key to initiation and development of counseling relationship and since he/she could be influenced by his/her own training background, skill, personality and culture and so on.
 - ✓ Beliefs: A counselor might think that his own religion, his own tribe or political ideology is the best and it may be unfair to expect a client to accept them or follow them.

So, he/she should have a clear understanding of those factors that might help or hinder his/her contribution.

The famous client-centered psychologist (C. Roger) tell us, that no matter what the counselor claims to be (or) believes in his/she would never influence his/her client. A good counselor according to Carl Roger is one who is “neutral” in every sense of the term (Yusuf, 1998). Major internal factors/conditions which enhance counseling are:

- rapport
- respect
- acceptance
- empathy
- congruence
- reinforcement
- sincerity
- flexibility
- clarification /question/
- relaxation
- listening
- confidentiality (privacy)

2.6.1 Counseling Techniques and Skills

Counseling is a science and an art. As a science it requires knowledge, techniques and skills. As an art, it calls for institution, some talent and creativity. The work requires a lot of work experience and experience to be effective (MOH, 2003).

The counselor-client relationship and interactions are very crucial elements in the counseling processes. The verbal and non-verbal techniques used by the counselor in his/her work are very important. There are more than 100 techniques in the literature ranging from very general to specific responses.

According to Yusuf (1998), techniques are only means to ends. There are specialized techniques when the situation is appropriate. Yusuf (1998) stated that because of personal inclinations, difference of opinion to their effectiveness or incompatibility with heir philosophy (theory), some techniques are used by some and ignored by others.

Some defines techniques as anything the counselor performances within the session. Others define it is a tool or method the counselor uses in order to facilitate effective counseling or positively change in the client (Gelso and Fretz, 1992 cited by MOH, 2003). However, many studies show and as MOH (2003) stated that the following are highly valuable techniques and skills to use in counseling:

1. Opening and building rapport: Greeting and welcoming the client, asking the client to be steady and starting some conversations are necessary. Attempting to make the client feel that he/she is welcome to the counseling session and establishing a relationship/some interaction/important.
2. Attentiveness: Attending behavior has been defined as appropriate eye contact, body language and verbal following.
Encouraging the clients talk more about themselves and their problems are some signs of attentiveness. Alertness, reflection of feelings, questioning and paraphrasing usually indicate attending skills.
3. Listening: in counseling session (listening) with empathy (to feel with, to see and feel that world the client does) is highly recommended. Efforts need to be made to understand both the thoughts and feelings must be open minded and non-judgmental (non-evaluating).
4. Paraphrasing: is important to use paraphrase during interactions with the client.
5. Reflection of feelings: during counseling process the skills of reflection of feelings is very helpful to label emotions.
6. Self-disclosure: disclosing experiences may help your clients feel that you understand what they are going through.
7. Summarizing: gives clients the opportunity to review what they have said and through the process of review to identify and abstract those areas of concern which are most important to them at a given time.

In the opinion of Stone and Shertzer cited by Yusuf (1998), the following observation should bear in mind. These are:

- Techniques are based on some kind of counseling theory.
- Counseling techniques are peril invention, peril in the sense of that they work for a particular instance at specific time, skill, terms and may not work for others.
- The variables dealt with in counseling are complex and changing subject matter in the individual being (person).
- Effective counselors adopt their respective techniques to particular problems and individuals involved.
- Research indicates that many counselors possess or use too few interviewing techniques.
- Regardless of training, counselors are prone to develop style of counseling, adopt particular techniques unique to their own experiences.
- Research shows that counselors employ rather consistent techniques with each client and expertness and experience personal versatility of approach.
- The description of counseling techniques they follow is general.

2.7. Personal Characteristics Which Facilitate Effective Counseling

There are many characteristics of an effective counselor that are stated by different researchers. But, the following are some of the major ones that are mentioned by MOH (2003):

- Has interest in working with and helping people.
- Has social relationship skills-warmth, interacting and understanding person.
- Has the intellectual competence to comprehend social and personal problems.

- Should have some flexibility and spontaneity-being free to move and is not mechanical and origin.
- Able to show acceptance and caring to others-understanding.
- Loving and respectful to the clients in a judgmental ways.
- Has positive regard to self and others respected the dignity of self and others respect the dignity of self and others.
- Shows congruence and transparency-manifest open and honest reactions, is flexible and able to change and adapt.
- Mature and emotionally stable resourceful, understanding and stable person.
- Empathetic is able to put himself on others' place; takes others' perspective into consideration.
- Responsible and dependable-can be trusted and stands for truth.
- Free from biases and prejudice fair and treats clients equally professional characteristics that facilitate effective counseling.

The following major factors also stated by MOH (2003). These are summarized as:

- Should have some technical qualification trained in one of the helping professionals and in counseling and should have some "expertise" in helping others.
- Able to gain information-focus on client's thoughts and feelings, able to generate responses from the client.
- Has some understanding of various world views and psychological theories work with several perspectives and theories, aware of many alternative approaches.
- Good understanding of the clients culture-able to communicate, verbally and non-verbally well with the clients; understands own and others' beliefs, values and attitudes.
- Able to listen attentively, accepting focused and reflective of the relationship (interview)

- Maintain confidentiality-maintain privacy and operates within ethical, moral and legal limitations.
- Recognizes limitations-accepts supervision, shares experiences with others and with the clients as seem, appropriate and etc.

2.8. Qualitative Elements of Counseling

As it is mentioned earlier, counseling is a helping relationship based on a dialogue between a client and a counselor. It is a situation of information trying to solve problems. According to MOH (2003), the following elements/conditions, features, climate, attitudes and approaches/ facilitate effective (positive) counseling:

- a) **Time and space is available:** - The setting room, an office or a quiet place needs to be available for the counseling session. The client needs to have adequate time to describe his situation, to get feedback, to raise concerns and to consider options. The counselor is available on schedule and/or when the need arises.
- b) **Forming working alliance:-** working relationship being developed by the client and the counselor to solve the client's problems together. Some general (formal and informal) agreements exist concerning the goals, tasks, relationship together to solve the problem.
- c) **Availability of consistent and accurate information:-** Any information provided behavior, and risk reduction should be consistent and accurate. The counselor needs to have a clear and up to date understanding of the facts about HIV infection and the AIDS disease. New information and developments should be reviewed constantly.
- d) **Privacy and confidentiality:-** Trust is one of the most important factors in the relationship between counselors and clients. It enhances their relationships and improves the chances that the clients will act decisively on the information.

- e) ***Emphatic and understanding of the client showing warmth, concern and caring attitudes and responses***:- It understands the other point's of view. Being able to think and feel through the other person's (client's) perspective. It is an active process that needs to be practiced by the counselors by clarifying communication, reflections of feelings and imagining other's thoughts.
- f) ***Showing respect and warmth***: acceptance, carrying and respect of the client. It is called as "unconditional positive regard". The counselors must positively prize or care for their clients, accept them for what they are, and treat them with respect. Clients are likely to reveal themselves when they trust the counselor and when they are cared for and accepted.

Showing genuineness:- Being up on minded, authentic, honest and congruent person is highly recommended. What you say and do must be accurate reflections of thoughts and feelings should be congruent. Genuine promote trust and positive relationships.

Then, in addition, to the structural conditions/facilities, cleanliness, seating arrangements, etc, the above conditions/tend to affect the general climate of counseling. Accordingly, one attempts to make the overall situation conducive for counseling work.

2.9. Common Counseling Errors

Counseling is a helping relationship and it has its own techniques and characteristics. But experience shows that there are a large number of errors which are made by "counselors" (MOH, 2003). Some of the common errors in counseling relationship are:

- Interrupting the client
- Speaking too quickly or too slowly
- Finishing of sentences of clients

- Controlling rather than encouraging the client's spontaneous expression of thoughts, feelings and needs.
- Looking away frequently
- Judging
- Moralizing, preaching and patronizing (telling the clients how they ought to be having or lead their lives).
- Providing unwarranted reassurance diverting a client's attention from an issue and inducing undue optimism by claiming that the problem is easy.
- Not accepting the clients feelings
- Give advising before the client has enough information or time to arrive at a personal solution.
- Encouraging dependence
- Using unacceptable paraphrasing or suggestions like you must try, you should, will tell you what do; it is a must, etc.

2.10. The History of Guidance and Counseling in Ethiopia

Like in many other developing countries, in Ethiopia the tradition of "helping" profession existed for a long time. Traditionally, when people faced crisis of any sort, or when they needed help and support, they received help from parents, families, friends elders, community leaders, tribal chiefs, religious people like priests, sheiks and or from traditional medicine men and women and so on (Yusuf, 1996).

The help people received from these traditional helping professionals was not significant and had no lasting effect in changing their behavior. Their approaches were crude and non-scientific. They had no frame of reference on how theoretically and professionally human behavior change.

Yusuf (1996) indicated that whether we like or not the help received from these groups will continue to exist because the majority of our people (60%) have no access to the so called " modern health services" which are offered by modern

helping professionals such as medical doctors, psychiatrist, counselors, and psychologists.

Counseling and psychotherapy services are not well developed and practice in Ethiopia. The concept and tradition of "modern" counseling services in Ethiopia has no centuries of history. It was in the early 1960s that the "word" "guidance" appeared in Ethiopian educational literature, while counseling was introduced in Addis Ababa University curriculum in 1967 (Yusuf, 1991). But what is disheartening is the fact that we neither have the names for the words psychology and counseling in our language, nor do we have professionals who could offer counseling services to the needy.

To day, our country has many psychological, educational and social problems. Millions of Ethiopians in all age group and all types of people (normal, abnormal) need psychological assistance. People who are HIV/AIDS victims and who need pre and post counseling to be offered by "professionally competent persons", generally, counseling a service is vital particularly today.

According to Yusuf (1991) the course was entitled "Guidance and counseling" and was offered to students in Addis Ababa University. It was not encouraging to note that some B.A. holders in Educational Psychology from AAU serving counselors with little professional input in their training.

Additionally, the last two government system as well as the present has given low priority to the discipline. Moreover, research efforts are minimal and professionals are non-exist. Generally, psychology in Ethiopia is a professional and a discipline which is known through it is very crucial to national survival. It is a discipline in search of identity (Yusuf, 1991).

Accordingly, in Ethiopian the role and relevance of counseling psychology has no half centuries of history. However, some helpful efforts were made to give counseling, its legitimate historic role.

For instance, the opening of starting of MA programs of in counseling psychology in 2004/2005 and the launched of Addis Ababa University counseling centers are created further bright for the development of counseling psychology. Additionally, in our country, counseling play great role in any prevention and control activities the spread of HIV/AIDS. Because of these factors counseling becomes a little better known than before.

2.10.1. Why Counseling Services Unique in Ethiopia?

In general speaking, counseling both a discipline and a profession is unique in Ethiopia. There are some factors that make counseling services unique in our country. Some major factors that are mentioned by Yusuf (1991) are:

- Neither the name, nor the concept of counseling and even psychology for that matter does exist in Ethiopia. It is just an area in psychological discipline which is known and therefore un-flourished and "under developed" (It is a discipline and a profession that is only known to academics in higher institutions and secondary schools).
- We do not use any kind of psychological tests (achievement, aptitude, personality interest... tests) which are standardized for use in Ethiopian reality in our schools i.e. any kind of "test" relevant to counseling is hardly available in Ethiopia situation.
- In Ethiopia, there is no single psychological laboratory where experiments on human and animal behaviors are carried on. Behavioral findings based on laboratory experiments simply do not exist.
- We do not use career/ vocational counseling to help our clients o prepare for jobs, enter, up on them and progress in them.
- We don't train/professional counselor in Ethiopia until to day.

- The social, economic, cultural and language problems are other problems which make counseling experiences unique in Ethiopia.

It is in these unique circumstances over and beyond the existing professional training deficiencies that our counselors (the so called 'counselors') are expected to function/work.

2.11. HIV/AIDS Counseling

There are different types of counseling to day. Some of them are: crisis counseling, problem-solving counseling, decision-making counseling, problem-solving counseling, vocational/career counseling; marriage and family counseling, peer group counseling, Grief counseling, HIV/AIDS counseling and so on. Among these HIV/AIDS counseling becomes popular in the world because of its roles to mitigate the psycho-social problems that related with HIV/AIDS.

Counseling is defined in the context of HIV/AIDS as follows:

- It is a helping relationship on discussion between a counselor and a client. It is not threatening, non-judgmental and unconditionally accepting relationship with the client. It is aimed at facilitating motivation, reducing the stressful impact of HIV/AIDS on the individual, preventing of transmission of HIV infection, understanding of problem solving and decision-making. This includes information, education, psychological support that allows individuals to make decisions that facilitate preventive behavior as well (MOH, 1996).

In the light of this, HIV counseling began in Ethiopia in the late 1980s with services expanding throughout the 1990s. Usually, counseling for HIV/AIDS is rendered in different settings. One of these is voluntary HIV counseling and Testing (VCT) centers (FDRE MOH, 2002). In many countries counseling and

testing are widely accepted as a necessary component of the national HIV/AIDS prevention intervention has a place with a comprehensive range of measures for HIV/AIDS prevention, care and support.

HIV/AIDS counseling is confidential communication between a client and care provider aimed at enabling the client to cope with stress and to take personal decision relating to HIV/AIDS (FDRE MOH, 2002). HIV/AIDS counseling process includes the evaluation of personal risk of HIV transmission, the facilitation of preventive behavior and evaluation of coping mechanisms when the clients is confronted with a positive result. The need for HIV/AIDS counseling is increased as HIV infection rate continue for raise and countries recognize the need for further people to know their sero-status as an important as prevention and intervention tool.

