

**ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE OF ADDO KEBELE
RESIDENTS TOWARDS VCT WESTERN ETHIOPIA, 2013**

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COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES
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Abstract

Background: Voluntary HIV counseling and testing (VCT) is one of the key strategies in the prevention of HIV in Ethiopia. However, utilization of the VCT services has been reported as low by previous studies. This research focuses on investigation of the households' Knowledge, Attitude and Practice in Addo Kebele so as to identify the gaps and to set up an appropriate action plan.

Objective: The purpose of this study is to investigate knowledge, attitudes, and practice towards VCT services among Ado kebele households.

Methods: A cross -sectional study conducted from February 20 to March 4,2013 at Addo kebele. Data collection was done using structured pretested questionnaires among 230 households that were selected by systematic random sampling. The data were analyzed by using scientific calculators and tally sheet and association will be seen by using chi- square test. Significant values can be declared at p-value of less than 0.05. Result will be presented using tables, percents and frequency.

Budget: The total budget used for this study was 4, 5013EBR.

1. **Conclusion and recommendation:** As the study clarified, Addo kebele households have good knowledge towards VCT for HIV/AIDS testing in general, but males had good attitude 168/170(98.8%) and practice129/170(75.9%) than females 50/56(89.3%) and 38/56(67.6%.) respectively. The kebele health policy makers are highly expected in making education on VCT for HIV/AIDS testing part of one of the topics under each topics of health education, which will update the knowledge of the households.

Key words: VCT, KAP and HIV.

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Acronym

VCT: Voluntary Counseling and Testing

HIV: Human Immunodeficiency Virus

AIDS: Acquired Immuno Deficiency Syndrome

NCHS: National Centre for Health Statistics

STDs: Sexual Transmitted Diseases.

KAP: Knowledge, Attitude and practice

WHO: World Health Organization

UNAIDS: United Nation Programme on HIV/AIDS.

UNICEF: United Nation International Children Emergence Fund.

CDC: Centers of Disease Control and Prevention

USA: United State of America

DHS: Demography and Health Survey

AIC: Aids Information Center

Chapter one

Introduction:

1.1 Back ground:

According the census in 2010, approximately, 1.2 million Ethiopians were living with HIV/AIDS and about 1.5 percent of adults are living with HIV/AIDS in 2011(1). Though, voluntary Counseling and testing remains a key strategy to control the spread of HIV and to provide support to those who are positive, early awareness about VCT is now recognized as a critical component in controlling the spread of HIV infection. So, as Addo Kebele is one of the kebeles found in Ethiopia, it is very important for it to have VCT (2).

Voluntary counseling and testing (VCT) is recognized as one of the few potentially effective and affordable methods for reducing the transmission of HIV in developing countries.VCT programs have been identified as an entry point for HIV prevention and care and support services (3). Different interventions showed that HIV counseling and testing based on knowledge of their antibody status; enables individuals to make informed choices; helps them to change behaviors that may put themselves or others at risk for HIV infection, take action to prevent prenatal transmission once persons learn they are infected, and also to seek early medical care if they are HIV-positive (1, 4).

Research indicates that even though there is a high level (over 95%) of awareness of existence of HIV/AIDS, there is a lower level of in-depth knowledge especially on modes of transmission. This makes VCT services an important avenue to receive important information (5). In a comparative study conducted by Kalichman and Simbayi (6), it was revealed that individuals who were not tested for HIV demonstrated significantly greater AIDS related stigmas, ascribing greater shame, guilt and social disapproval to people living with HIV.

VCT may also reduce reported risk behavior and prevent new infections notably among those testing positive and discordant couples (7). The cost per disability-adjusted-life-year saved is

similar to benefits from immunizations and improved management of sexually transmitted disease (7).

1.2 Statement of the problem:

HIV/AIDS has become the most devastating global epidemic the world has ever faced. At the end of 2002, over 20 million people had died, an estimated 42 million people globally were infected with HIV and over 5 million people were newly infected in that year. For example, an estimated 1.1 million people are currently living with HIV in the USA; yet one in five are unaware of their status (7).

In developed countries like America, According to (NCHS), AIDS became the leading cause of death among Americans between ages 25 to 44 years (8). It is not only a series a problem in developing countries; rather it is also a challenging problem in developed country. Because the epidemic is concentrated in the most productive age group regardless of economic or education status, it has a systematic impact on economic development at all levels, affects all development sectors, threatens the social fabric of society and fundamentally challenges the security and stability of a growing number of countries (9).

