ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

CLIENTS' PERCEPTION OF VOLUNTARY COUNSELING AND TESTING SERVICES THE CASE OF ARADA SUB CITY, Addis Ababa

BY

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JULY 2007

CLIENTS' PERCEPTION OF VOLUNTARY COUNSELING AND TESTING SERVICES: THE CASE OF ARADA SUBCITY, Addis Ababa

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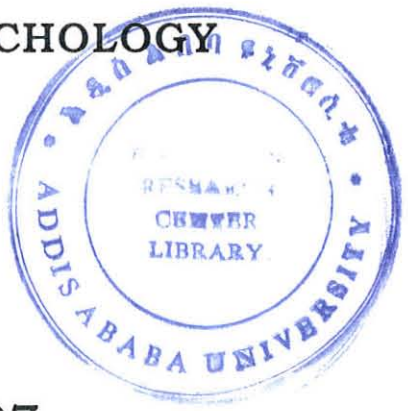
A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES
ADDIS ABABA UNIVERSITY
IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF ARTS IN COUNSELING PSYCHOLOGY



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ACKNOWLEDGEMENTS

First and foremost, I would like to thank the Almighty who pave the way and who did everything for me.

Special thanks are due to Dr. Yusuf O. Abdi, my thesis advisor, for his painstaking and unreserved efforts, continued interest and valuable suggestions. His critical and insightful comments were extremely important and helpful.

My sincere thanks also goes to Teshwal Ashagre who has been with me in time of need; be it financial help, professional support or brotherly advice.

I am also indebted to thank my best friends Tesfish, John, and Aman and Yaredo for their keen encouragement, which was a great moral support for my success. Hareg, Mesi and Yared too be thanked for their help in typing and editing this research paper.

I would like to thank Tropical College of Medicine (especially Ato Afework Ghiley, Academic Vice President) and Wogen AIDS Talk Line for their contribution for the fruitfulness of the research.

Last but not least, I thank all my family members who have been investing a lot on me. Without their support, everything would have been unthinkable.

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LIST OF ACRONYMS

AAU	Addis Ababa University
A-B-C	Abstinence-Be Faithful-Use of Condom
AIDS	Acquired Immuno Deficiency Syndrome
ARV	Antiretroviral
CAPS	Center for AIDS Prevention Studies
CDC	Center for Disease Control and Prevention
CSA	Central Statistics Authority
DPCD	Disease Prevention and Control Department
EDHS	Ethiopia Demographic and Health Survey
FDRE	Federal Democratic Republic of Ethiopia
EPP	Estimation and Projection Package
FHI	Family Health International
FWG	Family Welfare Government
HIV	Human Immune Virus
IEC	Information, Education and Communication
MOH	Ministry of Health
NACO	National AIDS Control Organizations
NACP	National AIDS Control Program
NPIN	National Prevention Information Network
OSSA	Organization of Social Service for AIDS
PCR	Polymerize Chain Reaction
PLWHA	People Living With HIV/AIDS
PRB	Population Reference Bureau
HAPCO	HIV/AIDS Prevention and Control Office
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Program on AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ABSTRACT

Voluntary Counseling and Testing (VCT) is a valuable component of a comprehensive HIV/AIDS prevention program and an effective method of changing behavior. As there is no cure for HIV/AIDS, VCT remains a key strategy to control the spread of HIV and to provide support to those who are positive. However, very little work has been done to improve the availability and quality of the service. Moreover, although many people in Ethiopia do not know they are infected, up to now only a small percentage of those with HIV/AIDS have had access to reliable Voluntary Counseling and Testing services. This research is done to assess clients' perception of VCT services, to explore clients' perceptions regarding VCT services attendance, to identify clients' expectations of VCT services, to assess barriers to VCT service, to assess the structure, resourcefulness and adequacy of the information given in VCT services compared to clients' needs and to suggest adequate intervention mechanisms to change the perception of clients. A cross sectional survey was carried out using a questionnaire adopted from UNAIDS. The study was conducted in Arada Sub City, Addis Ababa from March to April 2007. All the VCT centers found in the sub city, both governmental and private were included in the study. There were 19 VCT centers (7 governmental and 12 private) in the sub city. Using Purposive Random Sampling Technique, 10 from each VCT center and a total of 190 clients were selected and participated in the study. The analysis from the data revealed that most of the clients have positive attitude towards the counseling service. In most VCT centers, there is adequate space for privacy, but inadequate waiting area was common for most of them. Shortage of time allotted for the counseling sessions, and lack of follow up arrangement and inadequate referral system were the other common problems that clients were facing during their VCT service attendance. The study has suggested ways of improving the services: There should be adequate waiting area; A referral system, data base and networking system must be urgently established; Counseling sessions need to be monitored that they are of adequate enough; Efforts must be done to ensure affordable access to VCT services in public and private settings; As well as making people aware of the importance of VCT is important in increasing the number of people seeking VCT and in turn is crucial for controlling the spread of HIV/AIDS.

CHAPTER ONE

INTRODUCTION

1.1. Background of the Problem

HIV/AIDS became a major public health problem in nowadays. UNAIDS and WHO have estimated that more than 40 million people in the world were living with HIV/AIDS at the end of 2003 (WHO. 2004). Sub-Saharan Africa is the region with the highest burden, constituting almost 70% of people living with HIV/AIDS worldwide (UNAIDS, 2003).

Ethiopia is one of the countries most affected in the region with HIV/AIDS. HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986. A National HIV/AIDS taskforce was established in 1985 and the National AIDS Control Program (NACP) was established at a Department level at the MOH in 1987. HIV/AIDS surveillance activities began in 1989 (Gonder University, 2001.)

Although the prevalence of HIV was very low in Ethiopia in the early 1980s, in recent years the number of people infected with the virus has been increasing rapidly (Gonder University, 2001.)

The overall HIV incidence estimate for Ethiopia in 2005 was estimated at 0.26% and is projected to remain stable until 2010. In 2005, it was estimated that a total of 1,320,000 people were living with HIV/AIDS. Of the total, 634,000 were living in rural areas and 686,000 in urban areas. In the age group 15-29 years, there were more women living with HIV/AIDS than men; in the 30+ years age group, there were more men living with HIV/AIDS than women (CSA. 2000 and 2005 Reports.)

HIV/AIDS has had a detrimental socio-economic impact on Ethiopia. Findings from the ANC-based surveillance and studies conducted at schools, workplaces, and among orphans all indicate similar results. Some of the key impact analysis from the 2005 ANC-based surveillance are: impact on the annual numbers of TB cases, total population size, young adult (15-49 years) deaths, life expectancy, potential impacts of art on HIV prevalence, on aids deaths, on aids orphans etc.(PRB, 2000.)

Moreover, HIV/AIDS is a devastating illness for both the individual and their families. Ultimately the consequences of the disease extend beyond the family and local community. There is a direct, negative impact on the health and economic status of the whole country as well as on the costs of providing healthcare to infected individuals. For a country still developing and in greater need of a healthy workforce to generate the economy, the impact of HIV/AIDS is overwhelming (Gonder University, 2001.)

Approximately 91% of reported AIDS clients are between 15 and 49 years of age. Their deaths from AIDS have a significant adverse impact on the economic productivity of the nation and on the development of their children who are orphaned (Gonder University, 2001).

In Ethiopia, the overall health sector response to HIV/AIDS has been limited, both geographically and by programme. VCT facilities have been operationalized by NGOs in partnership with local health services, although not all provide antiretroviral therapy. The availability of antiretroviral therapy is still limited to a few pilot sites (WHO, 2004, Remane N, Zilhão I.)

To reduce the growth and size of HIV/AIDS epidemics at population level, prevention efforts must be effective. As stated by the WHO report (WHO,

2004), an effective Voluntary Counseling and Testing Services (VCT) program should begin with raising a community awareness on the benefits of the testing and counseling, both in preventing the spread of the infection and meeting the need for care and support in that community. Recent studies indicate that overall coverage of testing and counseling is extremely poor in countries with highest HIV/AIDS burden. Worldwide, only 5% of people with HIV/AIDS are estimated to be aware of their status (WHO, 2004.)

Therefore, access to testing and counseling is the key for successfully implementing antiretroviral therapy and avoiding re-infection and transmission by behavioral changes. However, HIV VCT is not available in most regions in Africa. There are few studies describing barriers to HIV testing in sub-Saharan Africa (WHO, 2004) which are particularly related to disclosure of HIV/AIDS status to sexual partners, fears of VCT attendance due to stigma and discrimination.

In Ethiopia, the concept and tradition of "modern" counseling service is fairly young, and the offering of counseling service in Ethiopia is limited mainly to the following settings: higher institutes, secondary schools, youth centers, family guidance associations of Ethiopia, counseling centers of HIV/AIDS and other settings, such as rehabilitation centers and orphanage (Yusuf, 1996.)

Concerning the access of VCT service in Ethiopia, Yusuf (2004) further stated that though HIV counseling is a basic instrument in behavioral change, prevention and control of the spread of HIV/AIDS, it is the most neglected and least developed in Ethiopia. And yet there is a great need for counseling service in Ethiopia.

1.2. Statement of the Problem

HIV voluntary counseling and testing (VCT) is now an integral part of HIV care and control programs. However, very little work has been done to assess the quality of VCT services. Few studies have been systematically conducted on VCT issues in Ethiopia. Most of the reported studies are based on evaluation of program interventions, which concentrated on youth in the main city of Addis Ababa.

Studies may be extended to actual and potential users of VCT services. Monitoring the quality of counseling may not only report the attendance, coverage and return rates of clients. Although good quality of service is reflected by clients' attendance, it is also important to ensure that effective counseling strategies have been provided. Perception of personal susceptibility to HIV/AIDS infection is the main factor motivating clients to overcome barriers for seeking VCT.

Though the HIV pandemic is devastating, it is possible to manage the HIV epidemic. One form of management is through the use of counselling. Sweat M., et al. (2000) states that voluntary counselling and testing (VCT) can elicit sustained behaviour change, prevent mother to child transmission of HIV, and act as a powerful prevention, support, and care mechanism. As such, it would be important to examine the factors that may have impacts on the counselling process and outcome. In order to gain an understanding of these factors, it would be essential to know the experiences and perceptions of clients.

Based on the above rationale, the present study was undertaken to assess clients' perception of the counseling services offered in VCT centers in the selected area.

BASIC Research Questions:

More specifically, the study aims at answering the following research questions:

1. Do clients' perception affect VCT service attendance?
2. What are the possible expectations of clients regarding VCT services?
3. What are the major barriers affecting VCT services attendance?
4. To what extent is the VCT center structured, resourceful and informative (give adequate information)?

1.3 Objectives of the Study

General Objective:

The general objective of the research is to assess clients' perception towards voluntary counseling and testing service-the case of Arada Sub City, Addis Ababa.

Specific Objectives:

1. to explore the clients' perception and attitude regarding VCT services attendance
2. to identify clients' expectations of VCT services
3. to assess barriers to VCT service
4. to assess the structure, resourcefulness and adequacy of the information given in VCT services compared to clients' needs
5. to suggest adequate intervention mechanisms to change the perception of clients

1.4 Significance of the Study

The researcher hopes that this study is important for the following reasons:

- It addresses clients' perceptions of VCT to improve their satisfaction and health outcomes, and help a continued and sustained use of services.
- Dissemination of the results will inform for programs and policy development on STD, HIV/AIDS and sexuality, to support decision-making to improve the coverage and quality of VCT services.
- The outcomes will contribute to the development of relevant messages on HIV/AIDS prevention.
- It gives a hint or provides information for counselors on how to treat clients seeking VCT and to enhance their interest on the area.
- There are only few or no research papers done on the relationship between clients' perception and VCT service attendance in the context of our country (Ethiopia); therefore, the study may bridge this gap.

1.5 Delimitation of the Study

The study is delimited to be done in Addis Ababa due to time and financial constraints. The choice is based on the assumption that most VCT centers are found in Addis Ababa.

1.6 Operational Definition

Voluntary Counseling and Testing (VCT): for the purpose of this study is defined as the process by which an individual undergoes confidential counseling to learn about his/her HIV status and to exercise informed choices in testing for HIV followed by further appropriate action (MOH, 2002).

Pre-test Counseling: In VCT, pre-test counseling is a pre-requisite to all clients intending to know their status. This can be done as an individual, couple or group session. Pre-test counseling provides an opportunity for clients to explore their risk of HIV, to learn about strategies for prevention of HIV, and helps clients decide whether or not to take the HIV test (NACO/MOH and FWG of India. 2004).

Post-test Counseling: As the name indicates post-test counseling is offered after HIV test result is available and it should be always offered whether the result is positive or negative UNAIDS (2000b) and FDRE MOH (2002) suggest that the main goal of post test counseling session is to help client understand their test results and initiate adaptation to their serostatus.

Client: in this research client refers to a person seeking health care services including VCT.

Confidentiality: refers to the prevention of any reference to, or discussion about client or a test result.According to FDRE MOH (2003) trust is one of the most important factor in the relationship between counselor and clients.

Perception- in this research refers to how clients view VCT. Or, it is the process of interpreting sensory information from the receptor organs to produce an organized image of the environment (Morgan, 1986).

