ORIGINAL ARTICLE

KONOWLEDGE, ATTITUDE AND PRACTICE OF VOLUNTARY CONFIDENTIAL COUNSELLING & TESTING IN GURAGE ZONE, SNNPR, SOUTH ETHIOPIA

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ABSTRACT

BACKGROUND: ***HIV/AIDS is pandemic growing at an extremely threatening rate worldwide. HIV voluntary confidential counseling and testing (VCCT) provides a critical entry point for both HIV/AIDS prevention and care and support of HIV infected and affected individuals. This study attempted to assess knowledge, attitude and practices related to voluntary confidential counseling and Testing services among people aged 10 to 50 years in Gurage zone South Nations and Nationalities Peoples Regions (SNNPR).***

Methods: A cross-sectional community based study was conducted from October 13-28,2004. A total of 657 participants were involved in the study from 52 Kebele in 12 woredas involving both urban and rural communities in the zone.

RESULTS*: Six hundred fifty four(99.5%) had good knowledge on HIV/AIDS and voluntary confidential counseling and testing. Condom use during sex with multiple partners was reported by 48% of the study subjects. Age at the first sexual intercourse has come down to the lower age groups, 3.8 % of the study subjects had their first sexual contact between the ages of 10-14 years. The result demonstrated that married subjects and those in the age group from 15-34 years used VCCT services more than the other counter parts and this difference was statistically significant (P<0.05). Subjects who had a positive attitude towards VCCT and other preventive methods against HIV infection used VCCT service significantly (P<0.05) more than their counterparts. Other background characteristics like educational status, sex, place of residence, religion, age occupation of subjects and their knowledge about HIV/AIDS and VCCT did not show association with VCCT service utilizationedge, attitude, practice Voluntary counseling and testing, HIV/AIDS.*

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CONCLUSION: ***The community had high level of knowledge and positive attitude towards preventive measures of HIV/AIDS including VCCT. Urban population was more informed about HIV/AIDS and VCCT. The age of initiation of first sexual activity has come down. Despite high level of knowledge, greater proportion of the study subjects were involved in high-risk sexual practices. There was an indication that stigma was prevailing in the study community and was one of the barriers for utilizing VCCT services in Gurage zone. Strong behavioral change communication strategies involving various sectors and the community at the grass root level should be designed to make the maximum use of VCCT services as a preventive strategy.***

KEY WORDS: ***Knowledge, attitude, practice Voluntary counseling and testing, HIV/AIDS***

INTRODUCTION

HIV/AIDS is causing nearly 16,000 new infections everyday day resulting in a global estimate of people living with the virus to be 42 millions. Out of this, 29.4 million adults and children are living with HIV/AIDS in sub- Saharan region and 58% of HIV adult patients are living in sub – Saharan Africa. Nearly 90% of the projected HIV infections and AIDS cases for this decade will occur in the developing countries (1-3). In Ethiopia From sentinel surveillance carried out in four major urban areas in 1992 and 1993 Sero-positivity rate increased from 11% to 20.2% (4-6). The major mode of transmission in Ethiopia was reported to be unprotected sex with multiple heterosexual partners (5, 8-10). Reports also show that in spite of high level of knowledge about risk factors of HIV/AIDS and other STDs greater proportion of subjects does practice high-risk sexual practices and had contracted STDS (11,12). Available strategies for control and prevention of HIV infection include information, education and communication (IEC) including voluntary confidential counseling and testing and other medical strategies are using anti retroviral drugs for prevention of vertical transmission.

Experience from Uganda showed that sero-positivity rates declined across 100% of VCCT sites suggesting that VCCT can be implemented on a national scale in developing countries as a method of decreasing the incidence of HIV infection (13, 14).

Studies in Ethiopia on different population groups had indicated that attitude, towards collaboration and participation on control programme including voluntary HIV test was greater than 74 %(15,16).

The success of HIV/AIDS programme depends on the extent to which they help curb the course of HIV epidemic and provide quality care to those already affected (17). HIV/AIDS policy of Ethiopia (1998) gives due emphasis for information education and communication programs, voluntary confidential counseling and testing (VCCT) and strategic planning that initiated multi-sectoral approach and decentralization of the control programme is being introduced in the country (4,6,18,19). As part of this initiative about 14 VCCT centers have been established in Gurage zone. However, the knowledge, attitude and practices of the community related to HIV/AIDS and VCCT was not assessed.

Therefore, this study investigated the knowledge, attitude and practices related to VCCT and HIV/AID in Gurage zone for future intervention measures and to design and implement appropriate behavioral change communication (BCC) strategies.

METHODS AND MATERIALS

The study was conducted in the setting of urban and rural communities in Gurage zone, South Nations, Nationalities and People's Regions (SNNPR), South Ethiopia from October 13-28, 2004. Gurage zone has a total projected population of 1,530,422, which is distributed in 12 Woredas. For the purpose of this study all permanent residents of Gurage zone between the age group 10-50 years who live with 5-10 kilometers of the VCCT centers in each woreda (service areas) were included in the study. Based on the current administrative organization, all rural kebles will have a maximum of 5000 population. Therefore, small towns having a total population greater than 5,000 were taken to be urban.

