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Spousal Response to Voluntary Counselling and Testing: An Analysis of Female Patients at Faith Alive Foundation Hospital Jos

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Abstract
The research is on spousal response to voluntary counselling and testing of human immunodeficiency virus and their reaction to HIV test results at the Faith Alive Foundation Hospital Jos, Nigeria. Survey questionnaire was combined with laboratory HIV tests to obtain information from respondents. All 244 new patients who attended hospital within the period of the study covering two months were sampled for the study. It was found that the majority (94.7%, n=231) of the women accepted voluntary counselling and testing and further took part in the HIV test while (5.3%, n=13) declined test. The majority (76.93%, n=10) of the women who rejected test said they needed to seek permission from their husbands. The laboratory HIV result showed that majority (62.77%, n=145) of the women tested HIV positive. The result further showed that 60.8% (n=138) of the husbands refused to come for the HIV test but 39.2% (n=89) accepted and appeared for the test. Husbands who refused to come for the test stated that they do not believe in HIV or that they were very busy and wouldn't have time for HIV test. Generally, spouses who did the test and received a positive result felt depressed; they cried and were angry over it. Post test counselling was done which enabled respondents to accept ARVs and plan for their future. Social mobilization and sensitization in addition to male-couple attendance at ante-natal care services are recommended to influence couples to accept voluntary counselling and testing.
Keywords: Gender, power relations, voluntary counselling and testing.
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Introduction

The information obtained from Nigeria Demographic and Health Survey carried out annually is very much revealing as it relates to issues of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). It shows that HIV/AIDS was first reported in 1986 in Nigeria when it was found in a young girl aged 13 years (NDHS, 2003, National HIV Sero-Prevalence, Sentinel Survey, 2010, p. 40). The spread of the virus is highly worrisome since the adult HIV prevalence increased from 1.8% in 1991 to 4.5% in 1996 to all time peak of 5.8% in 2001 but dropped to 5% in 2003 and 4.1% in 2010 (NDHS, 2003, National HIV Sero-Prevalence, Sentinel Survey, 2010, p. 40). The Federal Government of Nigeria has been making efforts to curb the high prevalence rate as reflected in the National Reproductive Health Strategic Framework and Plan 2002-2006 and the National Policy on HIV/AIDS, 2003. Reports from the NDHS (2008, p. 215) showed that 83.1% of men and women aged 15-49 years have never been tested for HIV. It is therefore necessary to find out the reaction of persons to voluntary counselling and testing as well as reasons they put forward against the test.

Introduction to the research problem

This research work at the Faith Alive Foundation Hospital, Jos, is a study in the types of responses exhibited by women who attended hospital and were requested to take part in voluntary counselling and testing (VCT) of human immunodeficiency virus (HIV) including their response to HIV test results (whether seropositive or seronegative). The primary service of the Faith Alive Foundation Hospital is voluntary counselling and testing and provision of anti-retroviral services to men and women. Since this service voluntary, it could be rejected or accepted. This study is necessitated by the basic assumption that power and authority between spouses is not equally distributed and that in a basically male dominated society such as Nigeria, power relation between spouses is often structured in favour of men. Consequently, it was assumed that women and men would react differently to voluntary counselling and testing based on their structural location in the society. There are researches that support this basic assumption. For example, Wall, Karshima, Kirschner and Arrowsmith (2004), have found in their study that a pregnant woman cannot access maternal services without first seeking the consent of her husband. In another study by Karshima, Idyorough and Ardill (2001, pp. 25-26), it was found that, "*A husband's/family's opinion influences where a pregnant woman should go for delivery. It is important to note here that husband's influence is very crucial in the choice of hospital facility and that influence is determined by the husband's position within the socio-economic system.*" Whereas this may be true of spousal

relationship in general and as it relates to health matters, this may not be clear in relation to access to voluntary counselling and testing, since, this health facility is currently less expensive; indeed antiretroviral drugs are being made available free of charge. It is therefore necessary for a study of this nature to be done to provide better understanding of spousal response to voluntary counselling and testing. The following research questions are intended for the study.

