

Assessment of Provider Initiated HIV Testing and Counseling Uptake and It's Associated Factors among Out Patient Department (OPD) Clients, in Pawie Hospital, Benishangul Gumuz, North West Ethiopia

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Assessment of Provider Initiated HIV Testing and Counseling Uptake  
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## **Abstract**

**Introduction:** HIV testing and counseling (HTC), long recognized as a critical component of a comprehensive HIV program, is the entry point for accessing needed HIV prevention, treatment and care, and support services. Provider-initiated testing and counseling is seen as one of several potential components in an overall strategy to increase uptake of HIV testing and counseling.

**Objective:** To assess uptake of Provider Initiated HIV testing and Counseling and its associated factors among OPD clients in Pawie Hospital, Benishangul Gumuz, North West, Ethiopia

**Methods:** Facility based cross sectional study was conducted among OPD clients of Pawie Hospital from January 30 to February 25, 2012. With sample size of 424 .Using systematic random sampling method every other client of OPD exit interview was conducted. Data was collected using pre-tested structured questionnaire on OPD clients & to supplement, in-depth interview was conducted on service providers. The questionnaire addresses the patients' willingness, acceptability of PITC, socio-demographic, knowledge on HIV/AIDS&PITC and perceived risk on HIV/AIDS. To describe the characteristics of the study population, percentage was calculated. Bi-variate and multivariate logistic regression was applied to examine the relationship. A p-value of less than 5% was used to declare association between factors and the dependent variable. For the qualitative part, thematic analysis was used.

**Result:** Among the total participants, 16.8% had poor knowledge about means of HIV transmission, and only 13 (4.5%) were knowledgeable about all of the ABCs of HIV prevention methods. There was also low (39.7%) self risk perception for HIV infection. However, the overall uptake of PITC is 80.7%. On a multivariate logistic regression analysis, those who can read /write were two point five times more likely to not accept PITC than those illiterates [AOR (95% CI) =2.47(1.08,7.09)].Those who had not perceiving risk of acquiring HIV were 2.16 times more likely to not accept PITC than those who had perceiving risk [AOR (95% CI) =2.16(1.28,5.44)]. And individual who had never tested HIV before were 8.2 times more likely to not accept PITC than those who had ever been tested [AOR (95% CI) =8.19(4.55, 14.61)].

**Conclusion:** In this study the client's knowledge on HIV transmission and prevention methods is low. Larger segment of clients lacks self perceived risk of HIV infection. However there was relatively high up take for PITC by clients. Therefore, to improve knowledge on HIV means of transmission, prevention and scale up PITC uptake, IEC/BCC to the public is recommended.

**Key Words:** PITC, Uptake, HIV, OPD, Pawie.

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## **List of Acronyms and Abbreviations**

**ABCs:** Abstinence Be-faithful and using Condom

**AIDS:** Acquired Immunodeficiency Syndrome

**AOR:** Adjusted Odds Ratio

**ART:** Anti Retro Viral Therapy

**EDHS:** Ethiopia Demographic and Health Survey

**FHAPCO:** Federal HIV/AIDS Prevention and Control Coordinating Office

**FMOH:** Federal Ministry of Health

**FGD:** Focus Group Discussion

**G8:** Group Eight Countries

**HAPCO:** HIV/AIDS Prevention and Control Coordinating Office

**HIV:** Human Immunodeficiency Virus

**HTC:** HIV Testing and Counseling

**IEC/BCC:** Information Education and Communication/Behavioral Change Communication

**MOH:** Ministry Of Health

**MPH:** Masters of Public Health

**OPD:** Outpatient Department

**OR:** Odd Ratio

**PITC:** Provider Initiated HIV Test and Counseling

**PLWHA:** People Living With HIV/AIDS

**PMTCT:** Prevention of Mather to Child Transmission of HIV

**SD:** Standard Deviation

**SPSS:** Statistical Package for Social Science Research

**STI:** Sexually Transmitted Infection

**TB:** Tuberculosis

**UNAIDS:** Joint United Nations Programme on HIV/AIDS

**VCT:** Voluntary Counseling and Testing

**WHO:** World Health Organization

## **CHAPTER ONE: INTRODUCTION**

### **1.1. Background**

After 1983 the first clinical cases of acquired immunodeficiency syndrome (HIV) were reported, AIDS has become the most devastating disease of humankind has ever faced. Infection with the human immunodeficiency virus (HIV) is a global pandemic [1].

The biggest epidemics in sub-Saharan Africa: Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe has either stabilized or is showing signs of decline. However, several regions and countries do not fit the overall trend. These demonstrate that positive behaviour change can alter the course of the epidemic. While stigma and discrimination, lack of access to services and bad laws can make epidemics worse [2].

The first evidence of HIV/AIDS epidemic in Ethiopia was detected in 1984. Since then, AIDS has claimed the lives of millions and has left behind hundreds of thousands of orphans [3].

HIV testing and counseling (HTC) is long recognized as a critical component of a comprehensive HIV program as the entry point for accessing needed HIV prevention, treatment and care, and support services [1,6].

As a strategy to increase HIV testing uptake, World Health Organization (WHO) and the United Nations Joint Programme on HIV/AIDS (UNAIDS) have recommended provider-initiated testing and counseling (PITC). “With this approach, an HIV test is” recommended”; 1) for all patients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection; 2) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and 3) more selectively in concentrated and low-level epidemics” [4].

UNAIDS, WHO and CDC recommend HIV testing in clinical settings where HIV is prevalent and where HIV care, treatment and support services are available [4]. This mandate calls for PITC for all clients seeking care in any clinical setting, including out-client settings such as out-patient departments and primary care clinics, and in-patient wards [5].

Voluntary HIV counseling and testing for the larger community started in Ethiopia after the National HIV/AIDS policy was launched in August 1998 and VCT guidelines were developed in 2000. Provider initiated counseling and testing at different outpatient departments was introduced in TB clinics at the end of 2005. In late 2006, the Millennium AIDS Campaign for Ethiopia was launched.

In Ethiopia there are three types of HIV testing [7]:

1. Client initiated, or voluntary counseling and testing
2. Provider initiated testing and counseling (PITC)
3. Mandatory HIV screening.

Ethiopia joined the UN General Assembly in issuing the Political Declaration on HIV/AIDS in 2006. The declaration necessitates commitment on the part of governments to move towards the goal of universal access to HIV prevention, treatment, care and support by 2010. Health facilities represent a key point of contact with people who are potentially infected with HIV. Provider-initiated testing and counseling in health facilities should be seen as one of several potential components in an overall strategy to increase uptake of HIV testing and counseling and knowledge of HIV status [5].

## **1.2. Statement of the Problem**

Dedicated efforts to promote and support HIV prevention are producing clear and impressive results. But while parts of the world experienced significant and encouraging decreases in HIV incidence, during the same period the incidence increased in some countries [2].

In the year 2008, there are around 33 million people living with HIV globally. Of these, 30.8 million are adults, including 15.4 million women and 2.5 million children. In same year, there were 2.7 million new infections. Additionally, there were a total of 2 million deaths from HIV/AIDS, including 1.7 million adults and 0.33 million children [1].

Every day, over 6800 persons become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services. The HIV pandemic remains the most serious of infectious disease challenges to public health [1].

In sub-Saharan Africa there were 22 million adults and children living with the virus in the year 2008, with an adult prevalence of 5%. There were 1.7 million adults and children newly infected in 2008. And there were a total of 1.5 million deaths of both adults and children within the same year (1). The estimated 1.3 million people who died of HIV related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of 1.8 million deaths attributable to the epidemic and where the majority of new HIV infections continue to occur, an estimated 1.8 million people became infected in 2009 in sub-Saharan Africa [2].

Ethiopia has one of the largest populations of HIV infected people in the world with an estimated 1.1 million people living with HIV [8]. The 2005 Demographic Health Survey estimated the national adult HIV prevalence in Ethiopia to be 1.4%, with infection levels highest in the Gambella (6%) and Addis Ababa (4.7%) regions. And in Benishangul Gumuz it was 3.3% [9].

According to the single-point estimate, the prevalence of adult infection in Ethiopia for the year 2010 is 2.4%: male 1.9%; female 2.9%; urban 7.7%; rural 0.9% and in 1.8% in Benishangul Gumuz Region. In same year, the estimated number of people living with HIV in Ethiopia was 1,216,908 including 79,871 children [8].

In an attempt to overcome the propagation of the epidemic, various preventive strategies have been employed as there is no cure presently and to tackle the devastating untoward effects of the disease. HTC has been introduced in many low-resource settings as it helps to create awareness of an individual's HIV status and offers the opportunity for counseling on risk behavior modification being a cornerstone in the prevention of HIV/AIDS [1, 6].

Limited knowledge of HIV status in many countries means that large numbers of people fail to receive HIV treatment, care and support in a timely manner, and do not take steps to prevent transmission to others because they do not know they are infected [5].

In recent years, access to HTC has been greatly expanded through establishing new testing sites, using rapid testing methods, and applying innovative approaches, such as mobile testing, community-based and home-based HTC, and community mobilization for HTC "events." However, uptake of HTC remains low. A 2008 report from the World Health Organization (WHO) noted that among those low- and middle-income countries that conducted population-based surveys between 2005 and 2007, only 10.9 percent of women and 10.3 percent of men had ever had an HIV test and received their test results, and a median of 20 percent of people living with HIV (PLWH) knew their HIV status [1].

Thus, Ethiopia being one of the world's most HIV/AIDS prevalent countries has been made/ making tremendous efforts towards tackling of the epidemic. With regard to VCT services, it was launched in 1998 along with the national HIV/AIDS policy and these efforts have been reflected by the consistent increase in the number of counseling and testing facilities as well as the parallel increase in the number of people being tested for HIV [10]. But according to Ethiopia DHS 2005 report, among the adult population of age 15-49 years, only 4% of women and 6% of men have been tested for HIV [9].

It is widely recognized that the low uptake of HIV testing and counseling is a major challenge in the response to the epidemic that needs to be urgently addressed. It has also been observed that many people who present symptoms of HIV infection and those who might otherwise benefit from knowing their HIV status through contact with health facilities are often not offered an HIV test. Based on these concerns, WHO and UNAIDS has developed draft guidance on “Provider- Initiated Testing and Counseling in Health Facilities” in order to improve HIV related diagnosis, treatment and care and to expand the availability and uptake of HIV testing and counseling in clinical settings [4].

In Ethiopia, there are many important reasons for providing provider-initiated HIV testing and counseling, including: Many people in Ethiopia do not know their status, routine HIV testing can increase access to HIV testing and therefore increase the number of individuals who know their status and to identify those who need ARV treatment, care and support [11].

In Ethiopia some studies were undertaken on willingness and acceptability of PITC especially for those clients with tuberculosis and sexually transmitted infection, **however** the diagnostic approach is not only meant for those with tuberculosis and sexually transmitted infection, but also for all clients with other cases.

On the other hand, there was no research done on any aspects of PITC in the study area. Therefore, the aim of this study was to assess uptake of provider initiated HIV testing and counseling and its associated factors among OPD clients, in Pawie Hospital, Benishangul Gumuz, North West Ethiopia.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1. HIV Counseling and Testing (HCT)**

HIV counseling is a voluntary dialogue between a counselor and client, a couple or a group of clients. It is a process of enabling clients to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning. The common components are pretest, post test and ongoing counseling [7].

Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers people living with HIV an opportunity to receive information and tools to prevent HIV transmission to others. Increased access to HIV testing and counseling is essential in working towards universal access to HIV prevention, treatment, care and support, as endorsed by G8 leaders in 2005 and the United Nation General Assembly of 2006 [12].

HIV testing and counseling (HTC), long recognized as a critical component of a comprehensive HIV program, is the entry point for accessing needed HIV prevention, treatment and care, and support services. In recent years, access to HCT has been greatly expanded through establishing new testing sites, using rapid testing methods, and applying innovative approaches, such as mobile testing, community-based and home-based HCT, and community mobilization for HTC “events” [1].

The Ethiopia Federal Ministry of Health and the HIV/AIDS Prevention and Control Office (MOH/HAPCO) developed an HIV/AIDS policy, different guidelines (PMTCT, ART, VCT etc) and strategic documents to create an environment conducive for the implementation of HIV prevention, care, and treatment and support programs. And the policy states that Counseling and testing, as a crucial intervention component of the HIV/AIDS prevention, care and support program shall be promoted and made widely available, affordable and accessible to all individuals and communities [7].

In Ethiopia the number of HCT service offering sites that were 1,230 in March 2008, demonstrates that among the health facilities studied (157) about 85% are providing HCT service. Similarly, the number of ART sites in 2008 reached to 131,360 in May, 2008 [13].



Evidence from both industrialized and resource-constrained settings suggests that many opportunities to diagnose and counsel individuals at health facilities are being missed and that provider-initiated HIV testing and counseling facilitates diagnosis and access to HIV-related services [4].

Since health facilities represent a key point of contact with people who are potentially infected with HIV, provider-initiated testing and counseling in health facilities should be seen as one of several potential components in an overall strategy to increase uptake of HIV testing and counseling and knowledge of HIV status [5].

## **2.2. Provider-initiated testing and counseling**

This approach refers to HIV testing and counseling which is initiated by health care providers for persons attending health care facilities. The major purpose of such testing is to make specific clinical decisions and/or offer specific medical services that could not be done without knowledge of the person's HIV status. It is emphasized that provider-initiated testing and counseling is voluntary and that the "Three C's" – informed consent, counseling and confidentiality must be observed for both these forms of provider-initiated testing and counseling [4, 5].

Provider-initiated HIV testing and counseling also aims to identify unrecognized or unsuspected HIV infection in persons attending health facilities. Health care providers may therefore recommend HIV testing and counseling to patients in some settings even if they do not have obvious HIV-related symptoms or signs. Such patients may nevertheless have HIV and may benefit from knowing their HIV-positive status in order to receive specific preventive and/or therapeutic services. In such circumstances, HIV testing and counseling is recommended by the health care provider as part of a package of services provided to all patients during all clinical interactions in the health facility [4, 5].

WHO sets two discrete categories for PITC namely diagnostic and routine offer: Diagnostic testing is part of a clinical process of determining the diagnosis of a sick person and it refers to situations where a medical condition or medical symptoms indicate a significant possibility of underlying HIV disease. And routine offer of testing and counseling means, offering an HIV test to all sexually active patients, who present for medical care regardless of their initial reason for seeking medical attention [5].