It has continued to be the largest killing disease in Africans (10). For example, since the beginning of the epidemic to 1998, more than 16 million adults have been infected by HIV in Africa (10). Its counseling in Ethiopia began in the late 1980s with services expanding throughout the 1990s, yet, it is reported that many people with HIV in Ethiopia do not know they are infected, and as there is no cure for HIV/AIDS (11).

It has now spread throughout the country, and is still spreading at an Alarming rate; more and more new infections occur everyday, not to mention the many who don't even know they have the virus (12) Various estimates of HIV infections in Ethiopia ranging from 2.1 to 3.0 million have been published in 2000 and an estimated 117,000 to 208,000 people aged 15-49 died of AIDS in 2001 alone (12). But these are all rough estimates and the incidence of HIV infections and AIDS cases apparently continue to rise rapidly. This indicates that only a fast committed response can avert a disastrous impact on Ethiopia's health and socio-economic development (12) While the epidemic has stabilized in the past decade, HIV/AIDS continues to be a major

development challenge for Ethiopia (13). National models of HIV prevalence showed the incidence of HIV infection declined by over 25 percent between 2009 and 2001(14) Although, HIV/AIDS is gradually reducing but still more efforts should be geared towards effective approaches that can result in lowering HIV infection among the citizen (14).

The spread of HIV in any community is in part determined by the knowledge of attitude towards its means of transmission. Before formulating public health policies for the prevention of HIV, it is critical to obtain information about the prevalent knowledge of attitude regarding HIV/AIDS (15).

Early diagnosis and treatment have dramatically increased lifespan and reduced HIV transmission; yet 55% of adults, ages 18–64, report they have never been tested for HIV. Among those who have been tested and were found to be infected, at least one-third discovered their status late in the course of their illness, thus missing the opportunity to receive the maximum benefits that early treatment provides which leads to:

- Missing the opportunity to receive the maximum benefits that early treatment provides
- The possibility of being infected by HIV may also increase, as the individuals suspect themselves as an infected.
- The possibility of transmitting HIV to other may also be increased if an infected individual is not unaware of his/her status.
- The probability of mother to child transmission is also at high risk if the mother does not know her status. For example about one million African children are estimated to have been infected as a result of mother-to-child transmission of HIV (16).

However in comparison to other countries there is lack of information (knowledge) regarding the most important determinant factors for the acceptance and practice of HIV-VCT services that is believed to be one of the best strategies for prevention and control of HIV/AIDS and care and support of already infected people. The result of this study will help to plan and implement targeted educational interventions and to design appropriate HIV-VCT services.

Uptake of VCT services varies greatly between settings and countries, several societal and delivery associated factors like, stigma, community mobilization, confidentiality, availability of treatment simple rapid testing (same day testing) and poor quality of services (17).

Similarly, HIV test-seeking behavior and test-receiving PRACTICE outcomes are also said to be influenced by the organization of a testing system described as the process one goes through to acquire testing services, the type of diagnostic test used, the process required to receive test results as well as the place where the test is offered (15).

Testing is more likely to be accepted when clients perceive their own risk and acknowledge behaviors placing them at increased risk, it is voluntarily and routinely offered, confidential and anonymous testing is available, alternative testing technologies are available and when providers & clients perceive VCT as HIV prevention means (4).

1.3. Significance of the study

This research focuses on investigation of the residents' Knowledge, attitude and Practice in Addo Kebele towards that takes place from March - May 2013.

HIV/AIDS is the major killing disease not only in developing countries but also in developed countries as the result of not having early HIV visiting service and not aware of the benefit of treatment offered in the early stage of HIV infection. So, as Addo Kebele is one of the Kebeles in developing countries further studying is necessary as:

1. Helps to categorize the residents based on their degree of risk factors which allow other concerned parties to take action in controlling HIV
2. Provides information for the residents regarding the benefits of VCT
3. Used as a reference for further studying
4. It would be useful in designing education materials to enhance the knowledge level of households and contribute to strategies to be adopted in increasing the uptake of VCT.
5. It could also help direct health policy makers in decision making process on VCT services.

Chapter two

2. 1. Literature Review

The identification of infected individuals is an important step in the control of the HIV epidemic. A 2003 report from the global HIV prevention working group revealed that less than one in five persons is at risk of HIV and had access to basic HIV prevention services globally. It also revealed that only one in ten people living with HIV has even been tested for the virus. Increased coverage with anti-retroviral treatment is expected to reduce the mortality and morbidity due to AIDS worldwide and will simultaneously provide countless new HIV prevention opportunities through client initiated and provider initiated routine (often of voluntary and confidential) good quality HIV counseling, testing and referral. In 1991 a study conducted in Kinshasa (Congo) demonstrated a marked increase in condom use among couples from less than 5% to 70% following the HIV-VCT intervention (18). Another study in Rwanda reported an increase in ever condom use before VCT intervention from only 7% to 16% in HIV sero-negative women and 35% in HIV sero-positive women (19).

