

**Family Guidance Association of Ethiopia (FGAE)
North Western Branch**

**Study on Factors Affecting Accessibility and Acceptability of
Voluntary Counseling and Testing Services for HIV/AIDS in
Bahir Dar town, North Western Ethiopia.**

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LIST OF ABBREVIATIONS

ANC:	Antenatal care.
AIDS:	Acquired Immune-Deficiency Syndrome.
CBOs:	Community Based Organizations
CRDA:	Christian Relief and Development Association
BD town:	Bahir Dar Town
FGD:	Focus Group Discussion
HIV:	Acquired Immune Deficiency Syndrome
MOH:	Ministry Of Health
NAC:	National AIDS Council
NACS:	National AIDS council Secretariat
NGO:	Non Governmental Organization
OSSA:	Organization for Social Support for AIDS
PLWHA:	People Leaving With HIV/AIDS
PHC:	Primary Health Care.
PMCTC:	Prevention of Mother to Child Transmission
RAS:	Regional AIDS Secretariat
RHB:	Regional Health Bureau
TB:	Tuberculosis
UNAIDS:	United Nations Program on AIDS
US - DHHS:	United States -Department of Health and Humanitarian Service
VCT:	Voluntary Counseling and Testing
WHO:	World Health Organization
WHO/GPA:	World Health Organization/Global Program on AIDS
UNICEF:	United Nations International Children's Fund

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SUMMARY OF THE MAIN FINDINGS OF THE STUDY

- A total of 505 individuals (166 Males in the age group 12-24 & 339 Female in the age group 15-49) were included in the survey. Nearly 71% of the respondents were in the age group 12-22, while the 8.3% are above the age of 34.
- Almost three two third of the respondents are never married. While, more than eight five percent are follower of the Orthodox Christian religion.

Awareness and Behavior towards HIV/AIDS

- Considerably high proportion of the study population (92.7%) knows about (heard about) HIV/AIDS.
- Radio, television and Anti AIDS clubs were identified as the major source of information on HIV/AIDS. While, More than 85% of the respondents have access to a functioning radio at home.
- Discussion about HIV/AIDS within family and between partners is found to be low. In this regard it is only 59% of the respondents reported that, HIV/AIDS has been raised as an issue and discussed with family members.
- The level of perceived vulnerability to HIV/AIDS is very low among the study population. Where only 50.2% feel at risk for HIV/AIDS.
- Despite the low level of perceived risk venerability to HIV/AIDS a considerable proportion of the respondents (85.5%) indicated that they have modified their behavior to avoid risk of HIV infection.
- Many people do know about condom but only 28.3% ever used condom.

Findings Related to Voluntary Counseling and Testing

- About 83% of the respondents know about whether one can check his/her HIV status or not and almost similarly proportion know where the VCT service is available.
- Radio and Health personnel, are indicated as the major source of information about the availability of the service.
- Out of those claimed to be aware of the VCT service, the overwhelming majority (83%) said that hospital is the preferred site for the service.
- More than ninety four percent of the respondents felt that VCT service is necessary. Desire to know the HIV status and avoiding risk behavior are the

two common reasons cited by the majority of those who knows about the service.

- Almost half of the respondents said that, every body should be tested for HIV. While commercial sex workers, youth, and couples before marriage are the other groups indicated to need the VCT service most.
- Abstaining from sex, avoiding pregnancy, looking for medical care, teaching others, and using condom are the most frequently mentioned measures to be taken by the respondents if identified themselves are HIV positive.
- Practically all (99.3%) of the respondents said that said that using the VCT service is not something to be afraid off. However, a quarter of them are not ready to tell their decision to be tested for anyone.
- Nearly three fourth of the respondents believe people will have negative attitude towards those who will be willing to be tested and disseminate rumors against them if they know that they have gone for the test.
- The person will be considered as having the virus, he/she will be considered as having promiscuous behavior or having multi-partner sexual contact, he/she will be regarded as a person having no confidence on what he/she did before, he/she will be outcasted by the community, are some of the rumors and fears that people forwarded about the person who would go for HIV test.

In conclusion, though the level of knowledge about HIV/AIDS among the study population seems to be high, there are still misconceptions and misinformation about the pandemic. Furthermore, it was identified that there are factors (concerns and issues) associated with the accessibility, acceptability and utilization of voluntary counseling and testing (VCT) service. To address these concerns and issues and reduce the stigma that prevails in the town associated with the disease and the service utilization an intensified IEC activity is recommended.

1. STATEMENT OF THE PROBLEMS & RATIONALE FOR THE STUDY

HIV/AIDS has become a prevalent disease and presents a global problem. Its impact if not controlled, will be profound and is considered to be highly destructive. It is fast spreading and expected to become the main causes of death among youth and middle age adults (highly productive and reproductive members of the society) (**Assefa B., 1994**).

UNAIDS estimate that globally there were 36.1 million HIV infected adults alive as of December 2000, nearly four times the number in 1990. The African continent particularly the Sub Saharan African countries are the most affected regions of the world (of the total HIV infected adults 25.3 million live in sub Saharan African countries) holding about 70.1 percent of all HIV infected individuals (**UNAIDS, 2000**).

Ethiopia is one of these countries that are affected by this rapidly spreading pandemic. The disease was only known in the country in 1984 and now it is spreading at an alarming rate. There were 83,487 cases of AIDS reported to the Ministry of Health since the beginning of the AIDS epidemic through June 2000. The true number of AIDS cases since the beginning of the epidemic in Ethiopia is not known, but probably numbered about 400,000 by the end of 1999 (**MOH, 2000**). In the same year it is estimated that there are about 2.6 million people living with HIV/AIDS (2.4 million adults and 250,000 children). This number is expected to grow to more than three million by the year 2006 (**MOH, 2000**). In terms of absolute number of people infected, Ethiopia ranked third next to South Africa and Nigeria, which has about 4.2 and 2.7 million HIV, infected people respectively.

As would be expected, HIV prevalence was low at its initial stage, in 1980's, and the increase has become rapid since the early 1990's. In 1989 adult prevalence was 2.7%, raised to 7.1% in 1997 and reached to 7.3% by the year 2000. Marked variation is also observed between urban and rural HIV/AIDS prevalence rates (13.4 percent verses 5 percent rural) (**MOH, 2000**). This means that for every 13

adults, one is infected and in urban areas one every 6 adult carry the AIDS causing virus in his/her blood.

The devastating effect of HIV/AIDS in getting more and more visible through time, about 1.2 million Ethiopians are estimated to have lost their lives due to HIV/AIDS from the beginning of the epidemic to 2000 and as the result life expectancy is said to have reduced from 50 years to 42 years. To day as much as 42 percent of the hospital beds in the country are estimated to be occupied by AIDS patients, draining the scarce resource allocated for the health sector. By causing a progressive rise in the death of infants and children, AIDS has further threatened many of the recent gains of child survival programs. An increase in both proportion and absolute number of HIV related chronic and resource-draining disease like TB is also another observation made by some researchers. **(MOH, 2000)**

Apart from its effect on the sectors mentioned above, AIDS would affect the economic development of the country in many ways. However, the loss of young adults in their most productive years of life is certainly the major one. With the continuing spread of the disease the industrial and agricultural sector of the economy will be the two most affected sectors of the country's economy **(MOH, 2000)**

Disruption of the family tie, increasing the number of orphan children (900,000 AIDS orphans are estimated to exist in the country by 2000), **(UN 2001)**. Increase in the number of street children, raising the burden of women and stress to the extended family etc. are some of the observed social effect of this progressively increasing pandemic **(MOH, 2000)**.

If it continues unchecked, HIV/AIDS will alter the path of the countries development by retarding growth, weakening human capital, discouraging investment, exacerbating poverty and inequality, and leaving the next generation increasingly vulnerable to the impact of the epidemic **(NAC, 2001)**

Recognizing the seriousness of the problem, the government of Ethiopia has established a national HIV/AIDS control program under the Ministry Of Health to coordinate intervention activities including the control programs undertaken by government, NGOs and other partners. Further, two medium term prevention and control plans were deigned and implemented between 1987 and 1996. However, the efforts made through several intervention programs were said to have low impact and the involvement of the public at the community level was said to be minimal. With the intention to strengthening the already initiated activities, the government commitment towards fighting the spread of this deadly epidemic is further expressed with the formulation of the HIV/AIDS policy in August 1998 and the establishment of National HIV/AIDS prevention council in April 2000 (**MOH, 2000; NAC, 2001, MOH 1998**)

The situation of HIV/AIDS in Bahir Dar Town,

The prevalence of HIV/AIDS in Bahir Dar town as estimated from the sero survey result of ANC attendants of Bahir Dar Health center indicated that, the town has the highest sero prevalence rate (20.8 percent) from the whole country. Furthermore, the sero surveys on HIV prevalence conducted among sex workers in Ethiopia from 1988 to 1999 showed that, the rate for Bahir Dar town was the highest during the whole period and has shown a progressive rise i.e., from 35.9 percent in 1988 to 69.4 percent in 1991. This is an indication of the fact that HIV/AIDS is becoming a serious threat to the public and is affecting a considerable proportion of people in the reproductive age category (**MOH, 2000**).

The annual report for reportable disease from the federal Ministry of health further showed that in 1998 about 14.9 percent of all reported AIDS cases are from Amhara national regional state (**MOH, 1999**). This coupled with the other risk factors like the prevalent early marriage, large influx of people to urban areas associated with the rapid growth of the town, availability of large number of commercial sex workers and low status of women is said to have greatly

contributed and contributing for the "high" prevalence rate of HIV/AIDS in the area.