CHAPTER TWO

REVIEW OF RELATED LITERATURES

2.1 The Concept of Counseling

By definition, "counseling" assumes a helping relationship in which a client, having identified a problem or concern, seeks the help of a mental health professional (Ndyanabangi, et al. 2004.)

Different scholars have described the word counseling. According to McLead (1993) counseling denotes a professional relationship between a trained counselor and clients. The relationship is usually person-to-person, although it may sometimes involve more than two people. Generally the relationship is designed to help clients to understand and clarify their view, and learn to reach their self-determined goal through meaningful, well informed choice and through resolution of problems of an emotional or interpersonal nature.

While Edwin defined counseling by explaining what it means and what it includes, Patterson defined it by exclusion or designating what counseling is not. Hence, Edwin, as cited in Shertzer and Stone (1980) defined counseling as "a process by which a client is helped to feel and behave in a more personally satisfying manner through interaction with the counselor, who provides information and reaction which stimulate the client to develop behavior which enable the client to deal more effectively with him/her self and his/her environment" (Shertzer and Stone, 1980).

On the other hand, according to Patterson as cited in Shertzer and Stone, 1980 counseling **is not**:-

a. Giving information, though information may be given in counseling
b. Giving advice, suggestion or recommendation

c. Influencing attitudes, beliefs, or behavior by means of persuading, leading, or convincing, no matter how indirectly, subtly, or painlessly.
d. Influencing, behavior by admonishing, warning, threatening or compelling without the use of physical force or coercion.
e. Selection and assignment of individuals for various jobs or activities.
f. Interviewing, while interviewing is involved.

Therefore based on the above points one can realize that no one has the right to tell clients what is best for them. So the client has to decide what is good for him/her. Generally from the above discussion it is clear that what is counseling is not. On the other hand one should briefly understand the nature of counseling or what counseling is.

Patterson further elaborated the nature of counseling as follows:

1. Counseling is concerned with influencing voluntary change of behavior on the part of client.
2. The purpose is to provide (individual right to make choice) conditions that facilitate voluntary behavior change.
3. As in all relationship limits are imposed on counselee.
4. Conditions facilitating behavioral change are provided through interview.
5. Listening is present in counseling but not all counseling is listening.
6. The counselor understands clients qualitatively.
7. Counseling is conducted in privacy and discussion is confidential.

From the above discussion of different scholars, it is clear that counseling is an interaction and a process between a client and a counselor that take place in private, through confidential dialogue, through which counselees (clients) are helped to define goals, make

decisions, and solve problems related to personal, social, psychological, educational... concerns.

2.2 Voluntary Counseling and Testing

Voluntary Counseling and Testing (VCT) is the process by which an individual undergoes confidential counseling to learn about his/her HIV status and to exercise informed choices in testing for HIV followed by further appropriate action. A key underlying principle of the VCT intervention is the voluntary participation. HIV counseling and testing are initiated by the client's free will (MOH, 2002).

Voluntary Counseling and Testing is considered as a gateway to prevention and treatment, an essential tool in the control of HIV/AIDS epidemic (WHO. 2004).

On the other hand, HIV testing and counseling is defined as a a direct, personalized and person-centered intervention, tailored to prevent transmission and obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy (CDC. 1994.)

Counseling in the case of HIV testing was designed to help persons interpret the meaning of negative or positive antibody results, to initiate and sustain behavioral changes that reduce risk of becoming infected and to assist HIV positive individuals in avoiding infecting others (WHO. 2004, CDC. 1994.) VCT is also a critical component of preventive strategies to reduce transmission of HIV/AIDS from mother to child.

2.2.1 The Role of VCT

Voluntary counseling and testing (VCT) service are important and effective in HIV/AIDS prevention. It is a significant entry point to care and support. They enable uninfected people to remain so and enable those infected with HIV to plan for the future and prevent HIV transmission to others. Those who are infected can also benefit from available care (WHO, 2001.)

VCT is now acknowledged within the international arena as an effective and pivotal strategy for both HIV/AIDS prevention and care. Research conducted in Kenya, Tanzania and Trinidad by Family Health International (FHI) in collaboration with UNAIDS and WHO has provided strong evidence to support the theory that VCT is both effective and cost effective as a strategy for facilitating behavior change(FHI, 2003.)

According to MOH (2002), Voluntary Counseling and Testing has the following major functions:

1. to provide information on the mode of transmission and methods of prevention.
2. to help those who wish to consider HIV testing, make a decision about whether or not to be tested and to provide support following the testing.
3. to provide information on the increased risk of HIV transmission associated with sexually transmitted infections (STIs) and give referrals for STI examination and treatment.
4. to provide information on the increased risk of opportunistic infections including TB associated with HIV infection.
5. to provide family planning information and referrals for women of child bearing age who are infected or at high risk of HIV infection.

6. to provide referrals to HIV positive and high risk HIV negative persons for necessary medical, preventive and psych-social services and home based care in the community.

Moreover, Voluntary Counseling and Testing (VCT) provides for all segments of the population, an opportunity to access complete and accurate information on HIV/AIDS. This is a critical entry point to prevention, care, support and treatment for all people, and particularly for those already infected and affected. It enables a person to confidentially explore and understand his or her risk of HIV infection, provides an opportunity to fully comprehend the implications of one's sero status and to learn about precautions for protection and for preventing the further spread of HIV infection. VCT facilitates personal, and more informed decisions about HIV testing (NACO/MOH and FWG of India, 2004).

In the event of a positive HIV test result, counseling strengthens strategies for coping with the immediate stress, possible stigma, psychological and social impacts. It provides referrals to appropriate facilities for care, support and treatment and promotes more informed choices for the future (NACO/MOH and FWG of India, 2004).

VCT is known to be an effective intervention in combating the spread of HIV/AIDS. However, monitoring the quality of counseling remains a challenge for most VCT program; good quality of services is not only reflected by client attendance, but it is also important to ensure effective strategies that facilitate changes adoption (AMREF. AMREF report 2001.)

According to UNAIDS (2000b) VCT has been shown to have 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 serostatus in a confidential environment with counseling and referral for on going emotional support and medical care. People who have been tested seropositive can benefit from earlier appropriate medical care and interventions to treat and/or prevent HIV associated illnesses. Pregnant women who are aware of their seropositive status can help people to make decisions to protect themselves and other from infection.

Measure Evaluation (2003) described that people who have got VCT service shows some behavior change that should contribute to lower rates of HIV spread, and also VCT help in reducing stigma and encouraging community support and care for those affected. Furthermore, Measure Evaluation (2003) suggested that VCT services are an essential early entry point to social support services and medical and associated care. Similarly according WHO (2004) VCT service is the key entry point to prevention service in population at risk and to care and support for people living with HIV/AIDS. It also strengthens prevention efforts, encourages infected people to avoid on-going transmission to others, and motivates those who are uninfected to remain so through risk reduction strategies. Furthermore WHO (2004) indicate that VCT and lead to reduction in the number of sexual partner or increased condom use and fewer sexually transmitted infections.

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

2.2.2 What Makes HIV Counseling Unique

HIV counseling is a confidential dialogue between a person and a counselor aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS (UNAIDS 2000b). Similarly FDRE MOH (2002) defined HIV counseling as a confidential dialogue between the client and counselor aimed at creating an enabling environment for person to cope with stress and to make personal decisions related to HIV/AIDS.

VCT differs fundamentally from other counseling relationships in two respects (Creswell, J. W. 1997.) First, VCT counselors in the United States are provided minimal formal training and generally are not mental health professionals. Given the clinical context in which VCT often occurs, test counselors are mostly nurses, medical assistants, and paraprofessionals such as outreach workers and volunteers with little more than a few days of formal training in HIV prevention counseling (Richards, K. A. 2000). Second, the "counseling" relationship in VCT is not requested by the client but imposed unilaterally by state laws regulating the provision of HIV testing. Counseling is thus a condition for receiving the test. Because clients are primarily seeking the test result, not a counseling session, any discussion about risk with the counselor is experienced as an unpleasant but necessary requirement for getting the test.

HIV counseling is not a lecture. An important aspect of HIV counseling is the counselor's ability to listen to the client in order to provide assistance and to determine specific prevention needs. Although HIV counseling should adhere to minimal standards in terms of providing basic information, it should not become so routine that it is inflexible or unresponsive to particular client needs. Counselors should avoid

providing information that is irrelevant to their clients and should avoid structuring counseling sessions on the basis of a data-collection instrument or form (Moyo, S., et al, 2002, July).

As it is explained in a manual prepared by FHI, HIV counseling requires some of the basic counseling skills as other types of counseling. But HIV counseling differs from other types of counseling because of (FHI, 1999):-

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

Similarly FDRE MOH (2003) suggests that HIV/AIDS counseling is different or unique because of:-

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

2.3 HIV Counseling in Ethiopia

HIV/AIDS counseling is a recent phenomenon. According to FDRE MOH (2002), HIV counseling in Ethiopia began in the late 1980's. AIDS pandemic, because of its total outcome, create feeling of fear and resentment. Moral breakdown accompanied by ideas of guilt and punishment is initial response to the disease. Stigmatization, Ostracism, rejection and discrimination will exacerbate the already heavy stress the victim has developed (FDRE MOH, 1996). Many of these problems may be minimized or solved through counseling the infected and affected individuals.

Concerning the development of HIV Counseling in Ethiopia, Yusuf pointed out that though HIV counseling is a basic instrument in behavior change, prevention and control of the spread of HIV/AIDS, it is the most neglected and least developed in Ethiopia. And yet there is a great need for counseling service in Ethiopia (Yusuf, 2004).

2.4 Operational Aspects of VCT Service

2.4.1 Categories of VCT Centers

VCT service delivery has been implemented in diverse models, each with benefits and challenges. These are:

A. 'Free-Standing' VCT sites

Sometimes, VCT services are set up in a stand alone location, organized through NGOs in remote rural areas, in community centers and at youth clubs and colleges. These increase access for specific groups, but can also promote stigma and discrimination for those who access these services. For this reason, there is an overall preference for VCT services to be integrated within functioning ongoing health facilities (NACO/MOH and FWG of India. 2004.)

B. Mobile /Outreach VCT services

VCT services are provided through mobile vans, within the community. This model is used for very specific target groups that may otherwise not access health services, example tribal populations in remote hilly areas (NACO/MOH and FWG of India. 2004.)

2.4.2 Site of VCT Centers

According to NACO/MOH and FWG of India (2004), several variations on integration exist such as:

i. integrated within primary health care services, hospitals, and clinics;

ii. run by non-government entities, across the private sector by private physicians and the corporate sector for their employees / their dependents, or by NGOs either as stand alone facilities or integrated within a larger health facility;

iii. VCTs as part of a franchised network, usually outside of government, where service delivery could use techniques of social marketing;

iv. VCT sites attached to research projects.

2.4.2.1 Proxemics

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

Accoording to Yusuf (1998), a number of alternatives employed for the physical setting or arrangement within the office are suggested but the most effective seating arrangement is across the table.

In respect to distance between counselor and client, Shertzer and Stone (1980), suggest that people have a personal space within which they are comfortable in their interactions with another person. The same authors further describe that the comfortable space or distance between two persons has been ascribed to cultural background, the relationship between the two parties, the sex of the participants, and their relative status.

2.4.2.2 Waiting Area

UNAIDS (2000a) suggest that in VCT centers a well-ventilated waiting area is important. During their stay in the VCT centers, clients must feel as comfortable and relaxed as possible. It is best if there is a waiting room or area, so that clients have somewhere to sit, out of the public gaze.

2.4.2.3 Counseling Room

The counseling office should be easy to access and yet not in a busy place of any center where every passer-by knows that this is the counseling and testing for HIV.

According to CDC (1994), counseling rooms must be private to ensure confidentiality of the counseling session. Similarly, UNAIDS (2000a) suggest that VCT to be carried out correctly and effectively, privacy must be ensured. Discussion risk factors and sexual relations is part of VCT for HIV infection and key information essential to the process will not be 'elicited' unless people can discuss these issues in private.

Similarly, according to Shertzer and Stone (1980), the counseling room should be comfortable and attractive. Counseling facilities should be

designed for comfort and relaxation. Therefore, from the above discussion it is indicated that for effective counseling process private is required. In addition to this to facilitate the counseling relationship the counseling room should be comfortable and attractive.

2.4.3 Confidentiality

VCT services to be acceptable, confidentiality must be guaranteed. In view of this UNAIDS (2000a) stated that many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. HIV services should therefore, always preserve individual's need for confidentiality.

According to FDRE MOH (2003) trust is one of the most important factor in the relationship between counselor and clients. It enhances their relationships and improves the chances that the client will act decisively on the information. Similarly UNAIDS (2000b) suggest that trust between the counselor and client enhances adherence to care, and discussion of HIV prevention. Furthermore UNAIDS (2000b) stated that in circumstances where people who test seropositive may face discrimination, violence and abuse. Hence, it is important that confidentiality be guaranteed.

According to UNAIDS (2000a) if it is not known that confidentiality will be respected, the up-take of VCT will be low. Therefore, there must be a system to guarantee confidentiality. Baggaley, et al (1998) describe that in some settings it has been shown that people feel more comfortable about VCT services if they can give a pseudonym. Also FDRE MOH (2002) suggests that in VCT settings, HIV testing and counseling could be either anonymous or confidential.