Research Questions

i) What are the types of reactions presented by women who attend Faith Alive Foundation Hospital, Jos and are requested to participate in voluntary counselling and testing? What are the reactions of their husbands to HIV test results?

ii) What are the reasons usually put forward by the women for their acceptance or rejection and other associated behaviours in relation to voluntary counselling and testing?

iii) In what ways can the cases of clients who are or may be HIV positive and their male spouses object to voluntary counselling and testing be handled so as to assist spouses to prevent mother to child transmission or to live positively and prevent the spread of the virus?

Research Objectives

1. To identify the various types of responses exhibited by women who attend Faith Alive Foundation Hospital and are requested to participate in voluntary counselling and testing and benefit from prevention of mother to child transmission (PMTCT) of HIV programme and safer sex. To find out the reactions of their husbands to HIV test results.
2. To ascertain the reasons usually put forward by the women for their type of responses.
3. To find out ways through which spouses who object to voluntary counselling and testing and those who test positive but their spouses reject voluntary counselling and testing could be assisted to benefit from PMTCT of HIV and/or contend with their positive serostatus.

Basic Concepts and Literature Review

Gender

Elsewhere we have explained that gender refers to:

> Social differentiation or cultural distinction between males and females and the attribution of certain roles on the basis of that differentiation. It seeks to explain the apparent commonality in the relations between male and female in terms of roles in power sharing, decision-making, division of labour and remuneration on labour both at home and in the work place (Idyorough, 2005, p. 8).

Power relation

Power relation in a sexual relationship refers to the ability to engage someone into sexual activity through the use of subtle or coercive means.

Justification For The Study

In HIV studies, responses to counselling services is often neglected as if it is not important; but if HIV is to be properly managed the way citizens respond to counselling services related to it should be of importance to all of us. Also, how do couples respond to each other when demand is placed on them to present themselves for voluntary counselling and testing services? Knowledge about these would enable us develop policies that would assist in reducing couple-to-couple transmission of HIV. Human rights violations such as wife abuse are becoming issues of concern these days. It is studies of this nature that would identify incidences human rights violations for further investigation and documentation.

Delimitations

Apart from the HIV test result and the practical observation of spousal reactions, other information obtained was based on self reports by the respondents. As self reports, reliability of the results depends on the truthfulness of their presentation. There are some respondents who received counselling but opted out of the HIV test. In this case, it is only their responses to pre-test counselling that were analysed.

Literature on voluntary counselling and testing

UNMEE (2006) describes voluntary counselling and testing as *"the process by which a person finds out whether or not he or she is infected with HIV; the virus that causes AIDS. VCCT Services are always voluntary and strictly CONFIDENTIAL. The dignity for the client is carefully maintained"*(also cited in UNMIS, 2006). The National Guidelines and Programme for the Implementation of PMTCT of HIV in Nigeria defines HIV Counselling as a:

> *Confidential dialogue between a person and a care provider aimed at making personal decisions to prevent infection or to enable the person to cope with stress related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour (Federal Ministry of Health, 2001, p. 20).*

Voluntary counselling and testing is a process in which someone is provided with information and counselled to accept and undergo HIV test. It also involves creating awareness in the client and getting him/her to know what HIV/AIDS is all about; its modes of transmission; how to avoid contacting it and remaining negative; how HIV test is carried out; and when the result is positive, how to live with HIV/AIDS and how to take care of those who are living with it without contacting it from them (Idyorough & Tsa, 2014).

The United Nations AIDS (UNAIDS) and World Health Organization's policy requirement on HIV testing is based on human rights approach which requires that every test must be carried out with informed consent of client, pre-test and post-test counselling, and confidentiality (UNAIDS, 2004). By informed consent it is meant that the idea of carrying out HIV test should be presented to the client and he or she must voluntarily consent to doing it and it should be done with strictest confidentiality.

In explaining what an HIV test is, the Center for Diseases Control (CDC) (not dated) states that in order to conduct an HIV test, blood, urine or oral fluid may be obtained from the person who is interested in the test and some reagents used on it to determine serostatus. This source further concludes that HIV test is necessary for every person (See also UNICEF, 1999).