Gurage zone has about 14 Voluntary Counseling and Testing centers, which were opened as a means of control of the spread of HIV/AIDS. The fourteen VCCT Centers were distributed in the different Woredas of the study area as follows: Each woreda has at least one VCCT center and in the case of three districts (Butajera, Wolkite Mestedader and Cheha) there were two voluntary counseling and testing centers per district.

A cross-sectional study design was used to determine the knowledge, attitude and practices related to HIV/AIDS and VCCT. The study subjects were those residents who were 10 years and above old during the survey who are residents of the urban and rural strata. The sample size was calculated using Epinfo version 2000 at the expected prevalence of VCCT utilization of 50%, assuming equal sample sizes for both urban and rural strata which gave a total sample size of 657 subjects to be selected from the urban and rural areas.

The study subjects were selected from the urban and rural strata using non-proportionate systematic sampling technique from a total of 52 kebeles in the rural and the urban communities, which had come from 12 woredas of the Gurage zone and the two city administrations (Wolkite Mestedader and Butajera). All kebeles within the service areas (5-10 km distance) around the VCCT centers in each woreda were included in the sampling. Both in the urban and rural areas the total sample size of 328 was divided using probability proportional to size of the kebeles within each urban-rural stratum. Then the households were selected from each kebele by using systematic sampling technique. In both rural and urban communities after identification of the sample household one person per household of those 10 years and above was selected using a lottery method.

An interviewer administered Amharic version structured questionnaire was used to assess Socio-demographic characteristics, knowledge, attitude and practice on the preventive methods of HIV/AIDS and VCCT of the community. The questionnaire was written in English first and then translated to Amharic and back translated into English by a third person and it was pre-tested and revised accordingly before the main study. Before the initiation of the quantitative data collection, qualitative data was generated using a focus group discussion (FGD) in order to refine the questionnaire and determine the general understanding of the study subjects. Each attitude question has got three choices: agree, neutral and disagree. For positive statements those who chose agree were considered to have positive response and those who chose neutral and disagree to have negative response. On the other hand, for negative statements, those who chose agree and neutral were grouped to have a negative response and those who chose disagree to have positive response. Each positive response was given a score of point and

negative response a score of 0 and overall attitude was calculated by summing the scores. Subjects who scored above 60% of the total were considered to have positive attitude and those who scored below 60% of the total were labeled to have negative attitude. For knowledge question each close-ended question has got 1 point if correct and a score 0 if incorrect answer was given. For the open-ended questions score 0 if incorrect answer was given, 1 if only one correct answer was given and 2 if 2 or more correct answers were given. Those who scored 60% & above of the total were labeled to have " good knowledge" and those who scored below 60% were labeled to have 'poor knowledge '. For practice questions those who have no any history of high-risk practice were considered to have safe practice & those who had at least a single history of high-risk practice were considered to have unsafe practice. The data collectors were trained on the process of data collection and the investigators verified more than 10 percent of the data during data collection. The questionnaires were checked using range and consistency check methods. The data were cleaned and edited before entering into a computer and then analyzed using SPSS for window version 11.0. Statistical tests for significance were carried out wherever appropriate at a level of significance of 5%.

Permission of the Kebele leaders was secured through an official letter from Gurage zonal HIV/AIDS prevention and control office. Subjects were clearly told about the benefits and harms of participating in the study through a two-way communication. Consent of subjects was secured before the initiation of data collection and subjects were assured about the confidentiality of the information they gave. To maintain confidentiality the names of subjects were not registered on the questionnaire.

RESULTS

Out of the 657 participants included in the study, 342(52.1%) were males and the rest 315(47.9%) females giving a sex ratio of 1.1:1. About half (49.9%) of the study population was from the urban areas and the rest from the rural kebeles. Over half of the respondents 336(51.1%) were single followed by those who were married 298(45.4%) and the majority 430(64.6%) of them had attended schools from grade 1-12, followed by those who attended more than 12 grade 60(9.1%). The most frequent occupation was student 251(38.2%) seconded by farmer 100(15.2%) and merchant 96(14.6%), respectively. The majority 550 (83.7) of the study subjects was Gurage by ethnicity followed by Amhara and Oromo. Most, 372(56.6%) were followers of orthodox Christianity followed by Muslim 222(33.8%). Regarding their age distribution 452(68.8%) are in the age range between 15-34 years (*Table 1*).

Table 1. Background Characteristics of the study population, Gurage zone, October 2004.

