Addis Ababa University
Department of Psychology

HIV Counselors' Understanding of the Developmental Needs, Concerns and Problems of their Adult Clients: the Case of VCT Counselors in Addis Ababa

By
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ABSTRACT

HIV/AIDS has become a widespread epidemic in Sub-Saharan Africa including Ethiopia. It has challenged the African societies in many ways today above and beyond toiling the life of millions of adults.

Different measures were taken by governmental and non-governmental agencies to cope up with the problem. A major effort has been that of establishing voluntary counseling and testing (VCT) centers. Counselors were employed and trained to shoulder the major responsibilities of VCTs. It is believed that the training given to them and/or the knowledge and skills of the counselors is expected to address the developmental profile of the adult counselees.

The purpose of this research is to attempt to assess the HIV counselors' understanding of the developmental needs, concerns, and problems of their adult clients.

The participants were 40 HIV counselors working in various VCT centers in Addis Ababa, drawn based on stratified sampling techniques. Data were gathered through an open-ended questionnaires being designed by the researcher.

The study found out the following limitations in the counseling services:

- The counselors understanding of the developmental needs, concerns and problems of their adult clients was not found adequate.
- The general role provisions of HIV counselors seemed to be that of the role of a facilitator to the adherence of HIV drugs (ART) while it was supposed to provide independent HIV counseling.
- Except for the adherence of ART drugs, there was no well designed follow up and family counseling to address the worries and problems of HIV positive adult clients related including to income, family responsibilities, social relationship child rearing and work loads.

Recommendations were forwarded based on the findings above.

I. INTRODUCTION

1.1. Background

In the past decade, no single sexually transmitted disease (STD) has had greater impact on sexual behavior or created public fear than HIV/AIDS. More than 15 million people in Sub-Saharan African countries have died from AIDS since the onset of the epidemic (UNAIDS, 2006).

Ethiopia is one of the countries in the Sub-Saharan region hard hit by this epidemic. According to the recent statistics from Ministry of Health (MOH, 2006), the overall prevalence of HIV in the population is 3.5% (3% among males and 4% among females). The estimated prevalence rate in urban areas was 10% (9.1% among males and 11.9% among females) and 1.9% in rural areas (1.7% among males and 2.2% among females). Incidence in the urban areas appears to have stabilized in the period between1996 and 2000; showing a slow and gradual decline since 2001; while it has stabilized nationwide, with the number of people newly infected and dying being almost equal. As a result, the estimated HIV incidence in Ethiopia for the year 2005 stood at 0.26% with the possibility of remaining stable until 2010.

Close to 1,320,000 people were estimated in 2005 to have been living with HIV/AIDS, of whom 634,000 were in rural and 686,000 in urban areas. More women were living with HIV/AIDS than men in the age group of 15-29 years; while in the age group of 30+ years, it was the men who exceeded in number. It was estimated that 137,500 new AIDS cases, 128,900 new HIV infections including 30,300 HIV positive births, and 134,500 AIDS deaths (including 20,900 in children (<15 years) occurred over the year 2005 (MOH, 2006).

Many efforts were made to fight and control HIV/AIDS since the onset of the pandemic. One of such efforts was the establishment of HIV Voluntary Counseling and Testing (VCT) centers in different parts of the country.

The word counseling is used to denote a wide range of procedures including advice giving, encouragement, information giving, test interpretation, and psychoanalysis.

In a wide range, H.B. and A.C. English (1958) define counseling as a relationship in which one person endeavors to help another to understand and to solve his adjustment problems. In this definition, they pointed out three important points:

i. The area of adjustment – e.g., educational counseling, vocational counseling, personal counseling, HIV counseling, etc.

ii. It is usually to help "normal counselees" but creeps imperceptibly into the field of psychotherapy

iii. It is preferably restricted to professionally trained persons.

Regarding the goal concerning counseling, it is dependent upon the purpose of the counseling. Roger (1951) points out the outcome of counseling is to effect changes in behavior which will enable the counselee to live a more productive, satisfying life, as he defines it within society's limitations.

Some have identified the preservation or attainment of positive mental health as the goal of counseling. If it is reached, the individual achieves integration, adjustment, and positive identification with others (Thorne, 1950).

It is sometimes thought to be the resolution of whatever problem were brought to the counseling relationship (Krumboltz, 1965). The purpose of HIV counseling is designed to reduce and to eliminate unnecessary risk (CDC, 2003).

Seble (2005) stated that VCT services are provided with the following importance:

- prevention of HIV transmission
- prevention of HIV acquisition
- early access to services
- legal support: normalization of HIV, challenging stigma, promoting awareness, supporting human rights

- counseling for adherence to Anti-Retro Viral (ART) and preventive therapies, coping with adverse effects of drugs, counseling about adherence in mother-to-child transmission

There are in general 155 VCT centers in Addis Ababa of which 39 are governmental, 26 NGO and the rest 90 are private.

According to the annual report of the Ethiopian Ministry of Health (July 1, 1997 – June 30 1998 E.C), these centers provided services to a total of 564,351 people – of whom13.7% were HIV positive (15.7% females and 11.6 males). The report also indicated that a total of 52 pregnant women were tested for HIV, of which 4,172 (8%) tested positive (MOH, 2006).

The present research attempts, therefore, to assess how far of the counselors in the 155 VCT centers engage in a counseling relationship that caters the developmental needs, concerns and problems of their adult clients.

1.2. Objectives

The objective of this study is to assess the provision of VCT in terms of meeting the developmental needs of the clients and its possible impact on the clients. Stated rather more clearly, it attempts to:

2. Identify the HIV counselors' understanding the developmental needs, concerns and problems of their HIV positive adult clients

3. Assess how far the counseling services which HIV counselors provide are structured to addressing the needs, concerns and problems of their HIV positive adult clients, and finally,

4. Compare and contrast the counseling services and the acquired behavioral changes against the ideal HIV counseling services that may help to understand the real developmental needs, concerns and problems of HIV positive adult clients.

1.3. Research Questions

- Do HIV Counselors understand the special developmental concerns, needs and problems of their adult clients including the following?
  - Physical vulnerability of adults and their need for physical exercise practices
  - dieting habits of their adult clients
  - addictions
  - workload
  - worries due to the clients' household financial and social responsibilities
  - help seeking strategies of their adult clients
- How do counselors address these needs and problems or what measures do they take during counseling?
- How effective are these measures or What changes do counselors observe as a result of the interventions they make to helping their clients, and
- What recommendations do counselors put forward to improving counseling services to their clients?

1.4. Operational Definitions

VCT: Voluntary Counseling and Testing

Adult: in this study refers to those who visited the selected VCT centers of Addis Ababa and were provided with HIV counseling services from the centers. More specifically, it refers to those clients who have families, earn their own income and shoulder different personal and social responsibilities.

HIV Counselors: counselors who provide HIV counseling services to those who are coming to VCT centers to be tested for HIV.

Developmental needs, concerns and problems: Developmental tasks of an individual which arise at or about a certain period in the life of the individual, successful achievement of which leads to his happiness and success in later tasks, while failure leads to unhappiness in the individual, disapproval by the society and difficulty with later tasks.

1.5. Limitations

Following are among the various limitations faced in the course of the present research.

5. The very nature of the topic by itself was a great limitation as there were few relevant studies that could be referred to while structuring the conceptual frame of the subject as well as the framing of research tools- all because of the novelty of nature of the topic.

6. The fact that the study attempts to look into only the counselors' understanding of developmental needs, concerns and problems of their HIV positive adult clients, to the exclusion of the views of the latter was quite a limitation.

7. Lack of confidence and reluctance to cooperate on the part of the counselors in the course of data collection was another limitation. Great efforts had to be exerted of to persuade many of the counselors to agree to fill out the designed questionnaire.

8. Nature of the data collecting process, which required much time and labor, also had a great contribution as a limitation. The allocated budget for the study could not even cover a quarter of the total cost and more than 1/3 of the budget was covered by the researcher.

II. REVIEW OF THE RELATED LITERATURE

This review work begins with a description of the meaning of an adult. Second, we try to examine the physical, cognitive and psychosocial descriptions of changes that commonly occur in the period of adulthood. These descriptions of changes may reveal the major developmental needs, concerns and problems of adults. Third, we shall describe the roles, functions, and techniques of counseling employed to help adults with problem behaviors. This would help us look in to the implications of HIV positive adults' developmental changes in HIV counseling process. Finally, we shall briefly discuss the status of HIV/AIDS in Ethiopia so as to understand the possible challenges in Ethiopia of providing quality VCT.

2.1. Who is an Adult?

Slicing life-span development in to stages or periods is a very arduous task because it varies across historical times and cultural set up (Papalia et al., 1996). Accordingly, there is no consensus in defining "who an adult is". This problem is due in part to the application of different criteria in conceptualizing adulthood. Some of these include physical and physiological, legal, social, and psychological criteria.

