



Profile of Clients Attending an Integrated Counselling and Testing Centre at a Private Rural Tertiary Care Hospital in India

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RESEARCH

Please cite this paper as: Quazi, S., Nimbarte, S., Selokar, D., Gaidhane, A., Mudey, A., Wagh, V. Profile of Clients Attending an Integrated Counselling and Testing Centre at a Private Rural Tertiary Care Hospital in India. AMJ 2010, 3, 6, 349-352 Doi 10.4066/AMJ.2010.236

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Abstract

Background

The human immunodeficiency virus (HIV) infection is a global pandemic and has grown into a public health problem of unprecedented magnitude. Integrated counselling and testing centre's (ICTCs) have established as a cost-effective intervention to reverse this epidemic. The objective of this study was to find out the profile of clients attending the ICTC.

Method

Data was collected over six months at an ICTC in a rural-private tertiary care hospital in Wardha district. 650 study participants attended the ICTC either by self referral or following referral by a health care provider. Data was collected by the counsellor and it was retrospective data.

Results

Seropositivity rate among ICTC clients was 12.5% (n=81), out of these, 70.5% were male. The majority (41.1%) of ICTC attendee belonged to the 16-30 years age group. Many attendees (31.5%) were skilled workers and 29.7% had completed their education up to high school level. Sero prevalence decreased with higher educational status and improved job type. 79.5% individuals were heterosexual and had a history of multiple sexual partners. All HIV positive clients were referred to a care and support programme but only 32% visited within one week and around 60.2% within one month.

Conclusion

ICTC centres at private rural hospitals should be encouraged so that people from such areas can access services to establish their HIV status. Seropositive clients can then be referred in a timely fashion to appropriate care and support programmes.

Key Words

VCTC, HIV positive, Risk Behaviour

Background

All countries in South East Asia are deeply concerned about the human immunodeficiency virus (HIV) epidemic and are trying to respond as well as they can¹. The HIV infection is a global pandemic and has grown into a public health problem of unprecedented magnitude. According to the acquired immunodeficiency syndrome (AIDS) epidemic update released in December 2007 by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), approximately 33.2 million people are living with HIV/AIDS worldwide.² Some organizations such as, UNAIDS, WHO, and National AIDS control Organizations (NACO) estimate national adult prevalence in India to be 0.36%, this amounts to 2.7 million HIV positive people.³

Counselling for HIV and AIDS has become a core element of a holistic model of health care; in this model, psychological issues are recognized as integral to patient management. Both pre- and post-test counselling have become standard components of prevention oriented HIV antibody testing programs.⁴ Integrated Counselling and Testing Centres (ICTCs), previously known as Voluntary Counselling and Testing Centres (VCTCs) provide key entry points for the 'continuum of care in HIV/AIDS' for all segments of the population.⁵

Even though the HIV epidemic is concentrated in urban India, increasing HIV infection from urban to rural and from core population to low risk groups has been documented. Existing studies document the profiles of ICTC attendees from urban area and/or those of ICTCs located within Government sector establishments but very few studies profile of ICTC attendees from rural areas.

Due to the increasing spread HIV infection into rural areas, this study aims to profile ICTC attendee in a private, rural, tertiary care hospital situated in Wardha district. Our study



population represents both urban and mostly rural area.

Method

Appropriate ethical approval was obtained prior to undertaking the study. The study was conducted in the ICTC of a private, rural, tertiary care hospital located in Wardha district. The study invited those who attended the ICTC over a six month period (Jan-June 2008,). Study participants attended the ICTC either by self referral or following referral by a health care provider. A counsellor undertook pre-test counselling with every client who visited the centre. If the test was negative, attendees were counselled regarding preventive measures for HIV. If the test was positive, then the attendees were advised appropriately, a counsellor undertook post-test counselling and the patients were referred for care, support and treatment programs. For all ICTC attendees the counsellor collected anonymous information using an interview schedule under strict confidentiality. Informed consent was taken from every client before data collection. Information regarding age, gender, marital status, education and occupational status, behavioural patterns was collected. Data was collected by the counsellor and it was retrospective data. National AIDS Control Organization protocol and guidelines were strictly followed. Data was collected and analyzed using SPSS 16.0. Results were presented as proportions.