In Uganda analysis of data from 3000 clients receiving HIV-VCT at the AIDS information centre (AIC) revealed a substantial reduction in risk behaviors at 3 and 6 months following the intervention (20) Awareness of HIV testing is reportedly lower when clients have not been tested previously and are fearful of their ability to cope with their test results. A pilot study done in rural village of Tanzania, among the 245 village residents who were offered VCT, 137 (55.9%) volunteered to participate and received both pre-test counseling and HIV testing (21). Studies conducted in west, east, and South Africa and Thailand in antenatal clinics revealed the median overall acceptability of VCT was 69% (Range 33%-95%(22).

A study done in 2000 in Harar, Ethiopia revealed more than three-fourth (85.4%) of the study subjects within the age group 15 – 49 years claimed to have an intention of having VCT. Condom use, not initiating sexual practice, and positive attitude towards VCT were positive predictors for intention of having VCT (8). Another study done in 2003 among newly married couples in Addis Ababa showed that 55% of study subjects reported having had pre-marital

VCT. Among those who did not have pre-marital VCT, 63.4% claimed to wish to have VCT, but had not had it for some reason. The main reason given by them was thinking that he/she feels healthy (11).

The demography and health survey of Ethiopia in 2000 (DHS) revealed that there is a high unmet demand for HIV testing with 69.4% of respondents in Urban and 64.0% in rural areas willing to be tested (12). The ongoing extension of the network of VCT centers and HIV laboratories (that include the involvement of the private sector health facilities in VCT activities) and improvements in the general health services can increase coverage of the wider population at risk of HIV infection once more counselors can be upgraded, employed and supported with test kits in the regions and rural areas (23, 24).

During the past 5 years, China has established 4293 VCT clinics all over the country, where free and professional HIV counseling and testing are available. This provides a unique opportunity for risk-taking persons to receive HIV counseling and testing services (23).

Holmes et al (25) found that more educated women for example were less likely to accept testing than women with no or less education. In a study conducted in 35 districts of the 10 regions of Ghana among adults, in-school and out-school youth and military personnel and their families revealed that there was a low uptake of counseling and testing services (23). According to Charles et al (25), participants were aware of the benefits of VCT. However, only a few (35%) had undergone VCT. On the part of adolescents, it has been established that they would often delay in seeking VCT until they found a family member or friend who supported the idea of testing (24).

Research indicates that a person would not necessarily accept VCT unless they are planning for marriage or to go abroad (27). In a study conducted among Mekelle University students, the majority preferred the VCT service to be provided in youth clubs, followed by Government Institutions (27). The author was of the view that this could be due to the free service given at the youth club and the cheap payment in Government hospitals, as well as fear of stigma and discrimination.

Chapter Three

Objective:

3.1 General objective,

To assess KAP of Addo kebele residents towards voluntary counseling and testing western Wellega, 2013

3.2 Specific objectives,

- To determine residents knowledge of voluntary counseling and testing for HIV
- To identify residents attitude towards voluntary counseling and testing for HIV
- To determine the residents' practice of voluntary counseling & testing for HIV.
- To determine the association between KAP of Addo kebele households towards VCT for HIV.

CHAPTER FOUR

4. Methods and materials:

4.1. Study area and period,

The study took place in Western Oromiya, Kelem Wellega, Sayo Wereda, Addo Kebele from March 25/2013-May 30/2013. The study area Addo is one of the kebeles in sayo Wereda 675 kms west of Addis Ababa. The kebele covered 5600 km² area. The climatic condition of the kebele is 'Woyina-dega'.

There were 10500 residents in the Kebele. Most of the households were farmers. The area produces all kinds of crops but, predominantly produces cash crops like coffee. During the cultivation of the crops most of the residents earns better income from coffee as compared to other crops in the year. In the kebele, there are one elementary school, one kind garden two NGO mini clinics, churches like Catholic, Protestant, Orthodox, 'Mulu-wandel', Muslim, and others like Jova.

4.2 Study Design,

Descriptive cross sectional study was conducted to assess the knowledge, attitude and practice of VCT for HIV testing of Addo kebele households (who were taken for study population).

4.3 Population:

4.3.1. Source of population:

Source population was the total number of Households in Addo Kebele, Kelem Wellega, Sayo wereda, Western Oromiya, Ethiopia.

4.3.2. Study population:

All the heads/responsible persons of the households in the kebele who were volunteer to participate in the study were included.