Physiologically, for example, adulthood is an achievement of the ability to reproduce. Legally, it is the age of voting, driving, consent and the like; socially, it is playing adult roles assuming such social titles as Mr., Mrs. Etc. Psychologically, it is having a sense or a concept of oneself as being an adult; not just a child or an adolescent (Knowles, 1980).

No matter how varied the definitions are, most developmental psychologists concur to the idea that an adult is a person who performs socially productive roles, feels emotionally and economically independent and, hence, assumes responsibilities for his or her life and that of others (Darkenward &Merriam, 1982). In many cultures, early adulthood is the time people usually enter into serious personal commitments-marry, start families, and take their place in the world of work. During this period, people define their relationship to society through love, work and play (Gormly & Brodzinsky, 1993).

In the discussion that follows, we shall elaborate on these issues taking the major dimensions of adult development one at a time.

2.2. Major Developmental Changes of Adulthood

The major domains of adult development can be, for our present purpose, classified in to physical, cognitive, and psychosocial changes.

2.2.1. Physical Changes

During early adulthood – the twenties and thirties - the individuals are at the peak of life, biologically and physiologically. However, not all physical systems reach their respective peaks simultaneously, nor do all systems peak during this period of life. Each system has its own unique pattern and rate of development. According to Gormly and Brodzinsky (1993), early adulthood is characterized both by biological maturation and decline.

Perhaps, because people are at their fittest during this period, they are less likely to practice preventive health habits. According to Santrock (1999), in young adulthood many people develop a pattern of skipping breakfasts, not eating regular meals, smoking and drinking moderately or excessively, failing to exercise and getting by with only a few hours of sleep at night (p. 389). For example, the American Cancer Society (1994) estimated that worldwide about 3 million people die each year because of smoking and that alcohol is the most frequently used (and abused) drug in many countries). Moreover, it is also found out that because of sexual practices, AIDS has become a leading cause of death among persons 15-49 years of age in most African countries resulting the death of more than 15 million Africans since the onset of the epidemic HIV/AIDS (UNAIDS, 2006).

In general, such a poor personal lifestyle of abusing the body is also associated with poor health, though the negative effects may not show up in the first part of early adulthood (Csikszentimialyi & Ruthunde, 1998). According to Csikszentimialyi and Ruthunde (1998), the negative impacts will probably surface later in early adulthood or in middle adulthood. On the other hand, whenever people stop smoking alcohol, and start dieting properly, and begin to practice healthy lifestyle, their health is likely to improve immediately (Katchadourian,1987).

2.2.2. Cognitive Changes

Piaget believed that an adolescent and an adult thinking is the same (Santrock, 1999). But some developmentalists differentiate the way of thinking of an adult from adolescent.

William Perry (1970) believes adults often view the world in terms of polarities – right/wrong, we/they or good/bad, for example. As youth mature and move in to adulthood years, they gradually become aware of the diversity of opinion and multiple perspectives that others hold, which shakes their dualistic perceptions.

Other researchers pointed out that advances in cognitive development occur during the adult years as a consequence of facing the multiple realities of work and intimate relationships. Young adults begin to develop a logic that says that the "truth" is partly an interpersonal, subjective creation that one's own perspective is only one of a number of potentially valid perspectives on reality, and that knowledge is not absolute or fixed (Sinnot, 1989).

Some other researchers believe that Piaget's cognitive stages describe increasing efficiency in acquisition of new information. It is doubtful that adults go beyond the powerful methods of scientific thinking characteristic of formal operational thought in their quest for knowledge (Schaie, 1977). According to Schaie, adults do progress beyond adolescents in their use of intellect. For example, in early adulthood, people typically switch from acquiring knowledge to applying knowledge.

There are still some other researchers who believe that adults tend to have a dialectical thought (Riegel, 1975); that is, there is in adulthood a recognition and acceptance of, even a desire for, conflict or contradiction. According to this view, youth and young adults, like young children, engage the world through a dialectical process of thought at a much higher level. The contradictions confronted are more often on the level of abstract ideas. Mature adults face conflicts in their lives in such areas as morality, ethics, politics, religion and meaning of life. Yet they do not necessarily need to solve the contradictions they confront. In maturity, the individual accepts these contradictions as a basic property of thought and creativity (Kramer, 1986).

In general, Kramer (1986) has summarized the major characteristics of adult thought to have three forms. First, adult thinking is relativistic. Unlike adolescents, who tend to think of the world in absolutistic ways, adults are more likely to accept the existence of mutually incompatible systems of knowledge. This results, in part, from the adult's expanding social world, which includes many differing, and potentially incompatible, viewpoints and roles.

The second feature of adult thought is the realization that contradiction is an inherent aspect of reality. No longer is there a need for necessarily resolving cognitive conflicts or conditions.

The final characteristic of adult thought, according to Kramer, is the tendency to integrate, or synthesize, contradictory knowledge in to an overriding and more inclusive whole. Contrary to the post formal thought of Kramer, recent thinkers on adulthood state that knowledge is always a synthesis or integration of different points of view. Each experience, looked at from a different angle or from a different perspective, yields to new information and new insights.

2.2.3. Psychosocial Development

i. Developmental Tasks of Adults

According to Gould (1978), adults question their roles in life, marriage and career goals. By the mid-thirties, yet another transformation occurs – the awareness that time is running out and the need to realign life goals.

Another view of adult developmental task is presented by Levinson (!980). Levinson suggests that at selected point in life each adult creates a life structure made up of a combination of interrelated social and occupational roles that are adapted to the individual's personality and skills. A life structure reflects a person's priorities and a pattern of life design. It is the answer to the question "What is my life like now?"

According to Levinson, the period of early adulthood is embraced by a series of developmental periods leading to the mid-life transition. The first three periods of early adulthood, from roughly 17 to 33, Levinson refers to as a novice phase because they provide an opportunity to build a life structure which, though it may not be suitable throughout life, will move people out of adolescence. The early adult transition is the bridge between pre-adulthood and adulthood. The Entry Life structure for adulthood is the time when people establish their initial way of living (example, they get married or remain single, choose a career, a geographical location). During the age 30 Transition people get chance to reappraise their earlier life span and modify it (example, switch jobs, opportunity to get married, have children, buy a house). The last early adulthood period in Levinson's scheme is called culminating life structure for early adulthood. At this point, adults seek to realize the goals and dreams they established in their early twenties.

ii. Life Events and Adjustment

At the most general level, life event is any experience that is deemed note worthy or significant by the individual and by the culture. More specifically, however, it is an event "whose advent is either indicative of or requires a significant change in the ongoing life pattern of the individual" (Holmes & Masuda, 1974).

Within this perspective, all life events are viewed as potentially stressful, and hence, require some adaptation on the part of the individual. Certainly, these makes sense when one is referring to such experiences as death of a spouse, divorce, loss of a job, and so on. However, life event theory suggests that even experiences generally regarded as positive, for example, marriage, birth of a child, and job promotion can be stress inducing, and thereby require some psychosocial adaptation. Nevertheless, the more personally catastrophic the event, the greater the stress and need for readjustment by the individual.

In young adulthood, the individual is confronted with a number of important life events and developmental transitions. The more commons ones include the development of intimate relationships, leaving the nuclear family, marriage, pregnancy, birth of a child, divorce, entrance in to the job market, change in financial status, change in social activities, and so on (Gormly & Brodzinsky, 1993).

2.2.4. Counseling and the Process of Helping Adults

However many techniques and schools of thought have been proposed by developmental psychologists to facilitate the natural process of adult development, I found the four models of Gould's frame of references to be revealing of the counseling aspects of adults.

Gould (1990) proposed four models based on four overlapping but distinct frame of reference that constitutes the critical reality space of therapeutic activity.

i. Existential Frame of Reference

This frame of reference attempts to understand patients' lifestyle. The counselor should make some decisions that will affect their clients' future in unknown ways. Appling this frame of reference in HIV-counseling assist to consider the great impact of individuals' life style in the counseling process. It's labeling the counselor to understand and answer whether his client live in urban or rural, educated or non educated, obedient or disobedient for societal rules and regulations.

ii. Contextual / Developmental Frame of Reference

The focus of this frame of reference is patients' experiences and conflict with facts of their immediate life situations. The conflict is usually driven by complex factors that call for new behavior. Considering this frame of reference in HIV counseling assist to Understand clients' responsibility and worries that come from I will not able to accomplish may responsibility because I'm HIV positive.

iii. Psychodynamic Frame of Reference

This frame of reference attempts to understand the influence of the driven new behavior in to the assumptions and conclusions of clients about themselves and others. This frame of reference gives a direction for HIV-counselors to see their clients' abnormal behaviors that come form being HIV-positive. And it able them to identify the appropriate counseling technique and provisional system to assist their clients.

iv. Vocational Conflict

This helps to identify where past behavior and present perception end - to determine what action will occur. This fame of reference help HIV-counselors to evaluate their follow up counseling guiding techniques that they made to understand their clients the required HIV care and way to life style.

This also implies that the capacity of counselors is highly relevant to their effectiveness. Shertzer & Stone (1968) stated three dimensions to distinguish effective from ineffective counselors.