Voluntary Counseling and testing

Voluntary Counseling and Testing (VCT) is one of the many different strategies stipulated in the policy and strategy documents, for the prevention and control activities that are planned to be carried out and currently undergoing at the national level (**NAC, 2001, MOH 1998**) The role VCT can play on HIV/AIDS prevention and control is said to be multifaceted, many indicated that VCT can be considered as entry point to prevention and care, medical care, for preventing mother to child transmission of HIV infection (PMCTC) interventions, for ongoing emotional and spiritual care and social support (**UNAIDS, 2000**). Hence, the need for expansion of VCT service and stimulating its utilization is outlined as a priority intervention area and as an entry point for HIV prevention, through creating more personal awareness and care (**NAC, 2001**).

However, despite the widely acclaimed and important contribution VCT can have in the prevention and control of HIV/AIDS, and the observed growing demand for the service (**NAC, 2000**), HIV testing may have far reaching implications and consequences for the person being tested. Although there are important benefits to knowing one's HIV status, HIV infection in many communities, is a stigmatizing condition, and this can lead to negative outcomes for people following testing. Stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid to seek HIV service because they fear stigma and discrimination from their families and communities. (**UNAIDS, 2000**) Furthermore, fear and stigmatization associated with HIV testing can minimize public acceptance of the VCT, dwarfing the role the service can play in prevention and control initiatives.

Apart from the social implication the HIV testing could have and the weakness observed in the existing service delivery points (**NACS, 2000**) findings of the few studies conducted in Ethiopia revealed that, other factors like lack of awareness about the mode of transmission of the disease (HIV/AIDS), lack of perceived benefit for having the HIV test, limitation related with the economic and physical access to the service etc. are some of the factors that can contribute for the low utilization of the already available services (**Michael, 2001**). However, none of the very few studies conducted so far in the country tried to give a comprehensive overview about the factors affecting the accessibility and acceptability of this widely acclaimed but scarce and underutilized service.

Hence, this study was done with the main purpose of filling the knowledge gap in identifying the factors that affect the accessibility and acceptability of VCT services and the result obtained from the study is utilized to forwarded recommendations that can be implemented by FGAE North Western branch.

2. OBJECTIVES

2.1 Major Objective

The study has the main objective of identifying factors (determinants) that affect the accessibility and acceptability of VCT Services for HIV/AIDS, in Bahir Dar Town.

2.2 Specific Objectives

- To assess the knowledge, attitude and practice of the community towards HIV/AIDS and VCT service
- To identify barriers and concerns related to VCT and its use.
- Based on the study findings to forward practicable recommendations for action.

3. DEFINITION OF KEY TERMS

HIV Counseling: HIV counseling has been defined as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and to take personal decisions related to HIV/AIDS (**WHO/GPA, 1994**)

Voluntary Counseling and Testing (VCT): VCT is the process by which an individual undergoes counseling enabling him or her to make informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential (**UNAIDS, 2000**)

4. REVIEW OF LITERATURE

Historical Perspective

Publicly funded HIV antibody counseling and testing service were initiated in USA in March 1985 to provide an alternative to the donation of blood as a means for high-risk persons to determine their HIV status. At that time, little was known about the prevalence and natural history of HIV infection. Counseling was considered as an essential adjunct to HIV testing. The counseling addressed the accuracy and consequence of test and was deigned to help persons interpret the meaning of positive and negative results. HIV counseling was based on the recognition that learning HIV status may be difficult for certain clients (**U.S. Department of Health & Human Service, May 1994**)

In 1987, with increased understanding about the scope and severity of the HIV epidemic and the predictive value of positive test, HIV counseling and testing were expanded. Persons seeking care for sexually transmitted infections, family planning, childbirth, or substance abuse were counseled and tested in an attempt to reduce their risk for HIV transmission. "The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others" (**U.S. Department of Health & Human Service, May 1994**)

The Situation of Voluntary Counseling and Testing (VCT) Service in Ethiopia

In Ethiopia HIV counseling service began in the late 1980's with services expanding throughout the 1990s. In the early 1990s several national level training programs were conducted by MOH and other NGOs like Christian Relief and Development Association (CRDA) and Organization for Social Service for AIDS (OSSA) for nurses and social workers from all regional hospitals and Addis

Ababa. About 3000 counselors were trained, however, as to how many of the trainees are currently on the job is not known **(NAC, 2000)**.

In addition to setting counseling services in health institutions, the Ministry of health collaborates with other NGOs to provide social services for PLWHA. A situational analysis conducted in September 2000, regarding VCT service revealed that there are 80 institutions in the country providing either HIV testing or counseling or both. The assessment further identified that few of the health facilities have full time counselors, referral system for HIV positive individuals to care and support centers and to other institutions involved in the VCT service is not well developed, there is no system to monitor and evaluate VCT services and the majority of health facilities have shortage of test kits **(NACS, 2000)**.

Further assessment reveals that demand for HIV testing is growing but service provision by government health facilities is limited due to shortages of physical facilities, test kits and trained manpower **(NACS, 2000)**.

Importance of having VCT service

HIV voluntary Counseling and testing (VCT) have been shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point for care. VCT provides people with an opportunity to learn and accept their HIV status in a confidential environment with counseling and referral for ongoing emotional support and medical care. People who have been tested seropositive can benefit from earlier appropriate medical care and interventions to treat and /or prevent HIV-associated illnesses. Pregnant women who are aware of their seropositive status can prevent transmission to their infants. Knowledge of HIV aerostats can also help people to make decisions to protect themselves and their sexual partners from infection. A recent study has indicated that VCT may be a relatively cost effective intervention for the prevention of HIV transmission **(UNAIDS, 2000)**. Several studies have demonstrated that VCT can prevent HIV transmission among sero discordant couples. There have also been some studies showing

significant behavior change in individuals following VCT. A recent multi-site study conducted in Kenya, United Republic of Tanzania and Trinidad has provided data on the role of VCT in HIV prevention and its cost effectiveness compared with other HIV prevention interventions. This study demonstrated that VCT significantly reduced sexual risk behavior - specifically, unprotected sex with non-primary partners, with commercial sex workers, and among couples who have been tested and counseled together. The study also showed that VCT could be cost-effective in terms of the cost per HIV infection averted. For example, The cost per client for VCT was \$29 in the United Republic of Tanzania and \$27 in Kenya, and was more cost-effective when targeted to HIV-positive persons, couples, and women. **(UNAIDS, 2000; Sweat ML et al, 2000).**

In general VCT can be considered as an entry point to prevention and care, medical care, for prevention of mother to child transmission of HIV infection (PMCTC), for ongoing emotional and spiritual care and social support. **(UNAIDS, 2000).** Hence, the need for expanding VCT service and stimulating its utilization is outlined as a priority intervention area and as an entry point for HIV prevention, through creating more personal awareness, and care **(NAC, 2001).**

However, Counseling services have been slow to gain acceptance in many countries, especially where HIV is highly stigmatized and access to services and support for HIV infected individuals is limited. Indeed, HIV testing has often been used as a diagnostic tool to confirm symptomatic AIDS. But a growing number of studies attest to the value of counseling and voluntary HIV testing in largely healthy populations. These services have been shown to contribute to an increase in safe behavior at the individual level, and are likely also to reduce the ignorance, fear and stigma associated with HIV infection in the population at large **(UNAIDS, October 1999).**

Factors affecting Uptake of the VCT

Although VCT is becoming increasingly available in the developing and middle-income countries, there is still great reluctance for many people to be tested. There are several possible contributing factors that must be addressed if VCT is to have an important role in HIV prevention and care.

In this regard studies showed that HIV testing might have far reaching implications and consequences for the person being tested. Although there are important benefits to knowing one's HIV status, HIV infection, in many communities, is a stigmatizing condition, and this can lead to negative outcomes for people following testing. People with HIV may experience social rejection and discrimination (**Karim Q., Karim S., Soldan K., Zondi M. 1995**). As the result stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. Many people are afraid to seek HIV service and decline service because they fear stigma and discrimination from their families and communities. Societal attitude towards HIV can have a strong impact on individual choices, and if people known to have HIV face discrimination and stigma, VCT is unlikely to be a popular intervention (**UNAIDS, 2000**).

The findings of studies outlined that protection and support of vulnerable women who test seropositive must be considered when developing VCT services. In Zambia, women said that it was thought to be shameful to have HIV, and if they were known to be seropositive, they worried that they would suffer discrimination. Studies from Kenya have also shown that women may be particularly vulnerable following VCT and in some cases have lost their home and children or have been beaten or abused by their husbands / partners if their status become known (**Temerman M. et. al 1994**). There is currently some evidence that, in highly stigmatized societies, women who believe themselves to be at high risk of infection are less likely than low risk women to choose to be tested for HIV infection or to come back for their test result (**UNAIDS, 1999**). In this regard,

unless women and their partners fully understand the benefits of an HIV test, they are unlikely to choose to have one. A negative result allows an individual to act to avoid infection in the future. It will also allow a woman to breastfeed, confident in the knowledge that it is the best for her child **(UNAIDS, 1999)**.

In some countries people with HIV are subject to discrimination at work or education. Unless legislation is in place to prevent this, some people will be reluctant to undergo VCT **(UNAIDS, 2000)**. Even in areas where VCT services are available, uptake of services is often poor. A common barrier for VCT is the lack of perceived benefit **(Baggaley R, et al, December 1995)**. If VCT is linked with medical care, and effort is made to improve medical services for people with HIV, this will help to reduce this barrier to testing. Offering interventions to prevent MCTC (mother to child transmission) can also be recognized as a major benefit of VCT **(UNAIDS, 2000)**.