4.3.3. Inclusion and exclusion criteria

Inclusion criteria:

Those who are age 15 years or above and lived in the kebele for at least six months

Exclusion criteria:

Residents those who are deaf, suffering from other serious medical or psychological problems

4.4 Study variables:

4.4.1. Independent variables,

Socio demographic data: age, sex, ethnicity, marital status, occupational status, educational status, annual income and religion.

4.4.2. Dependent variables

- Knowledge
- Attitude and
- Practice of VCT

4.5 Operational definitions:

The household(s) of the kebele (is) are expected to be knowledgeable if she/he answers 70 or above% 'yes' and not knowledgeable if less than the 70 %, good attitude if she/he answers 'yes' and good practice if she/he answers 70% of the given questions. But not good attitude or practice if less than 70% is answered.

4.6 Sampling size and sampling technique:

Sample size: The following formula to estimate a single population proportion was used to estimate the sample size

Where:

- n = the required minimum sample size
- $Z_{\alpha/2} = 1.96$ = Level of confidence 95%,
- d = Margin of error, assumed to be 5%
- p = Proportion of KAP of VCT 50%

N= the total households in the kebele

$$n = \frac{Z^2 \cdot p \cdot (1-p)}{d^2} = \frac{1.96^2 \cdot 0.5 \cdot (1-0.5)}{0.05^2} = 219$$

219 plus 5% of non respondent rate (219+11)=230.

Based on the above assumptions a total of 230 households were required for the study.

Sampling technique

All the households were listed from 1 to 510. Then the total number of households was divided by the sample size (510/230=2) and then selected every two households using simple lottery method for the first household and systematic sampling technique was employed.

Data collection method:

Data Collection tools and procedures,

A structured interviewer administered questionnaire was used to collect the data by trained data collectors. The questionnaire was pre tested in the same setup and with similar as the target group g at Shogo kebele two weeks before the data collection was started on 11 (eleven) respondents. Four data collectors, seven assistants and two supervisors were trained and facilitated the data collection. The principal investigator and the supervisors ensured the data quality with close supervision of the data collection process. All pieces of information filled were anonymous; there was no personal identification of the participant to ensure confidentiality and reliability of data filled.

4.7 Data processing and analysis:

Descriptive statistics was used to summarize information. The data was manually checked for completeness and analyzed by using scientific calculators and tally sheet. Also association was seen by using chi- square test. Significant values were declared at p-value of less than 0.05 and result was presented using frequency, tables, percentages and word descriptions.

4.8 Pre-test

A pre-test was done on 5% of the sample in order to approve how much the questionnaires could achieve the objective of the research. The pre-test was performed at Shogo kebele. The result of the pre-test study was used to modify the content and wording of the questionnaire.

4.9 Data Quality Management:

To ensure the quality of the data, any confusion was clearly explained to each of the data collectors at any time they want. The principal investigator was supervising the data collection process. Every day, questionnaires were reviewed and checked for completeness by principal investigator.

4.10 Ethical Considerations:

Written Ethical letter was obtained from Jimma University College of Public Health and Medical Sciences Department of Nursing, the letter for the permission of the study form Seyo Wereda Administration office and the kebele was also obtained. The purpose of the study was explained

to the study participants, verbal consent was secured and all pieces of information gained during the data collection were confidentially ensured. Any question regarding the questionnaire was answered to any study subject(s).

Dissemination plan

For dissemination purpose, the report of the research will be put in the university`s library. Besides this the output will be provided to the region administration so that it can be used as a reference in preparing plan for VCT in the kebele.

Chapter Five

RESULTS:

A total number of 226 respondents () from the households were participated in the study giving 98.3%% response rate. Male and female participants were significantly different in age distributions. 170 (75.2%) were males and 56 (24.8%) were females.

The highest of the residents age group: is age >45(50%) and lowest is age between 20-24 1(0.4%), . regarding educational status: 91(40.3%) were learned grade 5-8 and 19(8.4%) were illiterate. Concerning religion:75(33.2%) were Catholic, 14(6.2%) were Muslim and others 3(1.3%).with regard to marital status:185(81.9 %) were married, 3(1.3%) were single and occupational status: 220(97.4%) were farmers and 1(0.4%) is student. (Table 1).