Those people who learn that they are sero-negative can be empowered to remain HIV negative. For those HIV infected the development of less costly interventions to reduce mother-to-child transmission of HIV and HIV associated takes on new importance. Additionally, other medical and supportive care can help those living with HIV to live longer and preventive transmission to others. In higher prevalence settings many individuals tend to develop feeling of hopelessness and helplessness and also a sense that is too late for behavioral change. In these settings the power of desired change messages can be reinforced by effective and quality counseling services.

In all settings, learning one's sero-status with prevention counseling can be powerful prevention and care strategy (CDC, 2001).The importance of HIV/AIDS counseling in achieving this end has been acknowledge in the recent wider promotion and development of the HIV/AIDS counseling services. HIV/AIDS counseling services like VCT services has a crucial role in HIV prevention to help people to make changes in their sexual behavior.

The other major role of HIV/AIDS counseling is in facilitating early and appropriate up take of service for those people testing HIV positive and negative including medical care, family planning, emotional and social support, legal advice and so on. Increasing access to effective and quality HIV/AIDS counseling services can be also important in challenging stigma promoting awareness and supporting human rights.

Similarly, R. Venkatachalam (2004) state that:

When a person learns that he has been infected with HIV he is psychologically distressed. The psychological distress in this case would easily surpass that of any other disease. In India the stigma attached to this disease aggravates due the fact that HIV infection is a deadly disease, the stigma implicates serious and also insidious wreck on the character of the person. As a result of this person goes through the stages reminiscent of a person waiting to die without the help and support of loved ones.

HIV/AIDS counseling is the corner stone for early access to prevention as well as care and support services. Many studies indicated that the role of counseling as a means for prevention of HIV infection. Likewise, WHO's report (1992) sighted two main objectives of HIV/AIDS counseling. These are:

- To support the ability of infected person and those who care for them to cope with the stress of HIV/AIDS.
- To prevent the speared of HIV to others.

Similarly, FDRE MOH (2003) put two basic goals of HIV/AIDS counseling:

- To provide support and referral through infected and affected by HIV, through helping the infected individuals, families and friends.
- To prevent HIV infection.

FDRE MOH (2003) also noted that counseling operates at two levels of prevention:

- Primary prevention aims to keep people from becoming infected counseling plays a crucial role in helping people identify their own risk behaviors, explore options for reducing their risk and negotiate a risk reduction plan that is realistic and feasible.
- Secondary prevention aims to prevent people infected with HIV from transmitting the virus further. With proper counseling, HIV may avoid feeling alienated from society and therefore feel more accountable to it, adopting practice that minimize the risk of infected others.

Therefore, HIV/AIDS counseling is an integral part of many HIV/AIDS prevention, care and control program.

Similarly, UNAIDS (2002) also defined HIV/AIDS counseling as it is a confidential dialogue between a client and care provider aimed at enabling the client to cope with stress and personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behavior. FDRE MOH (2002) again stated that HIV/AIDS counseling as a confidential dialogue between the client and counselor aimed at creating an enabling environment for person to cope with stress and to make personal decisions related to HIV/AIDS.

From the above definitions one can understand that HIV/AIDS counseling has the following characteristics:

- ❖ HIV/AIDS counseling requires some of the same basic skills and procedures used for serious personal and emotional problems.
- ❖ It is conducted in privacy and the discussion is confidential.
- ❖ Its purpose is to provide conditions that facilitate voluntary change on the part of the client.
- ❖ HIV/AIDS related to counseling focuses on the prevention, coping behaviors, caring and support aspects.

- ❖ The ability to provide HIV test results to clients and managing their reactions and also managing the reaction of partners and family members are the concerns of HIV/AIDS counseling.
- ❖ It requires explicit discussion of sexual practices and death.

2.11.1. The Development of HIV/AIDS Counseling Service in Ethiopia

As any other countries of the world, Ethiopia is also affected by HIV/AIDS pandemic. Counseling is, therefore, implemented as one of means of preventing and controlling.

HIV/AIDS counseling started in Ethiopia in the end 1987, when two social workers from ministry of Health (MOH) were assigned to the former department of AIDS control to counsel AIDS patient. Their focus was on the sero-survey participants (commercial workers, long distance truck drivers) conducted in 1988 and 1989. Later, because of increased demand for counseling and testing from the hospitals mainly health professionals and social workers were trained to cover the needs (MOH, 2003).

Until, 1980 HIV testing was done mainly in public (government) health institution. After the preparation of the national HIV/AIDS policy many counseling and testing flourished in organization (FDRE MOH, 2003). This further expanded the opportunity or access for HIV testing and counseling for the community.

2.11.2. Role of HIV/AIDS Counseling

Many authors put the role of counseling as a very crucial means for prevention of HIV infection because it deals about highly related with behavioral change. Bringing behavioral change is the ultimate goal for any projects that are working at HIV/AIDS prevention and control.

In this view, WHO (1992) sighted that the two main objectives of HIV/AIDS counseling are:

- ❖ To support the ability of infected person and those who care for them to cope with the stress of HIV/AIDS.
- ❖ To prevent the spread of HIV to others

MOH (2003) also recognized that the two basic objectives of HIV/AIDS counseling:

- ❖ To provide assistance and referral to those infected and affected by HIV, through helping the infected individuals, families and friends.
- ❖ To prevent HIV infection.

Indeed counseling operates at two levels of prevention:

Primary prevention:

- Aims to keep people from becoming infected. That means by helping people to identify their own risk behaviors, explore options, for reducing their risk and negotiating a risk reduction plan that is realistic and feasible

Secondary prevention:

- Aims to prevent people infected with HIV from transmitting the virus further that providing proper counseling service people with HIV may avoid feeling more accountable to it, adopting practice that minimize the risk of infection others.

Moreover, King (1994) stated that HIV infection could certainly be avoided if the clients are given information and psychological support. He also indicated that trauma of the diagnosis of HIV infection/AIDS itemed not only from the fact that the disease is known to be fatal but also that is accompanied by social

stigma and rejection. Thus, it is normal for patient to experience anger, fear and sadness when conformed to the diagnosis of terminal illness such as AIDS.

Emotional stress that emerge from the knowledge that there is no cure from HIV/AIDS on hand and rejection, moral condemnation from the family and community members on the other hand lead the person to react introjectively /projectively.

Introjective reactions refer to a feeling of guilt, self-recrimination/ blaming and isolation. These may lead the individual to suicide/self-destruction. Projection refers to a behavior or sense of irresponsibility that the person blames the society /community; simply take measure in the sense of revenge which would lead to the spread of the deadly virus (HIV).

Accordingly, counseling is virtual management as well as HIV/AIDS care and fundamental part of good clinical management and an important vehicle for prevention of further infection.

As it is mentioned at the above, HIV/AIDS counseling has two fold importances (supportive and preventive) particularly when it is carried out by professional counselors.

Thus, counseling is a means of mobilization of psychological, social, and material resources of people with HIV/AIDS and their close associate as well as people concerned it.

In general, WHO (1998) set many roles of HIV/AIDS counseling; some of them are:

- Provision of psychological and social support to infected person.
- Impressing up on individuals and groups that change in behavior required. By indicating those that are acceptable realistic and feasible qualities. In this area counseling closely compliments education.

- Ensuring in the sustainable economic, intellectual and social productivity and integration of HIV infected person with in the larger framework of family and community.
- Minimizing psychological and physical morbidity.

HIV/AIDS counseling therefore, not a profession that should, be isolated rather it needs an interwoven relation with others helping activities or professions. The collaborated work of counseling with vocational rehabilitation agency, health worker social worker and peer leaders of he community and so on are very important to provide effective HIV/AIDS counseling services for beneficiaries.

2.11.3. What Makes HIV/AIDS Counseling Unique

HIV/AIDS counseling is one branch of counseling psychology. It is a recently emerged type. It requires some of basic counseling skill like other types of counseling. However, HIV/AIDS counseling is unique from other types of counseling with many factors. Regarding to this FHI (1999) notified that the reason of HIV/AIDS counseling differ from others. These are:

- The nature of HIV/AIDS
- Counselors are often practically concerned about their ability to provide HIV test results to clients, or to manage the reaction of clients, partners and families to positive test results.
- Counselor often fears that they do not possess the necessary skills for HIV/AIDS counseling or that they will be unable to control their own emotional reaction to the work.
- HIV/ADS counseling requires that the counselor consider the reactions and needs to partners and other family members as well as those of clients.

FDRE MOH (2003) moreover suggested that HIV/AIDS counseling is unique from others; because:

- The ability to provide HIV test results to clients and managing their reaction, and also managing the reaction of partners and families members are the concern of HIV/AIDS counseling.
- The nature of infection and the diseases requires some unique procedures and skills. It focuses on the prevention, coping behaviors, caring and supporting.
- It requires explicit discussion of sexual practice and death.

According to Yusuf (2003) expressed that HIV/AIDS counseling requires some of the basic counseling skills as other type of counseling, but the nature of HIV/AIDS as a central subject makes HIV/AIDS counseling unique. It includes additional as well as strategies taken from preventive and crisis counseling.

2.11.4. VCT

VCT is the process by which an individual undergoes counseling enabling him/her to make an informed choice about being tested for HIV (UNAIDS, 2000a). As earlier mentioned, HIV/AIDS counseling has been defined as a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS.

The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behavior. The objectives of HIV counseling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested and to provide support and facilitated decision-making following testing (UNAIDS 2000a). With the consent of the client, counseling can be extended to spouse and other sexual partners and other supportive family members or trusted friends where appropriate.

According to FDRE MOH (2003) VCT is the process by which an individual by his/her own initiative or voluntary undergoes HIV/AIDS counseling and HIV

testing. It is an HIV prevention intervention initiated by the client that provides the opportunity for the client to confidentially explore and understand his/her HIV risks and to learn his/her HIV test result.

Furthermore, Measure Evaluation (2004) described that people who have got VCT service shows some behavior change that should contribute to lower rates of HIV spread, and also VCT help in reducing stigma and encouraging community support and care for those affected.

VCT has been shown to have a role in both HIV prevention and for people with infection, as an entry point to care. VCT provides people with an opportunity to learn and accept their HIV sero-status in a confidential environment with counseling and referral for on going emotional support and medical care (UNAIDS 2000b). It also strengthens prevention efforts, encourages infected people to avoid on-going transmission to others, and motivates those who are uninfected to remain through risk reduction strategies. Similarly, WHO (2004) indicated that VCT can lead to reduce in the number of sexual partner or increased condom use and fewer sexually transmitted infections.

FDRE MOH (2003) stated that through VCT individuals gain knowledge on their HIV status. Most who are not infected with HIV become ambassadors for HIV prevention through reducing their risk and encouraging partners, family members and friends to access to VCT. But, FDRE MOH (2003) described that benefits of VCT depends on the availability care and support.

Additionally, UNAIDS (2000b) confirmed that VCT is an important entry-point to both HIV prevention and HIV related care. People who test sero-positive can have early access to a wide range of services including medical care, ongoing emotional support and social support. On the other hand, people who test sero-negative can have counseling, guidance and support to help them remain negative.

2.11.5. Components of VCT

The process of VCT consists two sessions, pre-test counseling and post-test counseling (FDRE MOH, 2003). In this view FHI (2003) also indicated that the gold standard for VCT follows a regimen of pre-test counseling and post-test counseling. More sessions can be offered before or after the test or during the time the client waiting for test results.

2.11.5.1. Pre-Test Counseling

In VCT, pre-test counseling is a pre-requisite to all clients intending to know their status. This can be done as an individuals, couple or group session.

As FDRE MOH (2003) recognized that the aims of pre-test counseling are:

- To ensure that any decision to take the test is fully informed and is prepared to take the test based on understanding of the personal, medical and implication of the test (positive result)
- To assist the client in understanding and identifying his/her personal risk and to support the client in exploring options for risk reduction.
- To provide the necessary preparation for the test result. Such preparation is vital in that clients/patients who have been prepared for a positive result are to face that result much more equally.

Regarding to this FHI (2003) suggested that pre-test counseling including providing reading materials before clients enter a group or private sessions with a counselor, and at this session the client may be asked why they want to be tested and about their behavior that they think that may put them at risk for HIV infection.

FHI (2003) also pointed out that if testing is warranted the counselor should:

- Describe the test and how it is done
- Explain HIV/AIDS and the way, HIV is spread.

- Discuss ways to prevent the spread of HIV
- Discuss the meaning of possible test results
- Ask what impact the result will have on him/her
- Address the matter of whom to tell about his/her test result
- Discuss the importance of telling
- His/her sexual partner(s) if he/she is positive.

Generally, the above points indicate that the components of pre-test counseling which includes establishing the reason for requesting the test, existing knowledge of HIV/AIDS misinformation and myths, risk assessment, testing and possible results together with their meanings. The important parts in pretest counseling include ensuring that the decision to test is based on information about implications of testing in the client's life and the preparation of the client to receive his/her results and to explore coping strategies.

2.11.5.2. Post-Test Counseling

Post-test HIV/AIDS counseling is provided after HIV test result is made available and it should be always offered whether the result is positive or negative.

FDRE MOH (2003) stated the aims of post counseling as:

- Provide emotional support those who have positive result.
- Prevention of further transmission of HIV-risk reduction.

According to UNAIDS (2000b) in post-test counseling when the blood test result is positive, the counselor should:

- Tell the result clearly and sensitively to the client.
- Provide emotional support and discussed how to cope.
- Ensure the client has immediate emotional support from a partner relative or friend.
- Deliver information on referral services that may help clients accept their HIV status and adopt a positive out look.
- Ensure sharing a test result with a partner or some one trusted is often.