Similarly, preliminary result from a large MCTC program in Botswana shows a relatively low uptake of VCT during the first eight months of operation. This was said to be due to fear of seropositive result, lack of facilities where partners can receive counseling and testing, worry about partners' reaction about the lack of effective treatment available for infected women and themselves **(Mazhani L et al, 2000)**. Uptake of VCT in other operational settings varies considerably in the UNICEF/UNAIDS MCTC pilot sites. Difference in testing schedules, maturity of the epidemic, seroprevalence in the community and attitudes to and availability of VCT in the community are thought to be important. It is also proposed that counselors' attitudes towards testing at the sites may be a key factor in uptake **(UNAIDS, 2001)**.

Furthermore, uptake of VCT in communities is said to be dependant on societal factors as well as factors associated with delivery of service. There may also be great differences in the theoretical and actual uptake rates. For example in Lusaka when students were asked if they wished to be tested for HIV there was

a very high rate of interest. When the service was provided initially, uptake was very low. However, with time, there has been increasing demand for VCT in Lusaka (**Baggaley R et al 1997**). Another study from Zambia examined the readiness to utilize the VCT services offered to 4812 participants from rural and urban sites. Although 37% initially expressed willingness to use VCT service only 3.6% actually came for VCT (**Rosenvard K et al., 1998**).

A study conducted in Uganda showed that interest in VCT is often "social", with clients showing interest in knowing their sero status before getting married, embarking on a new relationship, or making plans for the future. Premarital testing has increased over time and no doubt explains the increasing percentage of couples who come together. "Medical" reasons for VCT, such as feeling ill or having symptoms of AIDS, are cited less frequently (**UNAIDS, 1999**).

HIV testing in Bahir Dar

Blood-testing facility for HIV is available in Bahir-Dar Felege Hiwot hospital. According to the information obtained from the hospital, during the period that extend from September to April 2001, 785 individuals visited the HIV testing facility of the hospital, and it was indicated that most visited the center for a pre marital HIV screening (**FGAE, July 2001**). This is an indication of the fact that, the demand for the service is showing a progressive rise in recent time.

5. SOURCE OF DATA AND METHODS

5.1 Study Area

Description of the Study Area

Bahir Dar town is the capital city of the Amhara National Regional State. Administratively the town is divided into *seventeen* Kebele, and has a total population of 138,671 (*2001 projection*) with sex ratio of 1.0 male to 1.13 female. The age distribution of the population indicated that about 41,509 (29.9 percent) are female in the age group 15-49 while youth/ male in the age group 12-24 account for 18.6% percent of the population. (**Population Bureau of the Amhara National Regional State, 2001**).

5.2 Source and Study Population

Members of the community in the age group 12-24 (Males) and 15-49 (females) who are residing in the two randomly selected Kebeles from Bahir Dar town at the time of the survey were the source of population for the study. While people in the mentioned age group, residing in randomly selected households of the two study Kebeles and are willing to participate in the study were the study population.

5.3 Study Design

The study is a community-based cross sectional survey with both quantitative (descriptive) and qualitative components.

5.4 Sampling Unit

Households were the sampling unit for the community-based (descriptive) study while youth (in-school and out of school youth), attendants of FGA Bahir Dar clinic (both ANC followers and FP program attendants), commercial sex workers,

street children, students Bahir Dar University were the sampling unit for the qualitative study.

5.5 Sample Size Determination & Sampling Procedures

Sample size of **478** (323 for female in the age group 15-49 & 155 for male in the age group 12-24) is obtained from the calculation obtained using stat calc (**EPI info version 6**) for population survey/descriptive study using random sampling procedure (1993) and based on the following assumptions:

- Size of the target population:

Number of female age 15-49 years, living in Bahir Dar town (**N=41,509**) & youth male in the age group 12-24 (**N=25,739**)

- Expected frequency of the subject under study:

Risk perception towards HIV/AIDS (**22%**), a figure obtained from the findings of a similar study

- Worst acceptable frequency of risk perception towards HIV/AIDS 17.5% for female and 15.5% for male
- 95% confidence level

A systematic random sampling procedure was used to identify the study population for the community-based study. While, five to ten discussants were included in each sessions of focus group discussion.

For the qualitative study a total of seven focus group discussions (home and hotel based commercial sex workers, male and female youth, street children, youth male and female college students, and MCH followers) were conducted.

5.6 Questionnaire & Data Collection Instruments

A structured questionnaire prepared in Amharic was used to collect information for the descriptive part of the survey. While FGD guide was utilized for the qualitative study.

5.7 Data Collection And Management

Twenty-six interviewers, eleven males and fifteen females were recruited and trained for two days on the content of the questionnaire and interviewing techniques. Male interviewers interviewed male respondents, while female interviewers interviewed female respondents. Supervisors and the principal investigator closely followed the day-to-day data collection process.

Seven focus group discussions sessions were conducted with home and hotel based commercial sex workers, male and female youth, street children, youth male and female college students, and MCH followers. On average each FGD session took one hour. The principal investigator and his assistants conducted the FGD sessions. While, FGD guide and note taking is used as a data collection tool.

5.8 Entry and Exclusion Criteria

Information using questionnaire was collected from female in the age group 15-49 years and male between 12-24 years who are available in the sampled households, located in the two randomly selected Kebeles during the survey period and are willing to participate in the study are included in the survey. While people who are sick or unable to communicate for different reasons will be excluded from the study.

5.9 Ethical Considerations

Households and individuals were enrolled into the study after obtaining their prior consent. Information was provided to all on the objective of the study. Maximum effort was made to maintain privacy during interview and confidentiality of information was assured by omitting names of the study subjects from the questionnaire.

5.10 Ensuring Data Quality and Processing

Four supervisors closely followed the day-to-day data collection process and ensure quality of the data as well as its completeness and correctness. Data was entered and stored into a computer, and the EPI INFO Version 6.0 statistical packages was applied for the data analysis.

6. MAJOR FINDINGS OF THE STUDY

6.1 Socio-demographic characteristics

A total of 505 individuals (166 Males in the age group 12-24 & 339 Female in the age group 15-49) were included in the survey. Nearly 71% of the respondents were in the age group 12-22, while the 8.3% are above the age of 34.

Of the total individuals included in the study, 65% were found to be never married while 18.8% reported currently married. Two hundred and forty eight (49.1%) of the study subjects were attending school during the survey. While almost 62 percent have above elementary school level education.

Four hundred and thirty (86%) follows Orthodox Christian religion. Nearly forty four percent, 21% and 15% of the study subjects identified themselves as students, self-employed and jobless respectively. (Table 1).

6.2 Awareness And Behavior Towards HIV/AIDS

- About 92.7% (468) of the study population know (heard about) HIV/AIDS.
- Radio, television and Anti AIDS clubs are identified as the major source of information on HIV/AIDS for 81%, 45% and 21% of the study population respectively. While schools, health workers and friends are identified as the other common source of information regarding HIV/AIDS.
- More than 86% of the respondents have claimed to have an access to radio at home.

Table 1: Socio demographic characteristic of study population, Bahir Dar town, Amhara National Regional State, October 2001

Socio Demographic Characteristics	Number	Percentage
Sex	N = 505	
Male	166	32.9
Female	339	67.1
Age	N = 505	
12-17	163	32.3
18-22	194	38.4
23-27	76	15.0
38-33	30	5.9
35-40	29	5.7
41+	13	2.6
Marital status	N=505	
Married	91	18.8
Never Married	328	65.0
Divorced	28	5.5
Widowed	17	3.4
Separated	7	1.4
Others	34*	6.8
Religion	N = 505	
Orthodox	434	85.9
Moslem	54	10.7
Protestant	14	2.8
Catholic	1	0.2
Other	2	0.4
Education	N =505	
In School	248	49.1
Out of School	257	50.9
No formal education	61	12.1
1 - 6	107	21.2
7 - 8	94	18.6
9 - 12	219	43.4
12 +	23	4.6
Occupation	N = 505	
Jobless	75	14.9
House wife	51	10.1
Student	220	43.6
Govt. employee	34	6.7
Self employed	106	21.0
Others	19	3.8

* Includes those who did not revel their marital status

Table 2: Knowledge about HIV/AIDS and source of information of the study population; Bahir Dar Town, Amhara National Regional State.

	Number	Percentage
Availability of radio in the house	N=505	
Yes	435	86.1
No	70	13.9
Know about HIV/AIDS	505	
Yes	468	92.7
No	37	7.1
Source of regular information about HIV/AIDS	N=505*	
Radio	410	81.2
Television	228	45.1
News paper	106	21.0
Leaflets	84	16.4
Health workers	67	13.3
Church	52	10.3
Mosque	13	2.6
School	91	18.0
Friends	54	10.7
Families	25	5.0
Work place	12	2.4
Anti Aids club	106	21.0
Aids day calibration	31	6.1
Discuss with family members about HIV/AIDS	N=468	
Yes	275	58.8
No	193	41.2
Discus with partner/ boy or girl friend about HIV/AIDS	N=468	
Yes	139	29.7
No	61	13.0
I do not have regular partner	197	42.1
No answer	71	15.2

* Multiple answers

- Discussion about HIV/AIDS within family members and between partners is found to be low. It is only 59% of the respondents reported that, HIV/AIDS has been raised as an issue and discussed it with family members, while only 29.7% of the respondents reported that they have discussed HIV/AIDS with partners. (Table 2)

Table 3: Risk perception towards HIV/AIDS and measures taken to avoid HIV transmission among the study population, Bahir Dar town, Amhara National Regional State, October 2001

