

**ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCE
SCHOOL OF PUBLIC HEALTH**

**EFFECT OF COMMUNITY CONVERSATION
TOWARDS VCT UTILIZATION IN RURAL SNNPR**

By

EMEBET TEKLETSADIK (BSc in PH)

ADVISOR

Prof.MESGANAW FANTAHUN (MD, MPH, PhD)

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Emebet Tekletsadik

Approved by the Examining Board

Chairman, SPH

Prof.Mesganaw Fantahun

Advisor

Examiner

Signature

Signature

Signature

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BSc	Bachelor of Science
CI	Confidence Interval
CC	Community Conversation
EDHS	Ethiopia Demographic and Health Survey
FGD	Focus Group Discussion
HAPCO	HIV/AIDS Prevention and Control Office
HEWs	Health Extension Workers
HI	Health Institution
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitude, and Practice
NGO	Non -Governmental Organization
OR	Odds Ratio
PI	Principal Investigator
PIHCT	Provider Initiated HIV Counseling and Testing
PLWHAs	People Living With HIV/AIDS
SNNPR	Southern Nations Nationalities and Peoples Region
STI	Sexual Transmitted Infection
UNDP	United Nation Development Programme
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ABSTRACT

Background information: In contrast to, many initiatives implemented to prevent HIV/AIDS infection; many countries have not so far achieved the planned reduction in HIV/AIDS infection; the main reason mentioned so far being low utilization of VCT for HIV/AIDS. Community Conversation (CC) is a community based strategy meant to enhance the community to utilize VCT for HIV among many other functions.

Objective: This study is aimed to determine the disparity in knowledge, attitude and practice towards VCT service utilization of population 15-59 years age, between well and poor community conversation performing rural kebeles of Shebe Dino woreda, SNNPR.

Methodology: A cross sectional comparative community based study design was employed to compare the knowledge, attitude and practice towards VCT service among 15-59 years age population between poor and well community conversation performing rural kebeles in Shebe Dino woreda, from August 2010-May 2011. Kebeles were classified as poor or well based on their community conversation performance. A total of 6 kebeles (3 from each CC group) were selected by lottery method after stratifying each CC groups into three strata by their relative distance from the Woreda capital. The number of study participants sampled from each kebele is proportional to the size of study population in the kebele. A total sample of size 462, 231 (50%) from each comparative group were selected and studied. The qualitative data was collected from Focused Group Discussion and analyzed by thematic analysis. A hierarchical logistic regression model was used to determine independent predictors of VCT uptake in blocks of two at 95% CI.

Result: The two CC groups were homogeneous in their major socio demographic factors using two sample test of proportion ($P > 0.05$), and hence were comparable. VCT Knowledge didn't show statistically significant difference between well and poor CC performing kebeles, with a two sample proportion test of difference and 95% CI: 0.05 (-0.04, 0.14). But, attitude and utilization of VCT service was statistically higher in well CC performing kebeles than poor CC performing kebeles (73.0% vs.54.1%, $P < 0.001$) and (97.8 vs. 93.8, $P = 0.034$) respectively. Age group between 15-24 years, single, trader, knowledgeable about HIV transmissions, and positive attitude to VCT services were independent predictors of VCT service utilization.

Conclusion: Proportion of study participants' with positive attitude towards VCT and practice of VCT service utilization was higher in a well CC group compared to a poor CC kebeles. However the study population in the two CC groups is not different by their knowledge towards VCT service (i.e. CC does have effect on VCT attitude and practice but not on knowledge). VCT service utilization depends on one's age, occupation, marital status and knowledge of HIV transmission. Therefore, there should be consistent monitoring and evaluation of the CC program, not only by the criteria in use but also in terms of its effect on KAP of the target population towards VCT and or HIV to strengthen CC in all CC kebeles.

Key words: SNNPR, Shebe Dino woreda, knowledge, attitude and practice, VCT, well and poor community conversation performance

1. INTRODUCTION

1.1. Background

HIV/AIDS is a major crisis that is increasingly affecting the most productive segments of the population across development sectors in sub-Saharan African countries including Ethiopia. On the basis of the 2010 report, the global number of people living with HIV/AIDS was 33.3 million. Surprisingly, the sub-Saharan African countries, which constitute only 10 % of the world population bear a huge global burden about 22.5 million or 68% of the world wide HIV infection occurred in this region(1).

VCT for HIV/AIDS is included as one of the strategies for HIV/AIDS prevention in the recently approved National HIV/AIDS Policy (2). It is a vital point of entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, tuberculosis (TB) control, psychosocial and legal support, and prevention of mother-to-child transmission of HIV (PMTCT). High-quality VCT enables and encourages people with HIV to access appropriate care and is an effective HIV-prevention strategy, it also alleviates anxiety, increases clients' perception of their vulnerability to HIV, promotes behavior change, facilitates early referral for care and support including access to antiretroviral (ARV) therapy and assists in reducing stigma in the community. (2-4).

A study conducted from 1998-1999 in Ethiopia, on the effect of HIV-VCT on HIV incidence among a cohort of study participants indicated that HIV-VCT utilization decreases the incidence of HIV infection (5). In the absence of VCT services most women in Africa have no definitive way of knowing their HIV status until they themselves fall ill with identifiable symptoms of AIDS, or until they give birth to a baby who is diagnosed with the virus, and eventually dies from AIDS. HIV counseling began in Ethiopia in the late 1980s with services expanding throughout the 1990s (6).

Factor affecting VCT services utilization are availability and acceptability of VCT services, including legal issues, waiting time, worries about confidentiality and fear that results would be shared with parent(s) or partner(s) without their consent, inaccurate risk perception, fear of being labeled and stigmatized by families, friends and communities, perceptions of the consequences

of living with HIV, and inadequate responses from health care providers, including counselors. These all need attention to effectively meet the HIV prevention, care and support needs of youth (2, 7-10).

Despite of the benefits, VCT uptake remains low; the Ethiopian DHS revealed that only 2% of men have been tested for HIV, indicating that many people with HIV/AIDS in Ethiopia do not know their HIV serostatus (11).

To strengthen the country's(Ethiopia's) coordinated multi-sectorial anti HIV/AIDS response, preparation of different policies, programs, guidelines and plans, a new strategy; Community Conversation which can be used as one of the social mobilization tool for prevention and control of HIV/AIDS has been launched (12).

Community Conversation was initiated in Ethiopia in 2002 by the National HIV/AIDS Prevention and Control Office (NHAPCO) and in a first phase rolled out by NGOs with UNDP financial assistance targeting HIV prevention. It is highly flexible but dependent on the facilitators' skills to forward instead of dominating a group. Identifying, training and follow-up of skilled facilitators are critical for successful implementation of CC. The facilitators must be guided by a value system that includes sensitivity to local community experiences, gender sensitivity, respect, commitment to reduction of vulnerabilities, improvement of sexual and reproductive health and upholding human rights (13).

1.2. Rationale of the study

The fundamental outcome of CC is empowerment of communities and individuals to identify and address issues that are important to them (13). It is a powerful tool to reduce risk behavior towards HIV deep-rooted in a community's local context and promotes HIV prevention and stigma reduction (7, 13). However, data are scarce on the effectiveness of the program in Ethiopia. Therefore availing scientifically sound data on the aforesaid gaps will have paramount importance for evaluation of the program and differentiated approach for the implementation of the program. Therefore, this study is designed to assess the effect of CC intervention on knowledge, attitude and utilization of HIV/AIDS voluntary counseling and testing service while bridging the aforesaid gaps.

2. LITERATURE REVIEW

2.1. Knowledge, attitude and practice toward HIV/AIDS voluntary counseling and testing service.

Numbers of studies have assessed VCT information. From a study done in rural community of central Africa only 55.8% had ever heard about VCT (14). Compared to one study conducted inside the country; 93% in Mersa town, North Wello (15), those who know about the importance of VCT to know self sero status was low in Northern Nigeria; 55.0% in 2005 (16).

A pilot study done in Haraghe 2008 showed that most of study participants in different CC sites agreed on the importance of utilizing VCT services (13). Similarly 99.2% of study subject in Jijiga town agreed on the importance of utilizing VCT services and 84.0% recommend HIV test for their peers (17).

From a cross sectional study 26.8% of study participants' utilized VCT service in Nakuru, Kenya and 9.1% of them hadn't received counseling after HIV testing (18). A pilot study done in Haraghe district showed that 2916 CC members and their spouses underwent VCT during the project time (13). Forty four percent of study participants were tested after CC from study conducted in KwaZulu-Natal, Denmark (19). Another study done in Mersa town, North Wollo showed that 26.1% of the study participants utilized VCT service and of them 18.6% underwent HIV test before six months, 49.4% before one year, 27.9% before two years and 3.9% before three years (15). Similarly, in a study undertaken in Rakai, Uganda, 62.2% accepted VCT (20).

2.2. Factors affecting VCT service utilization

Different studies revealed different factors affecting VCT service utilization positively or negatively. Unlike a study finding from Uganda (20) a study conducted in North and South Gonder in 2004, with 96% response rate showed that; age from 15-19 years was found to be positively associated with VCT service utilization. In the same study 79.8% of males and 86.3% of the females were found to be willing to accept VCT. There was no significant gender difference among males and females in VCT acceptance with (p-value = 0.09) (21). This finding is in agreement with studies elsewhere (11, 20, 22).

A study undertaken in rural Tanzania showed that socio-demographic factors, such as marital status, area of residence, religion and ethnicity influenced VCT uptake among males and females in different ways, while self-perceived risk of HI, prior knowledge of VCT, and sex with a high-risk partner emerged as important predictors of VCT uptake among both sexes (23).

Another study conducted in rural community of central Africa showed that, significantly more singles expressed preparedness to test for HIV in the next six months ($p = 0.040$) than married ones. Singles were more likely to worry about their partners' current HIV status than married ones ($p < 0.001$). When compared with women, men showed more likelihood of responding to pressure from friends to test for HIV ($p = 0.039$) (14). Discussing HIV testing with family members was strongly associated with planning to test. VCT discussions with sex partners and with friends were also associated with HIV testing plans. Significant individual factors associated with VCT were: having ever had sex and HIV risk perception from study done in Ndola, Zambia (24).

From a study undertaken in Blantyre, Malawi the main reasons for seeking HIV counseling and testing were: recent knowledge about HIV 31.4%, current illness 22.5%, self-assessment of own behavior as risky 15.5%, suspecting sexual partner's unfaithfulness 13.7% and seeking HIV confirmatory test 9.8% and other reasons 6.9% (25). A study in South Africa showed that AIDS-related stigmas were persistent in some segments of South African society and stigmas can hamper efforts to promote voluntary counseling and testing and other HIV-AIDS prevention efforts (26).

VCT acceptance was lower among persons with no prior VCT, individuals with primary education or higher, individuals who were HIV-positive and persons reporting condom use in the past 6 months; consistent users. VCT acceptance was higher among the currently married and previously married. There was no statistically significant difference in utilizing VCT service by age, gender, and self-perception of HIV risk (20). VCT service utilization was positively affecting by educational status, urban residency, and masculine sex, being younger than 40 years old and unmarried status in men (11, 22). The main reason for not having VCT was self and partner trust in a study conducted in rural communities of Chiang Mai Province, Northern Thailand (27).

3. OBJECTIVES

3.1. GENERAL OBJECTIVE

To determine the disparity in KAP towards VCT service utilization among 15-59 years of age population between rural kebeles with poor and well community conversation performance on HIV/AIDS in Shebe Dino woreda, SNNPR, Ethiopia.

3.2. SPECIFIC OBJECTIVES

- To determine the difference in knowledge towards VCT service between well and poor community conversation performing rural kebeles among 15-59 years of age population.
- To assess the difference in attitude towards VCT service between well and poor community conversation performing rural kebeles among 15-59 years of age population.
- To examine the difference in practice towards VCT service between well and poor community conversation performing rural kebeles among 15-59 years of age population.
- To identify factors associated with VCT service utilization between well and poor community conversation performing rural kebeles among 15-59 years of age population

4. METHODOLOGY

4.1. Study Area and Period

The study was conducted in Shebe Dino woreda which is one of the 19 woredas in Sidama zone, Southern Nations Nationalities and Peoples Region, from August 2010–May 2011. Sidama zone is one of the administrative zones of Southern Nations Nationalities and Peoples Region. It is situated 274 km south of Addis Ababa. The capital of the zone, Hawassa town serves as the capital city of the region. The woreda town is Leku. It is 27km far from Hawassa town. It borders with four woreda: Dales woreda in the south, Hawassa zuria woreda in the north, Boricha woreda in the west and Gorche woreda in the East. The woreda comprise 35 kebeles (3 urban kebeles and 32 rural kebeles).

Based on the figure by the Central Statistic Agency in 2007, the woreda has the total population of 253,769, of whom 128,034 were men and 125,735 women; the total number of households in the woreda was 53,825 and the average population density was 936 people per square kilometer.

In the woreda, there is one district hospital, eight health centers, thirty two health posts, one private clinic and eleven Rural Drug vendors. In the woreda seven NGOs are working on HIV/AIDS.

4.2. Study Design

A cross sectional comparative community based study was conducted to determine the disparity in KAP towards VCT service utilization among population age between 15-59 years in rural kebeles with poor and well community conversation performance in Shebe Dino woreda, SNNPR, Ethiopia. The study employed both quantitative and qualitative (Focus Group Discussions /FGDs) methods.

Rural kebeles were classified into well and poor CC groups based on their major activities on CC performance. Four major criteria (CC methodology frame work, number of participants and CC groups, number of decisions undertaken and document handling and reporting) which were used by the woreda health office Multi-sectorial HIV/AIDS Response Core Process to monitor the kebele's CC performance by their CC were considered to classify the study kebeles into well and poor CC groups. These criteria were used by Zonal Health Department to award the kebeles in

the woreda by ranking all the kebeles in the woreda (as first, second, third.....) by their CC performance. In this study, the CC performance of each kebele was evaluated by giving weights to each activity (aforementioned four major criteria). Accordingly, all kebeles were evaluated out of ten (the sum of scores to each activity under the four criteria). A Kebele was labeled as a poor CC group if its CC score was less than the median value of 4.75; otherwise it was labeled as a well CC kebele. The validity of the cutoff point used to classify study kebeles in to well and poor CC groups in this study, was cross checked by comparing the kebeles labeled as well and poor against their ranks given by the Zonal health department. Accordingly kebeles which fall under well CC group were found to occur in the first 12 kebeles where as poor CC kebeles appeared beyond the first 12 kebeles.

Instrument used to classify well and poor CC performing kebeles, is presented in annex 5.