Background Characteristics (n=657)	Number	Percent
Sex		
Male	342	52.1
Female	315	47.9
Age group		
10-14	79	12.0
15-19	173	26.3
20-24	113	17.2
25-29	95	14.5
30-34	71	10.8
35-39	57	8.7
40-44	36	5.5
45-50	33	5.0
Residence		
Urban	328	49.9
Rural	329	50.1
Marital status		
Single	336	51.1
Married	298	45.4
Divorced	8	1.2
Widowed	15	2.3
Educational status		
Illiterate	112	17.0
Read & Write	55	8.4
Grade 1-6	172	26.2
Grade 7-8	121	18.4
Grade 9-12	137	20.9
Grade 12 & above	60	9.1
Occupation		
Student	251	38.2
Farmer	100	15.2
Merchant	96	14.6
House wife	106	16.1
House maid	13	2.0
Government employee	52	7.9
Private job	4	0.6
Other**	37	4.8
Ethnicity		
Gurage	550	83.7
Amhara	45	6.8
Oromo	22	3.3
Kembata	14	2.1
Hadiya	13	2.0
Others*	6	0.8
Religion		
Orthodox	372	56.6
Muslim	222	33.8
Protestant	42	6.4
Catholic	21	3.2

**Dependents, no specified job, * Silte, Sudka, Wesene

Overall knowledge of participants related to HIV/AIDS and VCCT was high. Some 654(99.5%) of them have heard about VCCT and 571(86.9%) have good knowledge and answered over 60% of the knowledge questions correctly. There was a statistically significant (p=0.039) difference in the level of knowledge between the urban and rural residents. One hundred and forty three respondents (21.8%) thought that a person infected with HIV may not live for many years without showing the signs, 272(41.4%) did not accept that persistent use of condom prevents both sexually transmitted infections (STI) and HIV/AIDS, 130(19.8%) do not accept that unsafe abortion exposes to HIV infection and 306(31.4%) responded that VCCT can not help to delay the progression of HIV infection to full-blown AIDS. Some 74.1% also think that VCCT is essential for pregnant women (Table 2).

Table 2. Knowledge of the study participants about HIV/AIDS and voluntary confidential counseling and testing, Gurage zone, October 2004.

Statements assessing knowledge (n=657)	Yes No. (%)	No No. (%)
Having many sexual partners increases the risk of being Infected with HIV/AIDS.	636(96.8)	21(3.2)
A person can be infected with HIV and may not show sign of the disease for many Years.	514(78.2)	143(21.8)
A person who looks healthy and carrying HIV virus can transmit the Virus to other People.	573(87.2)	84(12.8)
Using condom persistently prevents both STIs and HIV/AIDS.	385(58.6)	272(41.4)
Had heard about Voluntary counseling and testing	654(99.5)	3(0.5)
There is a test that can show whether a person is infected with HIV or not.	474(72.8)	183(27.9)
Unsafe abortion exposes to HIV infection.	527(80.2)	130(19.8)
Getting voluntary counseling and testing on HIV/AIDS is important.	627(95.4)	30(4.6)
VCCT can help in preventing the spread of HIV infection	589(89.6)	68(10.4)
VCCT can help to delay the progression of HIV infection to full-blown AIDS	451(68.6)	206(31.4)

Small proportion (5.8%) of the study subjects thought that diarrhea is a confirmatory sign for being infected with HIV/AIDS. One of the concerns about the quality of a voluntary counseling and testing service is the type of test used in the service delivery and its yield versus the period of latency required to detect the sub-clinical infection using this screening test. In Gurage zone there is a trend of getting screened twice before marriage happens: pre-engagement screening and pre-wedding screening. Therefore, assessment of the perception of the community about appropriate time for screening was highly important. The majority (56%) of the study population said that the appropriate time to detect HIV infection by blood test was

from 3-6 months after infection. The rest said that it is possible to know as to whether a person is infected or not if the blood is tested in less than three months time and in more than 6 months after infection has occurred in 11% and 5% of the cases, respectively. The rest 28% do not know the appropriate time between infection and the test when it will be possible to detect the infection through voluntary counseling and testing (fig.1.)

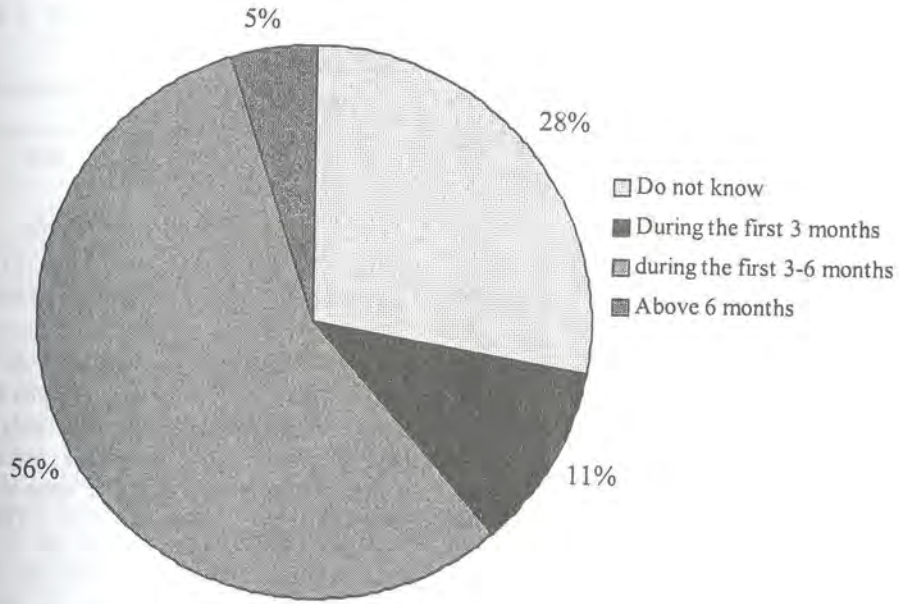

Figure 1. Time after infection when it is possible to know HIV infection by blood test as reported by the study participants, Gurage zone, October 2004 (n=657)