### **2.3. PITC Acceptance and its associated factors**

A Study in South India on Perceptions of Tuberculosis Patients on Provider- Initiated HIV Testing and Counseling shows, of the 568 interviewed TB patients, 73 (13%) reported that they had already been previously tested for HIV before TB diagnosis, among which 43 were HIV-infected. Of the 495 patients without known HIV status, 455 (92%) reported being referred for HIV testing by the time of interviews. While local guidelines asked counselors to inform patients that they should self-disclose their HIV results to their treatment provider, 247(56%) of patients reported being informed by the counselor to do so. 333 (75%) of patients reported voluntary disclosure of HIV results [14].

Another study conducted on Feasibility of Provider-Initiated HIV Testing and Counseling of Tuberculosis Patients in two districts of South India shows that in total, HIV status was ascertained for 3,705 (70%) of the 5,299 registered TB patients. There was no difference in the ascertainment of HIV status between male or female TB patients (71% vs. 69%),or between patients in Mysore district [15].

Study conducted in Cameroon, on assessing the accessibility of HIV care packages among tuberculosis patients shows that, a total of 2270 TB patients were registered and offered pre-HIV test counseling; 2150 (94.7%) accepted the offer of a test [16].

Study in Durban, South Africa on Routine, voluntary HIV testing Shows that, nearly half of patients accepted HIV testing; In this study, married people seem both more willing to be tested and more likely to be HIV negative. It also found that a significantly lower proportion of men had a perfect HIV knowledge score compared with women (8.9% vs. 15.0%). Unmarried men may be least likely to accept testing [17].

Study result on Knowledge, Attitude, and Practice of Voluntary Counseling and Testing for HIV among University Students, Tigray, Northern Ethiopia shows that, nearly 85% of the respondents were willing to accept VCT for HIV. 241 (58.4%) of the respondents believed that a person would not necessarily accept VCT, unless he/she is planning marriage or to go abroad, in addition 102(24.2%) of the respondents said that HIV/AIDS has treatment, this is mainly related to lack of knowledge that may be thinking the HAART (highly active anti-retroviral therapy) completely

treats HIV/AIDS cases. And female respondents were found to have more knowledge as compared with the male respondents [18].

Study on Missed opportunities for earlier HIV testing and diagnosis at the health facilities of Dessie town, North East Ethiopia shows that, all clients were asked by interviewer for their willingness for HIV test at the time of interview and 76.3% (326/427) were willing to have HIV test. Among 326 clients who showed willingness for HIV test at the time of interview, 37.7% were ready to have the HIV test on the same day. However, HIV test was actually offered at the time of interview for 91.1% clients who accepted the test. The major, 54.4%, reason of clients who were not willing for HIV test at the time of interview was either they were not ready or they wanted to discuss with their partner. Among the clients tested for HIV by data collecting trained counselors at the time of interview, 86.6% were HIV negatives while 13.4% (15/112) were HIV positives. Of HIV positive clients, 40.0% (6/15) were not willing to disclose their results to their partners. Moreover, half of the clients, 50.0%, who were not willing to tell to their partners were also refused to disclose their results to no other person [19].

Regarding PITC on tuberculosis patents, a study conducted in Arba Minch, Ethiopia to assess of acceptability of PITC among patients revealed that 73% were willing to be tested and 58% of those willing accepted the test. The overall acceptability rate was 35%. Fourteen (20.6%) were HIV positive and women were more likely to be HIV infected. Unemployment and self perceived high risk of HIV infection were associated with initial willingness. However, only being unemployed was associated with accepting the test [20].

Study conducted in Addis Ababa, on uptake of PITC among OPD clients with possible sign of HIV infection and its correlates. Though there was low knowledge about HIV transmission (5.2%); particularly mother to child transmission (11.4%) and about HIV prevention (27.6%), the willingness (70.0%) and acceptability (67%) noticed in this study was high. There was also low (38.2%) risk perception for HIV infection in this study population and the prevalence of HIV infection among the participants was 37.6% [21].

A study on assessment of VCT utilization, and willingness to accept provider initiated HIV counseling and testing among tuberculosis patients in Addis Ababa came up with a result, where by 86.2% of the patients were willing for PITC. The only adjusted correlates of willingness for PITC were being in older age group, and having demand for HIV testing. Key testing barriers include self trust (41.1%), lack of risk perception for HIV infection (24.4%), fear of learning positive result (13.9%), and stigma and discrimination attached to TB and HIV [22].

Another research on acceptability of PIHCT among Tuberculosis Patients in Addis Ababa revealed that, among those who were initiated by their treatment supervisor for HIV testing, 266 (66.2%) had under gone HIV testing. All of the HIV tested patients had collected their HIV test result. The reported barriers for acceptability of PIHCT include no risk perception for HIV infection 54(40.3%), tested before 53(39.3%), and fear of learning positive result 40(29.8%) of the study participants. The remaining reported perceived barriers. Acceptability of PIHCT was not significantly associated with other characteristics namely: sex, ethnicity, marital status, religion, occupational status, average household income among socio-demographics variables [23].

Another study on Patients with Tuberculosis in North West Ethiopia revealed that, the uptake of HIV testing among these patients was 70.6%. Knowledge on HIV/TB, ever heard of provider initiated HIV counseling and testing, awareness of the benefits of HIV testing and perceived stigma was strongly associated with uptake of HIV testing. Individuals who had formal education were 2.35 times more likely to be tested for HIV than illiterates. Individuals with a high awareness about the benefits of HIV counseling and testing were more likely to be tested than individuals with low awareness [24].

In summary the literature indicates that, there is low acceptance of PITC even though high willingness ; the reasons for not accepting the test were, mainly lack of perceived HIV risk and stigmatizing attitude about people living with HIV/AIDS.

## Conceptual framework for PITC uptake

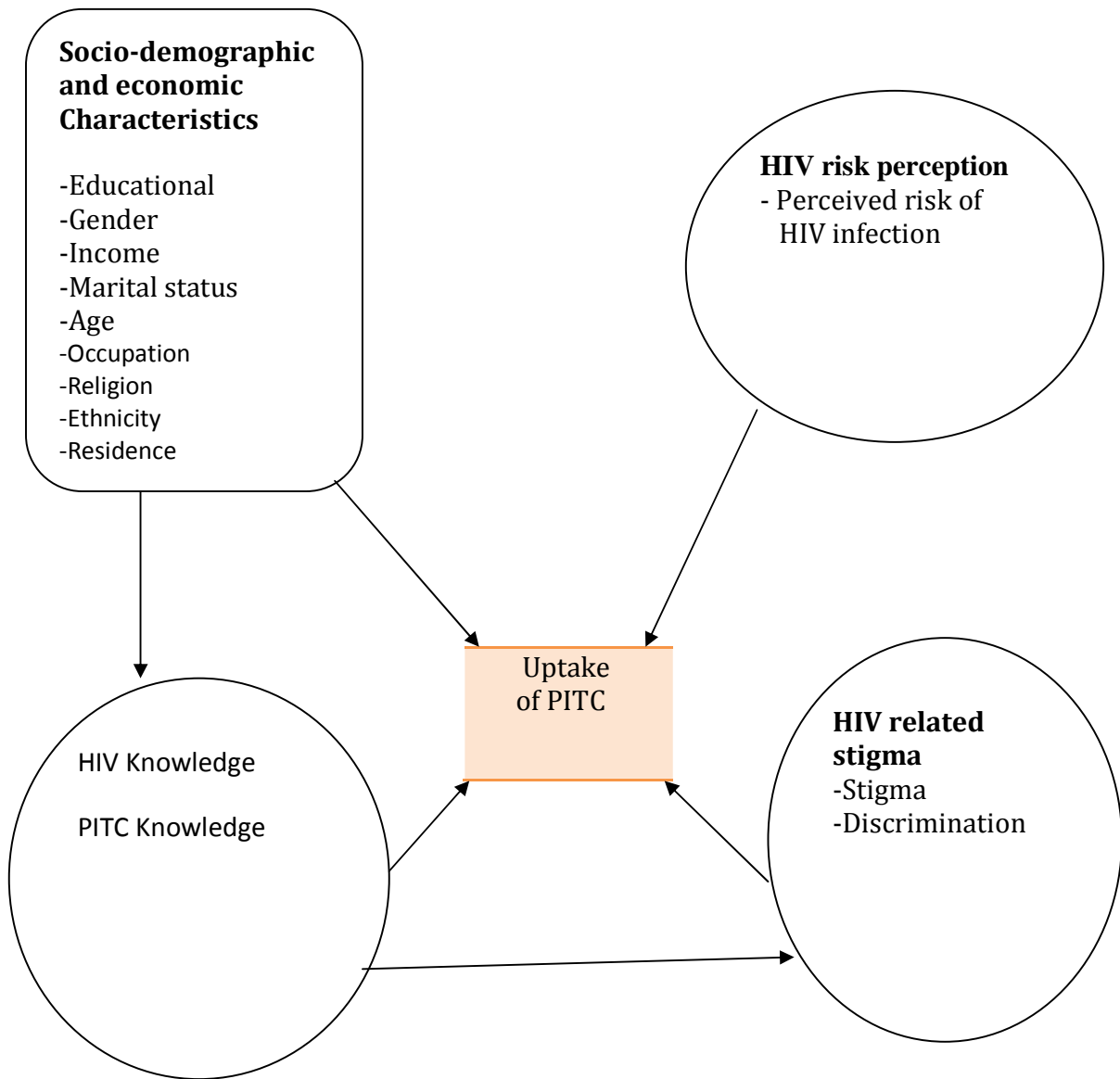


Figure .1 Conceptual framework for Predictors of uptake of PITC

### **CHAPTER THREE: Rational of the Study**

Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers people living with HIV an opportunity to receive information and tools to prevent HIV transmission to others [4].

The information obtained from this study would assist in the development of HIV/AIDS prevention, treatment and support interventions. As well as evidence based practices are important to make counseling and testing processes more effective and accessible.

Therefore, after assessing PITC uptake and its associated factors, the result of the study will help to, design measures to increase uptake of HIV testing strategy in the study area as well as it can be used as evidence based information for planners, policy makers and other implementers of the strategy in the country. In addition to this it is believed that it can be a reference for those who are interested to perform further research on the same topic.

## **CHAPTER FOUR: OBJECTIVES OF THE STUDY**

### **4.1. General Objective**

To assess uptake of provider Initiated HIV Testing and Counseling and its associated factors among OPD Clients in Pawie Hospital, Benishangul Gumuz, North West Ethiopia, February, 2012

### **4.2. Specific Objectives**

- ❖ To assess knowledge about HIV & PITC among OPD Clients of Pawie Hospital
- ❖ To assess Perceived risk towards HIV/AIDS among OPD Clients of Pawie Hospital
- ❖ To determine level of PITC acceptance among OPD Clients of Pawie Hospital
- ❖ To identify factors influencing uptake of PITC among OPD clients in Pawie Hospital

## **CHAPTER FIVE: METHODS AND MATERIALS**

### **5.1. Study area and period**

The study was conducted in Pawie Hospital, Metekel Zone, Benishangul Gumuz Region from January 30 to February 25, 2012.

Pawie Hospital is the only Hospital in Metekel Zone. It is found in Pawie woreda which was constructed by Ethiopian government to give service for settlers in 1977E.C. Initially it was built by bamboo wood to give emergency service for 48 villages. Gradually in 1981 saline construction substitute the old building by standardized new building to expand and provide the service to Metekel zone and some part of Amhara region. The new building contains administrative department, inpatient and outpatient and emergency department as well as kitchen and laundry service. It's estimated distance from Addis Ababa is 576 km, and 400km from Asossa which is the capital city of the region. The major health problems seen in the hospital are malaria, HIV/AIDS, diarrheal diseases, pneumonia and TB. The hospital provides health services for outpatients at OPDs of medical, pediatrics, surgery, gynecology/obstetric, MCH, ANC, HIV service (VCT, PMTCT, PITC, ART), TB, and Ophthalmology. In patient service are provided at four wards: medical, pediatric, gynecology/obstetric, and surgery. According to the hospital last three months (July, August and September) 2011report, average estimated number of patients (clients) visiting the OPD of the Hospital per day was 76 clients [25].

### **5.2. Study design**

Facility based cross sectional study was conducted among OPD clients in Pawie Hospital.

### **5.3. Source population**

The source population for this study was all OPD clients in Pawie Hospital.

### **5.4. Study Population**

The study population for this study was all clients who were visited OPD of Pawie Hospital during the study period.



## 5.5. Sample size determination

Sample size was calculated using a single proportion formula

$$n = \frac{\left[ Z_{\alpha/2} \sqrt{P(1-P)} \right]^2}{d^2}$$

Where, "n" is the required sample size, "Z" is a standard score corresponding to 95% confidence level "P" is the estimated prevalence of PITC among the study population and the degree of precision is represented by d. With an assumption of  $d=0.05$ ,  $\alpha=0.05$ , and  $P = 0.5$  (since there was no documented evidence about the magnitude of PITC among OPD Clients, the aforementioned value was taken), the total sample size required for the study was 385.

$$n = \frac{\left[ Z_{\alpha/2} \sqrt{P(1-P)} \right]^2}{d^2} = \frac{\left[ 1.96 \sqrt{0.5(1-0.5)} \right]^2}{0.05^2} = \frac{\left[ 1.96 \times \sqrt{0.25} \right]^2}{0.0025}$$
$$n = 385$$

By considering a 10% allowance for non-responses, the required sample size calculated was **424**.

## 5.6. Sampling technique

A systematic random sampling technique was applied to select the required number of cases. In order to select a representative sample from the study population, average client's flow of the Hospital was taken into account. Seventy six clients per day were seen at OPD according to the hospital average three month's report of July, August and September, 2011 [25]. At the beginning ten data collection days were assumed ( $76 \times 10 / 424 \approx 2$ ), so sampling interval of 2 was used. Using lottery method from the sample interval, the first client was selected. Following this, every other client was interviewed. As a result, client exit interview was carried out for 15 working days till the required sample size was obtained.

