

FACTORS ASSOCIATED WITH COUPLES HIV/AIDS COUNSELING AND TESTING
IN KANYAMA COMPOUND, LUSAKA

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This thesis submitted to the Department of Public Health, School of Medicine,
University of Zambia, Ridgeway Campus in partial fulfillment of the requirement for
the degree of Master of Public Health (MPH).



UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

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APPROVAL

This dissertation of Ian Membe is approved as part of the fulfillment of the requirements for the award of the degree of Master of Public Health by the University of Zambia.

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DEDICATION

I dedicate this thesis to my late father, Mr. D.R. Membe, who encouraged me in all things academic.

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TABLE OF CONTENTS

APPROVAL.....	i
DECLARATION.....	ii
DEDICATION.....	iv
ACKNOWLEDGEMENTS.....	v
LIST OF TABLES.....	vii
TABLE OF FIGURES.....	vii
1. ABSTRACT:.....	viii
2. INTRODUCTION.....	1
2.1 Introduction.....	1
2.2 Statement of the Problem.....	2
2.3 Justification of the Study.....	4
2.4 Problem Analysis and Conceptual Framework.....	8
2.5 Literature Review.....	9
2.6 Research Objectives.....	12
2.7 Research question.....	13
2.8 Research Hypothesis.....	13
2.9 Variables.....	13
3. MATERIALS AND METHODS.....	14
3.1 Data Collection and Analysis.....	14
3.2 Ethical Matters and Study Permissions.....	17
3.3 Study Duration.....	18
4. RESULTS.....	19
5. DISCUSSION.....	29
6. CONCLUSIONS.....	32
7. RECOMMENDATIONS.....	33
8. LIMITATIONS.....	34
9. REFERENCES.....	1
10. APPENDICES.....	4
10.1 Consent Forms.....	4
10.2 Questionnaire.....	6

LIST OF TABLES

<i>Table 1: Demographic Characteristics of the Study Population, Kanyama Compound, Lusaka.....</i>	<i>20</i>
<i>Table 2: Age difference of couples by testing, Kanyama Compound, Lusaka, Zambia</i>	<i>22</i>
<i>Table 3: Length of relationship by testing, Kanyama Compound, Lusaka, Zambia.....</i>	<i>22</i>
<i>Table 4: Religion/Church Affiliation and Testing by Testing in Kanyama Compound, Lusaka, Zambia.....</i>	<i>23</i>
<i>Table 5: Relationship between education level and testing in Kanyama Compound, Lusaka, Zambia.....</i>	<i>24</i>
<i>Table 6: Reasons for accessing couples CT, Kanyama Compound, Lusaka, Zambia.....</i>	<i>25</i>
<i>Table 7: Reasons for not accessing couples CT, Kanyama Compound, Lusaka, Zambia.....</i>	<i>26</i>
<i>Table 8: Proportion who informed others about their decision to go for couples CT, Kanyama Compound, Lusaka, Zambia.....</i>	<i>27</i>
<i>Table 9: Individuals discouraged from attending couples counseling and testing by those tested, Kanyama Compound, Lusaka, Zambia.....</i>	<i>28</i>
<i>Table 10: Whose idea was it to go for couples counseling and testing by those tested by sex by testing, Kanyama Compound, Lusaka, Zambia.....</i>	<i>28</i>

TABLE OF FIGURES

<i>Figure 1: Analysis of Factors Affecting Couples HIV/AIDS Counseling and Testing</i>	<i>8</i>
<i>Figure 2: Map of Zambia and Lusaka Urban Showing Location of Kanyama Compound</i>	<i>15</i>
<i>Figure 3: Age distribution histogram and bell curve, Kanyama Compound, Lusaka, Zambia</i>	<i>21</i>
<i>Figure 4: Education Level attained, Kanyama Compound, Lusaka, Zambia</i>	<i>24</i>
<i>Figure 5: How participants were invited to couples counseling and testing, Kanyama Compound, Lusaka, Zambia</i>	<i>27</i>

1. ABSTRACT:

Background: Couples counseling and testing has been widely identified as a key HIV/AIDS prevention and management strategy. However, there has been very low uptake of couples testing in Zambia.

Study Objective: The purpose of this study was to describe the factors associated with couples counseling and testing in Kanyama Compound.

Materials and Methods: A questionnaire was administered among individuals who were invited by the Zambia-Emory HIV Research Programme (ZEHRP) to attend couples counseling sessions at the Ministry of Health run Kanyama clinic. The study questioned both those who were invited and came for counseling as well those who were invited but did not attend counseling as a couple. Further, a qualitative focus-group discussion was held with individuals attending counseling sessions at the clinic.

Results: Unavailability of partners to go for couples CT (43%), distance to testing facilities (32%) and lack of transport money to attend couples CT (29%) are the likely major factors that hinder access to services. Social factors (age, socioeconomic, education etc) play a role but do not seem to be key enhancers nor hindrances.

Conclusion and Policy Implications: Various interventions are necessary to remove physical barriers to couples testing including workplace programs that enhance testing of working males with their partners. Mainstreaming of services at all health facilities needs to be initiated together with the development of structures and information systems.

Limitations: The study population was a convenient sample and subjects were not necessarily representative of the underlying population in Kanyama. Sample size, based on program outreach was small, which precluded more advanced statistical analyses for generalization purposes.

2. INTRODUCTION

2.1 Introduction

An estimated 33 million people in the world are HIV positive yet it is estimated that only 20% of them know their HIV status (PEPFAR 2008). According to the Zambia Demographic and Health Survey (ZDHS) (CSO, 2009), Zambia's adult (15 – 49 yrs) HIV prevalence has decreased from the previous 16% to 14%. This was further estimated to have reduced to 13.5% (CDC, WHO 2011). Though there is a combination of factors contributing to this reduction, voluntary counseling and testing (VCT) has played a major role in this reduction (CSO, 2009).

Based on the DHS findings, the National HIV/STI/TB council (NAC) carried organized a series of meetings that identified six keydrivers of the HIV AIDS epidemic. The introduction of provider initiated Diagnostic Counseling and Testing (DCT/PITC), which provides routine or 'opt out' testing has also helped many people accept to Counseling and Testing (CT) and reduce stigma associated with the same.

The ZDHS (CSO, 2009) also found that HIV prevalence was twice as high in urban than in rural areas and was also lowest among individuals who had never been married but highest among those who were married or had been married before (divorced, separated, or widowed). On average prevalence among married individuals was 33% compared to eight percent among unmarried individuals who had had sex before. This difference is significant statistically. Married or cohabiting couples, therefore, play an important role in the rate of incident and cumulative HIV/AIDS rates. Other studies have also confirmed that in generalized epidemics, as

is the case for Southern Africa, two-thirds of new HIV infections occur between couples with long term cohabiting or marriage relationships where trust is higher and condom use inconsistent (Allen, 2005; Desgrées-du-Loû A. &Orne-Gliemann J, 2008).

Intensive research on the efficacy of Couples HIV/AIDS Counseling and Testing (CHCT) has been carried out in various countries around the world including Zambia (CDC, 2007). In study trials carried out by the Zambia Emory HIV Research Project (), CHCT has been found to be able to reduce HIV/AIDS incidence by up to 60% (Dunkle et al., 2008). CHCT has, therefore, emerged as an important intervention in the fight against HIV/AIDS. Unlike general counseling and testing done by individuals separately, CHCT provides an environment for HIV prevention that is safe for disclosure of HIV status among partners. It also provides an opportunity for couples to consider their next steps together, including options for disclosure of status to children as well as those for access to other HIV services.

2.2 Statement of the Problem

There is very low couples VCT uptake in Zambia while the reasons for this are unclear. Couples counseling and testing (CHCT) is not as common as individual voluntary counseling and testing (VCT) as testing statistics imply it is much more difficult to bring a couple for CT together than it is to get an individual tested. Since HIV/AIDS in Zambia is primarily heterosexually transmitted (ZDHS, 2003) in generalized epidemics such as Zambia's, CHCT would play a major role in helping couples take charge of their sexual lives and thus reduce the spread of HIV/AIDS. The CHCT process is also very detailed and involves learning more about how HIV is transmitted and what behaviors can put a person at risk of infection, in addition to the meaning and implications

of the individuals' test results to the couple. Couples are also encouraged to not only know each others' results but also retest so that the 'window period' factor does not confound their results.

It has been reported that less than one percent of couples have been tested together in Africa (Allen, 2005; Vwalika, 2007). This may have improved slightly due to advancements with availability of anti-retroviral therapy (ART) and Prevention of Mother to Child Transmission (PMTCT) programs that target men, but the proportions are still appalling. Current counseling and testing trends show that more women than men get tested in Zambia (CSO, 2011). Recently, this is due to the fact that women also have more opportunities to get tested through Mother and Child Health (MCH) attendance, a situation that has improved with the proliferation of PMTCT programs. There are many factors that affect an individual's ability to disclose their status. These could include stigma and tend to impact on disclosure of one's status to their spouse. Most couples may only disclose their status in cases of visible HIV-related illness.