	Number	Percentage
Feel at risk for HIV infections	N= 468	
Yes	235	50.2
No	171	36.5
I do not know	62	13.3
Modify risk behaviors to avoid exposure to HIV infector	N =468	
Yes	400	85.5
No	68	14.5
Feel that AIDS is a pressing problem in the society	N =468	
Yes	427	91.2
No	33	7.1
I do not know	8	1.7
Types of behavioral change made to avoid risk to HIV	N =400 *	
Abstain from sex	181	45.3
Use condom	76	19.0
Avoid unsafe injection	108	27.0
Avoid sharing sharp objects	201	50.3
Avoid alcohol and <i>chat</i>	29	7.3
Measures felt necessary to avoid HIV transmission	N = 468*	
Abstain from sex	233	49.8
Use condom	243	51.9
Limit with one partner	307	65.6
Establish faithful relationship	49	10.5
Avoid sex with prostitutes	19	4.1
Avoid receiving blood	28	6.0
Avoid unsafe injection	54	11.5
Avoid mosquito bites	17	3.6
Avoid sharing sharp objects	138	29.5
Others	10	2.1
Healthy looking person can carry HIV	N =468	
Yes	369	78.8
No	48	10.3
I do not	51	10.9
AIDS virus can be transmitted from Mother to child	N =468	
Yes	413	88.2
No	33	7.1
I do not know	22	4.7

* Multiple answers

- The level of perceived vulnerability to HIV/AIDS is very low among the study population. Only 50.2% feel are at risk for HIV/AIDS whereas 36.9% do not feel at risk of HIV. However, a considerable proportion (91%) feel that AIDS is a pressing problem to their respective community. (Table 3)
- Despite the low level of perceived vulnerability to HIV/AIDS, a considerable proportion of the respondents (85.5%) indicated that they have changed their behavior to avoid the risk of HIV infection. Of those who claimed changed behavior to avoid the risk of HIV infection, 50% have reported to have stopped sharing with others sharp (cutting and piercing objects), 45% abstained from sex, 27% avoided unsafe injection and 19% started using condom. (Table 3)
- Limiting oneself to a single trusted sexual partner, using condom, abstaining from sex, avoiding sharp objects are the most frequently mentioned measures that has been taken to avoid contracting HIV. Furthermore, the response obtained from some of knowledge questions revealed that, about 79% of those who claimed to be aware of HIV/AIDS said that a healthy looking person can carry the AIDS causing virus and 413 (88.2%) said AIDS virus can be transmitted from mother to her child. (Table3).
- A great majority of the respondents (90.7%) reported to have some knowledge about how to delay or prevent pregnancy and almost the same proportion know about condoms, while only 70% of these ever seen a condom. The further, assessment made on the utilization of condom reveled that, out of those who claimed to have seen condom, 143 (40.1%) reported to have ever used condoms. (Table 4)

Table 4: Sexual practice of never married people and knowledge and utilization of condom and other reproductive behaviors of study population, Bahir Dar town, Amhara National Regional State, October 2001

	Number	Percentage
Have boy (girl friend (lover)	N=362	
Yes	84	23.2
No	278	76.7
Have had sex with boy/girl friend	N=84	
Yes	62	73.8
No	22	26.2
Have had sex with other person other than regular partner	N=84	
Yes	21	25.0
No	63	75.0
Have more than one sexual partner	N=62	
Yes	10	16.1
No	52	83.9
Know how to delay or prevent pregnancy	N =505	
Yes	458	90.7
No	42	8.3
No answer	5	1.0
Ever heard about condom	N = 505	
Yes	458	90.7
No	41	8.1
No answer	6	1.2
Ever seen condom	N = 505	
Yes	357	70.7
No	116	23.0
No answer	32	6.3
Importance of using condom	N =458	
Protect from STI's	190	41.5
Protect from HIV/AIDS	332	72.5
Protect from unwanted pregnancy	218	47.6
Ever used condom	N =357	
Yes	143	40.1
No	210	58.8
No answer	4	1.1

* Among those who are willing to tell their condom usage

- Questions posed to the never married and to those who did not revealed their marital status, to assess their sexual practice indicated that about 84(23.2%) have lovers (boy/girl friend) and out of whom, 73.8% said to have had experienced sex with their partner. About 25% of the respondents revealed

that they had sex with other persons other than their regular partners and 16% reported that they have more than one sexual partner at the moment.

(Table 4)

Table 5: Attitude of the study population towards People Living With HIV/AIDS, Bahir Dar town, Amhara National Regional State, October 2001

	Number	Percentage
	N=468*	
Willing to eat together with an AIDS patient	364	77.8
Willing to share drinking cup with an AIDS patient	360	76.9
Willing to give care for an AIDS patient	408	87.2
Not willing to have any type of contact with an AIDS patient	60	12.8
Believe that AIDS patients should be isolated from the society	55	11.8

* Multiple answers

- Misperceptions about HIV/AIDS are widespread in the study area. About 23% and 23.1% of the respondents have said that they are not willing to eat together and share drinking utensils with an AIDS patient, respectively. Similarly, 12.8% do not want to have any type of contact with an AIDS patient and 12% believe that AIDS patients should be isolated from the society.

(Table 5)

6.3 Findings Related to Voluntary Counseling and Testing

- Around 83% of the respondents know about whether one can check his/her HIV status or not. Similarly 82% indicated that they know where to get the VCT service or where VCT service is available in Bahir Dar. Radio and Health personnel are identified as the major sources of information about the availability of the service, with 45% and 43.5% of respondents mentioned these respectively. (Table 6)

Factors Affecting Accessibility and Acceptability of VCT Services in Bahir Dar

Table 6: Knowledge and attitude related to VCT service of the study population, Bahir Dar town, Amhara National Regional State, October 2001

	Number	Percentage
Know that one can check his/her HIV status	N = 505	
Yes	418	82.8
No	28	5.5
No answer	59	11.7
Know about the availability of VCT service	N=505	
Yes	414	82.0
No	89	17.6
No answer	2	0.4
Source of information about the availability of VCT service	N = 414	
Health personnel	180	43.5
Radio	186	45.0
Friends	68	16.4
Neighbors	53	12.8
School	56	13.5
Family Guidance Association	59	14.3
Sites where one can get the service	N =414 *	
Hospital	363	87.7
Health center	96	23.2
Private clinic	32	7.7
Family Guidance Association	72	17.4
Red cross	10	2.4
Other	14	3.4
Preferred location for VCT	N = 414	
Hospital	343	82.9
Private clinic	6	1.4
Health center	31	7.5
Family Guidance Association	24	5.8
Other s	10	2.4
Feel that VCT service is necessary	N=414	
Yes	390	94.2
No	19	4.6
I do not know	5	1.2
Reason for thinking that VCT is necessary	N=390*	
To know HIV status	326	83.6
To avoid risky behavior	212	54.4
To ensure HIV status	84	21.5
To take better care for partner (if positive)	4	1.0

* Multiple answers

- The Bahir Dar Felege Hiwot hospital and the Health center are the two sites where the majority of the respondents identified as places where one can get VCT service. Similarly, about 17.4 percent indicated FGAE as a source of information about the VCT service. (Table 6)
- Out of those claimed to be aware of the VCT service, the overwhelming majority (83%) preferred the hospital as a site for the service, whereas 7.5% and 5.8% indicated the health center and FGAE as the preferred location for the VCT respectively. (Table 6)
- Further probing question regarding the felt importance of the VCT service revealed that, 94.2% believe that VCT service is necessary. Desire to know HIV status and avoiding risk behavior are the two common reasons stated by 83.6% and 54.4% of those who know about VCT. (Table 6)
- The response to the question on when to use VCT has revealed that, 52.4% believed the service should be used at any time. However, about 6.5% indicated that VCT service should be used only when feeling sick. The need for using the VCT service before marriage is mentioned by 33.8%. (Table 6)
- When asked about readiness to use the VCT service, 94.4% of those claimed know HIV/AIDS expressed their willingness to use the service and, 76.7% said that, they are ready to pay for the service. Out of the 359 who expressed their readiness to pay for the service, 87.7% indicated that they could afford to pay from one to ten birr. (Table 7)
- Knowing HIV status, avoiding risky behavior, and taking a better care for self and partner are the most frequent reasons forwarded by the respondents about the importance of using VCT service. (Table 7)

Table 7: Perception and attitude towards HIV testing and its outcome of the study population, Bahir Dar Town, Bahir Dar town, Amhara National Regional State, October 2001

	Number	Percentage
Time where one has to be tested	N = 414*	
At any time	217	52.4
When feeling sick	151	36.5
Before marriage	140	33.8
If only has MPSC	57	13.8
Willing to use VCT service		
"If made available free of charge "	N = 468	
Yes	442	94.4
No	26	5.6
Willing to pay for the service	N=468	
Yes	359	76.7
No	109	23.3
Amount of Money ready to pay for VCT service	N=359	
1 -5	279	77.7
5 - 10	36	10.0
11- 20	27	7.5
21 - 50	7	1.9
51 - 100	10	2.8
Reason for being ready to use the VCT service	N =442*	
To know HIV status	442	100
To avoid risky behavior	5	1.1
To take better care for self	7	1.6
To take better care for my partner	2	0.5
Willing partner to use VCT service	N =468	
Yes	447	95.5
No	21	4.5
Reason for allowing partner to use the service	N=447*	
To know the health status of both of us	447	100
To get married with confidence	4	0.9

*** Multiple answers**

- For the question, who do you think is the section of the society who needs the VCT service most? About 50% of the respondents said that, every body should be tested, while commercial sex workers (33.8%), youths (31.6% and couples before marriage (16.7%) are the other groups indicated need the VCT service most. (Table 7)

Factors Affecting Accessibility and Acceptability of VCT Services in Bahir Dar

.....continued table 7: Perception and attitude towards HIV testing and its outcome of the study population, Bahir Dar town, Amhara National Regional State, October 2001

