

**BARRIERS TO VOLUNTARY COUNSELING AND
TESTING OF INDIVIDUALS IN SELECTED AREAS OF
THE GURAGE ZONE, ETHIOPIA**

WOLDEKIDAN KIFLE AMDE

**A mini-thesis submitted in partial fulfilment of the requirements for
the degree of Magister Artium in the School of Government,
University of the Western Cape**

The logo of the University of the Western Cape, featuring a stylized building with columns and the text "UNIVERSITY of the WESTERN CAPE" below it.

UNIVERSITY *of the*
WESTERN CAPE

Supervisor: Prof Michelle Esau

May 2008

KEY WORDS

Ethiopia

HIV/AIDS

Prevention

Voluntary Counselling and Testing

Barriers

Fear of stigma

Knowledge of HIV/AIDS

Risk perception of HIV/AIDS

Social capital

Perceived benefit of VCT



ABSTRACT

Despite wide acceptance of Voluntary Counselling and Testing (VCT) as a crucial entry point for the prevention, treatment, care and support of HIV-infected persons; the prevalence of testing in Ethiopia remains very low. A review of the literature identifies the set of factors that influence HIV testing of individuals to include socio-economic and demographic factors, knowledge of HIV/AIDS, risk perception, fear of stigma, social capital and the perceived benefit of VCT. By drawing assumptions based on the known literature, this mini-thesis explores the relationship between VCT usage and the above factors in order to explain the status of HIV testing in Moher and Aklil district, Gurage Zone, Ethiopia. The study hopes to address the dearth of material on VCT and contribute to it in a non-clinical and rural context.

Quantitative data was collected from 200 randomly selected rural dwellers in the chosen district using a structured questionnaire. Supplementary qualitative data was gathered from local people and pertinent officials using unstructured individual and group interviews. The Chi square test of independence was adapted to test for association between VCT and the proposed explanatory factors. The qualitative data was analysed using thematic and comparative analysis methods to discern patterns and provide insight into quantitative results.

The main results of the research are as follows:

- 1) No significant difference in the HIV-testing rate is found on the basis of age, income, or risk perception.
- 2) Sex is significantly related to the readiness to take the HIV test, and women are more likely to take VCT than men.
- 3) Persons with a high degree of knowledge of HIV/AIDS and VCT are less likely to take VCT than those lacking such knowledge.
- 4) Fear of stigma is significantly associated with the readiness to take the HIV test, where those with a high fear of stigma are less likely to take the HIV test than those with low fear. Fear of stigma is higher among men and those with high level of knowledge of HIV/AIDS and VCT.
- 5) The relationship between VCT usage and membership of community-based groups, which comprise the social capital of persons, is mixed. Only in the case of membership

of religious-oriented, community-based groups is the relation with VCT usage significant, where members are less likely to take the HIV test than non-members.

6) Many people took the HIV test, or perceived that it should be taken, for marriage purposes, because in this area the HIV test is accepted as a precondition for wedlock.

Future detailed research on the relationship between knowledge of HIV/AIDS and fear of stigma; and between sex and fear of stigma is recommended.



DECLARATION

I declare that *Barriers to Voluntary Counselling and Testing of Individuals in selected areas of the Gurage Zone, Ethiopia* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Woldekidan Kifle Amde

Signed:

Date:



DEDICATION

To my wife, Mrs. Tigist Shewarega, for her unwavering love and support

To my parents, Mr. Kifle Amde and Mrs. Tsehay Benti, for their belief and understanding



ACKNOWLEDGMENT

I would like to express my sincere gratitude to my supervisor, Professor Michelle Esau, for her comprehensive, critical and constructive comments.

I am also thankful to the Gurage Zone HIV/AIDS Desk; and Moher and Akilil District Health and HIV/AIDS Offices.

Last, but not least, I am grateful to all the research participants who shared their experience and knowledge with me.



LIST OF TABLES

TABLE 1 INCOME BY VCT USAGE	39
TABLE 2 KNOWLEDGE OF HIV TRANSMISSION METHODS BY SEX	40
TABLE 3 KNOWLEDGE OF HIV PREVENTION METHODS BY SEX	40
TABLE 4 HIV/AIDS RELATED MISCONCEPTIONS BY SEX	41
TABLE 5 KNOWLEDGE ON HOW TO LEARN HIV STATUS BY SEX	42
TABLE 6 KNOWLEDGE OF SPECIFIC PLACE TO TAKE THE TEST BY SEX	42
TABLE 7 PERCEIVED TREATMENT AFTER INFECTION BY SEX	45
TABLE 8 MEMBERSHIP TO COMMUNITY BASED INSTITUTIONS BY VCT USAGE	47
TABLE 9 REASON DURING LAST TEST BY SEX	48
TABLE 10 REASONS TO GET AND NOT TO GET HIV TESTING BY SEX	49
TABLE 11 PERCEPTION ON WHO SHOULD TAKE HIV TEST BY SEX	50

LIST OF CHARTS

CHART 1 DISTRIBUTION OF RESPONDENTS BY TESTING STATUS	35
CHART 2 SEX BY VCT USAGE	37
CHART 3 AGE BY VCT USAGE	38
CHART 4 KNOWLEDGE SCORE BY VCT USAGE	43
CHART 5 RISK PERCEPTION BY VCT USAGE	44
CHART 6 STIGMA SCORE BY VCT USAGE	46

CONTENTS

KEY WORDS	II
ABSTRACT	III
DECLARATION	V
DEDICATION	VI
ACKNOWLEDGMENT	VII
LIST OF TABLES	VIII
LIST OF CHARTS	VIII
CONTENTS	IX
CHAPTER 1 – INTRODUCTION	1
1.1 BACKGROUND	1
1.2 PROBLEM STATEMENT AND RATIONALE	2
1.3 ASSUMPTIONS	5
1.4 OBJECTIVES OF THE STUDY	5
1.4.1 <i>General objective</i>	5
1.4.2 <i>Specific objectives</i>	5
1.5 SCOPE OF THE STUDY	6
1.6 LITERATURE REVIEW.....	6
1.7 ORGANISATION OF THE STUDY.....	8
1.8 OPERATIONAL DEFINITION OF KEY TERMS.....	9
CHAPTER 2 – FACTORS INFLUENCING VCT USAGE	10
2.1 INTRODUCTION.....	10
2.2 DIMENSIONS OF VCT	10
2.3 EFFECTIVENESS OF VCT AS PREVENTION STRATEGY	11
2.4 DEMAND FOR VCT	14
2.5 DETERMINANTS OF VCT	16
2.5.1 <i>Socio-economic and demographic factors</i>	16
2.5.1.1 Sex	17
2.5.1.2 Age	18
2.5.1.3 Income.....	19
2.5.2 <i>Knowledge of HIV/AIDS, VCT</i>	20
2.5.3 <i>Self-perception of risk of HIV/AIDS</i>	21
2.5.4 <i>Fear of stigma</i>	22
2.5.6 <i>Perceived benefit of VCT</i>	25
2.6 CHAPTER SUMMARY	26
CHAPTER 3- METHODOLOGICAL APPROACH	27
3.1 INTRODUCTION.....	27
3.2 STUDY AREA.....	27
3.3 SAMPLING DESIGN AND SAMPLE SIZE	28
3.4 METHODS OF DATA COLLECTION AND ANALYSIS	30
3.4.1 <i>Data collection instruments and procedures</i>	30
3.4.2 <i>Method of Analysis</i>	31
3.5 ETHICAL CONSIDERATION	31
3.6 VARIABLES	31
3.6.1 <i>Dependent variable</i>	31
3.6.2 <i>Independent variables</i>	31
3.7 CHAPTER SUMMARY	34

CHAPTER 4 - RESULTS OF THE SURVEY	35
4.1 INTRODUCTION.....	35
4.2 PREVALENCE OF HIV TESTING	35
4.3 SOCIOECONOMIC AND DEMOGRAPHIC FACTORS AND VCT USAGE.....	36
4.3.1 <i>Sex and VCT usage</i>	37
4.3.2 <i>Age and VCT usage</i>	37
4.3.3 <i>Income and VCT usage</i>	38
4.4 KNOWLEDGE ON HIV/AIDS/VCT AND VCT USAGE	39
4.4.1 <i>Awareness about HIV/AIDS</i>	39
4.4.2 <i>Knowledge of HIV transmission methods</i>	39
4.4.3 <i>Knowledge on HIV preventions methods</i>	40
4.4.4 <i>HIV/AIDS related misconceptions</i>	41
4.4.5 <i>Knowledge about VCT</i>	41
4.4.6 <i>Knowledge on HIV/AIDS/VCT and VCT usage</i>	42
4.5 RISK PERCEPTION TO HIV/ADS AND VCT USAGE	43
4.6 FEAR OF STIGMA AND VCT USAGE	44
4.7 SOCIAL CAPITAL AND VCT USAGE	46
4.8 PERCEIVED BENEFIT OF VCT	48
4.9 CHAPTER SUMMARY	50
CHAPTER 5 - DISCUSSION OF RESULTS.....	51
5.1 INTRODUCTION.....	51
5.2 PREVALENCE OF HIV TESTING.....	51
5.3 SOCIOECONOMIC AND DEMOGRAPHIC FACTORS AND VCT USAGE.....	52
5.3.1 <i>Sex and VCT usage</i>	52
5.3.2 <i>Age and VCT usage</i>	53
5.3.3 <i>Income and VCT usage</i>	53
5.4 KNOWLEDGE OF HIV/AIDS/VCT AND VCT USAGE.....	54
5.5 PERCEPTION OF RISK TO HIV/AIDS AND VCT USAGE	54
5.6 FEAR OF STIGMA AND VCT USAGE	55
5.7 SOCIAL CAPITAL AND VCT USAGE	56
5.8 PERCEIVED BENEFIT OF VCT AND VCT USAGE.....	57
5.9 CHAPTER SUMMARY	58
CHAPTER 6- SUMMARY AND CONCLUSIONS	59
REFERENCES	61
ANNEXES.....	64
ANNEX 1 - QUESTIONNAIRE	64
ANNEX 2- GUIDING QUESTIONS FOR UNSTRUCTURED INDIVIDUAL AND GROUP INTERVIEWS	69

Chapter 1 – Introduction

1.1 Background

Human Immunodeficiency Virus (HIV) / Anti Immunodeficiency Syndrome (AIDS) has spread rapidly and claimed the lives of many Ethiopians since the first reported incidence in the mid-1980s. Ethiopia is now among the most heavily affected countries, with the sixth highest number of HIV/AIDS infections in the world. The country also has the third largest population in Africa living with the virus. In 2003, it was estimated that between 950,000 and 2.3 million people were living with HIV/AIDS, and 720,000 children were orphaned¹ as a result of the virus. In 2005, the prevalence rate in the country among the adult population was projected to be 4.4%. The prevalence rate is higher in urban areas than in rural areas: The 2005 study showed the prevalence rate in urban areas to be 12.6% but only 3.0% in rural areas, with the average being 4.4%.² The major mode of transmission of the virus in the country is sexual intercourse between heterosexuals. The majority of the infected persons include individuals between the ages of 15 and 49.³

There have been numerous efforts to address the HIV/AIDS epidemic in Ethiopia through priority intervention areas. These include Information Education Communication (IEC), Behavioural Change Communication (BCC), Condom promotion and distribution, Voluntary Counselling and Testing (VCT), Sexually Transmitted Infections (STIs) treatment and control, and Prevention of Mother to Child Transmission (PMTCT).⁴ In addition, the Federal Ministry of Health (MOH) and the HIV/AIDS Prevention and Control Office (HAPCO) developed an HIV/AIDS policy and other strategic documents to facilitate a practical environment for HIV prevention, care, treatment and support.⁵

¹ Ministry of Health in WHO, 2006

² HAPCO, 2006, p.10

³ Ministry of Health in WHO, 2006

⁴ HAPCO, 2006, p.39

⁵ HAPCO/MOH, 2007, p.2

In the year 2005, there were 658 VCT centres. There has also been a growing increase in the number of people receiving VCT services. In 2004/2005, 41,387 people were counselled and tested, while in 2005 the number jumped to 367,006.⁶ The increase in demand has been attributed to better accessibility of affordable and effective medical care for persons living with HIV.⁷

However, there is a growing recognition that, despite the encouraging results to date, in the light of the magnitude and spread of the virus in the country “the national response and intervention are still far from adequate”.⁸

1.2 Problem statement and rationale

Voluntary Counselling and Testing (VCT) is considered as the basic starting point for prevention, care, treatment and support services. It encourages people to learn their HIV status and its implications, and enables them to make behavioural changes in the future regardless of their HIV status.⁹ This service has been recognised in Ethiopia as a cost-effective preventive strategy and was initiated in the late 1980s.¹⁰

However, despite wide acceptance of VCT as the crucial entry point for HIV/Aids prevention and treatment, the practical reality concerning its usage in Ethiopia is worrisome. Many people are reluctant to undergo VCT and thus the incidence of testing in the country remains very low. According to the Demographic and Health Survey (DHS) 2005,¹¹ only 4% of women and 6% of the men in the general population experienced HIV testing. There is a stark discrepancy between the numbers in urban and rural areas. While 17.6% of women and 19.6% of men in urban areas took the test; only 1.2% of women and 2.9% of men in rural areas did the same. Similarly, the national Behavioural Surveillance Survey (BSS),¹² which involved ten different population groups, identified that the lowest testing rate was among farmers, i.e. 0.8%.

⁶ HAPCO, 2006, p. 39

⁷ HAPCO/MOH, 2007, p.2

⁸ HAPCO, 2006, p.39

⁹ HAPCO/MOH, 2007, p.2

¹⁰ Ministry of Health in WHO, 2006

¹¹ CSA, 2005, p.196

¹² MoH, 2002, p. 51

This research explores the factors that influence an individual's decision whether or not to choose VCT. The factors considered include: fear of stigma; perception of risk to self; perception of VCT; degree of knowledge of HIV/VCT; social capital and socio-demographic variables, such as age, sex, and income.

Broadly speaking, most of the studies in Ethiopia on VCT are based on subjects or documentation from antenatal clinics in urban areas. Not much is known about the state of VCT uptake outside the clinic context or in rural areas. There is no consensus on the factors that affect VCT, and the direction of influence of any of the identified factors.

One study asserted that factors like socio-demographic variables, previous sexual history, the degree of knowledge of HIV/VCT and self-perceived susceptibility were not found to be significantly associated with pre-marital HIV testing. On the contrary, this particular study attributed the occurrence of pre-marital HIV testing to whether or not couples have discussions about HIV and VCT.¹³

Alemu et al (2004) identified a set of factors prohibiting the spread and use of VCT services in the northern part of Ethiopia¹⁴ that are closely related to societal issues, including expectation of negative consequences in the aftermath of disclosure of an HIV-positive status. The repercussions include abandonment and abuse, dissolution of marriage, family break-up, discrimination, and psychological distress and depression. Another factor that deters people from undergoing VCT is dissatisfaction with the implementation of the service, which includes issues of accessibility, confidentiality and limited treatment options for Persons Living with HIV/AIDS (PLWHAs).

Shinn (2001) and Habte (2003) cited the culturally prompted practice of secrecy regarding personal matters as being the main contributing factor to the low level of VCT in the northern part of the country.¹⁵

Another factor put forward to explain the reluctance to take the HIV test was low perception of the risk to self. According to the BSS preliminary report in Ethiopia, self-

¹³ Habte, 2003, p.19

¹⁴ Alemu et al, 2004, p. 83

¹⁵ Shinn, 2001 and Habte, 2003, p.18

perception of risk was invariably very low across all societal groups, including those that exhibit risky sexual practices.¹⁶

A study also uncovered a discrepancy between the willingness to undergo HIV-testing and actually taking the test. In Harar, one of the regions in eastern Ethiopia, while close to three-fourths (73.6%) of the respondents expressed a willingness to ask their spouse to undergo testing, the numbers who underwent testing in reality were significantly lower.¹⁷ Likewise, another study in Ethiopia found that less than half (43.5%) of the people who underwent VCT showed up to collect the results.¹⁸ There was a similar result in an antenatal clinic in Ethiopia, where roughly one-third (35.0%) of the infected women returned for their results.¹⁹

With specific reference to the study area, namely the Gurage Zone, there is a lack of research on the socio-economic determinants of VCT in a context where there is high male migration to bigger towns and an estimated 100,000 people living with HIV/AIDS.²⁰ The Gurage Zone HIV/AIDS Desk (2007) has also emphasised the lack of research on HIV/AIDS-related topics, including VCT in the area.