Even though the benefits of CHCT are appreciated and acknowledged, couples find it easier to seek counseling and testing as individuals rather than together as a couple. According to ZEHRP program data only 10% of invited couples actually show up for CHCT (Allen, 2005; ZEHRP, 2008). In short, there is very low couples VCT uptake in Zambia while the reasons for this are unclear. There are a number of factors that could be associated with this low uptake: relationships are dynamic and complex, and HIV related issues may be emotionally intense; historical factors within the couple's relationship may affect their ability to deal with current

HIV status; cases of discordance (where one partner is HIV+ but the other is not) are also very common; and other factors such as culture, gender dynamics, religious background and economic status of either partner affect CT seeking behavior as well as post CT reactions (CDC, 2007).

Despite these factors, research has shown that the consequences of CHCT are not as negative as imagined:

- Ø In general, disclosure has not been associated with the break-up of marriages. (Maman, 2003; Kamenga, 1991; Nebie, 2001).
- Ø Less than 15% of discordant couples initially experience psychological distress. (Kamenga 1991).
- Ø Less than 5% of stable couples separate or divorce after disclosure of an HIV positive test result. Among these couples, in most instances, follow-up counseling services can ease tension, diffuse blame, and promote reconciliation.
- Ø Less than 5% of stable couples experience violence as a result of receiving CHCT services together. (Maman, 2003; Kamenga, 1991; Nebie, 2001)

2.3 Justification of the Study

Increasing couples VCT represents an important step in the reduction of HIV/AIDS amongst couples in Zambia. In the current situation close to 20% couples are discordant (Allen, 2005), couples CT is very important. There are, nevertheless, many factors that affect the ability of couples to undergo counseling and testing together. This study hopes to investigate these factors and also identify the more important of these.

Modeling has also shown that couples CT could have a profound effect on HIV incidence.

Modeling The Impact Of Couples' Counseling and Testing

A modeling exercise which analyzed Zambia's Demographic and Health Survey data and modeled that 55% to 93% of new heterosexually acquired HIV infections occurred in serodiscordant marital or cohabiting relationships. This study concluded with a modeled estimation to the effect that an intervention for couples which reduced transmission in serodiscordant urban cohabiting couples from 20% to 7% every year could avert 36% to 60% of heterosexually transmitted HIV infections that would otherwise occur (Kristin et. al, 2005).

There are, therefore, a number of reasons for studying factors that are associated with couples CT:

1. Couples represent the largest HIV/AIDS risk group in Zambia (CSO, 2009;Vwalika, 2007).

HIV/AIDS is the worst pandemic that has affected Zambia and other countries in the sub-Saharan Africa. A lot of funding has been 'pumped' into the fight against HIV/AIDS with combinations of various interventions that include prevention, care and treatment strategies. Within the prevention strategies, it is recognized that transmission is highest in married or cohabiting couples where there is a higher level of trust and also a higher level of emotional involvement. The latter makes it harder to reveal one's serostatus.

2. Testing only one partner in a couple does not result in HIV/AIDS reduction (Vwalika, 2007).

Because HIV/AIDS transmission occurs on both sides of the couple, testing one partner may not lead to HIV/AIDS reduction. Both couples have to know their status as well as that of their partner. HIV is partly also transmitted due to secrecy or avoidance to disclose one's risky behaviours. CHCT offers an opportunity for couples to discuss their behaviours together and thus take more responsible steps that might reduce chances of infection amongst discordant couples or re-infection if both are already HIV positive.

3. CHCT decreases transmission of HIV by more than 60% within discordant couples (Allen, 2003).

For the reasons outlined in the Problem Statement above, CHCT provides an atmosphere that allows for the marked reduction in the transmission of HIV. The key to HIV reduction seems to lie within how open couples are about their extramarital sexual behaviour. It is widely known that multiple concurrent partnerships (MCP) is one of the highest causes of HIV transmission in Zambia (CSO, 2009). MCP has, hence, been deemed a key-driver of the epidemic (NAC, 2008). CHCT may help to reduce MCPs as couples discuss their status together.

CHCT has been proven to be an effective tool in the fight against HIV/AIDS. Specifically:

- Ø The couple is able to receive the information together and can make informed decisions together about care, support, family planning, prevention and treatment strategies.

- Ø Partner notification or disclosure difficulties do not arise as both partners are attended to at the same time.
- Ø It saves time of working with the client on how the partner would be involved and saves the counselor the dilemma of 'conniving' with the client by pretending the client has never been for the test. This is likely to happen when a partner brings the partner after they have already been tested and found positive.
- Ø CHCT brings spouses/partners closer together as VCT helps to establish communication and understanding.
- Ø CHCT leads to increase in condom use, thus reducing transmission of STIs and HIV/AIDS re-infection as well as avoidance of unplanned pregnancies.

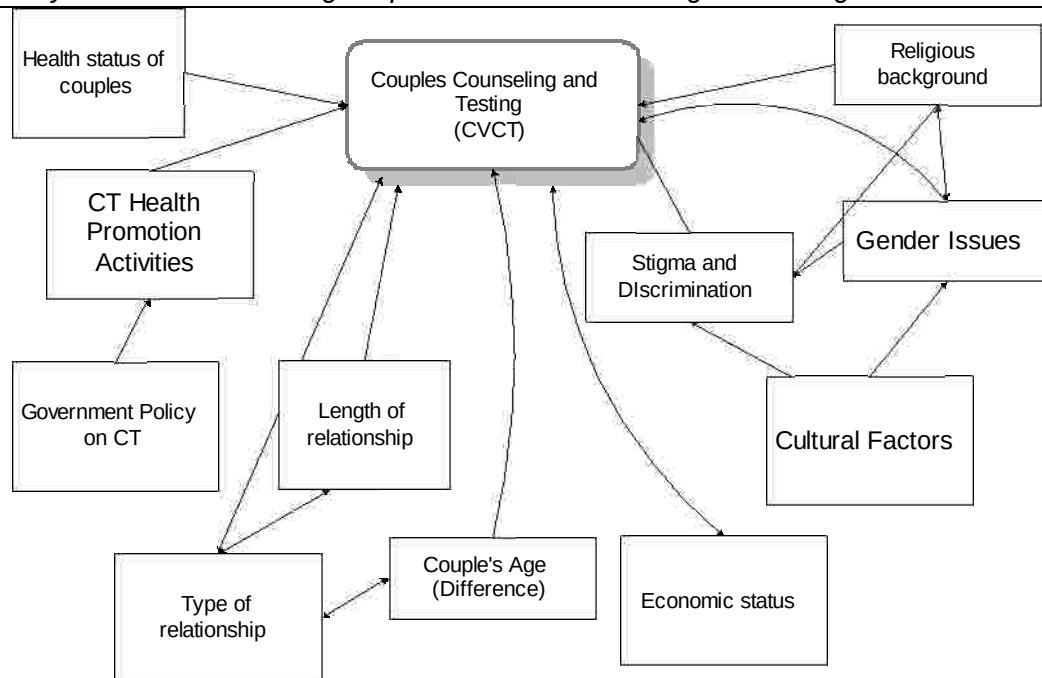
4. A number of studies have been carried out on the effectiveness of CHCT but there is very scanty literature on the factors that predispose couples to access CT as a couple. Specifically, there are no documented studies carried out on factors associated with Couples HIV/AIDS Counseling and Testing uptake for Zambia that could be generalized to the study area, Kanyama compound.
5. The study offers practical recommendations for improving CHCT uptake in both ZEHRP program and in other programs in Zambia – especially as the Zambia Prevention Strategy (2008) gets implemented (see recommendations section below).

Therefore, an understanding of factors that affect couples' decision to test together would help national CT programs plan better to increase CHCT.

2.4 Problem Analysis and Conceptual Framework

The factors in figure 2, below, were identified as important aspects that surround CHCT. These were then translated into research variables for investigation.

Figure 1: Analysis of Factors Affecting Couples HIV/AIDS Counseling and Testing



Using the Health Belief Model (HBM), the study analysed the various factors associated with CHCT uptake in couples in Kanyama as identified in the figure above. The HBM has the following constructs:

1. Perceived susceptibility
2. Perceived severity

3. Perceived benefits

4. Perceived barriers

5. Availability of cues to action

Using the HBM constructs the study tried to answer:

- q Precursors to action: which of the identified factors determine decisions to attend CHCT (based on *perceived susceptibility* to HIV/AIDS, *perceived severity* of HIV/AIDS or *perceived benefits* of CHCT)?
- q Which of the identified factors are hindrances (*perceived barriers* to CHCT)
- q Which of the identified factors encourage couples to access CHCT (*Availability of cues to action*)?

2.5 Literature Review

Source of HIV Infections

According to Desgrées-du-Loû and Orne-Gliemann (2008), in generalized epidemics like Zambia, a large proportion of HIV infections occur within stable relationships, either because of prior infection of the partners or infidelity. The ZDHS of 2007 reported that Zambia's HIV prevalence reduced from the previous 16% to 14%. It also confirmed that this reduction is not statistically significant. The Zambia DHS further acknowledges that prevalence is increasingly higher amongst better educated men and women; 19% among those with education higher than grade 12 compared to 10% among those with no education (CSO, 2009).

