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**ACCEPTABILITY OF PROVIDER-INITIATED HIV COUNSELING AND TESTING (PIHCT) AMONG OUT PATIENT
DEPARTMENT CLIENTS VISITING HOSPITALS IN TIGRAY REGION**

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ABSTRACT:

In this study a cross sectional survey in July 2009 was conducted in purposefully selected two hospitals, Axum Saint Mary and Adigrat Hospitals. Adult OPD clients who were willing to participate in the study and come to the hospitals during the data collection period were included in the study. A pre-test structured questionnaire was used for interview. Interviewers were trained data collectors. A total of 439 OPD clients were interviewed. Out of the total respondents 229(52.2%) were females and 210(47.8%) were males. More than half (56.0%) were married. More than 90% of the respondents had correct knowledge on ABC rules of HIV/AIDS prevention (ABC = Abstinence, be faithful and Use condom). However only 172(39.2 %) and 216(49.2%) of the respondents knew HIV/AIDS is not transmitted through mosquitoes and HIV/AIDS doesn't have vaccine respectively. One hundred ninety five (44.4%) of the respondents perceive that they are at risk of acquiring HIV/AIDS. Almost all 415(95.5 %) of the respondents have heard about HIV counseling and testing but only 340(77.4%) of the respondents heard about PIHCT. The major source of information for PIHCT were health workers and mass media as reported by 302(68.8%) and 206(46.9%) of respondents respectively. Three hundred eighty eight (88.4%) of the respondents said every person should be tested for HIV/AIDS but 253(57.6%) of the clients have ever had a test for HIV/AIDS. Out of these who had a test, only ninety nine (39.1%) had test in the hospitals included in the study. Four hundred twelve (93.8%) of the respondents said PIHCT is important but only 147(33.5%) of the respondents were initiated for HIV counseling and testing. This study found that OPD clients do have satisfactory knowledge on HIV/AIDS transmission and prevention but less practice in uptake of HIV counseling and testing. Clients were also have found to have positive attitude to provider initiated HIV counseling and testing but health professionals are not initiating HCT to all clients. This might be fear of stigma from the client side, workload from the professionals' side. Hence to promote PIHCT further orientation on PIHCT to health professionals and strengthening HIV/AIDS activities to combat sigma are recommended.

Keywords: HIV, AIDS, PIHCT, EPI-INFO.

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INTRODUCTION

The Human Immunodeficiency Virus epidemic continues to be a major public health problem worldwide. Globally, there were an estimated 34 million (50% women) people living with HIV/AIDS (PLWHA) and 2.7 million worldwide (50% women) new infections at the end of 2010. Sub-Saharan Africa (SSA) bears an inordinate share of the global HIV burden with 22.9 million (68%) of all PLWHA, of which 59% were

women, and 1.9 million (70.4%) of all new infections occurring in this region in 2010^{1,2}.

According to the 2005 projection of Federal Ministry of Health's sixth-report "AIDS in Ethiopia", the HIV national prevalence rate was estimated to be 3.5%; 3% among males and 4% among females. The estimated prevalence in urban areas was 10.5% and 1.9% in rural areas. The cumulative number of people living with HIV/AIDS is about 1.32 million out of which more than

277,800 are cases in need of ART. The Ethiopian Demographic Health Survey 2005 showed national HIV prevalence among adult age 15-49 old population to be 1.4%. Ministry of Health and other stake holders have also made a 2.1% point estimate of HIV prevalence based on the findings from AIDS six report in ETHIOPIA and EDHS 2005^{3,4}.

In the ongoing effort to prevent new HIV infections and to treat those with established infection, emphasis must be placed on developing strategies to effectively identify and engage HIV-infected patients into care, with HIV testing as a critical step. Much of the HIV testing in the developing world is done through maternity clinics offering antiretroviral drugs for the prevention of maternal to child transmission of HIV or specialty voluntary counselling and testing (VCT) clinics to which people come desiring knowledge of their status. Studies from such settings in South Africa and Côte d'Ivoire have identified factors including 'fear of a positive HIV test', low levels of education and poor housing as associated with low uptake rates^{5,6}. US and African studies have identified high rates of "missed opportunities" for making the diagnosis of HIV among primary care clinicians who did not offer HIV tests to their patients even if they had clinical syndromes associated with HIV infection or if they were from a high-risk socio-demographic group⁷⁻¹². Still, in many high-prevalence countries, fewer than one in ten HIV-positive individuals are aware that they are infected with the HIV virus¹³⁻¹⁷.