By exploring the association between VCT usage and the aforementioned independent variables, this study hopes to be instrumental in determining what intervention is needed to tackle barriers to VCT in the study area. The study also hopes to further the existing knowledge about VCT usage by individuals in Ethiopia, which so far has concentrated primarily on data provided by antenatal clinics in urban areas, focusing mainly on women. The study attempts to accomplish its aim by focusing on and involving subjects of both sexes randomly selected from a rural and non-clinic environment in Moher and Aklil district, Gurage Zone, Southern Nations Nationalities Peoples Regional state (SNNPR), Ethiopia.

¹⁶ MOH, 2002 in Habte, 2003, p.22

¹⁷ Habte, 2003, p.18

¹⁸ Sahlu et al 1999, p. 127 in Solomon, 2004, p.14

¹⁹ Temmerman et al., 1995 in Solomon, 2004, p.16

²⁰ Ethiopian Journal of Health Development, 2001, pp. 7-20

1.3 Assumptions

The study is guided by the following assumptions:

1. VCT usage is higher among individuals with less fear of stigma.
2. Individuals with moderate/high self-perception of risk are less likely to take VCT, compared with their counterparts with no/small perception of risk.
3. Individuals belonging to social groups and networks (Idir, Iqub, Mahiber, and Debo) are less likely to take VCT.
4. The lower the income of people, the less likely they are to take VCT.
5. Individuals lacking knowledge about HIV/AIDS or VCT are less likely to take VCT than their counterparts with better knowledge on the issues.
6. Teenagers (aged 15-19) are less likely to take VCT than their adult counterparts.
7. Women are less likely to take VCT than their male counterparts.
8. Marriage (meeting a marital requirement) is more likely to be the motivation for individuals to take VCT than any other reason.

1.4 Objectives of the study

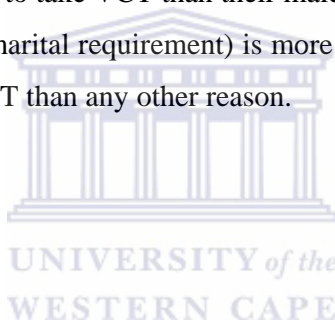
1.4.1 General objective

Acknowledgement of the importance of HIV Counselling and Testing (HCT) as a vital strategic entry point to prevention, treatment, care and support services necessitates an assessment of the different factors that affect individuals' behaviour towards counselling and testing. Therefore, this study primarily aims to examine factors that influence whether or not individuals undergo HIV counselling and testing, and their receptiveness of the test.

1.4.2 Specific objectives

This study sets out to attain the following specific objectives:

1. Provide a theoretical context within which the significance of VCT usage, demand for VCT, and factors influencing VCT usage are presented.
2. Identify the rate of HIV testing in the study area.



3. Identify factors that influence HIV testing among individuals.
4. Examine the influence of demographic factors (e.g. age, sex, and income) on the practice of HIV testing among individuals.
5. Examine the relationship between the level of social capital and the practice of HIV testing among individuals.
6. Examine the relationship between the self-perception of risk and the practice of HIV testing among individuals
7. Increase our knowledge of the practice of HIV testing among individuals.

1.5 Scope of the study

The study involved 200 individuals drawn from selected rural *Kebeles* (lower-level administrative structures) in Moher and Aklil district in Gurage Zone, SNNPR state, Ethiopia. Therefore, the generalisation of findings, as well as the applicability of conclusions, is confined to the target district. Even within the specific community, the study focused on individuals between the ages of 15 and 49, who comprise the most affected section of the society in the country (*Refer to Chapter 3 for detailed presentation on sampling and methodology*).



1.6 Literature review

Related literature was reviewed to establish the theoretical context within which the issue of VCT usage can be examined, and to gain insight into the different factors that influence HIV testing. Consequently, only literature pertinent to the issue of VCT usage was reviewed. This restriction was imperative for the focus of the study, in view of the extensive research existing in the area of HIV/AIDS.

Different topics of interest were addressed. The first topic covered set out to define the different ways in which VCT is conceived: as a prevention strategy, as an entry point to care and support services, as a psycho-emotional support, as a process of informed consent, as a strategy to challenge stigma or as a human right. Debate surrounding the differences in the conceived efficacy of VCT as prevention strategy was presented, i.e. whether it really brings about behavioural change and how to measure this effectively. One argument holds that VCT effects behavioural change. The second argument

qualifies the first by contending that change does happen but only in cases where the test results are HIV-positive, and not where the results are HIV-negative.

The other topic covered in the literature is the debate over what constitutes demand for VCT in a community. What can be used to measure VCT acceptability in a given society is debateable: is it the proportion of persons willing to take the test or the proportion of those who actually take the test? The latter position appears to be more acceptable since the former is clouded with the stark reality that rarely do those expressing willingness to take VCT actually do so.²¹

Because the primary focus of this study is on the factors that influence VCT usage, literature on a number of contributing factors was reviewed. There are opposing theories regarding socio-economic and demographic factors. While one group argues that such factors are only good enough to provide the profile of participants, the other group holds that these factors might shed light on existing structural differences, or even pre-existing stigma, which in turn would affect the use of VCT. The main point raised about the influence of these factors is that they can be an important influence if there is a restriction on taking VCT based on age, whereby minors are expected to obtain parental consent for the medical procedure. Sex is cited as a relevant influencing factor, as women might face numerous dilemmas and inhibitions due to their vulnerable position in the household as well as society. Other variables considered are age and income.²²

Another influencing factor that was considered is knowledge about HIV/AIDS/VCT. While one group argues that such knowledge indeed influences VCT usage positively, other groups argue that knowledge of this kind has no influence whatsoever, or rather influences VCT usage negatively.²³

Fear of stigma was identified as one of the major factors that inhibit individuals from undergoing VCT. Individuals face the dilemma of whether or not they should get tested mainly because “a positive result brings to reality their worst fears.”²⁴ Specifically, the crux of HIV stigma lies, not in the physical body but rather in the manner in which

²¹ Solomon, 2004; UNAIDS, 2001; Efficacy Group, 2000

²² Policy Project, 2006; Morrison, 2006; Maman, S., et al., 2001; UNAIDS, 2001; Solomon, 2004

²³ Habte, 2003; MoH, 2002; Shinn, 2001; HSRC, 2005

²⁴ Jackson, 2002, p.196

AIDS is conceptualised. It is common for AIDS to be viewed in the light of moral and theological perspectives: as a sin, evil, or abdication of moral responsibility. Such conceptions of AIDS have resulted in people adopting segregation, discrimination and exclusion as a way of dealing with AIDS. AIDS contains a striking blend of many elements of fear in the “social psyche”.²⁵

With regard to the influence of risk perception of VCT, one group argues that high or low risk perception motivates people to take VCT, while another group contends that risk perception has no role in determining VCT usage.²⁶

Social capital was the other important concept covered in the literature review. The debate here is that as much as VCT can be a source of support during the time of the personal crisis of HIV/AIDS, group norms and values could hold back individuals from taking VCT.²⁷

1.7 Organisation of the study

This mini-thesis comprises five different sections. Section one contains introductory information about the state of HIV/AIDS and VCT in Ethiopia, the assumptions explored by the study, the problem statement and the operational definition of key concepts. Section two comprises a literature review and theoretical framework. This section attempts to give an overview of pertinent works in the area and provide a theoretical context for examining the factors that influence the VCT usage of individuals. The third section describes the research design and methodological approach of the study. The fourth section focuses on a discussion of the results of the study. The fifth and final section presents conclusions and recommendations drawn from the study results.

²⁵ Goffman, 1963; Jackson, 2002; Solomon, 2004; Policy Project, 2006; Deacon, 2005; Blume, 2004

²⁶ MOH, 2002; Solomon, 2004

²⁷ Bourdieu in Porte, 1998; Porte, 1998

1.8 Operational definition of key terms

This section includes the operational definition of concepts that are key components of the study.

- **VCT** is a process including pre- and post-counselling, testing and knowledge of one's status; having a preventive role since it enables those experiencing it to alter their risky sexual behaviour, regardless of their HIV status, either by preventing the spread of the virus or further illness of the already infected.
- **Stigma** refers to an attribute or feature which "significantly discredits" an individual according to others.
- **Fear of stigma** refers to the anxiety of being on the receiving end of stigma as a result of one's HIV-positive status being known by others.
- **Risk perception** refers to the sense of exposure an individual feels to HIV/AIDS in the light of past experience.
- **Social capital** refers to the social ties and networks that people acquire in their day to day lives, owing to their membership in community-based traditional institutions. These are community-based social institutions that comprise part of the social capital of the local people:
 - *Eder or Idir* is a traditional association that operates at community level and provides a sort of insurance service.
 - *Iqub or Equb* is a saving group in which community members contribute cash regularly, and receive payment on a rotational basis.
 - *Mahiber* is a traditional and religious association common among Orthodox Christians, where members who voluntarily join the group pay homage to God or any of the many saints.
 - *Debo* is a co-operative of farmers which offers members support, often in the form of labour, either rotationally or in times of need/crisis.

Chapter 2 – Factors influencing VCT usage

2.1 Introduction

This chapter aims to establish a theoretical context within which the issue of VCT usage can be examined. Consequently, and despite extensive research in the area of HIV/AIDS, only literature pertinent to the issue of VCT usage was reviewed. The chapter includes material on the different dimension of VCT, the demand for VCT, the effectiveness of VCT as a prevention strategy and the factors influencing VCT uptake among individuals. The last topic discusses each influencing factor separately. The different influencing factors reviewed are: socioeconomic and demographic factors, knowledge of HIV/AIDS/VCT, self-perception of risk, perception of VCT, fear of stigma, social capital, and the perceived benefit of VCT.

2.2 Dimensions of VCT

VCT has been described as an intricate concept with multiple dimensions as it comprises components of different processes, including voluntariness, counselling and testing, all of which have their own varying definitions. This has resulted in numerous definitions of VCT. The principal definitions are highlighted briefly in subsequent paragraphs.

Firstly, VCT is seen as a prevention strategy, and described in terms of its role and function in deterring or containing the spread of the virus among people; and preventing further illness among those with an HIV-positive status. This conception is based on recognition of the inability to prevent HIV transmission medically and the lack of universal access to Antiretrovirals (ARVs) for sero-positive individuals.

Secondly, VCT is conceived to be a method of fostering health. As an entry point, VCT facilitates linkage with treatment and care services for those diagnosed as HIV-positive.²⁸

²⁸ Solomon, 2004, pp. 45-52

Thirdly, VCT is acknowledged as a form of psycho-emotional support that contributes to the emotional and psychological wellness of those infected with and affected by HIV/AIDS.

Fourthly, VCT is considered as a process of informed consent, in which it is important that people completely comprehend the testing process so that they can make informed decisions about testing. Voluntariness is the focal point of this definition.²⁹

Fifthly, VCT is conceived in terms of its role to normalise HIV/AIDS solely as another life-threatening illness and to challenge the stigma surrounding it, and to reduce the stigma currently attached to HIV-positive persons.³⁰

Finally, VCT is viewed in terms of its relation with human rights, and is thus an “ethical and moral obligation” and not just a mere health service. In other words, people have the right to be informed about HIV and its repercussions; to choose to either know or not know their status; and to get counselling and support while taking the test and dealing with the result.³¹

The brief outline above illuminates the diversity in the way VCT is envisaged, which can be attributed mainly to differences in emphasis on its different aspects. Although the concept is deconstructed for the purpose of analysis, VCT comprises all these aspects simultaneously.

The next section focuses on the debates regarding the effectiveness of VCT as a prevention strategy against HIV/AIDS and issues related to the measurement of VCT efficacy.

2.3 Effectiveness of VCT as prevention strategy

One of the issues of contention regarding VCT is the extent to which it lives up to its role as a prevention strategy against HIV/AIDS by effecting behavioural change among those who take the test.

²⁹ Solomon, 2004, pp. 45-52

³⁰ UNAIDS, 2001, p.8; Solomon, 2004, p.52

³¹ Solomon, 2004, pp. 45-52

The effectiveness of VCT is seen in terms of the attainment of two objectives: primary prevention, where those who test HIV-negative undergo behavioural change, and secondary prevention, where those who test HIV-positive experience behavioural change.³²

United Nations AIDS and International Development and Support (UNAIDS) described the issue of demonstrating the effectiveness of VCT as daunting, considering the intricate nature of the process and the possibility of different outcomes. The issue has generated a lot of interest, as it is imperative to prioritise as well as mobilise resources for the process. This is particularly important in the context of poor developing countries which, despite their acknowledgement of VCT services as an entry point for further care and support services and despite the high prevalence rate of AIDS; have not been able to scale up VCT services due to resource limitations. As a result, many people still cannot access the service.³³

Generally, when it comes to demonstrating the efficacy of VCT in bringing about change in risky behaviour, the results from different studies have not been conclusive. According to Solomon (2004:4), *“The pattern of results varied substantially across, and within, study populations and were often limited by methodological weaknesses.”*³⁴

Most studies conducted in the West agree that VCT is effective as a secondary prevention, since it brings about behavioural change among those who tested positive. However, there is not much support to the effectiveness of VCT as a primary prevention, bringing about behavioural change among those who tested negative.³⁵ Conversely, studies carried out in an African context reported mixed outcomes on the effectiveness of VCT in realising behavioural change among either those who tested positive or those who tested negative. As a case in point, a study in rural Uganda found that VCT did not bring about any behavioural change on those who underwent it, regardless of their sero-status, compared with those who did not undergo VCT. Conversely, another study in Uganda showed that those who underwent VCT displayed

³² UNAIDS, 2001, p.7; Solomon et al, 2004, p.4

³³ UNAIDS, 2001, p.7

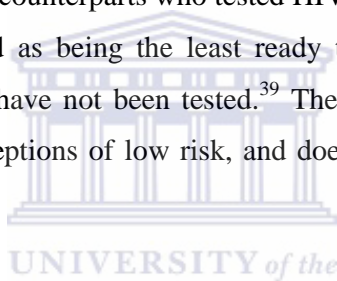
³⁴ UNAIDS, 2001, p.17

³⁵ Solomon, 2004, p.4

more behavioural change than those who did not experience VCT, despite their sero-status.³⁶

Regardless of the above contention, there is, nonetheless, consensus in the international literature (from studies in Africa as well as in the West) regarding the efficacy of VCT in bringing about behavioural change among those who tested positive, as opposed to those who tested negative.³⁷

Trials carried out in Kenya, Tanzania and Trinidad between 1995 and 1998 to investigate the effectiveness of VCT in reducing unprotected sex, found that infected individuals and couples were more likely to refrain from risky sexual behaviour, compared with their counterparts who tested HIV-negative.³⁸ Likewise, a study in Rwanda showed that women who tested positive were more likely to practice safe sex (i.e. use a condom) than their counterparts who tested HIV-negative. Women who tested HIV-negative were identified as being the least ready to compromise on the use of condoms with partners who have not been tested.³⁹ These results imply that an HIV-negative status prompts perceptions of low risk, and does not bring about behavioural change.



There is also contention about the appropriateness of the indicators adopted to demonstrate behavioural change. One indicator of behavioural change is the use of a condom. Nonetheless, it is arguable whether or not condom use can be employed as an indicator of behavioural change among HIV-negative people. Many HIV-negative people undergo VCT in order to find out their status and be able to start afresh in a monogamous relationship, in which they would probably stop using a condom. A case in point is a study in Uganda, which uncovered the fact that 27% of the participant individuals were taking the test because they were planning to get married. In the case of couples, 84% took VCT because they were planning to get married or start a relationship.⁴⁰ This makes condom use an inappropriate indicator of behavioural change among such groups of people. However, condom use can still be relevant as an indicator

³⁶ Solomon, 2004, p.5

³⁷ UNAIDS, 2001, p.14; Solomon et al, 2004, p.5

³⁸ Efficacy Group, 2000, pp. 176-177

³⁹ UNAIDS, 2001, p.14; Solomon et al, 2004, p.5

⁴⁰ Muller et al in Solomon, 2004, p.5

in the case of those individuals who are sexually active, but not married or faithful to one partner.

