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REFERENCES

ACRONYMS

AIDS = Acquired Immune Deficiency Syndrome

BCC= Behavioral Change Communication

FDRE = Federal Democratic Republic of Ethiopia

FGAE = Family Guidance Association of Ethiopia

FGD = Focus Group Discussion

HC=Health Centre

HIV= Human Immunodeficiency Virus

IEC =Information, Education and Communication

KAP = Knowledge, Attitudes and Practice

MOH =Ministry of Health

NGO = Non Governmental Organizations

OSSA = Organization for Social Service for AIDS

PLWHA= People Living With HIV / AIDS

SRH = Sexual and Reproductive Health

STI (D) = Sexually Transmitted Infections (Diseases)

VCT = Voluntarily Counseling and Testing

WHO = World Health Organization

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ABSTRACT

Although there have been some researches on assessment of challenges and obstacles on reproductive health of youth, it is difficult to get research that focuses on assessment of problems in relation to access to health care and VCT of HIV for youth in developing countries, particularly in Ethiopia.

Youth, as a beneficiary of service, should be able to choose from among various services available to them. In addition to this, they should be able to decide when and how the service should be offered, and should also feel free to complain when the standard of a service is not acceptable.

This study is a cross-sectional rapid assessment of challenges and obstacles observed in accessing youth to health care and VCT of HIV services.

The over all objective of the study is the identification of challenges and obstacles that prevent youth from getting health care services and VCT of HIV and to design possible strategies for intervention based on the findings

Study subjects are-

Youth: in schools and out of school youth (street youth, commercial sex workers, petty traders, youth who are with known HIV status)

Service providers: for institutional assessment

In order to collect the necessary data, both **qualitative** (focus group discussion and individual in-depth interview) and **quantitative** methods (self-administered questionnaires) have been utilized.

The study has been conducted in SNNPRG: Awassa, Yirgalem, Leku and Wolkite towns.

A total of 374 youths participated in the quantitative assessment and 120 in the focus group discussion and 15 in the in-depth interview.

The finding of this study indicated that the level of knowledge of the youth about HIV/AIDS is encouraging. However, it is observed that there is a wide gap between the high knowledge and the low practice. 89.7% of youth have heard of VCT service and 84.1% of participant have promised to test for HIV if it is charge-free.

According to the study the following are some of the challenges and obstacles that prevent youth from getting health care and VCT services: Lack of money, fear-of-family, lack of trust on service providers, lack of confidence in the quality of treatment and counseling, physical inaccessibility, lack of information about location of the services, fear of being identified by somebody and lack of privacy.

Based on the suggestion made by the respondents and the assessment findings the following recommendations (to improve and increase access to health care and VCT of HIV) are forwarded :

- Tailoring service provision according to sex and age.
- Targeting high risk groups.
- Integrating VCT of HIV with entertainment and recreational facilities.
 - Promoting Behavioral Change Communication (BBC) initiatives
 - Involve parents during awareness creation; train and bring them into planing, implementation and evaluation process.
 - Training of service providers.
- Establishing Pre and post VCT interventions
- Health promotion initiatives.
- Promoting VCT service through anti-AIDS clubs and VCT promotion through governmental, social and cultural settings are some of the recommendations forwarded. Hence these recommendations are vital as strategies for future interventions.

CHAPTER - 1

INTRODUCTION

Today's young adults are our future. Their energy, leadership and wisdom will shape the world during this new century. They will care for our own generations as we grow older and they will nurture the next generation to come (Net work family Health International, 2000). Consequently, protecting their good health is a vital concern for all of us. Effective strategies and programs to protect the reproductive health of young adults are needed in every country but are especially urgent for youth in developing countries. Service users are becoming more aware about quality of care and are now more vocal about issues caring dissatisfaction.

One of the strategies related to policy on HIV/AIDS in FDRE is HIV testing and screening. It emphasizes that testing shall be voluntarily conducted and shall be encouraged along with counseling services (MOH, 1998).

VCT of HIV/AIDS services partially depend on the information available among youth. Information is considered as one of the strategies to solve the problem of HIV/AIDS among the youth. According to MOH (1998) intensive, extensive and suitable IEC activities through all possible media, materials and methods taking into account the culture such as belief and the languages, shall be planned, tested, implemented and evaluated for continued success in educational efforts.

The virus that causes AIDS has already infected many Ethiopians. From every 13 adults one is infected. In urban areas, more than one out of six adults are infected and most of these people do not know that they are infected.

The purpose of this study is to: -

- To explore the level of knowledge attitudes and practice of youth.

- Find out key challenges and obstacles to access youth to health care and VCT of HIV/AIDS

- Find out gap in services and to make recommendation for future interventions.

Considering the problem of the youth, FGAE is increasingly focusing on the provision of SRH service from a client centered perspective. It has long been working rigorously in supporting the youth by rendering services that best fit their specific needs (FGAE,2000).

CHAPTER- 2

LITERATURE REVIEW

2.1 Youth

Family Health International (2000) stated that adolescence is the transition from childhood to adult hood marked by profound physical, emotional, mental and social change. Similarly Collin (1998) defines it as period of life when a child is developing into an adult. In Europe and USA this period is considered from 10 to 24 where as in developing countries such as Ethiopia it is mostly from 13 - 25 years of age (Youth to youth initiative, 1998). FGAE also considers all people aged 10-24 as youth.

According to Hawas (1997) the physical and emotional changes that occur around puberty can cause girls and boys great confusion and stress. It is important that young people have an opportunity to learn facts about their development and are able to discuss their concerns openly with each other and with a sympathetic, non-judgmental adult. This will help them to pass through puberty and adolescence with knowledge, confidence and self-esteem.

Change is the hallmark of adolescence. Emotionally, young people move toward independence from their parents or elders and establish new interests and relationship (Hasas, 1997). Young people seek information and clues about sexual life from a variety of sources ; parents, peers, religious leaders, health providers, teachers and mass media. They obtain information and make decisions within the context of the culture in which they live. Decisions and actions may be affected by violence, drug and alcohol use. The time of adolescence is fraught with challenges uncertainties, unfounded fears, internal conflicts and being confronted with a new body, with new feelings-and often with little help.

2.2 Youth: Sexual and Reproductive Health issues

Network Family Health International (2000) suggested only a tiny percentage of the world's resources is devoted to help youth in developing countries realize their potential. Given the huge numbers of youth and the seriousness of the problems, There is a temptation to comment on all available resources to action programs and just " get on with it ", evaluation may seem like a luxury. Because they are afraid, ashamed or desperate; many young women are willing to risk their lives to end an unplanned pregnancy " When an adolescent girl wants to interrupt a pregnancy she always goes where she should not, in the most isolated places where she knows no one will see her " says one west African health workers (Barnet B. and Stainj , 1998). The world Health organization (WHO) estimates that between 1 million and 4.4 million abortions are performed each year among young women (Age 10 to 24 years) and that most of these are unsafe because they are performed illegally (Trolley *et al*, 1998). In Senegal, young women who become pregnant may be shunned by their parents and forced to leave home. After pregnancy women's decisions is mostly influenced by male partners. In Tanzania out of 150 adolescents who underwent abortion, 46% said they told their male partners before anyone else, and 27 % told male partners after telling a friend or relative.

Sexually Transmitted Infection (STI) is another challenge for young people. Nearly half of all HIV infections worldwide occur in people under age 25. Seven in 10 new STI occur among individuals 15 to 24 years old (Facts and Figures, 1999) .

Similarly (Werner *et al*, 1998, cited in. Net work family Health international, 2000) stated that about a third of 333 million new Sexually Transmitted Diseases cases each year- excluding HIV/AIDS - occur among people younger than 25 and recent data support that the adolescent STD epidemic is growing. Mostly, young people may think they are too young or too sexually inexperienced to acquire STI. They may also think they are not at risk, since they incorrectly believe that STI only occur among people who are promiscuous or who engage in " bad " behaviors. All these will happen to young people as result of lack information about how to prevent STI. youth are less likely to seek proper information or treatment due to fear, ignorance, shyness or inexperience. The risk of acquiring

Trichomoniasis, Chlamydia, genital herpes or Human Papilloma Virus (HPV) is greater at first exposure to the STI.

Violence or coercion in relation to rape is another youth SRH issue. Records at the maturity Hospital of Lima, Peru, found that 90% of young mother's ages 12 to 16 were pregnant as a result of rape. For girls and women who typically have less power and less status in society, the short and long-term health consequences of sexual violence can be physically and emotionally alarming. Young women in Senegal said, " If you refuse, he is going to beat you and you will give in to his desires by force (McCauley *et al*, 1995).

A need assessment and baseline survey revealed that since first sexual experience occurs between ages 13 and 16, youth more than ever before require sexual and reproductive health information as well as some life-building skills such as negotiation skills, value clarification, refusal skills, decision making and goal setting. These skills will enable youth to cope with the demands and challenges of growing up, self-management and other transactions (Amazigo U. *et al*, 1995).

Lastly with the above mentioned challenges and problems in young people, the issue of youth and parents relationship have been considered as additional challenges. Parents often wonder, " Will my child make the appropriate decision?" Numerous studies have been conducted over the years to analyze parent- adolescent relationships. According to Meeks-Mithcell Heit (1987), in these studies, the overwhelming conclusion is that adolescent agree with their parents' ideas and share their values. The aforementioned statement might be true to developed countries. But in countries like Ethiopia, parent-adolescent conflicts are frequently observed. Besides, health service policies do not sufficiently incorporate the need of the youth.

2.3 HIV/AIDS and VCT in Youth

According to National AIDS secretariat (2000) voluntary HIV counselling and testing is the process by which an individual undergoes counselling so that she or he can be able to make an informed choice about being tested for HIV. This process is also

aimed at helping them to cope with stress and make personal decisions related to HIV/AIDS.

The objectives of voluntary HIV counselling and testing according to the national guideline of VCT in Ethiopia is:

1. To provide information on the mode of HIV transmission and methods of prevention.
2. To help those who wish to consider HIV testing make their own decision whether or not to be tested and finally to provide support following the testing.
3. To provide information on the increased risk of HIV transmission associated with other sexually transmitted infections (STIs) and give referrals for STI examination and treatment.
4. To provide information on the increased risk of opportunistic infections including tuberculosis associated with HIV infection
5. To provide family planning information and referral for women of child bearing age who are infected or are high risk of HIV infection, and
6. To provide referrals to HIV positive and high risk HIV negative persons for necessary medical, preventive and psycho-social services and home based care in the community.

Eyecup and Marcum (1999) stated about what lessons should be learned from AIDS Information Centre in Uganda. Experience shows that VCT should be part of comprehensive HIV prevention programme. Anonymity and protection of confidentiality are critical to ensure public trust. Integrating services such as family planning, STD detection and treatment, client centred approach greatly benefits clients. Once VCT becomes accepted by the public an increased number of clients are likely to request VCT for social reasons rather than medical reasons. On-going support of HIV positives through a post test club and cost sharing scheme for testing leads to behavioural change of the community and consequently reduces the risk of HIV transmission. A computerised management information system is also critical for routine monitoring and quality control.

Voluntary counselling and testing requires time, acceptance, accessibility, consistency, accuracy and confidentiality. VCT

service should clarify and address problems, provide information on available resources, help client to adopt a realistic approach to changes of life style, should motivate and facilitate decision making (WHO, 1990).

In developing countries up to 60 % new HIV infections are among 15 to 24 years old, with generally twice as many new infections in young women than young men (Weiss, 1996 cited in Family Health International).

In contrary in USA although adolescents represent less than 1% of the cumulative total reported AIDS cases, data on newly diagnosed cases of HIV infection from the 29 states requiring confidential reporting of persons with HIV infection suggest a high risk of HIV infection in adolescents (AIDS, 2000). Facts and figures (1999) stated around one-third of the 33 million young people living with HIV in the world at the end of 1998 are in the same age range. This is an age when most people start their sexual lives. In Malawi, Tanzania and Zimbabwe. Condom use among people under 25 is noticeably higher than among older groups. A recent study again in Malawi measured yearly HIV incidence at nearly 6 percent in teenage women as compared with less than 1% in women over 35. In Ethiopia, condom use has been promoted as a prevention strategy among young people. As a result condoms become more available and less costly and its use has become a socially accepted norm among young people. Condom sales increased from 3 million pieces in 1991 to 20 million pieces in 1996. Girls are exposed to HIV earlier than boys. A preliminary analysis of multi-site studies sponsored by UNAIDS and its partners shows that in western Kenya, nearly 1 girl in 4 aged 15-19 is already living with HIV, compared with 1 boy in 25.

Facts and figures (1999) stated about some reduction in HIV/AIDS prevalence. In many countries in both the industrialized and developing world, 15-19 years olds are increasingly abstaining from sex in the face of HIV. In Uganda, for example by 1995, 50% of the men and 46% of the women in that age group said they had never had sex. More than three-quarters increase over the 1989 figures for either sex.

A study by John and Jemmoh (2000) concluded adolescents are at risk for sexually transmitted HIV infection. Behavioral interventions are needed to reduce their risk. About 56% of adolescent women and 73%

of adolescent men have had sexual intercourse by the time they are 18 years of age.

Again Family Health International (2000) stated nearly 3 million new infections occur annually among young people, including 1.7 million in Africa and 700,000 in Asia and the Pacific. Every minute, five people age 15 to 24 are infected with HIV.

In Ethiopia ministry of health has developed a policy on HIV/AIDS prevention and control. It is suggested that experience shows that people living with HIV/AIDS (PLWHA) very often are subjected to social discrimination and stigmatization unless protected through government policy, educational efforts and counseling services (MOH, AIDS policy, 1998).

A KAP study in Gurage zone showed that the knowledge about HIV/AIDS/STD and measures taken to prevent and control is found to be very low. Polygamy is quite frequent, extra-marital sex involvement is common, condom knowledge and use is markedly low, use of media and accessibility to the majority of the rural population is very low.

According to ministry of Health (MOH) there will be about 21,500 new cases of pediatric HIV annually with the increasing prevalence HIV in pregnant women. Traditional Birth Attendants (TBAs) who handle about 90% of the deliveries, will be exposed to higher occupational risks (Baruda G. *et al*, 1994).

The General strategies in HIV/AIDS policy of Ethiopia are provision of IEC by all government sector ministries and institutions, NGOs and mass organizations, etc,. The services provided include STD prevention and control, HIV testing and screening, sterilization and disinfecting, HIV/AIDS surveillance, Notification and reporting, medical care and psychosocial support, Research and development, HIV/AIDS and human right, Regional and international relations, policy implementation and coordination. (MOH, AIDS policy, 1998).

According to Gebresenbt S. (1998) HIV/AIDS epidemic is increasing at alarming rate in Southern Nations Nationalities and Peoples Region. The registered cases have increased from 17 in 1990 to 5270 cases at the end of 1998. It is estimated that the actual number of cases could be five times greater than the reported cases. 87.5% of

HIV/AIDS cases in the region are the result of history of multiple sexual partners. Over 90% AIDS cases in the region occur in the most productive and reproductive age of 15-49 years.

A cross-sectional study by Gebresenbet S. (1998) was conducted in SNNPR. The study areas were Wolita sodo, Hoseena, Awassa and Dilla. The study aims at evaluating knowledge, attitude and practice on HIV/AIDS among high school students. 480 students participated in the study from all areas. The result of this study showed that out of 460 respondents 449 (97.6%) have heard about HIV/AIDS. The majority 397 (86.3%) do believe that AIDS is a disease in which the body defense against infection has been damaged. The idea that they can transmit the disease if and only if they developed signs of AIDS was disagreed by 345(75.0%) which is statistically significant ($P < 0.05$). The respondents who think that it is possible to avoid spreading the HIV virus by using condom during sexual intercourse are 399 (86.7%). Using sterile needles and other subjects 423 (92.0%). Sticking to only one faithful partner 431 (93.7%). Using own new blade for circumcision 390 (84.8%) and avoiding drug and alcohol use 373 (81.1%).