Information, education and communication (IEC) programmes for pre-natal mothers include requesting them to volunteer to participate in HIV test. Berer and Ray (1993, pp. 229-245) and DPH (1999) have explained the procedures involved in voluntary counselling and testing. According to these authors there are three stages involved in voluntary counselling and testing: (i) Pre-test counselling; (ii) the HIV laboratory test; (iii) Post-test counselling. This interactive relationship could be accepted or rejected by spouses based on preconceived ideas or some pre-existing structured relationship in the family; this is what we intend to study and if possible uncover certain issues relating to the subject matter.

Reaction to pre-test counselling

Before any HIV test is conducted the client is given a pre-test counselling (Berer & Ray, 1993, p.241). This counselling is necessary to get clients to prepare their minds for the test and its outcome. Kelly (2001, p. 519) suggests that: *"It is crucial that people be helped through the early phase of making a decision about getting tested and also when sorting through their reactions to the possible results."* Deciding to take a test may be a very difficult decision that needs proper counselling to all health care seekers and more demanding of proper counselling before decision making by women who are dependent socio-economically on their husbands. This position is substantiated by the findings by Gupta (*2000a)* that:

> *While men made the decision to seek voluntary counselling and testing independent of others, women felt compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing VCT services (p.4).*

Women who are poor and dependent, therefore, would need to be counselled properly to make a decision on their own to do the HIV test and how to convince their husbands to submit to the test.

Post-test counselling and reactions to HIV test result

According to Berer and Ray (1993, p.16) reactions to HIV result may include uncertainty, fear, stress, anxiety, depression, isolation and feeling of inability to cope. Furthermore, these authors are of the view that stigma, discrimination and a sense of hopelessness may follow when one receives a seropositive result (Berer & Ray 1993, p.231). Idoko (2002) states that people commit suicide when they know their status for fear of stigmatization. Idoko (2002) concludes that:

> *The issue of stigmatization is a serious one because it makes living positive with the infection difficult. If this continues, it means people will not embrace VCCT because they will not want to know their status and those who are aware of their positive status will continue to deny it (p.1).*

Given the depressive reaction to test result, it becomes necessary that proper post-test counselling be conducted to build self-confidence in the client and enhance post-test coping capacity, adjustment and survival.

Suggestions from literature

UNMIS (not dated) suggests that, "Increased equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS." Other researchers such as Pulerwitz, Marindo and Weiss (n.d.) suggest male involvement in ante-natal care as the way out of the problem of HIV infection reduction in Zimbabwe. In Swaziland, there is also male involvement in ante-natal programme to reduce mother-to-child transmission of HIV (IRIN, 2005). A similar project is also being carried out in Abidjan, Cote d' Ivoire (Tonwe-Gold, n.d.).

Research design, instrumentation and administration

Survey design with a questionnaire (Osuala 1982, p.180) was used in this study. The survey study was carried out at Faith Alive Foundation Hospital, Jos. The primary service of this hospital is voluntary counselling and testing and provision of anti-retroviral services to men and women. The questionnaire contained 39 questions with 28 of them pre-coded and only 11 open-ended. Section 'A' of the questionnaire elicited basic demographic information about the client, 'B' was on the HIV test result while sections 'C' and 'D' were on reaction to HIV test result and was completed by the counsellor based on his/her observation of the respondent. Four counsellors already working with the hospital were trained and used as research assistants for the study. All new patients visiting the hospital were sampled for the research. They numbered 246 in all but two (2) questionnaires were rejected reducing the number to 244 that were analysed. The Jos cosmopolitan, the immediate universe from which the sample was drawn is less than one million while the general universe of North Central Nigeria comprising six (6) states has a population of 15,682, 344 as per the 2006 population census figures. Salant and Dillman (1994, p.55) are of the view that in a heterogeneous population of less than 100 million people one could draw a sample size of 246 for less varied population or 384 for a relatively varied population. We assume that our universe is not varied culturally as it relates to relationship between couples as such a sample of 244 could be regarded as adequate.

