FACTORS INFLUENCING THE MOTIVATION OF YOUTH IN USING AND AVOIDING HIV - VCT SERVICES IN SOME SELECTED HIGHER EDUCATION INSTITUTES IN ADDIS ABABA

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES, ADDIS ABABA UNIVERSITY, IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER'S OF ARTS IN COUNSELING PSYCHOLOGY

BY

AZEZE NEGUSSIE

JUNE 2006

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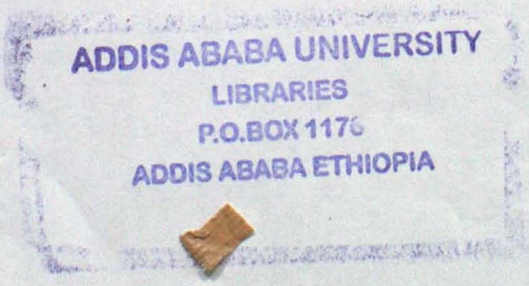

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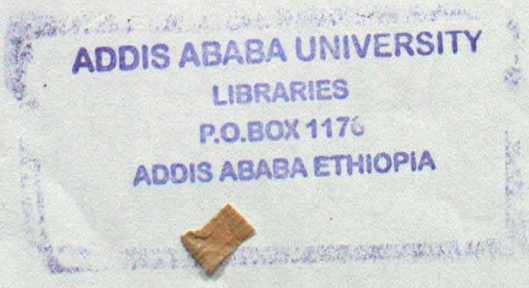

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Abstract

This thesis deals with the home or family and out of home as well as self related factors that influence the motivation of the youth of higher educational institutes in Addis Ababa to use and avoid HIV - VCT services. In undertaking the study, the descriptive survey method was used. Higher education institutes, parents and counselors were first identified using the purposive sampling method. Then, three sample higher education institutes i.e. colleges owned privately and by government were selected randomly from business and medical colleges in Addis Ababa. There were also three focus groups randomly selected from Universities and Colleges in Addis Ababa. Questionnaire, structured interview forms and focus groups discussions were employed for data collection. The subjects of the study included a total of 505 youth (college students), 25 parents, 18 counselors, and 18 focus group member youth under three focus groups from Universities and Colleges. Percentages, frequency distributions and gender, age, family level, access to multimedia and sexual experience differences and parity indexes were applied in analyzing and reporting the results. The major findings revealed that: the attitude of the youth themselves and the parents as well as the people in general towards HIV and HIV - VCT has great influence on the usage and avoidance of HIV - VCT services. Because of stigmatization of HIV, privacy and confidentiality are the most influential factors that the youth consider to use or avoid HIV - VCT services. HIV - VCT used female youth and youth in general found in the age group 20 - 23 years are higher in percentage or more prevalent than tested male youth and youth in general found in the age group 14 - 19 years respectively in higher education institutes in Addis Ababa. Recommendations forwarded include: VCT services should be integrated into other services including on going medical care and psychological as well as material and educational supports. A referral system should be developed in consultation with NGOs, community based organizations as well as with networks of people living with HIV and AIDS. The youth themselves and the parents as well as other groups of the community also should be sensitized through IEC using different multimedia so that they can improve or promote their attitude and awareness of HIV and the advantages of using HIV - VCT services to minimize VCT barriers. The counseling service should be more qualitative, practically meaningful and youth oriented. It should also take into consideration the different alternatives to minimize the cost and other VCT barriers.

CHAPTER ONE

1.1 Introduction

1.1.1 Background

AIDS is a disease caused by a new and deadly virus: HIV (Human Immunodeficiency Virus). HIV can remain in the body for years. It may stay for longer period of years even for decades before it shows up any visible symptom of damage. But, if once AIDS develops, in all known cases it has always proved fatal (UNAID 1996). The first case of AIDS were recognized in the United States in 1981. Since that time AIDS has become a major pandemic (Green J And McCreaner A, 1992). At present, there is no cure for AIDS, and no vaccine is available to protect against it.

The term AIDS (Acquired Immunodeficiency Syndrome) refers to the last fatal stage of HIV infection which is often called "full-blown AIDS".

Since the notification of HIV/AIDS as a global pandemic, every corner of the globe has been directly or indirectly affected by the burden of morbidity and mortality it has been causing. The recent estimate indicates that 45 million people are living with HIV/AIDS and 5 million are newly infected in 2002 globally. Awareness of the spread and the magnitude of the problem in the world is essential for further intervention measures. Sub Saharan Africa ranks first in HIV annual incidence when compared to other parts of the world (UNAID and WHO 2000).

In Ethiopia, HIV infection is increasing at an alarming rate after the first infection was identified in 1984 (MOH, 1995). In urban areas at least one out of every six adults is infected (MOH, 1995). According to UN AIDS estimate at the end of 1999, three million people were living with HIV in Ethiopia, 2.9 million of them being adults (15-49 years) making the adult prevalence rate of HIV infection 10-63% (UNAIDS, 2000). To date, AIDS epidemic has left behind 13.2 million orphans globally, 1.2 million of them in Ethiopia (UNAIDS and WHO, 2000)

AIDS can have big social, psychological, demographic and economic impacts on both the individual and the society. It will impact the economic development in a number of ways. As it affects large population groups, it can diminish the quality and quantity of labor force leading to social and economic crises in the country (UNAIDS 2000).

There is currently no vaccine which can prevent the spread of HIV infection. Only change in behavior by those at risk can halt its spread. The Voluntary Counseling and Testing can help to make changes in order to avoid infection or to prevent the infection of others.

However, HIV Voluntary Counseling and Testing (VCT) is not only about preventing the spread of infection but also it is about promoting and maintaining the physical and mental well being of all those whose lives are touched directly or indirectly by the HIV and are voluntary for the counseling and testing.

Counseling in the context in which it is used in this study is not something which only professionally trained counselor can do. Rather according to the Ethiopian real contemporary situation, it is something which anyone who is working, in whatever capacity with people affected directly or indirectly by HIV and who is volunteer to use VCT services. The good HIV- counselor needs good interpersonal skills, an understanding of the social, moral ethical context of HIV/ AIDS and the ways in which this affects people's lives. The counselor also needs an awareness of the issues confront those whose lives are touched by HIV, an understanding of the ways in which people can be helped and awareness of the ways in which they can be inhibited or hindered by the HIV-VCT service providers.

The HIV-VCT services are areas with high potential in playing great roles in both preventing the spread of HIV infection and treating the infected ones. HIV-VCT programs have demonstrated their ability to increase safe sexual behavior and use of care and support services among adults (Coates *et. al* 1998). By helping the clients be aware of their HIV serostatus and creating a personalized HIV risk reduction plan, VCT can provide information and support necessary to change risky behaviors that could lead to HIV - infection or transmission (CDC 1994). Counseling both before and after the test, and a risk reduction plan are the key features that distinguish VCT from other HIV - testing services.

VCT has become a widely advocated HIV/ AIDS prevention strategy among adults. Most clients of VCT services are in their mid - to late twenties (Ladner et al. 1996). Sixty percent of all new HIV infection in sub - Saharan Africa, however, occur among young people between the ages of 10 to 24 (UNAIDS 1998). Therefore the appropriate application of VCT to the youth is to be given much more attention, as a

strategy to reduce risk behaviors among them and it appears to be more challenging than it would be among adults. Therefore, to plan and apply this strategy, understanding the youth's experiences in relation to HIV - VCT and factors that inhibit or motivate them to use HIV - VCT services should be researched and identified. The identified motivators and inhibitors are hopped to help the HIV VCT services be appropriate and a better fit to the individual youths' age, culture, language, style, sexual orientation, etc. The researcher believes that there are researchable factors beyond the mere obvious ones that hinder the youth in higher education institutes in Addis Ababa not to appear to the HIV VCT centers despite the public strong and continuous advertisements and calls.

On the other hand, the researcher also believes that beyond the obviously known extrinsic "forcing" motivators like abroad flight, employment, marriage, life insurance, job promotion, DV lottery, etc, there are other underlying psychosocial, developmental, etc factors which are intrinsic motivators may be related to the quality, type and accessibility of the HIV-VCT service that instigate the youths to use HIV- VCT services. In general, it is the researcher's hypothesis that there are intrinsic motivators that instigate and multidimensional inhibitors that hinder the youth to use and to avoid not or to use the HIV - VCT services in higher education institutes in Addis Ababa respectively. Research also suggests that people especially the youth are not at liberty to do or believe any thing they want. Instead, they must construct their beliefs from information that can justify the conclusion (Levis 2000). To reach the conclusion, one must incorporate other pieces of information into his calculations by undermining or ignoring other possible risks or even advantages. For instance a youth intrinsically motivated and attracted to HIV- VCT services starts to calculate to draw his final conclusion, and adds other pieces of related information to his calculation ignoring other pieces of possible risks of using the HIV-VCT services like financial expense, time consumption, anxiety, fear of test result, stigmatization, etc. And then he/she will be instigated or will determine himself/herself to use HIC-VCT services. It applies to those who are inhibited not to use HIV- VCT service too. If a youth is hindered to avoid or not to use the services because of different reasons or factors from the beginning, he/ she also calculates to prove or justify it and concludes that appearing to the HIV- VCT centers doesn't help him/her much. The youth draws this conclusion ignoring or neglecting other sorts of information that state the advantageousness of using HIV-VCT services.

Because of the youths developmental stage, unlike adults, they have their own different psychological, social, economic, etc. Problems in most cases they don't want to open up themselves easily when asked to explain their problems or answer sensitive questions. Therefore it is very important to investigate what motivates them to be attracted and what inhibits or hinders them not to be attracted to or use the HIV - VCT services. Those who used HIV-VCT services are considered as positively motivated and the motivation might be intrinsic or extrinsic. But those who didn't use or avoided HIV-VCT services are considered as ether negatively motivated or indifferent ones. According to Wade and Travis (1998), motivation is an inferred process within a person that causes him/ her to move toward a goal or away from an unpleasant situation or activity. Therefore, the tested youth are in this thesis considered as people moving toward a goal because of their positive motivation, where as the untested youth are treated as people who have avoided (away from) an unpleasant condition or activity because of their either negative motivation or reluctance. But this research doesn't intend to examine further the degrees of positive and negative motivations.

The researcher believes that if once the motivating and inhibiting factors of the youth in higher education institutes in Addis Ababa are identified, the HIV-VCT service providers would be required to have special youth oriented trainings so that their services would be improved to be more attractive, appropriate and a better fit to the youth's psychosocial, cultural, educational, economic, etc. conditions.

Higher education institutes in Addis Ababa are believed to be better places where good representatives of the youth in Addis Ababa are available and accessible collectively with lots of problems related to HIV and HIV-VCT. Their random selection to become college students and their being diverse socially, culturally, economically, ethnically, etc are the other reasons why the researcher focused here to conduct his study on. In addition to it higher education institutes and the target groups are more convenient for the researcher because of their readiness to deal with, availability, proximity and accessibility. The subjects of the study are chosen randomly from some selected higher education institutes in Addis Ababa.

1.1.2 Statement of the problem

Although further research is needed to verify the ability of HIV-VCT to influence HIV- risk relate practices, some studies have shown that people adopt behavior with

lower risk of HIV transmission after becoming aware of their serostatus (Wolitski, RJ. et al, 1997). Moreover early detection of the HIV- status allows the negative (uninfected) ones to keep up their HIV-status and the positive (infected) ones to start appropriate medical treatment and psychological support as soon as possible, which improves survival and quality of life (CDC, 1998).

However, these advantages of HIV- VCT will not be gained if individuals at risk for HIV infection do not seek testing. Thus, it appears very important to investigate the prevalence of HIV-VCT among the youth of higher education institutes in the Adds Ababa as well as the major factors associated with the usage and avoidance of HIV- VCT services.

Despite the continuing effort that has been made up to now, evidences show that Addis Ababa has not managed to provide high-quality and youth- friendly HIV-VCT service for the youth. Although there are strong and continuing calls of the public in general and of the individual HIV-VCT services provider governmental and nongovernmental organization or centers in particular still many youths who are at risk for HIV infection are not using the services. There must be reasons or factors that influence these phenomena. In Addis Ababa, in which the present study was under taken, statistical data makes it clear that the number of youth who used HIV- VCT services is always below the expected number of youth in relation to the number of the total population of the youth residing even around the HIV-VCT service providing centers or clinics and hospital. The number of youth who uses the complete services of HIV-VCT has also been found to be relatively less than that of the adults unlike the prevalence of the infection and the degree of vulnerability. Therefore, it seems necessary to find out the root causes or main factors for all these phenomena and adopt VCT strategies appropriate to the youth of higher education institutes to reverse the contemporary situation.

The researcher believes that there is a need for investigating closely beyond the quantitative data in order to find out the root causes for the problems of higher education institutes of youth's motivational levels to use and to avoid the HIV - VCT services in Addis Ababa

That is:

- To further examine the factors related to the service providers, the nature of services or the attitudes and perceptions of the youth themselves and of their peers, family, partner, etc.
- To further examine the possible factors regarding to the parents and counselors' perceptions, attitudes roles and experiences in relation to the youth's motivation to use the HIV - VCT services.
- To examine closely the possible factors and explore possible solutions by using or applying appropriate approaches that might help to change the situation positively

From this point of view, this study will attempt to survey and explain the underlying home and out side of home factors that influence the motivation of the youth to use and to avoid the HIV - VCT services in some selected Higher Education Institutes in Addis Ababa.

1.1.3 Research Questions

The purpose of this study is to investigate the following basic issues:

1. What are the factors motivating the youth in higher education institutes to use HIV - VCT services in Addis Ababa?
2. What are the barriers or negatively motivating factors deterring the youth of higher education institutes from using HIV - VCT services in Addis Ababa?
3. What is the prevalence of the positively motivated and negatively motivated youth of higher education institutes in Addis Ababa?
4. Are there gender, age, family level, access to multimedia and sexual experience differences among the youth in higher education institutes in Addis Ababa in relation to the prevalence of the tested and untested ones?

1.1.4 Significance of the Study

Many research works indicate that HIV testing with appropriate counseling can have positive effects both on the whole population of that nation at large and on the single tested individual in particular. Thus it appears important to investigate the prevalence of HIV testing among the youth at risk of contracting and transmitting HIV and to examine factors associated with the usage and avoidance of HIV - VCT services. It is a single most important approach which the developing countries especially the sub

Sahara African countries including Ethiopia, where the spread of HIV infection is very high, can use to improve the quality of life of their people in general. However, current statistics of the ministry of health and other services providing clinics, hospitals and non governmental VCT - centers show that the participation rate of the youth in the HIV - VCT in Addis Ababa is low. The general situation in the various regions of the country is not much different. There could be different factors that may influence the participation or usage and avoidance of HIV - VCT of the youth of higher education institutes in Addis Ababa. This study attempts to identify and examine some of the main factors that affect or influence the youth's positive motivation to use and negative motivation to avoid HIV - VCT services in Addis Ababa.

This study is hopped to have the following potential significances:

1. It would provide the VCT centers, aid provider NGOs, the Ministry of Health, Ministry of Social Affairs and Ministry of Education with reliable information about the existence and prevalence of the different motivational levels in relation to the usage of HIV - VCT services among the youth of higher education institutes in Addis Ababa. It is also hoped to inform about the positively motivating and the negatively motivating or inhabiting factors of the youth of Addis Ababa. This study is expected to help the local HIV - VCT centers, international NGOs and the national ministries in large to make all the kinds of HIV - VCT services, including the referral systems and treatments, appropriate and youth oriented taking into consideration their (the youths') age, sex, individual differences, in general likes and dislikes or motivators and barriers (inhibitors) respectively.
2. This study is also hopped to raise up the awareness of the counselors, medical workers, social service workers, HIV - VCT planners (designers) or HIV - VCT service providers in general and other concerned individuals and organization about their responsibilities and rules in the process of attracting and providing their appropriate and youth oriented HIV - VCT services and referral systems.
3. It may also help to create strong link between the youths and the HIV - VCT services provider organizations and individual professionals that they can know, attract, communicate and help each other more closely and openly.

4. It may initiate further similar research on how the youth can be attracted to and benefited from HIV - VCT services, in different academic levels and areas of the country.

1.1.5 Delimitation of the Study

A study that attempts to treat the youth's positive motivation or instigation and impediments or negative motivation in relation to usage of HIV - VCT services in such a big city in Ethiopia like Addis Ababa is obviously broad and comprehensive. There is really great number of areas and youth population to be covered. But shortage of available time, budget, facilities and materials do not allow the researcher to consider them all. Therefore, the researcher prefers to delimit the scope of this thesis to a manageable size.

Accordingly, first it was determined by the researcher to restrict the study to the higher education institutes level as main source of data. Such a decision was felt appropriate for the following main reasons:

- Higher education institutes in Addis Ababa are the best places where the youth are available and accessible collectively.
- Higher education institutes in Addis Ababa are better places where better representative samples of the youth population are found because of their being demographically, socio economically, ethnically, etc. diverse.
- In Ethiopia, like other sub - Sahara African countries, more than half of the HIV/ AIDS carrier and patient population is found among the youth (age14 - 23). Therefore, according to the new Ethiopian education policy this age is much more appropriate to college level than any other educational level. Hence, searching for the identification of problematic factors and possible solution for them should take place at this level.

In the second place, the scope of this thesis is also delimited to include three main sample colleges and three more higher education institutes which are considered as samples to draw the sample youth subjects for the questionnaire and for the three additional focus groups members from respectively. Regarding the three main sample colleges, two of them are privately owned ones and the other one is government college. The privately owned ones are Saint Mary's college (SMC) and Universal Medical College (UMC). The governmental college is Commercial College of Addis

Ababa University (CCAAU). This is simply because St.Mary's collage is having first position among the private colleges in accommodating relatively greater number of youth population. Universal Medical College is chosen as sample for its being a better representative in having larger number of youth among private Medical Collages in Addis Ababa and its being accessible and available for the researcher. CCAAU is a higher institute where the greatest number of youth population is found among the government colleges in Addis Ababa. Regarding the additional sample higher education institutes from which the focus groups members were drawn are Addis Ababa University (AAU), Unity University (UU). and Africa Medical College (AMC).

Therefore, in general, the study was restricted to the above three colleges mainly and three additional higher education institutes for the focus groups discussions.

From each college or university also only limited number of youth were sampled.

1.1.6 Limitation of the study

It is always difficult if possible to discern all the limitations of ones own work. However, some of the perceived limitations of this study include the following:

A. This thesis does not aim at assessing all possible factors that may influence the youth's positive motivation or instigation to use HIV - VCT services or their negative motivation or barrier that deter them from using the services. It attempts to focus on and examine only those factors that have been experienced by the tested and untested youth. Thus the thesis concentrates on such factors as being tested, being untested, likes and dislikes, being attracted to use and being impeded not to use, the involvement and influence of other people and situations.

B. Being tested and untested are considered and treated as single and direct representation of positive motivation or encouragement to use and impediment or avoidance of HIV - VCT services respectively. The factors on each were based up on this disparity. But there might be still people who are positively motivated but have never been tested yet without any perceivable barrier; and the reverse also might happen. However, at this time, for the researcher, there is no any other better means to draw the instigating and deterring factors from. Thus, in this thesis, it was not possible to pinpoint perfectly the positively and negatively motivated youth including the intensity and duration of motivation.

C. Motivation may be likewise expressed in varies ways. However, in this thesis only two indices of motivation were used. These are using and avoiding HIV-VCT services.

1.1.7. Definition of Terms

There are some terms used in this thesis with special emphasis. They are listed below in alphabetical order with their operational definitions, ie, in the way in which they are used in this study.

Avoidance of HIV- VCT services: In this thesis, it is used to refer to the youth who have never been tested or never used HIV- VCT services.

Barrier: This refers to the situations or activities that deter the youth from using HIV- VCT services.

HIV- Status: This is sometimes known as serostatus. It is a youth's HIV position to be known as a result of HIV test. The status can be either HIV- (negative) or HIV+ (positive).

HIV- VCT: It is defined in this study as a strategy in which voluntary youth undergo pretest counseling, testing and posttest counseling so that they can be aware of their HIV- status and receive timely and appropriate medical treatment and/ or psychological help accordingly.

Pretest counseling is offered before taking an HIV- test. The counselor prepares the youth for the test by explaining what an HIV-test is, as well as by correcting myths and misinformation about HIV/ADIS. The counselor discusses the implications of knowing one's serostatus, and ways to cope with that new information.

Posttest counseling is offered after the HIV-test has been done for the youth. The main goal of this counseling session is to help the youth understand their test results and initiate adaptation to their seropsitive or negative status. When the test is seropasitive the counselor tells the youth the result, provides emotional support sensitively and discusses how he/she will cope. The counselor helps him/her to start appropriate medical treatment and psychological support as soon as possible which improves survival and quality of life of the seropositive youth. When the test result is negative, while youth is likely to feel relief, the counselor needs to discuss changes in behavior that can help the youth stay being HIV negative, avoiding as much as

possible HIV- risky behaviors by using condom, limiting the number sexual partners to be one to one and faithful.

Motivation: Is defined in this thesis in terms of individual's status with respect to going through (using or avoiding) HIV- VCT services. Those who received HIV-VCT are regarded as positively motivated and this motivation can be intrinsic (received VCT by their own choice) or extrinsic.(required and used the test for blood donation, insurance, surgical procedure, pregnancy, etc). On the other hand, those who did not receive HIV- VCT are regarded as either negatively motivated (inhibited) or amotivated (indifferent).

Service providers: This term includes counselors and medical service workers. In the Ethiopian present situation most of the counselors are nurses and some are medical doctors with short term trainings (1-5 weeks) on basic counseling for HIV VCT. But no one is professionally qualified counselor in all HIV-VCT centers as well as clinics and hospitals of Addis Ababa. The medical service workers are medical doctors, nurses, laboratory technicians for testing and some others like health assistants.

Sexual Experience: It is a term used to identify the sample youth whether he/she has ever made sexual intercourse.

Testing: In this thesis, this term refers to the activity of detecting the youth's serostatus (HIV-status) if he/she is seeking for it and has already been counseled in the pretest counseling session.

Youth: In this thesis, the term is used to mean young people between the ages 14 and 23 years.

1.1.8 Organization of the Report

The report of this thesis is organized and presented under five chapters. The first chapter which is the introduction part deals with general ideas in stating the background and the problem, raising questions, explaining the significance, describing briefly the delimitation and limitations of the study including definitions of some terms. The second chapter which is Literature Review, develops the background of the study by discussing the relevant literature from local and international situations of HIV-VCT services throughout the world, in Africa especially sub-Saharan Africa and Ethiopia that have been examined briefly. The third chapter

which is including methods and procedures tries to describe in detail how the study was conducted. The fourth chapter which consists of presentations and Analyses of data attempts to summarize and present the data collected from the field and states the main findings. It also tries to examine evaluate and interpret the implications of the results with respect to the research questions. In addition to this, some statistical treatments of the data collected are also shown. The last chapter which is chapter five that consists of Summary, Conclusions and Recommendations tries to draw inferences based on the result. This chapter also attempts to give a brief statement of the problems, methods and the most important findings. At the end of this chapter, some possible suggestions are forwarded on the basis of the findings and the conclusions of the thesis.

CHAPTER TWO

2.1 REVIEW OF THE RELATED LITERATURE

This Chapter as a whole deals with the literature review only. It is divided into three main sections. Some of the main sections have subsections. The first main section deals with the historical development of HIV-VCT in general in the world and its application. In the second section, the introduction application and need of HIV-VCT as well as factors affecting the services in developing countries especially in sub-Sahara Africa are reviewed. The last section reviews the historical perspective and the recent situations of HIV-VCT related issues and researches in Ethiopia.

2.1.1 HIV-VCT: ITS HISTORICAL DEVELOPMENT IN THE WORLD

AIDS is a disease caused by a new and deadly Virus: HIV (the Human Immunodeficiency Virus). For this Virus which causes AIDS, the internationally accepted name now is HIV. However, following the recognition of the AIDS epidemic in 1981, there was a period of two years before it became generally accepted internationally that the causative agent was a retrovirus. Nevertheless, detection of the activity of the viral enzyme allowed the identification of HIV when it was first cultured by Barrisinoussi and her colleagues at the Pasteur Institute in Paris in 1983. Another important developmental stage was the identification and purification of T-Cell growth factor which is called interleukin, a substance which led to the isolation of the first human retrovirus, human T-Cell leukemia Virus [HTLV-1] in 1980, HIV-1 1983 and Preparation of the Virus which were then available for genetic analysis and for the manufacture of the first generation antibody test [HIV-Test in 1984] by Morgan, Popovic et al. (Green and McCreaner 1989). Practical application of antibody tests or HIV- tests for the diagnosis of HIV-1 infection were introduced in 1985. They remain by far the most important way of detecting a symptomatic Carriage of the Virus and, if necessary, for confirming the etiology of AIDS- related symptoms. At first, caution was exercised in interpreting finding of a confirmed positive antibody or HIV positive test and many individuals were told that it only indicated "exposure at some time in the past" to HIV-1. implying that they may have developed antibody and eliminated the virus. But now many national and

international HIV-AIDS related experimental studies realized enough about the infection, that this event (HIV-Infection) is most unlikely to occur, if ever. It must be realized and conveyed to the Individuals concerned that a confirmed positive in the antibody test means that HIV-Infection with the virus persists and is almost certain to be present for life.

