

Spousal and Community Influence on Reactions to VCT and Decision Making in Rural Malawi

Lauren Gaydosh- University of Pennsylvania

Extended Abstract

Background

With an estimated 25 million adults and children living with HIV/AIDS in 2003, Sub-Saharan Africa is the region most severely affected by the AIDS epidemic (UNAIDS, 2006). Worldwide an estimated 38 million people were living with HIV in 2003, two-thirds of whom live in sub-Saharan Africa, which has only about 10 percent of the world's total population (UNAIDS, 2006). The developing countries of sub-Saharan Africa feel the devastating effects of the epidemic in all aspects of society. Approximately twenty years since the first case of HIV, the epidemic has contributed to a drastic decrease in the average regional life-expectancy to 45.6 years (World Development Indicators Database, 2005). With limited resources, the developing countries of sub-Saharan Africa find prevention strategies the most effective and realistic way to combat the epidemic (Ashford, 2001). New programs for prevention have developed throughout the world, with voluntary counseling and testing (VCT) quickly emerging as a critical part of any national prevention program.

VCT allows attendees to learn their HIV status and receive health counseling at little or no charge. The motivation behind the provision of VCT is that knowledge of HIV infection will cause behavioral changes in both positive and negative people (AVERT, 2005). In addition, the counseling segment of VCT informs attendees of effective ways to avoid infection, prevent transmission, or stay healthy while living with HIV, which many believe will quell the rising rate of new infections (Coates et al., 1998; The Voluntary HIV-1 Counseling and Testing Efficacy Group, 2000; Painter, 2001).

Advocacy for provision of VCT and expansion of existing VCT programs rests on several assumptions: VCT efficacy depends on the assumption that people want to be tested for HIV, and that those who want to be tested will go to the VCT center. Also, once people learn their results, advocates assume that those who are HIV-negative will work towards reducing risk behavior in order to remain HIV-negative, and that those who are HIV-positive will avoid infecting others.

There is much speculation about the effectiveness of VCT in preventing the spread of HIV/AIDS and very little is known about who seeks out VCT and what motivates them to attend. Some research suggests that behavioral risk factors do not influence likelihood of testing, and married and previously married individuals are more likely to enroll in VCT than never-married people, but this tells us little about the personal motivations behind HIV testing (deGraft-Johnson, 2005; Matovu et. al, 2005). There is also very little knowledge on the effects of VCT in terms of dissemination of information and sharing of results with partners, spouses, family, friends, and the community.

The limited research on VCT efficacy focuses on three limited measures of evaluation: behavioral change, partner roles, and community perception. Measures of behavioral change almost completely rely on quantitative measures, such as reduction in rates of new infection or rates of mother-to-child transmission (Allen et. al, 1992; De Vincenzi, 1994). This research also focuses exclusively on VCT attendees, examining self-reported behavioral changes, such as lower risk behavior or increased condom use (The Voluntary HIV-1 counseling and testing Efficacy Study Group, 2000; Allen, 2003; Matovu et. al, 2005; Mola et. al, 2006). One common weakness in this research is that it relies on self-report, and due to the sensitive nature of the subject matter, people are very likely to falsely report. A three site clinical trial conducted by the Voluntary HIV-1 counseling and testing Efficacy Study Group interestingly controlled for self-reporting error by comparing the reports of partners, and by testing for sexually transmitted diseases at several follow-up stages (2000). However, like most research on behavioral change, this study focused only on the tested population, and perhaps represents a bias in self-selection; those who elect to get tested may also be more likely to change their behavior. Because little is known about the people who decide to test, it is inaccurate to assume these behavioral changes would be present if testing occurred on a universal level.

There is also a noticeable lack of research on couple relationships and their effect on VCT. Little is known about the degree to which individuals in a relationship can control or modify sexual relations with partners, and also what role the spouse plays in an individual's decision to be tested (Painter, 2001). Women's ability to negotiate sexual behavior in marriage may be more severely restricted than for single women (Hufstader, 2005). With limited research on couples' sexual practices, very little is known about couples' lives - both social and sexual - before and after testing (Allen, 2003). In comparison to single men and women enrolled in a basic Health Information Program, single men and women individually enrolled in VCT were much more likely to report a decrease in unprotected sex (VCT Efficacy Study Group, 2000). In a similar study of HIV-discordant couples in Zambia, couple VCT prompted "sustained but imperfect condom use in the year following enrollment"; HIV-positive husbands were more willing to comply with condom use than HIV-negative husbands, suggesting men have more control over sexual behavior within marriage (Allen, 2003). It is suspected but unsupported that this male control over decision making applies to testing as well.