Nowadays WHO/UNAIDS and different nations are introducing provider initiated HIV testing and counselling besides to VCT in line to the efforts to scale up access to ART, prevention and care support programs. To help countries implement PIHCT, on 30 May 2007, WHO and UNAIDS issued guidance on PIHCT in health facilities. Though in Ethiopia documented evidences are not available, PIHCT in the form of campaigns have already started and hospitals in Tigray are striving to achieve 100% PIHCT, and hence this study is to assess the acceptability of PIHCT among most at risk populations.

METHODOLOGY

Description of study area:

This study was conducted in two selected hospitals in Tigray region. The hospitals were Axum St. Marry Hospital and Adigrat Hospital. These Hospitals were selected purposively. These two hospitals are zonal hospitals and offer services which are entitled for district/zonal hospitals. Some these services are OPD services, treatment sexually transmitted infections, post

abortion care, Antenatal care and delivery care, family planning services and inpatient services.

Study Design:

A descriptive cross sectional study design was used to describe proportion of acceptance and identify reason for non-acceptance PIHCT.

Source Population:

Target Population

Out-patient department clients who visit hospitals were the target of this study. These clients were selected purposively.

Study Population:

OPD clients who were visiting Axum and Adigrat Hospitals were the study population.

Sample Population

OPD clients who were visiting Axum and Adigrat hospital during the data collection period were the sample population. The data collection period was for ten days from to

Inclusion and Exclusion Criteria

All OPD clients who were visiting the selected Hospitals were considered for the study. To be included in the study, OPD client should be volunteer, healthy enough to have interview for an average of 20 minutes.

Sample Size Determination and sampling Technique/Procedures:

Adigrat and Axum hospitals were selected purposively and convenience sampling was used to select sample units. The sample size was determined conveniently. All OPD clients and who were willing were selected interviewed. Accordingly a total sample size of 439 was obtained during the 10 data collection period.

Data Collection Methods and Data Collectors

Questionnaire

A pre-tested and structured questionnaire was to collect data from respondents.

Questionnaire Development and Data Collection

The questionnaire was developed through reviewing relevant literatures and guidelines. A number of questions that could address the objective of this study were gathered and adapted. In order to improve the developed questionnaire valuable comments were received from different sources. The first draft questionnaire was an English version and translated to Tigrigna Language. The first draft was an English version for the mere fact that all literatures gathered were in English and translation was done to help data collectors to communicate easily with respondents. The questionnaire was pre-tested among 20 OPD clients in Axum and Adigrat hospitals. Based on the pre-test findings, corrections such as correcting ambiguous words and sentences were made. Eight data collectors

and two on spot supervisors were recruited for the study. These data collectors and supervisors were familiar with working in health facilities and were fluent Tigrigna speakers. The data collectors and supervisors were trained for two days which includes both theoretical and practical training. The training was conducted based on the guide that was developed by principal investigator for data collectors and supervisors. The principal investigator was also acting as trainer. The training was primarily aiming at clarifying on how to administer the questionnaire. Besides, the data collectors were trained on their responsibility for describing the purpose of the study, giving orientation, informing OPD clients about the importance of honest and sincere reply on responding to questions.

Data Management and Analysis

The completed questionnaire was checked for completeness, consistency and was coded by statistician and the principal investigator. Data clean up was performed to check for accuracy, consistencies and values. Questionnaires with major errors were discarded. The statistician using EPI info 2002 and SPSS Version 15 made the data entry and data analysis (generate frequencies) respectively.

Data Quality Assurance

The questionnaire was pre-tested before the actual data collection. Training was given for data collectors and supervisors. The questionnaire was prepared in local language for easy communication between data collectors and respondents. Supervisors were checking the completeness of each questionnaire each day and on the spot. The principal investigator was also check during submission.

Ethical Clearance

Before the fieldwork, a formal letter of cooperation was written from Mekelle University to both Axum and Adigrat hospital. Data collectors were requesting OPD clients for their oral consent to participate in the study before starting interview with the help information sheet prepared by the principal investigator. Response of respondents was kept anonymous and confidential. Besides data collectors were informing respondents that they have full right to discontinue or refuse to participate in the study at any time.