## **5.7. Eligibility Criteria**

### **5.7.1. Inclusion Criteria**

-OPD clients whose age was 15 to 64years were included in the study.

-Persons 15 years and above are considered mature enough to give informed consent to HIV test for themselves [7].

### **5.7.2. Exclusion Criteria**

-OPD clients with severe illness

- Unable to communicate

## **5.8. Study variables**

### **5.8.1. Dependent**

- PITC acceptance

### **5.8.2. Independent**

- Socio-demographic characteristics (age, sex, educational level, occupation, marital status, ethnicity, religion and income).
- Knowledge about HIV
- Knowledge about PITC
- Perceived risk of HIV infection
- Stigmatizing attitude towards people living with HIV/AIDS

## **5.9. Data collection procedure**

### **5.9.1. Data collection instrument**

Quantitative and qualitative data was gathered. A structured questionnaire was used to collect the quantitative data which was adapted from DHS as well as from different reviewed literatures. The questionnaire address the patients' socio-demographic factors, willingness, acceptability of PITC, knowledge about HIV/AIDS, knowledge about PITC and perceived risk on HIV/AIDS.

**For qualitative study:** qualitative part was added to supplement the quantitative assessment. For this in-depth interview, semi structured interview guide was developed. The session was supported with tape recorder and taken notes while interviews.

In-depth interviews were conducted on eight selected providers from various levels of qualification/profession (three diploma clinical nurses, one diploma midwife nurse, two BSc health officers and one Medical doctor) who were working in OPD of Pawie Hospital. This in-depth interview was made until saturation of information obtained from participants. While doing in-depth interviews, tape recorder was used to record voice from interview participants. The information obtained from in-depth interviews was transcribed. Results from this qualitative data were summarized and discussed along with quantitative findings.

### ***5.9.2. Data collection***

Four Diploma nurses who took PITC counseling training conducted the interviews using pre-tested structured questionnaire with close supervision from the principal investigator and one supervisor. The data collectors were recruited outside of Pawie Hospital health workers.

The key informant interviews were undertaken by principal investigator & one a research assistant was used to record voice of respondent using tape recorder.

### **5.10. Data quality control**

Two days training was given to data collectors and a supervisor on the objective of the study, on how to interview the questionnaire, and the way to keep the privacy and confidentiality.

Before actual data collection, the questionnaire was pre-tested in a health center of Pawie woreda (Felegsalam health center )on 5%(21) of the sample participants by trained data collectors to check for clarity of questions, their sensitiveness ambiguity and amendments like (arrangement of the questions order, options for the questions and skipping pattern) was made accordingly.

To ensure the consistency of data, the questionnaire prepared in English was translated into Amharic then back into English.

The principal investigator and the supervisor were supervised the data collection procedure closely; also checked all the data for completeness, clarity and inconsistency immediately after the data collection. Before analysis the data was cleaned thoroughly to check for errors during entry. The data was cleaned by computing frequencies and by sorted in to ascending and descending orders.

### **5.11. Data Processing and Analysis**

The quantitative data was entered and cleaned using SPSS for analysis. To describe the characteristics of the study population, means, frequencies and percentages were calculated. Bivariate and multivariable logistic regression analysis were done to examine the relationship between the independent variables and dependent variable of the study. A p-value of less than 5% was used to declare association between variables. Data analysis for qualitative data was followed thematic analysis. The records from notes and recorded voices from interview of the participants were made throughout to illustrate the study findings.

### **5.12. Ethical Considerations**

Data collection was started after the ethical clearance was obtained from health research and postgraduate coordinating office of College of Public Health and Medical Sciences of Jimma University. From Pawie Hospital Officials permission was obtained. The necessary explanation about the purpose of the study and its procedure was given and informed verbal consent was obtained from each respondent before interviewing. The confidentiality of the interview was kept using coded registrations rather than recording her/his name on the questionnaire. Finally, a specific safe place was arranged to put the questionnaires after completion of the interviews.

### **5.13. Dissemination plan**

The findings of the research will be submitted to department of Epidemiology, College of public health and Medical sciences, as partial fulfillment to the MPH and to Pawie hospital, Metekel zone health office, to regional Health Bureau and to other concerned bodies. The findings will be presented in different seminars, meetings and workshops and will be published in a scientific journal.

#### 5.14. Operational definitions

- ❖ **Provider-Initiated HIV testing and counseling:** is a process in which the individual undergoes counseling and HIV testing by health provider initiation.
- ❖ **Pre-test counseling acceptability rate:** Proportion of clients counseled and tested out of total willing among OPD clients.
- ❖ **Post-test counseling acceptability rate:** Proportion of clients who received the results from those who were counseled and tested.
- ❖ **Uptake:** The total number of patients who received the results out of the total interviewed for willingness among OPD clients.
- ❖ **Non-acceptors:** OPD clients who refused PITC.
- ❖ **Risk perception for HIV/AIDS:** respondents feeling of vulnerability of being infected for HIV/AIDS.
- ❖ **Willing:** An individual who agreed to accept the PITC recommendation among OPD clients.
- ❖ **Knowledgeable about HIV transmission:** Based on the six knowledge assessing questions for HIV transmission . **Good**-Knows all the 6 means  
**Fair**-Knows 3-5 means  
**Poor**-Knows 0-2 means
- ❖ **Misconception:** Study participants were considered to have misconceptions about HIV/AIDS transmission and prevention if, they agreed incorrectly to any of the four misconception questions.
- ❖ **Knowledge about HIV prevention:** respondents were considered knowledgeable about HIV prevention if they correctly identified the three main ways to prevent HIV transmission.
- ❖ **Accepting attitudes toward those living with HIV/AIDS:** Study participants were considered had overall accepting attitudes toward those living with HIV/AIDS if they correctly identified all five questions of accepting attitudes toward those living with HIV/AIDS.

## **CHAPTER SIX: RESULT**

### **6.1. Quantitative study result**

The study participants (total response rate) was 388 (91.5%) of the total 424 sampled clients.

#### **6.1.1. Socio-Demographic and Economy characteristics**

From the total 388 respondents, more than half, 198 (51%) of the study participants were male. The mean age of respondents was 30 years with  $SD \pm (10.7)$ . Age between 15-24 years old of the study participant's account 137(35.3%) followed by 25-34 years account for 131 (33.8%) of the study participants (Table 1).

Most, 311 (80.2%), of those interviewed OPD Clients were Orthodox Christians by religion followed by Muslim 62 (16.0%), the rest were Protestant and Catholic (Table 1).

Concerning ethnic group, most 306 (78.9%) of the study participants were Amhara followed by Agew 38 (9.8%), and the remaining were Kumbat, Shenasha, Gumuz, and few others (Table 1).

Regarding the marital status of the participants; 303(78.1%) were married, 19.8% were single and rest 2.1% were divorced. Forty nine percent of the participants were illiterate.

In line with occupational status, forty five point one percent of the respondents were farmers, and 20.9% were housewives. Majority 234(60.3%) of the respondents monthly income was greater than five hundred forty eight Ethiopian Birr (above poverty line) (Table 1).

**Table 1:-Socio demographic characteristics of OPD clients of Pawie Hospital, Benishangul****Gumuz, February, 2012 (n=388)**

<b>Variable</b>	<b>Number</b>	<b>Percent</b>	
<b>Age group</b>	15-24	137	35.3
	25-34	131	33.8
	35-44	77	19.8
	45-54	22	5.7
	55-64	21	5.4
<b>Sex</b>	Male	198	51.0
	Female	190	49.0
<b>Residence</b>	urban	94	24.2
	Rural	294	75.8
<b>Religion</b>	Orthodox	311	80.2
	Muslim	62	16.0
	Protestant	14	3.5
	Catholic	1	0.3
<b>Ethnic group</b>	Amhara	306	78.9
	Gumuze	5	1.3
	Shenasha	12	3.1
	Kumbat	17	4.3
	Agew	38	9.8
	Others*	5	2.6
<b>Marital status</b>	Married	303	78.1
	Single	77	19.8
	Divorced	8	2.1
<b>Educational status</b>	Illiterate	190	49.0
	Read and write	88	22.7
	Primary school	45	11.6
	Secondary school	44	11.3
	Tertiary level	21	5.4
<b>Occupation status</b>	Merchant	16	4.1
	Farmer	175	45.1
	House wife	81	20.9
	Student	56	14.4
	Gov't employee	27	7.0
	NGO employee	9	2.3
	Un employed	21	5.4
	Other	3	0.8
<b>**Income</b>	≤ 547 Eth Birr	154	39.7
	≥548 Eth Birr	234	60.3

Note;\*Tigre (3), Oromo (2),\*\* Poverty line- Income less than one dollar per day & the exchange with regard to the purchasing power in Ethiopian currency dollar which is 548 birr monthly. (Human development report 2007/8)

### **6.1.2. Knowledge and personal risk perception about HIV/AIDS**

In this study from all study participants, 287 (74.0%) had heard of HIV/AIDS. Two hundred thirty one (80.5%) of them believed that HIV is not a curable disease. Regarding means of HIV transmission; about 276(96.2%) ,273(95.1%)and 187(65.2%) participants know that Sexual intercourse, Blood contact and Transfusion of infected blood respectively are the most common ways of HIV transmission (Table 2). But few participants were able to identify mother to child transmission and Sharing of Sharps materials as modes of HIV transmission. In general based on Knowledge score, most of the participants 239(83.2%) had fair knowledge about means of HIV transmission and the rest 48(16.8%) had poor knowledge. On the hand, no one had good knowledge about means of HIV transmission. However, almost all of the participants had no misconception on transmission of HIV/AIDS (Table2).

Regarding HIV prevention ;out of 287 study participants who had heard of HIV /AIDS 265(92.3%) and 259(90.2%)of the participants mentioned abstinence and staying with only one uninfected partner, respectively, as means of HIV prevention methods. But only 13 (4.5%) were knowledgeable about all of the ABCs of HIV prevention methods. Two hundred forty (83.6%) of participants know anyone who is infected with HIV and /or who has died of AIDS and 263(91.6%) participants believed that a healthy looking person can be positive for HIV (Table 2).

On the other hand; of the total study clients, only one hundred fifty four (39.7%) of the participants perceived themselves as had risk for HIV infection. The majority 121 (78.6%) of participants rated their risk low (Table 2). Of these medium or high risk perceived participants 18(54.4%), 14(42.4%), 8(24.2%) and 4(12.1%) reasoned out that they had sexual contact with out condom , injected with unsterile needle, had multiple sexual partner and had sexual contact with HIV positive person respectively (Table 2).



**Table 2: Knowledge and personal risk perception about HIV/AIDS among OPD Clients of Pawie Hospital, Benishangul Gumuz, February, 2012 (n=388)**

Variables	Number	Percent
<b>Ever heard of HIV/AIDS</b>		
Yes	287	74.0
No	101	26.0
<b>Can HIV be cured</b>		
Yes	56	19.5
No	231	80.5
<b>Means of HIV transmission(*with multiple response)</b>		
Sexual intercourse	276	96.2
Blood contact	273	95.1
Mother to Child during pregnancy	3	1
Mother to Child during Breastfeeding	5	1.7
Sharing of Sharps materials	57	19.9
Transfusion of infected blood	187	65.2
Shaking hands a person living With HIV/AIDS	0	0
Wearing clothes of a person living with HIV/AIDS	0	0
Sharing a meal with a person living with HIV/AIDS	0	0
Mosquito bite	0	0
<b>Knowledge about Means of HIV transmission</b>		
Knowledgeable	0	0
Fair Knowledgeable	238	83.2
Poor Knowledge	49	16.8
<b>Means of HIV prevention(*with multiple response)</b>		
Avoiding Sex (abstinence)	265	92.3
Using a condom every time during sex	30	10.5
Staying with only one uninfected partner faithful	259	90.2
I don't know	7	2.4
<b>One knows anyone who is infected with HIV or AIDS</b>		
Yes	240	83.6
No	47	16.4

**A healthy looking person be positive for HIV**

Yes	263	91.6
No	21	7.4
I do not know	3	1.0

<b>Getting the virus</b>	Yes	154	39.7
	No	234	60.3

**Reasons for medium/high risk perception(\*multiple response)**

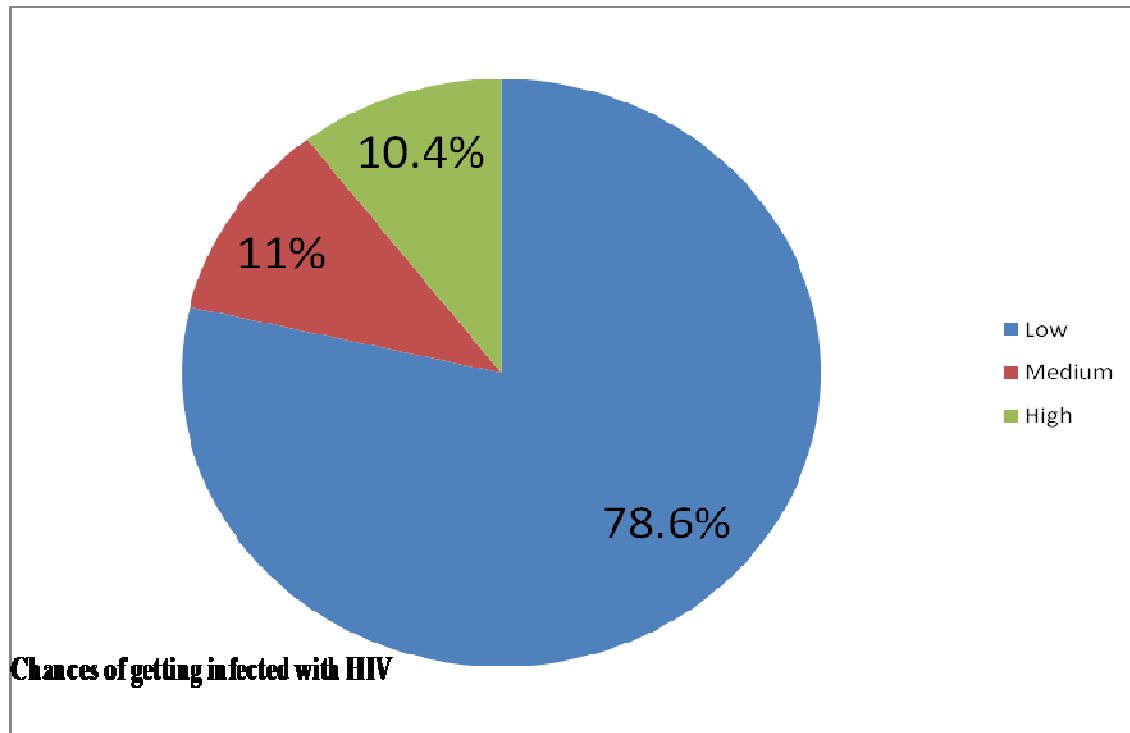
I had sexual contact with out Condom	18	54.5
I had multiple sexual partner	8	24.2
I had injection with un sterile needle	14	42.4
I had sexual contact with HIV positive person	4	12.1

**Reasons for not getting HIV virus(\*multiple response)**

I trust my sexual partner	233	99.6
No injection with un sterile needle	62	26.5
I always use condom	9	3.8

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In this study, of these perceived themselves as having risk for HIV infection majority, 121(78.6%) rated their risk as low (Figure 2).