Method of Data Analysis

The questionnaires retrieved from the Faith Alive Foundation Hospital were computed using Epi Info statistical programme recommended by WHO. Frequencies, probability values, and chi-square values were obtained and used in decision making.

Findings of the study

We present and discuss the findings in this section. The data showed that the majority (90.6%, n=221) of the respondents fall within the sexually active age range of 20-39 years of age. We also considered the marital and HIV status of respondents as shown in the distribution in table 1.

Table 1: Marital status of respondents and their HIV status

Marital status	Non-reactive	Reactive	Total
Consensual union	6	15	21
Row %	28.57	71.43	100.0
Col %	7.0	10.3	9.09
Married monogamy	58	75	133
Row %	43.61	56.39	100.0
Col %	67.4	51.7	57.58
Married polygyny*	20	51	71
Row %	28.17	71.83	100.0
Col %	23.3	35.2	30.72
Separated	1	3	4
Row %	25.0	75.0	100.0
Col %	1.2	2.1	1.73
Divorced	1	1	2
Row %	50.0	50.0	100.0
Col %	1.2	0.7	0.87
TOTAL	86	145	231
Row %	35.2	59.4	100.0
Col %	100.0	100.0	100.0

Missing cases: 13 respondents declined to undergo the HIV test.

****Polygyny is a customary practice of one man being married to several wives.***

***Chi square* = 5.88**

***Degrees of freedom* =4**

***P value* =0.2083**

Note: Four (4) expected cell are <5 therefore chi square cannot be used for analysis.

Table 1 shows that in the majority of the cases (57.58%, n=133) were married under the status of one man one wife. Data were further examined to establish the relationship between marital status and HIV status of the respondents and the calculated P-value was found to be 0.2083. We conclude that there is weak positive relationship between type of marriage and HIV status. The data on table 1 shows that 56.39% (n=75) of those

who were in monogamous marriage tested HIV positive which is very much higher than 43.61% (n=58) who were non-reactive. This finding on those in monogamous marriage confirms the position of UNFPA (2005) on couple-to-couple transmission of HIV and that it is no longer safe but risky for women to marry. This may be due to power relations in the family that is implicated in HIV and AIDS. This may not be unlikely that they failed to keep to one sexual partner. We proceed to look at the educational status of the respondents and the results are shown in table 2

Table 2: Level of education of respondents and their spouses

Level of education	Frequency (Wife)	Percent	Frequency (Husband)	Percent
None/Arabic School	39	16.0%	28	11.5%
Primary school	7	2.9%	1	0.4%
Secondary school	107	43.9%	65	26.6%
Tertiary education	91	37.3%	150	61.5%
Total	244	100.0%	244	100.0%

Table 2 above shows that the majority of the men (88.1%, n=215) and women (81.2%, n=198) had secondary and tertiary education and that men were more educated than women. Given the fact that the sample is made up of couples that many are educated, we expected a more equitable and favourable response to voluntary testing and counselling. We also analysed the level of education in relation to HIV status and the following result was obtained:

Table 3: Level of education and HIV status of respondents

Level of education	Non reactive	Reactive	Total
None/Arabic	11	27	38
Row %	28.9	71.1	100.0
Col %	12.8	18.6	16.5
Primary school	3	4	7
Row %	42.9	57.1	100.0
Col %	3.4	2.8	3.0
Secondary school	36	67	103
Row %	35.0	65.0	100.0
Col %	41.9	46.2	44.6
Tertiary education	36	47	83
Row %	43.4	56.6	100.0
Col %	41.9	32.4	35.9
TOTAL	86	145	231
Row %	37.2	62.8	100.0
Col %	100.0	100.0	100.0

Those who were non-reactive were 37.2% (n=86) while those reactive were 62.8%(n=145). Although, many of the women were also educated as reflected in table 2, we analysed data to see the relationship between dependence on husband and the HIV status of respondents and the following result was obtained. We proceeded to analyse the response of women to voluntary counselling and testing and the following result was received.