The lack of neutralizing capacity by the immune system of those infected means that, unless protective measures are taken, there is likely to be a continuing risk of infection to sexual partners. But, as has been proved by different national and international study findings, except HIV and Hepatitis B infections, most other viral infections can result in complete recovery with the development of solid neutralizing antibody which protects against infection (Green and McCreaner, 1989).

As many international study results revealed, HIV can remain in the body for many years, perhaps even for decades, before any damage shows up visible symptoms. But once AIDS develops, in all known cases, it has always proved fatal (Mahmud, 2004). There is also little prospect that drugs will be developed neither to cure the AIDS patient nor to eliminate HIV from its integrated state in the chromosomes. Therefore, early knowledge of HIV-status seems the only advantageous alternative that it enables the tested individuals to be aware of their serostatus and equipped with necessary, appropriate and timely risk reduction information on the basis of which he/she can reduce the risk of acquiring HIV infection, changing HIV to AIDS, or passing it on to others. Gradually, the need for the test became not only to identify antibody positives but also to carry out the predictive tests with a view to therapy. Hence, beginning from 1985, HIV-test has become available freely in many European countries and USA. These days, almost all nations of the world have already introduced the application of HIV-test. In many countries in the world, the incidence of HIV in the population has steadily risen and with it the need for expert counseling of people who are volunteer to take the test also has increased. HIV testing, with appropriate counseling, can have positive effects both on the population at large and on the single tested individual. The test with appropriate counseling is first and foremost based on the intent that everyone who wishes to, has the right to use it. It implies that the right to use is as fundamental as the right not to use, and that the services are provided on the basis of voluntarism. Therefore, though the exact

date or time since when it has got its new name is not distinctly known, as a package of volunteer based services, gradually it has begun to be called Voluntary Counseling and Testing (VCT) in different countries beginning from USA and Western countries (Allen,S et .al 1992). In most countries experiencing high HIV prevalence levels, however, opportunities and efforts to make VCT universally accessible have left much to be desired. From a healthcare perspective, VCT presents an entry point for important intervention opportunities in terms of prevention, support, and medical care. Particular emphasis has been put on the opportunity to engage in one –to-one health education and the potential impact of VCT on risk education has been intensively studied. Early out come evaluations revealed some inconsistent results (Beardsell S and Cayle A, 199). However, several studies have documented a significant reduction in risk behavior (Allen S, Serufilira A, Gruber V 1993), and even lower HIV incidence rates following the use of HIV-VCT (Allen S, et .al.1992). However, the application of HIV-VCT in relation to priority and quality of the services is left for the individual nation. Nevertheless, many researches indicated that the HIV-VCT works well if it is based on or works under the principles of cost effectiveness making use of the available resources. The applicability of this finding to the different nations with different socioeconomic standards is still relevant researchable issue. However, in general counseling in VCT processes has three parts. They are pretest counseling, posttest and follow- up.

Pretest Counseling

Pre-test Counseling is a counseling offered before taking an HIV test. In most cases, the counselor prepares the client for the test by explaining what an HIV-test is, as well as by correcting myth and misinformation about HIV/AIDS (UNAIDS 2000).

The counselor may also discuss the clients personal risk profile, including discussions of sexuality, relationships, possible sex and /or drug related behavior that increase risk of infection and HIV prevention methods. The counselor discusses the implications of knowing one's sera status, and ways to cope with that new information. According to some studies, it is better to provide the information to groups so that it can reduce costs and can be backed up by providing written material. However, it shouldn't be forgotten that everyone requesting VCT has to have access to individual counseling before being tested. But people who do not want pre test counseling shouldn't be prevented from taking a voluntary HIV test especially for those who have had VCT

earlier and may not wish to have further pre test counseling except testing. However, informed consent from the person being tested is usually a minimum ethical requirement before an HIV test (UNAIDS, 2000).

According to (UNAIDS 2000) pretest counseling has the following aims:

- To ensure that any decision to use or take HIV-VCT is fully informed and based on an understanding of the personal, medical, legal and social implications of positive result.
- To provide the necessary preparation for those who will have to face the trauma of positive result much more equably.
- To provide the individual, whether, he eventually elects not to be tested, or elects to be tested is found to be positive or found to be negative, with necessary risk reduction information on the basis of which he/she can reduce the risk of absence of earlier referral and treatment, passing the infection on to others, acquiring and/or reacquiring HIV infection.

Posttest Counseling

Post test Counseling should always be offered. When there is seropositive, the counselor tells the client the result clearly and sensitively, providing emotional support and discussing directly how he/she will cope. Sharing one's HIV status with a sexual partner is important to enable the use of safe sex practices, and should be encouraged. However it may not always be possible, especially for women who face abuse or abandonment if known to be sera positive (UNAIDS ,1998).

Counseling is also important when the test result is negative. While the client is likely to feel relief, the counselor must emphasize several points. Counselors need to discuss changes in behavior that can help the client stay HIV-negative such as safer sex practices including condom use and other methods of risk education. The counselor must also motivate the client to adopt and sustain new, safer practices and provide encouragement for these behavior changes. This may mean referring the client to ongoing counseling, support groups or specialized care services (UNAIDS, 2000). During the "window period", according to many studies, approximately 4-12 weeks immediately after a person is infected, antibodies to HIV are not always detectable. Thus, a negative

result received during this time may not mean the client is definitely uninfected, and the client should consider taking the test again in 1-3 months (WHO, 1995).

Although it is not a script to be followed, according to (UNAIDS, 2000) posttest counseling has the following procedures:

- To open the meeting in as a friendly fashion as possible
- To check that the client has actually come for his/her test results. He/she may have changed his/her mind and not want them, but still want to talk.
- To tell the client straightforwardly, without evasion or qualification what the test results are after relevant and appropriate discussion
- To indicate to the client that the counselor is ready and willing continue his/her counseling and follow up including referral if proved HIV positive

In general the effectiveness of HIV-VCT in bringing about safe sexual behavior and in increasing HIV- risk reduction plans and actions was still known among adults only. VCT has not yet been as common among the youth as it is among the adults in the world in relation to this (Coates et .al, 1998) said the following:

VCT has become a widely advocated HIV/AIDS prevention strategy among adults. VCT programs have demonstrated this ability to increase safe sexual behavior and use of care and support services among adults.

But the spread of HIV –infection is more prevalent among the youth than that of the adults. Sixty percent of all new HIV infections in sub-Saharan Africa and more than forty five percent in the world, however, occurs among the young people between the ages of 10 to 24 (UNAIDS ,1998). Therefore the application of VCT to the youth is to be given much more attention and especial emphasis. The barriers and motivating factors of the youth to use VCT should be researched and identified so that the package of the services would be youth oriented. According to some researches, in some countries where VCT services have been established, there has also been a reluctance of people to attend testing. This may be because of denial and of the stigma and discrimination and other- very motivating factors that the youth who test seropositive or even who went to the center for test may face, and the lack of perceived benefits of testing. To overcome such barriers of the youth, it is very important to challenge stigma and discrimination and other negatively influencing factors and at the same time to demonstrate VCT'S

effectiveness by making the services more appropriate, youth oriented and individualized (CDC, 1994).

2.1.2 VCT IN DEVELOPING COUNTRIES, ESPECIALLY IN SUB SAHARA AFRICAN COUNTRIES

The application of HIV-VCT in the Western countries has started earlier as mentioned above and is, inevitably a response to local conditions (Green, 1998). As such it has certain characteristics:

- HIV-VCT services providers including counselors are professional specialists.
- There are well-established voluntary groups often with telephone help lines aimed at those who are particularly at risk or know themselves to be infected.
- Most people are aware when they are at high risk because they know well the means of transmit ion and appear easily to the HIV-VCT centers but also they get ready and appropriate access to counseling and medical facilities on demand.
- A lot of VCT- centers around individuals who come forward for the services are available.

But the situation in many developing countries is different. To mention only a few key differences include:

- Many people are not close to hospitals or even to sexually transmitted, disease clinics. They find it very difficult to reach them particularly in rural areas. In the West most people are readily able to travel quite long distances because of the availability of relatively cheap public transport and personal vehicles. In most of the developing countries especially in Sub-Saran Africa, where the spread of HIV is alarmingly increasing, the people simply do not have these services available. Either the VCT has to be available locally, or the service providers have to come to them.
- The provision of services through the creation of professional specialists, especially counselors alone is unlikely to meet the demand in those developing countries especially in sub-Saharan Africa with high rates of HIV-infection. As Green (1988) tried to reveal the difficulty, assuming that a specialist counselor

might provide input into 500 cases per year, a country of 3 million people would heed 180 counselors if the infection rate was 3 percent. In practice, it is only likely that a counselor would reach this sort of case load if the volunteers were coming to see him in a hospital or clinic or VCT center. In a rural area, where the counselor had to go out and counsel, probably traveling long distances the number of cases seen might drop to 100-150 per year. This would increase the number of counselors and other service provider professional specialists needed by 3-5 times. Many developing countries especially Sub-Sahara Africa countries, where the population is relatively high with highest rate of HIV infection and with lower socioeconomic standard, would find it very difficult to obtain or pay for such large numbers of service providing specialists especially professional counselors. But according to the ADIS support organization (TASO) 2003, surveyed youth in Kenya said the most important characteristic they want in counselors is that they be well qualified professionals.

- Most people may not be able to identify whether they are at risk or not. Although health education campaigns play an important role in raising general awareness of HIV/AIDS and are thus of crucial importance in any HIV/AIDS strategy according to many researches on the area, there is little evidence that, in themselves, they have a great deal of impact on sexual risk behavior. Many studies also reveal that there is little evidence whether health educators themselves made it possible for people especially the youth because different impeding factors accurately to assess their personal level of risk.
- In contrast to developed countries which are well- resourced in proving VCT services including the referral system, the developing countries especially the Sub- Sahara African countries are in extreme short of resource in terms of money, materials and, crucially well trained manpower.
- In most Western countries there is a fairly uniform culture across the country. In many developing countries there are marked differences within countries. Differences within countries between rural and urban areas are often far more marked than in Western countries. This means that the service providers especially the specialist counselor may have to be familiar with a wide range of different cultures. Similar considerations apply to language. Few geographical

areas in the West have more than two major language groups and where these exist, it is common for people to be at least partially bi-lingual. Whereas in many developing countries there are many languages, of which a client may speak only one or two, Counseling through an interpreter makes things doubly difficult –if a suitable interpreter is available at all. Therefore according to many research findings, to make VCT for the youth more attractive and effective or to minimize deterring factors, it should be adjusted in a friendly and youth oriented fashion taking into account the individual youth's culture, language and his/her individual style (Marangwanda C and Kols A, 1997).

According to many studies on HIV-VCT for youth, there are two seemingly contrasting demands. As mentioned above, most surveyed youth need their counselors to be highly qualified professional specialists. At the same time many tested youth also need their counselors to be a youth friendly, easily approachable and above all familiar to their own language, culture and style. As many researches conducted in Kenya and Uganda on youth reveal, counseling young people requires special training and improved youth-oriented referral services. Because (TASO, 1998) many youth do not easily open up when asked to explain their problems or answer sensitive questions, providers require training to develop the skills needed to work with these clients. However, some youth tell them too much about their personal lives that it is often difficult for counselors to respond to. Counselors reported frustration when youth do not return for follow up or ignore such advice as discontinuing risk behaviors like unprotected sex.

To alleviate these two problems, research works conducted in Zimbabwe shown that training local people in basic HIV-counseling is a better alternative. In Zimbabwe (Baggaley R, et al 1998) a relatively large number of persons have been trained in basic HIV-counseling (ie. over 3000 in a country with an adult population of about 4-5 million) as well as others trained to offer more limited counseling in pre-and post-test situation. Some studies also have come up with innovative approaches to make the counseling components (situations) of VCT less money, labor and time intensive by introducing group education prior to pretest counseling using trained volunteers to conduct under the supervision of the counselors. Otherwise, it would be a burdon to the counselors and they may leave and burnout will be common.

In many developing countries including sub-Saharan Africa like Uganda, Kenya, Tanzanya, Zambia, etc. several studies have documented a significant reduction in risk behavior (king R,et al, 1995) and even lower HIV incidence rats following VCT. But because of finite limit to trained human and material resources available, the first thing to be given priority is always about maximizing the benefit to the society from the available resources. The debate about priority setting and concerns regarding the cost effectiveness of VCT should be seen in this perspective. In countries with extremely high HIV prevalence, such as Zambia (Feyikesnes K, et al. 1997), VCT will not necessarily be superior to less resource - intensive strategies in behavioral changes In this regard it is worth mentioning that a recent study from Tanzania and Kenya indicated that the VCT strategy might compete well in terms of cost- effective (Sweat M, et al, 1998). But the transferability of this finding to other sub-Sahara African countries is still a relevant and an important researchable issue.

Although VCT is becoming increasingly available among the developing countries too, including Sub-Saharan Africa, there is still great reluctance for many youth in comparison with adults to be tested. There are several possible contributing factors that must be addressed if VCT is to have an important role in HIV prevention and care. For example, HIV is highly stigmatized in many countries especially in developing counties and people with HIV may experience social rejection and discrimination. This fear of rejection or stigma is a common reason for declining testing. In some developing counties as related surveys show people with HIV are subject to discrimination at work or in education. Unless legislation is in place to prevent this, some people will be reluctant to undergo VCT. The need for protection and support of vulnerable youth who test seropositive must be considered when developing VCT services. In Zambia, according to a survey interview youth who are economic dependent to their parents said that it was thought to be shameful to have HIV this age and if they were known to be seropositive, they worried that they would suffer discrimination. Studies from Kenya have also shown that youth may be particularly vulnerable following VCT and in some cases have host their peers, parents and homes in general or have been beaten or abused by their parents or siblings if their status become known or sometimes even for appearing to the HIV-VCT center for test (Temmerman, M. et al. 1994).

2.1.3 HIV-VCT in Ethiopia

2.1.3.1 Historical perspectives of HIV/AIDS and HIV - VCT

Although Ethiopia is an ancient country with a rich potential of human and nonhuman resources including the harmonious diversity of cultures and religions, it has however remained backward in socioeconomic and political development, as well as in technological advancement because of many contributing factors. In accordance with the conventional health parameters such as maternal and infant mortality and morbidity from communicable diseases, malnutrition and average life expectancy, Ethiopia is placed among the least developed countries in the world.

Ethiopia, like any other country in the world has experienced the damage of HIV/AIDS pandemic. The first AIDS case was reported in 1986. Between then and June 2000, there were a cumulative total of 83487 AIDS cases reported to the Ministry of Health (MOH, 2001). This figure includes only reported cases in the above mentioned time gap. According to (UN AIDS 2000) estimate, three million people were living with HIV in Ethiopia, 2.9 million of them being youths and adult (15-49) years making the youth prevalence rate of HIV infection 10-63% (UNAIDS, 2000). Today AIDS epidemic has left behind 13.2 million orphans globally, 1.2 Million of them in Ethiopia (UNAIDS and WHO, 2000).

In response to this devastating epidemic, Ethiopia had developed important strategic frameworks to address the distractive effects and impacts of HIV/AIDS. For instance, the HIV and Aids prevention and Control Office (HAPCO) had been established in 2002. The HAPCO provides an institutional framework for the planning,

or the planning, coordination and evaluation of HIV/AIDS programming at rational, regional, woreda, and kebele community level. Among the most important activities under implementation are: IEC (Information, Education and Communication) and behavioral change, Voluntary Counseling and Testing (VCT), Management of sexually transmitted infections, management of blood safety for transfusions, Condom promotion and distribution, etc.

The above stated programmatic activities are implemented by government-related institutions, non-government organizations (NGO), AIDS Service Organization (ASO), Community Based Organization (CBO) and other relevant agencies. The health care and social service delivery system in Ethiopia is limited in providing quality services for adolescents and youths, especially in the prevention of HIV, control or STI and promotion of sustainable social behavior change. Few youth friendly services exist, while youth; In recognition of the need to narrow this gap, the united Nations Children's Fund (UNICEF) in collaboration with the HAPCO designed a training program to support capacity building for the development of youth friendly (MOH, 2002)VCT services in Ethiopia.

This is conformity with UNICEF's multi-sectoral HIV/AIDS prevention program whose focus is on youth as change agents, care and support of orphans, etc. A curriculum for the training of trainers (TOT) in anticipation of the establishment of new and strengthening of the existing youth-friendly VCT services at the national level has since been developed.

At present there are around forty VCT centers in Addis Ababa only. 95% of them are Hospitals and clinics, only 5% of them are purely VCT centers. In almost all the centers, the counseling is provided by nurses. In very few centers it is provided by medical doctors. But in no center at all counseling is provided by qualified counselors yet. More than 95% of these centers demand service charge from their clients from 10-250 Birr per person once. Only 5% of them provide their services freely only for poor people.

2.1.3.2 The Recent Role of VCT in Reducing the Spread and Damage of HIV/AIDS

Now,VCT in Ethiopia has a role in both HIV prevention and, for people with HIV infection, as an entry point to care. VCT provides people with an opportunity to learn and accept their HIV status in a confidential environments. People who have tested HIV positive can benefit from early and appropriate medical care and interventions to treat and/or prevent HIV-associate illnesses. Knowledge of HIV-status can also help people make decisions to protect themselves and their sexual partners from infection (Tsegazeab B.et al. 2003). Though VCT alone doesn't seem to shoulder and carry out effectively all the accumulated and alarmingly increasing HIV/AIDS related problems, it is providing

its possible psychosocial and medical supports. In relation to this, HAPCO (2002) revealed that VCT is one aspect of a broader HIV/AIDS intervention strategy and continuum of care. Therefore, the counselors should know what resources exist and when and where to refer to ensure that their clients receive the support and treatment that they need. However, VCT alone in Addis Ababa has lots of merits. It improves health and medical treatment by facilitating and directly providing pomp and effective treatment of opportunitic infections. It facilitates also early medical and nutrition care and informed decision on issues such as sexual life, positive living and others. It helps also to promote safe sex practice and widens opportunities to plan for the future. It also improves social, psychological and moral supports and strengthens the referral system to support groups and community networks including. Ongoing supportive counseling. VCT has also preventive role of the transmission of HIV infection by promoting positive living and supportive care as well as social behavioral change and ongoing preventive counseling (HAPCO, 2002).

However, VCT has its own demerits too, to a limited extent. It creates or rather causes problems with coping. A positive HIV test result can come as a great shock to a person and may be very difficult to accept. There is denial, anxiety, depression, fear, stress, and even suicidal feelings associated with receiving a positive. HIV test result. Nevertheless according to many survey, the demand for HIV-VCT in Addis Ababa is growing. Medical settings can not cope with this increased demand in addition to the testing that they already have to do for hospital and clinic patients. Testing, however, plays a crucial role in preventing further infections (UNAIDS, 2003).

2.1.3.2.1 Advantages to Have VCT for the Youth

VCT is an important entry-point to both HIV prevention and HIV related care. youth who test seropostive can have early access to a wide range of services including medical care, ongoing emotional support and social support (MOH, 2003). Youth who test seronegative can have counseling, guidance and support to help them remain negative. According to many studies VCT plays a crucial role for the youth in preventing further infection and in facilitating medical care with psychological support and follow up.

According to HAPCO (2002), HIV-VCT has the following advantages for the youth in Addis Ababa:

- A negative test can allay anxiety and motivate a youth to ensure that he/she remains negative.
- A positive result can motivate the youth to reduce high-risk behaviors.
- A positive result gives the clients and opportunity to learn how to take care of themselves and gives them the option to seek early treatment and improve their health through good nutrition.
- Previous sexual partners can be informed and given the opportunity to get tested for HIV.
- A positive result can alert doctors, dentists and other health service workers to take precautions with contaminated blood of an infected person.
- youth who test positive will have time to plan and adjust his way of life in general.
- Use of VCT facilities in the community can reduce fear, ignorance, stigma and discrimination in relation to HIV/AIDS.
- Knowledge of one's HIV serostatus can stimulate a community response in support of those needing care as well as contribute to an environment supportive of safer sexual behavior.
- It can increase the individual youth's awareness of safer options for reproduction, infant feeding, sexual life, reduction of mother to child transmission, etc.

2.1.3.2.2 VCT in Youth Friendly Condition

As many researches findings reveal, young people require special training and improve, youth-oriented counseling, testing and referral services. Because many youth do not easily open up when asked to explain their problems or answer sensitive questions. And sometimes some youth tell so much even about their personal lives that it might be difficult for the counselors to respond to or to deal with. As many studies show because of such mismatches with the counselor or with many youth do not the kind of service provided, many youth do not return for post test counseling or for follow up or ignore such advice as discontinuing risk behavior like unpracticed sex. Some, others are also reported to have avoided totally VCT because of fear of positive result and youth

unfriendly services. Therefore as some studies like Horizons (2001), VCT services provides require training to develop skills needed to work with the youth. Ethiopian providers too, according to some local studies say that they require additional communication and listening skills related to their work with youth (B.S.S, 2002).

According to available national reports, the demand of the youth for HIV-testing in Ethiopia is growing. The above mentioned report shows that a total of 80 HIV testing facilities and 5 counseling centers currently exist in Ethiopia as a whole. More than half of it are found in Addis Ababa only. For this reason, the National AIDS Council Secretariat has designed a program whereby VCT will be offered in youth friendly settings such as Family Guidance Association and youth clinics. In addition to the youth friendly approaches of communication, counseling, testing and referral-system, the concept of placing VCT sites in youth centers is to encourage the youth to go for testing and to provide them with a safe place where they can receive confidential pre and post test counseling HAPCO(2002). It is believed to motivate the youth the use HIV-VCT and minimize deterring factors of the youth from using HIV-VCT services like lack of confidentiality, privacy, fear of appearing to clinics and hospitals for test, stigma, youth-unfriendly service provision, etc.(MOH, 2004).

2.1.3.2.3 Reasons Why Youth of Addis Ababa May or May Not Want To have HIV Test

Although VCT is becoming increasingly available in Ethiopia, especially in Addis Ababa, there is still great reluctance for many people, especially for the youth to be tested MOH (2002). There might be several contributing factors that must be addressed if VCT is to have an important role in HIV prevention and care:

- Stigma - HIV is highly stigmatized in Ethiopia and the people with HIV may experience social rejection and discrimination.
- Lack of youth - friendly services - According to some local reports in relation to the HIV-VCT service, many youth were net interested in the way how the services were being provided. Some tested youth said that the services lack confidentiality, privacy, warmth and concern from the side of the service providers.

- Cost - except very few centers more than 90% of the VCT service providing centers demand the clients to pay from 10-250 Birr person. It is not little the youth of Ethiopia to afford. There are also other factors preventing untested youth from having an HIV test like fear of people find out, fear of positive result, peer influence, distance of service, beliefs, provider attitudes, perceived fear of youth-unfriendly VCT-service provision and providers, etc.

Youth are often particularly vulnerable to HIV infection (MOH, 2002). It is because of their developmental stage that influences their psychosocial, biological and economic situation. Therefore for VCT services to be effective for young people, they must take into account the emotional and social context of young people's lives, such as the strong influence of peer pressure and development of sexual and social identities (Tefera B.et al. 2004). They must also be "user-friendly" offered in non-treating, safe, easily accessible environments (UNAIDS, 2000). Therefore, VCT should be age appropriate using examples of situations that are familiar and relevant to youth including language that is non-technical and easily understood to minimize impediments of testing. According to HAPCO (2002), there are some factors that deter especially the youth from testing:

- Testing positive may reveal secrets about a person's individual life that he/she doesn't want others to know. For example his/her being matured for sexual affairs. As a result the community may ridicule him/her.
- A student who tests positive is asked to leave school, or does so because rejected and ridiculed by his/her peers.
- The person who tests positive may not be able to cope with the guilt, anger, depression or other personal reactions to knowing that he/she is HIV positive and may have infected people that they love. In most communities in Ethiopia including Addis Ababa, acquiring knowledge on one's health status is uncommon. Even terminally ill people are rarely told their exact health status for fear that they would lose hope.
- A woman who tests positive may be subject to domestic violence or be kicked out of home /and /or beaten.

- In most communities in Ethiopia, pre-martial sexual relationships are unacceptable for the youth in particular for the female youth. Therefore, even testing by itself may reveal sexually active status for the youth.

Nevertheless, early detection of HIV- antibodies allows the youth to start appropriate medical treatment and psychological support which improve survival and quality of life. However, these advantages of HIV-VCT will remain unachieved if the youth at risk for HIV infection do not seek testing. Thus, it appears important to investigate the prevalence of HIV testing and factors influencing to use and avoid testing among the youth of higher education institutes in Addis Ababa. Much research has been done on HIV-VCT internationally and locally. Studies on HIV-VCT prevalence among heterosexual adults and particularly among adults who are engaging in high risk sexual behavior have been performed in the western countries and USA as well as in developing countries especially in sub Sahara African countries including Ethiopia. These studies gave emphasis to the assessment of attitudes, knowledge and behavior of the adults in relation to HIV and HIV-VCT services.