1. **Experience**

More experienced counselors offered more congruence, empathy and unconditional positive regard than less experienced counselors.

2. **Type of counseling relationship**

Effective counseling is related to the type of relationship a counselor establishes with his client. Effective counselors communicate with and understand their clients, maintain an appropriate emotional distance and divest themselves of status concerns in regard to their clients.

3. **Non intellective factors**

Effective counselors can be distinguished from less effective counselors in regard to:

- Self-concept, motivation, values, feelings about others, and perceptual organization and
- Performance on certain standardized personality and interest inventories.

Further, counselor's effectiveness is associated with tolerance for ambiguity, understanding of the client, maturity, ability to maintain an appropriate emotional distance from the client, and ability to establish good social relationships with non-clients.

2.2.5. Voluntary Counseling and Testing for HIV / AIDS

The original design of VCT services stressed the making of a personal plan with a provider as a way of motivating both people who are HIV positive or negative to change their behavior in ways that would prevent their passing the virus to someone else (McCauley, 2004).

However, the plan and strategies of VCT services were designed to implement in industrialized countries (De Zoysa, 1995); many developing countries have been advocating the expansion of services for the potential reduction of the transmission of HIV.

Seble (2005) stated four important points for the important contribution of HIV counseling and testing:

iv. An ethical mandate to provide VCT for those who would like to know their status.

v. To enable people to be relieved from anxieties associated with uncertainty about HIV sero-status.

vi. To provide early education of HIV and to allow a referral to clinical and psychological care

vii. It may strengthen motivation for behavioral change

The provision of VCT aimed at engaging the client in four specific areas (CDC, 2003).

i. To enhance the client's perception of personal risk through an interactive discussion of the client's own risk situations and circumstances, focusing on the urgency for HIV risk reduction

ii. To support the client in any previous HIV prevention efforts and to acknowledge the client's strengths, skills and motivations, no matter how limited, as evidence of the client's capacity to reduce risk

iii. To seek to encourage the client to immediately begin work on a personal risk reduction step

iv. To ensure referral to medical, counseling and other support services

These points are summarized in figure 1.

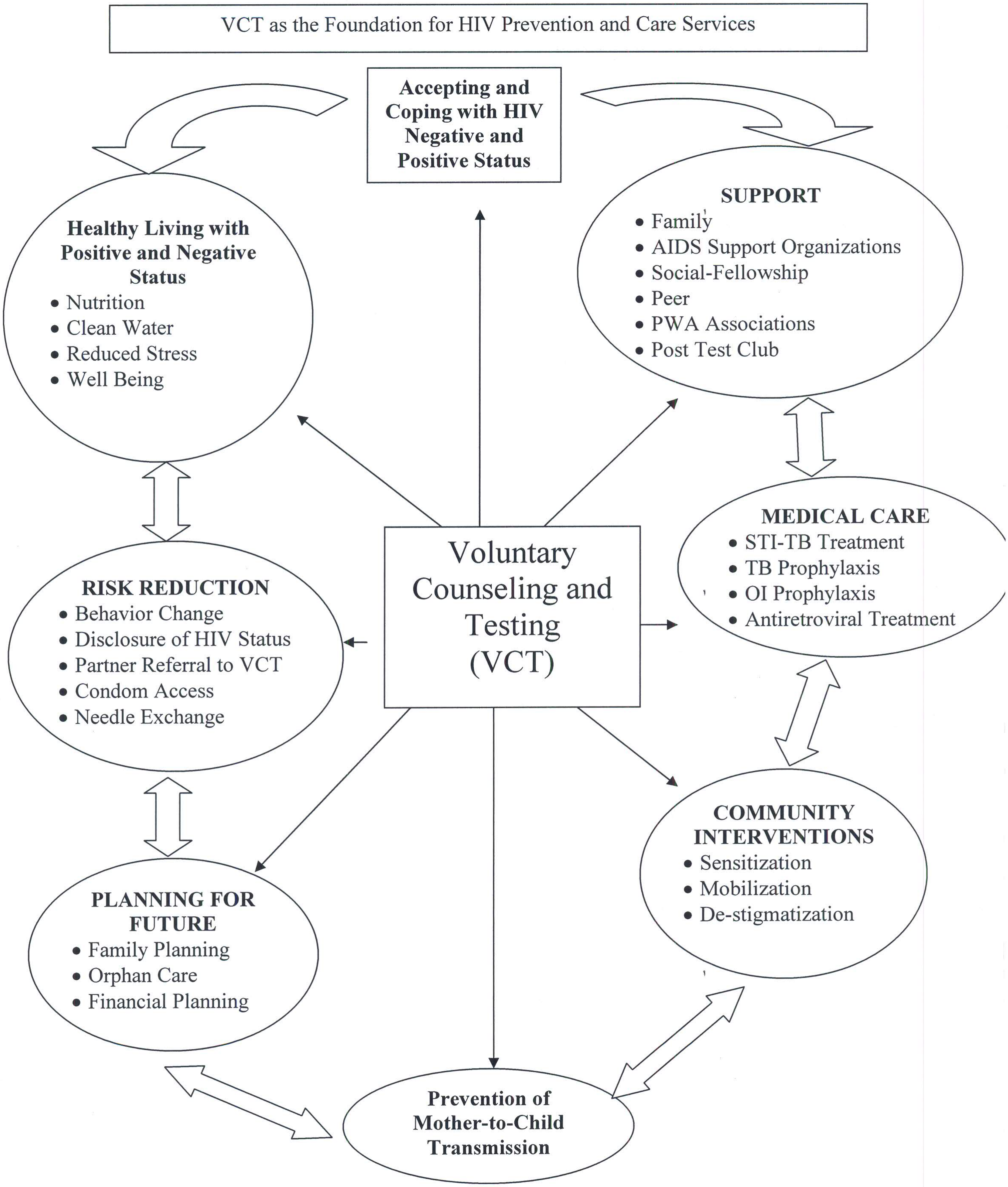

Figure 1 VCT as an entry point for prevention and care and support.
Source: CDC (2003)

III. METHODS AND PROCEDURES

3.1. Population

There are a total of 155 VCT centers at the moment of which 39 are governmental, 26 are non governmental, and the rest 90 are administered by private health centers. Table 1 provides their distribution by sub-city. Each center has its own counselors implying that there were a total of 155 possible counselors to sample from.

Table 1 The distribution of VCT centers in 10 sub cities of Addis Ababa

Sub city		GO	NGO	Private	Total
1	Addis Ketema	2	2	11	15
2	Akaki- Kality	2	1	9	12
3	Arada	7	1	11	19
4	Gulele	3	6	3	12
5	Bole	3	1	7	11
6	Kirkos	8	4	17	29
7	Nifas Silk- Lafto	4	1	10	15
8	Kolfe Keraniyo	2	3	4	9
9	Lideta	4	4	6	14
10	Yeka	4	3	12	19
	Total	***39***	***26***	***90***	***155***

Source: Data from Addis Ababa Health Bureau

3.2. Participants

The participants of this study were forty 40 HIV-counselors (16 males and 24 females) who are currently providing counseling services in VCT centers in Addis Ababa.

3.3. Sampling technique

Participants were drawn based on the stratified sampling technique in the sense that the VCT centers were first classified in to three groups or strata by ownership type (i.e. GO, NGO, or Private) and then representative sample was drawn from each stratum and sub-city proportionally (see details on Table 2). More specifically, one participant was randomly taken from a cell (connecting sub-city against type of ownership) with five or less VCT centers. For cells with more than five VCT centers, two to three participants were taken as representative.

Table 2 The number of VCT centers chosen from each of the 10 Sub cities of Addis Ababa

Sub city		VCT centers			
		Go	**NGO**	**Private**	**Total**
1	Addis Ketema	1	1	3	5
2	Akaki Kality	1	1	2	4
3	Arada	2	1	3	6
4	Gulele	1	2	1	4
5	Bole	1	1	2	4
6	Kirkos	2	1	3	6
7	Nifas Sild Lafto	1	1	2	4
8	Kolfe Keraniyo	1	1	1	3
9	Lideta	1	1	2	4
10	Yeka	1	1	3	5
	Total	*12*	*11*	*22*	*45*

3.4. Demographic characteristics of participants

All the sampled respondents are health professionals. Ninety two (92%) of them are nurses. They were given a minimum of 14 days and a maximum of 180 days training on counseling.

Sixty eight per cent (68%) of the respondents work in other medical institutions in addition to the counseling services.

On average, each counselor currently provides counseling services to about 12 clients per day, and has given counseling to about 2000 individuals since she/he started the service.

About 55 % of these respondents wish to quit their counseling job with in 2 years or less on average.

The following figures and table (Table 2) summarize the personal information of the respondents.