Higher Testing of Women than Men

Even as far back as 2004, Farquhar et. al. (2004) noted that many countries in sub-Saharan Africa had integrated counseling and testing and related HIV/AIDS services in antenatal services. However, even with the greater availability of such interventions, many who learnt that they were HIV infected did not implement intervention vertical nor sexual transmission. In both research and non research settings <75% of HIV infected pregnant women were tested and had learnt their HIV status and of those, <50% of these women obtained antiretrovirals to prevent mother-to-child transmission or used condoms postpartum.

HIV Sero-Discordance

It has long been established that a high proportion of incident HIV infections in sub-Saharan Africa occur within married HIV-discordant couples (Hudson, 1996; Robinson et al., 1999; CSO, 2009). In a study carried out in five African countries, the ratio of infected partner by sex was 1:1 (Desgrées-du-Loû and Orne-Gliemann, 2008). That is, there were as many women as men who were infected in discordant partnerships. According to R. Bunnell et al. (2005), infection incidence was measured around 10 to 20 percent among discordant couples. In a study by Allen S. et al. (2003), HIV discordant couples in Zambia increased condom use from 3% at baseline to 80% after CT interventions. The article also discussed the fact that marriage posed a risk for HIV infection for both men and women. In fact, according to the data from their services in Lusaka and Rwanda that were providing CT for couples, there were more recorded cases where more females than males were positive in sero-discordant relationships. This is

attributed partly to the fact that women were more likely to enter marriage relationships already infected.

Factors Associated With Couples HIV/AIDS Counseling and Testing

In a study carried out in Harare among factory working men (Dube S, Machekano R, McFerland W & Mandel J, 2000), a number of factors were identified that hinder couples counseling and testing. Only 7% of 3381 men managed to come with their spouses for counseling and testing after they had been asked to. A number of reasons were raised in the focus-group discussions:

- (a) They experienced difficulties with introducing the subject to their partners due to the uncommunicative nature of their relationships;
- (b) They expressed fear of discordant results which could lead to divorce;
- (c) They feared that results would reveal their partners or their own past, present and future infidelity;
- (d) They thought HIV counseling and testing was not a high priority compared to other issues in their lives. Therefore, they were reluctant to commit their time to VCT;
- (e) Their wives were often unavailable to come to an urban VCT center because they resided in rural areas;
- (f) The men reported that their wives assumed that they would be negative if the husbands HIV test results were negative;
- (g) Lastly, the men thought that there was a lack of interactive communication between counselors and clients during pre-test counseling.

Impact of Promotion on CHCT

Most program data has shown that invitations for couples counseling and testing do not yield significant numbers of couples coming for CT. In a program in an ANC program by the International Center for AIDS Care and Prevention (ICA) in Mozambique (Adiano et al., 2008) of 2,016 pregnant women only 2.7% of their partners came after a verbal invitation was made. The proportion increased three-fold so that about 9% partners responded and came for CT when formal letters were sent to 1,423 partners. Similar trends have been observed by the ZEHRP in Zambia where between 6 – 10% partners have responded to physical invitations by the cadre of network agents who invite couples for CT (Allen, 2005).

2.6 Research Objectives

General Objective

- to identify the factors that are associated with a couple's decision to seek Couples HIV/AIDS Counseling and Testing (CHCT).

Specific objectives

- to describe the socio-demographic characteristics of couples who seek CT together.
- to determine whether CHCT uptake is associated with availability of health services.
- to determine the role that male partners play in increasing or hindering a couple's decision to access to CHCT.
- to determine whether the length of relationship is a factor in CHCT uptake.
- to identify and recommend policy-related strategies that can enhance CHCT uptake.

2.7 Research question

Ø What are the factors that determine a couple's decision to seek Couples HIV/AIDS

Counseling and Testing (CHCT)?

2.8 Research Hypothesis

Ø There are various factors that affect Couples Voluntary Counseling and Testing in the social, cultural, economic and health policy environment. Social and cultural factors (the role of men; length of relationship etc.) affect CHCT access more than others.

Null Hypothesis:

H0: Social factors (the role of men in a relationship and length of a couples' relationship etc.) have little or no effect on a couples' decision to go for Counseling and testing as compared to other factors such as availability of VCT services.

2.9 Variables

Dependent:

- Couples counseling and testing uptake

Independent:

- Availability of CT services
- Gender
- Length of relationship
- HIV- related health status
- Household Income

3. MATERIALS AND METHODS

3.1 Data Collection and Analysis

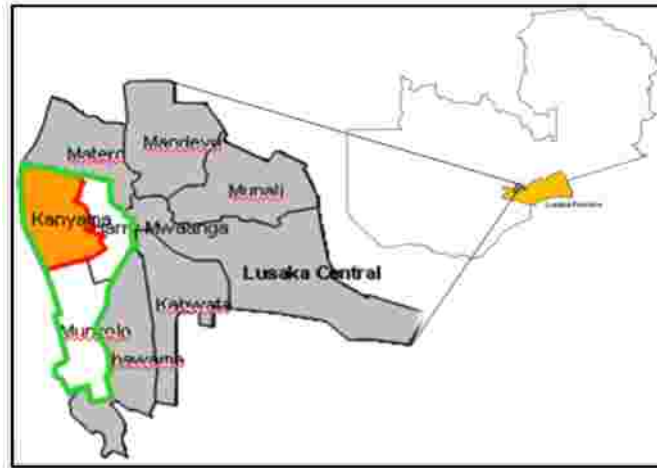
The study followed up the couples who had been invited to attend CHCT by the community facilitators under the ZEHRP project in Kanyama compound. Two groups of couples; those who had been invited and attended CHCT sessions and those who had been invited but did not come were selected on a 1:1 ratio. The study then investigated reasons for attending versus not attending CHCT. Data analysis also looked at those who came to a health center but did not get tested and the reasons for not testing. Analysis (with cross-tabs, chi-square, logistic regression) also included the couples' personal and social backgrounds following the Health Belief Model and variables in the conceptual framework above. Qualitative data was collected in two focus-group discussions with couples attending counseling and testing at the Maternal and Child Health (MCH) department at Kanyama Health Center.

Study Design: Cross-sectional Study.

Study setting/population: The study was conducted in Kanyama Compound in Lusaka.

- Study area was Kanyama Compound, which is part of Kanyama Constituency north-west of Lusaka.
- Kanyama has a total population of 69,016 in 15,775 households (CSO, 2000).
- The study participants were individuals who had been invited to attend couples HIV testing by a ZEHRP community facilitators.
- Study participants were individuals who had attended couples HIV testing at Kanyama health center, and those who had been invited but did not attend.

Figure 2: Map of Zambia and Lusaka Urban Showing Location of Kanyama Compound



Inclusion Criteria:

- A married couple was defined married man and woman married under constitutional or customary law.

Exclusion Criteria:

- Cohabiting couples were not married were not included as these were not previously a target for the ZEHRP intervention.
- Couples who were about to get married.
- Legally married couples who were not invited by the ZEHRP for CHCT.

Sampling

The sample size was calculated using the Epi-Info, StatCalc utility. Population size was based on ZEHRP's number of individuals counseled and tested in a CHCT setting. At 95% confidence level (ci), the study was sampled a total of 268 individuals out of total of 14,976 that had been invited by ZEHRP in 2008 (PEPFAR, 2008). The total number was based on the assumption by the program that an expected 6% of the invited individuals would come for couples testing. The

probability (power) that the two groups of those tested and those not tested would be statistically different was set at 0.9 (90%) with the ratio of 1:1. Following this ratio, the sample was shared so that it had 134 who had attended and 134 who had not attended CHCT Sessions. In actual data collection, a total of 270 questionnaires were administered (135 who attended and 135 who did not attend).

Sample Size for qualitative data was two Focus-Group Discussions of individuals of 15 to 20 individuals per group. The two groups interviewed had 16 and 20 individuals respectively. These were identified using convenience sampling of individuals attending couples counseling and testing at the health facility. The number of individuals in the FGDs was based on the average number that attended a single session at the center on a weekday.

Quantitative Methods:

Quantitative data collected with questionnaires was entered into a Microsoft Access 2007 database where it was also checked for quality using pivot tables. The data was then exported for analysis to Predictive Analytic Software – PASW 18 (Formerly SPSS). The replies to some questions such as “No Reponse (NR)” were recoded as missing values. Various descriptive statistics including frequencies, median, range, minimum and maximum, mean and standard deviation were used. Comparisons between groups were made using the Chi-Square test or Fischer’s exact test as appropriate for categorical variables, and using the t-test or Mann Whitney test for continuous variables. Level of significance was set at 5% and all tests were set as two-sided analyses. Logistic regression analysis was performed to test and adjust for

confounding effects of other identified factors associated with a couples' decision to go for counseling and testing together. Coefficient correlations were also used to test for the strength and statistical significance of relationships amongst the independent and dependent variables for continuous variables such as age and their relationship to couple testing.

Qualitative Methods:

Qualitative information was collected for verbal, in-depth analysis of issues raised in the quantitative surveys. Two FGDs were held with groups of 16 and 20 individuals each attending couples testing at the ZEHRP site at Kanyama Clinic.