The above discussion generally implies the fact that confidentiality should be strictly assured because it enhances the counseling relationship and improves the chances that client(s) will act decisively on the information provided.

2.4.4 Linkages or Referral

In the context of HIV prevention counseling and testing, referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with assistance in accessing services (CDS, 2001).

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

In regard, to this FDRE MOH (2002) suggests that the client and counselor together should assess and prioritize the clients' referral needs. Clients often require referral for medical and on-going psychosocial support. Hence a referral system should be developed in consultation with different government and non-government organizations. From the above discussion it is indicated that there should be a linkage between VCT centers and various organizations. Therefore a process for routine referral should be established, which results in the enhancement of VCT services.

2.5 Elements of VCT

According to FDRE MOH (2002) VCT is a process by which an individual voluntarily undergoes HIV/AIDS counseling and HIV Testing. Similarly FHI (2003) describe that the gold standard for VCT follows a regiment of pre-test counseling, testing (voluntarily) and post-test counseling. In short a look at the above points helps in understanding VCT as a process involving HIV counseling and testing.

2.5.1 The Counseling Process and Contents

UNAIDS (2000b) suggests that counseling as part of VCT ideally involves at least two sessions – pre-test and post-test counseling. Furthermore, UNAIDS (2000b) point out that more session can be offered before or after the test or during the time the client that more sessions can be offered before or after the test or during the time the client waiting for test results. Also according to FDRE MOH (2003) the counseling process of VCT services consists two sessions, pre test and post-test counseling. The above statements indicate that the counseling process in VCT involve at least pre-test and post-test counseling.

2.5.1.1 Pre-test Counseling

In VCT, pre-test counseling is a pre-requisite to all clients intending to know their status. This can be done as an individual, couple or group session. Pre-test counseling provides an opportunity for clients to explore their risk of HIV, to learn about strategies for prevention of HIV, and helps clients decide whether or not to take the HIV test. Counseling must be offered to any client who is considering taking an HIV test (NACO/MOH and FWG of India. 2004).

According to MOH and FWG of India (2004), Pre-test counseling aims:-

- To ensure that any decision to take the test is fully informed and

voluntary

- To prepare the client for any type of result, whether negative or positive or indeterminate
- To provide client risk reduction information and strategies irrespective of whether testing proceeds
- To provide options for PPTCT
- To provide an entry point to treatment and care

FHI (2003) suggests that pre-test counseling include providing reading materials before clients enter a group or private discussions with a counselor, and at this session the client may be asked why they want to be tested and about their behavior that they think that may put them at risk for HIV infection. Further more FHI (2003) point out that if testing is warranted the counselor should:-

- describe the test and how it is done
- explain HIV/AIDS and the way HIV is spread
- discuss ways to prevent the spread of HIV
- discuss the meaning of possible test results
- ask what impact the result will have on you
- address the matter of whom to tell about your test result
- discuss the importance of telling your sexual partner (s) if you and HIV positive.

Similarly according to FDRE MOH (2002) Pretest counseling should be offered before an HIV-test and at this session(s) ideally the counselor should assist the client to identify her/his risk of acquiring HIV and prepare the client for taking the test. Furthermore the counselor should ascertain the clients understanding of HIV transmission and the meaning of the test result by doing the following:

- Discuss the client understanding of the risk for risk
- Discuss what the virus is and how it is transmitted

- Ensure that the client understands the risks and benefits of knowing his/her HIV infection status.
- Emphasis should be given to religion and culture
- Discuss what the test result mean

2.5.1.2 Post-test Counseling

As the name indicates post-test counseling is offered after HIV test result is available and it should be always offered whether the result is positive or negative UNAIDS (2000b) and FDRE MOH (2002) suggest that the main goal of post test counseling session is to help client understand their test results and initiate adaptation to their serostatus.

MOH and FWG of India (2004), states that Post- test counseling aims:-

- To help client understand and cope with the HIV test results
- To provide the client with any further information required
- To help clients make an immediate and short-term and long-term future plans
- To help clients decide what to do about disclosing their test result to partners and others.
- To help clients reduce their risk of HIV/AIDS and take action to prevent infection to others
- To help clients access the medical and social care and support they need
- To establish link with PLHA groups, if needed

Similarly FDRE MOH (2003) indicates that the aim of post test counseling is to:

- Provide emotional support
- Prevention of further transmission of HIV/AIDS

According of FDRE MOH (2002) in post-test counseling the counselor should:

- Assure the test result and any other information the client provide remain confidential
- Provide HIV test results
- Interpret the HIV test results
- Ensure the client understand what the result mean
- Address immediate emotional concerns
- Reinforce the plan for reducing risk considering the clients HIV status
- Discuss with the client for additional medical and/or social services as appropriate
- UNAIDS (2000b) suggest that in post-test counseling when the blood test result is positive the counselor should
- Tell the result clearly and sensitively to the client
- Provide emotional support and discussed how to cope
- Ensure the client has immediate emotional support from a partner relative or friend.
- Offer information on referral services that may help clients accept their HIV and adopt a positive out look
- Ensure sharing a test result with a partner or some one trusted is often beneficial

Furthermore, UNAIDS (2000b) point out that when the test result is negative the counselor need to:

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

2.5.2 HIV Testing

According to FDRE MOH (2003) HIV testing can be classified as being done with voluntary or without informed consent. In VCT centers as the name indicate the testing should be voluntary with informed consent of the clients.

A review on the nature and quality of HIV testing (Beardsell S, Coyle A. Soc Sci Med. 1996 Mar.) states that the process of HIV testing is as follow: making the decision to be tested, accessing testing service, test counseling and waiting for the test results. Of these, most consideration is accorded to the HIV test counseling process. The conclusion of the review is that research is needed to examine both clients' and counselor's expectations, experiences and satisfaction with HIV test counseling (Beardsell S, Coyle A.. Soc Sci Med. 1996 Mar.)

FDRE MOH (2002) stated that all testing for HIV should be voluntary with informed consent; there should be no mandatory testing. UNAIDS (2000b) describe that HIV testing may have a far reaching implications and consequences for the person being tested. Although there are important benefits to know one's HIV status, HIV is in many communities a stigmatizing condition following testing. Stigma may actively prevent people accessing care, gaining support and preventing on-ward transmission. Hence testing should be voluntary and VCT should take place in collaboration with stigma reducing activities.

At the present time there are different facilities for HIV testing. According to UNAIDS (2000B) a wide range of different HIV antibody tests are available currently, including ELISA tests and many newer simple and rapid HIV TEST.

2.6 The Concept of Perception

According to Morgan (1986), perception is defined as the process of interpreting sensory information from the receptor organs to produce an organized image of the environment.

Morgan further explained that fortunately human perceptual systems normally give people a highly veridical image of the environment, so serious mistakes are rare. Infact, one of the great miseries of the mind is how our perception of the world can be as accurate and reliable as they are.

On the other hand, Lahey (2004), defined perception as the process of organizing and interpreting information received from the outside world.

Many of the ways in which we organized and interprete sensations are inborn and common to all humans. The Gestalt principles of perceptual organization, perceptual constancies, depth perception and visual illusions provide examples of the active, creative nature of perception.

Other factors that enter into the process of perception are unique to the individuals, such as motivational states and cultural learning experiences.

These factors ensure that we will perceive the world in a way that is largely universal among humans, but with a great deal of individuality due to differences in motivation, emotion, learning and other factors (Lahey.2004.)

VCT is an important step in the development of a comprehensive package of HIV/AIDS services; it is an effective strategy in reducing risk behaviors among individuals at risk for HIV/AIDS. VCT is the setting of information

exchanges between a provider and a client, it helps the individual to reach an appropriate decision and act on it. The counseling is supposed to include a discussion of medical and lifestyle issues grounded on individual's concerns, fears and values related to reproductive and sexual health. Individual perceptions towards VCT are shaped by cultural values, opinions about the role of health system and the nature of interactions with providers. Addressing clients' perceptions of VCT is crucial to improve their satisfaction and health outcomes (CDC. 1994), helping a continued and sustained use of services (Creel, Sass, Yinger 2002).

Therefore, in light of this review of related literature, perception of the clients in the selected VCT Centers were assessed and evaluated as it is found in the following consecutive chapters:

CHAPTER THREE

METHODOLOGY

3.1. Sampling of Sites and Target Population

3.1.1. Area / Site Sampling

This research was conducted in Arada Sub City, Addis Ababa, an urban area which contains an estimated population of more than 3,000,000 (CSA, 2005). The choice is based on the assumption that most VCT centers are found in Addis Ababa. In addition to this, Addis Ababa was selected since the estimated rate of infection for adults is much higher, a staggering 16.8 percent, according to the latest figures (FDRE, MOH, 2003).

The researcher, using Simple Random Sampling technique, select Arada Sub City among the ten sub cities found in the city. And, all the 19 VCT centers (A.A HIV/AIDS Secretariat Bureau, 2006), governmental and private, found in Arada Sub city will be included in the study.

The universe of the study includes all VCT Centers in Arada Sub City, Addis Ababa. From the list received 7 from government and 12 from private or a total of 19 VCT Centers were selected (see Table 3.1).

3.1.2 Respondent Sampling / Target Population

To appreciate fully the reason how clients' perception affect VCT service attendance, the study focused on identifying the main activities done at VCT services. For this reason, only one group of respondents (i.e. clients), who were directly involved in such a counseling process both tested and untested participated to provide data. Here the intention has been to collect first hand information in VCT Services which is the resource of data.

As expressed earlier there were 19 VCT Services in Arada Sub-city. The researcher, using Purposive Sampling Method, took ten clients (attempting equal sex proportion) from each VCT Center seeking VCT services. The rational beyond choosing Purposive Sampling Method was since it is appropriate for the purpose of the research (Yalew, 2006). And a total of 190 clients from 19 VCT Services were included in the study.

3.2 Subjects and Sampling Procedures

All clients who came to each VCT Centers and get the services (i.e., pre-test counseling, blood test for HIV and; post test counseling) were asked to participate in the study when they come in to and exit from the counseling services. Out of the 228 clients who were given the questionnaire, only 190 of them returned the result. However, 28 clients did not return probably because of their emotional reaction to their blood test results. Thus, a total of 190 clients, 10 clients from each VCT Service were involved in the study, in a period of 2 months (March to April 2007).

In general the number of participants and type of VCT Services included in the study are presented on Table 3.2.

Table 3.2 Number of Participants and Type of VCT centers in the study

No	Name of VCT Service	Type of VCT center	No of Participants		
			M	F	Total
1	Yekatit 12 Hospital	Gov	5	5	10
2	Ras Desta Hospital	Gov	5	5	10
3	Addis Ababa Police Commission Clinic	Gov	5	5	10
4	Tibebu Hospital	Gov	5	5	10
5	Arada Health Center	Gov	5	5	10
6	Gullelle Health Center	Gov	5	5	10
7	Woreda 13 Health Center	Gov	5	5	10
8	Nazrawit Hospital	Priv	5	5	10
9	Piassa Poly Clinic	Priv	5	5	10
10	Teklehaimanot Higher Clinic	Priv	5	5	10
11	Arsho Higher Clinic-Piassa Branch	Priv	5	5	10
12	Arsho Higher Clinic-Tedros Adebabay	Priv	5	5	10
13	Betezata Diagnostic Labolratory	Priv	5	5	10
14	Ethiopia Higher Clinic	Priv	5	5	10
15	Tesfa Higher Poly Clinic	Priv	5	5	10
16	Hema Integrated diagnostic clinic	Priv	5	5	10
17	Arada Giorgis Medium Clinic	Priv	5	5	10
18	Ethiopian Road Authority Clinic	Priv	5	5	10
19	Abebech Gobena	Priv	5	5	10
		TOTAL	**95**	**95**	**190**

3.3 Procedures of Data Collection

The procedure that was used for the study was limited to questionnaire method. The research consisted of two other experienced assistant researchers (one psychologist and one stastician) who evaluated the reliability and validity of the research questions.

The research project was a quantitative study regarding clients' perceptions of voluntary counseling and testing services. Data had been collected through scale/questionnaire from clients seeking VCT service, both male and female.

Topic of basic themes that were developed to further elaborate the questions at different situations were as follows: Knowledge of clients towards HIV/AIDS, preference of HIV prevention mechanisms, reasons for HIV infection, attitude and knowledge of clients to VCT, and facility and constraints of VCT centers.

A set of questionnaire, prepared and adapted was used to get information from clients of the target VCT centers (see Appendix A and B for the English and Amharic versions of the two questionnaires). The clients' questionnaire has got seven parts (36 in number and the items were closed-ended and open-ended). The first part was prepared to get information about the client's personal data (i.e., sex, age educational level, occupation, marital status and religion).

The second, sixth and seventh parts of the questionnaire were prepared to obtain information about clients' knowledge of HIV and VCT Services, and the facilities and constraints of counseling services in the VCT centers. Particularly the seventh part was designed to collect adequate data on constraints that hinder effective counseling services. With this perspective, the questionnaire addressed to: the counseling rooms, waiting areas, the time given to each counseling session, the number of the sessions, the counselor professional skills, confidentiality, a set of possible comments and factors that affect the provision of the service.

