

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/273879601>

# Factors Determining Voluntary Counseling and Testing (VCT) for the Human Immunodeficiency Virus (HIV) among Low Income Women: Focus Group Findings from Rural, Urban, and Peri-Urban...

Article in *Journal of Basic & Applied Sciences* · July 2014

DOI: 10.6000/1927-5129.2014.10.40

CITATIONS

2

READS

518

1 author:



Marisen Mwale

Mzuzu University

32 PUBLICATIONS 73 CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:



Behaviour Change Interventions and their Effect on Adolescent HIV risk reduction in Northern Malawi [View project](#)



Mzuzu University Undergraduate Research Supervision Projects [View project](#)

# Factors Determining Voluntary Counseling and Testing (VCT) for the Human Immunodeficiency Virus (HIV) among Low Income Women: Focus Group Findings from Rural, Urban, and Peri-Urban Women Groups in Lilongwe District-Malawi

Marisen Mwale\*

*Mzuzu University [Malawi] or College of Medicine [Malawi]/CDC/PEPFAR - USA*

**Abstract:** Most high prevalence sub-Saharan African countries tend to over-emphasize fidelity and condom use as major preventative measures relative to HIV and AIDS prevention. Studies of behavior change that focus exclusively on these strategies of most interest to the prevention community bias examinations of behaviour change downward by ignoring other potentially effective ways of limiting the epidemic. Regardless of the dearth in efficacy, as well as tolerance bottlenecks; the prevailing debate over provider initiated testing in Malawi may depict a shift towards HIV Testing and Counseling (HTC) in Acquired Immunodeficiency Syndrome (AIDS) prevention. The current study examines factors that determine VCT uptake among low income women in the Lilongwe district. A qualitative paradigm- the Focus Group Discussion (FGD) was utilized to inform the study. Convenient sampling was used to isolate three women groups namely; St John Nsamba, Women of Action, and National Association of People Having AIDS in Malawi (NAPHAM) support group as participants. The first two groups were sampled as primary groups, the former representing the urban domain with the later representing the rural domain respectively. Between 10 – 15 participants from each group, approximately within the age category 20-49 were involved. Findings suggest socio-cultural gender stereotypes inhibiting negotiating testing with partners as well as the social comparison or optimistic bias motivating ordinary women to underestimate their risk of contracting HIV relative to significant others as major barriers. Recurrent illnesses was considered the major motivator, downplaying the empirical impression about access to treatment as major incentive. The methodical conclusion drawn from the study is that VCT has the potential to mitigate the spread of HIV but for the preventative measure to be successful there is need to surmount various ethnographic and socio-cultural constraints currently impeding the intervention.

**Keywords:** VCT, Preventative health device, Diagnostic tool, Couple testing, Lilongwe, home-based service provision.

## INTRODUCTION

According to UNAIDS 42 million people in the world have HIV infection. Sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 67% of all people living with HIV and for 75% of AIDS deaths in 2012 [1]. Notably, the majority of new infections in the region could be preventable and are spread through unsafe sex. It is only recently that VCT services have been considered important as an entry point for prevention and care interventions for HIV/AIDS. Research has shown that VCT can lead to the practice of safe sexual behaviors and increased condom use, thus preventing further spread of the disease [2]. A meta-analysis of VCT concluded that testing resulted in reduction in risk for persons who are HIV infected and for serodiscordant couples [3]. Voluntary Counseling and Testing is also useful in targeting persons at high risk because risky behaviors are positively associated with the decision to take the HIV test [4]. It is also argued that VCT strengthens prevention efforts through risk-reduction strategies for

HIV infected people and above all else provides evidence-based approaches to specific recommendations for prevention and control of HIV/AIDS as well as being one of the monitoring and evaluating indicators of a second-generation HIV surveillance system [5-7]. Previous research in Africa and the USA has also suggested that VCT is more effective for HIV risk reduction when both partners participate, share their test results, and formulate risk-reduction plans based on serostatus results [8]. Access to VCT services nevertheless, remains limited and demand is often low in many high prevalence countries of sub-Saharan Africa. Furthermore, the quality and benefits of VCT, in particular with regard to confidentiality, counseling and access to clinical and social support, vary enormously. Malawi with a prevalence of 10.6% is among the ten countries with the highest prevalence in the world [9, 10]. According to the Biological and Behavioural Surveillance Survey [11] the proportion of respondents expressing an interest in getting tested for HIV amongst high-risk groups is consistently lower than those who have ever tested indicating an unmet need in terms of HIV counseling and testing [HTC] in the nation. Routine testing in hospitals and other health care facilities, for

\*Address correspondence to this author at the Mzuzu University [Malawi] or College of Medicine [Malawi]/CDC/PEPFAR - USA; Tel: + (265) 0999245017; E-mail: marisen.mwale@yahoo.co.uk

example, significantly increases uptake and case finding among the attendees of these facilities, but cost and convenience issues often limit the use of health care facilities among most risk group strata [1]. Although community-based approaches, like mobile VCT units or home-based VCT provision have been shown to dramatically increase the uptake of testing services, the rates of patronage still remain insignificant [5]. Considering the delineation of specific female VCT uptake as a gap in Malawi- with specificity extrapolated against female provider initiated testing and prevention of mother to child transmission (PMTCT) [12, 13], diverse socio-cultural stereotypes as well as gender related variables with most potentially negative social consequences of VCT such as family and relationship disruption, sexual violence, stigma and discrimination-affecting women; the fact that 60% of those infected with HIV are female [13]; the prominent female's physiological susceptibility [14] and the socio-economic gradient in access to VCT services among ordinary Malawians; the current study focused on factors motivating or inhibiting VCT uptake among low income women groups in rural, peri- urban and urban areas in the Lilongwe District of Malawi.