The main strategy of AIDS prevention programs in developing countries should make need assessment in attempt of determining knowledge attitude and practice followed by promotion of sexual behavior change. Many studies from Europe, USA and the African continent demonstrate that a high proportion of adolescent and young single adults are sexually active from an early age. Unprotected sex exposes young people to complications resulting from unplanned pregnancies and high risk of STI. Lastly while AIDS has no cure, HIV infection can be prevented and service providers can provide their services for youth that offer education and information about HIV prevention and Voluntary Counseling and Testing (VCT).

" Nowadays there is more danger in not talking about sexuality than in talking about it," says secondary school teacher in Cote d'Ivoire (Family Health International, 2000a). Counseling is critical for all reproductive health clients, including adolescents. The goal of counseling is to provide young people with facts that will enable them to make informed, voluntary decisions. one should offer information and guidance, but ultimately, the adolescent must decide whether to use contraception, which method to use, and whether to continue or quit a method. Services providers may be reluctant to

discuss sexual health issues with young adults. Some people believe that adolescents should not be sexually active, that only married youth should be sexually active or that sexual activity is acceptable for boys not girls.

According to Family Health International (2000a) service providers should recommend HIV testing by explaining the advantage of testing such as testing can enable couple to make decisions about future pregnancies, knowledge of HIV status can help adolescents prevent transmission to uninfected partners. In addition, health service providers should also understand that the clients will consider disadvantages to HIV testing such as distress, anxiety, uncertainty, depression, fear of the partners and families, fear of discrimination by the community, co-workers or relatives, concern that they may not have access to treatment. Hence, talk about the emotional, social and medical consequences of an HIV-positive result or HIV-negative test is found to be helpful to the client to make a plan for what he or she will do if HIV test is positive. After testing counseling the client in person, in private place is recommended.

2.4 Challenges and obstacles: Access to reproductive health services

Service users are becoming more aware about quality of care and are now more vocal about issues causing dissatisfaction (Alemayehu G. 2001). Inconvenient hours or location, unfriendly staff and lack of privacy are among reasons many young adults give for not using health services. A campaign in South Africa is trying to address such concerns through a certification process in which health services (clinics) that meet certain standards that help youth will receive recognition (Family Health International, 2000a).

Young people are at risk of health problems because they: -

Lack of knowledge and information: - Lack of basic knowledge about reproductive system, anatomy, how pregnancy or STI occur, how to prevent them and where and how to obtain protection.

Lack of access to services and programs :- Youth may have little or no money to pay for services, they may lack transportation or do not know how to use services; health workers may hold

judgmental attitudes toward adolescent sexual activity; health workers may not have up to date scientific information on contraceptive safety protection; clinics may not be open at hours that are convenient for young people; clinics often are designed for married women rather than single women ,men or adolescents. Requirements for medical tests and pelvic exams may discourage young people from seeking contraceptive; National health policy may prevent reproductive health information services.

Psychological or social barriers: Adolescents may be afraid to admit they are having sex. They may hold unrealistic views of individual pregnancy and STI risks - the " it cannot happen to me" syndrome; they worry that contraceptives will damage their health and future fertility. Adolescents are vulnerable to sexual violence, coercion and abuse. Motherhood may be a means for girls to gain status and respect in their families and communities. Young people may be afraid or embarrassed to seek help because of rape or incest. Sex for poor street children is sometimes a means of income.

2.4 Youth-friendly health services or programs.

Erulkar A.S (2000) suggested many youth programs reach the young long after they need the information rather than when the information is most crucial. Other programs may not deal with the most pressing concerns facing youth.

Health professionals and programme managers lack adequate information on cost- effective ways to reach the largest number of youth including both boys and girls, different age groups in school and out of school youth and married and unmarried youth. For instance, youth centers, places where adolescents meet for recreation can also provide access to reproductive health services information. At first glance, this seems like a reasonable approach. But a recent evaluation of 14 centers in Africa found that youth centers typically serve small numbers of youth (often older males) are not particularly good places to deliver health service information and are relatively expensive.

Other researchers have found that youth centers in Mexico were less - cost effective than a community youth programme in recruiting

family planning users. " We need accessible clinics with non-judgmental, friendly staff and reduced waiting times" says Kim Dickson-Telteh, in South Africa Department of Health. The South African campaign plans to use the stars to help adolescents identify clinics that might be friendlier to their needs. The campaign seeks to make health services more accessible and acceptable to adolescents health care in clinics through out the country and to help health-care providers improve their delivery of adolescent-friendly services.

A study by the Washington based International center for research on women, which made research with adolescents in Africa, Asia, Latin America and the Caribbean recommends that reproductive health services for youth be private, confidential, affordable, accessible, and staffed with sensitive providers (Wess *et al*, 1996 cited in Family Health International, 2000b). In addition, youth said that the most important factors determining their choice of clinic were staff attitudes, location and atmosphere, contraceptive methods available and clinic hours, in that order (Transgrud R. 1998 cited in Family Health International 2000b).

" The circumstances vary extensively regarding what kinds of clinical services will best serve" says Dr.Cynthia Waszak. Sometimes youth want service centers just for youth, other times they want them integrated into existing clinics. The most important thing is to ask youth and providers in a particular community what they want and what will work best for them. In many counties the attitudes of providers have discouraged even married adolescents. Focus on young adults, implemented by the U.S based pathfinder international, has developed workbooks to score clinics on the quality of their services to youth. The facility itself, including operating hours, location and privacy, staff performance, including respect shown to clients. Confidentiality and adequate time for interaction, administration procedures such as whether fees are affordable and whether drop in clients are welcome and how youth perceive the clinics services all these should be assessed (Nelson K. *et al*, 2000 cited in Family Health International, 2000 b).

Standards have been developed based on research of what adolescents say they want in clinical services. The standards include policies and processes that support adolescent rights, a physical environment, conducive to the provision of adolescent friendly

services, and the provision of psychosocial and physical assessment of youth. Using the self-assessment approach gives the clinics the opportunity to look at themselves and their operations.

Annable Erulkas and colleagues at the New York-based population council recently evaluated 14 community based youth centers in Kenya, Zimbabwe and Ghana. The evaluation suggested many youth, especially girls don't want to be associated with family planning organizations because it suggests sexual activity or because young people brand them as places for those sexually transmitted diseases. The evaluation also found that staff are highly knowledgeable but are often judgmental.

Generally youth-friendly services should actively involve adolescents in program designing and service delivery, and consider how adolescents' needs differ from those of adults and provide services that specifically meet the needs of young people. Providing youth-friendly services does not necessarily mean building a new clinic. It can mean adding adolescent-only hours or offering services in places where adolescents congregate such as youth centers, sporting events or work sites. It is advantageous to involve young people in planning and implementing health services, and make all staff receptionist, nurses, physicians- aware that they should treat adolescents with respect and dignity. It should be insured that young clients have privacy and that clinic policies emphasize confidentiality. There may be a need to revise clinic policies and procedures, so that to identify which specific target groups will be served. The group can be defined by age, school status, martial status or place of residence. (urban Vs rural). Parents involvement (day) at the health centers to provide information to adults about adolescents reproductive health should also be arranged.

CHAPTER - 3

AIMS AND OBJECTIVES

The aim of this study is to assess obstacles and challenges in accessing health care and Voluntary Counseling and Testing (VCT) of HIV/AIDS among the youth.

This study is designed to highlight area of satisfaction and dissatisfaction, obstacles and challenges in health services for youth as customers. In addition, quality, accessibility (in terms of affordability, location etc.) appropriateness of services, (whether services are youth-friendly) attitudes of service providers, technical competence of the service providers and the level of co-ordination will be assessed. Knowledge, Attitudes and Practice towards HIV/AIDS and VCT among youth and information and parents and youth communication will also be assessed.

This study has the following specific objectives:-

1. To identify key challenges and obstacles that prevent youth from using health care and VCT services.
2. To investigate youth expectations with respect to the different types of health services.
3. To assess the level of knowledge and attitude regarding HIV/AIDS and VCT of HIV/AIDS , and to assess the practice of prevention methods.
4. To design possible strategies for interventions based on the findings.

CHAPTER- 4

STUDY DESIGN

4.1 Study methodology

This study has been designed to assess challenges and obstacles in health care and VCT of HIV/AIDS service for youth with service at individual level. Related issues aimed at the multi-dimensionality of services and how these services meet the need of youth are also assessed.

In assessing health care services among youth, quality, accessibility and affordability issues should also be examined. This study concentrates on HIV/AIDS and VCT services. An assessment of knowledge, Attitudes and Practice related to prevention of HIV/AIDS is also considered crucial as preconditions for any intervention.

This study was a cross sectional rapid assessment with the following study subjects.

Youth : 1- In-school youth

2- Out of school youth (commercial sex workers, street youth, petty traders)

3- Youth with known HIV status

Health service providers: from HC, Hospital, VCT centers, NGO's such as OSSA,

Down of hope etc.

Structured and non-structured questionnaires have been developed to assess different areas of services. The quantitative study was conducted through self-administered questionnaire. It covers many areas including general socio-demographic particulars of the respondents and issues that are specific to each service. Generally an effort has been made to use a common topic guides which were used

by different researchers in other youth health studies. These include quality, accessibility, affordability, technical competence of service providers, youth -friendly programs, appropriateness of services and coordinated care. Psychosocial and cultural barriers for utilizing health services were also assessed in this study.

A qualitative study was conducted through focus group discussion with youth and in-depth interview with service providers to get information about questions that remain unanswered or are not addressed in the quantitative study.

In this study in- school youth and out-of-school youths were involved to avoid some selection bias. As recommended by different researchers the most important thing is to ask service providers what they want and what works best for them. Hence service providers from study areas were part of the study.

To get ethical acceptance all the concerned bodies at all levels were informed of the aim and objectives and expected advantages of the study. Ethical permission was obtained from SNNPRG, Regional health bureau ethical committee. Consent was requested from youth, and service providers before queries were presented to them.

The data collected through the quantitative study was processed and analyzed using a computer package Epi-Info version - 6.

4.1.1 Study population

The study was conducted in SNNPRG specifically at : Awassa, Yirgalem, Wolkite and Leku towns. These areas have been selected because of convenience and accessibility for the study and the possibility of getting a good mixture of suburban, urban and rural population. The selection is supposed to provide a good socio-economic mix, educational and health services are also available in the chosen towns. These towns also lie in actual and potential project areas of FGAE.

Study subjects are :-

- **In school youth:** include junior and high school students in the age bracket of 10-24

- **Out of school youth:** include street youth, petty traders, day labourer, shoe shiners, unmarried and married youth, school withdrawals from kebele, youth centers, associations and street
- **Youth with known HIV status :** from OSSA, Down of hope etc
 - **Health service providers** physicians, nurses, health assistants and paramedics from health centers, hospitals youth clinic /center has been included in this study.

4.1.2 Inclusion criteria

Youth : who are

- Residents of Awassa, Yirgalem, Leku and Wolkite towns.
- Students who are attending their schools in aforementioned towns
- Age from 10-24
- Out of school (drop-out or withdrawals from school, married, illiterates)
- At any level of economic status
- At present living with or without their parents

Service providers who are

- At present providing health services in Awassa, Yirgalem, Leku and Wolkite towns.
- Working in governmental or NGO health institutions
- Physicians, Nurses, Health Assistants and paramedics.

4.1.3 Exclusion criteria

- Youth who are not residents of Awassa, Yirgalem, Leku and Wolkite towns.

- Students who are not attending their school in these towns.
- Service providers who are not currently providing health services in these towns.
- Youth who are not in designated age groups
- Health service providers working in private sectors.

4.1.4 Determination of sample size

The problem of data base (sampling frame) is a common problem when conducting such study. Sampling frame is one of the limitations in this study to determine sample size.

Findings from knowledge attitudes and practice study on HIV/AIDS among high school students in Wolita, Hossana, Awassa and Dilla towns suggested that total male student in high school are 55% while the rest 45% are females. In addition, 82.8% of students are between 15-18 years of age (Gebresenbet S. *et al*, 1998).

On the basis of the above information, sample size calculation for cross-sectional prevalence study, and for estimation of a single proportion or percent (Daly and Bourke, 2000) recommended a formula.

$$N = \frac{Z_{1-\alpha/2}^2 p(1-p)}{d^2}$$

$Z_{1-\alpha/2}^2$ =the standard normal variable at (1-2) % confidence level and, d is mostly 5% i.e. with 95% confidence level + 1.96

Since it is not possible to estimate P, a, figure of 0.5 should be used to get the possible minimum large sample size.

d = 0.051 a margin of samples error tolerated

$$N = \frac{(1.96)^2 0.5 (1-0.5)}{(0.051)^2} = 370$$

Therefore a sample size of 370 obtained.

Assuming an 80% response rate, 30 was allowed for non-respondents and a sample size of 400 was required to get significant result.

4.1.5 Sampling Technique

Initially selection of subjects was made through stratified-sampling technique and later random or systematic samples of a predetermined size was taken by proportion from each group. Selection of in school youth has been done with equal proportion of study subject from each grade. Equal sample size is taken from grades 9,10 11 etc. One section from each grade, has been selected with due consideration to male- female proportion. Male-female proportion has been calculated from list of students.

Finally each study units have been selected through a simple random sampling, while selection of out of school youth was carried out through convenience sampling. The sample size was decided to be 400, for the quantitative study, and sample size fore each town is allocated based on the population size in each town.

Awassa = 150

Yirgalem= 100

Wolkite= 75

Leku= 75

It is important that the sample includes representative groups of study units with specific characteristics. Mekonen A. and Tesema F. (2000) stated that stratified sampling is only possible when we know what proportion of the study population belongs to each group. Hence, previous studies estimated 46% of youth are out of school in towns. In schools each grade from 9-12 had equal proportion of sample size . The same approach is followed in junior schools.

In addition to this, 12 youth with known HIV status (6 positive and 6 negative) were selected purposely based on their agreement to participate in quantitative study from each town . Selection was carried out by quota sampling. Any body who had visited VCT-centre included in the study until the required number of youth was obtained.

4.1.6 Questionnaire development

In this study self-administered questionnaire for youth were developed.

One of the problems was lack of validated questionnaire in previous literatures suitable for use in Ethiopian situation. It is known that validation is costly in terms of time and human resources.

Thus, efforts have been made in developing a new questionnaire for this survey, in which questions are standard type. The general demography part and the main theme to be assessed have been designed to suit our situation

By reviewing and examining different literatures the questions were formulated based on common guiding principles.

In this study the following guiding topics are used for formulation of questions.

- Acceptability
- Accessibility
- Affordability
- Quality
- Attitudes of youth towards health care service
- Technical competence of service providers
- Parent-youth relation
- Knowledge, Attitude, practice of youth (HIV/AIDS and VCT)
- Challenges and obstacles (Social, economic ,institutional barriers)

The questionnaire for youth has been divided into 3 sections.