4.3. Population

Source Population: The source population is 15-59 years old population residing in rural kebeles implementing CC in Shebe Dino woreda.

Study Population: The Study Population is 15-59 years old population living in the selected six kebeles of the Woreda where the study was conducted.

Inclusion Criteria: population 15-59 years old and lived in the kebeles for at least six month were included.

Exclusion Criteria:

- Those who were mentally retarded were excluded from the study.
- Kebeles which stopped the CC activities were excluded.

4.4. Sample Size Calculation

The sample size was calculated using two population proportion determination formula: by taking proportion of VCT service utilization of 20.1% among kebeles with well CC performance from a previous study (28). Because of scarcity of data on VCT service utilization among kebeles with poor CC performance, a 10% difference in proportion of VCT service utilization between well and poor CC performing kebeles was assumed to make a 10.1% the proportion of VCT service utilization among kebeles with poor CC performance.

Other assumptions considered for the sample size determination were: 95% confidence level, 80% power, level of significance; $\alpha=0.05$ and $r=1$. Finally sample size was calculated using sample size calculator for two population in Epi-info version 3.3.2.

$$n_1 = \frac{\left[Z_{\alpha/2} \sqrt{\left(1 + \frac{1}{r}\right) P(1-P)} + Z_{\beta} \sqrt{P_1(1-P_1) + \frac{P_2(1-P_2)}{r}} \right]^2}{(P_1 - P_2)^2}, \quad n_2 = n_1 r$$

Where:

n_1 = sample size from poorly performing kebeles, n_2 = sample size from well performing kebeles

P_1 = proportion utilized VCT in kebeles performing CC poorly,

P_2 = proportion utilized VCT in kebeles performing CC well.

$P_1 - P_2$ = effect size, P = average proportion

α = level of significance = 0.05

$1 - \beta$ = desired power = 80%

r = ratio of poorly to well performing = $n_1/n_2 = 1:1$

Z_{β} = coefficient at level of power 80% = 0.84

$Z_{\alpha/2}$ = coefficient at 95% confidence interval = 1.96

$P = (P_1 + P_2)/2$, $P_1 = 0.101$, $P_2 = 0.201$

$n_f = n_1 + n_2 = 220 + 220 = 440$. The final total sample size, 462 (231 from each comparable kebeles) was used by considering allowance for possible non-response rate of 5%.

4.5. Sampling Procedure

4.5.1. For the quantitative study

The study used five steps for sampling.

Out of 35 rural kebeles in the Woreda, 25 qualified to be sampled (seven kebeles had stopped CC)

Step 1: The 25 rural kebeles in the woreda were stratified by their CC status into well (n=13) and poor (n=12) CC performing kebeles using the annexed criteria (Annex 5).

Step 2: Then the kebeles under the two strata (well and poor) CC performing kebeles were further stratified into proximal, medium and distal by their distance from the capital of the woreda (Leku).

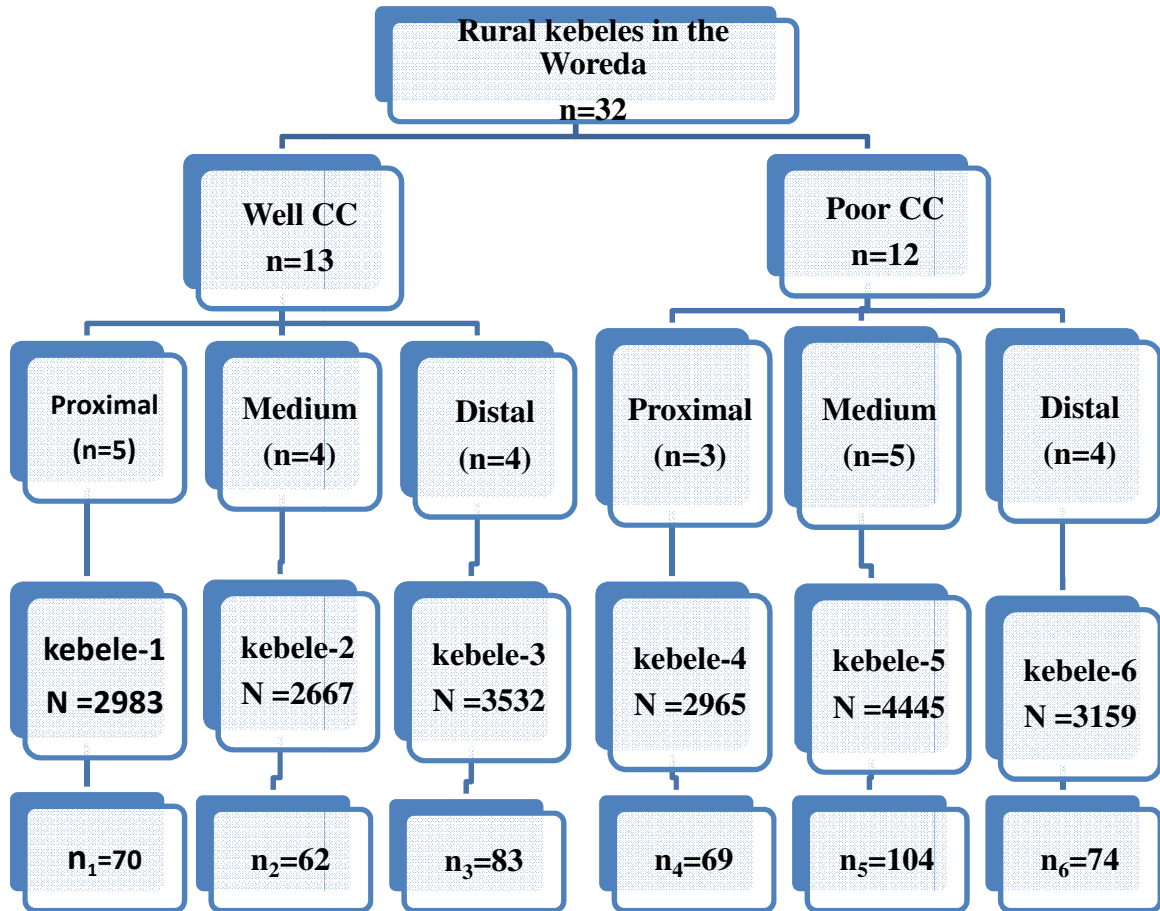
All kebeles in a given strata were assumed to be homogenous.

Step 3: One kebele was selected from each stratum by lottery method from proximal, medium and distal for each well and poor CC performing kebeles separately to be included into the sample.

Step 4: From each selected kebeles, individuals to be included into the study were determined proportionally with respect to size of eligible population in the selected kebeles.

Step 5: Finally by being at the center of the selected kebele a pen was spinned. A random direction towards the pointer of the pen was followed for data collection starting from the household in the center of the kebele until the required sample size is obtained. Data were collected from each kebele until the allocated sample size was reached. If there were no adequate study participants in the direction followed, data collectors turned to left or right straight until the desired number of study participants were got.

Schematic presentation of Sampling Technique



Key:

- N –eligible study population in selected kebeles
- $n_f = n_1 + n_2 + n_3 + n_4 + n_5 + n_6$ (the sum of the sample size in the selected kebeles)=total sample size.

Figure: 1 Schematic presentation of sampling frame.

4.5.2. For qualitative study

FGD participants (those who lived for six month in the kebeles, who know the language of the societies and those who were not selected for the quantitative study) were selected purposively. FGDs were organized for four different groups, for male and female group, two FGDs for each

well and poor CC groups. It was conducted in Morocho Negasha kebeles from well CC group and in Dobe Toga from poor CC group.

4.6. Data Collection Procedures

4.6.1. Quantitative Data

A structured questionnaire was adopted from BSS, other previously done similar studies and different materials on the topic (28, 29) which was translated in to Sidamgna language. Data were collected after conducting pre-test on 15% of the study participants in a place similar with the study area and modifications were done based on the findings. Information on Socio-demographic variables, CC, Sexual History and condom use, HIV/AIDS and VCT, Stigma and Discrimination was collected, which is presented in annex 3.

The interviewers were four males and four females Diploma Nurses whose mother's tongue language is Sidamgna, collected the data after two day training on households of the selected kebeles. Same gender interviewers were used to decrease embarrassment as some of the questions are about personal sexual lifestyle issues. One male and female data collector entered in to one house. In case they didn't get the targeted study subject; they went to the next house. Interview was conducted face-to-face in a household. One BSc degree holder in public health and PI supervised the data collection.

4.6.2. Qualitative Data

A focus group discussion was conducted after analyzing the quantitative study to get insight in to issues that cannot be addressed by the quantitative survey. Each session included 8 participants and lasted for 60-80 minutes. The sessions were held in areas convenient to the participants near their homes. Semi structured open-ended questions were used to guide the discussions. The discussions were moderated by the principal investigator and experienced MPH holder, which were assisted by translator and note taker. Each discussion was tape recorded after consent was obtained from the participants. Responses were transcribed and translated in to English. Thematic analysis was used to analyze the FGD data. Most important findings were incorporated in the report.

4.7. Data quality management

To ensure data quality, consistency was checked by translating the Sidamgna version back to English. Forward and back ward translation was done by different persons who had BSc degree in Public Health and Sidamgna language is their mother tongue. Pre-test was undertaken on the questionnaire before the actual data collection to construct the validity of the instrument.

The data collectors and supervisors were provided with intensive training on the objective of the study, contents of the questionnaires, interview techniques, and maintaining confidentiality of responses. The collected data were checked by Principal investigator on daily basis for incompleteness and/or inconsistency. If any incompleteness and/or inconsistencies appear, correction was made by going back to the household for which incompleteness appears.

Data were entered into Epi Info as part of data quality management. In data cleaning, logical checking techniques were employed to identify errors.

4.8. Data Entry and Processing

The questionnaires were checked for completeness and consistency by the principal investigator and then classified as partially incomplete and complete. Out of total questionnaires 2.2% were excluded from the analysis because they were partially filled. Fully completed questionnaires were coded and entered in to Epi Info version 3.5 for cleaning and exploration.

4.9. Data Analysis

The cleaned data were exported to SPSS 16.0 for windows for statistical analysis. Two sample proportion calculator in Stata version 9 was used to test hypothesis on population proportion differences in KAP of the study participants. The first step before analysis was data exploration to visualize the general feature of the data to be analyzed. After exploration, Percentages were used to determine the magnitude of KAP to ward VCT service among two groups of populations (poor and well CC Performing kebeles). Data were presented using tables and charts.

A two sample proportion test was used to test the presence of significant statistical difference in the proportion of VCT service utilization between poorly and well CC Performing kebeles, if any.

To determine the association between different predictors and VCT service utilization a logistic regression model was employed. First, each predictor was entered into a separate binary logistic

regression model to determine the crude effect of each variable on VCT uptake. Second, to account for the effect of confounders, a hierarchal logistic regression model was used in blocks of two. Socio demographic variables were entered in block one, followed by knowledge and attitude related variables entered into block 2 to determine the independent effects of the later predictors. Variables which were significant at a p value of 0.05 in the final multivariate logistic regression model were retained as independent predictors of VCT service utilization.

4.10. Study Variable

Dependent variable

- VCT service utilization

Independent variables

- Socio-demographic factors
- Socio- economic variables
- Knowledge about HIV/AIDS
- Importance of VCT
- Reason to utilize the service,
- Attitude toward PLWHAs
- substance abuse
- poor and well CC performance

4.11. Measurement of variables

Knowledge about VCT: was measured using twenty two “Yes” and “No” questions on knowledge of VCT service. Summated score of knowledge of VCT service was taken by summing positive responses for the questions. The median of the knowledge question (11) taken as a cutoff point for having a better awareness; therefore, participants with 11 or more scores were considered as knowledgeable about VCT service and who score less than 11 are taken as not knowledgeable.

Knowledge about HIV/AIDS transmission: was measured using four “Yes” and “No” questions on knowledge of HIV/ AIDS transmission. Summated score of knowledge about HIV/AIDS transmission was taken by summing positive responses for the questions. After revising the score of knowledge for HIV/AIDS transmission, a cutoff point 2 was taken as

having a better awareness; thus participants with 2 or more scores were considered as having a good knowledge for HIV/AIDS transmission.

Knowledge towards HIV/AIDS prevention: was measured using three “Yes” and “No” questions on knowledge of HIV/ AIDS prevention such as abstinence, faithfulness and condom. Summated score of knowledge about HIV/AIDS prevention was taken by summing positive responses for the questions. After revising the score of knowledge for HIV/AIDS prevention, a median value 2 was taken as having a better awareness; thus participants with 2 or more scores were considered as knowledgeable to HIV/AIDS prevention.

Stigmatizing Attitude: The numbers of indicators are six, namely: not willing to share meal with a person infected with HIV, not willing to give care to a relative patient, not willing to buy food from an HIV infected food seller/shop keep, want to keep secret the sero-status of an HIV infected household member, If a student has HIV, but is not sick, should he or she be allowed to continue attending school? If a teacher has HIV, but is not sick, should he or she be allowed to continue teaching? Those respondents with median score and above related to questions on HIV related stigma are considered as having stigmatizing attitude and those who score less than median are considered as not having stigmatizing attitude.

4.12. Operational Definition

Anonymous HIV Testing: Clients’ identifying information is not linked to testing information.

Attitude toward VCT: Those who agree on the importance of VCT in reducing HIV virus spread considered as having positive attitude reversely those who disagree considered as having negative attitude.

Community conversations: are facilitated sessions where people in the village or area can meet, engage in open discussions about issues in their community, identify and explore concerns and myths, catalogue resources available within the community and agree on areas where they need external support .

Counseling: Confidential dialogue between a client and care provider aimed at enabling the client to cope with stress and make personal decision related to HIV/AIDS.

Confidential HIV Testing: Client’s identifying information is linked to testing information of the client.

Discrimination: An action based on stigma and directed towards the stigma filed.

HIV tested: Anybody who had undergone HIV test regardless of the duration.

Risk perception of HIV/AIDS: Attitude towards perceiving themselves as susceptible to HIV infection.

Media: Radio/Television

Married: Currently in union

Poor Community conversation performing kebeles are: Those rural kebeles in Shebe Dino woreda which have score less than the median value (4.75).

Stigma: Negative feeling towards people with HIV/AIDS, intention to avoid people living with HIV/AIDS from social relationship.

Voluntary counseling and testing (VCT) for HIV: is the process whereby an individual or couples undergo counseling to enable him/her/them to make an informed choice about being tested for HIV

Well Community conversation performing kebeles are: Those rural kebeles in Shebe Dino woreda which have score greater than or equal to median value (4.75).

Willingness: Readiness to undergo to VCT.