### VCT Efficacy vis-à-vis Study Justification

HIV testing is the process by which blood or body fluids are analyzed for the presence of antibodies or antigens produced in response to HIV infection [15]. Through VCT, an individual undergoes counseling, enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual, and he or she must be assured that the process will be confidential [16]. It is usually combined with pre- and- post-test counseling. The pre-test counseling prepares the client by explaining and discussing the HIV test process, myths and misinformation about HIV/AIDS, implications of testing, risk assessment, risk prevention, and coping strategies. The main aim of post-test counseling is to help clients understand their test results and initial adaptation to their seropositive or seronegative status with referral as required. Voluntary Counseling and Testing is one of the key tools in HIV/AIDS prevention, and it includes benefits at the individual, community, and national levels. Although several strategies to increase the uptake of VCT among sub-Saharan populations have been suggested, factors that act as motivators for and barriers to uptake of VCT are rather elusive and difficult to delineate. It is estimated that up to 90% of HIV-positive individuals in low-income countries do not know their HIV status and may be unsuspectingly

spreading the disease [17]. This according to the World Health Organization and UNAIDS underscores an urgent public health priority to immediately scale up HIV testing, treatment, and counseling in most sub-Saharan African countries which command the status of being epicenter to and bear a disproportionate brunt of the global pandemic [18, 19]. More so for Malawi, as in other high HIV- prevalent countries of sub-Saharan Africa, residents of rural areas often lack opportunities to be tested for HIV and to learn their status [20]. While VCT has been available in various facilities in Malawi for years, most testing centers are located in major urban areas. The dearth and paucity of studies on the efficacy, impact and effectiveness of VCT programs in Malawi in particular justifies the need to conduct studies delving into how the strategy could be expediently used to mitigate the spread of HIV/AIDS.

### Methods

A qualitative paradigm- the Focus Group Discussion [FGD] was utilized to inform the study. The rationale for tool choice is based on FGDs' high face validity, that is their ability to measure what they are meant to measure, and their ability to foster a high degree of candor from participants in a naturalistic setting. Further the tool choice was warranted by the UN analysis that 'Prevention measures that are promoted globally are often at odds with what ordinary people perceive as acceptable strategies to protect themselves within their own social and family environment' [7]. Moreover, lay perceptions present a more complete picture of the factors that potentiate risk aversion/reduction: '[Ordinary people's] basic conceptualization of risk is much richer than that of the experts and reflects legitimate concerns that are typically omitted from expert risk assessment' [21]. Studies of behavior change that focus exclusively on the two measures of most interest to the prevention community- condom use and fidelity [faithfulness] or chastity [abstinence]- bias examinations of behaviour change downward by ignoring other potentially effective ways of limiting the epidemic. Consequently the FGD was used to learn how VCT could be used by ordinary Malawian women to complement other strategies in curbing the spread of HIV/AIDS. One of the main purposes of the study was to solicit information on ordinary women's knowledge, behaviours and perceptions regarding VCT. The study site is the district of Lilongwe, located in central Malawi. Convenient sampling was used to select the respondent groups involved in the study. About 10 – 15 participants from each of the three women groups

namely; St John Nsamba, Women of Action and NAPHAM support group were involved in the FGDs conducted at different intervals. The first two groups St John Nsamba and Women of Action were sampled as primary groups, the former representing the urban domain and the latter rural domain. NAPHAM support group was sampled as a control group not only because it was neutrally peri-urban but more so because the group's composition was unique. First, 100% of the respondents had undergone VCT and would be better positioned to inform the study on catalysts potentiating VCT uptake among ordinary women. Second, in an attempt to guard against gender bias the control group also included male respondents although the study targeted female respondents. In contrast the urban and rural primary groups' participants were women whose majority had not screened for HIV with a high probability of informing on factors that inhibit or demotivate ordinary women from uptaking VCT. Approximately the eligible participants were within the age category 20-49 all of whom were either married or widowed, infected or affected by HIV/AIDS. This composition of respondents might however have been recurrently exposed to education and information on HIV/AIDS and VCT considering the background of the women groups. One major limitation of the current study might therefore have emanated from possible repetition by respondents of information acquired from health education elsewhere thus introducing bias into the findings.