With the majority of HIV transmission occurring as a result of heterosexual intercourse, married adults, particularly women with HIV-positive husbands, are at high risk of infection, and couple counseling could prove a vital approach to combating the growing pandemic (UNAIDS, 2001). However, current VCT programs are rarely attuned to the unique needs of couples, and partners do not usually attend together (Painter, 2001). Couple counseling is particularly difficult because of stigma surrounding the open discussion of intimate details about the relationship between man and woman, especially within marriage (UNAIDS, 2001). While it is uncertain if and how couples change their behavior following VCT, the limited research on couples demonstrates the importance of partner input in decision making concerning testing, treatment, fertility, mother to child

transmission prevention, and how to manage the results (Painter, 2001; Allen, 2003; Baiden et. al, 2005; Bunnell et. al, 2005). In particular, husbands strongly influence women's view of the acceptability of VCT, and women with involved husbands are more willing to get tested, and more frequently express the intention of sharing results with their partners (Baiden et. al, 2005). The overwhelming majority of those tested express the desire to learn their results in the presence of their partners (deGraft-Johnson, 2005). Obviously partners play a critical role in the efficacy of VCT, and simply trying to convince partners to test has been largely unsuccessful; there must be further research on couple experiences, and a targeting of couples for VCT attendance in order to maximize the effectiveness of the program (Baiden et. al, 2005).

Some studies investigate public perception of VCT and sentiments concerning testing using a survey method with people in sub-Saharan Africa who had never attended VCT, revealing mixed community opinions about VCT programs and anxiety or fear about receiving results (Cartoux et. al, 1998; Duffy et. al, 1998; Nuwaha et. al, 2002; Thornton et al., 2005). This tells us little, however, about how or whether community perception influences an individual's decision to be tested. One requirement for the successful implementation of VCT programs is community acceptance, yet unfortunately there is limited research on community desires for and reactions to VCT. A population based study in rural Malawi found that the majority of the community expressed desire to be tested, with 76% of men and 61% of women (de-Graft-Johnson et. al, 2005). Similarly in a clinic based questionnaire survey of antenatal clinic attendants in Ghana, an overwhelming majority (92.6%) expressed willingness to be tested for HIV (Baiden et. al, 2005). However, this study only interviewed clinic attendants, and therefore does not capture the attitudes of those who do not independently seek clinic attention.

The available qualitative data on awareness of VCT services suggests that where centers are present, knowledge of availability is widespread (Pronyk et. al, 2002; Thornton et. al, 2005; Zachariah et. al, 2006). This only demonstrates that where there are VCT centers, people are aware of available testing, but does not indicate how the community responds to VCT. It is particularly difficult to evaluate community acceptability of VCT because residents are likely to censor their responses when talking to external researchers (Thornton et. al, 2005). Some evidence exists that the general population resents the limited capability of VCT to only provide to a select number of community members (Thornton et. al, 2005). However, no studies suggest that the public widely accepts or rejects the provision of VCT services.

Purpose

This study was designed to evaluate the effectiveness of VCT as an HIV treatment and prevention program, particularly examining the role of the spouse and the community in the decision making of married individuals. Using in-depth qualitative interviews with married couples approached for VCT in rural Malawi, this paper explores reasons for consent or refusal of HIV testing, and the extent to which VCT participants discuss their testing experiences with their spouses and communities. The results of this study will help evaluate the effectiveness of the VCT programs in the treatment and

prevention of HIV/AIDS in developing nations with poor health infrastructures and limited resources.

Data

The interviews I conducted took place alongside an ongoing longitudinal survey project, Malawi Diffusion and Ideational Change Project (MDICP). This project began in 1998 with its most recent wave completed in August, 2006. The purpose of MDICP is to examine the role of social interactions in changing demographic attitudes and behavior, particularly HIV, sexual behaviors and social networks. MDICP surveyed a random sample of three rural districts in the three regions of Malawi, Central, North and South, and a random sample of ever-married men and women living in villages in these districts. In the central district, Mchinji, where I conducted my interviews, the sample size consisted of approximately 1,500, and every person was offered VCT, while only a random sub-sample were offered couple VCT. In 2006, of the 946 individuals tested, there was 4.5% prevalence.

I conducted qualitative interviews with married couples who had been approached for VCT. When I drew my sample 422 individuals had been approached for VCT, and only 1 couple was found to be concordant HIV positive and there was also a limited number of discordant couples where only one spouse was HIV positive. Additionally, only 22 individuals of the 422 had been tested as HIV positive. Therefore from these 422 individuals I purposively chose a sample which included the maximum number of HIV positive individuals, concordant HIV positive couples, and HIV discordant couples. I randomly sampled the available pool of the types of couples I wanted to capture. My final sample included 21 married couples and 3 married individuals where I could not locate the spouse after several visits. Of those 21 couples, 5 had at least one partner who had refused VCT. Amongst the tested, 1 couple was concordant positive, 10 were concordant negative, and 5 were discordant. Of these 16 couples who participated in VCT, 9 were individually tested and counseled, and 7 were couple tested and counseled. In the semi-structured interviews conducted by trained interviewers fluent in the local language, the participants were asked to discuss the quality of the VCT program and their more general impression of the process. They also discussed their reasons for accepting or refusing VCT, and the conversations they had with their spouses, family, friends and neighbors concerning VCT both prior to and following the VCT visit.

Preliminary Findings

Preliminary findings include overwhelming support for and acceptance of VCT. Most respondents felt it essential to know their HIV status, and throughout the community VCT and HIV were frequent topics of discussion. Amongst married couples, women were unlikely to accept testing if the husband refused. However, women sometimes used their reproductive capacity as a bargaining tool to persuade their husbands to accept VCT. From the interviews it appears that people share their opinions on VCT freely and frequently, and most villagers express community-wide desire for easily accessible testing. In addition, married couples indeed discuss HIV and the decision to test, and establish plans to protect them in the future.

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