



**Assessment of The effectiveness of Participatory HIV/AIDS
prevention and support (PAPAS) on improving behavioral
change in
Gulomekeda Woreda Eastern Zone of Tigray**

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I. Abstract

Introduction: HIV/AIDS is becoming not only Health problem but Economical, Social and political problem from decades ago worldwide especially for the developing countries. Participatory AIDS Prevention and Support is implementing in Ethiopia starting from 2004 with the support of CRS. The existing PAPAS intervention coverage in Ethiopia is very limited. Nowadays, despite some emerging initiatives to meet the behavioral change for the community by providing Health education and life skills development, their proper implementation and effectiveness was not adequately measured.

Objective: To assess whether there is increased behavioral change among the community members in the area were PAPAS has intervention from those who get Health education

Methodology: A quantitative comparative cross sectional study was conducted in Eastern Zones of Tigray region Gulomekeda Woreda in Seven PAs the study participants were PAPAS Participants and PAPAS Non-Participants. Structured self administered questionnaire was used to collect data. The main outcomes measured during the study knew the prevention and transmission, change in behavior and their practice.

Result: A total of 306 people whose age is greater than 18 years were participated in the study 153 were PAPAS Participants and 153 are Non-PAPAS Participants. The study result showed there is great significance difference among PAPAS participants and non participants in Knowledge, attitude and skill (practice) as a result they PAPAS participants were active (in practicing condom use, in utilization of HIV testing, in decreased stigma and discrimination and in helping others as social funding.

Conclusion and Recommendation: Such studies were new for the region and even in Ethiopia may be in other world or not released out and this was my head ache for references problems, however. I was really eager enough to see what's their advantage as a result of PAPAS training and the disadvantage for the community who were not participating.

Such life skill trainings will play great significance in changing their behavior especially for those who are not able to write and read and there for my recommendation here is NGO's and GO's shall actively involved as a result will contribute much in decreasing transmission of HIV and its impact. The other thing I emphasized other researchers to investigate morel.

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III. List of abbreviations and Acronyms

ADCS: Adigrat Diocese Catholic Secretariat

AIDS: Acquired Immune Deficiency Syndrome

CRS: Catholic Relief Services

FHI: Family Health International

HCP: Health Communication Partnership

HIV: Human Immune Virus

MOE: Ministry of Education

PLWH: People Living With HIV

RH: Reproductive Health

STI: Sexually Transmitted Infections

YAK: Youth Action Kit

PAPAS: Participatory AIDS prevention and support

VCT: Volunteer counseling and testing

ART: Ante-retro viral therapy

WHO: World Health organizations

IGA: Income Generating Activities

Woreda: District area of Zone

Tabia: sub-Administrative area of Woreda

Kushet: sub-administrative area of Tabia

Gote: sub-administrative area of Kushet

HAPCO- HIV/AIDS prevention and control office

GO: Governmental organization

NGO: Non Governmental organizations

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IV. CHAPTER ONE: INTRODUCTION

1.1 Statement of the problem

In Ethiopia starting from the identified two reported AIDS cases in 1986 then the prevalence was increasing from time to time. Though promising news we heard that the prevalence is decreasing in recent time, there is a fear that the disease is slightly increased in rural areas (USAID 2008 HIV in Africa). In the year 2008 the number of PLWHA in Ethiopia was estimated to be 1.32million. The infection rate in urban areas is believed to be 7.7%, while in rural areas the infection rate stands at 0.9% (MOH 2009 AIDS Report)

The Federal Ministry of Health (MoH) HIV/AIDS Prevention and Control Office (HAPCO), in collaboration with the World Bank and other partners, undertook a study to look into the HIV epidemic, its major transmission dynamics and its potential evolution in Ethiopia to analyze current HIV responses and identify major geographic and thematic priorities that require greater emphasis. It indicates that there was a shortage or limitation in the way the information was transmitted in to the community since in Uganda was practically seen that there was Health education given to the community at large but they don't create behavioral change or very few. But in Southern Kenya those who get life skill education through different tool kits like:- In charge (tool kit given for children whose age is 15-19), PAPAS (Participatory AIDS Prevention and Support given for adults), PHAST (Participatory Hygiene and Sanitation transformation given for adults), YAK (Youth action Kit given those age 18-24) they bring promising in behavioral change (WHO 2008).

The existing evidence has shown that the epidemic is more heterogeneous across the nation with more urban and females affected than rural areas and males. Urban epidemic is on decline in major towns while rural epidemic is leveling off. But small towns are becoming hotspots and could potentially bridge further spread of the urban epidemic to rural settings. The dynamics of sexual

behaviors and networks in the hotspots and their surrounding communities as well as in the most at risk population groups and the general population is not fully understood, requiring further investigation to uncover the epidemic and its driving factors.(HAPCO 2010)

Trend of the Epidemic

Since the detection of the first two reported AIDS cases in 1986 in Ethiopia, the epidemic has rapidly spread throughout the country. According to the single point estimate, the national adult HIV prevalence is 2.2% in 2008 with an estimated 1,037,267 people living with HIV in the country. The epidemic which started in the mid-1980's, expanded rapidly and reached a plateau around the mid-1990s. In major urban settings, the epidemic is on decline while stabilizing in rural areas. However, there is significant variation in the epidemic among geographic areas and population groups. (MOH 2010)

Heterogeneity of the Epidemic

Across the country, urban areas and females are more affected than rural areas and males. Urban HIV prevalence was 7.7% in 2008 with an estimated 62% of total PLHIV in the country residing in urban areas, while rural HIV prevalence was 0.9% in 2008, which accounts for 38% of total PLHIV population in the nation. Among urban settings females are more affected than males in both urban and rural areas. In 2008, female HIV prevalence was 2.6% while male HIV prevalence was 1.8%. Females account for 59% of the total PLHIV in the country. According to DHS 2005, females are twice more affected than males.

Risk Factors

Expanded of small towns, displace people from their ordinary home, Economical problem, illiteracy, long Car drivers, un married sexually active Females daily laborers are some of the risk factors that contributed much in transmission of HIV and AIDS

Major Challenges

Methodology was the main problem, since Health education was given for long period in the country.

However, there is little behavioral change specifically

- system problem or methodological problem
- Limitation in Finance
- Lack of HIV/AIDS teaching and learning materials
- Institutional silence on HIV/AIDS
- Lack of resource integration among GO and NGOs and etc.

Policy and programmatic recommendations

- Ministry of Health should allocate much to alleviate the risk
- It needs clear established indicators for monitoring and evaluation for HIV program
- Since there are no any or little researches hence should support and allocate money

1.2 Rationale of the study

Participatory AIDS prevention and support (PAPAS) is one of the life skill tool kit and it is best method for behavioral change, which has been widely implemented within the community since 2004 in Ethiopia, Kenya and Uganda. So far many international and local organizations have been directly or indirectly involved in its implementation in Ethiopia. According to Health Communication Partnership September 2008 report, despite all efforts took place the effectiveness of PAPAS was not systematically studied. Hence, this study is intended to assess the effectiveness of (PAPAS) and the

result of the study is paramount importance in advocating the scale up of the program, and also helps as a basic to undergo further research in the area.

Tigray is one of the regional states of Ethiopia which is the fourth highly infected by the epidemic next to Addis Ababa 7.5% Diredawa 4.5% Harari 3.2% Tigray 2.7% (HAPCO-2007) respectively, Poverty, illiteracy; war and displacement are contributing much for the spread of HIV in the region. By the year 2008 HIV/AIDS prevalence among the general population of the region was 2.7% the prevalence is high among women than men which was 5.3 &4.1% respectively.(HAPCO 2008 AIDS Report)

Eastern zone is one of the 7 administrative zones of Tigray which is highly infected with the epidemic and Gulemekeda woreda is one of the nine administrative woredas in eastern zone of Tigray. Which is highly affected(Regional HAPCO 2008) the other justification is, it is border to Eritrea with many military and female sex workers and even small business also took place around hence there is an assumption of high risk for HIV infection. The third justification for this study is PAPAS tool kit was implemented six years before.

ADCS HIV/AIDS unit is contributing much in supporting infected and affected individuals in care and support as well as in prevention aspects since 2001.For its best performance Regional HAPCO awarded the team mainly in introducing the life skill tools:- like PAPAS, in charge and YAK starting from 2004. However there is no any data or study whether those tools bring much in changing their behavior or not. This is the fourth justification why I am interesting in identifying the result either of the Participatory tool kits (PAPAS) brings behavioral change from those who are not participated.