Almost all the respondents have heard about voluntary counseling and testing. The source this information for the majority was health facilities accounting for 26%, mass media 21%, more than one source 21.3%, friend /family 14.9% and school 13.9%. Religious institutions and sexual partner contributed in this regard smaller proportions in the study community (*Fig.2*).

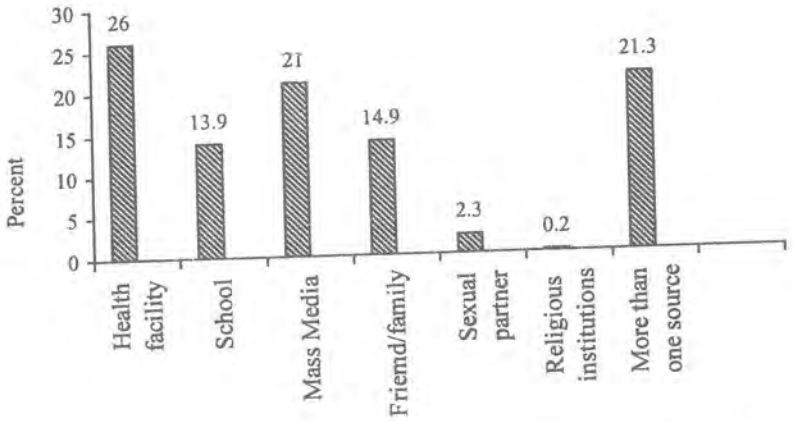

Figure 2. Sources of information about VCT service in Gurage Zone, October 2004.

The level of awareness of the respondents was assessed to figure out factors affecting the utilization of voluntary counseling and testing service. The majority 560(86.8%) mentioned unprotected sex and sharing of sharp objects between different people as the major modes of transmission of the virus to new people. Breast-feeding by HIV positive women was mentioned only by 2(0.3%) indicating a very low level of awareness about this particular issue in the study community (*Table .3*).

Table 3. Ways of transmission of HIV as reported by the study participants, Gurage zone, October 2004.

Ways of transmission of HIV (n=657)	Number	Percent
Do not know	19	2.9
Unprotected sex + Sharing sharp objects	560)	86.8
Sharing sharp instruments	57	8.7
Eating together	2	0.3
Not sticking to one to one relationship and not using the ABCs of prevention	5	0.8
Breastfeeding by HIV positive mothers	2	0.3

**More than one answer is possible*

According to the health belief model, people will be changing their behavior towards utilizing some preventive method like the voluntary counseling and testing service if they believe that they are at risk of acquiring the disease and if the method can prevent them from such a malady. Therefore, thinking of being at risk (risk perception) of HIV infection was assessed to determine how the study subjects fare in

regard to this issue. It was found out that 48.1% of the subjects who did use condom persistently during sex with multiple sexual partners did not perceive that they are at risk of acquiring the disease indicating low risk perception among people involved in high-risk sexual practices in the zone. It was also observed that subjects who had sexual encounters with casual partners used condom persistently whereas only 51.9% of the subjects who happened to have sexual affairs with multiple partners used condom persistently while the rest did not use indicating the fact that when people have acquaintances with partners there is a feeling that the person is healthy and trusting him/her (*Table 4*).

Table 4. Risk Perception of the study participants, Gurage zone, October 2004

Have multiple sexual partners	Think being at risk of HIV infection		
	Yes	No	Total
Yes	13(25)	*39(75)	52(100)
No	70(24.5)	216(75.5)	286(100)

*48.1% of the subjects who did use condom persistently during sex with multiple sexual partners do not perceive that they are at risk of acquiring the disease

Awareness and attitudes of the study participants about the behavior that a person found to be HIV positive is a critical entry point that can be utilized and given emphasis during the VCCT service delivery. This in turn will facilitate the preventive activities against the spread of the virus on the one hand and improve the quality of life of people living with the virus and increase their survival on the other. In this study most subjects mentioned that a person found to be positive should eat nutritious164 (25%), balanced diet 198(30.2%), try to save others from being infected and avoid being re-infected by the virus to prolong life 65(9.9%). Some 68(10.4%) mentioned all of the aforementioned actions (Table 5).

