LIVED EXPERIENCES OF COUNSELLORS IN COMMUNICATING HIV TEST RESULTS TO DISCORDANT HETEROSEXUAL COUPLES AT A SELECTED GENERAL HOSPITAL, CHINGOLA DISTRICT, ZAMBIA.

BY

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DECLARATION

I, **LUKIKA SUSAN MUTUTUBANYA** do hereby declare that this dissertation is my own original work which has not been submitted for a degree at this or another University for purposes of being awarded a degree or other academic qualification**.**

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Student	**Signature**	**Date**

APPROVAL

This dissertation written by **Susan Lukika Mututubanya** has been approved as a partial fulfillment of the requirements for the award of the Degree of Master of Education in Guidance and Counselling by the University of Zambia**.**

Examiner 1	**Signature**	**Date**
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DEDICATION

This study is dedicated to my late dad Mr. Alex Chiyosha Mututubanya, who believed that education was the answer to many human problems, and who I know would be most proud of today; to my mum Moddie Bwalya Mututubabnya who pushed me and said I could do it. I also dedicate this study to my husband Nchimunya, and my sons (and study mates) Chipo, Nchimunya, Mwila, David and Samuel who stayed up late studying as I studied and tolerated the time I was either away from home or too busy to thoroughly check their homework, which I delegated to the oldest.

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ABSTRACT

The purpose of study was to investigate the Lived experience of counsellors in communicating HIV test results to discordant heterosexual couples at a selected general hospital in Chingola District on Copperbelt province of Zambia. The study was an interpretive phenomenological design supported by qualitative approaches of data collection. 10 counsellor-participants, 8 female and 2 males in the study. Participants were selected using purposively qualitative data generated through use of interview guide; focused group discussion guide and observational checklist was analysed using thematic analysis approach which led to identification of emerging themes. Thematic analysis involved coding and categorising the emerging themes in relation to the study. The study revealed that communicating HIV test results to discordant couples was quite a problem. Couples were not willing to take tests nor receive test results. They often expressed fear of stigmatization, marriages ending up divorce or separation and unwillingness to disclose status to each other. The study further showed that, counsellors were ill-prepared in preparation of discordant couples for testing and communicating test results. It was also evident from the study that, periodically counsellors provided support to the couples once results had been accepted by making follow up visits; phone calls and providing food supplements through hospital management. Arising from the study findings, it was recommended that the hospital management work to upgrade the skills of counsellors dealing with discordant couple in communicating HIV test results. Through the hospital management, effort should be made to strengthen the support system for discordant couples once they have accepted their new status.

Key words: *HIV: AIDS; discordant couple; Counsellor; Lived Experience*

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

AIDS -	Acquired Immunodeficiency Syndrome
ART -	Anti-retroviral Treatment
ARV -	Anti-retroviral
CDHO -	Chingola District Health Office
HIV -	Human Immunodeficiency Virus
OPD -	Out-patients Department
PLWH -	People Living with HIV
PMTCT -	Prevention of Mother to Child Transmission
PrEP -	Pre-exposure Prophylaxis
VCT -	Voluntary Counselling and Testing

DEFINITIONS OF KEY TERMS OF THE STUDY

LIVED EXPERIENCE: This is a phenomenological approach in which individuals tell their stories to make meaning of their realities and experiences.

COUNSELLOR: One who helps a client look at their predicament in the right context and understand the important variables associated with these problems, all the while ensuring the client takes responsibility for their actions.

HIV: Human immunodeficiency virus. This is the virus that is transmitted through contact with contaminated blood, semen or vaginal fluids. It interferes with the body' s ability to fight infections and causes AIDS.

AIDS: Acquired immunodeficiency syndrome. This is the most advanced stage of HIV infection which is defined by the development of certain (recurrent) infections, cancers and other severe clinical manifestations.

DISCORDANT (SERODISCORDANT): a situation where a pair of long-term sexual partners in which one has a sexually transmitted infection like HIV and the other does not or is HIV-negative.

HETEROSEXUAL COUPLE: the romantic or sexual attraction between persons of the opposite sex.

CHAPTER ONE: INTRODUCTION

1.1 Overview

The purpose of this qualitative study was to investigate lived experience of counsellors in communicating HIV (human immunodeficiency virus) test results to discordant heterosexual couples at a selected general hospital, Chingola District on the Copperbelt province of Zambia. The chapter provides the background; statement of the problem; purpose of the study; objectives and research questions that guided the study. Further, the chapter has discussed the significance of the study; delimitations; limitations and theoretical framework. It ends with a summary of the chapter.

1.2 Background

Based on the available literature review, research shows that HIV pandemic has been around for many years and medical personnel as well as counsellors have remained, a vital tool to the fight against this pandemic. What remains a mystery even today, however, is ‘ what are the lived experiences of counsellors in communicating HIV test results to discordant couples in various testing centres in the world?’ The concept of discordant couple refers to a situation where a pair of long-term sexual partners in which one has a sexually transmitted infection like HIV and the other does not (William, 2018). The CDC (2017) as a result provided guidelines for counselling discordant couples in which the woman is HIV- infected and her husband is HIV-uninfected and how counsellor, are to deal with such a situation in a couple.

Counselling is an undeniably integral part of our everyday lives. This makes counsellors an indispensable asset in the life of the community. Counsellors, whether traditional or professionally trained, have been a part of life since time immemorial and their expertise continues to equip people from all walks of life with knowledge to help them cope with their various challenges (Mutswanga, 2010). In today’ s world with the onset of the HIV pandemic, counsellors are on the ground working with clients to prepare them for HIV tests and offer post-test counselling when needed. The experiences of counsellors in communicating HIV test results remains unclear to the majority of scholars in the field of HIV/AIDS despite the slowing down of infections.

Although there is a slow reduction in the number of new HIV infections, counsellors are needed now probably more than ever, to execute their skill in order to continue saving lives. At a global scale, UNAIDS Data reported in 2018 that although HIV related deaths had declined by about 34% (3.4 million in 1996 to 1.8 million in 2017), the progress is slower than the goals that have been set to lessen the number of new infections by 2020. In Africa, a steady decline of 30% in new HIV infections has been recorded. The UNAIDS Data report further states that there has been a decrease in the number of new HIV infections since 2010, from 56 000 to 48 000 in 2018.

Although there is a decline in the numbers of new HIV infections, the pandemic is still rampant. As a matter of fact, the decrease in HIV related deaths has meant an increase in the number of people living with the virus (UNAIDS Data, 2018). This entails that testing and adherence to treatment needs to continue if we are to see further progress in the fight against HIV/AIDS.

Testing for HIV is very important, more so for couples because it equips the client with information that empowers them to make the right choices such as abstinence in cases where the spouse is absent for long periods, safe sex (condom use), and being faithful to one faithful sexual partner. Testing can only be conducted after counselling is offered and full consent given thereafter from the client because the results will be positive, negative or indeterminate (unclear). This entails that the client is psychologically well prepared prior to result disclosure so that they are able to handle the outcome of the result. The client should be well counselled about the importance of testing for HIV and the dangers of not knowing one' s HIV status, among them transmission of HIV to the unborn or breastfed child as well as poor health during pregnancy.

The National AIDS Council of Zambia (2014) reported that the need for HIV testing services had hailed an increase in the need for qualified counsellors. Counsellors can be seen as the face of hope in what the client deems as an unusually hopeless situation when facing an HIV positive result. A counsellor is qualified to speak to the client in such a way that enables them to look at a difficult situation from a different perspective and develop hope. The counsellor gives the client an objective angle to view their current predicament, and further gives them hope so that they are able to realize that they can live a long, full life despite being HIV positive. Discordancy is where one person in the couple, either the man or the woman, is HIV positive and the other is HIV negative. This scenario usually ends in divorce for those who are married, or separation for those who are not. In either case, there is a stigma that is attached to one person being HIV

positive in a couple because rumours spread and it is the possibility of this that causes hopelessness. As a result, clients may entrust the counsellor with their lives with the hope that there could be some positive aspect or news in the situation. The client is usually willing, at that point, to do anything to feel or make their situation better, hence the client has the mandate to speak as positively to the client as ethics allow.

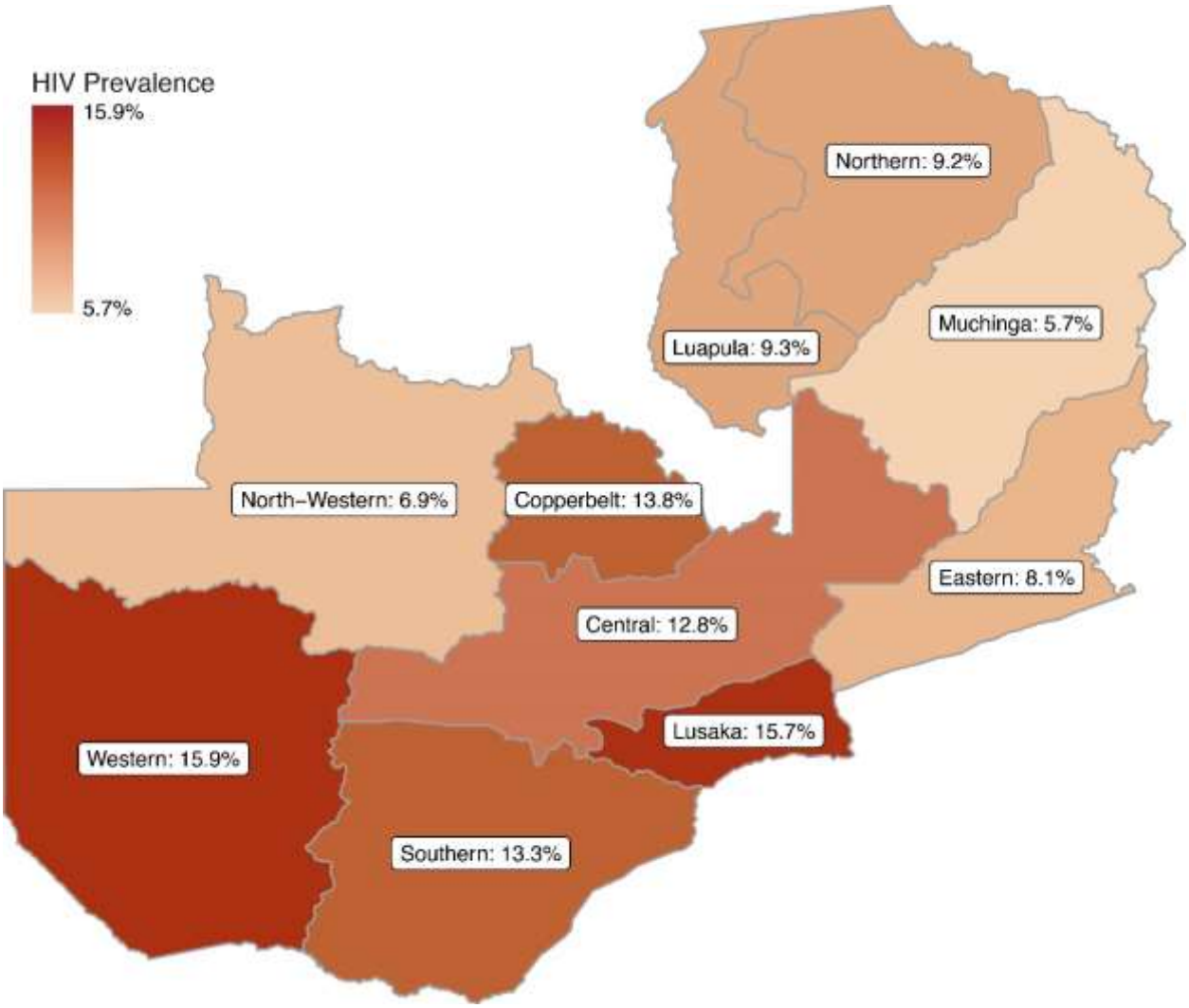
The latest National AIDS Council report (2007) showed that only 15% of Zambians had been counselled for HIV testing. However, by 2012 the percentage had increased by 119% which indicates that the invaluable counselling services are required more than ever. The increase in number of people getting tested for HIV entails that more people need to be counselled and so the counsellors are receiving a lot of mixed feedback on how the clients are being impacted by the HIV positive test result.