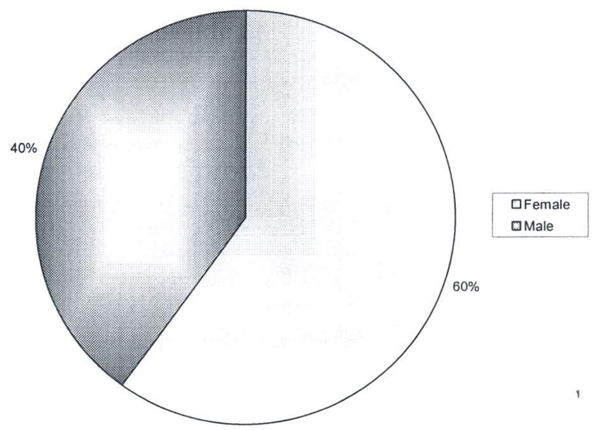

Figure 2 Distribution of Counselors by Sex

Table 3 Summary of Respondents

	Age	Training (in days)	No of Clients per Day	Total No of Clients, since they started counseling
Min	20	14	4	250
Max	48	180	50	8000
Average	32	51	12	2219

3.5. Tools

Self-constructed questionnaire[1] (open-ended items) was used to secure data regarding the HIV counselors' understanding of the developmental needs, concerns and problems of their HIV positive clients (See Appendix).

Prepared on the bases of the review of the recent findings of adult development, the questionnaire items centered on how the counselors understand the physical, cognitive, and psychological changes of their adult clients, measures they took to address these needs, the impact they observed to have ensued upon taking these measures, and recommended courses of actions for the future.

The questionnaire was divided in to two major sections. The first section, which contained 15 items, focused on gathering personal information of the counselors. The second section contained 60 questions, which were grouped under10 categories to help understand the various developmental needs, concerns and problems of HIV positive adult clients. These 10 categories attempted to assess the counselor's understanding of:

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[1] *Furthermore, in-depth interview was Head of the Department for Disease Prevention and Control, the Addis Ababa Health Bureau, to get information on the administrative process involved in understanding the needs, concerns and problems of HIV positive adults by the Bureau. The responses were mainly used to interpret findings rather than to answer the research questions.*

1. special features of the physical development of their adult clients
2. dieting habits of their adult clients
3. physical exercise practices
4. addictions
5. work load
6. additional counseling services
7. worries due to the clients' household incomes
8. help seeking strategies of the clients
9. worries and anxieties that are involved by the clients' incompletion of tasks
10. worries of the adult clients that are related with family responsibility and rearing their children

Each of these 10 categories were followed by the following 6 sub items to understand the counselors':

1. observations about their HIV positive clients
2. implications drawn from their observations during the counseling process
3. provisions they avail to the clients
4. changes observed after the provisions
5. reasons for the failure, if changes were not observed after the provisions
6. recommendations for future improvements of the counseling process

To maintain the clarity of the items, the questionnaire is prepared in the working language of the counselors – Amharic.

3.6. Pilot Test

To ensure the clarity of the questionnaire items, a pilot survey was made with 10 randomly selected counselors; each representing one VCT center.

A few problems were observed during the pilot project. Some counselors, thinking the questionnaire was a work evaluation, were not willing to respond to the questionnaire. This problem was solved by discussing the purpose of the questionnaire and the study to the counselors.

3.7. Procedure of data collection

After the preparation of the questionnaire and the interviews, a request, accompanied by a support letter from the Department of Psychology, was submitted to the Research Committee of the Addis Ababa Health Bureau to obtain an ethical clearance because the researcher was asked to produce this clearance during the field work. The researcher was granted the ethical clearance (see appendix) within four days the application letter was submitted.

Once the ethical clearance was obtained, the researcher gave orientation to the three hired to facilitate the task of data collection, that is, to distribute and collect the questionnaires to and from the selected VCT centers.

3.8. Data analysis

The procedure of analysis was such that first and foremost the responses were grouped thematically against each item and sub-item and then corresponding frequencies were tallied. These frequencies were used as descriptive measures with no attempt to calculate percentages or other statistical measures. It was felt that the frequencies in the various cells were so small that making statistical tests unwarranted.

IV. DATA PRESENTATION AND ANALYSIS

This section presents a descriptive summary and analysis of the data. The presentation is thematically organized as in the following way:

- Physical characteristics
- Nutritional needs, problems, and eating habits
- Physical exercise
- Substance abuse
- Workload and stress
- Financial worries
- Help seeking patterns
- Future worries

We shall present the data and conduct the analysis considering these themes one at a time.

4.1. Physical characteristics

The counselors were asked at the beginning a question regarding the general physical differences they might have observed between their adolescent and adult clients, the implication that this could have for structuring their counseling services, the kind of counseling services they have provided, major changes observed as a result of this provision, and recommendations they have for the future. Table 4 presents the summary of their responses.

As indicated on Table 4, some counselors (N=7) indicated that younger ones are stronger physically than adults and yet more vulnerable to factors spreading the virus (N=2). other responses seem irrelevant to physical differences but useful in the broader context of HIV/AIDS counseling. According to these respondents, younger clients tended to be emotional, unstable, and had difficulties accepting the test results (N=14). The implications of such differences for some counselors were interpreted to mean that younger clients are more vulnerable than adults (N=14) needing, therefore, more provisions of one kind or another. On the other hand, the provisions which the counselors availed to the clients were by and large limited to giving advice (N=18).

Asked about the changes they witnessed in the clients as a result of the counseling provisions, they failed to report any meaningful impact. In the same way, they still failed to give any explicit recommendation as to how to improve the provision in the future.

Table 4 General physical differences observed between younger and adult clients, implications drawn, measures taken and ensuing changes (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Younger clients become emotional and show difficulties accepting the test result • Younger ones are stronger physically than adults • Adults are more stable, better aware of HIV/AIDS, and more matured • Younger ones are more vulnerable to factors spreading the virus • No response • Incomplete	8 7 6 2 9 8
. Implications drawn	• Counseling younger clients takes much more time than adults to bring behavioral changes • It implies how vulnerable younger ones are compared to adults • Shows in adequate provision addressing the physical differences of the two groups • It is of no use for the provision of counseling services • No relevant response • No Response • Incomplete	2 14 2 2 4 12 4
Provisions to the clients	• No response • Advise • No provision	18 18 4
Changes observed	• No change • Not relevant response • Reduced their vulnerability • No response • Incomplete	5 2 1 21 11
Reasons for failure to change	• The non existence of provision addressing the problem • No response • Incomplete	9 30 1
Recommendation	• Improving the provision • Economic support • No response • Not relevant response	12 1 21 6

4.2. Nutritional needs, problems, and eating habits

It is expected that the balanced in any of its forms would contribute a lot building the immunity of persons living with HIV/AIDS. One area in which HIV counseling should focus is that of addressing nutritional problems, unhealthy eating habits, and alternatives solutions. Table 5 presents the summary responses of the counselors with respect to theses issues. As it can be referred to this table, almost all of them tend to report that their adult clients are nutritional vulnerable (N=38) and believed that this would mean lack of balanced diet worsening their health status (N=26). In order to address this problem, counselors reported that they were writing letter of recommendations to concerned authorities (and NGOs) so that the clients could get the required material support (N=25). And, some counselors (N=12) indicated that the clients managed to get material support which has helped them to improve their health conditions as per the letter of support that they wrote for them. The majority of the counselors (N=40) recommended, therefore, that there is a need for more material and financial support for the clients in the future.

Table 5 Problems HIV positive adults were observed to have regarding food, nutritional needs and eating habits, implications drawn, measures taken and ensuing changes (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Financial constraints and failure to meet material needs • No response	38 2
Implications drawn	• Lack of balanced diet worsening their health status • It implies the non existence of proper provision for the problem • No response • Incomplete	26 5 8 8
Provisions to the clients	• Writing letter of recommendation to concerned authorities so that the clients the required material support • No provision • No response	25 9 6
Changes observed	• No change • Incomplete • As per the letter of support that we wrote, they managed to get material support and improved in their health conditions • No response	11 14 3 12
Reasons for failure to change	• Incomplete • No provision • No response	5 14 21
Recommendation	• Improving provision and economic support • No response	32 8

4.3. Physical exercise

Adulthood being a period of physical vulnerability, there is a need to engage in physical exercise to reduce this vulnerability. However, the data on Table 6 shows that while some of the counselors even failed to notice the occurrence of this vulnerability in the first place (N=8), the majority reported at least that this vulnerability was very less (N=23). Obviously, this implies non-existence of the necessary provision in this regard as the majority of the counselors implicated (N=20). Again advice is the only support given as a counseling service (N=13).