The other three parts (i.e. Part 3, 4 and 5) of the questionnaire were prepared in the form of a rating scale. The rating scale was designed to

measure clients' preference of HIV prevention, reason for HIV infection and attitude towards VCT services offered in the VCT Centers. For this reason, Likert Scale was employed for two reasons. First it provides respondents a variety of specific categories from which they can select. Secondly, it allows subjects to prefer to answer anonymously when they are asked to rate their expressed opinion. The Likert Scale consisted of specific categories of expressed opinions represented by numbers 1= Strongly Disagree, 2= Disagree; 3= Undecided: 4= Agree; and 5= Strongly Agree. Thus each client had a score from 1 to 5 on each item, and a client's total score, representative of an overall attitude was simply the sum of the item scores.

At the beginning a Pilot Study questionnaire were administered for 40 clients before and after the Pre-test and Post-test counseling Services. But because of (1) three clients did not return for their results (post-test counseling), (2) five clients, who test HIV positive, were not willing to fill and return the questionnaire, and (3) two clients, who test HIV negative, were over-excited and they were running to tell their results for families, partners, friends, etc. it was difficult to collect the questionnaire. Therefore, due to these reasons, only 30 clients returned the Pilot Study questionnaires.

All the items in the initial questionnaire were pilot tested on 30 clients of Teklehaimanot Higher Clinic and Yekatit 12 Hospital. The respondents who took part in the pilot study were taken through Purposive Sampling method. The purpose of the testing was to collect data that would be used for screening the items. It was also to find out, if wording instruction and response categories of the instrument as a whole were clear and comprehensible to respondents. In other words the Pilot Study questionnaire was used for further validation of the items and ensures

their reliability. Face-to-face contacts with all respondents was possible and while providing the questionnaire to them, they were told to note down any ambiguous word, phrase, or sentence. As soon as they finished, discussion was held with these respondents and many of them had expressed their positive feeling about the items and pointed out items that were not clear to them. Based on the feedback received, an item analysis was made and a final questionnaire was designed. As a result of this study modifications were made.

Computing Coefficient of Alpha using the data collected during the Pilot Survey assessed reliability of the instrument. The computation yielded reliability coefficients are presented on Table 3.2.

Table 3.3 Reliability coefficient of the instruments

Instrument	Reliability coefficient
HIV knowledge	.81
HIV prevention	.76
Reason for HIV infection	.76
Attitude for VCT services	.89
VCT knowledge	.76
Facility of VCT centers	.85

The Content Validity of instruments was claimed on several grounds. The formulated instrument was critically approved by two senior graduate psychology students (the first Measurement and Evaluation and the other Counseling.

Finally it was indicated that high reliability coefficient (see Table 3.2) has been achieved, and it was sufficiently validated.

3.4 Variables

Variables included in the study are the following:

- The Dependent Variable is - Clients' Perception
- The Independent Variables are - Demographic factors:-
  -Type of VCT Center (Government versus private), and
  -Sex (Male versus Female)

To get sufficient information for the study only one data collection tool was employed. This is questionnaire.

3.5 Methods of Data Analysis

Depending on the nature of the collected data, different statistical techniques were employed. For the close-ended questionnaire items upon which clients were required to choose among the given alternatives, the value was first tallied within the respective category. Then, Quantitative Statistical analysis such as simple frequency counts, percentages, and mean were used accordingly. On the other hand, for the open-ended items, Qualitative Analysis was used.

Henceforth, based on the above listed methods of data collection and data analysis, the results from the response rate of clients are found in the following chapter.

CHAPTER FOUR

RESULT OF THE STUDY

4.1 Demographic Profile

A total of 190 VCT clients from 19 VCT (7 governmental, and 12 Private) centers were involved in the final study analysis. Of which 70 (36.84%) clients were from governmental, and 120(63.16%) clients were from private VCT centers.

The demographic characteristics of clients are shown in Table 4.1. The mean age of study subjects was 29 years; the age group 20 years or less accounts for 26(13.7%), 98(51.6%) were between the ages of 21-40 years and 66(34.7%) were above 40 years. There were equal sex proportion 95(50%) male and 95(50%) female client respondents.

With respect to their educational level 32 (16.8%) out of 190 were illiterate, 48 (25.3%) participants were in Primary & Junior level, 68(35.8%) were in Secondary level and 42 (22.1%) were in College & above level.

Regarding their occupation, Students account for 33 (17.4%), Merchant 18 (9.5%), Civil Servant 42 (22.1%), Daily Worker 17 (8.9%), House Wife 12 (6.3%), Bar Lady 16 (8.4%), Military (Police) 6 (3.2%), Unemployed 24 (12.6%) and Others 22 (11.6%).

Regarding their marital status 86 (45.3%) were Unmarried, 60 (31.6%) were Married, 22 (11.6%) were separated, 13(6.8%) Divorced and 9 (4.7%) were Widowed.

And of their religion, 85 (44.7%) of the clients are Orthodox, 62 (32.6%) Muslims, 23 (12.1%) Protestant, 9 (4.7%) Catholic and 11 (5.8%) Others.

Table 4.1: Socio Demographic Characteristics of 190 Clients

Variables	Categories	No	%
Age	≤20	26	13.7
	21-40	98	51.6
	>40	66	34.7
Sex	Male	95	50.0
	Female	95	50.0
Educational level	Illiterate	32	16.8
	Primary	48	25.3
	Secondary	68	35.8
	Tertiary	42	22.1
Occupation	Student	33	17.4
	Merchant	18	9.5
	Civil servant	42	22.1
	Daily Worker	17	8.9
	House wife	12	6.3
	Bar Lady	16	8.4
	Military/Police	6	3.2
	Unemployed	24	12.6
	Others	22	11.6
Current Marital status	Unmarried	86	45.3
	Married	60	31.6
	Separated	22	11.6
	Divorced	13	6.8
	Widowed	9	4.7
Religion	Orthodox	85	44.7
	Muslims	61	32.1
	Protestant	25	13.2
	Catholic	12	6.3
	Others	7	3.7
	TOTAL	**190**	**100%**

4.2 Clients' Knowledge of HIV/AIDS

To assess clients' knowledge of HIV/AIDS, clients were asked to rate the degree of transmission of HIV/AIDS through the listed six methods in a five scale item Six items (see Appendix A part Two).

Table 4.2 Clients rating of their Knowledge of the Ways of Transmission of HIV/AIDS:

Items	Category	Respondents		Total
		Male	Female	
Unsafe sexual intercourse	Yes	95	95	190(100%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
From mother to child during pregnancy	Yes	78	74	152(80%)
	I don't know	17	21	38(20.0%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Through contaminated blood	Yes	89	92	181(95.3%)
	I don't know	6	3	9(4.7%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
	No	95	95	190(100%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Insect bite	Yes	81	77	158(83.2%)
	I don't know	7	11	18(9.5%)
	No	7	7	14(7.4%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Sharing sharp utensils	Yes	95	95	190(100%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**

All the clients, 190(100%), answer "yes" for the first item. Whereas, 152(80%) of the clients answered "yes" and the rest 38(20%) respondents choose "I don't know" for the second item. For the third item, except 9(4.7%) respondents who choose "I don't know", most respondents i.e. 181(95.3%) choose "yes". For the fourth item all the 190 or 100% of the respondents choose the right answer which is "No". While 158(83%) respondents answered "Yes", the rest 18(9.5%) and 14(7.3%) respondents choose "No" and "I don't know" respectively for the fifth item. Finally, all respondents, 190 (100%) choose "Yes" for the last item In general since more than 50% of the respondents for the entire items got the right answer, it can be concluded that they have the knowledge how HIV can be transmitted from one person to the other.

4.3 Clients' Preference of HIV prevention

The respondents were asked to rate the degree of their preference to protect themselves from being infected by HIV/AIDS. Among the three common methods of HIV prevention (A- abstinence, B- be faithful and C- use of condom), they were asked to indicate the degree of their preference. The response rate of the respondents is found in the following table (see Appendix A, Part Three):

Table 4.3 Clients' Response Rate for their Preference of the Methods of HIV Prevention:

Items	Category	Respondents		Total
		Male	Female	
Abstinence	Strongly Agree	37	35	72(37.9%)
	Agree	28	28	56(29.5%)
	Undecided	9	9	18(9.5%)
	Disagree	18	19	37(19.5%)
	Strongly Disagree	3	4	7(3.7%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Be faithful	Strongly Agree	49	47	96(50.5%)
	Agree	28	29	57(30.5%)
	Undecided	9	10	19(10%)
	Disagree	6	6	12(6.3%)
	Strongly Disagree	3	3	6(3.2%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Use of condom	Strongly Agree	10	9	19(10.0%)
	Agree	12	13	25(13.2%)
	Undecided	19	18	37(19.5%)
	Disagree	23	23	46(24.2%)
	Strongly Disagree	31	32	63(33.2%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**

Among the three common preventive mechanisms, 128(67.4%) of the respondents 65 males and 64 females prefer Abstinence, 153(81.0%), 77 males and 76 females prefer being faithful and the rest 44(23.2%), 22 males and 22 females prefer using condom. From clients' response, it can be inferred that the second mechanism i.e. Be faithful has been given priority by more than 50% of the respondents, followed by Abstinence and Use of Condom.

4.4 Clients' Reason for HIV infection

When they were asked about their reasons why people can be infected by the HIV virus, they gave the following responses (See Table 4.4) for the summary result of clients' responses:

Table 4.4 Clients' Responses for Conditions for HIV infection:

Items	Category	Respondents		Total
		Male	Female	
Condom is not accessible in time of need	Strongly Agree	3	4	7(3.7%)
	Agree	22	22	44(23.2%)
	Undecided	25	25	50(26.3%)
	Disagree	25	25	50(26.3%)
	Strongly Disagree	20	19	39(20.5%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Lack of money	Strongly Agree	6	6	12(6.3%)
	Agree	10	9	19(10.0%)
	Undecided	21	22	43(22.6%)
	Disagree	35	36	71(37.4%)
	Strongly Disagree	23	22	45(23.7%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Negligence	Strongly Agree	49	46	95(50.0%)
	Agree	22	22	44(23.2%)
	Undecided	12	14	26(13.7%)
	Disagree	9	10	19(10.0%)
	Strongly Disagree	3	3	6(3.2%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Alcohol	Strongly Agree	32	32	64(33.7%)
	Agree	31	31	62(32.6%)
	Undecided	13	13	26(13.7%)
	Disagree	13	12	25(13.2%)
	Strongly Disagree	6	7	13(6.8%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
"Chat"	Strongly Agree	19	18	37(19.5%)
	Agree	35	35	70(36.8%)
	Undecided	22	22	44(23.2%)
	Disagree	16	16	32(16.8%)
	Strongly Disagree	3	4	7(3.7%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**

According to the responses that were taken from clients, 51(26.9%) respondents give priority for the first reason when condom is not accessible. While lack of money is accepted to be one reason for HIV infection for by 31(16.3%) of the respondents; negligence is for 139(73.2%) of the respondents. The rest 126(66.3%) and 114(60.0%) of the respondents respectively choose alcohol and "chat" as the two reasons for HIV infection.

4.5 Attitude of Clients towards the Counseling Services

Clients were asked to rate six items that were intended to measure their perception of VCT counseling. The rating scale was constructed in the form of Likert scale. As a result clients had five alternatives to select, ranging from strongly disagree up to strongly agree (see Appendix A, Part Five). Summary of clients' responses is found in Table 4.5 below:

Table 4.5 Clients' attitude towards counseling service by VCT type:

Items	Category	Respondents		Total
		Male	Female	
Most VCT Centers are with attractive environment	Strongly Agree	4	11	15(7.9%)
	Agree	15	16	31(16.3%)
	Undecided	23	7	30(15.8%)
	Disagree	33	33	66(34.7%)
	Strongly Disagree	20	28	48(25.3%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
VCT Service providers are trustful (confidential)	Strongly Agree	0	2	2(1.1%)
	Agree	0	4	4(2.1%)
	Undecided	20	26	46(24.2%)
	Disagree	44	37	81(42.6%)
	Strongly Disagree	31	26	57(30.0%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
VCT Service providers treat me with respect and dignity	Strongly Agree	8	4	12(6.3%)
	Agree	18	13	31(16.3%)
	Undecided	0	7	7(3.7%)
	Disagree	38	33	71(37.4%)
	Strongly Disagree	31	38	69(36.3%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Generally VCT Service delivery does not address the need of clients	Strongly Agree	28	15	43(22.6%)
	Agree	10	30	30(15.8%)
	Undecided	14	6	20(10.5%)
	Disagree	21	21	42(22.1%)
	Strongly Disagree	22	33	55(28.9%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Be faithful	Strongly Agree	26	25	51(26.8%)
	Agree	36	32	68(35.8%)
	Undecided	3	9	12(6.3%)
	Disagree	17	12	29(15.3%)
	Strongly Disagree	13	17	30(15.8%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**
Privacy is secured in most VCT Centers	Strongly Agree	4	12	16(8.4%)
	Agree	8	14	22(11.6%)
	Undecided	23	14	37(19.5%)
	Disagree	30	26	56(29.5%)
	Strongly Disagree	30	29	59(31.1%)
	TOTAL	**95(50%)**	**95(50%)**	**190(100%)**

A look at the distribution of the data on Table 4.5 revealed that out of the 120 respondents of private VCT centers, respectively 78(65.0%) and 42 (35.0%) of the clients showed a positive and negative attitude towards VCT services. And out of the 70 government VCT center respondents, 45 (64.3%) showed a positive attitude, while 25 (35.7%) showed negative attitude. In other words 64.3% of the government and 65.0% of the private VCT clients exhibited positive attitude towards the counseling service of VCT. From this it can be inferred that most of the clients (more than 50%), have a positive attitude for VCT.