The Zambia National Guidelines for HIV Counselling and Testing (MoH, 2006), affirms that with the rise in antiretroviral (ARV) treatments there also comes a great need for counselling services. Being on ARV therapy requires the client to be consistent in taking their medicine and it is the counsellor' s duty to educate the client on the importance of this consistency and correct intake of their drugs. This has in mind the client who, of course, is at the center of the scenario and in need of sound counsel from a trained counsellor that will give them an objective view of their situation, as well as encourage them that they are not alone but have support from a number of stakeholders such as counsellors. The statistics indicate the dire need for counselling services in Zambia. Effective counselling of HIV positive clients might always pause a challenge especially if the client is a couple. Couples offer a unique challenge in the counselling room especially with regards to an HIV discordant result because two people inevitably bring two different views. According to Okun (1984), where individual counselling focusses on the individual' s insight, fantasies, history and client-therapist relationship; couple counselling focusses on communication, power balances and imbalances, conflict resolution and any other issues that may come into play when dealing with what causes conflict in relationships. This may automatically mean more time will be spent and more effort will be invested in counselling a couple as compared to an individual because then, several interpersonal issues are to be considered. Although, counsellors are significant in the life of the HIV positive clients, it is not known what their lived experiences in communicating HIV test results to discordant clients.

A report by the World Health Organization, WHO (2012) indicates that as many as half of all HIV positive people in long-term relationships have HIV negative partners and because many people do not know their HIV status, WHO advocates for couples getting tested together.

In Zambia, studies have shown that HIV is most generally transmitted heterosexually (MoH, 2014). In a society that views an HIV positive result as a death sentence, it can never be easy for a counsellor to reveal such a result to a client. What could be more complex than this situation however, could be a scenario where a counsellor has to reveal (a discordant result) an HIV positive result to a couple where only one is HIV positive. A discordant test result is every counsellor' s nightmare because revelation of such a result usually has inconceivable reactions from the couple and would surely raise many questions in the minds of the clients, probably more so, to the HIV negative partner. In such instances, the counsellor will definitely expect a myriad of questions and emotions from the couple towards each other. As such, the way in which the counsellor handles the couple will have a resounding effect which will be either positive or negative on them because what will follow will be either tolerance, acceptance, and a desire to work through the ordeal together or a violent or passive separation which may have ripple effects. According to Mutswanga et al (2010), couple counselling is important because it helps the couple come up with non-destructive avenues of expressing themselves, understanding each other, and dealing with their problems; thus the counsellor is present to ensure that negative attitudes and behaviour do not develop. The map below shows HIV prevalence of HIV in various parts of Zambia and the extent to which it' s a problem (ZAMPHIA, 2016).

Fig. 1. HIV Prevalence among adults aged 15 – 49 years, by province (ZAMPHIA, 2016



However, experiences counsellors go through in communicating test results to discordant couples have not been adequately explored and documented hence the present study. The counsellor is like the silent witness in all this, as s/he is usually not thought of, not considered and blotted out. It is a breath of fresh air to be able to understand the experience of the counsellor throughout the entire ordeal, as s/he has a very important role to play including the communication of test results to discordant couples.

Grinstead et al (2001), did a research in which they highlighted the after-effects of HIV counselling and testing. They discovered that discordant couples were more likely to report a break in the relationship. They found that 14% of married women who were HIV positive reported the break-up of a marriage and 13% reported the break-up of a sexual relationship; 0%

of HIV positive married men reported a break-up in the marriage whilst 38% reported a break-up in a sexual relationship. This is quite a common trend in the society and it is a cause for concern and it is the job of the counsellor to ensure that an HIV counselling and testing session does not result in break-up of marriage.

Zambia' s Copperbelt Province is a mining province and can be regarded as an urban setup. According to the CSO (2014) it is one of the most developed and heavily populated provinces in Zambia whose rich mineral resources attract foreign exchange earnings to the country. A recent statistical projection from the CSO (2018) stated that the population of the Copperbelt Province would stand at 2, 480,657. A report on the Copperbelt Province by ZAMPHIA (2016) showed that the number of HIV positive females was 1,715 whilst that of males stood at 1,245. The CSO further reports that the province has recorded improvements in the education sector owing to the high enrollment of both boys and girls at primary, basic, high school and increased enrollment rates to tertiary and university education. Such a hype of activity in the province places it a head above most other provinces in terms of development, and this may reflect a biased report as far as other provinces which are not as developed are concerned. This being the case, good schools and technological advancement means the population is well informed and a step ahead in terms of access to information.

1.3 Statement of the Problem

In a bid to ensure that the Zambian people are aware of their HIV status at individual level (The National AIDS Council of Zambia, 2014) and also prevent further spread of the virus through known status and fast-track the elimination of the virus by ensuring that as many people as possible get tested and placed on treatment, the President of the Republic of Zambia Dr. E. C. Lungu mandated HIV testing for anyone who visited a public health facility for any ailment (Zambia Daily Mail, 2018). Although this initiative had been taken with a view of identifying individuals living with HIV and the extent of the problem, it has not been clear on what, the lived experiences were among counsellors communicating HIV test results to discordant couples in Zambia. It' s against this knowledge gap that the present study was conducted at a selected general hospital in Chingola District on the Copperbelt province of Zambia.

1.4 Purpose

The purpose of this qualitative study was to investigate the lived experiences of counsellors in the communication of HIV test results to discordant heterosexual couples at a selected general hospital in Chingola district of the Copperbelt Province in Zambia.

1.5 Study Objectives

The study was guided by the following objectives:

i) To establish the lived experiences of counsellors in communicating HIV test results to discordant couples at a selected hospital facility,

ii) To explore challenges surrounding communicating of HIV test results to discordant couples in the study site,

iii) To establish the support services, provide to discordant couple once HIV test results are communicated to them in the study sites

1.6 Research Questions

(i) How are the lived experiences of counsellors regarding communicating HIV test results to discordant couples in the study sites?

(ii) What challenges are encountered by counsellors in communicating HIV test results to discordant couples in the study site?

(iii) What support services are available for discordant couples once HIV test results are communicated to them?

1.7 Significance

It was hoped that the findings of the study would reveal the challenges that counsellors face in this regard, and inform them that their challenges are acknowledged. It was also hoped that the findings of this study would help counsellors have sufficient information on their lived experiences and know how to deal with some of challenges associated with communicating HIV test findings to discordant couples in the study area. Furthermore, this study would inform the Zambia Counselling Council (ZCC) and other relevant institutions with a possibility of improving on the counselling services available to discordant couples living with HIV.

Further, planners, managers and policy workers in the Ministry of Health (MOH) would have relevant information as the support the provision of counselling services to discordant counsellors and other clients, requiring counselling on the plight of counsellors. It was also hoped that the outcome of the study, would stimulate interest for further research in this field.

1.8 Limitations

Considering that the study is about counsellors in a health facility in Chingola, Copperbelt province of Zambia, the findings were limited in scope and not to be generalised to the rest of the health facilities in Zambia. This implied that the small the size of the sample and detail of findings in an interpretive phenomenological design is mostly unique to specific phenomenon but still required generalisation within countries. Due to the nature of the study, private health facilities were not to be targeted hence another reason for not generalising the study findings, although counsellor' s lived experiences may be so.

1.9 Challenges Encountered

There were problems encountered during data collection in the field. Some counsellors did not answer all the questions. Further, some counsellors viewed the study as a way of reporting them on their shortcomings in their work particularly the relationships with their clients hence not willing to share all their experiences. Another challenge was the study area was urban hence their views did not represent experience of counsellor in rural health facilities. This lead to the study to appear as though if interest was just on lived experiences of counsellors living in urban settings which consequently limited the outcome of the study.

1.10 Delimitations

Delimitation indicate the boundary of the study in the context and geographical coverage (Creswell & Plano, 2012). The study was done at the one health facility in Chingola district, province of Zambia. Although the study health facility has different categories of workers, it focused on counsellors. These were shown because of their direct linkage with the discordant couples seeking counseling support services at the facility. Further, they were believed to have had sufficient lived experiences on communicating HIV test results to discordant couples for them to be able to share their lived experiences. These attributes were rich with the information

required for the study. In addition, there is a department where counselling services are offered with sufficient number of counsellors.

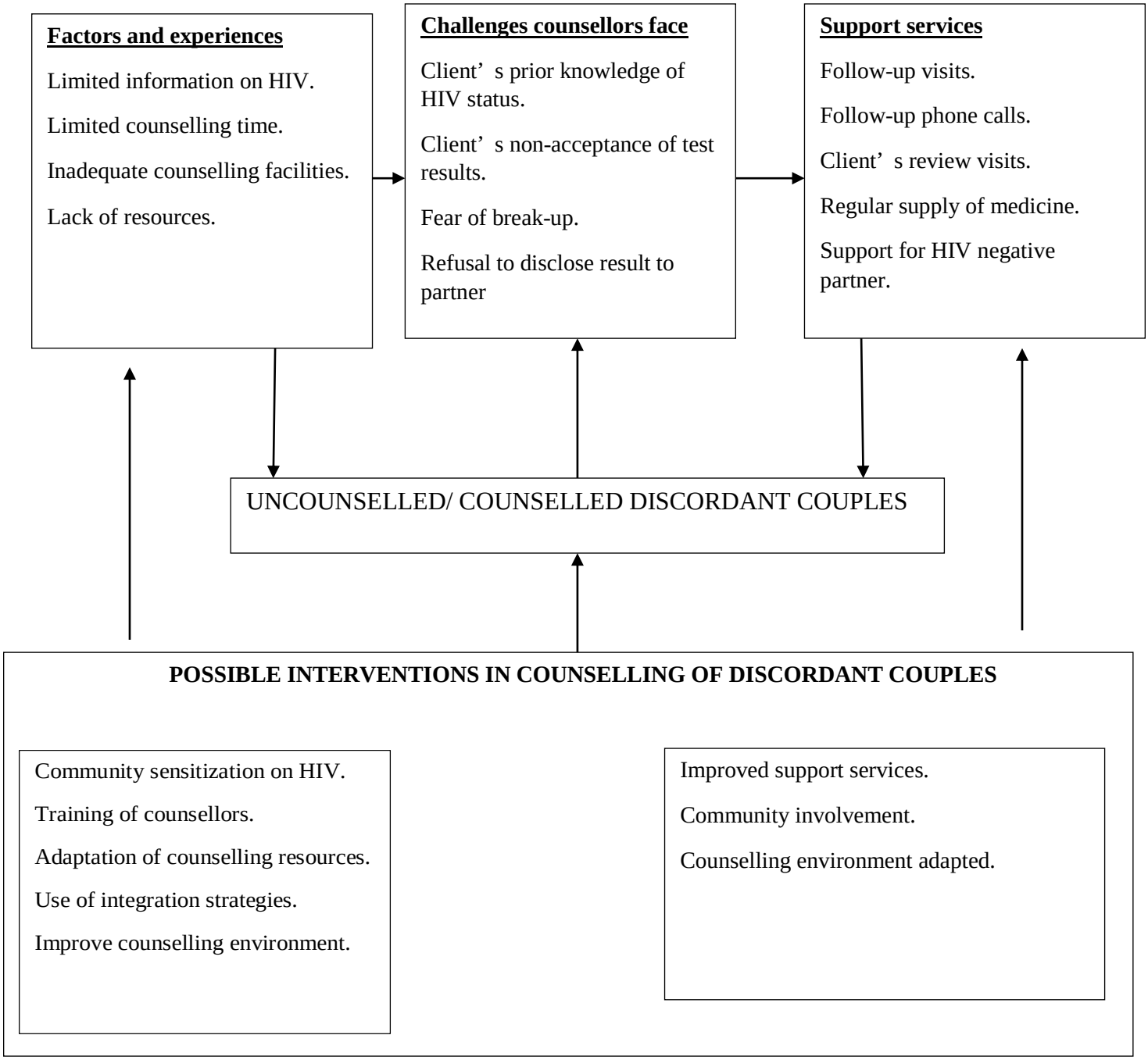
1.11 Theoretical Framework

The study employed a Person Centered Theory by Carl Rogers (1951) and expanded by Seligma (2006) and Corey (2012). In principle, the theory states that an individual helps oneself to cope with stress arising from workload when, through experiences acquires and understand the situation. It emphasizes on the need for self-actualization necessary to cope with pressure arising from complicated situations such as communicating HIV test results to discordant couples. According to the theory, it has the ability to make counsellors foster honesty, confidence and mutual trust needed to ably communicate HIV test results to discordant couples. Because of its centeredness as a support therapy provided by counsellors to clients living with HIV, it was believed that the theory, was a much relevant one to guide the outcome of the present study.