In Africa, the effectiveness of VCT in bringing about behavioural change in individuals, regardless of their HIV status, seems to be determined by other factors. One of these factors is whether couples take the test together or individually. VCT is effective if a person taking VCT has a partner with a different sero-status and they undergo counselling together. Such a scenario often results in reduced risky sexual behaviour and increased condom use. This result also holds true especially when it is the male partner who is HIV-negative, because in reality it is male partners who determine to a great extent the use of a condom.⁴¹

In order to demonstrate how effective VCT can be as a primary as well as a secondary intervention against HIV/AIDS, it is crucial to recognise the importance of scaling up efforts and mobilising scarce resources to this end. There is already consensus about the role and contribution of VCT to behavioural change among those testing HIV-positive, but there is little consensus about behavioural change among those testing HIV-negative. The lack of agreement is also exacerbated by the dubious nature of the indicators used to measure the behavioural change.

The next section highlights the debate surrounding the issue of the demand for VCT in a given society and how it is perceived by that society.

2.4 Demand for VCT

Finding the right indicators to measure demand for VCT has been challenging and contentious. Broadly speaking there are two arguments. The first argument emphasises that willingness to test is an indicator, and holds that the number of people willing to take the test is an appropriate indicator of the demand for VCT in a given society. However, there are studies that argue that using willingness or acceptability as an indicator can be erroneous. Studies in different countries (e.g. Abidjan, Kenya, Tanzania, Malawi, Zambia and Zimbabwe) have found a high acceptability rate of VCT in the population. However, using acceptability as an indicator of demand for VCT is

⁴¹ Van der Perre, et al in Solomon et al, 2004, p.5

debatable, as it is not often the case that people with a positive perception of VCT will undergo testing or plan to do so. Accordingly, it is common to find places where acceptability of VCT is very high, but the rate of HIV testing is very low. There is even a difference between a willingness to test and a willingness to know results. Many studies have highlighted this discrepancy. According to a study in Zambia that investigated the use of VCT, only 9.4% of those apparently willing did actually take the test. What is more, less than half of those who took the test showed up to collect their results. Therefore, the implication is that “although self-perceived risk and high-risk behaviours were positively associated with initial willingness to test, they were not associated with the actual use of VCT services, demonstrating that the use of VCT services may be predicated on far more complicated factors than attitudes towards these services.”⁴²

The second argument proposes that a more appropriate indicator of demand for VCT in a given society would be not the number of people who are willing to take the test, but the proportion of those who collected their test results (i.e. return rates). Studies that emphasise return rates as an indicator have, in general, identified the rate of return to be very low. According to a study in Ethiopia, less than half (43.5%) of the people who underwent VCT showed up to collect their results.⁴³ Likewise, a study in Nairobi found that only a bit over one-third (35.0%) of the women who took the test returned to collect their results.⁴⁴ Although their rates might be a bit higher, many other studies have also asserted the low rate of return. Furthermore, rate of return is a useful indicator, since a reluctance to collect test result implies a shift in a person’s interest to learn about his or her HIV status.⁴⁵

This rate of return to collect test results has also been identified as a way of measuring the effectiveness of the counselling procedure. For instance, in many African studies on VCT, clients were offered pre-test counselling in a group, with post-test counselling being offered individually. Being a member of a group during the pre-test counselling might put pressure on an individual member to take the test, but without the co-commitment to return for the results or to know one’s status. It is also worth noting that

⁴² Solomon et al, 2004, p.14

⁴³ Sahlu et al in Solomon, 2004, p.14

⁴⁴ Temmerman et al 1995 in Solomon et al, 2004, p.14

⁴⁵ Solomon et al, 2004, p.14

most of the studies about the acceptability of VCT were conducted in antenatal clinics that characteristically display the counselling procedure outlined above.⁴⁶

Finding ways to measure demand for VCT services in a society is divisive. While some insist the number of people willing to take the test can be a good reference, others highlight drawbacks of such a measurement, mainly the difference in the proportion of those expressing willingness to take the test and those actually taking the test. Hence, the second group propose that the number of people who actually took the test or return to collect their test result is a more reliable measure of demand for VCT.

The next section focuses on the factors that influence whether or not individuals take VCT.

2.5 Determinants of VCT

Numerous factors hinder the uptake of VCT service by more people. These determinants can be grouped into two broad categories, namely, internal and external barriers. Internal barriers include those factors that are related to the delivery of VCT services. External factors include those aspects that are characteristic of VCT clients or their respective communities. Depending on the nature of the influencing factor, strategies suggested to address the VCT barriers also vary. Revising policies and strategies is the proposed solution for internal barriers. Conversely, external barriers are often long established, as they relate to perceptions and fears, and thus can only change gradually.⁴⁷ Accordingly, external determinants are best suited to explain the difference in VCT usage at individual and community level, and they are the focus of discussion in subsequent sections.

2.5.1 Socio-economic and demographic factors

Studies have explored the significance of socio-economic and demographic factors on individual decisions to take the HIV test. Persons visiting VCT centres are often the subject of such studies. All the same, there is no consensus among these studies about the role that socio-economic and demographic factors play in the percentage of people

⁴⁶ Solomon et al, 2004, p.14

⁴⁷ Solomon et al, 2004, p.60

who take the HIV test.⁴⁸ The first group of studies assert that socio-economic and demographic factors are only useful to define the demographic and behavioural features of those clients who underwent VCT. Even when these factors happen to be significantly associated with the rate of HIV testing, they are regarded as falling short of fully accounting for differences in people's decisions to take VCT.⁴⁹

Conversely, these studies hold that these socio-economic and demographic factors play a significant role in influencing individual behaviour towards HIV testing. There is an assertion that socio-demographic variables might play a role in worsening other forms of stigma, when they serve as either sources or rationale for structural disparity in a society. HIV/AIDS stigma is compounded when coupled with existing structural disparities and/or other forms of stigma and discrimination, which might be based on sex, class, race, and sexuality. Accordingly, HIV/AIDS might affect to a different extent those PLWHAs who belong to different structural groups.⁵⁰

Likewise Morrison, highlighting the role of demographic attributes to stigma, stated that pre-existing stigma might be directed towards sex, sexual orientation, class or economic status; and these might be considered as features that either violate societal norm, or are expressions of inferiority or lack of strength. To substantiate his claim, Morrison added, *"In South Africa, AIDS was perceived as a poor African woman's disease, while in Mexico it was equated with homosexuality."*⁵¹

The sections below present the significance of selected socio-economic and demographic factors to HIV testing.

2.5.1.1 Sex

Sex has been one of the most frequently cited socio-demographic factors used to explain willingness to undergo VCT. The main assertion here is that the prevailing sex inequality affects a woman's decision regarding VCT. That is, women are apprehensive about how their partners would respond to testing, and they are also

⁴⁸ Fridlund & Msowoya, 2000 in Solomon, 2004, p.17

⁴⁹ Beardsell and Coyle in Solomon, 2004, p.17

⁵⁰ Policy Project, 2006, p.7

⁵¹ Morrison, 2006, pp.4-5

inhibited by the negative perceptions of their partners about VCT. This sex-based disparity is also parallel to the one that undermines a woman's ability to minimise her risk of infection. As a case in point, a study in a VCT clinic in Tanzania identified the principal barriers to VCT among women being: anxiety about the partner's reaction, the decision-making and communication pattern with the partner and partner's attitude to VCT.⁵² Furthermore, most studies demonstrated the challenge faced by women to practice or negotiate safer sex following VCT.⁵³

The other major assertion is that men and women have contrasting motives for taking VCT. Often men are said to take the test to confirm if they are HIV-negative, while women take the test to learn if they are HIV-positive. This difference in motive has been attributed mainly to the relative vulnerability of women. Again, the study in a VCT clinic in Tanzania showed that women's perception of their personal risk of HIV was the major factor prompting them to undergo VCT.⁵⁴

The level of stigma, perceived or actual, that women face when infected is more pronounced. In the African context, for instance, there is disparity in the consequences befalling men and women in the aftermath of disclosure. Women are blamed for bringing the virus into the family, especially when they happen to be the first to learn their sero-positive status. Women frequently incur the blame, despite the fact that their infection is often due to men's risky sexual behaviour.⁵⁵

2.5.1.2 Age

Age is the second demographic factor identified. It is considered by some studies as one of the determinants of VCT usage. In many countries, as part of medical procedures, young people are expected to attain a certain minimum age before they can undergo VCT without the consent of their parents. In countries like Malawi, Mozambique, Tanzania, Zambia and Zimbabwe, which are characterised by high rates of HIV infection, their respective legislation defines 18 years as the age of consent for medical procedures.⁵⁶ However, it is worth noting that despite the legal constraint of a minimum

⁵² Maman, S., et al., 2001, p. np

⁵³ UNAIDS, 2001, p.15

⁵⁴ Maman et al 2001 in Solomon, 2004, pp. 17-18

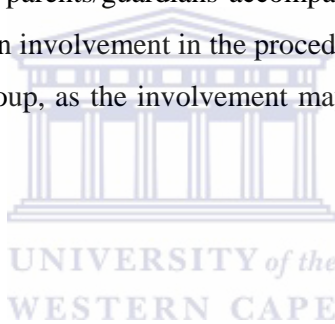
⁵⁵ Solomon, 2004, p.24

⁵⁶ Boswell and Baggaley, 2002

age of consent, VCT is very useful to this group, as a great proportion of youth become sexually active prior to this age. In Uganda, 72.0% of women have had sexual intercourse by the age of 18.⁵⁷ In Ethiopia, 35.0% of young women and 9.0% of young men had sex by age of 18.⁵⁸

According to a Behavioural Surveillance Survey (BSS) conducted in Ethiopia,⁵⁹ sex before marriage was common among the youth. Out-of-school youth had more sexual partners than in-school youth. Male youths also had higher number of sexual partners than their female counterparts.

From the above discussion, it is not clear whether VCT is considered as a major medical procedure or if VCT centres actually adhere to the minimum age-of-consent regulation. However, age can be a barrier to counselling and testing if persons below the minimum age are obliged to have their parents/guardians accompany them when taking the test. The need for parental/guardian involvement in the procedure might also stifle interest in taking the test among this group, as the involvement may mean lack of confidentiality or privacy.



2.5.1.3 Income

Income level has also been identified as one of the hurdles to VCT. In the face of abject poverty, people have either negative or indifferent attitudes towards VCT, as they are beset by other problems that require their immediate attention on a constant basis. For people living in abject poverty, being HIV-positive or negative is of little significance and might simply mean that they will not be able to cater for the needs of their families when they fall ill. They usually prefer not to know their HIV status.⁶⁰

Furthermore, in Ethiopia, for instance, although there are centres that offer VCT for free, other centres charge a minimal fee, which might be beyond the capacity of people from certain income groups and thus prove a potential obstacle to them taking VCT.

⁵⁷ DHS, 1995 in UNAIDS, 2001, p. 33

⁵⁸ CSA, 2005, p.205

⁵⁹ MoH, 2002, p. 20

⁶⁰ Solomon, 2004, p. 64

The aforementioned points imply that people from low-income groups are less likely to take VCT, either distracted by acute poverty and the constant struggle for survival, or the lack of finance to cover the fee for testing.

2.5.2 Knowledge of HIV/AIDS, VCT

Studies have shown that there is no strong linkage between knowledge of HIV/AIDS and VCT and a willingness to undertake VCT. In Ethiopia, several studies confirmed that knowledge of and about HIV/AIDS, VCT and VCT centres was widespread.⁶¹

Likewise, according to the BSS conducted in Ethiopia,⁶² at the national level, misconceptions regarding HIV/AIDS prevail among participants from all population groups. The gaps in knowledge differ among the groups, and the gap was pronounced among disadvantaged population groups, namely farmers and pastoralists. Despite satisfactory knowledge of prevention methods among the different population groups, close to half of the participants were not able to name the three prevention modes. Furthermore, although condoms were widely accessible, participants from all population groups held erroneous perceptions about them.

Contrary to the rate of knowledge about HIV/AIDS or VCT, the rate of VCT uptake in Ethiopia is still very low.⁶³ Similar results were also reported in South Africa, where despite the presence of knowledge of VCT (its function) and the whereabouts of centres providing the service (its accessibility), the uptake of VCT in rural parts of South Africa and among the aged was very low.⁶⁴

The preceding discussion points out that HIV/AIDS-related knowledge plays a minor role in influencing the behavior of individuals to take the HIV test.

⁶¹ Habte, 2003, p.19

⁶² MoH, 2002, pp. 57, 87 & 89

⁶³ Shinn, 2001 and Habte, 2003, p.18

⁶⁴ HSRC, 2005

2.5.3 Self-perception of risk of HIV/AIDS

With regard to the significance of the self-perception of risk, there is no consensus on which sero-status group would agree to VCT more, as a result of mixed results from different studies. A study in Northern Uganda showed that volunteering to be tested is not influenced by sero-status.⁶⁵ Similarly, the return rate for test results and post-test counselling in Ethiopia were not determined by sero-status, as the rate of return was the same for women from both sero-status groups.⁶⁶

Studies acknowledge that the view that a high perception of risk drives individuals to undergo VCT is mistaken. According to two studies that dealt particularly with the topic, their findings showed that there was no significant correlation between high-risk behaviour and willingness to do HIV testing.⁶⁷ Males with non-regular partners were more reluctant to know their sero-status, as they are aware of their sexual behaviour. This reluctance has been associated with psychological factors of denial and avoidance-coping.⁶⁸ According to a BSS conducted in Ethiopia,⁶⁹ participants from all population groups have, overall, a low perception of risk. This is true even for female sex workers. This low perception of risk might account for the low level of testing in the country.

High self-perception of risk results in anxiety about knowing one's status, which is characterised either by a reluctance to undertake VCT or a failure to return for the test result. If such people do take the test, it is when they are already seriously ill and showing symptoms of the viral infection.⁷⁰

People who take the HIV-test but do not return for their results or to participate in post-counselling were likened to those who were not willing to take the test in the first place, since they seem to have changed their minds about wanting to know their sero-status. Accordingly, a study in Burkina Faso discovered that, compared with HIV-positive women; HIV-negative women were three times more likely to return for their test

⁶⁵ Odwee & Okurut in Solomon, 2004, p.16

⁶⁶ Sahly et al in Solomon, 2004, p.16

⁶⁷ Sahly et al, Machezano in Solomon, 2004, p.16

⁶⁸ Wilson et al. in Solomon, 2004, p.16

⁶⁹ MOH, 2002, p. xx

⁷⁰ Solomon, 2004, p.66

results.⁷¹ There was a similar result in an antenatal clinic in Ethiopia, where only just over one-third (35.0%) of the infected women returned for their results.⁷²

These findings imply that individuals who return for their test results are those with the perception that their test results are negative. In fact, it has been argued that “people who are unlikely to be infected are the ones who take the test”.⁷³

The foregoing discussion illuminates the lack of consensus about the role of risk-perception in HIV testing. On the one hand, there are assertions that the more exposed or vulnerable people feel, the more likely they want to take VCT and confirm their status. On the other hand, others hold that if people feel more exposed to the virus, they are less likely to take VCT to avoid stigma and loss of status. Yet again, some researches suggest that persons with low perception of risk are the ones who are more likely to take VCT. The lack of consensus among studies here could be attributed to the difference in social context, which can play a decisive part in the role of risk-perception in VCT. That is, when people have so much at stake if found HIV-positive, they are less likely to take the HIV test, no matter how high their perception of the infection risk.

2.5.4 Fear of stigma

The concept of stigma refers to an attribute or feature which “significantly discredits” an individual according to others as defined by the respective cultural setting,⁷⁴ Goffman, who is one of the leading contributors to the conceptualisation of disease stigma, argued that people having socially-defined undesirable characteristics, for instance HIV/AIDS, acquire “spoiled identity” that results in social devaluation and discrimination.⁷⁵

Stigma can serve as a social control mechanism operating to maintain status quo. Accordingly, it can serve to enforce social norms, whereby the exhibition of a stigmatised characteristic or behaviour entails disrespect and discrimination.⁷⁶

⁷¹ Cartoux et al., 1998 in Solomon, 2004, p.16

⁷² Temmerman et al. in Solomon, 2004, p.16

⁷³ Manson in Solomon, 2004, p.16

⁷⁴ Policy Project, 2006, pp. 3-4

⁷⁵ Deacon, 2005, p.15

⁷⁶ Parker & Aggleton in HSRC, 2005, p.16 & Blume, 2004, pp.1-2

Fear of stigma has been identified as one of the major factors that inhibit individuals from experiencing VCT. Individuals face dilemmas whether or not they should get tested mainly because “a positive result brings to reality their worst fears.”⁷⁷

Likewise, people are inhibited from knowing their sero-status for fear of being stigmatised by their families, communities, workplace, school, and church. Fear of stigma is accentuated when it is coupled with lack of treatment facilities for PLWHAs, and breach of confidentiality of test results.⁷⁸

Specifically, the crux of HIV-specific stigma lies, not in the physical body, rather in the manner in which AIDS is conceptualised. It is common for AIDS to be viewed through moral and theological perspectives as evil, a sin or abdication of moral responsibility. Such conceptions of AIDS have resulted in people adopting segregation, discrimination, and exclusion as a way of dealing with AIDS. AIDS contains a striking blend of many elements of fear in the “social psyche”. The most commonly encountered stories about AIDS are those that link it directly to promiscuous homosexuality, prostitution, casual sex, and drug abuse.⁷⁹ This conception of HIV/AIDS invokes blame and social reprisal. According to a BSS conducted in Ethiopia,⁸⁰ stigma is pronounced in rural areas and particularly among females. The prevalence of a stigmatising attitude differs among the different target groups, ranging from 99.4% in male pastoralists to 55.7% in truckers.

