

**KNOWLEDGE, ATTITUDE AND PRACTICE TOWARDS VOLUNTARY
HIV COUNSELLING AND TESTING SERVICES AMONG HIGH
SCHOOL ADOLESCENT STUDENTS IN METTU TOWN, OROMIA
REGIONAL STATE.**



BY

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RESEARCH REPORT TO BE SUBMITTED TO DEPARTMENT OF EPIDEMIOLOGY,
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MPH).

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JIMMA ETHIOPIA

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Abstract

Background: Voluntary HIV counseling and Testing (VCT) is a process by which an individual undergoes counseling to enable informed about HIV status. This Voluntary counseling and testing (VCT) is a corner stone for successful implementation of prevention, care and support services among HIV negative and positive individuals. VCT is also perceived to be an effective strategy in risk reduction among sexually active young people. However, despite the benefits of VCT and the risks of HIV infection they are faced with, earlier studies indicate limited VCT utilization by adolescents. It is therefore important to understand the factors that influence adolescents decision to test for HIV in order to inform the design of strategies to increase VCT utilization among this population category.

Objectives: The purpose of the study is to assess adolescent students' knowledge and attitudes towards voluntary counseling and HIV testing services

Methods:- A school-based cross-sectional study was conducted from 9th -11th March, 2015 among 559 adolescent students making 99.6% response rate in Mettu town high schools, Oromia regional state, using self-administered structured questionnaires. Data was entered using Epi-Data version 3.1 and then analyzed using SPSS version 16 software. Binary and multi variable logistic regression done and the results were reported using OR and P. value, frequency tables, and chart.

Result: The findings revealed that 79.80% of students were knowledgeable about VCT services; 63.3% had favorable attitude towards VCT and 25.90% utilized the services and suggested that VCT services should be located in schools and youth clubs for better access by adolescents. Mass media were the primary sources of information cited by the participants. Multi variable logistic regression analysis with AOR showed significant association of sex, male students had utilized VHCT service about 1.80 times (1.17, 2.78) than female students. And also grade ten students about 1.98 times (1.29, 3.04), knowledgeable students about 3.45 times (1.67, 7.11), high HIV infection risk perceived students about 1.85 times (1.16, 2.94) and students with near distance of VCT center to their vicinity about 3.78 times (2.17, 6.56) utilized VCT service than those grade nine, not knowledgeable, low HIV infection risk perceived and distant VCT center students respectively at 95% CI and P. value <0.05.

Conclusion & Recommendation: Even though considerable number of the students were knowledgeable about VCT service, its utilization was very low. Voluntary counseling and testing utilization was influenced by sex, grade level, knowledge of VCT, personal risk perception and distance of VCT centre. The findings of the study clearly indicated a need for more action to increase voluntary HIV counseling and testing services utilization of adolescent students.

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Table of ContentsPage

Abstract.....	i
List of tables.....	v
List of figures.....	vi
Abbreviations.....	vii
CHAPTER ONE.....	1
1.1.INTRODUCTION.....	1
1.2 STATEMENT OF THE PROBLEM.....	3
CHAPTER –TWO.....	4
2. LITERATURE REVIEW.....	4
2.2. SIGNIFICANCE OF THE STUDY.....	6
Objectives:.....	9
3.1. General Objective:.....	9
3.2. Specific objectives:.....	9
CHAPTER –FOUR.....	10
RESEARCH METHODOLOGY.....	10
4.1 Study area and period.....	10
4.2 Study design.....	10
4.3Population.....	10
4.3.1 Target population.....	10
4.3.2 Study population.....	10
4.4 Inclusion and exclusion criteria.....	10
4.4.1 Inclusion criteria.....	10
4.4.2 Exclusion criteria.....	10
4.5 Sample size and sampling technique.....	10

4.5.1 Sample size	10
4.5.2 Sampling method	11
4.5.3 Sampling procedures	11
4.6 Data collection and data collection Instruments	14
4.6.1 Data collection	14
4.6.2 Data collection instrument	14
4.6.3 Data Collection Procedure	14
4.8. Pre-testing of the instrument	15
4.9 .Data quality management	15
4.10. Data Processing and Analysis	15
4.11. Ethical consideration	15
4.12. Operational Definition	16
CHAPTER – FIVE	18
RESULT	18
CHAPTER - SIX.....	27
DISCUSSION.....	27
CHAPTER SEVEN	30
CONCLUSION AND RECOMMENDATIONS	30
Limitation of the study	31
ANNEX.....	36

List of tables

Table 1. Calculated sample size for each school using proportional sampling, according to	12
Table 2. characteristics of study participants of Mettu town high schools, May 2015.....	19
Table 3. Knowledge, Attitude and practice towards VHCT among adolescentstudents in.....	20
Table 4. Reasons for not being tested for HIV among high school students in Mettu town,	21
Table 5. Accessibility of study participants of Mettu town high schools to VHCT service,.....	23
Table 6. Bivariate analysis of factors associated with utilization of VHCT service among	24
Table 7. Multiple logistic regression analysis of factors associated with VHCT utikization.....	26

List of figures

Figure 1. Conceptual framework of Knowledge and Attitude towards VHCT 8

Figure 2. Schematic Presentation of sampling procedure..... 13

Figure 3. Sources of information for VHCT service identified among high school students 22

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioral Surveillance Survey
CSA	Central statistics agency
FMOH	Federal Ministry of Health
EDHS	Ethiopian demography and health survey
FHAPCO	Federal HIV/AIDS prevention and control office
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
MoFED	Minister of Finance and Economic Development
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
STD	Sexually transmitted diseases
STIs	Sexually Transmitted Infections
UN	United nations
UNAIDs	United nation aid for international developments
VCT	Voluntary counseling and testing
VHCT	Voluntary HIV Counseling and Testing
WHO	World Health Organization

CHAPTER ONE

1.1.INTRODUCTION

Voluntary Counseling and Testing (VCT) is at the core of HIV and AIDS prevention, treatment and care programs. Timely access to treatment and related services requires knowledge of one's HIV status. Adolescents are at the epicenter of the HIV and AIDS pandemic. VCT is the entry point whereby people learn whether they are infected with HIV or not, and are helped to understand the implications of their HIV status and make informed choices for the future. Voluntary HIV counseling and testing (VHCT) was acknowledged as an efficacious and pivotal strategy for both HIV and AIDS prevention and care(1,2,).

Voluntary counseling and testing (VCT) is a major component of HIV prevention and care. VCT is also perceived to be an effective strategy in risk reduction among sexually active young people. HIV counseling and testing was identified as the key entry point to care, treatment and support services. It is the first gate whereby people learn whether they are infected with HIV or not, and are helped to understand the implications of their HIV status and make informed choices for the future. Voluntary HIV counseling and testing (VHCT) was acknowledged as an efficacious and pivotal strategy for both HIV and AIDS prevention and care (2,6). According to UNAIDS nearly 12 million young people, aged 15 to 24 in the world are living with HIV and AIDS, and more than 7,000 young people become infected with HIV every day (3,4). In 2008, an estimated 45% of new infections occurred globally among young people aged between 15 and 24 years (4). In 2010, young girls and young women aged 15-24 years were more vulnerable to HIV infection than older men and women (3). According to Lyons , 60% of these young people are adolescents between 14 and 19 years of age(8). As per 2013 UNAIDS gap report 15 countries account for nearly 75% of all people living with HIV, out of 4 million people aged 15-24 years living with HIV, 15-19 years adolescents accounts for 29%. In the same year there were 2.1 million new HIV cases per year. The majority of adolescents are at risk of HIV infection due to their involvement in unsafe sex (4). HIV infection from the unsafe injection of drugs, exposure to contaminated blood products or unsterilized skin-piercing procedures also put young people at risk (4). In 2007, Sub-Saharan Africa (SSA) alone had an estimated 1.7 million people who were newly infected with HIV (9).

Children and adolescents have a unique vulnerability to HIV infection. Moreover, adolescents were particularly vulnerable to HIV due to the strong influence of peer pressure, gender based violence, lack of access to education unsafe sex behavior and the development of their sexual and social identities that often led to experimentation. Counseling for safe sexual practices for adolescents is vital before initiation of sexual relations. Adolescent counseling also helps to delay their sexual debut and increases the practice of abstinence (9). Research conducted in Kenya, Tanzania, and Trinidad by family health international in collaboration with UNAIDS, WHO & the center for AIDS prevention studies (CAPS) at the university of California have shown that VCT is an effective strategy for facilitating change in behavior. VCT is also an important entry point for care and support. These findings have boosted interest and support for VCT as a valuable component of comprehensive HIV/AIDS programs among international organization, including the national AIDS programs of many countries and donors. VCT is more than drawing and testing blood and offering a few counseling sessions. It is a vital point of entry to other HIV/AIDS services, including preventing mother- to- child transmission; preventing and clinically managing HIV-related illnesses, tuberculosis control, psychosocial and legal support(9).