1.12 Conceptual Framework

It is true that human beings are social animals who strive when they are living in conjunction with other people. No matter how learned or independent a person may be, they will need the support of others. Counsellors are professionals who offer professional counselling services to the clients they meet on a daily basis. The work and experiences of counsellors is invaluable in that it helps save and better the lives of their clients. Although they are in the lead in offering assistance to others, they are often overlooked and forgotten by society. In this study, the conceptual framework shown in figure 2 below was used as a guide. It centred on information generated from fieldwork, covering experiences of counsellors in dealing with discordant couples, factors surrounding their behavior and conduct and indeed the support services available for the counsellors as well as for their clients who were discordant.

Figure 2: Various factors and challenges likely to lead to diverse lived experiences among counsellors



1.14 Chapter Summary

The focus of this chapter was the background to the study, statement of the problem, purpose, objectives, and research questions, significance of the study, delimitation and limitation of the study. The chapter also looked at discordant couples and how the various test results impact marriage or sexual relationships. The chapter also took a look at the theoretical framework which guided the significance of the study. The next chapter discusses the review of literature to support the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview

This chapter reviews the literature that prompted this study; that is, the challenges that counsellors face in communicating HIV results to discordant heterosexual couples. It will show the relevant literature on information on HIV/AIDS, and whether or not the literature addresses the lived experiences of counsellors in communicating HIV results to discordant heterosexual couples. It begins with a brief history of HIV/AIDS in Zambia and incorporates the necessary statistics and then takes a look at counsellor experience, couple counselling and the challenges they face in disclosing HIV results to discordant couples. The global perspective on HIV/AIDS is then taken into consideration, as well as the HIV pandemic in Zambia.

Issues such as testing as gateway to treatment, HIV mortality, trends fueling the spread of HIV, discordance, effects of the HIV pandemic on Zambia, and finally knowledge gaps.

2.2 Counsellor' s Lived Experience

Bott et al (2015) investigate HIV counselling and testing services from the perspective of the health worker. They give insight into the various challenges, apart from the rewards, that counsellors face in dealing with HIV positive clients. They cite among others, concerns about accidental exposure, staff shortages, high workloads, lack of infrastructure and lack of supplies. They also highlight what health workers described as " heavy emotional demands from observing clients suffer emotional, social and health consequences of being diagnosed with HIV and also from difficult ethical dilemmas related to clients who do not disclose their HIV status to those around them, including partners." Their study was inclined towards highlighting the fact that providers of HIV testing and counselling services need more resources and support and better protection against HIV exposure in the workplace. They further posit that health policy makers and ethicists need to address some ethical dilemmas related to confidentiality and non-disclosure, and translate those discussions into better guidance for health workers.

2.3 Challenges in Disclosing HIV Results

Keefe-Cooperman et al (2018) examined the efficacy of teaching communication skills for breaking bad news in graduate level counselling programs to ensure the adequate preparedness

of students in giving bad news. They state that repeated encounters of providing negative news can result in compassion fatigue (diminished ability to empathize or be compassionate towards someone) or professional burnout, showing that providing distressing information is emotionally draining for the counsellor and even the most seasoned specialist can struggle. Thus, many professional helpers tend to come up with ways and methods to use for the delivery of difficult news to clients. Besides this, there are many possible reactions that they will encounter when giving such distressing news to clients that counsellors worry may bring about negative outcomes.

2.4 Global Perspective on HIV/AIDS

HIV is a complex issue that brings about many questions and few answers. Having lived with the pandemic for over 30 years, the world is still grappling to come to terms with the resounding effects of this virus. Although we now have drugs that help prolong the life of the HIV positive individual, such people still face stigma from society as well as discrimination in many arenas of life. According to Anderson (2009), this stigma and discrimination is present not only in families and society, but in the health care sector as well. This shows us that there is still a lot that needs to be done in terms of counselling those who are affected by HIV. A more recent study by UNAIDS (2019) shows that in some countries (Guinea), the rate of discriminatory attitudes is as high as 80%! Discrimination can be detrimental to progress in HIV treatment because clients will shun seeking medical attention and taking their medicine. Counsellors are thus important in ensuring that people develop the right attitude towards people living with HIV.

In most communities, we find individuals (counsellors) who render their services to others and are usually there to offer a listening ear in times of distress. The members of the community may flock to them seeking help, which is mostly readily available. What is overlooked is the fact that these individuals are human beings just like everyone else, and face similar obstacles that the very people they assist face. No one really asks if they are sometimes agitated or fearful. Today, counsellors are right at the center of the HIV crisis, offering services to clients who flock health facilities and shelters to be counselled and tested for HIV. The plight of counsellors as they go about doing their duty is not really considered, as they may be thought of as having no challenges that everyday people go through.

2.4.1 Transmission of HIV

According to the Zambia National HIV/STI/TB/AIDS Council or ZNAC (2015), although there are only a handful of activities that put a person at risk of contracting HIV, vaginal sexual intercourse is the most common HIV transmission route among heterosexual couples, with the risk heightened if the couple practice anal sexual intercourse or engage in unprotected sex with multiple partners. Other activities that put one at risk are unprotected oral sex, sharing sharp instruments such as razor blades and needles and direct contact of blood with an HIV positive person. HIV can also be passed on from a mother to her unborn child, during childbirth or breastfeeding. Men who have sex with men are at a higher risk of contracting the virus because of the biological makeup of the anus, which does not produce the lubrication needed to protect it from bruises during sex. Heterosexual couples who also engage in anal sex are at a higher risk than those that practice vaginal sex. Girls and young women aged 15-24 are also at high risk of contracting the virus. This is as a result of vulnerability which mostly arises from poverty and forces them to engage in sex in exchange for gifts with much older men (aged 45+). Generally, women are at higher risk of contracting HIV than men because of the biological makeup of their reproductive system; where the larger surface area of the vagina makes them susceptible to receiving the virus in case of the most minor bruise.

2.5 HIV Pandemic in Zambia

According to ZNAC (2015), the first AIDS case in Zambia was reported in 1984 and by 1991 the Zambia National AIDS Program had recorded 15,000 cases out of which 14% of total deaths in the country arose. Since then an estimated one million Zambians have died, approximately 1.2 million people are living with the virus (ZNAC, 2015) and over 800,000 are on antiretroviral treatment. In the 1990s HIV prevalence was highest at 14.3%, and is now a generalized epidemic, as it is spread throughout the population. The HIV pandemic hit heavily on the Zambian economy, almost crippling it due reduced labor time which resulted from sickness or the need to care for sick family members. UNAIDS (2013) reports that approximately 13% of adults between the ages of 15 and 49 are HIV positive, this being the most economically active age group (ZCSO, 2015). Efforts were made by the Zambian government which immediately began to respond by setting up the National AIDS Control Program (ZNAC 2015) and later the

National HIV/AIDS/STI/TB Council (NAC) in 2002. These were put in place to coordinate all activities surrounding prevention, care and sensitization on HIV/AIDS.

2.5.1 Testing as Gateway to Treatment

The Zambia HIV Testing and Counselling (HTC) Implementation Plan of 2016 addresses the need to accelerate the scale up of HTC as part of the country' s set of comprehensive HIV prevention programs. It states that HIV testing and counselling is essential to the prevention of HIV as it is a critical gateway to services, where about 3, 816,765 people were tested for HIV in 2014 and 2015. It is very clear that at the center of this program is the counsellor, and yet these are not mentioned in the document, nor is their contribution acknowledged.

2.5.2 Couple Testing

In some instances, disclosing one' s HIV test result to a partner can be stressful especially if the result is undesired. There have been cases where a client refused to disclose their HIV test result to their partner because it was positive. Clients cite different reasons for refusing to disclose, rejection among the many reasons. It should be established right from the beginning, how the result disclosure will be undertaken to avoid time wasting and unnecessary stress on both the client and the counsellor.

Disclosure of HIV results to discordant couples is usually done in the counselling room, in the presence of the counsellor with the consent of both affected parties. According to Kairania et al (2010), about 81% of HIV positive partners in discordant relationships disclosed their HIV status to their HIV negative partner. Ultimately, disclosure of an HIV positive result in discordant couples is high, but requires consent from the HIV positive partner, and because there is no legal obligation to disclose such test results, counsellors have to walk the clients through the process to avoid making them feel rushed or coerced.

The International Journal of Epidemiology (2019) goes a step beyond individual HIV testing, to tackling couples' voluntary HIV testing and counselling as a way of reducing the number of new HIV infections. This should make a good read as far as this research work is concerned, but the journal only focusses on expenditure/monies being spent on the HIV pandemic, the cost-effectiveness of the said couples' voluntary HIV testing and counselling (CVCT) and reduction of new HIV infections. The journal highlights that CVCT was established in 73 Zambian clinics

between 2010 and 2016 to save costs on HIV counselling and testing of individuals and also reduce on new HIV infections. It concluded that CVCT is a cost effective prevention strategy in Zambia which also reduces the number of new HIV infections, but does in no wise document the input or challenges counsellors face in the process.

According to Desgrees-du-Lou and Orne-Gliemann (2008), " a couple-centered approach to HIV counselling and testing would facilitate communication about HIV status and adoption of preventive behaviours within couples" . The purpose of their study was to encourage couples to share test results and lessen partner violence by ensuring that partners received test results together in the context of couple counselling. This research comes close to including the facet of the counsellor but falls short in that it ends here. Although Desgrees-du-Lou, A and Orne-Gliemann make mention of the advantages of counselling couples, they do not make mention of the person offering this counselling and their plight.

In view of this, my research aims at establishing the lived experiences of the counsellor, in an attempt to reveal the difficulties, they face in disclosing test results to discordant couples.

2.5.3 HIV Mortality

The UNAIDS Data report of 2018 is a comprehensive report that ponders the progression in the fight against HIV and the progress of the goals that were set to end the AIDS epidemic by 2030. According to the UNAIDS (2013), about 36, 000 people died of AIDS-related illnesses in 2012. The report is mostly concerned with the rate of HIV infection and mortality rates as a result. As comprehensive as this report may be, it does not include any information on counsellors who deal with these issues daily.

2.5.4 Trends Fueling Spread

The Zambia Demographic and Health Survey of 2013-14 focused more on the numbers of people living with HIV, trends that fueled the spread of the virus and took a glance at couple infection rates.

2.5.5 Discordance

The HIV Testing and Implementation Plan of 2014-16 briefly looked at couples testing and discordant couples but does make mention of the limited number of skilled health workers

required to counsel these couples. Although it did consider couple counselling, the report did not provide any further information on the professionals who conduct the counselling and testing of these couples or provide any information on the challenges or lived experiences of counsellors in communication test results to discordant heterosexual couples.

2.5.6 Support for Discordant Couples

WHO (2016) reports that the partners of HIV positive clients are also offered HIV counselling and testing services to ensure that they get the support they need. This is important because the partner needs to be equipped with the right information that will enable them to make sound decisions. The support is not limited to information, but also involves medical support in terms of medication. The HIV negative partner is placed on Post-Exposure Prophylaxis (PEP), a type of anti-retroviral therapy (ART) which prevents the HIV from seroconverting in the body. It ensures that the partner is kept HIV negative whilst at the same time the viral load of the HIV positive client is suppressed using ART.

According to WebMD (2020), antiretroviral drugs are medications that are given to HIV positive people and are usually taken as a cocktail or combination, called ART. ART is a type of treatment that helps lower the viral load, fight infections and improve the overall health of an individual. Although they are not a cure for HIV, they can help reduce the chances of one passing the virus on to an uninfected person if taken correctly and consistently.