Results

Out of 650 people who attended the ICTC and consented to participation during the study period, 81 (12.5%) tested positive for HIV. Socio-demographic characteristics of the attendees are showed in Table 1. Males constituted 70.5% (458) of the total clients. 38.9% of attendees belonged to the 16-30 age group (mean age 23.5 years with +/- 4.4 SD). 17 (3.7%) clients were less than 15 years of age. The mean age of all clients was 34.9 years with +/- 15.97 SD. The distribution according to marital status showed that 71% clients of males and 65.6 % of HIV positive females were married of which 2.6% of females were widows.

A literacy rate among female clients was found to be 86.5% while that in males was 80.8%. 40% of male clients undertook skilled work while, 31.5% of female were house makers. 75% of ICTC attendees had self referred while the remaining 25% HIV positive clients were referred to ICTC by health care providers. Most of the referred clients had medical problems. Among the total clients 24 males (5.3%) and 99 females (51.6%) did not responds to questions asking about their previous risky behaviours. Of those clients who responded, 424 males (92.6%) had multiple sex partners and 6 (1.3%) were involved in homosexual practices.

All HIV positive clients were referred to a care and support programme but only 32% visited within one week and around 60.2% went within one month.

Discussion

Counselling and testing are important for prevention and control of HIV/AIDS. However, it is neither desirable nor feasible to counsel and test everyone in the general population. The subpopulations that are vulnerable undertake high risk behavior or have high HIV prevalence should thus be targeted by these services.

In 2006, more than 2.1 million clients were counselled and tested throughout the country. However, the target is to counsel and test 22 million clients annually by the year 2012. The ICTC general or VCTC is an ideal point for prevention, where HIV negative individuals learnt to use full array of existing services and interventions to adopt and maintain risk reduction behavior, and HIV positive individual use quality prevention services to adopt and sustain life long protective behavior and avoid virus transmission. Thus ICTC can represent an opportunity to clients for HIV prevention as well as care and support services.

The prevalence of HIV sero positivity in ICTC clients in the present study was noted to be 12.5% which slightly higher than that reported from a study conducted in district of Karnataka (9.6%) in 2007.⁶ HIV prevalence in the present study was more than the overall prevalence for Gujarat (7.3%)⁸ and South Kannada (9.6%)⁹. Sero positivity among ICTC clients in Gujarat in 2006-07 was as low as 2.7% in Dang, a dominating tribal and rural district.⁸ The seropositivity rate among the current study was lower than that reported from a study conducted in West Bengal (17.1%) in 2003.⁷ The reason for the lower seropositivity, compared to the latter study could be fact that the ICTC was situated in both a rural and private environment. The estimated adult prevalence of HIV in India is 0.36%. The difference in HIV prevalence in different studies may be attributed to the difference in health seeking behaviours in different parts of the country which depends on socio-cultural milieu of the community.

The present study clearly indicates that 70.5% of ICTC attendees were male. This gender ratio of attendance rates is in accordance with national figures and indicates the existence of some barriers preventing the access of females even now. Stigma and discrimination may also be a barrier for them.

According to the present study, 71.1% of the attendees belonged to the age group of 15-45 years (the most sexually active age group) which is lower than the national figure and the figure obtained from similar studies (92.4%) at Darjeeling⁷ and 88.7% at Udupi, Karnataka.⁶ The majority of the subjects (62%) had undergone education up to the 10th standard. In the study conducted by Sharma¹⁰ at Ahmadabad, 38.5 % of the ICTC attendees had completed education up to 10th standard. The difference may be due to regional demographic variation. However, it seems that education does provide some protection. As such the people who are well educated are more receptive to



information, education and communication and amenable to interventions.