VCT provides benefits for those who test positive as well as those tests negative. VCT alleviates anxiety, increases client's perception of their vulnerability to HIV, promotes behavioral change, facilitates early referral for care and support, including access to antiretroviral therapy and helps reduce stigma in the community. It offers holistic approach that addresses HIV in the broader context of people's lives, including poverty and its relationship to risky practices (6). Adolescents and youths understanding of HIV transmission has particular importance for HIV prevention, because in 2008 they accounted for 40% of new HIV infections among adults worldwide. The United Nations' report indicated that, in most countries, this age group still lacked comprehensive and correct knowledge of HIV. According to the same report, less than one-third of adolescent males and less than one-fifth of adolescent females in developing countries claimed adequate knowledge about HIV (11). Ethiopia's HIV and AIDS epidemic has been heterogeneous in spread and marked with regional variations. In the last several years, the trend showed that the national level of the HIV epidemic had been stabilized (12).

1.2 STATEMENT OF THE PROBLEM

The HIV/ AIDS epidemics have been witnessed in Ethiopia for the past more than two decades. The country's adolescents are highly affected, with a prevalence rate of 4% (13). The unstable nature of their relationships exposes them to these risks, while their susceptibility to sexual abuse and lack of skills to negotiate safer sex worsen their plight. Research has also established that lack of knowledge and low perception of own risk to HIV infection actually increases adolescents susceptibility to HIV infection adds that failure to acknowledge own susceptibility to HIV infection perpetuates risky behavior by adolescents.(5) Adolescents should therefore be an important target sector of the response to the HIV and AIDS epidemic. Voluntary counseling and testing is one such response. Research supports the effectiveness of VCT in empowering individuals with information to adopt protective behavior, in order to avoid being infected with the virus, as well as in enabling people living with HIV to adopt risk-reduction lifestyles, in order to avoid infecting their sexual partners. Linked to the above mentioned benefits, VCT also enables individuals to accept a positive HIV status, an important condition in the facilitation of timely access to and adherence to antiretroviral treatment. As adolescents represent the future of any country, enabling those adolescents living with HIV to live long and productive lives should be a global priority(5).

However, despite the benefits of VCT and the risks of HIV infection they are faced with, earlier studies indicate limited VCT uptake by adolescents. It is therefore important to understand the factors that influence (or would influence) adolescents decision to test for HIV in order to inform the design of strategies to increase VCT utilization among this population category. Understanding, knowledge, attitudes and service delivery are factors that influence VHCT Utilization of VHCT services among adolescents and the public is vital because it will facilitate HIV prevention efforts in the country in general(6). However there was no study done on adolescents students' knowledge and attitude towards VHCT in Mettu town. Thus this study will provide information about adolescent students' knowledge, practice attitudes and towards VHCT that help to take the necessary action.

CHAPTER –TWO

2. LITERATURE REVIEW

2.1. VOLUNTARY HIV COUNSELLING AND TESTING (VHCT) SERVICES

VHCT is a process in which individuals or couples undergo counselling to enable them to make informed choices about being tested for HIV. The decision to be tested must be entirely the couple's or the individuals being tested (17). HIV counselling and testing have been identified as the key to prevention, care, treatment and support services. Following counselling and testing, people learn whether they are infected and are helped to understand the implications of their HIV status and make informed choices for the future. The development of affordable and effective medical care for people living with HIV is urgently needed to improve access and quality of service because of increased demand (18). VHCT is recognized as one of the few potentially effective and affordable methods for reducing the transmission of HIV in developing countries. According to the UNAIDS report, there is very little information on VHCT services and young people. As the same UNAIDS report stated, in many areas with high-prevalence rates, young people, especially young women, are at a high risk of HIV infection and yet they often have no access to VHCT services. The report described the general vulnerabilities of young people to HIV and in particular the vulnerability of young women. Nonetheless, this has not been translated into increasing access to VHCT services for the affected young people (19).

2.1.1 Knowledge of VHCT by adolescents

Examining and understanding knowledge, attitudes and service delivery factors that influence VHCT service utilization are needed to improve the use of services thereby increasing the impact in the long run. This is vital among adolescents and the public, in order to facilitate an HIV prevention effort in the country. A study done on factors determining the acceptance of VHCT in Gurage Zone, Ethiopia. The study reported that 19.3% of the respondents had not heard of VHCT in general, and the main reason for non-use among those who did know about VHCT included un-cooperative partners and self-trust (23.1%), no information on VHCT (17.8%), and lack of nearby services (13.0%). The majority of the case studies were in the age group of 15-19 years (20).

A cross-sectional survey assessing the knowledge, attitude, behavior and practice towards VHCT for HIV prevention was carried out in Gondar town, Ethiopia. In that study 4.1% and 36.1% of the urban and the rural population respectively believed that VHCT is necessary to protect oneself from infection. The findings of the same study showed 42.2% of urban and 26.3% of rural adolescents would do an HIV test if the service were made available (21).

Amsale (2002) conducted a study on the perceived sufficiency and usefulness of information, education and communication (IEC) material about HIV in Addis Ababa. The study findings indicated that 50.6% of the respondents claimed that the IEC messages and materials were enough to increase their knowledge, 49.4% of respondents reported the messages were not adequate to change their attitudes. Similarly 57.6% of respondents stated that the messages were not sufficient to make them change their attitudes or to acquire practices relevant to HIV and AIDS prevention (22).

2.1.2 Attitudes towards testing for HIV

VHCT is an important tool that allows young people to evaluate their behavior and the consequences of that behavior. However, adolescents do not usually use the VHCT services for fear of being stigmatized.(23) argue that HIV testing may be perceived as a waste of time by adolescents hence they may not use the service. This is in contrast to what Mhloyi and Mhloyi (2000) referred to when they advocated for educating young people, especially girls, to reduce the rate of new infections by about 10% among adolescents(24).

2.1.3 Factors that influence VHCT utilization

In a study done in Dire Dawa administrative council of Ethiopia on factors contributing to VHCT utilization among the youth, 2.2% of the respondents did not have any information about VHCT(25). The study done on perceptions of high school students towards VHCT in Butajujra, Ethiopia revealed that a significant number of respondents were not willing to utilize VHCT services because of stigma and discrimination. Another study also showed that individual level barriers to HIV VCT uptake consist of low risk perception, low knowledge of HIV and benefits of treatment, lack of information about how and where to access testing as well information around the test itself, stigma and concerns regarding confidentiality as a deterrent from utilizing the VHCT services(26).

2.1.4. VHCT usage

The 15-24 years age group has the highest prevalence of sexually transmitted infections, indicating high rates of unprotected sex with multiple partners. Better communication, knowledge, and improved attitude among young people decrease risky behaviors that include sexual risk-taking and substance abuse. Expanding access to youth-friendly VHCT services provides quality services where they do not exist. This could include involving the youth in the management of the clinic, to train service providers in existing clinics and enhance links and referrals among schools, and between public and private clinics. The results from recent studies done in sub-Saharan Africa revealed that high-quality VHCT is an effective strategy for reducing HIV and sexual risk behaviors among adults, little is known about VHCT for youth, especially among adolescents aged between 15 and 19 years . Studies done in several Sub-Saharan Africa countries revealed that the youth actively seek and receive VHCT, although many have expressed concerns about confidentiality, cost, access and lack of trust in their sexual partners (30, 31).

2.2. SIGNIFICANCE OF THE STUDY

Voluntary counseling and testing for HIV is a gate way to prevention, treatment and care services. It is an essential tool in the effort to control HIV/AIDS epidemic. VCT is an effective intervention strategy in reducing risk behaviors among those individuals who are at risk for infection. So, it is a vital point of entry for HIV/AIDS services including prevention of transmission and management of HIV positive people, for demand of people to know their HIV sero-status, also provides benefits for those who tested positive as well as those tested negative and offers a holistic approach that can address HIV in the broader context of peoples' lives (32).

knowledge and attitudes towards VCT services and factors influencing VHCT utilization plays a significant role in designing intervention programs related to VHCT and this in turn contributes much in the prevention and control of the HIV epidemic among adolescent students. Youths, students , constitute a significant proportion of persons affected by HIV and a good number of them are also sexually active. Knowing the benefits of VCT, it is important to determine their awareness, attitude and utilization of VCT services, willingness to undergo VCT so that barriers can be identified and interventions can be planned. However, there was no study done on high school students in this study setting.

Hence this study aimed at assessing the knowledge, attitude of high school students towards VCT service in Mettu town and provides information. And this information could assist policymakers and program planners in improving the VHCT services for adolescents in Ethiopia, in Oromia region and especially in Mettu town. The results of this study can also serve as a stepping stone for a larger more detailed study on what needs to be done to bridge the gap between knowledge, attitudes and the utilization of VHCT services.