On the other hand UNAIDS (2000b) pointed out that when the test result is negative the counselor need to:

- Discuss change in behavior that can help the client to stay HIV-negative, motivate the client to adopt and sustain new; safer sex practices and provide encouragement for these behavior change.
- Refer to the client to on going support groups or specialized care services, if necessary.

Consequently, the above discussion indicate that post-test counseling sessions include informing the clients his/her results, check understanding of result, providing emotional support accordingly, exploring the clients concerns and needs; discuss risk reduction strategies exploring. UNAIDS (2000b) mentioned various societal and delivery associated factors. Some of them are:

- Stigma
- Communication mobilization
- Method of reporting / informing (confidentiality)
- Availability of treatment
- Poor qualities of services (e.g. lack of effective counseling)

2.11.6. Barriers to VCT

According to UNAIDS (2000 b) in some areas even through VCT services have been established people as reluctant to attend for counseling and testing. This may be because of denial and of the stigma discrimination that people who test sero positive may face, and lack of perceived benefits of testing. Similarly FDRE MOH (2003) suggests that although VCT became increasingly available in Ethiopia, many people are still reluctant to be tested. This reluctance is the result of barriers to VCT, such as stigma, lack of perceived benefit, poor access to clinical care and support, poor quality standards of counseling and testing and others. UNAIDS (2000 b) suggest that, to over come these barriers it is important to demonstrate its effectiveness and to challenge stigma and discrimination so that people are no longer reluctant to be tested.

Similarly, WHO (2004) also indicated factors that hinder VCT services. The following ones are summarized as:

- Wide spread fear of taking in HIV test.
- Potential for increased violence loss of security, discrimination, and isolation following sharing information about HIV sero positive.
- Scarce economic resource and completing priorities.
- Lack of access to drug therapist, psychological and clinical care.

Because of this, UNAIDS (2000b) suggests the following points in to make VCT services to be effective.

- The location and working hours should reflect the need of clients.
- Counseling sessions need to be monitored to ensure the quality of counseling.
- Informed consent of client is sought
- A referral system should be developed
- Counselors need adequate training and on-going support and supervision to ensure that they give good quality counseling and can cope with their stresses and avoid burnout.

In general, the above discussion indicate that even if VCT services are available people are still reluctant to be tested so as to solve this problem the service should be effective.

The operational aspects of VCT such as site (counseling room, seating arrangements and waiting area), confidentiality and the linkage or referral system can affect the effectiveness of VCT service.

2.11.7. Operational Aspects of HIV/AIDS Counseling

A. Site

Place of counseling is one of the important factors for effectiveness of counseling. Meeting clients in a place that is private and comfortable is precondition in HIV/AIDS counseling. Mann et. al (1992) stated that the counseling is a very crucial factor in HIV/AIDS counseling. According to him, location determines types of services, accessibility, effectiveness, cost and service sustainability.

Moreover, UNAIDS counseling Team (1999) recognized that the ideal place for providing HIV/AIDS counseling is an office of counselor where there is no interruption from phones or people walking in and out.

B. Counseling Room

There are no specific dimensions stipulated for counseling room. But, a counseling room should be spacious enough to accommodate the counselor desk or table, filing cabinet (s), two chairs or more depending on the type of counseling offered in the site (UNAIDS Counseling Team,1999). Usually, it is recommended that a counseling room would have enough light as well as proper ventilation.

The counseling rooms should be situated in places that are not going to draw attention from the public as this could further promote stigma to people seen entering such rooms. There is no need to identify them as HIV/AIDS counselors' rooms. The important thing is that the counseling rooms should provide the necessary privacy that clients require. Some one outside should not be able to tell who is inside and what is being in there. Counseling rooms must be private to ensure confidentiality of the counseling session/services (CDC, 1994).

Similarly, UNAIDS (2000a) suggested that HIV/AIDS counseling to be carried out correctly and effectively, privacy must be ensured. According to Shertzer and Stone (1980), the counseling room should be comfortable and attractive. Counseling facilities should be designed for comfort and relaxation.

Then, we can infer from the above discussion it is indicated that for effective counseling process private space is needed. Additionally to facilitate the counseling relationship the counseling room should be comfortable and attractive.

C. Waiting Area

Clients must feel as comfortable and relaxed as possible during their stay in the counseling center. As it is mentioned earlier the counseling should be easy to access and yet not in a busy place of any where every passer by knows that this is the HIV/AIDS counseling or Counseling and Testing for HIV.

It is best if there is a waiting room or area, so that clients have somewhere to sit, out of the public gaze. UNAIDS (2000a) noted that in HIV/AIDS counseling centers a well-ventilated waiting area is important.

D. Proxemics

Haase and Dimattia cited in Shertzer and Stone (1980) defined proxemics as the manner in which regulates the spatial features of his environment and conversely the impact of the environment on his subsequent behavior. This gives us the effect of physical distance between counselor and client, seating arrangement, furniture, and so on within the counseling office.

According to Yusuf (1998), a number of alternative employed for the physical setting or arrangement within the office are suggested but the most effective seating arrangement is across the table. Similarly, and Haase and Dimatti as

cited in the above stated that the best seating position is across the corner of the desk or table.

In regarding to distance between counselor and client, Shertzer and Stone (1980), recognized that people have a personal space within which they are comfortable in their interactions with another person. They also described that the comfortable space or distance between two people, has been ascribed to cultural background, the relationship between the two parties, the sex of the participants and their relative status.

E. Confidentiality

Confidentiality for bids any reference to, or discussion about client or a test result, except with a professional relationships, and only then with the consent of the client (FDRE MOH, 2003)

HIV/AIDS counseling services to be acceptable, confidentiality must be guaranteed. Many people afraid taking HIV testing because they fear stigma and discrimination from their families and community. HIV/AIDS counseling/VCT services should therefore always preserve individual's need for confidentiality.

According to FDRE MOH (2003) trust is one of the most important factor in the relationship between counselor and clients. It enhances their relationships and improves the chances that the client will act decisively on the information. Moreover, UNAIDS (2000b) stated that trust between the counselor and the client enhances adherence to care, and discussion of HIV prevention.

UNAIDS (2000a) reported that if it is not known that confidentiality will be respected up-take of VCT will be low. Then, there must be a system to guarantee confidentiality not only in HIV/AIDS counseling but also in any kind

of counseling service, because, it is one of the prominent features in counseling services.

Therefore, various evidences imply that confidentiality should be strictly assured since it enhances the counseling relationship and improves the chances that clients will act decisively on the information provided.

2.11.8. Linkages of Referral

In the context of counseling in general and HIV/AIDS counseling /VCT in particular, referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with assistance in accessing services (CDC, 2001).

Regarding to this UNAIDS (2000a) VCT has been shown to be more effective when it is developed in conjunction with support services such as medical, psychological, social and etc. FDRE MOH (2002) also described that referral is a key component of comprehensive HIV prevention services because not all facilities can address the variety of medical, psychological, environmental and structural issues that individual's ability to initiate and sustain behavioral change.

Referral services in general should afforded to all clients who are infected or at increased risk for HIV to facilitate access to any necessary, medical, nutritional preventive and psychological support and faith-based services. In high-prevalence area there should be a wide range of care and support activities in the community. Therefore, it will be vital for counselors to be aware of these resources and to be able to make appropriate referrals (UNAIDS 2000a).

In this view, FDRE MOH (2002) pointed out that the client and the counselor together should assess and prioritize the client's referral needs. Clients often

require referral for medical and on-going psychological support. Hence a referral system should be developed in consultation with different government and non-government organizations.

Accordingly, in HIV/AIDS counseling a process for routine referral should be established that results in the enhancement of the services.

The operational aspects of HIV/AIDS counseling services like counseling room, seating arrangements, waiting area, confidentiality and the linkage of referral system can affect the effectiveness of counseling services.

2.11.9. Professional Burnout

Many definitions of burnout share a view that it is a state of fatigue and emotional exhaustion that is the end result of a gradual process of disillusionment FDRE MOH (2003). In this view, burnout as the end result of a process implies an initial a state of high involvement and motivation. (FDRE MOH, 2003) also defined burnout as an individual stress experience that originates from emotionally demanding interpersonal relationship with clients.

Freundenberger cited in Mclead (1993) described that burnout in counseling occur when counselors with high and unrealistic aspirations regarding the degree to which they will be able to help other people. In many instances the amount help that can be offered, or the effectiveness of counseling is limited, there are also usually, many clients for them all to be deal with an ideal manner. Then, the result is that the counselor becomes caught between his/her own high standard, the impossibility of fulfilling these standards, and energy required in functioning at such a high level. This is the state of burnout.

UNAIDS (2000b) state that burnout is emotional exhaustion that results when a counselor has reached his/her limit to deal HIV and its related emotional

stress. This is especially true in high-prevalence areas, where the breaking of "bad news" may occur several times in a day. Moreover, FHI (1999) described that in many situations, it is the combination of counselor sense of high commitment, the stress of job, the lack of adequate support and isolation they might feel that can lead to burnout.

FDRE MOH (2003) indicated that the causes of burnout are:

i) Stressful tasks:

- Talking to clients about life treating illness and sexual issues
- Caring for a large number of people whose condition often lead to death.
- No being able to reassure clients about their conditions.
- Not having adequate or sufficient skill for counseling clients and their families.

ii) Organizational difficulties

- Not having necessary resources to meet the various and vast need of clients
- Not being consulted by the management when policy decisions are made acknowledgment as a counselor.
- Lack of supervision and/or suitable
- Pressure to provide other health services than counseling
- Lack of supervision and/or suitable supervisor.

iii) Personal issues

- Anxiety regarding infected with HIV by the clients
- Anxiety concerning being infected one self
- Anxiety about HIV infections in spouse/child.
- Over identification with the client.

Generally, it is important to acknowledge that HIV/AIDS counseling can be stressful and entails giving a lot of yourselves, not just in the time and energy, but in compassion, understanding and hope. HIV prevention counselors encounter many life and death issues in attending to their clients that can affect them physically, mentally, and spiritually. Hence, it is necessary to find a

balance personally and professionally, in order to sustain health and longevity counseling.

Mclead (1993) suggested that there are a range of organizational strategies designed to prevent stress and burnout, regular effective supervision is essential opportunities for counselor career development through expanding interests in training supervision writing and research also helpful, peer support, workshops and confidences also contribute to burnout prevention. UNAIDS (2000b) described that effective HIV/AIDS counseling services must find ways to ensure ongoing support and supervision of counselors and help them to cope with burnout and remain motivated.

2.11.10. Quality Assurance

Setting up HIV/AIDS counseling center and ensuring a quality that will create demand is a considerable challenge. In counseling, perhaps more than in any other area of service provision, service quality determines out-come, poor quality counseling can result in misunderstanding even resistance to behavior change. Then, counselors need adequate training and on going support and supervision to ensure that they give good quality counseling can cope with their work load (EDRE MOH, 2002).

Furthermore, CDC (1994) recognized stated the objective of quality assurance is to ensure that appropriate competent and sensitive methods are used in providing services to clients in counseling centers. Counseling programs should develop written quality assurance policies and procedures consistent with these standards and guidelines. In addition, client's feedback should be routinely used as factor in assessing the quality assurance of service provided.

In this view CAPS (2003) quality assurance can be done through:

- Periodic evaluation by the coordinating center
- Evaluation of counseling experience
- Supervision of counselors

FDRE MOH (2002) also noted that to ensure quality, programs managers/supervisors should accomplish the following:

For staff

- Training and continued education for counselors should be organized regularly.
- Ensure the counselors have the necessary time and resources to devote to counseling.
- Observing and giving feedback on counseling process both routine and periodic.
- Ensure that counselors have adequate training and skill in HIV/AIDS counseling.

Similarly CDC (1994) indicated that the standards for quality assurance include the following:

Facility

- The site must be geographically accessible to the population in services.
- The site must be operate during appropriate hours and minimize any delay in providing services.
- Counseling rooms must be private counseling session.

Staff

- Management staff must be ensuring that necessary resources and systems are available to ensure acceptable job performance.
- The program director must ensure adequate on-site supervision for staff.
- Counselors must meet locally established qualification standards
- Counselors and other relevant staff must be provided updates at least annually on scientific /public health aspects of HIV.

Record/forms

- Client records (confidential synonymous must contain a copy of the informed consent document, laboratory slip with test results, documentation of prevention counseling, result notification and formulation of risk reduction plans.
- Records with client's identifiers must be secured.
- All personal identifying information in connection with the delivery of services provided by to any person must not be disclosed unless required by law or unless the person provides written voluntary informed consent.
- Routine audits of risk assessment questionnaires, counseling and interview forms and client risk reduction plans must be conducted.

Additionally, FDRE MOH (2002) also suggested that indicators should be developed to monitor the standard of counseling such as:

- Counseling skills
- Interpersonal relationship
- Ability to gather and provide information

2.11.11. Criteria and Methods Used to Evaluate Counseling Services

Although it is estimated that over 250 different therapeutic approaches exist around the world to day, no single criterion psychometric devices is available to assess counseling out comes (Yusuf, 1996).

According Shertzer and Stone (1980) evaluation is not intended to be threatening process; its purpose is to provide insight that will help counselors perform higher and more efficient levels. Further more, they suggest that the major aim of evaluation is to ascertain the current status of counseling service within some frame of references and on the basis of this knowledge, to improve its quality and efficacy. Evaluation is a vehicle through which is learned whether counseling is doing what is expected of it.

After identifying some of the methodological problems associated with treatment evaluation Van Eura cited in Yusuf (1996) listed the following experimental designs that can be employed as they accord to the kind of research intended. These are:

- Pre-test/post design
- Reversal experimental design
- Multiple base line design
- Factorial design
- Single n design

Moreover, the author identified that these five steps of design have each inherent difficulty. And other scholars like Leviser, Robertson quoted by Yusuf (1996) reported that no single evaluation criterion areas seem to be superior to the others either theoretically or empirically.