But only very few studies were conducted on HIV-VCT among youth and even these few surveys didn't examine the different motivating and inhibiting factors taking into account the youth's developmental, psychosocial, cultural individual, etc conditions in relation to the usage of HIV-VCT services. They didn't collect information on these factors from many relevant and contributing sources like parents, counselors, peers, etc.

To mention only a few of these studies, UNAID/WHO'S Joint Nations Program On HIV/AIDS (UNAIDS/WHO,1998,2000,2002 and 2004) in Europe; Centers for Disease Control and Prevention (CDC, 1994,1995,1996,1998and 2001) in the United states of America ; different project partners like Horizons program (1998,2000,2002) in sub Saharan Africa ; other project partners in East Africa like AIDS Information Center (AIS,2000) in Uganda ; Kenyan Association of Professional Counselors (KAPC,2002) in Kenya ; HIV and AIDS Prevention and Control Office (HAPCO, 2002), HIV/AIDS Behavioral Surveillance Survey, (BSS ,2002) and (MOH ,2000,2002 and 2004) in Ethiopia are the best known in conducting related studies on the area of HIV-VCT.

However, no study at all has been published yet on HIV-VCT among the Addis Ababa youth aiming to assess and examine the possible factors that influence the youth's motivation to use and avoid HIV-VCT services. Therefore, this study is the first study

among the youth of higher education institutes in Addis Ababa city on the factors that influence the youth's motivation to use and avoid HIV-VCT services. The other significant point that makes this study new or different from the rest, that have been mentioned above, is that it gathers information on both positively motivating factors to use and negatively motivating or inhibiting factors to avoid HIV-VCT services respectively at the same time.

Having ever or never been voluntarily tested for HIV is an out come of many possibly contributing variable factors that influence the youth's motivational level negatively or positively. These factors might be related to the individual youth's age, sex, socioeconomic background, psychosocial condition or the appropriateness and inappropriateness the services and service providers to the need and style of the individual youth. The factors might also be related to the individual youth's awareness of HIV/ AIDS, peer parental or familial and partner influences, provider attitude, cost, stigma, fear of test result, belief distance of the services etc. All these possible factors that may influence the youth's motivational level in relation to the usage and avoidance of HIV - CVT services would be examined and analysed among the youth of higher education institutes in Addis Ababa for the first time. The prevalence and magnitude of the factors in influencing the motivational levels of the youth will be also explored and revealed unlike other related studies mentioned above did before.

The information is gathered from different contributing sources like the participant youths themselves, parents, counselors, etc. Collecting information on both motivating and deterring factors with their magnitude of influence in relation to the usage of HIV-VCT services makes this study different, original and very important in its being capable of assessing, examining, checking and balancing the factors under the two categories. Inhibiting factors or barriers can be minimized or weakened and the positive motivation or instigations to use HIV-VCT can be strengthened more, to make the services pleasant, attractive and youth-friendly to the youth of higher education institutes in Addis Ababa. The other issue that makes this study different from the above highlighted ones is that it gives a special emphasis to the youth's developmental, psychosocial, cultural, economic and individual conditions in relation to the usage and the avoidance of HIV-VCT services.

CHAPTER THREE

3.1 Methods and Procedures of the Study

In this study, the researcher used descriptive survey research method. The researcher attempted to obtain information about the current condition or situation of the youth's positive motivation and inhibition in relation to the use of HIV - VCT services in higher education institutes in Addis Ababa. It was also the purpose of the study to survey the main factors that influence the youth in using and avoiding HIV - VCT services in higher education institutes in Addis Ababa.

To achieve this end, the following methods and procedures of data gathering and analysis were used.

3.1.1 Subjects and Sampling procedures of the Study

The populations of interest in this study were the whole youth of higher education institutes in Addis Ababa. It is obvious that it is not possible to visit and survey all the youth of higher education institutes in Addis Ababa by taking into account the budget and time that were available for the research. Hence, the researcher decided to carry out a survey of small number of sample higher education institutes drawn from the whole target population. Accordingly, three colleges from the whole of Addis Ababa higher education institutes were first identified as the accessible and available population. These are St. Mary's College (SMC), Addis Ababa University commercial college (AAUCC) and Universal Medical College (UMC). 505 youth subjects were randomly selected from the 3 colleges. These three colleges were selected by taking into account their accessibility and r geographical distribution as well as the population size each of them has. The field of study and ownership (government and private) were also taken into consideration. For the focus groups discussions also, three more higher education institutes were sampled. They are Addis Ababa University, Unity University and Africa Medical College. There were 18 youth grouped under 3 groups for discussion. There were 6 members in each focus group, 1 from each higher education institute.

3.1.2 Instruments of Data Collection

Data that have both quantitative and qualitative values were gathered through two types of instruments that were developed and constructed by the researcher. Earlier, the relevant international and local literatures were reviewed, on the issues of using and avoiding HIV - VCT services. Based on this review, instruments for data collection were designed and constructed by the researcher in order to examine the importance and extent of the factors raised in the literature in the situation of Addis Ababa. The types of instruments that were developed and used are the following:

- Students' or youth's questionnaires
- Structured personal interview form for Counselors
- Structured personal interview form for parents.
- Structured and unstructured focus group interview and discussion

All the above instruments used for data collection are attached as appendix at the back of this report. The different data collection instruments that were used for the survey in the study are listed and explained below.

3.1.2.1 Students' (main participants') Questionnaire:

A questionnaire was developed by the researcher that consists of 25 main items and more than 50 factors under the main items to be filled in by the sampled participant youth or college students. The items were closed questions, semi closed list of choices and open - ended questions mainly asking information about the motivating and hindering factors of the youth to use HIV - VCT. Each item could be answered by either putting an "X" mark in a box for alternative responses such as "Yes" or "No" or by writing in words for those that ask the views of respondents. The items were randomly sequenced. The questionnaire type of instrument was selected to be used in order to direct the youth specifically to the area of interest of the research.

Blank spaces were also left especially around the end of the questionnaire to allow the respondent to add his/her own ideas in a form of any comment on factors that may motivate the youth to use or deter from using HIV-VCT services.

The different areas covered on the youth's questionnaire and the items related to these areas are shown in the table below.

Table 1: Item numbers on youth's questionnaire related to the different areas.

Areas	Item number
Background information about the respondent	1-14
Usage or Avoidance of HIV-VCT	16
Reasons (factors) for using HIV-VCT	17(17.1- 17.23) 20,22,23
Reasons (factors) for avoiding HIV-VCT	18 (18.1-18.28) 21,24,25
Reasons for dropout	19
Additional information on the subject	15

3.1.2.2 Interview forms:

Two personal interview forms, one for counselors and another for parents and one focus group interview (discussion) for three focus groups were used in this thesis

3.1.2.2.1 Personal interview for counselor:-

This was used to collect information from counselors in some VCT centers, clinics and hospitals mainly a bout their clients specifically youth's affairs in relation to HIV-VCT. Both open ended and close ended questions were included in the interview. The interview form included 23 items. The different areas covered on the interview form for counselors related to these areas are presented below:

Table 2: Item numbers on interview form for counselors related to the different areas.

Areas	Item number
Background information about the respondent	1,2,3,4,5
Counselor's view about his/her past and future professional training.	6,7,8,9,10
Counselors attitudes towards his/her job (counseling)	11,12
Number of clients in average per day	13
Counselor's view about the level of motivation of the youth to be tested	14,15,16
The prevalence of male and female youth who use HIV-VCT	17,18
Counseling dropout	19,20

General view of the counselor on the likes and dislikes of the youth in relation to HIV-VCT service provision	21,22,23

3.1.2.2.2 Personal Interview form for parents

This was used to collect information (data) from parents whose son(s) and daughter(s) were selected as samples for the study. This mainly consisted of questions about factors related to parents that affect the youth's motivation in using or avoiding of HIV-VCT services. It also consists of the parents' own awareness of and attitude towards HIV/AIDS and the usage of HIV-VCT services. The interview form comprised a total of 18 main items. The first 6 items were related to some background information about the respondent.

In the process of constructing the two interview schedules for counselors and parents, the researcher has taken into account from different literatures the relevant influencing factors and pertinent information needed from these two sources. On the basis of this account, the interview schedules made up of a combination of open ended and close ended questions, were finally prepared.

The different areas covered on the interview form for parents and the items related to them are shown below in Table 3:

Table 3: Item numbers on interview form for parents related to the different areas

Areas	Item number
Background information on the parents	1,2,3,4,5,6
Awareness of the parents about HIV-VCT	7,8,9,15
Attitudes of the parents towards HIV-VCT	10,11,12,13,14,17
Parent's view of HIV/ AIDS	15,16

3.1.2.2.3 Focus Groups Discussions

It was used to gather information about HIV and HIV-VCT related issues in addition to the information gathered through questionnaire and personal interview forms. The focus groups discussions took place in three focus groups each consisting of 6 members from 6 higher education institutes, one from each. Three of the higher education

institutes were chosen for the purpose of selecting the sample focus groups from only. They are Addis Ababa University, Unity University and Africa Medial College. Whereas, the rest three college are used also as samples to draw the sample youth from for the questionnaire, too. They are St. Mary's College, Addis Ababa University Commercial College and Universal Medical College. There are 18 youth age 18-23 randomly selected for the interview (discussion) in-group. They are all students of higher education institute in Addis Ababa. 9 of them are females and the rest 9 are males, three males and three females in each focus group. The discussion took 2 hours for each group.

The sample youth were asked mainly about their perceived motivating factors and barriers of VCT as well as their information sources and awareness of HIV and HIV-VCT related affairs in the group interview (discussion). Mostly open -ended questions were used in the interview for discussion. The interview form consisted of 15 main items out of which the first 7 items related to the background information of the respondents. But there were many other questions and responses related to the main items and even to some extent deviated from the main items as a result of continuation or further discussion on the main items.

The different areas covered on the interview (discussion) with the sample youth and the main items, related to these areas are presented in Table 4 below:

Table 4: Item numbers of the group interview form for the focus group related to the different areas

Areas	Item numbers
Background information	1,2,3,4,5,6,7
Access to multimedia about HIV/AIDS and VCT	8
Usage and motivating factors of VCT	9,10
avoidance and deterring factors (barries) of VCT	11
Likes and dislikes of the youth about VCT services	12,13
General comments on HIV-VCT services	14,15

3.1.3 Pilot Study

The researcher employed two methods for validating the instruments that were developed for data collection. In this process before the actual data collection the instruments developed were submitted for evaluation primarily to the advisor and also to

other three colleagues who work as experts of research and evaluation at the St. Mary's college. Then the draft instruments were tried out in a small-scale study that was undertaken in few selected colleges in Addis Ababa. The field trial had helped to identify ambiguities and misunderstandings as well as to test the validity and reliability of instruments for collecting the necessary data. Subsequently, refinement was made on the instruments according to the constructive suggestions and hints that were obtained from both the evaluators and the field test.

With some amendment and refinement, all instruments prepared were employed in the process of the data collection in the sample areas mainly higher education institutes and sample subjects.

3.1.4 Data Collection Process

The data collection process was accomplished by the researcher in collaboration with his three assistants, one from each of the three colleges. All of these assistants were college students recruited from each college. They were not involved in the interview part. But they were involved in the questionnaire part that they actively participated and assisted the researcher by briefly explaining about the aim of the questionnaire, distributing the questionnaires, giving instructions on how to fill in, explaining some questions if raised and finally by collecting the filled papers. Before they were involved in the task, they were given orientation about the study in general and the meaning (intention) of each question.

The students' questionnaire was administered by distributing it to students of three colleges who are in different year levels and departments. After brief explanation about the aim of the questionnaire, the students were given instruction on how to fill in the questionnaire. The students then individually responded to the 25 main items. The questionnaires were finally collected by the researcher from the hand of the assistants and mostly from the hands of the participants as soon as they were completed by the students. A total of 505 youth students from three colleges were included in the study. But the intention was to include 525 students.

Like wise, parents of the sample students were interviewed using the interview form for the parents. This was done by going to their residential areas. In this case, either the father or the mother or both responded to the interview. But it was not possible to find parents for all the sample students.

25 parents were interviewed out of the intended 40 parents. These parents were randomly selected among the parents of the sample students (participants) from the three sample colleges.

Counselors of HIV - VCT in VCT centers, clinics and hospitals were also interviewed using the interview form for counselors. This was done by going to the counselor's offices. There are at present more than 40 HIV - VCT services provider clinics hospitals and VCT centers in Addis Ababa. But it was very difficult to interview all of them because of shortage of time and absence of willingness and cooperation from the administration and even the individual counselors. However, the researcher succeeded to interview 18 counselors each from different services providing clinics, hospitals and VCT centers. But the intention of the researcher was to interview 25 counselors.

Focus group discussions also were used as a tool to gather informative data from them, the discussions among the focus groups members. There were 18 students (youth) randomly chosen from 6 higher education institutes. Among the focus group members, 9 of them were males and the rest 9 were females. 10 of the total sample focus group were untested, the rest 8 were tasted youth. 15 (about 84%) of them have ever made sexual relations with opposite sex.

The other thing done during the data collection process was to document some relevant information about HIV - VCT services especially related to the youth of higher education institutes in Addis Ababa. The document inspection took place and information gathered from HA PCO and HIV/AIDS Resource Center. But there were no, as such well organized and recorded documents available on the area of interest of the study. Whereas, in the higher education institutes in Addis Ababa, there was no any recorded document totally on the area of interest of the study

The researcher took and considered also his own observations and field notes that were related to the interests, attitudes and awareness of the participant and non participant individuals including service providers in dealing with HIV - VCT services in Addis Ababa among the youth that influence their motivational levels.

3.1.5 Data Organization and Analysis

The data collected from the sample colleges through the questionnaire were tallied, systematically organized in items and tabulated to facilitate analysis. The information gathered through interviews and the focus group discussion were also

organized systematically so that they can substantiate qualitatively or cross - check the results obtained from the responses of the questionnaire by analyzing and interpreting them qualitatively.

In analyzing and reporting the data, mainly the descriptive method was used. Some simple calculations were performed whenever it was deemed necessary.

The prevalence of the HIV - VCT used and unused youth in general as well as the gender differences among each group of youth were calculated using percentage. It attempted to show the variation between the number of HIV - VCT used and unused youth as well as the gender variations and others too, like age, family level, access to multimedia differences and sexual experience differences. First, the prevalence of the tested and untested youth was calculated by using percentage for each. And then the discrepancy or variation was calculated by dividing the percentage of the tested ones by that of the untested ones. The gender difference was also calculated by dividing the percentage of the female by that of the male for each group (tested and untested). The higher the quotient, the higher the discrepancy or the less the disparity between the tested and untested ones as well as the gender differences in each group. The less the quotient of the percentages the less the discrepancy or the higher the disparity. But if the quotient is one, this means, there is no any discrepancy between the prevalence of the tested and the untested ones and the same to the gender differences in each group. And we call this result perfect parity between the tested and untested ones as well as between gender (male and female youth). The prevalence differences of the different age groups, the different family levels and the access to multimedia were also considered and calculated.

In addition to this, a series of tables were also used to summarize and clarify the research data.

CHAPTER FOUR

4.1 Presentations and Analyses of Data

This chapter consists of two main sections. On the first section, the background information about each of the main data sources of the study that includes students of higher education institutes in Addis Ababa (youth), counselors and parents obtained from their responses is explained. In the second section, the data obtained from the research are presented and analyzed in relation to the research questions. In the same section, the findings of the research are simultaneously interpreted and discussed again based on the research questions.

4.1.1 Description of the Sample Population

As it was already described in chapter three, the main subjects of the study were primarily youth (college students), parents, counselors and the focus groups. The background information about these subjects as data sources for the study is presented next:

4.1.1.1 Background of the youth (College student) Respondents

As was already described in chapter three, the main data sources for the study were sample youth (College Students) drawn from three colleges of Addis Ababa. Some of the characteristics of these data sources as respondents to a questionnaire are shown below:

Table 4.1: Some socio demographic characteristics of youth samples:

	Tested Youth n=242				Untested Youth n=263				Sum Total
	SMC	AAUCC	UMC	TOTAL	SMC	AAUCC	UMC	TOTAL	
	n= 93(46%) %	n=82(41%) %	n=67(64%) %	n=242	n=109(54%) %	n=116(56%) %	n=38(36%) %	n=263(52%) %	n=505
Sex									
Male	48(n=45)	40(n=33)	51(n=34)	n=112	51(n=56)	53(n=62)	50(n=19)	n=137	n=249
Female	52(n=48)	60(n=49)	49(n=33)	n=130	49(n=53)	47(n=54)	50(n=19)	n=126	n=256
Age Group									
14 - 19	15(n=14)	10(n=8)	8(n=5)	n=27	88(n=96)	91(n=106)	95(n=36)	n=238	
20 - 23	85(n=79)	90(n=74)	92(n=62)	n=215	12(n=13)	9(n=10)	5(n=2)	n=25	n=265
									n=240
Ever had Sex									
Yes	81(n=75)	72(n=59)	65(n=44)	n=178	18(n=20)	11(n=13)	8(n=3)	n=36	n=214
No	19(n=18)	28(n=23)	35(n=23)	n=64	82(n=89)	89(n=103)	92(n=35)	n=227	n=291

Note: Percentages were rounded to the nearest whole.

SMC = St. Mary's college

AAUCC= Addis Ababa University Commercial College

UMC= Universal Medical College

As it can be observed from Table 4.1 above, there were a total of 505 youth (College students) who responded to or filled in the questionnaire. Out of these respondent 256 were females whereas, the remaining 249 were males. The researcher made his possible effort to take an equal number of sample youth from both sexes as much as possible. But especially some male youth were absent and some refused to fill in or to respond to the questions.

On the other hand 265 of the total sample youth were found in between age 16 and 19 years. Whereas the remaining 240 were between 20 and 23 years old.

291 of the total youth sample responded that they have never had sex, where as the remaining 214 responded that they have had sex already.

It can also be observed from Table 4.1 that different number of sample youth were taken from different colleges depending up on the total youth population and availability as well as accessibility of the youth in each college.

Out of the total 505 respondent youth, 263 of them responded that they haven't been tested for HIV. Whereas, the remaining 242 responded that they have used the HIV - VCT services. When these figure are expressed in percentage, they are 52% and 48% of the total respondent youth respectively.

4.1.1.2 Background of the Counselor Respondent

The other respondents of the study were counselors that were drawn from 18 clinics, hospitals and HIV - VCT centers - one from each. Among the few variables investigated about the counselor respondents through interview were characteristics related to their sex, age, years of counseling experience and counseling qualification (duration). These variables are shown in the following tables:

Table 4.2: Counselor's Sex

Counselor's Sex		
Sex	**No**	**%**
Male	3	17
Female	15	83
Total	18	100

Table 4.3: Counselor's Age

Counselor's age in year		
Age	**No**	**%**
18 - 28	5	28
29 - 39	9	50
40 - 50	3	17
51 - 61	1	5
Total	18	100

Table 4.4: Counselor's Experience

Counseling experience in year		
Service	**No**	**%**
0 - 2	10	56
3 - 5	6	33
6 - 8	2	11
Total	18	100

Table 4.5: Counselor's Training

Counselor's Training		
Duration In weeks	**No**	**%**
0 - 2	16	89
3 - 5	2	11
Total	18	100

Note: The Percentages were rounded to the nearest whole

As it is shown above in Table 4.2, about 83% of the sample counselors are females because, most nurses are females in Ethiopia. And about 56% of the sample counselors had service years between 0 - 2. About 89% of the sample counselors have taken training on basic counseling for HIV - VCT for a duration of 0 - 2 weeks. However, there are also some number of counselors included in the study with varying durations of trainings additionally for 2-10 days on HIV-VCT and PMTCT. (Prevention of Mother to Child Transmission).

4.1.1.3 Background of parent Respondents

In addition to students of higher education institutes (youth) and counselors, some 25 parents were also included in this study as respondents of an interview form.

Table 4.6: Parent respondents by sex and age

Age in year	Male		Female		Total	
	No	%	No	%	No	%
Below 35	-	-	1	4	1	4
35 - 45	5	20	3	12	8	32
46 - 56	10	40	3	12	13	52
57 - 67	2	8	-	-	2	8
Over 67	1	4	-	-	1	4
Total	18	72	7	28	25	100

Note: Percentages were rounded to the nearest whole

As it is seen above in table 4.3, there were 25 parents interviewed during the data collection process out of whom 18 were fathers and 7 mothers of the sample youth. Although the researcher's intention was to collect data from fathers and mothers of the sample youth equally, fathers are more available, ready and voluntary for the interview. That is why 72% percent of the sample parents are fathers.

Concerning the ages of the sample parents, 52% of them are found in between 46 and 56 years. However in general, the sample population of the study was comprised of four groups that included youth (College students), counselors and parents of the youth and the three focus groups from the youth in higher education institutes in Addis Ababa.

This diversed nature of the respondents has contributed to the study to collect pertinent data from different background and to cross check the obtained information from different samples. However, the information gathered from interviews of counselors and parents as well as from the focus group are used to analyze, interpret and crosscheck qualitatively the data obtained from the questionnaire responses of the youth (students) quantitatively.

4.1.1.4 Background of the Focus group respondent youth

As it was already described in Chapter Three, One of the data sources for the thesis under the interview part were sample youth of the focus groups. The focus groups were drawn from 6 higher education institutes in Addis Ababa Three sample youth drawn from each higher education institute. There were three focus groups each consisting of 6 members, one from each higher education institute.

Some of the few characteristics of these data sources as respondents to group interviews and discussions are shown in Table 4.7 below:

Table 4.7: Some characteristics of the three focus groups youth

Focus Group Number	**Gender**			**Age**		**Tested**	**Untested**	**Total**
	Male	Female	Total	18-19	20-23			
Focus Group I	3	3	6	4	2	3	3	6
Focus Group II	3	3	6	2	4	2	4	6
Focus Group III	3	3	6	3	3	3	3	6
Total	9	9	18	9	9	8	10	18

As it can be observed from Table 4.7, there were a total of 18 youth who responded and discussed in the focus groups discussions. Out of these respondents, 8 (44.4%) were tested youth and the rest 10 (55.6%) were untested youth. Regarding their age, 9(50%) of the total focus group members were found in 18-19 years whereas the rest 9(50%) were found under the age range of 20-23 years. As far as gender of the focus groups is concerned, 9(50%) of them were males and the other 9(50%) were females. This gender balance was also kept among the members in each focus group to make the discussion fair, balanced and representative.

4.1.2 Results and Discussion

The results of the study are presented and discussed in accordance with the following topics which are based on the four research questions: the factors motivating the youth in higher education institutes to use HIV-VCT services in Addis Ababa; the barriers, negatively motivating or deterring the youth of higher education institutes in Addis Ababa from using HIV-VCT service; the prevalence of positively motivated and negatively motivated youth of higher education institutes in Addis Ababa; and the gender, age, familial level, access to multimedia and sexual experiences differences among the youth in relation to the prevalence of HIV-VCT used and avoided youth of higher education institutes in Addis Ababa.

4.1.2.1 Factors Motivating the youth of higher education institutes to use HIV-VCT services in Addis Ababa

The most important thing in using VCT as a strategy to reduce risk behaviors among the youth which is more challenging than it would be among adults is finding and understanding youth's experiences with HIV-testing and the factors that inhibit or motivate them to use the services. These findings related to the youth's motivation and barriers are very helpful to develop strategies to reach youth with HIV-VCT services. Motivation of the youth to use HIV-VCT services is directly related to the number of tested youth who responded what encouraged or attracted them to be tested and how they would like the HIV-VCT services be provided. In relation to this, it was tried to survey the opinion of the youth themselves, the counselors and the parents as well as focus groups discussion using the questionnaire and interview forms prepared for them. The result obtained is presented and discussed as follows. But the responses obtained from the interview forms of the counselors and parents as well as from the focus group discussion are used qualitatively to cross- check or substantiate the quantitative results obtained from the questionnaire for the youth.

In connection with the motivation of the youth to use HIV-VCT, the total sample youth populations were asked to respond to or write what caused or motivated them to use the HIV-VCT services if they have ever been tested for HIV. There were 242 youth from total 505 sample youth populations who have been tested for HIV or undergone HIV-

VCT services and responded to the factors or reasons asking what motivated them to be tested. However, among the 242 tested youth 178 (73.5%) of them ever had sexual relation and considered as more vulnerable or at risk of HIV- infection. whereas the rest 64 (26.4%) of them have never made sexual relation and considered as relatively less vulnerable or at low risk of HIV - infection. But as long as sexual intercourse is not the only means by which HIV - infection is transmitted, having never made sex is not a guarantee for being risk free from HIV - infection. The infection can be transmitted by sharing sharp materials, needles, blood contact, wet - kissing, through the cracks of fingers and nails, etc. The probability of the transmission of the infection through these means is not negligible especially among the youth, moreover among the youth or students of higher education institutes who pass most of their time in groups together working, playing, etc.

Nevertheless, the responses of the sexually active or experienced youth of higher education institutes were calculated and summarized separately below. However, the response of the whole tested youth was summarized, analysed, presented and discussed as main data on the motivation of the tested youth. And whether there is a difference between the responses of the whole tested youth (242 youth) and that of the sexually active ones (178) for each cause or factor for testing in relation to their percentage was considered and treated comparatively at the end of this chapter.