**Figure 2:** Chances of getting infected with HIV virus among OPD clients (n=154) in Pawie Hospital, February, 2012

### 6.1.3. Attitude towards people living with HIV/AIDS

In this study, most of the participants mentioned that they are willing to care for HIV positive 355 (91.5%), purchase from shop of HIV positive person 304 (78.4%) and would share meal with HIV positive person 297 (76.5%). And also 364 (93.8%) of the participants said that an HIV positive teacher without symptom should be allowed to continue. In contrary to this, 256 (66.0 %) of the participants indicated that if somebody is HIV positive in the family they will keep it secret .In general most 201(51.8%) participant did not have accepting attitude towards people living with HIV/AIDS (Table 3).

Table3: **Accepting attitude toward those living with HIV among OPD clients in Pawie**

**Hospital, Benishangul Gumuz, February, 2012.**

<b>Variable</b>	<b>Number</b>	<b>Percent</b>
<b>Willing to share meal with a person you knew had HIV/AIDS</b>		
Yes	297	76.5
No	91	23.5
<b>Willing to care for HIV positive person</b>		
Yes	355	91.5
No	33	8.5
<b>Purchase from shop of HIV positive Person</b>		
Yes	304	78.4
No	84	21.6
<b>Keep secret if somebody is HIV positive in the family</b>		
Yes	256	66.0
No	132	34.1
<b>HIV positive teacher should be allowed to continue teaching</b>		
Should be allowed	364	93.8
Shouldn't be allowed	24	6.2
<b>Over all accepting attitude towards people living with HIV/AIDS</b>		
Yes	187	48.2
No	201	51.8

#### 6.1.4. Provider- initiated HIV testing and counseling

As shown in Table 4, 275 (70.9 %) of the participants know about PITC. Their main source of information was health workers 257 (93.5%). All participants who know about PITC 275(100%) feel that, PITC is important. The reasons given for feeling PICT is important was that it helps the clients get access to ART by 245(89.1%) and followed by 33(12%) makes easier for clients to get tested. (Table4).

Three hundred eighty 380 (97.9%) of the participants agreed that anyone should check his/her HIV sero status. Two hundred ninety four (75.8%) of participants had ever been tested for HIV. The type of tests were voluntary testing (self interest) 225 (76.3%) and initiation by health worker 70 (23.7%). Among those who undergo HIV testing, most 254 (86.1%) got the test in Government Hospital (Table4).

By Participants who never had tested indicated reasons were self trust accounts most 69(75.8%), followed by fear of the result 9(9.9%), thinking self as not being at risk 4 (4.4%) and partners trust 3 (3.3%) (Table4).

**Table 4: PITC knowledge among OPD clients in Pawie Hospital, Benishangul Gumuz, February, 2012.**

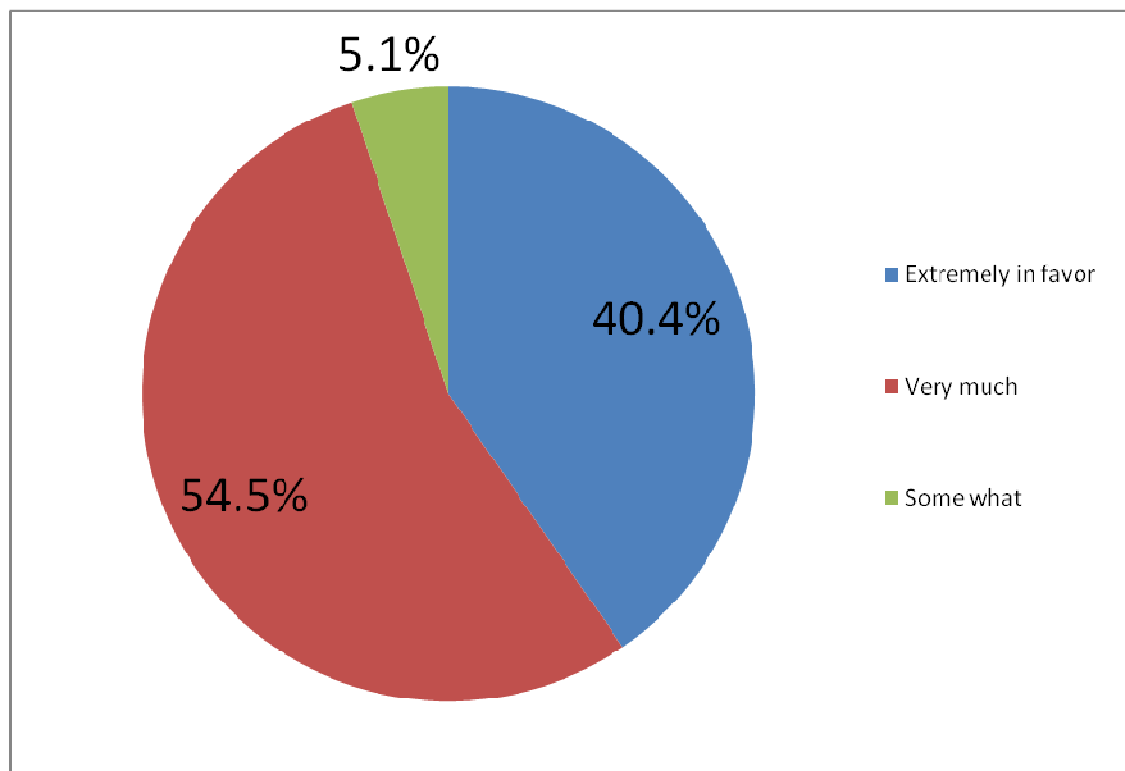
<b>Variables</b>	<b>Number</b>	<b>Percent (%)</b>
<b>Ever heard of PITC</b>		
Yes	275	70.9
No	113	29.1
<b>Source of information about PITC(* multiple response)</b>		
Health workers	257	93.5
Mass media	32	11.6
Friends	6	2.2
<b>Feel that PITC is important</b>		
Yes	275	100
No	0	0
<b>Reasons for feeling PITC is important(*multiple response)</b>		
Helps patients get access to ART is important	245	89.1
Makes easier for clients to get tested	33	12.0
Increase number of tested people	13	4.7

<b>Feeling that PITC has influence</b>		
Yes	9	3.3
No	266	96.7
<b>Any one should check his /her HIV sero-status</b>		
Yes	380	97.9
No	8	2.1
<b>People in need of HIV test(*with multiple response)</b>		
Female commercial sex workers	15	3.9
People with history of unprotected sex	3	0.8
TB patients	2	0.6
Those with multiple partners	11	2.8
Those who are sick	4	1.0
Any one at risk	7	1.8
Any person	347	89.4
<b>Ever been tested for HIV</b>		
Yes	294	75.8
No	94	24.3
<b>Reason of having HIV test</b>		
Voluntary testing	225	76.3
Initiated by health worker	70	23.7
<b>Site for your HIV test</b>		
Government hospital	254	86.1
Government health center	40	13.6
Stand alone VCT center	1	0.3
<b>Reasons given for not be tested</b>		
Unable to cope positive result	9	9.9
I am not risk person for HIV	4	4.4
Not sure of the confidentiality	1	1.1
Don't want to know the result	1	1.1
Partners trust	3	3.3
Self trust	69	75.8
Other*	4	4.4

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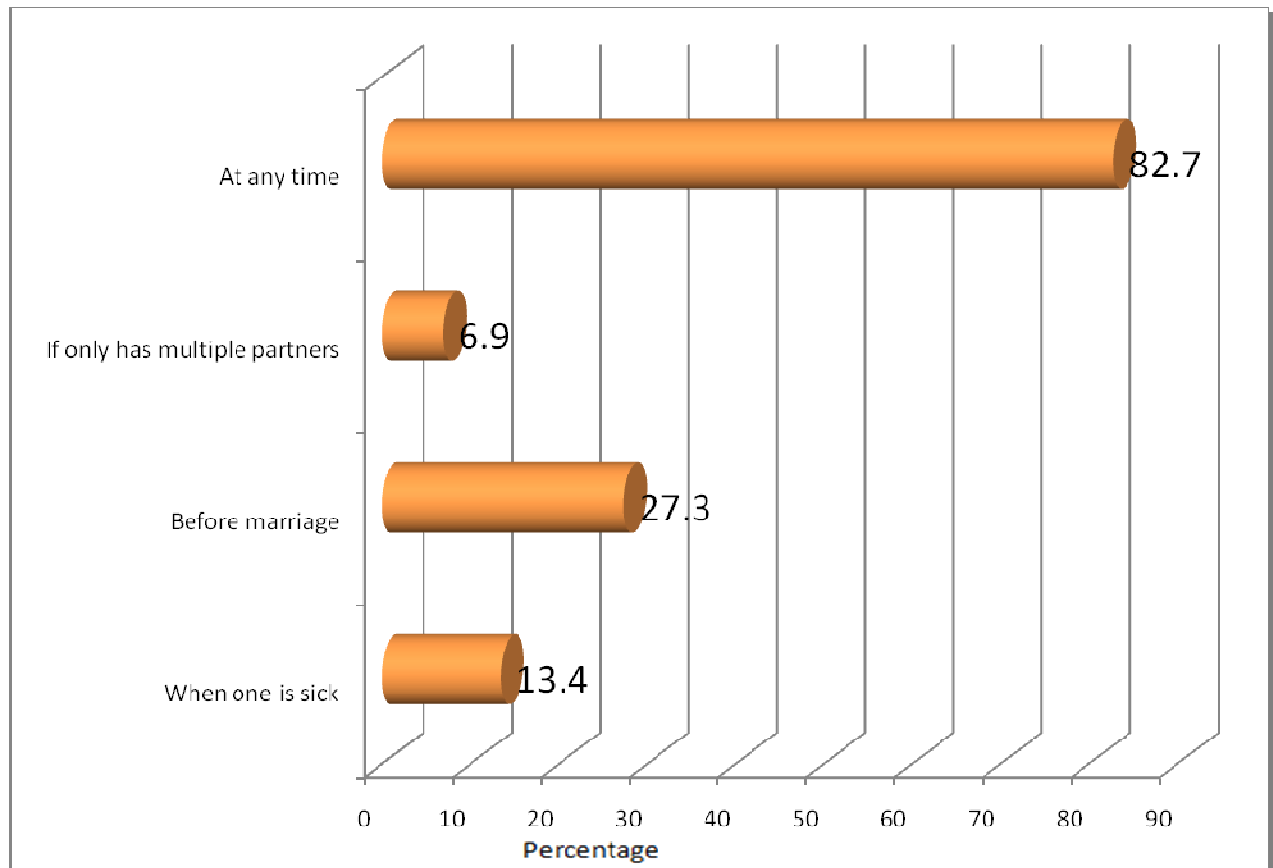
Note: Other\*=since I am aged (n=3) , it unnecessary for me(n=1)

As shown in figure 3; of 275 participants who support PITC, 150(54.5%) support it very much, 111(40.4%) extremely and 14(5.1%) somewhat.



**Figure3:** Extent of favoring PITC among OPD clients (n=275) in Pawie Hospital, Benishangul Gumuz, February, 2012

Concerning the time when a person should be tested for HIV, most participants 321(82.7%) recommend a person to be tested at any time followed by 27.3% before marriage and the rest said that when one is sick and when one had multiple sexual partners (figure 4).



**Figure4:** Time when one should be tested for HIV among OPD clients of Pawie Hospital, Benishangul Gumuz, February, 2012

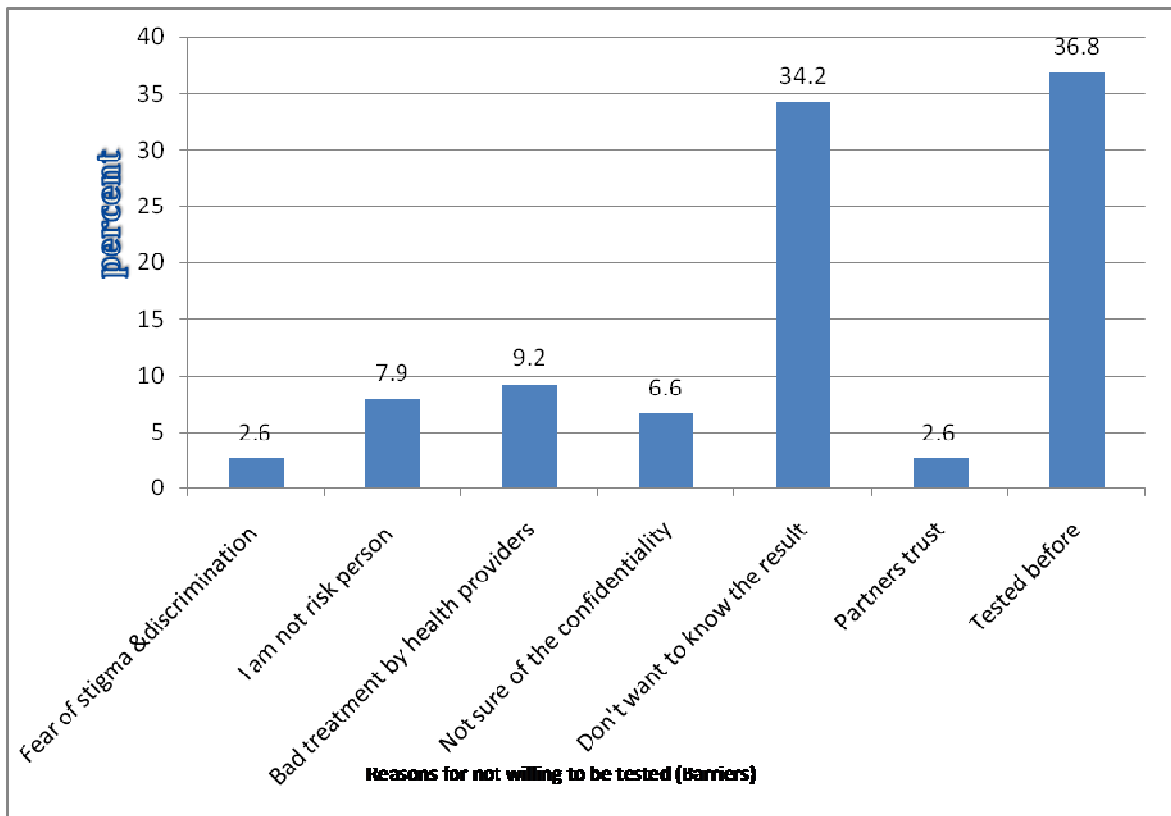


Three hundred forty (80.9%) participants were willing to take the HIV test. The major perceived facilitators for PITC willingness were TV/radio messages which accounts 295 (82.5%), knew that treatment is available 28(7.8%), and because he/she was sick 20(5.6%).In addition to this, pre and post test counseling acceptances were 315(80.9%) and 314 (80.7%) respectively by participants (Table 5).