Shertzer and Stone (1980) suggested that the use of supervisor ratings, peer ratings, sort analyses and client ratings to be criterion measures of effectiveness. Furthermore, it is pointed out that most research in counseling can be classified as either process research or out come research. Process research focuses on what occurs as counseling proceeds and outcome research is directed towards assessing the final product of counseling.

On the other hand, Yusuf (1998) set somewhat different criteria for evaluating counseling outcomes in Ethiopian context. The two criteria namely macro-level and micro-level evaluation are presumably appropriate for the Ethiopian situation. These are distinct but over lapping aspects.

According to him, the macro-level approach requires the global assessment of the role and emphasis counseling psychology has been given in Ethiopia. The micro level evaluation assesses deeply the outcome of psychotherapeutic interventions at a particular settings and an overall analysis of the counseling

as well as counselor characteristics. As we know, in our country very few researches concerning to counseling carried out. Little/no earlier research has been done on HIV/AIDS counseling in Ethiopia especially in region like Dire Dawa by professional counselors. Generally, the area is the untouchable with research by professionals.

2.11.12. Efficiency of HIV/AIDS Counseling

There are limitations of studies in this area. However, the available resource indicates difficulty on the efficiency of HIV/AIDS counseling. This is certainly one of the greatest weaknesses of HIV counseling (Mann, 1992). He also pointed out the crucial issue that must be incorporated in effective counseling. It includes:

- Client should ask what out come they expect. Where they would prefer to receive counseling from whom and why?
- Establishing effective community based on counseling potentially replicable models.

Davis and Fallow Field (1994) also stated on the effectiveness of counseling. According to their study the following factors believed to have significant impact on the effectiveness of the procedure or counseling.

1. Professional satisfaction

If a person is change of counseling acquired greater understanding of communication and necessary skill; he/she would more satisfy with what he/she does and less stressed. A major problem for all health professional in general counselor in particular is what has been called burnout. Such stress on health worker counselor reduces motivation.

According to Davis and Fallow-Field (1994) suggested that the problem can be avoided through:

- Developing and adequate framework of understanding communication that serves as guidance for the worker to there by develops confidence.
- Better skill with in the framework communication that result effectiveness of the person.
- A counseling approach would change the criteria of success. So that satisfaction may be derived from helping people in a broader sense not just solving their problem.

2. Client Satisfaction

The skilled implementation of counseling approach would increase client satisfaction. In this regard Davis et al., (1994) indicated that the increase ability to elicit the needs and expectation of the client not only enable to meet efficiency but also permits discussion and negotiation with the possibility of agreeing realistic goal. Then, basic counseling skill would help client satisfaction.

3. Treatment Adherence

They also sighted the adoption of basic skill in health care context is health care context is likely to reflect positively up on the treatment adherence. Then, clients much more likely to carry out the treatment or advice prescribed particularly when they are satisfied with professional communication. Clients are usually listen more to the professional they respect and who has greater understanding about the problems and difficulties from patients view.

4. Psychological Consequences

Improved counseling skill is also correlated to the benefits of client in psychological well being. This would involve direct positive effect and avoidance of unnecessary stress.

CHAPTER THREE

3. METHODOLOGY AND DESIGN OF STUDY

The aim of this study is to assess the counseling services offered in GOs and NGOs VCT centers of Dire Dawa, as well as, pointing out problems encountered in rendering the counseling service. To accomplish this approach followed was descriptive survey method. This method was selected since it is mainly appropriate to collect different kinds of data related with the problem under investigation.

3.1. Description of the Study Area

Dire Dawa is found 515k.m east of Addis Ababa and 350 km from Djibouti. It is the 2nd largest city in Ethiopia. The town is under the administration of Dire Dawa Administrative council which is directly accountable to the Federal Government. As it is the major commercial centers and there is high prevalence of HIV. The total population of the town is 383, 529 (DDDIPO, 2005). The prevalence of HIV/AIDS of urban and rural of Dire Dawa is 10.9% and 1.3% respectively (FDRE MOH, 2004).

Dire Dawa is one of the major towns expected to have high prevalence of HIV/AIDS and its consequence. Currently, Dire Dawa is becoming well known by its level of poverty and destitution, prevalence of high urban poverty HIV/AIDS, and related social evils are aggravated from time to time (DDDIPO, 2005).

3.2. Participants of the Study

The study focuses on identifying the main activities done at the counseling services. For this purpose individuals who are directly involved in a counseling process participated to information. Accordingly, the main participants of this study were clients, counselors and supervisors.

As the data obtained from the Dire Dawa Health and Social Affairs coordination Bureau, there are 2 VCT centers. One is GO VCT center and the other is NGO VCT center.

Counselor and client respondents were selected because they are the main participant in counseling process in VCT services and in their capacity to provide rich evaluation information about the counseling process. In the selection of supervisors due emphasis was given for the responsibility they hold in the VCT counseling services.

Table 1: Type and Number of Participants of the Study

Subjects	Number
Clients	52
Counselors	4
Supervisors	2
Total	58

3.3. Research Design

In this part the design of the study is explained in details. It consists of description of the manner in which discussion was made about the type of data needed for the study, subjects and sampling procedures, data gathering instruments, data collection procedures, methods of data analysis and other procedures that are crucial to the study.

The study followed both qualitative and quantities research designs. In this regard there are no hard and fast rules that are stated to use the one and reject the other or vice versa. Instead, prevailing trends favor the use of both designs in a single data. For instance, according to Aronson and others (1990) each data collection instrument has strengths and weaknesses. Regardless of this, the same authors suggested using each instrument accordingly as long as it is

appropriate to the purpose, size and situation under which research is conducted. Additionally, Best and Kahan (1989) stated the use of multiple data collection instruments as a rule, since each reveals different aspects of empirical reality.

3.3.1. Sampling Procedures

The population of the study includes the two VCT centers only available in Dire Dawa. According to the Dire Dawa Administrative Health and social Affairs Burea, a total of 2 VCT centers providing the service. These are: Dil Chora Hospital VCT center (GO) and Family and Guidance Association VCT center. Since, the number of VCTs in the town is only two; the researcher took both of them. Similarly, in both VCT centers there are 4 counselors then the researcher also took all of them to participate in the study.

Additionally, all clients who came to VCT centers and get the services (i.e, pre-test counseling) were asked to participate in the study when they exited from post test counseling and those who were willing to participate in the study were taken by using *convenient sampling technique* .A total of 56 clients were participated but later 4 were dropped out from GO VCT and then a total of 52 clients (i.e., 26 from Dil Chora Hospital and 26 from FGA Association Center) were involved in the study.

3.3.2. Data Gathering Instruments

Under this section, procedures of data collection, instruments of data collection, and the steps that the researcher followed in administering it are discussed.

To get sufficient information for the study the following three types of data collection tools were employed. These are questionnaire, observation and interview method

A. Questionnaire

Two sets of questionnaire, prepared and adapted were used to get information from clients and counselors of the target VCT centers (see Appendix A and B for the English version of the two questionnaires). The clients' questionnaire has got five parts (79 in number and the items are closed-ended and open-ended). The first part was prepared to generate information about the client's personal data (i.e. sex, age, educational level, occupation and marital status).

The second part was adapted from UNAIDS (2000a) to get information about counseling skills of counselors. Similarly, the third part was also adopted from UNAIDS (2000a) to get information about the contents of pre-test counseling and post-test counseling session.

The fourth part of the questionnaire was prepared in the form of a rating scale. The rating scale was designed to measure client's attitude towards the counseling services offered in VCT. For this reason, Likert scale was employed. The researcher used Likert scale because; it provides respondents a variety of specific categories from which they can select.

The other reason is that it allows subjects to prefer to answer anonymously when they are asked to rate their expressed opinion. The Likert scale consisted of specific categories of expressed opinion represented by numbers:

- 1 = strongly disagree, 2 = disagree;
- 3 = undecided; 4 = agree; and
- 5 = strongly agree

Then, each client has a score from 1 to 5 on each item, and a client's total score, representative of an overall attitude is simply the sum of the item scores. The fifth part of the questionnaire was prepared to obtain information about the facilities of counseling services in the VCT centers. This part was also designed to collect adequate data on constraints that hinder effective counseling services. With this perspective, the questionnaires addressed to the counseling rooms,

waiting area, the time given to each counseling session, the number of the session, confidentiality, a set of provision of the service.

The counselor questionnaire consists of 3 parts (51 in number) it consists of unstructured interview guides, close and open ended items were prepared (see the appendix C for the interview guide). The first part deals with personal information of the counselors, this part also prepared to get information about selection, training, supervision and support given to the counselor, problems faced by counselors in rendering the services and about counselors' general comments on the counselor's problems and their comments to improve the services.

The second part was prepared in the form of rating scale. The rating scale was prepared to measure counselors' attitudes towards counseling. To this effect Likert scale was selected and utilized for two reasons. This is because, it provides respondents a variety of specific categories from which they can choose and it also allows them prefer to answer anonymously when they are asked to rate their expressed opinion.

The 3rd part of the questionnaire was prepared to obtain information on the constraints that hinder effective counseling services.

B. Interview

In order to collect data from the supervisors' semi structured interview guide was prepared (see appendix 3 of the interview guide). The interview guides were mainly focused on issues of the support and supervision provided to the counselor, the role of the supervisor, on going training to counselors, ways of creating awareness about the VCT in the community to use the services, referral and linkage with other organizations or institutions, major constraints to provide the service and measures taken to over come the problems. The

information obtained using interview was used to substantiate the clients and counselors responses.

C. Observation

The research also observed the activities of the counselors, supervisors and the physical environment of the VCT centers.

3.3.3. Pilot Study

Before the implementation, the questionnaire was translated in to Amharic and administered to make the pilot study.

Pilot-study questionnaire were administered after the pre-test counseling and to collect after the post-test counseling.

All the items in the initial questionnaire form were pilot tested on 20 clients and 2 counselors of Addis Ababa Propride Enitoto Clinic VCT centers. The purpose of the testing was to collect data that would be used for screening the items. It was also finding out, instruction and response categories of the instrument as a whole were clear and comprehensible to respondents. The pilot study questionnaires were also used to ensure the reliability.

After calculating the internal consistency of the items, the weak items were weed out from further consideration (i.e. based on the feedback received an item analysis was made) and final questionnaire was designed as a result of this study modification was made on 6 items on clients and 5 items on counselors.

In the same way, after administering the attitude scale to preliminary samples, the researcher examined each item to see how well it discriminates between the client with most favorable attitudes (top 25 percent and those with least

favorable attitudes (bottom 25 percent). Those opinion statements up on which both the high score and the low score respond in the same way, have been discarded, on the assumption that they did not measure the same attitude as a scale as a whole. Based on these out of the 15 items of clients' attitude statement designed during the pilot stage, 3 items were discarded. Thus, the (i.e. 12 items) was constructed from the items that consistently elicit agreement from the most favorable pilot study subjects and vice versa.

The same procedure was done for counselor attitude statements. Based on these, out of 17 items of counselors' attitude statements designed during the pilot test, 4 item were discarded. Thus, the final scale (i.e. 13 attitude statement) was constructed from the items that consistently elicit agreement from the most favorable pilot-study subjects and vice versa.

And then, computing coefficient of alpha using the data collected during the pilot study survey assessed reliability of the instrument. The computation yielded reliability coefficients are presented as follows:

Table 2: Reliability Coefficient of the Instruments

Instrument	Reliability Coefficient (α)
Attitude scale of counselor	.57
Attitude scale of clients	.81
Counseling skill	.74
Content of pre-test counseling	.80
Content of post-test counseling	.83

The validity of instruments is checked on several grounds. The formulated instruments were approved by two senior graduate psychology students and one psychology instructor (MA) in Alemaya University have commented on the instrument in terms of clarity, precision, and relevance from assessing what is intended to assess. Then, content validity was confirmed.

Finally, the fact that moderate and high reliability coefficient has been achieved.

3.3.4. Data Collection Procedure

The department of psychology of Addis Ababa University gave to the researcher a letter of recommendation that requests cooperation from the concerned authority to collect data for the research work from the concerned organization. With this, first the researcher made contact with the organization heads, to ask permission and explain the purpose and objective of the study was introduced. Then after permission was granted from the director and coordinator, the researcher made a contact with VCT counselors. After identifying our target subjects, data was collected by the researcher and 4 other assistances who were Para -counselors in the HIV/AIDS Clubs in Dire Dawa town .These assistances were selected because they have better knowledge and willing to participate in the data collection. The data was collected from February 2006 to April, 2006.

The first step was training enumerators for the survey. The training was given for them on the survey questionnaire and how to approach the respondents. The field work was closely supervised by the researcher.

3.3.5. Data Analysis

Depending on the nature of the collected data, different statistical techniques were employed. For the close-ended questionnaire items up on which clients and counselors were organized in line with the objective of the study and SPSS(Statistical Package for Social Science)-10 windows version was applied to calculate different statistics. Then, after, to summarize the data obtained, simple frequency counts, percentage, mean and t- test were used.

For open-ended questionnaire items, the response of each individual was coded accordingly. After the data obtained they quantified into simple frequency counts and percentage.

In the attitude measurement scale, each response have five specific categories (i.e. 5 = strongly agree 4= agree, 3= undecided, 2= disagree and 1 = strongly disagree). Thus, an individual score was determined by the sum of the point values given for each statement. After scores were categorized into high and low using a mean test, the attitude score of each client or counselor was summed and then the median score was calculated. After the scores of each client or counselor was compared with the grand median. If the particular score was above the grand median, the observation was assigned o the “above median” category. If it was below the median, the observation was assigned to the “below the median” category. Scores that exceed the median would indicate a positive attitude towards counseling and vice versa.