Discussion questions ranged from those focusing on awareness and knowledge of HIV transmission dynamics, misperception of possible asymptomatic status persons and possible risk factors of such a trend, possible benefits of testing, motivators to testing and possible barriers to testing. Specifically the following questions were posited for discussion- (1) The number of known means to avoid HIV/AIDS, (2) The number of known ways HIV could be transmitted, (3) Whether the respondents agreed that a healthy-looking person could be HIV positive, (4) What benefits there are to uptake VCT, (5) What factors motivate VCT uptake, and (6) What factors inhibit VCT uptake. The number of known means to avoid HIV/AIDS were modeled after the Malawi Demographic Health Survey [22]. The discussion question whether respondents agreed that a healthy-looking person could be HIV positive was chosen for the FGDs because it is thought to be related to one's perception of risk as well as being a risk factor for contracting HIV/AIDS. While this was a small qualitative study with no intention to make

observations that would be statistically representative and generalisable to the wider population of women in Malawi, the sample was relatively large enough to capture adults whose varied experiences could shed light on a wide range of potentiating factors or inhibiting factors to the uptake of VCT. The three FGD sessions were recorded, translated and transcribed. Thematic content analysis was utilized to isolate and synthesize key themes. The process of thematic analysis involved the use of themes, which were identified inductively from transcribed interview data to encode qualitative information. The procedure utilized was developed by Boyatzis [23] and was orchestrated by coding themes based on category, definition, and indicators with analysis following. More specifically, participants' FGD data were analyzed inductively by preparing the data [transcribing and translating as warranted], reducing the data [reading, bracketing, gleaning, and winnowing text], categorizing [using constant comparative procedures] thematizing the data, and theorizing [24, 25]. Data collection was anonymous and consent sought to report and document findings.

## RESULTS

### Motivators for Testing

Respondents who had screened for HIV through VCT highlighted the main factors that had motivated their decision to test.

### *Recurrent Illness and Concern about Possible Symptoms of HIV*

The majority of women who confirmed screening for HIV through VCT referenced recurrent illness as the major factor motivating them to test. Respondents mentioned recurrent malaria, tumors, shingles, and diarrhea as other illnesses and possible symptoms of AIDS that prompted them to consider uptaking VCT. Most of these respondents were grateful that they had tested for HIV and confirmed that even though they were seropositive, knowledge of their serostatus coupled with access to Anti Retroviral Therapy (ART) had lifted a burden of worrying about their healthy and status:

*'It was better I knew about my status because apart from accessing treatment whenever I happen to be suddenly sick I don't engage in unwarranted assumptions about my status but rather immediately rush to the hospital to consult my doctor.....in contrast someone who has*

*not tested would continuously be anxious and just speculate her recurrent illness might be a sign of HIV/AIDS, but she would not be sure unless she underwent testing.....so the speculation in itself is even more depressing than just having the courage and uptake VCT.'*

### **Encouragement from Significant others**

One respondent alluded to encouragement from a relative although it is surprising that none of the respondents across the FDGs mentioned a health care practitioner as the source of motivation:

*'I suffered from malungo [febrile fevers] recurrently and my elder son encouraged me to go for VCT.'*

### **Personal Encouragement and Contact with People Living With HIV/AIDS [PLWHA]**

One respondent alluded to the fact that contact with an apparently health HIV positive person gave her the drive to consider screening for HIV:

*'There she was healthy but testifying that she was on ART....so I thought if she could look just as health as she is yet be HIV positive I could as well be infected so I considered it worthwhile to screen for HIV through VCT.'*

### **Availability and Presence of VCT Service Providers**

Especially so for the rural group, it was highlighted that the mere presence of mobile or outreach VCT service personnel in the vicinity was a factor strong enough to motivate women to screen for HIV:

*'In remote rural areas we women may be motivated and consider it a rare opportunity if the outreach and mobile VCT team visits our area therefore the availability and proximity may motivate uptake even when there was no prior intention to do so.'*

### **Planning to have a Child**

The possibility of preventing transmission of HIV to an unborn child was also highlighted as a motivator to testing even in the absence of recommendation from health care personnel at antenatal clinics:

*'We women may be motivated to test for instance if we want to have a child or if we are already pregnant but want to prevent transmission to the unborn child.'*

### **Motivation through Community Mobilization and Outreach Campaigns**

Respondents were also referred to the role of Health Education associated with Community mobilization in potentiating VCT uptake:

*'We may be motivated by drama groups that advocate and campaign for VCT.'*

### **Motivation by Prospective Employers**

One respondent highlighted a rare but emerging employer trend in Malawi where VCT is more or less still construed as a human rights issue:

*'I was seeking a job and one day together with two friends we went to a certain Asian who requested us to go for VCT before being considered for the job.'*

### **Risk Factors**

Possible risk factors highlighted as motivating screening for HIV included concerns about the fidelity or faithfulness of one's husband with women considering it prudent to test in case the husband had contracted HIV and had infected her. Further the socio-cultural gender role of women in Malawi where they are expected to care for the sick was considered a risk factor universally across the FDGs with respondents affirming that some women may seek to know their status if they have been caring for a positive relative. Further reference was made to the desire for vilification in cases where some women guilty-conscious of their behavior would want to know their status. Another risk factor alluded to concerned accidental exposure to blood for example in attending to an injured relative who could be bleeding profusely with the helper seeking to test afterwards.

### **Blood Donation Requirement**

One respondent also alluded to testing being motivated by the logistical requirements of blood donation:

*'If for example one wants to donate blood to a next of kin VCT might be a requirement to avoid donating HIV contaminated blood.'*

### **Curiosity**

Incidentally other respondents alluded to curiosity to just know or just willingness to know one's status.