1.3 Dissemination of Results

The results of this study will be primarily disseminated to the local organizations actively involved in implementation of the program. In addition the results will be disseminated to concerned Authorities such as regional HAPCO, Education Bureau, Youth and Sports Affairs, Regional Health Bureau, and other Non-governmental organizations in the region. Maximum efforts will be made to present the results to the community of Mekelle University and ensure its publication in any of the Journals available in the university. At the national level, the results of the study will be disseminated to Health Communication Partnership, and Catholic Relief Services (CRS) whereby their contribution is very vital in advocating at national and international level

1.4 Objective of the study

1.4.1 General objective

To assess the effectiveness of PAPAS tool kit on changing the behavior of the community towards HIV prevention and care

1.4.2 Specific objective

1. To assess utilization rate of VCT among PAPAS participants and PAPAS non-participants
2. To assess their knowledge on prevention and transmission of HIV/AIDS among PAPAS participants and PAPAS non-participants
3. To assess their attitude towards stigma and discrimination among PAPAS participants and PAPAS non-participants

V. CHAPTER TWO LITERATURE REVIEW

World health organization (WHO) and united nation immergence children's fund (UNICEF) had developed many life skill tool kits. PAPAS (Participatory HIV/AIDs Prevention and Support) is one of the tool kit which was designed in 1998 to promote HIV/AIDS prevention and to increase self support among the community. The Ethiopian ministry of Health then appreciated the tool and approved PAPAS as a strategy to promote the prevention and control of the disease starting from 2004 (HAPCO 2005). PAPAS is an adaptation of SARAR methodology of participatory learning which builds on people's innate ability to address and resolve their own problem. It aims to empower the community and highly involved to mitigate HIV/AIDS and its impact

. SARAR (S-self esteem, A-associative strength, R-resourcefulness, A-action planning, R-responsibility): is the father of all participatory approach that builds on local knowledge and strengthens local ability to: assess, prioritize, plan, create, organize, and evaluated the outcome. It was developed through a bottom up participatory process there for this can be important for the community to discuss on their real problem The implementation of this tool kit within the area was done by ADCS with Woreda Health office

This manual was drafted from the PHAST step-by-step guide participatory approach for the control of diarrheal disease. Many people were contributed to the development of SARAR methodology Lyra Srinivasan Sawyer, R.M. Simpson Hebert and S. Wood 1998. Geneva: World Health Organization 1998).

PAPAS has unique character related to HIV/AIDS and it has 8 Activities/topics with 7-15 pictures inside in each activity namely: 1) Community story, 2) Talking about HIV/AIDS 3) Who gets HIV/AIDS, 4) How HIV is spread, 5) Blocking the spread of HIV, 6) Local practices that spread HIV, 7) Reducing stigma and discrimination and finally 8) Helping for people who have HIV/AIDS.

In Ethiopia, there are initiatives by governmental and nongovernmental organizations to run a component of life skills education as means for HIV Prevention and Promotion of people's wellbeing. One of the tools which is widely implemented by different organizations is PAPAS tool kit. This tool kit was implemented in Ethiopia in 2004 as a sample in Gulomekeda Woreda Eastern zone of Tigray and in Diredawa (CRS Ethiopia IEC/BCC 2008 presentation report) this tool kit was designed to implement in the community those who are low educational background. By now Health Communication Partnership collaborates with several organizations implement PAPAS widely in Ethiopia (HAPCO 2009)

PAPAS aimed to achieve different initial outcomes by increasing people's skills, self-efficacy, knowledge, risk perception, awareness of stigma and planning for future goals. The initial outcomes was to help participants achieve minimum three to four behavioral outcomes namely increase their knowledge, promote their attitude towards safe sexual practices (i.e. abstinence, fidelity), stigma reduction and practiced in HIV testing as well as in social contribution with the ultimate goal of reducing HIV transmission.

PAPAS differs from other Health education programs, it is highly participatory than Health education. Participants discussed not only about HIV/AIDS but also life skills development such as communication skill, self-confidence, and decision-making, among all peoples in respect of Sex. They like the methodological approach of the tool kit since all participated in role-play, in discussions, in community mapping and on enthusiasm and action. The following are the key steps in the PAPAS program implementation.

Though there is no any results related to PAPAS in Ethiopia the effectiveness of other life skill assessments life skill like YAK (Youth Action Kits) and reproductive health interventions which incorporate life skills approach have been studied. Over the years, life skills education programs that include sexual and reproductive health information have proven to be effective in delaying the onset of sexual intercourse and, among sexually experienced youth, in increasing the use of condoms and

decreasing the number of sexual partners. Evaluation shows that life skills programs can contribute to the reproductive and sexual health of young people around the world.

Internationally reviewed by UNICEF found that approaches relying on life skills have been effective in educating youth about health-related issues such as alcohol, tobacco, and other drug use, nutrition, pregnancy prevention, and preventing HIV/AIDS and other sexually transmitted infections (STIs) an evaluation of the effectiveness of a peer sexual health intervention among secondary-school students in Zambia showed that a school-based peer sexual health intervention implemented in Zambia was effective in increasing knowledge, positive normative beliefs about abstinence and condoms, and personal risk perception.

A randomized, longitudinal study of Increased protected sex and abstinence following HIV risk-reduction intervention was conducted among Namibian youth in 1998. Among all 515 youths who enrolled in the programme, rates of either abstinence or sex with a condom were not different between control and intervention youths at baseline or in the follow-up period. However, analyses conducted among the subset of youths who were sexually inexperienced at baseline (n = 255) revealed that a higher percentage of intervention youths (17%) than control youths (9%), $P < 0.05$ remained sexually inexperienced one year later.

An evaluation of HIV/AIDS prevention intervention messages on a rural sample of South African youth's knowledge, attitudes, beliefs and behaviors was conducted over a period of 15 months in 2004. Results showed that over a period of 15 months sexual risk behavior reduced (multiple partners) and the number of sexually transmitted symptoms reduced. Attitudes towards persons living with HIV/AIDS improved. (UNICEF 2005)

A review of effectiveness of a school-based AIDS education programme for secondary school students in Nigeria was conducted in 1999. The study found that intervention students were less likely to feel AIDS is a white man's disease and were more likely to be tolerant of people living with the disease ($P < 0.05$). After the intervention, the mean number of reported sexual partners among the

experimental students significantly decreased from 1.51 to 1.06, while it increased from 1.3 to 1.39 among the controls. Among the intervention students there was also an increase in consistent use of condom and the use of the condom at last sexual intercourse.(UNICEF 2005)

A static group comparison of Impact Evaluation of a Community Based Adolescent Reproductive Health Program called INSYGHT in Ethiopia was conducted by save the children in July 2007. The results of the study revealed that Males who never had sex was 79.8% vs. 56.7%, for in-school ($p < 0.001$) in intervention and control groups. The proportion that reported at least 2 sexual partners last year, was 25% vs. 4.4% for males and 10.9% vs. 0.0% for females, respectively, in the intervention and non-intervention area,(Save the children 2007)

Training of Trainers (TOT) – (Six days)

The TOT was an essential part of the PAPAS program aimed at training and preparing the core training teams. The training teams, after they attend the TOT, are supposed to facilitate the PAPAS training sessions for the people from the selected “Gotes”.

Shadowing and Workshop (4 days)

Immediately following the TOT, the training teams conduct shadowing workshops for groups of people practice the PAPAS activities. The goal is to strengthen the facilitators’ skills before they begin implementing the actual training programs.

The PAPAS Workshops (4 days)

This is the actual PAPAS training provided for the community members. The goal of this workshop is to train community members who in turn go back to their household and implementing the PAPAS activities. The ideal number of participants is 22, but in some cases it may be as many as 25 and as least as 20.

Group formation

At the end of each graduation divided the large group (22) in to three small groups (7-8) and one facilitator in each small group. The facilitator will organize home visiting and meeting every month for every member to assess either practicing what expected from the individual. This is one of the technical components of the program. The goal of this formation is to maintain regular contact with the community and implement well.