Table 5. *What HIV positive* person *should do as reported by the study participants, Gurage Zone* October *2004.*

What HIV positive person should do (n=657)	Number	Percent
Eat nutritious and balanced diet	198	30.2
Try to save others	164	25
Avoid being reflected with the virus to prolong life	65	9.9
Stop life styles like smoking, drinking alcohol & chewing Chat	61	9.3
All of the above	68	10.4
Take anti-retroviral therapy	2	0.3
Pray	4	0.6
Live alone	2	0.3
Do not know	46	7.0

**More than one answer is possible*

During the focus group discussion some subjects said that VCCT does not have any benefit. In order to see as to how many people are sharing this idea, an assessment of their views about the benefits of VCCT was carried out. The majority responded that its benefit is to know ones HIV sero-status (58.3%) followed by those who said

to prevent the spread of the disease (20.8%) and to get anti-retroviral therapy (6.6%). Twenty-four people (3.6%) do not know the benefits it has and 14(2.1%) said that it does not have any benefit (*Table 6*).

Table 6. Benefits of Voluntary counseling and testing, Gurage zone October 2004.

Benefits of Voluntary counseling and testing (n=657)	Number	Percent
To know ones sero-status	382	58.3
To prevent the spread of the virus	136	20.8
To get anti retroviral therapy	43	6.6
Do not know	24	3.6
Does not have any benefit	14	2.1
For marriage (and also strengthens marriage)	5	0.8
To take care	4	0.6
To educate the public	1	0.2
To Identify people living with HIV/AIDS	1	0.2

When we analyze the knowledge and attitudes of the study participants about voluntary counseling and testing and HIV/AIDS by woreda, there was a similar trend in most woredas. Major disparities between the level of knowledge of the study subjects and their attitudes were observed in Kokir woreda. In this woreda study participants have a very high knowledge score but a lower attitude score. Despite the fact that there is a relatively higher level of knowledge and the positive attitude observed in the majority of the study subjects in all woreda, there was a statistically significant variation (p=0.000) of level of knowledge and attitude of subjects across woredas.

In a behavior change communication underlying knowledge and attitude need to be changed to bring about a change to the desired behavior/ action in the target community. Overall 87.7% of the study participants scored 60% and above on attitude questions using likert scale and were therefore labeled to have positive attitude. However, on some specific issues the responses of the study community was found to be unfavorable indicating the underlying negative attitude held by those subjects. Some of the areas that demand a focus in the future intervention activities were the fact that 26.9% of the study subjects did not disagree to the belief that HIV/AIDS is not as a big problem as the media suggests, 20.1% disagreed to the believe that a person with STD has a high risk of acquiring or transmitting HIV, 28.2 % agreed to the belief that if at all one has to use condom during sex, he/she has to use it only during sex with casual partners and 23.4% did not agree to the believe that VCCT is effective in averting morbidity and mortality from HIV/AIDS. It was also noted that 32.3% believe in isolating the residential areas of people living with HIV/AIDS (PLWA) and 29.7% believe in isolating household food utensils of PLWA (Table 7). Generally, single and married subjects had positive attitude towards VCCT and other preventive mechanisms of HIV infection as compared to widowed and divorced subjects and this difference was statistically significant (P< 0.05). There was no significant difference in terms of attitude of subject with respect to religion, occupation, place of residence and gender (P>0.05).

Table 7. Attitude of the study participants, Gurage zone October 2004.

Attitude statement (n=657)	Agree	Neutral	Disagree
	No. (%)	No. (%)	No. (%)
There is a belief that HIV/AIDS is not as a big problem as the media suggests	150(22.8)	27(4.1)	480(73.1)
I believe that a person with STD has high risk of acquiring or transmitting HIV	450(68.5)	75(11.4)	132(20.1)
I believe in abstaining from sex until I marry rather than using condom.	513(78.1)	42(6.4)	102(15.5)
If at all I have to use condom during sex, I believe in using it only during sex with casual partners.	185(28.2)	47(7.2)	425(64.7)
I believe that knowing one's status of HIV after voluntary counseling and testing is more preferable than not knowing.	577(87.8)	30(4.6)	50(7.6)
In my belief couples who prepare for marriage shou Screened through Voluntary Counseling and Testin before marriage.	627(95.4)	13(2.0)	17(2.6)
I feel that the result of HIV test must be given to ea individual whether it is done voluntarily or for the purpose of investigation by the health Professional request.	579(88.1)	45(6.8)	33(5.0)
In my belief a person with HIV/AIDS should hide himself/herself	90(13.7)	28(4.3)	539(82.0)
People believe that VCCT is effective in averting morbidity and mortality from HIV/AIDS	503(76.6)	50(7.6)	104(15.8)
If You were a parent, do you agree to allow your ch marry without getting his/her partner tested for HI	133(20.2)	29(4.4)	495(75.3)
I believe in isolating the residential areas of People living with HIV/AIDS	212(32.3)	38(5.8)	407(61.9)
I believe in Isolating household food utensils of Pec Living with HIV/AIDS	195(29.7)	42(6.4)	420(63.9)

Another important area that was assessed was the intention to use voluntary counseling and testing service and places where they want to use VCCT services among those have not used the service before the study. The majority (87.9%) had an intention of using the service if it is available (*Table.8*). When asked about the places they want to use VCCT service, 70.7% replied to use VCCT service in the nearby facility and 6.3% said that they can use the service in any facility regardless of whether the service is close to their place of residence or not both responses are encouraging and indicators of the success. However, 23.1% of the study subjects reported that they want utilize VCCT service which are far from their place of residence (district) to keep their status incognito, which is indicative of the presence of stigma, associated to the disease in the study community (*Fig.3*).