Through this, the data was arranged into a two by two table followed by the computation of the t- test to show whether there is a significance difference or not between government and non-government VCT centers. The significance level was set at $\alpha = 0.05$. So t- test was run and mean comparison was taken.

CHAPTER FOUR

4. RESULT OF THE STUDY

4.1. Data Analysis from Client Questionnaire

Table 3: Socio-Demographic Characteristics of the Clients

Variables	Categories	No	%
Sex	Male	25	48.1
	Female	27	51.9
Educational level	Illiterate	2	3.8
	Primary	2	3.8
	Secondary	15	28.8
	High school	17	32.7
	College and above	16	30.8
Occupation	Unemployed	5	9.6
	House wife	8	15.4
	Civil servant	19	36.5
	Student	7	13.5
	Military	7	13.5
	Merchant	2	3.8
	Others	4	7.7
Marital status	Unmarried	21	40.4
	Married	20	38.5
	Divorced	9	17.3
	Windowed	2	3.8

4.1.1. Skills of Counselors

Table 4: The Distribution of Clients Rating on the Counseling Skills Counselors by Type of VCT Centers

No	Counseling Skills	Category	Type of VCT		Total N=52
			Gov.t N= 26	NGO N=26	
1	Established good rapport	H	2(7.7%)	10(38.5%)	12(23.1%)
		M	15(57.7%)	12(46.2%)	27(52%)
		L	9(34.6%)	4(15.4%)	13(25%)
2	Listening actively/good listener	H	3(11.5%)	5(19.2%)	8(15.4%)
		M	19(73.1%)	16(61.5%)	35(67.3%)
		L	4(15.4%)	5(19.2%)	9(17.3%)
3	Supportive and non-judgmental	H	16(61.5%)	18(69.2%)	34(65.4%)
		M	7(26.9%)	4(15.4%)	11(21.5%)
		L	3(11.5%)	4(15.4%)	7(13.5%)
4	Use easy and clear language	H	6(23.1%)	6(23.1%)	12(23.1%)
		M	14(53.8%)	19(73.1%)	33(63.5%)
		L	6(23.1%)	1(3.8%)	7(13.5%)
5	Information gathering	H	2(7.7%)	12(46.2%)	14(27%)
		M	9(34.5%)	10(38.5%)	19(36.5%)
		L	15(57.7%)	4(15.4%)	19(36.5%)
6	Information giving	H	4(15.4%)	9(34.6%)	13(25%)
		M	18(69.2%)	15(57.7%)	33(63.5%)
		L	4(15.4%)	2(7.7%)	6(11.5%)
7	Give time for clients to understanding information and respond	H	2(7.7%)	2(7.7%)	4(7.7%)
		M	13(50%)	18(69.2)	31(59.6%)
		L	11(42.3%)	6(23.1%)	17(32.7%)
8	Facilitated voluntary decision making	H	19(73.1%)	19(73.1%)	38(73.1%)
		M	5(19.2%)	5(19.2%)	10(19.2%)
		L	2(7.7%)	2(7.7%)	4(7.7%)
9	Accepts clients feeling and help the clients for bringing good solutions for their problem	H	1(3.8%)	4(15.4%)	5(9.6%)
		M	13(50%)	18(69.2%)	31(59.6%)
		L	12(46.2%)	4(15.4%)	16(30.8%)

Major areas of counseling skill that are interpersonal relationship, listening information giving, supportive and non-judgmental use easy and clear language information giving, information gathering, give time for clients facilitation for decision making and accepts/ understanding clients problem and feelings an find solutions for their problem were taken and accordingly clients rated the counselors' skill.

As shown in Table 4 at above interpersonal relationship skill of counselors rated as high by 23.1%, medium by 52%, low by 25% of the clients. Regarding to listening skills of counselors rated as high by 18%, medium by 67% and low by 17%, supportive and non-judgmental skill of counselor 65.4% rated as high, 21.5% as medium and 13.5% as low. In easy and clear language skills of counselor also rated as high by 23.1%, medium by 63.5% and low by 13.5% of the clients. In respect to information gathering skills of counselor 27% rated as high 36.5% as medium and low, where as in information giving skills of counselor 25% as high, 63.5% as medium and 11.5% as low. In giving time for clients to understand information and to respond skill of counselors rated as high by 7.7% medium by 59.6% and 32.7% as by low. In accepting clients feeling and problems and help them by bring solutions together with clients skill of counselors rated as high by 9.6%, medium by 59.6% and low by 30.8%. With regarding facilitated voluntary decision making skill of counselors 73.1% rated as high, 19.2% as medium and 7.7% of the respondents as it was low.

Totally, there was difference in the score of counseling skill by the type of VCT centers, a big difference was observed in interpersonal relationship counseling skill of counselor where by 38.5% of the client NGO VCT center was rated to be high while only 7.7% clients of GO VCT center was rated to be high.

Similarly information gathering skills of counselors were considered to be high among 46.2% clients of non-governmental VCT centers but only 7.7% of clients in governmental VCT had such rating.

Table 5: Difference of Clients Rating For Go and NGO VCT Centers in Counseling Skill

Type of Vct	N	Mean	Std. Deviation	Std. Error mean	df	t
Go-Total	26	15.96	3.68	.72	50	6.83*
NGO-Total	26	18.42	4.99	.98		

* *t* – Value is significant at α 0.05 level (2- tailed)

Table 5 shows that, there is statistically significant in counseling skills of counselors between GO and NGO VCT centers $t(50) = 6.83, p < 0.05$. Then the test of significance between the mean scores of GO VCT center ($x = 15.96$) and NGO VCT center ($x = 18.42$) by the use of t-test revealed that the difference between the means on counseling skills of the counselors that rated by the clients is statistically significant. In other words NGO counselors have more skills than GO counselors. This may be NGO counselor got better trainings than GO counselors.

4.1.2. Contents of VCT Counseling Sessions

VCT counseling session contents were considered in terms of pre and post-test counseling process and practice. To ensure the coverage of pre and post test counseling contents items (All items of part three and part four see Appendix B) in the questionnaire were presented clients whether they *agree or disagree* on coverage of the contents of the *counseling session*.

4.1.3. Pre-test Counseling Contents

Table 6: The Distribution of Pre-test Counseling Session Content Coverage by GO and NGO VCT Center Client Respondents

Variables	Category	Client respondents		Total N = 52
		GO VCT N=26	NGO VCT N=26	
Reasons for attending discussed	Yes	26 (100%)	26(100%)	52(100%)
	No	0(0%)	0(0%)	0(0%)
Knowledge about HIV/AIDS and modes of transmission explored	Yes	24(92.3%)	25(96.2%)	49(94.2%)
	No	2(7.7%)	1(3.8%)	3(5.8%)
Misconception corrected	Yes	25(96.2%)	25(96.2%)	50(96.2%)
	No	1(3.8%)	1(3.8%)	2(3.8%)
Assessment of personal risk profile carried out	Yes	21(80.8%)	24(92.3%)	45(86.5%)
	No	5(19.2%)	2(7.7%)	7(13.5%)
Information concerning the process of HIV test given	Yes	22(84.6%)	26(100%)	48(92.3%)
	No	4(15.4%)	0(0%)	4(7.7%)
Discussion of possible test results and meaning of HIV positive and negative	Yes	23(88.5%)	24(92.3%)	47(90.4%)
	No	3(11.5%)	2(7.7%)	5(9.6%)
Capacity to cope with HIV positive results discussed	Yes	19(73.1%)	22(84.6%)	41(78.8%)
	No	7(26.9%)	4(15.4%)	11(21.2%)
Discussion of potential needs available support	Yes	16(61.5%)	16(61.5%)	32(61.5%)
	No	10(38.5%)	10(38.5%)	20(38.5%)
Follow up arrangements discussed	Yes	15(57.7%)	18(69.2%)	33(63.5%)
	No	11(42.3%)	8(30.8%)	19(36.5%)
Time allowed to think through issues	Yes	14(53.8%)	15(57.7%)	29(55.8%)
	No	12(46.2%)	11(42.3%)	23(44.2%)
Informed consent/ dissent given freely	Yes	24(92.3%)	25(96.2%)	49(94.2%)
	No	2(7.7%)	1(3.8%)	3(5.8%)
Adequate time for question and clarification given	Yes	9(34.6%)	10(38.5%)	19(36.5%)
	No	17(65.4%)	16(61.5%)	33(63.5%)

The content coverage of pre- test counseling session by client respondents was indicated in Table 6, all respondents reported that reason for attending the session was discussed, 49 (94.2%) of the client respondents assured knowledge about HIV/AIDS and its modes of transmission was explored, 50(96.2%) clients reported that misconception about HIV/AIDS was corrected. 45(86.5%) of

with that of NGO VCT center $t(50)=1.45, p<0.05$. Hence, the test of significance between the mean score of GO VCT center ($x=15.50$) and NGO VCT center ($x=14.54$) by the use of t-test revealed that the difference between the means on content coverage during pre-test counseling session is statistically insignificant. This means both VCT centers have similar content coverage during pre-test counseling session.

4.1.4. Post-test Counseling Contents

Table 8: The Distribution of Post-test Counseling Session Content Coverage by GO and NGO VCT Client Respondent

Possible post test counseling consents	Response	Client Respondents		Total N = 52
		GO N = 26	NGO N = 26	
Results given simply and clearly	Yes	26(100%)	26(100%)	52(100%)
	No	0(0%)	0(0%)	0(0%)
Enough time allowed for the result to sink in	Yes	23(88.5%)	16(61.5%)	39(69.2%)
	No	3(11.5%)	10(38.5%)	13(25%)
Discussion of the meaning of the result	Yes	24(92.3%)	26(100%)	50(96.2%)
	No	2(7.7%)	0(0%)	2(3.9%)
Discussion of personal, family and social implications	Yes	23(88.5%)	25(96.2%)	48(92.3%)
	No	3(11.5%)	1(3.8%)	4(7.7%)
Discussion of a personal risk reduction	Yes	20(76.9%)	21(80.8%)	41(78.8%)
	No	6(23.1%)	5(12.2%)	11(21.2%)
Dealing with immediate emotional reaction	Yes	17(65.4%)	19(73.1%)	36(69.2%)
	No	9(34.6%)	7(26.9%)	16(30.8%)
Checking availability of immediate support	Yes	16(61.5%)	17(65.4%)	33(63.5%)
	No	10(38.5%)	9(34.6%)	19(36.5%)
Discussion of follow up/care and support	Yes	10(38.5%)	12(46.2%)	22(42.3%)
	No	16(61.5%)	14(53.8%)	30(57.7%)
Options and resources identified	Yes	8(30.58%)	11(42.3%)	19(36.5%)
	No	17(65.4%)	15(57.7%)	32(61.5%)
Plans, intention as and actions reviewed	Yes	9(34.6%)	13(50%)	22(42.3%)
	No	17(65.4%)	13(50%)	30(57.7%)
Follow up plan discussed	Yes	12(46.2%)	15(57.7%)	27(51.9%)
	No	14(53.8%)	12(42.3%)	25(48.1%)
Referral discussed when necessary	Yes	11(42.3%)	12(46.2%)	23(44.2%)
	No	5(19.2%)	14(53.8%)	19(36.5%)

It is shown that in table 8 that out of 52 all of them (26 from GO and 26 from NGO) clients replied that HIV test result was given simply and clearly. Out of the total client respondents, 39 (69.2%) (23 from GO and 16 from NGO VCT) reported that enough time was allowed for the HIV test result to sink in 50 (96.2%) (24 from GO and 26 from NGO) client respondents agree that the meaning of test result was made clear while only 2 (3.9%) of both VCT centers disagree 48 (92.3%) of all respondents (23 from GO and 25 from NGO VCT) replied that discussion of personal family and social implication was addressed. With regard to risk reduction plan, 20 from GO and 21 from NGO, a total of 41 (78.8%) client respondents reported the discussion was made while 11 (21.2%) of clients' disagree 36 (69.2%) (17 from GO and 19 from NGO) clients respondents reported emotional reaction to test result was entertained, 33 (63.5%) (16 from GO and 17 from NGO VCT) clients respondents reported that availability of immediate support was checked; 22 (42.3%) (10 from GO and 12 from NGO VCT) clients reported that discussion was made about follow up care and support but 30 (57.7%) (17 from GO and 13 from GO) clients reported that negatively and 27 (51.9%) of clients replied follow up plan was also discussed while 25 (48.1%) clients disagree 19 (36.5%) 8 from GO and 11 from NGO VCT) clients reported that options and resources was identified and discussed- where as 32 (61.5%) of them were disagree. In the same way, 22 (42.3%) (9 from GO and 13 from NGO VCT) clients replied that plans, intentions and actions was reviewed. But 30 (57.7%) clients disagree. It is also indicated that 23 (44.2%) 11 from GO and 12 from NGO VCT client respondents reported that discussion about referral was made.

From the above, we can understand that the majority of that both government and non-government VCT clients agree on that result was given simply and clearly, time was allowed from the result of to sink in, the meaning of the result was discussed, discussion of personal, family and social implication and personal risk reduction plan and checking availability of immediate support was discussed.

On the other side, in both VCT many of client respondents reported identification of options and resources, plans, intentions and actions and referral was not discussed very well when compared with others issues during the post-test counseling session.