Dissemination of Results

This study on completion could serve as a base line data as well as a reference material to researchers, experts or policy makers for intervention. To reach these bodies the finalized paper will be submitted to Associate dean office for research and postgraduate studies, college of health Science in Mekelle University. In addition, a copy

of this material will be given to Tigray Regional Health Bureaus, respective wereda health offices and hospitals. The investigator is also planning to disseminate the results through publishing in available local and international reputable journals and through presenting it in relevant workshops and seminars organized by professional associations and other bodies.

RESULT

A total sample units of 442 were interviewed during the data collection period allocated. However three of the questionnaires were discarded for incompleteness and inconsistencies. Hence 439 questionnaires were entered into computer using EPI-INFO version 2002 and analysis was done using SPSS version 15 after exporting from EPI-INFO version 2002.

Socio-demographic Characteristics of respondents

Table 1 shows socio-demographic characteristics of OPD clients in Axum and Adigrat Hospitals. The mean and median ages of the respondents were 33.31 and 30.00 respectively. The standard deviation for age was 13.321.

Knowledge of respondents on HIV/AIDS

Besides OPD clients were asked whether he or she knew a person living with HIV/AIDS or not and whether he/she knew a friend or relative who died of HIV/AIDS or not. Accordingly, out of the total respondents 266 (60.6%) of them said they knew a person living with HIV/AIDS while the rest 173 (39.4%) said they didn't know a person living with HIV/AIDS. However paradoxically to this finding, 311 (70.8%) of the respondents confirm that they knew a person (friend/relative) died of HIV/AIDS while the rest 128(29.2%) of the respondents didn't knew a person died of HIV/AIDS.

Perceptual perception to exposure to HIV/AIDS infection

In this study an OPD client was asked whether he/she perceive that he/she is at risk of acquiring HIV infection. Accordingly 195 (44.4%) of the respondents perceived they are at risk of acquiring HIV/AIDS. While the rest 244(55.6%) of the respondents perceived that they are not at risk of acquiring HIV/AIDS. Out of those who perceived that they are acquiring HIV/AIDS 96(49.2%),52(26.7%), 15 (7.7%), and 11(5.6%) of perceived that they have little, moderate, high, very chance of being infected HIV/AIDS respectively. But the rest 21(10.8%) of the respondents who said the y perceive that they have chance of acquiring HIV/AIDS didn't want to mention their likely hood of being HIV infected.

Table 1- Socio-demographic characteristics of OPD clients in Axum and Adigrat Hospitals, July 2008 (n=439).

S.No.	Variable	Frequency (No. (%))	%
1	Sex		
	Male	210	47.8
	Female	229	52.2
2	Age category (in Years)		
	18-19	46	10.5
	20-24	95	21.6
	25-29	65	14.8
	30-34	58	13.2
	35-39	58	13.2
	40-45	36	8.2
	46-49	24	5.5
	50-54	13	3.0
	55-59	15	3.4
	60-64	14	3.2
	65 and above	15	3.4
3	Religion		
	Orthodox	369	84.1
	Muslim	54	12.3
	Protestant	4	.9
	Catholic	12	2.7
4	Ethnicity		
	Tigraway	408	92.9
	Amhara	15	3.4
	Oromo	7	1.6
	Guragie	3	.7
	Others (Europe, Saho and Eritrean)	6	1.4
5	Educational level		
	Illiterate (unable to read and write)	96	21.9
	Able to read and write	32	7.3
	1 st -4 th grade (primary cycle)	43	9.8
	5 th -8 th grade (secondary cycle)	84	19.1
	9 th -12 th grade (high school)	102	23.2
	12 th grade complete and above	82	18.7
6	Marital status		
	Single	148	33.7
	Married	246	56.0
	Divorced	29	6.6
	Widowed	16	3.6
7	Educational level of spouse		
	Single ,divorced and widowed	193	44.4
	Illiterate (unable to read and write)	75	17.1
	Able to read and write	19	4.3
	1 st -4 th grade (primary cycle)	30	6.8
	5 th -8 th grade (secondary cycle)	41	9.3
	9 th -12 th grade (high school)	43	9.8
	12 th grade complete and above	38	8.7
8	Occupation		
	Student	72	16.4
	Married	94	21.4