Multiple responses were allowed. The response provided by the tested and sexually experienced sample youth is summarized in Table 4.8 below:

Table 4.8 Responses of sexually experienced and tested sample youth showing what caused or positively motivated them to use HIV - VCT services.

Factors (Reasons) that motivated the tested and sexually experienced sample youth to use HIV - VCT Services	Sexual Experience				
	Ever had Sex N=178				
	Male	**Female**	**Total**	**14 - 19**	**20 - 23**
To know my HIV status	90(51%)	86(48%)	176(99%)	85(48%)	91(51%)
Distrust of partner	5(3%)	6(3%)	11(6%)	2(1%)	9(5%)
Being worried about HIV	45(25%)	50(28%)	95(53%)	50(28%)	45(25%)
Exposure to HIV risk	3(2%)	5(3%)	8(5%)	3(2%)	5(3%)
Pregnancy	0(0%)	2(1%)	2(1%)	1(0.6%)	1(0.6%)
Referral from clinics/ Hospitals	0(0%)	2(1%)	2(1%)	0(0%)	2(1%)
Push from parents/ home	1(0.6%)	0(0%)	1(0.6%)	1(0.6%)	0(0%)
Push from peer	14(8%)	6(3%)	20(11%)	10(6%)	10(6%)
Push from sexual partner	18(10%)	22(12%)	40(22%)	15(8%)	25(14%)
Plan to marry	9(5%)	6(3%)	15(8%)	3(2%)	12(7%)
Having HIV - symptom	0(0%)	1(0.6%)	1(0.6%)	0(0%)	1(0.6%)
Accessibility of the center	132(74%)	18(10%)	150(84%)	84(47%)	66(37%)
Youth friendliness of the counselor	92(52%)	83(47%)	175(98%)	87(49%)	88(49%)
Confidentiality of the services	86(48%)	90(51%)	176(99%)	81(46%)	95(53%)
Privacy of the services	86(48%)	91(51%)	177(99%)	83(47%)	94(53%)
Youth friendliness of the services	89(50%)	86(48%)	175(98%)	79(44%)	96(54%)
Blood donation	3(2%)	3(2%)	6(3%)	4(2%)	2(1%)
Life insurance	2(1%)	0(0%)	2(1%)	0(0%)	2(1%)
DV - Lottery / Any abroad flight	48(27%)	50(28%)	98(55%)	28(16%)	70(39%)
Information from multimedia about HIV and the importance of HIV - VCT	18(10%)	12(7%)	30(17%)	14(8%)	16(9%)
Awareness of the advantage of early knowledge of HIV - status	78(44%)	72(40%)	150(84%)	72(40%)	78(44%)
No definite reason	3(2%)	2(1%)	5(3%)	3(2%)	2(1%)
Any other	19(11%)	17(10%)	36(20%)	13(7%)	23(13%)

Note
- The questions were posed to all sexually experienced and tested sample youth.
- Multiple responses were allowed; therefore, percentages do not add up to 100%
- Percentages were rounded to the nearest whole.

Among the total 242 tested sample youth, 178(73.5%) of them responded that they have ever made sexual intercourse. The response of this group of sample youth among the total tested youth was considered and summarized separately because of the presumption that they are more vulnerable and at higher risk of HIV - infection. And the reason why they have used VCT or what motivated them to use VCT are different from that of the sexually inexperienced ones.

However, among the total 178 tested and sexually experienced sample youth 177(99.4%) of them responded that they were motivated to use HIV - VCT by the privacy and confidentiality of the services. According to the responses of the tested and sexually experienced sample youth, the next three most prevalent factors or reasons that motivated them to use HIV -VCT are the purpose to know one's HIV - status, youth - friendliness of the services and the counselors. They motivated about 99,98 and also 98 percent of the total tested and sexually experienced sample youth respectively.

Accessibility of the VCT and awareness of the advantage of earlier knowledge of the HIV- status are the next influential causes or factors that motivated each equally 150(84%) of the total 178 sexually experienced and tested sample youth to use HIV - VCT services. As shown above in Table 4.8, there are minor gender differences in relation to the prevalence of the responses of the tested and sexually experienced sample youth. This issue of prevalence in relation to gender differences is to be presented and discussed at the end of this chapter. And the prevalence difference between the responses of the total tested sample youth (242) and that of the total tested and sexually experienced (active) sample youth (178) to the questions asking what motivated them to use VCT is not noticeable. For example, the top five influential causes or factors that motivated the sample subjects to use HIV - VCT are the same for both groups of samples. Privacy of the services, confidentiality of the services. Knowing one's HIV - status, youth friendliness of the whole VCT services in general and youth friendliness of the counselor in particular are the most prevalent and influential causes or factors that motivated both the total 242 tested sample youth and the 178 tested and sexually experienced (active) sample youth in almost the same degree of prevalence. Therefore, the responses provided by the total (242) tested sample youth as well as by the total tested and sexually experienced (178) and inexperienced (64) ones categorized by gender differences is summarized in Table 4.9 A below:

Table 4.9 A: Responses of sexually experienced and inexperienced tested sample youth showing what caused or positively motivated them to use HIV - VCT services.

Factors (reasons) that caused or motivated the tested youth to use HIV - VCT Services	Sexual Experiences					
	Ever had Sex (N = 178)			Never had sex (N = 64)		
	Male	Female	Total	Male	Female	Total
To know my HIV-status	90(51%)	86(48)	176(99%)	26(41%)	22(34%)	48(75%)
Distrust of partner	5(3%)	6(3%)	11(6%)	0(0%)	0(0%)	0(0%)
Being worried about HIV	45(25%)	50(28%)	95(53%)	10(16%)	15(23%)	25(39%)
Exposure to HIV risk	3(2%)	5(3%)	8(4%)	1(1.6%)	1(1.6%)	2(3%)
Pregnancy	0(0%)	2(1%)	2(1%)	0(0%)	0(0%)	0(0%)
Referral from clinics /Hospital	0(0%)	2(1%)	2(1%)	1(1.6%)	0(0%)	1(1.6%)
Push from parents /home	1(0.6%)	0(0%)	1(0.6%)	1(1.6)	0(0%)	1(1.6%)
Push from peer	14(8%)	6(3%)	20(11%)	8(13%)	4(6%)	12(19%)
Push from sexual partner	18(10%)	22(12%)	40(22%)	3(5%)	2(3%)	5(8%)
plan to marry	9(5%)	6(3%)	15(8%)	2(3%)	3(5%)	5(8%)
Having HIV symptom	0(0%)	1(0.6%)	1(0.6%)	0(0%)	0(0%)	0(0%)
Accessibility of the center	132(74%)	18(10%)	150(84%)	20(31%)	18(28%)	38(59%)
Youth friendliness of the counselors	92(52%)	83(47%)	175(98%)	28(44%)	22(34%)	50(78%)
Confidentiality of the service	86(48%)	90(51%)	176(99%)	26(41%)	34(53%)	60(94%)
Privacy of the service	86(48%)	91(51%)	177(99%)	23(36%)	36(56%)	59(92%)
youth friendliness of the services	89(50%)	86(48%)	175(98%)	25(39%)	26(41%)	51(80%)
Blood donation	3(2%)	3(2%)	6(3%)	4(6%)	2(3%)	6(9%)
Life insurance	2(1%)	0(0%)	2(1%)	4(6%)	3(5%)	7(11%)
DV-Lottery/ any abroad flight	75(42%)	80(45%)	155(87%)	22(23%)	28(44%)	50(78%)
Info. from multimedia about HIV and importance of VCT	18(10%)	12(7%)	30(17%)	15(23%)	11(17%)	26(41%)
Awareness of the advantage of early knowledge of HIV status	78(44%)	72(40%)	150(84%)	34(53%)	26(41%)	60(94%)
No definite reason	3(2%)	2(1%)	5(3%)	7(11%)	3(5%)	10(16%)
Any other	30(17%)	24(13%)	54(30%)	27(42%)	24(38%)	51(80%)

Table 4.9 B: Responses of the whole (242) tested sample youth showing what caused or positively motivated them to use HIV - VCT services.

Factors (Reasons) that caused or motivated the whole tested youth to use VCT	**Frequency of the whole tested sample youth n=242**	**Age in Year**	
		14 - 19	20-23
To know my HIV-status	224(93%)	92(38%)	132(55%)
Distrust of partner	11(5%)	3(1%)	8(3%)
Being worried about HIV	120(50%)	51(21%)	69(29%)
Exposure to HIV risk	10(4%)	4(2%)	6(2%)
Pregnancy	2(0.8%)	1(0.4%)	1(0.4%)
Referral from clinics /Hospital	3(1%)	1(0.4%)	2(0.8%)
Push from parents /home	2(0.8%)	1(0.4%)	1(0.4%)
Push from peer	32(13%)	14(6%)	18(7%)
Push from sexual partner	45(19%)	18(7%)	27(11%)
plan to marry	20(8%)	5(2%)	15(6%)
Having HIV symptom	1(0.4%)	0(0%)	1(0.4%)
Accessibility of the center	188(78%)	78(32%)	110(45%)
Youth friendliness of the counselors	225(93%)	104(43%)	121(50%)
Confidentiality of the service	236(98%)	116(48%)	120(50%)
Privacy of the service	236(98%)	121(50%)	115(48%)
youth friendliness of the services	226(93%)	112(46%)	114(47%)
Blood donation	12(5%)	5(2%)	7(3%)
Life insurance	9(3%)	3(1%)	6(2%)
DV-Lottery/ any abroad flight	205(85%)	97(40%)	108(45%)
Information from multimedia about HIV and the importance of VCT	56(23%)	24(10%)	32(13%)
Awareness of the advantage of early knowledge of HIV status	210(87%)	96(40%)	114(47%)
No definite reason	15(8%)	8(3%)	7(3%)
Any other	105(43%)	42(17%)	63(26%)

Note. - The questions were forwarded to all tested youth.

- Multiple responses were allowed therefore, percentages do not add up to 100%
- Percentages were rounded to the nearest whole.

As shown above in Tables 4.9 A and 4.9 B, the responses of the tested sample youth to the questions asking what motivated them to use HIV - VCT were considered and summarized from different perspectives. The variables among the tested youth were taken into account. Accordingly, the responses of the sexually experienced and inexperienced ones, each categorized by gender difference as well as that of the total tested youth also categorized by gender were summarized and calculated separately. However, though the differences among the different categories of tested sample youth in relation to the prevalence of their responses to each of the list of causes or reasons asking what motivated them to use HIV - VCT are not as such noticeable, they are presented and discussed at the end of this chapter. But here, the responses of the total tested sample youth are considered and treated as the main sources of data of the study presented and discussed below. Nevertheless, the responses of the sexually experienced ones are also taken into consideration to each reason or factor. The underlying reason for doing so is that sexual intercourse is not the only means of transmission of HIV - infection especially among the youth of higher education institutes in Addis Ababa. Those who have never made sexual intercourse are also never free from risk of HIV - infection and related psychosocial motivations to be tested. However, it is undeniable that the level of risk of HIV - infection is higher among the youth who have had sexual intercourse (sexually experienced). Therefore, all the 242 tested youth among the total 505 sampled youth included in the study, responded to the questions. Accordingly, 236 of the 242 which is about 98% of the tested youth were caused or motivated to use HIV-VCT by the confidentiality and privacy of the HIV-VCT services equally. Regarding confidentiality and privacy of VCT, both the sexually experienced and inexperienced sample youth showed closer degree of motivational attribution for being tested. About 99% of the sexually experienced ones were motivated by confidentiality and privacy equally and in the case of sexually inexperienced ones too, about 94 and 92 percent of them respectively were motivated by them.

Sample counselors also were asked to answer from their practical experiences what the youth like most while using HIV-VCT services to cross-check the numerative (quantitative) data obtained from the sample youth about the issue in the questionnaire. The answer was quite conformable with the above data obtained from the responses of

the sample youth. Almost all the sampled counselors answered that what almost all the youth that have undergone HIV-VCT like most are confidentiality and privacy of the services. The counselors added that young people are most concerned about their privacy and are fearful that others who know them may find out that they sought an HIV test. Therefore youth prefer most to have tests in facilities where the confidentiality and privacy are well kept, so that it is not clear to any casual observer that they are there to have an HIV test. counselors were asked further to give reasons for their response. Some of the other reasons they mentioned were:

- Stigma and discrimination of people who test seropositive may face from their families, peers and community.
- Myth and belief of the youth that his/her sexuality should never be disclosed to others.
- Economic dependence of the youth that he/she might be abandoned or abused for appearing at the center for HIV-test.
- Unreasonable fear of others, because of their age i.e. their being inexperienced in human sexuality and generally, reality of the world.
- Need of using the services anonymously.
- Need of environment that allows the youth for private discussion of sexual matters and personal worries.

All the above-mentioned factors expressed by sample youth and counselors confirm findings of earlier studies conducted on HIV-VCT in different parts of Africa and discussed in the literature review part of this study.

Related questions were also raised to some parents of the sample youth in an interview with regard to the motivation of youth to use HIV-VCT. The parents were asked whether they have ever motivated their son/daughter to use HIV-VCT. The responses of the majority, 20 out of the 25 parents, which is 80 percent, responded that they never motivated them. They were further asked to tell their reason why they don't motivate their son/s/daughter/s/. Most of them told the following reasons:

- They never anticipate their son's/ daughter's sexuality
- They don't want to discuss sex related issues with their sons or daughters because test signals sexual activity of their sons/ daughters.
- Daughters and sons are not willing to deal with such issues with them.

- As a parent, especially for the girl, I would start imagining that she has already started moving out with men and I would get very annoyed and worried.

One such question forwarded to parents was that what their responses would be if they have heard that their daughter/ son had used HIV - VCT services out of their awareness. Out of the 25 parents who were included in the study, 19 of them (about76%) said that there is nothing they can do, but it surprises them that they had never expected him/her to be playing sex.

All the reasons mentioned above by the sample parents reflect that they need change in their attitudes towards the importance of HIV - VCT for the youth. They need also change of awareness about human developmental stages, human sexuality, communication skills with their sons and daughters, the advantage of early awareness of HIV - status, etc. Multimedia and HIV - VCT centers with clinics and hospitals are expected to play great roles in this area.

The parents' attitude towards HIV - test reflects to some extent the attitude of the Addis Ababa community in large, which is the main cause of stigmatization of HIV/ AIDS. That is why almost all the tested youth firmly insisted on privacy and confidentiality.

However, 5 of the sample parents (20%) said that they encourage and motivate their son(s) and daughter(s) to use HIV - VCT services. They also said that they would never be annoyed, worried or surprised if they heard that their sons/ daughters had used HIV - VCT services out of their awareness about the purpose and the issue. The reason they gave were:

- They don't want to interfere with their sons'/daughters'/ private affairs
- They believe that early awareness of serostatus is important
- They believe that it was their responsibility to discuss openly about the issue with their sons/ daughters and advise what to do, but they didn't do it. Therefore they have to accept positively what their sons/ daughters did by themselves.
- They believe that if their sons/ daughters asked them for their advice, they would encourage and motivate them to be tested but if they did it by themselves, they (parents) appreciate them and advise them to be more careful.

All these reasons mentioned by a few of the sampled parents (20%) may reflect the direction change in their awareness and attitudes towards HIV/AIDS, HIV - VCT, the

importance of early awareness of serostatus, the importance of considering and accepting the sons'/daughters' developmental stages with their biological, psychological, etc needs and decisions. This direction may give some crude picture about the present condition of parents of Addis Ababa in relation to their sons'/ daughters' motivation to use HIV - VCT.

In relation to the usage of HIV-VCT, each of the interviewed parents was asked to give his/her general comment, suggestion or advice if his/ her son/daughter asked him/her for his/her view about his/her intension of test for HIV. When their responses are summarized, the following general reflections are noted. Some parents answered that they would be shocked, because such a question was out of their expectation. They were believing that their son(s) daughter(s) have never been involved in sexual activities yet. But now they directly relate their son's and/or daughter's questions for the test to their sexual activity. Among these parents some of them said that they would very much be annoyed and offended and would abuse him/her. Some of them said that they would have nothing to say to their son/daughter for the moment.

Some other parents in contrast said that young people can make independent decisions about their life of course including HIV - test. They said that if he/she tends to go for testing and ask for their view or suggestion, they would encourage him/her to do it soon.

But, some other parents commented that as long as there is no continuous and ongoing counseling and medical supports, the advantage of being tested is very limited. Therefore, their view for the test is neither negative nor positive. But they never get surprised about the request of their son/daughter for test.

In general, on the bases of the responses of the sample counselors, parents and focus groups, there have been found (obtained) two main reasons for the youth not wanting others to learn about their testing experiences. The first one is that the youth want to avoid the stigma that some HIV - infected people suffer. The second one is that they prefer not to disclose that they are sexually active. As a result of stigma and the association of testing with sexual activity, youth are too much concerned about the privacy and confidentiality of the services. When the youth who have undergone the test have been asked for their opinion in the questionnaire to state what they like most about the HIV - testing services, most of them (about 92%) answered or responded that they

liked best privacy and confidentiality of the services. The sample counselors were also asked for their opinion to tell in the interview what their youth clients like and dislike most. Almost all (about 98%) of the sample counselors put privacy and confidentiality at the top followed by gender and age similarity of the counselor and youth friendliness of the services.

Next to privacy and confidentiality, the strongest factors that motivated 226 (about 94%) and 225 (about 93%) of the total 242 tested youth to use HIV- VCT are youth friendliness of the services including the referral system and youth - friendliness of the counselors respectively. Among the sexually experienced sample youth too, about 98% them were motivated by the above mentioned factors equally. And those who have never made sex also (80% and 78% of them respectively) were motivated by these factors. It was also raised during focus groups discussions with eighteen (18) youth, randomly selected from 6 higher education institutes. They were asked to tell what they wish most, the HIV - VCT services to be for them. Almost all (about 98%) of them answered that they like most the service providers especially the counselors to be youth friendly. They were further asked to make clear what do they mean by youth friendliness. They further expressed that they wish the counselors to be kind, good at communication, open minded, ready and patient to listen to the problems of the youth and easily approachable. They also wish the counselors to be qualified professionals and understanding or knowledgeable about HIV as well as human nature. In general, both tested and untested youth in the focus groups discussions gave emphasis for the counselor to be well qualified, good communicator, open, kind, knowledgeable and if possible not very far from their age. Of course they gave emphasis to privacy and confidentiality of the whole services too. Most of them said that they wouldn't mind talking with a counselor of the opposite sex. But some of them were not comfortable with this idea that they prefer their counselors to be the same sex to them.

In relation to youth friendliness of the services, the counselors were asked in the interview to forward their view from their experience. Almost all the sample counselors (about 99%) of them said that they try their best to adjust their counseling service in accordance with each client's age, perception of problem, individuality etc. They also said that some youth clients prefer to be counseled by their age and sex similar counselor. Almost all counselors gave emphasis to the deficiency of the service especially because

of the incompleteness (if not absent) of the referral system. It decrease the quality of the youth friendliness of the whole services. When they were asked their reason, they stated it as follows: Referral system should include services which are responsive to the youth's psychological and medical needs and priorities that are appropriate to their culture, language, age, developmental stage health condition, etc. But this very important part of the services is almost missing. There is no sustainable and appropriate network of services after test result for the youth that include ongoing psychological and medical support.

Under the motivating factors of the youth of higher education institutes in Addis Ababa to use HIV-VCT, the purpose of knowing HIV-status and awareness of the advantage of early knowledge of serostatus have been found being significant factors next to friendliness of the service. 224 (about 93%) and 210 (about 87%) sample youth out of the total 242 tested youth were motivated or attracted and used HIV-VCT because of the purpose of knowing HIV-status, and because of awareness of the advantage of early knowledge of their serostatus respectively. Among the sexually experienced and inexperienced ones, there was a moderate prevalence difference. In the case of knowing one's HIV- status about 99% of the sexually experienced and 75% of the sexually inexperienced youth were attracted by. It is because of the fact that the sexually active ones are more eager to know their serosatetus, as a result of their higher level of suspicion of being infected by HIV. Whereas, in the case of the awareness of the advantage of early knowledge of ones serostatus, about 84% of the sexually experienced and 94% of the inexperienced sample youth were attracted by it to use HIV-VCT services. The prevalence of this factor is higher among the sexually inexperienced ones may be that they are more encouraged to prove and keep up their expected HIV-(negative) serostatus. The difference between the purpose of knowing the serostatus and awareness of the advantage of early knowledge of the serostatus is that the latter one refers to the knowledge about HIV/AIDS in relation to its nature, infection, prevention, and treatment. This means, on the basis of the test result, the tested individual has already planned to keep up his/her being free from HIV infection if the result is seronegative, and to learn and accept his/her HIV serostatus with timely and appropriate counseling and referral for ongoing emotional support and medical care if the result is seropositive. Whereas, the earlier one purposes merely to know one's HIV serostatus mostly because

of being worried about the infection. This worry might be either imagined or reality based like having been involved in HIV-risky behavior, feeling or observing symptoms of HIV infection etc. However, sexually experienced youth are more worried than the inexperienced (never made sex) ones. As Tables 4.9 A and B showed above, about 53% them are worried about HIV infection whereas, in the case of sexually inexperienced ones about 39% of them are worried about it. The source of their worry might be related to the possible infection of HIV through means other than sexual intercourse or it might be because of lack of knowledge about the transmission of HIV infection.

The response of the sampled youth in the data showed that in general, a considerable number of youth were motivated by the above-mentioned factors and used HIV-VCT services. In this regard, in the focus groups discussions, the members of all the three groups were asked to forward their reasons why they have decided to be tested and to tell the advantage of being tested if any. Most of the members of the three focus groups, 67, 69 and 68 percent of them respectively who have been tested said that they have decided to be relived from their worry about HIV-infection. They have expressed their feelings of regret that they were involved in HIV-risky sexual activities, feelings of hopelessness, daydreaming, imagined worries and death feelings, etc. Therefore as they mentioned their main reason was to relieve themselves from these sufferings proving that they are free from HIV-infection. But relatively lower number of the focus groups about 33,31 and 32 percent of them respectively argued against this reason that they said their main reason was not mere relief of worries. Rather it was beyond that, to accept whatever the result is and to be helped by psychological support and /or medical care that enable them to cope with the result .They added that the test by itself was not an end or goal, rather it was an entry point to further care and support. These difference of purposes or reasons among the tested youth shown in both the data collected from the questionnaire and from the opinions of the focus groups discussions reflected differences of ideas especially awareness differences about HIV/AIDS and HIV - VCT services among the youth of higher education institutes in Addis Ababa. The majority of the youth have been more motivated by mere being tested hopping that they would prove negative and relieved from their worries about HIV infection rather than planning to be benefited from the timely and on going services being aware of their serostatus earlier. This is an indicative that there is awareness or information gap among the youth of higher education institutes

in Addis Ababa. IEC seems appropriate to be applied using multimedia and other means of communication among the youth to increase their level of awareness of HIV and HIV - VCT.

The other significant motivating factor next to the interest to know one's serostatus and to be benefited from the services is the plan to fly abroad. The collected data from the responses of the sample youth in the questionnaire showed that it motivated or rather forced many youth in the sample to be tested for HIV. 205 (about 85%) of the total 242 tested sample youth were motivated or forced, by their own plan or sudden chance of abroad flight, to be tested for their HIV serostatus. This kind of motivation to use HIV - VCT is different from the above mentioned motivating factors because of its being extrinsic motivator. It was not the youth's own choice and decision that came out of his/her own feelings and/or thought (intrinsic motivation) to be tested. Rather the decision to be tested was made by the youth because of the influence of environmental or external force (extrinsic motivation). This motivation is extrinsic and forcing one unlike the above ones because he/she is forced to be tested otherwise he/she wouldn't be allowed to leave for that country. There is no any statistical data or document available in the sample areas and even in other concerned offices of Addis Ababa that shows the average number of youth that use HIV - VCT per a given period of time for abroad flight to cross - check it with the data obtained from the responses of the sample youth in the questionnaire.

However, the sample counselors were asked related questions to tell the number and frequency of their youth clients who are students in higher education institutes in Addis Ababa that come to them to be tested for abroad flight in relation to other testees. Many counselors said that their number in average is more than many of their clients came to be tested because of other reasons or factors like push from parents or peers, HIV - symptoms, life insurance and other. The counselors also mentioned that there is gender difference in the prevalence of tested youth for the purpose of abroad flight including DV lottery. Almost all counselors said that female youth are more prevalent than male youth who are being tested for abroad flight in general, and even among the youth in higher education institutes. They said that it is mostly because of more abroad job and marriage opportunities for female than for male youth in Addis Ababa. In relation to the HIV - VCT services being provided for those who are ready to fly abroad, some counselors

expressed their professional complaint against the testing process of some embassies bitterly. They said that some embassies order the people who claim for flight visas including DV- Lottery, to some clinics, with which the embassy has a kind of contract or agreement, to be tested for HIV. The clinics test and tell them the test result carelessly, with out pretest and post test counselings, which is unprofessional, unethical and immoral.