The present study found that 92.6% of male clients undertook risky behaviors associated with heterosexual contacts followed by men having sex with men (1.3%). Heterosexual contact was the commonest mode of transmission which is supported by the findings of another study from eastern India.¹¹ A large proportion of study subjects (5.3% males and 51.6% Females) did not disclose their risk status. This is likely to be attributed to the fear of discrimination or punishment which still prevails in the society for HIV infected individuals.

All HIV positive clients are referred to a care and support programme but only 32% visited within one week and around 60.2% went within one month. Thus about 40% of HIV positive individuals missed an opportunity to undergo care and support. If these clients remain out of the care, they are at risk of spreading HIV infection to other uninfected people. This missed opportunity may be avoided if ICTC are supported with the outreach activities.

This study from a private hospital does not offer nationally generalizable results as this institution caters for a mostly rural population. However the pattern of ICTC attendee may be similar in other private establishments especially if situated in rural area. Very few studies have been done to establish the profile of clients attending an ICTC of a rural private tertiary care hospital. Due to stigma and discrimination faced by people living with HIV/AIDS in India, their health seeking behavior is extremely complex. This study gives an overview of profile of clients preferring the private setup compared to government. There is a need to upscale ICTC services within private sector.

Conclusion

To conclude, given the high HIV positivity rate compared to national average, ICTCs at private rural environments should be encouraged so that local people can easily access services and benefit from timely care and support programmes. ICTCs should be supported by outreach components so that all HIV positive patients can be followed up and linked to the care, support and treatment programs.

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PEER REVIEW

Not commissioned. Externally peer reviewed.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests



Tables

Table 1: Socio demographic profile of voluntary counselling and testing attendees (n=650)

| Variables | Male (%) n=458 | Female (%) n=192 | Total (%) N=650 |
|---------------------------|-------------------|---------------------|--------------------|
| Age groups (years) | | | |
| < 15 | 17 (3.7) | 24 (12.5) | 41 (6.3) |
| 16-30 | 178 (38.9) | 89 (46.4) | 267 (41.1) |
| 31-45 | 151 (33) | 44 (22.9) | 195 (30) |
| 46-60 | 75 (16.3) | 24 (12.5) | 99 (15.2) |
| > 60 | 37 (8.1) | 11 (5.7) | 48 (7.4) |
| Marital Status | | | |
| Child | 15 (3.3) | 15 (7.8) | 30 (4.6) |
| Married | 325 (71) | 126 (65.6) | 451 (69.5) |
| Unmarried | 118 (25.7) | 46 (24) | 164 (25.2) |
| Widow | 00 | 05 (2.6) | 05 (0.7) |
| Occupation | | | |
| Unskilled | 88 (19.2) | 58 (30.2) | 146 (22.5) |
| Semiskilled | 141 (30.8) | 61 (31.8) | 202 (31.1) |
| Skilled | 183 (40) | 22 (11.5) | 34 (5.2) |
| Unemployed | 7 (1.5) | 12 (6.3) | 19 (2.9) |
| Housewife | 00 | 34 (17.7) | 205 (31.5) |
| Student | 39 (8.5) | 05 (2.5) | 44 (6.8) |
| Education | | | |
| Illiterate | 88 (19.2) | 26 (13.5) | 114 (17.5) |
| Primary School | 77 (16.8) | 56 (29.2) | 133 (20.5) |
| High School | 107 (23.4) | 86 (44.8) | 193 (29.7) |
| Jr College | 156 (34.1) | 23 (12) | 179 (27.5) |
| Graduate & PG | 30 (6.5) | 01 (0.5) | 31 (4.8) |

Table 2: Risk behavior profile of the study subjects

| Risk behavior | Male (%) | Female (%) | Total (%) |
|--------------------------------|------------------|------------------|------------------|
| Heterosexual Multiple partners | 424 (92.6) | 93 (48.4) | 517 (79.5) |
| Homosexual Partner | 06 (1.3) | 00 | 06 (0.9) |
| Blood Transfusion | 04 (0.8) | 00 | 04 (0.6) |
| No Response | 24 (5.3) | 99 (51.6) | 123 (19) |
| Total | 458 (100) | 192 (100) | 650 (100) |