From the ongoing discussion it is evident that the social control role of stigma and its impact could also account for an individual’s unwillingness to take the HIV test, by creating anxiety about the consequences of an HIV-positive status. Accordingly, fear of stigma stifles willingness to take VCT. Hence, the higher the level of fear of stigma, the less likely the individual would be to undergo VCT.

2.5.5 Social capital

The social capital level of individuals is assumed to impact on them whether or not they take VCT. Social capital, which is understood to mean “social ties and networks”, is closely linked with the social control dimension of stigma. In other words, social capital

⁷⁷ Jackson, 2002, p.196

⁷⁸ Solomon , 2004, p.65

⁷⁹ Aggleton, 1988, p. 29

⁸⁰ MOH, 2002, p. 84

is considered as one of the main sources of social control, as it serves to enforce societal norms and values.⁸¹

Despite popular conceptions that social capital is all-beneficial, there are instances when, as a source of social control, social capital might result in the following undesirable outcomes. Firstly, the exclusion of outsiders, when the same social ties that bring about rewards for members are employed to exclude others from entering the group. Secondly, the unwarranted expectations by the group of the individual member, which is in contrast to the first, as it is the member who is barred by the group from realising the expected benefits. Thirdly, the constraints on individual freedoms, where by virtue of involvement in the community or group, individuals are expected to live up to group expectations, despite differences in individual taste. Fourthly, “downward levelling norms”, which confine individuals to less ambitious groups and thereby force more ambitious members to leave the group.⁸²

We can imply that the socially controlling influences of social capital can partly contribute to the difference in HIV testing among individuals, in that the fear of confronting these sanctions and pressures makes an individual reluctant to take the test. The individual wishes to avoid being different from the rest of the group, and so maintains the presumption of an HIV-negative status. Different groups will have different influences on their members with regard to taking VCT.

There are studies that demonstrate a positive contribution by social capital towards VCT. According to a study in Zambia, the decision of young people on whether or not to undergo the HIV test was determined by relational aspects like interaction with families. The study examined the role of different groups before and after the test, and concluded that adolescents discussed VCT with family and friends before and after it, and they would not take the test until a member of the family or a friend had encouraged the action. The study showed that the youngsters who talked with their families about getting tested were six times more likely to plan to take an HIV test⁸³ than those who did not have such discussions.

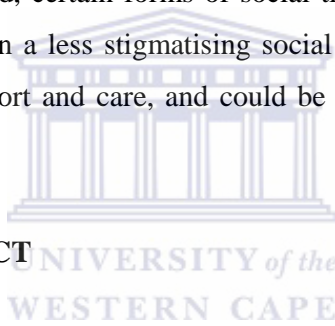
⁸¹ Bourdieu in Porte, 1998, p.12

⁸² Porte, 1998, pp. 15-17

⁸³ Denison, 2006, pp.5-6

Conversely, the fear of stigma harboured by the youth and their anticipation of negative response from family and friends were identified as inhibitions against undergoing VCT. Specifically, the qualitative data on Zambian youth showed that they were afraid their families would question their sexual behaviour and relationships if the families knew they planned to visit or had visited VCT centres. The youth also admitted that fear of mockery by their peers either for taking the test or for being infected was a major deterrent factor.⁸⁴

From the ongoing discussion it is evident that social capital, particularly as a source of social control, significantly influences whether individuals take VCT or not. However, there are contrasting assertions about the nature of the influence. On the one hand, it is seen to play a deterrent role towards taking VCT. The more socially connected people are, the more likely they are to be exposed to social reprisals associated with having HIV/AIDS. On the other hand, certain forms of social ties were claimed to encourage individuals to take the test. In a less stigmatising social context, social connectedness could also be source of support and care, and could be less deterring to the taking of VCT.



2.5.6 Perceived benefit of VCT

Belief by individuals that they will benefit from VCT has been identified as one of the factors explaining their decision to undergo VCT. This has been confirmed by different studies that focus on the people who visit VCT centres, and their respective reasons. The main group that perceives a benefit from VCT comprises couples wanting to make plans for the future, namely for marriage, giving birth or to have unprotected sexual intercourse, or making changes in their lives to reduce their vulnerability to HIV infection.⁸⁵

These statements imply that the more significant the benefits that individuals perceive or hope to get from taking VCT, the more likely they would take the test.

⁸⁴ Denison, 2006, pp.5-6

⁸⁵ Gibney et al; Maman et al in Solomon, 2004, p.17

According to the Ethiopian DHS 2000,⁸⁶ although only 2.0% took HIV testing, two-thirds of these men surveyed expressed their willingness to take the test. Similarly, a BSS conducted in Ethiopia, which involved ten different population groups,⁸⁷ revealed a discrepancy between actual practice and individual perception of the benefits of HIV testing. That is, despite a large proportion of persons (over 76%) reporting willingness to undergo VCT in the future, the proportion of individuals who actually experienced VCT was very small. Except for the uniformed services, 27.3% of whom were tested, among the other population groups the number who underwent testing was less than 11%. Bearing in mind that this study was conducted in a rural context, it is worth noting that testing rate among farmers was the lowest of all groups, i.e. 0.8%⁸⁸. However, the BSS falls short of providing explanation about the difference between the different community-based traditional institutions.

2.6 Chapter summary

In this chapter, pertinent literature was reviewed to put the issue of VCT in context, and to gain insight into factors that influence individual behaviour towards taking VCT. Discussion on the issue of efficacy of VCT as a preventive strategy was presented, highlighting debates as to how to measure effectiveness. The demand for VCT and contentions regarding appropriate indicators of demand was also discussed. Most importantly, a review of the different factors influencing VCT put forward in the literature was made. These factors included socio-economic and demographic variables (sex, age and income), fear of stigma, social capital, self-perception of risk, perceived benefit of VCT, and knowledge of HIV/AIDS. Under each of the above factors, contesting ideas were presented about the role and significance of each to influence VCT behaviour. By doing so, this chapter lays the ground for subsequent sections. The chapter to follow presents the methodological approach that informed the survey.

⁸⁶ CSA, 2001, p.169

⁸⁷ including in-school youth, out-of-school youth, uniformed services, transport workers, farmers, pastoralists, factory workers, and female sex workers

⁸⁸ MoH, 2002: pp. 89 & 96

Chapter 3- Methodological Approach

3.1 Introduction

This chapter presents methodological aspects of the study. The chapter includes brief discussion on the selection and profile of the study area, the sampling design and determination of sample size, data collection and analysis methods, and ethical considerations.

3.2 Study area

The study was based on data collected from randomly selected households in Moher and Aklil district, Gurage Zone, Southern Nations Nationalities Peoples Region (SNNPR), Ethiopia.

To give a brief description of the study area, the Gurage Zone, which is part of the SNNPR, is located in the south western part of Ethiopia. Gurage Zone is inhabited by different nations and nationalities including the Gurages, Kebenas, and the Marekos. The Zone has an area of 72 km². According to the region's statistics office (2004/2005), the population in the Zone is projected to be 1,666,979 (48.4% and 51.6% female) by the year 2007/08. According to PEDD (1998 E.C.), the overwhelming majority of the people (95.0%) live in rural areas engaged in agriculture. The remaining 5.0% of the population live in urban centres.

For administrative purpose, the Zone is divided into thirteen districts, with Moher and Aklil being one of the districts. Each district is again structured into rural and urban *Kebeles* (the lowest government administrative structures). The zone is also broadly divided into two categories namely East and West, with the Moher and Aklil district belonging to the Western part of Gurage.

Moher and Aklil district is chosen for this study to allow assessment of the different determinants of individuals' usage of VCT. Although the district resembles other districts in the Zone in many socioeconomic and demographic aspects, it is distinctly known for having strong affiliation to the traditional Ethiopian Orthodox Church, which

has shaped values and norms in the area on different facets of every day life. This particular situation is deemed relevant to explore, particularly in relation to social capital, which is one of the explaining variables in the study.

The total population of the district is projected to be 118,464 (47.6% male and 52.4% female) by the year 2007/08. For administrative purpose, the district is divided into 29 rural and one urban *Kebeles* (lower level administrative structures).

3.3 Sampling Design and Sample Size

Sample size

A statistical formula $[n = ((Z_{\alpha/2})^2 (P*Q))/E^2]$ was used to determine sample size for the study. To this effect, rate of HIV testing at the national level was taken into account. The Demographic and Health Surveys (DHS) and Census reports indicated that proportion of individuals who take HIV/AIDS testing to be very low. That is, among the adult population age 15-49, four percent of women and six percent of men have been tested for HIV at some time. The figures for the SNNPR are even smaller (2.7% female, 3.9% male)⁸⁹. However, taking the highest national prevalence rate and assuming an increase in the testing rate from the maximum 6.0% to 12.0%, P is taken to be 0.12.

Thus, taking P to be 0.12 and fixing the level of confidence at 95 percent, the sample size was determined as follows:

Figure 1 Sample size formula

$$n = \frac{[Z_{\alpha/2}]^2 P*Q}{E^2} = \frac{(1.96)^2 * 0.12 * 0.88}{(0.05)^2} = 162$$

Assuming a 19 percent contingency, the final sample size n was taken to be 200 (i.e. 162+38).

⁸⁹ CSA, 2006, pp.196-197

Sampling procedure

A multi-stage sampling procedure was used in the study. A brief description of the sampling process at the different stages is presented below.

Stage 1- Selection of farmers associations

Four farmers associations were randomly selected. The sampling frame did not include all the 29 farmers associations in the district, rather only those farmers associations that are adjacent or relatively near to the district town, which is Hawariat. This is due to logistic constraint including wide geographic coverage of the district, difficulty of accessing transportation facilities, and financial constrain. Farmers associations that are farther from the district town were excluded. The four randomly selected farmers associations include Chedza, Qorer, Yeshehara, and Ginab.

Stage 2- Selection of households

Two hundred households were selected from the four farmers associations. Despite difference in relative household and population size among the four selected farmers associations, the sample was equally distributed among them. That is, 50 households from each farmers association.

It was not possible to find in time the list of all households in each farmers association, as the district officials pointed out the lack of such a list and the time- and financial-implications of preparing one. However, each farmers association was divided into certain number of villages. Five villages were selected from each farmers association to draw a sample of ten households from each. By dividing the total households in the village by ten, a sampling interval was obtained for each farmers association. The starting sample household (between 1 and the sampling interval) was selected from the village list prepared by the enumerators. The rest of the households were selected by continuously adding the sample interval to the number of the next selected household.

Stage 3- Selection of respondents

Once the households were selected, individual respondents were also selected randomly. This was done by first preparing a list of all members of the household that are between the ages of 15 and 49 as a sampling frame. Then the lottery method was used by enumerators to pick a household member to take part in the study.

3.4 Methods of data collection and analysis

In order to explore the assumptions and address the research question, data was gathered to this effect through a predominantly quantitative approach. However, the research also had a qualitative dimension since supplementary qualitative data was gathered using qualitative methods.

3.4.1 Data collection instruments and procedures

Data was gathered from respondents using pre-tested structured questionnaire. The questionnaire was prepared in English and later translated into Amharic (the local language). The questionnaire comprises four major parts. Section one contains socioeconomic and demographic variables. Section two includes questions about HIV/AIDS related knowledge and perception. Section three focuses on issues related to risk perception. Section four deals with knowledge, perception, and actual VCT usage. Section five comprises questions about fear of stigma. The final section focuses on different aspects of social capital.

To supplement the quantitative data, qualitative data was collected through unstructured interview guides with individuals and groups from the area. The participants for the qualitative data include those who did not take part in the quantitative data collection, specifically three senior ranking officials at Zone and district level, and seven local people (3 women and 4 men).

The questionnaire was administered using face to face interviews by sixteen enumerators (9 male, 7 female). The enumerators work as 'Extension Health Workers' in the selected farmers associations. The enumerators were given a one day orientation

on the study instruments, interviewing skills, and purpose of the study. The actual data collection by the enumerators took three days.

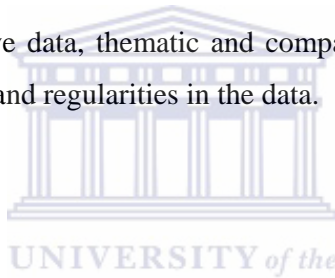
3.4.2 Method of Analysis

The data collected using the structured questionnaire was cleaned and entered into Statistical Package for Social Sciences (SPSS).

The analysis part consists of descriptive statistics (frequencies and cross tabs). More importantly, to test whether certain factors are associated with HIV testing, chi square test of association was used. The chi-square statistic answers whether the two variables are independent. The above statistical tools were adopted because of their appropriateness. The chi square test was computed with 95.0% confidence level.

With respect to the qualitative data, thematic and comparative analysis methods were employed to discern patterns and regularities in the data.

3.5 Ethical consideration



Ethical clearance to conduct the study was obtained from the Zone Health Office, Zone HIV/AIDS Desk, and the District Health Office. After explaining the purpose of the study, oral consent was obtained from the respondents. Confidentiality of the information was maintained by leaving out names of respondents.

3.6 Variables

3.6.1 Dependent variable

The dependent variable to be measured in this study is usage of HIV testing, that is, whether or not the individual has ever undergone HIV testing.

3.6.2 Independent variables

The selection of the explanatory variables is informed by literature on the topic. The literature highlights the role of certain factors in influencing the behaviour of

individuals regarding HIV testing. The ensuing presentation highlights the main explaining factors and the different indicators used to measure them.

Socioeconomic and demographic variables

1. The literature suggests that various socioeconomic and demographic factors are likely to influence individuals practice with respect to HIV testing. Such variables are also relevant to get insight if there is any local pre-existing stigma that reinforce HIV-specific stigma, and undermines uptake of VCT. Variables selected in this study to this effect include:

Age- this variable takes two values, namely those below and above 19 years

Sex – this variable has two values, male or female.

Family's monthly income- this variable has been transformed into two categories, that is, those earning monthly income of 200 Ethiopian Birr (ETB)⁹⁰ or less, or those earning above 200 ETB.

2. **Knowledge about HIV/AIDS-** this variable was measured using nineteen questions on knowledge about VCT, HIV transmission and prevention, and misconceptions on HIV/AIDS. Each correct response is assigned a score of 1 and an incorrect response a score of zero. The knowledge score takes two values, low or high, with the average as the threshold. The questions used to measure the variable include:

- Whether one heard about HIV or not
- Knowledge of different ways of getting HIV
- Knowledge about the different ways of preventing HIV
- Whether one thinks there is cure for AIDS
- Whether one thinks people can get the virus by sharing meals with the infected person
- Whether one thinks people can get the virus from mosquito bites
- Whether one thinks a pregnant person can transmit the AIDS virus to her unborn child
- Whether one thinks there is a way to prevent the transmission of the virus from the mother to her unborn child
- Whether one thinks people can get the virus through supernatural means

⁹⁰ 1USD = 8.8 ETB

- Whether one thinks it is possible for a healthy looking person to have the AIDS virus
 - Whether one heard about VCT
 - Whether one can know if he has HIV
 - Whether one knows where to go if one wants an HIV/AIDS test
3. **Risk perception-** this variable has two values, i.e. whether one's risk perception is low (i.e. none/small) or high (i.e. moderate/high).
4. **Fear of stigma-** this variable is measured using five different questions. Scores were assigned to the response: 1 correct, 0 incorrect. The variable was then transformed to have only two values, high level of fear of stigma or low level of fear of stigma. The average score is used as a benchmark. These questions are:
1. Whether or not family/relatives let the individual, if sick, be treated in their homes
 2. Whether one should be ashamed of oneself if one was infected with the virus that causes AIDS
 3. Whether one should be blamed for bringing the virus that causes AIDS
 4. Whether or not individuals treat at their homes a family member who is sick
 5. Whether one brings shame to one's family if infected with the virus that causes AIDS
5. **Social capital-** refers to social ties and networks in this study. Membership to community based traditional institutions is considered to make up individuals' social capital. To understand whether a relationship exists between social capital and VCT respondents were asked two questions. First, whether one is a member of any community based institution. Second, to which community based group does the individual belong to (E.g. Idir, Iqub, Mahiber, and Debo)
6. **Perceived benefit of VCT-** two variables are considered to have insight about individuals' perception towards VCT. These are: whether marriage is the reason to get HIV/AIDS test and whether one is willing to undergo VCT in the future.

