

**FACTORS INFLUENCING ACCEPTABILITY OF MEN AND WOMEN TO
TEST FOR HIV IN MARRIAGE:A CASE STUDY OF KINONDONI
DISTRICT**

By

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**A Thesis submitted to the School of Public Administration and Management for
Partial Fulfillment of Master's Degree in Health System Management(MHSM)
of Mzumbe University**

2015

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a thesis entitled *Factors Influencing Acceptability of Men to Test for HIV in Marriage*, in partial fulfilment of the requirements for award of the degree of Master of Business Administration of Mzumbe University

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ABSTRACT

This study investigated the factors influencing acceptability of HIV testing among married couples at Mbweni dispensary. The research objectives were to explore knowledge of married couples on the importance of HIV testing in marriage, to assess the attitude of married couples towards HIV testing in marriage, and to determine the level of acceptability of men to test for HIV status.

The study adopted a case study design and used interviews and questionnaires to collect primary data while secondary data were obtained from reviewed related literatures. The study involved 50 respondents of whom 15 were men, 35 were women. Moreover, the sampling techniques were both non-probability and probability sampling which include purposive sampling, convenient sampling and simple random sampling. The study report is presented using descriptive statistics namely, frequencies and percentages.

From the findings of the study the majority 35 (70%) were not knowledgeable on the importance of HIV testing in marriage. Moreover, on the attitude towards HIV testing in marriage, it was found that 15 respondents, that is, 30% preferred to test their HIV status in marriage. Furthermore, on the acceptability by men on HIV testing the results showed that most of men who previously tested their HIV status were forced, 50% were forced by management so that they can be employed.

On the recommendations, awareness through massive campaigns should be promoted as a strategy to make the married couples aware. Couples should be empowered to initiate and sustain communication around HIV and AIDS in order to reduce the negative attitude towards HIV testing and counseling which is enshrined in secrecy. Gender power balance should be encouraged as an expression of autonomy. Male testing campaign should be launched.

Based on the findings it can be concluded that among the problems facing the family due to failure of practicing voluntary couples HIV testing is low level of awareness on the importance of couples testing their HIV status.

DEDICATION

This work is dedicated to my husband Dr.Faustin Kamugisha for being a model among married men of voluntary HIV testing and my lovely children Frick Kemanzi and Brian Muhanuzi whose love and support encouraged me to accomplish this academic goal.

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CHCT	Couples HIV Counseling and Testing
Etc	Et Cetera
HBCCT	Home Based Couples Counseling and Testing
HCT	HIV Counselling and Testing
HIV	Human Immune Deficiency Virus
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOH	Ministry of Health.
MOHSW	Ministry of Health and Social Welfare
MHSM	Masters Of Health System Management
MTCT.	Maternal to Child Transmission
PICTC	Provider Initiated Counseling and Test Care
PICT	Provider Initiated Counseling and Testing
PLWHA	People Living With AIDS
PMTCT	Prevention of Mother to Child Transmission
PT	Participant
TACAID	Tanzania Commission for Acquired Immune Deficiency Syndrome
TV	Television
UNAIDS	United Nations Joint Programme for HIV and AIDS
VCT	Voluntary Counseling and Testing

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CHAPTER ONE

1.0 Introduction

This chapter presents the background information of the study, statement of the problem, research objectives, research questions, rationale of the study and the conceptual framework.

Background information

AIDS is pandemic. It is estimated that about 35.0 million of the world population are living with HIV/AIDS (WHO, 2012). Approximately 1.4–1.7 million of people die from HIV-related causes globally. The Sub-Saharan Africa is the most affected region with 24.7 million people living with HIV and accounts for almost 70% of the global total of new HIV infections up to the end of 2013 (WHO 2013). However, it is estimated that the most 19 countries with highest rate in the world are all found in Africa (WHO, 2013). Globally, South Africa is reported to have the largest population living with HIV/AIDS, with over 5 million people infected, followed by Nigeria in second place (MoH-RU, 2009). Statistics have shown _ According to the WHO 2013 report, about 12.9 million people living with HIV were receiving ART of which 11.7 million were receiving ART in low and middle-income countries (WHO, 2013).

There is globally a substantial evidence about the decrease of new HIV infections (UNAIDS, 2008). It is reported that there havebeen 2.3 million new HIV infections, showing a 33% decline in the number of new infections from 3.4 million in 2001. At the same time the number of AIDS deaths decreased from 2.3 million in 2005 to 1.6 million in 2012 (UNAIDS, 2012). Despite this decrease, in some parts of the globel, Tanzania included, this pandemic remains challenging. This challenge is one of the reasons for the choice of this topic.

Over the past decades, the international community has taken a strong position on the HIV pandemic. Combating HIV/AIDS, Malaria and other diseases is one of the eight targets of the Millennium Development Goals (MDGs). The main focus is to stop and begin to reverse the spread of HIV/AIDS by 2015. The MDG report of 2009

confirms the number of new cases of HIV infection is dropping down in many countries (MoH-RU, 2009). Tanzania is among several countries that made a commitment to address the recommendations of the International HIV Counseling and Testing Workshop held in Lusaka, Zambia, in January 2008, which advocated for a renewed emphasis on innovation to improve the prevention of HIV Counselling and Testing (HCT) and capacity building for counselors to provide effective counseling for married and cohabiting couples (MoH-RU, 2009). On a negative note, counselling has not yet been accommodated as a discipline and a department in many of our universities. Hence, the infrastructure for capacity building for counselors to provide effective counselling is still fragile.

Lack of testing for HIV/AIDS among married couples is considered to be one of the challenges that accelerate the spread of the pandemic. In Tanzania, HIV prevalence is higher (16.3% and 7.5%) among the married group as compared to other groups (TACAID, 2013). Yet, there are factors that are associated with the epidemic including, low and less persistent use of condoms; infidelity or multiple sex partners, traditional beliefs such as widow inheritance and genital mutilation, mobility, transactional sex and lack of male circumcision.