Conceptual Framework

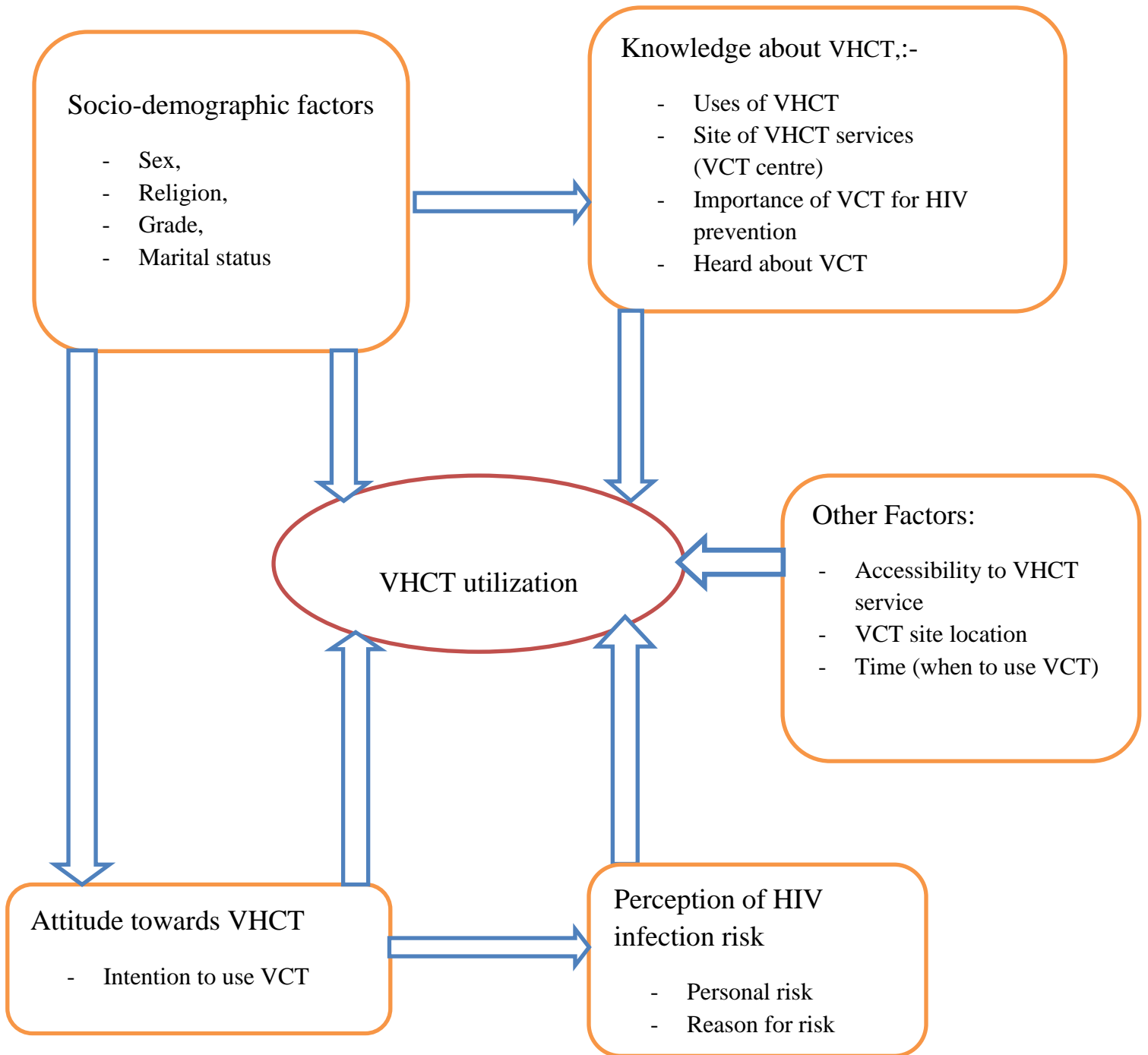


Figure 1. Conceptual framework of Knowledge and Attitude towards VHCT

Adopted from (Gatta A. Abraham Dec.2012)

CHAPTER -THREE

Objectives:

3.1. General Objective:

- ❖ The purpose of the study is to assess Mettu high schools adolescent students' knowledge, attitudes and practice towards VHCT services.

3.2. Specific objectives:

- to determine knowledge of adolescent students towards VHCT services
- to assess attitude of adolescents students towards VHCT services
- to assess practice of adolescent students towards VHCT service
- to determine factors that influence VHCT utilization service

CHAPTER –FOUR

RESEARCH METHODOLOGY

4.1 Study area and period

This study was conducted in Mettu town high schools which is the capital town of Ilu Ababora Zone and is located at about 620km South west of Addis Ababa on the main road to Gambella town. And currently the town has only two government high schools. The study was conducted from 9th-11th March, 2015 / Megabit 1st-3rd, 2007 E.C.

4.2 Study design

School based cross sectional survey

4.3 Population

4.3.1 Target population

The target population in this study were all adolescent students in Mettu town high schools enrolled in grades 9-10 for the academic year of 2007 E.C

4.3.2 Study population

The study populations were those adolescent students from whom data was collected.

4.4 Inclusion and exclusion criteria

4.4.1 Inclusion criteria

Adolescent students (15-19 years) who were at school during the study period

4.4.2 Exclusion criteria

Night time high school students were not included

4.5 Sample size and sampling technique

4.5.1 Sample size

Sample size was determined by using single population proportion

A research done on high school adolescent students in Addis Ababa, indicated that 75.7% of the adolescent students were knowledgeable about VHCT services(6)

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

d²

$$n = \frac{(1.96)^2 (0.757 * 0.243)}{(0.05)^2} = 283$$

(0.05)²

Since the total target population is less than 10,000 so that the sample size is adjusted by the finite population correction formula = $\frac{n}{1+n/N}$, $\frac{283}{1+283/2606} = 255$

$$1 + \frac{n}{N} = 1 + \frac{283}{2606}$$

Design effect was considered = $255 * 2 = 510$

Where:- n=the required minimum sample size

- level of confidence 95%, which gives the percentile of normal distribution, $Z_{\alpha/2} = 1.96$
- d (margin of error) = 0.05
- p = proportion of students VHCT = 0.757
- Estimated non-response rate = 10% = $510 * 0.1 = 51$

Based on the above assumptions, a total of 561 students were required for the study.

4.5.2 Sampling method

For the current study, a multistage sampling technique was designed to ensure the representativeness of the study population.

4.5.3 Sampling procedures

The desired sample sizes determine the number of students from each grade of both high schools based on a proportional sampling procedure.

1. The study included both high schools in Mettu town,
2. Sample from the total number of students presented in each high school was taken by using proportional sampling procedure as follows: ($n_j = N_j / N * n$)

Where n_j = students sample from each school, N_j = total number of students in each school that are included in the source population, N = total number of students in both high schools which are included in the source population, n = total sample size.

3. The total sample size to be selected for the study from each high school was proportionally allocated for both high schools and then for grades.
4. Number of sections under each grade were listed and 30% of them sampled randomly by lottery method.
5. After proportional allocation of the study subject, students were selected randomly from each sampled section by using lottery method. The method was independent simple random sampling.
6. class attendance sheet were used as frame for each section after being checked.

Table 1. Calculated sample size for each school using proportional sampling, according to the size of both high schools in Mettu town, May 2015.

Name of high school	Population size per school			Sample size per school/grade		
	Grade-9	Grade-10	total	Grade-9	Grade-10	total
Mettu high school	451	343	794	97	73	170
Abdibori high school	935	883	1818	224	165	389
Total	1386	1226	2612	321	238	559