3.7 Chapter summary

The chapter highlighted the methodological approach employed for the research. A multistage systematic sampling was used to select respondents for the study from four farmers associations. The chapter also described the data collection and analysis tools used, which include a combination of tools appropriate for qualitative and quantitative study. The chapter comprised a description on the nature of the variables and their respective values. This chapter is useful in providing information about the methodological aspects of the study, and helps put the research in context. The next chapter deals with the presentation of findings of the survey.



Chapter 4 - Results of the Survey

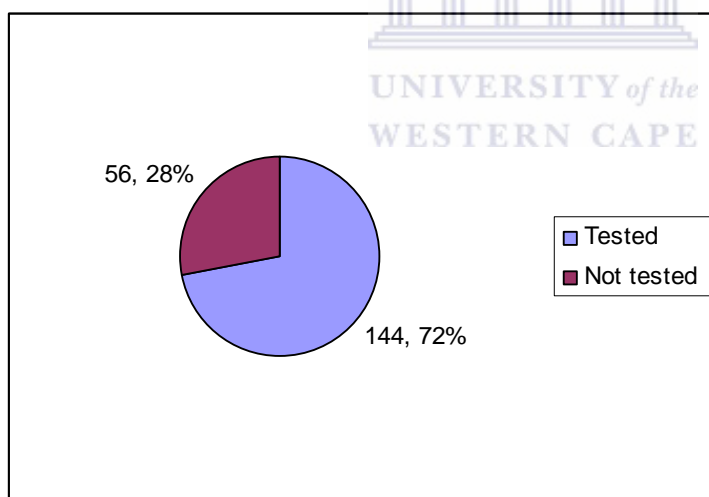
4.1 Introduction

This chapter aims to present the results of the survey administered. In particular, the chapter sheds light on whether or not the explaining variables are indeed related to whether or not individuals take VCT. Chi square test of independence is employed to decide whether or not the relationship between the VCT usage and the explaining variables is significant. In addition, percentage and frequency are used to illustrate the findings.

4.2 Prevalence of HIV Testing

To get information on testing prevalence, respondents were asked if they had ever been tested. The majority of the respondents admitted that they did not take the test while the rest of the respondents claimed to take the test, as depicted in the chart below.

Chart 1 Distribution of respondents by testing status



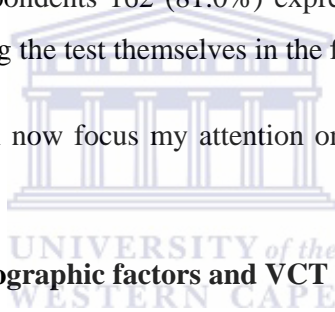
The manner in which respondents took the test differs. Accordingly, while 32 (58.2%) of the respondents claimed to ask for the test, the rest 23 (41.8%) were required to take the test for different reasons such as ailments and requirement to acquire visa to certain countries or marriage. With regard to the duration since they took the test, over half 28 (52.8%) claimed to take the test in the past 12 months while it had been 13-23 months 9 (17.0%) and above 2 years 16 (30.2%) since the rest took the test.

With respect to counseling, the vast majority of the respondents 50 (98.0%) claimed to have received pre-test counseling. Similarly the vast majority of the respondents 48 (94.1%) claimed to receive counseling after taking the test. The remaining respondents 3 (5.9%) stated that they did not receive any counseling after taking the test.

Respondents who claimed to take the VCT were also asked if they actually collected their test results. Accordingly, 35 (77.8%) respondents gave a positive response. On the other hand, 10 (22.2%) stated that they did not collect their test results. Here, 11 respondents did not want to give a decisive response to this question perhaps due to the sensitive nature of the information particularly if HIV status is positive.

It is worth noting that information was also collected about willingness to take HIV test for both those who had taken the test before and those who had never taken the test. While 25 (12.5%) of the respondents expressed their strong or moderate disagreement, close to four-fifth of the respondents 162 (81.0%) expressed their strong or moderate agreement to the idea of taking the test themselves in the future.

In subsequent sections, I will now focus my attention on the findings as per variables identified earlier.



4.3 Socioeconomic and demographic factors and VCT usage

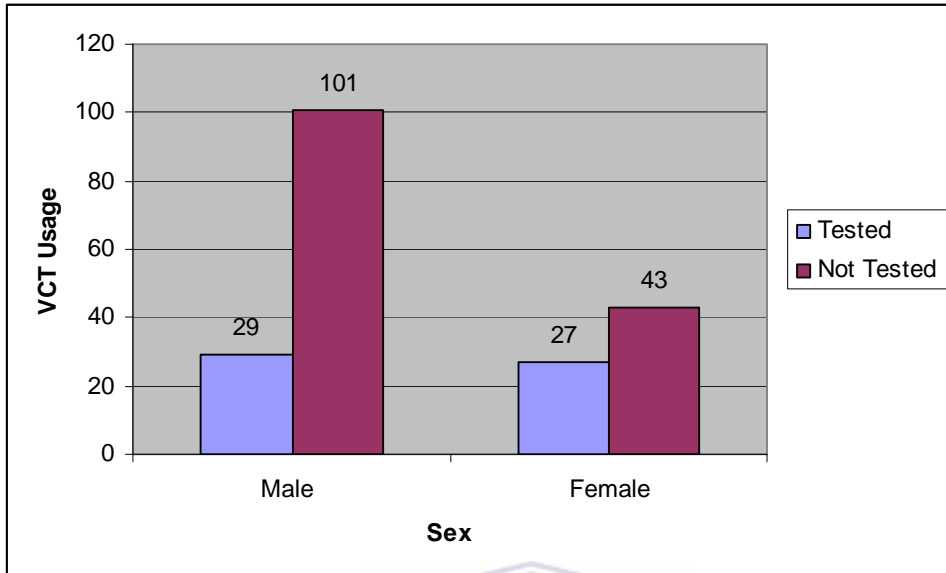
This section is a review of the socioeconomic and demographic accounts of respondents. With respect to marital status while close to two-thirds of the respondents 131 (65.0%) were married, the remaining 69 (35.0%) respondents were single, as illustrated in the figure below.

The distribution of respondents by educational level shows that 117 (58.5%) were educated. The rest of the respondents, 83 (41.5%) were illiterate.

In subsequent sections, the association of some of the socioeconomic and demographic factors (namely, sex, age, and income) with whether or not individuals take VCT is explored.

4.3.1 Sex and VCT usage

Chart 2 Sex by VCT usage

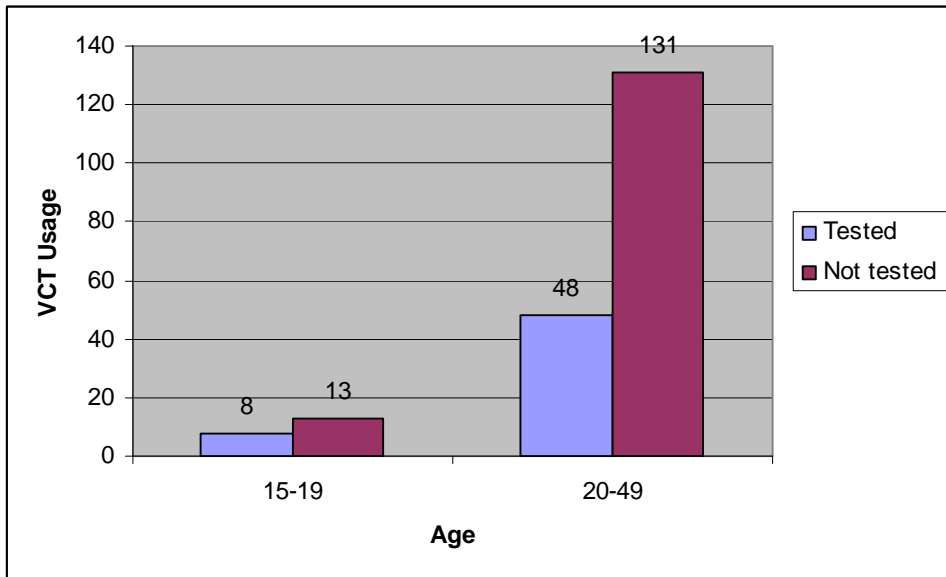


As depicted in the above figure, of the total 200 respondents, 130 (65.0%) were male and 70 (35.0%) were female. Examining the assumption whether men are more likely to take VCT, the cross classification between sex and VCT usage revealed that they are significantly associated with one another. While 38.6% of the female respondents tested for HIV, only 22.3% of the male respondents took the test. The chi-square test shows that the relationship between sex and VCT usage is significant ($\chi^2=5.970$; $df=1$; $p=0.015$). However, the results depict that it is the women who are more likely to take the test.

4.3.2 Age and VCT usage

With respect to age, the mean age of the respondents is 34.2 (+/- 10.0). The majority of the respondents (137, 68.5%) were aged 30 or above. Looking into the assumption whether minors are less likely to take VCT than adults, the cross classification of age and VCT usage, as depicted in the table below, shows that there was a testing rate of 38.1% among 15-19 year olds, and 26.8% among 20-49 year olds. The chi-square test shows that the relationship between age and VCT usage of individuals is not significant ($\chi^2=3.888$; $df=3$; $p=0.274$). That is, the difference in VCT usage across and between the two age categories is not significant enough statistically, and thus age does not influence taking HIV test.

Chart 3 Age by VCT usage



4.3.3 Income and VCT usage

Close to three-fourths of the respondents (73.3%) had an average monthly family income of 200 Ethiopian Birr (ETB)⁹¹ or less. The rest of the respondents had an average family income ranging between 201 and 2100.

Exploring the assumption whether people from low income family are less likely to take VCT than those from high income families, the cross classification of respondents' monthly family income and their VCT usage revealed that there was a testing rate of 22.4% among those in the income range of 0-200 ETB, and a testing rate of 22.6% among those in the income range of 201-2100 ETB. The chi square test shows that the two variables are not significantly related ($\chi^2=0.001$; $df=1$; $p=0.979$). Hence, there is no statistically significant difference in testing among people from different income categories, and thus income level influences little HIV testing.

⁹¹ 1USD = 8.8 ETB

Table 1 Income by VCT usage

Average monthly income	VCT Usage		Total
	Yes	No	
0-200	19	66	85
	22.4%	77.6%	100.0%
201-2100	7	24	31
	22.6%	77.4%	100.0%
Total	26	90	116
	22.4%	77.6%	100.0%

In relation to income, the respondents were from different occupational categories⁹². The majority of the respondents were farmers 124 (62%). The rest were students 32 (16.0%), unemployed 25 (12.5%), and merchants 19 (9.5%).

4.4 Knowledge on HIV/AIDS/VCT and VCT usage

This section is a review of the respondents' knowledge on HIV/AIDS and VCT related issues. Different variables dealing with various aspects of knowledge are considered first, and then they are transformed into one variable, knowledge index, to assess the relationship of knowledge on different HIV/AIDS related issues to VCT usage.

4.4.1 Awareness about HIV/AIDS

Respondents were asked if they are aware about HIV/AIDS. Almost all participants (99.0%, 198) claimed that they have heard about HIV/AIDS. Only 2 female participants stated that they have not heard about HIV/AIDS.

4.4.2 Knowledge of HIV transmission methods

Respondents were requested to list the different modes of transmission for HIV. The following table depicts the proportion of respondents citing the specific method, and its distribution by respondents' sex.

⁹² The category 'merchants' refer to those that are self-employed and engaged in trading business of different scales. The category 'unemployed' includes housewives, those engaged in unpaid work, and the job less.

Table 2 Knowledge of HIV transmission methods by sex

Transmission methods	Male	Female	Total
Sexual intercourse	108 (83.7)	53 (79.1%)	161 (82.1%)
Via infected blood	52 (40.3%)	25 (37.3%)	77 (39.3%)
Sharing razor blade, needles, etc.	83 (64.3%)	46 (68.7%)	129 (65.8%)
Mother to child	40 (31.0%)	27 (40.3%)	67 (34.2%)
Total cases	129 (65.8%)	67 (34.2%)	196 (100.0%)

Sexual intercourse is the method cited by the highest proportion of respondents (161, 82.1%). The second most known transmission method was sharing blade which was mentioned by 129 (65.8%) of the respondents. The other two less known methods were via infected blood (77, 39.3%) and mother-to-child (67, 34.2%).

4.4.3 Knowledge on HIV preventions methods

Respondents were asked to cite the different ways to reduce HIV transmission. The ensuing table summarizes the distribution of respondents along the different prevention methods they reported.

Table 3 Knowledge of HIV prevention methods by sex

Prevention methods	Male	Female	Total
Condom	72 (55.8%)	25 (37.9%)	97 (49.7%)
Abstinence	52 (40.3%)	27 (40.9%)	79 (40.5%)
Being faithful	81 (62.8%)	38 (57.6%)	119 (61.0%)
Not sharing razor blades, needles	67 (51.9%)	43 (65.2%)	110 (56.4%)
Total cases	129 (66.2%)	66 (33.8%)	195 (100.0%)

The most known prevention method was being faithful, which was cited by 119 (61.0%) of the total respondents. the second most known method of prevention was not sharing blades, which was mentioned by 110 (56.4%) of the respondents. The other two methods were less known: while using condom was mentioned by 97 (49.7%) of the respondents, abstinence was cited by 79 (40.5%) of the respondents.

Looking at the significant disparity across sex, higher proportion of male respondents was aware about condom than their female counterparts (55.8% and 37.9%, respectively). Conversely, higher proportion of female respondents was aware about the prevention role of not sharing blades than their male counterparts (65.2% and 51.9%, respectively).

4.4.4 HIV/AIDS related misconceptions

Respondents were asked different questions to see the existence of common misconceptions. The following table summarizes the distribution of respondents who gave correct response on these questions.

Table 4 HIV/AIDS related misconceptions by sex

Respondents who said	Male	Female	Total
There is no cure for AIDS	97 (75.2%)	54 (77.1%)	151 (75.9%)
People cannot get the virus by sharing meals with the infected person	117 (90.7%)	48 (68.6%)	165 (82.9%)
People cannot get the virus from mosquito bites	87 (67.4%)	29 (41.4%)	116 (58.3%)
A pregnant person can transmit the AIDS virus to her unborn child	72 (55.8%)	47 (67.1%)	119 (59.8%)
There is a way to prevent the transmission of the virus from the mother to her unborn child	74 (57.4%)	33 (47.1%)	107 (53.8%)
People cannot get the virus through supernatural means	119 (92.2%)	60 (85.7%)	179 (89.9%)
It is possible for a healthy looking person to have the AIDS virus	97 (75.2%)	52 (74.3%)	149 (74.9%)
<i>Total cases</i>	<i>129 (64.8%)</i>	<i>70 (35.2%)</i>	<i>199 (100.0%)</i>

The above table depicts that there is relatively less misconceptions regarding whether or not people can get the virus through supernatural means, or whether or not people can get the virus by sharing meals with an infected person, or whether or not there is cure for AIDS, or whether or not a healthy looking person can have the virus, since most respondents gave correct responses on these items (89.9%, 82.9%, 75.9%, 74.9%, respectively). On the other hand, there is relatively higher misconception about whether or not a pregnant woman can transmit the virus to her unborn child, or whether or not there is a way to prevent transmission of the virus from the mother to her unborn child, or whether or not the virus can be transmitted through mosquito bites, as only less than three-fifth of the respondents gave correct responses on each of these issues (59.8%, 53.8%, and 58.3%, respectively).