Studies from Uganda have shown that 6.3% of men and women aged 15-49 who are currently in union are HIV positive, compared to 1.6% of those who are not in union. Moreover, 5% of cohabiting couples are HIV discordant, with 3% do infected male and 2% do infected females with another 3% of cohabiting couples HIV positive concordant. Within these couple relationships, multiple sexual partnerships are common, particularly among men. While only 2.6% of currently married women report having 2 or more sexual partners in the last 12 months. Nearly one third (29.8%) of currently married men have had 2 or more sexual partners. Furthermore, condom use among married couples is low. The studies quoted above in line with our study show that the married couples are more affected than those who are not in union. Nevertheless, the objectives of our study are not addressed that is knowledge of the importance of HIV testing, attitude and acceptability of HIV testing among married men. The observed gap is covered by our study.

While 53% of un married women and 55% of un married men report condom use in recent sex, contacts only 3.5% and 4.8% of currently married men and women respectively used a condom in recent sex contacts (Reniers G 2012). From these insights, one can rightly conclude that married people by not using condoms, are exposed to HIV infection. This reality supports the timing of this study.

Despite these realities, only 12.5% of currently married women and 12.7% of currently married men have ever tested for HIV and received the results, and only 3.3% of married women and 4.3% of married men have done so in the last 12 months. Incredibly, 90.1% of married women and 88.6% of married men do not know the HIV status of their spouses (Reniers G 2012). Amazingly, the quoted data from Uganda evidence that the number of men who test their HIV status is slightly higher than the number of women, though women have opportune moments for HIV testing during pregnancy. This is not in line with our study whereby the number of married men who test for HIV status is lower than the number of married women .

There has been growing support and demand for HIV voluntary counseling and testing services (VCT) that foster risk-reduction behaviour based on knowledge of serostatus and link HIV-infected individuals with care and supporting services. Thus, if all or most men would break this reluctant behaviour, prevention, protection and derivative care would be simple and smooth. However, there are several compelling arguments for HIV VCT: (1) individuals have a right to know their infection status to protect themselves and others from infection, (2) HIV VCT may enable people to cope with the anxiety associated with the uncertainty of not knowing one's serostatus, (3) early detection of HIV may improve the medical and psychological support for HIV-infected persons, and (4) HIV VCT has been shown to promote behaviour change (Maman, et al., 2001). These and many other reasons determine whether a person will choose voluntary testing or not at his/her own discretion (Reniers G, 2012).

Tanzania, like other countries in sub-Saharan African Region, has been devastated by the HIV epidemic for almost one quarter of a century (WHO, 2012). This epidemic

poses major threats to national development and has been declared a national disaster. About 35.0 million people are currently HIV-infected (WHO,2012). The annual number of new infections outstrips by far the number of individuals enrolled into antiretroviral therapy (ART). This high incidence of new HIV infections in the country indicates that HIV prevention efforts are not having the expected impact, a situation that threatens gains in roll out of ART, AIDS treatment, and care programmers in the country.

In view of the country's commitment to universal access to HIV prevention, care and treatment, and the Millennium Development Goals (MDGs), re-invigoration of HIV prevention is necessary. Currently, Tanzania is experiencing a generalized HIV/AIDS epidemic. Different parts of the country are disproportionately affected by the epidemic. The prevalence ranges from less than 1 % in Pemba and 1.2% in Unguja to 14.8% in Njombe region (Tanzania HIV and Malaria Indicators Survey (THMIS, 2012). Generally, in Tanzania some regions show decreasing rate of the people being infected while other regions new infections are on the increase. HIV status of some regions are very high,i.e Njombe 14.8%, Iringa 9.1%, Mbeya 9.0%, Shinyanga 7.4%, Ruvuma 7.0%, Dar es salaam 6.9%, Rukwa 6.2, Katavi 5.9%, Pwani 5.9% and Tabora 5.1% (Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12).

With all the above in mind, this study, therefore, intends to explore couple HIV testing in marriage, particularly the factors influencing acceptance of HIV testing among men. The findings of the study will help the planners, policy makers and health workers find how to improve the ways and techniques of attending to the couples for HIV testing in marriage.

1.2 Statement of the problem

In sub-Saharan Africa, a large proportion of new HIV infections occur within stable relationships (Dunkle KL, 2013). So far several studies have found that over 80% of married couples are not aware of their own or their partners HIV status. Findings suggest a need for interventions to increase awareness of HIV status and promote couples HIV counselling and testing. (Kaiser R, 2011)

While 53% of never-married women and 55% of never-married men report condom use at last recent sex, only 3.5% and 4.8% of currently married men and women respectively used a condom in a recent sex contacts (Reinier G 2012). From these insights, one can rightly conclude that the married by not using condoms are exposed to HIV infection.

Research has shown that, 90.1% of married women and 88.6% of married men do not know the HIV status of any of their partners or spouses (Reinier G 2012). The low rate of VCT participation among men in Tanzania is alarming. This epidemic poses major threats to national development and has been declared a national disaster. (TCAID, 2013).

The central question of investigation is why do married men and women do not test for HIV status after in marriage? To the best of my knowledge similar research on *Factors influencing Acceptability of Men and women to Test for HIV in Marriage* has never been done in Kinondoni. It is a new venture which will consequently reduce a research gap.

1.3 Significance of the study

- Apart from adding to the pool of body of knowledge in the area of HIV testing, this study will be vital in several areas including acting as future research base which other researchers would cite and develop more building and stronger researches.
- Productivity ought to increase if, and only if, recommendations and all findings will be implemented by policy makers and relevant sectors, institutions, organizations, etc.

- Standards of living will increase when married couples are fully aware of the merits behind testing and disclosing results to their marital partners.
- This study is also a requirement for the award of Masters of Health System Management.

1.5 Scope of the study

The study is limited to Kinondoni district in Dar es Salaam region, Tanzania. This will not prevent to extend the conclusion beyond this area. Furthermore, secondary sources will cross borders of the district and search for additional data from other parts of Tanzania.

1.6 Research objectives

General objectives

The main objective of this study is to explore the factors that influence acceptability of men to test for HIV status in marriage in Kinondoni district.