S.No.	Variable	Frequency (No. (%))	%
	Government employee	67	15.3
	Non-government employee	27	6.2
	Merchant	28	6.4
	Farmer	75	17.1
	Daily Laborer	31	7.1
	Commercial sex worker	7	1.6
	No work	23	5.2
	Others	15	3.4
9	Average monthly income (in Birr) (based on quartile)		
	0-99	123(29 were with 0 values)	28.0
	100 - 400	302	68.8
	401-840	0	0.0
	841-7000	3	.7
	Didn't mention	11	2.5
10	Family size (based on quartile)		
	1-3	167	38.0
	4	75	17.1
	5-6	102	23.2
	7-13	87	19.8
	Didn't mention	8	1.8

Table 2- Knowledge of OPD clients in Axum and Adigrat Hospitals on HIV/AIDS, July 2008

S. No	Knowledge Question	Yes (correct Knowledge)		No(wrong Knowledge)		I don't know	
1	Currently there is no cure for HIV/AIDS	308	70.2	76	17.3	55	12.5
2	Currently there is no vaccine for HIV/AIDS	216	49.2	126	28.7	97	22.1
3	Muti-sexual partners are at risk of acquiring HIV/AIDS	411	93.6	19	4.3	9	2.1
4	HIV/AIDS can be transmitted through contaminated sharp materials	418	95.2	11	2.5	10	2.3
5	Mosquitoes don't transmit HIV/AIDS from infected person to healthy person	172	39.2	194	44.2	73	16.6
6	Being faithful to sexual partner reduces risk of HIV/AIDS	418	95.2	15	3.4	6	1.4
7	Sexual Abstinence prevents transmission of HIV/AIDS	415	94.5	14	3.2	10	2.3
8	Correct and consistence use of condom prevents transmission of HIV/AIDS	335	76.3	43	9.8	61	13.9
9	Main mode of HIV/AIDS is unsafe sex	413	94.1	8	1.8	18	4.1
10	HIV/AIDS doesn't transmit by eating together with infected person	354	80.6	67	15.3	18	4.1
11	Apparently Healthy looking person could be HIV/infected	379	86.3	39	8.9	21	4.8

Respondents were also asked to speak out their reasons for not perceiving they are not at risk of HIV infection and why they perceive they are at risk of HIV/AIDS. Table 3 and 4 shows respondents' reasons.

Table 3- respondents' reasons for perceiving of HIV infected in Axum and Adigrat Hospitals, July 2008

S. No.	Reason	No	%
1	I had multiple sexual partners	31	7.1
2	I had sex without condom	24	5.5
3	I had sharp materials injury or contact	31	7.1
4	I had sex with a partner living with HIV/AIDS	2	.5
5	Others	16	3.6
6	I don't know	7	1.6
Remark- there were respondents who didn't want to mention their reasons			

Table 4- respondents' reason for not perceiving at risk of HIV/AIDS, July 2008

S. No	Reason	No	%
1	My spouse is faithful	186	42.4
2	I had never had sharp materials injury	93	21.2
3	I always use condom correctly and consistently	20	4.6
4	I have been Abstaining from sexual activities	59	13.4
5	others	21	4.8
6	I don't know	17	3.9
remark: multiple answer are possible			

Acceptability of provider initiated HIV counseling and testing (PIHCT)

Out of the total respondents 415(95.5%) said that they have heard about HIV counselling and testing while the rest 24(4.5%) said they have never heard about HIV counselling and testing. Concerning Voluntary confidential counselling and testing and provider initiated HIV counselling and testing, 395(90.0%) and 340 (77.4%) of the respondents have heard VCCT and PIHCT respectively while 44(10.0%) and 94(22.6%) of the respondents have never heard about VCCT and PIHCT. Those respondents who have heard PIHCT were asked for source of information and the results are depicted in table 5.

S. No.	Source on information	No	%
1	Health workers	302	68.8
2	Mass Media	206	46.9
3	Family Members	108	24.6
4	Friends	85	19.4
5	Others	77	17.5
Remark: multiple answer is possible			

Three hundred eighty eight (88.4%) of the respondents said that every person should be tested while the rest 51(11.6%) of the respondents didn't think that every person should get tested for HIV/AIDS. Out of those OPD clients who said every person should be tested, 322(73.3%), 102(23.2%), 85(19.4%), 118(26.9%), 133(30.3%),20(4.6%) said an individual should get tested before marriage, when a person plans to have

children, getting VISA, when having multiple sexual partners, any time and other reasons respectively.