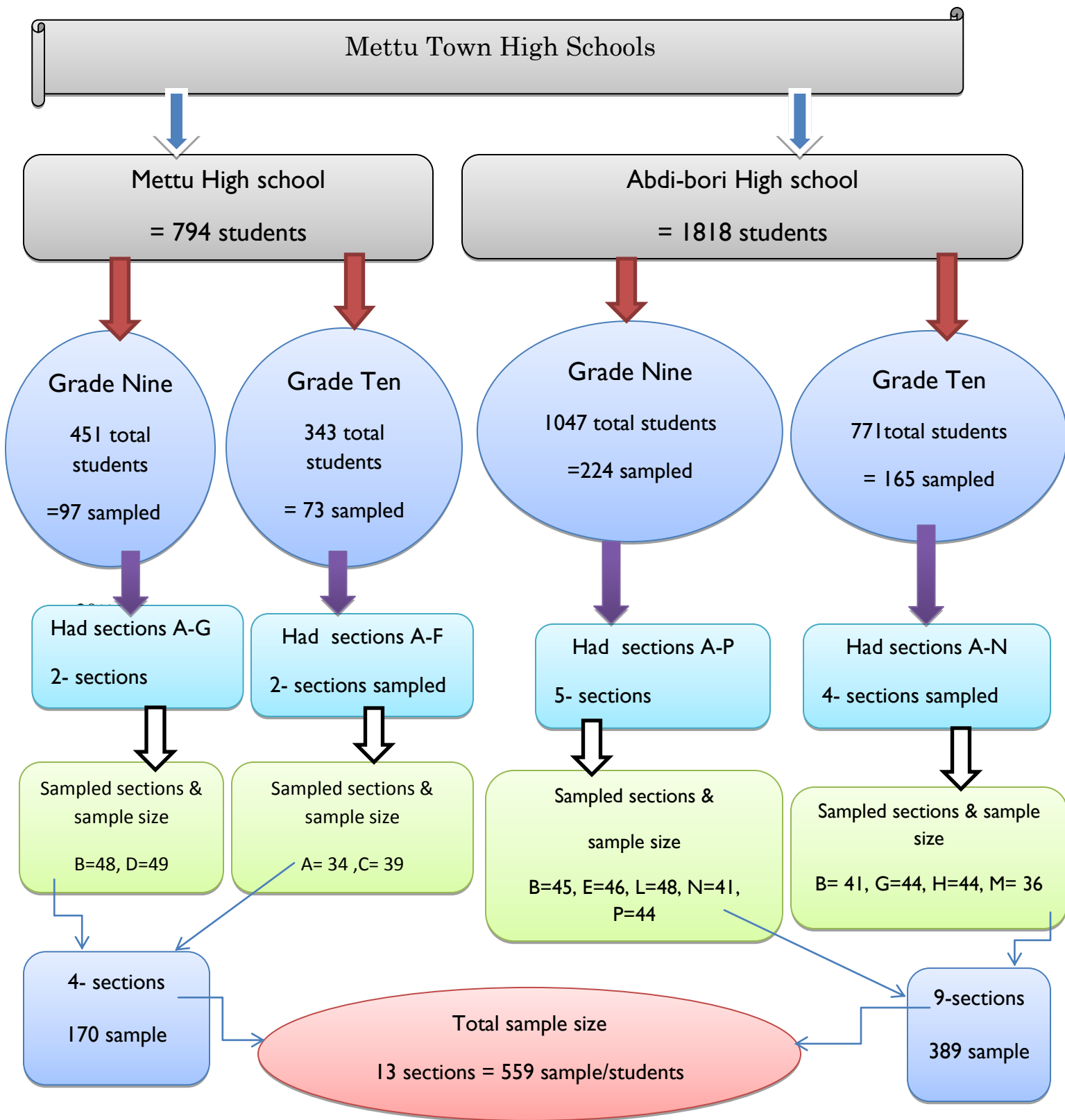


Figure 2. Schematic Presentation of sampling procedure

4.6 Data collection and data collection Instruments

4.6.1 Data collection

Structured self-administered questionnaire with few open ended questions was used to collect data for the survey. The questionnaire is adopted from previous similar studies in English, and then translated in to Afan Oromo. All information that was filled by the study subject is anonymous; there was no personal identification of the respondents to ensure anonymity of the responses.

4.6.2 Data collection instrument

Structured questionnaire with mostly close-ended questions but a few open-ended questions were included. The questionnaires were structured to give demographic data, knowledge of HIV/AIDS; knowledge, attitudes and practice towards VHCT services.

4.6.3 Data Collection Procedure

Ten BSc holder teachers and three BSc holder in health were used to facilitate the data collection. After selection of the respondents from the sampled sections, other students were allowed to leave the class. Then the respondents were handed the questionnaires by data collectors after a thorough explanation about the purpose of the study, their rights the importance of their participation, confidentiality and informed consent was obtained. The respondents then filled in the questionnaires and gave back to data collection facilitators after completion. Data collection was at the same time to prevent information contamination.

4.7. Variables

4.7.1 Dependent Variables

VHCT Utilization

4.7.2 Independent Variables

- Socio-demography -Sources of information
- Intention to use VCT-Location of VCT services
- Accessibility to VCT service- use of VHCT service
- Preference of counselor - personal HIV infection risk
- Who benefits from HCT - confidentiality
- importance of counseling for HIV testing - time (when to use VCT service)
- Is VHCT Important for HIV prevention

4.8. Pre-testing of the instrument

The questionnaire was pretested using randomly chosen 5% of the sampled size students with a similar target group. The respondents involved in pre-testing did not participate in the actual study. The pre-test finding showed that the questionnaires were well developed and consistent with English version except one item that was removed after pre-test.

4.9 .Data quality management

To ensure the completeness, accuracy and consistency, Public Health qualified individual and language graduate from University did translate the questionnaires to Afan Oromo and then back translation to English was done by a third party, to check for consistency.

Pre-testing of the data collection instrument was done. Orientation was given for facilitators and supervisors. Data was checked thoroughly for completeness after collection

4.10. DataProcessing and Analysis

Data was coded, edited, cleaned manually and entered using Epi Data version 3.1 and then exported to SPSS windows version 16.0 software for further analysis.

Binary logistic regression was performed and all independent variables that have significant association in binary logistic regression analysis with p value less than 0.25 under 95% CI. werecandidates and then entered in to multi variable logistic regression. Independent variables with P-value < 0.05 under 95% CI were considered as having significant association with outcome variable and considered as statistically significant and the result were reported by using p value and odds ratio.

Descriptive statisticsresult were illustrated in the form of frequency tables, depicted graphs and charts in order to provide an overview of the findings.

4.11. Ethical consideration

Letter of ethical clearance was obtained from Research Ethics Committee of college of public health and medical sciences of Jimma University. Letter of permission was obtained from Mettu town education office and high schools. Finally verbal& written consent was requested from the study participants included in the study immediately before the data collection. Anonymity and confidentiality was ensured for information obtained from study participants before the distribution of data collection questionnaires.

4.12. Operational Definition

Knowledge about VCT: For knowledge about VCT six-item of knowledge towards VCT indicator was used. Each question had a response of “Yes” for correct answers or “No” for wrong answers. Scores of all the respondents was sum up and the mean value was calculated. Participants who scored greater than or equal to the mean were considered as knowledgeable and the others not knowledgeable.

Attitude: A six-items attitude indicator, responded as either “Yes” or “No”, towards VCT test was used to assess the student’s level of attitude towards VCT. Scores of all the respondents was sum up and the mean value was calculated. Respondents who scored greater than or equal the mean were considered as having favorable attitude and those scored less than the mean score were considered as having not favorable attitude towards VCT .

Practice of VHCT (Utilization): Practice was assessed using one question having “Yes” or “No” response. Those who responded “Yes” were considered as they had had VCT service in the past.

Counselling: isa purposeful and confidential dialogue between a counsellor and client aimed at enabling a person to cope with stress and make personal decisions about taking an HIV test.

HIV counselling: HIV counselling is a voluntary dialogue between a counsellor and client, couple or a group of clients. It is a process of enabling clients to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning. The common components are pre-test, post-test and ongoing counselling.

HIV testing - is the obtaining of a bodily sample for the specific purpose or performing a medical test or a number of medical tests to determine the HIV status of a person.

Voluntary counselling and testing (VCT) is a process by which an individual undergoes counselling to enable them to make an informed decision about being tested for HIV, assess their personal risk for HIV and develop a risk reduction strategy.

Willingness to accept HIV testing: readiness to undergo Voluntary HIV Counselling and testing.

Perception risk: Students’ attitude towards perceiving themselves as susceptible to HIV infection

High risk perception: Students were considered to have high perception risk if they had been exposed to at least one of the conditions like having sex without condom, having sex with prostitution, having sex with HIV infected person and having injury with HIV infected sharp materials.

Low risk perception: Students were considered to have low perception risk if they had no sexual contact, if they had used condom during sexual intercourse and being faithful to their sexual partners.

Misconception: respondents are considered to have misconceptions about HIV/AIDS transmission if they agreed to any of the following three statements about HIV and AIDS: (1) a mosquito bite can transmit HIV (2) sharing a meal with someone who is HIV positive can transmit HIV, and (3) a healthy-looking person cannot be infected with HIV.

Stigma: negative feeling towards people with HIV and AIDS, intention to avoid people living with HIV and AIDS in social relationships.

Discrimination: an action or treatment based on stigma and directed towards stigmatisation.

Accessibility: for this study it was defined as the sum of economic, physical (geographical), cultural accessibility and not merely the physical presence of VHCT service.

Adolescents: for the purpose of this study adolescents will mean high school students aged 15 to 19 years in Mettu town Oromia regional state

Youth: those aged 15-24 years

high school students : respondents who were enrolled in the current academic year in at least one of the classes from grade 9 to 10 during the data collection period and will be attending the class.

Age category : age category for this study was done based on EDHS 2011 age category for adolescents who were tested for HIV in the past 12 months.

Near VHCT centre/site:- the VHCT service site is said to be near to clients vicinity if available within the district of the service users and can be reached within 1hr journey on foot or 5km away from the vicinity of clients

4.13. Dissemination plan of the study finding

The result of the study will be presented to Jimma University community as part of MPH thesis and a copy of study will be disseminated to Jimma University College of public health and medical science, department of Epidemiology, Mettu town education and health office, to the respective high schools and submission to scientific journal for possible publication.