Table 1: Socio demographic characteristics of residents, in Addo Kebele from March-2013-

Characteristics		Male n%	Female n%	Total n%
Age	20-24	1(0.6%)	-	1(0.4%)
	Grade1-4	42(24.7%)	13(23.2%)	55(24.3%)
	Grade5-8	81(47.6%)	20(35.7%)	101(44.7%)
	Grade9-10	26(15.3%)	5(2.9%)	31(13.7%)
	Grade11-12	7(4.1%)	9(16.1%)	16(7.1%)
	Diploma	3(1.8%)	1(1.8%)	4(1.8%)
Religion:	Orthodox	21(12.4%)	16(28.6%)	37(16.4%)
	Muslim	9(5.3%)	5(8.9%)	14(6.2%)
	Mulu-wangel	43(25.3%)	11(19.6%)	54(23.9%)
	Catholic	59(34.7%)	16(28.6%)	75(33.2%)
	Protestant	36(21.2%)	7(12.5%)	43(19%)
	*Others	2(1.2%)	1(1.8%)	3(1.3%)
Marital status:	Widowed	9(5.3%)	27(48.2%)	36(15.9%)
	Married	157(92.4%)	28(50%)	185(81.9%)
	Divorced	2(1.2%)	-	2(0.9%)
	Single	2(1.2%)	1(1.2%)	3(1.3%)
Occupational Status:	Farmer	165(97%)	55(32.4%)	220(97.4%)
	Student	1(0.6%)	-	1(0.4%)
	Teacher	4(2.4%)	1(1.2%)	5(2.2%)
	TOTAL	170(75.2%)	56(24.8%)	226(100%)
6.Monthly income:	1000-1300	47900, 47males	18550,	66450, 62 (27.4%)

		(27.6%)	15females (26.8%)	
		134100,102 males (60%)	64050, 25females (44.6%)	198150,127 (56.2%)
	>2300	182000,149 (87.6%)	82600, 40 (71.4%)	264600,189 (83.6%)
	Total			
37 households of the total respondents said, " we do not know our annual income." From this, females are 16(7.1%) in number and males are 21(9.3%) in number.				

Two hundred twenty three (98.7%) of the respondents had sexual experience, or ever had sexual intercourse; of which 168 of the total 170 males (98.8%) and 55 of the total 56 females(98.2%) are females. And of the total, 148(87.1%) male and 28(50%) female has one sexual partner faithful. Which means 9(5.3%) of male and 27(48.2%) female are widowed, two male and one female households (1.3%) are unmarried and 5(2.9%) male households did not responded to the given question. And 92.4%of male respondents have sexual partner and 48.2% of female respondents have sexual partner currently. Regarding to identifying prevention methods, majority 173(76.5%)of the households said 'yes' for faithfulness out of which 87.1% of the respondents are male and 46.4% are female respondents. And minority 4(1.8%) said, for condom use (male) (Table 2).

Table 2. Sexual experience profile of the residents, in Addo kebele, March 2013.

Characteristics		Males N (%)	Female N (%)	Total N (%)
❖ *Have you ever had any sexual Experience?	Yes	168(98.8%)	55(98.2%)	223(98.7%)
	No	2(1.2%)	1(1.2%)	3(1.3%)
❖ How do you protect yourself From HIV?	Faithfulness	148(87.1%)	25(44.6%)	173(76.5%)
	Abstinence	9(5.3%)	27(48.2%)	36(15.9%)
	Using condoms	4(2.4%)	-	4(1.8%)
	No response	9(5.3%)	4(7.1%)	13(5.8%)
Do you have sexual partner currently?	Yes	157(92.4%)	27(48.2%)	184(81.4%)
	No	9(5.3%)	28(50%)	37(16.4%)
	No response	4(2.4%)	1(1.2%)	5(2.2%)

❖ If no, why?	Until we are tested	4(2.4%)	1(1.2%)	5(2.2%)
	Abstinence	9(5.3%)	27(48.2%)	36(15.9%)
❖ How many partners do you have currently?	One	148(87.1%)	28(50%)	176(77.8%)
	More than one	6(3.5%)	-	6(2.7%)
	No one	11(6.5%)	28(50%)	39(17.3%)
	No response	5(2.9%)	-	5(2.2%)
	TOTAL	170(75.2%)	56(24.8)	226(100%)

Concerning information regarding VCT services, 98.7% of them knew about or have heard of VCT services from different sources; 2.2.% from media (radio), 12.8 % from TV, 32.3% school, and 25.7% from Friends respectively and others gave multiple sources of information about VCT. Ninety-two percent (92%) of the Households know that VCT is an important service for prevention of HIV infection. That is 11.5% of them said it helps to know HIV status, 3.1 said to start its treatment soon, 20.8% said to protect others not to be infected, 6.6% to break the stigma and discrimination and 50% said for all of the above reasons. Two hundred twenty three of the households knew where to get VCT service and 3 households of the total respondents do not know from where to get the service of VCT even the availability of the service itself. Knowledge of households towards VCT at Addo Kebele is showed in Table 3.