3.2 Ethical Matters and Study Permissions

The study sought clearance from the University of Zambia Ethics Committee. This covered the study risks, benefits, informed consent and confidentiality issues. Informed consent (both oral and written) was collected from respondents whose age range was from 19 to 68. All data collected was de-identified to reduce possible identification of specific participants. Permission to carry out the study was also sought from the Permanent Secretary's office at the Ministry of Health. Further permission was taken from the ZEHRP Program, the Lusaka Urban District Health Management Team (LUDHMT) and Kanyama Clinic before commencement of actual data collection activities.

The following was explained to participants prior to enrollment:

- r Research objectives and expected outcomes;

- r Benefits of the research to the subjects and others;
- r Confidentiality of all personal information obtained;
- r Voluntary participation with opt out option at any stage;
- r No adverse effects if individual decided to withdrawal from study.

3.3 Study Duration

The study took a total of nine weeks.

4. RESULTS

This cross-sectional study sought to investigate the factors associated with couples counseling and testing uptake in Kanyama compound. A total of 270 respondents were interviewed. These were split into two equal groups of those who were invited (135) and attended and those who did not attend couples counseling and testing (135). All the participants lived in Kanyama compound and those who attended had gone to the ZEHRP center at Kanyama clinic. Of the 135 who attended, only two (2) people attended but did not get tested. A total of 80 males and 186 females were interviewed with four missing sex data values.

Background Statistics of Study Population

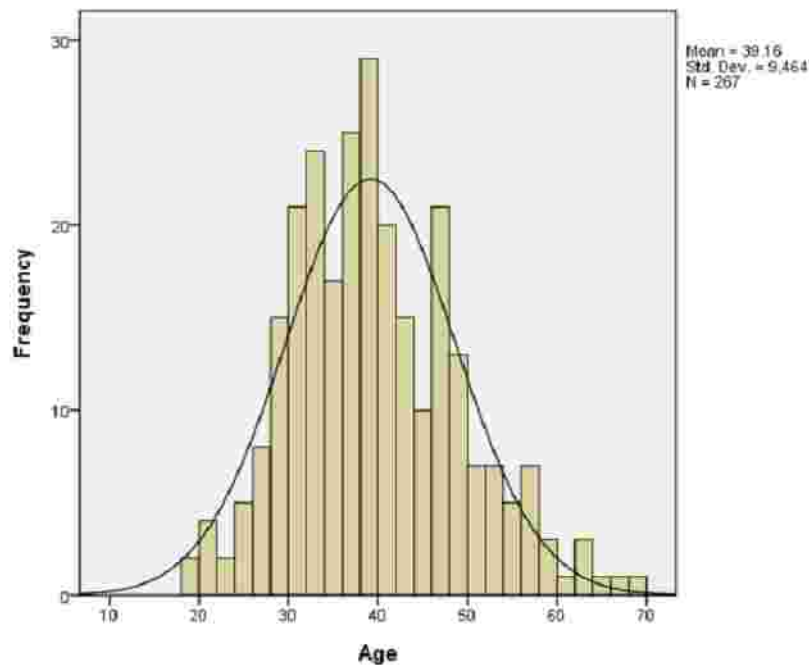
Table 1, below, shows the background characteristics of individuals who participated in the quantitative survey. The age distribution had mean=39.2, median=38.0 and mode=32). On religion/church attendance, most of the respondents were Pentecostal, followed by Seventh-Day Adventists. The majority of the respondents had attended some level of school. Whilst most survey respondents were married to one person (78.6%) a few (16.3%) were widowed, divorced or separated at the time of the survey and only two respondents reported being in a polygamous relationship. 17.1% of the respondents were neither in formal or informal employment. There were fewer individuals who did not own the house they lived in at the time of data collection compared to those who did.

Table 1: Demographic Characteristics of the Study Population, Kanyama Compound, Lusaka

Characteristic	Value N=270 (100%)
Age in Years	
<= 19	2 (0.7%)
20 – 32	71 (26.3%)
33 – 45	124 (45.9%)
46 – 58	63 (23.3%)
59 – 71	7 (2.6%)
Religion/Church Attendance	
Protestant	30 (11.1%)
Pentecostal	82 (30.4%)
Catholic	38 (14.1%)
Seventh Day Adventist	46 (17%)
Jehovah's Witness	13 (4.8%)
New Apostolic	35 (13%)
Moslem	2 (0.7%)
Other	23 (8.5%)
Have you been to school?	
Yes	258 (95.6%)
No	11 (4.1%)
Sex	
Female	186 (68.9%)
Male	80 (29.6%)
Type of Work	
Informal	187 (69.3%)
Formal	37 (13.7%)
House work/ child care	20 (7.4%)
Other work	15 (5.6%)
Looking for work	7 (2.6%)
Retired	3 (1.1%)
Farming	1 (0.4%)
Number of Children	
<=1	22 (8.1%)
2-7	209 (77.4%)
8-12	34 (12.6%)
Do you own home you live in?	
No	153 (56.7%)
Yes	110 (40.7%)
Current Marital Status	
Married to one person	214 (79.3%)
Married to more than one person	2 (0.7%)
Cohabiting	1 (0.4%)
No married	7 (2.6%)
Separated	6 (2.2%)
Divorced	13 (4.8%)
Widowed	25 (9.3%)

The Figure 4 below shows the age distribution bell curve of the respondents. With the measures of central tendency within one standard deviation from the mean age (39), median(38) and mode(32),the graph shows a relatively uniform age distribution of the respondents.

Figure 3: Age distribution histogram and bell curve, Kanyama Compound, Lusaka, Zambia



Factors Associated with Couples Counseling and Testing

The study sought to investigate factors that encouraged a couple's decision to go for CT together. Out of 236 who were invited by community workers from the Zambia Emory HIV Research Project (ZEHRP), 36.0% of those who did not go for CT as a couple had actually been invited by a community worker. Out of those who were invited and went to the clinic only a small proportion (0.1%) did not get tested. A two-sided chi-square test shows a significant ($p=0.001$) of the likelihood to test for people who go to the clinic.

A grouped-age analysis of age and testing showed that there were more tested in the 46-58 age-group (15.8%) compared to 7.9% who did not test. The differences in the other age categories (≤ 19 ; 20-23, 33-45, and 59-79) were minimal. Table 3, below, shows the differences based on age differences between couples while table 4 shows the relationship between testing and length of marital relationship. A correlation analysis of age of respondent and testing showed no significant covariance between age and testing with product moment correlation $r=0.20$ and $p=0.810$. A similar analysis of age difference of couples also showed no significant covariance with $r=0.30$ and $p=0.753$.

Table 2: Age difference of couples by testing, Kanyama Compound, Lusaka, Zambia

Couple age difference	Tested (N=135)	Not Tested (N=135)
<5 Years	1 (1%)	1 (1%)
6-10 Years	49 (25%)	97 (49%)
11>	34 (17%)	65 (33%)

Table 3: Length of relationship by testing, Kanyama Compound, Lusaka, Zambia

Length of relationship	Tested (N=135)	Not Tested (N=135)
≤ 1	1 (0.5%)	3 (1.5%)
2 - 12	57 (27.7%)	95 (46.1%)
13 - 23	36 (17.5%)	76 (36.9%)
24 - 34	9 (4.4%)	23 (11.2%)
35 - 45	4 (1.9%)	9 (4.4%)

The main reasons for not attending couples CT, amongst those who did not attend, ranged from unavailability of partners (16.3%) to partners already knowing their status (15.6%) and couples finding it difficult to discuss couples CT (8.9%). Only very few individuals (2.2%) reported that their partners would hinder them from going to CT.

In terms of religion and church attendance, most of the participants attended a Pentecostal Church (30.4%) followed by Seventh Day Adventists (17.0%). A two-sided Chi-Square test did not show a significant relationship between religion/church attendance and testing ($p=0.306$). A further recoding of this variable into Christian and non-Christian showed that out of those who reported being Christian, 53.4% got tested compared to the 4.3% who got tested out of the non-Christian. The Pearson moment correlation of $r=0.009$ and $p=0.99$ (regression) did not show covariance nor a significant relationship between religion and couple testing.