4.6 Clients' Knowledge of VCT

Clients were asked to rate for their knowledge of VCT using eleven VCT related questions. They were given different alternatives to choose among the given options and indicate their previous experience about VCT service (see Appendix A, Part six). Their response rates are found in the following Tables 4.6.1-4.6.2 as follows:

Table 4.6.1- Item 1

Items	Category	Respondents		
		Male	Female	Total
Do you know about VCT service?	Yes	95	95	190(100%)
	Total	**95**	**95**	**190(100%)**

As it is indicated in Table 4.6.1 above, all the 190(100%) of the clients know what VCT means. Hence, it can be inferred from this that all clients had knowledge of VCT Services.

Table 4.6.2 - Item 2

Items	Category	Respondents		
		Male	Female	Total
What was your first source of information about VCT?	Family	4	3	7(3.7%)
	Friends	6	7	13(6.8%)
	Health Centers	15	16	31(16.3%)
	School	22	22	44(23.2%)
	Mass Media	23	22	45(23.7%)
	Anti HIV/AIDS Clubs	19	19	38(20.0%)
	Religious Organizations	6	6	12(6.3%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

The first source of information about VCT for most clients is mass media 45(23.7%), school 44(23.2%) and anti-AIDS clubs 31(16.3%) ranking first, second and third respectively. Whereas, for the other 16.3%, 6.8%, 6.3% and 3.7% of the respondents, their primary source of information were Health Centers, Friends, Religious Organizations and Family respectively.

Table 4.6.3-Item 3

Items	Category	Respondents		
		Male	Female	Total
Where do you get VCT service?	Hospitals	17	15	32(16.8%)
	Family	18	18	36(18.9%)
	Health Centers	25	27	52(27.4%)
	Private Clinics	26	25	51(26.8%)
	Red Cross Clinics	9	10	19(10.0%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

Private clinics, health centers and family are the three major areas respectively where 52(27.4%), 51(26.8%) and 36(18.9%) of the clients get VCT service.

Table 4.6.4-Item 4

Items	Category	Respondents		
		Male	Female	Total
Which place is preferable for VCT service?	Hospital	29	30	59(31.1%)
	Clinics	28	28	56(29.5%)
	Health Centers	25	25	50(26.3%)
	Family Planning Clinics	13	12	25(13.2%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

Whereas, clients' preference for attending counseling are Hospitals(1st), clinics(2nd), health centers(3rd) and family planning clinics(4th) constituting 59(31.1%), 56(29.5%), 50(26.3%) and 25(13.2%) respectively.

Table 4.6.5-Item 5

Items	Category	Respondents		
		Male	Female	Total
Is VCT service important?	Yes	64	63	127(66.8%)
	No	19	19	38(20.0%)
	I don't know	12	13	25(13.2%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

Concerning the importance of VCT, 127(66.8%) of the clients (64 male and 63 female) answered "Yes" i.e. VCT is important. However 38(20.0%), (19 male and 19 female) answered "No" or VCT is not important. While the rest 25(13.2%), (12 male and 13 female) respondents did not decide.

Table 4.6.6-Item 6

Items	Category	Respondents		
		Male	Female	Total
If it is important, why?	To know one's status	26	27	53(27.9%)
	To care	21	22	43(22.6%)
	Other	17	14	31(16.5%)
	Total	**64(33.7%)**	**63(33.2%)**	**127(66.8%)**

For the question why VCT is important, 53(27.9%) of the clients answer "to know one's status", while other 43(22.6%) answered "to care". The rest 31(16.5%) choose the alternative "others"; i.e. they have other reasons than the given ones why VCT is important.

Table 4.6.7-Item 7

Items	Category	Respondents		
		Male	Female	Total
When do you think is VCT service important?	Always	28	32	60(31.6%)
	When ill	6	3	9(4.7%)
	Before marriage	16	19	35(18.4%)
	When going abroad	8	2	10(5.3%)
	Hesitation	6	7	13(6.8%)
	Total	**64(33.7%)**	**63(33.2%)**	**127(66.8%)**

Concerning the conditions when VCT is important, 60(31.6%) of the clients replied "Always" and 35(18.3%) "Before Marriage". While the rest reasons i.e. "Hesitation", "When going abroad" and "When ill" respectively constitute 13(6.8%), 10(5.3%) and 9(4.7%).

Table 4.6.8-Item 8

Items	Category	Respondents		
		Male	Female	Total
If no charge for VCT, who should be tested?	Prostitute	13	12	25(13.2%)
	Drivers	9	10	19(10.0%)
	Students	12	13	25(13.2%)
	Pregnants	3	4	7(3.7%)
	Couples	7	6	13(6.8%)
	Children & Youth	3	4	7(3.7%)
	All except Children	15	16	31(16.3%)
	Others	33	30	63(33.2%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

The response rate of the clients for the eighth item (If no charge for VCT, who should be tested?) was as follows: The first three are "Others"-63(33.2%), "All except children"-31(16.3%) and "Prostitute"- 25(13.2%) and "Students" -25(13.2%). The rest chosen groups of the society were "Drivers", "Couples", "Pregnants" and "Children and Youth" constituting respectively 19(10.0%), 13(6.8%), 7(7.3%) and 7(7.3%) respectively.

Table 4.6.9-Item 9

Items	Category	Respondents		
		Male	Female	Total
Would you test for HIV if it is charge free?	Yes	50	50	100(52.6%)
	No	36	35	71(37.4%)
	Undecided	9	10	19(10.0%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

When they were asked they would be tested if VCT were given charge free, 100(52.6%) of the clients replied "Yes" and 71(37.4%) replied "No". While the rest 19(10.0%) did not decided.

Table 4.6.10-Item 10

Items	Category	Respondents		
		Male	Female	Total
If a person is with Positive HIV status, what should be the next action?	Abstinence	21	18	39(20.5%)
	Stop giving birth	7	6	13(6.8%)
	Prayer	9	10	19(10.0%)
	Condom	9	9	18(9.5%)
	Health treatment	40	40	80(42.1%)
	No solution	9	12	21(11.1%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

The tenth item was about the next action that a person with HIV Positive should take. Hence their response revealed the following results: Health treatment= 80(42.1%), Abstinence=39(20.5%), No Solution=21(11.1%), Prayer=19(10.0%), Condom=18(9.5%) and Stop giving birth=13(6.8%) getting the first to the sixth ranks respectively.

Table 4.6.11-Item 11

Items	Category	Respondents		
		Male	Female	Total
If you are with Negative HIV status, what will be your next action?	I will care	45	43	88(46.3%)
	Condom	13	12	25(13.2%)
	Abstinence	19	19	38(20.0%)
	I' ll have sexual partner	15	17	32(16.8%)
	I won't take measure	3	4	7(3.7%)
	Total	**95(50%)**	**95(50%)**	**190(100%)**

For the last item, which was about the action that clients themselves should take if they were with HIV Negative Status, 88(46.3%), 38(20.0%) and 32(16.8%) of the clients chose to take care of themselves, to abstain and to have sexual partner respectively. While the rest 25(13.2%) and 7(3.7%) of the clients chose to use condom and not to take any measure constituting the fourth and fifth choice.

4.7 Facilities and Constraints

4.7.1 Privacy

To assess the availability of separate space or room for counseling session, an item (see Appendix A Part Seven item number one) was included in the questionnaire and clients were asked to rate the counseling space. Table 4.7 shows clients' response rate for this particular item:

Table 4.7.1 Frequency and percentage distribution of clients ration to the availability of private space for counseling

Category	Respondents		
	Gov VCT	Priv. VCT	Total
Yes, there is adequate space	57 (81.4%)	92 (76.7%)	149(78.4%)
Yes, there is some but not adequate	13 (18.6%)	28 (23.3%)	41(21.6%)
Total	**70(100%)**	**120(100%)**	**190(100%)**

Among all, 149 (78.4%) (57 from government and 92 from private VCT centers) clients agree with the presence of separate room to ensure privacy. The rest 41 (21.6%) of the clients reported that there was separate room but not adequate to ensure privacy.

Clients' response rate on the provision of privacy in VCT centers revealed that all the VCT centers under study have a separate room; with more than 50% of the rooms adequate enough for the counseling process.

4.7.2 Waiting Area

To assess if there exists a waiting area in the VCT centers and to judge their quality, two questions were prepared and included in the questionnaire (see Appendix A, Part 7, items number 2 and 3). Clients' response for these questions is found in the next table (Table 4.7) based on the type of the VCT center that the clients get the service from:

Table 4.7.2 Distribution of clients rating to the availability of Waiting Area:

Items	Category	Respondents		Total
		Gov. VCT	Priv. VCT	
Is there a waiting area	Yes, there is adequate	26(37.14%)	63 (52.5%)	89(45.8%)
	Yes, but not adequate	44(62.86%)	57 (47.5%)	101(54.2%)
	Total	**70 (100%)**	**120(100%)**	**190 (100%)**
How do you rate the waiting area	Very Good	22 (31.4%)	66 (55%)	88(46.3%)
	Good	48 (68.6%)	54 (45%)	102(53.7%)
	Total	**70 (100%)**	**120(100%)**	**190 (100)%**

In Table 4.7 it is indicated that 89 (45.8%), (26 government and 63 private) respondents reported that there was adequate waiting area, while 101 (54.2%) VCT clients reported that there was some waiting area but not adequate.

With respect to the quality of the VCT center, out of 190 clients 88 (46.3%), that is 22 from government and 66 from private VCT centers, rated the waiting area was very good but 102 (53.7%) or 48 from government and 54 from private VCT rated that the waiting area was good, with no significant difference between government and private VCT centers.

4.7.3 Counseling Sessions

Clients were asked about the number and adequacy of the counseling sessions. Their response is found in Table4.7.4 below:

Table 4.7.3 Clients' Rating to the Number and Adequacy of Counseling Sessions

Items	Category	Clients respondents		Total
		Gov.	Private	
Do you think that the number of counseling sessions is adequate?	Yes	19	62	81(42.6%)
	Undecided	23	42	65(34.2%)
	No	28	16	44(23.2%)
	Total	**70 (100%)**	**120(100%)**	**190(100%)**
Do you think that the time given for each counseling session is adequate?	Yes	21	68	89(46.8%)
	Undecided	25	36	61(32.1%)
	No	24	16	40(21.1%)
	Total	**70 (100%)**	**120(100%)**	**190(100%)**

To assess the number and adequacy of the counseling sessions, clients were asked to rate the items in the questionnaire (see Appendix A part seven item number one). Concerning the number of counseling sessions, 81(42.6%), 19 government and 62 private respondents answer "Yes". While 44(23.2%), 28 government and 16 private respondents answer "No", the rest 65(34.2%) of the respondents, 23 from government and 42 from private VCT centers did not decide whether the number is adequate or not.

On the other hand, with respect to the adequacy of the time given for each counseling session, among all the respondents, 89 (46.8%) (21 from government and 68 from private VCT centers) clients respond that the given time for each counseling session is adequate. While 40 (21.1%)

clients (24 government and 16 private) reported that the given time is not adequate. The rest 61(32.1%) respondents (25 government and 36 private) respondents did not decide.

4.7.4 Seating Arrangement

To assess how the seating arrangement of the VCT services seemed, an item was prepared and included in the questionnaire (Part Seen, item number six). Among 190 clients, 98 (51.6%) reported that there was a typical office seating arrangements, 51 (26.8%) responded that the seating arrangement was across the corner of the counselor table, while 41 (21.6%) reported that the seating arrangement was in front of the counselor and there was no table in between.

4.7.5 Confidentiality

Clients were asked about the way or how confidentiality was ensured (Part seen Item Number 7). Among 190 client respondents, 71(37.4%) reported that confidentiality was assured by anonymous testing and 79(41.6%) clients reported that keeping HIV test results and the issues discussed during the counseling sessions as a secret ensured it, while the remaining clients, 40(21.1%) reported that discussion was not made about the way how confidentiality is ensured.

Finally clients were asked to enumerate the problem they face in the VCT centers and during the counseling process. Among 190 client respondents, 76(40%) clients reported shortage of time, lack of adequate waiting area, and too long waiting time for the HIV test result.

Clients' response for the open ended question which was about "other comments for the VCT centers that they have been getting the services..."

revealed that all VCT centers have separate room for counseling. But in 2 government VCT centers windows were left opened and uncovered. Hence the conversation was heard outside the counseling room. Also in one private VCT center the door was left open as a result conversation was heard and visual privacy was not maintained.