Kebele classification by distance from Woreda Capital:

Proximal: Kebeles within 5kms from the Woreda capital

Medium: Kebeles within 5-10kms from the Woreda Capital

Distal: Kebeles above 10 kms distance from the Woreda Capital

4.13. Ethical Considerations

Ethical clearance was obtained from the Institutional Review Board of the Faculty of Medicine, Addis Ababa University before the study was undergone. Permission was obtained from Shebe Dino woreda administration. Information sheet was prepared and read to the eligible participants to obtain verbal consent (Annex: 4). Without permission no data collector tried to enter the house of any body. Data collectors approached the households of the comparative group by extending their greetings and reintroducing themselves. After introduction, the data collectors continue explaining the purpose and other information of their visit by reading the information sheet to the 15-59 years population. Then they were requested for verbal consent. Data collection was

conducted after verbal consent had been obtained. Any person found to be sick in the household during data collection was advised to visit the nearby health facility.

5. RESULT

5.1. Description of the study population

Nineteen thousand and seven hundred fifty one people were eligible, (15-59yrs) for the study. Four hundred fifty two study participants completed the interview giving a response rate of 97.8%. The main reason for non response was being busy in the farming activities (60% were farmers). Non response rate was not different by CC status.

Of the 452 who participated in the study, 226 (50.0%) were in well CC performing kebeles and 226 (50.0%) in poor CC performing kebeles. Females study participants were 121 (53.5%) in well and 113 (50.0%) in poor CC performing kebeles. Most of the study participants; 119 (52.7%) in well and 109 (48.2%) in poor CC performing kebeles were in the age between 15-24 years. The median and inter quartile range for age was 22 (18-30) vs. 23 (19-30) years in well and poor CC groups respectively.

Majority of the study participants, (101 (44.7%) vs.106 (46.9%)) had no educational and (39 (16.8%) vs.34 (15.0%)) were secondary and above in well and poor CC group respectively. Regarding religion about (183 (81.0%) vs.180 (79.6%)) of the study participants were protestant in poor and well CC groups. Almost all of the study participants; 218 (96.5%) in well and 216 (95.6%) in poor CC groups were Sidama in ethnicity. Married study participants were (141 (62.4%) vs.121 (53.5%)) followed by single (84 (37.4%) vs.102 (45.1%)) in poor and well CC groups respectively. Most of them; (37.6% vs.30.5%) were student in occupation, followed by house wife (27.0% vs.26.5%) and farmer (23.0% vs. 23.7%) in well and poor CC groups respectively, (Table1).

To ensure the comparability of the study participants between well and poor CC performing kebeles, hypothesis was tested using two sample test of proportion for major socio-demographic factors. Accordingly, the study participants in well and poor CC performing kebeles were not

statistically different ($P>0.05$) by sex, age, religion, ethnicity, education, marital status and occupation. Therefore, the study participants in well and poor CC performing kebeles were comparable.

Table1. The Socio-demographic characteristics of study participants Shebe Dino Woreda, Sidama Zone, SNNPR, November, 2010.

Variables		Well CC	Poor CC	Total
		N=226 (%)	N=226 (%)	N=452 (%)
Sex	Male	105 (46.5)	113 (50.0)	218 (48.2)
	Female	121 (53.5)	113 (50.0)	234 (51.8)
Age	15-24	119 (52.7)	109 (48.2)	228 (50.4)
	25-34	80 (35.4)	91 (40.3)	171 (37.8)
	35-59	27 (11.9)	26 (11.5)	53 (11.7)
Education	No education	101 (44.7)	106 (46.9)	207 (91.6)
	Primary	87 (38.5)	86 (38.1)	173 (38.3)
	Secondary and above	39 (16.8)	34 (15.0)	73 (16.2)
Religion	Protestant	183 (81.0)	180 (79.6)	363 (80.3)
	Catholic	17 (7.5)	11 (4.9)	28 (6.2)
	Orthodox	14 (6.2)	11 (4.9)	25 (5.5)
Ethnicity	Other	1 (0.4)	4 (1.8)	5 (1.1)
	Sidama	218 (96.5)	216 (95.6)	434 (96.0)
	Other	8 (3.5)	10 (4.4)	18 (4.0)
Marital Status	Single	102 (45.1)	84 (37.2)	186 (41.2)
	Married	121 (53.5)	141 (62.4)	262 (58.0)
	Other	3 (1.3)	1 (0.4)	1(0.2)
Occupation	Farmer	52 (23.0)	58 (25.7)	110 (24.3)
	House wife	61 (27.0)	60 (26.5)	121 (26.8)
	Trader	15 (6.6)	16 (7.1)	31 (6.9)
	Student	85 (37.6)	69 (30.5)	154 (34.1)
	Other	13 (5.8)	23 (10.2)	36 (8.0)

5.2. The Respondent's Sexual history.

Majority of the study participants; (146 (64.6%) in well and (160 (70.6%)) in poor CC performing kebeles started sexual intercourse by the time of data collection. From those who started sexual intercourse, (13 (9.4%) vs. 25 (16.2%)) ever used condom in well and poor CC group. Almost all and equal number of study participants in well and poor CC performing kebeles each have no risky behavior for HIV ((224 (99.1%) vs. 223 (98.7%)) (Table 2).

There was no statistically significant difference in well and poor CC performing kebeles ($p>0.05$) by ever had sex, age at first sex, ever used condom, frequency of condom use and risky behavior for HIV.

Table 2: The Sexual history of study participants by CC, Shebedino Woreda, November, 2010.

Characteristic		Well	Poor	Total
		N (%)	N (%)	N (%)
Ever had sex(n=226,226)	Yes	146 (64.6)	160 (70.6)	306 (67.7)
	No	80 (35.4)	66 (29.2)	146 (32.3)
Age at first Sex (n=226,226)	10_14	33 (14.9)	26 (11.9)	59 (13.4)
	15-19	162 (73.0)	158 (72.1)	320 (72.6)
	20-24	27 (12.2)	35 (16.-0)	62 (14.1)
Ever used Condom (n=138,154)	Yes	13 (9.4)	25 (16.2)	38 (13.0)
	No	121 (87.7)	129 (83.7)	250 (85.6)
Frequency of Condom use (n=14,25)	Always	2 (14.3)	3 (12.0)	5 (12.8)
	Sometime	12 (85.7)	22 (88.0)	34 (87.2)
Risky behavior for HIV (n=226,226)	Yes	3 (1.3)	2 (0.9)	5 (1.1)
	No	224 (99.1)	223 (98.7)	447 (98.9)

5.3. Frequency of CC attendance and Knowledge about it.

Study participants who had ever heard about CC were not statistically different between well 170 (75.2%) and poor CC performing kebeles 157 (69.5%) (P=0.17) using a two sample test of proportion. The number of participants who attended CC in a year preceding the survey were 115 (50.9%) in well and 104 (46.0%) in poor CC performing kebeles. Almost equal proportion of study participants attended CC for less than 3 time in a year preceding the survey in well and poor CC group (54 (52.4%) vs.51 (52.0%)), (Table 3).

Table 3: Study participants' Knowledge and Frequency of CC attendance by CC performance, Shebe Dino Woreda, November, 2010.

Characteristics		Well	Poor	Total
		N (%)	N (%)	N (%)
Ever heard about CC	Yes	170 (75.2)	157 (69.5)	327 (72.3)
	No	56 (24.8)	69 (30.5)	125 (27.7)
Attended CC in the year preceding the survey	Yes	115 (50.9)	104 (46.0)	219 (48.5)
	No	111 (49.1)	122 (54.0)	233 (51.5)
Frequency of CC attendance (n=103,98)	< 3	54 (52.4)	51 (52.0)	105 (52.2)
	3 or more	49 (47.6)	47 (48.0)	96 (47.8)
Family member attended or attending CC	Yes	154 (68.1)	130 (57.5)	284 (62.8)
	No	72 (31.9)	96 (42.5)	168 (37.2)

5.4. Source of information about VCT

Almost all of the study participants ever heard about VCT 221 (97.8%) in well and 220 (96.9%) in poor CC performing kebeles. Regarding VCT information, the three major cited sources in a well CC group were health institutions 168 (76.0%), HEWs 126 (57.0%) and media 84 (38.0%) whereas HEWs 138 (62.7%), health institutions 114 (51.8%) and media 85 (38.6%) were the three major sources in poor CC group. The presence of significant difference in the source of VCT information between the two CC groups was tested by a two sample test of proportion. Accordingly only health institutions were statistically the significant source of VCT information in well CC groups compared to the poor CC groups (P<0.001). However other sources; HEWs,

spouse, relatives, friends, media and school as a source of VCT information were not statistically different between the two CC groups (Table 4).

Table 4: Source of information about VCT, by CC performance, Shebe Dino Woreda, November, 2010.

Variable		Well N=221 (%)	Poor N=220 (%)	P-value
Source of information	Neighbors	19 (8.6)	24 (10.9)	0.40
	Spouse	5 (2.3)	7 (3.2)	0.55
	HEW	126 (57.0)	138 (62.7)	0.20
	Health Institutions	168 (76.0)	114 (51.8)	<0.001
	Friends	47 (21.3)	41 (18.6)	0.50
	Relatives	7 (3.2)	6 (2.7)	0.80
	School	69 (31.2)	60 (27.3)	0.36
	Media	84 (38.0)	85 (38.6)	0.89

5.5. Knowledge of the study participants on VCT service

Out of the total study participants 99 (43.8%) in well and 87 (38.5%) in poor CC group were found to be Knowledgeable about VCT (those who score greater than the mean score of 6.4 were considered to be knowledgeable about VCT). The observed difference is not statistically different between well and poor CC performing kebeles, with a two population proportion test of difference, and 95% CI: -0.05 (-0.04, 0.14), (Table 5).

Almost 40 % of study participants did not cite that VCT is important before marriage in both well and poor CC performing kebeles (90 (39.8%) vs. (92 (40.7%)). Similarly equal number of study participants did not mention that VCT is important before pregnancy (223 (99.1%) vs. 218 (97.3%)), during pregnancy (224 (99.6%) vs. 215 (96.0%)) and to start Antiretroviral therapy ((210 (92.9%) vs. 201 (88.9%)) in well and poor CC performing kebeles. To determine

predictors of VCT knowledge, a multivariate logistic regression model was used. Socio demographic variables and sources of information (media, HEWs, spouse, relatives, health institutions and school) which does have more than ten events per covariate were fitted into the model. Finally only four variables; sex, media, spouse and school were independent predictors of VCT knowledge with AOR and 95 % CI 15.3 (8.2, 28.6), 3.5 (2.2, 5.7), 4.7 (1.2, 17.7), 2.7 (1.6, 4.5) respectively. However the distribution of the aforementioned four variables is the same in both CC groups (Table 4).

Higher number of study subjects cited that VCT service is important to know self (99.1%) in well CC performing kebeles than (91.6%) in poor CC performing kebeles; but the observed difference is not statistically significant, with a two population proportion test of difference at 95% CI; -0.02 (-0.00,0.05). Similarly, large number of study subjects (81.4%) in well CC performing kebeles than in poor CC performing kebeles (70.4%) cited that VCT is important at any time but, the observed difference is not statistically significant, with a two population proportion test of difference at 95% CI; -0.07 (-0.00,0.15).

5.6. Attitude of study participants towards VCT service

Those who agreed up on the importance of VCT in reducing HIV/AIDS spread were 221 (97.8%) in well and 212 (93.8%) in poor CC performing kebeles. The observed difference is statistically significant between well and poor CC performing kebeles, with a two population proportion test of difference at 95% CI: 0.04 (0.003, 0.08), (Table 5).

Similarly equal number of study subject (88(38.9%)) in well and (85(37.6%)) in poor CC performing kebeles liked anonymous type of HIV test.

5.7. VCT Practice of the study Population

Larger Number of study participants in well CC performing kebeles underwent HIV test than in poor CC performing kebeles (170 (56.1%) vs.133 (43.9%)). About 3/4th of the study participants, 165 (73.0%) from well and 124 (54.9%) in poor CC performing kebeles had undergone HIV test on voluntary basis. Almost all of voluntarily tested respondents 165 (100%) in well and 122 (98.4%) in poor CC performing kebeles took the test for the purpose of knowing their HIV status. The majority 77 (45.3%) in well and 49 (37.1%) in poor CC performing kebeles had their most recent HIV test within the previous year. Most of those who were tested; (97.7%)

were in well and (98.6%) were in poor CC performing kebeles took the test in a health center. Majority of the tested respondents in well (71.7%) and in poor CC performing kebeles (58.8%) had been given counseling service. Those who had been tested (34.1%) in well and (28.8%) in poor CC performing kebeles stated that they were provided with only pretest counseling while (3.5%) in well and (2.7%) in poor CC performing kebeles stated that they were provided with only post test and (33.6%) in well and (26.1%) in poor CC performing kebeles stated that they were provided with both pre and post test counseling.

Utilization of VCT service was statistically higher in well CC performing kebeles than poor CC performing kebeles (73.0% vs.54.1%, $P < 0.001$), (See table 5).Correspondingly, FGD discussants in well CC performing kebeles stated that majority of the people in their kebele's had been tested for HIV because the most of test result was negative.

“All of the people in this kebeles had been tested for HIV, because most of the tested people told us that they are negative”. (30yrs, female, married, in well CC)

Table 5: Comparison of the study participants’ KAP towards VCT service utilization between well and poor CC performing kebeles in Shebe Dino Woreda, November, 2010.

KAP To Ward VCT		CC performance		Proportion difference 95%CI)	P- Value
		Well N=226	Poor N=226		
Knowledge about VCT	Knowledgeable	99 (43.8)	87 (38.5)	0.05 (-0.04,0.14)	0.25
	Not knowledgeable	127(56.2)	139 (61.5)		
VCT reduces the spread of HIV/AIDS	Agree	221(97.8)	212(93.8)	0.04 (0.003,0.08)	0.034
	Disagree	5 (0.02)	14 (0.06)		
Utilization of VCT	Tested through VCT	165 (73)	124 (54.1)	0.18 (0.09,0.26)	< 0.001
	Not tested	61 (27.0)	102 (45.1)		

5.8. Reasons for VCT Service Utilization.

Approximately three fourth of the study participants 165 (73.0%) in well and 124 (54.9%) in poor CC performing kebeles utilized VCT service voluntarily. Regarding reasons for VCT service utilization the majority; 98.2% in well and 93.8% in poor CC groups underwent VCT to know self HIV status (Figure 2). About one fourth of respondents 24 (14.5%) in well and 11

(8.9%) in poor CC performing kebeles reported that utilization of VCT service was as a result of PIHCT. Fourteen (8.5%) of the respondent in well and 8 (6.5%) in poor CC performing kebeles reported that utilization of the service was for job recruitment.