2.5.7 Effects of HIV Pandemic on Zambia

The Zambia Country Report to the UN General Assembly Special session on HIV/AIDS (2014), highlighted several issues on the issue of the pandemic in the country. Among the highlights was prevention of mother to child transmission (PMTCT) in which it was reported that there was a marked drop in the HIV transmission rate from 24% in 2009 to 12% in 2012. There was also an increase in the number of people being counselled due to the increase in the number of people being tested for HIV. The report further stated that there was a marked decrease in the number of HIV-related deaths, and HIV positive people are living longer due to the successful implementation of the Antiretroviral Therapy (ART) program. Furthermore, the report stated that significant gains were expected to be made in lowering HIV transmission in discordant couples with the introduction of Treatment as Prevention (TasP). The report however, did not have any

information on counsellors who work with the clients through their various ordeals in dealing with HIV infection.

2.6 Knowledge gap

The study by Bott et al (2015) entails that although the researchers made a consideration to the plight of the health care provider, they did not indicate categorically the challenges that counsellors face in disclosing HIV test results to discordant couples. This study was more concerned about challenges that have implications for consent, privacy and confidentiality.

Keefe-Cooperman et al (2018) focus on the PEWTER model which is a structured model for applying counsellor skills in providing support to those receiving bad news focuses on help rendered to the client through Preparing, Evaluating, Warning, Telling, Emotional Response, and Regrouping. It was developed in 2004 for medical personnel and counsellors, (ibid). Although they do stress the challenges in communicating bad news, they do not focus on the plight of counsellors in dealing with HIV discordant couples.

2.7 Summary

This chapter was looking at the relevant literature that was reviewed in relation to the topic at hand. Although research has dealt with counsellors in many aspects with regards to their involvement in the fight against the HIV pandemic, there is an area that has not been explored. It is important that we understand the challenges that counsellors face in communicating HIV results to discordant couples. This is because such information can give us ideas on how to better counsel couples or even alter the counselling syllabus to include aspects that may be missing. This research is intended to bring to light the plight of counsellors with the hope also, of saving marriages so that society is preserved so the lived experience of counsellors needs to be established and documented in order for their plight to be addressed accordingly.

CHAPTER THREE: METHODOLOGY

3.1 Overview

In this chapter, the researcher provides details on research methods, study site, target population sample size, sampling procedure, characteristics of participants, data collection instruments, validity and reliability, data collection procedure and indeed trust-worthiness data used. Further, it discusses the data analysis, ethical considerations and finally gives a summary of the chapter.

3.2 Research Design

Creswell & Plano (2012) define research design as a blueprint that explains the procedures that the researcher follows in the collection and analysis of data. An interpretive phenomenological design approach was used in the study and interviews and using focused group discussions supported by use of qualitative approach to data collection. These had open-ended questions which helped to solicit views and opinions on the lived experiences of counsellors in communicating HIV test results to discordant couples at the selected health facility in Chingola district in Zambia.

The researcher was present during the discussions and used an observation checklist as the focused group discussions were being conducted. The interview guide was also employed in order to offer direction and clarification to the group discussants as well as to seek further clarification from them with regards to their answers to the various questions, or just to offer clarification in case the respondents were not clear with something. The presence of the researcher served as a safety net in case there were vague answers given that could be further clarified by asking the respondent more questions. This method was chosen because of the nature of the research, which required that the respondents fully understand the real meaning of the questions, be given enough time to think their answers through and also be able to interact with the researcher.

3.3 Population

Creswell & Plano (2012) define population as a group of individuals who have the same characteristics. The reason for selecting counsellors is that, the researcher believed that counselor respondents had knowledge and experience on communicating HIV test results to discordant

couples to contribute positively to the study. A population is a target group of objects or subjects that are singled out for the study (Kasonde-Ng' andu, 2013). The target population were counsellors involved in HIV counselling and have had interactions with discordant couples at the health facility. These were selected because they had had their own lived experiences to share and contribute to a positive outcome of the study.

3.3.1 Characteristics of the Respondents

In order to assist readers following the findings of the study, the table below provides the characteristics of the findings:

Table 3.1: Characteristics of the Respondents

s/n	Gender	Age	Qualifications	Years of Experience as Counsellors
C1	M	47	Certificate in Counselling	16
C2	M	26	Diploma in Counseling	03
C3	F	54	Certificate in Counselling	13
C4	F	46	Certificate in Counseling	16
C5	F	27	Degree in Counselling	05
C6	F	33	Diploma in Counselling	07
C7	F	47	Diploma in Counselling	17
C8	F	34	Diploma in Counselling	10
C9	F	43	Diploma in Counselling	15
C10	F	28	Degree in Counselling	05

The table above shows that there were more female respondents (8) in the study than males (2). Thus we can conclude that there were more female counsellors than males at the study facility. On the part of qualification, the highest qualification of counsellors was a degree in counseling while the lowest qualification was a certificate in counselling. In terms of work experience, the highest was 17 years of service while the lowest period of working as a counsellor was 5 years.

On the ages of respondents, it was clear from the findings that, the oldest respondents was aged 54 while, the youngest was 27 years of age. Generally, the respondents were mature with relevant experience to contribute positively to the outcome of the study

3.4 Sample size

According to Creswell & Plano (2012), sample size refers to the number of respondents selected from the universe to constitute a desired sample. A sample also helps to reduce the number of participants in the research to make it manageable as well as controllable on the part of the researcher. The sample consisted of 10 counsellor– respondents drawn from the study health facility. The sample size of 10 was seem to be a possible point of the researcher reaching point of saturation.

3.5 Sampling Procedure

According to Kasonde- Ng' andu (2013), a sampling procedure is the process of selecting respondents, places and objects to participate in a given study. There are two broad sampling approaches that helps in this process; these are probability and non- probability (Creswell & Plano, 2012). The various ways of doing probability sampling are simple random, stratified, interval and cluster sampling. In this study, a purposive sampling procedure was used. A homogeneous sampling technique was employed to generate the required data. This is a method of selection where a sample has units which are the same or are similar characteristics, for example, all respondents in this study were counsellors and involved in HIV testing and communicating results.

3.6 Research Instruments

This study took a triangulated approach in the use of data collection tools to produce a more complete understanding of the problem. These approaches provide a strong conclusion and richer insights evidenced on the outcome. According to Mutsau and Chihambakwe (2012), a key informant is a specialist in a topic or someone who may be able to shed more light on the process. In this case, our specialists were counsellors whom the study targeted. These seemed to have sufficient information to contribute to the study their experience in the counselling of discordant couples. Mutsau and Chihambakwe (2012:78), believe that a case study type of

research is one in which " the evaluator analyses the goals, plans, resources, needs and problems of the case in its natural setting (as opposed to experimental conditions), to prepare an in-depth report of the case with descriptive and judgmental information, perceptions of various stakeholders and experts, and summary conclusions" . The design was chosen because of its ability to give in rich, detailed and in-depth information. Case studies also help scholar to have a much clear understanding of what is happening the on the ground and produce new hypotheses which can be used for later testing Vissak (2010).

(a) Interview guides

In order to achieve success in collecting the required data, an interview guide was used. This tool had open ended questions. It is a written instrument that presents respondents with an opportunity to freely respond to the questions. It offers a respondent the ability to give detailed responses to the questions thereby providing rich information for a study of this kind. The use of interview guide helps researcher to ' secure in depth results that are presented descriptively (Creswell & Plano, 2012). This study adopted unstructured questions which enabled the collection of qualitative data. In addition, questions used provide room for detailed responses.

(b) Focused Group Discussion Guide

This is an instrument which is used to guide a focused group discussion. The discussion itself involves gathering of people from similar or same background or experiences together to discuss a particular topic or theme of interest. It is a form of qualitative research where question are set to guide the discussion which may center on belief; opinions; views or ideas (Kasonde-Ng' andu, 2013). In this study, the discussion involved the researcher and counsellors involved in HIV counselling and are involved in testing and communication of test results.

(c) Observation Checklist

This was an instrument which had a set of questions aimed at evaluating the performance and behavior of counsellors in relation to their clients. It assists a researchers identify gaps in knowledge and skills with a view of making improvements. Use of this type of instrument required: Confidence in speaking; ability to control emotions; body posture/gestures and Choice of words. Further Attitude towards fellow counsellors and personal grooming of the researcher.

3.7 Data Collection Procedure

The procedure was chosen because it allows respondents to freely respond to an issue in order for the researcher to gather a lot of information because the respondents were given to write without interference. This method of collecting data was through open-ended interviews using interview guides and focused group discussion guides. Open-ended interviews involved the interviewer writing in the spaces. Creswell & Plano (2012) see interviews as one of the qualitative research methods that enables the researcher to find out what is in another person' s mind, it is an ideal method in that we can easily capture one' s feelings, thoughts and interest with it than other forms of research instruments. Kasonde-Ng' andu (2013) adds that interview guides to a large extent help the researcher to control responses, situations, interview schedules as well as interview environments in order to collect the required data from respondents.

Before beginning the data collection process, permission was sought from the University of Zambia, Institute of Distance Education and the researcher got an introductory letter for the institute. A combination of interviews and focused group discussions were used helped to obtain information from the counsellors concerning their lived experiences in communicating HIV test results to discordant couples.

3.8 Trustworthiness of data

A pilot study was done in which the counsellors were interviewed prior to the main data collection. This information was compared to the final information that was collected after study groups and further interviews and found to be congruent. Further, three different instruments were used to collect the data.

3.9 Data Analysis

Data analysis is the process of inspecting, cleaning, transforming and modeling collected information with the goal of discovering useful information, suggesting, conclusions and supporting decision-making (Kasonde-Ng' andu, 2013). In order to ensure that the results were valid, the researcher crosschecked the response by numbering the responses and then marking what was entered. Qualitative data that was generated through use of interview guides and focused group discussion guides was analysed using thematic analysis. This involved data cleaning coding and categorization of the date in order to arrive at themes and subthemes. The

emerging themes and subthemes were then presented descriptively and supported by use of voices of the respondents. For purpose of identifying sources of voices in the presentation of findings, the respondents were coded as C1= Counselor 1; C2= Counsellor 2 and so forth.

3.10 Ethical Considerations

Research work that involves dealing with people requires the utmost care and consideration for their privacy and respect for their beliefs and feelings. The researcher must be committed to ethical conduct that transcends the life of the research. The ethical clearance for this study was given by the University of Zambia in collaboration with Zimbabwe Open University under the Institute of Distance Education (IDE) in Zambia. Furthermore, the researcher was given clearance from the District Health Office, in case there was need to engage other health facilities under the said. The actual hospital which was the research site also gave the researcher clearance to go ahead and engage the respondents under the jurisdiction of the hospital. Full consent was obtained from the respondents prior to the study and this was quite easily obtained because the researcher took time to explain to them the nature of the study. Hence, they being counsellors, understood the nature of the research and how central they were to it, and offered their assistance without reserve.

The participants were treated with utmost respect and regard for their privacy and personal views. Mutswanga and Mafumbate (2010) indicate that respect is a virtue one possesses that enables them to hold other people in high esteem and treat them honourably. Consent were obtained from the participants before they participated in the study and they were fully enlightened on the study. Furthermore, the participants were allowed to express themselves with no interference from the researcher. They were granted full autonomy in dealing with their clients. Mutswanga and Mafumbate (2010) define autonomy as the right or condition of self-government which means to be independent and free from external influence or control in making decisions.

3.11 Summary

This chapter was focusing on the research methodology that was used in the study. A survey approach was used in this research, where data was to be collected through open ended interview guides and focused group discussion guides. The interviews were done with key informants from

the health center. In order to ensure that the results were valid, the researcher crosschecked the responses with what was entered. The chapter also highlights the ethical considerations of the research, where the respondents were treated with utmost respect, and no names were mentioned either of respondents or their clients.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Overview

This chapter presents the findings of the study which have been presented according to the research questions shown below. The chapter begins with the characteristics of the respondents before presenting the findings according to the set objectives. The data was collected through interviews; focused group discussions and observations, done using qualitative approaches. The themes emerging from the analysis done have been indicated in the course of presenting the findings. The following research questions have guided findings:

(i) How are the lived experiences of counsellors regarding communicating HIV test results to discordant couples in the study sites?
(ii) What challenges are encountered by counsellors in communicating HIV test results to discordant couples in the study site?
(iii) What support services are available for discordant couples once HIV test results are communicated to them?