Out of the total respondents, 253(57.6%) have ever had a test for HIV/AIDS while the rest 186(42.8%) have never tested for HIV/AIDS. Out of those who have ever tested,158(62.4%), 4(1.6%), 33(13.0%), 29(11.5%), 30(11.9%), and 23(9.0%) attribute their being tested for knowing status, blood donation, getting sick, marriage, pregnancy and other reasons respectively. (Multiple answers were possible).Out of those who said they have ever tested, 137(54.2%), 112(44.3%), 14(5.5%), 23(9.1%), and 16(6.3%) said that they were motivated to have a test for HIV/AIDS by themselves, health worker, friends, spouse and others respectively. (Multiple answers were possible) Respondents who ever had tested for HIV test were asked the last time the made test, the mean and median months that these respondents made a test were 12.37 months and 7 months prior to the data collection period respectively. Table 6 depicts respondents' test for HIV/AIDS for the last time in months (classification based on quartile)

Table 6: distribution of months in which respondents made HIV test for the last time, July 2008

S. No	Test done for the last time (in months)	No	%
1	1-3 months	65	25.7
2	4-7 months	67	26.5
3	8-12 months	57	22.5
4	13-78 months	60	23.7
5	Didn't mentioned	4	1.6

Respondents were also asked for the place or health facility that they had test for the last time. Their response showed 125(49.4%) had their test in other health facilities other than the health facility they visited for OPD service. Ninety nine (39.1%) of them get tested for the last time in the health facility interviewed for this study while twenty nine (11.5%) of them get tested in mobile HIV counseling and testing sites (campaign). This study also tried to assess the reason for having HIV test prior to the data collection period. Table 7 shows reasons mentioned by respondents who have never got tested for HIV test.

Provider initiated HIV counseling and testing (PIHCT)

Interviewers were made to classify what PIHCT mean and its difference with VCCT to respondents before asking clients' attitude towards PIHCT. After the explanation 412(93.8%) of the respondents said PIHCT is important while the rest 27(6.2%) didn't that PIHCT is important (didn't supported it). Respondents were also asked about the specific pros and cons of PIHCT. Table 8 shows importance mentioned by respondents. Respondents were also made to speak out what influence could PIHCT could have other than the above mentioned pro and cons in their own words. Sixty nine

(15.6%) of the total respondents said it may result in fear, stress and frustration to have HIV counseling and testing. On the other hand 149(33.7%) of the total respondents said PIHCT helps to one's HIV status, 19(4.3%) to reduce stigma and discrimination, 27(6.1%) to control HIV transmission, 35(7.9%) to increase awareness on HIV/AIDS, and 95(21.5%) to start treatment on time. Only 147(33.5%) of the total OPD clients were initiated for HIV counseling and test during their stay with health professionals prior to the exit interview while the rest 292(66.5%) were not initiated for HIV counseling and test. Out of those OPD clients who were initiated only 83(56.5%) were tested for HIV while the rest 64(43.5%) didn't have test.

Table 7: reasons suggested by OPD clients in Axum and Adigrat Hospital for not having HIV test prior to the data collection period, July 2008.

S.No.	Reason for not having HIV test	No.	%
1	Fear of stigma and discrimination by the society	7	3.8
2	Fear of expecting the result to be positive	3	1.6
3	Fear of partner's or spouse's reaction	3	1.6
4	Difficulty of tolerating positive result	8	4.3
5	I am not at risk of HIV/AIDS	16	8.6
6	Service cost (HIV test) is expensive for me	18	9.7
7	There is no VCT center	3	1.6
8	I though having HCT is not important	1	.5
9	I am not sure about the service confidentiality	2	1.0
10	I don't want to know the result of the test	8	4.3
11	I believe my partner or spouse	55	29.6
12	I am confident in my status/my self	96	51.6
13	I don't have reason /not mentioned	17	9.1
14	Others	16	8.6

Out of those who got test 77(92.8%) said that they received a pre-test counseling and said satisfied by the counseling given to them. But the rest 6 (7.2%) received pre-test counseling but were not satisfied by the pre-test counseling offered to them. The reasons attributed for their dissatisfaction were inadequacy of information and incompetent health professionals.