Table 3: Knowledge of households about VCT at Addo Kebele in Frequency and Percent.

Characteristics		Frequency n=226	Percent %
1. Do you know about VCT?	Yes	223	98.7%
	No	3	1.3%
2. If yes,	Via school,	73	32.3%
	Via TV,	29	12.8%
	Via Radio,	5	2.2%
	All,	58	25.7%
	From friends	58	25.7%
3.If no, why?	Lack of information	3	1.3%

4. Do you know the importance of VCT	Yes	208	92%
	No	18	8%
5.if 'yes' what are they?	a. It helps to know HIV status	26	11.5%
	b. for getting treatment if there is infection,	7	3.1%
	c. to protect others not to be infected	47	20.8%
	d. to protect others not to be infected	3	1.3%
	e. because somebody had it,	-	-
	f. to break the barriers of stigma and discrimination	15	6.6%
	g. all	113	50%

6. If your blood is contaminated with HIV, what will you do?	a.I protect others not to be infected	28	12.4%
	b. I will start its treatment soon	7	3.1%
	c. I give its education to others	22	9.7%
	d. all	167	73.9
	e. others (specify) 1 said, I do not know what to do, and other said, to disappear form the area.	2	0.9%

Regarding their attitude and practice towards testing for HIV, from the 98.3% of the respondent rate, 96.5% have agreed that voluntary counseling and testing is important for HIV testing and 60(26.5%) of them said it helps someone to know his/her HIV status, 18 (8%) said it helps someone to care him/herself from not being infected, 17 (7.5%) said to care others not to be infected, 123 (54.4%) all of the above reasons in general. When we come to the practice of households in Addo kebele, males have good practice (p-value=0.5%), but females have poor practice towards VCT (p-value 0.08%). From the total 167(73.9%) of the households used VCT, from whom 129 of 170(75.9%) were males and 38 of 56(67.9%) were females. The reason for majority 150(66.4%) of them for being tested was to know their status, others 6(2.7%) said because they had multiple sexual partners and the rest 8(3.5%) kept quite (no response). 24.1% of the total males and 32.1% of the total Females have not tested for HIV. Out of those (59 respondents) who had not used VCT so far, 55of the total 226respondents (24.3%) said because of fear of the result, 4(1.8%) lack of interest to know their HIV status. For the counseling, 216 (95.6%)of the respondents choose for any trained counselor, 3.1% prefer counselors from religious leaders and 1.3% any person. Out of these respondents, 167of the total (170) 98.2% is male and 49 out of the total (56) 87.5% is female.

From 98.3% of the participants of the study who knew that the service is available, the majority of them 111(49.1%) said that testing is important for any one regularly and 8(3.5%) after exposure to its risk.

Regarding the benefits of voluntary counseling and testing for HIV, 75(33.2%) of the respondents said HIV negative ones are more beneficiaries than those HIV positive, 17(7.5%) of the respondents said HIV negative ones are more beneficiaries than those HIV negative and 134(59.3%) of the respondents said voluntary counseling and testing for HIV benefit for both HIV positive and negative. From this 103(60.6%) were male and 31(55.4%) were female. Thirty-six (15.9%) of the respondents identified health facilities being the location of the VCT service they know i.e. Hospital only, 8(3.5%) Health centre only, 12(5.3%) at Clinic only, 13(5.8%) at other like in the village and 154(68.1%) of them identified all of the above health facilities being the location of the VCT service.

From the total respondents, 23(10.2%) did not discuss with their partner one another which means 14(8.2%)of male and 9(16.1%) of females. Attitude and practice of the residents towards VCT services at Addo Kebele is showed at (table 4).

Table 4.1: Attitude of the residents towards VCT services at Addo Kebele from March 2013-May 2013.

Characteristics	Male N (%)	Female N (%)	Total N (%)
1. Do you think VCT for HIV testing is important?			
Yes	168(98.8%)	50(89.3%)	218(96.5%)
No	2(1.2%)	6(10.7%)	8(3.5%)
2.If yes, why ?			
Helps someone to know his/her HIV status	51(30%)	9(16.1%)	60(26.5%)
Helps someone to care his/herself from not being infected	12(7.1%)	6(10.7%)	18(8%)