FGD discussants in well CC performing kebeles were more encouraged to have VCT by HEW in health post than discussants in poor CC performing kebeles. But, majority of FGDs discussant in well and poor CC performing kebeles were encouraged to have VCT at community meeting.

“We were encouraged to utilize VCT by HEW in health post and kebele meeting,” (33yr, male, married, in well CC,)

FGD discussants in well CC group more encourage their peer to have VCT after they had it than discussant in poor CC groups.

“I encouraged my friend to have VCT, after I had it” (26yrs, male, married, in well CC,)

The participants in well CC performing kebeles suggested activities such as health education about the importance of VCT at religious place, edirs, “debos” and during house to house visit. Similarly, participants in poor CC performing kebeles recommended health education about the importance of VCT during house to house visit, peer education and social mobilization.

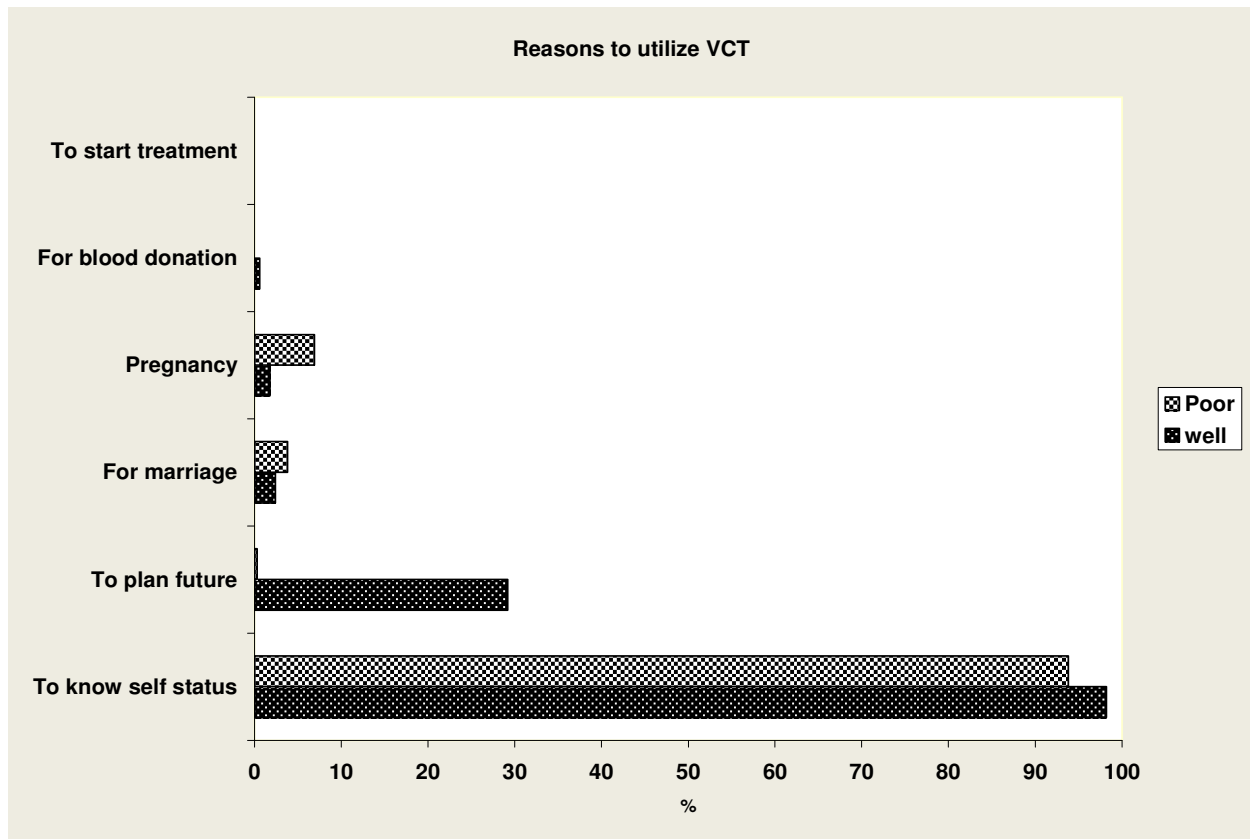


Figure 2: Reasons for VCT service utilization by CC performance of kebeles, Shebe Dino woreda, November, 2010.

5.9. Reason for not utilizing VCT service.

Self and partner trust were mentioned as main reason for not having HIV test (36.1%) in well and (29.4%) in poor CC performing kebeles (Figure 3).

According to the FGD discussants in both poor and well CC performing kebeles, there are no cultures and religion which prevent them from having VCT.

“Nobody prevents us from having VCT; instead the community and religious leaders inform us how to prevent ourselves from HIV”. (33 yrs, male, married, in well CC,)

Lack of awareness about the importance of VCT service was the main reason mentioned by all and almost equal FGD discussants in well and poor CC group for low utilization of VCT service.

“The people do not know the importance of VCT” (35yrs, female, married, in poor CC,)

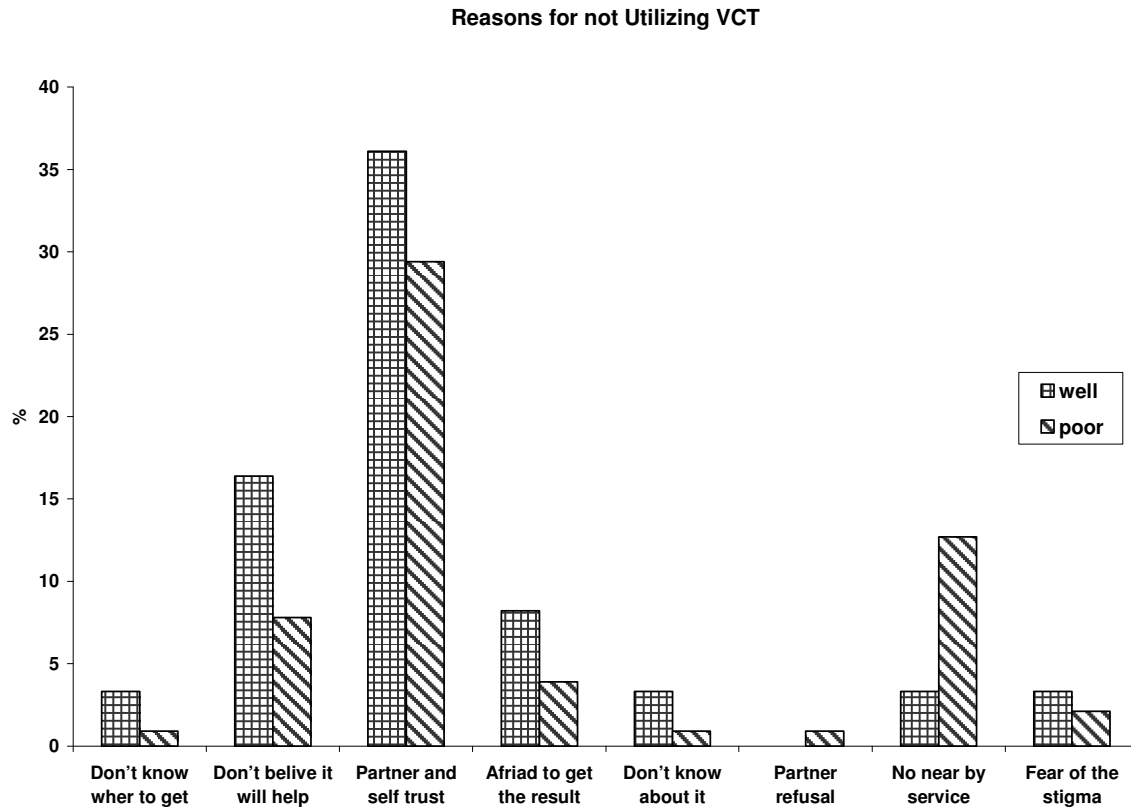


Figure 3: Reasons for not being tested by CC performance, Shebe Dino worda, November, 2010.

5.10. Association of demographic variables with VCT uptake (Model 1)

The effect of socio demographic characteristics on VCT uptake was assessed by fitting them into a separate logistic regression model (Model I). Accordingly, as shown in table 6, those found in age between 15-24 years were 3.14 time more likely to be tested than those between 35-59 years [AOR (95% CI) =3.14 (1.37, 7.20)]. Single were three time more likely to be tested than married [AOR (95% CI) =2.55 (1.09, 5.99)]. Traders were 3.36 time more likely to be tested than farmer in occupation [AOR (95%CI) =3.36 (1.03, 10.96)]. Furthermore, participants in well CC performing kebeles were found to be 2.51 times more likely to be tested than participants in poor CC performing kebeles [AOR (95% CI) =2.51 (1.63,3.86)].

But sex, age other than 15-24 years, religion, occupational status other than trader, and alcohol consumption, did not show statistically significant difference with VCT uptake in bivariate and multivariate analysis.

Table 6: Association of demographic variables and source of information with VCT uptake, Shebe Dino woreda, November, 2010 (n=452).

Covariates		Had VCT		COR(95% CI)	AOR(95% CI)
		Yes	NO		
Sex	Male	142	92	1	1
	Female	147	71	1.3 (0.912,1.93)	0.84 (0.40,1.74)
Age	15-24	152	76	1.51 (0.91,2.55)	3.14 (1.37,7.20)*
	25-34	92	53	1.31 (0.75,2.29)	1.44 (0.77,2.67)
	35-59	45	34	1	1
Religion	Orthodox	15	10	1	1
	Protestant	233	130	1.2 (0.52,2.74)	1.55 (0.63,3.86)

	Catholic	18	10	1.2 (0.39,3.65)	1.50 (0.43,5.19)
	Other	23	13	1.18 (0.41,3.37)	1.45 (0.44,4.75)
Marital status	Married	169	93	1	1
	Single	117	69	1.07 (0.73,1.58)	2.55 (1.09,5.99)*
	Other	3	1	1.77(0.18,17.34)	4.81 (0.39,59.28)
Occupation	Farmer	72	38	1	1
	House wife	72	49	0.78 (0.45-1.32)	0.71 (0.35-1.45)
	Trader	27	4	3.56(1.16,10.9)*	3.36(1.03,10.96)*
	Student	97	57	0.9 (0.54,1.50)	0.87 (0.36,2.10)
CC	Other	21	15	0.79 (0.34,1.60)	0.66 (0.28,1.58)
	Well	165	61	2.23(1.50-3.30)*	2.51 (1.63,3.86)*
	Poor	124	102	1	1
Alcohol consumption	Ever drunk	31	15	1.19 (0.62,2.27)	1.12 (0.50,2.50)
	Never drunk	258	148	1	1
Source of information					
Media	Yes	107	62	0.23(0.08,0.69)*	0.84 (0.52,1.4)
	No	177	90	1	1
Health Extension Workers	Yes	185	79	1.89(1.28,2.79)*	2.2 (1.4,3.4)*
	No	104	84	1	1
Relative	Yes	10	3	0.25(0.08,0.73)*	2.2 (0.54,8.8)
	No	274	149	1	1
Health institution	Yes	203	79	0.34(0.12,0.99)*	2.4 (1.5,3.8)*
	No	81	71	1	1
Spouse	Yes	9	3	0.25(0.08,0.72)*	2.2 (0.5,8.7)
	No	274	149	1	1

*statistically significant at 95% CI

5.11. Association of knowledge, attitude and VCT uptake (Model 2)

Participants who agreed on the importance of VCT in reducing the spread HIV infection were 3.5 times more likely to be tested than those who disagreed [AOR (95%CI) = 3.51 (1.15, 10.67)]. Those knowledgeable about HIV transmission were twice more likely to utilize VCT service than not knowledgeable ones [AOR (95%CI) =2.03 (1.05, 3.91)].

There was no statistically significant difference in utilizing VCT service by risky behavior of HIV, the preferred ways to get VCT result, attitude towards PLWHAs, knowledge about VCT service and HIV prevention.

Table 7: Association of knowledge, attitude, risky behavior of HIV, preferred way to get VCT result and stigma/discrimination with VCT Uptake, Shebe Dino woreda November, 2010 (n=452).

Covariates		Had VCT		COR(95% CI)	AOR(95% CI)
		Yes	No		
VCT Knowledge	Knowledgeable	166	99	1.15 (0.78,1.70)	1.38(0.83,2.31)
	Not knowledgeable	123	64	1	1
HIV transmission Knowledge	Knowledgeable	226	137	2.20 (1.21,3.9)*	2.03(1.05,3.9)*
	Not knowledgeable	23	26	1	1
VCT reduces the spread HIV virus	Agree	284	150	4.92 (1.77,14.)*	3.51(1.2,10.7)*
	Disagree	5	13	1	1
Preferred way to hear test result	Telephone	13	9	1	1
	Face to face	180	99	1.25 (0.52,3.05)	1.94(0.71,5.38)
Knowledge of HIV prevention	Secret letter	96	55	1.21 (0.49,3.01)	1.61(0.56,4.58)
	Knowledgeable	83	32	1.65 (1.04,2.6)*	1.76 (0.95,3.29)
Risky behavior of HIV	Not knowledgeable	206	131	1	1
	Yes	3	2	0.84 (0.14,5.11)	1.07 (0.13, 9.1)
Attitude towards PLWHAs	No	286	161	1	1
	Accepting	66	26	1.56 (0.95,2.57)	1.73(1.01,2.98)
	Stigmatizing	223	137	1	1

6. DISCUSSION

As Ethiopian DHS showed, only 2% of men have been tested for HIV. This indicates that many people with HIV/AIDS in Ethiopia do not know their HIV sero-status (11), though HIV test is a vital point of entry to HIV/AIDS prevention and care programs. CC is one of the nation's strategies since 2002 to increase VCT service utilization, but Ethiopia has shortage of data on the effect of CC on VCT. This study is therefore aimed at determining the role of CC on VCT.

This study is strong in that it has used a comparative cross sectional study design having a power of 80% to discriminate the difference than simple cross sectional study. The findings from the

quantitative study were triangulated by a qualitative study. The study population were also homogenous on major socio demographic characteristics, other than residence (CC level), and hence were comparable. It is good that many previous studies on VCT have addressed the knowledge, attitude, and other factor components related to VCT, but they failed to determine the role of CC on VCT. Unlike the previous studies, this study is aimed to determine the effect of CC on VCT knowledge, attitude and practice.

Apart from its strengths, this study has some short comings: it was difficult to establish temporal relationship between CC and KAP of VCT. All kebeles in the woreda except those which stopped CC were included. The included kebeles might not totally represent all rural kebeles in the Woreda. There might also be a translator bias during FGD. Another possible bias which might have been introduced is a pocketing bias as the study participants from each kebele were selected not at random.

