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## Self-reported reasons for seeking HIV testing by people living with HIV/AIDS (PLWHA) in a tertiary hospital in Nigeria

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## ABSTRACT

**Objective:** To assess the reasons for HIV testing among people living with HIV and AIDS (PLWHA) that were receiving care/treatment in the University of Ilorin Teaching Hospital (UIITH), Ilorin.

**Methods:** The study was a descriptive cross-sectional survey conducted on 300 people living with HIV and AIDS receiving care at the antiretroviral therapy (ART) clinics of the hospital. All the patients who came to the clinic during the period of data collection and met the inclusion criteria were recruited into the study consecutively. Data were analyzed using the EPI-INFO 2005 software package. **Results:** The mean age of the respondents was 39 years (SD=9.32), ranging between 19 and 65 years. About two thirds (64.7%) were females, among which 62.7% were married. Slightly less than half (47.3%) of the respondents were not informed before they were tested for HIV while 11% did not receive post-test counselling. The main reason for HIV test was because client was sick and not responding to the treatment for other illnesses and during routine medical test when spouse tested positive. **Conclusions:** The findings from this study reveal that the majority of respondents were tested for HIV/AIDS when they had protracted illness or lost their partners to AIDS. To achieve the WHO goal of universal access to HIV prevention, care, treatment and support, there is an urgent need to rapidly scale up HCT services at all levels of the health care system, while pursuing innovative human right approaches to provider-initiated testing and counselling (PITC).

### 1. Introduction

In Africa, HIV/AIDS has had its most devastating impact on morbidity and mortality of people of all ages and across socioeconomic strata. There is therefore, the need for an effective and feasible intervention for the control of new infections using appropriate risk reduction strategies<sup>[1]</sup>. HIV counseling and testing remains the entry point to comprehensive HIV care and support services and the expansion of this services has been advocated as a central component of public health efforts to reduce the HIV incidence in Africa<sup>[2, 3]</sup>. It has been shown that HIV testing

is still low in many African countries thereby necessitating action by governments of African countries to increase access to HIV counseling and testing<sup>[4]</sup>. Similarly, it was observed in the United States that patients with HIV infection were generally discovered at an advanced stage, usually in the course of medical care and often during care for complications of AIDS<sup>[5]</sup>. The timeliness of HIV diagnosis and the initiation of HAART are major determinants of survival for HIV-infected people<sup>[6]</sup>. Earlier diagnosis is likely to result in early access to appropriate care and increase the proportion of HIV-infected patients receiving care, thereby improving the quality of care for persons and populations<sup>[7]</sup>. Other benefits of increasing access to HCT services include the opportunities it offers to intensify preventive behaviours, referral for treatment, care and support services for infected individuals. The study was

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embarked upon to explore the reasons why and how people living with HIV/AIDS got tested for HIV infection.

## 2. Materials and method

The study was a cross-sectional survey of people living with HIV/AIDS (PLWHA) receiving various forms of care at the University of Ilorin Teaching Hospital (UIITH). UIITH, which at the time of the study, was the only centre providing comprehensive HIV care in Kwara State. All HIV positive patients who came to the clinics during the period of data collection and consented to participate in the study were enrolled into the study consecutively as they were attending the clinics.

Data were collected with the aid of a pre-tested interviewer-administered questionnaire by six research assistants who were recruited and trained. The questionnaires were administered on each of the clinic days for two months. Approval was obtained from the Ethical Committee of University of Ilorin Teaching Hospital. Both verbal and written informed consents were obtained from each of the respondents after the purpose of the study had been explained. Respondents were allowed to decide whether or not to participate in the study. Confidentiality of participants was ensured throughout the study.

Data were analyzed using standard statistical procedures including the use of Epi 6 statistical software.

## 3. Results

A total of 300 patients were included in the study. The mean age of the respondents was 39.04 years (SD=9.32 years) with a range of 19 to 65 years. The modal age group was 35 to 39 years and 84.3% of the respondents were below 50 years of age. About two-thirds (64.7%) of the respondents were females. About three-quarters (73.3%) of the respondents were Yoruba by tribe. One hundred and eighty eight (62.7%) of the respondents were married, 17% of them were widowed, 9.3% were single, 6.0% were divorced and 5.0% were separated. 32% of the respondents had primary education, 29.3% had secondary education, 25% of them had tertiary education, while the remaining 13.7% had no formal education. The predominant occupation of the respondents was trading or business(39.7%), followed by civil service (19.3%), artisan (13%), driving (5.7%), farming (4.0%), and others (4.3%). Muslims constituted 52.3% and Christians 47.7% of the respondents (Table 1).