Table 6 Participation in physical exercise, counseling provisions to make this happen, changes observed, and recommendations (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Very less • Did not notice if it existed • No response • Incomplete • Good	23 8 4 2 3
Implications drawn	• Implies the importance of exercise for their health • Indicate non existence of related provision • No response • Incomplete	9 20 9 2
Provisions to the clients	• Advices • No designed provision • No response	13 7 10
Changes observed	• No change • No response • Incomplete • Not relevant	20 13 5 2
Reasons for failure to change	• No provision • No response	27 13
Recommend ation	• Providing the service • I don't know • Not relevant	28 2 10

4.4. Substance Abuse

It is possible that some counselors would engage in substance abuse either before or after learning that they are HIV positive. Hence, counseling services should address these issues to enable the clients build a healthy life style. As it can be seen on Table 7, the majority of the counselors (N=32) have reported that they have noticed their counselors having had at least one or more of such bad habits as drinking alcohol, smoking cigarette, chewing chat, and related others. As some \counselors said (N=5), such counselors might use substance abuse as a coping mechanism to the frustrations they have relating to their HIV status. It is surprising, however, that the psychological support given to such persons is only limited to counseling (N=29). And as expected, very of them reported to have witnessed little behavioral changes (N=5) and some of them suggested the need for more rehabilitative services (N=15).

Table 7 Commonly observed problems of substance abuse, implications, measures taken and changes observed (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Alcohol, cigarette, chat and related drug use • Not relevant	32 8
Implications drawn	• Serious implications for health which is already vulnerable • Not relevant • No implication • I don't know • Incomplete	20 5 9 4 2
Provisions to the clients	• Advice • No provision • No response	29 2 9
Changes observed	• No change • Reduced the negative impact of drug use • No response • Incomplete	14 5 15 6
Reasons for failure to change	• No provision • Because they are stigmatized and discriminated, they use drug as a coping mechanism • No response • Incomplete	14 5 19 2
Recommendation	• rehabilitation service for drug users, raising community awareness about HIV/AIDS • No response • I don't know	22 15 3

4.5. Workload and stress

Given that adulthood is a period of assuming different responsibilities for one's life and that of others both at home and outside, it is possible that the clients could be overloaded with work and this could induce stress in them . Exploring this situation, counselors should, therefore, enable the clients to restructure their life patterns. As indicated on Table 8, in fact counselors reported that their clients have attempted to change their previous work but surprisingly because they felt a need to reduce stressful experiences of stigma while some of them were reported to have given up hope, become increasingly anxious and lost meaning in life (N=6). Many of the counselors (N=27) reported to have helped the clients by giving them advice and very little have reported that this advice enabled them to get behavioral change (N=4).

Table 8 Workload and stress among the adult clients, counseling provisions, changes observed, and recommendations (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Attempt to shift the previous job • Give up hope, become increasingly anxious and loss meaningless in life • No response • Incomplete • No observation • Not relevant	24 6 1 3 4 2
Implications drawn	• Its impact on their health status • No response • Incomplete	26 13 1
Provisions to the clients	• Advice • No provision • No response	27 3 10
Changes observed	• No change • Developing their self confidence • No response	13 4 23
Reasons for failure to change	• No provision • No response • I don't know • Incomplete	5 27 3 5
Recommendation	• Providing the service & economic support • No response	19 21

4.6. Financial Worries

As it can be seen on Table 9, many counselors (N=27) reported that their clients have poverty related problems which may imply a link between HIV/AIDS and poverty. Referring the clients to NGO support (N=13) and advice (N=10) are the services which the counselors reported to provide to the clients.

Table 9 Clients' financial and related worries, counseling provisions, measures taken, and changes observed (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Poverty related problems • Anxiety, giving up hope and loss of meaning in life • Societal misunderstanding about HIV/ AIDS • No response • Incomplete	27 1 2 8 2
Implications drawn	• Economic problems put much effect in the counseling process and function • No response • Special focus on reducing anxiety and counseling on how to live with HIV • The non existence of provision • The problem can never be solved by counselors • Incomplete	15 14 1 6 2 2
Provisions to the clients	• Referring clients to supporting NGOs • No provision • Advice • No response	13 6 10 11
Changes observed	• No change • Helped them get support from NGOS • Incomplete • No response • No response	10 2 3 21 4
Reasons for failure to change	• The non existence of the provision • Poverty • No response • NGOs being fewer in number and inability to meet existing demand	4 4 31 1
Recommendati on	• Reducing poverty • Improving the provisions • Raising societal awareness • No response • Raise the number of NGOs	10 9 8 12 1

4.7. Help seeking patterns

Adulthood is a period of independence in many ways. But, for various reasons persons living with HIV may require help from others. This desire would, however, create a feeling of uneasiness, a feeling of being dependent, a sense of worthlessness. Hence, clients need counseling services to equip them with the proper understanding of the essence of help seeking and necessary skills. As indicated on Table 10, this problem was observed, among others, by such problems of the clients as the unwillingness to reveal their problems to others (N=6). As regards the counseling services rendered to them, the counselors hardly appear to provide any psychosocial empowerment except that of advice or rather encouraging them to go for help seeking from NGOs (N=23).

Table 10 Adult clients' observed help seeking patterns, counseling provisions, and changes observed (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Poverty related problems • Unwillingness of clients to reveal their problems to others • Not observed • No response • Incomplete	16 6 6 9 3
Implications drawn	• Impact of poverty • No response • The non existence of provision	5 28 7
Provisions to the clients	• Referring them to NGOs • Building clients self- confidence • No response	23 5 12
Changes observed	• No change • Improving clients self confidence • Incomplete • No response	2 2 4 32
Reasons for failure to change	• The non existence of provision • No response	4 36
Recommendation	• Improving the provision • No response	14 26

4.8. Future worries

Because adulthood is a period of responsibility, adults with HIV positive may worry with the accomplishment these responsibilities particularly on learning that they have the virus. These worries may include, for example, incompleted tasks, the retiring parents, the wellbeing and education of one's kids ….. As indicated on Table 11, some of these problems include:

- Anxiety, depression and loss of meaning in life
- Fear of death and leaving family with out someone holding responsibility for them
- Poverty related problems

It is, therefore, one major goal of the counseling service to do justice to these problems by way of helping parents develop appropriate coping skills and preparations to dealing with these problems. Saddening is, however, that these problems were not attended properly in the sense that the clients were either given advice (N=18) or referred to NGOs (N=2) or not attended altogether (N=20). Rather interesting is the response of some counselors, of course few of them (N=2), indicating that the issue is not the counselor's responsibility.

Table 11 Clients' worries about uncompleted tasks, counseling provisions, and changes observed (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Anxiety, depression and loss of meaning in life • Fear of death and leaving family with out someone holding responsibility for them • Poverty related problems • No response •	10 9 8 1 3
Implications drawn	• Impact of poverty • The non existence of provision • No response • Incomplete	9 7 23 1
Provisions to the clients	• Advice • No provision • Referring them to NGOs for support • Incomplete • No response	18 6 2 1 13
Changes observed	• No change • Improving the previous conditions • No response • Incomplete	9 4 21 6
Reasons for failure to change	• The non existence of provision • No response • Incomplete	10 28 2
Recommen dation	• Providing the service • Economic support • No response • This is not the counselors' responsibility	12 5 21 2

Table 12 also presents a similar scenario; that the future of one's children and parents is the source of worry for the adult clients while there are little counseling provisions to these problems.

Table 12 Worries related to rearing up one's children and supporting the retiring parents (N=40)

Issues	Responses	Freq.
Observed behaviors of the clients	• Poverty related problems • Fear for families' future destiny • No response	13 12 15
Implications drawn	• The impact of poverty • The demand of provision • No response	9 7 24
Provisions to the clients	• Advice • Referring them to supporting NGOs • No provision • No response • Incomplete	15 3 3 15 4
Changes observed	• No change • Reduced their Anxiety • No response • Incomplete	6 4 19 11
Reasons for failure to change	• The non existence of provision • No response • Incomplete	8 29 3
Recommendation	• Providing the service • Reducing poverty • It is not counselors responsibility • No response • Incomplete	9 4 3 19 5

V. FINDINGS AND DISCUSSION

The counselors did not mention the physical differences between their adolescent and adult clients clearly. The implication of these differences and the kind of counseling services provided in this regard are also unprofessional and limited to giving advices only.

In addition to this, the counseling service does not focus on addressing the clients' nutritional problems and their unhealthy eating habits, and in providing alternative solutions. In this regard, the major provisions of the counselors were limited to writing letters of recommendations to concerned authorities and NGOs.

In the need to engage clients in physical exercises and healthy lifestyles to reduce their vulnerability to the effects of the virus, some of the counselors even failed to notice the vulnerability in the first place, and also in this regard, giving advice was the only support given as a counseling service.

Concerning clients' workload, financial worries and stresses, many of the counselors reported to have helped the clients by giving advice and referring the clients to the support of NGOs.

Future worries of clients with regard to problems related to income, parental responsibilities, child rearing, completing tasks interrupted because of the advert of the virus into their lives, were also not attended properly. The provided services were limited in the sense that clients were either given advice or referred to NGOs.

This might be due to several reasons:

- Most of nurses and heath professionals in charge of the HIV counseling process are engaged in offering other health services in addition to HIV counseling. Thus, this implies that the quality of the counseling services offered to adult clients does not seem to be standard and professional.