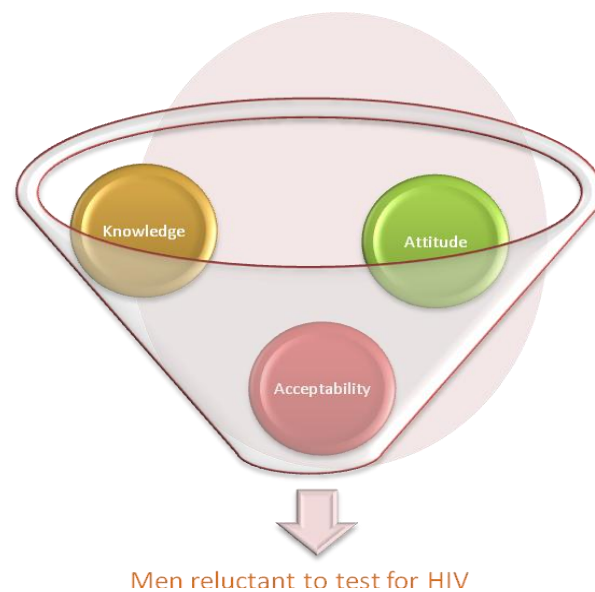
Specific objectives

1. To explore the knowledge held by married men and women on the importance of HIV testing in marriage.
2. To assess the attitude of married men and women on the importance of HIV testing in marriage.
3. To determine the level of acceptability to test for HIV between married men and women.

Research questions

1. What do married men and women know concerning the importance of HIV testing in marriage?
2. What is the attitude of married men and women towards the importance of HIV testing in marriage?
3. What is the level of acceptability to test for HIV between married men and women?

Figure 1.1 Conceptual framework



The above funnel illustrates the factors which act as barriers to testing for HIV status among men in Kinondoni district. Lack of knowledge of the importance of HIV testing acts as a barrier to HIV testing. Moreover, the negative attitude towards the importance of HIV testing poses a threat to HIV testing. The anticipated feeling of being found HIV positive tends to discourage HIV testing. Furthermore, the refusal to HIV testing due to male dominance in patriarchal societies acts as an obstacle to HIV testing. Men who always undermine and downtread women (in African context) often are reluctant to accept testing their HIV status or even when they do test, sharing of HIV testing results with their wives becomes difficult.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter include a theoretical part, an empirical part and the Hypotheses.

2.2 Theoretical part

HIV testing patterns

There is a number of reasons why people go for HIV testing . Some reasons for HIV testing are part of medical check-up or medical procedure, prenatal care, required health or life insurance, marriage certificate, or to get married, job or military service, or immigration requirement (Chandra, et al., 2012). In this context it is obvious that voluntary testing for HIV is not in the list. Hence, our study is important as it addresses the issue of voluntary testing for HIV in marriage bond.

Nonetheless, it is important for every individual to be aware of ones HIV status, and to identify individuals who have been tested for HIV only as part of blood donation, because HIV screening for blood donation has become routine and mandatory in every country. Blood donors who are tested for HIV positive are told their HIV status, and absence of such notification essentially indicates HIV-negative status; therefore all donors become aware, directly or indirectly, of their HIV status. Individuals who take HIV test outside the context of blood donation, without being given their HIV test result may be unaware of their HIV status, and are described separately in whichever reporting system and should therefore be traced for results awareness. Testing HIV should not be tied to blood donation. Our study remains important as it considers the knowledge related to the importance of HIV testing, the attitude towards the importance of HIV testing and acceptance of HIV testing.

Factors Determining decisions to get tested for HIV among men

Individual factors

Perceived benefits of HIV testing

Although both men and women describe HIV testing as a means of planning for the future, the major factors that motivate them to seek testing differ remarkably. In one qualitative study that was conducted in Kenya, male informants who went to the

clinic alone primarily described HIV testing as a preventive health measure. Some men used HIV testing as a way to confirm their suspicious serostatus and the serostatus of their respective future partner before committing to a relationship.

Men also described HIV testing as a way to regain a partner's trust after being suspected of infidelity. However, couples describe testing as a preventive health measure that they use before unprotected sexual intercourse, marriage, or pregnancy. Several couples also mentioned testing as a means to reaffirm one's commitment to relationship and as a way to try to diagnose and treat other reproductive health problems (Kaiser R. et al. 2011). This study, unlike our study is not totally restricted to the married couples as it has been said that *"some men used HIV testing as a way to confirm their suspected HIV-negative serostatus and the negative serostatus of a partner before committing to a relationship."* Hence there is a research gap which is bridged by our study.

Perceptions of risk

According to the study carried out in Kenya, perception of personal susceptibility to HIV infection seems to be the primary factor motivating women to overcome other barriers to HIV testing. There are several reasons to why women and men felt that they might be infected, such as their own illness or the illness or death of a child and/or partner. Only a few men were motivated to undergo testing because they feared they were already infected as a result of sickness or past sexual behaviours (Kaiser R. et al. 2011). This study, unlike our study, underlines the factors which motivate women to overcome barriers to HIV testing. Our study mainly considers the factors which act as barriers to HIV testing.

Relational factors

Partner's attitudes toward HIV testing

The social meaning of HIV testing and what partners ascribe to this meanings are important barriers in the decision to undergo testing and to involve a partner in the testing experience. For both men and women, HIV testing imply a lack of faith in the partnership, a lack of trust in a partner's behaviour, and an acknowledgment of their own risky sexual behaviours. Most couples are afraid that communicating their

desire to be tested could threaten the relationship. Several women present HIV testing as another strategy the couple could use to try to understand the reproductive health problems they are having (Kaiser R. et al. 2011). From these insights we can rightly say that the couples have on the importance of HIV testing is affected by false implications of HIV testing: sign of marital infidelity and promiscuity.

Decision-making autonomy

In the research carried out in Kenya male and female informants frequently referred to the need for women to seek permission from partners before HIV testing. In contrast, men generally made the decision to test for HIV on their own without soliciting the consent of their partners. Informants reported that men could pass by the clinic, see an advertisement, and drop in to be tested, whereas women would be less likely to enter the clinic as they were passing by and get tested (Kaiser R. et al. 2011). Concluding from the study carried out in Kenya, women are not exercising their natural right to autonomy and men are.