CHAPTER – FIVE

RESULT

In this chapter the results of study will be presented as follows. In Section 5.1, socio-demographic characteristics of the respondents were summarized. This was followed by the findings related to knowledge, attitude and practice towards VHCT service including influencing factors of VHCT service presented in Sections 5.2. In Section 5.3, the main findings related to the respondents' perception of personal HIV infection risk are shown. Finally, results on association of various variables with utilization of VHCT service was the other concern of this chapter.

5.1. Socio-demographic Characteristics of the study subjects of Mettu town high schools

Table 2 represents the Socio-demographic characteristics of the respondents of the study participants. A total of 559 students participated in the study, making the response rate 99.6%. Out of the total respondents, 294 (52.6%) were males and the rest were females. The mean age of the study participants was 16.42 (SD \pm 1.087) years. Three hundred and twenty-one (57.4%) of the respondents were grade nine. The majority of the respondents 401 (71.7%) were Christian in religion followed by Muslim, 132 (23.6%). Among the total respondents, the majority 553 (98.9%) were not married before.

Table 2. Characteristics of study participants of Mettu town high schools, May 2015

Variables	Frequency	Percentage (%)
Sex		
Male	294	52.6
Female	265	47.4
Age category		
15-17 years	468	83.7
18- 19 years	91	16.3
Grade		
Grade Nine	321	57.4
Grade Ten	238	42.6
Religion		
Christian	401	71.7
Muslim	132	23.6
Others	26	4.7
Marital status		
Un married	553	98.9
Married	6	1.1

NB: Age of the participants was categorized based on the EDHS 2011 age category of adolescents who were tested for HIV.

5.2. Knowledge, attitude and practice towards VHCT services

Items used to measure knowledge towards VCT among high school adolescent students of this study included the importance of VCT for HIV transmission prevention, whether the study participants knew that one can test for HIV and know his/her status, whether the participants have heard about VCT, could easily get VCT service, knew the site/location of VCT to get VCT service and knew cost of VCT service. Hence the study finding revealed that the majority of the respondents 79.8% (n=446) were knowledgeable. Concerning attitude towards VCT service, counseling for VCT, intention to seek VCT service, whether the participants had thought that their sexual partners HIV test have importance for them, recommending VCT for partners, if the HIV should be free or not, who did they think benefits from HIV testing, were items used to measure attitude of the participants towards VCT and 63.3% (n=354) of the respondents were found to have favorable attitude towards VCT service. Also practice of the participants was measured using a single item that was, have you ever been using VHCT service to check whether the respondents had had HIV testing in the past and only 25.9% (n=145) of the participants had utilized VHCT service before the study as shown in table 3 below.

Table 3. Knowledge, Attitude and practice towards VHCT among adolescent students in Mettu town high schools, Oromia regional state, May 2015

Variables	Frequency	Percentage(%)
Knowledge towards VHCT		
Knowledgeable	446	79.8
Not knowledgeable	113	20.2
Attitude towards VHCT		
Favorable attitude	354	63.3
Not favorable	205	36.7
Practice		
Utilized	145	25.9
Not utilized	414	74.1

5.2.2. Reason for not testing for HIV

Of the four hundred fourteen respondents who did not have HIV test before the study, the reason for not being tested for HIV for 50.7% (n=210) and 9.4%(n=39) respondents were, that they had no risk of HIV infection and did not trust the available service quality respectively as presented in the table 4.

Table 4. Reasons for not being tested for HIV among high school students in Mettu town, Oromia regional state, May 2015.

Variables	Frequency	Percentage(%)
What was your reasons for not being tested for HIV(N=414)		
I have no risk of HIV infection	210	50.7
I did no see the importance of testing	91	22.0
I trust myself and partner	74	17.9
I do not trust the quality of the available VCT service	39	9.4

NB. The participants chose multiple response

5.2.3. Sources of information about VHCT service

For majority of the respondents 55.3%, Radio/TV was source of information about VHCT service. Respondents identified multiple sources of information about VHCT services as indicated in figure three.

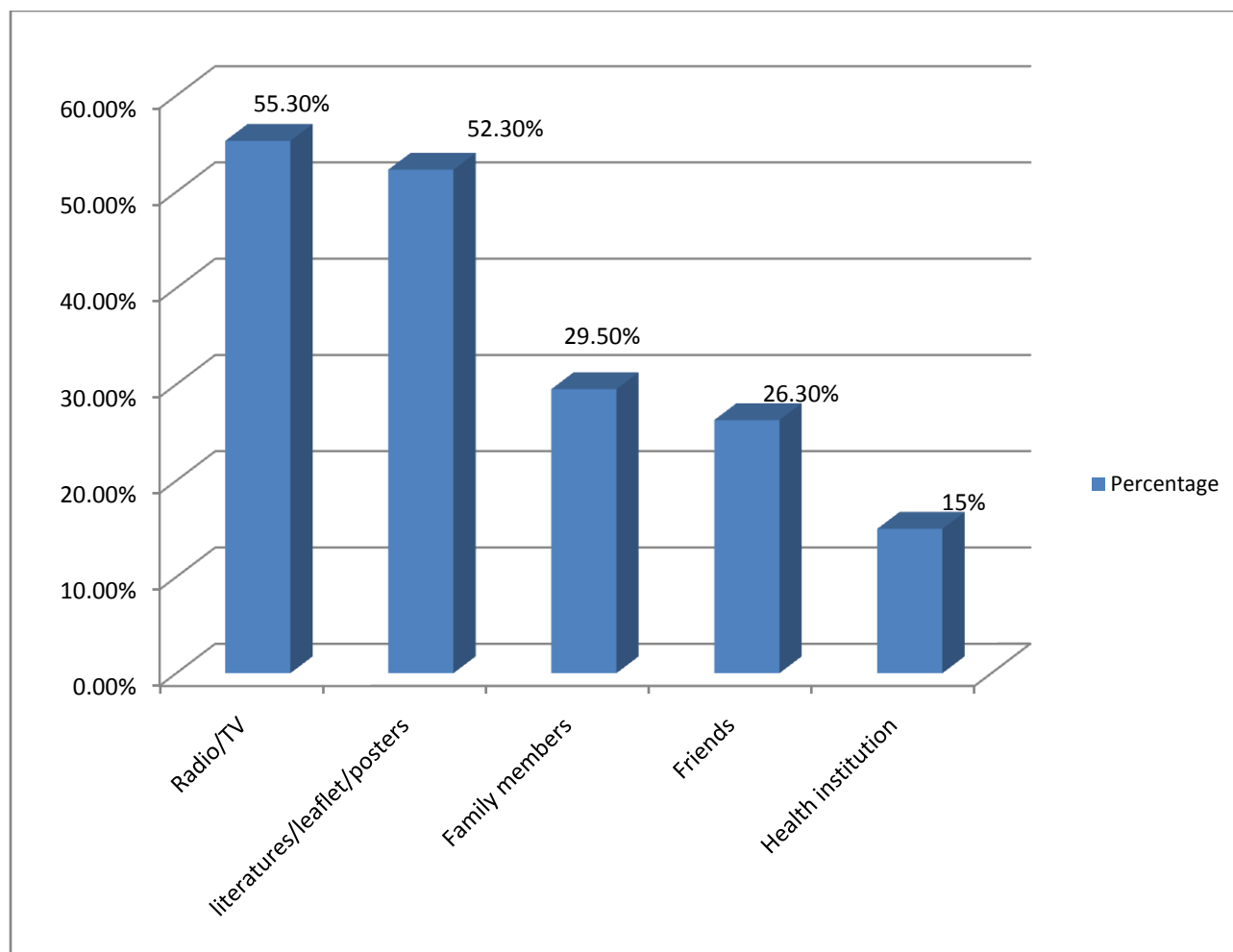


Figure 3. Sources of information for VHCT service identified among high school students in Mettu town, Oromia regional state, May 2015

5.2.4. Accessibility of students to VHCT service

Among five hundred fifty nine participants of this study, majority 66.6% (n=372) , 79.1% (n=442) and 61.9% (n=346) of the them responded that VHCT sites were near to their vicinities, the VHCT service center was located in the health facility and they were accessible to the service as shown in table 5 below.

Table 5. Accessibility of study participants of Mettu town high schools to VHCT service, May 2015.

Variables	Frequency	Percentage(%)
Is VHCT service site near your area or far		
Near	372	66.6
Far	187	33.4
Location VHCT service center		
In a Health facility	442	79.1
In Youth club or association	121	21.6
Accessibility to VHCT service		
Accessible	346	61.9
Not accessible	213	38.1

5.3. Perception of personal risk and Reason for the risk of HIV infection

Regarding perception of personal risk of HIV infection, the responses were classified into low and high risk of acquiring infection. Majority of the respondents 74.4% (n=416) responded as they were at low risk of HIV infection and their reasons for low risk were prevention methods well known 41%(n=229) followed by no risk behavior 32.1%(n=168). But 25.6% (n=143) of the respondents rated their HIV infection risk status as it was high and reason for their high risk were ignorance 10.4%(58) followed by repeated sex risk and shortage of knowledge 3.2% (n=18) and 2.1% (n=12) respectively.