Helps same one to care others not to be infected	14(8.2%)	3(5.4%)	17(7.5%)
All	91(53.5%)	32(57.1%)	123(54.4%)
3. Of no, why?			
Lake of knowledge about the use VCT	1(0.6%)	1(1.8%)	2(0.9%)
Lack of interest to have VCT	1(0.6%)	3(5.4%)	4(1.8%)
No response	-	2(3.6%)	2(0.9%)
4. If you know the use of counselor, who do you think counsel the residents?			
Anybody who is a trained counselor	167(98.2%)	49(87.5%)	216(95.6%)
Religious leaders	2(1.2%)	5(8.9%)	7(3.1%)
Others(specify)	1(0.6%)	2(3.6%)	3(1.3%)
5. Who do you think needs to be tested?			
Any one regularly	70(41.2%)	16(28.6%)	86(38.1%)
After pregnancy	5(2.9%)	9(16.1%)	14(6.2%)
Before marriage	3(1.8%)	4(7.1%)	7(3.1%)
All of the above	91(53.5%)	20(35.7%)	111(49.1%)
After exposure to its risk	1(0.6%)	7(12.5%)	8(3.5%)
6. Who do you think benefits from being tested?			
HIV positive one	9(5.3%)	8(14.3%)	17(7.5%)
HIV negative one	58(34.1%)	17(30.4%)	75(33.2%)
Both	103(60.6%)	31(55.4%)	134(59.3%)
Total	170(100%)	56(100%)	226(100%)

Table 4.2: Practice of the resident to towards VCT services at Addo Kebele from March 2013

1. Have you ever been using VCT service?			
Yes	129(75.9%)	38(67.6%)	167(73.9%)
No	41(24.1%)	18(32.1%)	59(26.1%)
2.If Yes, how is the service?			
Good	11(6.5%)	3(5.4%)	14(6.2%)
Very good	116(68.2%)	28(50%)	144(63.7%)
No response	2(1.2%)	7(12.5%)	9(4%)
3.If no, why?			
Fear of result	40(23.5%)	15(26.8%)	55(24.3%)
Lack of interest	1(0.6%)	3(5.4%)	4(1.8%)
4. What was your reason for being tested?			
Just to know my status (no particular reason)	119(70%)	31(55.4%)	150(66.4%)
Multiple sexual partners	9(5.3%)	-	6(2.7%)
No response	1(0.6%)	7(12.5%)	8(3.5%)
5.At where it is given			
Hospital only	23(13.5%)	13(23.2%)	36(15.9%)
Health center only	4(2.4%)	4(7.1%)	8(3.5%)
Clinic only	4(2.4%)	8(14.3%)	12(5.3%)
All	128(75.3%)	26(46.4%)	154(68.1%)
Other specify	9(5.3%)	4(7.1%)	13(5.8%)
6 Did your partner know you being tested?			
Yes	115(67.6%)	29(51.8%)	144(63.7%)
No	14(8.2%)	9(16.1%)	23(10.2%)
Total	129(75.9%)	38(67.9%)	167(73.9%)

Generally, as knowledge, attitude and practice of Addo kebele households towards VCT for HIV testing was analyzed and the association was done and justified by chi table, the p-value of the knowledge, attitude and practice of the respondents was 0.12,11,1 respectively which was more than the given p-value (less than 0.05) making the p-value accepted. As the chi-square measures whether a relation is likely due to chance and also the chi-square test statistic 12.12 exceeds the critical value of 3.341, it included that there was significant association between knowledge, attitude and practice of the respondents towards VCT for HIV. As the result of P-value explains regarding to knowledge, males are with P-value of 0.03, and for females 0.09, attitude, males P-value 2.7 and female P-value 8.1 and practice for males P-value 0.3 whereas females P-value 1.1.

Table of KAP of Addo kebele households towards VCT for HIV

Variables		Male	Female	P-value
Knowledge	Yes	168	55	0.12
	No	2	1	
Attitude	Yes	168	50	11
	No	2	6	
Practice	Yes	129	38	1.4~=1
	No	41	18	

Chapter six

Discussion:

This study tried to gather different information about VCT services from households on the hope that it will help to show their point of view on the existing services and how to make it more accessible so as to serve these respondents better.

Among 226 households at Addo kebele who were offered VCT (167%), volunteered to participate and received both pre-test counseling and HIV testing which is high when compared with study done in Tanzania in which among the 245 residents only 137 (55.9%) were used VCT (21) might be as the research it self was done long period of time ago, there might not that much awareness creation as of now days.

as a point of concern in the findings of this study (for the sake of clarifying about the use of condom too), only 4 out of 226(1.8%) of those reported condom use, and out of those reporting condom use; It is clean that none of them were females, showing that the males, even in this study subjects dominate the ability or choice of condom use 4 out of 17(2.4%).