**Table5: PITC willingness and acceptance among OPD clients in Pawie Hospital, Benishangul Gumuz, February, 2012**

<b>Variables</b>	<b>Number</b>	<b>Percent</b>
<b>Willingness to take HIV the test</b>		
Yes, I am willing	315	80.9
No, I am not willing	73	19.1
<b>Reasons to be tested(Facilitators)</b>		
TV/Radio messages	295	82.5
Knowing that treatment is available	28	7.8
Encouraged by someone who was tested	5	1.5
Worried about the previous sexual contact	3	0.8
Parents/family/friends advised to have test	4	1.1
Was sick	20	5.6
Health worker recommendation	6	1.7
<b>Acceptance of pretest counseling and testing session</b>		
Accepted	315	80.9
Not accepted	73	19.1
<b>Acceptance of Post test counseling session</b>		
Accepted	314	80.7
Not accepted	74	19.3

On the other hand; the perceived barriers for PITC willingness were being tested before accounts 28 (36.8 %), did not want to know the result 26 (34.2%), fear of discrimination by health providers 9 (9.2%), lack risk perception for HIV 6 (7.9%), not sure of the confidentiality 5(6.6%), partners trust 2(2.6%), and fear of stigma and discrimination following the positive result 2(2.6%) (Figure5).



**Figure5: Reasons for not willing to be tested (Barriers) by OPD clients of Pawie Hospital, Benishangul Gumuz, February, 2012.**

### 6.1.5. Factors associated with uptake of PITC

A logistic regression model was used to examine factors associated with uptake of PITC.

The bi-variate analysis revealed that , age group of 45-64 years old were 4.15 times more likely to not accept PITC than the age group of 15-24 years with [OR(95%CI) = 4.15(1.77, 8.65)]. The odds of not to accept PITC was 4 times higher for those who can read/write than illiterates [OR (95% CI) =4.1(2.15-7.27)].

On the other hand acceptance for PITC is not significantly associated with sex, Residence, religion, ethnicity, marital status, occupation and income ( $P>0.05$ ).

Those who had not perceiving risk of acquiring HIV were 2.43 times more likely to not accept PITC than had perceiving risk of getting HIV [OR(95%CI)= 2.43(1.37, 4.33)].

Knowledge variables about HIV and means of HIV transmission, prevention and knowledge about PITC were not significantly associated with PITC acceptance ( $p>0.05$ ). Also, feeling that PITC is important and has an influence, and attitude toward those living with HIV related variable were also not significantly associated with PITC acceptance ( $p>0.05$ ).

Those who had not ever heard about PITC were 1.85 times more likely to not accept PITC than who have ever heard. [OR (95%CI) =1.85(1.09, 3.13)]. Individual who had not tested HIV before were 8.3 times more likely to not accept PITC than those who had ever tested [OR (95%CI) = 8.31(4.85, 14.79)].

In Bi-variate, variables that were found at ( $p<0.25$ ) were candidate for analysis of multivariate logistic regression analysis.

After adjusting independent variables; from all variables candidate for multivariate logistic regression analysis, educational status, self risk perceptions, and ever been tested for HIV have shown to have statistically significant association with acceptance of PITC.

Pertaining to the association of the variables, those who can read /write were two point five times more likely to not accept PITC than illiterates [AOR (95% CI)=2.47(1.08, 7.09)].

On the other hand , those who had not perceiving risk of acquiring HIV were 2.16 times more likely to not accept PITC than those who had perceiving risk [AOR (95% CI) =2.16(1.28, 5.44)].

And individual who had never tested HIV before were 8.2 times more likely to not accept PITC than those who had ever been tested [AOR (95% CI) =8.19(4.55, 14.61)].

**Table 6: Multivariate logistic regression analysis of factors with acceptance for PITC among OPD Clients of Pawie Hospital, Benishangul Gumuz, February, 2012**

<b>Variables</b>	<b>Not accepted</b>	<b>Accepted</b>	<b>Crude OR (95% CI)</b>	<b>Adjusted OR (95% CI)</b>
	<b>N (%)</b>	<b>N (%)</b>		
<b>Age</b>				
15-24	17(24.3)	119(37.9)	1.00	1.00
25-34	25(33.8)	106(33.8)	1.64 (0.85-3.15)	2.67 (0.95 -7.50)
35-44	15(20.3)	62(19.7)	1.60 (0.76- 3.39)	0.603 (0.17-2.05)
45-64	16(21.7)	27(8.6)	4.15(1.77-8.65) *	2.80(0.71-11.00)
<b>Education status</b>				
Illiterate	23(32.4)	167(52.9)	1.00	1.00
Read and write	32(43.2)	56(17.8)	4.1(2.15-7.27) *	2.47(1.08-7.09) *
Primary	8(10.8)	37(11.8)	1.5 (0.62-3.59)	0.54 (0.16-1.89)
Secondary &above	10(13.6)	55(17.5)	1.41 (0.65-3.06)	2.95(0.76-11.50)
<b>Self risk perception</b>				
Yes	17(24.3)	137(43.3)	1.00	1.00
No	56(75.7)	178(56.7)	2.43(1.37- 4.33) *	2.16(1.28-5.44) *
<b>Ever been tested for HIV</b>				
Yes	28 (38.4)	264 (83.5)	1.00	1.00
No	45 (61.6)	51(16.5)	8.3(4.85-14.79)*	8.19 (4.55-14.61) *
<b>Ever heard about PITC</b>				
Yes	44(59.5)	232(73.6)	1.00	1.00
No	29 (40.5)	83(26.4)	1.85 (1.09-3.13) *	1.67(0.66-4.24)

## **6.2. Qualitative study result**

### **6.2.1. In-depth interview participants**

A total of eight health workers in OPDs of Pawie hospital were involved in this in-depth interview. The participants were selected purposively include one medical doctor, two health officers, three diploma clinical nurses and two midwives. After in-depth each interview notes and records were first transcribed. Then each response were summarized and analyzed in groups of themes. Accordingly themes of analysis;

### **6.2.2. Acceptance of PITC recommendation by OPD client**

Questions regarding acceptance of PITC by clients in your hospital; all the interviewed health workers in the Hospital responded that, most OPD clients accept PITC recommendation especially those from rural part of the community even though there are some individuals who refuse PITC like some educated, and urban resident clients.

### **6.2.3. Reasons given for not accepting PITC recommendation**

Regarding reasons for refusing the test; In general, all of the in-depth interview participants (health workers) reported as they have encountered clients refusing PITC. The key informants tried to recall what has been said by the clients refusing the test. To cite some of them:

A 38 years old male health worker was one of the interviewed key informants. According to him, those not trust themselves were saying “...*let me think of it and better to make the test another time*”.

According to a 25 years old woman key informant; like religious leaders says “...*I trust my wife and I have no multiple sexual partners*”.

*40 years old men also respond that:* According to him, One day one lady said, “...*this result is not mine, might be changed*”.

Another 23 old women key informant recalled refusal: according to her, when we ask clients they give as different reasons like; “...since today my blood is turbid, I do not want to conduct HIV tested”, “... I do not want to make test here”. And “...I made HIV test before” But most health workers agreed that, clients who perceive them self at risk acquiring HIV were refuse the recommendation.

#### **6.2.4. Suggested measures to scale up PITC acceptance**

Most of the interviewed health workers underlined the following points to be done in future:

- Health education at community set up is in need.
- Sometimes due to kit problem PITC was missed. Therefore, Lack of HIV test kit should be resolved
- At community level awareness creation is required to test their partners
- Health information dissemination at ANC should be done
- PITC to be also done for EPI and Family planning users at hospital set up

## **CHAPTER SEVEN: DISCUSSION**

The results of this study demonstrated the uptake of PITC among OPD clients and its associated factors. Accordingly over half (51%) of the study subjects were male, 35.3% were between 15-24 years followed by 25-34 years old. The average age of the participants was 30 with  $SD \pm 10.7$ . Seventy eight point one percent of the participants were married, 80.2% were Orthodox Christians by religion, 78.9% Amhara, 45.9% were farmers and 49% were illiterates in education.

From all study participants, 287 (74.0%) reported that they had heard of HIV/AIDS which it is comparable with the study conducted in North Gondar Administrative Zone [28].

Majority (96.2%) of the respondents mentioned sexual intercourse as a means of HIV transmission which is comparable with a study conducted in Gurage Zone [29]. Similar to study conducted in Addis Ababa and EDHS report, only a few (2.7%) participants mentioned mother to child transmission as a means of HIV transmission. But in this study no subjects had misconception about HIV transmission which is consistent with studies done in Addis Ababa [21, 22, 23].

Majority of the participants mentioned abstinence 92.3% and faithfulness 90.2% as method of prevention, which is consistent with a study done Western Amhara Region (30). But which higher than DHS 2011 report [31]. This difference might be due to the fact that, since DHS report is over all country report, it could contribute for the observed difference.

Only 10.5 % participants mentioned condom as method of prevention, which is lesser than a study conducted in Addis Ababa 51.7%[21].The difference in this study and study of Addis Ababa might be due to the fact that, socio cultural and difference in access for information between urban and rural communities.

In this study, no one was knowledgeable about means of HIV transmission among participants and only 13 (4.5%) were knowledgeable about all the ABCs HIV prevention methods. This is lower than a study conducted in Addis Ababa with knowledge about HIV transmission 5.2% and about HIV prevention 27.6% [21]. For this difference Studies revealed that Knowledge of HIV preventions is higher among urban than rural people [31]. This implies that urban people could have access for information's which could help to explain the difference.

Only few (10.4%) of the participants reported high risk perception to HIV which is congruent to report of EDHS and study done in Addis Ababa 11% [9,21]. Studies identified personal risk perception as one of the predictor for accepting HCT [20], and in this study more than half (60.3%) of the study participants lack risk perception for HIV infection. This is also supported by the in-depth interview, service providers witnessed that some clients who refuse PITC were saying”...*I trust my wife and I have no multiple sexual partners.*” Such behaviour might be challenges in the future for scaling up of HCT which may create threat for subsequent treatment and prevention services.

Higher proportions of participants reported that they are willing to care at home for a relative with AIDS 355 (91.5%), willing to purchase from shops of HIV positive persons (78.4%) and believed that HIV positive teachers without symptom should be allowed to continue teaching (93.8%) which are comparable with the findings of Addis Ababa’s studies and EDHS 2011 report [21, 22, 31]. Overall, accepting attitudes regarding all situations was 187(48.2%) which is higher than EDHS 2011 report (27.6%).The difference might be since EDHS report is country wide, differences in the source of information, representativeness of the sample, and selection methodology all of which could help to explain the differences.

In this study self reported prevalence of HIV testing is 75.8%, this is in line with previous studies. A study done on Predictors of uptake by tuberculosis patients in South Africa found 73.6%self reported HIV testing [27] and a study done in Addis Ababa found 78.4% of TB patients had been tested for HIV [23].

In this study about 70.9% of the participants have heard about PITC and majority (94.9%) of them support it extremely/very much. Majority (89.1%) of study participants feel that PITC is important because, it helps the clients to get access for ART. A similar result was also reported from a study conducted on Tuberculosis Patients in Addis Ababa, where 94.1% of the study participants were extremely or very much in favor of routine HIV test [23]. And it is also supported by all in depth interviewed health workers. These results suggest that, PITC is beneficial in improving access to testing and thus the number of HIV-infected patients identified and linked to medical care and support services.



Most of the participants (80.9%) were willing to undergo PITC and this is also supported by all in-depth interviewed health workers which is comparable with studies in Dessie town, Addis Ababa and Zambia [19, 23, 26]. But lower than study conducted in Cameroon on tuberculosis patients with 94.7% [16]. This difference might be due to the fact that socio-cultural difference of the two countries.

All those who were willing to undergo PITC, accepted the pretest information and testing. And also almost all study subjects who were accepted the pretest session accepted the post test session, it is comparable with a study in Arba Minch [20]. This is also supported with in-depth interview result obtained from health workers in OPDs.

The overall uptake of PITC in this study is 80.7% which is comparable with a study done on tuberculosis patients in Addis Ababa [22]. This relative high uptake of PITC among OPD clients is window of opportunity for scale up of the approach in other setting which consequently will have an impact on prevention and control of HIV transmission.

The perceived facilitators for acceptance of PITC willing were TV/radio messages, knowing that the treatment is available, sickness, and health worker recommendation this is congruent to a study done on OPD clients with possible clinical sign of HIV infection in Addis Ababa in [21].

On other hand; reasons given as a barrier to accept PITC were being tested before , do not want to know the result, bad treatment by health providers, lack of risk perception for HIV and not sure of the confidentiality of test. These ideas were also supplemented with in-depth interviews results that the providers recall what had been said by clients; like” *...I do not want to make test here...*,” *let me think of it and better to made the test on other time*” and “*...since today my blood is turbid, I do not want to conduct HIV tested*” were some of the barriers that challenges PITC acceptance.

