ACCEPTABILITY AND UTILISATION OF SERVICES FOR VOLUNTARY COUNCELLING AND TESTING AND SEXUALLY TRANSMITTED INFECTIONS IN KAHSEY ABERA HOSPITAL, HUMERA, TIGRAY, ETHIOPIA

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Objectives: *A study was conducted to assess the acceptability and utilization of voluntary counselling and testing (VCT) and sexually transmitted infection (STI) services in Kahsey Abera Hospital, Humera.*
Methods: *Retrospective data was taken from hospital consultation logbooks from January 2002 to February 2003, and focus group discussions were conducted in March 2003 in the community.*
Results: *While the services were known and utilization is increasing, important misconceptions about the medical services, disease transmission, and STI treatment persist. Although hospital care was generally considered of high quality, persons often go to pharmacies to self-treat for STIs due to concerns about confidentiality, and the stigma of HIV deters many from wanting to know their serostatus.*
Conclusions: *Additional education is needed on HIV/AIDS, STIs, and the medical services provided. Education may make use of community health workers or outreach workers in a small group where participants can feel comfortable to ask sensitive questions. HIV/AIDS treatment is planned for the near future and may be significant in reducing HIV/AIDS stigma.*

INTRODUCTION

Voluntary counselling and testing (VCT) is a useful prevention tool (1-3). Barriers to using VCT service include the stigma of AIDS (4-6) as well as cost and physical accessibility (7). The shame surrounding sexually transmitted infections (STIs) as well as misunderstandings of their causes lead many persons to seek traditional or informal care for treatment (8-11).

Medecins sans Frontieres (MSF) has collaborated with the Tigray Health Bureau (THB) on Kala azar treatment program for several years in the Humera Woreda. Since 2001, MSF and the THB have initiated an HIV/AIDS/STI project. The purpose of this study was to assess the acceptability and utilization of the VCT and STI services provided at Kahsey Abera Hospital (KAH) in Humera.

MATERIALS AND METHODS

This research used qualitative data (focus group discussions and in-depth interviews) conducted in March 2003, as well as quantitative data (retrospective data from KAH records from January 2002 to February 2003).

A total of 12 focus group discussions were conducted in Humera, among youth, adults, medical professionals, Red Cross volunteers, commercial sex workers, and migrant workers. With the exception of medical professionals, all groups were separated by gender. Male moderators led male focus group discussions, and females led female groups. The moderator was the only researcher present and tape-recorded the conversations. Focus groups were conducted in Tigriyan or Amharic language. The moderator who led the discussion made a summary of the answers immediately after the conclusion of the focus group discussion. Two additional researchers later listened to the tape and made summaries. The lead researcher analysed the summaries and discussed points with the researchers and listened to the original tape as necessary for clarity.

Quantitative data was taken from records from the VCT logbook and STI records in KAH. Records were entered into a computer and analysed using EPI INFO 6.0.

VCT was introduced in 2001 as an integrated

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service within the KAH in Humera, and in two clinics in 2003. The service in KAH is provided in a room that is identified by number only to keep the service as confidential as possible. Persons access the service in two ways: 1) a self-initiated visit to the hospital with the sole purpose of using the VCT service or 2) as an inpatient/outpatient using the service on the suggestion of a physician. Patients referred by a physician receive the same VCT service as self-initiated visits. There is no HIV testing for diagnostic purposes that is not voluntary, without appropriate counselling and informed consent.

Serostatus is checked with the Determine rapid test, and confirmed with the Capillus rapid test. Unigold is used as tie-breaker. The VCT counsellor administers and interprets the rapid tests. Generally, test results and post-test counselling are given the following day, unless the user makes clear he or she will be unable to return at a later date.

The THB and MSF collaborated to modify the treatment for STIs. As of January 2003, the THB and MSF initiated syndromic management of STIs in KAH and four clinics, and reinforced drug supply.

More recently, other components of comprehensive care for people living With HIV/AIDS have been introduced in KAH, including treatment and prophylaxis for opportunistic infections, nutritional support, and anti-retroviral (ARV) treatment since January 2004.

In March 2003, the THB and MSF researched community perceptions of HIV/AIDS, STIs, and explored barriers to accessing the VCT and STI treatment services in KAH. The purpose of the study was to better understand the accessibility, acceptability, and utilization of these services in the hospital prior to introducing additional VCT and STI clinics in more sites in the region.

RESULTS

1. **VCT service:** Over the course of 14.5 months, the VCT service recorded 803 consultations (average 54/month). Generally, the number of consultations has increased. The average for Jan-Feb 2002 was 36 consultations/month, and for the same period in 2003 the average was 113/month.