Many respondents said that faithfulness is enough to protect oneself from HIV; and seem to overlook the fact that open discussion between partners about sexuality is necessary for the Faithfulness strategy to work. Among the respondents in this study 26.1% revealed a high unmet demand for HIV testing which is less when compared with the demographic health survey of Ethiopia (EDHS, 2000) which revealed that there is a high unmet demand for HIV testing with 64.0% (12) to which one of the reason could be that education on HIV testing is being given at health institutions at OPD level as one of the main topic un the morning on some of the days.

From households those who used VCT services, majority of the residents said that testing is important for those to be married, and some of them agreed that testing for HIV before marriage is important; and only 6.2% of them identified the importance of getting a test after pregnancy.

Study limitations:

- Closed houses during data collection period
- Sensitivity of the issue under study

Chapter seven

Conclusion:

In this study, males were more knowledgeable and willing to VCT for HIV testing than females. The other socio-demographic characteristics of the respondents in this study did not influence the acceptance of VCT for HIV testing. Even though the study reflects the contribution of the socio-demographic characteristics of the respondents, much emphasis should have to be given for the disclosures of the partners' especially for the females' practice of VCT for HIV testing.

Recommendations:

1. 6.2% and, 3.1% of the study participants accepted an ‘opt-out’ approach to HIV testing in clinical settings (after pregnancy and before marriage respectively). So, the VCT service provision can be considered such as integrating HIV testing into antenatal examinations or a marriage license

As the result of lack of knowledge of the advantage of Voluntary counseling and testing for HIV,

2.1 Many of the participants did not have VCT service (especially females),

2.2 Sixty nine (69) respondents did not know exactly that VCT service is given at all site i.e. at Hospital, Health center, Clinic and other(mobile sites in the village where many people found.) and

2.3 There was less discussion between partners about their VCT service. So, raising quality of counseling through proper training of counselors and making the service more households friendly, could motivate them use the Service.

- So, Sayo Wereda health policy makers are highly expected in making education on VCT for HIV/AIDS testing part of one of the topics under each topics of health education, which will update the knowledge of the households.

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ANNEX I: QUESTIONNAIRE

**JIMMA UNIVERSITY,
COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES,
DEPARTMENT OF NURSING**

My name is Aman, I am graduating class nursing student in Jimma University. I am collecting data on for the study entitled assessment of KAP of residents towards VCT March, 2013.

Your answers are Completely Confidential. I would greatly appreciate your help in responding to this study.

Are you willing to participate?

Yes

No

Thank you in advance.

Socio demographic data:

What is your,

1. Age -----

2. Sex

A. Male

B. Female

3. Educational status:

A. Illiterate

E. Grade 11-12

B. Grade1-4

F. Diploma

C. Grade 5-8

G. Degree

D. Grade 9-10

4. Religion:

A. Christian

D. Catholic

B. Muslim

E. Protestant

C. Mulu-wangel

F. Others(specify)_____

5. Marital status:

A. married

C. Divorced

B. single

D. widowed

- a. Lack of information
- b. Other reason

4. Do you know the importance of VCT?

- a. Yes
- b. no

5. If 'no' explain is your reason

6. if 'yes' why?

a. it helps to know HIV status

b. for getting treatment if there is infection,

c. to protect others not to be infected

d. because some body had it,

e. to break the barriers of stigma and discrimination

f. all

D. VCT service (attitude)

1. Do you think VCT for HIV testing is important?

A. Yes

B. No

2. If yes, why

A. Helps someone to know his/her HIV status

B. Helps same one to care his/herself from not being infected

C. Helps same one to care others not to be infected

D. all

3. Of no, why?

A. Lack of knowledge about the use of VCT service

B. Lack of interest to have VCT service

C. No response

4. If you know the importance of counselor, who do you think counsel the residents?
- A. Anybody who is a trained counselor
 - B. Religious leaders
 - C. Others (specify)-----
5. Who do you think needs to be tested?
- a. Any one regularly
 - b. Before marriage
 - c. After pregnancy
 - d. all
 - e. After exposure to its risk
6. Who do you think benefits from being tested?
- A. HIV positive one
 - B. HIV negative one
 - C. Both

E.VCT service (Practice)

1. Have you ever been using VCT service?
- A. Yes
 - B. No
2. If yes, how is the service?
- A. Very good
 - B. Good
 - C. Bad
 - D. Very bad
3. If no, why?
- A. Because of distance
 - B. Lack of information
 - C. Lack of interest
 - D. Fear of result
4. What was your reason for being tested?
- A. Just to know your status (no particular reason)
 - B. Multiple sexual partners
 - C. Had unprotected sex
 - D. no response
5. At where it is given?
- A. Hospital only
 - B. Health center only
 - C. Clinic only
 - D. all
6. Did your partner know about your being tested?
- A. Yes
 - B. No