4.4.5 Knowledge about VCT

Respondents were asked whether or not they are aware of a way a person can learn his/her HIV status. As depicted in the table below the vast majority of the respondents

(93.5%) stated that it is by taking a test at the health centers, the remaining 6.5% of the respondents admitted that they had no idea as to how this can be done.

Table 5 Knowledge on how to learn HIV status by sex

Knowledge on how to learn HIV status	Sex		Total
	Male	Female	
Don't Know	10	3	13
	7.7%	4.3%	6.5%
Health Centre	120	67	187
	92.3%	95.7%	93.5%
Total	130	70	200
	100.0%	100.0%	100.0%

Respondents were also asked if they specifically know where to go to take the test. As depicted in the table below, the vast majority (95.5%) gave a positive response while the remaining respondents (4.5%) admitted they had no idea where to go to have the HIV test.

Table 6 Knowledge of specific place to take the test by sex

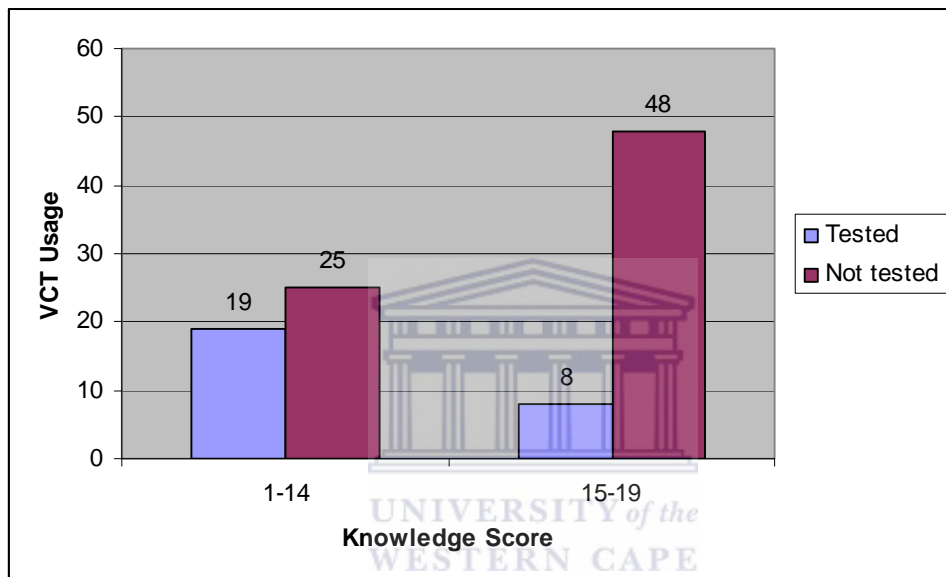
Knowledge on where to take the test	Sex		Total
	Male	Female	
No	4	5	9
	3.1%	7.1%	4.5%
Yes	126	65	191
	96.9%	92.9%	95.5%
Total	130	70	200
	100.0%	100.0%	100.0%

4.4.6 Knowledge on HIV/AIDS/VCT and VCT usage

The above mentioned variables were transformed into one, i.e. Knowledge index/score. Average score of knowledge was taken after coding and scaling from total score of 19 from the questions about knowledge on transmission, prevention, and VCT; and misconceptions about HIV/AIDS (ranging between 0=min and 19=max). Respondents' average knowledge score was 14.8. Participants with the score of 15 and above were, thus, considered knowledgeable. Accordingly, while 44 (44.0%) lack knowledge, the rest of the respondents 56 (56.0%) were knowledgeable. Disaggregated by sex, the proportion of male respondents with knowledge score of 15 and above was higher than their female counterparts (58.9% male, 48.1% female).

Investigating the assumption whether individuals with high level of knowledge are more likely to take VCT, the cross tabulation of respondents' knowledge score on HIV/AIDS/VCT and their VCT usage reveal that there was a testing rate of 43.2% among those lacking knowledge as opposed to a testing rate of 14.3% among those with high knowledge scores. The chi square test shows that the two variables are significantly related ($\chi^2=10.438$; $df=1$; $p=0.001$). However, unlike the assumption, it is rather those lacking knowledge that are more likely to take VCT.

Chart 4 Knowledge score by VCT usage



4.5 Risk perception to HIV/ADS and VCT Usage

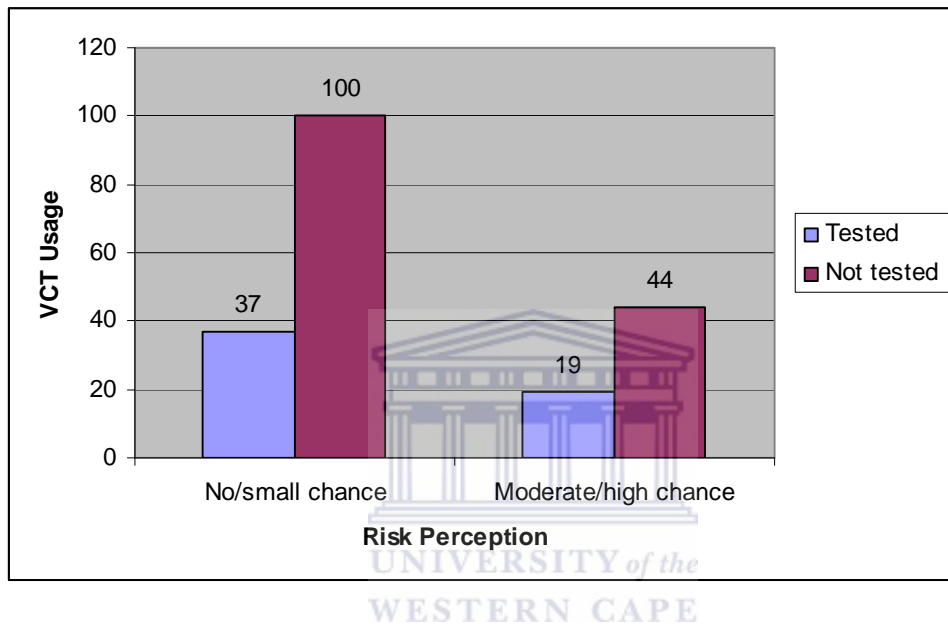
To gain insight about perception of vulnerability to HIV/AIDS, respondents were asked whether or not they have ever had sex. Accordingly, three-fourths 151 (75.5%) of the respondents admitted to having sex while the rest 49 (24.5%) claimed that they never did. Disaggregated by sex, more men had sex than women (76.9% and 72.9%, respectively).

On the other hand, the majority of the respondents (68.5%) perceived that they had no/small chance of being exposed to the virus. The remaining respondents (31.5%), conversely, believed that they had moderate/high chance of being exposed to the virus. There was no difference between men and women in this regard.

Exploring the assumption whether individuals having high risk perception are more likely to take VCT than those with low risk perception, cross classification of

respondents' risk perception and their VCT usage indicate a testing rate of 27.0% (37) among those with no/small perception of risk and a 30.2% (19) testing rate among those with moderate/high perception of risk. The chi square test shows that the two variables are not significantly related ($\chi^2=0.213$; $df=1$; $p=0.645$). Hence, there is no significant among individuals with different risk perception to HIV/AIDS, and thus level of risk perception influences taking HIV test only slightly.

Chart 5 Risk perception by VCT usage



4.6 Fear of stigma and VCT usage

Five questions dealing with the issue of fear of stigma were transformed into a single variable called stigma index or stigma score, which takes two values. To get information about participants' response on the five questions, the following table highlights specifically how respondents expect to be treated if they were infected with HIV.

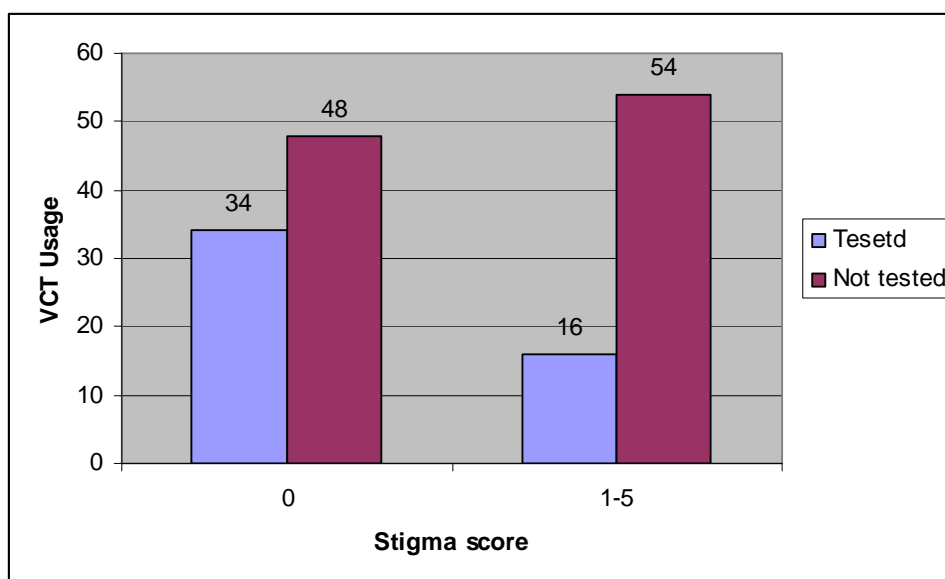
Table 7 Perceived treatment after infection by sex

Stigma	Male	Female	Total
If a member of my family is sick with the AIDS virus, I would treat him at my home	121 (93.8%)	68 (97.1%)	189 (95.0%)
If I become sick with the virus that causes AIDS, my family/relatives would let me be treated in their household	100(77.5%)	60 (85.7%)	160 (80.4%)
I should not be ashamed of myself if I was infected with the virus that causes AIDS	92 (71.3%)	56 (80.0%)	148 (74.4%)
I should not be blamed for bringing the virus into the community if I was infected with the virus that causes AIDS	99 (76.7%)	56 (80.0%)	155 (77.9%)
If I was infected with the virus that causes AIDS, I don't bring shame to my family	78 (60.5%)	45 (64.3%)	123 (61.8%)
Total cases	129 (64.8%)	70 (35.2%)	199 (100.0%)

Average score of stigma was taken after coding and scaling a total score of 5 from the variables about perception of treatment after testing HIV positive, particularly about fear of stigma. The average score for stigma was 0.99. Respondents with score of 1 and above were considered to have high fear of stigma, and those with the score of zero were considered as having low level of stigma. Accordingly, while 82 (53.9%) had low fear of stigma, the rest of the respondents 70 (46.1%) harbour strong fear of stigma. There is also disparity between the two sexes whereby men were more likely to embrace fear of stigma than women (51.0% and 37.0%, respectively).

Examining the assumption whether individuals with high fear of stigma are less likely to take VCT, the cross tabulation of respondents' stigma score and their VCT usage revealed a testing rate of 41.5% (34) among those with low stigma score (low fear of stigma) as opposed to a testing rate of 22.9% (50) among those with high stigma score (high fear of stigma). Chi square test shows that the two variables are significantly related ($\chi^2=5.922$; $df=1$; $p=0.015$). Hence, there is a statistically significant difference in testing rate among individuals having different level of fear of stigma, and thus those with low level of fear of stigma are indeed more likely to take HIV test.

Chart 6 Stigma score by VCT usage



In line with this, one of the benefits of VCT is reduce HIV transmission through reduction of risky behaviour after the test. This involves disclosing one's HIV status to partner to make viable changes in sexual behaviour. Asked if they would tell their partners the results of their HIV tests, the majority 145 (87.9%) gave a positive response. The remaining 20 (12.1%) asserted that they would not tell the test result to their partner. A significant proportion of the respondents (35) did not want to respond to the question or were not sure about their action. Disaggregated by sex, the proportion of respondents willing to share their HIV test results to their partners was higher among female than male respondents (reported by 92.7 and 85.5 percent, respectively).

4.7 Social capital and VCT usage

To get information about the level of individuals' social capital respondents were asked if they belong to any community based institutions in the form of Idir⁹³, Iqub⁹⁴, Mahiber⁹⁵, or Debo⁹⁶, all of which are very popular in the country as well as in the

⁹³ *Eder or Idir* is a traditional association that operates at community level and provides a sort of insurance service.

⁹⁴ *Iqub or Equb* is a saving group in which community members contribute cash regularly, and receive payment on a rotational basis.

⁹⁵ *Mahiber* is a traditional and religious association common among Orthodox Christians, where members who voluntarily join the group pay homage to God or any of the many saints.

particular study area. Over three-fourths of the respondents 157 (78.5%) claimed that they are members of such groups. The rest of the respondents 43 (21.5) stated they did not belong to any of those groups.

The cross tabulation between respondents membership in any of the community based institutions in the community and their VCT usage reveal a testing rate of 29.3% for those belonging to the different community based institutions as opposed to a testing rate of 23.3% among those that do not belong to any of those groups. The chi square test shows that the two variables are not significantly related ($\text{Chi}^2=0.612$; $\text{df}=1$; $\text{p}=0.434$). Hence, there is no statistically significant difference in testing rate between those with better level of social capital and those with little, and thus social capital influences little whether individuals take HIV test or not.

Table 8 Membership to community based institutions by VCT usage

Debo membership	VCT usage		Total
	yes	No	
Yes	46	111	157
	29.3%	70.7%	100.0%
No	10	33	43
	23.3%	76.7%	100.0%
Total	56	144	200
	28.0%	72.0%	100.0%

Looking at the distribution of respondents by their membership to the specific groups, two-thirds of the respondents expressed their membership in Idirs. The other group having the next highest membership rate was Mahiber, cited by 42.2% of the respondents. Iqubs also attracted membership from 28.8% of the respondents. Membership in Debo was cited by 3.2% of the respondents.

Analysis of membership to specific groups was also done to see if there is any significant relationship. While there was no statistically significant relationship between membership to Idirs and Iqubs, and VCT usage; there was a statistically significant relationship ($\text{chi}^2=6.276$; $\text{df}=1$; $\text{p}=0.012$) between membership to Mahiber and VCT usage, and thus those belonging to such groups are less likely to take HIV test than those that are not members.

⁹⁶ *Debo* is a co-operative of farmers which offers members support, often in the form of labour, either rotationally or in times of need/crisis.

With respect to the treatment of PLWHAs in these groups, when asked if they think there are members that live with the HIV in their respective groups, 49 (31.6%) stated there are such members while 74 (37.0%) stated there are not. The rest (32, 20.6%) could not give a decisive response.

When respondents, who claimed that there are members living with HIV/AIDS in their respective groups, were asked if PLWHAs are receiving support in the groups, the majority (38, 82.6%) gave a positive response. On the other hand, the rest of the respondents (8, 17.4%) stated that no support is given to the PLWHAs in the groups.

Conversely, respondents were also asked if they are aware of PLWHAs in the groups that were subject to different forms of discrimination. Accordingly, only eight respondents stated that they are aware of PLWHAs that were made not to participate in group activities. Similarly, only seven respondents were aware of PLWHAs that were subject to insult in their respective groups.

4.8 Perceived benefit of VCT

To get information about the motive of those who took the test, respondents were asked what their reasons were when they took the test last time. Respondents gave varied responses. The major ones include know self (40.4%), marriage (36.8%), plan for the future⁹⁷ (19.3%), protect partner (8.8%), and protect child (5.3%).

Table 9 Reason during last test by sex

Reason during last test	Male	Female	Total
Marriage	11 (35.5%)	10 (38.5%)	21 (36.8%)
Plan for the future	4 (12.9%)	7 (26.9%)	11 (19.3%)
Protect partner	1 (3.2%)	4 (15.4%)	5 (8.8%)
Protect child	1 (3.2)	2 (7.7%)	3 (5.3%)
Visa application	0 (0.0%)	1 (3.8%)	1 (1.8%)
I was sick	0 (0.0%)	1 (3.8%)	1 (1.8%)
Know self	16 (51.6%)	7 (26.9%)	23 (40.4%)
Total	31 (54.4%)	26 (45.6%)	57 (100.0%)

Respondents were also asked to share their perception regarding what they consider are reasons to take HIV testing. Marriage was cited by the largest proportion of respondents, cited by 130 (69.1%) of the respondents. The other reason reported by the

⁹⁷ Plan for the future refers to making changes in their lives to reduce vulnerability to HIV infection, such as not having unprotected sex.

second highest proportion of respondents (89, 47.3%) is plan for the future. The other reasons were cited by relatively fewer numbers of respondents. The following table summarizes the different reasons cited by respondents as reasons for taking VCT.