OPD clients who were initiated but didn't get tested were asked for their reasons not to accept the initiation and not get tested. Table 9 depicts reasons of OPD clients for not having test after initiation by Health professional for HIV test.

At the end of the interview, OPD clients were asked to suggest any idea they have. Forty three (9.7%) of the respondents said PIHCT is good and should be continued and 51(11.5%) of the respondents said the education on PIHCT should be sustainable

Table 8: pros and cons as of PIHCT as suggested by OPD clients in Axum and Adigrat Hospitals, July 2008.

S. No.	Pro/con	Yes		No		I don't know	
		No.	%	No.	%	No.	%
1	PIHCT helps individuals to get ART	385	87.7	23	5.2	31	7.1
2	PIHCT enable people to have HCT easily	372	84.7	44	10.0	23	5.3
3	PIHCT enable PLWHA not to be stigmatize	341	77.6	63	14.4	35	8.0
4	PIHCT increases number of people who undertake HCT	379	86.3	40	9.1	20	4.6
5	PIHCT do have influence on clients (positive/negative)	125	28.5	280	63.8	34	7.7
6	PIHCT could make clients no to visit health facilities for other medical services fearing HCT	158	36.0	242	55.1	39	8.9
7	PIHCT violets individuals'(people) right	42	9.6	373	85.0	24	5.4
8	PIHCT exposes women for sexual violence	90	20.5	309	70.4	40	9.1
9	PIHCT could force individuals to have HCT without their consent	98	22.3	313	71.3	28	6.4

Multiple Logistic Regression Analysis of Factors Associated with Having Been Tested for HIV

After adjusting for significant independent variables (see Table 7), age group (20-24) and clients with single in marital status agreed any one can check his/her sero-status were each associated with higher odds of having tested for HIV following their supervisor initiation. Patients who were at younger age group (20-24) had higher odd of acceptability of PIHCT (AOR= 4.8; 95% CI= 3.7-11.1) than older age group patients. Patients who were single by marital status were almost five times more likely to get tested for HIV following their supervisor initiation than married and divorced (AOR=4.99, 95% CI=1.80, 13.84) as shown in table 10.

DISCUSSION

HIV testing is fundamental to both prevention and treatment of HIV. There are many approaches that are adopted at the national level for HIV/AIDS Prevention and Control. Efforts to increase the coverage of HIV testing have recently extended to the provision of "opt-out" or routine HIV testing, where the healthcare provider rather than the client or patient initiates the test. This study tried to look into some of the important factors that affect the acceptance of PITC

among the different professional and community groups in the study area.

Table 9: Reasons of OPD clients in Axum and Adigrat hospitals for not having test after initiated by Health professional for HIV test, July 2008. (n=64)

S. No.	Reasons for not having test	No.	%
1	Fear of stigma and discrimination by the society	6	9.4
2	Fear of positive result	4	6.3
3	Fear of partner's or spouse's reaction	1	1.6
4	Difficulty to tolerate positive result	6	9.4
5	I am not at risk of HIV/AIDS	6	9.4
6	Difficulty to pay the cost for HIV test	1	1.6
7	There is no clean and safe HIV test service	1	1.6
8	HCT is not useful	1	1.6
9	I am not sure about the confidentiality of the test	1	1.6
10	I don't want to know the result of the test	5	7.8
11	I believe my partner or spouse	21	32.8
12	I am confident in myself	35	54.7
13	Fear of stigma or discrimination by the health professional	1	1.6
14	I was tested before	22	34.4
15	Others	16	25.0
16	I don't know/ don't want to mention	11	17.2

Table 10: Univariable and Multiple Logistic Regression Analysis of Factors Associated with acceptability of PIHCT