Accessibility, availability and cost of the VCT services also motivated fair number of youth to be tested in Addis Ababa. The data gathered from responses of the tested sample youth in the questionnaire showed that 188 (about 78%) of the whole 242 sample tested youth were motivated by accessibility of the testing centers. According to the document obtained from AIDS Resources Center, there are more than 40 HIV - VCT services providing clinics, hospitals and VCT centers. Almost all of them demand some amount of money for the services, from 10 -250 Ethiopian birr per person. Though there is no problem concerning the availability and accessibility of the centers in Addis Ababa, as some counselors and youth themselves mentioned in the interviews, reducing the price of testing services especially for the youth is essential. Some sample counselors in the interview suggested that to lower the prices for the youth, service providers should consider different alternatives like cost sharing, sliding pay scales, free VCT days or weeks, etc. They suggested that it would motivate the youth to be tested.

According to the data gathered from the responses of the sample tested youth in the questionnaire, there were many other factors or reasons next to the above mentioned main factors that motivated the youth to be tested. Some of these factors to be mentioned or elaborated by adding the sample counselor's parents' and focus groups' responses of the interviews to the obtained data from the responses of the tested youth in Tables 4.9 A and B are as follows: Among tested youth some 50% responded that they have been tested because of distrust of their partners and they were worried about infection of HIV. This issue was raised in the discussions with the three focus groups of the youth. Most (about 67%) of them said that they usually seek an HIV test while they are healthy but felt or imagined that they are at risk. Both sexually experienced and inexperienced focus groups members expressed that they feel at risk even without having made any sexual intercourse. Of course, the degreed of feeling of being at risk varies between the sexually experienced and inexperienced ones. Having HIV - symptoms and feeling ill are seldom

reasons that tested youth responded in both the questionnaire and in the focus groups interviews (discussions).

Among the total 242 tested youth, some 26% (64) responded in the questionnaire that they have never had sexual relation. It might be an indicator that these youth either may not know well about the transmission of HIV/AIDS or they have problem of imagined fear of HIV infection or may be they know well that there are many other ways other than sexual intercourse through which HIV infection is transmitted.

However, the sample counselors' views in their responses to the interview on the issue were different from each other. But what is common is that it opposes to the youth's responses. The counselors mostly said that the youth seek HIV tests because of exposure to HIV - risk behavior but not imagined fear of HIV - infection. This reason was given by the majority of the sample counselors (about 85%). They further mentioned their perceptions and practically proved reasons from their experiences that most youth appear (seek) HIV - test to know their HIV status to be relieved from their worry about HIV infection as a result of involvement of HIV risky behavior. Some of the sample counselors also revealed that counseling the youth requires special training and improved, youth oriented counseling and referral services. They didn't hide that they lack trainings in counseling the youth. They further displayed that counseling youth is difficult because of two main reasons. The first and most difficult one is that they do not acknowledge risk factors and decide to change their behavior. The other difficulty is that they do not easily reveal and explain their genuine feelings, thoughts, and problems for further counseling and discussion. Therefore, responses to "Information from Multimedia" and some other factors that were grouped under the question "Any other." were also considered and summarized. They also have motivated not a few number of youth to use the HIV - VCT services as shown in Table 4.9 above. About 24% of the total tested youth were motivated by the information they gained about HIV and the importance of VCT through the multimedia and decided to be tested. Multimedia includes radios, televisions, newspaper, journals, posters, pamphlets, etc.

The sample counselors, also while they were asked to give their opinion what to do to attract the youth to the VCT service providing centers, they said that the multimedia are expected to contribute a lot. They further explained that, different, qualified and well trained professionals, especially psychologists, medical workers, sociologists and others

are highly expected to use the multimedia to attract and motivate the youth to use HIV - VCT services. They also commented on some unprofessional and inappropriate expressions, dramas, audiovisuals, etc that deter the youth from being tested.

In the focus groups discussions too, most of the tested and untested youth agreed upon the idea that there is a gap yet in the multimedia while they have been expected to contribute a lot in creating awareness in the public especially among the youth of higher education instituted in Addis Ababa about HIV/AIDS, HIV - VCT and the importance of earlier awareness of serostatus.

Whereas, about 44% of the total tested youth responded in the questionnaire that they were motivated by other factors although that they haven't been mentioned in the questionnaire. Most of them didn't mention specifically what has motivated them in addition to what they have already mentioned earlier. This is because multiple response were allowed. Among the sexually experienced and inexperienced tested sample youth too, 30 an 80 percents of them respectively responded that they had their own other reason or reasons caused them to be tested. For the case of the sexually inexperienced tested sample youth, the prevalence of this factor is high, it might be because of their own imagined fear, which is either beyond our common sense, experience and maybe knowledge about the transmission of HIV-infection or the reverse. However, some of the focus groups respondents specifically mentioned cost and good will of some VCT centers as some other motivating factors. Especially for the youth, decreasing the price of the services attracts them much. The good will is related to the quality of the service provision.

There were also some other contributing factors in motivating the youth intrinsically or extrinsically to use HIV - VCT services. But as long as the sample youth were allowed to respond to many alternative factors at the same time (multiple responses) the factor that has been selected or responded to by each sample youth is not the only decisively causing factor per se. Rather each factor is a contributing one to each sample youth to use or not to use HIV - VCT services or to be tested or not to be tested. The degree of contribution of a factor depends up on the number or percentage of the tested sample youth influenced or motivated by that factor. Therefore, though they were not as such significant in general, the following factors also have contributed to the youth to use the services per se at different degrees of contribution.

A fair percentage of tested youth, ranging from about 1% to 19% were pushed by their friends or parents to be tested. It was shown in Tables 4.9 A and B that 45 (about 19%) of the tested youth were motivated, rather pushed to be tested by their sexual partners and 32 youth (about 14%) by their peers. But only 2 youth (about 1%) of the tested sample population were pushed by their parents to use HIV - VCT services. These findings are indicators that young people in higher education institutes in Addis Ababa discuss and learn about HIV and HIV - VCT much more with their sex partners and peers than with parents. Most youth of higher education institutes in Addis Ababa do not disclose, HIV and HIV - VCT related issues to their parents. This finding exactly matches with the result obtained from the interview with the parents on related matters.

Among the tested sample youth15 (about 7%) of them have no definite reason or factor that motivated them to be tested. They have been tested merely by chance. Therefore, the tested youth can be categorized into three groups, i.e. intrinsically motivated, extrinsically motivated and with no motivation (a motivated) or indifferent youth.

Almost the least significant contributing factors except some that have been discussed above are extrinsic motivating factors. But abroad flight / DV - lottery was not included here though it is an extrinsic motivator, because of its being significant factor. These factors in their order of significance as shown in Table 4.9 were presented as follows: plan to marry 20 youth (about 9%) blood donation 12 youth (about 5%) life insurance 9 youth (about 4%), referral from clinics/ hospitals 3 youth (about 2%) and pregnancy 2 youth (about 1%).

In general it was summarized that most of the tested youth (88%) were motivated intrinsically, some of them (about 11%) extrinsically and a few of them (about 1%) have no definite motivating factors (a motivated).

4.1.2.2 Barriers or Negatively Motivating Factors that deter the youth of higher education institutes from using HIV - VCT services in Addis Ababa

In Addis Ababa, where VCT services have been established and providing their services, many youth of higher education institutes were found untested yet. Mainly it was because of barriers or negatively motivating factors or reasons that deter the youth from using the services. To some extent it was also because of the youth's reluctance or indifference to attend for testing.

In general, from the total 505 sample youth, 263 (52%) of them were found untested and responded to the reasons or factors asking why they haven't been tested. However, among the total 263 untested sample youth, 227 (86.3%) of them were sexually experienced meaning ever had sex. This group of youth are in common sense more vulnerable or at risk for HIV infection and are expected to be tested, otherwise more likely to have been deterred from using the services by a barrier or barriers of VCT. However, as has been mentioned earlier, there are many other means of transmission of HIV - infection other than sexual intercourse especially for the youth of higher education institutes. And the sexually inactive or inexperienced sample youth are never free from risk of HIV infection. But the response of the sexually active (experienced) youth to each reason or factor asking for the perceived barrier(s) deterring them from using HIV - VCT was considered and summarized separately below. And the response of the whole untested sample youth was summarized analyzed, presented and discussed as main data on the VCT barriers of the untested youth. Whether there are differences between the responses of the sexually experienced (227) youth and the whole untested (263) sample youth to each of the deterring reasons or factors for not using VCT were considered and treated comparatively using the percentages of the responses for each reason. It was presented at the end of this chapter.

Multiple responses were allowed. The responses provided by the untested but sexually active (experienced) sample youth is summarized in Table 4.10 below:

Table 4.10: Responses of untested but sexually experienced sample youth showing what negatively motivated or deterred them from using HIV - VCT services.

n=36

Factors (Reasons) that deterred the untested but sexually experienced sample youth from using HIV - VCT	Sex and Frequency			Age in Year	
	Male	**Female**	**Total**	**14 - 19**	**20 - 23**
Stigma	17(47%)	18(50%)	35(97%)	16(44%)	91(53%)
Fear of positive result	18(50%)	18(50%)	36(100%)	15(42%)	21(58%)
Attitude towards provider	3(8%)	1(3%)	4(11%)	2(6%)	2(6%)
Do not feel at risk	1(3%)	1(3%)	2(6%)	0(0%)	2(6%)
Never had sex	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)
Lack of youth friendly Services.	10(28%)	9(25%)	19(53%)	8(22%)	11(31%)
Inconvenient hours of Services.	5(14%)	7(19%)	12(33%)	7(19%)	5(14%)
Inaccuracy of the test	3(8%)	4(11%)	7(19%)	3(8%)	4(11%)
Peer influence	5(14%)	3(8%)	8(22%)	5(14%)	3(8%)
Distance of services	1(3%)	3(8%)	4(11%)	3(8%)	1(3%)
Cost	12(33%)	15(42%)	27(75%)	16(44%)	11(31%)
Fear of people finding out	15(42%)	17(47%)	32(89%)	18(50%)	14(39%)
Waiting period for test result	0(0%)	2(6%)	2(6%)	1(3%)	1(3%)
Belief	1(3%)	2(6%)	3(8%)	2(6%)	1(3%)
Do not want to have a test	3(8%)	3(8%)	6(17%)	4(11%)	2(6%)
Parent or home influence	4(11%)	6(17%)	10(28%)	7(19%)	3(8%)
Lack of confidentiality of the service	6(17%)	8(22%)	14(39%)	8(22%)	6(17%)
Lack of privacy of the services	7(19%)	9(25%)	16(44%)	10(28%)	6(17%)
Influence of sexual partner	2(6%)	6(17%)	8(22%)	3(8%)	5(14%)
Religion	2(6%)	3(8%)	5(14%)	3(8%)	2(6%)
Attitude toward the counselor	1(3%)	1(3%)	2(6%)	1(3%)	1(3%)
Attitude towards the testing	1(3%)	0(0%)	1(3%)	0(0%)	1(3%)
Attitude towards the referral system	2(6%)	3(8%)	5(14%)	2(6%)	3(8%)
Attitude towards the tester	1(3%)	2(6%)	3(8%)	2(6%)	1(3%)
Perceived the services as useless	8(22%)	6(17%)	14(39%)	6(17%)	8(22%)
Because of lack of time	6(17%)	8(22%)	14(39%)	5(14%)	9(25%)
No definite reason or factor	9(25%)	10(28%)	19(53%)	10(28%)	9(25%)
Any other factor/ reason	4(11%)	6(17%)	10(28)	6(17%)	4(11%)

Note - Multiple responses were allowed, therefore, percentages do not add up to 100%

- Percentages were rounded to the nearest whole.

Among the total 263 untested sample youth 36 (13.7%) of them responded that they have ever made sex. The response of this group of untested sample youth was given especial emphasis and considered as well as summarized separately. The underlying reasons for doing so is that this group of untested youth are presumed to be more vulnerable and at higher risk of HIV - infection. And the reason why they didn't use HIV - VCT or their perceived barriers impeded them not to use VCT, are different from that of the sexually inexperienced ones. However, the result of the study showed above in Table 4.10 that among the total 36 untested but sexually experienced sample youth, 32(about 89%) of them equally for each reason or factor responded that they were deterred from using VCT because of the VCT barriers like stigma, fear of positive result and fear of people finding out them. The next 6 most prevalent reasons or factors that the untested but sexually experienced sample youth attributed their perceived barriers of VCT are cost (about 75%), no definite reason (about 53%), lack of youth - friendliness of the services (about 53%), lack of privacy of the services (about 44%), lack of time (about 39%) and perceived the services as useless (about 39%).

The prevalence difference of the responses to each cause of factor between male and female untested but sexually experienced sample youth was left to be presented and discussed at the end of this chapter. However, the prevalence difference between the responses of the total untested sample youth (263) and that of the total untested but sexually experienced or active sample youth (36) to the questions asking what deterred them from using VCT is not noticeable or considerable. For example the top 8 prevalent and influential perceived VCT barriers presented above and in Table 4.10, that are responded by the untested but sexually experienced (36) sample youth are responded by the total untested (263) youth too, in the same order of prevalence or degree of influence.

Therefore, the response provided by the total untested sample youth (263) as well as by the total untested but sexually experienced (36) and inexperienced (227) sample youth categorized by gender differences is summarized in Table 4.11 below:

Table 4.11: Response of untested youth showing what negatively motivated or deterred them from using HIV VCT services.

Factors (reasons) that negatively motivated or deterred the untested youth from using HIV - VCT Services	Sexual experience						Sum total frequency of the whole untested sample youth n=263	Age in Year; n=263	
	Ever had Sex; n=36			Never had Sex; n=227					
	Male	Female	Total	Male	Female	Total		14-19	20 - 23
Stigma of HIV/ AIDS	17(47%)	18(50%)	35(97%)	110(48%)	111(49%)	221(97%)	256(97%)	120(46%)	136(52%)
Fear of positive result	18(50%)	18(50%)	36(100%)	108(48%)	110(49%)	218(96%)	254(97%)	125(48%)	129(49%)
Attitude towards provider	3(8%)	1(3%)	41(11%)	8(4%)	6(3%)	14(6%)	18(7%)	8(3%)	10(4%)
Do not feel at risk	1(3%)	1(3%)	2(6%)	66(29%)	60(26%)	126(56%)	128(49%)	72(27%)	56(21%)
Never had sex	0(0%)	0(0%)	0(0%)	112(49%)	115(51%)	227(100%)	227(86%)	185(70%)	42(16%)
Lack of youth - friendly services	10(28%)	9(25%)	19(53%)	70(31%)	63(28%)	133(59%)	152(58%)	75(29%)	77(29%)
Inconvenient hours of services	5(14%)	7(19%)	12(33%)	39(17%)	47(21%)	86(38%)	98(37%)	48(18%)	50(19%)
Inaccuracy of the test	3(8%)	4(11%)	7(19%)	45(20%)	35(15%)	80(35%)	87(33%)	42(16%)	45(17%)
Peer influence	5(14%)	3(8%)	8(22%)	98(43%)	91(40%)	189(83%)	197(75%)	100(38%)	97(37%)
Distance of services	1(3%)	3(8%)	4(11%)	16(7%)	22(10%)	38(17%)	42(16%)	23(9%)	19(7%)
Cost	12(33%)	15(42%)	27(75%)	88(39%)	90(40%)	178(78%)	205(78%)	110(32%)	95(36%)
Fear of people finding out	15(42%)	17(47%)	32(89%)	92(41%)	101(44%)	193(85%)	225(87%)	130(49%)	95(36%)
Waiting period for test results	0(0%)	2(6%)	2(6%)	6(3%)	7(3%)	13(6%)	15(6%)	7(3%)	8(3%)
Belief	1(3%)	2(6%)	3(8%)	7(3%)	8(4%)	15(7%)	18(7%)	9(3%)	9(3%)
Don't want to have a test yet	3(8%)	3(8%)	6(17%)	9(4%)	10(4%)	19(8%)	25(10%)	15(6%)	10(4%)
Parent or home influence	4(11%)	6(17%)	10(28%)	20(9%)	28(12%)	48(21%)	58(22%)	30(11%)	28(11%)
Lack of confidentiality of the services	6(17%)	8(22%)	14(39%)	45(20%)	50(22%)	95(42%)	109(41%)	57(22%)	52(20%)
Lack of privacy of the services	7(19%)	9(25%)	16(44%)	37(16%)	52(23%)	89(39%)	105(40%)	56(21%)	49(19%)
Influence of sexual partner	2(6%)	6(17%)	8(22%)	22(10%)	28(12%)	50(22%)	58(22%)	28(11%)	30(11%)
Religion	2(6%)	3(8%)	5(14%)	12(5%)	18(8%)	30(13%)	35(13%)	18(7%)	17(6%)
Attitude toward the counselors	1(3%)	1(3%)	2(6%)	11(5%)	12(5%)	23(10%)	25(10%)	14(5%)	11(4%)
Attitude towards the testing	1(3%)	0(0%)	1(3%)	18(8%)	17(7%)	35(15%)	36(14%)	19(7%)	17(6%)
Attitude towards the referral system	2(6%)	3(8%)	5(14%)	6(3%)	8(4%)	14(6%)	19(7%)	12(5%)	17(6%)
Attitude towards the tested	1(3%)	2(6%)	3(8%)	33(15%)	32(14%)	65(29%)	68(26%)	33(13%)	35(13%)
Perceived the services as useless	8(22%)	6(17%)	14(39%)	110(48%)	95(42%)	205(90%)	219(83%)	115(44%)	104(40%)
Because of lack of time	6(17%)	8(22%)	14(39%)	96(42%)	100(44%)	196(86%)	210(80%)	103(39%)	107(41%)
No definite reason or factor	9(25%)	10(28%)	19(53%)	95(42%)	98(43%)	193(85)	212(81%)	110(42%)	102(39%)
Any other factor or reason	4(11%)	6(17%)	10(28%)	53(23%)	47(21%)	100(44)	106(40%)	59(22%)	47(18%)

Note - The question were forwarded to all untested youth.

- Multiple responses were allowed
- Percentages do not add up to 100% because of multiple responses.
- Percentages were rounded to the nearest whole.

As shown above in Table 4.11, the responses of the untested sample youth to the questions asking what deterred them from using HIV-VCT were summarized and calculated from different perspectives of the total untested sample youth. The minor variables among the untested sample youth were taken into consideration. Accordingly, the responses of the sexually experienced and inexperienced untested sample youth each categorized by gender difference as well as that of the total untested sample youth also categorized by gender were summarized and calculated separately. However, though the differences among the different categories of the untested sample youth in relation to the prevalence of their responses to each of their lists of reasons or factors asking what deterred them from using VCT are not considerable, they are presented and discussed at the end of this chapter. But now, here, the responses of the total untested sample youth are considered and treated as the main sources of data of the study presented and discussed below. However, the responses of the sexually experienced (active) but untested sample youth are also taken into accounts to each reason or factor. It indicated that sexual intercourse is not the single means of transmission of HIV infection especially among the youth of higher education institute. Those who have never made sex are also never free from risk of HIV infection and related psychosocial barriers of VCT. Therefore, among the total 505 sample youth, all the 263 untested youth have responded to the questions. Accordingly, about 98 and 97 percent of the whole untested sample youth were deterred from using HIV - VCT services because of stigma of HIV and fear of positive result respectively. Among the total (36) sexually experienced but untested youth too, about 97 and 100 percent of them were deterred from using VCT because these two factors respectively. But there is an implication in this finding that many youth denied that they have ever made sex. Because among the total untested youth about 97% responded that they fear positive result but at the same time only about 14% of the total untested youth responded they have ever made sex. Therefore, their responses to the question asking whether they, ie the sample youth have ever made sex is less dependable. However, these factors are the top two barriers of VCT. They are also interrelated one another. According to the responses of the sample youth, almost all respondents who considered stigma as their barrier at the same time they considered fear of positive result too as their barrier to be tested. This is an indicative result leading to conclude that fear of positive result is caused by fear of rejection as a result of stigma. Stigma was a common

reason or factor for not being tested for almost all (about 98%) of the untested sample youth.

In the focus groups discussions also almost all the untested youth including those who said that they haven't ever made sex said that they haven't been tested yet because they fear a positive result. One of the focus group members said that it took him around three years to decide whether to go for a test because of fear of positive result. It indicates that the youth do not want to disclose that they have made sex because of cultural reason. Or they exaggerated the chance of transmission of HIV infection through non sexual means.

Among the total 263 untested youth 227 (about 87%) of them said that hey have never had sex. But many of them (about 75%) gave some other factors or reasons related to the consequence or result of HIV - risky behavior like stigma of HIV, fear of positive result, cost etc. for not being tested yet. This result is also another indicator to generalize that the youth's knowledge of HIV and its means of transmission is low in higher education institutes of Addis Ababa.

The other influential factor that many untested youth (about 86%) considered it as a barrier to be tested is fear of people finding out. In the focus groups discussions, the untested youth were asked to say something on this factor. Most of them (about 72%) said that it (fear of others finding out) has prevented them from seeking the test. This fear is related to stigma of HIV and especially for the youth related to the tendency not to disclose that they are sexually active.

In the three focus groups discussions, the members were asked to tell whom they wouldn't like most to learn or find out their being tested. Most of them in each group (about 72,75 and 71 percent respectively) said the 'parents' and some of them (about 28, 25 and 29 percent respectively) said their 'sex partners'. Almost all the counselors in their interview also mentioned that as a result of stigma, parents' attitude towards and awareness of HIV and HIV-VCT as well as the association of testing with sex, youth are much concerned about people finding out while appearing to the VCT centers.

Another common factor or reason among many untested youth (about 84%) that has been considered as a significant barrier was perception of the VCT service as useless. Among the sexually experienced untested sample youth too a fair percent (about 39%) of them were deterred from using VCT because of this VCT barrier. The counselors further

commented on the issue that this perception is a result of lack of perceived psychological and medical benefits. A second year student from Addis Ababa University in a focus group discussion also commented by asking the following question.

"If a poor youth had gone to a clinic for a test and proved positive, what is the advantage of VCT without any ongoing and integrated support and care services?"

Some parents also during the interview undermined the benefits of VCT. One parent said that the advantage it has for the HIV+ (positive) ones is to take care of your self by adjusting your life style and start taking the tablet earlier. It is impossible for a person with little income, especially for a youth, without continuous psychological, medical and material support from VCT.

Generally, as a result of the data obtained from the different sources it seems that there were two gaps from the sides of the VCT services and the beneficiaries of the VCT services. From the side of the VCT services, it sounds that it lacks practicality to offer a systematized, sustainable and genuine support and care through the referral system to the clients especially to the youth of higher education institutes in Addis Ababa. On the other side, the beneficiaries of VCT service especially the youth of higher education institutes in Addis Ababa have not yet fairly understood the benefits of VCT as a result of which they considered it as useless and/or became indifferent for it.

About 81% (212 youth) of the total 263 untested sample youth have no definite factor or reason why they haven't been tested. They were indifferent neither positively nor negatively motivated to be tested or not to be tested respectively. They were rather amotivated ones. About 53% of the total untested but sexually experienced sample youth too, didn't have any definite reason or factor for not being tested. This means, they are indifferent or amotivated ones. But as long as they are sexually experienced, they are at a higher risk of HIV- infection than the sexually inexperienced ones. Therefore this result is an indicator of the fact that the youth of higher education institutes in Addis Ababa need promotion of the advantage of VCT as an integral part of HIV education through IEC. It may also lead to a kind of interrelation that it is so because of denial and rejection as a result stigma.

Cost has prevented 205 (about 87%) of the untested youth from seeking VCT services. About 75% of the total untested but sexually experienced sample youth responded that cost deterred them from using HIV - VCT. Cost was raised in the discussions with the focus groups of tested and untested youth. Most (about 97%)of them agreed upon the idea that most youth of higher education institutes in Addis Ababa have no money and they usually ask for it from parents even for little amount. One first year student from Unity University College said the following regarding cost in a focus group discussion:

"Though the amount of money to be paid in some clinics is relatively fair, I think it prevents a number of youth who want to be tested from having it. Because, most youth of higher education institutes do not have their own money, and asking a parent money for HIV test is unthinkable."

As it has been mentioned earlier, on the basis of the surveys on some documents regarding the costs of HIV-testing facilities, it was found that the cost of an HIV-test ranges from 10to 250 Ethiopian birr in Addis Ababa. It also included the counseling services. Some youth in the focus groups discussions further forwarded their view that they need some providers in Addis Ababa to have free testing days or to provide special exemptions especially for the youth.

Peer influence also was found being one of the influential barriers that contributed for the prevention of 197 (about 75%) of the total untested sample youth from testing. Among the sexually experienced but untested sample youth too, about 23% of them were influenced by their peers not to be tested. Peer influence was more powerful than any other influences of family/parents, spouse, etc in motivating the youth positively or negatively to be tested or not to be tested respectively. This is an indicative finding that peers are influential and primary information and decision sources among the youth of Addis Ababa higher education institutes regarding the usage and avoidance of HIV-VCT service. This finding reaffirms the importance of peer to peer communication about HIV and VCT issues.