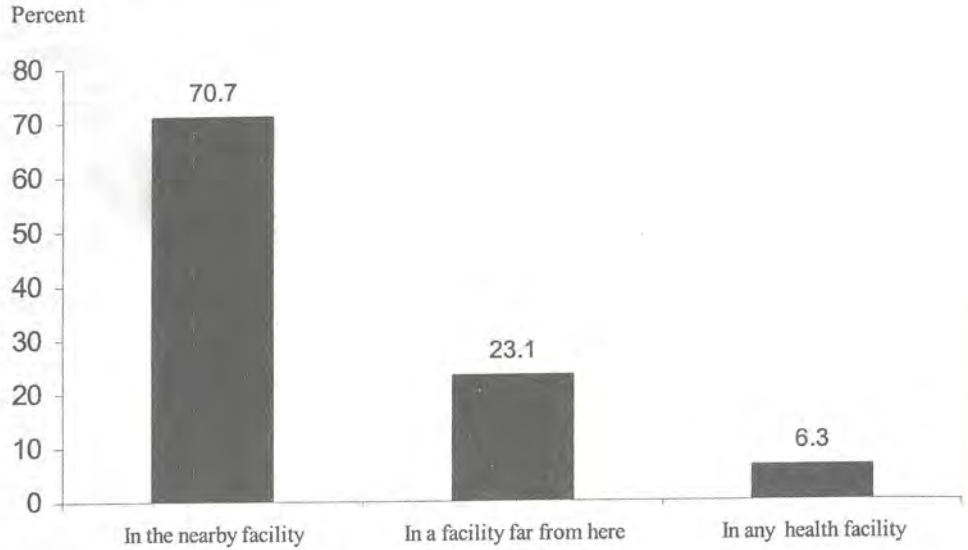

Figure 3. Preference of facilities for using voluntary counselling and testing service, Gurage zone, October, 20054(n=499)

With regard to the mode of notification of voluntary counseling and testing result, over half (51.2%) preferred face to face counseling which is again supportive of the use of VCCT as a preventive strategy. However, the fact that about 47.2% study participants opted for being notified their results either anonymously or without counseling and only with the notification of the health professional or the counselor is again indicative of the presence stigma related to the disease which is a barrier against using VCCT as a preventive strategy against HIV/AIDS (Fig.4).

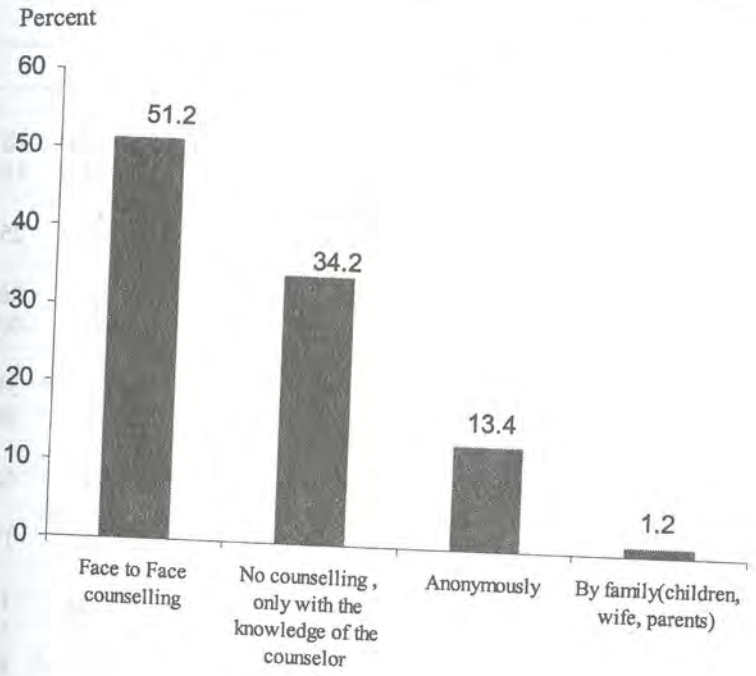

Figure 4. Preference of the study participants on the mode of notification of their HIV-serostatus after VCT, Gurage zone , October, 2004

Assessment of the practices related to HIV/AIDS and voluntary confidential counseling and testing displayed that out of 370 of them who had sexual experience, 52(14%) had history of multiple sexual partners and only 27(51.9%) used condom persistently during sex with multiple sexual partners. The rest 48.1% did not use condom persistently during sex with multiple sexual partner. All of the 10 individuals who had sex with casual partners had used condom persistently.