S.No.	Variable	Acceptors	Non-Acceptors	OR (95%CI)	AOR (95% CI)
1	Sex		253 (57.6%)		
	Female	90	139	1.64 (0.49-5.9)	1.57 (0.51-4.8)
	Male	55	155	1	1
2	Age category (in Years)				
	18-19	19	27	2.2 (0.9-7.8)	1.8 (0.5-5.7)
	20-24	53	42	4.2 (2.2-12.6)	4.8 (3.7-11.1)
	25-29	20	45	3.9 (1.6-9.4)	2.2 (0.9-5.9)
	30-34	18	48	3.2 (1.3-7.9)	2.0 (0.8-5.3)
	35-39	20	38	3.0 (1.1-7.8)	1.9 (0.7-5.4)
	40-45	8	28	4.0 (1.1-8.7)	2.0 (0.7-6.1)
	46-49	4	20	1.6 (0.5-5.6)	1.7 (0.4-6.5)
	+50	3	54	1	1
3	Marital status				
	Single	63	85	4.0(1.63,9.96)	4.99 (1.80, 13.84)
	Married	70	176	1.16 (0.83, 3.29)	1.42(0.65, 3.12)
	Divorced	8	21	1.51 (0.67, 3.44)	1.41 (0.58, 3.41)
	Widowed	4	12	1	1

The results of this study demonstrate the acceptability of PIHCT among adult patients and the factors influencing its uptake. Over half (52.25%) of the study subjects were female, almost half (46.9%) years old. The mean and median ages of the respondents were 33.31 and 30.00 respectively. The standard deviation for age was 13.321. Fifty six percent of the participants were married followed by single 33.7%, and 23.2% had 9th-12th grade followed by Illiterate 21.9%.

In this study, it was found that only 292(66.5%) of the total OPD clients were initiated for HIV counseling and test during their stay with health professionals prior to the exit interview while the rest 147(33.5%) were not initiated for HIV counseling and test. This result is very low with results reported from a population based study on routine testing in Botswana, where 81% of the study participants were extremely or very much in favor of routine HIV test⁸ and this difference could be due to the difference in time horizon and awareness of the community on PITC.

Out of those OPD clients who were initiated only 145(49.15%) were tested for HIV while the rest 147(50.85%) didn't have test. An institution based study in Addis Ababa in 2006 found that 26.4% of TB patients tested for HIV after their provider initiation. This is suggesting that more than two fold increase in acceptability of PIHCT than a study conducted at the start of the service in the city¹¹. This is due to the previous study was conducted at the earlier implementation of PIHCT.

In this study, all patients reported that they have heard of HIV/AIDS. This result is comparable with the results observed among the community (100%) in north Gonder¹⁰. This finding is also comparable with a recent finding from BSS round two that Revealed that 98% of study populations were aware of HIV /AIDS^{9,11}.

After adjusting for significant independent variables, age group (20-24) and clients with single in marital status agreed any one can check his/her sero-status were each associated with higher odds of having tested for HIV following their supervisor initiation. Patients who were at younger age group (20-24) had higher odd of acceptability of PIHCT (AOR= 4.8; 95% CI= 3.7-11.1) than older age group patients. Patients who were single by marital status were almost five times more likely to get tested for HIV following their supervisor initiation than married and divorced (AOR=4.99, 95% CI=1.80, 13.84). In this study educational was not associated with acceptability of PIHCT. The result of this study is different with the

findings from other studies. A study from Botswana reported that the level of education was significantly associated with acceptance of testing. Another study conducted on TB patients in Addis Ababa in 2006, also showed that educational status of patients was significantly associated with having been tested for HIV.

Strengths and Limitations of the study

Strengths

- HIV status wasn't asked, and privacy and confidentiality were assured to maximize validity of self report on HIV testing.
- Survey questions were asked in a culturally sensitive and nonjudgmental manner.

Limitations

- Self report might introduce social desirable response
- As this study is cross sectional, causality cannot be determined from findings

CONCLUSION AND RECOMMENDATIONS: This study found that OPD clients do have satisfactory knowledge on HIV/AIDS transmission and prevention but less practice in uptake of HIV counseling and testing. Clients were also have found to have positive attitude to provider initiated HIV counseling and testing but health

professionals are not initiating HCT to all clients. This might be fear of stigma from the client side, workload from the professionals' side. Hence to promote PIHCT further orientation on PIHCT to health professionals and strengthening HIV/AIDS activities to combat stigma are recommended. After adjusting for significant independent variables (see Table 7), age group (20-24) and clients with single in marital status agreed any one can check his/her sero-status were each associated with higher odds of having tested for HIV following their supervisor initiation. Patients who were at younger age group (20-24) had higher odd of acceptability of PIHCT (AOR= 4.8; 95% CI= 3.7-11.1) than older age group patients. Patients who were single by marital status were almost five times more likely to get tested for HIV following their supervisor initiation than married and divorced (AOR=4.99, 95% CI=1.80, 13.84).

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