Table 6. Bivariate analysis of factors associated with utilization of VHCT service among high school students in Mettu town, May 2015.

Variables	<u>VCT service Utilization</u>		P. value	COR	95% CI
	Utilized (%)	Not utilized (%)			
Age category					
18-19 years	29 (5.1)	62 (11.1)	0.160	1.42	(0.87, 2.31)
15-17 years	116 (20.8)	352 (63)		1	
Sex					
Male	92 (16.4)	202 (36.1)	0.003	1.82	(1.24, 2.69)
Female	53 (9.5)	212 (38)		1	
Grade					
Grade ten	72 (12.9)	166 (29.7)	0.046	1.47	(1.01, 2.16)
Grade nine	73 (13)	248 (44.4)		1	
Knowledge about VCT					
Knowledgeable	135 (24.1)	311 (55.7)	< 0.001	4.47	(2.26, 8.82)
Not knowledgeable	10 (1.8)	103 (18.4)		1	
VCT center near the students' vicinity					
Yes	126 (22.5)	246 (44.0)	< 0.001	4.53	(2.69, 7.62)
No	19 (3.4)	168 (30.1)		1	
Attitude towards VCT					
Favorable attitude	73 (13)	281 (50.3)	< 0.001	0.48	(0.33, 0.71)
Not favorable attitude	72 (12.9)	133 (23.8)		1	
Personal HIV infection risk perception					
High	50 (8.9)	93 (16.7)	0.005	1.82	(1.20, 2.75)
Low	95 (17)	321 (57.4)		1	

Multiple logistic regression analysis of factors associated with VHCT utilization among high school students in Mettu town

As presented in the table 7 from the socio-demography, sex and grade of the respondents were statistically significant with VCT utilization in which males utilized VHCT service 1.8 times at 95% CI (1.17, 2.78) than females. Grade ten students also practiced VCT service 1.98 times at 95% CI (1.29, 3.04) than grade nine participants. But other socio-demographic variables of the respondents did not show statistical significance. Other variables, such as knowledge of the respondents towards VHCT service, distance of VHCT center relative to the respondents vicinity, and attitude towards the service of VHCT and perception of personal HIV infection risk had showed statistical significance. Knowledgeable students had utilized VCT service 3.45 times (1.67, 7.11) than those students who were considered as not knowledgeable. Those respondents whose residence were considered to be near to VHCT center practiced VHCT service 3.78 times (2.17, 6.56) than those whose vicinities were far way. The other variable that showed positive association with utilization of VHCT service was personal risk perception to HIV infection, in which those participants who considered their risk as it was high, utilized VHCT service 1.85 times (1.16, 2.94) than those respondents with low risk perception. Finally those students with favorable attitude towards VHCT service were 65% at 95% CI (0.23, 0.54) likely to utilize VHCT service than those students who were found to have not favorable attitude.

Table 7. Multiple logistic regression analysis of factors associated with VHCT utilization among high school students in Mettu town, May 2015

Variables	<u>VCT service Utilization</u>		P. value	AOR	95% CI
	Utilized (%)	Not utilized (%)			
Sex					
Male	92 (16.4)	202 (36.1)	0.008	1.80	(1.17, 2.78)
Female	53 (9.5)	212 (38)		1	
Grade					
Grade ten	72 (12.9)	166 (29.7)	0.002	1.98	(1.29, 3.04)
Grade nine	73 (13)	248 (44.4)		1	
Knowledge about VCT					
Knowledgeable	135 (24.1)	311 (55.7)	0.001	3.45	(1.67, 7.11)
Not knowledgeable	10 (1.8)	103 (18.4)		1	
VCT center near the students' vicinity					
Yes	126 (22.5)	246 (44.0)	< 0.001	3.78	(2.17, 6.56)
No	19 (3.4)	168 (30.1)		1	
Attitude towards VCT					
Favorable attitude	73 (13)	281 (50.3)	< 0.001	0.35	(0.23, 0.54)
Not favorable attitude	72 (12.9)	133 (23.8)		1	
Personal HIV infection risk perception					
High	50 (8.9)	93 (16.7)	0.009	1.85	(1.16, 2.94)
Low	95 (17)	321 (57.4)		1	

CHAPTER - SIX

DISCUSSION

This chapter presents a discussion based on the major findings presented in chapter five. Findings that were discussed include demographic characteristics, knowledge of VHCT, attitudes towards testing for HIV and factors that influence VHCT utilization.

Concerning Socio-demography of the respondents, the respondents who participated in this study were 15 to 19 year old with the mean age 16.42. There were more males than females who participated in the study. About fifty-three percent (n=294) of the total respondents were males while forty seven percent were females. And this indicated that more males than females were participated this study. This study was in line with study done in Butajira town high school SNNP and preparatory school in Gondar town North west Ethiopia, 65% males and 52.1% males respectively (25, 36). Among the socio-demographic variables, sex and grade of the respondents were significantly associated with utilization of VHCT service in which males more utilized the service than females.

This study attempted to assess the knowledge and attitude of the high school adolescents students of the study area towards VCT utilization. 95.2% of the respondents had heard about VCT service before the study. This study is in line with study done in Butajira high school SNNP 96.7%, Debre Brehan town high school all the respondents had heard, But higher than the study done in Debre Markos Northwest Ethiopia 81% (25, 34, 39). The respondents cited school and media as their main sources of information for VHCT services. This study is comparable to the study done in other parts of the country (6, 25). Based on the items to check the adolescent students' knowledge towards VHCT, 79.80% of the respondents were found to be knowledgeable and the rest 20.20% were not knowledgeable. This was in line with study done at Addis Ababa high schools in which 75.7% of the participants were knowledgeable (6). This finding showed that there was still a gap of knowledge towards VHCT service in the study area. Thus public health administration and other concerned bodies need to work to make students more knowledgeable about VHCT. Concerning attitude towards VHCT, considerable proportion (63.3%) of the respondents were found to have favorable attitude towards utilization of VCT. This finding was comparable to the study done in Northwest Ethiopia 73.3% (35).

The participants attitude towards VHCT was high and appreciable which is very important and needed in the prevention and control of HIV. Majority believed that VCT is necessary for different reasons including knowing self-status. Even though considerable proportions of the respondents were knowledgeable and also had favorable attitude towards VHCT service only 25.9% of the respondents (9.5% females and 16.4% males) had utilized VHCT service in the past. Although there was apparent discrepancy between knowledge towards VHCT and utilization of VHCT service among the study participants, the findings was higher than the study done at Butajira high school SNNP 18.5% and 9.3% which was reported by BSS in 2005 for VCT use among in-school youth (25,31). This showed an increment in the acceptance of VCT as preventive measure. The reason for this improvement could be either positive behavioral changes or expansion of VCT service in the country in the last few years. But the finding was much lower than the study done in Addis Ababa high schools (62.2%), and Debre Brehan high school (38.3%), (6,34). The dissimilarity of the findings could be due the life style and culture of the living residence that could be influenced by different information sources and the difference in knowledge and practice that could exist between big city and small towns. The reason for testing for HIV was to know self-status for 86.2% of the respondents and exposure to risk of infection (4.8% unprotected sex, 4.1% repeated sex with multiple partner) were other reasons among the tested.

More than half of those respondents who had not utilized VHCT services considered themselves as they had no risk. This finding was in line with study done in Debre Brehan high school (34). Regarding preference of counselor, 70.7% of the respondents preferred trained health personnel followed by 23.1% peer (youth) counselor. And the proposed location for VHCT service by respondents, was 42% school followed by health facility 37.4%.

The study also assessed VCT site distance whether VCT site was near or far relative to the participants residence. VHCT near the respondents vicinity showed statistical significance with the utilization of VHCT service and those participants whose houses were near to VHCT centre were about 3.8 times CI (2.17, 6.56) utilized VCT service. This finding was in line with study done at other part of the country (34).

This study also revealed that the perception of being at risk and utilization of VCT were significantly associated. Significant number of students who perceived themselves at high risk for HIV infection had utilized VCT service when compared to those who considered themselves

to be at low risk. This study was inline when compared to the study done at Debre Markos (39). But the finding was vice versa when compared to Debre Brehan high school in which those participants who considered themselves as having low risk of HIV infection had more utilized than those who considered themselves at high risk of acquiring HIV infection(34).

Regarding factors influencing VHCT service, the respondents mentioned distance to the VHCT services as a barrier to utilization of services. Respondents suggested that the VHCT services should be within the school premises for easier access. This finding is supported by the Ethiopian VHCT guideline which says VHCT services can be provided through the following four models of delivery: 1) integrated services provided in public, NGO, and private health facility settings, as designated VHCT units or under other programs; 2) stand-alone counselling and testing services provided at sites outside health facilities; 3) outreach VHCT services for special populations such as people in remote rural areas, refugees, and schools(9); and 4) VHCT services provided by trained practitioners in government agencies, NGO, and private sector institutions as part of comprehensive workplace HIV programs (9). These VHCT sites are for the general public but they are often not designed to address adolescents' especial needs.