Persons that used the service were mainly men (80.2%). The average age was 26 years (range 2-65 years). People primarily came from Humera (69.9%). The main occupations of persons using VCT service were military (29.5%), migrant workers (18.3%), and farmers (14.8%).

Visits to the VCT service were mainly self initiated (64.1%), or by medical referral from the hospital IPD or OPD (35.9%). Medical referral means that a nurse or physician has suggested that the patient consider VCT. Persons who made a self-initiated visit to VCT were much more likely (79.8%) to come in for test results and post-test counselling than persons who came to the service from a medical referral (59.4%)[1]. Thirty persons (3.7%) refused testing, of whom 27 (90.0%) were medical referrals to VCT.

Overall, 725 of 803 (90.3%) persons recorded a test result, of which 182 (25.1%) tested positive. There were 3 (0.4%) discordant pairs of tests. Positive test results were significantly more frequent among medical referrals (47.6%) than self-initiated users (14.9%)[2]. The majority of persons with a positive test result (59.4%) had no formal education.

Focus group discussions revealed that with few exceptions, all participants had heard of the VCT service and knew where it was offered. There was minor confusion about times and days of the service, and misperceptions about how the service was delivered. Many persons did not know about the counselling aspect, and thought VCT was simply a blood test.

The principal barrier to utilizing VCT services is the feeling of powerlessness in the face of a positive test result. The community generally considers someone with HIV to live an immoral sexual lifestyle, terminally ill, and a contagious threat to others. The stigma of AIDS is extreme--someone known to have HIV will be ostracized by the community, and certainly lose their job.

"I believe most people know about it [VCT service], but few people are using it. The reasons others are not testing themselves is that they question themselves 'what if I become positive? There is no cure and why should I shorten my life as a result of the stress?' Therefore only people who plan to marry and winners of the Diversity Visa [persons travelling abroad sometimes need HIV test result certificate] are using it mainly" Junior Nurse, KAH "Most of the people say 'what do I do if my result is positive?' It's preferable to keep quiet until it happens by itself." CSW, 24 Humera.

Participants felt a positive result might lead a person to commit suicide to avoid a prolonged, isolated death from AIDS. The path of HIV infection is perceived as one of painful illnesses and wasting.

[1] (Odds Ratio 2.73, 95% Confidence Interval 1.96 – 3.81, $p<.05$)
[2] (Odds Ratio 3.53, 95% Confidence Interval 2.45 – 5.09, $p<.05$)

suffered alone as community, friends, and family reject anyone with the illness.

Others stated that a reaction of some persons who test positive is to seek revenge, and infect as many others as possible via sexual contact or sharing razors. Two groups suggested that the government intervene to separate persons with HIV from society. "It is good if the government can collect people who have HIV so that they don't infect others" migrant worker, Humera.

Some persons stated their reaction to HIV would be tolerant and that they would not hesitate to care for someone with HIV/AIDS. However, acceptance still meant telling no one of one's serostatus. In an extreme example, counsellors noted that they had faced the situation of a couple testing prior to marriage, having discordant test results, and the seropositive partner electing to not inform or misinform the other.

Multiple participants said they would care for loved ones, but would actively avoid an acquaintance or stranger suspected of having HIV. Caring for someone with HIV/AIDS had to be kept discreet to avoid ostracism of the entire household. Participants also noted that caring for someone with HIV/AIDS had a serious economic and emotional toll.

All groups did, however, name benefits of testing, even if the outcome was a positive HIV test result. The advantage was consistently named as changing one's lifestyle to preserve one's health and prevention of transmission to others.

Main comments from focus group discussions were complimentary to both the quality of service and the openness of the staff. A few groups, however, noted inconsistencies in testing, largely from a misunderstanding of the testing window period that cast doubt on the validity of the testing service. Participants recalled hearing of a person testing positive then subsequently testing negative at a later date, or that some persons got their test in one day, while others had to wait three months.

Availability of service was another obstacle. In Humera, participants spoke of long waiting lines. A young man noted the VCT counsellor could only see a handful of persons per day, so after a long walk to the hospital, the line would probably be too long to be seen that day. Sitting in line to use the VCT service in Humera also had confidentiality implications, as anyone can see you are waiting to be tested.

It is important to note that although the correct modes of HIV transmission appear to be very widely known, there remain important misconceptions about how HIV might spread. Groups stated that someone with HIV would be ostracized by the community for fear of catching the disease. Behaviours the community would consider a risk included shaking hands, coughing, sharing eating utensils, or eating in a restaurant where the cook had HIV. Others said that disposed condoms posed a risk of HIV passing to children or entering the food chain and being passed on via chicken's eggs.