Reaction to voluntary counselling and testing

We found that 94.7% (n=231) of the respondents took part in the pre-test counselling and further accepted to undergo the actual test out of which 62.77% (n=145) tested positive. It was found that 86.15% (n=199) of those who accepted to undergo the test voluntarily were pregnant women who did so as part of their ante-natal requirement. This number of pregnant women includes those who take ante-natal care (ANC) in surrounding clinics outside Faith Alive Foundation Hospital but were referred for voluntary counselling and testing that is provided free in this hospital. The others (13.85%, n=32) who were not pregnant but also accepted to undergo the test put forward the following reasons: That they or their husbands were already sick and wanted to know what was the problem with them; the other co-wife (or co-wives) had been persistently sick or had already tested HIV positive; husband's girlfriend had died of illness suspected to be AIDS; husband or child had recently died. Reasons for refusal were further investigated.

It was found that 5.3% (n=13) of the respondents declined to take part in the actual HIV test and they provided reasons as shown in table 4:

Table 4: Reasons for rejecting voluntary counselling and testing

Reason	Frequency	Percent
I already know my status	1	7.69%
I don't want to do it, I am afraid	1	**7.69%**
My husband wouldn't support or agree	1	**7.69%**
I have to seek permission from my husband/I need to consult my husband	10	76.93%
Total	13	100%

From table 4, it has been found that those women (76.93%, n=10) who declined to take part in HIV test did so because they were yet to get the approval from their husbands which they believed they needed to. This result substantiates the findings by Gupta (2000a) that women do not seek voluntary counselling and testing independently but are usually compelled to discuss testing with their partners first. It also supports the findings of Wall, Karshima, Kirschner and Arrowsmith (2004); Karshima, Idyorough and Ardill (2001), and Idyorough and Karshima (2005) that have shown that women seek permission from their husbands before accessing health services. The percentage of women who could not immediately access HIV test but had to go and seek permission from their husbands before they may do so is significant enough to be of worry to health service planners and providers. Furthermore only 25.82% (n=63) of the respondents said that their husbands would be willing to do the HIV test if invited to come and do it while the remainder (74.18%, n=181) said their husbands would not like to do it or that they do not know what their husband's reaction would be. All these reactions and anticipated reactions are issues of gender and power relations as reflected in the works of Berer and Ray (1993), Berer (2004), Gupta (2000a, 2000b, 2000c), Idyorough and Karshima (2005), Rivers and Aggleton (n.d, and 2001).

As a follow up to the female respondents, husbands were invited through their wives to come for the voluntary counselling and testing but 57.14% (n=132) of them refused to show up for the test. Respondents were asked why their husbands did not like to do the test and they provided the following responses: he does not believe in HIV; he feels he does not have HIV; he doesn't want to be told what to do; he feels he is not sick and doesn't need it; and some said they wouldn't know why. The reaction is shown in the table below:

Table 5: Reaction of husband to invitation for HIV test

Reaction of husband to the invitation for HIV test	**Non-reactive**	**Reactive**	**Total**
Husband volunteered to come for the test without questioning	33	22	55
Row %	60.0	40.0	100.0
Col %	39.3	15.4	24.2
Husband raised some questions but later volunteered to come for the test	11	23	34
Row %	32.4	67.6	100.0
Col %	13.1	16.1	15.0
Husband completely objected to the test	40	98	138
Row %	29.0	71.0	100.0
Col %	47.6	68.5	60.8
Total	**84**	**143**	**227**
Row %	**37.0**	**63.0**	**100.0**
Col %	**100.0**	**100.0**	**100.0**

Missing cases = 4 from 231 women who accepted VCCT.
***Chi square* = 16.60**
***Degrees of freedom* =2**
***P value* =0.00024**

The calculated χ^2 was 16.60 with a df=2 while the critical table value at 0.05 is 5.991. Since the calculated value is more than the critical value we reject the null hypothesis and conclude that there is difference between those husbands who volunteered to come for HIV test and those who did not in respect of their HIV statuses. This means that husbands who anticipated that they would be non-reactive were the ones that showed up for the test compared with those who were afraid they might be reactive. Husbands, who did not experience

signs and symptoms in their bodies and were faithful to their wives, were the ones that openly volunteered to have the test while some husbands whose wives were positive objected to HIV test. Although 39.2% (n=89) finally accepted and took part in the HIV test, we did not further investigate the discordant rate; we did not determine husbands who were HIV negative as against their wives who were HIV positive.