Implementation Assessment

The implementation status in the community is determined based on proper completion of PAPAS activities stated in the book including the community outreach and the report from the cluster's organized at the end of every PAPAS discussion. For the community to reach the implementation they should also address minimum three outcomes and is assessed through continuous technical assessments such as visiting and evaluated every month among the clusters and evaluation at every three months with the graduating group in presence of the Tabia Health extension package workers and from ADCS Health and HIV/AIDS unit, Randomly site visits, Lessons Learned Workshops

2.1 The need for Life skill (PAPAS)

PAPAS is a participatory methodology to be used with community groups including youth. The main objective is to help communities talk about HIV/AIDS and then to take action against the disease. It is a transformational methodology in that it brings about fundamental change in people's attitude and behavior.

Health education was given for the peoples especially for those who visited Health institutions for their health problem as long as modern health services were took place in Ethiopia from the concept Almata declaration "Health for all" by the year2000.

The recent Ethiopian Health Extension Package program, Health education is one of the 17 Health extension package components as a result many individuals have better knowledge in Health related information mainly in Environmental health and in HIV/AIDS but the problem is in changing their behavior (MoH 2007). Starting from Apr 2004 different Tool kits were implemented to achieve behavioral change with in Government and non Government institutions. ADCS (Adigrat Diocesan Catholic Secretariat) is one of local Church based NGOs in Tigray which implemented the tool kits.

VI. CHAPTER 3: RESEARCH METHODOLOGY

3.1 Study design

This is a quantitative comparative cross sectional study to assess knowledge, attitude and practice of HIV/AIDS in 7 kebeles of Gulomekeda woreda eastern zone of Tigray the Study populations for PAPAS Participants and PAPAS Non-Participants were aged 18-49. These subjects of study were selected by lottery method for select the direction and selecting households as a sample frame. The numbers of subjects to be selected from each Gote were 22 individuals. The subjects who were absent during the study period were replaced by others. Socio-demographic variables: sex, age, educational status, religion, ethnicity, were identified first.

3.2 Description of Study Area

The study was conducted in Gulomekeda Woreda Eastern Zones of Tigray the area is an average of 35 km away from Adigrat to north and has field work. The regional population according to the 2007 Census is about 4,314,456 the region is subdivided into 7 administrative zones, Eastern Zone is one of the 7 zones of the region and have 9 Administrative woredas .The estimated total population of Eastern zone according to the 2007 Census is 755, 633. Gulomekeda is one of the boarder Woredas in Eastern zone with 18 administrative Tabia(Kebele) with 98,000 populations.

ADCS (Adigrat Diocese Catholic Secretariat) implemented activities within 7 kebeles of Gulomekeda Woreda by calling Watershade management program starting from 2001. Integrated water shade management program and Health and HIV/AIDS program implemented PAPAS jointly within 21 “Gotes”. Three Gotes from each Tabia. Each Tabia has minimum of 12 small administrative units called “Gote”.

Thereafter for this study one Gote from each Tabia was randomly selected with lottery method from PAPAS implemented and non-PAPAS implemented Gote's)

3.3 Study population

The study populations for PAPAS participants and Non-PAPAS Participants were aged 18-49. 22 individuals from each Gote ($7 \times 22 = 154$) from PAPAS participants and the same number ($7 \times 22 = 154$) from non PAPAS participant were selected randomly by lottery method. As much as possible it was much considered for Geographical location for fear of contamination among the implementing and non implementing areas. As a result of the concerted efforts of the organization and Woreda Health office, more than 1042 community members were passing through the participatory tool kit. However there was no conducted any study either PAPAS brings positive change or not. This is why I was interesting to see the result of the PAPAS tool kit. Every person has equal chance for the study there for 14.7% (154 of 1042) was get the chance

3.4 Inclusion Criteria

For the PAPAS participants, both male and female aged 18-49 who were trained with the Participatory AIDS Prevention and Support (PAPAS) life skills education and available in the study area were included in the study. For the PAPAS Non-participants, both male and female aged 18-49 who did not pass through the tool kit (PAPAS) in terms of location, sex and culture were included in the study.

3.5 Sample Size and Sampling Procedures

3.5.1 Sample size Determination

The study population is community members whose age is greater than 18 (male and female) who are participating PAPAS tool kit and non participants for the tool kit. In one Gote there are 40-60 households with a population of 180-270 peoples, between 18-49 years old 47% (source from Tabia

Health extension 2010 report). From PAPAS group and non PAPAS group individuals will be selected randomly with rotating sharp pencil for the starting direction during data collection. The sharp pencil pointed will be the starting point for the study with considering Gender aggregation there for 22 individuals will be selected from each Gote in both the participants and from non participants. $22*7=154$ from PAPAS group and $22*7=154$ from non PAPAS group.

3.5.2 Sampling Procedures

Participatory AIDS Prevention and Support (PAPAS) life skills have been implemented in group form having 20-24 members in each group. First we select PAPAS implemented area and the 21 Gotes were registered alphabetically from (A-U) then 7 gotes were selected randomly, the same procedure was followed for the other target area.

22 individuals were randomly selected from each Gote's the same in PAPAS and non-PAPAS participants all members has equal chance for the study. All in all 153 PAPAS participant and 153 non-PAPAS participants were included in the study. PAPAS Non-Participants were made more or less comparable to the PAPAS participants in geographical location, culture, and sex.

3.6: Quantitative

3.6.1. Interview:

A face- to- face interview was conducted by using structure questionnaire specially developed for this purpose having the information on socio Demographic Characteristics, economic status, and maternal health care utilization (ANC and delivery) by door-to-door interviewing the respondents

3.6.2 Questionnaire Development

After reviewing of relevant literatures, many that could address the objectives of the study were gathered and adapted from previous similar studies and other materials. The questions and statements were grouped and arranged according to the particular that they can address. After extensive revision, the final version of the English questionnaire was developed. An individual who have a very good

ability of both English and Tigrigna languages translate the English version to Tigrigna. Another individual of similar ability then translated the final or the agreed Tigrigna version of the questionnaire back to English with the first to check for any inconsistencies or distortion in the meaning of words in the content of the instrument

3.7: Variables of the study

Dependent variables:

- Safe sexual Practice
- Abstinence
 - Number sexual partners
 - Consistent Condom use
- Practice towards HIV testing
- Attitude towards People having HIV in their blood

The main Independent Variable:

- PAPAS Participation

Other independent Variables

- Age
- Sex
- Marital status
- Parental status
- Parents educational status
- Religion
- Residence(urban versus rural)

3.8: Operational Definitions

Effectiveness of PAPAS: This is measuring whether the behavioral outcomes of the program are achieved or not. In the community PAPAS life skills education have been implemented the behavioral outcomes expected from targeted community groups are improved safe sex practices (Abstinence, fidelity and consistent condom use), Increase HIV testing, and Stigma reduction. Hence, in this study the effectiveness was separately measured for the above stated expected behavioral outcomes.

Safe sexual Practices: In this context safe sexual practice includes Abstinence, number of sexual partners, and consistent condom use.

Abstinence: This is defined in terms of having sexual intercourse with only with one partner it was measured as ever having sex for the last three months as of the study time period.

Sexual Partner: It is having an opposite sex partner for the sake of having sexual intercourse. In this context it was measured in terms of the number of sexual partners in the last three months among those who were sexually active. Having more than one sexual partner in the last three months was regarded as having multiple sexual partners.

Consistent Condom use: This refers to using condom at every act of the sexual intercourse. In this study consistency was measured in terms of the frequency of condom in the last three months among those who had more than one sexual intercourse.

Practices towards HIV testing: It is ways in which study subjects demonstrate their knowledge and attitude through action. This refers to whether Study subjects have ever undergone HIV testing or not.

Attitude towards People having HIV in their blood: This is the feelings study subjects have towards people having the virus in their blood. This is expressed with stigmatization which includes preconceived ideas of why they acquire the virus, socializing with PLWHA, Caring for them. In this study five item questions were rated scale from strongly agree to strongly disagree.

Practice towards social funding: This refers the willingness of the community to contribute money for the needy individuals among the community

3.9: Data collection Process

3.9.1. Recruiting and Training

Before starting collecting the actual data, the English version questionnaire was translated into the local Tigrigna language. And then the Tigrigna translated back translated to English by the supervisors this is to make adjustments if there is any difference meaning in the translations. In addition both the English and the Tigrigna questionnaires were sending to Woreda Health experts for further development. As the issue is more sensitive,

3.9.2. Personnel

Four Supervisors and Four data collectors who have at least completed Diploma hired and trained, the training was conduct for one day, since they were working in data collection, the training was more focused on the methods of conducting the study including self administered questionnaire, methods of ensuring quality data. The data collectors were assigned in to the PAPAS implementing Gotes and the rest two data collectors assigned in to non PAPAS implemented areas and one data collector is expecting to address maximum of two Gotes. The area was very scattered then hence I try to adjust one supervisor for one data collector.