	Number	Percentage
Who are the people who need HIV test if the service is made available	N =414*	
Everyone	205	49.5
Female sex workers	140	33.8
Drivers	44	10.6
Students	44	10.6
Pregnant woman	12	2.9
All adults	14	3.4
Children	18	4.3
Couples before Marriage	69	16.7
Youth	131	31.6
People with of unprotected sexual	41	9.9
Measure a person should take if fund he/she is HIV positive	N =414 *	
Abstain from sex	221	53.4
Avoid pregnancy	52	12.6
Avoid Marriage	31	7.5
Get Divorced	20	4.8
Use condom	70	16.9
Look for medical case	101	24.4
Commit social	17	4.1
Revel status to other	116	28.1
Teach others	9	2.2
Care for self	5	1.2
Be more religion	2	0.5
Others	2	0.5
Measures a person should take if found self is free from HIV	N=414*	
Will be careful to avoid the risk of HIV	358	86.5
Will stat to use condom	34	8.2
Will get married	71	17.1
Will abstain from sex	41	9.9
Will avoid risky behaviors	115	27.8
Will get married	1	0.2

* Multiple answers

.....continued table 7: Perception and attitude towards HIV testing and its outcome of the study population, Amhara National Regional State, September 2001

	Number	Percentage
Measure to be taken if found oneself is HIV positive	N = 414*	
Stop sex	188	45.4
Avoid pregnancy	44	10.6
Avoid marriage	28	6.8
Get divorced	13	3.1
Start to use condom	52	12.6
Look for medical can	87	21.0
Teach others	149	36.0
Take betters care for self	7	1.7
Teach others	1	0.2
Will beg god for forgiveness	1	0.2
Other	2	0.5
Types of measures to take if reveled that partner is HIV positive	N =414	
Stop having sex	123	29.7
Avoid pregnancy	47	11.4
Avoid marriage	34	8.2
Get divorced	56	13.5
Start to use condom	64	15.5
Look for medical care	52	12.6
Will check my blood	144	34.8
Will take care of partner	214	51.7
Will stop having any contact	21	5.1
Other	52	12.6

*** Multiple answers**

- When asked about what measures people should take if identify as having HIV in their blood, 53.4% said that, should avoid sex if found HIV positive, while 28.1% and 24.4% said that people who identify themselves as having the AIDS causing virus in their blood should revel their status and look for medical care respectively. (Table 7)
- Abstaining from sex, teaching others about the disease, looking for medical care, start using condoms and avoiding pregnancy are among the mentioned measures to be taken by the respondents if find out that they are HIV positive. (Table 7)

- Respondents were asked about the measures they would take if their partner is found HIV positive and accordingly 51% said, would take the necessary care for their partner, 34.8% indicated that they would check their HIV status, and 29.7% said that they would stop having sex with their partner. (Table 7)
- About 87 percent of the respondents from both groups indicated that they would be careful and avoid risky behaviors if found are HIV negative. (Table 7)
- Practically all (99.3%) of the respondents who are aware of VCT said that volunteering to be tested is not something to be afraid of. However, about 27% of them are not ready to tell other about their decision to have an HIV test. Fear of rejection by community and uncertainty about the outcome of the result are the two major reasons given by respondents who are not willing to tell about their decision to be tested to others. (Table 8)
- Despite their reluctance to tell others about their decision to be tested, about 80.2% of the respondents said that what ever the outcome would be; they are ready to revel the result of their HIV test. Fear of rejection by the society or the stigma associated with HIV positive status is the main reason given by the respondents for deciding not to tell their HIV status to others. (Table 8)
- When asked about the attitude of the community towards those who would go for the test, about 73.2% believe that people will have negative attitude towards those who will be willing to be tested and disseminate rumors against them if they know that they have gone for the test. (Table 8).
- The person will be considered as having the virus, he/she will be considered as having promiscuous behavior or having multi-partner sexual contact, he/she will be regarded as a person having no confidence on what he/she did before, he/she will be outcasted by the community, are some of the rumors

and fears that people forwarded about the person who would go for HIV test.

(Table 8)

Table 8: Perceived attitude of the community members towards VCT, Bahir Dar Town, Amhara National Regional State, September 2001.

	Number	Percentage
Using VCT service is something to be afraid	N = 414	
No	411	99.3
Yes	3	0.7
Perceived attitude of people towards a person who volunteer for VCT	N=414	
People would think that the person has AIDS	303	73.2
People would say nothing	19	4.6
People can have both positive and negative attitude	20	4.8
People would suspect that some thing is wrong with him/her	5	1.2
People would think that the person has no confidence on himself/herself	8	1.9
People will point their finger at him/her	2	0.5
People will not have good attitude about him/her	5	1.2
People would believe that the person is promiscuous	2	0.5
People would think that the person is courageous (Has confidence in him/herself)	3	0.7
Ready to tell others e about the decision to the test	N =414	
Yes	280	67.6
No	110	26.6
I Do not know	24	5.8
Reason for not telling others the decision to be tested	N =110	
Fear of social rejection (if the test becomes positive)	78	70.9
Fear the outcome of the result	31	28.2
I do not know	1	0.9
Ready to tell outcome (result) of the test	N =414	
Yes	332	80.2
No	43	10.4
I do not know	39	9.4
Reason for hesitating or deciding not tell the HIV test to others	N = 82	
Fear of social rejection or stigma	53	64.6
Will not tell if only I am positive	29	35.4
Reason given for the need for having HIV test before pregnancy	N = 414	
To give birth to an AIDS free child (baby)	107	25.8
Have importance but I can not give the reason	267	64.5
If positive she should not become pregnant	2	0.5
For the health of the mother and the baby	14	3.4
If free she can have the child she wanted	11	2.7
To Make sure of her HIV status	4	1.0
Other	31	7.5
I do not know	1	

- About 64.5% of the respondents believe that taking the HIV test is necessary before getting pregnant however; they failed to give specific reason for it. Whereas, 25.8% said that, by taking HIV test and by ensuring her HIV free status a mother can give birth to an AIDS free child while 3.4% said that taking the HIV test has something to contribute for the health of the mother and the child. (Table 8)

6.4 Findings of the Qualitative Study

Seven focus group discussions (home and hotel based commercial sex workers, male and female youth, street children, youth male and female college students, and MCH followers) were conducted and the findings are summarized as follows.

All the discussants believe that HIV/AIDS is a problem for their respective community and further indicated that death from HIV/AIDS is a common talk of the town. Furthermore, all agree that many people in Bahir Dar are involved in risky behaviors, having multiple sexual partner, extramarital sexual affair, unprotected sex etc. are some of the risk behaviors indicated to be common in the area.

Condom and its utilization

Level of knowledge and awareness towards the importance of condom to prevent HIV/AIDS is said to be moderately prevalent. Users could get condom, usually Hiwot Trust, easily with the least possible price everywhere including small shops. This is confirmed by female sex workers (bar and home based) of Bahir Dar town who use condoms whenever they practice sex with clients. They have enough stock of condom whether their clients came with or with out condoms.

Youth clients usually volunteer to use condoms during sexual acts while, married men aged 45 and above mostly demand to perform sex without condom and are willing to pay extra money for such service. These people believe immunity goes

hand in hand with aging if complemented by washing the genital organ with lemon or local Areki after sexual intercourse.

Farmers from surrounding areas of Bahir Dar town who are coming in market days are clients of home-based female sex workers. Since these peasants did not get adequate awareness in the area of prevention of HIV/AIDS, usually claim to make love with out condom even though told to do so immediately before intercourse.

Among the respondents of street children aged between 13-16 nearly half started doing sex but with condom. Particularly the street girls said that this their job where they generate money to buy food. While the boys indicated that they practice sex for satisfaction and when some time asked by elder girls.

Among five female college students interviewed, two reported to have experienced sex and used condom. One of those who didn't experienced sex so far has said, "I will start doing sex with my husband without condom, and of course after proving that both of us are free from AIDS". While the other two said they would use condom when they are going to start lovemaking. They all agreed blood test is the only means of knowing whether a person is free from HIV/AIDS or not. Three out of five female college students do volunteer for HIV/AIDS blood test if it is going to be provided free of charge.

Male students form higher academic institution (Bahir Dar University-technology Faculty) have indicated that they don't have the urge and confidence to buy condoms publicly fearing that they will be labeled as a womanizer and an extravagant both by the school community and by family members.

For instance, one of the students expressed his experience regarding the issue. One day his mother found a condom in his pocket when washing his clothe. He was fired from home for quite a number of weeks. This was due to the reason

that his parents believed he should never practice sex before completing his studies and for they assume that he will demand more money for such exercise. Another student also shared his experience and said "one day I was taking shower with my colleagues when the condom I had in my pocket fall down on the floor and all my friends laughed and labeled me a womanizer, since then I got that nick name."

Awareness about HIV/AIDS

For all respondents except for home based sex workers, loosing weigh, dysentery, coughing, swellings around mouth, change in the color of skin etc. are symptoms, which leads to suspicion of HIV/AIDS infection. However, these symptoms could be indicators of other diseases beside HIV/AIDS. Female sex workers for instance said these symptoms could indicate the person might have TB, Ameba, Malaria, etc. Therefore it is a hasty generalization to label a person he/she is a victim of AIDS by symptoms observed. Instead, " said the hotel based female sex workers " suspects and non-suspects should go to places where VCT services are provided and test for HIV/AIDS and know their HIV status.

Male students and home based female sex workers including street children (both sexes) don't know where VCT services are provided in town. While female college students know that Bahir Dar hospital and hospitals in Addis Ababa are providing VCT service. In fact all students have information that people who have got a chance to go abroad and volunteer would-be married partners are checking their blood for HIV/AIDS in Addis Ababa.