A very high percentage (60.8%, n=138) of the men completely objected to coming for the HIV test when they received invitation to do so through their wives; even though it was very probable that they also could be HIV positive. Husbands who objected to coming for the HIV test advanced the following reasons: That they do not have time because they were busy on their farms or other work schedules, they do not approve of their wives having HIV test, they do not believe in HIV, they were afraid of the outcome of the test, they were ignorant of what they would do with a positive result. A significant number (10.6%, n=20) claimed that they do not have HIV therefore they needed no HIV test while 16.5% (n=31) claimed that they had done HIV test before. This finding validates the issue of gender and power relations in the family as put forward by Olukoya (cited in IWHC document), Gupta (2000a) and Dunne (n.d.). The implication here is that HIV counsellors would have to do a lot to convince these male couples to come for HIV test.

The respondents, whose husbands declined test, were asked what they intended doing over the reaction of their husbands and they made the following remarks: that they would inform in-laws and/or co-wives (24.7%, n=27), continue putting pressure on their husbands to accept HIV test, refuse having sex with them until they do HIV test. However, some (65.1%, n=71) respondents said they did not know what to do or that they would do nothing. Respondents could not suggest ways by which their husbands could be convinced to accepted doing HIV test. This confirms the powerlessness of women in matters of sexuality and health and supports the findings by Gupta (2000a), Rivers and Aggleton (n.d).

Common reactions to HIV result that is positive

The common reaction amongst women when their results were presented to them was to cry over it (16.02%, n=37), some (6.49%, n=15) remarked that they were cheated by their husbands while others said that their co-wife (or wives) were responsible for their predicament. Some were very angry while many others were confused over the test result. Some few could not believe the result and rejected it. The findings of this study validate those of Berer and Ray (1993:10, 16, and 231) as to the typical reaction women put up in response to HIV test result. The implication of this finding is that a qualitative pre-test and post-test counselling has to be properly done and clients enabled to take a decision about their future before the final result is released to them, a position held by Kelly (2001, p.519). Knowing one's positive status could be very devastating as such the person should be counselled on taking a decision on future life in general but more specifically on how to live a positive life before serostatus is made known whether the result is going to be negative or positive.

In this particular research, the four counsellors that took part provided post-test counselling services to the respondents. Part of the post-test counselling involved planning for the future. The counsellors discussed the future plan with the couples. There were three future plans: (1) for couples who were HIV negative, (2) for couples who were HIV positive, (3) for a woman who was HIV positive but her husband declined test. Those who were HIV negative were counselled on how to live a HIV negative life and successfully remain HIV negative. Those who were HIV positive were counselled to accept and collect antiretroviral drugs, continue with ante-natal care, use of condom to avoid re-infection, modified obstetric care and plan for modified infant feeding. The women who were HIV positive but their husbands turned down invitation for HIV test also received post-test counselling for HIV positive persons and in addition arrangements were made to contact their male spouses for direct counselling and to convince them to accept voluntary counselling and testing and anti-retroviral services; if found positive. No case of discordant couples was detected; where only one couple was infected.

Summary of Findings

In this study, the majority (90.6%, n=221) of the respondents were found to be in the age bracket of 20-39 and were still in their sexually active period. It was found that 94.7% (n=231) willingly accepted voluntary counselling and testing; out of which 62.77% (n=145) tested positive. This finding has implication for couple-to-couple transmission of HIV. It was found that 86.15% (n=199) of those who accepted to undergo the test voluntarily were pregnant women who did the test as part of their ante-natal requirement. The other 13.85% (n=32) who were not pregnant but also accepted to undergo the test did so because their husbands were sick or a co-wife had been sick or had tested HIV positive or husband's girlfriend had died of suspicious illness or husband or child had recently died. This shows that individuals who voluntarily present themselves for HIV test usually have their reasons for doing so; and in most cases it is when they are surrounded by suspicious ill-health or death of someone near them that they go for HIV test; in search of explanations. There is need to change this state of things such that individuals begin to accept to do the test just for the sake of it and to enable them plan for their future health life. The women who declined taking part in HIV test did so because they (76.93%, n=10) were yet to take permission from their husbands. Health and social workers who are involved in counselling