Table 9: Difference of Post-Test Counseling Session Content Coverage of GO and NGO VCT Centers

Item	N	Mean	Std. Deviation	Student Error Mean	df	t
GO	26	19.65	3.77	.74	50	-2.49
NGO	26	20.19	3.86	.76		

Table 9, also shows that no significant difference between the mean scores of GO VCT center ($\bar{x}=19.65$ and NGO VCT center ($\bar{x}=20.19$) as measured by the content coverage items of post-test counseling session $t(50)=-2.49, p < 0.05$. Thus, the content coverage of post-test in both VCT centers appeared to be similar.

4.1.5. Attitude of Clients towards the Counseling Services

Clients were asked to rate statements that are intended to measure the extent of attitude towards VCT counseling. The rating scale was constructed in the form of Likert scale. As a result clients have five alternatives to select, ranging from strongly disagree up to strongly agree. Thirteen items (see appendix A part Five) of opinion statements were used as a measuring device. The following table is the summary result of client responses.

Table 10: Clients' Attitude towards Counseling Service by VCT Type

Item	Client respondents		
	Government VCT	NGO VCT	Total N = 52
Below median	11(42.3%)	8(30.8%)	19(36.5%)
Above median	11(42.3%)	15(57.7%)	26(50%)
Undecided	4(15.4%)	3(11.5%)	7(13.5%)
Total	26(100%)	26(100%)	52(100%)

The median for the 52 respondents, i.e. the grand median is 39.5. As shown in table 10, indicates clients who scored above the grand median and those who scored below are categorized in terms of the type of VCT center where they got the service (i.e. GO and NGO) forming a two by two contingency table. When we look at the distribution of data on the table, it reveals that out of the 26 client respondents of GO VCT center client respondents 11 (42.3%) fall below the median, while equal number of respondents i.e. 11 (42.3%) fall above the median. But 4 of them were undecided/neutral. Similarly out of 26 NGO VCT center client respondents, 8 (30.8%) fall below the median where as 15 (57.7%) fall above the median and 3 (11.5%) of client respondents were undecided/neutral. This indicates that, 11 (42.3%) of GO and 15 (57.7% of NGO VCT clients exhibited positive attitude o the counseling service of VCT. In general 50% of all clients have exhibited a favorable attitude towards the counseling service.

Though 19% of clients exhibited unfavorable attitude towards counseling, almost all (99%) reported that they took the test on the basis of their consent. But only some of the clients reported that they are indirectly forced to take the test to get only the HIV test result certificate to conform their sero-status for scholarships, to go abroad and for marriage.

Table 11: Difference of Clients Attitude counseling Towards Counseling between GO and NGO VCT Center

Type of VCT	N	Mean	St. Deviation	Std. Error of Mean	df	t
GO	26	38.73	3.10	.61	50	-1.42
NGO	26	39.65	2.13	.42		

As indicated in the above table, the attitude of clients' towards counseling between GO and NGO VCT center has not showed a significant difference with

that of NGO VCT center $T(50) = -1.42$, $P < 0.05$. Hence, the test of significance between the mean scores of GO VCT center ($X = 39.65$) by the use of t-test revealed that the difference between the mean of attitude of clients' is statistically insignificant. Thus, there is a tendency of similar attitude of GO and NGO clients' towards counseling.

4.1.6. Facilities

4.1.6.1. Privacy

To assess the availability of separate space or room for counseling session, items (see appendix A part 4 item number 3 in the questionnaire asked clients to rate the consoling space.

Table 12: Frequency and Percentage Distribution of Clients Rating to the availability of Private Space for Counseling

Items	Category	Client respondents		
		GO VCT N = 26	NGO VCT N = 26	Total N = 52
Is there adequate space to ensure private	Yes, there is adequate space to ensure privacy	0	10(38.5%)	10(19.2%)
	Yes, there is some but not adequate to ensure privacy	26(100%)	16(61.5%)	42(80.8%)
	No, there is no private space	0	0	0
	Total	26(100%)	26(100%)	52(100%)

As indicated in the above Table 12, among all client respondents, 10 (38.5%) from NGO VCT clients agree with the presence of adequate separate room to ensure privacy. Where as all of them from GO VCT clients reported that there is adequate separate room to ensure privacy. While all 26 (100% from GO VCT clients agree on presence of separate room but it was not adequate to ensure

privacy. Where as 16 (61.5%) of NGO client respondents replied that there was separate room but not adequate.

Table 13: Difference in GO and NGO VCT Centers of Private Space for Counseling

Type of VCT	Category	N	Mean	Student Deviation	Student Error Mean	df	t
GO	Privacy	26	2.00	.00	.00	25	-3.95
NGO	Privacy	26	2.38	.49	.097		

As presented in Table 12, there was no statistically significant difference between the mean scores of GO VCT center ($\bar{x}=2.00$) and NGO VCT center ($\bar{x}=2.38$) as measured by the levels of privacy of GOs and NGOs VCT centers $t_{(25)} = -3.95$, $p < 0.05$. In other words, both VCT centers room have similar problems to ensure privacy. One was not better with the other in ensuring privacy.

The researcher's observation revealed that both VCT centers have separate room for counseling. In respect to the quality of the rooms, there was a difference between the two. The GO VCT center office was highly congested/small; it was very hot, no window, no ventilator and it was found that in front of the other services rooms because of this there was great/full of noise, and other patients and hospital workers were walking around there.

Even, the conversation was heard and visual privacy was not maintained while in the NGO VCT center it was better in quality than GO to ensure privacy. But the problem here was sometimes, they used the office for other purposes i.e., they used for treatment for other patient. It posed on attempting to ensure privacy.

4.1.6.2. Waiting Area

Table 14: Distribution of Clients Rating to the Availability of Waiting Area

Item	Category	Client Respondents		
		GO VCT N = 20	NGO VCT N=26	Total N = 52
Is there a waiting area	Yes, there is adequate area	0	5(19.2%)	5(19.2%)
	Yes, there is some but not adequate	2(7.7%)	21(80.8%)	22(42.3%)
	Not at all	24(92.3%)	0	24(92.3%)
	Total	26(100%)	26(100%)	52(100%)
How do you rate the waiting area	Very good	-	2(7.7%)	2(7.7%)
	Good	2	20(76.9%)	22(7.7%)
	Not good	0	4(15.4%)	4(7.7%)
	Total	2(77%)	26(100%)	28(53.8%)

As it is showed in the above table14, among all client respondents only 5 (19.2%) of he respondents from the NGO VCT center reported that there was adequate waiting area for counseling service and 2 (7.7%) of clients from GO VCT center said that there was a waiting area but not adequate whereas 21 (80.8%), client from NGO responded that here was a waiting area but it was not also adequate. The majority of client (24 (92.3%) of clients from GO VCT center confirmed that there was no a waiting area at all.

Regarding to the rating of the waiting area, only 2 (7.7%) of he client respondents rated the waiting area as very good. Where as, 22 (42.3%) (2 from GO and 20 from NGO) of the respondents the waiting area was good and 4 (7.7%) from NGO VCT clients rated the waiting area was not good.

The researcher's observation confirmed that there was a waiting area in NGO VCT center. But it was not adequate and very good. In the waiting are

information about HIV/AIDS was given for the clients was not enough. In the waiting area, only posters were available. These were no leaflets, movie or video drama. In addition to this, the waiting area was also used for other services (for clients that were coming for other purposes like medical examination. Where as in GO VCT center, even there was no a waiting area at all. This is highly crippled the services.

4.1.6.3. Seating Arrangement

In both VCT center i.e. 52 (100%) clients responded that the seating arrangement was across the corner of the counselor table. The observation at also confirmed that the seating arrangement was across the table in both VCT centers.

4.1.6.4. Confidentiality

Clients were asked what they have discussed during the counseling process about the way or how confidentiality was ensured. Among the 52 clients respondents, 15 (28.8%) reported that confidentiality was ensured by anonymous testing and 20 (38.5%) clients replied that keeping HIV test results and the issues discussed during the counseling session as a secrete ensured it, while the remaining clients reported that discussion was not made about the way how confidentiality is ensured. The discussion revealed that an issue about confidentiality was ensured by keeping HIV test result and issues discussed as secrete in both VCT centers.

Finally, clients were asked to list the major problem in the VCT center during the counseling process. Among the 26 client respondents from GO VCT center, 22 (42.3%) of them reported that lack of conducive office and waiting area. Additionally, 16 (30.8%) of them reported that lack of skilled and experienced counselors 44 (84.6%) of respondents in both VCT center mentioned that they had a problem in shortage of time in counseling process. Furthermore 17

(32.3%) of them-replied that lack of follow up arrangements. Among the total client respondents 15 (28.9%) of them reported that the VCT center is not near and inaccessible for beneficiaries. That is far from their house.

Moreover, some of the clients from NGO VCT center clients reported that the center didn't deliver ART service and the center referred clients to GO hospital to get the service because of these clients mentioned they suffered to get ART and they said it should be in VCT services.

The other thing is that HIV test result certificate is given in both cases for only referral purpose to refer clients for support or services like, (medicine and material like food, money,.) and visa in both VCT centers.

Additionally, half of the client respondents reported that the counseling services played a great role for bringing behavioral change and helped them to get different service but the centers was not adequate to serve beneficiaries effectively. And, in both center, they mentioned there was not hot-line counseling service. They said hot-line counseling service assisted those individual who did not interest to go the VCT physically because of different reasons.

4.2. Data Analysis from Counselor's Questionnaire

Socio-Demographic characteristics of counselors' a total of 4 counselors, (2 from government and 2 from non-government participated in this study.

Table 15: Distribution of Counselors Socio-Demographic Characteristics (N = 4)

Characteristics	Categories	Counselor Respondents in No
Sex	Male	1
	Female	3
Profession	Nurse	4
	Psychologist	0
	Physician	0
	Others	0
Years of experience in VCT counseling	Less than a year	0
	One year	1
	Two years	1
	Three years	2
	Greater than 3 years	0
Educational level	Primary	0
	Secondary	0
	Tertiary	4
Working hours/day	4 hours	0
	6 hours	0
	8 hours	4
	Greater than 8 hours	0
Working days/week	5 days	2
	6 days	2
	7 days	0
How many clients do you counsel	5 and less	0
	6 to 10	4
	11 to 15	0
	16 to 20	0
	More than 20	0

All counselors who participated in this study were professionally nurse and they were tertiary educational level. In respect to counseling experiences 2 of the respondents had 3 years of experience while 1 of the respondent has one year and the other one has 2 year experience. All counselor respondents work 8 hours per day. Among the 4 respondents, 2 counselors from GO VCT center

work 5 day per week (from Monday to Friday) the other two (i.e. NGO VCT) work 6 days (from Monday to Saturday) per week.

Moreover, among 4 counselors, 2 of them reported that they counseled of clients per day while 2 counselors for NGO VCT center counseled 8 clients. The observation also confirmed this.

4.2.1. Selection of Counselors

The counselors were interviewed how they were selected to render counseling session. All of them were reported that they were proposed by their immediate boss. There is no one that employed as counselors from the very beginning previously, their work were other.

Moreover, NGO VCT counselors and one from GO VCT center counselor said they were working others activities on their profession in their organization. They provided counseling services as an additional work.

4.2.2. Pre-Service Training of Counseling

All counselor respondents reported that they have go pre-service training out of the four respondents. Among four of them 2 counselor respondents (from NGO VCT center) reported that their pre-service training duration was 15 days, the remaining 2 counselors (from GO VCT center), their pre-service training duration was 5-10 days (one counselor for 5 days, the other one is to days).

All counselors (4 of them) rated the training was good. While all of them mentioned that their pre-service training was inadequate and they reported that they feel that they need more training in the area of burn out management, how to mitigate obsession problem implementation of ART, information gathering techniques and managing clients' emotional reaction, and different theories and therapy approaches.

4.2.3. In-service Training of Counselors

Among 4 counselors 2 respondent (one from GO VCT center and one from NGO VCT center) responded that they did not get any in-service/on-going training and refreshment courses for a week. But the other two reported that they got in-service training two times after they got basic training.

4.2.4. Supervision

Furthermore, the counselors were interviewed whether their work have been supervised or not. Accordingly, out of the 4 counselor respondents 2 (from GO counselor VCT center) of them replied that their works were supervised 1 time per year. They said the supervision taken place inadequate way. The other 2 (from NGO VCT center) their works were supervised by two times per year. These also said supervisor supervised their work not adequately and can not provide technical support and emotional support. Generally, all of them said the supervision were not good and carried out by professionals or trained persons, there is no person that did only counseling supervision.

Table 16: Attitudes of counselors Towards Counseling services Distribution of Attitude Score Above and Below the Median (N = 4)

Category	Counselor respondents		Total N = 4
	GO VCT N = 2	NGO VCT N = 2	
Above median	1 (50%)	1 (50%)	2 (50%)
Below median	1(50%)	1(50%)	2(50%)
Total	2 (100%)	2 (100%)	4 (100%)

The grand medium score for the 4 counselors is 49. Then, the counselors who scored below and above the grand median are categorized in terms of the type of VCT (i.e. GO and NGO) centers. As it is indicated in table 15, two counselors fall above the median. The other, two counselors were fall below the grand median. Then, half of the counselors have not favorable attitude towards counseling.

Table 17: Difference of Attitude of Between GO and NGO Counselor

Type of VCT	N	Mean	Std. deviate	Std. error of mean	df	t
GO	2	48.42	2.83	2	2	.33
NGO	2	50	.71	.50		

As table 17, reflected that there was no difference statistically between the attitude of counselor of the GO and NGO VCT center $t(2) = 0.33, p < 0.05$. Accordingly, it appears that there is a tendency of similar attitude on the part of the counselors, in both VCT centers towards counseling services.