MCH/ANC service attendee believe that it is possible to get HIV test in Bahir Dar hospital and two of the discussants further indicated that they have heard that the service is also available in some private clinics in the town. Almost all agreed that, getting tested is very useful for the person and his/her partner whether he found to be positive or negative after the test. They further indicated that women

should only decide to become pregnant after being tested and stressed that this is very useful for the health of both the women and her child, one FGD discussant said, "I will be tested for the sake of my child". However, four of the nine discussants noted that they are not ready for the test.

Fear of the outcome of the result, uncertainty about husband's reaction and fear of rejection by the community are some of the reasons given by the women for not deciding to be tested. One of the four discussants who refused to be tested, "I am not willing to be tested not only because of fearing the social consequence, but also because I do believe that the hospital environment by itself is risky for HIV infection."

Particularly home based female sex workers who were less active to read and express their mind during the interview seem that they have very limited knowledge about the importance of VCT service. However, they are willing to learn and be aware about the where about of the service and the benefits that could be acquired.

When female sex workers and street children were asked whether they're voluntary or not to go for VCT service. Most said that we do volunteer and some aren't. The former support the idea that they want to know whether they are free or not, while the later rather pose a question that if we are positive who is going to take care of us since our job which is associated with sex is getting our livelihood (in fear of loosing or not having clients).

Those female sex workers who are supporting the idea of going to VCT justify by saying that if the result is negative it is a blessing and an encouraging result that would help the person either to withdraw from the job and look for other or to continue using condom. Whereas if the result is positive, does not mean it is the end of life and hope rather would alert the person either to stop doing sex or

practicing with condom with his/her sex mate and get a continues counseling for life to smoothened and sustain.

Therefore, the female sex workers indicated that the service should be started as soon as possible so as to save the generation. But they said that, before the commencement of the service the concerned stakeholders should device a means and a strategy that could create a condition where the future life and destiny of female sex workers is well taken care of.

Some hotel based female sex workers and female street children said that they are not ready to go for VCT even if it is provided free of charge. They believe that free medical service would not come up with reliable results. One female sex worker said that, "since the physician are providing service without pay; I do not think we will get a reliable result from the HIV test. This is the information and experience we had for any type of medical service rendered freely".

The male students from higher academic institutions are not willing to go for the service of VCT. They indicated that the result would be negative or positive the initiative by itself has a negative connotation or implication which would led to be labeled as a potential victim of HIV/AIDS that in turn affect the image and reputation of the student then after.

Moreover, if the result happened to be positive he/she would be marginalized by the school community and by the general public as well. Some people had committed suicide because they reveled that they are positive. There would also be a possibility of vengeance upon the society at large, which would aggravate the danger of HIV/AIDS, which is already a rampant killer, and non-curative disease in the contemporary world, they said.

When indicating about the stigma or social persecution associated with being HIV positive or an AIDS patient, the women group discussants said, In this town

if people know that you are HIV positive, they would avoid you, unwilling to have any contact with you, will not even look at you properly. Almost similar type of expression is used by street children to indicate how much AIDS patient are isolated in the community.

The male college students indicated that no body would volunteer for such a service unless the government and/or other concerned organization intervened in awareness creation programs and socio-cultural and socioeconomic support for those who are victim of HIV/AIDS. Awareness creation programs should cover the entire people and should be sustainable until a full guarantee of attitudinal change is achieved.

Unlike the male students, female students support the idea of HIV/AIDS test voluntarily. "Since the benefit is for both, the individual who is testing his/her blood, be the result is negative or positive, and for the society at large. The positives will be alerted and the negatives will take maximum care and the society will learn more through this process. Above all those unfortunate people who are positive should get cautious counseling service so that they can lead a sustainable life", said one female collage student and FGD particapnts.

The idea of paying for HIV test was not accepted by most FGD participants. Most indicated that they do not have the financial capacity to pay for such a service. According to some of the discussants from the different groups, asking people to pay for the service the outcome of which could be devastating is unfair. However, many of the women group FGD particapnts indicated that they are willing to pay between 5 to 50 Birr for HIV test.

7 CONCLUSION AND RECOMMENDATION

HIV voluntary Counseling and testing (VCT) has been shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point for care. VCT provides people with an opportunity to learn and accept their HIV status in a confidential environment with counseling and referral for ongoing emotional support and medical care. People who have been tested sero-positive could benefit from earlier appropriate medical care and interventions to treat and /or prevent HIV-associated illnesses (UNAIDS, 2000).

In view of this fact, the Family Guidance Association of Ethiopia (FGAE) is in the process of establishing voluntary counseling and testing (VCT) service in the Bahir Dar town, the capital of the Amhara National Regional State. UNICEF has contracted FGAE to implement the program. The main targets of the program are targeting women in the reproductive age group and youth aged between 10 and 24 years. Before the commencement of the program it is found necessary to conduct a study on factors affecting accessibility and acceptability concerning voluntary counseling and testing (VCT).

Accordingly the results of the cross-sectional survey have identified a very high level of awareness about HIV/AIDS, (92.7% Know about HIV/AIDS) with a very low level of perceived vulnerability to HIV/AIDS (50.2% feel are at risk for HIV/AIDS). This high level of awareness about HIV/AIDS and the corresponding low level of perceived vulnerability among the general public were also reported in various studies conducted elsewhere in the country. For example the result of one nationwide survey (**Policy Project, September, 2000**) had revealed that between 93% of the rural and 98% of the urban study subjects were aware of HIV/AIDS. However, only 35% of the urban and 42% of the rural study subjects were reported vulnerable to HIV/AIDS. Similarly a recent VCT study (**Michael, 2001**) conducted in Dire Dawa revealed a high level of awareness about HIV/AIDS (97.0%) and a low level of risk perception (26.8%).

Some of the attitude questions posed to the respondents indicated the level of affirmative attitude of the respondents towards people living with HIV/AIDS is not as widespread as that of the level of awareness about the disease. For instance, about 13% of the respondents claimed to be aware of HIV/AIDS reported that they are not willing to have any type of contact with People Living With HIV/AIDS (PLWHA), while about 12% believed that PLWHA should be isolated from the rest of the community. However, this finding shows a better level of attitude among the target population as compared to the similar findings of study conducted in Dire Dawa (**Michael Dejene, 2001**), where 22% of the respondents expressed their unwillingness to have any type of contact with an AIDS patient.

The low level of risk perception and the associated negative attitude observed among the respondents towards PLWHA could be a good indication of the fact that apparently high level of awareness about the disease is not sufficient enough to bring the desired level of change in perception and attitudinal about the disease. In this regard much has to be done to educate the people about the modes of HIV transmission.

It is also identified that a high level of awareness about condom and moderate level of condom utilization among the target population. This finding has similarity with that of the nation wide condom survey in which awareness about condom was between 93% and 95% in an urban setup (Addis Ababa and Debre Berhan). (**Policy Project, September 2000**). However, the moderate level of reported condom use in the study is a little higher as compared to the finding of the nation wide condom survey where 33% of the respondents reported ever use of condom. Surveys conducted in Sub Saharan Africa also showed that despite the relatively high levels of knowledge among young people about HIV/STIs, still many engage in risky behaviors, with fewer than 10% of the sexually active adolescent females in Sub Saharan Africa reporting condom use (**UNAIDS, 2001**).

However, participants of the qualitative study, particularly the female sex workers, noted that their young clients usually volunteer to use condom during sexual acts while married men aged 45 and above mostly prefers to perform sex without condom for which are willing to pay additional money. There is a widely spreaded belief among this group that immunity goes well along age if complemented by washing the genital organ with lemon or local liquor (Areki) after sexual intercourse. Misconceptions like this are also reported in high prevalence among the general public.

The high level of awareness about condom but the reported low utilization rate coupled with the wide spread misconceptions about its protection capacity is an indication of the fact that high risk behavior capable of propagating the disease is still widely practiced in the area. This calls for a well-organized and vigorous IEC through meetings and/or discussion sessions to the commercial sex workers and their potential clients in the effort to bring about behavioral change. The commercial sex workers should also be trained on how to disseminate information and education pertaining to HIV/AIDS and skill to negotiate on how to perform safe sex.

Although the majority of the focus group participants' mainly male students and home based commercial sex workers including street youth (both sexes) stated that they do not know where VCT services are provided in town. However, the findings of the questionnaire survey showed that there is a substantial level of apparent awareness about the availability of VCT services in Bahir Dar town.

The hospital is the commonly mentioned place where the majority of survey respondents have identified as a site where VCT service is provided. However, health facilities like the health center and FGAE clinic where the service is not actually available are also mentioned by 41.6% of the respondents as a site where the service is available. This reflects the fact that, many people have incomplete (inadequate) knowledge about the whereabouts of the service and

many take VCT service synonymous with the conventional blood testing facility where HIV testing takes place without other related services.

Apart from the non-availability of VCT service in many developing countries for the youth, when asked about whether or not they are willing to take the test, most of them reported ready to be tested and wish the service to be more widely available. In the pilot phase of a study of young couples in rural areas of Western Kenya, of those participated 95% reported would accept a free HIV test. However, when asked a small payment for the service (a \$4 fee), the potential demand reduces significantly down to 31-40% (**Damesyn et al., 1998**). Unlike the findings of the above study, a high level of willingness to utilize the service as well as readiness to pay for service is reported in a survey that is conducted to assess barriers and concerns related to VCT and its utilization in Dire Dawa (**Michael, 2001**).

The findings of this study with regard to demand and willingness to pay for the service is not different from the above cited findings (practically the findings of the study conducted in Ethiopia). Accordingly the finding of the study showed that demand for VCT is high with 94.2% of the respondents feel the service is necessary and same proportion (94.4%) expressed their willingness to use the service if made available free of charge. Furthermore, a higher proportion of the study subjects (95.5%) said that they would allow their partner to use the service and quite a substantial proportion of those who have expressed willingness to use the service reported their readiness to pay for it. However, the majority of the respondents (88%) reported could only pay an amount in the range of one and ten Birr.