- KAP
- Voluntary Counseling and Testing
- Questions for individuals who have undergone HIV testing

Most part of the questions are closed type while some are open ended which allow the inclusion of additional comment or opinions. The proposed questionnaire is available in Appendix- A and B. The Likert-scale is one of the popular composite psychosocial scales to measure satisfaction towards services delivery. In this scale respondents are asked to indicate their degree of agreement or

disagreement with each statement. (Polit and Hungler, 1999 cited in Alemayehu G- 2000)

4.1.7 Pre-testing

It is found necessary to pre-test the questionnaire to :-

- Determine the length of time required
- Check the logical sequence of questions
- See the clarity of wording and simplicity of the language
- Reduce some biases as a result of un- standardized questions

The pre test was applied on 10 youth (6 in-school and 4 out-of-school youth) in Awassa town. The youth were 6 male and 4 female. The average time needed to complete a questionnaire is 45 minutes. Problems faced during the pretest were presented by data collectors , and then correction and adjustments were finally made on the questions.

4.1.8 Data collection

During data collection, the purpose of the study has been sufficiently elaborated to the informants. The convenient time for conducting the interview was decided by the respondents. The data collection has been confidential and anonymous, and this has reduced the potential biases occurring because of the informants mistrusting the intention of interviews, and avoiding needless questions or giving misleading answers.

Consent has been obtained from the participant which resulted in a better co-operation and a high response-rate. Data collectors were trained on how to collect data and administer- the questionnaire; the same to supervisors. The data collector was supposed to introduce her/himself and inform the subjects about the purpose of the study and stress no service provider will see the response. In addition, any queries had to be clarified during the interview. The questionnaire for students has been administered in school, in separate class after selection of study units. For health service providers it was conducted in their work place and, for out of school youth it was in any place which is convenient for data collection. Follow-up has been made on those who refuse to participate so that any difference between respondents and non-

respondents can be analyzed. Data collectors, supervisors and co-investigators for this study have been recruited and oriented about the assessment. Data collectors are 12th grade completes. Supervisors have the experience in data collection for such research undertakings.

4.1.9 Data processing

After administering the questionnaire, each supervisor, mostly in the same day, completes coding and checking the questionnaire for accuracy and completeness. Data entry follows immediately by computer using Epi-Info version-6.

Open-ended questions have been categorized before coding. In addition to this "other specify category" has been categorized afterwards. Answers that were difficult or impossible to categorize have been categorized into separate residual category called "Others".

4.1.10 Data Analysis

Data was analyzed by computer using Epi-Info version - 6 statistical package.

The finding of this study is presented in proportion, frequencies and percentage frequencies in 2x2 or 2x3 contingency tables for convenience of comparing results. Analysis is also made by using measures of central tendencies: mean, median and standard deviations. Data obtained from this study is presented in tables and descriptive approach. The findings is tested using the chi-square (χ^2) for examining difference in two variables. Thus from the findings it is possible to highlight areas of challenges and obstacles in service delivery for youth in relation to HIV/AIDS and VCT which will in turn lead to some conclusions and recommendations in designing future strategies and interventions. A comparative analysis has been done between in-school and out of school youth to get a significance difference between groups by using χ^2 .

4.2 Focus Group study

4.2.1 Study population

In this study unstructured focus group discussion and interview were conducted. The rationale for conducting focus group discussion was

to find out if there is any additional opinion or questions that remain unanswered. Study subjects enrolled in focus group discussion were youth from schools and out of schools.

See Appendix- C and D for List of guide topics or questions to be covered in the group discussions. There is also in-depth interview for service providers in each town. Guide Topics are available in Appendix- E and F

4.2.2 Sample size

Each group is composed of 6 people. 5 youth focus group discussions have been conducted in each town i.e. out of school youth (male and female), In-school youth (male and female) and commercial sex workers. Generally, 30 people have been recruited and participated in youth focus group discussion in each town. A total of $30 \times 6 = 120$ individuals were involved. 6 service providers from different sectors in each town were involved in the in -depth interview. A total of $6 \times 4 = 24$ service providers have been included in the study.

4.2.3 Sampling technique

Selection was by systematic sampling technique to have a final sample size of youth. Service providers have been recruited from health centers and other health service institutions. Convenience sampling to get a total number of 6 service providers in each FGD has been used. The inclusion and exclusion criteria mentioned in section 4.1.2 and 4.1.3 has been also applied for FGD.

The focus group discussions was conducted in four different towns i.e. Awassa, Yirgalem, Leku and Wolkite . Six people participated in each focus group. The participants were " knowledgeable " people from different sub-groups of youth. In each town there were five focus group discussions (i.e. student: male and female, commercial sex workers, street youth: male and female). They were asked to give their view and discuss on different ideas about HIV/AIDS.

Unstructured interview was carried out in Awassa VCT- centre. Participants were youths who have been visiting the centre. The interviewees were randomly selected and had the interview in Awaasa malaria sector office which was considered convenient for this purpose. 3 male and 3 female, a total of 6 youths have participated.

4.2.4 Data collection

Some background information has been given before the discussion. The moderator encouraged participants to talk freely about all topics to be discussed . All discussions were tape recorded for later full transcription. To ensure the highest possible reliability of data the moderators have taken notes during the discussion and immediately after the completion of the discussion.

4.2.5 Data analysis

The actual analysis of qualitative study has been made with a search for themes (Polit and Hungler, 1999). Textual analysis has been employed.

4.3 Ethical considerations

Consent has been requested from youth and service provider prior to the study and they have agreed to participate in the study. For ethical reason further information and contact with service providers and other organisation has been facilitated for those youth or service providers who were in need of existing service provision and other information.

CHAPTER - 5

RESULT

5.1 Quantitative study

5.1.1 Socio-demographic characteristics

The sample size allocated for study towns was based on the total population of these towns.

352 youth have agreed to be interviewed; non-respondent rate was (4.6 %). 59.4 % were males and the rest 40.6% were females; male to female ratio was 1.5:1. The ages of interviewees were between 10-24. The mean age of respondents was 17. The majority of the sample population 319 (91.1%) were unmarried. 18 (5%) married 12 (3%) were divorced , the spouses of the remaining 3 have died. See table 1 and 2 .

Most of the respondents 207 (60%) were students living with their family. 36(10.2%) respondents were commercial sex workers, 59 (16.8) were youth who are petty traders; others were street youth and daily labourers.

Table-1 : Frequency and Percentage distribution of the respondents by age group

Age group	Freq.	Percent
10-11	2	0.6%
12 - 15	81	23.0%
16 -19	193	55.0 %
20 -24	76	21.4
Total	352	100.0%

Table-2: Frequency and percentage distribution of youth by occupation

Occupation	Freq.	Percent
Students	215	61%
Petty traders	59	16.8%
Daily labourers	14	4.0%
Commercial sex workers	36	10.2%
Governmental employees	2	0.6%
Street - Youth	15	4.3%
Unspecified	11	3.1%
Total	352	100 %

Orthodox Christian is the dominant religion in study areas. About 187 (56%) are orthodox, another 87 (26.3%) are protestants, 42 (12.7%) are Muslim. Catholics are 14 (4.2%).

In this study most of study subjects 254 (72.2%) were in school youth while out of school youth were 98 (27.8%). The majority were high school students. See Table: 3 below for detailed educational status .

Table-3: Distribution of the respondents by educational status

Level of Education	Freq.	Percent
Illiterate	18	5.1%
Read and write	42	11.9%
Junior School	105	29.8%
High school	187	53.2%
Total	352	100.0%

An attempt was made to see if there is any difference between respondents and non- respondents. Most of non-respondents: don't want to discuss issues about HIV/AIDS due to fear and negligence. As can be deduced from their expressions and feelings, most of non-respondents seem to be individuals with high-risk behaviours for HIV infection.

5.1.2 Knowledge, Attitudes and Practice on prevention of HIV/AIDS :-

Almost all (96.6%) respondents have heard about HIV/AIDS. When asked whether HIV is transmitted through sexual contact; majority 328 (96.5%) of young people agreed, 3 (1%) disagreed, 9 (2.6%) had no idea. In addition to this 303 (90.2%) agreed that HIV- could be transmitted through blood contact, 11 (3.3%) individuals disagreed; whereas 22 (6.5%) had no idea at all. There are few young people (5%) who believe eating together with infected person is a risk situation for HIV - transmission. 319 (94.1%) of the respondents have heard about condom, out of whom 294 (92.2%) had an opportunity to see condom once or more in their lifetime. For question " How to prevent HIV'' abstinence is the most frequently mentioned preventive method 237 (74.8%) followed by condom use 67 (21.1%) and the last one being faithful to one partner, which accounts for 4.1%.

The respondents were asked whether or not they are at risk for HIV infection, and 76 (22.4%) of the sampled youth admitted that they might be infected, whereas 134 (39.4%) said no, the same proportion (38.2%) refrained from giving either of the responses.

Table-4: Percentage distribution of people by HIV status, age and sex , Awassa HC (Sept- 1999- March 2000)

Age group	Male		Female		Total		Percent	
	- ve	+ve	- ve	+ve	- ve	+ve	- ve	+ve
0-4	11	1	7	0	18	1	3.7	0.95
5-14	13	2	4	1	7	3	1.7	2.9
15-29	52	1	35	4	87	5	21.5	4.8
20-29	139	17	95	36	234	53	57.9	50.5
30-39	43	18	5	15	48	33	11.88	31.4
40-49	3	6	5	1	8	7	1.98	6.7
50-59	1	3	1	0	2	3	0.49	2.9
60+	0	0	0	0	0	0	0	0
Total	252	48	152	57	404	105	100%	100%
Percent	49.5	45.7	29.8	54.2	79.3	20.6		

Source: Awassa Health Centre

Table-5: Distribution of reported AIDS cases by marital status, Awassa HC (1999)

Marital status	Male	Female	Total	Percent
Single	10	24	34	32.4
Married	8	18	26	24.8
Divorced	0	0	0	0
Widowed	1	0	1	0.95
Children	5	5	10	9.5
Unspecified	8	26	34	32.4
Total	32	73	105	100%

Source: Awassa Health centre

As indicated in Table 4 youth between the age of 20 to 29 and unspecified groups are the most affected group by HIV as compared to other groups. Unspecified groups don't know how they became infected: They might have been infected through blood contact or because of sharing some personal materials such as blades and needles etc. However this group needs further detailed study. Early age adult group are the second highest HIV infected group. According to this report no HIV infection is found in old age. The least reported cases are children under 5 years. Even though specified age groups have participated in this study, it is impossible to see any similarities among different age groups and no comparison is made in this respect.

It is shown in Table 5 that there is some kind of relation between marital status and HIV infection. Single individuals are the most affected group followed by married ones. No cases are found in divorced groups. For obvious reasons, in this study, single individuals are afraid that they might be infected by HIV as compared to married couples or divorced people. There was significant association between having fear to test for HIV and marital status although more single youth have fear to test for HIV ($\chi^2 = 15.02, df= 6, P= 0.02$).

The intention to nurse AIDS patient among youth was investigated in four categories and 231 (72.2%) showed willingness to nurse in any situation. However, 34 (10.6%) said yes if it is a must, and on the contrary 42 (13.1%) said no, 13(4%) said no under any circumstances.

Almost one third of youth in this study had sexual intercourse at least once or more, Among those sexually active groups, mean age at first sex was 16 years. Concerning preventive action at first sex, 59 (51.7%) made unprotected sex where as 55 (49.3%) used condom. Almost a quarter 27 (25.7%) of the sampled youths had multiple sexual partners.

Regarding communication about HIV/AIDS , it was found that 79 (73.%) of the respondents discussed the issue with their lovers, whereas 25 (23%) did not talk about it. The proportion that discussion about HIV/AIDS with family accounts for 62 %.

Table-6 : Percentage distribution of respondents by factors contributing to unprotected sex.

No	Contributing factors	Frequency		Total
		Yes	No	
1	Lack of access	41 (12.1%)	297 (87.9%)	338
2	Lack of money	37 (10.9%)	301 (89.1%)	338
3	Negligence	67 (20%)	271 (80%)	338
4	Alcoholism	215(63.6%)	123 (36.4%)	338
5	Chat -chewing*	127 (37.5%)	211 (62.5%)	338

***Chat: green leaf stimulant**

According to the information in Table 6, alcoholism is one of the most factors that contributes to unprotected sex (63.6%); chat chewing is the next (37.5 %) . Hence most of unprotected sex are as a result of having emotional stimulants .

5.1.3 Challenges and obstacles in providing VCT and health care services to youth

The respondents were asked whether there is a means to test one's HIV status, and most of the youths 263 (77.4%) do believe that there is, 18 (5.3%) said that there is no way, 59 (17.4%) said didn't know.

According to this study, the first widely available source of information about VCT service is mass media, and anti-AIDS clubs are the next. Health service providers are considered to be the third source of information. In relation to the previous question respondents were asked about their orientation on the existence of VCT service; 305 (89.7%) said yes , the rest 35(10.3%) said no.

The respondents were also inquired about the preferred place for VCT services. The responses are summarised below.

Table-7: Percentage and frequency distribution of interviewees by preferred place for VCT Services.

No	Health Institution	Frequency
1	Hospital	126 (40.6%)
2	Clinics	9 (2.9%)
3	Health Centre	53 (17.1%)
4	Family Guidance clinic	122 (39.4%)
	Total	310 (100%)

As revealed by the data in the table the most preferred place of VCT service is hospital followed by FGAE clinic; the least preference being clinics.

The following are the opinion of young people in response to the question "when does a person should test for HIV ?" 10% said any time; 7% replied during illness; 58 % said before marriage; 6% replied during travel to abroad; 19% were in doubt. For a question "If VCT is delivered freely who should be tested for HIV first", 47.3% of respondents said commercial sex workers, 24.3 % said drivers, 6.2% said pregnant women, 9.8 % new couples and 12.4 % said young people.

When Young people were asked about their willingness to test for HIV- if VCT is delivered freely, 286 (84.1%) said yes I do, 16 (4.7%) said no, 27 (7.9%) are in doubt, and 11 (3.3%) had no idea . Few young people 23 (6.8%) said that they would not change their sexual experience even if their status is HIV negative. If their HIV status is found to be positive; 63.4% decided to give up sex at all, 8.6 % said to commit suicide, 28 % decided to go to a prayer in church or mosque.

A Total of 264 (78.1) are willing to pay for VCT -service if there is service charge but 74 (21.9%) said no. Those who are willing to pay were asked to point out the cost, and the response ranged from 1-800 Birr, The mean is 40 Birr. Since 4 respondents said that they could pay 300 -800 Birr, the data has been found very skewed to take mean value. However, most frequently mentioned value to pay is 10 Birr .

A Total of 273 (81%) youth said it is fearful to be tested for HIV. Some of the reasons mentioned are: hopeless if positive, "I know what I did", social stigmatisation, negative response from family . In addition 219 (64.6%) would not tell if they decided to test. As far as making a decision about whether to inform their HIV- status: 261 (77.0%) said Yes I do. The rest 78 (23%) said no. Most frequently stated reasons are fear of stigmatisation and loss of friend and families.

The respondents were asked whether they do have risk behaviour for HIV-infection. 71 (21%) said yes, whereas the majority (79%) felt that they are not at risk.

Most of the young people 266 (78.7%) heard of anti- AIDS club, out of whom 154 (46.8%) are members in the clubs.

Visit to any health institution during illness was also asked, and 262 (78.2%) young people said they visit health institutions during illness or another case. Among those 26.6% visited private clinics, 193 (66.8%) Governmental Health facilities, 4.2% private pharmacy.

Table-8: Percentage distribution of response by quality of health service indicators

No	Indicators	Percent	
		Agree	Disagree
1	Most health facilities are attractive	36%	64%
2	Service providers are confidential	32%	68%
3	Service providers treat with respect and dignity	33%	67%
4	Existing health service addresses young people's need	48%	52%
5	Easy access to health service provision	56%	44%
6	Privacy is secured	27%	73%

Note that in the table measure of variables are aggregated from four to two categories i.e. Agree and Disagree

As clearly revealed by information from Table 8 , most of the respondents perceived that the health care services for young people is of poor quality. Responses for attractiveness of health facilities were 112 (34%) strongly disagreed, 99 (30.1%) disagreed, 92 (28 %) agreed, the rest 26 (7.9%) strongly agreed. Concerning securing confidentiality by service providers 68% said no, whereas 32% strongly agreed. Young people who are strongly satisfied with the respect and dignity provided by service providers are only 33%.