3.9.3. Data Quality assurance

In order to ensure the quality of data, supervisors and data collectors were given adequate orientation training,, proper categorization and coding of the questionnaire. Every day, 10% of the computed questionnaires were reviewed and checked for completeness and relevance by the supervisors and principal investigator and the necessary feedback offered to data collectors in the next morning before

they start actual procedure the supervisors, with principal investigator were used to identify eligible discussants and the questionnaire was adequately being reviewed prior to data collection.

3.9.4: Data Processing and Analysis

After data collection, each questionnaire checked visually for completeness and end coding at the right margin of the questionnaire followed by almost all variables in the questionnaire. The corresponding code number was written carefully at each margin. The principal investigator entered the data accordingly. Frequencies and summary were used to describe the study population in relation to relevant variables and outlines. Any errors identified at this time were corrected after revision of the original data using the code numbers and statistical commands. Frequencies and measures of variation were used to describe the study population in relation to socio-demographic and other relevant variables. The degree of association between independent and dependent variables were assessed

3.10. Ethical Consideration

The proposal was reviewed by Woreda Gulomekeda Health Office department of HIV/AIDS prevention team. The survey was commenced after written consent obtained from the Woreda Health Office, the data collectors gave the consent form to each Kebele/Village leader.

Prior to the actual data collection, the researcher asked their permission for participants then they required to give oral consent then the researcher managed to get informed consent and understand them used only for academic purpose. Informed verbal consent was secured for every individual in each study areas. Each respondent were informed about the objective of the study and assurance of confidentiality. At the end of each interview session, respondents who were non-PAPAS participants were advised to attend in such participatory tool kits for their present (next) life

3.11: Communication of the result

The final report will be presented as partial fulfillment of the degree of Masters of Social work Department of Social work to IGNOU and a copy of it will be offered to Regional Health Bureau, Woreda Gulomekeda Health office department of HIV prevention and control office, .

VII. CHAPTER FOUR: RESULTS

4.1 Socio-demographic Characteristics

306 people were participated during the study 164(53.5%) were males the rest 142(46.5%) were females. 81(52.9%) were males and 72(47.1%) were from PAPAS participants and 83(54.2%) Males 70(45.8%) Female from Non-PAPAS participants all 100% of the respondents were from rural area.

The predominant religions of the study participants were

Orthodox 290(94.7%) Muslim 9(2.9%) and the rest are Catholic 7(2.2%) respectively.

Regarding to the educational status 99(32.3%) were illiterate 80(26%) were grade 1-6 76(24.8%) were grade 7-8 the rest 51(16%) were grade 9 and above.

The family size of the respondents, 39(12.7%) with no children, 84(27.4%) had 1-2 child 142(46.4%) had 3-4 child 41(13.3%) had 5and above children's

The marital status of the respondents, 298(97.3%) were married only 8(2.3%) were not get married and there was no large significant change among PAPAS and non-PAPAS participants.

Table 1 Socio- Demographic characteristics of PAPAS Participants and PAPAS Non-participants

Variable	Frequency	%	Frequency	%
	Graduated	%	un graduated	%
Sex				
Male	81	52.9	83	54.2
Female	72	47.1	73	45.8
Total	153	100	153	100

Educational status

No writing and reading	48	31.37	51	33.33
Grade1-6	42	27.45	38	24.80
Grade7-8	33	21.56	43	28.10
Grade 9 and above	30	19.60	21	13.72
Total	153	99.99	153	99.99

Religion

Orthodox	146	95.4	144	97.6
Catholic	4	2.8	3	8
Muslim	3	1.8	6	1.6
Others				
Total	153	100	153	100

Family size

Not yet	18	11.76	21	13.71
1-2	42	27.45	42	27.45
3-4	73	47.71	69	45.07
5 and above	20	13.07	21	13.72
Total	153	99.99	153	99.99

Marital status				
Yes	151	98.6	147	96.1
No	2	1.4	6	3.9
Total	153	100	153	100

Assessment related to their Knowledge and attitudes of PAPAS Participants and PAPAS Non-participants

Out of 306 study participants 141(46.07%) were experienced sexual intercourse under the age of eighteen and this indicates many individuals are engaged to sex in early time females are highly sexually active at the age from thirteen. There was no much significant difference among the graduated and un-graduated groups.,

From the above 306 studied participants 63(20.58%) were practicing sexual intercourse before their marriage and this can contributed much in getting HIV/AIDS the other thing is there is no any difference among PAPAS participants and non-PAPAS participants regarding sexual practice

Out of the total 306 study participants 45(14.7%) experienced sexual intercourse in the last six months. The proportions of people who ever had sexual intercourse in the last six months for the PAPAS participants and PAPAS Non-Participants were (5)3.2% Vs(40) 26.1% respectively. The study was conducted to examine the difference in the proportion of people having sexual intercourse in the last six months among the PAPAS Participants and PAPAS Non-Participants. After controlling the result showed that there was significance difference between the two study groups.

Out of the total 306 study participants 21(6.8%) experienced sexual intercourse without condom in the last six months. The proportions of people who never use condom during sexual intercourse in the last six months for the PAPAS participants and PAPAS Non-Participants were (0)0% Vs(21) 6.8% respectively. The study was conducted to examine if they use condom or not use

during the intercourse. Among the PAPAS Participants and PAPAS Non-Participants and we observed there is great difference among the graduated and un-graduated groups.

People attitude towards people having HIV in their blood was assessed using four questions. Response categories included the four item (1=say nothing, 2=teach others, 3=others, 4=don't know).The sum of the scales for the four questions was measured [Positive Attitude 69.2 score), Negative Attitude (30.8).

From a total of 306 study participants their attitude towards people having HIV in their blood, the majority 212(69.2%) were found to have positive attitude, and the remaining 91(30.86%) negative Attitudes respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from 142(92.9%) Vs 70 (45.7%) for positive Attitude, and 11(7.1%) Vs 83 (54.3%) for their negative Attitudes respectively. The analysis indicates there was statistical significance difference among the two study groups.

People attitude towards HIV/AIDS prevention was assessed using eight questions. (Abstain from sex, use condom properly, Limit sex to one partner, Avoid eating chickens which swallow condom, Prevent mosquito bite, avoid eating together in one dish, others, Don't know) The sum of the scales for the eight questions was measured [Having good knowledge 66.2 score), having poor knowledge (33.8).

From a total of 306 study participants who responded the correct responder from questions, the majority (66.2%) were found the right response, and the remaining (33.8%) response poorly Attitudes respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from (98.7%) Vs (35.7%) for positive response, (1.3%) Vs 83 (64.3%) for negative response respectively. The analysis indicates there was statistically great significance difference among the two study groups.

People attitude towards HIV/AIDS transmission was assessed using nine questions. (Multiple partner, Doing sex with prostitutions, Doing sex with home ladies, Mother to child Mosquito bite

from HIV person, Eating chickens which swallow condom, Doing sex even using condom effectively, Others Don't know) The sum of the scales for the nine questions was measured, those who have good knowledge 75.4 score), and those who Have poor knowledge are (24.6).

From a total of 306 study participants who responded the correct responder from questions, the majority (75.4%) were found the right response and the remaining (24.6%) response poorly respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from (97.3%) Vs (54.5%) for positive response, (2.7%) Vs(45.5%) for poor response respectively. The analysis indicates there is high statistically significance difference among the two study groups

Table 2 assessment related to their Knowledge and attitudes of PAPAS Participants and PAPAS Non-participants

Variable	Frequency	%	Frequency	%
	Graduated	%	un graduated	%
How old are you when you get married				
<18	70	45.7	71	46.4
>18	78	50.9	76	49.6
Don't	5	3.2	6	3.9
Total	153	99.98	153	99.99

With whom you practice your first time sex				
Boy/girl friend	13	8.4	16	10.4
Husband/Wife	117	76.6	126	82.3
Acquaintance				
C. sex worker	23	15	11	7.2
Other (Specify)....				
Total	153	100	153	99.99

During the past six months, if you had sexual intercourse out of your marriage are you using condom

Yes	4	2.6	6	3.9
No	1	0.6	21	13.7
No doing	148	96.7	113	73.8
Not remember			13	8.5
Total	153	99.99	153	99.99

If you had more than one sexual partner how often do you use condom

Never	4	2.6	21	13.7
Occasional			13	8.4
Always			6	3.9
Other	149	97.4	124	81
Total	153	153	153	100

If someone knows that he/she is HIV positive what will be done?

say nothing	2	1.3	54	35.2
he/she teach others	142	92.8	70	45.7
Other (specify	8	5.2	1	. 6
Don't know/Not sure	1	0.7	28	18.4
Total	153	100	153	99.99

What do you think the prevention of HIV/AIDS from being infected?