The expenses of VHCT are also mentioned in this study, and are supported in literature as a barrier in terms of access by young persons. Baggaley and Boswell (2002:16) reported that for VHCT services to reach young people, VHCT must be free. Any attempt to introduce or scale up VHCT for young people must take cost analysis in to consideration (3). Similarly the finding strengthens results obtained from a 2004 study done on knowledge and attitude towards voluntary counselling and testing for HIV in North West, Ethiopia in which 93.8% of respondents reported their willingness to use the VHCT service if such services were to be made available free of charge (21).

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

This chapter presented conclusions based on results of a study. The findings sited in chapter five served as a basis for recommendations in this chapter to bring about better access to VHCT services in the future, especially for adolescents, by identifying factors that affect access to the service.

In this study more males hadutilized VHCT service for HIV than that of the females. Still distance of VCT matters, in which the respondents preferred to be tested at school . The other socio-demographic characteristics such as age, marital status and religion of the respondents in this study did not influence the utilization of VCT for HIV. Knowledge of HIV and VCT among the students was high and though they had a positive attitude towards VCT, however, the utilization of VCT services was low. Finally this study concluded that VCT utilization was influenced by sex, grade, knowledge and attitude towards VCT, and personal risk perception of HIV infection.

Recommendations for improving access to VHCT services

Zonal and Woreda Health Office

- ✓ School adolescents should be provided with a VHCT service at their schools, with trained medical personnel or peer educators to increase access to the same service for the school age population.
- ✓ VHCT education should focus on to close the gap between knowledge and utilization VHCT service.
- ✓ Behavior change communication in order to act on perception of personal risk as most students considered themselves as they were at low risk of HIV infection

School

- ✓ More information on HIV/AIDS transmission and prevention ways and VHCT service.

Limitation of the study

- The result of this study was totally dependent on the response from the participants that we might not be sure. e.g. Utilization of VHCT service in the past.
- Only daytime students were included in the study, this might affect the generalization.

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ANNEX QUESTIONNAIRE

My name is _____.(data collector) I am working _____ . We are collecting data among students here in _____ (name of school) about knowledge and attitude towards voluntary HIV counseling and testing services.

So this is a research designed to explore the knowledge and attitudes of adolescentsstudents aboutVHCT and HIV prevention, and you are kindly requested to fill all the questions below. And I would like to remind you that your genuine answer is of paramount importance to the outcome of the research and that all the answers and your identity are kept anonymous.

The benefit of this study:- is that the results of the study will help responsible parties to identify the weaknesses and strengths of the program to take corrective action in places where there are problems and simultaneously to put effort on strengthening better where there are positive achievements. There is no financial or in kind item to be provided for you up on participating in this study.

Risk: There will not be any type of risk that may come on you or others up on providing information in this study

Confidentiality:- All information you give will be kept strictly confidential and your name will not be written in this form and will never be used in connection with any of the information you tell us.

Free participation and withdrawal:- Your participation is voluntary and you are not obliged to answer any questions you don't want to respond. You may also withdraw from the study at any time and you would not be penalized for your decision to withdraw.

Thank you in advance.

Consent form

I understood all the above provided information and I entered the study after complete understanding of the objective, confidentiality, risks and benefits of the study and my participation is also completely voluntarily.

Signature of participant_____

Data collector signature_____

Date_____

Date_____

FoormiiWaliigaltee (Consent form)

Odeeffannoowaa’ eekayyoo, haalaeegumsaiccitii, miidhaa fi bu’aawaa’eeqorannookanaanaafkennamegutummaaguutuuttiegganhubadheeboodaqorannoomana barumsaakeenyattigeggeefameirrattihirmaadheera.Hirmaannaankookunisfedhiikooguutuudhaant a’uuisaa nanmirkanneessa.

MallattooHirmaataa_____

MallattooQindeessaa_____

Guyyaa_____

Guyyaa_____

I. Socio demographic data

- 1. Age-----
- 2. Sex-----
- 3. Grade-----
- 4. Religion: Christian----- Muslim----- Others-----
- 5. Marital status: Married----- Single----- Divorced-----

II. Knowledge about HIV/AIDS (transmission, prevention)

101. How many modes of HIV transmission do you know? ----- Please list them

102. Where do you get your information about HIV/AIDS?

School-----Friends-----

Radio-----

TV-----

Others (specify) -----

3. Which way of transmission is the most common cause of infection in our country

4. List the prevention methods that you know

5. Which prevention method(s) do you think most relevant for young people? -----

III. HCT service (knowledge, attitude and practice)

1. Do you know that one can test for HIV and know his/her status?

Yes---- No -----

2. Have you ever heard about HCT? Yes ----- No -----

3. How did you come to know about HCT

From friends----- From family members-----

From literature----- From adverts/ posters-----

From radio/TV ----- Others specify-----

4. What are the uses of HCT service

5. Is HCT important for prevention of HIV transmission? Yes ----- No ----

6. When do you think is appropriate to have HCT?

Any time, -----

Before marriage -----

Before initiation of sexual contact -----

Before pregnancy -----

After pregnancy -----

Any time a person feels at risk -----

Others specify -----

7. Who do you think benefits from being test?

HIV positive individuals-----

HIV negative individuals-----

Both HIV negative & positive individuals

8. Do you think counseling is important for HIV testing?

Yes ----- No ----

9. Why? -----

10. Who do you think needs to be tested?

High risk groups ----- Those to be married ----- Everybody who is sexually active ----

Only those suspected by medical personnel to be HIV positive -----

Others, specify -----

11. Do you know where you can get the service?

Yes ----- No -----

12. Is there service near your area or far?

Near ----- Far ----- Very far -----

13. Where is the service located?

In a health facility ----- In youth club or association -----

It is a stand- alone service (giving only HCT) -----

14. Do you know how much it costs to be tested for HIV?

Yes ---- No ----

15. Do you think it is accessible for you to get the service?

Cost wise? Yes ----- No ----- Distance wise? Yes ----- No -----

Is the location convenient? Yes ----- No -----

16. Do you think the test should be free? Yes ----- No -----

17. Where do you think should a HCT Centre be located for easy access for adolescents?

In a health facility----- In schools----- In youth clubs-----

In a separate service Centre for HCT alone----- Others (specify) -----

18. Who do you think should counsel adolescents?

Trained health personnel----- Trained non-medical personnel ----

Trained youth (peer group) counselors ----- Religious leaders -----

Traditional healers----- Anybody who is a trained counselor-----

19. Have you ever been using HCT services?

Yes ---- No ---- if no, go to question no. 28

20. If yes, how did you find the service?

Very good ---- Good ----- Bad ---- Very bad -----

21. Can you provide reasons for your answer for the above question? -----

22. How do you rate the confidentiality of the counseling and testing process?

Very good ----- Good --- Poor ---- Very poor -----

23. How long did it take before the result of the test? -----

24. When do you think should a test result be given?

Immediately after the test ----- Few hours after the test -----

Few days after the test ----- It doesn't matter when -----

Others, specify -----

25. What was your reason for being tested?

Just to know your status ----- Had unprotected sex -----

Multiple sexual partners ----- Thinking that your partner could have risk factor ----

You had other risk factor for the infection ----- Others (specify) -----

26. Did your partner know about you being tested? Yes ---- No -----

27. If yes, did you partner take the test as well? Yes ----- No -----

28. If no, have you ever think of testing for HIV? Yes ----- No -----

29. If no, why not?

You have no risk-----You don't see the importance of being tested -----

Trust oneself and partner ----- You don't trust the quality of the test available -----