When asked about whether service delivery is in accordance with a need of the youth, most young people 52% disagreed where as 15.1% have also strongly disagreed. In addition, agreement responses for "No long waiting time and bureaucracy in health institutions", again most youth, 111 (33.7%) disagreed, 69 (21. %) strongly disagreed .More over 73% of the youth disagree for securing privacy during consultation where as 9.7% strongly disagreed

Table-9: Percentage distribution of respondents by reasons for selecting specific health institution

No	Reasons for Visit	Freq.	Rank
1	Good treatment	160 (30.8%)	1
2	Attractive environment	16 (3.1%)	8
3	Technical- competence of the staff is very good	96 (18.5%)	2
4	Treat with respect and dignity	53 (10.2%)	4
5	Affordable price	93 (18%)	3
6	Confidentiality secured	27 (5.2%)	7
7	Privacy secured	38(7.4%)	5
8	Closeness to home	35(6.8%)	6

No	Reasons for Visit	Freq.	Rank
	Total	518 (100%)	

Table-10 Percentage distribution of respondents by perceived challenges and obstacles

Rank	Hindering factors	Percent
1	Lack of money	26.2 %
2	Physical inaccessibility	14 %
3	Lack of trust on service providers about	13 %
4	confidentiality	12.1%
5	Fear-of-family	10 %
6	Hesitation on the quality of	10 %
7	treatment/counselling	9 %
8	No idea where to go in time of need	5 .7 %
	Privacy may not be secured during consultation	
	Fear of exposure to somebody during visit	
	Total	100 %

As presented in Table 10 , the three most frequently cited challenges and obstacles limiting youth's access to health care services, in decreasing order, are lack of finance, physical inaccessibility and lack of trust on service providers in securing confidentiality.

Time of a day convenient for youth to get VCT service was assessed. Generally 73% of youths prefer the afternoon from 1pm-5pm. Specific to occupation 59% of commercial sex workers prefer morning from 6am-8am, where as 62 % of students choose the time from 1pm-5pm.

For increased utilisation of health care services most respondents suggested improvement on the quality of the services in relation to health facilities and technical competence of service providers, affordable price, confidentiality and incorporating health care service with recreational and sport facilities.

Similarly, for better utilisation of VCT services most respondents suggested promotion of VCT and awareness creation initiatives to be integrated with recreational facilities so as to attract so many

youth, strengthen post -test follow-up, and create strong and organised counselling system.

Table-12: Existing VCT service situation in different towns

Situation	Awassa	Yirgale m	Leku	Wolkite
Priority of VCT	Equal for all	No	No	pre-marriage
Trained counsellor	Very good	No	No	No trained counsellor
Time taken for result	1-2 month	No	No	1/2- 1 day
Place of counselling room	well	No	No	Uncomfortable
Likely source of initiative to test	Anti AIDS club	No	No	pre-marriage as a requisition
Lack of diagnostic-kit	No problem	No	No	High shortage
Young client proportion	78%			82 %

5.1.4 Bivariate and multivariate analysis

Bivariate and multivariate analysis have been made to determine the relationship between socio- demographic factors and various aspects of knowledge, attitudes and practice of HIV/AIDS prevention, VCT-perceptions, acceptability, affordability and quality of health service.

Compared to out-of-school youths, large number of in school youths have more than one sexual partners. Moreover, responses of individuals about their risk of contracting HIV had no significant association with preventive measures taken at first sex.

The difference in nursing AIDS patient as compared to malaria patient was statistically significant ($\chi^2 = 105.61$ df = 9, P=0.001). In Wolkite all interviewees heard of HIV/AIDS (100%) where as in other town very few young people did not know about HIV/AIDS, but the difference was not significant.

Statistically significant association was not found with religion in nursing AIDS patient and malaria patient. See Table 13 .

Table-13: Percentage and frequency distribution of respondents in relation to their willingness to nurse malaria and AIDS patient by religion.

No	Religion	Intentions to nurse			
		Malaria patient		AIDS patient	
		Yes	No	Yes	No
1	Orthodox	96.7	3.3	86.4	13.6
2	Muslim	95.1	4.9	87.8	12.2
3	Protestant	83.9	16.1	76.5	23.5
4	Catholic	76.9	23.1	53.8	46.2

Note that figures are in percent

33.5 % of the surveyed youths are claimed to be sexually active. The variable age at which sex started redefined as 7-13 = Rape, >13 = not rape. Among raped groups almost 77.7% experienced their first sex without protection. This is also true for 54.2 % of those groups who started sex without being raped.

Among youth who have sexual partner more female 41 (78.8%) than males 38 (67.8%) have taken an initiative to discuss about HIV/AIDS with their partner.

In fact, there was no significant association between sex and test for HIV- if VCT is charge - free. There were some more females (84.8%) than males (83.2%) who are willing to test.

Risk behaviour was strongly associated with occupation of youth ($\chi^2 = 22.30$. $df = 11$ $P=0.02$). Commercial sex workers are more predominantly risk groups. Student is the second predominate risk group for HIV. There was no significant association between willingness to test and occupation if VCT is charge-free.

As far as comparing youth occupation with informing HIV- status to some body is concerned, it is observed that there is significant association ($\chi^2 = 22.57$, $df = 11$, $p=0.20$). Commercial sex workers ranked first; 86 % of them are willing to inform their result for somebody, students are the next 78.6% , the last are street youths 73 %. Preventive action taken at first sex was investigated in order

to know its association with willingness to test. As such 48.9% who had used condom at first sex are found to be willing to test. 51% youth who had not used condom at first sex were willing to do a test. However, there was no significant association.

More youth, 228 (80%), who have claimed that they have no risk behaviour for HIV were willing to test for HIV as compared to youth who admitted that they are at high-risk behaviours; which is only 56 (19.7%). Out of school youth predominately accepted the importance of VCT service as compared to in school youth. (96% and 92% respectively). As far as the importance of VCT service is concerned it has been investigated in each town and almost in all study areas more than 90 % of youth confirmed its importance.

There is a significant association between towns and chewing *chat* as a risk factor for HIV among high school students ($\chi^2 = 8.60$, $df = 3$, $P= 0.035$) and the same is true for alcohol use ($\chi^2 = 2.96$, $df = 3$, $p=0.05$).

There is a significant association between experiencing sex with multi-partner and preventive action during first sex ($\chi^2 = 6.51$, $df= 4.16$, $P=0.01$) . Youth with more than one partner sexual contact had not taken prevention measures during their first sex.

Students who have participated in anti- AIDS clubs have no association with risk behaviours to HIV. In addition to this, there is no significant difference between knowledge of condom to prevent HIV in the respective towns. No significant association is also revealed between preventive action at first- sex and young people admitted risk for being infected with the virus.

There were different reasons for the test : Suspicion 45% ; the need for establishing the status 33% ; pre-marital 16 % and the least was immigration requirement. After a result, more abstinence in HIV- positive group was revealed. A very few tended to inform their result either to father or brother. Mothers were the first person to be informed equally to lover. 63.6% Youth with HIV- positive status have joined Down of Hope.

Table-11: Existing VCT service as evaluated by youth who have undergone HIV test

No	Indicators	Agree	disagree	Total
1	Generally I am satisfied with VCT service	22 (100%)	0 (0%)	22
2	VCT service was not helpful	2 (10%)	18 (90%)	20
3	Service providers treat with respect and dignity	21(100%)	0	21
4	Privacy was secured	20 (95%)	1	21
5	Confidentiality was secured	21(95%)	1	22
6	Service providers are not technically competent	0	21(100%)	21
7	Time for VCT was not convenient	5 (23%)	16(77%)	21
8	There is a lot to be done in VCT	2(10%)	20(90%)	22

Based on the information obtained from youth who have undergone the test, generally existing provision of VCT service is encouraging. Almost all have satisfied with VCT service. 23 % agree that time for service delivery was not convenient, and almost all agree that privacy was secured.

5.2 Qualitative study

5.2.1 Results on Focus Group Discussions

Most of the ideas expressed in group discussions are almost similar to the survey study. However the following ideas are focused and discussed in details and elaborated.

Most participants have mentioned that the existing health service is not youth-friendly. The environment in health facilities is not as such interactive and attractive. Health delivery inequality is reflected among different socio-economic status of the communities. Staff are not welcoming, more emphasis is given for married couples, Long waiting time, privacy and confidentiality is not secured. The staff are always busy and do not have enough time for counselling even to listen young people. These are some of the reasons given by the participants about the existing health service, and whether it is designed to address the need of youth or not.

As a result of such inconveniences, some participants concluded that young people prefer to disclose their reproductive health problem to private sectors or illegal drug dealers.

A wide age difference between service providers and clients create a barrier for disclosing health problems. Some service providers in most cases act like a parent and blame young people for what happened on the individuals.

Almost in all focus group discussions the existence of Voluntarily Counselling and Testing (VCT) service is well known among young people. Few of the respondents said that they know that testing is done somewhere around.

With regard to the attitudes of youth towards service providers, participants have shown good attitudes but some clearly stated that they have wrong attitudes as a result of lack of transparency, poor communication, less emphasis given for youth's problems and low professional-ethical commitment in some service providers. Participants also stated that some service providers conclude as if most health problem is brought about by negligence of young people.

It was generally agreed that youths have at present a very good knowledge about HIV/AIDS. However, behavioural change for safe sex practice does not seem to be internalised and needs more effort. Participants also reported that they frequently come across a challenging situation for unprotected sex, of course some responded positively.

The issue of the place where voluntarily counselling and Testing (VCT) service should be delivered was discussed in detail. Health institutions (health centres, hospitals) , anti-AIDS clubs , schools, youth centres are some of the places that are suggested during the discussions. However, almost all participants agreed VCT service should be delivered in health institutions, since many health problems are presented there; so that VCT for HIV can also be seen together with other health problems. Hence, young people will be courageous to use this service. Few participants also strongly believe that youth centres with some recreational activities will be very efficient places for VCT service.

The groups agreed that acceptability of health services as well as VCT by young people can be ensured as far as the service addresses the needs of youth such as strong health education, sustainable awareness creation (not on-and-off type) and counselling services given together with entertainment facilities.

With regard to accessibility of health care service and VCT, most participants stated that there is a need for strong advocacy of already existing youth service, extended provision of VCT-facilities where youth are more frequently seen. In addition; time of service, privacy, confidentiality should also be strictly considered to insure accessibility of health care among youth.

It was noted, in the groups, that affordability of health care service is one of the major factors that influence accessibility of health service delivery. It is more severe for street youth and youth from poor family. More over, the problem becomes more serious if health problems are not discussed with family. student-fee scheme is recommended by the groups to tackle affordability issues.

Most participants agreed that quality of health services as well as Voluntary Counselling and Testing (VCT) services could be improved if it is supported by strong service providers training which would increase technical competence, which would mean well co-ordinated service delivery, well equipped health facilities with up to date /modern/ technology and client oriented service delivery with dignity and respect.

Generally, participants identified major challenges and obstacles towards voluntary counselling and testing for HIV-infection. Poor publicity of these services, fear of social stigma, parent's unfavourable attitude towards young son or daughter of deciding to know HIV-status, lack of money, self-denial, fear of being HIV positive or anxiety.

The issue of being HIV positive or negative was discussed, and most participants stated that this idea and its meaning is not well internalised by the youth. Consequently some of the reasons for not testing for HIV resulted due to the low awareness in this area.

One of the challenges and obstacles for Voluntary Counselling and Testing (VCT) and health service delivery, as frequently cited by the group is lack of recreational places. As result young people are exposed to drugs, chat, smoking and alcoholism which in turn leads to reproductive health problems such as HIV, STI, illegal abortion and injection.

In focus group discussions it has been found out that since youth are dependent on their family, responsible parents are conscious of what happened and will happen on their son which might surely bring conflict between parents and youth.

As revealed by the focus group discussions youth are seriously concerned with the idea of confidentiality and privacy whatever health issue is presented. As a result most participants frequently complain about confidentiality. Some participants also suggested service providers should not be from the locality where the service is provided so that the client could not easily be identified.

In most focus group discussions it was recommended that emphasis should be given on training and awareness creation programs by having all-inclusive training for parents and youths. Good family environment should be maintained for open discussion on reproductive health issues, HIV and VCT services.

The group also agreed on creating favourable condition to bring together young people with their interest and finally get into the main track such as health problems and so on.

It was discussed in detail that it is important to establish partnership from different sectors to address youth's issues from different areas. For instance, teachers, youth clubs, development workers, different support groups and son on.

In most focus group discussions the issue of capacity building through different initiatives to address the problem of deprived young people, such as commercial sex workers and street youth has been discussed thoroughly. It has been agreed that without creating some means for earning one's living , prevention of HIV/AIDS will not be effective.

Participants frequently mentioned lack of parent's involvement, as a major challenge for accessing young people to VCT. The consensus reached states that parents should be provided with adequate training, seminars, and information why, how, when VCT services are needed.

5.2.2 Results on service provider's in-depth interview

In-depth interview was conducted in Wolkite, Awassa, Yirgalem and Leku. The participants were knowledgeable people from different service area and organisations. Some are from health centres, health departments, laboratories ,OSSA and Dawn of Hope.

Most of the informants have good attitudes towards youth in relation to service provision. However almost more than half complain about frequent behavioural un-stability among youth that makes regular follow up difficult.

Almost all service providers appreciate knowledge and attitudes of HIV/AIDS in youth; however the practice to prevent HIV/AIDS is low which needs more attention.

Most informants noted that most of the clients in voluntary counselling and testing are youth. This is largely due to anti-AIDS club's strong youth mobilisation. Once young people are informed about this service, they immediately over crowd VCT centre for a time being. In addition, emotional attributes of being young also contribute for increasing service consumption.

Youths are also emphasised promotion of HIV testing through cultural and social settings such as church, mosques, youth associations and clubs.

A serious problem, as stated by the informants, is shortage and lack of testing materials. It is shame and contradictory to have a lot of voluntary people to test who are convinced by the different interventions and mobilisation and facing shortage of testing materials. This is the situation, for example, in Wolkite town

Participants in the interview noted that shortage of service providers is not considered a problem but trained health professional in VCT is a serious problem in most of the towns. In contrast excess-trained counsellors have been found in Awassa VCT centre.

Delayed test result created client- drop out at each stage of VCT. For instance, in Awassa for ELISA-HIV test negative results were disclosed early where as positive results delayed for rechecking, Conventionally clients assume that if somebody's result delayed it is positive, and to prevent this problem negative results also were made to be delayed until re-checking is completed. Other groups of

informants, from Wolkite didn't report the delay of result since rapid test kit was used for testing.

In Wolkite town there is a tendency to provide VCT service primarily for pre-marriage requests, and consequently voluntary youth which are in need of the service were mostly ignored.

It was noted in the interview that all facilities for Voluntary Counselling and Testing in health institution are shared facilities with other services. There is no allocated budget or facilities specifically to this services. This situation affected the effectiveness, efficiency, quality of VCT services. More over rooms are not suitable to keep privacy and confidentiality.

Most informants stated co-ordination and integration of VCT service with other health service delivery is not well organised. It is suggested that this area should be the concern for program designer, since it has great contribution for acceptability and quality of VCT service. Most participants agreed that there should be awareness creation activities to get more young people in this service area.