Abstain from sex	118	29	37	8.7
use condom properly	131	32.6	89	19.7
Limit sex to one partner	149	36.6	30	7
Avoid eating chickens	2	0.4	104	24.5
Prevent mosquito bite	3	0.73	147	34.7
avoid eating together in one dish	3	0.73	16	3.7
Don't know			6	1.4
Total	406	99.99	423	99.97

What do you think the transmission of HIV/AIDS

Multiple partner	150	26.1	148	24.5
Doing sex with prostitutions	150	26.1	149	24.7
Doing sex with home ladies	116	20.2	16	2.6
Mother to child	143	24.6	16	2.6
Mosquito bite from HIV person	4	0.68	135	25.3
Eating chickens swallow condom	2	0.34	106	17.5
Doing sex even using condom	9	1.5	16	2.6
Others –specify				
Don't know			15	2.4
Total	574	99.97	603	99.97

Utilization/Practice towards HIV testing among PAPAS participants and PPAPAS non participants

From a total of 306 study participants on HIV testing during marriage time, 27(8.8%) had HIV test at the time of marriage and the rest 281(91.2%) were not testing. The proportion of HIV testing among PAPAS Participants and PAPAS Non-Participants was, 11(7.1%) and 11(7.1%) respectively. While the proportion of people who never had HIV test among PAPAS Participants and PAPAS Non-Participants was 142(92.9%) and 142(92.9%) respectively here we can't see any change.

From a total of 306 study participants for HIV testing during life time 182(59.4%) had HIV test among which 124(40.6%) had never HIV test during their life time. The proportion of people who did HIV test among PAPAS Participants and PAPAS Non-Participants was 153(100%) and 29(18.39%) respectively similarly the proportion of people who never had HIV test among PAPAS Participants and PAPAS Non-Participants was 0(09%) and 124(81.7%) respectively here is the big difference among.

People responded for their motivation of doing HIV test was assessed using six questions. (Just to know my status, to get married, Peer influence, Family Influence, VCT campaign after training, Partner influence, Other) The sum of the scales for the five questions was measured, as a result 162(77%) from VCT campaign after training, 7(3.3%) to know their status, 27(12.9%) to get marriage, 13(6.2%) peer influence

108 people from Non PAPAS participants were responded not yet testing for HIV/AIDS so to know why not yet testing assessed using five questions. (Service not available, Fear of being stigmatized if positive, lack of awareness, No risk assumption, and other) The sum of the scales for the five questions was measured, as a result 6(5.5%) was not get the test for fear of stigma and

discrimination if their result is HIV positive, 26(24.1%) was due to lack of awareness 76(70.3%) was assumed they have no any risk assumption.

Utilization/Practice towards HIV testing among PAPAS participants and PPAPAS non participants

Variable	Frequency	%	Frequency	%
	Graduated	%	un graduated	%

Have you had an HIV test during married?

Yes	11	7.1	11	7.1
No	142	92.8	142	92.8
Total	153	99.99	153	99.99

Have you ever had an HIV test?

Yes	153	100	29	18.9
No			124	81.1
Total	153	100	153	100

If “YES” what motivates you to have HIV test?

Just to know my status			7	15.5
To get married	11	6.7	16	35.5
Peer influence			13	28.8
Family Influence				
VCT after training	153	92.3	9	20
Partner influence				
Other (Specify				
Total	164	100	45	99.99

If no what hinders you from getting HIV test?

Service not available			
Fear of being stigmatized		6	5.5
Lack of awareness		24	24
No risk assumption		78	70.4
Total	0	108	99.99

Attitude towards stigma and discrimination having the virus in their blood among PAPAS and non-PAPAS participants

Their attitude towards people having HIV in their blood was assessed using five questions. Response categories included the five item (1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree).The sum of the scales for the five questions was computed with the possible three categories [Positive Attitude (strongly agree and agree), Neutral attitude (undecided), Negative attitude (disagree and strongly disagree)].

From a total of 306 study participants who responded attitude towards people having HIV in their blood 157(51.3%) were found to have positive attitude, 70(22.8%) were neutral and the rest 79(25.1%) were negative Attitudes respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from 134(87.5%) Vs 23 (15.%) for positive Attitude, 9(5.8%) Vs 61 (39.8%) for neutral Attitude, and 10(6.5%)Vs 69 (45%) for negative Attitude respectively. the analysis was used to test for significance difference among the two study groups the results showed that there was statistical significance difference among the two study groups in the proportion of positive Attitude, Neutral and negative attitude,

Their attitude to assess stigma and discrimination was assessed using five questions. Response categories included the five item (1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree).The sum of the scales for the five questions was computed with the possible three

categories [Positive Attitude (strongly agree and agree), Neutral attitude (undecided), Negative attitude (disagree and strongly disagree)].

From a total of 306 study participants who responded to attitude towards people having HIV in their blood questions, 161(52.6%) were found to have positive attitude, 79(25.8%) were neutral and the rest 66(21.5%) were negative Attitudes respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from 137(89.7%) Vs 24 (16.9%) for positive Attitude, 13(8.4%) Vs 66 (43.1%) for neutral Attitude, and 3(1.9%)Vs 63(41.1%) for negative Attitude respectively. the analysis was used to test for significance difference among the two study groups. There for the results showed that there was statistical large significance difference among the two study groups in the proportion of positive Attitude, Neutral and negative attitude,

Their attitude towards stigma and discrimination was assessed using five questions. Response categories included the five item (1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree).The sum of the scales for the five questions was computed with the possible three categories [Positive Attitude (strongly agree and agree), Neutral attitude (undecided), Negative attitude (disagree and strongly disagree)].

From the eligible 306 study participants who responded, 156(50.9%) were found to have positive attitude, 62(20.2%) were neutral and the rest 88(28.7%) were negative Attitudes respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from 137(89.7%) Vs 19 (12.4%) for positive Attitude, 13(8.4%) Vs 49 (32.1%) for neutral Attitude, and 3(1.9%)Vs 85(55.5%) for negative Attitude respectively. the analysis was used to test for significance difference among the two study groups. There for the results showed that there was statistical large significance difference among the two study groups in the proportion of positive Attitude, Neutral and negative attitude,

Table 4 Attitude towards stigma and discrimination having the virus in their blood among PAPAS and non-PAPAS participants-

Variable	Frequency	%	Frequency	%
	Graduated	%	un graduated	%
People having HIV in their blood should not be blamed for their promiscuity				
Strongly agree	122	79.7		
Agree	12	7.8	23	15.03
Undecided	9	5.8	61	39.8
Disagree	10	6.5	69	45.09
Strongly disagree				
Total	153	99.99	153	99.99

I will be willing to move into a home of the neighborhood who has HIV				
Strongly agree	86	56.2	8	5.2
Agree	51	33.3	16	10.4
Undecided	13	8.4	66	43.1
Disagree	3	1.9	53	34.6
Strongly disagree			10	6.5
Total	153	99.99	153	99.99

I am willing to eat from the same plate with a person having HIV

Strongly agree	30	19.6	3	1.9
Agree	107	69.9	16	10.4
Undecided	13	8.4	49	32.1
Disagree	3	1.9	71	46.4
Strongly disagree			14	9.1
Total	153	99.99	153	99.99

I would take care of a family member with AIDS.

Strongly agree	70	45.7	36	23.5
Agree	83	54.3	106	69.2
Undecided			11	7.2
Disagree				
Strongly disagree				
Total	153	100	153	99.99

Attitude towards their contribution for the affected and infected individuals among PAPAS and non PAPAS participants

Their attitude to assess contribution on social fund was assessed using five questions. Response categories included the five items (1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree).The sum of the scales for the five questions was computed with the possible three categories [Positive Attitude (strongly agree and agree), Neutral attitude (undecided), Negative attitude (disagree and strongly disagree)].