### **INCENTIVES AND PERCEIVED BARRIERS TO VCT**

#### **Incentives/Benefits of Testing**

##### ***Possibility of Accessing Treatment and Consequently Living Longer***

The possibility of living longer if testing was uptaken earlier was the most common perceived benefit of testing across the FGDs:

*'Being self-motivated to test even before the inception symptoms prolongs life, one may live longer and more positively as compared to a person who undergoes VCT when sick and with already lower immunity- compliance to drugs [ART] may even be problematic in such a case.'*

##### ***Prevention of Further Transmission of HIV to others***

The possibility of limiting transmission of HIV to others was universally affirmed across the FGDs:

*'Transmission of HIV unintentionally or unknowingly is prevented since most people who test positive choose to change their life style especially if it was an extroverted promiscuous one following counseling and a bid to live longer and positively.'*

##### ***Prevention of Transmission to One's Partner in Case of Sero-Discordancy***

The possibility of limiting transmission to spouse was overwhelmingly emphasized with the associated need to promote couple counseling:

*'One is able to limit transmission to one's spouse in case of sero-discordance since the couple is motivated to protect one another for example through condom use.'*

Other highlighted benefits in the light of couple testing included instilling more intimacy between partners, development of trust and enhancement of faithfulness or fidelity in case the couple is tested negative. Further, relative to sero-discordance between couples respondents were of the views that:

*'Compared to a couple who already know their status and may protect each other, a couple that is not aware of their status may subsequently transmit HIV to each other even if they were sero-discordant initially since they don't take measures to protect themselves through condom use because of the apparent ignorance.'*

*'One partner may play a guardian role reminding the one infected to take the dosage [ART] and of appointments with physicians as well as treatment in case of illness.'*

Relative to positive living one insightful contribution concerning couple testing focused on compliance to drug regimens:

*'Couple testing may lead to compliance to drugs bearing in mind that in most cases women or men do undergo VCT clandestinely without the foreknowledge of their partner leading to lack of and fear of disclosure compounded by further secret taking of the dosage.....some wives bury the ARVs in mealie-meal and some husbands hide the ARVs in drawers at work places creating a scenario where the other partner might skip a dose when the other is present for fear of being discovered culminating in drug non-compliance which might be detrimental to one's health.'*

##### ***Prevention of Mother to Child Transmission***

A chance of preventing transmission of HIV to an unborn child was universally cited as another benefit of uptaking VCT:

*'If tested positive a pregnant woman is given Niverapin to prevent transmitting HIV to the unborn child.'*

##### **Perceived Barriers to VCT**

###### ***Concerns about Partner***

Concerns about how the husband would react to testing were rife amongst the respondents across the three FGDs. It was highlighted that most partners are often hostile when a wife suggests and negotiates for VCT with some men assuming the wife is being unfaithful. Further due to cultural stereotypes most

women don't have the courage and are powerless to negotiate for VCT:

*'We fear being divorced if we push for VCT and also feel losing a husband far outweighs the benefits of testing.'*

Paradoxically the women also stipulated that in case their partner goes for testing which may explain the relatively higher male VCT uptake rate, the reason is because most men are just more promiscuous and their conscience about indulgence in risky sexual behaviors dictates and justifies their intentions and subsequent uptake of VCT.

### **Fear of VCT aftermath**

The element of fear of the aftermath of VCT was considered a factor strong enough to deter many prospective VCT patrons. It was stressed unanimously that most women still feel a positive test result implies the end of everything with the presumption that they may die soon. Fear also constituted the anxiety, worry, distress a positive test result might bestow with some women fearing being perceived as promiscuous if tested positive especially in cases where the husband would be negative:

*'The husband may say you are a prostitute or have always been unfaithful.'*

Fear about being stigmatized and discriminated against was also universally pinpointed as a major barrier to uptaking VCT:

*'Most of us women fear being ostracized, ridiculed, reviled and despised by fellow women.....they may say look at her she has it kachilombo [the HIV virus] she went there and they found it.'*

Another sentiment that cropped up with respect to fear was the element of shame in itself and the related fear of being shunned especially by members of the opposite sex in case status was disclosed:

*'Some of us women fear being shunned and no longer being marketable to members of the opposite sex.'*

Other respondents just felt they would not be courageous enough or have the peace of mind to accept a positive test result with other respondents highlighting a significant factor of concern about the plight and future of the children.

### **Knowledge Gap**

The element of ignorance about the benefits of uptaking VCT was also highlighted with its associated factor about some women eliciting ambivalence and mixed feelings about the whole process.