Table 10 Reasons to get and not to get HIV testing by sex

Reasons to get HIV testing	Male	Female	Total
Marriage	87 (70.2%)	43 (67.2%)	130 (69.1%)
Plan for the future	66 (53.2%)	23 (35.9%)	89 (47.3%)
Protect partner	30 (24.2%)	15 (23.4%)	45 (23.9%)
Protect child	28 (22.6%)	11 (17.2%)	39 (20.7%)
If I am sick	21 (16.9%)	12 (18.8%)	33 (17.6%)
Total cases	124 (66.0%)	64 (34.0%)	188 (100.0%)
Reasons not to get HIV test	Male	Female	Total
Lose partner	28 (24.1%)	17 (25.8%)	45 (24.7%)
Fear of knowing	50 (43.1%)	26 (39.4%)	76 (41.8%)
Stigma	64 (55.2%)	32 (48.5%)	96 (52.7%)
Uncertainty about confidentiality	23 (19.8%)	17 (25.8%)	40 (22.0%)
Total cases	116 (63.7%)	66 (36.3%)	182 (100.0%)

Conversely, respondents were also asked to identify reasons they believe justify not taking HIV test. Accordingly, stigma was the highest reported reason cited by 96 (52.7%) of the respondents. The second highest reported reason for not taking HIV test was the fear of knowing, cited by 76 (41.8%) of the respondents. Other less reported reasons include loss of partner and uncertainty about confidentiality (cited by 24.7% and 22.0%, respectively).

Respondents identified different groups which they think need to undergo HIV testing. The following table summarizes the distribution of the different response categories. The highest proportion of respondents 49 (30.2%) reported that the general public should undergo HIV test⁹⁸. Those getting married were reported by the second highest proportion of the respondents (29.0%). The two next categories considered to need HIV testing highly were anyone at risk and truck drivers, soldiers, and travelling sales persons, reported by 18.5% and 16.% of the respondents, respectively. Sex workers and those using the services of sex workers were mentioned as groups need in HIV testing by 13.6 and 9.3 percent of respondents, respectively. Other categories include those with multiple partners (9.9%), and those who are sick (9.3%). Only 1.0% of the respondents think that anyone sexually active require HIV testing.

⁹⁸ This assertion, although it appears extreme, seems to be entrenched with recognition of the different modes of transmission of the virus, whereby everyone is vulnerable to a certain extent.

Table 11 Perception on who should take HIV test by sex

Who should go for HIV test	Male	Female	Total
Sex workers	14 (13.3%)	8 (14.0%)	22 (13.6%)
Users of sex workers	9 (8.6%)	6 (10.5%)	15 (9.3%)
Truck drivers, soldiers, travelling sales persons, etc.	20 (19.0%)	6 (10.5%)	26 (16.0%)
Anyone at risk	20 (19.0%)	10 (17.5%)	30 (18.5%)
Those with multiple partners	8 (7.6%)	8 (14.0%)	16 (9.9%)
Anyone sexually active	2 (1.9%)	0 (0.0%)	2 (1.2%)
Those who are sick	11 (10.5%)	4 (7.0%)	15 (9.3%)
Those getting married	31 (29.5%)	16 (28.1%)	47 (29.0%)
The general public	33 (31.4%)	16 (28.1%)	49 (30.2%)
Total cases	105 (64.8%)	57 (35.2%)	162 (100.0%)

4.9 Chapter summary

This chapter comprised a range of results of the survey. Results were disaggregated by VCT usage and gender. The results covered mainly focus on the relationship between VCT usage and the different factors influencing it including socioeconomic and demographic factors, knowledge on HIV/AIDS/VCT, fear of stigma, self-risk perception, social capital, and perceived benefit of VCT. This chapter essentially presented the quantitative survey results. The following chapter serves to provide the qualitative analyses of the findings presented here.

Chapter 5 - Discussion of Results

5.1 Introduction

This chapter presents the discussion of the main quantitative findings, and attempts to provide insight into these results using the qualitative data gathered. The chapter is organized into different sections, each dealing with the main aspects of the study namely, prevalence of VCT usage and factors influencing VCT usage.

5.2 Prevalence of HIV testing

With respect to prevalence of HIV testing, 28.0% of the respondents did undergo HIV testing at some time. This figure is higher compared to other studies such as the DHS 2005 that identified a testing rate of 4.0% and 6.0% among women and men, respectively⁹⁹.

Possible explanation for this high testing rate could be drawn from the qualitative information. First, according to the District HIV/AIDS office, during a one year period (August 1998 to June 1999), a total of 3300 persons underwent HIV testing. This include 1795 male and 1505 female. Most people underwent the testing during this period as a result of intensive VCT campaign referred as the Millennium Campaign. This is a period just before the celebration of the Ethiopian Millennium which happened on the 11th of September 2007. The district has one of the best testing rates both in the region and in the Zone. The second reason for the high testing prevalence could be the recent increase in accessibility of VCT centres in the district. It has only been less than two years since all the four VCT centres in the district were set up. To sum up, the high testing prevalence could be attributed to the recent increased access to testing facilities, and the behavioural change campaign. This is further corroborated by the fact that it had been only a year or less since over half of the respondents (52.8%) took VCT.

On the other hand, it is also worth noting the huge disparity between proportion of individuals who expressed willingness to take the test (81.0%) and those who actually took the test (28.0%). Such a disparity is also confirmed by other studies such as the

⁹⁹ CSA, 2006, p. 196

Ethiopian BSS¹⁰⁰, which found disparity of similar proportion, i.e. 76.0% willingness and 11.0% testing for most studied groups. This is also related to the issue of measuring VCT demand in the literature, whereby VCT acceptance should not be measured in terms of number of people willing to take the test but rather by those who actually undergo the test and collect their results¹⁰¹. Willingness seldom materializes into practice.

5.3 Socioeconomic and demographic factors and VCT usage

5.3.1 Sex and VCT usage

One of the assumptions made prior to the actual survey was that women are less likely to take the test than their male counterparts. Despite the relationship between sex and VCT being strong, this assumption was rejected because it is rather women who are more likely to take VCT than men. There was a testing rate of 38.6% among female respondents as opposed to a testing rate of only 22.3% among male respondents. This result is in contrast to most other studies conducted in Ethiopia including DHS 2005¹⁰², which identified lower testing prevalence among women than men.

According to discussion with local people, there is a high sense of vulnerability among women in the area. As a case in point, there are instances whereby the wife requires her husband to take VCT when he returns to his village after a long stay in the city. Such an acceptance of VCT arose after distressing impact of HIV/AIDS in the locality, whereby the disease was spread in the community through local people commuting between their village and cities. Women's concern in this regard is acknowledged in the community, and it is accepted if she insists on her husband taking VCT, or if she takes one herself. The sense of vulnerability coupled with acceptance of VCT in the area might prompt women to take the test, and might explain the high testing rate among this group. However, this result requires further investigation as it cannot be accounted to the higher uptake of women during the recent VCT campaign, since far more men took the test in the 12 months prior to the study.

¹⁰⁰ MoH, 2002, p. 87

¹⁰¹ Sahlu et al in Solomon, 2004, p. 14

¹⁰² CSA, 2006, p.196

5.3.2 Age and VCT usage

Another assumption tested in this survey was that teenagers (aged 15-19) are less likely to undergo HIV testing than their adult counterparts. The assumption does not hold since it is not corroborated by the finding. Despite the relationship between age and VCT usage not statistically significant, the proportion of younger respondents (less than 19 years old) taking the test was higher than their older counterparts (above 19 years). That is, there was a testing rate of 38.1% among those between the age of 15 and 19 as opposed to a testing rate of 26.8% among those aged 20 and above.

The information from the qualitative data also supports the absence of any age-specific constraints to VCT usage. Teenagers can take VCT without consent/company of adults. The higher proportion of younger respondents who took the test could be attributed the ongoing effort targeting school community including students to bring about behavioral change and promote HIV testing.

5.3.3 Income and VCT usage

Prior to the actual study, it was assumed that the lower the income of people, the less likely they are to take VCT. This assumption, however, is not supported by the results of the study, which depict the lack of significant difference in the testing rate of people from different income categories.

The results are also in contrast to the assertion in the literature that poverty stricken people are less likely to take HIV test because they are constantly challenged by the quest for survival and thus are indifferent or reluctant to learn their HIV status¹⁰³. The responses from the interviews conducted support the quantitative result, as they claimed that VCT services in the district are freely accessible, which perhaps nullifies the impact of income difference on VCT usage. The lack of difference across income categories could also be attributed to the general low income level of respondents, whereby a monthly income of 200 ETB is the total average. A significant proportion of the respondents are, therefore, living in abject poverty. Hence, the results purport the

¹⁰³ Solomon, 2004, p. 64

importance of making VCT services accessible, physically as well as financially, for all so that low income and rural dwellers are not marginalized.

5.4 Knowledge of HIV/AIDS/VCT and VCT usage

It was assumed at first that individuals lacking knowledge about HIV/AIDS or VCT are less likely to take HIV testing, compared to their counterparts with better knowledge on the issues. This assumption, however, is accepted conditionally. That is, results support that there is a statistically significant difference in testing rate among people depending on difference in knowledge in HIV/AIDS/VCT. However, unlike the assumption, those having high level of knowledge are less likely to take VCT than those with low level of knowledge (14.3% vs. 43.2%).

This finding is difficult to explain as it defies common sense: the more aware people are, the more empowered they are to take favorable action. This result might make sense if linked with result about fear of stigma. It was found that people having high level of knowledge are more likely to have high fear of stigma. This probably accounts for lower testing rate among people with high level of knowledge. The link between knowledge on HIV/AIDS/VCT and fear of stigma begs for further investigation.

In line with this, officials reiterated the ease of convincing poor farmers to take VCT compared to the educated urbanities, who are often reluctant or anxious about their life after such a procedure.

5.5 Perception of risk to HIV/AIDS and VCT usage

Another assumption put forward in this study was that individuals with moderate/high self-perception of risk are less likely to take VCT, compared to their counterparts with no/small perception of risk. This assumption is not supported by results, which identify that there is no statistically significant difference in testing rate between people having different perception of risk. The majority of respondents, despite being sexually active, have no/low perception of risk to HIV/AIDS. The low risk perception to HIV/AIDS shared by overwhelming proportion of people is similar to the results of other studies

such as the Ethiopian BSS¹⁰⁴ that generally identified low perception of risk among all studied groups including female sex workers.

Discussion with senior ranking officials and local people reported is sexual intercourse as the major mode of HIV transmission in the region. This is despite the fact that sex outside wedlock is taboo in the area particularly for girls, and the high value placed on the virginity of women prior to wedlock.

Merchants that commute between the district and other towns are considered the main high risk groups. In addition, female migrants from the district who work in the capital city and other major towns as domestic servants are the other group considered high risk. Respondents also alleged the dwindling cultural practice of wife inheritance, as contributing to the spread of the virus. This is a practice where the deceased husband's brother marries the widow (his brother's wife). This practice often takes place with little publicity and without either party taking VCT. Furthermore, another declining cultural practice reported to contribute to the spread of HIV is the practice of best ladies spending the night at the wedding place, as part of the cultural wedding ceremony. This leads to the girls socializing and engaging in sexual practices as they are away from the supervision of family members. This practice is facing growing pressure to die out by community leaders. The other principal mode of transmission of HIV is Mother-to-Child. The quantitative data depicted that there is lack of knowledge about this mode of transmission.

5.6 Fear of stigma and VCT usage

The study assumes initially that VCT usage is higher among individuals with low fear of stigma than those with high fear of stigma. This was also evident from the results of the study, which depicts a difference in testing rate among people with different levels of fear of stigma, whereby those having levels of fear of stigma being less likely to take VCT.

Generally, interviews with local people show the absence of open stigma and discrimination against persons living with HIV/AIDS. Participants rather emphasized

¹⁰⁴ MoH, 2002, p.89

the presence of support and care for PLWHAs. Hence, the fear of stigma that stifles the will to take VCT can be considered as imagined rather than being real.

In relation to this, local officials pointed out the presence of relatively higher level of readiness to take HIV test among uneducated low income people, as opposed to those that are educated and well off. It seems that fear of stigma influences more the latter group than the former one, perhaps due to the fact that the latter group have or feel they have a lot more at stake in terms of social and economic status if found HIV positive.

One official said, *“There is resistance among the educated. They have their own fear. They have fear of taking the test. That is what we find challenging. I am talking about those assuming position of authority. We don’t have problems about others. They are changing.”*¹⁰⁵

5.7 Social capital and VCT usage

The assumption held at the start of the study about social capital was that individuals belonging to social groups and networks (Idir, Iqub, Mahiber, or Debo) are less likely to undergo HIV testing. This assumption was not supported by results. For one thing, the relationship between membership to community based traditional institutions and taking VCT was not statistically significant. For another, contrary to the assumption, those that do not belong to any groups were less likely to take VCT than those who are members (23.3% vs. 29.3%).

Response from the interviews depict that the environment in the different community based traditional institutions is less stigmatizing, which is contrary to the above assumption. The community based institutions were reported to play active role in providing support and care to those living with the virus, and who disclose their HIV positive status. They are exempted from contributing certain fees, such as monthly membership fee in *Idir*. There are also practices whereby bedridden patients are given their life long contribution by the *Idir* to cover medical expenses, which normally is given only when members, their families are deceased. Furthermore, members living with the virus are given support through the *Debo* institution. In this institution members help out in farming or carrying out other labour-demanding activities.

¹⁰⁵ September 12, 2004

The positive treatment of PLWHAs has also been reinforced by ongoing awareness enhancing initiatives. There is an effort to involve traditional leaders as change agents in the district. Recently, 61 traditional leaders were given awareness raising training.

Analysis of the relation between membership to the specific groups and VCT usage brought a contrasting result in the case of Mahiber, unlike in the case of other community based institutions, whereby the relationship was found to be significant. There was a statistically significant difference in testing rate between those belonging to Mahiber and those that do not, with members less likely to take VCT than non-members (16.7% vs. 33.6%). Hence, the assumption that individuals belonging to social groups and networks are less likely to have taken HIV test is accepted in as far as it refers to Mahiber membership. The reason for this social group to have a significant but negative relationship with HIV testing could be attributed to the religious nature of the group, which is prone to look at the issue of HIV/AIDS as a sin, or could turn to blaming of infected persons for their predicament.

5.8 Perceived benefit of VCT and VCT usage

The other assumption explored in this study was that marriage, or meeting marital requirement, is more likely the motivation for individuals to take VCT. The assumption is accepted as it is supported by results. Results depict that marriage comprises the second highest motivation for taking HIV test. Marriage was cited as the motivation for taking VCT by 36.8% of those who already took the test.

This finding is further strengthened by the responses from the interviews. Respondents reiterated that taking VCT is a precondition for marriage in the whole Gurage Zone. No couple can marry without having the test more than once taking into account the nature of the virus, as it may not be detected at the early period of infection. Families or parents have to receive test results of the couple before approving the engagement and allowing the wedding to proceed. This practice has been sanctioned as a norm, and is enforced by the community and elders. This norm was actively embraced since five years ago.

A key informant woman, who also serves as a midwife in the locality, stated,

Couples planning to marry are told to get tested before they spend a lot of money on wedding preparation. I advise them. They have to get tested three times. Once every three month. That is a must. After the third test, he can buy his wife gifts and get married¹⁰⁶.

The practice leaves little room for cheating about test results or test certificates. The woman added,

Three witnesses from the man's side and three more witnesses from the woman's side accompany the couple to the testing centre to witness the testing and confirm the credibility of the test result. ... Since the result is given in English, the witnesses often are educated or have completed 12th grade. ... No one gets married without testing¹⁰⁷.

5.9 Chapter summary

This chapter expanded on and provided more detail into the survey results. Each variable identified and spoken to in chapter four was expanded on from a qualitative perspective. In this way I was able to enhance the quantitative discussion contained in chapter four. Furthermore, the narratives of officials and ordinary people could also be brought to the fore.

¹⁰⁶ September 14, 2007

¹⁰⁷ September 14, 2007

Chapter 6– Summary and Conclusions

This research explored whether certain factors influence taking VCT or not. The study is relevant in light of the low level of testing in the country, and the dearth of information regarding VCT uptake in rural area and outside the clinic context.