Fear of partner's reaction

The major perceived barrier to HIV testing for women informants was fear of a partner's reaction according to the research carried out in Kenya (Kaiser R. et al. 2011). Several women chose not to inform their partners about their intention to get tested for HIV because they feared the reaction, for many of the women who talked to their partners about testing before going for clinic, had tense and hostile arguments. The decision to get tested was often one that women fought hard to defend. If a woman underwent a test without the consent of her partner, conflict between them frequently arose. Similarly, men also feared their partners' reaction but for very different reasons. Men did not fear tension, hostility, or possible abandonment by their partner but they were afraid that the partner might discover that they had extramarital affairs (Kaiser R. et al. 2011). The insights offered here enrich our study on the aspect of attitude. From the research carried out in Kenya, we can discover the cause of negative attitude towards the importance of testing. Fear of partner's reaction is a contributing factor to the negative attitude.

Environmental factors

Time and money: In Tanzania, where the per capita gross domestic product is less than US\$ 750 (US Central Intelligence Agency Database, 2000), we expect that the direct and indirect costs associated with HIV testing would be barriers to HIV testing irrespective that HIV testing is free of charge service. Time is not a barrier to HIV testing. It is a matter of planning. There are other factors which are connected to behaviours which can rightly be called behavioural barriers to HIV testing.

Behavioural Aspects of HIV Counselling and Testing (HCT) among couples

Barriers to HCT

Low HIV Risk Perception

The most commonly cited reason for never having had an HIV test among women (31.2%) and men (45.6%) 15-49 years is that they do not need to be tested or that they have a low risk of being infected with HIV. Uganda Demographic and Health Survey data depicts the lack of perceived risk of HIV infection as a major reason for not taking a test. An estimated 21% of women and 23% of men perceive themselves to be at high risk of getting infected with HIV. Thus, the perceived threat of HIV is not enough to warrant the recommended behaviour of HIV counselling and testing (MoH-RU, 2009). From the research carried out in Uganda, We can rightly say that lack of knowledge of the importance of HIV testing is a barrier to HCT.

Fear

Fear of knowing one's status, as well as the resulting consequences, is another major behavioural barrier. In the research carried out in Uganda, sixteen percent of women and 9% of men do not want to know if they have the virus. Individuals are concerned not only with the health implications of taking a HIV positive test result, but also with the reactions of their partners (separation, loss of income, physical abuse), family members blame, negligence, and the community at large (gossip, discrimination). Many couples are afraid to bring up the subject of going for counselling and testing with their partner, as they fear it will lead to arguments about infidelity.

Couple communication about HIV is low; 83-84% of couples have not discussed AIDS among them (MoH-RU, 2009). The lack of discussion on HIV testing points out to the lack of knowledge of the importance of HIV testing. This is an indication of the research gap which is bridged by our study. The fear that HIV testing will lead to arguments about infidelity points to a negative attitude to the importance of HIV testing. This finding is in accordance with one of our objectives that of determining the attitude of married couples to HIV testing.

Structural and Economic Barriers

The cost of a HIV test is cited by 18% of women and 13% of men as a reason for never having had a HIV test (Uganda Ministry of Health & ORC Macro 2006). Distance to the testing site is also given as a reason for not testing by 3% of women and 5% of men.

Lack of Familiarity with Couples HIV Counselling and Testing

Couples HCT in particular faces its own challenges. Uganda's current HCT policy is not so explicit on couples counselling and testing, and promotion for CHCT has been low. Providers and clients alike still think of testing as an individual process. Logistically, it is difficult to bring the couple together for HCT at the same time, given different work and home schedules. As with other aspects of health, male involvement is low.

Misconceptions

Importantly, many people do not realize that couples can have different HIV test results. Misconceptions around discordance are highly prevalent in Uganda: 75% of both men and women incorrectly believe that if one partner is infected with HIV, the other partner is necessarily infected as well (MoH-RU, 2009). Very few clients or counsellors are able to give accurate information about why HIV discordance exists. Four dominant explanations of discordance are that the HIV negative couple member is actually infected; the virus is just taking time to show up in his/her blood; that some people are immune from HIV infection; that HIV infection is only through "rough" sex, and that HIV negative status is viewed as a reward from God. These

explanations can undermine the motivation of discordant couples to engage in HIV risk reduction behaviours. There is also a belief that monogamy is 'safe'. However, a faithful and or married individual only knows if he or she is faithful, not necessarily whether or not their marriage is monogamous. Thus, this conviction that being faithful reduces HIV risk is incomplete without taking into account the fidelity of one's partner.

Low Capacity to Provide CHCT

Lack of knowledge about where to go for Couple HIV Counselling and Testing (CHCT), and low capacity of counsellors to deliver effective counselling for couples are further barriers. Couples require specialized counselling; hence there is increased need to improve the capacity of counsellors. Inadequate support services for couples following HCT reduce the potential long-term benefits of the service. A facility assessment revealed that health units are often understaffed, in some health facilities there are no staff members trained in HCT, and referral mechanisms are inefficient (MoH-RU, 2009). Breach of confidentiality by health workers was also given as a key reason why HIV testing services are shunned in the communities; people prefer outreaches to facility-based static HIV counselling and testing for fear of their HIV status to be known in the neighbourhood. In our view, low capacity to provide HIV counselling and testing can affect the attitude of the married on the importance of HIV testing in marriage of the concerns of our research.

Knowledge and experience of Voluntary Counselling and Testing

The research conducted in at Entebbe and the findings from the FGDs as well as the individual interviews are presented in an integrated manner. Four focus groups of eight members each (four women and four men) were formed. The individual interviews were conducted with 219 people (82 women and 137 men, aged between 18 and 60 years).

In all the FGDs, HIV/AIDS/STDs were mentioned spontaneously as major public health problems responsible for significant morbidity and mortality. The causation/modes of transmission (sexual intercourse, mother to child and through contaminated blood) of HIV/AIDS were also well articulated.