### **Social Comparison/Optimistic Bias**

An interesting and rather significant finding possibly associated with low risk perception was the optimism and social comparison bias posited relative to how other women perceive VCT:

*'Some apparently health women may feel it a waste of their time to even consider or think about VCT.....they perceive HIV/AIDS as others' problem not necessarily concerning them.....generally they feel invulnerable and not at risk of contracting HIV hence no need to even consider VCT.'*

### **Carefree Mentality/Attitude**

Another controversial finding concerned how other women would behave regardless of the possibilities of being infected:

*'Other promiscuous women may suspect they are infected but may continue to indulge in risky sexual debuts to deliberately spread the virus to others.....they may retort I can't die alone.....they may be carefree and never even consider screening or they may shun screening indefinitely.'*

### **Lack of Motivation**

Respondents also alluded to motivational factors as inhibiting general responses to VCT with other women considered unconcerned or unmotivated and wanting the service providers to come to them not least of concerns being the long distance to testing centers especially among the rural women:

*'It might be the presence of the service providers that might motivate us to uptake VCT because centers are located very far away.'*

### **Rights Issues**

Another inhibiting factor revolved around concerns about individual rights vis-à-vis being apparently coerced to undergo HIV testing:

*'Some of us women claim we have the right not to test or test, to know or not to know our serostatus and don't want that right violated.'*

### **Provider Attitude**

Respondents were also of the view that the attitude of service providers might have a bearing in demotivating women from uptaking VCT:

*'Most providers focus more on clients perceived to be positive and interventions are also likewise and this attitude puts off many would be motivated to test.'*

### **DISCUSSION**

The efficacy of VCT as a preventative strategy relative to the spread of HIV/AIDS has been widely documented. Empirical research findings are replete with anecdotal and observational implications of the strategy's potential in mitigating the spread of HIV/AIDS with respect to not only risk reduction but overall behavioural change [2, 26-30]. In Malawi for instance, barriers of cost and convenience on tolerance and acceptance are minimized by the fact that service provision is free in public and generic health centers across the nation courtesy of the commitment of several stakeholders. The paradox however stems from the lack of acceptance and tolerance of the preventative strategy not only in Malawi but other concerned sub-Saharan African nations. Questions raised about VCT efficacy range from those concerning human rights, confidentiality, client self-motivation, client self-efficacy, coping mechanisms, HIV/AIDS risk perception, medical-ethics, to professional relevancy across the continuum.

The study therefore provides insightful findings that could significantly inform research with respect to factors that may potentiate uptake of VCT among ordinary people. Not only that, the findings above all else provide an eye-opener on factors inhibiting VCT uptake among low-income ordinary women in Malawi. This category of the population was worth focusing on due to the credence and authenticity documented widely on the role socio-economic disparities, deprivation and poverty lend to susceptibility to contracting HIV/AIDS. However the lessons drawn from the current study may be limited because only one district was researched. Respondents were drawn from around Lilongwe city which is in the Central region of Malawi yet the country has three regions with diverse

cultural groupings. Despite this limitation, the fact that the urban and peri-urban groups of the population is multi-cultural with residents emanating from across all the three regions due to emigrational trends and urbanization might have consolidated the attitudinal diversity with respect to HIV/AIDS and VCT. Socio-demographic factors were also not incorporated into the study design.

The study regardless of the limitations posited provides insightful findings without militating against further research possibilities especially from the quantitative domain. In as far as the findings are concerned; though there is cause for optimism considering the fact that the majority of respondents were aware of the benefits of testing; it is rather worrisome to note that most respondents were concerned about their partner's [husband] infidelity or unfaithfulness and ironical negative attitude toward as well as impossibility of tolerating VCT within the marital setting. Sentiments about fearing being divorced and labeling that concern as far outweighing the prudence of uptaking VCT depicts a very counterproductive element with respect to the fight against HIV/AIDS but significant variable previous motivational studies might have overlooked. Consistent with the finding Lowy documents that in the United States, about three and a half million women are at risk of contracting HIV/AIDS because they mistakenly believe they are in a monogamous relationship, when, in fact, their partners are being unfaithful [31]. This empirical paucity about the poignancy of negotiating partner testing and disclosure has been extensively documented [32-37]. Concerns about partner unfaithfulness and infidelity as motivators and husband intolerance as a barrier to VCT among ordinary women further underscore the need to emphasize more on strategies that are hinged on commitment to one partner such as 'Zero grazing' in Uganda and 'One love' currently being advocated in Malawi.

Reference to stigma and discrimination is not a surprise empirical validation to that effect being replete [32, 38-40]. The current study however depicts that in Malawi issues of stigma might still be a major barrier in relation to intentions to or even considering uptaking VCT. It cannot be overlooked that the anticipated psychological trauma of being ostracized, ridiculed, reviled and despised might play a significant role in deterring apparently health, asymptomatic but potentially infected persons from uptaking VCT not least of all those who may actually be negative but are just willing and curious to know their status but worried



about the traumatisation in case they test positive. The result posits the risk of jeopardizing on design and implementation of programmes to promote preventive testing and re-strategizing of VCT as a two fold Public health rationale. Specifically emphasizing first, that apart from the benefits of antiretroviral treatment, informing HIV positive people of their serostatus would be crucial if they are to limit further transmission of the virus. Second, that it is hoped those who find out that they are HIV negative will take steps to protect themselves from infection in the future. However, as the current study has reflected, the anticipated psychological trauma on its own may realistically and primarily be endured by those who might suspect that they have symptoms of HIV or are already very sick. On the contrary, asymptomatic HIV positive people may continue to transmit the virus unknowingly while efforts at increasing knowledge of HIV status among those who are HIV negative may be less effective.