4.2 Research Question 1*: How are the lived experiences of counsellors regarding communicating HIV test results to discordant couples in the study sites?*

In order to establish the lived experiences of counsellors in communicating HIV test results to discordant couples, the participants through interviews and focused group discussion shared the following experiences**:**

4.2.1 Clients had Limited Information on HIV

On the issues of information or knowledge about HIV, the findings revealed that some discordant couples had limited knowledge about HIV which posed a challenge in accepting the test results.

This was evidenced by one counsellor C1, who had this to say: *C1: We sometimes have clients with very limited information on HIV. You would wonder if they live on this planet because HIV has been around for a while and it has been spoken about in many spheres. It is surprising that as a counsellor you have to begin talking about HIV from scratch, even though the client is*

aware of some of the facts but just to be sure you get the information across. This view was supported by counselor C4 who observed that*: Some clients are not aware of the modes of transmission all they know is a little basic information.*

Contributing to a focused group discussion, counsellor C2 believed that: *Some clients pretend they do not know much, they want you to explain to them from the basics of HIV. One client I had pretended she did not know anything, but as we continued talking, she started to open up about how she had taken care of her sister who had died from HIV related complications. From the way she spoke, I realized she probably just wanted to assess my level of understanding*.

The significant findings on information on HIV, was that most of the discordant couples did not have sufficient knowledge on HIV and this affected their level of acceptance of test results and need to change their status.

4.2.2 Limited Counselling Time

In an attempt to establish how much time counselors had to attend to discordant couples with hope of communicating their HIV test results, responses were quite varied. While majority of the respondents felt that they did not have sufficient time to work with one discordant couple that may not be ready to quickly receive the test results, others believed had sufficient time to work with clients until were ready to receive and accept the HIV test results. These views were supported by one counsellor, C7 who had this to say*: It is not possible to have enough time to counsel a client adequately, especially when we have other clients waiting to be seen outside. This place is very busy, and before you even start listening to one client, another client is knocking at the door because they feel the one in the counselling room has taken too long.*

In contributing to the discussion, counsellor, C 6 reported as follows: *I feel like the client should also be given time to grieve in cases where they are given an unexpected piece of bad news. With the limited time we have, clients cannot have the chance to properly grieve, and some even leave this place with their grief still very intact. This is problematic because when someone moves around with grief, they become absent minded and can be hit by a moving vehicle.*

Another counsellor C8 believed that*: As counsellors, we face a lot of pressure because we can assess a client and know that they need a lot of time being counselled but we also have to consider time. When there is not enough time, as a counsellor you become concerned about how*

best to help the client. We really have to engage our skills in order to help the client as much as possible in the little time we have together and that is not easy.

Arising from the above findings, it was clear had counsellors had a lot of clients to attend to hence, did not have sufficient time to pay particular attention to discordant couples who were not ready to receive their HIV test results.

4.2.3 Inadequate Counselling Space

On whether or not counsellor had sufficient working space at the facility, the responses were negative. The respondents stated that they did not have sufficient office space, as the place was often crowded with clients seeking counselling services thereby making it to difficult have privacy when communicating HIV test results to discordant couples at the study facility. The respondents observed because of the shortage of space, there situations when that other counsellors were testing, others were counselling within the same environment thereby creating confusion and lack of confidentiality as services were being provided. These finding were evidenced by several contributions given by the responded. Counsellor C3 for example, had this to say*: As you have noticed, counselling space is a big problem. Our room is small, and we do not have enough rooms to do all the essential work that is required of us as counsellors, in relation to serving our clients.*

Counsellor C4 added by noting that: *Even though we rotate and do not all come on the same days, space is still a problem. We cannot properly counsel clients in such an environment.* Contributing to the discussion, counsellor C10 shared a thought on the consequences of not having enough space for counseling by stating that*: I have noticed that most clients do not open up about their situation when they come into our counselling room. There is no privacy and the presence of other counsellors puts them off. I usually have to move my clients to a different room just to get them comfortable enough to speak out. This is not done often because time does not allow for it.*

On the whole, it was quite evident that the study health facility did not have enough space from which to provide counselling services. This situation made it difficult when it came to communicating HIV test results to discordant couples who very much needed privacy as they received their test results.

4.2.4 Lack of Resources

With regards to resources to support the HIV testing of discordant couples and other clients at the health facility, the findings showed that, although it is not a usual occurrence, there are times when the hospital runs out of reagents or testing resources and this causes delay in testing and communicating test results to the discordant couples and other clients. The respondents reported that such dilemmas often affected VCT services work for up to a week, with vital clients missing an opportunity to get tested. Further, the findings were that at times only first line testing kits were available, and second line or confirmatory test kits were not available or vice-versa, thereby creating delays which often made the discordant couples anxious in accessing their HIV test results. These findings, were supported by counselor, C5 who reported that: *We have days when there are no reagents to use. When this happens, it can go on for up to a week and the only people who get tested are in-patients who are very ill, upon an order from the doctor or clinician. This means that some clients go home without a much needed test.*

Another C3, counsellor contributing on the same reported that: *We sometimes have instances where we are ordered to test only inpatients because reagents are not enough, and we receive clients who clearly need to get tested. As a counsellor you are now torn between sticking to regulations and assisting the clients. Sometimes you just have to be courageous and break the rule in order to help a client who really needs help.*

Another counsellor, C9 narrated: *One day I had a couple who came in looking like they had been fighting prior to their coming. After a few minutes of conversing with them I realized an HIV test would help them move to the next level of possible reconciliation. Despite the fact that the reagents were very few, I had to test them to set their minds at ease and after counselling I told them to return after three months.*

Generally, the findings showed that there were times when the health facility did not have or had insufficient testing resources thereby resulting in delayed communication of HIV test results to discordant couples. This situation created anxiety and worries in the clients.

4.3 Research Question 2: What challenges are encountered by counsellors in communicating HIV test results to discordant couples in the study site?

4.3.1 Prior Knowledge of HIV Status

On the question of whether discordant couples had prior knowledge on their HIV status, it was evident that most of them did not have prior knowledge of their status in some cases, HIV positive partners who were aware of their HIV status did not reveal it to the other partner. Further, the findings also showed that, the respondents had encountered clients, both male and female, who had prior knowledge of their HIV status and in some instances were actually on ART, but feigned ignorance when confronted with results in the presence of the other partners. The study showed several factors including; fear of rejection by their partner and stigma and discrimination from society that would result. In support of these findings, counsellor C6 observed that*: Some clients who are HIV positive come here having not disclosed their status to their partners for fear that they would be rejected. It is common for such people to pretend they had no idea they were HIV positive, but in the end they come out and tell their partner.*

Contributing on the same counsellor added by saying that: *C9: Some clients come with their spouses and expect the counsellor to reveal their status to them, because they failed to find ways of doing it themselves. I once had a client who came to me and explained that he had not told his wife his HIV status because he was afraid and he did not know where to start. He asked if he could come with his wife, and I said he could bring her. It was good because then I could counsel her and test her, thereby helping her learn more and hopefully accept her husband' s HIV status. I felt his decision was wiser than remaining mute and keeping it a secret.*

Another counsellor C10 noted that*: I had a client who, in the presence of his wife refused having prior knowledge of his HIV status. I called him aside and told him I could tell he had been on medication for a while. He folded and agreed to be honest with his wife. What followed was a series of counselling sessions but afterwards the wife was able to accept the HIV status of her husband and agreed to be placed on pre-exposure prophylaxis (PrEP).*

On the whole, the findings showed that most discordant couples in the study health facility had no prior knowledge of their HIV status until they were tested and given results, while others had

prior knowledge of their status but had not revealed their status to their partners for fear of stigmatization and discrimination.

4.3.2 Non-acceptance of Results

With regards to accepting results, the findings revealed that at times, the HIV negative partner refused to accept the results of their partner. Majority of the counsellor-respondents had experienced non-acceptance of results from even the HIV positive partners. The counsellor respondents cited examples of where the women were HIV positive partners, the men would sometimes storm out of the counselling room in rage as a sign of refusing to accept the results of their wives. These experiences were supported by counsellor C1 who observed that: *I once had a client who refused to accept his HIV test result. He said it was not possible for him to be HIV positive while his wife remained negative. I had to explain to him some of the factors that made it possible for a discordant test result.* Sharing on the same experience, counsellor C3 added by stating that: *I had a client who refused to accept the HIV result of her husband. She said there was no way she could be negative and he positive. I had to explain the aspect of discordancy in order to make her understand.*

In support of the same experience, counsellor C8 reported that: *I once counselled a client who refused to believe that she was HIV negative and actually requested a retest. She said she had been nursing her late daughter who had been sick for over eight years until she died. Considering her contact with body fluids such as pus, blood and faecal material, she said she should be positive as a result. I did a confirmatory test and it was also negative. I had to tell her that the test does not lie and urged her to return for a confirmatory test after three months for her to be sure because she was still doubtful.*

In short the study showed that most discordant couples, did not easily accept results of their HIV test or were not willing to share information on their status with their partners for fear of being labelled by the other partners or friends.

4.3.3 Fear of breakup

On the question of status of marriage once HIV test results were revealed, the findings revealed that in instances where a married couple was facing a discordant result, issues of infidelity came in and the one who was positive was seen as having been given the death sentence. The findings

also showed that some of the respondents were optimistic in their approach to the counselling session and saw no reason why a discordant couple should end up with a divorce just because of partners had tested positive. Further, the findings indicated that, outcomes that were believed to possibly emanate from a decision of marriage dissolution such as depression and family break-up were also mentioned. Family break-ups were common as a result of discordant couples not willing to accept the HIV test results as was evidenced by the contribution of counsellor C9 who observed that*: I sometimes gauge the atmosphere that has been created from the beginning, and looking at some clients, I fear that there might be separation or divorce when I look at their characteristics portrayed.*

Another counsellor C4, noted that: *Usually when it is the man that is HIV positive, the women are quick to offer their support and it is easier to counsel such couples. When it is the woman that is HIV positive on the other hand, the man is more difficult to convince to support his wife. There are instances when I counsel them and ask them to return, but even as they leave I remain with feelings of uncertainty as to whether they will return or even stay together.*

Adding to these findings, counsellor C2 shared her experience by reporting that*: I once witnessed a man storm out of the counselling room and leave his wife. I had to go after him in order to bring him back and also calm him down. Such cases leave you wondering sometimes as to whether such a relationship will last or not.*

From the above findings, it was clear that most counsellors had fear that the discordant couple' s marriages might breaking up because the clients in many cases were not willing to accept the HIV test results.

4.3.4 Refusal to Disclose Results

It was clear from the findings that, discordant couples, despite some having been married for several years, preferred to be told the results separately instead of in the presence of the other partners. The findings showed that counsellor respondents felt that it was important that results were disclosed to both parties so that each of them is aware of the status of the other. One respondent further stated that results could be withheld for a certain period of time while the couple was counselled until such a time that the counsellor was satisfied that the couple was ready to receive the results. Supporting these findings, counsellor C9 observed that*: Some clients*

refuse to disclose their results. One couple which had come for VCT had a discordant result. They were engaged and planning on getting married. The lady was HIV positive but did not want the man to find out, at least not until they were married. She refused to share her result with him, even though they had agreed at the start that they would share the results. She pretended to have lost her paper which contained the test result and just told him she was also negative.

Contributing to the same discussion, counsellor C1 had this to say: *I counselled a couple where the man did not want his wife to know his test result. The wife automatically knew something was wrong, although she wondered what it could be because her own test result was negative. She did not imagine that his was positive. In the end he disclosed to his wife.*

On the whole, it was evident from the study that**,** despite being married for several years, most discordant couples preferred to be told the results separately instead of in the presence of the other partners. These was as a result of having fear that their relationship with the partner would break up.

4.4 Research Question 3: What support services are available for discordant couples once HIV test results are communicated to them?

The third research question was on support services that were provided to discordant couples once HIV test results were communicated to the couple. The findings revealed that counsellor through the study health facility were providing various assistance to the discordant couples once HIV test results were given to them. These included:

4.4.1 Follow-up visits

It was found that, counsellors had put in place a provision to follow up discordant couples to their homes, whose HIV test results had been given to them. The counsellor respondents were of the view that by visiting the client and ensuring that they are progressing according to the counselling agenda, the measure would help them accept their new status as a couple. It was also shown that follow-up visits helped in checking to ensure that the clients were taking their medication as prescribed by their health-care provider and that couples were using condoms correctly and consistently as was evidenced by counsellor C6 who had these to say*: We do make follow up visits, especially when the client misses an appointment. We have to ensure that the*

client is adhering to the medication that they have been give because those who miss appointments are usually defaulters who also do not take their medicine.