From a total of 306 study participants, 296(96.7%) were found to have positive attitude, 10(3.3%) were neutral respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from 153(100%) Vs 143 (93.4%) for positive Attitude, 0(0%) Vs 10 (6.6%) for neutral Attitude respectively. the analysis was used to test for significance difference among the two study groups in relation to social fund. There for the results showed that there was no much statistical difference among the two study groups in the proportion of positive and negative Attitude, however little difference in Neutral

Their attitude to assess the contribution of money for those who are affected and infected individuals, assessed using five items (1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree).The sum of the scales for the five questions was computed with the possible three categories [Positive Attitude (strongly agree and agree), Neutral attitude (undecided), Negative attitude (disagree and strongly disagree)].

From a total of 306 study participants 217(70.9%) were found to have positive attitude, 63(20.5%) were neutral and the rest 24(15.6%) were negative Attitudes respectively. The proportion among PAPAS Participants and PAPAS Non-Participants varies from 143(93.4%) Vs 76 (49.6%) for positive Attitude, 10(6.5%) Vs 53 (34.6%) for neutral Attitude, and 0(0%)Vs 24(15.6%) for negative Attitude respectively. the analysis was used to test for significance difference among the two study groups in relation to social fund. There for the results showed that there was statistical large significance difference among the two study groups in the proportion of positive Attitude, Neutral and negative attitude.

Table 5 attitude towards their contribution for the affected and infected individuals among PAPAS and non PAPAS participants

Variable	Frequency	%	Frequency	%
	Graduated	%	un graduated	%
I will ready to contribute money for care and support of those suspected of illness/death of AIDS.				
Strongly agree	67	43.7	41	26.8
Agree	86	56.3	102	66.6
Undecided			10	6.6
Disagree				
Strongly disagree				
Total	153	100	153	100

I will ready to contribute money monthly for those orphanages

Strongly agree	35	22.8	10	6.5
Agree	108	70.8	66	43.2
Undecided	10	6.5	53	34.6
Disagree			24	15.7
Strongly disagree				
Total	153	100	153	100

VIII. Discussion

This community based cross-sectional study tried to assess the knowledge, attitude and practice of the PAPAS tool kit and identify the factors affecting knowledge, attitude and utilization of HIV/AIDS practices in 14 Gotes (7 Gotes for PAPAS and 7 Gotes for non-PAPAS participants) of Gulomekeda Woredas/Eastern Zone of Tigray Region

In addition, the study tried to investigate where the problem was and assessed the factors that contributed the impact of HIV/AIDS in addition tried to know the possibility that contributed still the transmission root of the disease.

So far most studies on this subject have been limited or not in the country with little information In this study, it was learnt that close to 100% of PAPAS participants were tested for HIV/AIDS and at least 90% know the prevention and transmission of IV/AIDS and at least 80% contributed in social funding. However, a considerable number do not understand and still minor confusions look at in PAPAS participants.

When we come to compare PAPAS participants and non-PAPAS participants the difference in their knowledge, attitude and practice as we look at in the above, very big difference especially in utilization of VCT, stigma and discrimination as well as in social contribution and we can simply summaries the effectiveness of the tool kit.

This study finding is consistent which showed that people who get tool kit training utilized more than 80% and this is the best outcome considered with other implementation areas in Harar region and Meki zone of southern part of Ethiopia (65 and 62% respectively) which was presented in ECS-CRS annual Health and HIV/AIDS assembly (2010) This might be the fact that serious implementation and integration with concerned Woreda Health offices and active follow-up. Ethiopia was conducted in both rural and urban areas where as the study was exclusively rural environment

since implemented in rural areas. The study was not conducted in Ethiopia but in Harari and Meki they try to show only those who get PAPAS

The results of this survey revealed that the people who have not had attend PAPAS tool kit were less likely to seek the above three basic concepts of HIV/AIDS than the people who had the chance for the tool kit had enough interventions on the three dimensions of HIV/AIDS/knowledge, attitude and skill. This tool kit influence the health seeking behavior of individuals among participants and non participants. In general, PAPAS participants are more likely to accept concepts of HIV/AIDS as they are likely to have greater experience in prevention and transmission, in utilization of VCT service, stigma and discriminations and in money contribution for affected and infected individuals.

Another possible explanation for this is that all PAPAS participants have 100 % utilization for VCT but closely 25% for non PAPAS participants. On the other hand, tend to believe and interpreted that they don't know even the transmission and prevention of HIV/AIDS as well. Due to experiences and accumulated knowledge gained from the training, likely to have more confidence all about HIV/AIDS and thus can be great importance obtaining. Non-PAPAS participants however they are less likely to have knowledge and self confidence as well and they had less likely to seek information on HIV/AIDS services available.

We can see from the study many community members likely to have low knowledge and negatively contributed on the impact Therefore, efforts should be done to expand the tool kit in large community would probably increased their behavioral change as a result utilization of VCT services and will contributed much in HIV reduction and related impacts. There is strong evidence from the analysis of the data to validate the prevailing association that PAPAS participants were five times more likely in knowledge, attitude and utilizations than those with are not participated. Most

IX. Conclusion

The study results showed that how PAPAS tool kit was effective in changing their knowledge (prevention and transmission of the disease), their attitude especially in stigma and discrimination, their interest in helping for those affected and infected individuals, and practicing in HIV testing, The individuals who are not participated in the tool kit are very prone to be affected by HIV/AIDS and its impact so the difference in knowledge, attitude and skill is as a result of PAPAS. All in all the tool kit was effective enough in changing behavior of the individuals.

X. Recommendations

The fact that PAPAS tool kit was effective enough in changing people knowledge, attitude and skill there for expanding this tool kit is expanding knowledge, attitude and skill as well. Obviously its tremendous contribution in the prevention and control of HIV/AIDS will be increased and this can contributed much in the national HIV/AIDS policy.

Hence the following are some of the key recommendations:

- This program should expanded geometrically than arithmetically then could bring about an encouraging result in the promotion of Voluntary counseling and testing practices and reducing HIV related stigma and discrimination
- Concerted efforts are demanding from different sectors such as from Health and education sector, from nongovernmental organizations for its scale up
- It needs further longitudinal study with larger samples to measure its effectiveness such studies will help for evidence based decision making for its scale up.

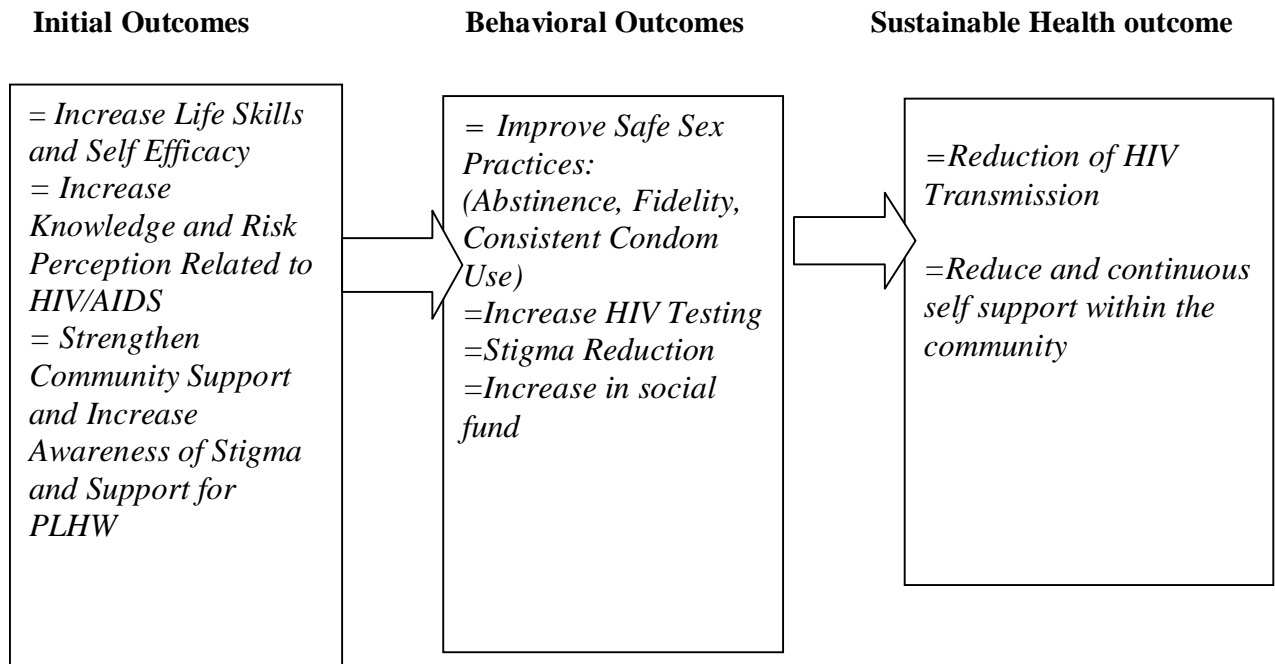
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XII. Annex 1. PAPAS Conceptual Framework