It was not expected that streaks of optimism, being non-committal and lacking concern about HIV/AIDS and VCT could be alluded to as proximate barriers to uptaking VCT in the current study considering the severity of AIDS and its high prevalence rate in Malawi. Notwithstanding; low perception of risk, and personal optimism through perceptions of AIDS as other's problem may be explained from the perspective that people may often view threats as not personally relevant and typically see themselves as facing less risk than average others [which could be true for only half a population] [41]. There is a general tendency to believe in one's invulnerability to diseases [42, 43]. It is very comforting, though incorrect, to believe that it hasn't happened to me, and it won't happen to me because it can't happen to me. Unfortunately, it can and might but many people tend to downplay the possibility of contracting HIV/AIDS. It is very difficult and taxing to bring about attitudinal and behavioral change because of this social comparison or optimistic bias stemming from both cognitive processes [e.g., the greater availability of the precautions that one takes] and motivational processes [e.g., wishful thinking] and prompting unwarranted risk taking as well as poor health seeking behaviours because health messages seem more applicable or relevant to other people [44].

With respect to motivators to testing, the sentiment in the current study especially among the rural group about being motivated by the visitation and subsequent proximity of a VCT service provider team and allusions of preference to home-based service provision in mobile and outreach campaigns was extremely

insightful. The finding is consistent with those in a study that occurred parallel to a larger Malawi Diffusion and Ideational Change Project [MDICP] funded by the National Institute of Child Health and Human Development [NICHD]. Hypothesizing that rural Malawians would respond more enthusiastically to, and favor rapid testing in other settings rather than routine health facilities as well as over testing with delayed results; it was found out that most respondents favored VCT and the dissemination of results within their homes over other areas such as hospitals [20]. According to the study results, one of the most prominent justifications for home-based service preference was that the home protected their privacy and the confidentiality of the test result in a way that getting tested in a hospital or other service center could not. This specifically highlights the pertinent need for an opportunity to come together, to discuss serostatus results in a safe setting, and to negotiate a risk-reduction plan- a strategy that could be considered in all studies of serodiscordant couples, and may have potential to reduce the high rate of transmission among such couples in developing countries.

The current study's provider proximity and preference for home-based provision of VCT is also consistent with findings from a study conducted on the Likoma Island of Malawi [45]. The study was aimed at measuring the uptake of home-based VCT and estimate HIV prevalence among members of the poorest households in a sub-Saharan population. It was observed that despite the fact that less than a quarter of the study population had previously participated in facility based VCT, home-based provision of VCT was very well accepted in the study population. When present at home at the time of the VCT team's visit, more than 75% of respondents accepted to be tested and immediately retrieved their HIV test results. Uptake was even higher among the poorest, suggesting a strong unmet need for VCT in the most disadvantaged subgroups of the population.

The current study's finding coupled with the MDICP and Likoma findings are insightful in the sense that they highlight a gap in accessibility to VCT services especially in rural Malawi begging the question as to whether the majority of people are really not motivated to uptake VCT or rather that the service in itself is not readily available. The finding also sheds light to the implication that home-based provision of VCT services has a potential of not only increasing uptake of VCT among ordinary women who may not have contact with routine health services or who are reluctant to visit

them due to other extraneous factors. There is also hope to reduce the socio-economic gradient in VCT utilization which has ramifications in the overall fight against the pandemic. Not only that, home-based VCT has the potential to promote couples oriented testing with empirical findings depicting current strong self-selection among couples in the use of VCT [46]. The current study actually alludes to clandestine patronage with its implications vis-à-vis compliance to drug regimens. Overallly the findings therefore point to implications in scaling down and mitigating an emerging threat in exponential prevalence rates in the name of serodiscordant coupling.

In relation to couple testing, the current study posited the potential to instill intimacy between partners, fostering of trust and enhancement of faithfulness or fidelity if partners tested negative. Above all else couple testing was considered a precursor to positive living as well as a means of limiting transmission of HIV to one's partner in cases of serodiscordancy but only when all partners were aware of their serostatus since ignorance was shown to exponentially perpetrate the opposite trend. The findings are consistent with those of a study conducted among a cohort of Rwandan women [47]. The study results show that the discordancy HIV-seroconversion rates decreased in seronegative women whose partners were not tested. In the same vein another interesting empirically documented finding highlights that counseling of couples and/or partner testing appears to be effective at altering risk behavior as well as more effective than individual testing and counseling when the two are compared [48].

Overall although offering less reason for optimism in the design and implementation of VCT programmes in Malawi the foregoing findings present important implications relative to the proximate efficacy of VCT in promoting Behavioral change relative to the HIV/AIDS pandemic. The factors that potentiate VCT uptake as unveiled may be fundamental for VCT Policy development, implementation and evaluation and as well for an overall public health impact. There is however need to address prevailing gaps especially concerning awareness of the benefits of testing considered not comprehensive enough through community mobilization and outreach campaigns and scaling up home-based provision through door to door services if necessary. The need to address these prevailing gaps hinges upon the backdrop that VCT will have significant impact on the epidemic only if it is able to attract and target large numbers of HIV-positive

individuals, particularly those who are not yet ill, are asymptomatic, are unaware of their serostatus, are still sexually active and hence posit an exponential probability of further transmitting and spreading the virus.