4.2.5. Constraints of Counselors

Table 18: Distribution of Problems Encountered in Provision of Counseling Perceived by Counselors (N = 4)

No	Item	Counselor Respondent		Total
		Government VCT n = 2	NGO VCT N = 2	
1	Work load	2	2	4
2	Lack of emotional and technical support	2	1	3
3	Lack of supervision	2	2	4
4	Staff turn over	1	0	1
5	Staff moved to other posts	1	0	1
6	Lack of privacy	2	0	2
7	Lack of confidentiality	1	0	1
8	Lack of waiting area	2	0	2
9	Lack of in-service training	1	0	1
10	Lack of administrative and financial support	1	0	1
11	Lack of incentives	2	0	2
12	Lack of experience	0	0	0

As indicated in table 18 all of the counselors (4 of them) reported that the presence of work load, 3 respondents assured that the lack of emotional and technical support, 4 of them said lack of supervision; GO counselors also reported that lack of privacy, also waiting area and incentives. These are the major constraints of perceived in the provision of the services counselors were also asked/ interviewed

the major problems of the VCT centers. Accordingly, the repeatedly mentioned problems in GO's VCT center is lack of incentives for counselor, lack of adequate/intensive in-service/ on-going training, lack of adequate office, waiting area, no hot line counseling service lack of experiences, supporting staff and work load are the major ones.

Table 19: Difference of Constraint GO and NGO VCT Center

Type of VCT	Category	N	Mean	Std. Deviation	Std. Error mean	df	t
GO	Constraint	2	7	1.41	1.00	2	3.67
NGO	Constraint	2	1.5	.71	.50		

Additionally, as presented in Table 19, there was no statistically significant difference between the constraints in GO and NGO VCT centers $t(2) = 3.67, p < 0.05$. Therefore, it reveals that in both VCT centers there are similar constraints to provide the services for clients that is one is not much better than the other..

According to them, these created the mismatch between the demand of the service problem, no vertical and horizontal relationship with professionals like psychologists, social worker, psychiatrists etc to refer client when beyond us.

On the other hand, the main constraints faced by counselors are work load, lack of educational materials like IEC, managing clients emotional reactions to their HIV test results, net work in coordinate manner concerning prevention work, clients unwillingness to attend post-test counseling sessions and lack of well organized follow-up counseling, lack of adequate and coordinated referral system and inadequate technical support and shortage of time. Because of these counselors experienced considerable stress.

Where as all counselors confirmed even if the VCT centers were not adequate, the number of clients increased from day to day when compare previously. And, they said VCT is the key for prevention and control the virus and also it is an entry

point providing many services for beneficiaries. That is why; people were coming to the VCT centers and know their sero-status,

4.3. Data Analysis from Supervisors Interview

Among the 2 VCT centers, there were 2 the so called supervisors (for each one). The NGO supervisor trained Health Officer in Profession, the GO one is a nurse. She is female. But both of them are not trained in counseling supervision. The NGO supervisor is also coordinator for other project activities that are carried out by the organization. The GO VCT center supervisor was also busy with other activities/ in hospital. As GO VCT center supervisor said she assigned as a supervisor just for fulfill the procedure and to get fund from donors.

She assigned as a supervisor more than 3 years but she tried to supervise only at once with her 3 days training of basic counseling not counseling supervision.

The so called supervisors were interviewed about what were their roles in the VCT center. The NGO VCT center supervisor replied that in addition to his regular duties i.e. coordinating, planning, monitoring and controlling other many project activities and his role in counseling services was facilitation and administrative support to the counselor and supervising the work of counselors.

The GO VCT center supervisor reported that she was not having a significant role because the hospital administration was not provided her the legitimacy authority and training for her. She has a lot responsibility with other activities.

Both of them reported that to ensure privacy they were separate room for counseling and to ensure confidentiality the GO VCT center supervisor reported that anonymous testing was used while the NGO VCT center called supervisor reported that confidentiality was assured to the client by keep test result and other issues a secret.

The NGO VCT center supervisor reported that the support given to the counselors have more of management/administration area and very less technical and emotional support because he need training in counseling and supervision to do so. While the GO VCT center so-called supervisor reported that there was no technical, management and technical support for counselors because she didn't have enough training and conducive environment and authority for supervision. In general, both assured that the support given to counselors by the supervisors was not adequate. They said that it is better to say there is no supervisor in the VCT centers.

Additionally, the NGO VCT center supervisor reported that the VCT center charge clients for the service they provide. The charge of the service is 5 birr. But the GO VCT center provides the service with free of any form of charge.

In respect to linkage with other institutions/organizations, the NGO VCT center supervision responded that the center have some relationships with organizations especially with the hospital, but both reported that there is no a well-organized linkage with other institutions.

The major constraints faced by counselors as reported by supervisors were lack professional counselors, lack of training, lack of experience, work load, lack of educational materials, like supervisor guide lines, lack of vertical and horizontal relationship with other organizations and professionals, limited VCT centers and inadequate technical and emotional support.

Both of supervisors mentioned that although their services were inadequate and insufficient, the number of clients increase from time to time. This indicated that VCT is crucial for prevention of the HIV and an entrance to provide services related with the problem. Additionally, in Dire Dawa, now a days many people considered blood test for HIV before marriage. This is one indicator for bringing desired behavioral change in he community. They mentioned also youths and teenagers came to the VCT centers to blood test for HIV.

CHAPTER FIVE

5. DISCUSSION

HIV/AIDS has become a prevalent disease and is a top global problem. Its impact is becoming severe and it is considered as highly destructive. It spreads at alarming rate and to become the main cause of deadly virus especially for young and middle age (highly productive and reproductive members of the society).

Although great deals of efforts are on curative medicine and effective vaccine for problem remain elusive. The primary prevention through the provision of information, education and communication strategies (IEC) to bring behavioral change have been given to all groups with special emphases to young and vulnerable groups. But the efforts to bring the needed behavior is not that much remarkable. Accordingly, a better way to some one who knows his/her status will be reliable to take preventive measures than some one who does not. Thus, to day VCT is becoming an ideal/core means of prevention and control mechanisms.

According to UNAIDS (2002), VCT is now acknowledged as effective strategy for HIV prevention. HIV testing through VCT is essential for access to AIDS care. With regard to the importance of VCT, the study also indicated that the majority of the respondents felt the service is necessary and reason given by the respondent are the desire to know HIV status; avoiding risk behavior, to get counseling service, to get ART services and so on.

Moreover, the importance of VCT services was reported by UNAIDS (2000b), the knowledge of HIV status can help people to make decision to protect themselves and other from infection and knowledge of HIV status acquired voluntarily in a psychological and social supportive environment will be a significant motivator

for the individuals and their partners to initiate and maintain safer sex behavior.

According to UNAIDS (2002), in some area even though VCT service has been established, people are reluctant to attend for counseling and testing. This may be because of lack of adequate services. Similarly, FDRE MOE (2003) suggested that although VCT become increasingly available in Ethiopia, many people are still reluctant to be tested. This reluctance of VCT is may be due to factors such as lack of perceived benefits, poor access to clinical and support, poor quality of standard of counseling and testing services.

Counseling is a science and an art, as a science it requires knowledge, techniques and skill. As an art it calls for intuition some talent and creativity. Counseling requires a lot of experience and patience to be effective. But, the result of this study indicates that the experience of counselors ranges from one year to three years. This shows that counselors are not well experienced. The counselor-client relationship and interaction is crucial element in the counseling process. The skills that the counselors possess are very important. Davis & Fallow-field (1994) also mentioned that the criteria to be a counselor, they should have effective communication capacity and skill. WHO (1992) confirmed this training and interest on the skill of counseling is a fundamental issues in considering the effectiveness of counseling. Then, counseling particularly HIV/AIDS counseling requires especial skills.

While the findings indicate that the counselors interpersonal relationship and interaction skills were performed medium as perceived by clients in both VCT centers. But the interpersonal relationship and integration skill of counselors in NGO VCT center was higher than the GO VCT center counselors.

Similarly, the result of this study indicates that counselors performed information gathering, information giving and facilitated vulnerably decision

making skills at medium level as perceived by clients. This might be because of the NGO VCT center had got better training than the GO VCT counselor.

This study confirmed that there was a statistically significance difference between government and non-government VCT centers in counselor skills.

Davis and Fallow-Field (1994) pointed out that if the person is change of counseling acquired greater understanding of communication and necessary skills he/she would more satisfy with what he/she does and less stressed. The skill implementation of counseling ability to elicit the needs and expectation of the clients not only enable to meet but also permit discussion and negotiation with possibly of realistic goal.

According to UNAIDS (2000a) reports of counselor selection have indicated that this process is often inadequate. Managers who have little understanding of the needs and responsibilities of counselor select counselors. But in practical those who are self motivated to be a counselor are more likely to be empathetic and proficient counselors. Based on to the result of-this study in both VCT centers counselor respondents assured that they were assigned by their organization to be a counselor. There was no counselor that was hired for counseling purpose directly.

Counselors in VCT services need training which should consist of basic information HIV, transmission routes, risk factors, possible and available interventions, as well as the role and processes of pre-test, post-test and on going counseling. For the later they will often need to acquire new skills. UNAIDS (2000a) suggest that there are several modes of counseling training for VCT services. A short course training modes usually have a duration of one month (4 weeks).

Moreover, FDRE MOE (2002), also indicated that any one selected to be a VCT counselor should be given at least one month training on counseling. Where as other modes of training offer longer time and more-in depth training. The result of this study indicated the training offered to the counselor was very short.

In this study all counselor respondents reported that the duration of their counseling training was 10-15 days. Therefore, counselors have not got adequate training and also there is no standardized training for counselors.

In counseling especially HIV/AIDS counseling perhaps more than in any other areas of service quality determines outcome. Poor quality counseling can result in misunderstanding and even resistance to behavior change. Then, counselors need adequate training, on going support and supervision to ensure that they give good quality of counseling service.

The result of the study indicates that half of the counselors have never got any ongoing training and other got inadequate on going training (they got 2 times in their after they got basic training). All of them reported that the support they have got from supervisors was not adequate/almost nil.

VCT counseling contents were considered in terms of pre-test and post-test counseling. In other words, the process of VCT counseling consists of at least two session, pre-test and post-test counseling. With each session there are several elements that make up the prevention intervention (FDRE MOH, 2003).

Pre-test counseling is offered before HIV testing. The counselor prepare the clients for the test by explaining HIV/ AIDS and its modes of transmissions, what an HIV test is and its importance, as well as myth and misconception about HIV/AIDS. The counselor also discuss the clients personal profile and HIV prevention method, the implication of knowing one's sero-status, the way to cope with new information (HIV test result), and potential needs and variable

In favor of this, Davis & Fallow Field (1994) indicated that the place as private room with sound proof, no telephone and "do not disturb on the door. Meeting clients in a place that is private and comfortable is a pre-condition for HIV/AIDS counseling. Then, conduciveness of place is fundamental criteria for effective counseling. Most counseling literatures indicate the importance of privacy and avoidance of disturbance. Because, place of counseling is one of the most important factor for the effectiveness of counseling. So, these factors affect the counseling activities.

In addition to separate counseling room, a well ventilated waiting area is important in VCT centers. The result of this study indicate that one VCT center i.e. NGO VCT center has a waiting area despite it was not adequate.

HIV infection is still a stigmatized condition in many areas. Then, counselors and all the staff involved must maintain confidentiality; lack of confidentiality will result in reduction of clients who seek the service. A therefore, HIV testing should be voluntary and should take place in collaboration with stigma reducing activities.

According to UNAIDS (2000a), if confidentiality will not be respected; the up-take will be low. Then, there must be a system to guarantee for confidentiality. Similarly, MOH (2002) suggested that in VCT setting, HIV testing and counseling could be either anonymous or confidentiality. With regard to VCT service delivery, the study results revealed that the majority of study subjects preferred confidentiality testing.

Accordingly, confidential method has been reported as good entry, Points towards attaining behavioral change. This may indicate that confidentiality could be considered as key element for implementation of effective and sustainable VCT service. The importance of keeping HIV counseling and testing

both voluntary and confidential have been paramount public health importance since the VCT service is becoming available.

Seating arrangement is the other factor that affects effective counseling. The result of this study indicates in both VCT centers the seating arrangement was found that there was a table between counselor and a table. According to Yusuf (1998) different seating arrangements have their own advantage and disadvantage. However, the most effective is across the corner of the table because if there emotional clients the counselor can protect him self and it is also comfortable for discussion.

And the findings indicated that if the VCT centers become adequate in all direction, it has a significant role for prevention and control of the virus, because, the number of clients will be increased in number from time to time.

The result of findings indicated that the majority the clients rated counselor's interpersonal relationship, information gathering, time for clients to understand information and respond, use easy and clear language, information giving skills to be medium. Many respondents of clients reported that majority pre-test counseling and post-test counseling were covered. Half of the client and the counselor respondents have positive attitude towards the counseling while some of the clients and half the counselors had not favorable attitude towards counseling. Few of the clients couldn't decide whether favorable or not. Additionally, in both VCT centers, there were separate room for counseling and only VCT center (i.e. NGO VCT center) has a waiting area but not adequate. The seating arrangement was there was a table in between (i.e. between counselors and clients).

Respondents of client also mentioned the problem, they faced in the VCT center and during the counseling session :1, lack of adequate waiting area 2, conducive office that ensure privacy 3, shortage of time 4, lack of the follow up arrangement.

The information obtained from counselors indicated that counselors are less experienced in counseling, got less training and all counselors are nurses in profession. No counselor respondents were self-motivated/employed to be a counselor. Counselors have got 5-15 days basic/ pre service training. But in service/ on going training was almost nil. The result indicated that, two counselors got on-going training only once after taking pre-service training. Similarly, counselors have never got emotional and technical support and their works also are not supervised especially the GO VCT center counselors. However, it has been stated in the VCT guideline of FDRE MOH (2002) the work of counselor should be supervised to ensure the quality of the service.