need to present this issue for discussion during counselling. They need to be convinced that in matters of health it is either life or death. Knowing one's health status is a personal choice that has to be decided at the right time and delays could be dangerous. However, the exhibition of those responses by women is an indication of power and authority relations within the family. This is further buttressed by the reactions of some husbands who refused to come for HIV test when they were issued with invitation.

Power relation was also reflected in the refusal of some men to accept invitation to appear for HIV screening when they were invited through their wives. Some of these husbands out rightly said they do not believe in HIV or that they do not have HIV therefore they needed no HIV test. These responses defer from findings of Christopoulos, Weiser, Koester, Myers, White, Kaplan, and Morin (2012) where respondents indicated preference to live in uncertainty or feared partner discord or discrimination based on HIV status as reasons for objection to HIV testing. Also Turan, Bukusi, and Cohen (2011) in their study of 1525 women in Kenya demonstrated that anticipations of HIV/AIDS stigma can be barriers to acceptance of HIV testing. The women whose husbands declined appearing for the HIV test said they would inform relations to put pressure on their husbands.

The common reaction of women to HIV test result was to cry over it; be angry or depressed. Some could not believe it so they rejected it. On the other hand men who accepted invitation and underwent the HIV test were calm over their result, may be because their wives had told them and they expected a positive result. The counsellors discussed the future plan with the couples which ended up with acceptance and collection of antiretroviral drugs, continued ante-natal care, use of condom to reduce re-infection, modified obstetric care and plan for modified infant feeding.

Recommendations

Based on our findings we make the following recommendations; that:

(i) Since the majority of the respondents were HIV positive and fall in the sexually active age range of 20-39 years; the government, NGOs, health service providers and social workers should ensure that they capture more of the persons in this age bracket in their HIV campaigns. In this age bracket they are expected to be either in tertiary institutions or in the workplace; thus, tertiary institutions and workplaces should be the target institutions where individuals would be captured for HIV/AIDS awareness and voluntary counselling and testing/prevention-of-mother-to-child-transmission.

(ii) Couples should be counselled and encouraged to maintain marital fidelity so as to avoid couple-to-couple transmission of HIV. More emphasis should be laid on encouraging men to maintain fidelity so as to avoid couple-to-couple transmission of HIV.

(iii) Couples that are HIV positive should be counselled and encouraged to always use condom during sex so as to avoid re-infection between them. In particular, couples with discordant results should be seriously counselled to come back again for confirmatory tests and to take up safer sex so that the other sexual partner would be protected.

(iv) Male-couple involvement in ante-natal attendance should be introduced and promoted so that men would also benefit from health education given to pregnant women. In this process they would be sensitized enough to accept voluntary counselling and testing/prevention-of-mother-to-child-transmission.

(v) Post-test counselling is necessary and should be continued. Couples should be jointly involved in post-test counselling so that they jointly plan for the future. That is to say, there is need to promote male-involvement in voluntary counselling and testing/prevention-of-mother-to-child-transmission.

(vi) There is need for research which would trace husbands whose wives are positive but had objected to voluntary counselling and testing and interview them directly and counsel them on acceptance of HIV test since this aspect was not covered by this study. Such interview would reveal husbands' perspectives in place of what their wives revealed they (their husbands) had said.

Conclusion

Finally, we suggest that the battle against HIV/AIDS should be taken seriously by laying more emphasis on gender equity and equality in access to education and economic resources of the country including health services. Access to education, economic resources and income as presently distributed gives men social and economic power including sexuality and power over women and makes women vulnerable to HIV/AIDS. It is when formal education and gender awareness are combined with economic liberation and men and women come to understand, appreciate and practice gender equity and equality that that HIV/AIDS would be eliminated; otherwise we continue to wait in vain for a scientific breakthrough to provide a cure or vaccine.

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