4.7.6 Linkages or Referral

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

However, a look at the response rate of clients given for the open ended question revealed that in most VCT centers the issue of referral has not been given much emphasis (attention). Moreover, those clients who are infected or are at high risk HIV have not been afforded the services to facilitate access to any necessary medical, nutritional and psychosocial support and faith-based services.

As a result of the above results, the discussions made are found in the next chapter as follows:

CHAPTER FIVE

DISCUSSION OF THE RESULT

Perception is the interpretation of sensations. It is active processes in which perceptions are created that often go beyond the minimal information provided by the senses (Morgan, C). From the definition of perception it can be deduced that perception is based on knowledge. We interpret information that we receive. Hence, in one way or the other, clients' perception depends on their knowledge.

Hence, the response rate of the clients revealed that more than half of the clients are knowledgeable how HIV can be transmitted from one person to the other.

From clients' response, it can be inferred that most of the clients give priority for "B" (be faithful) than the rest two mechanisms. While fewer than the first group of respondents prefer "A" (abstinence), and the least of them prefer "C" (condom). In short, it can be concluded that the second mechanism. i.e. Be faithful has been given priority by more than 50% of the respondents than the rest two as a preventive mechanism.
According to the responses collected and analyzed, clients reasons why people can be infected by HIV/AIDS were ranked as follows: The first reason why people can be infected by HIV is Negligence; while alcohol is the second, "chat"-third, absence of condom in time of need-fourth, and lack of money-fifth reasons for HIV infection for most of the respondents.

The finding of this study indicated that a little more than half of the clients tend to show favorable attitude towards counseling service. However, the frequency distribution of this study indicated than more clients of private VCT centers showed favorable attitude toward

counseling services than their government counterpart. This is mainly because, as reported by clients, in most cases clients get better quality service in private VCT centers than in governmental centers.

As it is indicated in the result section, despite the restricted access of the services, all of the clients know what VCT means. And for most clients, their primary source of information about VCT is mass media, school and Anti-AIDS clubs ranging first, second and third respectively. While the rest of the clients, private clinics, health centers and family are the three areas respectively where they get VCT service from.
Whereas, clients' preference for attending counseling services are hospitals(1st), clinics(2nd), health centers(3rd) and family planning clinics(4th).

On the other hand, more than half of the clients with almost equal sex proportion responded that VCT is important. However for the question why VCT is important, clients have different reasons; "to know one's status", "to care" or "others"; i.e. they have other reasons than the given ones why VCT is important.

Discussion of risk factors and sexual relationship is part of VCT counseling; however, key information essential to the process will not be elicited unless people can discuses these issues in private. Hence, for effective counseling private space is required.

The finding of this study revealed that all VCT centers under study have a separate room for the counseling process. Among all, more than half of the respondents indicate that the counseling rooms are adequate enough for the counseling purpose; only some of them reported that the counseling rooms are inadequate to ensure privacy. It was found that

there was no significant difference between the levels of privacy by type of VCT center.

The results of this study indicate that all VCT centers have a waiting area despite their inadequacy in most VCT centers. Out of 190 clients, only some of the respondents agreed that the waiting areas are very good. However, more than 50% of the respondents rated the waiting areas as poor/not good.

Concerning the number of counseling sessions, except few of them, most respondents indicated that the number is adequate. While, with respect to the adequacy of the time allotted for each counseling session, most clients reported that it is not adequate to effectively utilize the service.

Seating arrangement is the other factor that affects effective counseling. According to Yusuf (1998) different seating arrangement have their own benefit and draw backs. However, the most effective is across the table. Similarly Haase and Dimattia as cited in Shertzer and Stone (1980), suggest that the best seating position is across the corner of the desk or table.

The result of this study indicates that in most VCT centers the seating arrangement was across the corner of the counselor table. Most clients (>50%) reported that seating arrangements was across the corner of the counselor table. Hence, this study indicated that effective seating arrangement was there in some VCT centers.

HIV infection is still a stigmatized condition in many areas. So counselors and all the staff involved must maintain confidentiality. Lack of confidentiality will result in reduction of clients who seek the service.

The findings of this study indicate that in most VCT centers discussion was made about how confidentiality is ensured. And this is usually done in some VCT centers by anonymous testing and/or keeping clients secret.

Finally, lack of referral systems is also another problem that hinders effective counseling.

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

Some VCT clients reported that they were looking for an on-going support from their counselors. However, their need for a referral system was not being assessed by the service providers and the clients themselves.

Hence, the findings of this study indicated that, efforts to provide care and support services for the clients attending the counseling services was not made in most of the VCT centers.

In general the mismatch between the expectation of clients and practical situation in regard to availability of adequate waiting area, adequate time of counseling sessions, referral system, and care and support, addressing clients' needs, access to VCT, have contributed to the development of unfavorable attitude towards the counseling services.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary:

Voluntary Counseling and Testing is now acknowledged within the international arena as an effective and pivotal strategy, a gateway or an essential tool for both HIV/AIDS prevention and care (treatment). It enables people to learn whether they are infected, understand the implications of their sero status and make more informed choices for the future.

Despite its importance, only a little effort has been done on the area. Moreover, up to now, only a small percentage of those with HIV/AIDS have had access to reliable Voluntary Counseling and Testing services. However, as there is no cure for HIV/AIDS, VCT remains a key strategy to control the spread of HIV and to provide support to those who are positive.

Assessing clients' perception towards voluntary counseling and testing service has felt essential (the general objective of the study) to conduct this study. More specifically, the present study was conducted with the following specific purposes: to explore the clients' perceptions regarding VCT services attendance, to identify clients' expectations of VCT services, to assess barriers to VCT service, to assess the structure, resourcefulness and adequacy of the information given in VCT services compared to clients' needs and to suggest adequate intervention mechanisms to change the perception of clients.

To conduct the study, survey method was used. The instrument used to collect adequate information or data from the respondents was questionnaire.

Arada Sub city was selected among the ten sub-cities found in Addis Ababa using Simple Random Sampling method. And all the VCT centers, found in the sub-city, 7 governmental and 12 private, were included in the study. From each VCT center, 10 clients with equal sex proportion were taken using Purposive Sampling Method. Thus, a total of 190 voluntary clients were taken for the study (i.e. 70 clients from government and 120 clients from private VCT centers). The data were collected directly from the source through administration of questionnaire.

The collected data were tabulated for the purpose of analysis. The analysis for the collected data included statistical application involving Frequency counts, Percentage, Average, Median and Chi-square test.

More than 50% of the clients have positive attitude towards the counseling services.

On the other hand, the majority of the clients have reported that there were separate rooms for the counseling purpose, waiting area which is though it inadequate and with a typical seating office arrangement and also confidentiality was ensured.

The most common problems that clients were facing during their VCT service attendance were: shortage of time allotted for the counseling sessions, lack of adequate waiting area, lack of follow up arrangement and inadequate referral system.

6.2 Conclusions:

From the findings of the study, the following conclusions are drawn:

1. The exploration made based on the results indicates that more than 50% of the clients included in the study had positive attitude of the counseling services. Or in other words, it can be concluded that more than half of the respondents perceive VCT as good.

2. Concerning the second objective of this research i.e clients' expectation of VCT Services, the findings of the study revealed that the demand for VCT is growing up; However, access to VCT services remained limited.

3. With regard to the barriers to VCT Services:
   a) There were adequate place (Counseling Rooms) for privacy with a typical Seating Arrangement, but inadequate Waiting Areas reserved for the counseling purpose;
   b) Lack of referral systems is also another problem that hinder effective counseling; and
   c) The time allotted for each counseling session was not adequate enough to successfully implement the service.

4. Confidentiality was maintained in most of the VCT Centers. Information about the individuals were kept secret by minimizing the access to the records.

6.3 Recommendations:

In light of the findings of the present study, the following points are reasonably recommended:

a) Short Term Recommendations:

1. It is appropriate if there is adequate waiting room or area so that clients can get somewhere to sit out of the public gaze and read relevant materials. Hence, VCT Centers should make it available;
2. A referral system, data base and networking system must be urgently established. VCT centers in association with different responsible bodies should establish such a system.
3. Counseling sessions need to be monitored that they are of adequate enough to accomplish the service effectively. The VCT centers should give empasis to such a problem and give adequate time for each counseling sessions.
4. Efforts must be done to ensure affordable access to VCT services in public and private settings. Hence, MOH together with other responsible bodies should increase access to VCT.

b) Long-Term Recommendations:

1. Since perception is based on information or knowledge, making people aware of the importance of VCT is crucial for controlling the spread of HIV/AIDS.
2. It is also expected from MOH to sensitize policy makers on the importance of VCT.
3. Culturally appropriate HIV/AIDS information must be available to clients.
4. Finally, in order to control the spread of the disease and to eradicate the problem from the country in a sustainable way, further researches need to be done on the area.

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APPENDICES

APPENDIX – A

ADDIS ABABA UNIVERSITY

POSTGRADUATE PROGRAM

DEPARTMENT OF PSYCHOLOGY

A Questionnaire for Clients (Code a)

Dear Participants:-

This questionnaire is designed to assess clients' perception towards VCT services.

At present HIV/AIDS pandemic brought social, development and public health crisis in our society. HIV/AIDS cast a shadow on the future generation who are supposed to nurture the next generation to come and future hope for their country.

Your participation in this study is a great input in the process of preventing HIV/AIDS and your cooperation by giving genuine information is highly valuable to complete the study. And, bear in mind that:-

1. The information to be obtained through the questionnaire is going to be used only for the study undertaking.
2. All information you provide will be treated as confidential.
3. You will not be responsible for the research out come. So you are requested to complete the questionnaire as genuinely as you can.

Would you please complete the questionnaire by giving care and due attention, please!

Thank you

For your cooperation!

The Researcher

PART ONE: Socio-Demographic Profile:

INSTRUCTION: *The following questions are designed to assess your personal data. Please give your responses either by writing the right information on the blank spaces or by circling the letter of your choice:*

1. Name of VCT center you are seeking/ looking for VCT service

_____Sub City _____ Woreda _____ Kebele _____

2. Age: _____

3. Sex: A. Male B. Female

4. Educational status: A. Illiterate B. Primary level
C. Secondary Level D. Tertiary level

5. Occupation: A. Student B. Merchant C. Civil servant
D. Daily worker E. Housewife F. Bar lady G. Military/Police
H. Unemployed I. Others/ specify _____

6. Marital Status:
A. Unmarried B. Married C. Separated
D. Divorced E. Widowed

7. Religion: A. Orthodox B. Muslim C. Protestant
D. Catholic E. Others (specify) _____

PART TWO: Clients' knowledge, Attitude and Practice of VCT

INSTRUCTION: *Please indicate your answer by circling the number of your choice. (**1-Yes** **2-I don't know** **3-No**)*

AIDS transmitted through:

1. Unsafe sexual intercourse	1	2	3
2. From mother to child during pregnancy	1	2	3
3. Through contaminated blood	1	2	3
4. Getting together	1	2	3
5. Insect bite	1	2	3
6. Sharing sharp utensils	1	2	3

PART THREE: Clients' Preference of HIV Prevention:

INSTRUCTION: *Please indicate the degree of your agreement or disagreement by circling the number of your choice.*

5-Strongly Agree 4-Agree 3- Undecided 2-Disagree 1-Strongly Disagree

Which mechanism/option do you use to prevent yourself from being infected by HIV?

1. Abstinence	5	4	3	2	1
2. One-to-one	5	4	3	2	1
3. Use condom	5	4	3	2	1

PART FOUR: Clients' Reason for HIV infection:

INSTRUCTION: *Please indicate the degree of your agreement or disagreement by circling the number of your choice.*

5-*Strongly Agree* **4-*Agree*** **3- *Undecided***

2-*Disagree* **1-*Strongly Disagree***

- **What conditions do you think that forced you/others to do unsafe sex?** *(more than one choice is possible)*

1. Condom is not accessible in time of need	5	4	3	2	1
2. Lack of money	5	4	3	2	1
3. Negligence	5	4	3	2	1
4. Alcohol	5	4	3	2	1
5. "Chat"	5	4	3	2	1

PART FIVE: Attitude of Clients towards the VCT Services:

INSTRUCTION: *Please indicate the degree of your agreement or disagreement by circling the number of your choice.*

5-*Strongly Agree* **4-*Agree*** **3- *Undecided***

2-*Disagree* **1-*Strongly Disagree***

1. Most VCT centers are with attractive environment.	5	4	3	2	1
2. VCT service providers are trustful (confidential).	5	4	3	2	1
3. VCT service providers treat me with respect and dignity.	5	4	3	2	1
4. Generally VCT service delivery does not address the need of clients.	5	4	3	2	1
5. I have an easy access to VCT service in time of need.	5	4	3	2	1
6. Privacy is secured in most VCT centers.	5	4	3	2	1

PART SIX: Clients' Knowledge of VCT:

INSTRUCTION: *Please indicate your answer by circling your choice:*

1. Do you know about Voluntary Counseling and Testing service?

   A. Yes B. No

2. What was your first source of information about VCT?

   A. Family B. Friends C. Health Centers D. School

   E. Mass media F. Anti- AIDS club G. Religious Organizations

3. Where do you get voluntary counseling and testing service?

   (***more than one choice is possible)***

   A. Hospital B. Family C. Health Centre

   D. Private Clinics E. Red Cross clinic

4. Which place is preferable for VCT service?

   A. Hospital B. Clinic

   C. Health Center D. Family Guidance Clinic

5. Is VCT service important?

   A. Yes B. No C. I Don't Know

6. If it is important, why? (***more than one choice is possible)***

   A. To Know One's Status B. To take care

   C. Other (specify) _____

7. When do you think that voluntary counseling and testing is important? ***(more than one choice is possible)***

A. Always B. In time of illness C. Pre- marriage

D. To go abroad E. In- doubt/Hesitation

8. If no charge for VCT; who should be tested?

(more than one choice is possible)

A. Commercial sex workers B. Drivers C. Students

D. Pregnant women E. Couples F. Children and Youth

G. All but children H. Other specify_____

9. Would you test for HIV if it is charge free?

A. Yes B. No C. Undecided

10. If a person is with Positive HIV- status, what should be the next action? ***(more than one choice is possible)***

A. Abstinence B. Give-up bearing child C. Prayer

D. Condom uses E. Medical following-up F. No Solution

11. If you are with negative HIV- status, what will be the next action?

(more than one choice is possible)

A. I will take care of myself B. Condom use

C. Abstinence D. I will have sex partner

E. I won't take measure F. Others specify_____

PART SEVEN: Facilities and Constraints/Barriers

INSTRUCTION: Please circle your choice, except the questions that require written response.