Moreover, the criteria used to classify kebeles into well and poor CC groups are quite general and not specific to HIV/VCT topics. The bottom line assumption was if kebeles had generally well CC performance, they would address HIV/VCT well. However, a problem arises as there are lots of community felt problems to be discussed in CC, the share of HIV/VCT might be low. Consequently, even in a well CC kebele, HIV/VCT topics might be addressed poorly.

More than 96% of the study participants from each CC kebeles (97.8%) in well and (96.9%) in poor had ever heard about VCT; almost equal number of people heard about VCT in well and poor CC performing kebeles. The findings from both well and poor CC sites from the current study is far higher than study finding from rural communities of Central Africa (14) where VCT information was as high as 55.8%. This might be due to the time gap between the two studies (the current study is the most recent study).

Knowledge on VCT service did not show statistically significant difference between well (43.8%) and poor CC performing kebeles (38.5%). It might be partly due to equal distribution of determinants of knowledge on VCT such as sex and sources of VCT information (media, spouse, and school) between the two CC groups. Similarly it might be due to comparable distribution of CC facilitators; HEWs between well and poor CC groups (Tables 1 and 4).It can also be related to the skill of facilitators in addressing the different aspects of HIV/VCT. The intrinsic feature of

CC; encouraging discussion among the CC participants instead of the information dissemination practice might also have played a role (12). Another might be explanation is the criteria used (methodological frame work of CC, number of participants and groups, number of decisions undertaken and document handling and reporting) to classify the study kebeles into well and poor CC groups. That is Kebeles labeled as well might have performed HIV poorly because of other competing topics to be discussed during CC sessions. The presence of other competing topics is explained in FGD as all and almost equal number of FGD discussants said that most of the time the main discussion was about agricultural issues than about health issues in both CC groups.

“Most of the time we discussed about agriculture than about the about health, like how to reduce maternal death and to stop harmful traditional practice....” (35yrs, female, married, in well CC)

Similarly the main discussion topic was about agriculture then about saving in poor CC groups.

“Mainly we discussed about agriculture how to dig the land and work in groups” (35yrs, male, married, in poor CC)

Similarly poor CC kebeles might have performed HIV/VCT well. The proportion of knowledgeable study participants is low in both CC groups (43.8% in well and 38.5% in poor) when compared to the study finding from North Nigeria; 55.0% (16) in 2005. This finding is supported by the FGD finding where majority of the CC session is covered by issues related to rural development, agriculture and saving than HIV/VCT.

The proportion of the study participants who agreed on the importance of VCT service in reducing the spread of HIV infection was statistically significantly higher in a well CC group ($P=0.034$). This may be related to the trustworthiness of information from health institutions as health institutions were cited as a source of VCT information by significantly higher proportion of study participants from a well CC group compared to poor CC group ($P<0.001$) (Table 4). In addition those in well CC performing kebeles had positive attitude towards VCT service more than those in poor CC performing kebeles ($p<0.001$).

Positive attitude towards VCT in this study (97.8% in well and 93.8% in poor CC groups) is consistent with studies in East Haraghie 2008 and Jijiga (13, 17).

Significantly higher proportion of study participants from well CC performing kebeles have utilized VCT compared to participants from poor CC performing kebeles ($P < 0.001$). This finding is internally consistent with the finding presented in Table 4 where majority of respondents from well and not from poor CC groups cited health institution as their source of VCT information. Those majorities who were informed of VCT in health institutions might have been tested for HIV in the health institution as a result of the information they were provided with. The qualitative study result from well CC group also supports this finding; “*All of the people in this kebele had been tested for HIV*”. Generally as with a pilot study done in East Haraghe 2008, (13), study participants from well CC group utilized VCT service.

VCT service utilization in both well (73.0%) and poor (54.9%) CC groups are lower than the finding from EDHS 2005 among rural residents (85%). This might be due to lower VCT knowledge of study participants reflected in this study.

Those who were in the age range of 15-24 years were found to be positively associated with VCT service utilization ($P=0.01$), which was similar with study done in North and South Gonder 15-19 years (21).

Singles were found to be positively associated with VCT service utilization ($P=0.03$); which was similar with study done in Kasenyi, Uganda (30). Possible explanation consistent with the finding is that singles were more likely to worry about their partners' current HIV status than married ones from study conducted in rural community of central Africa (14).

Traders were more likely to be tested than farmers ($P=0.04$), this might have occurred as a result of possible exposure of traders to different source of information than farmers.

Moreover, those in well CC performing kebeles utilized VCT more than those in poor CC performing kebeles ($p < 0.001$), analogous with study done in Sidama zone (28), East Haraghe (13) where after the CC program initiation VCT service uptake showed increment.

Those who were knowledgeable about HIV transmission were more likely to undergo HIV test than those who were not knowledgeable ($p=0.04$); which was similar with a study finding from Blantyre, Malawi (31).

7. STRENGTHS AND LIMITATIONS

Strengths

- The study employed both quantitative and qualitative study design.
- Structured questionnaire adopted from a standard questionnaire (from BSS)
- Comparative study with initially determined power (80%)

- Homogenous study population on major socio demographic characteristics, other than residence (CC level), hence comparable.

Limitations

- Difficult to establish temporal relation between KAP of VCT service and CC.
- The study didn't include kebeles which stopped CC.
- The possible translator bias during FGD.
- The criteria used to classify the kebeles in the woreda in to well and poor CC groups were quite general and not specific to HIV/ VCT activities. Therefore there might be a chance of labeling kebele with poor HIV/VCT performance into well CC group and vice versa.
- Pocketing (study participants with similar knowledge, attitude or practice may cluster together) might have occurred.

8. CONCLUSION

- VCT knowledge of the study participants was not different between well and poor CC performing kebeles and is low in both CC groups
- Study participants in well CC group have positive and higher attitude towards VCT than poor CC group.

- VCT service utilization was higher in well CC performing kebeles than in poor CC performing kebeles.
- Being in age group between 15-24 years, single, trader in occupation, knowledgeable about HIV transmissions and positive attitude to VCT service, were independent predictors of VCT service utilization.

9. RECOMMENDATION

To HIV programme coordinator:

- Health education on the importance of VCT and on ways of HIV transmission should be scaled up, and the health education to be given should be cognizant of one's occupation, marital status and age.
- The community in the study area in general and those in poor CC group in specific need to be mobilized in order to utilize VCT service.

To CC programme coordinator:

- Consistent monitoring and evaluation of the CC program, not only by the criteria in use but also in terms of its effect on KAP of the target population towards VCT and or HIV should be in place.
- Careful identification and training of skilled facilitators followed by close follow through supervision or review meetings should be emphasized.
- Refreshment training to CC facilitators and supervisor.

10. REFERENCE

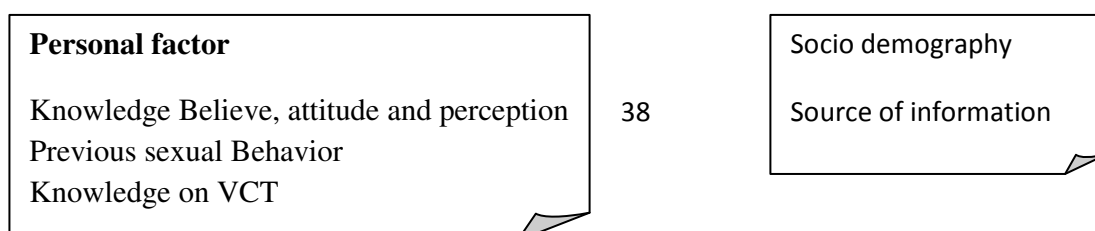
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11. ANNEXES

ANNEX 1: Conceptual Frame Work



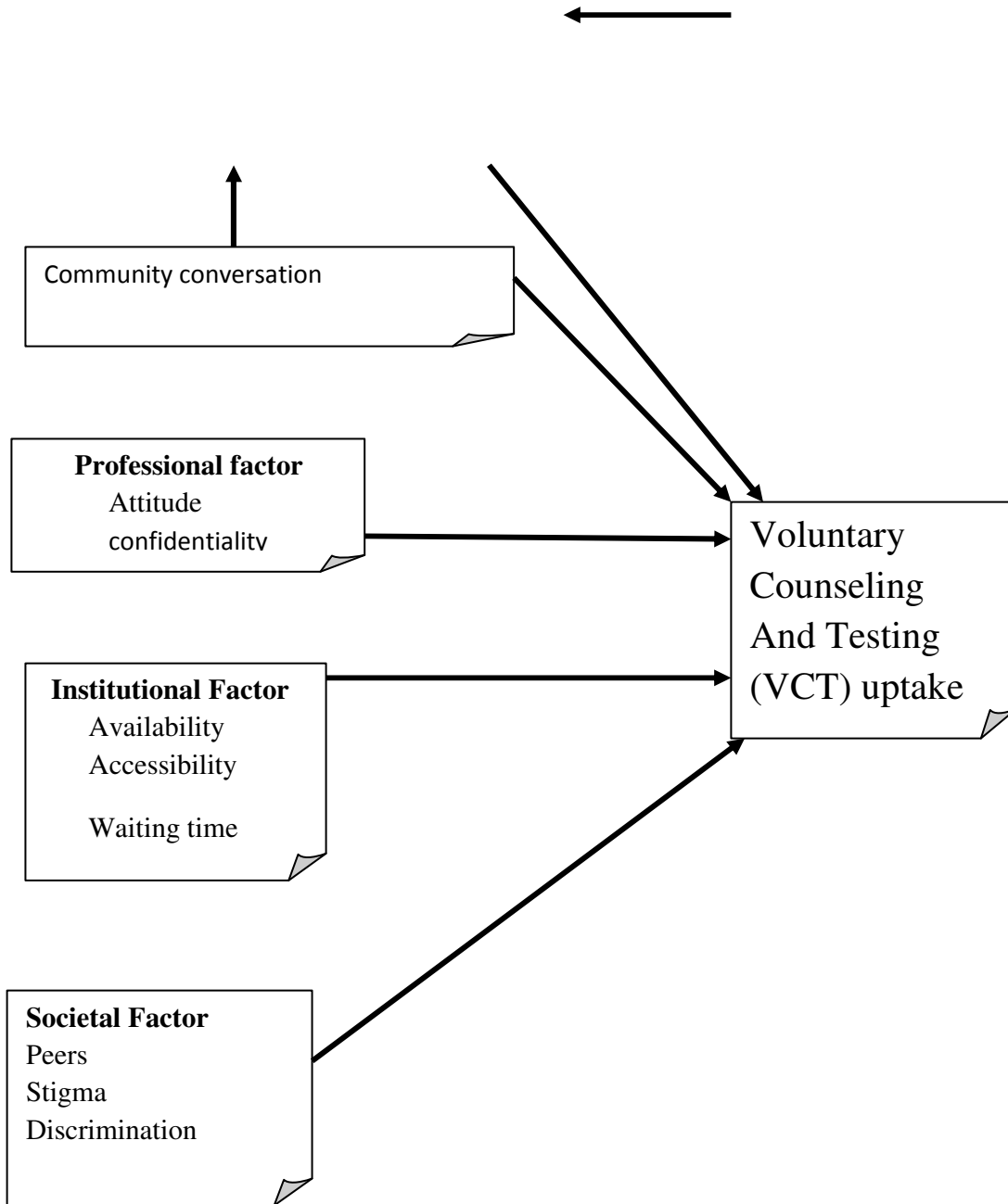


Figure1: Conceptual frame work on KAP to VCT service utilization.

ANNEX 2: DESCRIPTION OF FGD PARTICIPANTS

FGD discussants

Characteritic					
	Kebele CC	No of		Duration	Date
FGD No	Performance	Participant	Place	of Session	
			Morocho		27/05/03
FGD1	Well	8	Negasha	60min	
FGD2	Poor	8	Dobe Toga	80 Min	28/05/03
			Morocho		27/05/03
FGD3	Well	8	Negasha	60min	
FGD4	Poor	8	Dobe Toga	80min	28/05/03

ANNEXES 3: Questionnaire

3.1. Questionnaire for Quantitative Assessment English Version of the Questionnaire

Questionnaire prepared to collect information to study the disparity in KAP towards VCT service utilization among 15-59 years population in rural kebeles with poor and well community conversation performance in Shebe Dino woreda, SNNPR, Ethiopia.

Identification

- 001. Id number of HH/ Questionnaire-----
- 002. Sub city-----
- 003. Kebeles-----
- 004. Community conversation performance of kebeles. 1. Well 2. Poor

Part I: Socio Demographic variables

No	Questions	Alternative responses	Skip to
101	Sex?	Male -----1 Female -----2	
102	Age?	_____(Completed years) Don't know-----8	
103	What is your religion?	Orthodox -----1 Protestant -----2 Catholic-----3 Muslim-----4 Adventist-----5 Cultural -----6 21. Others (specify) _____	
104	Ethnicity?	1. Sidama 6. Oromo 2. Wolayita 7. Tigre 3. Kembata 8. Gamu 4. Guraghe 9. Dorze 5. Amhara 10. Hadiya 21. Others (specify) _____	
105	Your educational status?	Not able to read and write-----1 Able to read and write -----2 Formal education _____grade (write the last grade completed) Above 10+3-----3	
106	What is your current occupational status?	Farmer -----1 Housewife -----2 Trader-----3 Private employee-----4 Civil servant -----5 Student -----6 Daily laborer-----7	

		No response-----99 21. Others (specify) _____																					
107	What is your monthly income?	_____birr per month No income-----1 Don't know-----88 No response-----99																					
108	Are you member of edir at your community?	YES-----1 NO-----2																					
109	Do you drink alcoholic beverages like Tela, Teji, Areke, Beer and the likes?	Have ever drunk-----1 Have never drunk-----2 No response-----99																					
110	How often do you drink alcoholic drinks?	Every day-----1 At least once a week -----2 Less than once a week-----3 I drink it in the holidays-----4 Always after chewing -----5 21. Others (specify) _____																					
111	Have you used substances or drugs like.... In the past four weeks?	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>DK</th> <th>NR</th> </tr> </thead> <tbody> <tr> <td>1. Khat</td> <td>1</td> <td>2</td> <td>81</td> <td>99</td> </tr> <tr> <td>2. Cigarate</td> <td>1</td> <td>2</td> <td>81</td> <td>99</td> </tr> <tr> <td>3. Shisha /Gaya</td> <td>1</td> <td>2</td> <td>81</td> <td>99</td> </tr> </tbody> </table>		Yes	No	DK	NR	1. Khat	1	2	81	99	2. Cigarate	1	2	81	99	3. Shisha /Gaya	1	2	81	99	
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1. Khat	1	2	81	99																			
2. Cigarate	1	2	81	99																			
3. Shisha /Gaya	1	2	81	99																			
112	Are you supporting anyone (children, parents or others) now?	Yes-----1 No-----2 No response-----99																					
113	If yes, how many people are you supporting now?	Number of adults _____ Number of children _____																					
114	With whom are you now living?	With my father and mother-----1 With my mother-----2 With my father-----3 With my relative-----4 With my family(spouse, child) -----5 With my boy/girl friend-----6																					