In support of the findings, counselor C3 reported that: *Follow up visits are done in order to ascertain whether the clients are living well together. We also check on their sex lives to ensure that all is well in that department. We move around with condoms to distribute to couples just in case they need them.*

These views were also supported by counsellor C7 who noted that: *One of the clients we visited said she had a renewed hope because we had showed her care in visiting her. She said she would take her life more seriously because other people showed her that her life mattered. After she got better, she started coming to the hospital for reviews by herself. It is very encouraging to me as a counsellor when I see a client' s perspective changed because of me. It has taught me that people value our efforts as counsellors.*

Arising from the above findings, it was evident that counsellor made follow up visits of the discordant couples whose results were known to ensure they took they regular took medications as well as ensuring that they were progressing according to the set agenda.

4.4.2 Follow-up phone calls

Besides making physical follow ups of discordant couples whose HIV test results had been known, the findings revealed that counsellors offered post-test support via the use of phone calls. Since clients avail their addresses and phone numbers, it was possible for the counsellor to call the client and ask how they were keeping up. The counsellor- respondents believed that, this was a good way of keeping in touch with discordant couples and readily available to provide the required assistance. These views were supported by counsellor, C1 observed that: *We call clients on the phone to ask how they are doing because sometimes transportation is a challenge. We also have clients living in quite remote areas which are hard to reach. We call such clients up just to catch up on how they are and how they are coping with their situation.*

Contributing on the same counsellor C9 noted that*: Phone calls can be very convenient because instead of waiting for transport for days, you can easily get in touch with a client who is far away. When you want to know if a client is taking their medication as they should be, a phone call is helpful because it also reminds them to do so.*

In addition, counsellor C6 felt that*: Phone calls are a convenient way of finding out why a client has not been to the hospital for a review. There was a time I was told that my client has passed on two months earlier, hence the absence. I felt bad.*

In general, the findings showed that, apart from physical follow up of discordant couples, counsellors were also using phone calls as a way of following up the clients thereby providing the support needed from time to time.

4.4.3 Review Visits

All the respondents made mention of this strategy as an excellent way of keeping in touch and offering continued support to the client. The couple was encouraged to come for review visits as a pair as often as possible so that progress could be achieved together. Review visits are also used as a way to physically check the client' s health status. Their body weight is checked against their height and advised concerning diet or taking their medicine.

4.4.4 Regular Supply of Medication

It was reported that, the HIV positive clients were often initiated on ART if they were not already initiated, they were given a time-frame in which to return to the health center for both physical and psychological review for medication purposes. Those who were already on ART, were regularly supplied with medication by the health facility. The counsellor-respondents felt that the strategy as an excellent way of keeping in touch, offering continued support to the client and ensuring they had a regular supply of medication. This view was supported by counsellor, C10 who noted that*: Review visits are a must and must be adhered to strictly because it is these that give us a clear picture of the health of the client and medication status. We need to monitor the client closely, especially in cases where their medicine has been changed. We also need to check for body functions, how the liver and kidneys are performing, viral load and CD4 count. So review visits help us gauge the health of the client both physically and psychologically.*

Contributing to the same discussion, counsellor C3 believed that, *Review visits help us know whether a couple is living in harmony. It is easy to assess whether or not there is acceptance after a few questions. So the review will give us insight as to whether the couple requires more counselling or are on the right track.*

In short, the findings revealed that discordant couples had a regular supply of medication, were regularly reviewed hence, their progression was regularly being monitored by the counselors in support of other medical staff.

4.4.5 Support for HIV negative partner

The study found that, HIV negative partner was placed on PrEP in order to offer them proactive protection against acquiring the virus, for a given period of time, pending laboratory test results of the partner. The findings further showed that PrEP was for only people who were not HIV positive but were at risk of getting HIV and these were placed on PrEP to take a pill every day. The study also indicated that discordant couples were often encouraged to return every three months for retests and review to check on their HIV status and also ensure that they were adhering to treatment as noted by counselor *C4 who said that: We need to place the HIV negative partner on PrEP to ensure that they maintain their HIV negative status if they consent to it, so that their chances of contracting the HIV are lessened exponentially. As an added advantage, this also helps the couple to remind each other to take their medication on time. The client is also advised to return every three months for retests whilst their partner is tested regularly for viral load suppression and adherence to medication.*

This view was further supported by counsellor C10 who had this to say: *The HIV negative partner is encouraged to return after three months, and at given intervals after that, in order to be tested for HIV. They are also encouraged to remind their partner to take their medicine as a way of ensuring that they adhere.*

In sum, the findings showed that discordant couples who were HIV negative had support from the counsellors in that they were put on PrEP and regularly monitored and tested periodically as a way of ensuring that they remained negative.

4.5 Chapter Summary

In this chapter, the findings of the study have been presented. Among the significant findings were that: most of the discordant couples did not have sufficient knowledge on HIV thereby affecting the level of acceptance of test results thereby making the work of the counsellor more challenging. It was also found that counsellors had a lot of clients to attend to against limited time to pay particular attention to discordant couples and the study health facility did not have

enough space nor resources to support the services required by the discordant couples. It was evident from the study, that some discordant couples did not have prior knowledge of their HIV status and once information on their status was available they were not willing not share it with their partners for fear of stigmatization and breaking up of their marriages. On the support to discordant couples, it was evident that counselors made physical follow ups of discordant couples, used phone calls and ensured clients regularly received the required medication. The next chapter, discusses the findings of the study.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1 Overview

The Chapter discusses the findings on the lived experiences of counsellor with regard to communicating HIV test results to discordant couples at a selected Health facility in Chingola district of Zambia. The discussion has been guided by the following objectives:

i) To establish the lived experiences of counsellors in communicating HIV test results to discordant couples at a selected hospital facility,

ii) To explore challenges surrounding communicating of HIV test results to discordant couples in the study site,

iii) To establish the support services, provide to discordant couple once HIV test results are communicated to them in the study sites

5.2 Objective 1: Lived experiences of counsellors in communicating HIV test results to discordant couples in Study Site

On the issue of lived experiences of counsellor in communicating HIV test results to discordant couples, there were several experiences shared during the study. Below are, the significant experience of counsellors in their working with discordant couples:

5.2.1 Discordant couples had Limited Information on HIV

With regards to clients' knowledge on HIV and their status, it was found that discordant couples had limited knowledge on HIV and their personal status. The study showed that, there was a relative number of clients coming for HIV counselling and testing but exhibited ignorance on HIV as well as their status. Because of the situation, counsellors tended to take more time to provide the required information to discordant couples before HIV tests were conducted and results shared with the couples. The couples exhibited ignorance concerning the subject of HIV yet, the disease had been around over thirty years. These findings were in line with the Zambia National HIV/STI/TB/AIDS Council or ZNAC (2015) report which noted that despite the heavy investment made in the areas of sensitization and advocacy on HIV/AIDS, most Zambian

continued to show ignorance of the disease and continue to resist getting tested for HIV. Because of this situation, a greater part of the Zambian population including discordant couples was unaware of their HIV status although there are only a handful of activities that put a person at risk of contracting HIV. The study noted that despite the information available on HIV/AIDS, there were some discordant couples who believed that HIV was airborne can be caught on buses and in other public places. Others believed one could catch it from being in close contact with those who are HIV positive, sharing utensils such as cups and plates or washing their clothes. This showed that counsellor had a lot of work in raising the level of awareness to discordant couples before they could provide support to such couples.

5.2.2 Limited Counselling Time

On the issue of time to work with discordant couples, it was found that counsellors lacked adequate time to provide information on HIV, conduct HIV tests and reveal results to the discordant couples in one sitting. It was also clear that the counsellors had a lot of HIV/AIDS clients to attend to at the study health facility thereby making it difficult to provide the much needed attention to discordant couples. Time was seen as a serious challenge to the counsellors making them to now fast track the counselling session and cram as much information into the few minutes, which was not healthy to the clients especially the discordant couples with issues of marriage at stake.

Counselling differs from medical diagnosis that can be proved in a lab. A counsellor cannot simply look at a client and suggest what the problem is because counselling is more complicated than what meets the eye. Counselling therefore entails that a certain amount of time is spent with the client to ensure that the session is wholesome. Some clients require a lot of time spent with them to ensure that they understand their situation and are well aware of how to handle it. Time is a factor that is usually limited because of the number of clients that have to be attended to. From the findings of the study, counsellors working with discordant couples did not seem to have sufficient time to spend with the clients, as a result compromising the quality of counselling services given to their clients. It is evident when they return for their review sessions that some discordant couples, probably learnt very little from the previous session.

Counselling is a practice that requires time in order for any session to be effective. There are many issues that need to be dealt with before, during and after the counselling session for a HIV

test could be conducted (Chikopela, Mandyata; Ndhlovu & Mpolomoka, 2019). These actions require time which the counsellors at the study health facility do not seen to have to support their clients. Ndhlovu (2015) makes mention of a number of attending skills that are required in counselling, which cannot be achieved without taking time. According to him, attending is the process of how counsellors attend to clients. These include various activities that must be considered such as listening. If the counsellor is aware of the limited time that s/he has with the client, s/he is likely to rush the counselling session and get very little across to the client. The dynamics of counselling require that the counsellor creates a relationship with the client in which is established what is expected of both parties. This includes creating trust in order for the client to be open about their situation. In speaking, there are hidden messages in body language that can only be deciphered through closely paying attention. According to Chikopela, Mandyata, Ndhlovu, & Mpolomoka (2019), when the counsellors are distracted by limited time, these would not be achieved as they should be, and the counselling session may end up a failure or half-done thereby worsening the situations for discordant couples who need more time for their counselling sessions. This ultimately may lead to discordant couples leaving without being assisted properly by the counsellors

5.2.3 Inadequate Counselling Space

With regards to working space for the counsellor at the study health facility, the study revealed that counselors had similar experiences. There was an inadequate number of counselling rooms, and the ones available were actually multipurpose, shared by several counsellors and other medical personnel. Further, it was evident from the study that the available counselling facilities were very small in size thereby making it difficult to ensure privacy in the counselling sessions. The counsellors often had to use the same room for multiple purposes at the same time. Clients in crisis who urgently required counselling had to be moved from one place to another in search of counselling space and some privacy.

These findings agreed with Munachaka (2006), who observed that limited rooms for counselling was a factor that could have negatively impacted on the quality of the counselling provided to HIV/AIDS clients. The other rooms alternatively used for counselling, although not exclusively counselling rooms, were multipurpose and doubled as testing and screening room. This makes it difficult to get through to the client and get them to explain their problems thoroughly. Clients

often have serious private issues that cannot be discussed in the presence of disturbances. They require privacy and an inviting environment that enables them to be free and open when they speak. This, however is not the case due to the limited rooms and space.

The counselling environment is the place where the counselling is conducted, and this should be conducive for the session. Organising a counselling environment means that there is enough space, proper ventilation and sufficient lighting (Rule, et al., 2008). An uncomfortable counselling room will automatically discourage the client from being free to speak their mind and the counsellor will have a hard time putting the client' s mind at ease. Before anything is said or done, the environment is the first welcoming factor to the client.

5.2.4 Lack of Resources

With regards to resources for testing the discordant couples, the study showed that, there were times when the study health facility runs out of one line or both lines of testing resources and thereby making the counsellors to ask the clients including the discordant couples to wait for a long time before could have their tests done and results released to them. The long wait for one or both reagents to be available often made clients to lose time and patience at times.

At the study health facility, mainly rapid tests were used to conduct HIV testing and these were Alere Determine HIV 1 & 2 (Determine) and Standard Diagnostic Bioline (SD Bioline). Determine was usually used to test whilst SD Bioline was usually preferred as a confirmatory tester in cases of a positive results. Sometimes it was the other way round especially in instances where one was expiring before the other. In such times, they had to wait for reagents to be ordered and made available before they could go ahead with the VCT services. In such times, the counsellors had to focus on other activities that did not require the use of reagents. Although such activities were limited in nature, such as entering client information in different books, or even going out in the field to conduct different kinds of surveys, the discordant couples did not appreciate them as so them as a waste of time. This study found that counsellors less access to resources affected their work at the facility. Due to this factor, these counsellors have to make clients wait for a long time before they could access the required services at the centre. For this reason, counsellors (Chisanga, 2011), propose added approaches to counsellors work that centered on prevention as opposed to curative in order to eradicating HIV/AIDS among potential discordant couples through community mobilization programmes on HIV/AIDS in the health

facility catchment areas. These are done through activities such as peer education and behavior change communication, workshops, seminars, home visits and mobilization to disseminate HIV/AIDS information on the transmission, prevention, care and treatment.