Lack of youth friendly services too, contributed a lot in deterring the youth of Addis Ababa higher education institutes from using HIV-VCT services. It was found out from the data above that 152 (about 85%) of the untested youth were prevented from testing because of the influence of perceived lack of youth friendly services. Among the total 36

sexually experienced but yet untested youth also, 19 (about 53%) of them responded that they were deterred from being tested because of this VCT barrier. In the focus groups discussions, too the youth were asked what they like most the HIV-VCT services to be for them and what they think the services lack. As already has been mentioned above, almost all (about 98%) of them like most the services to be confidential and private, youth oriented, etc. However, there were some youth in the focus groups, (about 2%) of the members especially who haven't yet been tested and who do not even tend to do it for future too. They claimed that they wish the service providers particularly the counselors to be well-qualified professionals to understand their problems. They also further wished the counselors to be kind, understanding and genuine. But they perceived that the counselors are not so and nor are the whole VCT services.

About 49% of the total untested sample youth were influenced not to be tested by feeling of not being at risk. But it was found from their background information and other responses to HIV - risk related questions like ever had sex and fear of positive result respectively that more than 97% of them were at risk of HIV infection. This percent of the total untested sample youth responded above that they haven't been tested because of fear of positive result. This means they knew that they are at risk. Even among the sexually experienced but untested sample youth too, about 6% of them responded that they haven't been tested because they didn't feel that they are at risk. It is an indicative finding that, there is inconsistency in the responses of the youth in relation to their feeling of being at risk of HIV infection. There is also an indication that they attempted to cover up that they have ever made sex and are at risk of HIV - infection. It is all related to the cultural meaning of making sex for a youth student in Addis Ababa as well as stigma of HIV and level of awareness or knowledge of HIV - related issues. It is an interesting finding that displays the higher education youth's being in need of more information and education on HIV issues in Addis Ababa. This finding can be also an indication to conclude that it happened because of denial and rejection as a result of stigma.

Perceived lack of confidentiality and privacy of the services also contributed to about 42 and 40 percent of the total untested sample youth respectively not to be tested yet. Among the total sexually active but untested sample youth too, about 20 and 16 percent of them responded that they were not tested because of the impediment of the above two factors respectively. This perceived fear and strong concern about privacy and

confidentiality is an indicative finding that there is higher level of stigma and discrimination or social rejection of HIV and HIV-infected people respectively among the community of Addis Ababa.

About 41% of the total untested sample youth were, to some extent influenced not to be tested by other barriers or deterring factors that haven't been mentioned in the list. However, most of them wrote that they didn't decide yet. This means, the barrier here is indecisiveness that can be caused by different factors.

The rest of the factors also have contributed their deterring influences to the untested youth not to use HIV--VCT services in different degrees of impediment. But they are in general considered as insignificant barriers of testing because of the fact that they contributed their impeding influences only to relatively few untested youth.

In general, most of the untested youth were negatively motivated to avoid testing by stigma and fear of positive result. Many untested sample youth also were prevented from testing by some other barriers of VCT. However, fair number of the sample youth were yet untested with no definite barrier or negatively motivating factor.

4.1.2.3.The prevalence of positively motivated and negatively motivated or deterred youth of higher education institutes in Addis Ababa

Among the total 505 sample youth, those who used HIV-VCT were considered as youth who have already been positively motivated intrinsically or extrinsically to have been tested. Whereas, those who were not tested were treated or considered as negatively motivated to have avoided or deterred from using HIV-VCT services. However, it was found that there were some indifferent sample youth in both groups. Among the tested sample youth there were found some youth, who have used the services with no any kind of positive motivation. Likewise, among the untested youth also, there were some youth found having never been tested yet for no definite negative motivation or barrier of VCT. Therefore in order to see the prevalence of the positively motivated and negatively motivated or deterred ones, the indifferent ones (with no definite reason) were sorted out separately from both tested and untested samples. But as long as multiple response were allowed, a tested or untested respondent was considered as an indifferent one if and only if his/her reason for having been tested or not tested was only "no definite cause or factor" without any additional cause or reason to it. Based on this, the table below, unlike

Tables 4.9 and 4.11 considered the response "no definite reason" per se for each youth respondent in both tested and untested groups. These youth who responded to others or another reason or factor in addition to "no definite reason" were not considered in this study as an indifferent or amotivated ones.

Table 4.12: The prevalence of positively motivated and negatively motivated youth.

	Tested Youth n=242				Untested Youth n=263				Sum Total sample youth
	SMC	AAUCC	UMC	TOTAL	SMC	AAUCC	UMC	TOTAL	
	n= 93(46%) %	n=82(41%) %	n=67(64%) %	n=242 (48%)	n=109(54% %	n=116(59% %	n=38(36%) %	n=263(52%) %	n=505
Sex									
Male	48(n=45)	40(n=33)	51(n=34)	46 (n=112)	51(n=56)	53(n=62)	50(n=19)	52(n=137)	49(n=249)
Female	52(n=48)	60(n=49)	49(n=33)	54(n=130)	49(n=53)	47(n=54)	50(n=19)	48(n=126)	51(n=256)
Age Group									
14 - 19	15(n=14)	10(n=8)	8(n=5)	11(n=27)	88(n=96)	91(n=106)	95(n=36)	90(n=238)	
20 - 23	85(n=79)	90(n=74)	92(n=62)	89(n=215)	12(n=13)	9(n=10)	5(n=2)	10(n=25)	52(n=265)
									48(n=240)
Ever had sex									
Yes	81(n=75)	72(n=59)	65(n=44)	74(n=178)	18(n=20)	11(n=13)	8(n=3)	14(n=36)	42(n=214)
No	19(n=18)	28(n=23)	35(n=23)	26(n=64)	82(n=89)	89(n=103)	92(n=35)	86(n=227)	58(n=291)
Indifferent									
Male	6(n=3)	3(n=1)	2(n=1)	4(n=5)	22(n=1)	23(n=12)	8(n=4)	20(n=27)	13(n=32)
Female	2(n=1)	3(n=2)	2(n=1)	3(n=4)	14(n=7)	17(n=8)	6(n=3)	14(n=18)	9(n=22)
Positively motivated	93(n=42)	97(n=32)	97(n=33)	96(n=107)					43(n=107)
Male	98(n=47)	96(n=47)	97(n=32)	97(n=126)					49(n=126)
Female									
Negatively Motivated					80(n=45)	81(n=50)	79(n=15)	80(n=110)	44(n=110)
Male					87(n=46)	85(n=46)	84(n=16)	86(n=108)	42(n=108)
Female									

SMC = St. Mary's College

AAUCC = Addis Ababa University Commercial college

UMC = Universal Medical College

Note: Percentages were rounded to the nearest whole.

On the basis of Table 4.12, prevalence was treated from different perspectives. However, on the basis of the basic questions of the study, prevalence is presented and discussed by considering the following four pair groups of respondent sample youth: tested and untested youth; positively motivated and indifferent youth; negatively motivated and indifferent youth; and positively motivated and negatively motivated.

The Prevalence of Tested and Untested youth

As has been shown in Table 4.12, about 48 percent of the total sample youth population i.e. 242 youth out of 505 were tested for HIV. Though it is blow 50%, this prevalence of testing in relation to the present multidimensional barriers of VCT found and discussed in this study earlier, it was an encouraging result. As the sample colleges were selected randomly, there were differences in the prevalence of testing among them. In SMC, 46 percent, in AAUCC 41 percent and in UMC 64 percent of their respective total sample youth were tested. The percentage of youth who used HIV - VCT services in UMC was relatively higher. It was an indicative finding or result that it might be because of their better level of awareness or knowledge of HIV - VCT services. As long as they are medical students, they were expected to have a better awareness about health and health related matters than non-medical students. The result found proved this common sense expectation.

However, higher percentage of the total youth sample was untested yet. 52 percent of them never used HIV - VCT services. About 14% of this untested youth sample were sexually experienced (active). As it has been mentioned and discussed in else where of this chapter, there were many and different kinds of barriers prevented or deterred them from using VCT. Nevertheless, a fair number (45(17%)) of this group sample youth have no any perceived negative motivation or barrier of VCT for not having been tested.

The prevalence of untested youth samples among the sample colleges is closer to each other except UMC. 54% of SMC, 59% of AAUCC and 36% of UMC were untested. In the case of UMC, there was higher prevalence of testing and less prevalence of

avoidance of VCT. It was interpreted and attributed to the sample college's being a medical college and that the student's knowledge of HIV and benefits of HIV - VCT services is higher. It also implies that IEC through different multimedia by different professionals has a contributing role in increasing the prevalence of testing among the youth in Addis Ababa among the higher education students (youth).

The prevalence of positively Motivated and Indifferent youth

The tested group of youth were divided into two on the basis of the result obtained and the objective of the study too. Of the total number of tested youth, about the 4 percent was neither negatively nor positively motivated. They were indifferent and tested by mere chance. Whereas, the rest 96% of the tested youth have been either intrinsically or extrinsically motivated. The prevalence of positive motivation and indifference among the three sample colleges is different. For example, in SMC about 5%, in AAUCC about 4% and in UMC about 3% of the tested youth didn't have any definite motivating factor for using VCT. Whereas, the rest 95% in SMC, 96% in AAUCC and 97% in UMC were motivated by at least one motivating factor to use VCT to be tested. Among the three sample colleges, the least prevalence of indifference and the highest prevalence of positive motivation was obtained in UMC as a result. It implies that as youth are equipped with information and education related to the human nature and health related issues, they have done more planned, purposeful and reasonable activities in relation to HIV and HIV - VCT.

The Prevalence of Negatively Motivated and Indifferent Youth

Like the tested youth, the untested youth also were divided into two, based on the result obtained from the data of sources in relation to the reason or cause (if any) why they haven't yet been tested. In general, among the untested youth, those who have no any definite perceived barrier or impending factor why they haven't used HIV - VCT yet, are considered as indifferent. Whereas, those untested youth because of perceived barrier or negative motivation, were regarded as negatively motivated youth. On the basis of this conceptual consideration and obtained result, 17% of the whole untested sample youth were indifferent that they didn't have any definite reason why they haven't yet been

tested. And about 83% of them found having been perceptually, negatively motivated to avoid HIV - VCT services.

The prevalence of negative motivation and indifference among the different sample colleges obtained has been shown in Table 4.11. About 84% of SMC, 83% AAUCC and 82% UMC responded that they were deterred from using VCT by a kind or kinds of perceived barriers of VCT. There was no as such noticeable difference of prevalence of barriers among the different sample colleges. However, relatively the least prevalent perceived barrier or negative motivation was found among the UMC students. This finding or result is an indicative finding that leads to further research to examine whether knowledge of human nature and health decreases perceived barriers of VCT.

On the other hand about 17% of SMC, 18% of AAUCC and 18% of UMC untested sample youth responded that they didn't have any perceived barrier of VCT that deterred them from using HIV - VCT services. They were indifferent ones neither negatively nor positively motivated.

The prevalence of positively motivated and negatively motivated youth of higher education institutes in Addis Ababa.

About 97% of the tested sample youth and about 46% of the total sample youth of all sample colleges were positively motivated to use HIV - VCT services. They were tested not by mere chance rather because of their being either intrinsically attracted or extrinsically forced to do it or both.

Whereas, about 83% of the untested sample youth and about 43% of whole sample youth of all sample colleges were negatively motivated to avoid HIV - VCT services. They avoided testing not with no perceived barrier of VCT, rather because of felt impediments and/or real inhibitors of testing.

The prevalence of motivation and inhibition among the different sample areas did not show as such noticeable differences. For example, about 96% of SMC, 97% of AAUCC and 97% of UMC tested youth were positively motivated to be tested and about 84%, 83% and 82% respectively of the untested sample youth were negatively motivated to avoid HIV - VCT. The prevalence of positive motivation among the tested sample youth is higher than the prevalence of negative motivation among the untested sample youth. It is a very interesting finding that among the tested ones the prevalence of

positively motivated ones is higher because of less prevalence of the indifferent ones. It implies that most youth of higher education institutes in Addis Ababa go to testing purposefully when they are convinced that it is beneficial. Whereas, among the untested ones, the prevalence of negatively motivated ones is relatively less because of relatively higher prevalence of indifferent ones among the group. This is an indicative result that many Youth of higher education institutes in Addis Ababa who have never used VCT themselves do not know clearly the impending factor or reason because of its being beyond their comprehension and/or do not want to disclose why they haven't yet used the VCT services. It implies that there might be some underlying psychosocial factors to be addressed to through further investigation that deterred the youth of higher education institutes in Addis Ababa from using HIV - VCT services.

4.1.2.4 Gender, Age, Family level, Access to Multimedia and Sexual Experience Differences among the youth in Addis Ababa Higher Education Institutes in Relation to the Prevalence of the Tested and Untested Ones.

In recent years, it seems that conditions in Addis Ababa have changed positively to some extent with regard to stigmatization of HIV/AIDS and usage of HIV - VCT services in general and among the youth in particular. However, even among the youth, there have been discrepancies found in the prevalence of using HIV - VCT services. The causes of prevalence differences were many factors related to the individual youth's psychosocial, economic, cultural and religious situations etc. However, gender, age, family level, access to multimedia and sexual experience differences were significantly perceivable and observable differences in the prevalence of tested and untested youth. Therefore, the prevalence of tested and untested sample youth is presented and discussed by considering the above five basic differences or variable factors observed in it.

Gender Differences in the prevalence of tested and untested youth

The opportunities for information, education and communication as well as participation in almost any activity are open today to females on equal terms with males in Ethiopia. The right to know any information about HIV related issues and using HIV - VCT services are parts of the opportunities. It also includes the need for protection and support of vulnerable females who test seropositive.

But in some other countries, especially in Africa, it is common to think to be shameful to have HIV for a female especially for a girl youth. If she were known to be seropositive following VCT, she would lose her home or be abused or beaten by her partner or parents. It affects the prevalence of using VCT services.

However, in this study as it has been found from different data of different sources the prevalence of tested female youth is higher than the prevalence of tested male youth of higher education institutes in Addis Ababa. The prevalence difference of gender among the tested and untested youth is presented and discussed on the bases of the data obtained from the sample youth questionnaire and from the sample counselors' interview responses.

The data obtained from the responses of the sample youth in relation to prevalence showed that the tested female youth are more prevalent than the tested male youth in almost all sample colleges. This is shown in Table 4.13 in which the number and percentage of tested male and female youth are listed based on the response of the sample youth.

Table 4.13: The prevalence of male and female youth in 3 sample colleges who used HIV-VCT service.

	HIV-VCT used youth n=242			
	SMC	**AAUCC**	**UMC**	**Total**
	n = 93	n = 82	n = 67	n = 242
Sex				
Male	n = 45 (48.4%)	n = 33 (40.2%)	n = 34 (50.7%)	n = 112 (46.2%)
Female	n = 48 (51.6%)	n = 49 (59.7%)	n = 33 (49.3%)	n = 130 (53.7%)

In almost all sample colleges the tested female youth are more prevalent than the tested male youth. For example in SMC out of the 93 male and female tested youth, 48 (51.6%) of them were female youth. Whereas, only 45 (48.4%) of them were male youth. This means female youth are more prevalent than the male youth.

In AAUCC also out of 82 male and female tested youth 49 (51.6%) of them were female and only 33 (40.2%) of them were male youth. This means the tested female youth are more prevalent than the tested male youth.

But in the case of UMC, the prevalence of tested female youth and male youth are almost equally prevalent. Out of 67 tested male and female youth 34 (50.7%) of them were males whereas, 33 (49.3%) of them were females. The prevalence difference in this college was not as big as in other sample colleges. Nevertheless, it showed that female youth were slightly less prevalent than male youth. However, totally, out of 242 male and female tested youth, 130 (53.7%) of them were females whereas, 112 (46.2%) were males. The prevalence difference index was about 1.2 which indicated that tested female youth were more prevalent than tested male youth.

The other source of data obtained regarding the prevalence of tested male and female youth was the response of the counselors to the interview. The response, the sample counselors gave, showed a clear distinction (difference) in the prevalence of male and female tested youth. This is shown in Table 4.14 in which the sample counselors responded about the prevalence of tested male and female youth from their experiences.

Table 4.14 : Response of sample counselors indicating the prevalence of male and female tested youth.

No. of the respondents n=18	**Females are more prevalent**	**Males are more prevalent**	**They are equally prevalent**	**Total**
	15 (83.3%)	1 (5.5%)	2 (11.1%)	18(100%)

Out of the 18 sample counselors 15 (83.3%) of them responded that females are more prevalent than males among the youth of higher education institutes in Addis Ababa who used HIV-VCT services. Only 1 (5.5%) of them responded that male youth are more prevalent than female youth.

Among the untested youth too, the prevalence of male and female youth is different in each sample area as well as totally. The response of the sample youth showed this difference of male and female among the untested youth. This prevalence discrepancy is shown in Table 4.15, in which the number and percentage of the untested youth are listed.

Table 4.15: The prevalence of male and female youth in 3 sample colleges who didn't use HIV-VCT service.

	Untested youth n=263			
	SMC	**AAUCC**	**UMC**	**Total**
	n = 109	n = 116	n = 38	n = 263
Sex				
Male	n = 56 (51.4%)	n = 62 (53.4%)	n = 19 (50%)	n = 137 (52.1%)
Female	n = 53 (48.6%)	n = 54 (46.5%)	n = 19 (50%)	n = 126 (47.9%)

The prevalence of male and female among the untested youth is the reverse of the prevalence of male and female among the tested youth. Female youth were more prevalent than the male youth among the tested youth. Whereas, among the untested youth, males are more prevalent than the females. For example, 56(51.4%) of the untested youth were males in SMC. In AAUCC also 62(53.4%) of the untested youth were males, whereas, only 54 (46.5%) of them were females. The prevalence of males was higher than that of females in both of the above two sample colleges. whereas, in UMC the prevalence of the untested males and females was equally 50% and the prevalence difference index was showing the gender parity in the prevalence of untested male and female youth. However, 52.1% of the total untested youth were males where as only 47.9% of them were females. The prevalence difference index was 0.92, which showed that the prevalence of untested female youth was less than that of untested male youth. In general, these considerable differences of sex indicated that gender itself is a reason or factor to use or avoid HIV - VCT services. To know the reason why this is so, it needs further research work.

Age difference in the prevalence of tested and untested youth

While conducting this study, age was also considered as a variable among the youth. One of the questions in the questionnaire for the sample youth was age (date of

birth). However the responses they gave were tallied to two groups i.e. from 14 - 19 years in one group and 20 -23 years in another group. It was on the basis of this age categorization (grouping) the age difference in the prevalence of tested and untested youth treated.

The response they gave showed that there was a considerable difference of age between tested and untested youth. It showed that age was one of the factors that contributed its role for the youth to be tested and to be untested yet. This age difference is shown in Table 4.16 in which the age difference is shown in the prevalence of the tested and untested youth.

4.16: The prevalence of different age group youth in 3 sample colleges.

	Tested Youth n=242				**Untested Youth n=263**				**Sum Total**
	SMC n=93	AAUCC n=82	UMC n=67	TOTAL n=242	SMC n=109	CCAAU n=116	UMC n=38	TOTAL n=263	n=505
Age Group									
14 - 19	14(14%)	8(10%)	5(8%)	27(11%)	96(88%)	106(91%)	36(95%)	238(90%)	
20 - 23	79(85%)	74(90%)	62(92%)	215(89%)	13(12%)	10(9%)	2(5%)	25(10%)	265(52%)
									240(48%)

Note: Percentages were rounded to the nearest whole.

In all the sample colleges, the youth who are found in age group 20 - 23 are more prevalent than the youth who are found in age group 14 -19 among the tested youth. Out of 242 tested youth 215 (about 89%) of them were found in 20 - 23 age group. The rest 27(about 11%) were found in the age group 14 - 19 years. In SMC, out of 93 tested youth 79(85%) of them were found in the age group 20 - 23. In AAUCC and in UMC also the prevalence of the tested youth in this age group were about 90 and 92 percent compared to the youth found in 14 - 19 age group.

Where as, among the untested youth, out of the total 263, about 90% of them were found in the age group 14 - 19 and only 10% of them were found in the age group 20 - 23. Therefore, the prevalence of this age group of tested youth was by far more than the prevalence of this age group of untested youth as well as that of the age group of 14 - 19 tasted youth. Generally this result or finding is an implication showing that age is also one of the contributing variables (factors) in using VCT.

Family level differences in the prevalence of tested and untested youth.

The family level of the sample youth was treated from the perspectives of their own perceptional responses about their parents' income in terms of meeting their family's basic needs and from their parents' educational level. The results are obtained, presented and discussed from these two data gathered from the responses of the sample youth. The responses they gave showed that family level differences are not as such contributing factors that influence the prevalence of tested and untested youth. This is shown in Table 4.17 in which the perceptions of the respondents about their family's income are listed on the basis of the responses of the sample youth. Table 4.17: Responses of the tested and untested sample youth to the extent to which their parents' income in meeting their family's basic needs.

Parents' income	Tested n=242	Untested n=263	Total n=505
Extremely adequate	5(2.1%)	4(1.5%)	9(1.8%)
Fairly Adequate	98(40.5%)	102(38.7)	200(39.6%)
Adequate	105(43.4%)	118(44.8%)	223(44.2%)
Average	21(8.6%)	25(9.5%)	46(9.1%)
Inadequate	11(4.5%)	9(3.4%)	20(3.9%)
Very inadequate	2(0.8%)	5(1.9%)	7(1.4%)
Total	242	263	505

Out of 242 tested youth, 105 (43.4%) of them said that their parents' income is adequate to meet their family's basic needs. This was the most prevalent response among the tested youth. Among the untested youth also it was the most prevalent response that 118 (44.8%) out of the total 263 youth responded to. The second prevalent response also was the same for both the tested and untested youth. It was "Fairly Adequate" for both tested and untested having the percentage 40.5 and 38.7 respectively. On the bases of the results obtained above there were no as such visible differences of perception of the family's level from the perspective of their felt income among the tested and untested youth. It didn't look to affect or influence the prevalence of tested and untested youth. However, the least prevalence responses are different between tested and untested

samples. Among the tested youth, the least prevalent response was "very inadequate", which is only 0.8% whereas, among the untested youth it was "Extremely Adequate" which is about 1.5%. The result didn't show any implication regarding the expected barrier of VCT for the untested youth related to economic problem. Therefore, though there is no any indication found as a result in relation to the family's perceived income, contributing positively or negatively for using or avoiding VCT respectively, the differences in the least prevalent responses between the tested and untested youth is an indicator that it needs further research on the area why it happened so.

The other source of data gathered in relation to the family's level was the parents' educational level. Some responses to closer grade levels were joined together. The results obtained showed similarity or relationship to the perceived income level to some extent. This is shown in Table 4.18 in which the parents' educational level is determined on the basis of the response of the tested and untested sample youth.

Table 4.18: The parents' educational level

Educational level	**Tested N=242**	**Untested N=263**	**Total N=505**
Illiterate	3(1.2%)	4(1.5%)	7(1.4%)
Grades 2 - 8	75(31%)	81(30.8%)	156(30.9%)
Grades 9 - 12	86(35.5%)	93(35.4%)	179(35.4%)
Certificate	36(14.9)	38(14.4%)	74(14.6%)
College diploma	24(9.9%)	25(9.5)	49(9.7%)
1st degree and above	18(7.4%)	22(8.4%)	40(7.9%)
Total	**242(100%)**	**263(100%)**	**505(100%)**

Out of 242 tested youth, 86(35.5%) said that their parents' educational level is in grade 9 - 12. This grade level is the most prevalent response among the tested youth. Among the untested youth also, this grade level is the most prevalent response. Out of 263 untested youth, 93(35.4%) responded that their parents' educational level is in this grade level. The second and third prevalent responses are also the same grade levels for both tested and untested sample youth which are 31%; 14.9% and 30.8%; 14.4%

respectively. Therefore, on the basis of this result obtained from the responses of the sample youth, grade level of the parents didn't seem to have influence in the prevalence of tested and untested youth.

In general, the family level of the sample youth, as has been treated from the perspectives of the parents' income level and educational level, has not been found contributing noticeable influence in the prevalence difference of tested and untested youth. Therefore unlike gender and age group, it didn't show influencing difference in the prevalence of tested and untested youth.

Access to Multimedia Differences in the Prevalence of Tested and Untested Youth

The access to multimedia about HIV/AIDS and VCT for the sample youth in general was considered and treated by making use of the data gathered from the responses of the tested and untested sample youth as well as from the tested youth separately. Both tested and untested sample youth were asked whether they have the access to the multimedia about HIV/ AIDS and VCT. The response they gave showed that there is no distinct difference or significant imbalance among the tested and untested youth in relation to their access to multimedia. The response showed that almost equally, tested and untested ones have the access. This is shown in table 4.19, in which whether the sample youth have the access to the multimedia based on their responses.

Table 4.19 Responses of sample youth whether they have the access to the multimedia.