Part II: community conversation

201	Have you ever hear about community conversation	YES-----1 NO-----2	
202	Did you attend community conversation	YES-----1	

	in the last year in your kebeles?	NO-----2→	Q204
203	For how many times do you attend the conversation?	_____	
204	Is there a family member who was/is attending community conversation?	YES-----1 NO-----2	

Part III: Sexual History and condom use

No	Questions	Alternative responses	Skip to
301	Marital status?	Single-----1→ Married-----2 Divorced-----3 Separated-----4 Widowed-----5	303
302	If you are married, at what age had you first married?	_____ years	
303	Have you ever had sexual intercourse?	Yes-----1→ No-----2 No response -----99	304 315
304	If yes at what age you had sex first?	Age in year _____ Don't know -----81 No response -----99	
305	Have you had sexual intercourse in the past one year?	Yes-----1→ No-----2 No response -----99	306 310
306	If yes, have you ever used condom?	Yes-----1→ No-----2	307
307	If yes, how often you have used condom when you have sexual intercourse in this one year?	Always-----1 Sometime-----2	
308	Did you practice multi-partner sex in the last one year?	Yes-----1 No-----2 No response -----99	310
309	If yes, with how many different people had you sex during the past one-year?	_____ number	
310	Have you had sexual intercourse with non-regular partner?	Yes-----1 No-----2 No response -----99	Q312

311	If yes, was that in the past 12 months?	Yes-----1 No-----2 don't know -----88	
312	If you have a boy/girl friend, did you ever have sex with your friend?	Yes-----1 No-----2 →	314
313	If yes, what was the action to prevent HIV?	Condom -----1 HIV testing-----2 Nothing-----3 21. Others (specify) _____	
314	If answer for Q.312 is no, why didn't you have sex with your friend until now?	Not before HIV testing -----1 To avoid pregnancy-----2 To protect from STIs-----3 Not before marriage-----4 21. Others (specify) _____	
315	Did you have any STI in the past one year?	Yes-----1 No-----2 No response -----99	
316	Do you think you have any risky behavior for acquiring HIV?	Yes-----1 → No-----2 No response -----99	Q317
317	If yes, what would that be?	21. Others(specify)_____	

Part IV: HIV/AIDS and Voluntary Counseling and Testing

No	Questions	Alternative responses	Skip to																					
401	Do you know a person who has HIV or AIDS?	Yes-----1 No-----2 No response -----99																						
402	What are the means of HIV transmission?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. Through unsafe sex-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. From mother to baby -----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. Sharing contaminated sharp instrument----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. By greeting HIV positive person -----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. Sharing meal -----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>6. Mosquito bite -----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> </table>		Yes	No	1. Through unsafe sex-----	1	2	2. From mother to baby -----	1	2	3. Sharing contaminated sharp instrument----	1	2	4. By greeting HIV positive person -----	1	2	5. Sharing meal -----	1	2	6. Mosquito bite -----	1	2	
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		7. Infected blood transfusion -----1 2 8. By living together with HIV positive person in one house -----1 2 9. By using the same toilet with HIV positive person 10. By eating room with HIV positive person 11. pregnancy-----1 2 88. Do not know----- 21. Others (specify) _____																			
403	How people can avoid being infected with HIV/AIDS?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes No</td> </tr> <tr> <td>1. Abstinence from sex -----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>2. Faith fullness to partner-----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>3. Using condom-----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>4. Avoiding sharing of sharp materials</td> <td></td> </tr> <tr> <td>5. Eating enough balanced diet, burning food and drinking alcohols.</td> <td></td> </tr> <tr> <td>6. Avoid unscreened blood transfusion-----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>7. Do not know-----</td> <td style="text-align: right;">88</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> </tr> </table>		Yes No	1. Abstinence from sex -----	1 2	2. Faith fullness to partner-----	1 2	3. Using condom-----	1 2	4. Avoiding sharing of sharp materials		5. Eating enough balanced diet, burning food and drinking alcohols.		6. Avoid unscreened blood transfusion-----	1 2	7. Do not know-----	88	21. Others (specify) _____		
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21. Others (specify) _____																					
404	Do you think that someone who looks healthy could have HIV/AIDS?	Yes-----1 No-----2 Do not know-----88																			
405	Can a person who has HIV/AIDS be cured?	Yes-----1 No-----2 Do not know-----88																			
406	Do you think that someone who has HIV/AIDS, can live peacefully with the virus?	Yes-----1 No-----2																			
407	If so, for how many years can a person live with the virus?	From 1-5years-----1 From 6-10years-----2 From 11-15years-----3 above 15years-----4																			
408	How can you know if you or somebody has HIV/AIDS?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes No</td> </tr> <tr> <td>1. Simply by looking-----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>2. By physical examination of health personnel-</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>3. Go to traditional healer/wizard -----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>4. Go to counseling and testing service -----</td> <td style="text-align: right;">1 2</td> </tr> <tr> <td>88. Do not know</td> <td></td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> </tr> </table>		Yes No	1. Simply by looking-----	1 2	2. By physical examination of health personnel-	1 2	3. Go to traditional healer/wizard -----	1 2	4. Go to counseling and testing service -----	1 2	88. Do not know		21. Others (specify) _____						
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409	Do you think you might be infected by HIV?	Yes-----1 No-----2 → May be-----3 Do not know-----88	Q410																		
410	Why do you think that you might be infected by HIV?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes No</td> </tr> <tr> <td>1. More than one Sexual partner-----</td> <td style="text-align: right;">1 2</td> </tr> </table>		Yes No	1. More than one Sexual partner-----	1 2															
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		2. Have had sex without condom-----1 2 3. have had sexual intercourse with Commercial sex worker-----1 2 4. Injuries with contaminated sharps -----1 2 5. Blood transfusion-----1 2 21. Others (specify) _____																																		
411	Why do you think that you might not be infected by HIV?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. Have never made sexual intercourse-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. Have abstained from sex-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. One faithful partner-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. Did not share needle for injection-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. I always use condom-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </table>		Yes	No	1. Have never made sexual intercourse-----	1	2	2. Have abstained from sex-----	1	2	3. One faithful partner-----	1	2	4. Did not share needle for injection-----	1	2	5. I always use condom-----	1	2	21. Others (specify) _____															
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412	Have you heard of voluntary HIV Counseling and testing?	Yes-----1 No-----2																																		
413	From where did you get the ?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. Neighbors -----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. Spouse-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. Health Extensions Workers-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. Health institutions-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. Friends-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>6. Relatives-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>7. school-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>8. Media-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>9. Family (father, mother, sister, brother, children-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </table>		Yes	No	1. Neighbors -----	1	2	2. Spouse-----	1	2	3. Health Extensions Workers-----	1	2	4. Health institutions-----	1	2	5. Friends-----	1	2	6. Relatives-----	1	2	7. school-----	1	2	8. Media-----	1	2	9. Family (father, mother, sister, brother, children-----	1	2	21. Others (specify) _____			
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21. Others (specify) _____																																				
414	Is VCT available in your community?	Yes-----1 No-----2	→Q407																																	
415	Do you know where you can get the service other than your area?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. Hospital-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. Health center-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. Family guidance-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. Private clinic-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. Don't know-----</td> <td style="text-align: right;">8</td> <td style="text-align: right;">1</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </table>		Yes	No	1. Hospital-----	1	2	2. Health center-----	1	2	3. Family guidance-----	1	2	4. Private clinic-----	1	2	5. Don't know-----	8	1	21. Others (specify) _____															
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416	How long in time did it take you to get to the service site by foot walk?	Hours _____																																		
417	Please do not tell me the result have you ever had VCT in the Past?	Yes-----1 No-----2	→ Q427																																	

418	When did you test for HIV?	Before three months-----1 Before six months-----2 Before one year -----3 Before two years-----4 Before three years-----5 Before four years-----6 Don't know-----81																															
419	What was the reason for having HIV test?	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Voluntary-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Ordered by health worker-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. required for work-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Required for visa-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	1. Voluntary-----	1	2	2. Ordered by health worker-----	1	2	3. required for work-----	1	2	4. Required for visa-----	1	2	21. Others (specify) _____															
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420	If voluntary for what reason?	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. To know self status-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. To plan future -----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. For marriage-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Pregnancy-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. For blood donation-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>6. To start treatment-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	1. To know self status-----	1	2	2. To plan future -----	1	2	3. For marriage-----	1	2	4. Pregnancy-----	1	2	5. For blood donation-----	1	2	6. To start treatment-----	1	2	21. Others (specify) _____									
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421	Where did you take the test?	-----																															
422	Did you have counseling during HIV test?	Yes-----1 No-----2	→ Q424																														
423	When did you receive counseling?	Before HIV test-----1 After HIV test -----2 Before and after HIV test-----3 Other/specify-----21																															
424	Were you satisfied for the services given?	Yes-----1 No-----2	→ Q426																														
425	What was the reason for being satisfied?	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Warm reception-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Quick service-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Confidentiality -----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Privacy-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. professionalism of health care workers-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>6. Referral for care and support-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>7. Free service-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>8. Brief counseling-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	1. Warm reception-----	1	2	2. Quick service-----	1	2	3. Confidentiality -----	1	2	4. Privacy-----	1	2	5. professionalism of health care workers-----	1	2	6. Referral for care and support-----	1	2	7. Free service-----	1	2	8. Brief counseling-----	1	2	21. Others (specify) _____			
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426	If No for Q 417 what is the reason you did not have VCT before.	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Do not know where to get-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Do not believe it will help-----</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Do not know where to get-----	1	2	2. Do not believe it will help-----	1	2																						
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		3. Partners and self trust-----1 2 4. Afraid to get the result-----1 2 5. Do not know about it -----1 2 6. Partner refusal-----1 2 7. No near by the service-----1 2 8. Fear of stigma-----1 2 9. Cost of service-----1 2 21. Others (specify) _____																												
427	Do you think counseling is Important for HIV testing?	Yes-----1 No-----2 Do not know -----88																												
428	Who do you think benefits from testing?	HIV positive person-----1 HIV negative person-----2 Both HIV positive and negative persons-----3 Do not know-----88																												
429	Which method of testing you prefers if both types are available?	Confidential linked testing-----1 Anonymous testing-----2 21. Others (specify) _____																												
430	Would you be willing to pay for VCT services?	Yes-----1 → No-----2	Q433																											
431	How much do you want to pay for VCT services?	_____ Birr																												
432	If you have HIV test Which way do you prefer to obtain the HIV test result?	Face to face-----1 Telephone-----2 Secretary letter-----3 Relative/ Partner-----4 21. Others (specify) _____																												
433	Do you agree that VCT is important to prevent the transmission of HIV/AIDS?	Agree-----1 Disagree-----2 → Neutral-----3	Q434																											
434	What are the advantages?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1.Prevention of partners/others-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2.Knowing self-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3.Self care for future life-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4.Prevent mother to child transmittion-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5.Choosing partner-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>6.To plan future life-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>7.To start antiretroviral treatment-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>21. Others (specify) _____</td> <td></td> <td></td> </tr> </table>		Yes	No	1.Prevention of partners/others-----	1	2	2.Knowing self-----	1	2	3.Self care for future life-----	1	2	4.Prevent mother to child transmittion-----	1	2	5.Choosing partner-----	1	2	6.To plan future life-----	1	2	7.To start antiretroviral treatment-----	1	2	21. Others (specify) _____			
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435	When does person should have a test for HIV?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. Any time-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. During illness-----</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> </table>		Yes	No	1. Any time-----	1	2	2. During illness-----	1	2																			
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		3. Before marriage-----1 2 4. During travel to abroad-----1 2 5. In doubt-----1 2 6. Before pregnancy-----1 2 7. During pregnancy-----1 2 8. Do not know-----88 21. Others (specify) _____	
436	Who do you think should go for an HIV/ AIDS test?	<p style="text-align: right;">Yes No</p> 1. Sex workers-----1 2 2. Partner of sex workers-----1 2 3. Those to be married-----1 2 4. Any one at risk-----1 2 5. Any one sexually active-----1 2 6. those with multiple partners-----1 2 7. Those who are sick-----1 2 8. Do not know-----81 21. Others (specify) _____	
437	By whom do you prefer to get VCT counseling?	<p style="text-align: right;">Yes No</p> 1. Physician (Doctor)-----1 2 2. Nurse-----1 2 3. Trained counselor-----1 2 4. Religious leader-----1 2 5. Community leader-----1 2 6. HIV/AIDS positive people-----1 2 7. No need of counselors-----1 2 21. Others (specify) _____	
438	Are you willing to have VCT whether you had it before or not?	Yes-----1 No-----2 →	Q432
439	Where would you go?	Government health institution having VCT center-----1 NGOs health institution having VCT center-----1 Private health institution having VCT center-----1	
440	In your opinion what time is convenient for VCT service delivery?	Morning from 8:30am-12: 30am-----1 After noon---1: 30pm- 5:30pm-----2 Any time-----3 21. Others (specify) _____	

PARTV: Stigma and Discrimination

No	Questions and filters	Alternative response	Skip to
501	If your test is positive for HIV, would you tell for any of the following	<p style="text-align: right;">Yes No</p> 12. Your spouse-----1 2 13. Your family(mother, father, brother, sister,	

	Individuals about your test result?	child)-----1 2 14. Your sexual partners-----1 2 15. Your neighbor-----1 2 16. Your relatives-----1 2 17. Your religious leaders-----1 2 18. Your community leader-----1 2 19. Your friends -----1 2 21.Others (specify) _____	
502	If your tests is positive for HIV and prefer to disclose your HIV test result, how likely is it that the following might happen to you?	Yes No 1. Neglected by family-----1 2 2. Martial breakage-----1 2 3. Physical abuse by Spouse/ sexual partner-----1 2 4. Neglected by friends-----1 2 5. Increased emotional-----1 2 Support from family and relatives---1 2 6. Increased emotional support from peers, spouse/ sexual partners--1 2 7. Break up of sexual relationship--1 2 21. Others (specify) _____	
503	Would you be willing to share a meal with a person you knew had HIV?	Yes-----1 No-----2 Don't know-----88 No response-----99	
504	If a student has HIV but is not sick, should he or she be allowed to continue attending school?	Yes-----1 No-----2 Don't know-----81 No response-----99	
505	If a relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household?	Yes-----1 No-----2 Don't know-----81 No response-----99	
506	If a teacher has HIV but is not sick should he or she be allowed to continue teaching in school?	Yes-----1 No-----2 Don't know-----81 No response-----99	
507	If you knew a shopkeeper or food seller had the HIV virus, would you buy food from them?	Yes-----1 No-----2 Don't know-----81 No response-----99	
508	If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret	Yes-----1 No-----2 Don't know-----81 No response-----99	

Supervisor name _____

Checked by supervisor: Signature _____ Date _____

3.2.SIDAAMINYNU QOOLoo.