The PAPAS program can be summarized by the conceptual framework in the following Figure which draws from health behavior theories such as the Health Belief Model and the Social Learning Theory (Bandura, 1995). In general, PAPAS aims to the different behavioral outcomes by increasing their behavioral change as a result of life skill training



XIII. Annex 2 Instructions and Questionair

- 1) Please, circle the coded questions (1, 2, etc...) based on your answer.
- 2) In some questions provided with DASH (.....).Please fill in the appropriate information on the space provided
- 3) If your answer includes the “others” choices, please specify and write the information on the space provided
- 4) For attitude questions, please select one of your decisions from the choices given

S/N	Questions	Responses by coding	Skip To
1	Socio Demographic Characteristic		
1.1	Respondents Address	Region _____ Zone _____ Woreda _____ Kebele _____ Kushet _____	
1.2	Sex	Male Female	
1.3	How old are you on your last birth day	Age: _____years	
1.4	Educational status(School grade)	1,No writing and reading 2,Grade 1-6 3,Grade 7-8 4,grade 9 and above	
1.5	Religion	1,Orthodox 2,Muslim 3,Catholic 4,Protestant 5, Others (Specify).....	
1.6	Marital Status	1,Single 2,Engaged 3,Married 4,Widowed 4,Divorced	
1.7	Number of Children	1,Not yet 2,One-Two 3,Three-Four 4,Five and above	
2	Sexual Practice and Behavior related		
2.1	Are you married in your life time?	1,yes 2,No	

2.2	How old were when you get married?	Age, ____years 1,Don'tknow/remember	
2.3	With whom you practice your first time sex?	1,Boy/girl friend 2,Husband/Wife 3,Acquaintance 4,Commercial sex worker 5, Other (Specify)....	
2.4	During the past six months, if you had sexual intercourse are you use condom?	1,yes 2,No 3.Don'tknow/Don't remember	
2.5	If you had more than one sexual partner how often do you use condoms?	1,Never 2,Occasional 3,Always 4, Other (Specify).....	
2.6	If some one knows that he/she is HIV positive what will be do?	1. say nothing 2. he/she teach others 3. Other (specify)----- 4. Don't know/Not sure	
2.7	What do you think the prevention of HIV/AIDS from being infected?	1. Abstain from sex 2. use condom properly 3. Limit sex to one partner 4. Avoid eating chickens which swallow condom 5. Prevent mosquito bite 6. avoid eating together in one dish 7. others (specify)----- 8. Don't know	
2.8	What do you think the transmission of HIV/AIDS	1. Multiple partner 2. Doing sex with prostitutions 3. Doing sex with home ladies 4. Mother to child 5. Mosquito bite from HIV person 6. Eating chickens which swallow condom 7. Doing sex even using condom effectively 8. Others -----specify 9. Don't know	
3	Practice towards HIV testing		
3.1	Have you had an HIV test during married?	1,Yes 2,No	
3.2	Have you ever had an HIV test?	1,yes 2,No	
3.3	If your answer to Q3.1&3.2 is "YES" what motivates you to have HIV test?	1,Just to know my status 2,to get married 3,Peer influence 4,Family Influence	

		5,VCT campaign 6,Partner influence 7, Other (Specify).....	
3.4	If your answer to Q3.1&3.2 is “NO” what hinders you from having HIV test?	1,Service not available 2,Fear of being stigmatized if positive 3,lack awareness 4,No risk assumption 5, Other (Specify)...	
4	People’s Attitude towards People having HIV in their blood and their affected family		
4.1	People having HIV in their blood should not be blamed for their promiscuity.	1,Strongly agree 2,Agree 3,Undecided 4,Disagree 5,Strongly disagree	
4.2	I will be willing to move into a home of the neighborhood who is HIV positive.	1,Strongly agree 2,Agree 3,Undecided 4,Diagree 5,Strongly disagree	
4.3	I am willing to eat from the same plate with a person having HIV in his/her blood.	1,Strongly agree 2,Agree 3,Undecided 4,Diagree 5,Strongly disagree	
4.4	I would take care of a family member with AIDS.	1,Strongly agree 2,Agree 3,Undecided 4,Diagree 5,Strongly disagree	
5	People towards social fund		
5.1	I will ready to contribute money for care and support of those suspected of illness/death of AIDS.	1,Strongly agree 2,Agree 3,Undecided 4,Diagree 5,Strongly disagree	
5.2	I will ready to contribute money monthly for those orphanages.	1,Strongly agree 2,Agree 3,Undecided 4,Diagree 5,Strongly disagree	

Thank you again for your cooperation

መጻኑዊ

1. እቶም ብኮድ ዝተቀመጡ ሕቶታት መልስታትካ መሰረት ብምግባር ኣክብቦም (1, 2, ወዘተ...)
2. ሓድሓድ ሕቶታት ግለፅ ዝብሉ እቶም ስለዚ ትክክል እዩ ትብሎ መልሲ ኣብቲ ዳሽ ኣስፍር
3. መልስካ ካሊእ ዝብል እንተኮይኑ እንታይ ከምዝኮነ ፅሓፍ
4. ናይ ዝንባሌ ሕቶታት ንዝኮኑ ካብቶም ዝተዘርዘሩ ትኣምነሉ ምረፅ

ተ.ቁ	ሕቶታት	ትፅቢ ት(መልሲ)ብኮድ	ሕለፍ ናብ
1	ኩነታት ማሕበራውን ስነ ህዝብን		
1.1	ናይ ተሳተፍይ ኣድራሻ	ዞባ _____ ወረዳ _____ ጣብያ _____ ቁሽት _____	
1.2	ፆታ	1,ተባዕታይ 2,ኣነስታይ	
1.3	ዕድመካ/ኪ ክንደይ እዩ	ዕድመ: _____ ዓመት	
1.4	ኩነታት ትምህርቲ	1,ምንባብይኩን ምፅሓፍ ዘይክእል 2,ካብ1-6 3,ካብ7-8 4,ካብ 9ይ ክፍሊ ንላዕሊ	
1.5	ሃይማኖት	1,ኦርቶዶክስ 2,እስልምና 3,ካቶሊክ 4,ፕሮቴስታንት 5, ካሊ እ (ግለፅ).....	
1.6	ኩነታት ሓዳር	1,ዘየእተየ/ዘይተመርዐዎ 2,ሕፁይ/ሕፅይቲ 3,ዘእተወ/ዘእተወት 4,ሰብኣያ/ሰበይቲ ዝሞተ 5, ዝተፋተሐ/ዝተፋተሐት	
1.7	በዝሒ ቆልዑ	1,ገና/ዘይወለደ/ት 2,1-2 3,3-4 4,ካብ 5 ንላዕሊ	
1.8	ዝለገለ ትምህርቲ ናይ ወላዶም	1,ዘይቱምሃረ 2,ቀዳማይ ደረጃ 3,ካልኣይ ደረጃ 4,ኮሌጅ/ዩኒቨርሲቲ ዝተመረቀ 5, ካሊ እ (ግለፅ)..... 6,ኣይፈልጥን	
2	ግብረሰጋ ግኑኝነት ዝምልከቱ ሕቶታት		
2.1	ተመርጺካ/ኪ ትፈልጥ ዶ?	1,እወ 2,ኣይፋሉን	ቁፅሪ 2.1 መልሲ እወ እንተኮይኑ