5.3 Objective 2: Factors that have led to the identified lived experiences among counsellors in communicating test results discordant couples in the study site.

5.3.1 Prior Knowledge of HIV Status

On the issue of prior knowledge on HIV status, the study found out that there were several instances in which the HIV positive partners were aware of their HIV status for a while, but did not reveal their status to the other partners. The counsellor-respondents reported that they had in the course of their work encountered discordant couples, both male and female, who had prior knowledge of their HIV status and in some instances were actually on ART, but feigned ignorance when confronted with HIV test results in the presence of the other partners. When asked why they were not willing to disclose the HIV status to the other partners, counsellors reported that couples had fear of rejection by their partner, stigma and discrimination from society hence, could not share such status with any one including their partners. This proved difficult because it often gave birth to a different level of distrust in the HIV negative partner, and tended to give the counsellor the task of reconciling the couple and ensuring that they work out their problem amicably. The study gave an impression that counsellors are forced to have long explanations of HIV status, what it means to married couples as well as adjustments in general lifestyle and taking ART. Further, counsellors were made to spend more time discussing issue of sexual lifestyle and issues of acceptance and psychological healing.

These findings were consistent with Fakolade, Adeniyi, & Tella, (2005) in which it was reported that counsellors encountered clients having prior knowledge of their HIV status on ART but were unwilling to disclose their status for fear of being taken to be morally weak in the community. Such clients advanced the fear of get divorced or separated or stigmatized and discriminated. Based on these findings, it seems to be a challenge because there is a heightened level of uncertainty concerning the acceptance of the result by the HIV negative partner, and a high chance of them not accepting to take their PrEP medication.

5.3.2 Non-acceptance of Results

On whether counsellors had experiences with discordant couples who could not accept the HIV test results, majority of the counsellor-respondent acknowledged having had experienced non-acceptance of results from even the HIV positive partner. The study revealed that respondents felt that, it was not possible for one person to be positive and the other negative. It was from such that counsellor was made to so start a session from where the counsellor had to begin from the basics of HIV modes of transmission and make the client understand the dynamics of HIV transmission. Sometimes clients stated that the testers were defective, although they rarely asked for a retest. Others yet thought that the counsellor was lying to them. These findings have also been reported by other scholar such, Reniers & Armbruster (2012), who showed there were instances where the woman was HIV positive and the man HIV negative and marriages ended in divorce while, instances where the man was HIV positive and the woman HIV negative where the woman promises to stand by her husband through it all. The study explains this situation from a cultural teaching on marriage where a woman is expected to remain faithful to the man, and questions are raised when she is found to be HIV positive.

5.3.3 Fear of breakup

Regarding fear of marriage breaking up, the findings revealed that some of the respondents were optimistic in their approach to the counselling session. They saw no reason why a discordant couple should end up with a divorce. On the other hand, most of the respondents feared for their marriages ending up with a divorce. The couple and counsellor' s fear, among others was that the couple would end up dissolving the marriage in divorce or separation. Break-up of the relationship between two people is one of the first things that comes to mind when one sees a discordant test result. Dissolution of marriage affects many other people, not just the couple but other family members as well. There are cases where there are children and dependents involved who, if the marriage breaks will be negatively affected in the long run. The counsellors is forced to be cautious when revealing HIV test results to discordant couples.

It is important as a counsellor to have a positive attitude towards the counselling session because sometimes when the counsellor has a negative perception, this can be communicated to the client in various ways like body language or voice tone and end up affecting the client negatively. There is no need to think of divorce because with the right approach, the clients in such a

position would still choose to deal with their situation amicably. The thoughts arising from the study are also echoed by WHO (2016) reports' which noted that, partners of HIV positive clients require HIV counselling and testing. This helps to ensure that they get the support needed for them to continue trusting each other despite discordant nature between them. This is important because the partner needs to be equipped with the right information that will enable them to make sound decisions. The support is not limited to information, but also involves medical support in terms of medication, food supplements and psychosocial related support much desired. The HIV negative partner is placed on Pre-Exposure Prophylaxis (PrEP), a type of anti-retroviral therapy (ART) which prevents the HIV from seroconverting in the body. It ensures that the partner is kept HIV negative whilst at the same time the viral load of the HIV positive client is suppressed using ART (WHO, 2016).

5.3.4 Refusal to Disclose Results

It was clear from the findings that, discordant couples despite being married for several years, preferred to be told the results separately instead of in the presence of the other partners. This is highly discouraged because one of the reasons that led to the propagation of couple counselling and testing was the prevention of mother to child transmission (PMTCT) of HIV. The respondents stated that they felt it was important that results are disclosed to both parties. It was unanimous among all the counsellors interviewed that result disclosure was best done with both individuals present as a couple for the sake of transparency, as well as for support to be rendered effectively. In Zambia, the government set up the National AIDS Control Programme (ZNAC 2015) and later the National HIV/AIDS/STI/TB Council (NAC) in 2002 which did not deal with issues with sensitization and advocacy on HIV, but had invested in rapid testing of HIV clients with support from the counselling units in health facilities. These services have been put in place to coordinate all activities surrounding prevention, care, sensitization and counselling of clients in various health facilities on issues of HIV/AIDS and more so as a support to discordant couples.

5.4 Objective 3: Support Counsellors Give to Discordant Couples once Test Results are Communicated in the Study Sites.

In order to establish the support services that were available for discordant couples at the study health facility, counsellor respondents were asked to share information on the support services they engaged in support of such clients. There several responses cited by the respondents including the following:

5.4.1 Follow-up visits

On the whether follow ups were made as part of the support to discordant couples, the study revealed that, couple counselling was a complex issue especially in the face of an HIV discordant result. Getting the client to accept the result tended to take a long time and more than one counselling session. Furthermore, acceptance of the HIV positive result by the HIV negative spouse is another issue that requires time and patience. However, it was clear from the findings that, counsellors had put in place a provision to follow up discordant couples. Such couples were visited to ensure that clients, were progressing according to the counselling agenda. This includes checking to ensure that the clients are taking their medication as prescribed by their health-care provider. It also entails making sure that the couple are using condoms correctly and consistently. All the respondents agreed that this is a very effective way of not only offering support and care, but also assessing the environment in which the client lives, to check for hindrances in adherence to treatment and counselling practice. Follow-up visits communicate care and concern to the client and this encourages them to begin to do as the health care provider has advised, for instance, in situations where the client refused to take their medicine. Upon seeing the counsellor and the amount of concern that is being shown, even the most difficult clients begin to adhere to counselling and health guidelines, thus turning their situation around for the better. These findings were in line with Desgrees-du-Lou and Orne-Gliemann' s (2008) work which reported that, a couple-centered approach to HIV counselling and testing and communication of test results much depended on openness of the discordant couples and counsellors about HIV status and adoption of preventive behaviours within couples. The study supported the idea that counsellors should encourage couples to share test results and lessen partner violence by ensuring that they received test results together in the context of couple counselling.

Counsellors have put in place a provision to follow up on cases of discordant couples by visiting the client and ensuring that they are progressing according to the counselling agenda. This activity included checking to ensure that the clients were taking their medication as prescribed by their health-care provider. It also entailed making sure that the couple were using condoms correctly and consistently. All the respondents agreed that this was a very effective way of not only offering support and care, but also assessing the environment in which the client lived, to check for hindrances in adherence to treatment and counselling practice. Clients were followed up to ensure that they were coming to terms with their situation and ensure that they were fitting into their environment well despite their situation.

5.4.2 Follow-up phone calls

Besides making physical follow ups of discordant couples whose HIV test results had been known, the findings revealed that, counsellors offered post-test support via the use of phone calls. Since clients avail their addresses and phone numbers, it was possible for the counsellor to call the client and ask how they were keeping up. This method requires skill in order to be able to locate any agitation or negativity in the voice tone of the client and perceive the avenue to take in order to assist the client. Phone calls can also be used to check on the client' s adherence to taking their medication, or ask about any physical or psychological ailments. Phone calls can be a convenient mode of following up because the client can be located anywhere at any time. In times when transport is not readily available, a phone call is a sure way of keeping in touch with clients especially those who live in far flung areas. All the respondents stated that this is a good way to keep in touch with the client.

Goldstein, et al, (2010) reports that HIV clients require constant monitoring. The study calls for counsellors and other medical staff associated with management of HIV clients to use a variety of modes to regularly interact with them. From time to time, they require psychosocial support and use of modes such email, phone calls allow them to feel being supported by a caring medical team. Use of phone calls allows a counsellor to locate any agitation or negativity in the voice tone of the client and perceive the avenue to take in order to assist the client (Goldstein, et al, 2010). Phone calls are used to check on the client' s adherence to taking their medication, or ask about any physical or psychological ailments. Phone calls have been seen by counsellors as, a convenient mode of following up because the client such as the discordant couples, can be

located anywhere at any time. In times when transport was not readily available, a phone call was a sure way of keeping in touch with clients especially those clients who live in far flung areas.

5.4.3 Review Visits

The HIV negative client is asked to return to the health center after three months to be retested and is also put on Pre-exposure Prophylaxis (PrEP) which is taken for a short course to prevent the virus from taking hold in the body in case of exposure. The couple is encouraged to come for review visits as a pair as often as possible so that progress is achieved together.

5.4.4 Regular Supply of Medication

It was reported that, the HIV positive clients were often initiated on ART if they were not already initiated, and they were given a time-frame in which to return to the health center for both physical and psychological review for medication purposes. Those who were already on ART, were regularly supplied with medication by the health facility. The counsellor- respondents felt that the strategy as an excellent way of keeping in touch, offering continued support to the client and ensuring they had a regular supply of medication.

The study also indicated that, HIV negative clients were asked to return to the health center after three months to be retested and was also put on Pre-Exposure Prophylaxis (PrEP) which was taken for a stipulated time frame to prevent the virus from taking hold in the body in case of exposure. The couples are encouraged to come for review visits as a pair as often as possible so that progress is achieved together. Review visits are also used as a way to physically check the client' s health status. Their body weight is checked against their height and advised concerning diet or taking their medicine. The counsellors cited patience as a requirement to helping the clients. Patience is helpful because many clients take a while before they can accept the HIV status of their positive partner. Thus, when the counsellors work as a team, they are able to deal with patients, they are able to deal with and help even the most difficult clients. According to Anderson (2009), this helps to reduce stigma and discrimination present not only in families and society, but in the health care sector as well. This shows us that there is still a lot that needs to be done in terms of counselling those who are affected by HIV and indeed support the require from a health facility.

5.4.5 Support for HIV negative partner

The study found that, the HIV negative partner is placed on PrEP in order to offer them proactive protection against acquiring the virus, for a given period pending laboratory results of the partner but some discordant couple tend to refuse to be on PrEP. The study further stated that the clients were encouraged to return every three months for retests and review to ensure that they were adhering to treatment and also share their experiences to be counselled in case the need arose. In line with the present study, PrEP is only for people who not HIV positive but are at risk of getting HIV, to prevent HIV by taking a pill every day. When someone is exposed to HIV through sex or injection drug use, these medicines keep the virus from taking a hold and permanently infecting the person, (CDC, 2020).

5.5 Chapter Summary

The chapter has presented the findings of the study on the lived experiences of counsellors on communicating HIV tests to discordant couples at a selected health facility in Chingola district of Zambia. It is evident from the study that counsellors had challenges in communicating HIV test results to discordant couples in the study sites. The changes ranged from: fear of marriage divorce or separation; fear for stigmatization and fear of contracting HIV in the process of interacting with the other partners. Among the challenges experienced, were: limited resources for testing; delayed release of results and irregular supply of food supplements. The finding also showed that counsellors made follow ups on discordant couples once accepted HIV test results, made periodical calls to clients and supplied food supplements to discordant couple associate with the health facilities. The next chapter, provides a conclusion and makes recommendations.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Overview

This Chapter presents a summary, conclusion and recommendations of the study based on the study on the lived experiences of counsellors in communicating HIV test results to discordant couples at a selected health facility in Chingola district on the Copper belt province of Zambia.