Eggenote, laotenna loossu babbadoshe affate xorre xoqqolli umi kaishi seejjotena mirmarru horro aanna 15-49 dirri weddeli giddo shaabbadini wooradi, sidaamu zoone woodiidi dagga dagoomuna qooqqowu mangiste tophiyaho assinooni xinxallo .

maayima

01. Tene xa'mmo kirro-----

02. woorada-----
 03. qabbale
 04. xa'mmanchu su'mma.

DargaI: Socio-demography

kirro	Xa'mmona	Maaraxona qollo.	Haaki ra harii
Q101	Koo/tee?	Koo/labaho-----1 Tee(meeyate)-----2	
Q102	dirro?	_____(Wo'ma Dirro) Diaffomo-----1	
Q103	Ama'noki maati?	Oritodokisete -----1 Isilaamaho-----2 Kiristanaho-----3 Katoolikete-----4 Wollu noro (xawissi)-----21	
Q104	Sirichiki maati?	1. Oromo 7. Amahara 2. Hadiya 8. Tigrete 3. Kambataho 9. Woolayitatte 4. Guraagete 10. Sidaamaho 5. Gaamote 11 Lomu gobbani 6. Dorzete 21. Wollu norro xawiss)_____	
Q105	Boorreesitena nabbabe affatto?	Afeemo-----1 Diafeemo-----2	
Q106	Tenne yannara lossiki maati?	Mangistete lossassinchoti-----1 Minni ammati-----2 Daddaalanchoho-----3 Minni lossasinchooti-----4 Rossanchoho-----5 simmu xaadoshi dadali lossasinchooti-----6 Barru losanchooti-----7 uula loosire galeemo-----8 Wolle-----21 Diafommo-----99	
Q107	Qariqarrikira iddirete miilla ikkoto?	Ee-----1 Dee'ni-----2	
Q108	Konni lewu (6) agani giddo mittu agani, gobbbaani wollewa hadhe	Ee-----1	

	eggenoto?	Dee'ni.-----2 . Diqqolemo-----99	
Q109	Dimbissa agatto me'e higge agatto?	1.wo'manka barra.-----1 2.samintete mitte higee. -----2 3.saamintete mitte yanara worroni. -----3 4.horrontani diafommo. 99. Diqqolemo.	
Q110	Tenne shoolle saminte Giddo hajjanjaniki xagga horronisiroto?	Ee, dee'ni, diaffomo, diqqolemo caatte 1 2 81 99 Shisha/Gaayya 1 2 81 99 Hashiishshe 1 2 81 99	
Q111	Teene yanna kaa'llato manni no (osso, mini manni hattono wollu) ee yittoro,me'ee manna kaa'llatto)?	1.ee. 2.dee'ni. 99. diqolleemo. ossote kiiro _____ Weddellu kirro _____	

Dargall. Maayimate xaadooshi xa'mmo

	Xa'mmo	Maaraxona qollo.	Haak ira harii
201	Siimmu xaaddoshshe assite eggenoto/ta?	1. ee. 2. dee'ni.	Q301
202	Siimmu xaadooshe mittu aleeni ikkino manni leddo assite eggenooto?	1. ee. 2. dee'ni.	Q301
203	Mitto aleeni no manni leddo siimmu xaadoshi yannara kondome hooronsi rato/ta ?	1. ee 2. dee'ni	Q301
204	Me'e higeeti kondome horonsiratohu /tahu?	1.woo'manka woyite 2. mitte mitte yannara	

DargallIII: Eggeno ,la'ona heddo xorre xoqqoli ana.

kiro	Xa'mmona	Qollote furcho darga	Haaki ra harii
301	Xorre xoqolli daafira maacishite egeenootto?	1. ee.----- 1 2. dee'ni.----- 2	
302	Maccishshotohu hikkiniti?	ee de'no 1. radiyoteni/telewi shinete-----1 2 2. qarqaruni-----1 2 3. addi addi woraqatani-----1 2 4. qarqqaru xena ekistenshine waayini---1 2 5. fayyimate aggarooshi xawinni.----- 1 2 6. rossu minini ----- 1 2 7. minn manni winni (Anna,ama,Rodduwa ,assotewini)1 2 8. leddo millani ----- 1 2 9. wollu heeriro (xawisso)----- 21	
303	Xorree xoqqoli taraawanno doggo affoto/ta?	Ee de'no 1. siimu xaaddoshini----- 1 2 2. Amatewiini ossote -----1 2 3. Hiv/aids,sayissano siwiila Horronsiratani-----1 2 4. Xorre xoqolini amadintimo munde wolleho atteni----- -----1 2 5. Dishichu iddamateni -----1 2 6. Sagalle leddo ittateni-----1 2 7. Foollateni-----1 2 8. Diaffomo -----81 9. Wollu heriir(xawissi)-----21	
304	Hiitto assineti HIV/AIDS gargadha dandiinanihu?	Ee Dee'no 1. Siimmu xaadoshini qorropheni-----1 2	

		2. Mimitoho amanamametenni-----1 2 3. Kondome horronsirateni-----1 2 4. HIV/AIDS amaadantino munde wolleho aa hoogate----- -----1 2 5. HIV/AIDS sayisa danditano uduune horronsira agurate. -----1 2 6. Mitteni sagga'la hoggateni-----1 2 7. Binichote idammate gargadhateni-----1 2 8. wollu herirro(xawissi)-- ----- 21 9. Diaffomo/ma-----81	
305	Keerrancho lawwano manni xorre xoqqoli nosiiha laawwahe?	1. Ee 2. Dee'ni 81.Diaffomo/ma	
306	Attino qolleno wollu manni xorre xoqqoli noosi gede hittoni affatto?	<p style="text-align: center;">Ee dee'no</p> 1. La'ateni calla.-----1 2 2. keraancho mancho xinxalate. ----1 2 3. Buddu fayyimate oggeye wayini.--1 2 4. Umi kaishi HIV/AIDS maramaraniwa harrateni. ----- -----1 2 5. Wollu nooro xawissi -----21 6. Diaffomo/ma -----81	
307	Xorre xoqolli amadano'e yitte heddato?	1. Ee----- 1 2. Dee'ni----- 2 → 3. Ikkarano hoogarano daandano-----3 4. Wollu noro(xawissi)-----21	Q309
308	Amadameemo yite mayira heddato?	<p style="text-align: center;">Ee dee;ni</p> 1. Mittu alleeni no manni leddo xaadoshe assoto/ta daafira-----1 2 2. Kondomi weello siimu xaadoshshe assoto/ta daafira.--- -----1 2 3. Siimu xaaddoshe buunabeetete menti leddo assoto daafira. .-----1 2 4. HIV/AIDS munde ammadamino siwwilini qassirateni. .-----1 2 5. Muunde ateeniino adhatenino-----1 2 6. wollu noro(xawissi) -----1 2	

309	Diamadameemo yite maayira dihedatto?	Ee de'no	
		1. Siimu xaddoshe assite eggenootoki daafira.-----1 2 2. Siimu xaadoshini qorophoto daafira-----1 2 3. Mitte/chcho galte noohe daafira.-----1 2 4. Miilace wollu leddo horronsirootoki daafira.---1 2 5. Konddome womanka woyite hoorosiratto daafira-1 2 6. wollu noro(xawissi) -----21	
310	Miilace wollu leddo horronsirootoki daafira?	1. ee----- 1 2. dee'ni----- 2 99. diqolleemo	
311	Konddome womanka woyite hoorosiratto daafira?	1. ee----- 1 2. dee'ni----- 2 Diaffomo/ma -----81	
312	Xaadoshini qorophoto daafira?	1. ee----- 1 2. dee'ni----- 2	
313	Alleeni noo xammora ee yittoro mammote?	Kondome horronsiratani-----1 Hiv/aids,sayissano siwiila-----2 Wollu noro(xawissi)-----21	
314	Marramaramateni ayi horronsiranoha lawanohe?	1. Umokinna galiteki amanooto daafira 2. Wuxeeta maacishsha saalifatottoo daafira. 3. Isi daafira afooto daafira. 4. Galtekki gibbino daafira. Wollu noro(xawissi)-----21	
315	Seejjotena mirrimaru horro HIV/AIDS gargartano yitte heddato?	1. ee----- 1 2. dee'ni----- 2 99. diqolleemo	
316	Fayyimate agaarooshi egenamawini afirato dafiira?	1. ee----- 1 2. dee'ni----- 2	

		99. diqolleemo	
317	Ee yitarro mammote seejjamito?	Wollu noro(xawissi)_____21	

DargaIII: eggenote, hassatotte, heddotena and loossu xa'mmo.

No	Xa'mmona	Maaraxona qollo	Haaki ra harii
401	Umi kaishi xorre xoqqoli seejotena mirmarru horro daafira macciishshite egenoto/ta?	1. ee----- 1 2. dee'ni----- 2	
402	Mashalaqe hikkini affirito/tta	Ee de'no 1. Qarqarruni -----1 2 2. Gallitekiwayini-----1 2 3. Leddo miillani-----1 2 4. Fiixxuwini-----1 2 5. Roosisanchu wayinni-----1 2 6. Raadonetena/teleewishinete-----1 2 7. Minni manni winni(annu, ammate,rodduwinina ossote) -----1 2 8. Fayyimata agarooshi uurinshuwani---1 2 9. wollu noro (xawissi) -----21	
403	Umni kaishi xorre xoqqoli seejona mirmarru horro uyyinani dargi qarqqarikira no?	1. ee----- 1 2. dee'ni----- 2 →	Q406
405	Hakkira harrate lekkate maage yanna adhanohe?	saa'atte _____	
406	Qarqariki gobbani tenne horro hikkini affirato?	1. Hoosipitaletteni 2. Fayyimate agarooshi xawwini. 3. Minni manni seejo widdoni. 4. Gillete fayimate minniwayini. 5. wollu noro xawissi	

407	Konni albani maramadhitena seejjante eggeennooto?	1. Ee----- 1 2. Dee'ni----- 2 →	Q417
408	Alleenii noo xammora ee yittoro mammote?	1. Sassu aganni alibani. 2. Lammu aganni alibani. 3. Mittu dirri alibani. 4. Lammu dirri alibaani. 5. Sassu dirri alibaani. 6. Shoollu dirri alibaini 7. Wollu noro (xawissi) 81. Diaffomo	
409	Maayiraati maramadhatena seejjamate kaitohu?	1. Umi kaishini. 2. Fayimatte bagarooshi loosasine hajjajoni. 3. Loossoho hassi'neena. 4. Baarra gabbarra fullate. 5. wollu noro (xawissi)	
410	ummi kaishshi ikkiro maayira?	Ee de'no 1. Ummo affate-----1 2 2. Alibira hinga hedatte-----1 2 3. Adhana adhamatte. -----1 2 4. Goddowi noota yannara. -----1 2 5. .Munddee ate yannara. -----1 2 6. Xaggichcho horronsira hannafate. ---1 2 7. wollu noro (xawissi) -----21	
411	Hiikoti assirotoku mirimara?	-----	
412	Mirrimaru yannara seejjo affiroto.	1. ee----- 1 2. dee'ni----- 2 →	Q414
413	Ee yitarro mammote seejjamito	1. Mirrimaru alibani. 2. Mirrimaru geeddenoni. 3. Alibaniina gedensaani. 4. wollu noro (xawissi)	
422	Uyinanni horroni hagidhato?	1. ee----- 1 2. dee'ni----- 2 →	Q424

423	Ee yittoro/taro maayirra?	Ee dee'ni 1. danchu albini-----1 2 2. rake horronsirato daafira-----1 2 3. wuxxeeta maanxani daafira-----1 2 4. Mittichiki callu horronsiratto daafira-1 2 5. Fayyimate agaarooshi egeenamawini afirato dafiira-- -----1 2 6. Calla marramarramoto/ta daafira-----1 2 7. Garri seejjo afirato daafira-----1 2 8. Wollu noorro (xawissi)-----21	
424	Xa'mmo 413 tera dee'nni yittoro/taro mayyirati?	Ee dee'ni 1. Rakke horro afiratto daafira-----1 2 2. Lowwo yanna agadhateni-----1 2 3. Wuxxeta wolleho kullateni-----1 2 4. Mittu alleeni noo manni noowa-----1 2 5. Baatoshuu kainohuni-----1 2 6. seejjo garrita affira hoogate-----1 2 7. Woollewa kaa'lotte sonkaniki daafira--1 2 8. Fayyimate oggeye garruni horro uyitanoki daafira.-----1 2 9. Wollu noorro (xawissi)-----21	
426	Xammo 407 tte dee'ni yittoro maayira?	5. Hikko uyyinaniro affotoki daafira 6. Dixaaqamanno yitte heddato daafira. 7. Umokinna galiteki amanooto daafira 8. Wuxeeta maacishsha saalifatottoo daafira. 9. Isi daafira afooto daafira. 10. Galtekki gibbino daafira. 11. Mannu yannota waajoto/ta daafira. 12. Baatooshu qarrini.	
427	seejjo hiv/aids mirmarira kayikase yitte heddato?	1. Ee 2. De'no 81. Diafomo/Ma	
428	Marramaramateni ayi horronsiranoha lawanohe?	1. HIV/AIDS mundensa giddo noo manni 2. HIV/AIDS mundensa giddo nooki manni 3. Aleeni noori lamunku 81. Diaffomo	
429	Lamunku mirmarru Danni heeriro hiikkone dodhdhato ?	1. Mashalaqena wuxeetu xaado 2. Mashalaqetena wuxxeetu babbadoshe 21. wolla herriho-(xawisso)	