In this study , those who can read / write were two point five times more likely to not accept PITC than those illiterate [AOR (95% CI) =2.47(1.08-7.09)].This also supported with key informant Health works idea, “ *...individuals who refuse PITC were like some educated individuals* ”. Similarly, according to EDHS2011 report more education is associated with higher testing refusal rates .But study in Addis Ababa reported that the level of education was significantly associated with acceptance of testing [23].

Previous studies conducted on Tuberculosis Patient in Arba Minch and North West Ethiopia found that risk perception was predictor for HIV testing [20 , 24]. Similarly in this study, those who had not perceiving risk of acquiring HIV were 2.16 times more likely to not accept PITC than those who had perceiving risk [AOR (95% CI) =2.16(1.28, 5.44)]. This can be explained as, those individuals who had perceiving risk of acquiring HIV might have had better information and awareness about HIV/AIDS and PITC, and are more likely to accept PITC.

In addition to this, individual who had never tested HIV before were 8.2 times more likely to not accept PITC than those who had ever been tested [AOR (95% CI) =8.19 (4.55, 14.61)]. This can be explained as, those who had tested before could have more exposure of information /knowledge regarding HIV/AIDS before they came PITC services. This is Consistent with studies done in North West Ethiopia and Botswana [24, 26]. Which implies that, tested individual for HIV in any way before could result to more likely to uptake of PITC.

## **8. Strengths and Limitations**

### **8.1. Strength**

1. The study includes both quantitative and qualitative data.
2. Data collection was carried out by those trained in PITC counseling.

### **8.2. Limitation**

1. As this study is cross sectional, cause-effect could not be determined from findings
2. Self report might introduce socially desirable response

## **9. Conclusion and Recommendation**

### **9.1. Conclusion**

This study demonstrated that, the clients Knowledge on HIV transmission and prevention methods is low.

Larger segment of clients lacks self perceived risk of HIV infection.

Most clients expressed Stigmatizing attitude towards people living with HIV/AIDS.

A considerable proportion of study subjects have not heard about PITC. However, there was relatively high up take for PITC by clients. The key perceived facilitator for PITC willingness was TV/radio messages where as barrier was being tested before.

Lack of self perceived risk of HIV infection, those who can read/write and being not tested before were found to be negatively associated with uptake of PITC.

### **9.2. Recommendations**

1. FMOH and Regional Health Bureau should target IEC/BCC to the public, so as to improve Knowledge about HIV means of transmission and prevention.
2. FMOH and Regional Health Bureau should work to raise public Knowledge about PITC.
3. FMOH and Regional Health Bureau should make sure that all materials like test kits always available in health facilities.
4. FMOH of Ethiopia should make sure that every health facilities are implementing the PITC approach and work hard on the scale up, as the identified uptake in the study was promising for subsequent service provision in line with care, support, treatment and prevention.
5. Zonal Health Office and the health facility authorities should work to improve public knowledge about HIV means of transmission and prevention as well as to raise knowledge about PITC
6. For research; further studies should be done on client's aspect and on other aspects of PITC uptake.

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## **Annexes**

### **Annex I: Structured English Version Questionnaire**

#### **Jimma University**

#### **College of Public Health and Medical Sciences**

Questionnaire for assessment of Uptake of the Provider Initiated HIV Testing and Counseling and its associated factors among OPD clients, Pawie Hospital, Benishangul Gumuz, North West, Ethiopia

**01.** Questionnaire identification number -----

#### **1. Information sheet**

I am a master's student in public health at Jimma University, and I am currently working on a thesis concerning assessment of the uptake of PITC and its associated factors among OPD clients of Pawie Hospital. You are selected to be one of the participants in the study. The study will be conducted through interview and your name is not going to be required (registered) and the information you give us will be kept confidential and will be used only for study purpose. A code number will identify every participant and no names will be used. If a report of the result is published, only summarized information of the total group will appear. The interview as well the use of information, which is extracted while providing the service, is voluntary; you have the right to participate, or not to participate (refuse to do so) at any time during the interview. Your refusal will not have any effect on services that you or any member of your family receives. However, your participation is important to fulfill the study and in order to help design appropriate HIV testing strategy in health facilities in Pawie Hospital and other similar setups. Ten to fifty minutes of your time is all that it will require.

#### **Was the information/objective clear?**

1.  Yes
2.  No

#### **Are you willing to participate in the study?**

1.  Yes
2.  No

Thank you!!



**2. Consent form**

I have been informed about this study and understand its purpose and objective.

I have been informed that the information I give will be used only for the purpose of this study; my identity, the information I give will be treated confidentially. I have also been informed that I can refuse to participate in the study, not to respond to question I am not interested or stop responding to question at any time in the process. Based on the above information I agree to participate in the study voluntarily.

Signature of respondent-----Date-----

Signature of the interviewer-----Date-----

**3. Result**

- a. Completed
- b. Respondent not available
- c. Refused
- d. Partially completed
- e. Other (please specify) -----

**4. Checked by supervisor**

Name -----signature----- date -----

NB:

- 1. No need of coercing the patients to be included in the study.

**Part One: Socio-Demographic Variables**

No	Questions	classifications	Remark
101	How old are you at your last Birth day?	Years (Completed years))_____	
102	Sex of the client	1.Male 2.Female	
103	Residence	Specific_____	
104	What is your religion?	1.Orthodox 2.Muslim 3.Protestant 4.Catholic 5. Other (specify)..... .....	
105	To which ethnic group do you belong?	1.Amhara 2.Gumuze 3.Shenasha 4.Berta 5.Tigray 6. Kumbat 7.Agew 8. Others (specify)..... .....	

106	What is your current marital status?	1.Married 2.Single 3.Divorced 4.Widowed 5.Living together	
107	What is your educational status?	1.Illiterate 2.Read and write 3.Primary school 4.Secondary school 5.Tertiary level	
108	What is your current occupation?	1. Merchant 2. Farmer 3. House wife 4. Student 5. Government employee 6. NGO employee 7. Un employed 8. Other (Specify)..... .....	
109	What is your average Household income per month?	1. In cash: .....Eth. Birr 2.No income 99.No response	

**Part Two: - Knowledge about HIV/AIDS**

No	Questions	Classifications	Skip to
201	Have you ever heard of HIV or the disease called AIDS?	1.Yes 2.No-----> 99.No response	<b>Stop here</b>
202	Can HIV be cured?	1.Yes 2.No 99.No response	
203	How is HIV/AIDS Transmitted? <b>(Multiple response is possible, Needs probing)</b>	1.Sexual intercourse 2.Mother to Child during pregnancy 3.Mother to Child during breastfeeding 4.Transfusion of infected blood 5.Sharing of Sharps with someone who is infected(Needles, etc) 6.shaking hands a person living With HIV/AIDS 7.wearing clothes of a person living with HIV/AIDS 8.sharing a meal with a person living with HIV/AIDS 9.Mosquito bite 10.Blood contact 11.Other(Specify)..... 99.No response	

204	<p>How can people protect themselves from getting HIV/AIDS?</p> <p><b>(Multiple response is possible, Needs probing)</b></p>	<p>1.Avoiding Sex (abstinence)</p> <p>2.Using a condom every time during sex</p> <p>3.Staying with only one uninfected partner faithful</p> <p>4.Others (specify).....</p> <p>88.I don't know</p> <p>99.No response</p>	
205	<p>Do you know anyone who is infected with HIV or who has died of AIDS?</p>	<p>1.Yes</p> <p>2.No</p> <p>99.No response</p>	
206	<p>May a healthy looking person be positive for HIV?</p>	<p>1.Yes</p> <p>2.No</p> <p>99.No response</p>	

**Part three: Personal risk perception**

No	Questions	Classifications	Skip to
301	Do you think you can get the virus?	1.Yes 2.No-----→ 99.No response	<b>Q 304</b>
302	What are your chances of getting infected with HIV?	1. High 2. Medium 3. Low-----→ 99.No response -----→	<b>Q304</b> <b>Q401</b>
303	If the answer is medium or high, what are the reasons?	1.I had multiple sexual partner 2.I had sexual contact without Condom 3.I had injection with unsterile needle 4.I had sexual contact with HIV positive person 5.Other (specify)..... 99.No response	
304	If your response is no to question number 301, what are the reasons?	1. I trust my sexual partner. 2.No injection with unsterile needle 3.I always use condom 4. Other (specify)..... ..... 5.No response 99.No response	

**Part four; Stigmatizing Attitude towards people living with HIV/AIDS**

No	Questions	Classification	Skip to
401	Would you be willing to share a meal with a person you knew had HIV/AIDS?	1. Yes 2. No 88. I do not know 99.No response	
402	If a Family member/Relative of yours became ill with HIV, the virus that causes AIDS, would you be willing to care for him/her in your own household?	1. Yes 2. No 88. I do not know 99.No response	
403	If you knew a shopkeeper or food seller had HIV, would you buy food from them?	1. Yes 2. No 88. I do not know 99.No response	
404	If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret.	1. Yes 2. No 88.I do not know 99.No response	
405	If a teacher has the HIV virus but is not sick, should he/she be allowed to continue teaching?	1. Should be allowed 2. Shouldn't be allowed 88.I don't know 99.No response	

**Part five: provider-initiated HIV counseling and testing.**

s. No	Questions	Classifications	Skip to
501	Have you ever heard of PITC?	1.Yes 2.No -----> 99.No response	<b>Q 508</b>
502	If your response to Q501 is yes, where did you get the information? <b>(Multiple response is possible, Needs probing)</b>	1.Health workers 2.Mass media 3.Family member 4.friends 5.Other(specify)..... 99.No response	
503	To what extent are you in favor of PITC?	1.Extremely in favor 2.Very much 3.Some what 4.Not at all 99.No response	
504	Did you feel that PITC is important?	1.Yes 2.No-----> 88.I don't know 99.No response	<b>Q 506</b>
505	If your response to Q504 is yes, what are the reasons for feeling that PITC is important?	1. Helps patients get access to ART is important? 2.Makes easier for clients to get tested 3.Results in less discrimination of HIV positive patients 4.Increase number of tested people 5.Other(specify)..... 99.No response	



506	Did you feel that PITC has influence?	1.Yes 2.No-----> 3. I don't know 99.No response	<b>Q508</b>
507	If your response to Q506 is yes, what are the reasons for feeling that PITC has influence?	1.Will cause patients to avoid seeing health professionals for fear of being tested 2.Violet patients human right 3.Leads to more violence Against women 4.Other(specify)..... 99.No response	
508	Do you agree that any one should check his /her HIV sero-status?	1.Yes 2.No 99.No response	
509	At which time should one be tested for HIV? <b>(Multiple response is possible, Needs probing)</b>	1.When one is sick 2.Before marriage 3.If only has multiple partners 4.At any time 5.Other (specify)..... 99.No responses	
510	Who are people in need of HIV test? <b>(Multiple response is possible, Needs probing)</b>	1.Female commercial sex workers 2.Drivers 3.People with history of unprotected sex 4.TB patients 5.Those with multiple partners	

		6. Any one sexually active 7. Those who are sick. 8. Any one at risk 9. Others (specify)..... 99. No responses	
511	Have you ever been tested for HIV?	1. Yes 2. No-----> 99. No response	<b>Q 514</b>
512	If your response to Q511 is yes, what was the reason of having HIV test?	1. Voluntary testing by your self 2. Initiated by health worker for diagnosis. 3. Donation of blood 4. Routine ANC 5. Others(specify)..... 99. No response	
513	If your response to Q 511 is yes, where did you do your test?	1. Gov't hospital 2. Gov't health center. 3. Stand alone VCT center 4. Private clinic/hospital 5. Others(Specify)..... 99. No response	
514	If your response to Q 511 is no, what are your reasons for not to be tested? <b>(Multiple response is possible, Needs probing)</b>	1. Fear of stigma and discrimination 2. Fear of partner's reaction 3. Unable to cope with the positive result 4. I am not risk person for HIV 5. Difficult to pay for VCT service 6. Belief as Being tested is not useful	

		<p>7. Not sure of the confidentiality</p> <p>8. Don't want to know the result</p> <p>9. Partners trust</p> <p>10. self trust</p> <p>11. Other (specify).....</p> <p>99. No response</p>	
515	Are you willing to take HIV the test?	<p>1. Yes, I am willing</p> <p>2. No, I am not willing-----&gt;</p> <p>3. I don't know</p> <p>99. No response</p>	<b>Stop here</b>
516	Record if the client accepted the pretest counseling and testing session	<p>1. Accepted</p> <p>2. Not accepted</p> <p>3. I don't know</p> <p>99. No response</p>	
517	Record if the client accepted the Post test counseling session.	<p>1. Accepted</p> <p>2. Not accepted-----&gt;</p> <p>3. I don't know</p> <p>99. No response</p>	<b>Q519</b>

518	<p>If your response to Q517 is yes ,what were the reasons to be tested?<b>(Facilitators)</b></p> <p><b>(Multiple response is possible, Needs probing)</b></p>	<ol style="list-style-type: none"> <li>1.TV/Radio messages</li> <li>2.Knowing that treatment is available</li> <li>3.Knowing that test results will be confidential</li> <li>4.Heard that I could take test and get result on the same day</li> <li>5.Was encouraged by someone who was tested</li> <li>6.Was worried about the previous sexual contact</li> <li>7.Parents/family/friends advised to have test</li> <li>8.Was sick</li> <li>9.Because you recommend it</li> <li>10.other(specify).....</li> <li>99.No response</li> </ol>	
519	<p>If your response to Q517 is no, what were your reasons for not being willing to be tested?<b>(Barriers)</b></p> <p><b>(Multiple response is possible, Needs probing)</b></p>	<ol style="list-style-type: none"> <li>1.Fear of stigma and discrimination following the positive result</li> <li>2.Fear of partner’s reaction</li> <li>3.Unable to cope with the positive result</li> <li>4.I am not risk person for HIV</li> <li>5.Fear of discrimination (bad treatment) by health providers</li> <li>6.No access to good quality clinic</li> <li>7.Other people advised not to test</li> <li>8.Belief that testing is not useful</li> </ol>	

		9. Not sure of the confidentiality 10. Don't want to know the result 11. Partners trust 12. Tested before 13. Other (specify)..... 99. No response	
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**Do you have any question? That is the end of my interview.**

**Thank you very much for taking time to answer these questions.**

## **Annex II: In-depth Interview guide**

### **Instruction:**

My name is..... and I am working a research on assessment of uptake of provider initiated HIV testing and counseling and its associated factors among OPD Clients in Pawie Hospital. Your presence is very important. We are going to have group discussion. I will ask you very general questions.