Counselors reported that the existence or workload, lack of on going training and support, lack of incentives for additional work, lack of hot line service, lack

of supervision, lack of waiting area and conducive office to ensure privacy and lack of educational materials were the main problem that hinder the effectiveness of the services.

The results of the interview of the supervisors showed that the GO VCT center supervisor was not actively participating in the supervision. She has been assigned with other work and therefore was not giving supervision, where as the as NGO VCT center supervisor reported that he worked the supervision besides his regular work. Both supervisors indicated that they did not give technical and emotional support for counselors. The supervision was rather more of administration. This is because they did not get adequate training in counseling and supervision. Especially, the NGO VCT center supervisor didn't take training related with counseling.

From the finding of this study, the following conclusions can be drawn.

- All counselors were not self-motivated to be a counselor at selection stage.
- The training given to the counselors was not adequate and not standardized. The training was not given by professional counselors.
- Counselors do possess only few of basic counseling skills rated high by the clients.
- Half of clients and counselors of the targeted VCT center have positive attitude towards the counseling service.
- There is no adequate space for private and inadequate/ no waiting area for counseling.
- The seating arrangement is there was a table in between the counselor and the client.
- The counselor experiences considerable stress as a result of lack of adequate training, support and supervision.
- The supervision is not adequate/almost nil/.

- The presence of work load, on counselors and supervisors, lack of incentives for additional work, lack of on going training and support for counselors, lack of educational materials, inadequate supervision on the work of counselors and inadequate linkage with other organizations are problems that hinder the provision of effective counseling services.

6.2. Recommendations

In the light of the finds of the study, the research put forth the following recommendations:

A. short-term recommendation

- there should be comprehensive and standardized counselor training program
- designate an area in the setting that provides physical privacy
- Conducive environment should be created in the environments as providing well furnished office, waiting area rooms, crucial equipment such as PC, file cabinet for recording purposes and adequate professionals and supportive staff
- Recruitment of professional counselors
- Provide an immediate in-service training for counselors.
- There should be adequate waiting area and conducive office that can ensure privacy.
- Counselor should be selected and assigned by observing their self-motivation and commitment..
- Supervisors should be trained and if possible they should be professional in counseling.
- Counseling session need to be monitored to ensure the quality of the service.
- Equipped VCT center with adequate staff and equipments
- Make accessible to VCT service make sustainable.

B. Long term Recommendation

- Number of VCT centers should be increased
- Development of tools for monitoring the quality and contents of counseling and counselor needs would be useful.
- Establish well-organized and strong net work, with different organizations/ institution like, universities (AAU, psychology department), community based organization, hospitals, other service providers as well as network of peoples living with HIV/AIDS to make the service effective and sustainable.
- Monitoring systems and clients follow up scheme should be designated to ensure the continuity and efficacy of counseling services
- Continuous sensitization/ creating awareness among people for the relevance of VCT services for the prevention of HIV.

Appendix A
ADDIS ABABA UNIVERSITY
POST GRADUATE PROGRAM
DEPARTMENT OF PSYCHOLOGY

Questionnaire for Clients (Code 01)

Objectives: This study is aimed at evaluating (assessing) the counseling services in different HIV/AIDS counseling centers in Dire Dawa. The purpose of this questionnaire is to obtain information about the attitude of clients towards counseling services, counseling skills of counselor, counseling contents and problems faced by clients to get the services.

N.B.

- The information to obtain through the questionnaire is going to be used only for the study undertaking.
- All information you provide will be treated as confidential.
- You will not be responsible for the research outcome. So you are requested to complete the questionnaire as genuinely as you can.
- If there is an ambiguity in the statement it is necessary to ask.
- Do not write your name on the questionnaire. Then, the cooperation of clients by giving genuine information is highly valuable to complete the study.

Thank You in Advance
For Your Cooperation

PART ONE: Personal Data

1. Name of the counseling center _____ Woreda _____ Kebele _____

2. Age _____

Female

Male

3. Sex _____

4. Educational status

(tick one)

illiterate

primary level

Secondary level

Tertiary level

5. Occupation

(tick one)

student

Government employee (civil servant)

Military

housewife

Merchant

unemployed

other please specify _____

6. What is your current marital status (tick one)

Married

Single

Divorced

Windowed

Other (please specify) _____

PART TWO: Counselors' Professional Skills

Instruction: Please put a tick make (✓) where your response is with a respect to each statement in only one of the three (i.e. 5. high, 3- medium and 1 = less) choices

No	Skill	Score		
		5	3	1
1	Greets me			
2	Introduces self			
3	Engages client in conversion			
4	Listens actively both verbally and non-verbally			
5	Is supportive and non-judgmental			
6	Uses appropriate balance of open and closed questions			
7	Uses silence well to allow for self expression			
8	Seeks clarification about information given			
9	Avoids premature conclusions			
10	Probes appropriately			
11	Summarizes main issues discussed			
12	Gives information in clear and simple terms			
13	Gives clients time to absorb information and to respond			
14	Has up-to-date knowledge about HIV			
15	Repeats and reinforces important information			
16	Summarizes main issue			
17	Accommodates language difficulties			
18	Talks about sensitive issues plainly and appropriate to the culture			
19	Priorities issues to cope with limited time in short contacts			
20	Uses silences well to deal with difficult emotions			
21	Is innovative in overcoming constrains			
22	Manage clients distress			
23	Flexible involving partner or significant others			

PART THREE: Counseling Contents

Instruction: Indicate your responses with mark (✓) on the space provided
Pre-test counseling (During the session have the following occurred?)

No	Item	Category	
		Yes	No
1	Reasons for attending discussed		
2	Knowledge about HIV/AIDS and modes of transmission explored		
3	Misconception corrected		
4	Assessment of personal risk profile carried out		
5	Information concerning the process of HIV test given		
6	Discussion of possible test results and meaning of HIV positive and negative		
7	Capacity to cope with HIV positive results discussed		
8	Discussion of potential needs available support		
9	Follow up arrangements discussed		
10	Time allowed to think through issues		
11	Informed consent/ dissent given freely		
12	Adequate time for question and clarification given		

Post-test Counseling

Instruction: Indicate your responses with tick Mark (✓) on the space provided

Post-test counseling (During the session have the following occurred?)

No	Item	Category	
		Yes	No
1	Results given simply and clearly		
2	Enough time allowed for the result to sink in		
3	Discussion of the meaning of the result for me/partner		
4	Discussion of personal, family and social implications including who, if any to tell		
5	Discussion of a personal risk reduction plan		
6	Dealing with immediate emotional reactions		
7	Checking availability of immediate support		
8	Discussion of follow up care/support		
9	Options and resources identified		
10	Immediate plans, intentions and actions reviewed		
11	Follow up plan discussed		
12	Referral discussed when necessary		

PART FOUR: Attitude

Instruction: Each of the statement below expresses an attitude towards counseling please put a tick mark (✓) what you opinion is with respect to each statement in only one of the five alternative.

(i.e. 5 = strongly agree, 4 = agree, 3 = uncertain, 2= disagree, and 1= strongly disagree)

No	Items	5	4	3	2	1
1	I am under a terrible strain during counseling sessions so it scarce me to take a blood test					
2	Counseling is fascinating and encouraging to take a blood test					
3	Counseling sessions make me feel good and at the same time it is stimulating to come again					
4	Counseling sessions are very interesting to me					
5	I enjoyed dealing with the counselor					
6	I get more satisfaction and confidence from counseling than other					
7	I have a feeling of dislike dealing with a counselor					
8	I have a problems in communicating with the counselor					
9	I discuss with the counselor feel with the counselor what I feel (my problem)					
10	The counseling session is painful					
11	The counseling environment is very stressful					
12	In general I have a positive attitude towards counseling services					

PART FIVE: Facilities and Constraints

Instruction: Please put a tick mark (✓) what you response is with respect to each statements, expect the questions that require written response.

1. Is the VCT in your neighborhood?

Yes No

2. Is there a separate room or space to ensure counseling session to be privacy?

- Yes, there is adequate space
 Yes, there is some but not enough
 No

3. Has the counseling office enough facility?

Yes No

4. Describe what you have discussed to ensure confidentiality?

5. Describe the seating arrangement in the counseling office

6. Is there a waiting area in the counseling center?

- Yes, there is adequate are
 Yes, there some but not enough
 No

6.1. How do you rate the waiting area? .

Very good Good Poor

7. How many sessions do you in a week?

1 2 3 4 5

8. Do you think the numbers of counseling sessions are adequate?

Yes No

9. Describe what you have discussed to ensure confidentiality?

10. Please list the problems that you faced during the counseling sessions?

11. Please list the problems that you face in the VCT center?

12. What do you think to be improved for "effective" counseling services?

13. Do you have any recommendation to enhance the counseling services where you have been given the services?

14. What is your general comment about the VCT services?

Appendix B
ADDIS ABABA UNIVERSITY
POST GRADUATE PROGRAM
DEPARTMENT OF PSYCHOLOGY
Questionnaire for Counselors (Code O₂)

Objectives: This study is aimed at evaluating (assessing) the HIV/AIDS counseling centers in Dire Dawa.,

The purpose of this questionnaire and interview is to obtain information about counselor selection, training attitude, support and supervision, factors that enhance/obstacle for effective counseling services in the center.

The information to be obtained through the questionnaire and interview is going to be used only for study to undertaking. Then, the cooperation of counselors by giving genuine information is highly valuable to complete the study. All information you provide will be treated as confidential. Then, you are requested to complete the questionnaire as genuinely as you can.

N.B. - Don't write your name on the questionnaire.

- If there is an ambiguity in the statement don't hesitate to ask.

Thank You in Advance
For your cooperation.

Items for Interview for Counselors

PART ONE: Personal Data

1. What is the name of your counseling center _____ woreda
_____ kebele _____
2. Age _____
3. Sex: Female Male
4. What is your educational background? ⁱ
5. What is your educational qualification?
6. How many yours of experience in counseling? And HIV/AIDS counseling?
7. Is your office has adequate facilities?
8. How many clients do counsel per day?
9. How many hours per day do you do counseling?
10. Totally, how many clients do you have in your center that are registered and get the services?
11. How could you selected to be a counselor? By whom you selected?
12. Have you got training on HIV/AIDS counseling? If yes, for how many days
_____ weeks _____ or years training: _____.
13. Do you have in-service training program?
14. Do you have any horizontal and vertical relations with professionals like sociologists, counselors, psychologists, health workers?
15. When things are beyond your ability/experience, how do you do? Do you have any referral system/or technical of emotional support with other institutions and senior counselors? If you have can you tell me?
16. Are the clients' numbers in increase from time to time or decline? If not increase would explain the reasons?
By which method do you give the service by hot lines, by face to face other

17. Do you have access to designated counseling supervisor to provide you with support and supervise you work? _____

18. How often has your work been observed by counseling supervisor.
19. What kinds of feelings had when they came to the counseling center for the first time? _____
20. Do you believe that counseling service that you provided bring any behavioral change on your clients? If there are, could you mention some major ones?
21. Are clients with draw from the client session? Why?
22. Has VCT center any significant role in reducing HIV/AIDS prevalence rate in Dire Dawa?
23. What are five major problems of in your counseling center? Can you tell me by prioritizing?
24. What are the major five problems that you faced as a counselor?

25. In your opinion, what things should be done to enhance your counseling center (please tell me at five major recommendations).
26. Any addition comment _____

PART TWO: Attitude of Counselors' Towards Counseling

Instruction: Each of the statements below expresses an attitude towards counseling. Please put a mark with a tick (✓) what your opinion is with respect to each statement in one of the five alternatives (i.e. 5= strongly agree, 4= agree, 3= uncertain, 2= disagree, and 1= strongly disagree).

No	Item	5	4	3	2	1
1	I feel emotionally drained by my work as a counselor					
2	My work is very stressful					
3	I learn something new in my work every day					
4	I feel positively valued by counselees in my counseling duties					
5	I feel positively valued by colleagues/the administration in my counseling duties					
6	I feel isolated my work					
7	I feel I can help my clients					
8	I will go on with my counseling job for the future					
9	I want to change my job					
10	My work is very rewarding/interesting					
11	My work environment is very stressful					
12	I learn something new in my work every day					
13	In general I have positive attitude towards counseling					

Appendix C

ADDIS ABABA UNIVERSITY POST GRADUATE PROGRAM DEPARTMENT OF PSYCHOLOGY

Items Interview for Supervisors (Code 3)

1. What is the name of the VCT center?
2. Educational and professional background?
3. What is your vital role in this VCT center?
4. Have you taken trainings on counseling supervisors?
5. Do you think the training is adequate?
6. Would you explain how would you ensure the privacy of counseling sessions and confidentiality?
7. Do you charge for the services? If you yes, how much?
8. Would you briefly discuss about in-service training that you gave to your counselor?
9. Could you mention the support that you provided for the counselor? Are the supports are adequate and help the counselor increase his efficiency and effect evenness? If not, why?
10. Do you have any links with other instructions? If so you have, what are they and what kind of links do you have?
11. What are obstacles the counselors faced in providing quality services in your VCT center?
14. Do you think that the counseling services bring significant and significant change on clients' behavior? If you say yes, what kind? If not, what is the reason?
 - With what way create awareness the community to use the services
 - Are the numbers of beneficiaries/clients increase from time to time or decline?
 - Could you suggest five major points to enhance your counseling services cent? _____
 - Would you comment about the counseling services in your center.


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Declaration

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

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Date: June, 2006

This Thesis has been submitted for examination it is my approval as University Advisor.



Advisor



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Date