Response	**Tested youth n=242**	**Untested youth n=263**	**Total n=505**
Yes	238 (98.3%)	254(96.6%)	492(97.4%)
No	4(1.7%)	9(3.4%)	13(2.6%)
Total	**242(100%)**	**263(100%)**	**505(100%)**

Out of 505 total sample youth, 492(97.4%) said that they have the access to the multimedia about HIV/AIDS and VCT. Out of the total number of tested youth (242), 238 (98.3%) said that they have the access. Among the untested sample youth also out of the total 263 untested youth, 254 (96.6%) responded that they have the access to the

multimedia about HIV/AIDS and VCT. Those who said that they have the access of the medias were by far more than those who responded that they didn't have the access among the tested and untested youth proportionally to a closer extent. Therefore, in the prevalence of tested and untested youth, the access to multimedia differences is not noticeable. In relation to the access to multimedia, the tested - untested parity index showed only 0.98, which is very close to 1 where there is absolute parity between the tested and untested youth. The mere opportunity of the access by itself did not bring about difference in the prevalence of being tested and untested.

However, by further analysis of the data obtained from the tested youth's responses in relation to the contributing motivational factors for the youth to be tested, it was found that multimedia have a share in motivating them to use VCT services. They were asked to choose and respond to the factor or factors that motivated or contributed positively for them to use VCT services. The response they gave showed, as it has been presented and discussed in almost else where of this chapter, that there were many positively contributing variable factors. Among these factors, information from the multimedia about HIV and the importance of VCT was found being the one. Out of the total 242 tested youth, 56(23.14%) responded that they were motivated or at least, in addition to other motivating factors, influenced by the information from the multimedia too, to use VCT services.

Among the focus group members also, almost all (about 99%) of them in each focus group said that though it is not sufficient, they have the access to the multimedia to be informed through about HIV/AIDS and the importance of using HIV - VCT services. But only less than half of them were tested yet. The tested ones were further asked to tell whether the information from the multimedia contributed to their motivation and decision to use HIV - VCT services. Almost all (about 98%) of them said yes. However, they commented on its being insufficient quantitatively and especially, qualitatively, that it is not well integrated and systemized involving different qualified professionals. They further commented on it that the information must be youth oriented and professionally studied.

Generally, the very interesting result or finding obtained here is that though access had its own potential advantage in motivating the youth to use HIV - VCT

services, mere access or opportunity only by itself didn't show noticeable realization of the potentiality in bringing about prevalence change of tested and untested youth.

This finding implied that the potentially motivating effect of access to or opportunity for multimedia can be realized if other multidimensional factors as necessities are attained earlier or with in it. Further research work is needed to identify the appropriate factor(s) to be attained earlier or within the information through the multimedia as a necessary condition to realize the potentially motivating effect of the access to multimedia. However, as the data gathered from different sources indicated, beyond the mere access, the quality of the information through the multimedia is rather hopped to attract the attention of the youth and consequently to lead them to use VCT. This means, if access is related with quality, the potential benefit of multimedia can be realized so that difference in access can bring about difference in the prevalence of tested and untested youth in Addis Ababa especially among the youth of higher education institutes.

Sexual Experience Difference among the Youth of Higher Education Institutes in Addis Ababa in Relation to the Prevalence of the Tested and Untested Ones.

Sexual experience among the tested and the untested sample youth was considered and treated as an important variable. Among the total (242) tested sample youth, 178(73.5%) of them were sexually experienced or active. Whereas, the rest 64(26.4%) were sexually inexperienced i.e. have never made sexual intercourse. The response of each group of the tested youth to each question or reason asking what motivated them to use HIV - VCT was treated and summarized separately. The response given by the total 242 tested sample youth was calculated, presented, analysed and discussed as main source of data on the reasons or factors that motivated the tested youth to use HIV-VCT did not show considerable variation of prevalence except very few factors. This is shown in Table 4.20 below:

Table 4.20: Responses of both sexually experienced and inexperienced tested sample youth to the factors (reasons) that motivated them to be tested

Reasons (factors) motivated the sample tested youth to use VCT	Response of the tested and sexually experienced sample youth; n= 178	Response of the tested but sexually inexperienced sample youth; n=64	Total n= 242
To know my HIV - status	176(99%)	48(75%)	224(93%)
Distrust of partner	11(6%)	0(0%)	11(5%)
Being worried about HIV	95(53%)	25(39%)	120(50%)
Exposure to HIV - risk	8(4%)	2(3%)	10(4%)
Pregnancy	2(1%)	0(0%)	2(0.8%)
Referral from clinics / hospitals	2(1%)	1(1.6%)	3(2%)
push from parents/ home	1(0.6%)	1(1.6%)	2(0.8%)
push from peer	20(11%)	12(19%)	32(13%)
push from sexual partner	40(22%)	5(8%)	45(19%)
plan to marry	15(8%)	5(8%)	20(8%)
having HIV - symptom	1(0.6%)	0(0%)	1(0.4%)
Accessibility to the counselor	150(84%)	38(59%)	188(78%)
Youth friendliness of the counselor	175(98%)	50(78%)	225(93%)
Confidentiality of the services	176(99%)	60(94%)	236(98%)
Privacy of the services	177(99%)	59(92%)	236(98%)
Youth friendliness of the services	175(98%)	51(80%)	226(93%)
Blood donation	6(3%)	6(9%)	12(5%)
Life insurance	2(1%)	7(11%)	9(3%)
DV - lottery or any other abroad flight	155(87%)	50(78%)	205(85%)
Information from multimedia about HIV and HIV - VCT	30(17%)	26(41%)	56(23%)
Awareness of the advantage of early knowledge of the serostatus	150(84%)	60(94%)	210(87%)
No definite reason	5(3%)	10(16%)	15(8%)
Any other	54(30%)	51(80%)	105(43%)

Note: Multiple responses were allowed; therefore, percentages do not add up to 100%

Percentages were rounded to the nearest whole.

As Table 4.20 showed us above, among the tested and sexually experienced sample youth, the 8 most prevalent reasons (factors) that motivated them to be tested are:

- Privacy of the services
- To know my HIV - status
- Confidentiality of the services
- Youth friendliness of the services
- Youth friendliness of the counselors
- DV - Lottery or any abroad flight
- Awareness of the advantage of early knowledge of one's HIV - status and
- Accessibility of the center

Likewise, among the tested but sexually inexperienced sample youth too, the 8 most prevalent reasons that motivated them to use HIV-VCT are the above-mentioned factors. For example, the most prevalent reason or factor among the sexually experienced ones for their being tested is privacy of the services that accounted for 99% of the sexually experienced subjects. This factor was the second most prevalent reason among the sexually inexperienced ones too that accounted for 92% of them. Confidentiality that accounted for about 99% of the sexually experienced sample subjects is the second most prevalent factor. Likewise, this factor is the first and most prevalent factor among the sexually inexperienced sample youth too.

In general, the influential factors or reasons for using HIV - VCT are common for both groups of tested sample youth. It was an indicative finding that the youth of higher education institutes in Addis Ababa are either aware of the fact that HIV - infection is not transmitted through only sexual intercourse and may be they are aware of other means other than sexual intercourse by which HIV - infection is transmitted or are not aware of the fact that sexual intercourse is one of the main means of transmission of HIV - infection. Or may be many the tested youth did not want to disclose because of cultural reasons that they have ever made sexual intercourse.

Among the total 263 untested sample youth too, 227 (86.3%) of them were sexually inexperienced (have never made sex) whereas, the rest 36(13.7%) of them were sexually experienced (have ever made sex). The response of each group of the untested

sample youth to each reason or factor asking what deterred them from using HIV - VCT was considered and summarized independently. The response given by the total 263 untested sample youth also was calculated, presented analysed and discussed as main source of data on the reasons or factors that are deterring the untested youth from using HIV - VCT services.

Except very few factors, the prevalence of almost all the reasons or factors attributed by both sexually experienced and inexperienced untested sample youth for their being deterred from using HIV - VCT are similar. This is shown in Table 4. 21 below:

Table 4.21: Responses of both sexually experienced and inexperienced untested sample youth to the factors that deterred them from using HIV - VCT services.

Factors (Reasons) that deterred the untested but sexually experienced sample youth from using HIV - VCT	Responses of the untested but sexually experienced subjects n=36	Response of the untested and sexually inexperienced subject n=227	Total n=263
Stigma of HIV / AIDS	35(97%)	221(84%)	256(97%)
Fear of positive result	36(100%)	218(83%)	254(97%)
Attitude towards provider	4(11%)	14(6%)	18(7%)
Do not feel at risk	2(6%)	126(56%)	128(49%)
Never had sex	0(0%)	227(100%)	227(86%)
Lack of youth friendly Services	19(53%)	133(59%)	152(58%)
Inconvenient hours of Services	12(33%)	86(38%)	98(37%)
Inaccuracy of the test	7(19%)	80(35%)	87(33%)
Peer influence	8(22%)	189(83%)	197(75%)
Distance of services	4(11%)	38(17%)	42(16%)
Cost	27(75%)	178(78%)	205(78%)
Fear of people finding out	32(89%)	193(85%)	225(87%)
Waiting period for test result	2(6%)	13(6%)	15(6%)
Belief	3(8%)	15(7%)	18(7%)
Do not want to have a test	6(17%)	19(8%)	25(10%)
Parent or home influence	10(28%)	48(21%)	58(22%)
Lack of confidentiality of the service	14(39%)	95(42%)	109(41%)
Lack of privacy of the services	16(44%)	89(39%)	105(40%)
Influence of sexual partner	8(22%)	50(22%)	58(22%)
Religion	5(14%)	30(13%)	35(13%)
Attitude toward the counselor	2(6%)	23(10%)	25(10%)
Attitude towards the testing	1(3%)	35(15%)	36(14%)
Attitude towards the referral system	5(14%)	14(6%)	19(7%)
Attitude towards the tester	3(8%)	65(29%)	68(26%)
Perceived the services as useless	14(39%)	205(90%)	219(83%)
Because of lack of time	14(39%)	196(86%)	210(80%)
No definite reason or factor	19(53%)	193(85%)	212(81%)
Any other factor	10(28%)	100(44%)	106(40%)

Note:- - Multiple responses were allowed; therefore, percentages do not add up to 100%

- Percentages were rounded to the nearest whole.

As Table 4.21 showed us above, among the untested but sexually experienced sample youth the 6 most prevalent factors deterring the untested youth from using HIV - VCT services with percentages of prevalence are:

- Stigma 89%
- Fear of positive result 89%
- Fear of people finding out 89%
- Cost 75%
- No definite reason 53% and
- Lack of youth friendly services 53%

Among the untested and sexually inexperienced sample youth too, the above mentioned factors are most prevalent reasons attributed as barriers of VCT for them. As an example "fear of positive result" is the first and most prevalent reason for not being tested among the untested but sexually experienced sample youth. Likewise, among the sexually inexperienced untested youth too, this reason or factor (fear of positive result) is the second most prevalent reason considered as a barrier of VCT for them. It is a very interesting and an indicative finding that untested youth of higher education institutes in Addis Ababa whether they have ever made sex or not consider themselves as vulnerable or at risk of HIV - infection. The reason for this conception might be either because of less knowledge of the youth about the transmission of HIV - infection or because of the fact that the youth are aware of the different means of transmission of HIV - infection other than sexual intercourse especially among the youth of higher education institutes in Addis Ababa. This finding paves the way to further study on the issues. However, there are indications in relation to the sample youth's responses to the question asking whether they have ever made sexual intercourse that they do not want to disclose their being sexually active because of cultural reasons. For example, among the 242 tested youth 64 (about 27%) of them reported that they have never made sex. But in addition to their being tested they showed other signs of fake that they were motivated by privacy of the services, the need to know their serostatus and others. Among the total 263 untested youth

too, 227 (about 87%) of them responded that they have never made sex in their life. But their reasons why they haven't been tested are similar to that of the sexually active ones. For example "fear of positive result" is a common reason for both groups. It all shows us that those who reported their being sexually inexperienced are to some extent faking good. Because in most parts of Ethiopia, being virgin especially for youth is culturally a sign of cleanliness. Whereas, sexuality is considered culturally as un cleanliness or an immoral act. This is why the researcher considered and treated the responses of the total tested and untested sample youth.

CHAPTER FIVE

5.1 Summary, Conclusions and Recommendations

5.1.1 Summary

In this chapter, first, the problem of the study and the methods used in conducting the research are briefly explained. Subsequently, the major findings of the research are summed up.

The main problem of the thesis focused on investigating the factors that influence the youth of higher education institutes in Addis Ababa positively and negatively in relation to the undergoing of HIV- VCT services. More specifically, this thesis aimed at surveying and finding out the major factors that influence the usage and avoidance of HIV- VCT services of the youth in higher education institutes in Addis Ababa.

In order to achieve the main purpose of the research, a descriptive survey was employed. Accordingly, after the target population as well as the accessible population were identified, 6 higher education institutes were selected using the random sampling method. Three of them were colleges from which 505 youth were randomly selected for question aire. The rest three higher education institutes were two universities and one college from which the three focus group members were selected randomly in addition to the above mentioned three colleges for discussion. In general, to collect the relevant data for the study, questionnaire, interview forms and focus groups discussions were prepared, piloted and finally used. The collected data were systematically organized and analyzed mainly through the descriptive and explanatory survey method.

The major findings of the research include the following:

- Responses of the tested and sexually experienced sample youth of higher education institutes in Addis Ababa show that there are many reasons or factors that positively motivate them to use HIV- VCT services though there are still many HIV- VCT barriers.

Among the tested sample youth of higher education institutes of Addis Ababa, the majority were sexually experienced.

- 20-23 years old sample youth of higher education institutes of Addis Ababa have better chance to be motivated and use HIV- VCT services than those who are 14-19 years old.

- Privacy and confidentiality of the services motivated the majority of the tested youth of higher education institutes in Addis Ababa. The purpose to know one's HIV- status, youth friendliness of the services including the referral system and many other factors or reasons also motivated the tested youth in general to use HIV- VCT services.
- Some variables among the tested sample youth were considered and treated. Accordingly, the responses of the sexually experienced and inexperienced ones, each categorized by gender differences too, were considered and summarized. Therefore, the sexually experienced and female youth were more prevalent than the sexually inexperienced and male youth among the tested youth in higher education institutes in Addis Ababa
- In some cases, it seems that there is a need to make changes in the attitude of parents regarding the importance of using HIV-VCT services for their sons/daughters. However, there are some clues that reflect the direction change in the awareness and attitude of parents towards HIV/AIDS and the importance of using HIV-VCT services among the youth
- The youth of higher education institutes in Addis Ababa do not like others to learn about their testing experiences because of two main reasons. The first one is that the youth want to avoid the stigma that the HIV- infected people suffer from. The second one is that they prefer not to disclose that they are sexually active
- Most tested youth of higher education institutes in Addis Ababa are motivated intrinsically to use HIV- VCT services. However, there are some tested youth who are motivated extrinsically and very few with no definite motivating factors (reasons) too, but tested just by chance.
- There are many factors deterring the youth of higher education institutes in Addis Ababa from using HIV- VCT services though there are relatively lesser number of youth who are positively motivated and tested. Therefore, the majority of the total sample youth population was untested. Among this untested population, most of them are negatively motivated and are deterred or avoided HIV- test because of many factors or VCT barriers. But few of this untested population do not have any negative motivation that deters them

from using VCT. Rather they didn't use VCT because of no definite factor (reason) or VCT barrier.

- Though even the minor variables among the untested sample youth were taken into consideration like the sexual experience and gender differences, the prevalence of their responses to the reasons or factors asking what deterred them from using VCT are not as such considerably different.
- The most influential VCT barriers deterring the youth from using HIV-VCT are stigma and fear of positive test result among the untested sample youth population. But there is an implication here that many youth denied that they have ever made sex. Because, among the total untested youth, about 97% of them responded that they fear positive test result but at the same time only 14% of the total untested youth responded that they have ever made sex. In addition to this, those who responded that they have never made sex ever, at the same time responded that they are deterred from using VCT because of fear of positive test result. Therefore, it seems that some sample youth faked good because of cultural reasons in relation to the meaning of sexual intercourse for a youth. That is why the researcher considered the response of the total untested sample youth.
- There are other influential factors that are deterring the untested sample youth next to stigma and fear of test result. These VCT barriers are like fear of others (people) find out that he/she is using HIV- VCT, lack of youth friendliness of the services, cost, lack of privacy and confidentiality of the services, attitude and personal belief of the individual youth, etc. But there are also youth who didn't use VCT (untested youth) with no definite factor or VCT- barrier. They are neither positively nor negatively motivated. Rather they are indifferent or a motivated ones.
- Peer influence is the most influential factors of all social influences among the youth to use or avoid HIV-VCT services. The influence of peer is more powerful than that of the parents, other family members and relatives as well as sexual partners to push the youth to use or avoid HIV- VCT services.
- The prevalence of the untested youth is higher than the prevalence of the tested ones in general. However, among the sample higher education

institutes, this prevalence is closer except one sample college where there is a noticeable prevalence difference between the tested and untested sample youth.

- The prevalence of the positively motivated sample youth is higher than that of the indifferent ones among the tested sample youth in general. But the degree of prevalence difference among the different sample colleges is different. For example in UMC, about 97% of the tested youth are motivated either intrinsically or extrinsically and the rest about 3% of the tested youth were tested by mere chance. Whereas, in SMC, about 96% of the tested youth are motivated to use VCT and the rest abut 5% were tested with no definite reason or factor that motivated them to be tested.
- The prevalence of the negatively motivated sample youth is higher than that of the indifferent ones among the untested youth in general. But unlike the prevalence difference of the positively motivated and indifferent ones, the prevalence difference of the negatively motivated and the indifferent ones among the untested sample youth of the different sample colleges is closer to each other.
- The prevalence of the positively motivated youth among the total tested sample youth is higher than the prevalence of the negatively motivated sample youth among the total untested sample youth in general and in each sample college.
- Gender difference is a considerable variable that has an influence in the prevalence of tested and untested youth. In general, tested female youth are more prevalent than the tested male youth. But there is only one sample college where the tested female youth are less prevalent than the tested male youth.
- Age is another influential variable factor that affects the prevalence of tested and untested sample youth of higher education institutes in Addis Ababa. Among the tested youth in general and in each sample college, the youth who are found in age group 20-23 years are more prevalent than the youth who are found in age group 14-19 years. Whereas, among the untested youth, those

who are found in age group14-19 years are more prevalent than those who are found in age group 20-23 years.

- The family income level difference obtained (found) on the basis of the response of the sample youth themselves doesn't seem to have considerable influence on the prevalence of the tested and untested sample youth in the higher education institutes in Addis Ababa. The parents' educational level also doesn't seem to have noticeable influence in bringing about a difference between the prevalence of the tested and untested sample youth.
- The mere opportunity of the access to the multimedia in relation to HIV/AIDS and HIV-VCT by itself doesn't bring about visible difference in the prevalence of being tested and untested. However, the access as an opportunity has its own potential advantage in motivating the youth to use HIV-VCT. But mere access or opportunity only by itself doesn't show noticeable realization of the potential in bringing about prevalence change of tested and untested youth. It implies that the potentially motivating effect of access to or opportunity for multimedia can be realized if other multidimensional factors as necessities are attained earlier or within the multimedia. If access is related with quality, the potential benefit of multimedia can be realized so that difference in access can bring about difference in the prevalence of tested and untested youth in higher education institutes in Addis Ababa.
- Sexual experience difference doesn't seem to have a considerable influence in making a difference in the prevalence of tested and untested sample youth. Of course, most of the tested youth are sexually experienced and among the untested youth, most of them are sexually inexperienced. But among the tested sample youth, the influential factors that motivated the sample youth strongly to use VCT are common for both the sexually experienced and in experienced sample youth. Among the untested youth, too, the top VCT barriers that deterred them from using HIV- VCT are common to both the sexually experienced and inexperienced sample youth.

5.1.2 Conclusions

Based on the major findings of the study, the following conclusions are made:

- There are two important points to conclude regarding the motivation of the youth in higher education institutes in Addis Ababa to use HIV- VCT. The first one is that though there are many barriers of VCT, there are also motivators that attracted the youth to use HIV-VCT services. Secondly, of all the motivators, the youth are much more concerned about the confidentiality of their HIV-testing, their privacy and that they don't want others to find out that they have sought an HIV- test. Therefore, youth people are much more motivated or attracted to have tests in facilities where they won't run into parents or neighbors and where it is not clear to casual observers that they are there to have an HIV- test
- Girls (female youth) and the youth generally found in age group 20-23 years have higher opportunity than male youth and generally youth found in age group 14-19 years to be motivated and tested in higher education institutes in Addis Ababa
- Though the majority of the tested, and untested sample youth are sexually experienced and inexperienced respectively, there are also youth who have never made sexual intercourse among the motivated and tested youth and sexually experienced among the untested sample youth. Therefore the real reasons or causes for these youth's being tested and being untested respectively need to be given the necessary especial attention.
- The benefits of VCT are often not widely known and understood. Promotion of the advantages of VCT is likely to be integral part of HIV-education programmes and included in IEC materials. VCT without associated support and care services has been shown to be unpopular among the youth. Therefore, an explicit policy of care and support for the youth following VCT seems vital to be developed in conjunction with VCT.
- In Addis Ababa where VCT services are available, uptake of the services among the youth of higher education institutes is not as it was expected to be.

The common barriers to VCT are stigmatization and related fears as well as the lack of perceived benefit of VCT services. Cost and many other VCT barriers like lack of the awareness of the advantage (benefit) of earlier knowledge of HIV-status and the influence of others especially of the peers and family members also impede the usage of VCT services.

- It is good that the prevalence of tested youth in higher education institutes in Addis Ababa is now fair. But more has to be done to make this fair prevalence of testing more prevalent and more meaningful, productive and effective in bringing about behavioral changes in relation to the prevention and control of HIV/AIDS and the importance of HIV-VCT services among the youth of higher education institutes in Addis Ababa.

5.1.3 Recommendations

In the preceding chapters it was thoroughly discussed that there is a considerable number of higher education institute youth students in Addis Ababa who are motivated by different factors and used HIV VCT services. Services providers at different VCT centers, hospitals and clinics as well as government with authorities and NGOs at various levels show effort to encourage and facilitate testing of the youth. Fair number of parents are now willing to help their sons and daughters use HIV-VCT services. The youth themselves show and tell that they are motivated to be tested. As a result of all these, the prevalence of the tested youth in higher education institutes in Addis Ababa is relatively fair. However, there are still some problems connected with the usage of HIV-VCT services among the youth that remain unresolved. In light of this, the following recommendations are forwarded based on the major findings and conclusions of the study.

1. Awareness about the problems of the youth in higher education institutes in Addis Ababa in relation to the usage of HIV-VCT services and considering polices alone may not bring about solutions. Increasing mobilization and access for VCT services should be used to motivate and increase the number of youth of higher education institutes in Addis Ababa seeking VCT services. Increasing the training of service providers in counseling skills especially for the youth about HIV and HIV -VCT should be considered as a means to motivate the youth to be tested and

minimize the VCT barriers. Training should combine acquiring skills for working with the youth and knowledge of high quality VCT counseling. A youth oriented (specific) VCT counseling curriculum should be developed. A separate room and an optional area only for the youth seeking HIV-VCT should be established so that the youth do not meet adults or adult family members while testing or seeking VCT. VCT. should be provided regularly during specific hours at the separate youth center with devotion to serve the youth and the results must be available the same day.

2. In order to encourage the youth participation or usage of VCT, intervention should be taken not only by the service providers but also by the government, the people, the parents, non governmental organizations and other funding agencies. Such interventions should consider encouraging the youth to be tested by creating awareness about the advantage of VCT and by tackling stigmatization and discrimination among the people to bring about attitudinal change towards HIV and HIV-VCT. And VCT should be used as an entry point among the youth for prevention and care by facilitating: normalization and destigmatiztion of HIV/AIDS, peer, social and community support including youth living with HIV, promotion of behavioral changes like safe sex, early management of opportunistic, infections, access to early medical care, acceptance and coping with serostatus, access to condoms for both male and female youth etc. Therefore, parents and the community as a whole should be sensitized and encouraged towards this goal
3. A referral system for the tested youth should be developed in consultation with NGOs, community based organizations, hospital directors and other service managers, as well as with networks of people living with HIV and AIDS. Regular meetings among service providers should be held to review and improve the referral system for the tested youth so that they can be offered the proper and ongoing medical and psychological care and financial support if the test result is positive, and the necessary psychological help (counseling) to keep up one's HIV-negative status if the result is negative. It can make VCT meaningful and practically beneficial for the youth.

4. Cost has been proved to be one of the barriers of VCT especially for the youth of higher education institutes in Addis Ababa. Therefore, to alleviate this problem, the price of testing services should be reduced. Different options should be used as alternatives to lower prices for the youth by the service providers such as cost sharing, sliding pay scales, free VCT days, etc.
5. It has been found out that rather than the mere access, the quality of the message about HIV/AIDS and HIV- VCT through the multimedia, influences the prevalence of being tested and untested among the youth of higher education institutes in Addis Ababa. Therefore, there should be a qualitative multimedia campaign that involves different professionals to increase awareness of youth friendly facilities and encourage VCT among the youth of higher education institutes. The campaign should build visibility through radio, TV, print media and community mobilization activities. Peers also have been found out being one of the most influential factors to use or avoid VCT. Thus, the access to the qualitative multimedia campaign paves the way for the peers to encourage one another to seek testing.
6. Further research need to be conducted to survey and examine the possible factors that influence the youth of Addis Ababa in general to use and avoid HIV-VCT services. There should be also further research work to examine all the possible socio-demographic factors or variables that may influence the prevalence of being tested and untested.