430	HIV/AIDS mirmaarrirrana seejjote baata baxxato?	1. ee----- 1 2. dee'ni----- 2	Q432
431	Ee yiitoto magge birra?	-----Birra	
432	Wuxxeta hitte doggoni maccisha baxxato?	1. Mitten leddo offolate 2. Bilibilunni 3. Boorresancho dabidaabeni 4. Fixxu/galitetewaani 21. Wollu herriro-(xawissi)	
433	Seejjotena mirrimaru horro HIV/AIDS gargartano yitte heddato?	Ee-----1 dihedeemo-----2 Lamunkuwa dinomo-----3	Q435
434	Horrosi maati?	Ee dee'ni 1. Galittena wolleho tarrawanoki gedde assate-----1 2 2.Ummo affirate-----1 2 3. Alibilitete heeshora agadhateamuuwuwin ossote saa'ata gargaradhet-----1 2 4. Amuuwini ossote tarrawa gergarate ----1 2 5 .Galtte marraxirate-----1 2 6. Alibilitete heeshshora horronsirate ----1 2 7. Hiv/aids xagga horronsirate-----1 2 8. Wollu herriro-(xawissi)-----21	
435	Seejjetona mirmarru horro maamote assira hassisano yaatto/ta?	Ee dee'ni 1. womaanika woyite . ----- 1 2 2. xibbu amaddano yannara -----1 2 3.adhamani yannara-----1 2 4.baarra gobbani fullani woyitte-----1 2	

		5.ummo ammaniki yannara-----1 2 6.goodonbara alibaani-----1 2 7.goodonbani yannara-----1 2 8. Wollu herriro-(xawissi)-- -----21 9.diaffomo/ma -----81	
436	Seejotenna mirmarru horro uyinanni darga ayi harrona yaato?	Ee dee'ni 1.maayimansa woxxeho horronsirano seen-1 2 3 adhwona adhwantino manooti.-----1 2 4.toggo qarri giddo no manni -----1 2 5. Siimmu xaadooshe wo'manka woyite assano manni -- -----1 2 6 mittu alleeni simmu xaadoshe assano Manni-----1 2 7 .xiwaamanchu manni-----1 2 8.Wollu noorro (xawissi).-----21 9. Diaffomo-----81	
437	Hitte ogeyee widdoni horro affirotorooti hagidhatohu.	ee dee'ni 1. (Dookiteru widdoni-----1 2 2. Nurisete widdoni-----1 2 3.Rossino seejjasinchi-----1 2 4. Amanote uurinshuwa murrotini-----1 2 5 Qarqarru murrotini-----1 2 6 Seejjo dihassisano'e-----1 2 21. wollu herriro-(xawissi)	
438	Konni gaddensaani seejjamana marramaraama baxxato?	ee-----1 dee'ni-----2 →	Q440

439	Hikkira harrato horro affirate?	<ol style="list-style-type: none"> 1. Mangiistete fayyimate uurrinshuwa. 2. mangistete gobbani noo fayyimate uurrinshuwa. 3. Mittichchu manni minnino fayyimate horro xaawa. 	
440	Ate heddoni horro me'e sa'atani uyiniroo daanchaho?	<ol style="list-style-type: none"> 1. soddo 2.30am-6.30am 2. Barra 7.30pm-11.30pm 3. Woomante yannara. 4. Wollu noorro xawissi. 	

IV. BABBADE KAA'LLAANA FAFFISSA.

	Xa'mmona	Maaraxona qollo.	Haaki ra harii
501	Xorre xoqqoli nooheta affitoro ayirra kullato?	<p style="text-align: right;">Ee dee'ni.</p> <ol style="list-style-type: none"> 1. Galittekirra -----1 2 2. Minni mannira-----1 2 3 siimu xaadooshi miilara -----1 2 4.fiixxikira -----1 2 5.qariqaru mannira-----1 2 6.amaanote uurrinshuwa cimeeyera.---1 2 7.qarqarru murrootira-----1 2 8.loosasinchikira-----1 2 9.milliikira-----1 2 21. Wolla herriro-(xawissi) 	
502	HIV/AIDS mundeeki giddo noota affe wolleho kulitorro maayi agadhanohe?	<ol style="list-style-type: none"> 1. Minni manni fafiisano'e. 2. Galite'ya winni baxxemo. 3. Galite'ya ganttano'e. 4. Hosseemo miilla gibbano'e. 5. Coyyi ka'llo minni manni woyyi fixxuwi affiremмо. 6. Galte'yaawiina wollu wayini ka'llo afiremмо. 7. Hassabete ka'llo fayyimate oggeye wayni affiremмо. 8. Koo/tee xaadooshi uurano. 21. Wollu norro (xawissi). 	

503	HIV/AIDS muundesi giddo no maanni leddo saggale offolite ittato?	1. ee 2. dee'ni 81. diaffoomo	
504	Leddoki fixxi HIV/AIDS amadamiro mullisi kala'ncho ikkato?	1. ee 2. dee'ni	
505	Rossano mundensa giddo HIV/AIDS heerirona xiibbu malaati annansa hoogiro rosso rossara fajjato?	1. ee 2. dee'ni	
506	Rossiisanchu munde giddo HIV/AIDS heerirona xibbu malaati anaasi hoogiro roossisa gedde faajinansi?	1. ee 2. dee'ni	
507	Shaqqatu daddalanchina saggalete hirroranichi HIV varrese giddonsa hedhuro insawinni hidhato ?	1. ee 2. dee'ni	
508	Minni giddo mittichu HIV/AIDS amaadamiro wolleho kullatte agaramato?	1. ee 2. dee'ni	

3.3. Questionnaire For Qualitative Assessment Topic Guide for FGD

You are all welcome. We are happy that you could make time to us. We are a team selected from Sidamo zone health Bureau and from Addis Ababa university department of community health (Individual says own Name). We are carrying out a study called the disparity in KAP to ward VCT service utilization among 15-59 years age group. The study is aimed to improve the effectiveness of community conversation activity among 15-59 years population. We would like

to identify based on your knowledge and experience ways to improve the effectiveness of community conversation for the prevention of HIV/AIDS.

The result could be useful to individuals, families, or community and the country at large by showing the disparity in outcome with the same strategy, curtail the epidemic through enhanced the government action. You have been purposely selected to participate in this exercise because we believe that, as reproductive age group, the key member of your community, you have vital information and experience to share with us on this subject. Individuals are free to decide on whether or not to participate in the discussion. We also encourage members to feel free to say anything concerning the topics of discussion.

Thank you very much (The facilitator asks participants to introduce themselves at this stage).

1. What is your /the communities level of awareness and participation in community conversation programs, if any?
 - ✚ Do you know about CC and do you participate?
 - ✚ What is the importance of it?
 - ✚ What are the reasons for low participation?
 - ✚ Which topics are discussed during CC sessions?
 2. From whom (where, when) does the community in this area get information about VCT?
 - ✚ If from CC, PROBE: what aspect of VCT is discussed? (Site, about knowledge, only information to utilize VCT, whom to be tested,.....)
 3. What is the attitude of community towards VCT and a person who had VCT?
 4. Are there any cultural and religious practices in the area that could promote/prevent VCT Service utilization?
 5. Why do you think that people in this community don't utilize VCT service?
 - ✚ What is that? And how it influence?
 6. What could be done to encourage people to utilize VCT service?
- We thank each of you for time and cooperation and we do appreciate all your suggestions

ANNEX 4: English version Sheet and consent forms

4.1.English version Participant Information Sheet

Description of the study

Title of the study: The disparity in KAP towards VCT service utilization among 15-59 years population age in rural kebeles with poor and well community conversation performance in Shebe Dino district.

Objective of the study: to determine the disparity in KAP towards VCT service utilization among 15-59 years population age in rural kebeles with poor and well community conversation performance.

Introduction: HIV/AIDS voluntary counseling and testing service is used to reduce HIV infection. However, HIV infection reduction is not attained by many countries, it is due to less effective implementation and utilization of intervention on HIV/AIDS like CVT and community conversation according to studies conducted in country and abroad.

Rationale of the study

The role of 'Community Conversations' (CC) is making traditionally conservative Ethiopians open up and face the realities of HIV, including the need to treat people affected by the pandemic with greater respect and acceptance(13, 14). However, Ethiopia has shortage of study done on the effectiveness of the program. Therefore availing scientifically sound data on the abovementioned gaps will have paramount importance for evaluation of the program and differentiated approach for the implementation of the program. The study is designed to assess the impact of CC intervention on the knowledge, attitude and utilization toward HIV/AIDS voluntary counseling and testing service while bridging the abovementioned gaps.

Information which is necessary for the study will be taken from the response of the study population. As the study will be conducted through interviewing alone, the individual will not be subjected to any harm as far as the confidentiality is kept. To safeguard the confidentiality, no personal identifiers will be used on data collection form. The recorded data will never be accessed by a third person except the principal investigator, and will be kept with a firm confidentiality in much secured place plus it will not be used for other purposes.

4.2.Sidamu Information Sheets

Sidaaminynu Qooloo

Eggenote ,laotenna loossu babbadoshe affate xorre xoqqolli umi kaishi seejjotena mirmarru horro aanna 15-49 dirri weddeli giddo shaabbadini wooradi, sidaamu zoone woodii=di dagga dagoomuna qooqqwu mangiste tiphياهو assinooni xinxallo .

Konni daafiro atilte: xa'mmate hassinomahu atti atoo mashaloffe su'mmaki ayirrano kulla hooggate qalle ee'nnemmo. Qolla hassiratooki xa'momaayi xaamo hasira hogitoro/taro dand'aato. Coyeella ikkiro kaayini xammina xa'mmo horro affe golli konni horro afidhi gedensanni notta affe hassiseno qollo klie qallanteemmo.

xiinxalote aanna : 15-49 dirri weddeli giddo shabbaadino sidaamu zoonera wddmqg tophiyaaho assinooni xinxalora qollote hawaale keere heerrito. Tenne xa'mmo qollqte alibaani tinni xinxalo maayira hasiisanoro afaa hassiisanohe. hassiratooki xa'momaayi xaamo hasira hogitoro/taro dand'aato. Coyeella ikkiro kaayini xammina xa'mmo horro affe golli konni horro afidhi gedensanni notta affe hassiseno qollo klie qallanteemmo

wooradi, sidaamu zoone woodii=di dagga dagoomuna qooqqwu mangiste tiphياهو assinooni xinxallohassiisanohe. hassiratooki xa'momaayi xaamo hasira hogitoro/taro dand'aato. Coyeella ikkiro kaayini xammina xa'mmo horro affe golli konni horro afidhi gedensanni notta affe hassiseno qollo klie qallanteemmo. Tinni xiinxalo harro maaasitireetete digirre addisaabu yuniweerisite gagoomu agooshi minniraati tinni xinxallo addisabu yuniweeriste faayimate rossi minni wodhishshi fajjo afidhinota ikkitana. HIV/AIDS heerirrona xibbu malaati anaasi hoogiro roossisa gedde faajinansi heerirrona xibbu malaati. anaasi hoogiro roossisa gedde faajinansi Galte'yaawiina wollu wayini ka'llo afiremmo. mundeeki giddo noota affe wolleho kulitorro maayi agadhanohe. Siimmu xaadooshe wo'manka woyite assano manni Fayyimate agaarooshi egeenamawini afirato dafiira.

4.3.English Version Consent Form

My name is _____ and I am working with the School of Public Health of Addis Ababa University. You have been invited to take part in a study on VCT service utilization. Before you decide whether to take part, it is important for you to understand why the research is being done.

This study is conducted as a partial fulfillment of a Master thesis in Addis Ababa University, School of Public Health. It has got ethical approval from the Ethical Review Committee of the school of public health of Addis Ababa University. The study is being conducted on Shebe Dino districts, Sidamo zone, from six kebeles. The aim of the study is to determine the disparity in KAP to VCT service utilization among population age between 15-59 years in rural kebeles with poor and well community conversation performance in Shebe Dino woreda.

That is why we contacted you for taking part in the study. All information that is collected about you during the study will be kept confidential, and your names will never be mentioned in any analysis and dissemination of findings.

Confidentially and content: - I'm going to ask you some general and in-depth personal questions. Your answers are completely confidential; your name will not be written on this form, and will never be used in connection with any of the information you tell me.

You do not have to answer any questions that you do not want to answer and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand for our study objective and for future action. We would greatly appreciate your helping. If you have any questions about this study you may ask me or the principal investigator Emebet Tekletsadik (Tel: 09 16 86 69 14 or E-mail: emuye2010@gmail.com)

IRB (Institution of Reviewed Board) Tel: 0115538734 or E-mail: aaumfirb@yahoo.com
would you willing to participate? If yes, _____ (1) continue. No _____ (2) stop.

Result Code _____ 1=Completed 2=partially completed 3. Other

Interviewer Name _____ Signature _____

Date of interview [____/____/____] Supervisor name _____

Checked by supervisor: Signature _____ Date _____

(Signature of the interviewer certifying that consent has been obtained verbally).

4.4.Sidamu Consent Form

Mashaalaqetena Suummu Yaate Forime

Evaluation of CC performance on each kebeles was done by considering four criteria and variables on each of them for the activity. They did it by using the monitoring result of each kebeles CC performance from September, 2009 to August, 2010.

Table1: List of criteria and weight used to classify kebeles into poor and well CC groups

Criteria and Variables	Weight Was Given
1. Implementing CC according to its methodological frame work.	3
• <i>Establishing and strengthening relation ship</i>	0.5
• <i>Identification of Concern</i>	0.33
• <i>Exploration of Concern</i>	0.5
• <i>Identifying and organizing capacity and resources</i>	0.33
• <i>Decision making and planning</i>	0.5
• <i>Implementation/Action</i>	0.51
• <i>Reflection and review</i>	0.33
2. The number of participant and groups.	2
• <i>which started 4-6 CC groups</i>	0.5
• <i>which had 240-360 participant at the beginning</i>	0.5
• <i>which graduated 240-360 number of participant</i>	0.5
• <i>which graduated 4-6 CC group</i>	0.5
3. The number of decisions undertaken during conversation and making them as part of kebeles development agenda and implementing it.	4
	1
• <i>For those with 4-5 number of raised topics for conversation.</i>	1.5
• <i>For those with 4-5 agenda get decisions during conversation and making part of the kebeles development agenda.</i>	1.5
• <i>For those implementing 4-5 agenda which taken as part of the kebeles development agenda</i>	
4. For document handling and reporting	1
• <i>With 14-20 number of minute “Qale Gubae”</i>	0.34
• <i>With 14-20 attendance list</i>	0.33
• <i>With 7-10 monthly reports</i>	0.33
Total	10

DECLARATION

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in this or another University and all the sources of materials used for this thesis have been fully acknowledged

Name: Emebet Tekletsadik

Signature: _____

Date_____

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

Name: Professor Mesganaw Fantahun

Signature: _____

Date_____