52% of the respondents were diagnosed to be HIV positive 1 to 3 years ago, nearly forty percent were diagnosed less than a year ago, while 8.0% and 1.3% were diagnosed 4–6 years and over 6 years ago respectively as shown in Table 2.

Out of all the respondents, 158 (52.7%) were informed before HIV testing was done for them, while 142 (47.3%) knew they were tested for HIV after the result of the test came out. The majority of respondents—267 (89%)— received post test counselling, while 33 (11.0%) were not counselled after their

HIV testing (Table 2).

On the reasons for HIV testing: One hundred and ninety two (64%) of respondents were tested for HIV because they were either very sick or not responding to treatments given for other illnesses. Forty one (13.7%) had the test during routine medical test, 28 (9.3%) because their spouses tested positive, 12 (4%) requested for it (VCT) and 8 (2.7%) had the test during antenatal care. Other reasons included screening during blood donation 6 (2%), child tested positive 5 (1.7%), premarital screening. 2 (0.7%) and others 3 (1%) (Table 3).

**Table 1**  
Socio-demographic characteristics.

Parameters		Frequency	Percentage
Age range(Years)	15–19	1	0.3
	20–24	9	3.0
	25–29	40	13.3
	30–34	50	16.7
	35–39	55	18.3
	40–44	47	15.7
	45–49	51	17.0
	Above 50	47	15.7
Sex	Female	194	64.7
	Male	106	35.3
	Total	300	100.0
Marital status	Divorced	18	6.0
	Married	188	62.7
	Separated	15	5.0
	Single	28	9.3
	Widowed	51	17.0
	Total	300	100.0
Family type	Monogamy	172	63.2
	Polygamy	100	37.8
	Total	272	100.0
Educational status	No formal education	41	13.7
	Primary	96	32.0
	Secondary	88	29.3
	Tertiary	75	25.0
	Total	300	100.0

**Table 2**  
History of HIV/AIDS disease (n=300).

Parameters		Frequency	Percent
Duration of illness from diagnosis	Less than one year	116	38.7
	1–3years	156	52.0
	4–6years	24	8.0
	Greater than 6years	4	1.3
Informed about the test before it was done information before HIV test	Yes	158	52.7
	No	142	47.3
Received post-test counselling	Yes	267	89.0
	No	33	11.0

Only 89 (29.7%) of the respondents suspected HIV infection before they were tested for the infection. Out of these, 47 (52.8%) made the suspicion when they noticed HIV-related symptoms or signs, 21 (23.6%) suspected when their partners/spouses tested positive, while the remaining 21 (23.6%) suspected when they lost their spouses or partners (Table 3).

The first responses of the respondents to their positive HIV status varied. Majority, 169 (56.3%) of the respondents felt sad and broke down with emotions, 95 (31.7%) took it in good faith, 28 (9.3%) was in a state of denial, 6 (2%) attempted suicide, while 2 (0.7%) were depressed and decided not to eat when they first knew they are HIV positive (Table 4).

**Table 3**  
Reasons for the respondents' HIV testing.

Parameters	Frequency	Percent
Reasons for Respondents' HIV testing		
Non-response to treatment given/Prolonged sickness	192	64.0
Routine medical test	41	13.7
Spouse tested positive	28	9.3
Voluntary counselling and testing (VCT)	12	4.0
During antenatal care	8	2.7
Premarital screening	2	0.7
Others	12	4.0
Total	300	100.0
Suspicion of HIV infection by the respondents before the test		
Yes	89	29.7
No	211	70.3
Total	300	100.0
Reasons for suspecting HIV infection before the test (n=89)		
Suspicion following symptoms/signs	47	52.8
Suspicion following spouse/sexual partner's positive test	21	23.6
Suspicion following death of spouse/lover	21	23.6
Total	89	100.0

**Table 4**  
Initial reactions to HIV positive results.

Respondents' first reaction to the result of the test	Frequency	Percent (%)
Felt sad and broke down with emotions	169	56.3
Took it in good faith	95	31.7
Was in a state of denial	28	9.3
Attempted suicide	6	2.0
Depression and decided not to eat	2	0.7
Total	300	100.0

#### 4. Discussion

Our study shows that the majority (64.0%) of the respondents were tested for HIV when they were falling ill frequently or not responding to the treatment given to them for other illnesses. This finding is also consistent with a similar study which showed that about two-thirds of respondents citing similar reasons why they were tested[8–10].