- This was made apparent in their responses to the questionnaire concerning developmental needs, concerns and problems of their adult clients, most of them had to consult third parties, like to other concerned NGOs, rather than attempt to address the needs, concerns and problems of their adult clients on their own. The fact also indicates that the major provisions of HIV counseling depend on the proposed services of NGOs.

- The activity plan of the giant NGOs, like USAIDS, Family Health International (FHI), Christian Relief and Development Aids (CRDA),etc, who are providing funds for HIV related activities, has a limitation to attain the interest and the problem of the majority of HIV positive adult clients'.

- Moreover, the specific devotion of the service to facilitate in the adherence of Anti Retro viral (ART) drugs is one of the problems in the provision of HIV counseling. Hence, the purpose of the service seems to be to facilitating and creating awareness about the importance of HIV drugs than understanding the developmental needs, concerns and problems of adult clients. Perhaps, the professionals with only two weeks of training could be fit only for such role of awareness rather than counseling. This hypothesis is more evident in the fact that the counseling service is limited to adherence as it is provided to HIV positive individuals after they tested positive.

- The non-existence of other related follow up and family counseling services have great impact on solving worries and problems of HIV positive adult clients with regard to problems related incomes, parental responsibility, child rearing, completing tasks interrupted because of the advert of the virus in to their lives.

VI. CONCLUSION AND RECOMMENDATION

Generally, the study found out the following important points about HIV counseling process in the selected centers of Addis Ababa as well as the HIV Counselors' understanding of developmental needs, concerns and problems of their HIV positive adult clients.

- Since counseling services are provided by nurses and health professionals, HIV positive adult clients do not get standard and professional HIV counseling services. The Para-counselors try to solve the major developmental needs, concerns and problems of their HIV positives adult clients by retiring to NGOs than attempting to provide appropriate professional counseling solutions, which they cannot.

- The overall provisions of HIV counseling services seems to be playing the role of facilitators to the adherence of HIV drugs (ART) while it was supposed to provide independent HIV counseling.

- Except for the adherence of ART drugs, there is no well designed follow up and family counseling to address the worries and problems of HIV positive adult clients related including to income, family responsibilities, social relationship child rearing and work loads.

- The interest and provisions of western local and international NGOs determine the nature and goal of major activities of the counseling process.

According to the findings of the study, the following important points are recommended to improve and provide appropriate counseling services in the VCT centers.

i. The counseling process should be designed in appropriate purpose of HIV counseling than playing the role of a facilitator to the adherence of HIV drugs (ART); and its nature, goal and major activities must be free from the interest and provisions of western local and international NGOs.

ii. Professional psychologists should participate in the training, and in the design of manuals (the focus areas of the topics) used in the training of HIV counselors.

iii. HIV counselors who are currently engaged in the counseling process should get additional training on the techniques of counseling, and about the developmental needs, concerns and problems of their adult clients.

iv. Professional psychologists should involve in the counseling process

v. The counseling process should include follow up and family counseling to reduce worries and problems of HIV positive adult clients, with regard to problems related to financial incomes, parental responsibilities, child rearing, completing tasks interrupted because of the advent of the virus in to their lives.

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APPENDIX

በኤች.አይ.ቪ/ኤድስ የበጐ ፈቃድ ደም ምርመራ እና ምክር አገልግሎት ተቋም ውስጥ ለሚሰሩ ካውንስለሮች የቀረበ መጠይቅ

❖ መግቢያ

ይህ መጠይቅ በ HIV/AIDS የምክር አገልግሎት ዙሪያ መረጃ ለማሰባሰብ ታቅዶ የተዘጋጀ ነዉ፡፡

የጥናቱ ዋና ዓላማ በኤች.አይ.ቪ/ኤድስ የበጐ ፈቃድ የደም ምርመራና ምክር አገልግሎት ተቋማት ውስጥ የሚሰሩ ካውንስለሮች ከኤች.አይ.ቪ/ ኤድስ ጋር የሚኖሩ ጐልማሳ ደንበኞቻቸው በእድገት ምክንያት የሚከሰቱባቸውን አካላዊ፣ አዕምሯዊና፣ ሥነ ልቦናዊ ለውጦች የሚገነዘቡበትን መንገድ ለመረዳትና በካውንስሊንግ ሂደቱ ጐልማሳ ደንበኞቻቸውን ተገንዝበው እንዴት የስነልቦና ድጋፍ እንደሚሰጡና ከዚያ አኳያም የሚያጋጥሟቸዉን የአገልግሎት ችግሮች ለማወቅ ነዉ፡፡

❖ የቃል ትርጓሜ

በዚህ መጠይቅ ውስጥ ጐልማሳ ደንበኛ ማለት የራሳቸውን ኑሮ ለመምራት ትዳር የመሰረቱ እንዲሁም የቤተሰብ ኃላፊነት ያለባቸውንና ወደ ኤች.አይ.ቪ የበጐ ፈቃድ ደም ምርመራ ተቋም መጥተው በመመርመር ቫይረሱ በደማቸው መኖሩን ያወቁ ደንበኞችን ነው፡፡

❖ መመሪያ

መጠይቁ በሶስት ዋና ዋና ክፍሎች የተከፈለ ነው፡፡

የመጀመሪያው ክፍል የካውንስለሩን ማንነት ለመገንዘብ የሚረዳ መረጃ ሲሆን ሁለተኛ ውና ሶስተኛው ክፍል ደግሞ የጐልማሳ ደንበኞችን አካላዊ፣ አዕምሯዊና፣ ሥነ ልቦናዊ እድገታዊ ለውጥ በካውንስሊንግ ሂደቱ እንዴት እንደሚስተናገድ ለማወቅ ይጠቅማል፡፡

ትክክለኛውን መረጃ በመጠይቁ መሠረት በትዕግስት በመሙላት ለሚያደርጉልኝ ቀና ትብብር በድጋሚ አመሰግናለሁ፡፡

I. ግላዊ መረጃ

1. እድሜ ____________
2. ፆታ ____________
3. የትምህርት ደረጃ ____________
4. የተማሩት ትምህርት ____________
5. ከዚህ ቀደም ተሰማርተዉበት የነበረ ሙያ ____________
6. የኤች.አይ.ቪ/ኤድስ ካውንስለር ለመሆን የወሰዱት ሥልጠና ነበር? ________
7. ካለ ለምን ያህል ጊዜ ሰለጠኑ? ____________
8. በአሁን ሰዓት ከኤች.አይ.ቪ./ኤድስ ካውንስለርነት በተጨማሪ የሚሰሩት ስራ አለ? ___
9. ካለ የስራዉ አይነት ይገለፅ ____________
10. በቀን በግምት ለምን ያህል ሰዉ የካውንስሊንግ አገልግሎት ይሰጣሉ? ________
11. የካዉንስሊንግ አገልግሎት ከጀመሩ አንስቶ እስካሁን በግምት ለምን ያህል ሰዉ የካዉንስሊንግ አገልግሎት ሰጥተዋል? ________
12. ለወደፊቱ የኤች.አይ.ቪ./ኤድስ ካውንስለርነት የተለየ ሥራ ቢያገኙ ሥራዎን ይለውጣሉ? ________
13. ለምን ____________
14. ከአሁን በኋላ በኤ.ች.አይ.ቪ./ኤድስ ካውንስለርነት በግምት ለስንት ዓመታት አገለግላለሁ ብለው ይገምታሉ? ____________
15. ለምን? ____________

II. አካላዊ የእድገት ለውጦች በተመለከተ

16. እርስዎ ዘንድ የካውንስሊንግ አገልግሎት ለማግኘት በሚመጡ ወጣቶችና ጎልማሶች መካከል በዕድሜ እና በዕድገት ምክንያት የሚመጡ የተገነዘቧቸዉ አካላዊ ልዩነቶች አሉ?

16.1 አሉ ☐ የሉም ☐

16.2 ካሉ ምንድናቸው?

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16.3 እነኚህ ልዩነቶች ለኤ.አይ.ቪ./ኤድስ የካውንስሊንግ አገልግሎት ምን ዓይነት ጠቀሜታዎች ይኖራቸዋል ብለዉ ይገምታሉ?

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16.4 እርስዎ እነዚህን አካላዊ ልዩነቶች ግምት ውስጥ በማስገባት ለጎልማሳ ደንበኞች ያደረጉት ወይም ያላደረጉት የካውንስሊንግ ድጋፍ አለ? ምንድን ናቸው?

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16.5 ይህን ድጋፍ በማድረግዎ ወይንም ባለማድረግዎ በምክር አገልግሎቱ ላይ ያመጣው ለውጥ አለ? ካለ ምንድነው?

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16.6 ለውጥ ካላመጡ ለምን አላመጡም?

16.7 ለወደፊቱ ለውጥ ለማምጣት ምን መደረግ አለበት ይላሉ?

17. አመጋገብንና የአመጋገብ ሥርዓትን በተመለከተ ከቫይረሱ ጋር የሚኖሩ ጐልማሶች የሚታዩባቸው ችግሮች አሉ?