Please take a few minutes to tell me your experiences about uptake of PITC of OPD clients in this Hospital. I am interested in all your ideas, comments and suggestions. There are no rights or wrong answers. All comments, both positive and negative, are welcome.

If you don't mind, I will record (audiotape) the discussion. The purpose is to ensure that I don't miss anything you said. All comments are confidential, used for research purposes only.

Are you willing to participate in the interview?

YES  → **Thanks for willing.**

NO  → **Thanks stop interviewing**

### **Points for In-depth Interview for Health Professional**

#### **Part I**

1. Please check the appropriate category
  1. Male
  2. Female
2. What is your current age in a complete year? \_\_\_\_\_
3. What is your profession? \_\_\_\_\_

## Part II

1. What do you say about importance of Provider initiated HIV/ADIS counseling and test?
2. For whom it is offered in your hospital?
3. How is the acceptability of PITC test in your Hospital?
4. Is there anyone who refuses or not accept test?
5. Why do you think that they do not accept the offered test?
6. Who refuses PICT Service in your hospital?
7. what trials are/were made in your hospital to increase acceptance of PITC by Clients
8. What activities to be made in order to improve the services to all clients in your Hospital?

### Annex III: Amharic Questionnaire

#### በአማርኛ የተዘጋጀ ቅጽ

በጅም ዩኒቨርሲቲ የህብረተሰብ ጤናና ህክምና ሳይንስ ኮሌጅ

ይህ መጠይቅ በፓዊ ሆስፒታል በቤ/ጉ/ክ/መ/ በተመላላሽ ህክምና ክፍል የሚታከሙትን ህሙማን በጤና ባለሙያ አነሳሽነት ለሚደረግ የኤች.አይ.ቪ ምርመራ እና ምክር አገልግሎት አቀባበል /አወሳሰድ ሁኔታ የተመለከተ ጥናት።

01 የመጠይቅ የመለያ ቁጥር \_\_\_\_\_

#### 1. መረጃ ቅጽ

እኔ የጅም ዩኒቨርሲቲ የህብረተሰብ ጤና የድህረ ምረቃ ስሆን ጥናቱም በተመላላሽ ህክምና ክፍል ውስጥ ለመታከም በፓዊ ሆስፒታል የሚመጡ በጤና ባለሙያ አነሳሽነት ለማድረግ የኤች.አይ. ቪ ምርመራና ምክር አገልግሎት አቀባበል ሁኔታ ቃለ መጠይቅ አደርጋለሁ ። እርስዎም በዚህ ጥናት ተሳታፊ እንዲሆኑ ተመርጠዋል ። ይህ ጥናት የሚካሄደው በቃለመጠይቅ ሲሆን ። በቃለ መጠይቁ ላይ ስም አይመዘገብም እንዲሁም የሚሠጡት መረጃ በሚስጥር ይያዛል ። የመረጃው ጠቀሜታው ለዚህ ጥናት ብቻ ነው ። ለሁሉም ተሳታፊ መለያ ቁጥር እንጂ ስም አይጻፍም ። የጥናቱ ሪፖርት ለመታተም ቢፈለግ እንኳን የሁሉም ተሳታፊ መረጃ በተቀናበረ መልኩ እንጂ በግል አይቀርብም ። ቃለመጠይቁም ሆነ በምርመራ ወቅት የሚሰበሰቡትን መረጃዎች የመጠቀም ሁኔታ በፈቃደኝነት ላይ የተመሰረተ ነው ። እርስዎም በዚህ ጥናት ውስጥ የመሳተፍ ያለመሳተፍ ወይም በማንኛውም ወቅት መጠይቁን የማቋረጥ ሙሉ መብትዎ የተጠበቀ መሆኑን እናረጋግጣለን ። ሆኖም ባለመሳተፍዎ የሚያገኙት አገልግሎት ላይ ምንም ዓይነት ተጽኖ አይኖረውም ። ነገር ግን እርስዎ በጥናቱ ተሳትፈው የሚሰጡት መረጃ የጥናቱን ዓላማ ለማሳካትና የኤች.አይ.ቪ ምርመራ በተመለከተ ለሚደረጉ እንቅስቃሴዎች ጉልህ የሆነ ሚና ይጫወታል።

መረጃ ዓላማው ግልጽ ነው

1. አዎን 2. የሰም

በጥናቱ ላይ ስመሳተፍ ፈቃደኛ ነዎት?

2. አዎ 2. አይደለም

አመሰግናለሁ።

ፈቃደኛ ከሆነ/ች ወደ ቃለ መጠይቁ ይገቡ

#### 02. ተሳታፊው/ዋ የፈቃደኝነት ማረጋገጫ ቅጽ

ስለጥናቱ በቂ የሆነ መረጃ ተሰጥቶኛል የጥናቱንም አሳማ በሚገባ ተረድቼዋለሁ። የተነገራኝን ዝርዝሮች የተረዳሁ ሲሆን በጥናቱ ስመካፈል የሚያስፈልጉትን ቅድመ ሁኔታዎች ተገንዝቤያለሁ። እናም በጥናቱ ስመካፈል ፈቃደኛ ነኝ።  
የተሳታፊው/ዋ ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_  
የቃለመጠይቅ አድራጊው ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_

#### 03. ውጤት

- ሀ. የተጠናቀቀ ስ. ተጠያቂው አልተገኘም
- ሐ. ተጠያቂው ፈቃደኛ አይደለም መ. በክፍል የተመለሰ
- ሠ. ሴሳ ካስ ይገለጽ

04. በተቆጣጣሪው ደረጃ ገጥ ስም \_\_\_\_\_ ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_  
ማሳሰቢያ

- 1. ግለሰቦች በመጠይቁ እንዲሳተፉ ለማድረግ ምንም አይነት ጫናና ማስገደጃ ማድረግ አይስፈልግም።
- 2. በጥናቱ ስመሳተፍ ፈቃደኛ ካልሆነ/ች የግለሰቡን እድሜና ጾታ ይመዘገቡ።



ክፍል አንድ: ስለማህበራዊ ሁኔታ የሚያመለክቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች	አስተያየት
101	እድሜዎ ስንት ነው?	_____ ዓመት/በመሉ ዓመት ይገለፅ	
102	የተጠያቂው ፆታ	1. ወንድ 2. ሴት	
103	መኖርያዎ የት ነው?	_____	
104	ሐይማኖትዎ ምንድን ነው?	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ ካለ ይገለፅ 99. መልስ የለም	
105	ብሔርዎ- ምንድን ነው?	1. አማራ 2. ገመዝ 3. ቩ-ቫ 4. በርባ 5. ት.ሬ 6. ከምጠባ 7. ስገጦ 8. ሌላ ካለ ይገለፅ  99. መልስ የለም	
106	በአሁኑ ወቅት የጋብቻ ሁኔታዎ እንዴት ነው?	1. ያገቡ 2. ያላገቡ 3. የተፋቱ 4. ባል/ሚስት የሞተባቸው 5. ያልተጋቡ ጥንዶች	
107	የትምህርት ደረጃ ስንት ነው?	1. ያልተማረ 2. ማንበብና መፃፍ የሚችል 3. አንደኛ ደረጃ ያጠናቀቀ 4. ሁለተኛ ደረጃ ያጠናቀቀ 5. ከፍተኛ ደረጃ ያጠናቀቀ	
108	በአሁኑ ወቅት ያሉብት የስራ አይነት ምንድን ነው?	1. ነጋዴ 2. ገበሬ 3. የቤት እመቤት 4. ተማሪ 5. የመንግስት ሰራተኛ 6. መንግስታዊ ያልሆነ ድርጅት ሠራተኛ 7. ስራ የሌለው 8. ሌላ ካለ ይገለፅ	
109	ጠቅላላ የቤተሰብ አማካይ የወር ገቢ ስንት ነው?	1. _____ የኢ/ሳ/ሳ  2. ገቢ የሌለው  99. መልስ የለም	

**ክፍል ሁለት፡ ስለ ኤች.አይ.ቪ. ኤድስ. የለዎትን እውቀት አስተያየት**

ተ.ቀ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች	አስተያየት
201	ኤች አይ ቪ/ኤድስ በሽታ ሰምተው ያውቃለ?  	<ol style="list-style-type: none"> <li>1. አዎ ሰምቻለሁ</li> <li>2. አልሰማሁም</li> <li>99. መልስ የለም</li> </ol>	<p>መልስዎ አልሰማሁም</p> <p>ከሆነ ቃለመጠይቁን እዚህ ላይ ይጨርሱ</p>
202	የኤች አይ ቪ ኤድስ በሽታ ፈዋሽ መድኃኒት ያለው ይመስልዎታል?  	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. የለውም</li> <li>88. አላውቅም</li> <li>99. መልስ የለም</li> </ol>	
203	የኤች አይ ቪ ኤድስ በሽታ በምን መንገድ ሊተላለፍ ይችላል?  ከአንድ በላይ መልስ ይቻላል።  <b>አታንብበው የሚሰጡትን መልስ አክብብ</b>	<ol style="list-style-type: none"> <li>1. በግብረ ሥጋ ግንኙነት</li> <li>2. ከእናት ወደ ፅንሰ በእርግዝና ጊዜ</li> <li>3. ከእናት ወደ ልጅ በጡት በመጥባት</li> <li>4. በኤች አይ ቪ ኤድስ የተበከለ ደም መቀበል</li> <li>5. ኤች አይ ቪ ኤድስ ከያዘው ሰው ጋር በጋራ ስለታም ነገሮችን መጠቀም</li> <li>6. መጨባበጥ</li> <li>7. የኤች አይ ቪ ኤድስ በሽታኛ ልብሶች መልበስ</li> <li>8. ኤች አይ ቪ ኤድስ ከያዘው ሰው ጋር አብሮ መመገብ</li> <li>9. በወባ ትንኝ</li> <li>10. በደም ንክኪ</li> <li>11. ሌላ ካለ ይገለፅ</li> <li>99. መልስ የለም</li> </ol>	
204	አንድ ሰው በኤች አይ ቪ ኤድስ እንዳይያዝ በምን መንገድ መከላከል ይቻላል?  <b>-ከአንድ በላይ መልስ ይቻላል።</b>  <b>አታንብበው የሚሰጡትን መልስ አክብብ</b>	<ol style="list-style-type: none"> <li>1. ከግብረ ስጋ ግንኙነት በመቆጠብ</li> <li>2. ግብረ ስጋ ግንኙነት በፈፀሙ ቁጥር ከንደም መጠቀም</li> <li>3. ከበሽታ ነፃ ከሆነ/ች ጋር አንድ ለአንድ መወሰን</li> <li>4. ሌላ ካለ ይጠቀስ</li> <li>88. አላውቅም</li> <li>99. መልስ የለም</li> </ol>	
205	ከኤች አይ ቪ ጋር የሚኖር አልያም በኤድስ በሽታ የታመመ ወይም በበሽታው የሞተ ሰው ያውቃለ?  	<ol style="list-style-type: none"> <li>1. አውቃለሁ</li> <li>2. አላውቅም</li> <li>99. መልስ የለም</li> </ol>	
206	ጤነኛ የሚመስሉ ሰዎች የኤች አይ ቪ ቫይረስ ሊኖርባቸው ይችላል?  	<ol style="list-style-type: none"> <li>1. ይችላል</li> <li>2. አይችልም</li> <li>99. መልስ የለም</li> </ol>	

**ክፍል ሦስት: ስለ ኤች አይ ቪ ኤድስ የመጋለጥ ግላዊ እሳቤ**

ተ.ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች	አስተያየት
301	የኤች አይ ቪ ቫይረስ ሊይዘኝ ይቻላል ብለው ያስባሉን?	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አላስብም</li> <li>99. መልስ የለም</li> </ol>	መልሱ አላስብም ከሆነ ወደ ቁጥር 304 ይህዱ
302	የራስዎ የኤች አይ ቪ/ኤድስ ተጋላጭነት ምን ያህል ይመስልዎታል?	<ol style="list-style-type: none"> <li>1. አነስተኛ ተጋላጭ ነኝ</li> <li>2. መካከለኛ ተጋላጭ ነኝ</li> <li>3. በጣም ተጋላጭ ነኝ</li> <li>99. መልስ የለም</li> </ol>	መልሱ አነስተኛ ተጋላጭ ነኝ ከሆነ ወደ ቁጥር 401 ይህዱ
303	የጥያቄ 302 መልስ መካከለኛ/ በጣም ተጋላጭ ከሆነ ምክኒያቱ ምንድነው? <b>ከአንድ በላይ መልስ ይቻላል</b>	<ol style="list-style-type: none"> <li>1. ያለ ኮንዶም የግብረ ስጋ ግንኙነት ስለፈጸምኩ</li> <li>2. ኤች አይ ቪ ፖዘቲቭ ከሆነ ሰው ጋር የግብረ ስጋ ግንኙነት ስለፈጸምኩ</li> <li>3. ብዙ የወሲብ ንደኞች ስለነበሩኝ</li> <li>4. ሌላ ሰው በተጠቀመበት መርፌስለተጠቀምኩ</li> <li>5. ሌላ ካለ ይጠቀስ</li> <li>99. መልስ የለም</li> </ol>	
304	የጥያቄ 301 መልስ አላስብም ከሆነ ምክኒያቱ ምንድን ነው?	<ol style="list-style-type: none"> <li>1. በአንድ ሰው ተወስኜ ስለምኖር</li> <li>2. በተበከለ መርፌ ስለማልጠቀም</li> <li>3. ሁልጊዜ ኮንዶም ስለምጠቀም</li> <li>4. ሌላ/ይጠቀስ/</li> <li>99. መልስ የለም</li> </ol>	