This finding highlights two main issues. Firstly, it suggests that the majority of the PLWHA got their HIV testing in the health care facilities where so many missed opportunities exist for HCT. In 2007, the World Health Organization/United Nations Joint Programme on HIV/AIDS (UNAIDS) launched the guidance on provider initiated testing and counseling in health facilities[11] to help ensure that human immunodeficiency virus (HIV) is systematically diagnosed to improve treatment outcomes and increase access to prevention services. It was reported that countries that have promoted PITC policies in the health facilities have demonstrated that the strategy increased access to HCT services[12,13]. The guidelines ensure confidentiality and informed consent[14]. In the guidance, HIV testing through PITC or client-initiated services does not, under any circumstances, represent an endorsement of compulsory or mandatory testing. Testing for HIV must remain a confidential and voluntary process. In spite of the fact that several countries have adapted this recommendations appropriate training of health care personnel need to be instituted to guarantee the rights of clients. Other entry points such as antenatal care services, premarital HCT services should be strengthened to offer HCT services at every opportunity.

Secondly, the finding suggests that majority of the patients were diagnosed late with advanced stages of the disease after they had repeatedly been sick. This assumption is supported by the study in the United States[5] which showed that HIV infection is generally discovered late in the course of medical care and often during care for complications of AIDS. There is therefore, the need to increase public awareness on the benefits of HIV testing to the general populace, so that HIV infection can be identified early enough to ensure better treatment outcomes and survival.

The lateness in accessing HIV test by the respondents may be related to the prevailing HIV stigma and discrimination in the community. Many of the patients had suspicion of their HIV status before actually taking the test. In addition, poor access to VCT and ART services in the state at the time of the study may have been contributory to the late presentation of the clients for HCT. All these may have contributed to clients presenting late and therefore may have poor prognosis of treatment.

It was observed that only a few respondents (4%) knew their HIV status through voluntary counseling and testing. This finding is similar to a WHO report, which revealed poor uptake of VCT[2]. This implies that uptake of VCT is very low. These findings suggest as earlier alluded to that for countries to achieve universal access to HCT services other alternative strategies need to be employed in addition to VCT. Such strategies include provider initiated testing and counseling among others.

About half of the respondents claimed that they were not informed before the HIV test was performed on them. This situation is not uncommon in developing countries where there is poor compliance of the health care providers to the standard procedures for HIV-testing. Lack of pre-

test counselling may prevent HIV–infected persons from being prepared for the outcome of the result and also likely worsen adjustment to HIV positive status. Failure to counsel a person before HIV testing is also an act of stigmatization and violation of human rights<sup>[15,16]</sup>. Also about 11% of respondents claimed that they did not have post–test counseling after HIV test. HIV positive individuals who were not counseled after the HIV test was performed may have missed the opportunity for intensifying health education on risk reduction strategies which might have helped them to avoid continued transmission of HIV infection. Also the opportunity to offer the necessary social, emotional and psychological support to cope with the disease and treatment would have been missed. Health providers of HCT services need to be trained on post–test counseling as a critical component of HCT service provision.

The study also showed that about two–thirds of the clients tested for HIV had initial negative reactions to the HIV positive result. About half of the respondents were sad and broke down with emotions, while some even contemplated suicide. These patients could have been supported to pass through these negative emotions successfully if they went through the process of pre–test counselling or rather through the provision of adequate information about the benefits and consequences of a positive or negative test. This would have enabled the clients to make an informed decision of whether or not to take test. If the client decides to eventually take the test, they would have been prepared psychologically on the possible outcome of the results and develop their own strategies to cope with the lifelong implication of the disease and its treatment. Also, the post–test counselling offers the opportunity to intensify the risk reduction messages and prevent further transmission of infection in the community in addition to the support offered to the patient. It is therefore important for health care workers to inform and adequately prepare patients of the possible outcomes of the HIV test through pre–test counselling and support them thereafter through post–test counselling<sup>[17–19]</sup>.

The findings from this study revealed that the majority of respondents were tested for HIV/AIDS when they had protracted illness or lost their partners to AIDS. To achieve the WHO goal of universal access to HIV prevention, care, treatment and support, there is an urgent need to rapidly scale up HCT services at all levels of the health care system, while pursuing innovative human right approaches to provider–initiated testing and counselling (PITC).

### Conflict of interest statement

We declare that we have no conflict of interest.

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