As suggested by the participants voluntary counselling and testing services should be attractive and youth- friendly , should provide this service together with some recreational activities such as youth sports, library for better and more client consumption.

Some service providers are strictly concerned about young people with negative HIV- status as a result of their experience. This is because unless and otherwise strict and sustainable follow up, orientation and counselling is provided, the liklihood of being infected with HIV is high.

As it was recommended, in the in-depth interview, having a trained health service provider with counselling skill is an essential component of quality of care .

Lastly service providers stated that most youth entered into complicated situation as a result of poor parent- child relation. Hence, awareness creation interventions for parents should be part of VCT promotion.

CHAPTER- 6

DISCUSSION

This study explores and provides a highlight on knowledge, Attitudes and Practice of HIV preventive methods among youth in selected towns, with an emphasis on assessing the existing VCT Service. The study also attempted to investigate the acceptability and accessibility of health care and VCT services among the youth.

A total number of 374 interviewees responded to structured questionnaire; 15 service providers were attended for in-depth interview; In addition, 5 focus group discussions contained 120 youths from different segment of young people were conducted in each town.

According to this study HIV/AIDS is known almost by all young people (96.6%). This result is almost the same (97.6%) with the study conducted in SNNPRG, Awassa in 1998. Some young people 2.6% had no idea whether HIV is transmitted through sexual inter course. These groups are street youth. This is partially attributed to lack of access to source of information. It has happened due to lack of exposure for any type of mass media, for being illiterate to read and such groups' interest might be totally for searching their daily - earning.

Still some of the respondents believe that eating together could be one of the risk factors. As a result there is more work to do in this regard. As far as preventive methods are concerned one to one relationships is taken as minor action, whereas condom use is predominantly mentioned as preventive measure. In fact almost all youths have mentioned abstinence as the best method. Thus, it appears that HIV/AIDS should focus on promising abstinence.

A Total of 59 (17.4 %) of the youth didn't know whether there is any means to know about one's HIV status. This indicates a need for awareness creation in this area. A need to test for HIV still is predominantly stated for pre-marriage couples. This tendency at present is more prevalent in Wolkite town.

Suggested fee for VCT service was very skewed. It ranged from 1-800 Birr. This is due to perception difference about the service. However 10 Birr was the most frequently mentioned cost. More young people are fearful to test for HIV, and this needs a great awareness creation campaign. The question on whether or not having a risk behaviour for HIV infection is not freely disclosed by many young people. Only 21% of youth admitted to have a risk behaviour. But 54.2 % of the sexually active youths did not use any protection during first sex.

The preference of one health institution to others heavily depends on provision of good treatment. Secondly technical competence of service providers and quality of health service delivery is the least preferred.

Several studies on youth sexual behaviour indicated that the youth becomes sexually active at their early age. For example, sexual debut as early as nine years was reported in Zimbabwe.

This study also supports the findings of various studies conducted in other developing countries. In this study seven-year was the minimum age at which youths reported having first sex. The variable divided in to two groups i.e. the rape group 7-13 and other 14-24, among the raped group 77.7% encountered unprotected sex.

The Washington based international research organisation has conducted youth - oriented research (youth to youth initiative,1998). Based on the findings it recommends that reproductive health service for youth have to be private, confidential affordable, accessible and staffed with sensitive providers. In this study also youths frequently mentioned this issue. Acceptability, accessibility and quality of health service delivery evaluated in a variable "why youths prefer specific health institution?". 31 % for good treatment, 18.5 % of youths said very good technical competence of service providers, 18 % of youth said because services are delivered at an affordable price, 7.4 % because privacy is secured, accessibility in relation to closeness to home

was 6.8% , confidentiality 5.2 %. Hence, these should be considered when launching youth-friendly health services.

The respondents were also asked their reasons why they need to test for HIV if VCT service is charge-free: Among those who responded positively they said just to know their status 127 (39.5%), to take care for the future 65 (20.2%).

Unstructured interview was conducted in Awassa VCT- centre. All voluntarily visited this service. A young person was there with his partner due to one event of unprotected sex with commercial sex worker. If positive, he replied, he will try to adjust himself with this condition and join organisation for PLWHA. His partner had another boy friend three months ago. If both are negative they have decided to live together. Another young person was there just to know his status and he admitted that he is with no risk behaviour for HIV. Another young female was there as a result of her husband is AIDS patient. She requested him to test for HIV for a long time due to his high-risk behaviour, he refused completely and she looks hopeless. If positive, she said "I look for my last day to die, nothing to do at all". A young student aged 18 who is a high school student in 10th grade was visiting VCT centre as a result of doubt about her boy friend; since his behaviours changed through time. She gave up any relation with him four months ago, and finally she came to know her status. If positive, when she was asked, felt very distress and disturbed. If negative she said I would have no- sex at all until I found a person with negative status and good behaviour.

All these show that youth who visit VCT can be grouped in to two: Those *just to know* their status with no risk exposure and those *after exposure* to risks. Interview was conducted for a counsellor at Awassa VCT- centre; she informed the investigator a one time sensitisation by anti - AIDS club creates a crowd around the VCT- centre. As a result, the role of anti-AIDS clubs for voluntary counselling testing should intensified.

Two individuals in this study said they will not be tested even if testing is free: their reason is they don't have trust on efficacy of diagnostic materials. The efficacy of diagnostic test should be known to youth. It might add some youth to this service. 25 out of 321 respondents have no idea for a time being whether they decide to test or not.

The most and frequently mentioned factors (in qualitative and quantitative study) which hinder youth to visit VCT service is "fear of being positive". This is the best area to work on. The meaning of being - Positive should be clear for youth. The following are some of the reasons why young people fear to test: The nature of the disease, " I know what I did" , deadly no means of cure, makes oneself hopeless, peoples may ostracise me, being burden to family or family may refuse to live together.

Several other factors preventing youth from accessing themselves to health care and VCT service has been mentioned by respondents: Negligence before and after the problem, inconvenient time, fear to be there, health service does not address needs of young people, poor approach of service providers, low awareness among youth about service provision, youth addiction to alcohol and *chat*, unaffordable fee for health service, immorality among youth, in adequate counselling specific to VCT service, culture and religion, lack of awareness about VCT service, family influence, fear of being positive. Studies in South Africa also shows that inconvenient hours or location, unfriendly staff and lack of privacy are among reasons many young complain for not using health institutions. Therefore, helping clinics to be friendly to youth is important. Some studies emphasis that clinic based services alone can not serve the needs of all youth. We have to design services that reach out in to the community to where the youth are. Otherwise many young people will never get the services they need. In this study also, youths strongly suggested that services should be accessible to youth as much as possible. This includes physical accessibility.

Respondents forwarded different suggestion to have a wide and effective utilisation of health care and VCT services. These include : a wide and intensive provision of education, agreed by 132 participant out of 328, charge-free service; service providers should approach the client with respect and dignity, integration of health services with recreational facilities, wide provision of VCT service in areas where it is inaccessible, sustainable youth sensitisation and mobilisation initiatives. In relation to this idea the South Africa study(Family health international.2000b) suggested standards should have been developed based on research of what youth say and they want in health service. The standards includes policies and procedures that support youth's rights, a physical environment

conducive to the provision of adolescent friendly services and the provision of psychosocial and physical assessment of youth.

The involvement of parents was strictly stressed in group discussions ; with out creating awareness for parents, VCT - service would not be possible. In focus group discussion a girl aged 18 said; If at all I tell my parents that I am going to test for HIV, surely they think that I have contracted with HIV or I am sexually active. Most of youth have the same idea. Innovative services for youth that involve parents have been developed in general clinical settings in many countries. In Zambia, according to Ahertage (1997), for example, the Lusaka urban youth friendly health service project used participatory need assessment and learning exercises to involve community leaders and parents, The number of youth using the service doubled or as a result of the project involving parents, with significantly more non- pregnant teenage girls seeking counselling and contraceptive services. In this study 26.8% respondents agreed on the need to create awareness among the communities.

There are some differences among the towns studied in the existing VCT service. For instance there is a very good community awareness and VCT- service delivery in Wolkite town, all heard about HIV/AIDS, which is not the case in other towns. More individuals who neglected the importance of VCT service are found more in other towns than in Wolkite.

Factors that force to indulge in unsafe sex are investigated among towns: Inaccessibility of condom by one or another reason stated by respondents 36.5% in Awassa, 26.8% in Yirgalem, 21.9% in Leku and 14.6% in Wolkite. Wolkite is still better based on the above information. Inaccessibility towards condom could be by negligence or low awareness about condom use. Hence there is encouraging awareness and community interventions in Gurage Zone. Especially in Wolkite town no parents are willing to have marriage of their sons or daughter with out a certificate of HIV- status. Which is not the case in Awassa, Yirgalem and Leku.

Almost all young people in Wolkite town accept strict rule to test for HIV before marriage; even most before any sexual practice, again which is not the case in other study areas.

The physician at Wolkite HC said " It is shameful having a crowd of young people for voluntary testing and counselling; after strong intervention with little or no diagnostic -Kit" . In addition, he said almost 70 % of clients are young. In fact the prioritisation of Wolkite VCT-service is more to pre-marriage. Service providers also give due attention for pre-marriage. Some young people reported that they couldn't get the service in time of need.

The difference of time taken for result is due to using different diagnostic test in Awassa and Wolkite. Wolkite HC uses rapid diagnostic kit. where as Awassa uses ELISA test and it is examined in Regional Laboratory, re-checking also done in this area.

CHAPTER- 7

SUMMARY AND RECOMMENDATIONS

7.1 SUMMARY

According the investigation made in the survey and group discussion youth's overall knowledge of HIV/AIDS was found to be encouraging and almost all of the youth recognised HIV/AIDS as a major public health problem as well as that it is a social and development issue.

Most youth have heard of and have some idea about VCT service. Little knowledge prevailed about what it means, its purpose, scope, how it is delivered, by whom, where and when it is provided. Generally, young peoples' orientation about VCT service is poor.

Willingness to use VCT services is rated to 84.1% of participant. 94% young people confirmed the importance of the service. It should be designed and organised to meet the SRH needs of youths. To this effect the following measures should be taken: integration of recreational facilities with health service, involve parents, launching strong awareness creation initiatives. As frequently mentioned by participants quality of health care depends on technical competence of service providers, age difference between providers and clients, quality of diagnostic facility and environment at which service provided.

The issue of affordability of health care and VCT Service was discussed. It has been identified as hindering factor. Those who couldn't attend health service in time of need due to lack of money are 39%. A suggestive fee that could be paid for VCT service is 10 Birr, of course almost 23 % did not suggest any amount of fee to pay. Similarly 26% suggested charge free service. 21.8% of youth are not willing to pay any fee for this service.

Most participant agree that the current health service delivery couldn't address the need of the youth. Moreover most of them agreed that, there is no easy access to health service in time of need.

Challenges and obstacles that prevent youth from using health care and VCT service are also outlined: Lack of money, geographical inaccessibility, lack of trust (confidentiality) on service providers, fear of family, lack of confidence in the quality of treatment and counselling, lack of information on location of services and lack of privacy, fear of exposure. In addition lack of awareness, orientation and sensitisation on VCT service, service without entertainment, addiction to alcohol or *chat* are some of those challenges and obstacles .

The current practice in preventing HIV at first -sex is very discouraging. Most youth did not use condom or other preventive action. This indicates that the level of awareness do not correspond with practice.

Some service providers from their experience strictly advocate for handling or sustainable follow up of HIV- negative status

individuals. These group need strict follow up since they usually are proud of their status, and they may dare to involve in unsafe sex. With regard to this issue, it is suggested that VCT should not only concentrate on identifying the status but also on how to follow-up.

Integration of voluntary counselling and Testing (VCT) with other health service is not still given due attention. The culture of integration and looking it as part of routine activities is still underdeveloped. Integration should start by allocating financial, human and all resources. The investigator has seen VCT services with no stationary and furniture where as HIV/AIDS is increasingly becoming social and developmental issue.

However behavioural change intervention and preparing youth for future reproductive challenges is crucial. Voluntary counselling and testing service should give priority to those people who are sexually inactive.

In this study town differences have been observed and strategies should be designed accordingly. For instance, Leku and Yirgalem towns need primarily youth awareness creation and sensitisation what, how, when, where VCT service is delivered, where as Awassa and Wolkite need more of strengthening and organising current VCT service to put it in sustainable way. Specially Wolkite's service is fully "acceptable but not accessible" in terms of lack of diagnostic material and selection of clients.

Increased familiarity with sexual partner often leads to a perception of decreased risk. A 23 years age commercial sex worker in Wolkite town said during early relation with her client she was usually using condom. However, through time she gave up using condom. The same happened in Malawi, girls perceived little risk in having sexual relations with a boy whose mother new their family.

Finally, wise decision must be made about how to allocate the very limited human and financial resources to reach all youth. Many interventions reach youth long after they need the information rather than when the information is most crucial. Practical behavioural change interventions should be emphasised. This problem has been revealed in this study. Most youth experience unsafe sex during first sex. Youth in some places try to delay their sexual

debut but others begin to have sex quite early. This is important because teenagers who have an early sexual debut are more likely to have sex with high risk partner or multi- partners and are less likely to use protection.

Risk perception should be addressed correctly, even youth who have accurate knowledge about HIV, often do not heed warnings to reduce risky sexual behaviours, and some youth at high risk for example do not adopt safer behaviours because they incorrectly perceive as their risk is low. Perceived risk can also decrease as relationship matures.

7.2 RECOMENDATIONS

Voluntary counselling and testing is one of the preventive actions to prevent HIV/AIDS pandemic. Knowing one's HIV status has a great individual and collective advantage to tackle the problem from its roots through different approach.

It is obvious that identification of gaps, challenges and obstacles that prevent youth from health care and VCT is essential to plan an effective and sustainable programme. In this study different issues were investigated and discussed, and on the basis of the findings the following recommendations are forwarded:

1. Behaviour Change Communication (BBC)

In this study most youth suggest a need of intensive provision of information education and communication for effective and sustainable programme. To have improved VCT service youth should be empowered to challenge and cope with attributes of puberty. This power could be achieved only through strong BBC programme. Awareness creation initiative should be designed about what VCT means, how, when, and where VCT is delivered . Developing self-esteem, a sense of hope and goals for the future and respect for others should also be part of the process to defeat hopelessness.

BBC aims at positively influencing the behaviour of individuals and groups with the most effective education, communication and information strategies. The goal of BBC is to influence youth's sexual behaviour and ensure their adoption of and adherence to recommended health practices in order to prevent HIV infection and

its associated morbidity and reduce its social effects. BBC is better delivered through peer education, since youths are generally influenced by their mates.

2- Service provision should be tailored according to sex and age

Respondents in this study complained about age difference between health service providers /counsellors and youth. As a result young people are afraid to disclose their problem . Sometimes providers act like parents and blame and judge on problem presented by youth. Sometimes they could not easily probe or comprehend the youth problem from its root.

Based on the findings in this study one must consider sex differences in terms of perceptions of risk and motivations for behavioural change when designing a programme for HIV/AIDS. In group discussion, surprisingly almost all-commercial sex workers in Wolkite preferred to have male service providers and counsellors, probably they pass most of their time with male partners.

3-Integration of VCT service with entertainment and recreational facilities (create youth- friendly environment)

This idea is presented by almost all-young people. It helps youth to be acquainted with the situation and service providers easily. Hence, through time youth accept the service as part of his/her life . The challenges frequently mentioned by the respondents " plain fear to test for HIV" could be resolved through this approach . Through entertainment and recreational facilities there is a possibility of getting many youth and to conduct effective message by creating stories, parables and dramas. Besides, one who needs the VCT service can not be easily identified by others.