Some symptoms of AIDS such as diarrhoea, prolonged fever, loss of weight, herpes zoster, recurrent boils, darkening of skin, brown hair and psychosis were easily cited. However, the issue of asymptomatic HIV only came into the discussion of the FGDs after probing and asymptomatic infection appeared not certain/clear with the majority of the FGD participants. There were expectations, however, as the following quote from one FGD participant illustrates “This AIDS is *confusing*, sometimes you see a fat lady without any symptoms yet you are sure she must be infected because she has killed at least five men”.

- i. In the same urban based FGD, voluntary counselling and testing was mentioned as the only sure way of “proving” that one is actually infected with HIV. Among the reasons mentioned for undergoing VCT were: showing symptoms of AIDS; loss of sexual partner; in marriage; mandatory requirements like joining the army, getting a scholarship, demand for sexual partner, worries after unprotected sex with un trusted sexual partner, blood transfusion, and after being involved in a road traffic accident (Bwambale F,2008).

In the individual interviews, 38 (17.4%) of the 219 people interviewed had ever undergone an HIV test. Of the 38 participants 36 had received their results and of these 9 (25%) tested positive for HIV.

Regarding intention to test in the next one year (if the facilities were accessible), 140 (63.9%) said they were likely to undertake the test, 61 (27.6%) said they were unlikely and 18 (8.2%) said that they were not sure.

- ii. The factors influencing acceptance of VCT for HIV are considered under attitudinal beliefs, social influence, self-efficacy, awareness, and risk of infection with HIV ((Bwambale F,2008).

Attitudinal beliefs

- iii. In the FGDs it was said that positive consequences of VCT would encourage testing such as: encouraging of positive living like eating a good food, stopping smoking, drinking and “generally caring about your health”; planning for one’s future as in making decisions about marriage and having children. Other positive

consequences mentioned were gaining confidence in life with what one does, and practising safer sex or abstinence. It was said that if one was found negative there is greater likelihood of adopting safer sexual practices or abstinence so as to jealously guard one's seronegative status. A common echo was "*you would be foolish to infect yourself after knowing that you are negative*". It was also said that some people after testing become goodwill ambassadors in encouraging others to test and also protect themselves and others against infection. ((Bwambale F,2008).

On the other hand it was said that anticipated consequences of being found positive would discourage HIV testing. Among the negative consequences mentioned were: loss of hope leading to destructive behaviour, early death through worries, and sometimes suicide. "*It may be better not to know your status and you live longer*" was a common expression. It was also mentioned in all FGDs that once people are found positive they may decide not to "*die alone*" and may deliberately spread the HIV. Other negative consequences of VCT mentioned included stigma from society and rejection from friends, relatives, and sexual partners. In the individual interviews, people were asked the advantages and disadvantages of undertaking VCT. Women were more likely to mention rejection whereas men were more likely to mention suicide. (MoH-RU, 2009).

Social influence

It was said that the decision to undertake VCT is mainly a personal individual decision. However, the decision was also said to be influenced by other people ("*important others*"), such as spouses, sexual partners, prospective marriage partners, relatives, friends, health workers/counsellors, religious leaders, political leaders and those that have undergone VCT in the past. In the individual interviews the people were asked the most likely source of influence on decision of VCT. It appears that about three quarters of the people said that they would influence the decision to undergo HIV test by themselves. It was interesting that sex never appeared to have influence on this decision ($\chi^2 = 0.49$, 1 degree of freedom and P-level = 0.39).

Self-efficacy, barriers and supports

Among the problems mentioned about VCT were that testing centres were too far especially for coupled with poor means of communication/transport as in rural areas. The services were also said to be expensive and out of reach of many people especially the youth and women. Poor perceived quality of care was also mentioned as a barrier in form of time taken to give the results (many people preferred instant), long waiting time before VCT, confidentiality and secrecy in handling of the results. The issue of sensitivity and specificity of the results were also mentioned anticipating the danger and consequences of labelling one as HIV positive while it is not the case.

It was reported that, FGDs participants were asked about what can be done to increase the number of people undertaking VCT, the mentioned responses were: to bring services nearer to the people; to provide free services, and offer help (especially with anti-retroviral drugs) to those found to be HIV positive. A common expression was *“what is the use of VCT if one cannot manage the very expensive AIDS drugs”* (Wawer JM,1999)

Other two issues emerged from the FGDs and individual interviews that were considered very important and are described herein separately. These issues were labelled Awareness and Risk of HIV infection (Wawer JM,1999). The issue of awareness is accordance with our study on the knowledge of importance of HIV testing. Moreover, the aspect of risk of HIV infection can reveal some insights on the attitude of the importance of HIV testing among the married.

Awareness

- iv. It was said that, in the FGDs lack of awareness on the need for VCT reduces the number of people undertaking VCT. It was reportedly said that among the strategies for HIV control the government had never encouraged people to undertake VCT. *“...May be they fear the consequences of testing, otherwise why haven't I heard a lot of campaign for testing on Radio,”* was one reaction in one of the FGDs. In improving the percentage of people who would undertake VCT

people suggested increased mobilisations, and campaigns through the famous FM radio stations, and through seminars/workshops (Bwambale F,2008).

Risk of HIV infection

Another issue that seem important in VCT is the perceived risk of HIV infection. In the FGDs it was said that people who considered themselves at increased risk of HIV infection were more likely to dertake an HIV test. Similarly, it was said that people at low risk of HIV infection were less likely to consider HIV testing. However most people in FGDs appeared to underestimate their risk of HIV infection, for example by saying that they can choose partners carefully such as those not infected (e.g. fat ones).