17.1 አሉ ☐ የሉም ☐

17.2 ካሉ ምንድናቸው?

17.3 እነኚህን አመጋገብንና የአመጋገብ ችግሮችን መገንዘብ ለኤች.አይ.ቪ. ኤድስ የካውንስሊንግ አገልግሎት ምን አይነት ጠቀሜታ ይኖራቸዋል ብለው ይገምታሉ?

17.4 እርስዎ ይህን የአመጋገብ ችግር ግምት ውስጥ በማስገባት ያደረጓቸው ወይንም ያላደረጓቸው ድጋፎች አሉ?

17.5 ይህን ድጋፍ በማድረግዎ ወይም ባለማድረግዎ በምክር አገልግሎቱ ላይ ያመጣው ለውጥ አለ? ምንድናቸው?

17.6 ድጋፎቹ ለውጥ ካላመጡ ለምን እንደሆነ ይግለጹ?

17.7 ለወደፊቱስ አመጋገብንና የአመጋገብ ችግሮችን በተመለከተ ለውጥ ለማምጣት ምን መደረግ አለት ይላሉ?

18. ወደርስዎ የሚመጡ ከቫይረሱ ጋር የሚኖሩ በተለይም የአእምሮ ሥራ የሚሰሩ ጉልማሶች በአካል ብቃት እንቅስቃሴ (ማለትም በስፖርታዊ እንቅስቃሴ) የመሳተፍ ሁኔታ ምን ይመስላል?

18.1 በተለይ የአዕምሮ ስራ ለሚሰሩ ጎልማሶች ስፖርታዊ ሁኔታን በተመለከተ ታቅዶ የሚሰጥ የካውንስሊንግ አገልግሎት ምን ይመስላል?

18.2 እርስዎ ይህን የአካል ብቃት እንቅስቃሴ በአግባቡ ያለማድረግ ችግር ግምት ውስጥ በማግባት ያደረጉት ወይም ያላደረጉት የካውንስሊንግ ድጋፎች አሉ? ምንድናቸው?

18.3 ይህን ድጋፍ በማድረግዎ ወይም ባለማድረግዎ በካውንስሊንግ አገልግሎቱ ላይ ያመጣው ለውጥ አለ? ምንድነው?

18.4 ድጋፎቹ ለውጥ ካላመጡ ለምን አላመጡም?

18.5 ለወደፊቱስ ለውጥ ለማምጣት ምን መደረግ አለበት ይላሉ?

19. ወደእርስዎ ከሚመጡና ከቫይረሱ ጋር የሚኖሩ ጐልማሶች በብዛት የሚታዩባቸው አደገኛ ና ሱሶችና አደንዛዥ ዕፆች ካሉ፡-

19.1 ምንድናቸው?

19.2 የጐልማሳዎቹ ለአደገኛ ሱሶችና ለአደንዛዥ ዕፅ መጋለጣቸው በምክር አገልግሎቱ ላይ የሚያመጧቸው ተፅዕኖዎች ምንድናቸው?

19.3 እርስዎ ይህን ለአደገኛ ሱሶችና ለአደንዛዥ እፆች መጋለጥን ግምት ውስጥ በማስገባት ያደረጉት ወይም ያላደረጓቸው ድጋፎች አሉ?

19.4 እነኚህን ድጋፎች በማድረግዎ ወይም ባለማድረግዎ በምክር አገልግሎቱ ላይ ያመጡት ለውጦች ካሉ ምንድናቸው?

19.5 ለውጥ ካላመጡ ለምን አላመጡም?

19.6 ለወደፊቱስ ለውጥ ለማምጣት ምን መደረግ አለበት ይላሉ?

20. ወደእርስዎ ለካውንስሊንግ አገልግሎት የሚመጡ ጎልማሶችን የስራ ብዛት ወይም ክብደት በተመለከተ:-

20.1 ቫይረሱ በደማቸው ውስጥ መኖሩን ካወቁ በኋላ ምን አይነት ለውጦች ያደርጋሉ?

20.2 በካውንስሊንግ አገልግሎቱ በስራ ብዛት ወይም ክብደት ጋር በተያያዘ ጎልማሳ ደንበኞች ምን አይነት ለውጥ እንዲያመጡ ነው የሚጠበቀው?

20.3 ይህ ለውጥ እንዲመጣ በካውንስሊንግ አገልግሎቱ ለጎልማሳ ደንበኞች ምን አይነት ድጋፍ ነው የሚሰጠው?

20.4 ወደእርስዎ የሚመጡ ጎልማሶችን የስራ ብዛት ወይም ክብደት በተመለከተ እስካሁን ያደረጉት ወይንም ያላደረጉት ድጋፎች አሉ?

20.5 ካሉ ድጋፎቹ ምን አይነት ለውጦችን አስከተሉ?

20.6 ያደረጓቸው ድጋፎች ለውጥ ካላመጡ ለምን አላመጡም?

20.7 ወደፊትስ የጎልማሳ ደንበኞችን የስራ ብዛት ወይም ክብደትን በተመለከተ አይነተኛ ለውጥ ለማምጣት ምን መደረግ አለበት ይላሉ?

21 ወደ ካውንስሊንግ አገልግሎት የሚመጣ አንድ ጎልማሳ ስለሚኖሩት የቅርብ እንዲሁም ጠቃሚ ግለሰቦች፣ መወጣት ስለሚጠበቅበት ሃላፊነትና ማህበራዊ ትስስሩን በተመለከተ፡-

21.1 ለማወቅ የሚደረገው ሙከራ ምን እንደሚመስል ቢገልፁልን

21.2 ጎልማሶቹ

22 አንድ ውንስለር ወደ ምክር አገልግሎቱ ተቋም ወጥቶ ድጋፍ ከማያገኝና ከቫይረሱ ጋር ለማኖር አንድ ጉልማሳ ደንበኛው የቅርብ ሰዎች የሚያደርገው ሌላ ተጨማሪ የምክር አገልግሎት አለ?

ሀ. አለ ☐ የለም☐

ለ. ካለ ለማን ለማን እንደማሰጥ ይገለጽ?

ሐ. ከሌላ ያልተሰጠበት ምክንያት ይገለጽ?

መ. ከቫይረሱ ጋር ለሚኖሩ ጐልማሳ የቅርብና ጠቃሚ ሰዎች ተጨማሪ አገልግሎት አለመስጠት በካውንስሊንግ ሂደቱ ላይ ምን አይነት ተጽእኖ ያስከትላል?

መ. እርስዎ በበኩልዎ ከቫይረሱ ጋር የሚኖሩ ጐልማሳ ደንበኛዎ የቅርብ ሰዎች ያደጉት ድጋፍ አለ? ካለ ይገለጽ?

ሠ. እነኚህን ድጋፍ በማድረግዎ ወይም ባለማድረግዎ በካውንስሊንግ ሂደቱ ላይ ምን አይነት ለውጦችን አስከተለ?

ረ. የእርስዎ ድጋፍ ለውጥ ካላስከተለ ምክንያቶቹ ምንድናቸው?

ሰ. ወደፊትስ ይህን ለውጥ ለማምጣት ምንአይነት እርምጃዎች ሊወስዱ ይገባል?

4. ከቫይረሱ ጋር አብረው ለሚኖሩ ሴትና ወንድ ጉልማሶች መካከል የሚደረግ የምክር አገልግሎት የተለያየ መሆን አለበት?

ሀ. የለበትም ☐ አለበት ☐

ለ. ካለበት የልዩነቶቹ አይነት ይገለጽ?

ሐ. ከሌለበት ያልኖረበት ምክንያት ይገለጽ?

መ. ለወንዶችና ለሴቶች ጉልማሶች የሚደረግ የምክር አገልግሎት አለመለያየት ወይም መለያየት በካውንስሊንግ ሂደቱ ላይ ምን አይነት ተጽእኖ ያሣድራል?

ሠ. ለወንዶችና ለሴቶች ጉልማሳ ደንበኞችዎ መካከል የተለያየ የምክር አገልግሎት በመስጠት ያደረጉት ወይም ያላደረጉት ድጋፍ አለ?

ረ. ይህን ድጋፍ በማድረግዎ የታየ ለውጥ አለ? ምንድናቸው?

ሰ. ለውጥ ካልታየ ለምን ለውጥ ያልታዩባቸው ምክንያቶች?

ሸ. ወደፊትስ ለውጥ ለማምጣት ምንመደረግ አለበት ይላሉ?

5. ወደምክር አገልግሎት የሚመጡ ጉልማሶች በቫይረሱ ምክንያት ከራሳቸውና ከገበያቸው ምክንያት ባብዛኛው የሚገቡባቸው ችግሮችና ጭንቀቶች፡፡

ሀ. ምን ምንድናቸው

ለ. እነኚህ ችግሮችና ጭንቀቶች መኖራቸው በምክር አገልግሎቱ ላይ ምን አይነት ተጽዕኖ ያሣድራሉ?

ሐ. እነኚህ ችግሮችና ጭንቀቶችን ለመቀነስ በበኩልዎ ምን አነት ድጋፍ አድርገዋል?