30. If you want, can you get HCT service easily? Yes ----- No -----

31. If no, why not?

It is expensive for you -----The location is far -----

You don't trust the confidentiality ----- The result takes a long time -----

You don't want to know your status at all -----

IV. Perception of personal risk

1. How do you rate your personal risk of being infected with HIV at the moment?

Very high ----- High ----- Moderate ----- Low ----- Very low -----

2. Can you explain the reason for the above answer -----

3. How do you rate your sexual partner(s) risk of having HIV infection?

Very high ----- High ----- Moderate ----- Low ----- Very low -----

4. Do you intend to have HCT for HIV in the future?

Yes ----- No -----

5. Do you think it is important for you to have your partner tested for HIV?

Yes ----- No -----

6. Do you have any intention of asking your sexual partner to seek for HCT?

Yes ----- No -----

V. Stigma and discrimination

1. Have you ever seen a person living with HIV/AIDS?

Yes ---- No -----

2. Do you think it is safe to live with a person with HIV in the household?

Yes ----- No -----

3. What precautions do we need to take to live with a person living with HIV/AIDS?

Separate beds ----

Separate eating utensils -----

Avoid external body contact -----

Use gloves to clean his/her materials -----

Avoid contact with body fluids -----

Separate toilet -----

Better to keep the person in a healthy facility ---- Others specify -----

4. If one of your family members were a person living with HIV/AIDS. Would you tell anyone?

Yes ----- No -----

If yes, to whom -----

If no, why not -----

5. Do you discuss about HIV/AIDS at home?

Yes -----, with whom -----

No -----

6. Who would you tell your HIV test result if you test positive?

Your family -----

Your partner(s) -----

Your friends -----

No one -----

Others, specify -----

I. Hawwaassummaa(Socio-demography data)

1. Umurii (waggaadhaan) _____ 2. Saala _____ 3. Kutaa _____

4. Amantii: Kiristaana Jiimakanbiraa

5. Haala Gaa' ilaa:- kanfuudhe/ eerumteka fuune/ eerumne

kan hike/hiikte

II. Hubannoowaa'ee "HIV/AIDS" (karaaittiindaddarbu, karaaittiinofiirraa ittisamu)

101. karaa 'HIV' nittiin, namairraanamattidaddarbuudanda'umeeqabeekta? _____

Tarreesi:- _____

102. Odeeffannoowaa'ee "HIV/AIDS" eessaa argatte?

1. Manabarumsaa 2. hiriya 3. Raadiyoo 4. Televiziyinii

99. Kanbiraa (yoojiraateibisi) _____

103. Biyyakeenyakeessatticaalaattikaraan "HIV" ittiindaddarbumaal?

104. "HIV" karaaofiirraaittisuundanda'amukanbeektukanaagadittitarreesi

105. Mala/karaa HIV/AIDS ofiirraaittiinittisanukeessaa, isa kami/warrakamituirraacaalaa dargaggootaaf mijataadha?

Tarreesi:- _____

III. Tajaajilagorsaa fi qorannoo “HIV” (Hubannoo, Ilaalchaa fi shaakala)

201. Akka “HIV” dhiigaofiqorachiisaniiwaa’eeofiibeekuundanda’amunibeektaa ?

1. Eeyyee 2. lakkii

202. Fedhiidhaangorsaa fi qorannoodhiigaa “HIV” dhaafjiraachuuisaadhageesseenibeektaa?

1. Eeyyee 2. lakkii

203. Waa’eeetaajaajilagorsaa fi qorannoo “HIV” kandhageessebeekte/hubateenyuirraa?

1. Hiriyaairraa 2. miseensamaatiiirraa
3. baruuleeirraa 4. beeksisaa/poosteriiirraa
5. Raadiyoo/TV irraa 99. kanbiraa (yoojiraateibisi)_____

204. Faayidaantajaajilagorsaa fi qorannoo “HIV” maalii?

Tarreessi:-1. _____

205. Tajaajilligorsaa fi qorannoo “HIV” ,“HIVn” namairraanamattiakkahindarbineittisuufni

fayyadaa? 1. Eeyyee 2. Lakkii

206. Tajaajilagorsaa fi qorannoo “HIV” argachuuf, yerooninnisirriinyoomi?

1. Yerookamiyyuu, 2. fuudhaa fi eerumadura
3. Walquunnamtiisaalautuuhinjalqabindura 4. Ulfaa’uudhaandura
5. Ulfaa’uudhaanbooda 6. yeroonami “HIV”ttisaaxilamuuisaaofishakukamiyyuu----
99. Kanbiraayoojiraate(ibisi) _____

207. Qorannoo “HIV” irraakanfayyadamueenyu?

1. Namoota “HIV”tiinqabaman 2.namoota “HIV”tiinhiinqabamine
3. namootahunda

216. Tajaajilqorannoo HIV bilisa/tolata'uuqabajetteeyaaddaa?

1. Eeyyee
2. Lakki

217. dargaggootisalphaattiakkaargatanuufjechaiddoontajaajilgorsaa fi qorannoo "HIV" eessattita'uuqabajetteeyaadda?

1. Dhaabbatafayyaakeessatti
2. Manabarumsaakeessatti
3. Kilabiidargaggootaakeessatti
4. Qophaaisaaofidanda'ee

99. kanbiraa (yoojiraateibisi) _____

218. TajaajilagorsaaHIV dargaggootaafeenyuutukennufiiqabajetteeyaadda ?

1. Ogeessafayyaaleenjiikanqabu
2. Namaogeessafayyaahintaanegaruuleenjiikanqabu
3. Dargaggeessakeessaagorsuudhaankanleenjiqabu
4. Geggeesitootaamantii
5. Namaaadaadhanfayyisan
6. Namagorsairrattileenjiqabukamiyyuu

219. Tajaajilagorsaa fi qorannooHIV fayyadamteebeektaa ?

1. Eeyyee
2. lakki

deebi'ingaaffii lakk.219. yoolakkita'e , garagaaffiiLakk. 228ti darbi

220. Deebi'ingaaffiilakk. 219 eeyyeeyoota'e, haalakenniinsatajaajilichaaakkamittiilaaltee?

1. Baayyeegaariidha
2. Gaariidha
3. Gadheedha
4. Baayyeegadheedha

221. Deebi'ikeekanaanoliitiif sababaisaamaalijetteeyaadda? _____

222. haalaadeemsakenninsatajaajilagorsaa fi qoranno HIV hiccitiieeguuirrattimaaljetta ?

1. Baayyeegaariidha
2. Gaariidha
3. Gad-bu'aadha
4. Baayyee gad-bu'aadha

223. Bu'aaqorannoo "HIV" argachuufyerooammamsieegsisee? _____

224. Bu'aanqorannoo "HIV" yoomkennamuuqabajetteeyaaddaa?

1. Qorannooboodaattatamaan
2. Qorannooboodasa'amuraasabooda
3. Eggaqoratamaniiguyyaamuraasabooda
4. Yoomiyyuuyoota'erakkoohinqabu

99. kanbirayoojiraate (ibbisi) _____

225. Sababiati HIV dhaafqoratamtemaalture?

1. Ofibeekuuf (sababaaddaahinqabu)
2. Walquunnamtiisaalaaofieeggannoohinqabnewaaninraawwadheef
3. Walquunnamtiisaaladaangaahinqabne (namabaayyeewajjin)
4. Hiriyaankoo HIV ttiwaansaaxilamte/saaxilamewaannattifakkaateef
5. Waanbiraa HIV ttiwaannasaaxiluwaannamudateef

99. Kanbiraayoojiraateibsi _____

226. HIV dhaafqoratamuukeehiriyaankeenibeekaa/beektii?

1. Eeyyee
2. lakki

227. Eeyyeeyoota'e, hiriyaankeesqoratamteettii/qoratameeraa?

1. Eeyyee
2. lakki

228. Yoolakkita'e, "HIV" dhaafqoratamuuyaaddebeektaa?

1. Eeyyee
2. lakki

229. Yoolakkita'e, maaliif?

1. Waanti HIV ttinasaaxiluwaanhinjirreef
2. Faayidaanqoratamuuwaannattihinmullanneef
3. Ofista'eehiriyaakoowaaninamanuuf
4. Qulqulinatajaajilaqorannoo HIV jiruttiwaananihinamanneef

230. Yooqoratamuubarbaadde, tajaajilaqorannoo HIV salphaattiargachuunidanddeessaa?

1. Eeyyee
2. lakki

231. Debiingaaffiilakk. **230.yoolakkita'e**, maaliif?

1. Kaffaltiinisaaacimaawaanta'eef
2. iddoontajaajilichiittiargamufagoowaanta'eef
3. haalaegumsahicitiwaananiittihinamanneef
4. Bu'aanqorannoobeekuufyeroodheeraawaanfudhatuuf
5. Waa'eeofiikootiibaruuwaananihinbarbaanneef

IV. Akkaataanamootnibalaa HIV ittiilaalanu (Perception of personal risk of HIV)

301. Ammayerookannatticarraa "HIV" ttisaaxilamuukeekkamittiilaalta?

1. Baayyeoli'aanaa
2. Oli'aanaa
3. Giddugalleessa
4. Gad-aanaa
5. Baayyee gad-aanaa

302. Deebi'iikeekanaaoliitiifisababiinisaamaaljettaa? _____

303. Carraa "HIV" ttisaaxilamuuhiriyaakeetiaakkamittiilaalta?

1. Baayyeoli'aanaa
2. Oli'aanaa
3. Giddugalleessa
4. Gad-aanaa
5. Baayyee gad-aanaa

404. Maatiikeekeessaanamnitokkoutuu HIV qabaatee/qabaatee, namabiraattinihimta?

1. Eeyyee

2. lakki

“Eeyyee” yoota’e, eenyutti _____

“Lakki” yoota’e, maaliif? _____

405. Waa’ee “HIV” maatiiwaliinnimaryattuu?

1. Eeyyee

2. lakki

“Eeyyee” yoota’e ,Eenyuuwajjin _____

406. QoratamteeyooHIV dhiigakeekeessaattiargame, eenyuuttihimattaa?

1. Maatiikootti

2. Hiriya (dhiira/dubartii) kootti

3. Hiriyootakootti

4. Namaniittihimuhinqabu

5. AbbootiiAmantaa

99. Kanbiraayoojiraateibisi _____