These findings suggest that the demand for the service is high in Bahir Dar (particularly among the study population) and could be taken as an indication of the level of awareness of the study population both about the disease and the importance of having the HIV test. In this regard the need to an organized and

well equipped VCT centers in an attempt to address the felt needs should be given a prime attention. Furthermore, enhancing the capacity of the health facilities in terms of the needed laboratory equipment and ensuring the regular and adequate supply of HIV test kits that would be required to perform VCT should be ensured. In this connection, qualified counselors and laboratory technologists are much required.

However, the high level of willingness observed among the respondents to use the service "if made available" and to pay for it, should be interpreted with caution and the introduction of fee for this essential but not widely known service should be adequately thought about before anything is done in this regard. This is said because of the fact that many studies conducted elsewhere in Africa have shown that uptake of VCT in communities is dependent on social factors as well as factors associated with delivery of service. There may also be great differences in theoretical and actual uptake rates. For example in Lusaka when students were asked if they wish to be tested for HIV high rate of interest has been manifested. However, the uptake was very low when the service was made available initially. But, with time, there has been increasing demand for VCT in Lusaka, **(Baggaley R et al., 1997)**. Another study from Zambia examined the readiness to utilize the VCT services offered to 4812 participants from rural and urban sites. Although 37% initially expressed willingness to use VCT service only 3.6% actually came for VC, **(Rosenvard K et al., 1998)**. A study conducted in Uganda showed that Interest in VCT is often "social", with clients showing interest in knowing their serostatus before getting married, embarking on a new relationship, or making plans for the future. Premarital testing has increased over time and no doubt explains the increasing percentage of couples that come together. "Medical" reasons for VCT, such as feeling ill or having symptoms of AIDS are cited less frequently **(UNAIDS, 1999; 2)**.

Sharing HIV status is not only important in enabling people to receive emotional support from family and friends and help in future decision making, it also reflects

people's ability to understand and accept their HIV status (**UNAIDS, 2001**). Fear of rejection by the society or the stigma associated with HIV positive status and fear of the outcome of the result were the main factors affecting acceptability of VCT. For example, in a study from Uganda, 22 families with 1 or more adult members with HIV were interviewed about their responses to HIV and stigma (**McGrath et al., 1993**). Approximately half of the PLHA interviewed said that had not informed any of their family members, and indicated that they feared family members would worry or would not understand. Some said that they feared rejection if their families knew of their positive status.

In this study, the same were found be the major reasons for non-willingness of people to tell their decision to be tested. The findings of the VCT survey conducted in Dire Dewa (**Micahel, 2001**) has also shown fear of discrimination and stigma associated with the disease are the reasons sited by many for not being ready to tell others about their decisions to be tested. This fact is an indication of the need for an intensive and continuous education about HIV/AIDS among community members before embarking on a wide scale VCT service.

Based on these findings it can be concluded that though the level of knowledge about HIV/AIDS among the study population seems to be high, there are still misconceptions and misinformation about the pandemic. Furthermore, there are factors associated with the accessibility and acceptability of voluntary counseling and testing (VCT). All these concerns and issues have to be addressed through culturally sound and viable IEC and counseling strategies. In other words, IEC need to be intensified to reduce the stigma that prevails in the town. User friendly and quality VCT services have to be expanded and the existing facilities need to be strengthened to address the challenges.

Finally it will be reasonable to implicate that, FGAE North Western Branch has a **grater** role to play in sensitizing the people particularly the youth and women in the reproductive age group about HIV/AIDS and VCT. Furthermore, a joint effort has

to be made and means be designed by all the concerned on how to reach the mariginalized section of the community (female sex worker and street children) with HIV/AIDS related information and VCT service. The need for reaching collage students through a well deigned comprehensive and sustainable IEC activities that give prime attention on awareness raising about HIV/AIDS and VCT is not an area to be overlooked.

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ANNEX 1. Questionnaire

**bFÝdÿnt y.drG yMKRÂ ydM MRm% xgLGlÖTN btmlkt
ytzUj ymr© msBsbpÃ**

KFL xND"- x«ÝSY mr©			
001			qblª _____ . ybaT qÜ R _____ .
002	ò-		wND 1 saT 2
003	:D»		xmT
004	(yUBÒ hùnª-) bxhùnù wQT ÆLTÄR nãT?	ÆLTÄR nÝ 1	tlÄYtÄL 5
		xGBc½ xSWQM 2	lªS (YgLI) 6
		TÄÊ ftÖlhù 3	_____ .
		äèB¾L 4	
005	(yhYÿñT hùnª-) hYÿñTä MNDnW?		ârèiKS KRStEÄN 1
			ÑSlpM 2
			Pét½S-NT 3
			µèlpK 4
			lªS (YgLI) 5
006	yTMHRT hùnª- (yTMHRT dr©)		bTMHRT SY Älù 1
			kTMHRT baT WÄ 2
			¥NbBÄ méF y¥YCL 3
			mdb¾ TMHRT ÄLtk-tlù GN ¥NbBÄ méF y,CL 4
			mdb¾ TMHRT ktk-tlù Ä«ÄqqÜT KFL Y«qS 5
007	bxhùnù wQT bMN S% SY ts¥RtêL	S% ylªlW 1	bGL S% y,tÄd,, 5
		ybaT XmbªT 2	lªS kl YgLI 6
		t¥¶ 3	_____ .
		ymNGST tqè¶ 4	
008	ÊD×N xSChù?		xlN 1
			ylNM 2
KFL hùlT"- xªDSN btmlkt			
009	xªDS Sl,ÆlW b>- ÄWÝlù?		xä 1
			xSWQM 2
			xSWQM µlù wd Äq½ qÜ_R 17 YzlL

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010	Sl x ^o DS xB ² WN gpz ^o TMHRT y,ÄgßùT (y,sÑT) kyT nW? l^oSS? hùlùNM mLiC mZGB''''	%Dx 1 t ² l ^o vpiN 2 Uz ^o È 3 b ^o ¶ {ùhùæC 4 y ^o « ^o Â ÆlÑÃæC 5 b ^o «tKRStEÄN 6 mSgþD 7	T/b ^o T mMH ^o N 8 kÛd@c ² 9 kb ^o «tsic ² 10 kS ^o i- 11 k{rx ^o DS wÈèC KbB 12 bx ^o DS qN bxL ŠY 13 l ^o Š (YgLI) 14 .
011	x ^o DSN lmkŠkL MN MN ¥DrG XNd,gÆ bþzrZ,,LÝ?	yGBr SU GnùÝnT xl¥DrG 1 bGBr SU GNßùnT gpz ^o ÷NiM m«qM 2 xND lxND bmwsN 3 lFQr ³ ã -¥Ý bmçN 4 kbù ^o b ^o T s ^o èC UR GnùÝnT Äl¥DrG 5 dM ÆlmqþL 6 N{ùH ÆLçn mRØ ÄlmwUT 7 kTNÝ NKš X ^o :SN mkŠkL 8 MŠu ^o Ä Sl-M ngéCN mU ^o :TN ¥SwgD 9 l ^o Š (YgLI) 10	
012	« ^o n ³ y,mSL sW yx ^o DS ŠYrS bdÑ WS lpñrW YCŠL BlW ÄMÄlù ?		xã 1 xYCLM 2 xŠWqM 3
013	yx ^o DS ŠYrS kXÄT wd LJ y,tŠlF YmSLã-L?		xã 1 xYmSlÝM 2 xŠWQm 3
014	XRSã X ^o :Sã bx ^o DS ŠYrS ym«ÝT :DLã MN ÄHL nW? L«Ý xLCLM YŠlù wYS bÈM L«Ý XCŠlhù YŠlù?		L«Ý xLCLM 1 L«Ý XCŠlhù 2 xŠWQm 3
015	XRSã bGLã X ^o :Sã kx ^o DS lmkŠkL ÄdrçùT yEH¶ lWöC xlù ?		xã 1 ylM 2 yIM ìlù wd Äq² qÜ R 17 Yzll
016	ÄdrçùècWN yEH¶ lWöC YzRZ,,?	yGBr SU GnùÝnT Äl¥DrG 1 ÷niM m«qM 2 n{ùH (xÄþS) ÆLçn mRØ ÄlmwUT 3 MŠu ^o Ä l ^o löC Sl-M ngéCN ÄlmêÈS 4 l ^o Š (YgLI) 5	
017	bb ^o T WS kb ^o «tsBã (wŠiCã) UR Sl x ^o DS b>- twÄY-Chù -WÝŠChù?		xã 1 xÄWQm 2
018	kTÄR Ùd ³ ã (FQr ³ ã) UR x ^o DSN mkŠkL Sl,òLÈcW mNgìC twÄY-Chù -WÝŠChù?		xãN 1 xÄWQm 2 TÄR (FQr ³) ylÝM 3
019	yx ^o DS b>- bx ^o µÈbþÄChù kFt ³ CGR nW BlW ÄSÈlù?		xã 1 xYdlM 2

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		x\$WQM	3
020	bxuÆbpã bxαDS ytÄz sW bpñR kzþH b-C ktzrz,,T WS yT@cÜN xBrW lYDrG fYdß¼ nãT (MRÅãCÜ Ynbbù)	xBé mB\$T xBé m«ÈT sp-mM/ST-mM XNKBubα YDrG kxαDS b>t¼ UR MNM xxYnT GNßùnT YDrG FÝd¼ 4 xYdlùM	1 2 3
021	yxαDS b>t©C kþBrtsbù mglL xlÆcW BlW ÄMÀlù?	xã x\$MNM x\$WQM	1 2 3