## CONCLUSION

The most important methodological conclusion that can be drawn from the study is that demand for VCT services may increase both as a diagnostic and public health preventative tool in the medical management of people infected with and affected by HIV in Malawi in particular and other high prevalent countries of sub-Saharan Africa in general. The current study highlights among other factors the need to reinforce couple counseling and testing as well as overall public health education on the benefits of VCT. Above all else the study unravels the unequivocal need to emphasize on home based service provision which may guarantee not only confidentiality but help abate and mitigate the pandemic by targeting a new wave to the crisis vis-à-vis HIV/AIDS relative to Malawi and other affected sub-Saharan nations in the name of serodiscordant coupling. Also unveiled in relation to home based provision of VCT is an important element that the service innovation may also tap on that exponentially higher poor rural-populace who may not have contact with routine health services or are often reluctant to patronize such service centers in generic hospitals or other facilities due to extraneous variables. As the study further postulates, home based VCT service provision also promises to substantially reduce the socioeconomic gradient in VCT utilization observed in several sub-Saharan African countries with substantive implications in the fight against the pandemic. Notwithstanding, with an efficacious vaccine and cure for HIV and AIDS still elusive, focusing on stringent mitigative strategies such as VCT remains the window of hope in our desperate war against the HIV/AIDS pandemic not only in Malawi but sub-Saharan Africa in general.

## REFERENCES

- [1] UNAIDS. Voluntary Counseling and Testing. UNAIDS Technical update, Geneva, Switzerland 2012.
- [2] Vidanapathirana J, Abramson MJ, Forbes A, Fairley C. Mass media interventions for promoting HIV testing (Review), The Cochrane Collaboration, Wiley 2007; Issue 3.
- [3] Weinhardt L, Carey M, Jonson B, Bickham N. Effects of HIV counseling and testing on sexual risk behavior: A meta-analytic review of published research, 1985-1997. *Am J Public Health* 1999; 89(9): 1397-405. <http://dx.doi.org/10.2105/AJPH.89.9.1397>