			ናብ ቁፅሪ 3.1ሕለፍ
2.2	ክትምርጥ/ዐዊ ከለኪ ዕድመኪ ክንደይ ነይሩ?	ዕድመ, ___ ዓመት 1.አይፈልጠን	
2.3	ፆታዊ ርክብ ንመጀመርታ ጊዜ ምስ መን ፈጻምካ/ኪ?	1.ምስ ዓርከይ 2.ምስ በዓል/ቲ ገዛይ 3.ምስ ፋይቶ 4. ካሊእ (ግለፅ)....	
2.4	አብ ዝሓለፈ 6ተ ወርሒ ፆታዊ ርክብ እንተጌርካ ኮንዶም ተጠቂምካ/ኪ ዶ ነይርካ/ኪ	1.እወ 2.አይተጠቀምኩን 3.አያስተውሶን	
2.5	ካብ ሓደ ንላዕሊ ፆታዊ ርክብእንተጌርካ/ኪ ክንደይ ጊዜ ተጠቂምካ/ኪ ትኾን/ኒ?	1. አየተጠቐምኩን 2. ሓልሓሊፉ 3. ኩሉጊዜ 4. ካሊእ ግለፅ	
2.6	ዝኾነ ሰብ ሻይረስ አብ ደሙ ምህላዉ እንተፈሊጡ ወይ ኤች አይቪ ሻይረስ ኤድስ ከምዘምፅእ እንተፈሊጡ እንታይ ክገብር አለዎ?	1. ንማንም ክዛረብ የብሉን 2. ንካልኦት ክምህር አለዎ 3. ካሊእ ግለፅ 4. እርግፀኛ አይኮንኩን	
2.7	ናይ ኤች አይቪ ኤድስ መከላኸሊ መንገድታት እንታይ እዮም ትብል/ሊ?	1. ግብረስጋ ግንኝነት ዘይምግባር 2. ኮንዶም ብአግባቡ ምጥቃም 3. ምስ ሓደ/ሓንቲ ጥራሕ ምውሳን 4. ኮንዶም ናይ ዝበልዐት ደርሆ ስጋ ዘይምብላፅ 5. ጣንጡ ከይትነኸሰካ ምጥንቃቕ 6. ኤች አይቪ ምስዘለዎ ሰብ ዘይምብላፅ 7. ካሊእ ግለፅ 8. ዝፈልጦ የብለይን	
2.8	ኤች አይቪ ኤድስ ብኸመይ ይመሓላለፍ ትብል/ሊ?	1. ምስ ቡዙሓት ዝግበር ርክብ 2. ምስ ፋይቶታት ወይ ዒዋሉ ፆታዊ ርክብ ምግባር 3. ምስ ናይ ገዛ ቆልዑ ርክብ ምግባር 4. ካብ አደ ናብ ዕሽል 5. ጣንጡ ካብ ሕሙም ናብ ጥዑይ 6.ኮንዶም ናይ ዝበልዐት ደርሆ ስጋ ብምብላፅ 7. ብኮንዶም ፆታዊ ርክብ	

		ብምግባር 8. ካሊኦ ግለፅ 9. ዝፈልጦ የብለይን	
3	ናይ ኤች ኣይ ቪ ምርመራ ዝምልከት		
3.1	ክት ምርጫ/ዊ ከለኪ ምርመራ ጌርካ/ኪ ዶ ነይርካ/ኪ?	1.እወ 2.ኣይፋሉን/ኣይተመርመር ኩን	
3.2	ኣብ ሂወትካ ኤች ኣይ ቪ ምርመራ ጌርካ/ኪ ዶ ትፈልጢ?	1.እወ 2.ኣይፋሉን	መልስካ ኣይፋሉን እንተኮይኑ ናብ ቁፅሪ3.5 ስገር/ሪ
3.3	ቁፅሪ 3.173.2 መልስካ እወ እንተኮይኑ ንክትምርመር ዝገበረካ እንታይዩ?	1.ኩነታተይ ንምፍላጥ 2.ቅድሚ መርዓ 3.ኣዕርክተይ ደፋፊኦምኒ 4.ቤተሰብይ ደፋፊኦምኒ 5.ናይ ምርመራ ወፍሪ 6.ካሚመ ኣብ ሕክምና ምስክድኩ 7. ካሊኦ (ግለፅ).....	
3.4	ቁፅሪ 3.173.2 መልስካ ኣይፋሉን እንተኮይኑ ንክይትምርመር ዝገበረካ እንታይዩ?	1.ኣብ ከባብየይ ስለዘየለ 2.ስለ ዝፈርሕ እንድሕር ሃልዩኒ 3.ብህብብኡ ምንም ኣፍልጦ ኣይብለይን 4.ሰውነተይ ስለዘይጥረጥሮ 5.ካሊኦ (ግለፅ).....	

4	ሕብረተሰብ ኣብ ደሞም ኤች ኣይ ቪ ቫይረስ ንዘለዎምን ቦቲ ቫይረስ ንዝተጠቐሑ ስድራን ዘለዎ ኣመለካክታ		
4.1	ሰባት ኣብ ደሞም ኤች ኣይ ቪ ብምህላዎም ጥራሕ ክነግልሎም የብልናን	1.ብጣዕሚ ይስማዕማዕ 2.ይስማዕማዕ 3.ኣይወሰንኩን 4.ኣይስማዕማዕን 5.ብጣዕሚ ኣይስማዕማዕን	
4.2	ኣብ ደሞም ኤች ኣይ ቪ ቫይረስ ዘለዎም ኣብ ኃረቤተይ እንተልዮም ንምካድ ድልው እየ	1.ብጣዕሚ ይስማዕማዕ 2.ይስማዕማዕ 3.ኣይወሰንኩን 4.ኣይስማዕማዕን 5.ብጣዕሚ ኣይስማዕማዕን	
4.3	ኣብ ደሞም ኤች ኣይ ቪ ቫይረስ ምስ ዘለዎም ኣብ ሓደ ሸሓነ ክምገብ ይክእል እየ	1.ብጣዕሚ ይስማዕማዕ 2.ይስማዕማዕ 3.ኣይወሰንኩን 4.ኣይስማዕማዕን 5.ብጣዕሚ ኣይስማዕማዕን	
4.4	ንናይ ኤድስ ሑሙማት ክካናከናምን	1.ብጣዕሚ ይስማዕማዕ	

	ክሕብሕቦምን እየ	2,ይስማዕማዕ 3,ኣይወሰንኩን 4,ኣይስማዕማዕን 5,ብጣዕሚ ኣይስማዕማዕን	
5	ሕብረተሰብ ኣብ ናይ ማሕበረሰብ ሓገዝ ዘለዎ ኣመለካክታ		
5.1	ብሰንኪ ኤይድስ ንዝሓመሙን ንዝሞቱን ሓገዝ ዝውዕል ቅርሺ ነከዎዕኦ ድልዊ እየ	1,ብጣዕሚ ይስማዕማዕ 2,ይስማዕማዕ 3,ኣይወሰንኩን 4,ኣይስማዕማዕን 5,ብጣዕሚ ኣይስማዕማዕን	
5.2	ወለዶም ብሰንኪ ኤይድስ ንዝሰኣኑ ወገናት ዝውዕል ወርሓዊ መዋጮ ከዋዕዕ ድልዊ እየ	1,ብጣዕሚ ይስማዕማዕ 2,ይስማዕማዕ 3,ኣይወሰንኩን 4,ኣይስማዕማዕን 5,ብጣዕሚ ኣይስማዕማዕን	

ንዝገበርኩምዎ ምትሕብባር ደጊሜ የመስግን

XIV. Annex 3 DECLARATION

I hereby declare that the dissertation entitled

**ASSESSMENT OF THE EFFECTIVENESS OF PARTICIPATORY HIV/AIDS
PREVENTION AND SUPPORT (PAPAS) IN IMPROVING BEHAVIORAL CHANGE**

(write the title in block letters) submitted by me for the partial fulfillment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

Place:

Signature: _____

Date: **NOV/2011**

Enrolment No: **099111064**

Name: **BISRAT ZERYIHUN WELDEMARIAM**

Address: **ADIGRAT/TIGRAY/ETHIOPIA**

CERTIFICATE

This is to certify that Mr. Miss/Mrs. _____

Student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his/her project work for the course **MSWP-001** His/Her project work entitled.

Which he/she is submitting is his/her. genuine and original work.

Place: _____ Signature _____

Name _____

Address of the supervisor _____

Phone No: _____

**PROFORMA FOR SUBMISSION OF MSW PROJECT PROPOSAL FOR APPROVAL
FROM ACADEMIC COUNSELOR AT STUDY CENTRE**

Enrolment No _____

Date of submission: _____

Name of the study centre: _____

Name of the guide: _____

Title of the project: _____

Signature of the student: _____

Approved/not approved

Signature: _____ **Name & Address of the student:** _____

Name & Address of Guide: _____

_____ **Date** _____