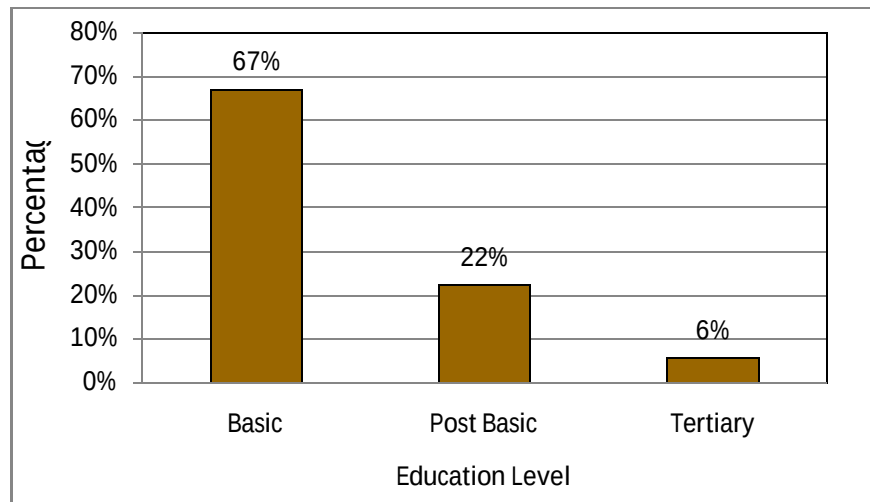
Table 4: Religion/Church Affiliation and Testing by Testing in Kanyama Compound, Lusaka, Zambia

Church/ Religion*	Tested N=135	Not Tested N=135
Pentecostal	45 (19%)	30 (13%)
Protestant	20 (9%)	8 (3%)
SDA	20 (9%)	16 (7%)
New Apostolic	18 (8%)	11 (5%)
Catholic	16 (7%)	15 (6%)
Jehovah's Witness	2 (1%)	11 (5%)
Moslem	2 (1%)	0 (0%)
No Religion	10 (4%)	7 (3%)

**Row for missing values not included*

The Figure 5 below shows the education levels of participants. Most participants (N=86) had received basic education (from Grade 1-9) while a few (N=29) had received post-basic education (Grade 10-12). The minority (N=10) had attained tertiary education from certificate to diploma levels.

Figure 4: Education Level attained, Kanyama Compound, Lusaka, Zambia



The table below shows the relationship between education level and couples testing. Logistic regression analysis did not show a significant relationship between education and couples testing ($p=0.282$).

Table 5: Relationship between education level and testing in Kanyama Compound, Lusaka, Zambia

		Tested	
		Yes (N=135)	No (N=135)
Education Level	Basic	86 (32.5%)	95 (35.8%)
	Post-Basic	29 (10.9%)	31 (11.7%)
	Tertiary	10 (3.8%)	5 (1.9%)

The analysis of testing and work type as well as well other economic status indicators such as whether they owned their dwelling and type of dwelling did not show significant differences across the different categories. Chi-Square tests for significance for work type ($p=0.623$) and owns dwelling ($p=0.136$) did not show significant relationship between economic status and testing. Table 6, below, shows the reasons cited for attending couples counseling and testing.

Table 6: Reasons for accessing couples CT, Kanyama Compound, Lusaka, Zambia

Reason	N=135 (%)
Just wanted to know my status	127 (94.1%)
To plan for my future	87 (64.4%)
Study volunteer	27 (20.0%)
Partners sexual behavior	22 (16.3%)
Work related	21 (15.6%)
Past sexual behavior	15 (11.1%)
Spouse requested me	13 (9.6%)
Planning to have children	12 (8.9%)
Planning to get married	9 (6.7%)
Taking care of HIV+	7 (5.2%)
Church requested me	6 (4.4%)
Exposed to HIV at work	4 (3.0%)
Developed HIV symptoms	3 (2.2%)
Blood transfusion	3 (2.2%)

**Total % does not add up to 100% as this was a multiple response question*

Table 6 above shows that most people attending couples attended CT because they wanted to know their status (mentioned by 94.1%) and also make appropriate plans for their future (mentioned by 64.4%). The qualitative reasons for attending CT also confirmed that most people went so they could learn their status.

“We came because we felt that it is important these days to know your status.”

Only very few reported that their partner’s request to go for CT was a key reason for going. The questionnaire interview asked the respondents to rank the main reasons for attending couples CT. “I went to just learn my status” was ranked first by 24.4% (N=91) of the respondents followed by, “I went to get tested in order to plan for my future” which was ranked both second and third highest by 16.3% and 10.4% of those who responded respectively.

Other comments from the qualitative interview including Focus Group Discussions were:

“We wanted to make sure because I was frequently sick”

“Because my husband was sick”

“My child was sickly”

“We went to get tested to avoid quarrels”

“We wanted to rebuild our relationship”

Table 7 below shows the reasons for not accessing couples CT. Of the 40 who mentioned that their partner was a hindrance leading to their not going for couples CT, 95% were females.

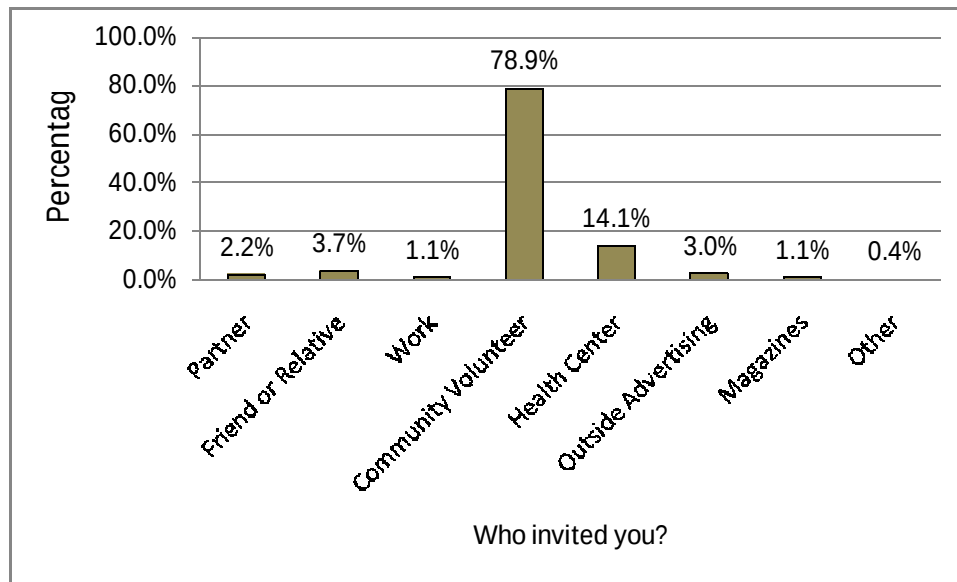
When weighted by number per sex/gender group the percentage of females was still higher at 20% compared to 3% of males.

Table 7: Reasons for not accessing couples CT, Kanyama Compound, Lusaka, Zambia

Reason for not attending CT	N=135 (%)
Partner not available	43 (43.6%)
Already know status	38 (38.6%)
Distance to CT place	32 (32.5%)
Lack of transport money	29 (29.4%)
Difficult to discuss	21 (21.3%)
Partner would hinder	21 (21.3%)
Fear of past lifestyle	15 (15.2%)
Status based on partner	11 (11.2%)
Not high priority	9 (9.1%)

The below shows how couples came to know about couples counseling and testing services. All but one of the participants who had gone to a clinic for couples CT went to the ZEHRP project supported Kanyama clinic to receive services.

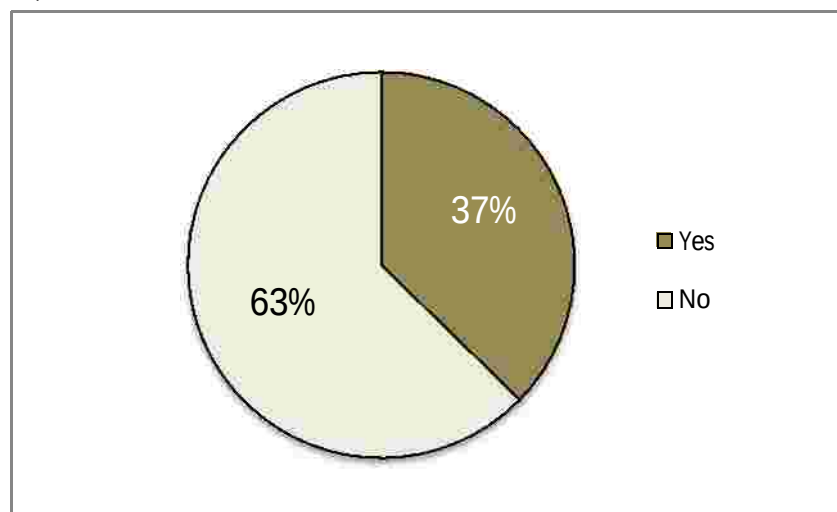
Figure 5: How participants were invited to couples counseling and testing, Kanyama Compound, Lusaka, Zambia



*Total % does not add up to 100%, as this was a multiple response question

Of those who were tested out of those invited by community volunteers from the Zambia Emory HIV Research Project (ZEHRP) only(1) 0.1% reported being tested at a non-ZEHRP supported site.

Figure 6: Proportion who informed others about their decision to go for couples CT, Kanyama Compound, Lusaka, Zambia



A cross-tabulation of testing by “talking to others about the decision to go for couples CT” showed that out of the number who got tested, there were slightly more (28.2%) who did not talk to others apart from their spouse about their decision to go for couples CT than those who did (21.4%). Out of those who did not get tested, there were over twice the number of respondents who did not talk to others (35.5%) compared to 14.5% who did talk to others about their decision to go or not to go for couples CT.

Very few (16%) felt they were discouraged by their spouses to go for couples CT compared to those who did not (78%). Of the number who were discouraged by their spouses, a weighted by sex value of 28% were male while 72% were female.