1. Is there a separate room or space to ensure counseling session to be private? A. Yes, there is adequate space C. Not at all

B. Yes, there is some but not adequate

2. Is there a waiting area? A. Yes, there is adequate area C. Not at all

B. Yes, there is some but not adequate

3. How do you rate the waiting area?

A. Very good B. Good C. Poor/Not Good

4. Do you think the number of counseling sessions is adequate?

A. Yes B. Undecided C. No

5. Do you think the time given for each counseling session is adequate?

A. Yes B. Undecided C. No

6. Describe the seating arrangement in the counseling office?

_____

_____

7. Describe what you have discussed to ensure confidentiality?

_____

_____

8. What is your over all opinion of your interaction with the counselor during pretest and posttest counseling?

_____

_____

9. Please list the problems that you encountered in VCT center?

_____

_____

10. What do you think be improved for "Good Quality" counseling services?_____

_____

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

_____

_____

APPENDIX B

አዲስ አበባ ዩኒቨርሲቲ
የድሕረ ምረቃ መርሐግብር
የሳይኮሎጅ ትምህርት ክፍል

ውድ ተሳታፊዎች፡

ይህ መጠይቅ በፈቃደኝነት ላይ የተመሰረተ የምክርና ምርመራ አገልግሎት ፈላጊዎች የአገልግሎቱ ተጠቃሚ እንዳይሆኑ ፈተናና እንቅፋት የሚሆኑባቸውን ነገሮች ለማወቅ የተዘጋጀ ፎርም ነው፡፡

በአሁኑ ሰዓት የኤች.አይ ቪ. / ኤድስ በማህበረሰባችን ላይ እያደረሰ ያለው የማኅበራዊ፣ የኢኮኖሚ እና የጤና ችግር አሉ የሚባል ጉዳይ አይደለም፡፡ በኤች.አይ.ቪ. ምክንያት ብዙ ወገኖቻችንን አጥተናል፡፡ ብሎም ኤች.አይ.ቪ. / ኤድስ የወደፊት ተሥፋና ሐገር ተረካቢ በሆነው አዲሱ ትውልድ ላይ ጥላውን ጥሏል፡፡

የእርስዎ በጥናቱ ላይ ተሳታፊ መሆን ደግሞ ወረርሽኙን ከአገራችን ለማጥፋት ለሚደረገው ርብርብ የበኩሉን አስተዋጽኦ ያበረክታል፡፡

ልብ ይበሉ፡-

1. በመጠይቁ የሚሰበሰበው መረጃ ለጥናቱ አላማ ብቻ ይውላል
2. እርስዎ የሚሰጡት መረጃ በአስተማማኝ ሁኔታ ለታሰበለት አላማ ብቻ ይውላል
3. ለጥናቱ ውጤት እርስዎ ተጠያቂ አይሆኑም

...ስለዚህ በተቻለዎ መጠን መጠይቁን በትክክል እንዲሞሉ ይጠየቃሉ

ስለትብብርዎ አመሰግናለሁ!

ክፍል አንድ፡ የግል መረጃ

መመሪያ :- የማከተሉት ጥያቄዎች የርስዎን ግላዊ መርጃ ለማወቅ የተዘጋጅ ናቸው።

እባክዎ ትክክለኛውን ምርጫዎትን ፊደሉን በማክበብ ይግለጹ:

1. የማእከሉ ስም ---------- ክፍለ ከተማ ---------- ወረዳ ---------- ቀበሌ ------

2. እድሜ _____ ዓመት

3. ጸታ ሀ. ወንድ ለ. ሴት

4. የትምህርት ደረጃ ሀ. ያልተማረ ለ. አንደኛ ደረጃ

ሐ. ሁለተኛ ደረጃ መ. ሦስተኛ ደረጃ

5. ሥራ ሀ. ተማሪ ለ. ነጋዴ ሐ. የመንግስት ሠራተኛ

መ. የቀን ሠራተኛ ሠ. የቤት እመቤት ረ. ሴተኛ አዳሪ

ሰ. ወታደር/ፓሊስ ሸ. ሥራ የሌለው ቀ. ሌላ (ይገለጽ)_____

6. የጋብቻ ሁኔታ ሀ. ያላገባ ለ. ያገባ ሐ. የተለያዩ

መ የተፋታ ሠ. የሞተበት

7. ሃይማኖት ሀ. ኦርቶዶክስ ለ. እሥልምና ሐ. ፕሮቴስታንት

መ. ካቶሊክ ሠ. ሌላ (ይገለጽ)_____

ክፍል ሁለት: ኤች.አይ.ቪ. ለተላለፍ የሚችለው፡-

5- በጣም አስማማለሁ 4- አስማማለሁ 3- ለመወሰን እቸገራለሁ

2- አልስማማም 1- ፈፅሞ አልስማማም

1. በግብረ ሥጋ ግንኙነት	5	4	3	2	1
2. ከእናት ወደ ልጅ	5	4	3	2	1
3. በቫይረሱ በትበከለ ደም	5	4	3	2	1
4. አብሮ በመኖር	5	4	3	2	1
5. በተናካሽ ነፍሳት	5	4	3	2	1
6. ሥለታማ ነገሮች በጋር በመጠቀም	5	4	3	2	1

ክፍል ሦስት: በቫይረሱ ላለመያዝ የሚከላከሉበት መንገድ የትኛው ነው?

5- በጣም እስማማለሁ 4- እስማማለሁ 3- ለመወሰን እቸገራለሁ
2- አልስማማም 1- ፈፅሞ አልስማማም

1. መታቀብ	5	4	3	2	1
2. አንድ ላንድ መወሰን	5	4	3	2	1
3. ኮንዶም መጠቀም	5	4	3	2	1

ክፍል አራት: እርስዎንም ሆነ ሌሎችን ሰዎች ወደ ልቅ የግብረስጋ ግንኙነት ይገፋፋሉ ብለው የሚያስቡዋቸው ምን ዓይነት አጋጣሚዎችን ነው?

5- በጣም እስማማለሁ 4- እስማማለሁ 3- ለመወሰን እቸገራለሁ
2- አልስማማም 1- ፈፅሞ አልስማማም

1. በተፈለገበት ጊዜ የኮንዶም አለመገኘት	5	4	3	2	1
2. የገንዘብ እጥረት	5	4	3	2	1
3. ግዴለሽነት	5	4	3	2	1
4. አልኮል	5	4	3	2	1
5. ጫት	5	4	3	2	1

ክፍል አምስት: *በፈቃደኝነት ላይ የተመሠረተ የምክርና ምርመራ አገልግሎት ተጠቃሚዎች በአገልግሎቱ ዙሪያ ያላቸውን አመለካከት ለመቃኘት የተዘጋጀ መጠይቅ*

5- በጣም እስማማለሁ 4- እስማማለሁ 3- ለመወሰን እቸገራለሁ
2- አልስማማም 1- ፈፅሞ አልስማማም

1	ብዙዎች የምክርና ምርመራ አገልግሎት ጣቢያዎች ምቹና ተስማሚ ናቸው	5	4	3	2	1
2	የምክርና ምርመራ አገልግሎት ባለሙያዎች ታማኝና አስተማማኝ ናቸው	5	4	3	2	1

3	የምክርና ምርመራ አገልግሎት ባለሙያዎች በፍቅርና በአክብሮት አስተናግደውኛል።	5	4	3	2	1
4	ባጠቃላይ የምክርና ምርመራ አገልግሎት አሰጣጥ የተጠቃሚዎችን ፍላጎት ያማከለ አይደለም	5	4	3	2	1
5	በፈለግኩበት ጊዜ ሁሉ የምክርና ምርምራ አገልግሎት ማግኘት እችላለሁ።	5	4	3	2	1
6	በብዙዎች የምክርና ምርምራ አገልግሎት መስጫ ጣቢያዎች ነፃነት ይከበራል።	5	4	3	2	1

ክፍል ስድስት: የአገልግሎት ተጠቃሚዎች ስለ አገልግሎቱ ያላቸው እውቀት:

መመሪያ:- መልስዎን ምርጫዎችን በማክበር ወይም በባዶ ቦታዎች ላይ በመግፍ ይግለፁ።

1. በፈቃደኝነት ላይ ስለተመሰረተ የምክርና ምርምራ አገልግሎት ሰምተው ያውቃሉ?
   ሀ. አዎ ለ. አላውቅም
2. ስለአገልግሎቱ መጀመሪያ መረጃ ያገኙት ከየት ነው?
   ሀ. ከቤተሰብ ለ. ከጋደገኛ ሐ. ከጤና አገልግሎት ሰጪዎች
   መ. ከትምህርት ቤት ሠ. ከመገናኛ ብዙኃን ረ. ከፀረ-ኤድስ ክበባት
   ሰ. ከሃይማኖት ድርጅቶች ሸ. ሌላ /ይገለፅ/ ----------
3. የምክር ምርመራ አገልግሎት ከየት ያገኛሉ?
   ሀ. ከቤተሰብ ለ. ከጋደገኛ ሐ. ከጤና አገልግሎት ሰጪዎች
   መ. ከትምህርት ቤት ሠ. ከመገናኛ ብዙኃን ረ. ከፀረ-ኤድስ ክበባት
   ሰ. ከሃይማኖት ድርጅቶች ሸ. ሌላ /ይገለፅ/ ----------
4. ለምክርና ምርምራ አገልግሎት ተመራጩ ቦታ የትኛው ነው?
   ሀ. ሆስፒታል ለ. ክሊኒክ ሐ. ጤና ጣቢያ
   መ. የቤተሰብ መምሪያ ክሊኒክ ረ. ሌላ /ይገለፅ/ ----------
5. የምክርና ምርምራ አገልግሎት ይጠቅማል?
   ሀ. አዎ ለ. አላውቅም ሐ. አይጠቅምም
6. ጠቃሚ ከሆነ ለምን?
   ሀ. እራስን ለማወቅ ለ. ለጥንቃቄ ሐ. ሌላ ካለ

7. የምክርና ምርምራ አገልግሎት የሚያስፈልገው መቼ ነው?

ሀ. በማንኛውም ጊዜ ለ. በህመም ጊዜ ሐ. ከጋብቻ በፊት

መ. ወደ ውጭ አገር ስመሄድ ሠ. በምንጠራጠርበት ጊዜ

ረ. ሌላ ----------

8. የምክርና ምርምራ አገልግሎት በነፃ የሚሰጥ ቢሆን መመርመር ያለባቸው እነማን ናቸው?

ሀ. ሴተኛ/ወንደኛ አዳሪዎች ለ. ሾፌሮች ሐ. ተማሪዎች

መ. ነፍሰጡር ሴቶች ሠ. እጮኛሞች ረ. ህፃናትና ወጣቶች

ሰ. ከህፃናት በስተቀር ሁሉም ሸ. ሌላ----------

9. የኤች.አይ.ቪ. ምርመራ በነፃ ቢሆን እርስዎ ለመመርመር ዝግጁ ነዎት?

ሀ. አዎ ለ. እርግጠኛ አይደለሁም ሐ. አይደለሁም ----------

10. አንድ ሰው ኤች አይ ቪ ፖዘቲቭ ቢሆን (ቫይረሱ በደሙ ውስጥ ቢገኝ) ማድረግ ያለበት ምንድን ነው?

ሀ. መታቀብ ለ. ልጅ አለመውለድ ሐ. መጸለይ መ. ኮንዶም መጠቀም

ሠ. የህክምና ክትትል ማድረግ ረ. ምንም ተስፋ የለውም

11. ተመርምረው ኤች አይ ቪ ፖዘቲቭ ቢሆኑ (ቫይረሱ በደምዎ ውስጥ ቢገኝ) ምን ያደርጋሉ?