4- Parental and Community involvement

Most of the successful programme has included strong parental and community involvement and clear messages about how HIV/AIDS is prevented. One of the obstacles to access youth to VCT service as outlined in this study is a wide gap between youth and parents. Parents should be aware of what VCT means and finally they should encourage their sons and daughters to test for HIV. Parental involvement should be in the phases of planning, implementing and evaluation of the programme. Community as a whole should have a correct perception of VCT services. This could be achieved through sustainable intervention in this respect.

5- Training of service providers

Quality of service provision mainly is influenced by technical competence of the providers. The level of training is directly related to the acceptance of the service by youth. Intensive and up to date training on how to conduct counselling, how to effectively address the problem of youth, and how to provide youth-friendly service should be considered.

6-Health promotion initiatives

Health promotion is not IEC. Health promotion is promoting healthy life style by creating conducive environment for young people. Promoting health through creating good environment by involving the community , policy makers and government institution. For example application of rules and regulations such as no smoking, no *chat* chewing, no alcohol under 20's regulations in school, restaurant, workplace, shops, and supermarkets and in different settings could be considered as health promotion initiative..

7-Promoting VCT service through anti- AIDS clubs

The investigator found out the role of anti- AIDS clubs in promoting VCT service to be great. Many youth are volunteers for VCT service as a result of strong youth sensitisation. Almost 72% youth volunteers for testing are initiated through anti- AIDS clubs.

8-Establishing pre and post -VCT interventions.

It is a matter of early age counselling and post-VCT skill development initiatives for deprived groups. It has been discussed previously that most of the information has reached youth long after young people entered to the problem. VCT service should not only target or aim at to " Know ones- status" , but what to do before? and what to do then? Should also be recognised. The findings in this study show that some youth especially out of school youth and commercial sex workers were concerned with what after HIV status is known: If negative; commercial sex workers said " How do I earn my life?" . If positive what are the opportunities to earn one's life. Hence, VCT service should be supported by post-VCT initiatives such as : creative, skill development, enabling youth to earn -life should also be recognised. Counselling should also be provided at early age . In this study late child hood (7-13 age) unsafe- sexual practice has been observed.

9-Introduction of high-tech and well-organised service delivery.

Some of the diagnostic materials are with low specificity and sensitivity; and takes a long time to know the result. Some youth are complaining of false- positive result and long waiting time during case study at Awassa VCT- Centre. This might result in increasing number of dropouts. Hence introduction of high quality diagnostic facilities at most will improve the uptake of VCT service.

Well-organised service delivery is a rational management system. Thus , attention should be given to how facilities are organised, including operating hours, location and privacy, staff performance, including respect shown to clients, confidentiality and adequate time of interaction, administrative procedures, such as whether fees are affordable or not.

10-Targeting high risk groups

Voluntary Counselling and testing should target at those high-risk groups and help them to know their status. This consequently is a good opportunity to play a role in preventing HIV with known status. It should include those practising multiple sexual contact, commercial sex workers, youth addicted to Alcohol and *chat*.

11-VCT promotion and implementation through social and cultural institutions.

Organising young people through their involvement in social and cultural settings, such as church, mosque, youth associations ,clubs and supports groups is of paramount importance according to the findings of this study.

12- Improving affordability of service and indigenous resource mobilisation.

Identification of local resources is crucial to ensure sustainability of the programme. Establishing subsidised fee scheme could also be an opportunity for deprived groups (commercial sex workers and street youth). It enables them to earn their livelihood without risky- life style, especially during post-VCT.

13 -Involve all stakeholders in planning, implementing and evaluation of the programme.

In this study the involvement of different groups from different areas (teachers, parents, religious leaders and youth clubs or associations etc) was discussed by participants. Besides, partners involvement in all the process brings strong- commitment for sustainable, effective, acceptable and high quality VCT service.

APPENDIX-A

Dear Participant,

This is an assessment to identify challenges and obstacles that prevent youth from health care and VCT services.

This study is conducted by Family Guidance Association of Ethiopia (FGAE), Awassa branch.

At present HIV/AIDS pandemic brought social, development and public health burden in our society. We lost so many of our friends as a result of HIV infection. HIV/AIDS cast a shadow on the future generation who are supposed to nurture the next generation to come and future hope for their country.

Your participation in this study is a great input in the process of preventing HIV/AIDS.

would you please complete the questionnaire by giving care and due attention

Thank You

Questionnaire for assessment of challenges and obstacles to access health care

and VCT of HIV to youth.

Notice : Circle the choice

Section : 1 Demographic Information

01- Survey No _____

02- Town 1. Awassa 2. Yirgalem 3. Leku 4. Wolkite

03- Sex 1. Male 2. Female

04- Age _____ year.

05- Marital status 1. Married 4-separated
 2. Single 5. Other specify _____
 3. widowed

06- Religion 1. Orthodox 4. Catholic
 2. Muslim 5. Other specify _____
 3. Protestant

07- Educational status 1. In- school 2. Out-of school

08- Educational grade 1. Illiterate 3. Junior school
 2. Read and write 4. High school

09- Economic status 1. No job at all 6. Commercial sex worker
 2. House wife 7. With parents
 3. Student 8. Shoe shiner
 4. Government employee 9. Party traders
 4. Lottery and news paper 10. Daily labourers
 distributors 11. Other specify _____

SECTION : 2 HIV/AIDS Knowledge, Attitudes and Practice

10- Have you ever heard of HIV/AIDS ? 1. Yes 2. No

(If no stop here)

11- If yes, what was the source of information ?

1. Mass media
2. Reading materials
3. Health professionals
4. Church
5. Mosque
6. Friends
7. Family
8. Anti-AIDS club
9. AIDS-Day
10. School
11. Other specify

12-

AIDS transmitted	Agree	Disagree	Don't know
1. Sexually	1	2	3
2. Not from mother to child	1	2	3
3. Through contaminated blood	1	2	3
4. Gating together	1	2	3
5. Insect bite	1	2	3
6. Other specify	1	2	3

13- Have you ever heard of condom ? 1. Yes 2. No

(If no go to Ques. 16)

14- Have you ever seen condom ? 1. Yes 2. No

(more than one choice is possible)

15. Why using condom ?
1. Prevent from sexually transmitted infection
 2. Prevent HIV-infection
 3. Prevent pregnancy
 4. For all of the above
 5. Other specify

16.

To prevent HIV	Agree	Disagree	Don't know
1. Abstinence	1	2	3
2. It is good to use condom	1	2	3
3. One-to-one	1	2	3

17. Do you think a person thought to be healthy could have HIV?

1. Yes 2. No 3. Don't know

18. Do you think you might be infected by HIV?

1. Yes 2. No 3. Don't know

19. Do you want to nurse malaria patients

1. Yes 2. No 3. If it is must 4. Never even if is must

20. Do you want to nurse AIDS patient

1. Yes 2. No 3. If it is must 4. Never even if it is must

21. Age at which you did first sex is: -----

22. What was the action to prevent HIV at first time sex?

1. Condom 2. Nothing 3. Other specify-----

23. Do you have boy/girl friend ? 1. yes 2. No

(If no go to ques 29)

24. If yes, Did you ever have sex with your friend ? 1. yes 2. No.

(If no go to ques. 26)

25. If yes, what was the action to prevent HIV ?

1. Condom 2. Nothing 3. HIV- testing 4. Other specify-----

26. Why don't you have sex with your friend ?

(more than one choice is possible)

1. Not before marriage
 2. Not before HIV-testing
 3. To avoid pregnancy
 4. To protect from STD
27. Did you practice multi-partner sex? 1. yes 2. No
28. Have you ever discussed about HIV/ AIDS with your boy/girl friend ?
1. yes 2. No. 3. Don't have friend
29. Have you ever discussed about HIV/AIDS with your family?
1 yes 2. No
30. What conditions forced youth to do unsafe sex ?

(more than one choice is possible)

1. Condom is not accessible in time of need
2. Lack of money
3. Negligence
4. Alcohol
5. *chat*
6. All of the above
7. Other specify-----

SECTION: 3 Voluntary Counselling and Testing for HIV

31. Is there any means to know HIV - status ?
1. yes 2. No 3. Don't know
32. Do you know about Voluntary Counselling and Testing service?
1. Yes 2. No *(If no go to ques. 36)*
33. What was the first source of information about this service?

- | | |
|-----------------------------|------------------------|
| 1. Health service providers | 4. School |
| 2. Mass media | 5. Anti- AIDS club |
| 3. Friends | 6. Other specify ----- |

34. Where do you get voluntary counselling and testing service?

(more than one choice is possible)

- | | |
|--------------------|---------------------------|
| 1. Hospital | 4. Family guidance clinic |
| 2. Health Centre | 5. Red cross clinic |
| 3. Private clinics | 6. other specify----- |

35. Which place is preferable for VCT service?

1. Hospital
2. Clinic
3. Health Centre
4. Family Guidance clinic
5. Other specify-----

36. Is VCT service is important?

- | | | |
|--------|-------|------------------------|
| 1. Yes | 2. No | 3. Other specify ----- |
|--------|-------|------------------------|

37. If it is important why?

(more than one choice is possible)

1. To Know HIV- status
2. To take care
3. Other specify -----

38 If it is not important why ?

39 When voluntary counselling and testing is important ?

(more than one choice is possible)

- | | |
|-----------------------|-----------------------|
| 1. Any time | 4.To go abroad |
| 2. In time of illness | 5. In- doubt |
| 3. Pre- marriage | 6. Other specify----- |

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

(more than one choice is possible)

- | | |
|---------------------------|--------------------------|
| 1. Commercial sex workers | 6. Per -marriage couples |
| 2. Drivers | 7. Young people |
| 3. Student | 8. All but children |
| 4. Pregnant women | 9. Other specify----- |
| 5. Adult women | |

41. If a person with positive HIV- status what should be the next action ?

(more than one choice is possible)

- | | |
|--------------------------|-------------------------|
| 1. Abstinence | 5. medical following-up |
| 2. Give-up bearing child | 6. Commit suicide |
| 3. Prayer | 7. Hopeless, nothing |
| 4. Condom use | 8. Other specify |

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

1. Yes 2 No 3 Not sure 4. Don't know

43. If yes or no. Why?

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

(more than one choice is possible)

- | | |
|----------------------------|-----------------------|
| 1. Take care of my self | 5. No change at all |
| 2. Condom use | 6. Other specify----- |
| 3. I will have sex partner | |
| 4. Abstinence | |

45. If you are with positive HIV- Status what will be the next action ?

(more than one choice is possible)

- 1. Abstinence
- 2. Give-up being child
- 3. Avoidance
- 4. No marriage at all
- 5. Condom use
- 6 Commit suicide
- 7 Medical follow-up
- 8 prayer
- 9 No change once happened
- 10 Other specify-----

46. If your boy / girl friend is with positive HIV status what will be your action?

(more than one choice is possible)

- 1. Abstinence
- 2. Condom use
- 3. Take care of my friend
- 4. Avoid any sex partner
- 5. Go to HIV - testing
- 6. medical follow -up
- 7. Other specify _____

47. If charge for testing is to be requested; will you pay ? 1. Yes 2. No

48. If yes how much ? _____

49. Do you think to VCT or testing is Stressful ?

- 1. yes
- 2. No
- 3. Seriously stressful.

50. Why stressful to test for HIV?

51. If you decide to test for HIV; will you inform for some body?

- 1. Yes
- 2. No

52. If No why ?

53 Do you inform the result for some body ?

- 1. yes
- 2. No

54. If No why?

55. Do you have risk behaviour for HIV ?

1. Yes 2. No

56. Have you ever heard of Anti- AIDS club 1. Yes 2. No

57. If yes do you take- part in Anti- AIDS club 1. Yes 2. No

58. Have you ever visited (for help) any health institution

1. Yes 2. No.

59. If yes ? which one of the following ?

1. Private clinic
2. Government Hospital, Health centre etc.
3. Private pharmacy
4. No where
5. Other specify-----

60. Why do you prefer this health institution ?

- | | |
|----------------------------------|------------------------|
| 1. Good care | 6. Confidential |
| 2. Attractive environment | 7. Privacy secured |
| 3. Good technical competence | 8. Near to home |
| 4. Treat with respect and dainty | 9. Other specify _____ |
| 5. Affordable | |

61. Have you ever remembered that you missed health service support in time of need? 1. yes 2. No.

62. If you remembered, why you missed ?

(more than one choice is possible)

1. No money
2. Fear of family
3. Because it is far
4. Being there is shame
5. I don't know where to go
6. Confidentially may not secured
7. Privacy may not secured
8. Technical Competence may be poor
9. Other specify _____

No	Questions	Strongly agree	Agree	Disagree	Strongly disagree
63	Most health organisations are with attractive environment	1	2	3	4
64	Health service providers are trust full (confidential)	1	2	3	4
65	Health service providers treat me with respect and dignity	1	2	3	4
66	Generally health service delivery is not address a need of young people	1	2	3	4
67	I have an easy access to health service in time of need	1	2	3	4
68	Privacy is secured in most health facilities	1	2	3	4

69. What are the challenges and obstacles towards health care service for young people ?

70. What are the challenges and obstacles towards Voluntary Counselling and Testing for HIV in youth ?

71. What do you suggest for intensive use of health care service by young people?

72. Generally what do you suggest for intensive and widely use of Voluntary Counselling and Testing service by young people ?