6.2 Summary of Findings

As outlined in the presentation and discussion of findings, this section makes a summary of some of the key findings in the study as follows:

(i) Most of the discordant couples did not have sufficient knowledge on HIV thereby lengthening the amount of time spent on counselling and affecting the level of acceptance of test results once communicated to them.

(ii) Counsellors had a lot of clients to attend to against limited time hence were not able to allocate sufficient time nor pay particular attention to discordant couples at the health facility.

(iii) Health facility did not have enough working space, which affected the privacy when testing and communicating HIV test results to discordant couples.

(iv) Health facility from time to time, had no resources such as reagents to support testing. This negatively affected the counsellors' relationship with discordant couples.

(v) Most of the discordant couples did not have prior knowledge of their HIV status hence they had difficulties in accepting their HIV test results when communicated to them.

(vi) Partners who were aware of their status were not quite willing to share the information with their partners for fear of stigmatization and breaking up of their marriages.

(vii) Counselors made efforts from time to time to provide physical follow ups, made phone calls, supplied food supplements and medication to discordant couples, used phone calls.

6.3 Conclusion

The study established that counsellors did face challenges, especially when disclosing HIV test results to discordant couples. Often it took time to be able to convince discordant couples about the result, time counsellor did not really have. Further, it was difficult to convince the discordant couples to begin taking their medication. Some clients believe the results were faulty and demand a retest, while others just plainly refuse and storm out of the counselling room. This not only affected the client, but the counsellor as well. At times counsellors did not have sufficient room to conduct their practice and this affects their work. Lack of reagents or testing kits is also another challenge which counsellors are faced with, apart from experiencing emotional fatigue in dealing with emotionally diverse clients. It was evident from the findings that, counsellors dealing with discordant couples at the study health facility, experienced a lot challenges in their attempt to provide service to discordant couples.

6.4 Recommendations

6.4.1 Establish more Counselling Centers

Among the challenges that the respondents faced were lack of sufficient time to spend on one case and a limit in counselling rooms. The study recommends that the Zambia Counselling Counsel in collaboration with the Ministry of Health establish counselling centers in order to meet the growing demands for counselling services. This will also decongest hospitals and enable people to access counselling services closer to their homes.

The counsellors needed more privacy with their clients in order for them to be assisted effectively.

6.4.2 Make Resources Available

It was discovered during the study that there are times when the hospital runs out of reagents to use for testing clients. This resulted in clients leaving the hospital without being tested,

especially for those who were self-referred. Some clients whom the medical staff requested for HIV tests were also at times not tested as a result of the same. This meant an inconclusive diagnosis for the client. As such, the study recommends to the Ministry of Health that reagents be made available at all times in hospitals and all testing centers to ensure that clients do not leave without being fully attended to.

6.4.3 Mandatory Sharing of Results

Currently there are no laws in Zambia that make it mandatory for married couples to share their HIV results. The World Health Organisation condemns strongly the enactment of laws that make such a mandate, as is the case in some African countries. Due to the negative outcomes that results from non-disclosure, this study recommends that a law be passed through the Ministry of Health that mandates the sharing of HIV results between married couples.

6.4.4 Counsellor' s Refresher Courses

Due to the emotional stress and burnout that counsellors face when dealing with discordant couples, provision for in-service of counselling be put in place by the health facility management as a way of upgrading counselling skills of counsellors. This could ensure a fresh perspective on one' s job and also better experience from learning from other counsellors.

6.4.5 Increase Number of Counselling Rooms

The limited number of counselling rooms was one of the major concerns among the counsellors which affected their work and hindered it in some areas.

The study recommends to the Hospital Management that they increase the number of counselling rooms in order to be able to accommodate more clients and also render quality counselling services to them.

6.4.6 Community Sensitization

The lack of acceptance and knowledge of HIV by the community at large is a factor that plays a major role in the way a couple receives their HIV test result. As such, the communities need on-going sensitization concerning the issue of HIV including modes of transmission and care and support. This will be a step towards reducing stigma and discrimination.

6.5 Suggestions for Future Research

A comparative study of public and private health facilities on lived experience of counsellors in communicating HIV test results to discordant couples in the study district of Chingola district on the Copperbelt of Zambia.

REFERENCES

Anderson, J.B. (2009). *HIV Stigma and Discrimination Persist, Even in Health Care.* Journal of Ethics. USA: American Medical Association.

Bott, S. et al. (2015.) *Rewards and Challenges of Providing HIV Testing and Counselling Services: Health Worker Perspectives from Burkina Faso, Kenya and Uganda.* London: Oxford University Press.

Centers for Disease Control and Prevention (2020). https://www.cdc.gov/hiv/risk/prep [Accessed on October 24, 2020]

Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. (2014). *Zambia Demographic and Health Survey 2013-14.* Maryland, USA: Central Statistical Office, Ministry of Health, and ICF International.

Central Statistical Office. 2018. *Zambia in Figures.* Lusaka: CSO.

Creswell J.M. & Plano, C.V.L. (2012). *Designing and Conducting and Evaluating Quantitative and Qualitative Research*.4th ed. Sydney: Pearson.

Cherry, K. (2019). *History and Key Concepts of Behavioral Psychology.* https://www.verywellmind.com [Accessed on September 29, 2020]

Chikopela, R., Mandyata, J., Ndhlovu, D. & Mpolomoka, D. (2019). *Counselling HIV and AIDS Learners with Hearing Impairment: gaps in Practice in Lusaka' s Secondary Schools in Zambia*. European Journal of Special Education Research. Vol. 4 (1), 87-104, ISSN L- 2501-2428.

Chisanga, G.M. (2011). *Access to HIV and AIDS information to learners with hearing impairment in selected basic schools in central and Northern Province. Zambia*. Unpublished research.

Desgrees-du-Lou, A & Orne-Gliemann, J.(2008). *Couple-centered Testing and Counselling for HIV Serodiscordant Heterosexual Couples in Sub-Saharan Africa.* Reproductive Health Matters.

Fakolade, O.A., Adeniyi, S.O. & Tella, A. (2005). A comparative study of risk behaviour and HIV/AIDS awareness among adolescents with and without hearing impairment in south-western part of Nigeria. *International Journal of Emotional Psychology and Sport Ethics* 7(8), 24-31.

Goldstein, M.F., Eckhardt, E.A., P., Berry, R., Paradise, H. and Cleland, CM. (2010). *What do deaf high school students know about HIV? AIDS education and prevention, 22 (1) :523-537.*

Grinstead, O. A., Gregorich, S. E., Choi, K. H. & Coates, T. (2001). *Positive and Negative life events after Counselling and Testing: the Voluntary HIV-1 Counselling and Testing Efficacy Study.* San Francisco: Lippincott Williams & Wilkins.

Kairania, R. M., (2010). *Disclosure of HIV Results among Discordant Couples in Rakai, Uganda: A Facilitated Couple Counselling Approach.* AIDS Care. https://www.researchgate.net/publication [Accessed on October 3, 2020]

Keefe-Cooperman, K., Savitsky, D. K., Koshel, W., Bhat, V. & Cooperman, J. (2017). *The PEWTER Study: Breaking Bad News; Communication Skills Training for Counselling Programs.* https://www.doi.org [Accessed on September 29, 2020]Ministry of Health. (2014). *Zambia 2010 Census of Population and Housing; Copperbelt Province Analytical Report.* Lusaka: CSO.

Ministry of Health. (2015). *Zambia Demographic and Health Survey.* Lusaka: CSO.

Ministry of Health. (2016). *HIV Testing and Counselling (HTC) Implementation Plan.* Zambia: Ministry of Health.

Ministry of Health. (2019). *Zambia Population-based HIV Impact Assessment (ZAMPHIA) 2016: Final Report.* Lusaka: Ministry of Health.

Ministry of Education (2006). *HIV/AIDS Work Policy for the Education Sector for Management and Mitigation of HIV/AIDS* (1st ed) Lusaka: Ministry of Education.

Munachaka, J. (2006). *‘ Teachers Vulnerability to HIV/AIDS Infection: The Case of Lusaka District.’ MEd. Dissertation, Lusaka: Unpublished, University of Zambia*.

Mutswanga, P., Munemo, T. E., Marufu, O., Hlatswayo, L., Chikutsa, A., Mberi, E. (2010). *Abnormal Psychology in Counselling Module.* Harare: ZOU.

Mutsau, S. & Chihambakwe, W. 2012. *Monitoring and Evaluation in Counselling.* Harare: ZOU.

Ndhlovu, D. (2015). *Theory and Practice of Guidance and Counselling.* Lusaka: UNZA Press.

Kasonde-Ng’ andu, S. (2013).. *Writing a Research Proposal in Educational Research.* Lusaka: UNZA Press.

Okun, B. (1984). *Marriage and Family counselling.* Michigan: Eric/CAPS.

Research Methods for the Social sciences. https://www.lumenlearning.com [Accessed on 12 October(2020]

Rule, et al. (2008). *HIV/AIDS and Disability: Three Country Study – Uganda, Zambia, South Africa. A Report commissioned by the World Bank*. South Africa: University of KwaZulu-Natal.

Source: UNAIDS Data 2018.

Wall, M.K. et al. (2018). International Journal of Epidemiology. *HIV Testing and Counselling Couples Together for affordable HIV Prevention in Africa.* Oxford University Press.

William. E (2018). Medical Guidelines of Counselling of Discordant Couples, New York: Lippincott Williams & Wilkins

World Health Organisation. (2016). *Guidelines on HIV Self-Testing and Partner Notification. Supplement to Consolidated Guidelines on HIV Testing Services.* Geneva:WHO.

WebMD. 2020. *Antiretrovirals: HIV and AIDS Drugs*. https://www.webmd.com/hiv-aids/aids-hiv-medication [Accessed on 25th October, 2020]

Vissak, T. (2010. *The Qualitative Report.* Volume 15 Number 2. https//www.nova.edu/ssss/QR/QR15-2/vissak.pdf [Accessed on October 17, 2020] www.unicef.org/zambia

APPENDICES

Appendix 1: Interview Guide for Counsellors

1. What is your gender?
2. How old are you?
3. How long have you been a counsellor?
4. What is your highest qualification in counselling?
5. How many years have you worked as a counsellor?
6. In your view, how much information on HIV do discordant couples come with when first visit your facility?
7. What are your views on time available for you to attend to clients particularly the discordant couples?
8. Could you comment on your working environment? What are some of your experiences?
9. What would you say about resources to support your work with discordant couples? Are they available? If not why?
10. In your opinion, do discordant couples have prior knowledge about their status before coming to the facility for help?
11. What is your assessment of acceptance levels of the HIV test results among discordant couples?
12. What support services are available from your side as a counsellor for discordant couples at your centre?
13. What goes through your mind before you disclose a discordant test result to a couple?
14. What are the challenges you face in communicating such results?
15. What kind of support do you offer to discordant couples after results are given

Thank you for your responses

Appendix 2: Focused Group Discussion Guide for Counsellors

1. In your views, how much information on HIV do discordant couples come with when first visit your facility?
2. What are your views on time available for you to attend to clients particularly the discordant couples?
3. Could you comment on your working environment? What are some of your experiences?
4. What would you say about resources to support your work with discordant couples? Are they available? If not why?
5. In your opinion, do discordant couples have prior knowledge about their status before coming for help ate the facility?
6. What is your assessment of acceptance levels of the HIV test results among discordant couples?
7. What support services are available from your side as a counsellor for discordant couples at your centre?
8. What goes through your mind before you disclose a discordant test result to a couple?
9. What are the challenges you face in communicating such results?
10. What kind of support do you offer to discordant couples after results are given

Appendix 3: Observational Checklist for Counsellors

Ratings

Item	**Good**	**Fair**	**Poor**
Confidence in speaking			
Emotional when talking to client			
Body posture/gestures			
Choice of words.			
Attitude towards fellow counsellors.			
General attitude during talking (towards clients).			
General etiquette/ courtesy.			
Personal grooming.			