It is worth noting that the research findings can be generalized only to reflect the state of VCT in the Moher and Aklil district. Some of the research findings confirm existing studies conducted in urban or clinical context while other findings were either contrary or different. With respect to socioeconomic and demographic variables, the study confirmed age and income are of no consequence whether individuals take VCT or not. In contrast, sex of the person was closely associated with VCT. A surprise finding here is women were more likely to take VCT than men, which can be attributed to high sense of vulnerability of women, acceptance of VCT in the area, and the ease for women to negotiate VCT.

Unlike previous studies, the research found knowledge on HIV/AIDS/VCT influencing VCT. What is more unexpected about this finding is, the higher the level of knowledge, the less likely the person takes VCT. Further exploration is due why knowledge influences people not to take VCT, instead of prompting them to take the test.

The situation in the rural context was that risk perception has no significant influence whatsoever on VCT, contrary to previous studies in Ethiopia that identified low risk perception as a reason for low level of VCT uptake.

Similar to studies conducted in urban or clinical context in Ethiopia, fear of stigma negatively influences whether individuals take VCT. However, the unexpected finding, in light of past studies, is men were more likely to have high level of fear of stigma than women. The relationship between sex and fear of stigma is reckoned worth exploring further in future research.

Social capital has no influence on whether individuals take VCT or not unless the source of social capital are not social ties and networks that are religious in their nature. Religious social ties and networks, as in the case of Mahiber, influence HIV testing

negatively, perhaps due to the inclination of members in such groups to pass moral judgment on the disease as well infected person. This topic is also worth exploring in future research.

Another interesting finding in this research is, unlike most communities in Ethiopia, the Gurage community accepted VCT as mandatory for wedlock for both partners. This has contributed to the high prevalence of testing rate in the community, as revealed in this research, and is worth nurturing or replicating in other communities.



References

Books and Journal Articles

- Alemu, S et al (2004), "Knowledge and attitude towards voluntary counselling and testing for HIV: A community based study in Northwest Ethiopia," in **Ethiopian Journal of Health Development**. 2004:18(2).
- Aggleton, P (1988). **Social aspects of AIDS**. The Falmer Press. London.
- Central Statistical Authority (2001). **Ethiopia Demographic and Health Survey 2000**. Addis Ababa.
- Central Statistical Authority (2006). **Ethiopia Demographic and Health Survey 2005**. Addis Ababa.
- Deacon, H (2005). **Understanding HIV/AIDS Stigma; A Theoretical and Methodological Analysis**. HSRC Research Monograph. HSRC: South Africa
- Efficacy Group (2000). "Efficacy of Voluntary Counselling and Testing for HIV in Reducing Risk." **Reproductive Health Matters**, Vol. 8, 16, 2000, 176-177.
- Ethiopian Journal of Health Development (2001). "Special Issue on HIV/AIDS Prevention and Control in Ethiopia 2001-2005," **Ethiopia Journal of Health Development**, 2001, 7-20.
- Goffman, E (1963). **Stigma**. Pelican Books: London
- GPSDO (1998/99) **KITCHA: The Gurage Customary Law**
- Habte, D et al. (2003). "Assessment of the usage of pre-marital HIV testing services and determinants of VCT in Addis Ababa," **Ethiopia Journal of Health Development**, 2006; 20(1):18-23
- Policy Project (2006). **Siyam'kela: HIV/AIDS stigma indicators- A tool for measuring the progress of HIV/AIDS stigma mitigation**. POLICY Project, South Africa
- Jackson, H (2002). **AIDS Africa: Continent in crisis**. SAFAIDS: Harare
- Ministry of Health (2002). **HIV/AIDS Behavioural Surveillance Survey: Round One**. Addis Ababa
- Planning and Economic Development Department (1998). **Gurage Zone Socio-Economic Baseline Survey**. Wolkite: Ethiopia

Internet (WWW) reference

- Blume, L (2004). *Stigma and Social Control*. Department of Economics Cornell University. Available <http://www.cramton.umd.edu/workshop/papers/blume-stigma-and-social-control.pdf>
- Boswell, D. and Baggaley R (2002). *Voluntary Counselling and Testing (VCT) for Young People*. Paper presented at the XIVth International AIDS Conference, July 7-12, Barcelona, Spain.
- Denison, J. (2006) *Social Relationships and Adolescents' HIV Counselling and Testing Decisions in Zambia*. Washington: Population Council/Horizons. Available www.popcouncil.org/horizons/publications.html
- HSRC (2005). *HIV epidemic in South Africa may have entered a phase of levelling off*. Media Brief Factsheet. Available <http://www.hsrc.ac.za/Factsheet-44.phtml>
- Maman, S., et al. (2001). *Women's barriers to HIV-1 testing and disclosure: challenges for HIV-1 voluntary counselling and testing*, AIDS Care 13(5): 595-603. Available <http://www.informaworld.com/smpp/content~content=a713612779~db=all>
- Morrison, K (2006). *Breaking the Cycle: Stigma, Discrimination, Internal Stigma and HIV*. United States Agency for International Aid (USAID). Available http://www.policyproject.com/pubs/generalreport/Breaking_the_Cycle.pdf
- Portes, A (1998): *Social Capital: Its Origins and Applications in Modern Sociology* Annual Review of Sociology, Vol. 24. (1998), pp. 1-24. Available [http://links.jstor.org/sici?sici=0360-0572\(1998\)24:1<3C1:ASOCIOAA>2.0.CO;2](http://links.jstor.org/sici?sici=0360-0572(1998)24:1<3C1:ASOCIOAA>2.0.CO;2)
- Shinn, David H. (2001). *HIV/AIDS in Ethiopia: The Silence Is Broken; the Stigma Is Not*. Africa Notes, No. 1 Available <http://www.csis.org/africa/ANotes/ANotes0107.pdf>.
- Solomon, V. (2004). *Critical Review and Analysis of Voluntary Counselling and Testing Literature in Africa*. Available <http://www.hst.org.za/uploads/files/vct.pdf>.
- UNAIDS (2001): *The Impact of Voluntary Counselling and Testing: A global review of the benefits and challenges*. Geneva (UNAIDS). Available <http://www.lrs.org.za/HIV&AIDS/C/C3%20UNAIDS%20VCT%20Impact.pdf>.
- WHO (2005). *Summary Country Profile for HIV/AIDS treatment Scale up* Available http://www.who.int/3by5/support/june2005_eth.pdf.

Government reports and document

HAPCO (2006). *Report on the progress towards implementation of the Declaration of commitment on HIV/AIDS*. Reporting period: January 2003-December 2005.

HAPCO/MOH (2007). *Guidelines for HIV Counselling and Testing in Ethiopia*

Available http://www.who.int/entity/hiv/topics/vct/ETH_HCT_guidelinesJune26_clean.pdf.



Annexes

Annex 1 - Questionnaire

1. Sex of the respondent
 1. Male
 2. Female
2. Age _____ years
3. Marital status
 1. Single
 2. Married
 3. Other
4. Educational Level
 1. Literate
 - 4.1 Grade completed _____
 4. Illiterate
 5. Other (Specify) _____
5. Occupation
 1. Farmer
 2. Merchant
 3. Unemployed
 4. Student
 5. Civil servant
 6. Others (specify)
6. Family's average monthly income _____ Birr

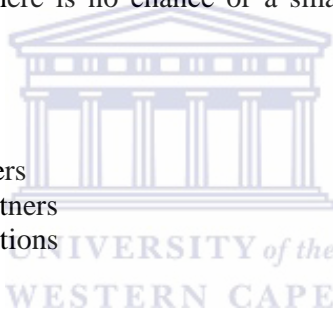
HIV/AIDS - Knowledge and Beliefs

7. Have you ever heard about HIV?
 1. Yes
 2. No
 3. Don't know
8. What are the different ways people get the AIDS virus? Please mention all you know.
 1. Unsafe sex
 2. Blood transfusion
 3. Sharing blades
 4. Mother to child
 5. Don't know
 6. Other (specify) _____
9. What are the different ways people can prevent the AIDS virus? Please mention all you know.
 1. Using condom consistently
 2. Abstinence
 3. Being in a faithful monogamous relationship
 4. Not sharing blades
 5. Don't know
 6. Others (specify) _____
10. Is there a cure for AIDS?
 1. Yes
 2. No
 3. Don't know
11. Can people get the virus by sharing meals with the infected person?
 1. Yes
 2. No
 3. Don't know
12. Can people get the AIDS virus from mosquito bites?
 1. Yes
 2. No
 3. Don't know
13. Can a pregnant person transmit the AIDS virus to her unborn child?
 1. Yes
 2. No
 3. Don't know

14. Is there a way to prevent the transmission of the virus from the mother to her unborn child?
 1. Yes
 2. No
 3. Don't know
15. Can people get the AIDS virus because of supernatural means?
 1. Yes
 2. No
 3. Don't know
16. Is it possible for a healthy-looking person to have the AIDS virus?
 1. Yes
 2. No
 3. Don't know

Risk Perception

17. Have you ever had sex?
 1. Yes
 2. No
 3. Don't know
18. What are the chances that you have been exposed to HIV? Would you say there is no chance, a small chance, a moderate chance, or a high chance?
 1. No chance
 2. Small chance
 3. Moderate chance
 4. High chance
 5. Already have HIV
 6. Don't know
19. Why do you think that there is no chance or a small chance that you have been exposed to HIV?
 1. Abstains from sex
 2. Always uses condoms
 3. Has only one partner
 4. Limits number of partners
 5. Partner has no other partners
 6. No transfusions or injections
 7. Partner looks healthy
 8. Partner tested negative
 9. Trusts partner
 11. Don't know
 10. Other (please specify) _____
20. Why do you think that there is moderate chance or a high chance that you have been exposed to HIV?
 1. Had sex without condom
 2. Had sex with a person who has HIV
 3. Had many partners
 4. Shared injection with others
 5. Don't know



VCT- knowledge, perception, motive, practice

21. Have you ever heard about VCT?
 1. Yes
 2. No
 3. Don't know
22. How can a person find out if he or she has HIV (the virus that causes aids)?
 1. Go to counselling/testing facility
 2. Don't know
 3. Other (specify) _____
23. What do you think are the reasons to get an HIV/AIDS test?
 1. Marriage
 2. Plan for the future

3. Protect partner
 4. Protect child
 5. If I'm sick
 6. Don't know
 7. Other (specify) _____
24. What would be reasons not to get an HIV/AIDS test?
1. Lose partner
 2. Fear of knowing
 3. Stigma
 4. Uncertainty about confidentiality
 5. Don't know
 6. Other (specify) _____
25. Who should go for an HIV/AIDS test?
1. Sex workers
 2. Users of sex workers
 3. Truck drivers, soldiers, travelling sales persons, etc.
 4. Anyone at-risk
 5. Those with multiple partners
 6. Anyone sexually active
 7. Those who are sick
 8. Those getting married
 9. Other (specify) _____
 10. Don't know
26. Do you know where to go if you wanted an HIV/AIDS test?
1. Yes
 2. No
 3. Don't know
27. Would you talk to your partner/spouse before having an HIV/AIDS test?
1. Yes
 2. No
 3. Don't know
28. Would you tell your partner/spouse the results of an HIV/AIDS test?
1. Yes
 2. No
 3. Don't know
29. I don't want to know the results, but have you ever been tested to see if you have the AIDS virus?
1. Yes
 2. No
 3. Don't know
30. If yes, when was the last time you were tested?
1. 12 months ago or less
 2. 13–23 months ago
 3. 2 or more years ago
 4. Don't know
31. The last time you had the test, did you yourself ask for the test, was it offered to you and you accepted, or was it required?
1. Asked for the test
 2. Offered and accepted
 3. Others (specify) _____
32. The last time you had the test, what were your reasons?
1. Marriage
 2. Plan for the future
 3. Protect partner
 4. Protect child
 5. If I'm sick
 6. Don't know
 7. Other (specify) _____
33. Did you receive counselling before getting tested?
1. Yes
 2. No
 3. Don't know

34. Did you receive counselling after getting your results?
 1. Yes 2. No 3. Don't know
35. I don't want to know the results, but did you get the results of the test?
 1. Yes 2. No
36. The last time you had the test, have you faced any difficulty in getting the test?
 1. Yes 2. No 3. Don't know
37. If yes, please explain _____

38. You would undergo VCT in the future
 1. Strongly disagree
 2. Disagree
 3. Don't know
 4. Agree
 5. Strongly agree

HIV/AIDS Stigma and Discrimination

39. If a member of your family is sick with the AIDS virus, would you treat him at your home?
 1. Yes 2. No 3. Don't know
40. If you become sick with the virus that causes AIDS, would your family or relatives let you be treated in their household?
 1. Yes 2. No 3. Don't know
41. Do you agree or disagree with the following statement: you should be ashamed of yourself if you were infected with the AIDS virus.
 1. Agree 2. Disagree 3. Don't know/no opinion
42. Do you agree or disagree with the following statement: you should be blamed if you were to bring the disease into the community
 1. Agree 2. Disagree 3. Don't know/no opinion
43. Do you agree or disagree with the following statement: you would bring shame to your family if you were to be infected by HIV
 1. Yes 2. No 3. Don't know

Social Capital

44. Are you a member of any community based institution?
 1. Yes 2. No
45. If yes, please mention the groups?
 1. Idir (voluntary self-help association focusing on supporting members during bereavement)
 2. Iqub (voluntary self-help association focusing on revolving resources among members)
 3. Mahiber (voluntary religious association)
 4. Others (Please specify) _____
46. What are the functions of each of these groups?
 46.1 Group name _____
 1. Religious
 2. Financial/work-related
 3. Social
 4. Other (specify) _____
- 46.2 Group name _____ Function _____
 1. Religious

2. Financial/work-related
3. Social
4. Other (specify) _____
- 46.3 Group name _____ Function _____
1. Religious
2. Financial/work-related
3. Social
4. Other (specify) _____
47. Which of these groups are functional / located in the community and which are outside?
 - 45.1 Group name _____
 1. In
 2. Outside
 - 45.2 Group name _____
 1. In
 2. Outside
 - 45.3 Group name _____
 1. In
 2. Outside
48. How many members do each of the groups, which you are a member of, has?
 - 46.1 Group name _____ group size _____ members
 - 46.2 Group name _____ group size _____ members
 - 46.3 Group name _____ group size _____ members
49. Are there members living with the virus in your group?
 1. Yes
 2. No
 3. Don't know
50. Do you think chronically ill persons living with AIDS virus receive support in these groups?
 1. Yes
 2. No
 3. Don't know
51. Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have the AIDS virus or has the AIDS virus?
 1. Yes
 2. No
 3. Don't know
52. Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have the AIDS virus or has the AIDS virus?
 1. Yes
 2. No
 3. Don't know
53. How often do you visit other people's houses? That is friends or neighbours.
 1. Every day
 2. Several times a week
 3. At least once a week
 4. At least once a fortnight
 5. At least once a month
 6. Over a month
 7. Never
54. How often do friends or neighbours come to your house to visit you?
 1. Every day
 2. Several times a week
 3. At least once a week
 4. At least once a fortnight
 5. At least once a month
 6. Over a month
 7. Never
55. When friends or neighbours come to your house to visit, how often, if any, do you talk about HIV/AIDS related matter?
 1. Always
 2. Sometimes
 3. Never

Annex 2- Guiding questions for unstructured individual and group interviews

1. Perception towards sexuality to get insight on whether or not there is moral judgment, shame, or blame that might be attributed with the fact that HIV can be transmitted sexually

- How is sex perceived locally, particularly by community leaders, who set or enforce norms?
- How is sex before marriage conceived in the community? Any difference between sexes?
- How is sex by married people with someone other than their own partners perceived? Is there any difference between the sexes?

2. Perception about PLWHAs to examine if people indeed make value judgments about PLWHAs

- How does HIV (the AIDS virus) come about?
- What differentiates HIV from AIDS?
- What is the reason why some people are infected while others are not?
- Who is the most at risk of contracting HIV in the community?
- How would you describe a person with AIDS virus? (with respect to sex, age, income)

3. Treatment of PLWHAs in the community

- How do people in the community treat people with AIDS virus?
- How do families treat family members having AIDS virus?
- What are the common languages used to refer to persons living with AIDS virus?

4. Voluntary counselling and testing

- How do people feel about undertaking VCT?
- What are the barriers for VCT in their community?
- What are advantages and disadvantages of undertaking VCT?

5. Social capital

- What types of groups exist in the community?
- What are the functions of groups?
- How are individuals with HIV/AIDS treated in these groups?