Table 8: Individuals discouraged from attending couples couns tested, Kanyama Compound, Lusaka, Zambia

		Tested N=135	Not Tested N=135
Spouse discouraged me from going for couples CT	YES	23 (8.7%)	42 (15.9%)
	NO	95 (36%)	206 (78%)
	CANNOT TELL	2 (0.8%)	3 (1.1%)

Table 9 below shows a cross-tabulation of whose idea it was to seek couples testing by whether they actually got tested by sex of respondent.

Table 9: Whose idea was it to go for couples counseling and testing by those tested by sex by testing, Kanyama Compound, Lusaka, Zambia

		Tested (N=(135)	Not Tested (N=135)
Male	Me	31 (41%)	23 (31%)
	My Spouse	3 (4%)	10 (13%)
Female	Me	65 (37%)	62 (35%)
	My Spouse	19 (11%)	10 (6%)

5. DISCUSSION

The Zambia Demographic Health Survey (ZDHS, 2007) reported multiple concurrent partnerships as a key driver of the HIV/AIDS epidemic. Most programs implementing behavioural modification programs relating to sexual behaviour have not been seen to be successful as sexual behaviours occur in very complex and multi-factor milieus. This increased level of insecurity amongst partners in monogamous relationships, therefore, becomes an important incentive for HIV testing. The ZDHS, program data (PEPFAR, 2010) and other studies are showing an increasing intention to get tested by individuals. However, there seem to be hindrances that continue to affect couples testing that do not apply to individuals.

The study looked at factors that encouraged or hindered individuals and couples who were invited for couples testing. Most of the people who went to get tested actually got tested. It is obvious that chances are higher that once a couple attends a couples' session at the health facility, they will likely not go back without testing. Therefore, getting people to a facility offering testing services is one important step in increasing the numbers of couples testing.

The main reason for couples not testing was actually the unavailability of especially male partners. A qualitative study carried out in Harare among factory workers (DubeS. et.al.,2000)also identified unavailability of partners.The other factors identified in the Harare study such as fear of divorce were also mentioned in Kanyama seem to be common across even cultures.Other factors considered in the Harare study including culty to discuss or communicate around sexual issues; the hindrance by partners; and the fear of their own past or

partner's past lifestyles were also mentioned here. It would seem interpersonal relationships between couples are not at a level where they are able to freely discuss matters that directly impact on their health, especially those of a sexual nature. It is therefore, a concern that only very few individuals went to couples testing because their partners encouraged them to. Even with individual testing, evidence seems to continue to point to higher testing among women compared to male counterparts (PEPFAR Zambia, 2010).

With the current HIV/AIDS rates at around 15.3% (CDC, 2011), any behaviours that have the potential to increase the HIV/AIDS incidences amongst couples need to be given due attention. Another important factor is that it seems that couples still find it difficult to discuss testing issues so that they may not even bring up the subject of testing. This concurs with findings from other countries (Kamenga, 1991) where they found that most people did not report failing to go because they were hindered by their partners. While, it might be comforting to note that couples are not hindering each other, they are also not actively encouraging each other to attend testing services. Third-parties that interface with communities can, therefore, play an important role in getting couples to discuss these decisions but also encourage actual testing.

It would seem that distance to health facilities continues to be a hindrance to accessing health care including CHCT uptake. Larsson et.al (2010) also found that distance to health facilities was cited as an important factor that discouraged men from going to couples testing with their wives. The unavailability of facilities near to where people live, therefore, creates a further

barrier that makes it even harder for couples to get tested together. Unavailability of facilities combined with lack of transport money to go for CHCT seem to have an important net effect on the overall access to CT by couples. In his case study of factors affecting access to rural health facilities, Mwasi (2010), also found that distance, time and money were the strongest barriers to health facility attendance.

In his study, on factors affecting access to rural health facilities by Mwasi (2010), that utilized Geographical Information Systems (GIS) to study factors in the Baringo area of Kenya, ethnicity and religion did not seem to affect health facility attendance patterns. It was interesting to note the differences in testing habits amongst various religious groups in the study reported here. Even though Christians in general had higher testing rates than other religious groups, further investigation is required with stratified sampling based on religion as a key variable to determine the differences and their significance.

The conceptual framework used in this study included age related factors and their influence on couples decision making concerning a health issue such as HIV testing. Some of the literature reviewed also did not find significant associations between a couples' age difference and health decision-making. A study that looked at contraceptive decisions and HIV/AIDS concerns among married couples in Malawi found no significant association between spousal age difference and contraceptive use as a preventative strategy against HIV in marriages. Even though there was a non-significant association even in this study, it would seem that couples who had been married longer seemed to have a greater propensity to test together.

The study also seems to indicate that there might be stigma issues related to couples testing so that very few people feel free to discuss these issues in public. Almost twice the number of those who did not get tested did not discuss their decision with anybody in the community. The study suggests stigma issues are still prevalent that may be discouraging couples from accessing counseling and testing services. Further, those that felt they were discouraged when they talked to other relatives and friends were much fewer than those that talked to general community members. All in all, there is little to no discouragement from other people concerning couples counseling and testing. A few members in the focus-group discussion mentioned the fear of couples testing destabilizing their marriages but most felt it was better knowing than being in doubt.

6. CONCLUSIONS

Individuals who participated in this study did not seem to have major hindrances with couples counseling and testing from social and community factors. This demonstrated that factors such as age-difference, length of marriage or level of education were not the major hindrances to CHCT. Other factors such as religion were also not key precursors to action and decision making for this health-related behaviour. On the hand, couples who actually went to a testing site ended up actually getting testing, proving that some assumed fears of testing are not valid. All in all, the unavailability of partners, especially male partners, to go for testing is the biggest reason couples are not able to access couples CT together. This compounded by the lack of

physical access to testing facilities (distance and lack of transport money) are the main reasons couples are not able to access CHCT together.

7. RECOMMENDATIONS

Integrated Workplace Programs:

To counter the hindrance of unavailability of male partners for couples CT, the government and supporting donors should begin to discuss workplace related couples testing. Special days in the month could be initiated where employees could bring their partners for testing in the workplace environment.

Community Linkages

Seeing that couples who actually get to a CT site end up being tested, programmes seeking to reach out to couples will have greater effect as they work through community-networks such as those supported by community volunteers. These facilitators should actively encourage people to attend couples testing and link them to the health facilities. Existing cadres of volunteers who carry out other health related campaigns should be able to easily link couples to specific services in the health facilities.

Early introduction to couples HIV/AIDS Testing

In the light of the seeming likelihood to test among couples have been married longer, counseling and testing programs should be mainstreamed in early marriage counseling to encourage practice early on in marriage, especially for younger couples. Marrying ministers in traditional, secular and religious settings should include HIV/AIDS counseling in their marriage

preparation talks. Community-based programs working in the field of HIV/AIDS should emphasise couples HIV/AIDS testing in their menu of topics.

Policy Recommendation to the MoH:

Couples CT activities will need to be made available at all health facilities to reduce the hindrance of distance and related travel costs. This is ground for institutionalizing and scaling up couples CT services in the country. Other structures will need to be put in place for this to be carried out effectively. The current Ministry of Health counseling and testing systems do not have appropriate structures for encouraging couples testing. Most of the couples testing are happening in ANC/MCH settings, which are primarily designed to cater for women alone. The current registers recording systems also do not have appropriate fields for capturing couples testing. Training for couples testing needs to be enhanced so that CHCT trained staff become as ubiquitous as individual couples and testing counselors. These actions will ensure that issues of physical access are not hindrances to couples CT.

Future Studies:

Future studies should endeavor to investigate in better detail with relatively larger samples to investigate the impact of religion on couples testing. A special focus could be placed on specific groups and their response to couples testing.

8. LIMITATIONS

One key limitation of this study was that there was no master list from which to draw random cases to be interviewed. To fulfill ethical requirements, all the records of those who were invited at the ZEHRP project had been de-identified so that the study had to rely on a purposive sampling method to identify those who were invited and tested. This also made finding the respondents difficult, which prolonged the overall time taken to fill the full sampling quota. The study looked at a largely private issue so that there might be chances of social bias or giving of generic responses that might bias the study. There was also a lack of literature to compare the results of the study with.

The study also faced time constraints in that the ethics approval and permissions with the different stakeholders took quite a bit of time to go through. The permissions took weeks to months to be granted. The study also faced a challenge in the qualitative data collection as there were insufficient numbers at the beginning to meet the required threshold for the focus-group discussions. Nevertheless, these challenges did not affect much the outcomes of the study even though they did have an impact on the timeliness of its execution.

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10. APPENDICES

10.1 Consent Forms

Couples Counseling and Testing Study Consent Form

1. Introduction and Purpose

I'm _____. I am doing research on health issues in your community. We're trying to get information that will help us understand better how people in your community have responded to invitations to HIV and AIDS couple counseling and testing programs under the Zambia Emory Health Research Project. This information will help us better understand why people go or refuse to go for HIV counseling as a couple.

2. Procedures

The purpose of my visit is to ask you some questions related to health. I am conducting a study on couples counseling and testing relating to HIV/AIDS. The interview will take about 30 minutes. I will ask you some questions about yourself, such as your age, and some of your behaviors. I will ask you questions and write down your answers on a questionnaire form. I will not put your name on the questionnaire form and your name will not appear with any typed information. I will be asking other people in your community the same questions.