In the individual interviews people were asked to estimate their risk of being infected with HIV in the coming one year. Of the 219 people, 50 (23%) said they had no chance of being infected, 88 (40%) said their chance is either very small or small, 67 (30%) said their chance is either big or very big, 9 (4%) said they are already infected, 3 (2%) said they could not access the risk, whereas data for 2 (1%) was missing. Sex of respondents did not influence the estimated perceived risk of acquisition of HIV (Fishers exact test 9.9, 7 degrees of freedom, $P=0.19$). It was interesting to note that intention to test for HIV in next one year was positively correlated with perceived risk of HIV infection (Pearson's correlation coefficient $r=0.28$ $P<0.001$). (M.O.H,2000)

In Tanzania, several studies have examined factors associated with VCT and HIV serostatus disclosure, but most of them have focused only on women. A study of men attending a VCT clinic in Dar es Salaam indicates that some men view HIV testing as a cue to action to take precautionary preventive measures (Maman, Mbwambo, Hogan, Kilonzo, & Sweat, 2001).

The low rate of VCT participation among men in Tanzania is alarming. Surprisingly, many men engage in risky sexual behaviors that place them and their partners at risk. Men seek extramarital sexual partners to increase their sense of masculinity and self-

esteem (Oyediran, Isiugo-Abanihe, Feyisetan, & Ishola, 2010; Silberschmidt, 2001; Smith, 2007).

In another study conducted among 584 married men in Mbeya, one of the regions with the highest HIV prevalence in Tanzania, 39% of the participants reported to have had sex with women other than their wives (Mbago & Sichona, 2011). This fact shows infidelity is on the increase. Consequently, marital infidelity can affect the attitude related to the importance of HIV testing as one living a promiscuous life will have a negative attitude for fear of being found positive.

A recent study has revealed that the only risky behaviour associated with HIV among men in Tanzania is the number of sexual partners in the last 3 years (Ghebremichael & Paintsil, 2011). All these realities disclose the facts that there is a low level of the knowledge of the importance of HIV testing and the attitude towards HIV testing is negative. If one knows his or her HIV status to be negative, he/she cannot engage in risky behaviours. Even if he or she is positive chances are that after counseling one will not involve himself or herself in extramarital activities.

Increasing the number of men who receive VCT services is crucial in curbing the AIDS epidemic in Africa. Some of the factors underlying the risky sexual behaviours of men are related to gender role norms that encourage men to be sexually active and to have multiple partners as a rite of passage to adulthood (Barker & Ricardo, 2005). Furthermore, the well-documented gender power imbalance in sexual relations that exists in many African countries also reduces woman's ability to negotiate safer sex as many men refuse to use condoms despite having multiple sexual partners (Langen, 2007). These contemporary gender roles also influence women's ability to seek VCT services and prevent some women from sharing their serostatus with their partners (Peacock & Levack, 2004).

In Dar es Salaam, it was reported that women's fear for their partners' reactions was the most common barrier to HIV testing and that men needed to give women permission to attend the VCT clinic (Maman et al., 2001). Gender role norms,

gender power imbalance and the inability of women to negotiate safer sex act as barriers to HIV testing and affect negatively the exercise of the right to autonomy.

Considering the low rate of VCT participation, the high rate of risky behaviors reported among males, and the important role men play in their households, it is crucial to investigate HIV testing behaviours of men. The present study examines the factors influencing acceptance of HIV testing among men.

2.3 Empirical literature reviews

In the empirical literature review the aim is to learn from different studies how these have conceptualized issues and what they have found empirically concerning VCT of HIV for men in sub-Saharan countries and particularly in Tanzania. Different studies have been conducted and showed different findings.

Overall HIV testing experience in Tanzania and most parts of the world

Blood donation has been the championing cause of HIV testing for most donors who needed their test results after testing. HIV testing experience of men and women aged 15–44 shows basic patterns in HIV testing that may occur in any context, including blood donation. Among all persons aged 15–44 between 2006–2010, 33% had never been tested for HIV in any context, 17% had only been tested as part of blood donation, and 51% have ever been tested outside of blood donation (Chandra, et al., 2012).

This distribution was similar to the pattern seen for all persons aged 15–44 in 2002. HIV testing experience varies significantly by sex. Among men in 2006–2010, 38% had never been tested for HIV in any context, 20% had only been tested as part of blood donation, and 42% were ever tested outside of blood donation. Among women, a lower percentage (13%) than that for men (20%) had been tested only as part of blood donation, but a significantly higher percentage (59%) than that for men (42%) had ever been tested for HIV outside of blood donation. This sex difference in testing outside blood donation is largely driven by prenatal HIV testing (Chandra, et al., 2012). As a result of these differences by sex, a lower overall percentage of women (28%) than that of men (38%) had never been tested for HIV in any context.

Having never been tested for HIV in any context was more common among younger persons and those who were not married and were not currently cohabiting. Among those never married, not currently cohabiting persons, a higher percentage of those who had never had sexual intercourse had never been tested (77%) compared with those who had ever had sexual intercourse (33%) (Chandra et al.,2012). There seems to be no significant association was seen between educational attainment and HIV testing outside blood donation if one was to attach education to testing ignorance, but persons aged 22–44 with bachelor’s degrees or higher were more likely to have been tested as part of blood donation (23%) than those with no high school diploma or GED (7.9%). As a result of these patterns, persons with no high school diploma or GED were more likely (32%) to have never been tested for HIV in any context than those with bachelor’s degree or higher (21%). However, income is highly associated with testing in many incidences. A higher percentage of persons aged 20–44 with a household income below 100% of poverty had never been tested for HIV in any context (29%) compared with those with household incomes 400% of poverty or higher (23%) (Chandra, et al.,2012). Having been tested for HIV only as part of blood donation was more common among men (20%) than among women (13%). Persons aged 20–44 with household incomes 400% of poverty or higher were about twice as likely (21%) as those with (Chandra, et al., 2012).

Non-receipt of HIV test results

Non-receipt of HIV test results does not necessarily indicate lack of knowledge of the test result, for example, because individuals may assume that they will only be contacted if they are HIV-positive, and the absence of notification would signifies they were HIV-negative. They may therefore report “no” on receiving the test results because they were never personally contacted by the testing facility. However, not receiving test results may sometimes reflect true unawareness of the test result. As indicated in several reports that a higher percentage of currently married women did not receive their most recent HIV test result (16%) compared to currently cohabiting women (10%). This difference between currently married men

(14%) or cohabiting men (11%) was not significant (Chandra, et al., 2012; Maman, et al., 2001).