መ. እነኚህን ችግርዎች ለመቀነስ ባደረጉት ወይም ባላደረጉት ድጋፍ ምክንያት ምን አይነት ለውጦች ታዩ?

ሠ. ለውጦች ካልታዩ ምክንያታቸው ምንድነው?

ረ. እነኚህን ችግሮች ለመቅረፍና ለውጥ ለማምጣት ወደፊትስ ምን መደግ አለበት?

6. ከቫይረሱ ጋር የሚኖሩ ጉልማሶች በአብዛኛው የሚከሰቱ የአድልዎና የመገለል ችግሮች፡፡
ሀ. ምን ምንድናቸው?

ለ. እነኚህ ችግሮች በምክር አገልግሎት ላይ ምን አይነት ተፅእኖ ያሳያል?

ሐ. እርስዎ በበኩልዎ እነኚህን የአድልዎና የመገለል ችግሮች ለመቅረፍ ያደረጉት ወይም ያላደረጉት ድጋፎች ምንድናቸው?

መ. እነኚህን ድጋፎች በማድረግዎ ወይም ባለማድረግዎ በምክር አገልግሎቱ ላይ ምን አይነት ለውጦችን አመጣ?

ሠ. በምክር አገልግሎቱ ላ ለውጥ ካላመጣ ምክንያቶቹ ምንድናቸው?

ረ. ወደፊትስ እነኚህን ችግሮች ለመቅረፍና ለወጥ ለማምጣት ምም መደረግ አለበት?

7. ከቫይረሱ ጋር ለሚኖሩ ጎልማሶች የሚሰጥ የኤች.አይ.ቪ. ኤድስ የምክር አገልግሎት /Type of Counseling/?

ሀ. የካረንስሊንግ አይነት /Type of Counseling/ ምን አይነት መሆን አለበት?

ለ. ከቫይረሱ ጋር ለሚኖሩ ጎልማሶች የሚሰጠው አገልግሎት ምን ያህል ጊዜ መውሰድ አለበት?

ሐ. እርስዎ ከቫይረሱ ጋር ለሚኖሩ ጎልማሳ የሰጡት ፈጅም የምክር አገልግሎት አማካይ ጊዜ

መ. የሰጡት አጭሩ የምክር አገልግሎትና ጊዜ በአማካይ?

ሠ. ከቫረሱ ጋር ለሚኖሩ ጎልማሶች የሚሰጠው የምክ አገልግሎቶችና (Type of Counseling) የጊዜ መጠን ላይ የሚታዩ አባይት ችግሮች ምንድናቸው?

ረ. በግልዎ ይህን ችግር ለመቅረፍ የወሰዷቸው ወይም ያልወሰዷቸው እርምጃዎች ሳሉ?

ሰ. የወሰዷቸው ወይም ያልወሰዷቸው እርምጃዎች በምክር አገልግሎቱ ላይ ምን አይነት ለውጦች አስከተሉ?

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ሸ. ያስከተሉት ለውጥ ከሌለ ምክንያት ይግለፁ

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ቀ. ወደፊትስ አይነተኛ ለውጥ ለማምጣት ምን አይነት የምክር አገልግሎት ሂደትና ለአንድ ጎልማሳ የሚሰጥ ድጋፍ ጊዜ ምን መምሰልና መሆን አለበት?

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Translation of the Questionnaire

Questionnaire for HIV counselors who provide counseling services in VCT centers

1.6. Introduction

The purpose of this questionnaire is to collect information about HIV counseling.

The objective of the study is to assess HIV counselors' understanding of the developmental needs, concerns and problems of their adult clients, and to understand their counseling provision techniques and their major problems during their attempt to provide the services in the counseling services.

1.7. Terminology

The word 'adults' in this study refers to those who visited the selected VCT centers of Addis Ababa and were provided with HIV counseling services from the centers.

More specifically, it refers to those clients, who have families, earn their own income and shoulder different personal and social responsibilities.

1.8. Instructions

The questionnaire is divided into two parts.

The first part contains questions used to gather information that would help to understand the personal information of the respondents. The second part is targeted at assessing the respondents' understanding of the physical, cognitive and psychological developmental changes of adult clients in the counseling process.

I would like to thank you in advance for your cooperation and patience in filling out your responses for the questions.

I. Personal Information

1. Age
2. Sex
3. Educational Level
4. Specialization
5. Work experience before the HIV counseling service
6. Have you been given any training to be a counselor?
    7. If you were trained, for how long?
8. Do you have additional job(s) other than the counseling service?
    9. If you have, please mention:
10. What is your rough estimate for the average number of your counseling clients per day?
11. Your rough estimate for the total number of individuals you have provided counseling since you started working as a counselor:
12. Do you plan to switch jobs if you get the opportunity (quit working as a counselor)?
    13. Why?
14. For how long do you expect to stay in the counseling job?
    15. Why?

II. About Counseling Services

16. Have you observed any physical differences that occur due to age and development between your adolescent and adult clients?

    16.1 Yes ☐ No ☐

    16.2 If your answer is yes, what were they?

    16.3 What implications do these differences have on the counseling process?

    16.4 Have you provided any assistance to your clients taking these differences in to consideration? Please mention.

    16.5 Did providing / not providing these assistances bring any change on the counseling service? What were the changes?

    16.6 If no changes were acquired, why not?

    16.7 What is your recommendation to improve the counseling service regarding this point?

17. Are there any problems of adult clients that are usually observed regarding nutrition and their eating habits?

    17.1 Yes ☐ No ☐

    17.2 If your answer is yes, what were they?

    17.3 What implications do these problems have on the counseling process?

    17.4 Have you provided any assistance to your clients taking these problems in to consideration? Please mention.

    17.5 Did providing / not providing these assistances bring any change on the counseling service? What were the changes?

17.7 What is your recommendation to improve the counseling service regarding this point?

18. How do you describe your clients', especially those who have non-physical (office) jobs, participation in sports and physical exercise?

18.1 Have you provided any assistance to your clients taking this in to consideration? Please mention.

18.2 Did providing / not providing these assistances bring any change on the counseling service? What were the changes?

18.3 If no changes were acquired, why not?

18.4 What is your recommendation to improve the counseling service regarding this point?

19. About substance and drug abuses: If there are commonly observed substances and drugs used by your clients

19.1 What are they?

19.2 Its implication on the counseling service

19.3 Have you provided any assistance to your clients taking this in to consideration? Please mention.

19.4 Did providing / not providing these assistances bring any change on the counseling service? What were the changes?

19.5 If no changes were acquired, why not?

19.6 What is your recommendation to improve the counseling service regarding this point?

20. About the workloads of your adult clients:

20.1 Did the clients have made attempts to change their workloads after they found out they were HIV positive?

20.2 What kind of change is expected from clients by the counseling service considering their workloads?

20.3 What assistance is provided by the counseling service to bring about the desired result?

20.4 Have you provided any assistance to your clients taking this in to consideration? Please mention.

20.5 What changes did your assistances bring?

20.6 If no changes were acquired, why not?

20.7 What is your recommendation to improve the counseling service regarding this point?

21. Is there an additional counseling service provision for people close to an counseling client such as family, relatives, friends, colleagues, etc.?

21.1 Yes ☐ No ☐

21.2 If your answer is yes, what were they?

21.3 If no, why not?

21.4 How did the absence of such a provision affect the counseling process?

21.5 Have you personally given any assistance for people close to your clients? If you have, please describe.

21.6 What effects did your providing these assistances have on the lives of your clients?

21.7 If your assistances were ineffective, why not?

21.8 What is your recommendation to improve the counseling service regarding this point?

22. About the most common financial income related worries & problems faced by adult clients

22.1 What are they?

22.2 What assistances are provided by the counseling service in this regard (in alleviating such worries and problems)?

22.3 What personal assistances have you made in this regard?

22.4 What change(s) did your personal assistances bring?

22.5 If the assistances were ineffective, why not?

22.6 What is your recommendation to improve the counseling service in the future in this regard?

23. About techniques (methods) used by adult clients to get help from other people when they are faced with problems caused by the HIV virus

23.1 What techniques are frequently used by your clients?

23.2 Does the counseling service suggest such methods? If it does, what are they?

23.3 If such methods do not exist, how did it affect your counseling service?

23.4 What is your recommendation in this regard?

24. About unaccomplished targets and / or plans, due to the HIV virus, of adult clients

24.1 How much is this the cause for their worries?

24.2 What counseling provisions are there in this regard?

24.3 What changes were brought about by these provisions?

24.4 If the provisions were ineffective, why not?

24.5 What is your recommendation for the future in this regard?

25. About the responsibilities of adult clients related to raising children and family care

25.1 What problems are your clients commonly faced with in this regard?

25.2 What assistance do clients get from the counseling service on as to how to pass these responsibilities to relatives and / or people close to them?

25.3 If the assistances were ineffective, why not?

25.4 What is your recommendation for the future to effectively solve such responsibility related problems?