3. Risks of Participation

There is no anticipated risk involved with this interview. Some questions may make you feel uneasy. You may be embarrassed telling me your thoughts. You don't have to answer any question(s), if you don't want to.

4. Benefits of Participation

You will help me understand the response to counseling and testing better. We hope that you and others in your community will benefit from this information.

5. Compensation

You will not receive monetary compensation for this interview.

6. Privacy

What we talk about will be kept private. Your name will not be attached to any written forms or notes from this interview. All written materials will be locked in a cabinet. Only the researcher and the supervisor will see this information. All written material will be destroyed after the research is successfully concluded. Your name or other facts that might point to you will not appear when we present this project or publish its results.

7. Voluntary Participation, Refusal and Withdrawal

This interview is completely voluntary. You can discuss as much as you like or as little as you like. You do not have to answer any questions that you do not feel comfortable with. You can stop the interview at anytime without giving reason. Your relationship with health and social service providers in the community will not be affected in any way. You can still receive services and take part in other programs.

CONSENT TO PARTICIPATE IN THE STUDY

Dear participant having been explained to the nature and purpose of the study, risks, and confidentiality, you may sign below to declare your participation as voluntary and not forced.

Sign/Thumbprint.....Date.....

Witness (Name).....Sign.....

CONTACT PERSONS FOR ANY QUERIES OR INFORMATION RELATED TO THE STUDY.

1. Mr. Ian S. Membe, University of Zambia, Department of Community Medicine, P.O Box 50110, Lusaka. Cell 077 640 947
Email: imembe@gmail.com
2. DrSH Nzala, University of Zambia, Department of Community Medicine, P.O Box 50110, Lusaka
3. The Chairman, Research Ethics Committee, Department of Community Medicine, P.O Box 50110, Lusaka. Tel: 260-1-25606

10.2 Questionnaire

Couples Counseling and Testing Questionnaire

INDIVIDUAL FORM (ENGLISH)		INDIVIDUAL Form No. 	FORMNO
IDENTIFICATION			
Q01	COMPOUND / ZONE Kanyama / _____		COMP
Q02	HOUSEHOLD NUMBER @ _____		HHNO

INTERVIEW HISTORY												
		VISIT 1	VISIT 2	VISIT 3								
Q03	DATE OF VISIT (DD / MM / YY)	___ / ___ / ___ (DATEVIS1)	___ / ___ / ___ (DATEVIS2)	___ / ___ / ___ (DATEVIS3)								
Q04	INTERVIEWER CODE «RA_CODE»	___ (INTVIS1)	___ (INTVIS2)	___ (INTVIS3)								
Q05	RESULT OF VISIT SEE CODES BELOW	___ (RESVIS1)	___ (RESVIS2)	___ (RESVIS3)								
Q06	NEXT VISIT DATE (DD / MM / YY)	___ / ___ / ___	___ / ___ / ___									
Q07	NEXT VISIT TIME	_____	_____									
RESULT OF VISIT CODES <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">01 Completed interview</td> <td style="width: 50%;">05 Incomplete interview-need to return</td> </tr> <tr> <td>02 Respondent not at home-need to return</td> <td>06 Incomplete interview- no return</td> </tr> <tr> <td>03 Respondent not available- need to return</td> <td>07 Respondent absent during fieldwork</td> </tr> <tr> <td>04 Made contact-refused</td> <td>08 Other (SPECIFY)</td> </tr> </table>					01 Completed interview	05 Incomplete interview-need to return	02 Respondent not at home-need to return	06 Incomplete interview- no return	03 Respondent not available- need to return	07 Respondent absent during fieldwork	04 Made contact-refused	08 Other (SPECIFY)
01 Completed interview	05 Incomplete interview-need to return											
02 Respondent not at home-need to return	06 Incomplete interview- no return											
03 Respondent not available- need to return	07 Respondent absent during fieldwork											
04 Made contact-refused	08 Other (SPECIFY)											
Q08	INTERVIEWER SIGNATURE @ _____											
Q09	COORDINATOR SIGNATURE @ _____											

Q10	DATA CLERK CODE	— —
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SECTION 1 BACKGROUND CHARACTERISTICS

READ OUT: We'll start with a few questions about your background.

No.	Questions and filters	Coding categories	Skip to																																							
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Q12	What languages do you speak? <i>MORE THAN ONE ANSWER IS POSSIBLE</i>	<table border="0"> <thead> <tr> <th></th><th>YES</th><th>NO</th></tr> </thead> <tbody> <tr> <td>BEMBA</td><td></td><td></td></tr> <tr> <td>ENGLISH.....</td><td>1</td><td>2</td></tr> <tr> <td>KAONDE.....</td><td></td><td></td></tr> <tr> <td>LOZI.....</td><td>1</td><td>2</td></tr> <tr> <td>LUNDA.....</td><td>1</td><td>2</td></tr> <tr> <td>LUVALE.....</td><td></td><td></td></tr> <tr> <td>NYANJA.....</td><td>1</td><td>2</td></tr> <tr> <td>TONGA.....</td><td></td><td></td></tr> <tr> <td>OTHER (SPECIFY) @</td><td>1</td><td>2</td></tr> <tr> <td></td><td>1</td><td>2</td></tr> <tr> <td></td><td>1</td><td>2</td></tr> <tr> <td></td><td>1</td><td>2</td></tr> </tbody> </table>		YES	NO	BEMBA			ENGLISH.....	1	2	KAONDE.....			LOZI.....	1	2	LUNDA.....	1	2	LUVALE.....			NYANJA.....	1	2	TONGA.....			OTHER (SPECIFY) @	1	2		1	2		1	2		1	2	BEMBA ENGLISH KAONDE LOZI LUNDA LUVALE NYANJA TONGA OTHLAN1
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Q13	What tribe do you belong to?	BEMBA ENGLISH..... KAONDE..... LOZI..... LUNDA..... LUVALE..... CHEWA TONGA.....	TRIBE																																							

		OTHER (SPECIFY) @_____	
Q14	Where do you go to pray? <i>IF NO RELIGION ENTER NONE</i>	PROTESTANT..... 01 PENTECOSTAL..... .. 02 CATHOLIC..... .. 03 SEVENTH DAY ADVENTIST 04 JEHOVAH'S WITNESS..... 05 NEW APOSTOLIC.....06 CATHOLIC..... 07 MOSLEM..... ..08 HINDU..... 09 NONE 10 OTHER (SPECIFY) @_____ 11	RELIGION
Q15	Have you ever attended school?	YES 1 NO 2	EDUC
No.	Questions and filters	Coding categories	Skip to
Q16	What is the highest (grade/form) you completed? <i>CONVERT FORMS TO GRADES</i> <i>IF LESS THAN GRADEONE COMPLETED ENTER 00</i>	GRADE..... 1 [][] DIPLOMA 2 [][] CERTIFICATE..... 3 [][] DEGREE OR ABOVE..... 4 [][]	EDUCLEV

Q17	OBSERVE SEX OF RESPONDENT	MALE..... 1 FEMALE..... 2	SEX
Q18	What was your main activity of employment in the last 12 months? <i>IF REPLIES WORK PROBE FOR WHETHER IT IS FORMAL OR INFORMAL</i> <i>IF REPLIES UNEMPLOYED PROBE FOR REASON AND NOTE BELOW.</i> WORK2 _____ _____ _____	WORKING (FORMAL)..... .01 WORKING (INFORMAL) 02 FARMING.....03 GOING TO SCHOOL/STUDYING .. 04 LOOKING FOR WORK..... 05 RETIRED..... 06 TOO ILL TO WORK..... ...07 HANDICAPPED, CANNOT WORK ...08 HOUSEWORK/CHILD CARE..... 09 OTHER 10 (SPECIFY) @ _____	WORK1
Q19	How long have you been living continuously in [NAME OF COMPOUND]? <i>IF LESS THAN 1 MONTH ENTER 00</i>	MONTHS1 [][] YEARS.....2 [][]	LIVE
Q20	In the last 3 months, on how many separate occasions have you slept away from your home? <i>READ OUT THE OPTIONS</i>	NEVER..... . 1 1-5 TIMES..... 2 6-10 TIMES 3 MORE THAN 10 4	TRIPS
Q21	How many children do you have?		