**ክፍል አራት፡፡ ከኤች አይ ቪ ጋር የሚኖሩ ሰዎችን የማግለል አመለካከት በተመለከተ**

ቁጥር	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች	አስተያየት
401	የኤች አይ ቪ ቫይረስ በደሙ ውስጥ ካለ ሰው ጋር ምግብ አብሮ ለመመገብ ፈቃደኛ ናት?	1. አዎ 2. አይ  88. አላውቀውም  99. መልስ የለም	
402	በቤተሰብ ውስጥ ወይም ከዘመድ መሀል አንድ ሰው በኤች አይ ቪ ቫይረስ ቢያዝ በራሱ ቤት ውስጥ ሰውየውን/ሴትየዋን ለመንከባከብ ፈቃደኛ ናት?	1. አዎ _____1 2. አይ _____2 88. አላውቀውም  99. መልስ የለም	
403	አንድ ባለስቅ/ምግብ ሻጭ በቫይረሱ እንደተያዘ ቢያውቁ ዕቃ/ምግብ ይገዙታል?	1. አዎ 2. አይ  88. አላውቀውም  99. መልስ የለም	
404	ከቤተሰብ አባል ውስጥ አንዳቸው በኤች አይ ቪ ቢያዙ ሚስጥር ሆኖ እንዲቆይ ይፈልጋሉ?	1. አዎ 2. አይ 3. አላውቀውም 4. መልስ የለም	
405	አንድ መምህር በቫይረሱ ከተያዙ ነገር ግን ምንም የሀመም ምልክት ከሌለባቸው ማስተማር እንዲቀጥሉ መፈቀድ አለበት?	1. አለበት 2. የለበትም 88. አላውቀውም  99. መልስ የለም	

**ክፍል አምስት፡ በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎት አጠቃቀም**

ተ.ቀ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች	አስተያየት
501	በጤና ባለሙያ አነሳሽነት ኤች አይ ቪ ኤድስ ምክርና ምርመራ አገልግሎት መኖሩን ስምተው ያውቃሉ?	1. ሰምቻለሁ 2. አልሰማሁም 99. መልስ የለም	መልሱ አልሰማሁም ከሆነ ወደቁጥር የተመሠረተ የኤች 508 ይህዱ
502	ለቁጥር 501 መልሱ ሰምቻለሁ ከሆነ መረጃው ከየት ነው ያገኙት? <b>ከአንድ በላይ ምለስ ይቻላል።</b> <b>ኢታንብበው የሚሰጡትን</b> <b>አክብብ</b>	1. ከጤና ባለሙያዎች/ተቋማት 2. ብዙሀን መገናኛ 3. ከቤተሰብ 4. ከጓደኛ 5. ሌላ ካለ ይጠቀስ 99. መልስ የለም	
503	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ኤድስ ምክርና ምርመራ አገልግሎትን ምን ያክል ይደግፋሉ?	1. እጅግ በጣም 2. በጣም 3. በመጠኑ 4. አልደግፍም 99. መልስ የለም	
504	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምክርና ምርመራ አገልግሎት ጠቃሚ ነው ብለው ያስባሉ?	1. አዎ 2. አይጠቅምም 88. አላውቀውም 99. መልስ የለም	መልሱ እይጠቅምም ከሆነ ወደ 506 ይህድ
505	በቁጥር 504 መልሱ አዎ ከሆነ በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምክርና ምርመራ ለህመማን መጀመሩ ምን ጥቅም አለው ብለው ያስባሉ? <b>/ከአንድ በላይ መልስ ይቻላል/</b>	1. ህመማን የፀረ ኤድስ መድኃኒት እንዲያገኙ ይረዳል 2. ህመማን በቀላሉ እንዲመረመሩ ያደርጋል 3. ኤች አይ ቪ ፖዘቲቭ በሆኑ ህመማን ላይ የሚደረግ አድልዎ ይቀንሳል 4. የተመርማሪ ቁ ር እንዲጨምር ያደርጋል 5. ሌላ ካለ ይገለጽ 99. መልስ የለም	

506	<p>በጤና ባለሙያ አነሳሽነት</p> <p>ላይ የተመሰረተ የኤች አይ ቪ ምክርና ምርመራ አገልግሎት ተፅዕኔ ለው ብለው ያስባሉ</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. የለውም</li> </ol> <p>88. አላውቀውም</p> <p>99. መልስ የለም</p>	<p>መልሱ የለውም ከሆነ ወደ 508ይሂዱ</p>
507	<p>በቀጥታ 506 መልስ አዎ ከሆነ በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምክርና ምርመራ አገልግሎት መጀመር ምን ተፅዕኖ ይኖረዋል ብለው ያስባሉ?</p> <p><b>-ከአንድ በላይ መልስ ይቻላል</b></p>	<ol style="list-style-type: none"> <li>1. ህሙማን የኤች አይ ቪ ምርመራን በመፍራት ወደ ህክምና ማዕከል እንዳይሄዱ ያደርጋል</li> <li>2. የህሙማን ሰብአዊ መብት ሊጥስ ይችላል</li> <li>3. በሴቶች ላይ የታወቀ ጥቃት እንዲደርስ ያደርጋል</li> <li>4. ሌላ ካለ ይጠቀስ</li> </ol> <p>99. መልስ የለም</p>	
508	<p>ማንኛውም ሰው የኤች አይ ቪ ምርመራ ማድረግ አለበት ብለው ይስበሉ?</p>	<ol style="list-style-type: none"> <li>1. አዎ</li> <li>2. አልስማማም</li> </ol> <p>99. መልስ የለም</p>	
509	<p>አንድ ሰው የኤች አይ ቪ ምርመራ ማድረግ ያለበት መቼ ነው?</p> <p><b>-ከአንድ በላይ ምልስ ይቻላል::</b></p> <p><b>አታንብበው የሚሰጡትን አክብብ</b></p>	<ol style="list-style-type: none"> <li>1. ሲታመም</li> <li>2. ከጋብቻ በፊት</li> <li>3. ከአንድ በላይ ወሲብ ጓደኛ ሲኖረው</li> <li>4. በማንኛውም ጊዜ</li> <li>5. ሌላ ካለ ይጠቀስ</li> </ol> <p>99. መልስ የለም</p>	
510	<p>የኤች አይ ቪ ምርመራ የሚያስፈልገው ለማን ነው ይላሉ?</p> <p><b>-ከአንድ በላይ ምልስ ይቻላል::</b></p> <p><b>አታንብበው የሚሰጡትን አክብብ</b></p>	<ol style="list-style-type: none"> <li>1. ለሴተኛ አዳሪዎች</li> <li>2. ለሾፊሮች</li> <li>3. ያለ ኮንዶም የግብረ ስጋ ግንኙነት ያደረገ/ች</li> <li>4. ለቲቢ ህሙማን</li> <li>5. ከአንድ በላይ ወሲብ ጓደኛ ያለው</li> <li>6. የግብረ ስጋ ግንኙነት ማድረግ የጀመረ/ች</li> <li>7. ለታመሙ ሰዎች</li> <li>8. ማንኛውም ሰዎች አይ ቪ ተጋላጭ ስሆነ ሰው</li> <li>9. ለማንኛውም ሰው</li> <li>10. ሌላ ካለ ይጠቀስ</li> </ol> <p>99. መልስ የለም</p>	

511	<p>የ ኤች አይ ቪ ምርመራ አድርገው ያውቃሉ?</p>	<ol style="list-style-type: none"> <li>1. ተመርምራ አውቃለሁ</li> <li>2. ተመርምራ አላውቅም</li> </ol> <p>99. መልስ የለም</p>	<p>መልስዎ ተመርምራ  አላውቅም ከሆነ ወደ ቀጥር 514 ይሂዱ</p>
512	<p>ለቀጥር 511 መልስዎ አዎ ከሆነ በምን ምክንያት ነበር የ ኤች አይ ቪ ምርመራ ያደረጉት?</p>	<ol style="list-style-type: none"> <li>1. በራሴ ፍላጎትና ጥያቄ</li> <li>2. በጤና ባለሙያ ትዕዛዝ</li> <li>3. የደም ልገሳ ለማድረግ</li> <li>4. በእርግዝና ክትትሉ ገዜ</li> <li>5. ሌላ ካለ ይጠቀስ</li> </ol> <p>99. መልስ የለም</p>	
513	<p>ለ511ኛው ጥያቄ መልሱ አዎ ከሆነ የኤች አይ ቪ ምርመራ ያደረጉት የት ነው?</p>	<ol style="list-style-type: none"> <li>1. የመንግስት ሆስፒታል</li> <li>2. የመንግስት ጤና ጣቢያ</li> <li>3. ለኤች አይ ቪ የምርመራ አገልግሎት ብቻ የሚሰጡ ድርጅቶች</li> <li>4. የግል ሆስፒታል /ክሊኒክ</li> <li>5. ሌላ ካለ ይጠቀስ</li> </ol> <p>99. መልስ የለም</p>	
514	<p>ለቀጥር 511 መልስዎ ተመርምራ አላውቅም ከሆነ በምን ምክንያት ነው የ ኤች አይ ቪ ምርመራ ያላደረጉት? <b>ከአንድ በላይ መልስ ይቻላል።</b> <b>አታንብበው የሚሰጡትን ሁሉ መልስ አክብበው</b></p>	<ol style="list-style-type: none"> <li>1. አድልዎና መገለል በመፍራት</li> <li>2. የጓደኛ ቁጣ መፍራት</li> <li>3. ውጤት ለመቀበል ስለምፈራ</li> <li>4. ኤች አይ ቪ ይይዘኛል ብዬ ስለማላስብ</li> <li>5. የኤች አይ ቪ ምርመራ ዋጋመክፈል ስለማልችል</li> <li>6. መመርመር ጥቅም አለው ብዬ ስለማላምን</li> <li>7. ሚስጢራዊነቱን መጠበቁን ስለምጠራጠር</li> <li>8. ውጤቱን ማወ ስለማልፈልግ</li> <li>9. ጓደኛዬን ስለማምነው</li> <li>10. ራሴን ስለማምነው</li> <li>11. ሌላ ካለ ይጠቀስ</li> </ol> <p>99. መልስ የለም</p>	
515	<p>የኤች አይ ቪ ምርመራና ምክር አገልግሎት ለመቀበል መጀመሪያ ፈቃደኝነትዎን ማረጋገጥ እፈልጋለሁ። ፈቃደኛ ኖት?</p>	<ol style="list-style-type: none"> <li>1. አዎ ፈቃደኛ ነኝ</li> <li>2. አይ ፈቃደኛ አይደለሁም</li> </ol> <p>88. አላውቀውም</p> <p>99. መልሱ አልተሰጠም</p>	<p>መልሱ ፈቃደኛ አይደለሁም ከሆነ ወደቀጥር 517 ይህዱ</p>
516	<p>ለጥያቄ 515 መልሱ አዎ ከሆነ አገልግሎቱን ለመቀበል ምን አነሳሳህ /ሽ? <b>ከአንድ በላይ መልስ ይቻላል?</b></p>	<ol style="list-style-type: none"> <li>1. በሬዲዮ/ቲቪ የሚነገሩ መልዕክቶች</li> <li>2. መድኃኒቱ መኖሩን ማወቄ</li> <li>3. ውጤቱ በሚስጥር እንደሚያዝ በማወቀ</li> <li>4. በአንድ ቀን ውስጥ ተመርምሮ</li> </ol>	

	<p><b>አታንብበው የሚሰጡትን</b></p> <p><b>አክብብ</b></p>	<p>ውጤት ማወቅ ስለሚቻል</p> <p>5. ከዚህ በፊት ተመርምሮ በሚያውቅ ሰው ተገፋፍቶ</p> <p>6. በፊት ስለነበረኝ የግብረሰጋ</p> <p>ግንኙነት በመጨነቅ</p> <p>7. ቤተሰቦቼና ጓደኞቼ ስለመከፋፈል</p> <p>8. ስለታመምኩ</p> <p>9. እርሶ ስላዘዙኝ</p> <p>10. ሌላ ካለ ይጠቀስ</p> <p>99. መልሱ አልተሰጠም</p>	
517	<p>ለጥያቄ 515 መልሱ አይ ከሆነ አገልግሎቱን ላለመቀበል ምክንያቶች/እንቅፋቶችን ይጠቀሱ?</p> <p><b>-ከአንድ በላይ መልስ ይቻላል?</b></p>	<p>1. አድልዎና መገለል በመፍራት</p> <p>2. በባለሙያ አድልዎና መገለል በመፍራት</p> <p>3. የጓደኛ ቁጣ መፍራት</p> <p>4. ውጤት ለመቀበል ስለምፈራ</p> <p>5. ኤች አይ ቪ ይይዘኛል ብዬ ስለማሳሰብ</p> <p>6. ጥሩ እና ጥራት ያለው የህክምና ማዕከል አቅርቦት ስለሌለ</p> <p>7. ሌሎች ሰዎች እንዳልመረመር ስለመከሀ</p> <p>8. መመርመር ጥቅም አለው ብዬ ስለማ ላምን</p> <p>9. ሚስጢራዊነቱን መጠበቁን ስለምጠራጠር</p> <p>10. ውጤቱን ማወቅ ስለማልፈልግ</p> <p>11. ጓደኛዬን ስለማምነው</p> <p>12. ተመርምሮ ስለማውቅ</p> <p>13. ሌላ ካለ ይጠቀስ</p> <p>99. መልስ የለም</p>	
518	<p>ለጥያቄ 515 መልሱ አዎ ከሆነ የቅድመ ምርመራና ምክር አገልግሎቱን መቀበላቸውን ይመዝገቡ</p>	<p>1. በሽተኛው ተቀብለዋል</p> <p>2. አልተቀበሉም</p> <p>88. አላውቀውም</p> <p>99. መልሱ አልተሰጠም</p>	<p>መልሱ አይ ከሆነ ቃለመጠ ይቁን እዚህ ላይ ይጨርሱ</p>
519	<p>በሽተኛው የድህረ ምርመራ ምክርና አገልግሎት መቀበላቸውን ይመዝገቡ</p>	<p>1. ተቀብለዋል</p> <p>2. አልተቀበሉም</p> <p>88. አላውቀውም</p> <p>99. መልሱ አልተሰጠም</p>	

ስለ ሰጡን መልስ እና መሰግናለን!!!