From the result it seems that there is a tendency of trusting the person with whom one is familiar when it comes to the use of condom as a means of preventing HIV infection. Of 12 persons who had sexual contact with commercial sex workers 4(33.3%) did not use condom persistently. Overall 89(13.5%) of the study population have utilized voluntary counseling and testing service and only 2(2.25%) are positive for HIV infection (Table 8.)

Table 8. Practices of the study participants related to VCCT and HIV/ AIDS, Gurage Zone, October 2004

PRACTICES	YES #(%)	NO #(%)
Ever had sexual intercourse (n=657)	370(56.3)	287(43.7)
Had multiple (more than one) sexual partner in the past years (n=370)	52(14.0)	318(86.0)
Used condom persistently during sex with multiple sexual partners (n=52)	27(51.9)	25(48.1)
Ever had sex with casual partner (n=370)	10(2.7)	360(97.3)
Used condom persistently during sexual intercourse with casual partner (n=10)	10(100)	0(0.0)
Had history of sexually transmitted infections (STI)(n=370)	17(4.6)	353(95.4)
Had sexual contact with commercial sex workers (only for males)(n=177)	12(6.8)	165(93.2)
Used condom persistently (only for males) during sexual contact with commercial sex workers (n=12)	8(66.7)	4(33.3)
Had history of Unwanted pregnancy (Only for Females)(n=193)	18(9.3)	175(90.7)
Had history of Abortion (Only for Females)(n=193)	20(10.4)	173(89.6)
Used VCCT service (=657)	89(13.5)	568(84.5)
VCCT result was positive (n=89)	2(2.25)	87(97.75)
Intention to use VCCT in the future (for those who have not us the Service is available (n=568)	499(87.9)	69(12.1)
Intention to ask ones partner VCCT service (if the service is available) (n=568)	422(74.3)	146(25.7)

Population in the age group between 10-14 years have stated sexual practice in the study community indicating the fact that that the age of initiation of sexual activity has come down in that segments of the population in "the Window of Hope" age group had started practicing sexual activity (Fig.5).

A total of 14 study subjects had more than one sexual partner in the last 6 months from the time of the survey out of which the majority (79%) had one additional partner followed by those who reported to have two and three additional partners accounting for 14% and 7% of the cases, respectively (*Fig.6*). All of the study participants who reported to have additional sexual partner during the last six months were males.

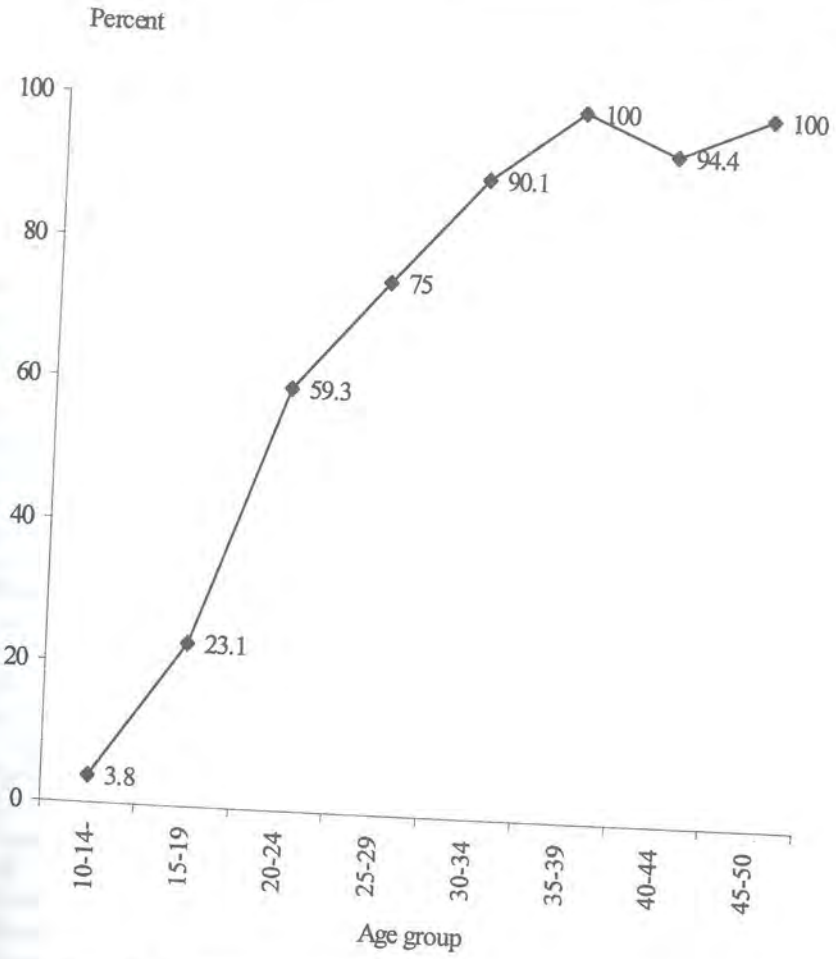

Figure 5. Sexual practice by the diffrent age groups of study participants Gurage zone, October 2004(n=657).