		NUMBER OF CHILDREN[][]					NUMCHL
Q22	In the last 3 months, have you at any time been sick?	YES.....1 NO.....2					BNSICK
Q23	What is the main roofing material of the house you now live in?	GRASS, THATCHED, TIN..... 1 CORRUGATED ROOF (TIN OR ASBESTOS) <i>WITH UNFINISHED CEILING</i> 2 CORRUGATED ROOD <i>WITH FINISHED CEILING</i>3 TILE WITH UNFINISHED CEILING..... 4 TILE WITH FINISHED CEILING.....5 OTHER (SPECIFY _____) 6 DECLINED TO ANSWER.....99					ROOF
Q24	What kind of toilet facility does your house have?	OWN FLUSH TOILET 1 SHARED FLUSH TOILET..... 2 TRADITIONAL PIT TOILET..... 3 VENTILATED PIT LATRINE.....4 NO FACILITY, BUSH, FIELD.....5 DECLINED TO ANSWER.....99					TOILET
Q25	Does your house have any of the following: <i>READ OUT THE OPTIONS</i>	TAP DRINKING WATER	YES 1	NO 2	DEC 99		HHTAP
		ELECTRICITY	1	2	99		HHELEC
		A TELEVISION	1	2	99		HHTV
		AN ELECTRIC/GAS KITCHEN STOVE	1	2	99		HHGAS
							HHSTOV
							HHTEL

		A TELEPHONE	1	2	99		
Q26	Do you own the dwelling you now live in?	YES.....1 NO2 DECLINED TO ANSWER.....99					OWNHOM
SECTION 2: SEXUAL BEHAVIOUR							
<i>READ OUT: We'll start with a few personal questions but please feel free to respond honestly.</i>							
No.	Questions and filters	Coding categories	Skip to				
Q27	Are you currently <i>READ OUT RESPONSES</i>	MARRIED TO ONE PERSON.....1 MARRIED TO MORE THAN ONE PERSON.....2 NOT MARRIED BUT LIVING WITH A SEXUAL PARTNER UNDER THE SAME ROOF (COHABITING).....3 NOT MARRIED AND NOT LIVING WITH A SEXUAL PARTNER UNDER THE SAME ROOF.....4 SEPARATED.....5 DIVORCED.....6 WIDOWED.....7 DECLINED TO ANSWER.....99					MARSTAT

Q28	If currently married or cohabiting, how long have you been living with your spouse or sexual partner?	YEARS [_ _] MONTHS [_ _] DECLINED RESPONSE..... 99	MARYRS MARMNT MARNR
Q29	How old is your spouse? <i>WHERE NECESSARY, CALCULATE DATE FROM AGE</i> <i>IN CASE OF POLYGAMOUS RELATIONSHIP ONLY NOTE AGE OF FIRST SPOUSE</i>	[_ _] DO NOT KNOW.....88 DECLINED TO ANSWER.....99	AGESPO

SECTION 2: ACCESS TO COUNSELLING AND TESTING SERVICES

READ OUT: We'll now look at counselling and testing services.

No.	Questions and filters	Coding categories	Skip to
Q30	How did you learn about couples counseling and testing services at the Zambia Emory HIV Research Project (or this service)? <i>MORE THAN ONE ANSWER IS POSSIBLE</i>	YOUR SPOUSE OR SEXUAL PARTNER.....1 A RELATIVE, FRIEND, OR NEIGHBOR.....2 YOUR PLACE OF WORK.....3 A NETWORK AGENT INVITED ME....4	SRVLRN1 SRVLRN2 SRVLRN3 SRVLRN4

		A SCHOOL/COLLEGE.....4 A CLINIC, DOCTOR'S OFFICE, OR HEALTH CENTER.....5 BILLBOARDS, BUSES, OR TRAINS..6 TELEVISION, RADIO, NEWSPAPER, MAGAZINE.....7 SOMEWHERE ELSE (SPECIFY..... 8 DECLINED TO ANSWER.....99		SRVLRN5 SRVLRN6 SRVLRN7 SRVLRN8 SRVOTH SRVDEC
Q31	Have you ever been approached by a network agent from the ZEHRP?	YES NO		INA
Q32	Did you go to a ZEHRP affiliated health facility?	YES NO	->CHK2	ZVIST
Q33	Did you actually get tested at the ZEHRP facility?	YES NO	-> CHK1 -> CHK2	ZTEST
Q34	[CHK1] CHECKLIST 1: FOR THOSE WENT FOR CT I WOULD LIKE TO ASK YOU QUESTIONS ON WHY YOU WENT TO GET TESTED AS A COUPLE			
1. I went to get tested because I was concerned about my <u>own</u> past sexual behaviour TRUE c FALSE c				
2. I went to get tested because I was concerned about my <u>partner's</u> past sexual behaviour TRUE c FALSE c				

3. I went to get tested because I am exposed to HIV in my line of work which is _____	TRUE c	FALSE c
4. I went to get tested because of I had had a blood transfusion	TRUE c	FALSE c
5. I went to get tested because I am/was taking care of persons who with HIV	TRUE c	FALSE c
6. I went to get tested because I wanted to know my HIV status	TRUE c	FALSE c
7. I went to get tested because I developed symptoms of A S	TRUE c	FALSE c
8. I went to get tested because my work required me to	TRUE c	FALSE c
9. I went to get tested because my spouse requested me to	TRUE c	FALSE c
10. I went to get tested because I was planning to get married	TRUE c	FALSE c
11. I went to get tested because my church required me to get tested before marriage	TRUE c	FALSE c
12. I went to get tested because we were planning to start ving children	TRUE c	FALSE c

13. I went to get tested in order to plan for the future	TRUE c	FALSE c
14. I went to get tested because as part of my volunteering for an HIV/AIDS study	TRUE c	FALSE c

15. Other reasons I went to get tested

Of all these reasons, what the top three reasons you went to get tested as COUPLE in the order of importance.

(INSTRUCTION: Please RANK THE TOP THREE reasons they went to get tested as a couple by indicating the number of the question)

1. _____
2. _____
3. _____

Q35	Which ZEHRP affiliated health facility did you go to?	_____		ZCLINIC
Q36	When was the first time you came to access this service	WITHIN THE LAST MONTHS.....1 WITHIN THE LAST THREE MONTHS.....2 WITHIN THE LAST SIX MONTHS.....3 WITHIN THE LAST ONE YEAR.....4 MORE THAN ONE YEAR AGO.....5		SRVTIM

Q37	After visiting the ZEHRP project did you access counseling and testing services at another service provider?	YES.....1 NO.....2		ACCESS
Q38	Did you access these services with your sexual partner?	YES1 NO.....2	-> Q42 -> Q42	ACCESSP

Q39	[CHK2] <u>CHECKLIST 2: FOR THOSE WHO <i>DID NOT</i> GO TO CT</u>		
Please tell me ALL the reasons you did not go for CT as a couple 1. I find it difficult introducing the subject of counselling and testing to my partner TRUE ☐ FALSE ☐ 2. My partner would divorce me if one of us was found positive and the other negative MOST LIKELY ☐ LESS LIKELY ☐ NOT LIKELY ☐ NOT AT ALL LIKELY ☐ 3. I am afraid of going to counselling and testing because of my past sexual lifestyle TRUE ☐ FALSE ☐ 4. HIV counselling and testing is not a very high priority right now TRUE ☐ FALSE ☐ 5. My partner is never available to go with me for couple counselling and testing TRUE ☐ FALSE ☐ 6. I already know my status TRUE ☐ FALSE ☐ 7. I know our status based on my partner's test results (I haven't taken the test myself) TRUE ☐ FALSE ☐ 8. The couples counselling and testing facility is very far away TRUE ☐ FALSE ☐ 9. My partner would stop me from going for couples counselling and testing TRUE ☐ FALSE ☐ 10. I do not have enough transport money to go to the couples testing facility TRUE ☐ FALSE ☐			
Q40	What was your main reason for NOT accessing couples' counseling and testing services at the ZEHRP site?	 	ACCESSN
Q41	Did you access couples counseling and testing services from another CT provider?	YES.....1	ACCESS2

		NO.....2	
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Q42	Do you, in future, plan to attend couples counseling and testing services?	YES.....1 NO.....2		ACCESSF
Q43	Have you discussed this decision with your sexual partner/spouse (s)?	YES.....1 NO.....2		ACCESSF2
Q44	Between you and the spouse, who started the idea or discussion to go for couple's CT	ME.....1 MY SPOUSE.....2 CANNOT RECALL.....3 OTHER (SPECIFY)_____		ACCESSF3
Q45	Did your spouse try to stop you from going to couples CT	YES.....1 NO.....2 CANNOT SAY.....3 OTHER (SPECIFY)_____		ACCESSF4
Q46	Did you tell other members of the community about your decision to undergo couples' counseling and testing?	YES.....1 NO.....2		ACCESSC
Q47	Who did you inform? <i>MORE THAN ONE ANSWER IS POSSIBLE</i>	IMMEDIATE FAMILY MEMBERS (CHILDREN AND OTHER PEOPLE I LIVE WITH).....1 OTHER RELATIVES.....2 FRIENDS.....3 COMMUNITY MEMBERS.....4 NONE.....5		ACCESSC2
Q48	Who amongst these people encouraged you?	IMMEDIATE FAMILY MEMBERS (CHILDREN AND OTHER PEOPLE I LIVE WITH).....1 OTHER RELATIVES.....2 FRIENDS.....3 COMMUNITY MEMBERS.....4 NONE.....5		ACCESSC3
Q49	Who among these people discouraged you?	IMMEDIATE FAMILY MEMBERS (CHILDREN AND OTHER PEOPLE I LIVE WITH).....1 OTHER RELATIVES.....2 FRIENDS.....3 COMMUNITY MEMBERS.....4 NONE.....5		ACCESSC4

Thank you for taking time to talk to me about Couples' Counseling and Testing services