- [4] Miller A. Behavioral risk for HIV infection associated with HIV-testing decision. *AIDS Educ Prev* 1996; 8(5): 394-402.
- [5] CDC. Revised Guidelines for HIV counseling, testing and Referral and Revised Recommendations for HIV Screening of Pregnant women. *Morbidity and Mortality Weekly Report* 2012; (50): 304-370.
- [6] NAC. National HIV Prevention Strategy (2009-2013), NAC Secretariat, Lilongwe 2009.
- [7] UNAIDS/WHO. Initiating second generation HIV surveillance systems: Practical and logistical guidelines. Geneva, Switzerland 2002.
- [8] Coates TJ, Grinstead O, Gregorich S. Efficacy of voluntary HIV-1 counseling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomized trial. *Lancet* 2008; (356): 103-112.
- [9] Demographic Health Survey. Malawi Statistical Office. Zomba, Malawi 2011.
- [10] UNAIDS/WHO. Initiating second generation HIV surveillance systems: Practical guidelines. Geneva, Switzerland 2008.
- [11] NAC. Biological and Behavioral Surveillance Survey 2006 and Comparative analysis of 2004 BSS and 2006 BBSS, NAC Secretariat, Lilongwe 2006.
- [12] MACRO. Annual Reports (2007-2010), MACRO Secretariat, Lilongwe 2010.
- [13] NAC. National HIV/AIDS Policy- A call to renewed action (SUMMARY), NAC Secretariat, Lilongwe 2008.
- [14] Marcus R. Gender and HIV/AIDS in sub-Saharan Africa: The cases of Uganda and Malawi. *Bridge* 1993; (13): 452-81.
- [15] WHO. Testing and Counseling. (serial on the internet) 2003 November 10(cited 2012 December 6) Available from <http://www.who.int/hiv/topics/vct/testing/en/print.html>
- [16] UNAIDS. Tools for Evaluating HIV Voluntary Counseling and Testing. Joint United Nations Programme on HIV/AIDS. Geneva, Switzerland 2000.
- [17] UNICEF. How does HIV affect young people? (serial on the internet) 2006 October 4 (cited 2012 November 12) Available from <http://www.unicef.org>
- [18] WHO. Guidance on Ethics and Equitable Access to HIV Treatment and Care (serial on the internet). 2006 June 20 (cited 2012 January 7) <http://www.who.int/hiv/pub/advocacy/en/guidanceethics>
- [19] UNAIDS/WHO. Initiating second generation HIV surveillance systems: Practical guidelines. Geneva, Switzerland 2008.
- [20] Kimchi E. Reactions to At-Home Voluntary Counseling and Rapid HIV Testing in Rural Malawi. Student Summer Fellowship report. PARC, Pennsylvania 2005
- [21] Slovic P. Perception of risk. *Science* 1987; (236): 280-85.
- [22] Demographic Health Survey. Malawi Statistical Office. Zomba, Malawi 2000.
- [23] Boyatzis R. Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage 1998.
- [24] Merriam SB. Qualitative research and case study applications in education. San Francisco, CA: Jossey-Bass 1998.
- [25] Seidman I. Interviewing as qualitative research. A guide for researchers in education and the social sciences (2<sup>nd</sup> ed.). New York City, NY: Teachers College, Columbia University 1998.
- [26] Dillnessa E. Couple voluntary counseling and testing among VCT clients in Addis Ababa, Ethiopia. *Ethiopia Med J* 2010; 48(2): 95-103.
- [27] Matovu JK. Preventing HIV transmission in married and cohabiting HIV- discordant couples in sub-Saharan Africa through combination prevention. *Curr HIV Res* 2010; 8(6): 430-440. <http://dx.doi.org/10.2174/157016210793499303>
- [28] Orne-Gliemann J, Tchendjou PT, Miric M, Gadgil M. Couple-oriented prenatal HIV counseling for HIV primary prevention: an acceptability study. *BMC Public Health* 2010; (10): 197-241.
- [29] Conkling M, Shutes EL, Karita E, Chomba E. Couples' voluntary counseling and testing and nevirapine use in antenatal clinics in two African capitals: a prospective cohort study. *J Interven AIDS Sociol* 2010; 13(10): 1758-806.
- [30] Aarnio P, Olsson P, Chimбири A, Kulmala T. Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. *AIDS Care* 2001; 21(12): 1537-46. <http://dx.doi.org/10.1080/09540120902903719>
- [31] Lowy J. Monogamous women risk diseases. *Scripps Howard* 1999.
- [32] Rajaraman D, Surender R. HIV testing in Botswana: Lessons for Policy and Practice 2009.
- [33] Maman S, Mbwambo J, Hogan N, Kilonzo G, Sweat M. Women's barriers to HIV-testing and disclosure: challenges for HIV-1 voluntary testing and counseling. *AIDS Care* 2001; (13): 595-603.
- [34] DePaoli M, Manongi R, Klepp K. Factors influencing acceptability of Voluntary counseling and HIV-testing among pregnant women in Northern Tanzania. *AID Care* 2004; (16): 411-25.
- [35] Van der Straten A, King A, Grinstead A, Selulilira A, Allen S. Couple Communication, sexual coercion and HIV risk reduction in Kigali, Rwanda. *AIDS* 1995; 9(8): 935-44. <http://dx.doi.org/10.1097/00002030-199508000-00016>
- [36] Katz DA, Kiarie JN, John-Stewart GC. Male perspectives on incorporating men into antenatal HIV counseling and testing. *Plos One* 2009; 4(11): 709-68. <http://dx.doi.org/10.1371/journal.pone.0007602>
- [37] Wolff B, Nyanzi B, Katongole G. Evaluation of a home-based voluntary and counseling and testing intervention in rural Uganda. *Health Policy Planning* 2005; (20): 109-16.
- [38] Castle S. Doubting the existence of AIDS: a barrier to voluntary HIV testing and counseling in urban Mali. *Health Policy Planning* 2003; (18): 146-55.
- [39] Lie G, Biswalo P. Perceptions of the appropriate HIV/AIDS counselor in Arusha and Kilimanjaro regions of Tanzania: Implications for hospital counseling. *AIDS Care* 1994; (6): 139-51.
- [40] Bracher M, Santow G, Watkins SC. 'Moving' and Marrying: Modelling HIV Infection among Newly-weds in Malawi. *Demographic Res* 2003; 1(7): 207-45. <http://dx.doi.org/10.4054/DemRes.2003.S1.7>
- [41] Lutalo T, Kidugavu M, Wawer M. Contraceptive use and HIV counseling and testing in rural Rakai district, SW Uganda. Abstract C246. Paper presented at the 13<sup>th</sup> International Conference on HIV/AIDS, Durban, South Africa 2000.
- [42] Buzwell S, Rosenthal D. Exploring the sexual world of the unemployed adolescent. *J Commun Appl Social Psychol* 1995; (5): 161-66.
- [43] Rosenthal D, Shepherd H. A six month follow-up of adolescents. Sexual risk-taking, HIV/AIDS knowledge, and attitudes to condoms. *J Commun Appl Social Psychol* 1993; (3): 53-65.
- [44] Weinstein A. Why it won't happen to me: Perception of risk factors and susceptibility. *Health Psychol* 1984; (3): 431-57.
- [45] Helleringer S, Kohler HP, Frimpong J, Mkandawire J. Increasing Uptake of HIV Testing and Counseling among the poorest in sub-Saharan countries through home-based service provision. *J AIDS* 2009; (51): 185-93.
- [46] Glick H. Scaling up HIV Voluntary Counseling and Testing in Africa: What can evaluation studies tell us about potential prevention impacts? *Evaluat Rev* 2005; 29(4): 331-57. <http://dx.doi.org/10.1177/0193841X05276437>

- [47] Allen S, Serufilira A, Bogaerts J, *et al.* Confidential HIV testing and condom promotion in Africa: Impact on HIV and gonorrhoea rates. *J Am Med Assoc* 1992; 268(23): 3338-43. <http://dx.doi.org/10.1001/jama.1992.03490230068030>
- [48] Kamenga M, Ryder R, Jingu M, *et al.* Evidence of marked sexual behavior change associated with low HIV-1 seroconversion in 149 married couples with discordant HIV-1 serostatus: Experience at an HIV counseling center in Zaire. *AIDS* 1991; (5): 61-67.

---

Received on 25-03-2014

Accepted on 09-05-2014

Published on 18-07-2014

<http://dx.doi.org/10.6000/1927-5129.2014.10.40>

© 2014 Marisen Mwale; Licensee Lifescience Global.

This is an open access article licensed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted, non-commercial use, distribution and reproduction in any medium, provided the work is properly cited.