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5.3 Appendices

5.3.1 Appendix I

An Overview of the Research Area

The research was conducted in Addis Ababa city. The Addis Ababa city state covers a total area of 530.14 square kilometers. This makes about 0.046% of the total area of Ethiopia, which is 1,133,380 sq. kms. The region has a total population of about 3.7 million that accounts for about 4.8% of the total population of Ethiopia in general. About 99.9% of the population resides in the city whereas about 0.1% of the population lives in the rural and semi rural areas of the region.

The Addis Ababa region has predominantly Amharic speaking inhabitants that accounts for more than 98.6% of the region's total population. Other inhabitants and residents in the Addis Ababa city include non Amharic speaking Ethiopians (about 0.4%) and foreigners residing in the city for different reasons (about 1%)

The dominant religions in Addis Ababa are both Christian Orthodox and Islam.

The economy of the city is mainly dependent on local and foreign trades and related incomes from the productions of industries and factories and social services.

Out of the total population of the city, about 15% are youth found in the age group of 14 - 23 years. Of this youth population in turn, about 23% of them are students at present in privately owned and government higher education institutes in Addis Ababa. This age group has lots of social, psychological and economical problems. To cite only one from social problems as an example, the spread of HIV infection among these youth is very high. Nevertheless, though HIV - VCT has been proved as a better alternative to prevent and control the spread of HIV - infection, absence of disclosure of HIV/ AIDS related issues and reluctance to use the HIV - VCT services among the youth are clearly observed social problems. It is because of many and different VCT - barriers.

The administrative structure of the Addis Ababa city is comprised of 10 sub cities and more than 200 Kebeles.

5.3.2 Appendix II

List of Sample High Education

Institutes with their sample Population.

No	Name of the Higher Education institute	Sample Youth			Remark
		M	F	T	
1	Saint Mary's College (SMC)	101	101	202	For questionnaire and only 3 youth for focus groups discussion too.
2	Addis Ababa University Commercial College (AAUCC)	95	103	198	For questionnaire and only 3 youth for focus groups discussions too.
3	Universal Medical College (UMC)	53	52	105	For questionnaire and only 3 youth for focus groups discussions too.
4	Addis Ababa University (AAU)	1	2	3	Only for Focus groups discussions
5	Unity University (UU)	1	2	3	For Focus groups discussions only
6	Africa Medical College (AMC)	1	2	3	For Focus groups discussions only
7	Total	253	261	514	- 505 youth were used for questionnaire in general. - 9 youth were used for both questionnaire and focus groups discussions. - 9 youth were used for focus groups discussions only - 18 youth were used for 3 focus groups discussions in general.

THE ADDIS ABABA CITY KEBELE, KIFLEKETEMA AND CITY BOUNDRIES AS WELL AS ADMINISTRATIVE DIVISIONS.

KEBELE BOUNDRY
KIFLEKETMA BOUNDRY
CITY BOUNDRY

Scale: 1:1,500 000

Source: Central Statistical Authority Maps prepared for [illegible] the boundries of Kebeles and Kifleketemas.

Conducted in May, 2003.

5.2.3. Appendix III

Main Variables of the Study

The main Variables treated in the study were participation or usage and avoidance of HIV - VCT services of the youth in higher educational institutes in Addis Ababa. These variables were considered as main ones that specifically concern the tested and the untested sample youth respectively as compared to their age, Sex, access to multimedia and sexual experience differences.

The dependent variables treated in the research under the participation or usage of the sample youth in higher education institutes in Addis Ababa included being tested and being positively motivated among the tested sample youth. The independent variables included here were:

- the quality of the HIV - VCT services,
- cost of the services,
- privacy and confidentiality of the services,
- peer attitudes towards the services,
- parental attitudes towards the services,
- access to the qualitative information about HIV/AIDS and HIV - VCT through multimedia
- socio - demographic factors like age, sex, etc,
- the youth - friendliness of the services,
- the quality of the referral system,
- accessibility of the services,
- awareness of the individual youth , etc.

Likewise, the other dependent variable treated in this study under the main variable, avoidance of HIV - VCT services is being untested. The different independent variables included here were:

- stigmatization,

- fear of positive result,
- lack of the quality of HIV - VCT services,
- lack of privacy and confidentiality of the services,
- lack of youth - friendliness of the services,
- peer influence,
- cost of the services,
- parent or home influence,
- perception of the individual youth about the importance of VCT
- inconvenience of the services hours.
- fear of people finding out,
- lack of the quality of the referral system,
- personal belief, etc,

5.3.4. Appendix IV: Instruments of Data collection (English and Amharic versions)

5.3.4.1. Students' (youth's) Questionnaire

Addis Ababa University

School of Graduate Studies

Department of Psychology

Addis Ababa

Dear Students!

The main purpose of this questionnaire is to gather information on the underlying personal, service provision, home, peer and in general Addis Ababa Community based factors that positively motivate (facilitate or instigate) and negatively motivate (impede or hinder) the youth of higher education institutes in Addis Ababa to use and to avoid respectively the HIV - VCT services.

Therefore, you are kindly requested to provide honest and accurate responses to each of the following items.

Thank you in advance for your cooperation.

Instruction

For items with alternatives, show your response by putting an "X" mark in the box given. Multiple response is possible if necessary. But for items that demand for your suggestion or perspective, please respond by writing on the space provided.

I- **Background Information**

Date _____

1. Name of the College _____
2. Your sex

   2.1. Male ☐ 2.2. Female ☐

3. Your date of birth in Ethiopian calendar, month _____ year _____

4. Place of birth:-

4.1 In Addis Ababa ☐ 4.2 Out of Addis Ababa ☐

5. Your grade level

4.1. 1st year ☐ 4.2. 2nd year ☐

4.3. 3rd year ☐ 4.4. 4th year ☐

6. Ethnicity _____

7. Religion _____

8. How do you perceive your parents income in terms of meeting the family's basic needs?

8.1 Extremely adequate ☐ 8.6. Very inadequate ☐

8.2 Fairly Adequate ☐ 8.7 Extremely inadequate ☐

8.3 Adequate ☐ 8.8 If any other, please state ☐

8.4 Average ☐

8.5 In adequate ☐

9. Your parent's educational level

9.1. Illiterate 9.2. Grade 2-6

9.3. Grade 7-9 ☐ 9.4. Grade 10-12 ☐

9.5. 12th grade complete ☐ 9.6. Certificate ☐

9.7. College Diploma ☐ 9.8. 1st Degree and Above ☐

6.9. If any other, please state _____

10. Do you have permanent sexual partner that has continued for more than a year?

10.1 Yes ☐

10.2. No ☐

10.3 If any other please state _____

11. Have you ever made sexual relation?

11.1. Yes ☐

11.2. No ☐

12. If your response to item number 11 is Yes, have you ever made sex with prostitutes?

12.1. Yes ☐

12.2. No ☐

13. If your response to items number 11 is yes, what is the number of your sex partner for the last five years?

13.1. 1 ☐ 13.2. 2 ☐

13.3. 3 ☐ 13.4. 4 ☐

13.5. ≥ 5 ☐

14. If your response to item number 12 is yes, do you use condom consistently?

11.1. Yes ☐ 11.2. No ☐

II- **Concerning the Factors that Influence the Youth to Seek or Avoid HIV-VCT**

15. Do you have HIV + friends/ relatives?

12.1. Yes ☐ 12.2. No ☐

16. Have you ever used HIV - VCT services?

13.1. Yes ☐ 13.2. No ☐

17. If your response to item number 16 is yes, what caused or motivated you to use the HIV - VCT services?

17.1. To know my HIV - status ☐

17.2. Distrust of partner ☐

17.3. Being worried about HIV ☐

17.4. Exposure to HIV risk ☐

17.5. Pregnancy ☐

17.6. Referral from clinics or Hospitals ☐

17.7. Push from parents / home ☐

17.8. Push from peer ☐

17.9. Push from sexual partner ☐

17.10. Plan to marry ☐

17.11 Having HIV symptom

17.12. Accessibility of the centers ☐

17.13. Youth- friendliness of the counselors ☐

17.14. Confidentiality of the services ☐

17.15. Privacy of the services ☐

17.16. Youth friendliness of the services ☐

17.17 Blood donation ☐

17.18 Life insurance ☐

17.19 DV lottery or any other abroad flight

17.20 Information from the multimedia about HIV/AIDS and the importance of VCT ☐

17.21 awareness of the advantage of early knowledge of HIV- status ☐

17.22 No definite reason ☐

17.23 If any other, please state _____

_____

_____

18. If your response to items number 16 is No, what caused or deterred you from using HIV-VCT services?

18.1. Stigma ☐

18.2. Fear of Positive result ☐

18.3. Attitudes towards providers ☐

18.4. Do not feel at risk ☐

18.5. Never had sex ☐

18.6. Lack of youth - friendly services ☐

18.7. Inconvenient hours of service ☐

18.8. Inaccuracy of the test ☐

18.9. Peer influence ☐

18.10. Distance of service ☐

18.11. Cost ☐

18.12. Fear of people finding out ☐

18.13. Waiting period for test results ☐

18.14. Belief ☐

18.15. Don't want to have a test yet ☐

18.16. Parent or home influence ☐

18.17. Lack of confidentiality of the services ☐

18.18. Lack of privacy of the services ☐

18. 19. Influence of sexual partner ☐

18.20. Religion ☐

18.21. Attitude towards the counselors ☐

18.22. Attitude towards the testing ☐

18. 23. Attitude towards the referral system ☐

18. 24. Attitude towards the tester ☐

18.25 Perceived the service as useless ☐

18.26 Because of lack of time ☐

18.27 No definite reason or cause ☐

18.28 If any other, please state _____

_____

19 . If you had sought to be tested for HIV and took the pretest counseling but did not come back for the rest of the services including the test what is/ are your reason (s) _

_____

_____

_____

20. If you have used HIV - VCT services, please list down at least five possible factors in their order of significance from most significant to least significant that instigated or positively motivated you to use the services (if any).

20.1. _____

20.2. _____

20.3. _____

20.4. _____

20.5. _____

21. If you have avoided (neglected) meaning never used HIV - VCT services, please list down at least five possible factors in their order of significance from most significant to least significant that hindered or deterred (negatively motivated) you not to use or to avoid the service (if any).

21.1. _____

21.2. _____

21.3. _____

21.4. _____

21.5. _____

22. If you have been tested for HIV status, how could you get tested?

22.1. Being intrinsically highly motivated ☐

22.2. Being forced extrinsically like blood donation, life insurance pregnancy, abroad flight, new job etc ☐

22.3. Being pushed by others like parent, peer, partner, etc ☐

22.4. Just in a sudden without preplanned intensions or motivation ☐

22.5. If any other, please state _____

_____

23. Do you have the access to multimedia about HIV /AIDS and HIV - VCT

23.1 Yes ☐ 23.2 No ☐

24. If you have used HIV - VCT service, what do you like most the services to be for future in relation to the processes of counseling, testing, reporting the test result, referral system, follow up etc? _____

_____

25. If you have avoided (neglected) meaning, never used VCT, how do you think that the barriers or impediments deterred you from using HIV - VCT services could be alleviated? _____

_____

5.3.4.2 Interview form for Parents

Addis Ababa University

School of Graduate Studies

Department of Psychology

Addis Ababa

Dear Parents!

The main purpose of this interview is to gather information on the underlying home and outside of home based factors that facilitate or hinder the usage of HIV - VCT services of the youth in Addis Ababa.

If you are volunteer, I want to ask you some questions related to your sons' or daughters' usage or avoidance of HIV - VCT services. It is very important that you respond openly and honestly as much as possible. The information you provide in answering the question will be useful to promote and improve the quality of HIV-VCT services provision so that the deterred or hindered youth from using these services would be positively motivated and attracted and make use of the opportunity to make themselves healthier, happier and more productive.

Thank you in advance for your support and cooperation

I. Background Information

Date _____

1. Sex

   1.1. Male ☐ 1.2. Female ☐

2. Age _____

3. Religion

   3.1. Christian ☐

   3.2. Muslim ☐

   3.3. If other Specify _____

4. Level of Education

   4.1. Illiterate ☐

   4.2. Grade 1-6 ☐

   4.3. Grade 7-10 ☐

4.4. Grade 11-12th complete ☐

4.5. College Diploma ☐

4.6. Degree and Above ☐

5. Occupation _____

6. Present Residence

6.1 In Addis Ababa ☐

6.2 Out of Addis Ababa ☐

II. Concerning the HIV test of your son(s) and/or daughters

7. Do you discuss about sex related issues with your son/or daughter openly? If so when? How often? Where? _____

8. Have you ever discussed about HIV-AIDS related issues with your sons and/or daughters?

8.1. Yes ☐ 8.2. No ☐

9. If your response to item number 12 is yes, What is your discussion about in most cases?

9.1. Nature of HIV/AIDS ☐

9.2. Means of transmission ☐

9.3. Importance of HIV - VCT Services ☐

9.4. Avoidance of HIV - VCT services ☐

9.5. Avoidance or minimization of HIV risky behaviors ☐

9.6. Stigmatization ☐

9.7. If any other, please state _____

10. Have you ever advised or motivated your Son/ Daughter to use HIV - VCT services?

14.1. Yes ☐ 14.2. No ☐

11. What would be your response if you heard that your Son/ daughter had used HIV - VCT services out of your awareness? _____

_____

12. What would be your comment, suggestion or advice if your son/ daughter asked you for your view about his/ her intension of HIV test? _____

_____

13. If your response to item number 14 is yes, please state your reason for doing so. _____

_____

14. If your response to item number14 is No, please, state your view for not doing so? ___

_____

15. What do you think are the main factors or causes for the alarmingly increasing spread of HIV/ AIDS in Ethiopia among the young people? _____

_____

16. What do you think is/are the better way(s) to prevent and control this alarmingly increasing spread of HIV/ AIDS among the youth in Addis Ababa? _____

_____

17. What is your attitude towards HIV+ people or AIDS patients especially the youth?___

_____ Why? _____

18. What would be your response if your Son's or daughter's HIV test result proves HIV + (Positive)? _____

5.5.4.3 Interview Form for Counselors

Addis Ababa University

School of Graduate Studies

Department of Psychology

Addis Ababa

Dear Counselor!

The main purpose of this interview is to gather information on the underlying personal, environmental and service provision related factors that facilitate or hinder the usage of HIV - VCT services among the youth of higher education institutes in Addis Ababa.

If you are volunteer, I want to ask you some questions, related to your counseling service provision and your clients' behavior especially their likes and dislikes regarding the usage of HIV -VCT services. It is very important that you respond openly and honestly as much as possible. The information you provide in answering the questions will be useful to promote and improve the quality of HIV - VCT services provision so that the deterred or impeded youth not use these services would be positively motivated and attracted and make use of the opportunity to make themselves healthier, happier and more productive.

Thank you in advance for your support and cooperation

I. Background Information

Date _____

Name of Clinic / Hospital or HIV -VCT center _____

1. Sex

   1.1. Male ☐ 1.2. Female ☐

2. Age _____

3. Religion

   3.1. Christian ☐

   3.2. Muslim ☐

   3.3. If any other, Specify _____

4. What is your Background?

4.1. Nurse ☐

4.2. Clinical Officer ☐

4.3. Medical Doctor ☐

4.4. Social worker ☐

4.5. Professional counselor ☐

4.6. Persona living with HIV or AIDS ☐

4.7. If other please specify _____

5. Counseling experience in years:_____

II Information Concerning Youth Clients' Attitudes, Activities and Interests in Relation to HIV-VCT Service

6. Describe the counseling training have you received in terms of time or duration and level of qualification? _____

_____

7. Are there any areas in which you feel you need more training?_____

_____

8. Have you had follow up or ongoing training?

8.1 Yes ☐ 8.2 No ☐

9. If your response to item number 8 is yes, please, describe it _____

_____

10. If you response to item number 8 is No, do you think ongoing training would be a good idea?

10.1. Yes 10.2 No

11. How do you feel about your Job? _____

12. Do you feel valued or undervalued by your clients (explain in what ways)?_____

_____

13. How many clients on average do you see per day? _____

_____

14. How is the youth's interest (motivational level) to use HIV - VCT services in general?

14.1. Very high ☐

14.2. High ☐

14.3. Average ☐

14.4. Low ☐

14.5. Very low ☐

14.6. If any other, please state _____

15. If your response to item number 14 is low or very low, what do you think are the major reasons(causes)? _____

_____

16. If your response to item number 14 is low or very low, what do you think are the major reasons (causes)? _____

_____

17. How do you compare the general prevalence of using HIV - VCT services of female and male youth in your HIV - VCT center at present?

7.1. Male youth are more prevalent than female youth ☐

7.2. Male youth are less prevalent than female youth ☐

7.3. They are equally prevalent at present ☐

7.4. They are equally less prevalent at present ☐

7.5 If any other, please state _____

18. Please, give reasons for any of your responses to item number 17. _____

_____

19. What have you done in your part to make the youth more interested in or positively motivated to use HIV - VCT services? _____

_____

20. Please, list down at least five possible actions that can be taken in your HIV - VCT center to help the youth to avoid or weaken the barriers that impede using HIV - VCT services and to strengthen their positive motivation to use the opportunity.

20.1. _____ 20.4. _____

20.2. _____ 20.5. _____

20.3. _____

21. If there are youth (client) who dropout, using only the pretest counseling, please mention the reasons you know or think _____

_____

22. Please, list down at least three activities what your clients especially the youth like most and dislike most separately in the process of HIV - VCT services provision.

22.1. Like most	**22.2. Dislike most**
22.1.1. _____	22.2.1._____
22.1.2. _____	22.2.2._____
22.1.3._____	22.2.3._____

23. Please feel free to give any comment you have on the conditions of VCT services provision and on other deterring or/and positively motivating factors that impede or instigate respectively the usage of the services. _____

_____

5.3.4.4 Interview form for Focus Groups Discussions

Addis Ababa University

School of Graduate Studies

Department of Psychology

Addis Ababa

Dear Student!

The main purpose of this group interview (discussion) is to gather information on the underlying personal, service provision, home, peer and in general Addis Ababa Community based factors that positively motivate (facilitate or instigate) and negatively motivate (impede or hinder) the youth of higher education institutes in Addis Ababa to use and to avoid respectively the HIV-VCT services.

Therefore, you are kindly requested to provide honest and accurate responses to each of the following items.

Thank you in advance for you cooperation.

I- Background Information

1. Date _____
2. Sex _____
3. Age _____
4. Level of education _____
5. Place of birth _____
6. Ethnicity_____
7. Have you ever made sexual relation?_____

II- concerning the factors that influence the youth to seek or Avoid HIV-VCT services

8. Do you have multimedia access about HIV-AIDS and HIV-VCT related issues?
9. Have you ever used HIV-VCT services?_____
10. If you have used HIV-VCT services, what is/are the factor (s) that positively motivated you (if any) to be tested?

11. If you haven't been tested for HIV yet, what is/are the factor(s) that deterred you (if any) from using VCT?
12. What do you like most about the VCT services in general to be for you for future?
13. What do you dislike most about the VCT services in general?
14. What is your comment on the VCT service providers and provision in general?
15. How do you think that the VCT barriers can be minimized and the youth of Addis Ababa can be attracted to use HIV-VCT?

5.3.4.5 ለወላጆች ቃለ መጠይቅ ማቅረቢያ ቅጽ

በአዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት ቤት
የሣይኮሎጂ ዲፓርትመንት
አዲስ አበባ

ውድ ወላጅ!

የዚህ ቃለ መጠይቅ ዋነኛ ዓላማ በአዲስ አበባ ከተማ በሚገኙ የግልና የመንግስት ከፍተኛ የትምህርት ተቋማት ውስጥ የሚማሩ ወጣት ተማሪዎች በፈቃደኝነት ላይ የተመሰረተ የዘIV የምክርና የምርመራ አገልግሎት መጠቀምና አለመጠቀምን በተመለከተ በቤትም ሆነ ከቤት ውጭ አጋዥ ወይም አደናቃፊ የሆኑ መሰረታዊ ምክንያቶች የሚጠቁመ መረጃዎች ለመሰብሰብ ነው::

ስለዚህ ፈቃደኛ ከሆኑ በፈቃደኝነት ላይ የተመሠረተ የHIV የምክርና የምርመራ አገልግሎት መጠቀምና አለመጠቀምን በተመለከተ ስለራስዎ ልጅ/ልጆች ጥቂት ቃለ መጠይቆችን ልጠይቅዎ ፈልጋለሁ:: በተቻለ መጠን ለቃለ መጠይቆች የሚሰጡት ምላሽ በግልጽነትና በሀቅ ላይ ተመሠረተ ቢሆን ከፍተኛ ጠቀሜታ አለው:: ለቃለ መጠይቆች የሚሰጡት መልሶች በፈቃደኝነት ላይ ለተመሠረተው የምክርና የምርመራ አገልግሎት አሠጣጥ ጥራት በመጨመር፣ ወጣቶች አገልግሎቱን ጠንዳይጠቀመ ራሳቸውን ጤናማ፣ ደስተኛና ምርታማ ጠንዲሆኑ በጠጅገ ይረዳል::

የመላሹን የግል መረጃ በተመለከተ

ቀን _____

1. ጸታ
   1.1 ወንድ ☐ 1.2 ሴት ☐
2. ዕድሜ _____
3. ሀይማኖት
   3.1 ክርስቲያን ☐ 3.2 መስሊም ☐ 3.3 ከዚህ ውጭ ሌላ ከሆነ ☐
4. የትምህርት ደረጃ

4.1 ያልተማረ ☐ 4.3 7-10 ክፍል ☐ 4.5 የኮሌጅ ዲፕሎማ ☐

4.2 1-6 ክፍል ☐ 4.4 11ኛ-12ኛ ☐ 4.6 የመጀመሪያ ዲግሪ ☐

5. ሥራ _____

6. በአሁኑ ወቅት የመኖሪያ ቦታ

6.1 አዲስ አበባ ☐ 6.2 ከአዲስ አበባ ውጭ ☐

የልጅዎን/ልጆችዎን HIV ምርመራ በተመለከተ

7. ከልጅዎ/ልጆችዎ ጋር ስለ ተቃራኒ ጾታ ጓደኝነትና ግንኙነት በተመለከተ በግልጽነት ተወያይታችሁ ታውቃላችሁ ከሆነ መቼ? በየስንት ቀን? የት ቦታ?

_____ _____

_____ _____

8. ከልጅዎ/ልጆችዎ ጋር ኤች አይ ቪ/ኤድስን በተመለከተ ተወያይታችሁ ታውቃላችሁ?

8.1 አዎን ☐ 8.2 የለም ☐

9. በተራ ቁጥር 8 ለቀረበው ቃለ መጠይቅ የሰጡት ምላሽ «አዎ ከሆነ» ከሆነ ብዙ ጊዜ ውይይታችሁ በተለይ ምን ላይ ያተኮረ ነው?

9.1 የኤች አይ ቪ ኤድስን ተረጥሮ በተመለከተ ☐

9.2 የ መሠራጫ መንገዶችን በተመለከተ ☐

9.3 የHIV የምክርና የምርመራ አገልግሎትን የመጠቀምን ጠቀሜታ በተመለከተ ☐

9.4 የHIV የምክርና የምርመራ አገልግሎትን ስለ አለመጠቀምን ጠቀሜታ በተመለከተ ☐

9.5 ለHIV የሚያጋልጡ ባህሪያትን ስለመተው ወይም መቀነስ በተመለከተ ☐

9.6 መገለልን በተመለከተ ☐

9.7 ከዚህ ውጭ ሌላ ካለ ☼ባክዎን ይግለጹት_____ _____

_____ _____

10. ልጅዎ/ልዶችዎ በፈቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ አገልግሎት (HIV - VCT)☼ንዲጠቀሙ መክረው ወይም አበረታትተው ያውቃሉ?

10.1 አዎን ☐ 10.2 የለም (አላደረኩም) ☐

11. ☼ርስዎ ሣያውቁ ልጅዎ/ልጆችዎ በፈቃደኝነት ላይ የተመሠረተ የHIV ምክርና ምርመራ አገልግሎት ከንደተጠቀሙ ከሌላ ሰው ቢሰሙ የርስዎ ምላሽ ለልጅዎ/ልጆችዎ ምን ይሆናል?_____ _____

12. ልጅዎ/ልጆችዎ በፈቃደኝነት ላይ የተመሠረተ የHIV የምክር የምርመራ አገልግሎት ለመጠቀም አስበው የርስዎን ሀሳብ/አመለካከት ቢጠይቁዎት የ☼ርስዎ አስተያየትና ምክር ምን ይሆናል?_____ _____

13. በተራ ቁጥር 10 ለቀረበው ቃለመጠይቅ የሰጡት ምላሽ አዎ ከሆነ ☼ባክዎን ምክንያትዎን ይግለፁ?_____ _____