ሀ. እጠነቀቃለሁ ለ. ኮንዶም እጠቀማለሁ ሐ. እታቀባለሁ

መ. ምንም አይነት እርምጃ አልወስድም ሠ. ሌላ

ክፍል ሰባት - የምክርና ምርመራ ማእከሉ አደረጃጀት፡-

መመሪያ፡- ከዚህ ቀጥሎ የቀረቡት ጥያቄዎች መልስዎን ከተሰጡት አማራጮች በመምረጥ ወይም በተሰጡት ባዶ ቦታዎች ላይ መልስ በመጻፍ ያመልክቱ።

1. የምክርና ምርመራ አገልግሎቱ በነፃነት እንዲከበናወን የሚአሰችል በቂና የተለዩ ክፍል አለ?

ሀ. አዎ - በቂ ቦታ አለ ለ. አዎ - መጠነኛ ቦታ አለ ሐ. የለም

2. የእንግዳ ማረፊያ (መቀበያ) ቦታ አለ?

ሀ. አዎ-በቂ ቦታ አለ ለ. አዎ - መጠነኛ ቦታ አለ ሐ. የለም

3. የእንግዳ መበያውን እንዴት ይመገኙታል?

ሀ. በጣም ጥሩ ነው ለ. ጥሩ ነው ሐ. ጥሩ አይደለም

4. ለምክርና ምርመራ አገልግሎት የተመደበው የውይይት ጊዜ ቁጥር በቂ ይመስልዎታል?

ሀ. አዎ ለ. አላውቅም ሐ. አይደለም

5. ለውይይት የተመደበው ጊዜ በቂ ይመስልዎታል?

ሀ. አዎ ለ. አላውቅም ሐ. አይደለም

6. በምክርና ምርመራ አገልግሎት መስጫ ክፍል ወስጥ ያለው ወንበር አቀማመጥ እንዴት ይገልጹታል? _____

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8. በቅድመ እና ድሕረ ምርመራ የውይይት ጊዜ ከምክር አገልግሎት ባለሙያው ጋር ስለነበራችሁ ግንኙት ምን አመለካከት አለዎት? _____

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9. በምክርና ምርመራ አገልግሎት መስጫ ጣቢያው ውስጥ ያጋጠመዎትን ችግር ይዘርገፁ? _____

_____

9. የውይይቱን አስተማማኝነትና ሚስጥራዊነቱ ለማስጠበቅ በምክርና ምርመራ አገልገሎት ወቅት ከባለሙያው ጋር የተደረገውን ውይይት ይግለፀ?

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10. ጥራት ያለው የምክርና ምርመራ አገልግሎት ለመሥጠት መሻሻል ያለበት ብለው የሚአስቡት ነገር ምንድነው? _____

_____

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11. በፈቃደኝነት ላይ ስለተመሰረተ የምክርና ምርመራ አገልግሎት ያለዎት አጠቃላይ አስተያየት ምንድነው? _____

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APPENDIX C

Frequency Table for Socio-Demographic Profile of Clients

VCT type	Frequency	Percent
Gov	70	36.8
Priv	120	63.2
Total	190	100.0
Age	Frequency	Percent
<20	26	13.7
21-40	98	51.6
>41	66	34.7
Total	190	100.0
Sex	Frequency	Percent
male	95	50.0
female	95	50.0
Total	190	100.0
Educational Level	Frequency	Percent
Illiterate	32	16.8
Primarr	48	25.3
Secondary	68	35.8
Teritiary	42	22.1
Total	190	100.0
Occupation	Frequency	Percent
Student	33	17.4
merchant	18	9.5
Civil Servant	42	22.1
Daily Worker	17	8.9
House Wife	12	6.3
Bar lady	16	8.4
Military/Police	6	3.2
Unemployed	24	12.6
others	22	11.6
Total	190	100.0
Marital Status	Frequency	Percent
unmarried	86	45.3
married	60	31.6
separated	22	11.6
divorced	13	6.8
widowed	9	4.7
Total	190	100.0
Religion	Frequency	Percent
orthodox	85	44.7
muslim	61	32.1
protestant	25	13.2
catholic	12	6.3
others	7	3.7
Total	190	100.0

APPENDIX D

Frequency Table for Clients' Response Rate

Clients' Knowledge of HIV transmission

HIV knowledge 1	Frequency	Percent
Yes	190	100.0
HIV knowledge 2	Frequency	Percent
Yes	152	80.0
I don't know	38	20.0
Total	190	100.0
HIV knowledge 3	Frequency	Percent
Yes	181	95.3
I don't know	9	4.7
Total	190	100.0
HIV knowledge 4	Frequency	Percent
No	190	100.0
HIV knowledge 5	Frequency	Percent
Yes	158	83.2
I don't know	18	9.5
No	14	7.4
Total	190	100.0
HIV knowledge 6	Frequency	Percent
Yes	190	100.0

Clients' Preference of HIV Prevention

HIV prevention1	Frequency	Percent
strongly disagree	7	3.7
disagree	37	19.5
undecided	18	9.5
agree	56	29.5
strongly agree	72	37.9
Total	190	100.0
HIV p:evention2	Frequency	Percent
strongly disagree	6	3.2
disagree	12	6.3
undecided	19	10.0
agree	57	30.0
strongly agree	96	50.5
Total	190	100.0
HIV prevention3	Frequency	Percent
strongly disagree	63	33.2
disagree	46	24.2
undecided	37	19.5
agree	25	13.2
strongly agree	19	10.0
Total	190	100.0

Clients' Reason for HIV infection

Reason1	Frequency	Percent
strongly disagree	39	20.5
disagree	50	26.3
undecided	50	26.3
agree	44	23.2
strongly agree	7	3.7
Total	190	100.0

Reason2	Frequency	Percent
strongly disagree	45	23.7
disagree	71	37.4
undecided	43	22.6
agree	19	10.0
strongly agree	12	6.3
Total	190	100.0

Reason3	Frequency	Percent
strongly disagree	6	3.2
disagree	19	10.0
undecided	26	13.7
agree	44	23.2
strongly agree	95	50.0
Total	190	100.0

Reason4	Frequency	Percent
strongly disagree	13	6.8
disagree	25	13.2
undecided	26	13.7
agree	62	32.6
strongly agree	64	33.7
Total	190	100.0

Reason5	Frequency	Percent
strongly disagree	7	3.7
disagree	32	16.8
undecided	44	23.2
agree	70	36.8
strongly agree	37	19.5
Total	190	100.0

Clients' Attitude towards VCT Services

VCT attitude1	Frequency	Percent
strongly disagree	15	7.9
disagree	31	16.3
undecided	30	15.8
agree	66	34.7
strongly agree	48	25.3
Total	190	100.0

VCT attitude2	Frequency	Percent
strongly disagree	2	1.1
disagree	4	2.1
undecided	46	24.2
agree	81	42.6
strongly agree	57	30.0
Total	190	100.0

VCT attitude3	Frequency	Percent
strongly disagree	12	6.3
disagree	31	16.3
undecided	7	3.7
agree	71	37.4
strongly agree	69	36.3
Total	190	100.0

VCT attitude4	Frequency	Percent
strongly disagree	43	22.6
disagree	30	15.8
undecided	20	10.5
agree	42	22.1
strongly agree	55	28.9
Total	190	100.0

VCT attitude5	Frequency	Percent
strongly disagree	51	26.8
disagree	68	35.8
undecided	12	6.3
agree	29	15.3
strongly agree	30	15.8
Total	190	100.0

VCT attitude6	Frequency	Percent
strongly disagree	16	8.4
disagree	22	11.6
undecided	37	19.5
agree	56	29.5
strongly agree	59	31.1
Total	190	100.0

Clients' Knowledge of VCT

VCT knowledge1	Frequency	Percent
yes	190	100.0

VCT knowledge2	Frequency	Percent
family	7	3.7
friends	13	6.8
health centers	31	16.3
school	44	23.2
mass media	45	23.7
anti HIV/AIDS clubs	38	20.0
religious organizations	12	6.3
Total	190	100.0

VCT knowledge3	Frequency	Percent
hospitals	32	16.8
family	36	18.9
health centers	52	27.4
private clinics	51	26.8
red cross clinics	19	10.0
Total	190	100.0
VCT knowledge4	Frequency	Percent
hospital	58	30.5
clinics	56	29.5
health centers	51	26.8
family planning clinics	25	13.2
Total	190	100.0
VCT knowledge5	Frequency	Percent
yes	127	66.8
no	38	20.0
I don't know	25	13.2
Total	190	100.0
VCT knowledge6	Frequency	Percent
0	63	33.2
to know one's status	53	27.9
to care	43	22.6
other	31	16.3
Total	190	100.0
VCT knowledge7	Frequency	Percent
0	63	33.2
always	60	31.6
when ill	9	4.7
before marriage	35	18.4
when going abroad	10	5.3
hesitation	13	6.8
Total	190	100.0
VCT knowledge8	Frequency	Percent
prosutestit	25	13.2
drivers	19	10.0
students	25	13.2
pregnants	7	3.7
couples	13	6.8
children & youth	7	3.7
All except children	31	16.3
others	63	33.2
Total	190	100.0
VCT knowledge9	Frequency	Percent
yes	100	52.6
no	71	37.4
I don't know	19	10.0
Total	190	100.0

VCT knowledge10	Frequency	Percent
abstienance	39	20.5
stop giving birth	13	6.8
prayer	19	10.0
condom	18	9.5
health treatment	80	42.1
suicide	21	11.1
Total	190	100.0

VCT knowledge11	Frequency	Percent
I'll care	88	46.3
condom	25	13.2
Abstienance	38	20.0
I will have sxual partner	32	16.8
I won't take measure	7	3.7
Total	190	100.0

VCT Facility and Constraints

VCT facility1	Frequency	Percent
yes-adequate	149	78.4
yes-not adequate	41	21.6
Total	190	100.0

VCT facility2	Frequency	Percent
yes-adequate	89	46.8
yes-not adequate	101	53.2
Total	190	100.0

VCT facility3	Frequency	Percent
very good	88	46.3
good	102	53.7
Total	190	100.0

VCT facility4	Frequency	Percent
yes	81	42.6
undecided	65	34.2
no	44	23.2
Total	190	100.0

VCT facility5	Frequency	Percent
yes	89	46.8
undecided	61	32.1
no	40	21.1
Total	190	100.0

APPEENDIX F

Reliability coefficient

Clients' Knowledge of HIV transmission: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
HIVknow1	17.76	10.047	.778	.698	.722
HIVknow2	18.21	10.806	.663	.489	.752
HIVknow3	17.80	10.023	.745	.615	.729
HIVknow4	20.34	15.959	-.139	.058	.883
HIVknow5	18.29	10.514	.594	.379	.769
HIVknow6	17.87	10.473	.728	.616	.737

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.805	.775	6

Clients' Preference of HIV Prevention: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
HIVprev1	6.65	12.822	.654	.447	.624
HIVprev2	6.39	11.699	.532	.286	.766
HIVprev3	7.81	12.390	.613	.416	.660

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.762	.770	3

Clients' Reason for HIV infection: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Reason1	14.06	33.208	.808	.757	.586
Reason2	14.29	32.567	.825	.746	.577
Reason3	12.72	34.025	.827	.730	.579
Reason4	13.29	66.463	-.005	.040	.828
Reason5	13.49	64.283	.131	.029	.805

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.758	.665	5

Clients' Attitude towards VCT Services: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
VCTattitude1	17.67	84.625	.830	.719	.853
VCTattitude2	17.31	85.252	.893	.814	.844
VCTattitude3	17.37	85.293	.819	.711	.855
VCTattitude4	17.96	84.427	.760	.604	.866
VCTattitude5	18.57	83.241	.799	.664	.858
VCTattitude6	17.72	124.213	.098	.038	.934

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.892	.869	6

Clients' Knowledge of VCT: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
vctknow1	28.53	226.790	.481	.856	.732
vctknow2	25.46	238.440	.422	.464	.741
vctknow3	26.75	223.722	.580	.724	.722
vctknow4	27.18	179.400	.794	.913	.674
vctknow5	27.87	169.497	.694	.847	.692
vctknow6	28.28	205.874	.550	.877	.719
vctknow7	28.06	206.959	.505	.860	.726
vctknow8	24.84	262.127	-.005	.031	.788
vctknow9	28.24	264.785	.136	.139	.763
vctknow10	26.14	260.207	.105	.051	.767
vctknow11	27.59	266.815	.012	.068	.770

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.758	.719	11

VCT Facility and Constraints: Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
VCTfacility1	7.46	50.260	.885	.798	.759
VCTfacility2	7.39	77.436	.918	.868	.795
VCTfacility3	7.45	77.074	.928	.873	.793
VCTfacility4	6.97	42.951	.924	.907	.765
VCTfacility5	7.32	105.383	.016	.081	.914

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.852	.856	5

Declaration

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

Name: Temesgen Tadele

Signature: _____

Date: July 30, 2007

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

Name: Yusuf O. Abdi (Ph.D)

Signature: _____

Date of Approval _____