KFL fST"- ySntêLi ÆBRÄTN btmlkt			
022	XRGZÂN YzGyT wYM mk\$skL XNd,ÒL ÄWÝlù?	xãN x\$WQM	1 2
023	Sl ÷NiM sMtW ÄWÝlù?	xãN sMc½ x\$WQM	1 2
024	÷NiM xYtW ÄWÝlù?	xYc½ x\$WQM xYc½ xWÝlhù Sl÷NiM x\$WQM μlù wd Äq _____ YZllù	1 2
025	y÷NiM _QM MND nW BlW ÄSÆlù? (lα\$S)	÷NiM kxÆ\$zR b>- Yk\$sk\$L ÷NiM kxαDS ŠYrS Yk\$sk\$L ÷NiM XRGZÂN lmk\$skL Y«Q¥L lα\$ μl Y«qS ..	1 2 3 4
026	XRSã wYM ytÝ%np Û- Ûd¼ã ÷NiM t«Q¥Chù -WÝ\$Chù/ ÄWÝlù?	xãN x\$WQM	1 2
Äq½ qÜ R 27 XSk 30 \$Sgbù säC BÒ Y«yQ			
027	ysαT/ywND Ûd¼ xl>?	xãN ylÝM	1 2
028	yGBR SU GNßùnT xDRUChù -WÝ\$Chù?	xãN xDRgN xÄWQM	1 2
029	kxND bSY yÛ- Ûd¼ (FQr¼ xlãT)?	xãN ylÝM	1 2

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030	kWté Ūdā WÀ klāS sW UR yGBr SU gNBùnT xDRgW ĀWÝlù?	xāN xŠdrGkùM xŠWQM	1 2 3
bfÝdÝnT y.drG yMKRĀ ydM MRm% xgLGlÖTN btmlkt			
031	xND sW bdÑ WS_ yxāDS ŠYrS mñ,,NĀ xlmñ,,N lÝrUg_ y,ÖlW mNgD y,ñR YmSLā-L?	xāN xŠWQM	1 2
032	bfÝdÝnT sl.drG yMKRĀ ydM MRm% xgLGlÖT mñ,,N sMtW ĀWqÛ nbR?	xāN sMc½ xŠWQM sMc½ xŠWQM ìlù wd Āq½ qÛ R 36 YzlL	1 2 2
033	l_Āq½ qÛ_R 32 mLsù xāN kçn YHN mslù xgLGlÖT mñ,,N k¥N sÑ?	k«Ā ĒlÑĀ kĒĀp× kÜd¾ü k_r bāT ktMHRT bāT lāS ìl YglA	1 2 3 4 5 6 .
034	l_Āq½ 33 mLsù xāN kçn xgLGlÖtÛN yT ¥GBT XNd,ÖL bþzrZ,,LÝ	çSpE-L «Ā ĒbþĀ yGL KlþnþK ybātsB mM¶Ā KlþnþK qY mSgL lāS ìl YglA	1 2 3 4 5 6
035	bFÝdÝnT y.drG yMKRĀ yMRm% xgLGlÖTN lmS«T ybl« y,mr«W i- yT nW BlW ĀSĒlù	çSpE-L KlþnþK «Ā ĒbþĀ lāS ìl YglA	1 2 3 4 .
036	yxāDS ŠYrS bxND sW dM WS_ mñR Ālmñ,,N lÝrUg_ y.drGw ydM MRm% bRSā xmlþkT xSfSgþ nW YSlù?	xā xSfSgþ nW xĀSfLGM lāS YglI	1 2 3
037	y dM MRm%W xSfSgþ nW ìlù MN _QM y,s_ YmSLā-L? (YzRZ,,LÝ)	ŠYrsù māZ xlmĀZN lÝwQ lwdōT lm«NqQ lāS YglI	1 2 3
038	y dM MRm%W xĀSfLGM ìlù MKNĀTā MNDN nW ?	_____ _____ _____	. . .

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039	xND sW MN gþzª (MN spçN) nW dÑN ¥SmRmR ÅlbT BlW ÅSÆlù?		b¥N³WWM gþzª 1 bHmM gþzªª (bb>¬ gþzª) 2 UBÒ kmf{Ñ bõT 3 lª\$ (YgLI) 4
040	bfÝdÝnT y,drG yMKRÂ ydM MRm% xgLGlÖT bnÉ y,s_ bþçN MN ÉYnT sãC bQD,Å mmRmR xlÆcW BlW ÅSÆlù? lªSS? hùlùNM mLiC mZGB'''	hùlùM sW 1 ybùÅ bªT sªèC 2 èØéC 3 t¥¶ãC 4 nFs«ùéC 5 xêqE sãC 6	HÉÂT 7 xÄpS tUbþãC 8 wÈèC 9 lªSS 10 _____ .
041	xND sW bdÑ WS_ yxªDS ŠYrS bMRm% bþgÝ MN ¥DrG (MN RM© mWsD) xlbT BlW ÅSÆlù? lªSS? hùlùNM mLiC mZGB'''		yGBr SU GnùÝnT mtW 1 XRGZÂN mk\$Kl (mtW) 2 ÅlYgET 3 mÍ-T 4 ÷NiM m«qM 5 yHKMÂ XRÄ¬ ¥GßT 6 %SN mGdL (¥ ÍT) 7 lª\$ Y«qS 8 _____ .
042	XRSã tmRMrW ŠYrsù bdmã WS_ ÆYgÝ («ªn³ bþçnù) MN ÅdRULù?		%sªN m«bQ XjM%lhù 1 ÷NiM X«qÝlhù 2 TÄR XY²lhù 3 GnùÝnT x\$ðRGM 4 lª\$ (YgLI) 5
043	lmùlª ÅHL XRSã ydM MRm% tdR LãT yxªDS ŠYrS bdmã bþgÝ MN RM© YwSÄlù? (MN ÅdRULù) lªSS? hùlùNM mLiC mZGB?'''		yGBr SU GnùÝnT mtW 1 XRGZÂN mk\$Kl (mtW) 2 UBÒN mtW 3 mÍ-T 4 ÷NiM m«qM 5 yHKMÂ XRÄ¬ ¥GßT 6 lª\$ YgLI 7
044	lmùlª yTÄR Ùd³ã (FQr³ã) dM WS_ yxªDS ŠYrS bMRm% bþgÝ XRSã MN ÅdRULù? lªSS? hùlùNM mLiC mZGB'''		yGBr SU GNnùnT xÌRÈlhù 1 XRGZÂN Xk\$K\$lhù 2 x\$gÆM 3 XÍ-lhù 4 ÷NiM X«qÝlhù 5 HKMÂ Xk-t\$lhù 6 y%spN dM xSmrM%lhù 7 lÜd³ü XNKBµbª xdRULhù 8 ¥N³WWM GNnùn-CNN xÌRÈlhù 9 lª\$ (YgLI) 10 _____ .

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045	<p>bfÝdÝnT y.drG yMKRÂ ydM MRm% xgLGlÖtÜ bzþH xQ%bþÃ bnÉ y,s bþçN (bMKRÂ MRm%) bxgLGlÖtÜ t«Ý, lmçN fÝd% YçÂlù?</p> <p>LMN .</p>	<p>xã 1 fÝd% xLçNM 2 XRG«% xYdlhùM (x\$WQM) 3</p>
046	<p>l_Äq% 45 mLs xãN kçN wYNM FÝd% xYdlhùM kçN MKNÂTân YglALÝ</p>	<p>_____ . _____ .</p>
047	<p>yTÂR Ûd%ã (FQr%ã) yxgLGlÖtÜ t«Ý, XNDTçN (XNÂþçN) YfQÂlù?</p> <p>LMN .</p>	<p>xã 1 xLfQDM 2</p>
048	<p>l_Äq% 47 mLs xãN kçN wYNM FÝd% xYdlhùM kçN MKNÂTân YGl{ùLÝ</p>	<p>_____ . _____ .</p>
049	<p>lzþH xgLGlÖT m«n% KFÃ XNÂþkFlù bþ«yqÜ lmKfL fÝd% YçÂlù?</p>	<p>xã 1 xLkFLM 2</p>
050	<p>MN ÄHL BR lmKfL fÝd% YçÂlù?</p>	<p>BR _____ .</p>
051	<p>YHN yMKRÂ yMRm% xgLGlÖT m«qM y,ÄSf% ngR nW BlW ÄSÆlù?</p>	<p>xÄSf%M 1 ÄSf%L 2 bÈM ÄSf%L 3</p>
052	<p>ÄSf%L µlù LMN? MKNÂTân bþzrZ,,LÝ</p>	<p>_____ . _____ .</p>
053	<p>lmúlª xND sW dñN l¥SmRmR MRm% ¥:kL mýçN sþsñ sãC lsWyW wYNM lsªTyê y,ñ%çW xStÄyT MN lþçN YC\$L BlW YgM-lù?</p>	<p>_____ .</p>
054	<p>XRSã MRm%WN lÝDrG bþwSnù WúnªãTN llª\$ sW YnG%lù</p>	<p>xãN 1 xLnGRM 2</p>
055	<p>l_Äq% qÜ_R 54 mLsù xLnGRM kçN MKNÂtÜ MNDnW?</p>	<p>_____ .</p>
056	<p>yMRm%WN W«ªT llª\$ sãC lmNgR FÝd% nãT</p>	<p>xãN 1 FÝd% xYdlhùM 2</p>

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057	FÝd¾ xYdlhùM µlù MKNĀTā MNDnW?	_____.
058	kXRGZĀ bōT ydM MRm% ¥DrG _QÑ MNDnW BlW ĀSÆlù	_____ _____ _____.