2. **STI programs:** two months, there were 90 consultations (average 45/month) of which 52.8% were male. The average age was 29 years (range 17-65). By occupation, patients were mainly unemployed or did not specify (57.5%), farmers (30.0%), commercial sex workers (15.0%), drivers (6.7%), housewives (6.7%), and prisoners (5.0%). Nearly one-half the patients (47.7%) came from outside Humera. The patients were primarily first visits (70.7%), repeat visits (14.6%), partner notifications (10.9%), or follow up visits (3.7%).

Focus group discussions demonstrated that the hospital was not the first choice for treatment of STIs, mainly for reasons of privacy. While the quality of care was considered superior at official health structures, persons first sought care at a traditional healer or a pharmacist. There is intense shame surrounding STIs, and a traditional healer or pharmacist is faster and more anonymous. Persons acknowledge that the hospital gives proper care, but fears that doctors might judge them, they will have to register their name, endure many questions, and have to participate in partner notification. For a married couple, partner notification can result in divorce. As health care workers noted, it is not unusual for a person with an STI to not inform their partner, and make repeat medical visits due to re-infection. Health care workers gave an example of a married woman who had come in for STI treatment, and when she notified her husband, the reaction was a denial that the illness was an STI accompanied by fierce accusations of the wife's infidelity. The outcome of these situations has been domestic strife and re-infection.

It is easier, faster, and more private to use a traditional healer, who does not imply the illness is transmitted sexually, or by simply ordering pills over the counter from a pharmacist. Persons usually ask the advice of peers for which antibiotic to order, and then purchase a small number of pills they can afford. The pharmacist is not consulted on symptoms or recommendations. Home remedies named included holy water and incense. Usually the clinic only gets patients after the aforementioned alternatives have failed.

"People buy medicine with the amount of money they have, no examination, no waiting for a turn" man, Mycadre.

"Most women in our community have their own definition of an STI, and for management they burn

herbs and sit on the smoke, however the symptoms usually worsen and once they cannot tolerate it anymore they come to the clinic" health worker, Baeker. "Men go to the drug shop and order a kind of medication, in a dosage recommended by others from experience. The symptoms go away with the first does of the medication or self-resolve, only to reappear in a latent stage" health worker, Humera.

Direct access to STI treatment in Humera is not being used. In practice, although persons can access the STI treatment in Humera directly, this has never been done; all patients have been referred from the OPD. Importantly, there are many other perceived modes of STI transmission. Poor hygiene, urinating in direct sunlight, or facing the moon, were all mentioned as popular conceptions of causative agents of STIs. A health care worker observed that many persons did not have the knowledge to link STI symptoms with unsafe sex. However, STIs were generally considered serious, and all groups noted that STIs could result in sterility and other long-term sequelae.

DISCUSSION

The service is well known and the numbers of users are steadily increasing. This would suggest the VCT and STI services are acceptable and considered to deliver quality care.

Misconceptions about HIV and STIs were common, reinforcing the need for continued health education to improve understanding of HIV/AIDS, STIs, and the medical services available. Health educators should reinforce prevention messages but also include options for living with HIV infection. Information on the VCT and STI services (i.e. that counselling is part of the service, not only testing, and that partner notification is not mandatory) should also be given to increase understanding and acceptability of the services. As much as possible, the education should be conducted in small groups, where persons are comfortable to ask questions about facts and rumours they have heard. Literacy rates suggest that the message should be oral or with audiovisual mediums. The possibility of using peer educators or community health workers should be explored.

Many of those who attended VCT for pre-test counselling and had blood taken for testing, did not return for test results. In response to this, same day testing and results has since been introduced in KAH, and is recommended in this setting.

The main barrier to accessing VCT was the fear of the consequences of a positive result. At the time of this research, there was no ARV treatment available in Humera, but this has since been introduced. The availability of improved medical care and treatment may impact upon the perception of powerlessness for those who test positive. Since the introduction of ARV treatment in an MSF project in Khayelitsha, South Africa, the VCT uptake has increased from fewer than 1000 HIV tests in 1998 to more than 12,000 tests in 2002. Provision of comprehensive care, including ARV treatment, is hoped to reduce stigma surrounding HIV, and reduce barriers to accessing VCT in order to know one's status. With the cost of generic ARV drugs at less than $300 per patient per year, the possibility of treatment is opening to more countries.

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