Non-Hispanic black men (6.9%) were less likely not to receive their most recent HIV test result, compared to non-Hispanic white men (12%). Among women, non-Hispanic black women (8.0%) were also less likely not to receive their most recent HIV test result compared with non-Hispanic white (14%) or Hispanic (14%) women. The data suggest that a higher percentage of heterosexual women did not receive their most recent HIV test result (13%) than lesbians (6.2%) or bisexual (8.9%) women. While a similar pattern was seen for men by sexual identity, there were too few gay men who did not receive their test results to be able to show these percentages in the report.

Significant associations were seen between non-receipt of HIV test results and the HIV risk-related measures included in the report discussed above. Using the broadest measure of “HIV risk-related behaviours in the past 12 months,” 5.9% of men reporting one or more of these indicators did not receive the results of their most recent HIV test, compared with 12% of men who reported none of those indicators. For women, 8.2% reporting one or more of these indicators did not receive the results of their most recent HIV test, compared with 13% of those who reported none of these indicators.

Similar percentages not receiving their HIV test results were seen among men and women reporting each specific type of reason for their most recent HIV test result. Men and women whose test was required for nonmedical reasons, such as health or life insurance or employment, were most likely to have not received test results (Chandra, et al., 2012).

HIV testing and disclosure of results thereof to sexual partners is one of the key strategies in HIV prevention as it promotes safer sex practices, prevent new infections to partners, reduce the risk of MTCT, increase social support, and reduce depression (Mwanga,2012).

However, disclosure of HIV test results to partner can either be beneficial or harmful. It is beneficial when it encourages the partners to access HIV prevention and care services and it is harmful when it brings adverse consequences such as stigma, discrimination, rejection, divorce, blame, shame, and abandonment (Mwanga, 2012). Pursuing couple HIV testing as a main avenue for making men more willing to test does not seem to work in its current form in this region. Men's reasons for not accepting couple HIV testing include worries and fear related to relationship problems, lack of full understanding of why they should be tested, distance of health facilities and lengthy waiting time, HIV is treated as a special disease in health facilities and this is stigmatizing, Health facilities are not male friendly, health workers treat men and their wives badly. With all these in mind, HIV services must be better adapted to local gender systems taking into account that incentives, health-seeking behaviour and health system barriers differ between men and women.

However, the predominant factors enabling to uptake HIV testing are deterioration of physical health and/or death of sexual partner or child. The roll-out of various HIV testing initiatives such as 'opt-out' provider-initiated HIV testing and mobile HIV testing has improved uptake of HIV testing by being conveniently available and attenuating fear of HIV-related stigma and financial costs. Other enabling factors are availability of treatment and social network influence and support.

Major barriers to uptake HIV testing comprise perceived low risk of HIV infection, perceived health workers' inability to maintain confidentiality and fear of HIV-related stigma, the perceived psychological burden of living with HIV, direct and indirect financial costs of accessing HIV testing, and gender inequality (UNAIDS, 2011).

Prevention Strategies

Several different drivers are responsible for the epidemic in different parts of the country. Factors that have been associated with the epidemic include, but not limited to low and less persistent use of condoms, multiple sex partners, mobility, transactional sex, cross-generational sex, poor quality of transfused blood, male

circumcision, gender inequities accompanied with poverty, most at risk populations to mention some. Prevention strategies, therefore, have focus on these major drivers depending on which greatly matters in the respective group and or geographical area (Allen, S, 1991).

Tanzania is Already committed to accelerating HIV prevention with the target of reducing new infections (Allen, S, 1991). A sound and comprehensive HIV prevention strategy that comprehensively addresses the current drivers of the epidemic and targets HIV prevention interventions at population groups with the highest risk of new infections is, therefore, required. The development of this National HIV Prevention Strategy and Action Plan was conceived to address this objective. This report is a product of a systematic review of the trends and drivers of the HIV epidemic in Tanzania, their alignment to existing HIV prevention programmers and resources, and consistency with global best practices conducted to inform the formulation of the HIV prevention strategy.

However, HIV testing among married couple is considered to be a major challenge (Bunnell, 2005). Studies have shown that, acceptability to test for HIV among married couple between men and women is fostered by gender power relations (Reniers G, 2012).

It is at this time of obvious need and within this conducive environment that stakeholders in Tanzania and other Eats African countries are joining forces to design and implement a national communication campaign for Couples HIV Counseling and Testing (CHCT). The mass media campaign will be national in scope, with a service delivery component and intensified interpersonal and community mobilization approaches all districts in the host country. This strategy addresses the communication aspects of the campaign (MoH-RU, 2009; Chandra, et al., 2012).

There are several impacts realized once a person decides to voluntarily test. Recently, the impact of HIV VCT was rigorously evaluated through a randomized control trial to test its efficacy in reducing risk behaviors among women and men in

Dar es Salaam, Nairobi, and Port of Spain. The study found that individuals randomized to receive HIV VCT significantly change their risk behaviors compared to those who receive health education (Chandra, et al., 2012).

Moreover, there is a close relationship between HIV testing and disclosure of test results among married couples in most cases. With all benefits mentioned before, the disclosure rate in some developing countries remains low as it ranges from 16.7% to 86% this depicts high range between countries and shows high rate of HIV testing but without uncovering results to partners. In many countries, disclosure of one's HIV status is done by the patient himself/herself to a person whom he/she preferred to tell. However, in some countries, health care providers are the ones who decide who are first to reveal the status to, whether the patient him/herself or family members (spouse, parents) (Mwanga, 2012; Siu, et al., 2014). It then becomes the family's decision whether or not to tell the patient the truth or to hide it for the sake of patient's best interests. However, in spite of the good intention of involving family members in HIV disclosure, in some families, revelation has resulted in discrimination and psychological stress. Women suffer more from such negative consequences than men. Nevertheless, with many other adverse effects of disclosing HIV test results to partners, most people have found it to be useless to voluntarily test while indirectly involuntarily indulge into endless problems which actually may influence early deaths. This has influenced hesitation to HIV testing and, therefore, perpetuating reluctance among married men mostly.