Section : 4 Only for a person with known HIV - Status (VCT - clients)

73. What was your initiative for HIV- testing -

- 1. Pre -marriage testing
- 2. To go to abroad
- 3. In- doubt
- 4. Just to know
- 5. Other specify _____

74. Was it voluntarily ? 1. Yes 2. No

75. What was the result ? 1. HIV - positive 2. HIV- negative
(If HIV- negative go to ques. 80)

76. What was your action about having sex ?

(more than one choice is possible)

1. Separated from my friend
2. Encourage my friend for HIV- testing
3. Abstinence
4. Condom use
5. No change At all
6. Other specify_____

77. Who was the first person to know your result ?

(more than one choice is possible)

- | | |
|---------------|------------------------|
| 1. My partner | 6. Sisters |
| 2. Mother | 7. Family |
| 3. Father | 8. My best friend |
| 4. Brother | 9. No body |
| 5. Relative | 10. Other specify_____ |

78. What was your action after being HIV-positive

1. Disclosure my status
2. Join organisations (Such as dawn of hope or OSSA)
3. No disclosure at all

79 Do you think you had risk behaviour for HIV?

(more than one choice is possible)

1. Yes
2. No.

80. If you are with HIV negative status, what was your action having sex?

1. Abstinence
2. Encourage my friend for HIV testing
3. Condom use
4. No Change at all
5. Other specify_____

81. What time is convenient for VCT service delivery ?

1. Morning from 6 am - 8 am

2. From 8 am - 12 am
3. Afternoon 1pm - 5 pm
4. From 6pm- 9 pm

No	Question	Strongly agree	Agree	Disagree	Strongly disagree
82	Generally I have benefited and satisfied with pre-counselling .	1	2	3	4
83	Generally I have not benefited and satisfied with post- counselling.	1	2	3	4
84	Service providers treated me with dignity and respect	1	2	3	4
85	Counselling room was comfortable and privacy was secured	1	2	3	4
86	Service providers were confidential and trustful	1	2	3	4
87	I was not satisfied with the technical competence of service providers	1	2	3	4
88	Time at which VCT service delivered was not counselling	1	2	3	4
89	Generally there is still a lot to do with VCT service	1	2	3	4

90. Since you are a client for VCT service what makes you annoyed and inconvenient?

91. Any recommendation, suggestion and comment about VCT service for future interventions ?



APPENDIX-B

wÈt\$ bf"d"nT SY ytm\rt x@C.xY.v!. bdM WS_ mñ,,N lYrUg_ y,drG yMKRÂ
ydM MRm% xgLGlÖTN btmlkt XNÄ!h#M Sl x@C.xY.v!.¼x@DS ÆlWN GN²b@½
ZNÆl@Â LMD lYwQÂ b-@Â tìYrT ymgLgl#N h#n@¬ lmgMgM ytzUj m-YQÝÝ

bx!T×ùÃ b@tsB mMŹÃ db#B QRNÅF y.µÿD _ÂT
 _QMT 1994

WD wÈèC bxh#n# wQT x@C.xY.v!.¼x@DS bwÈt\$ \$Y XÃdrs ÃlW g#ÂT
 kFt¾ kmçn# ytnú ywdøT yhgR tSÍ yçnW wÈT lb@tsb# lwgn#Â l|g,,
 l!ÃdRG ÃlWN ywdøT TLÑN bxSg! H#n@- \$Y _lÖ-L bz!HM b>- wgñÒCNN
 x_tÂLÝÝ

bz!H _ÂT yxNt¼ yxNcE túTæ x@C.xY.v!.¼x@DSN lmöÈ-R wdøT l, \,,
 |%ãC kFt¾ xStêAå xlWÝÝ Slz!H g!z@HN s_tH b_N"q&Â bTk#rT m-Yq\$N
 XNDTä\$LN XN-Y"lNÝÝ

kYQR- URÝ _Ãq&ãc\$ bwND Û- täLtêLÝÝ çñM wÈT s@èC ywND Û- ÆlBT
 h#l# ys@T Û-N b,gLi# "ST Xytk# XNÄ!Ãnb# bTHTÂ xN-Y"lNÝÝ

S1 TBBRH¼> bÈM XÂmsGÂlNÝÝ

mmŹÃÝ ymr_kWN mL\$ q\$_R xKBbW

KFL lÝ x-"\$Y mr©	
01	y_ÂT q\$_R
02	kt¥ 1 (xêú 2 (YRU>lM 3 (lk# 4 (wLqE-@
03	Û- 1 (wND 2 (s@T

04	XD»	_____xmT
05	yUBÔ h#n@-	1 (ÆLTÄR n" 3 (tlÄYtÄL 2 (xSgÆh#M 4 (äèB¾L 5 (l@S µl YGl]# ((((((((((((((((((((((((((((
06	hYÿñTH MNDN nW)	1 (âRèiKS KRStEÄN 3 (Pét&S-NT 2 (ÑSl!M 4 (µèl!K 5 (l@S µl YGl]# _____
07	yTMHRT h#n@-	1 (bTMHRT \$Y n" 2 (bTMHRT \$Y xYdlh#M
07	yTMHRT dr©	1 (ÿNbBÂ mÚF yÿYCL 2 (ÿNbBÂ mÚF y.CL 3 (mlSt¾ h#lt¾ dr© T¾ab@T 4 (kFt¾ h#lt¾ dr© T¾ab@T
08	yn#é ¾y ¾ h#n@-	1 (¾ yl@lW 2 (yb@T Xmb@T 3 (tÿ¶ 4 (ymNG T \¾t¾ 5 (lÖt¶½ Uz@È xzê¶ 6 (yb#Â b@T \¾t¾ (s@t¾ xÄ¶) 7 (kb@tsB kzmD UR 8 (l!STé 9 (xnSt¾ ymNgD \$Y NGD 10 (yg#LbT \¾t¾ 11 (l@S µl Y qs# _____

KFL 2 Ý Sl x@C.xY.v!.¾x@DS ÄlWN GN²b@½ ZNÆl@Ä LMDN btmlkt			
09	x@DS Sl,ÆlW b>- sMth -W' lH)	1 (xä 2 (x\$WQM x\$WQM µl _Äq&W bz!H Yq\$M	
10	ktzrz,,T WS_ Slx@C.xY.v!. ¾x@DS TMHRT yM-gßW kyt\$ nW)	1 (kmgÄ¾ Bz#hN 6 (kÜd@c& 2 (kÿNbB 7 (kb@tsic& 3 (k-@Ä ÆlÑÄâC 8 (kir x@DS wÈèC KbB 4 (kb@tKRStEÄN 9 (bx@DS qN b;L \$Y 5 (mSg!D 10 (kT¾ab@T mMH%N 11 (l@S µl Ygl[#((
11	x@DS	XSY¥lh#	xLS¥¥M
	1 (bGBr U GNß#nT Yt\$lÍL	1	2
	2 (kXÄT wd ?ÚN xYt\$lFM	1	2
	3 (bdM l!t\$lF YC\$L	1	2
	4 (xBé bmB\$T Yt\$ÍL	1	2
	5 (bTN" NKš Yt\$lÍL	1	2
			3
			3
			3
			3
			3

	6(10\$ µl Y_qs# ((((((((((((((((((((((((((((
12	S1 ÷NiM sMtH -W" LH)	1(xāN	2(x\$WQM x\$WQM µl wd _Äq&16 £D		
13	÷NiM xYtH -W" LH)	1(xāN	2(xYc&& x\$WQM		
14	y÷NiM _QM MNDNnW BlH -SÆlH) (kxND b\$Y mmlS Yò\$L)		1(kxÆlZR b>- Yk\$Sk\$L 2(kx@DS ŠYrS Yk\$Sk\$L 3(XRGZÂN lmk\$SkL Y-Q¥L 4(k\$Y lt-qsT bÑl# Y- Q¥L 5(10\$ µl Y-qS ((((((((((((((((((((((((
15	x@DSN lmk\$SkL	XS¥¥lh#	xLS¥¥M	x\$WQM	
	1(yGBr U GNß#nT xl¥DrG 2(bGBr U GNß#nT wQT ÷NiM m-qM 3(xND lxND mwsN 4(10\$ µl Y_qs#((((((((((((((((((((((((1 1 1	2 2 2	3 3 3	

16	-@n¾ y,mSlW sW yx@C.xY.v!. ŠYrS bdÑ WS_ l!ñrW YC\$L BlH -MÄlH)	1(xāN 2(xYCLM 3(x\$WQM		
17	xNt X%SH bx@C.xY.v! ŠYrS ym- "T XDLH MN ÄHL nW)	1(L-" XC\$lh# 2(L-" xLCLM 3(x\$WQM		
18	bwE wYM btQ¥_ y-mm sW lmNkÆkB l¥S-mm	1(f" d¾ n" 2(f" d¾ xYdlh#M 3(yGD kçn xS-M¥lh# 4(yGD b!çNM x\$S-MM		
19	bx@DS y-mm sW lmNkÆkB l¥S-mm	1(f" d¾ n" 2(f" d¾ xYdlh#M 3(yGD kçn xS-M¥lh# 4(yGD b!çNM x\$S-MM		
20	yGBr U GNnß#nT fAmH -W" LH)	1(xW" lh# 2(x\$WQM x\$WQM µl wd _Äq& 23 £D		
21	ymjm¶Ä GBr U GNß#nT StfAM XD»H SNT nbR) _____>mT			
22	kx@C.xY.v! ŠYrS lmk\$SkL bmjm¶Äw yGBr U GNß#nT yt- qMkW mk\$SkÄ MN nbR)	1(÷NiM 2(MNM xLt-qMk#M 3(10\$ µl Ygli#((((((((((((((((((((((((

23	yFQR Ûd¾ x1H¾ x1>)	1 (xãN 2 (yl"M mLs# yl"M kçn wd _Ãq& 29 £D
24	l_Ãq& 23 mLs# xãN kçn yGBr U GNß#nT -dRUŞCh#)	1 (xãN 2 (xÃdRGM mLs# xÃdRGM kçn wd _Ãq& 26 £D
25	l_Ãq& 24 mLs# xãN kçn kx@C. xY.v!.N lmkŞkL ywsÄCh#T XRM© MN nbR)	1 (÷NiM 2 (MNM xLt-qMk#M 3 (ydM MRm% xDRgÃL 4 (l@Ş µl YGli# ((((((((((((((((((((((((((((((((
26	yFQR Ûd¾ ñéH yGBr U GNß#nT ÃLf]¥Ch#bT MKNÃT MNDN nW) (kxND bŞY mmLS YÒSL)	1 (kUBÒ bðT xÃsfLGM 2 (lx@C·xY·v!. mUl_ xlmUlÈCNN úÂrUG_ _„ xYdlM 3 (XRGZÂN bmF%T 4 (yxÆlzR b>-N bmF%T 5 (l@Ş µl Ygli# (((((((((((((((((((((((((((

27	kxND bŞY yFQR Ûd¾ W+ yGBr U GNß#nT xDRgH -W' lH)	1 (xãN 2 (xDRg@ xŞWQM
28	S1 x@C.xY.v!.¾x@DS kFQr¾H UR twÃYtH -W' lH)	1 (xãN & 2 (xŞWQM 3 (yFQR Ûd¾ yl"M
29	S1 x@C.xY.v!.¾ x@DS kb@tsB UR twÃYtH -W' lH)	1 (xãN 2 (xŞWQM
30	wÈtŞ Ãl ÷NiM yGBr U GNß#nT XNÃ!fAM y.gÍûT h#n@-ãC yT@cŞ ÂcW) (kxND bŞY mmLS YÒSL)	1 (÷NdM bqŞl# ¥GßT S1¥YÒL 2 (ygNzB CGR 3 (cLt"nT 4 (yxL÷çL m-_ 5 (ÅT 6 (kŞY yt-qs#T h#l#M 7 (l@Ş µl Y_qs# ((((((((((((((((((((((((((((((((

KFL 3Y yx@C. xY.v!. ŠYrS bDM WS_ mñ,,N lYrUg_ y.drG yMKRĀ ydM MRm%: xgLGl#TN btmlkt		
31	xND sW bdÑ WS_ yx@C.xY.v!. ŠYrS mñ,,N lYrUg_ y,CLbT mNgD Āl YmSL L)	1 (Yñ%L 2 (xYñRM 3 (xSWQM
32	bDM WS_ yx@C.xY.v!. ŠYrS mñ,,N lYrUg_ y.drG yMRm%: xgLGlÖT mñ,,N sMth -W' lH)	1 (xāN 2 (sMc& xSWQM 3 (sMc& xSWQM µLH wd _Āq& 36 £D
33	YH xgLGlÖT mñ,,N bmjmŹĀ kYN sYH)	1 (k-@Ā ĒlÑĀ 2 (kmqĀ¾ Bz#!N 3 (kÜd¾ü 4 (kTMHRT b@T 5 (kir x@DS KbB 6 (l@S µl Ygli# ((((((((((((((((((((((((((((((((
34	YHN xgLGlÖT yT Yg¾L) (kxND bSY mmlS YÒSL)	1 (çSpE-L 2 (-@Ā Èb!Ā 3 (GL Kl!n!K 4 (b@tsB mMŹĀ 5 (qY mSqL 6 (l@S µl Ygli#((((((((((((((((((((((((((((((((
35	bf"d"nT y.drG yx@C.xY.v!. ŠYrS yMKRĀ yMRm%: xgLGlÖT lms- T ybl- y,mr-W i- yT nW BlH -SĒlH)	1 (çSpE-L 2 (Kl!n!K 3 (-@Ā Èb!Ā 4 (b@tsB mMŹĀ 5 (kSY kt-qs#T y-@Ā DRJT l@S µl Ygli#
36	yx@C.xY.v!. ŠYrS bxND sW dM WS_ mñR Ālmñ,,N lYrUg_ y,drgW ydM MRm%: bxNt xmlµkT xSfSg! nW TŞlH)	1 (xāN xSfSg! nW 2 (xĀSf1GM 3 (l@S µl Ygli#((((((((((((((((((((((((((((((((
37	ydM MRm%W xSfSg! nW µLH MN _QM y,s_ YmSL L) (kxND bSY mmlS YÒSL)	1 (bŠYrs# mĀZ xlmĀZN lYwQ 2 (lwdöT lm-NqQ 3 (l@S µl Ygli# ((((((((((((((((((((((((((((((((

42	bf"d"nT y,drG yx@C.xY.v!. yMKRÂ ydM MRm% xgLG1ÖT bz!H xQ%b!Ã bnÉ y,s_ b!çN bxgLG1Öt\$ t-" , lmçN f"d¾ nH)	1(xãN 2(F" d¾ xYdlh#M 3(XRG-¾ xYdlh#M 4(x\$WQM
43	l_Ãq& 42 mLSH xãN wYNM f"d¾ xYdlh#M kçN MKNÄTHN BTgLAL")	
44	xNt tmRMrH ŠYrs# bdmH WS_ EYg" ¼-@n¾ BTçN¾ XRM©H MN YçÂL) (kxND b\$Y mmlS YÒ\$L)	1(%s@N m-bQ XjM%lh# 2(÷NiM X-q¥lh# 3(TÄR XY²lh# 4(yGBr U GNß#nT xö¥lh# 5(MNM lW_ xÄmÈM 6(l@S µl Ygl[#((((((((((((((((((((((((((((((((((((
45	lMúle ydM MRm% xDRgH yx@DS ŠYrS bdmH WS_ b!g" XRM©H MN YçÂL) (kxND b\$Y mmlS YÒ\$L)	1(yGBr U GNß#nT xlmfoM 2(LJ ÄlmWLD 3(¥N¾WNM GNß#nT xìRÈlh# 4(UBÒ xlmSrT 5(÷NdM m-qM 6(%s@N mGdL 7(y?KMÂ MKR xgLG1ÖT Xk-t\$lh# 8(ilÖT b@T XyÄlh# 9(xNÁ SltÄZh# _N"q& x\$DRGM 10(l@S µl Ygl[#((((((((((((((((((((((((((((((((((((
46	LMúle yTÄR Üd¾H ¼FQr¾H¾ dM WS_ yx@C.xY.v!.ŠYrS b!g" yM-dRgW MNDN nW) (kxND b\$Y mmlS YÒ\$L)	1(yGBr U GNß#nT xìRÈlh# 2(÷NiM X-q¥lh# 3(lÜd¾ü XNKbub@ xdRULh# 4(¥N¾WNM GNß#nT xìRÈlh# 5(y%s@N dM xSmrM%lh# 6(?KMÂÂ yMKR xgLG1ÖT Xk-t\$lh# 7(l@S µl Ygli# (((((((((((((((((((((((((((((((((((
47	lMKRÂ ldM MRm% xgLG1ÖT m-n¾ KFÄ b!-yQ lmKfL F"d¾ nH)	1(xãN 2(xLkFLM
48	MN ÄHL BR lmKfL f"d¾ nH)	_____BR

49	YHN yMKRÂ yMRm% xgLG1ÖT m-qM y,ÄSf% ngR nW BlH -SÆlH)	1 (xÄSf%M 2 (ÄSf%L 3 (bÈM ÄSf%L
50	ÄSf%L µLH lMN MKNÄTHN BTzrZRL")	
51	xNt MRm%WN lÿDrG BTwSN Wœn@HN lsW TnG%lH)	1 (xãN 2 (xLnGRM
52	l_Äq& q\$ _R 51 xLnGRM kçn lMN)	
53	yMRm%WN W-@T ll@lÖC sãC lmNgR f" d¾ nH)	1 (xãN 2 (xLnGRM
54	F" d¾ xYdlh#M µLK lMN)	
55	lx@C.xY.v! ŠYrS y,ÄUL_ ÆHRY xl" T\$1H)	1 (xãN 2 (yl"M
56	Sl ir x@DS KbB sMtH -w" lH)	1 (xãN 2 (SMc& X\$WQM
57	l_Äq& 56 xãN kçn mLSH bir x@DS KbB TútlH)	1 (Xútlh# 2 (xLútFM
58	wd ¥N%WM -@Â DRJT b?mM wYM ll@S xgLG1ÖT ýdH -w" lH)	1 (xãN 2 (ÿ@!& x\$WQM
59	l_Äq& 58 mLs# xãN kçn ST-mM wYM ll@S xgLG1ÖT yT nW yMTýdW)	1 (yGL Kl!n!K 2 (ymNG T -@ÂÈb!Ä/çSpE-L 3 (yGL mD n!T b@T 4 (yTM xLýDM 5 (l@S µl Ygl{ ((