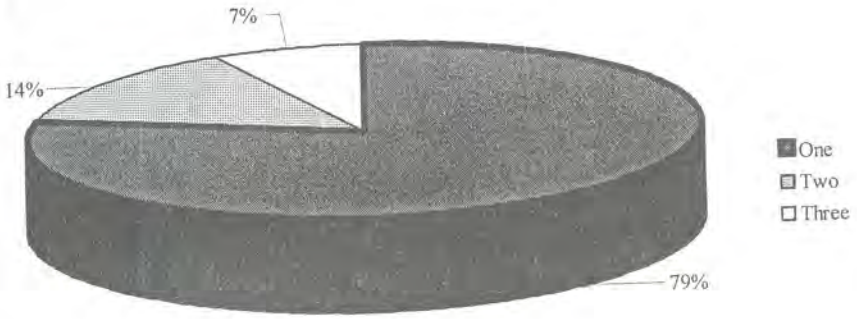

Figure 6. Number of partners of subjects who have more than one partner during the last 6 month, Gurage zone, October, 2004(n=14).

DISCUSSION

The findings demonstrated that large proportion of the study population had good knowledge about HIV/AIDS and its prevention methods, which is consistent with the findings of other studies (6,11, 14, 20,21,22 23). There was a significant difference (P<0.05) in the level of knowledge between urban and rural community. A similar finding was recorded in another study done among the urban and rural communities of Jimma town (20). The urban community had higher level of knowledge than the rural, which an expected event due to a better access to information education and communication (IEC) messages as compared to the rural community. Younger age groups were towards VCCT and other preventive methods against HIV infection as compared to older ones (P< 0.05). This might be due to the better access to information of the younger age groups through schools and different clubs which in turn affects their attitudes positively.

Regardless of high level of knowledge observed in the study community higher percentage of the study population was practicing high-risk sexual practices. Unsafe sexual practices like not using condom persistently during sex with multiple sexual partners were stated by 48.1% of the study subjects, which is consistent with the finding of a study in Jimma (20). Other reports (6, 12, 21) also documented the same pattern in that higher prevalence of STI infection was observed

despite high level of knowledge about the means of transmission of HIV/AIDS and other STIs.

This study also disclosed that initiation of sexual activity had come down to the age below 15 years. About 3.8 % of the study population started their first sexual intercourse in the age group 10-14 years, which was otherwise considered to be "the Window of Hope age group". This was very small as compared to the finding of a study in Jimma area, which reported 10.6% (20), Keffa (22) and the reports of behavioral survey in Assosa (24). This finding suggests that the preventive measures against HIV/AIDS should give due attention to the lower age groups as these group of the populations are also equally vulnerable to the pandemic.

The majority of the study participants believe that couples preparing for marriage should be screened for HIV infection and they have a positive attitude towards utilizing VCCT services. A similar finding was reported by other studies (15, 16, 20). Generally, there was a statistically significant (p< 0.05) difference between married subjects and other counterparts in their knowledge and attitude about VCCT and HIV/AIDS. Married subjects have higher knowledge and positive attitude and they are also the ones who utilized the VCCT service the most (P< 0.05). This might be due to the fact that there they are screened as a requirement for marriage and also they have undergone the screening that happened when the husband comes from the cities before any sexual intercourse, which is a reality in Gurage zone. Experiences of other countries had demonstrated that VCCT is the most effective strategy in bringing positive behavioral change on HIV/AIDS (14). The national HIV/AIDS policy focuses on intensification of IEC and expansion of VCCT services as part of the multi-sectoral approach to HIV/AIDS prevention (4, 6, 18, 19). From this study it was observed that there is a fertile ground for the implementation of VCCT as a preventive strategy as the majority of the study population has a positive attitude toward it. However, this study has also directly and indirectly indicated the existence of stigma as a barrier to the use of VCCT services as a preventive strategy.

Conclusion: The general understating of the community about the HIV/AIDS, VCCT and the other preventive strategies was quite high compared to findings of similar studies elsewhere in the country. However, this high level of knowledge did not help to bring desired change in attitude and practice in some segments of the study community. Presence of certain segments of the community holding negative attitudes may be barrier to implementation of key intervention strategies like VCCT and home based care and support for people living with HIV/AIDS, and consequently need attention in the behavior change communication activities. Regardless of high level of knowledge certain segment of the community was observed to practice high-risk sexual activity.

Recommendation: a strong Behavior Change Communication (BCC) based two-way communication strategies including repeated discussions, individual counseling, dialogues, panel discussions, persuasions community support group discussions with active involvement of the grass root community, religious leaders, community based organization and other opinion leaders is important to reduce stigma and discrimination in order to increase the use VCCT and home based care as a means of prevention of HIV AIDS.

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