60	YHN y-@Â DRJT ymr_KbT MKNÄT MNDN nW) (kxND bSY mmlS YòSL)	1(„ ?KMÂ Sl,s_ 2(xµEb!W ½Gb!W bx-“SY dS YSL 3(-@Â ÆlÑÃäc\$ XWqt\$ xScW 4(-@Â ÆlÑÃäc\$ THTÂ xScW 5(êUW tmÈÈ" nW 6(,S-!R Y-B"l# 7(?KMÂÂ MRm%W lBò bxND KFL Slçn 8(lb@t& Sl,qRB 9(l@S µl YGli# ((
61	-mH wYM y-@Â ÆlÑÃ MKR fLgH xgLGlÖt\$N ú-g" yqrHbTN xUE, -S-WúlH)	1(xS-Wúlh# 2(xSS-WSM
62	l_Äq& 61 mLS xS-Wúlh# µLK MKNÄTH MN nbR) (kxND bSY mmlS YòSL)	1(gNzB xLnbr"M 2(yb@tsB F%Ò 3(-@Â DRJt\$ Yrq¾L 4(Xz!Ä SýD sW b!Äy"S b,L 5(yT mýD XNd,gÆ" Sl¥\$WQ 6(-@Â ÆlÑÃäc\$ MS-!R \$Y-Bq\$ YCSl# b,L 7(CGËN l-@Â ÆlÑÃ úêY l@S sW b!s¥S b,L 8(„ ?KMÂ wYM MKR xSg"M b,L 9(l@S µl Ygli# ((

k 63(68 ÄlWN µnbBH b"\$ mSY¥T xlmSY¥THN q\$ „N b¥KbB Gl{

		bÈM XS¥¥lh#	XS¥¥lh#	xLS¥¥M	bÈM xLS¥¥ M
63	xB²¾WN y-@Â DRJèC wÈt\$N y,SB Gb!Ä xÌM xScW	1	2	3	4
64	-@Â ÆlÑÃäc\$,S_ÈN Y-B"l#	1	2	3	4
65	y-@Â ÆlÑÃäc\$ THTÂÄ xQRiT Ärp¾L	1	2	3	4
66	bx-“SY y-@Â xgLGlÖt\$ ywÈt\$N h#n@-Ä F\$T ÄgÄzb xYdlM	1	2	3	4
67	wd -@Â DRJT kýDh# Älmg#SST xgLGlÖT xg¾lh#	1	2	3	4

76	yGBr U GNß#nTN btmlkt ywsDkW XRM© MN nbR) (kxND bSY mmlS YØSL)	1(kÜd¾ü UR GNß#nT xöMh# 2(Üd¾ü MRm% XND-drG gííh# 3(yGBr U GNß#nT xöMh# 4(÷NiM X-q¥lh# 5(MNM lW_ xSdrGh#M 6(l@S µl Ygl[# ((((((((((((((((((((((((((((
77	W-@t\$N bmjmqÄ lYN ngRK) (kxND bSY mmlS YØSL)	1(lFQR Üd¾ü 5(lzmD 2(lXÂt& 6(lXHt& 3(lxÆt& 7(lb@tsB 4(lwND» 8(l,qRb" gd¾ü 9(lYNM xLngRk#\$M 10(l@S µl Ygli# ((((((((((((((((((((((((((((
78	yx@C.xY.v ŠYrS t-qE mçNHN µwQH b"§ ywsDkW XRM© MN nbR) (kxND bSY mmlS YØSL)	1(yx@C.xY.v! ŠYrS t-qE mçn@N GLA xdrGh# 2(ktSÍ ¯H wYM msL DRJT UR bmçN b¥St¥R \$Y Xg¾lh# 3(%s@N GLA xSdrGh#M			
79	lx@C.xY.v! ŠYrS y,ÄUL_ ÆHRY nbr" T§lH)	1(xän 2(xLnbr"M			
80	(yx@C.xY.v! ŠYrS µLtgßBH yGBr U GNß#nTN btmlkt ywsDkW XRM© MN nbR)	1(GBr U GNß#nT xöMk# 2(Üd¾ü XNDTmrmR gíí" T 3(÷NiM X-q¥lh# 4(kbðt\$ MNM lW_ xSdrGh#M 5(l@S µl Ygl{ ((((((((((((((((((((((((((((
81	(yx@C.xY.v! ŠYrS ydM MRm% xgLGlÖT bSNT s>T b!s_ TmRÈlH)	1(k¥lÄW 12(2 s>T 2(kqn# 2(6 s>T 3(kqn# 7(11 s>T 4(k12 s>T XSk M<t\$ 3 s>T			
k 82(91 ÄlWN µnbBH b"§ mS¥YT xlmS¥YTHN q\$ „N b¥KbB Gl{					
		bÈM XS¥¥lh#	XS¥¥lh#	xLS¥¥M	bÈM xLS¥¥ M
82	bx-"§Y QDm MRm% yMKR xgLGlÖt\$ bÈM xRKè¾L½ -Qä¾L	1	2	3	4
83	bx-"§Y DHr MRm% yMKR xgLGlÖt\$ xL-qm"M½ xRk! XLnBrM	1	2	3	4
84	yx¥µ¶ãc\$ THTÄÄ xq%rÆcW bÈM xRKè¾L	1	2	3	4

85	yMKR xgLG1öt\$ KFL i_ ÄlÄ Bc¾ Slnbr MS-!ÊN h#l# lmG1A bÈM xmCè¾L	1	2	3	4
86	hk!äc\$½ x¥µ¶äc\$½ y\$si%è¶ mR¥¶äc\$,S_R ym-bQ ClÖ-cW bÈM xRKè¾L	1	2	3	4
87	y-@Ä ÆlÑÄäc\$ yMKRÄ ydM MRm% xgLG1ÖT xsÈÈcW y,Ärµ xYdlM	1	2	3	4
88	yMKRÄ ydM MRm% y,s_bT s>T xmcE xYdlM	1	2	3	4
89	bx-"\$Y ydM MRm%Ä MKR xgLG1T xsÈ_ bÈM Bz# ngR YqrêL	1	2	3	4
90	bx-"\$Y bxh#n# wQT ÄlWN yx@C.xY.v! yMKRÄ ydM MRm% xgLG1ÖT btmlkt yxgLG1öt\$ t-" , XNdmçNH m-N bwqt\$ mçN nbrbT wYM QR Äsß" ngR xl yMTlW µl bZRZR BTgLAL")				
91	lwdöt\$ wÈt\$ yMKRÄ yx@C.xY.v! ydM MRm% xgLG1ÖT t-" , XNÄ!çN MN mdrG wYM mà\$T xlbT T\$1H)				

APPENDIX-C

FOCUS GROUP DISCUSSION (FGD) GUIDE TOPICS FOR YOUTH

- 1- How far the existing health care service is in accordance with the need of youth?*
- 2- What is the attitude of young- people towards health service providers?*
- 3- The extent of Knowledge, Attitudes and Practice of HIV / AIDS among youth ?*
- 4- What is known about or knowledge about Voluntary Counselling and Testing (VCT) among young- people ?*
- 5- Where should be Voluntary Counselling and Testing be delivered? what are pre-conditions for efficient and effective delivery of this service ?*
- 6- What are challenges and obstacles that prevent youth towards voluntary counselling and testing ?*
- 7- What are the strategies to establish acceptable, accessible, quality and affordable VCT service among youth ?*

8- Recommendations, suggestions any comment for future interventions.

APPENDIX-D

**bf"d"nT \$Y ytm\rt yx@DS yMKRÂ ydM MRm% xgLGlÖTN btmlkt wÈèC
ÃšcWN x-"\$Y xmlµkTÂ h#n@¬ l¥_ÂT yb#DN WYYT mnš _Ãq&ãC (FGD
guide Topics)**

- 1 bxh#n# g!z@ ÃlW y-@Â xgLGlÖT ywÈt\$N F\$TÂ h#n@¬ MN ÃHL
ÃgÂzb nW)
- 2 wÈt\$ l-@Â ÆlÑÃãC ÃlW xmlµkT MN YmSSL)
- 3 wÈè S1 x@C.xY.v!. /x@DS ÃšcW x-"\$Y GN²b@ ZNÆl@Â LMD MN
YmSSL)
- 4 bf"d"nT \$Y ytm\rt yx@DS yMKRÂ ydM MRm% xgLGlÖTN btmlkt wÈt\$
SlxgLGlÖt\$ MN ÃW"L)
- 5 YHN xgLGlÖT s!s_ xgLGlÖt\$ y,s_bT Mn xYnT i¬ /Gb! / mçN xlbT)
MN QDm h#n@¬S m¥\$T xlbT)
- 6 wÈt\$ y-@Â xgLGlÖt\$ XÂ bf"d"nT \$Y ytm\rt yMKRÂ ydM MRm%
xgLGlÖT t-" , XNÄYçN y,ÃGçT CGÉCÂ XNQíèC MNDNÂcW)
- 7 YH xgLGlÖT bwÈt\$ tqÆYnT XNÄ!Ãg"½ bflg g!z@ yxgLGlÖt\$ t-" ,
XNÄ!çN½ yšq xgLGlÖT XÂ ywÈt\$N xQM ÃgÂzb XNÄ!çN MN >YnT SLT
mqyS xlbT)

8 wdōT wÈt\$ bsōý bf"d"nT \$Y ytm\rt yMKRÂ ydM MRm% xgLGlÖT t-
" , XNÄ!çN MN Yš\$L) MN Y=mR) bx-"\$Y MN YdrG) x-"\$Y xStÃyT
Ys_bT

APPENDIX-E

IN-DEPTH INTERVIEW GUIDE TOPICS FOR SERVICE PROVIDERS

1. *What is service provider's attitude towards youth?*
2. *What is the extent of health service consumption by young people relative to other groups ?*
3. *How service providers see the Knowledge, Attitudes and Practice of HIV/AIDS among youth ?*
4. *What is the extent of Voluntary Counselling and testing service consumption by young people relative to other groups ?*
5. *How service providers offer VCT service ? How do they measure the outcome and impact of this service ?*
6. *What are the challenges and obstacles in delivery of VCT service ?*

7. *Recommendation, suggestion and comment to establish effective and efficient future interventions relation to*

-Young people

-Service providers

-Health facilities

APPENDIX-F

bf"d"nT \$Y ytm\rt yx@DS yMKRÂ ydM MRm% xgLGlÖT btmlkt xgLG1T
sÀãC ¼-@Â ÆlÑããC¼ S1 xgLGlÖt\$\$ Ã\$çWN x-"\$Y |úB l¥_ÂT ytzUj yGL
"1 m-YQ mnš _Ãq&ãC

(In-depth interview Gude topics for service providers)

- 1 xgLGlÖT sÀW -@Â ÆlÑããW wÈt\$N l¥glgL ÆlW ZNÆl@xQRiT
MN YmS\$S)
- 2 kwÈTnT XD»Â ÆHRY UR tÃYø wÈt\$ b-@Â xgLGlÖt\$ ym-qÑ h#n@-
kl@lÖC UR s!nÉiR MN YmS\$S)
- 3 wÈt\$ S1 x@C.xY.v!.¼x@DS ÆlW GN²b@ ZNÆl@Â LMD xgLGlÖT sÀ
XNdmçNH m-N XNÁT TmZnêlH)
- 4 wÈt\$ bf"d"nT \$Y ytm\rt yx@DS yMKRÂ ydM MRm% xgLGlÖTN ÆW" L)
µwqS t-"¥nt\$ MN ÆHL dRú*
- 5 lz!H xgLGlÖT ¼xgLGlÖT sÀ XNdmçNH m-N bzRû ÆlW |% yMTs-#T
xgLGlÖT XNÁT nW) MN ÆHL túKaL T\$1H)
- 6 bz!H xNÉR b|% zRFH MN CGÉC xU_mW|L) XÃNÄNÇN bZRZR BTnGr")
- 7 wdÖT wÈt\$ bsöW y-@Â xgLGlÖt\$Â btlyM bf"d"nT \$Y ytm\rt yMKRÂ
ydM MRm% xgLGlÖT t-" , XNÄ!çN MN mdrG xlbT

kwÈèC xNÉR
k-@Â ÆlÑÑãC xNÉR
k-@Â DRJèC xÌM xNÉR wzt
x-“SY xStÏyT S_bT

APPENDIX-G

yMr© xsÆsB mMrÏ

- 1 ¥N¾WM mr© sBúb! Sl,sbSbW mr© -NQö ¥wQ xlbT
- 2 ÆLtrÄW ngR µl kwÄ!h# -Yö ymrÄT GÁ¬ xlbT
- 3 t-ÏqEãc\$N bmjmqÏ Slxä\$1# ¥SrÄT xlbT
- 4 t-ÏqEãc\$N y,s-#T mr© bÈM ,S-!%êE XNdçn S¥cW XNd¥YÚF½ l¥N¾WM
ll@S wgN xúLæ XNd¥Ys_ ¥SrÄT xlbT
- 5 m-Yq\$N kmÑ\$-cW böT y_Ät\$N MNnT½ x\$¥WN½ _Ät\$N ¥N XNd,ÄµýD½
x@DS bxh#n# g!z@ y,ÄdRsWN xSkðnT½ b¥SrÄT yXnRs# túTæ x@DSN
lmk\$Kl b,µýdW xNQS"s@ WS_ kFt¾ xStêAå xNÄlW ¥SrÄT xlbT
- 6 mr© sBúb!W ysbsbWN mr© l¥NM ¥úyT ylbTM
- 7 mr© sBúb!W t-ÏqEWN bTHTÄ mQrB xlbT
- 8 t-ÏqEW mr©WN ks- b"\$ bTKKL mä\$T\$N ¥rUg_ y¯dl ngR µl t-ÏqEWN
b¥SrÄT mà\$T ÄlbT Xz!ÄW mStµkL xlbT
- 9 ¥NbBÄ múF y,ÄScG%cW t-ÏqEãCN mr© sBúb!W XÄnbb\$CW y,s-#TN
mLS mÑ\$T xlbT
- 10 b¥N¾WM h#n@¬ mr© sBúb!W t-ÏqEW mLS b,s_bT ngR \$Y xStÏyT½
mS-T ytlÏy yXJ½ yDMA½ MLKTÄ GÖT ¥úDR mLS m-öM bFi#M ytklkl
nW
- 11 t-ÏqEW yflgWN mLS lmmLS né mçN xlbT ¥N¾WM GÖT xYfqDM

12 bz!H _ÂT WS_ XD»ÃcW 24 XÂ k24 b-C yçñ# lxQm m-N ydrs# wÈèC
 YútÍl#

13 mr© b,sbsBbT wQT kmr© sBúb!WÂ kt-ÃqEW bStqR ¥NM sW bxµÆb!W
 mçN möM xStÃyT mS-T ylbTM Slz!H lmr© msBsB xmcE yçñ ì-
 mflG ÃSfLUL

14 ¥N¾WM _Ãq& µl½ töÈÈ¶WN m-yQ YgÆL

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