Although it is difficult for men to go for HIV testing, women are more affected with the disease than men irrespective of regular visiting to the voluntary testing and counseling units due to naturally entitled gender roles and responsibilities (MoH-RU, 2009). Then, women account for half of the 33 million people living with HIV around the world. In sub-Saharan Africa, home to two-thirds of the world's people living with HIV, women are even harder hit, making up 60 percent of those infected. However, not only are women biologically more susceptible than men to HIV, many behavioral and social factors play into women's vulnerability (MoH-RU, 2009).

If a young woman is uninfected with HIV at the time of her marriage, traditional wisdom says that she has avoided the disease altogether. More and more, however, research shows that marriage is not enough to protect people from HIV, either women or men (Maman, S. et al., 2001). Thus, if the above thinking was true, fewer women would be infected possibly than men or equivalent to men, but this is not the same as less is always known about men status due to hiding tendency and if more women are infected by HIV, men should be the most vulnerable to this deadly disease. Altogether, there are hidden complexities in realities of both married men and women as to who is the first susceptible and who is the next (Maman, S. et al., 2001).

Reasons for HIV testing differ between men and women. In several studies from different parts of the world, men and women respondents who ever had an HIV test outside of blood donation were asked their main reason for having the test, or their most recent test if they had been tested more than once. According to Chandra, et al., (2012), the most commonly reported reasons for women were prenatal care, medical procedure or checkup, and finding out if infected. Whereas, the most common reasons for men to test were to find out if they are infected, medical checkup or procedure, and requirement for job or military service. Thus, these and more other reasons depict most aspects that takes men and women to test are not voluntary as it is usually considered happening. This needs a more debatable discussion which will reveal valid percentages of men and women from the compelling factor of prenatal care. More so, higher percentages of men than women reported that their most recent HIV test was required for health or life insurance, for a marriage license, for job or military service, or for immigration or travel (Chandra, et al., 2012).

The transformation of men previously not used to test for HIV is more or less equivalent to the behaviour change process when individuals are to be exposed to a health message, individuals will first assess the susceptibility and severity of the perceived threat. Low perceived susceptibility or severity will result in inaction; the individual will ignore the message if they deem it to be trivial or irrelevant. If the individual does feel at risk of a serious threat, they will then assess the extent to

which the recommended behavior effectively prevents the threat (response efficacy), as well as the extent to which they are capable of performing the recommended behavior (self-efficacy). When these efficacy components are sufficiently high, the individual is likely to engage in the recommended behavior. (Allen, S1991).

However, if the individual feels that the recommended behavior is unlikely to prevent the threat, or that they are unable to engage in the recommended behavior (low efficacy component), denial or avoidance result. Thus, health messages and campaigns must strike a careful balance between perceived susceptibility, severity, self-efficacy, and response-efficacy in order to be effective. The CHCT campaign will seek to achieve this balance based on the available evidence. Some may include ambitious targets on increasing HIV prevention knowledge, reducing HIV prevalence, scaling up VCT, Prevention of Mother to Child Transmission (PMTCT), and ART services, increasing accessibility to information and services, and improving access and availability of condoms (Allen S1991).

It is inevitable to avoid talking of violence in marriage when addressing couples' testing habits. There is a number of violence associated with HIV testing among married couples. Physical violence is commonly reported in current partners (who have just married). Nearly a third of women had experienced at least one physically violent episode perpetrated by a current partner, such as slapping, twisting an arm, grabbing, punching, and kicking, in the three-month period prior to testing. A small proportion of women who disclosed their serostatus to partners reported a negative reaction. Most women said that partners showed support and understanding when told the test results. However, the proportion of women who reported this positive reaction is significantly greater among HIV-negative women compared to HIV-positive women. Regardless of the women's serostatus, only a small percentage of women's male partners said they would come for HIV testing. Violence differ from one place to the other, some common violence and many others as mentioned beforehand include physically assaulted, told to leave the house or abandoned and so forth. Thus, not only women are physically, psychologically, emotionally affected by this violence in marriage resulting from HIV testing but also men are even the most affected group. Several studies suggest that violence prevalence among married

couples is considerable and justifiable for fear of a partner's violent reaction (Maman, et al., 2001)

According to the Tanzania HIV/AIDS and Malaria Indicator Survey, 6% of adults aged 15 to 49 years were infected with HIV in 2007-2008 (Tanzania Commission for AIDS, 2008). The spread of HIV in Tanzania has been attributed to the high rate of multiple sexual partners and the low rate of HIV testing (Tanzania Commission for AIDS, 2008). In 2007-2008, only 19% of women and men aged 15 to 49 years had been both tested for HIV and were aware of the results (Tanzania Commission for AIDS, 2008). From a public health perspective, knowledge of one's own as well as a partner's HIV status is imperative because it can lead to a decrease in risky sexual behavior and HIV infection (Allen et al., 1992). In addition, VCT serves as the gateway for HIV-positive people to benefit from increased access to antiretroviral treatment (Wringe et al., 2008).

A study conducted among HIV discordant couples to assess the impact of VCT on condom use in Zambia revealed that men who learned of their positive HIV status were more likely to report 100% condom use than HIV-negative men (Allen et al., 2003).

The authors suggested that the HIV-positive men intentionally used condom after becoming aware of their status to protect their uninfected partner. The effect of knowing one's HIV status has also been shown to be associated with a reduction in sexual risk behaviors in the United States, with HIV-positive persons aware of their HIV status reporting a lower prevalence of unprotected anal or vaginal intercourse compared with HIV-positive persons unaware of their status (Marks, Crepaz, Senterfitt, & Janssen, 2005). These findings are similar to other studies showing that HIV-positive individuals who were aware of their partner's HIV status were more likely to use condoms than those who were unaware (Bunnell et al., 2008).

HIV testing for couples has been promoted as a strategy to improve testing rates and as a gateway to HIV prevention (Burton, Darbes, & Operario, 2010). Couple's testing has the potential to improve use of HIV prevention interventions (Farquhar et

al., 2004) and identify and treat discordant couples (Matovu, 2010). Nevertheless, there is reluctance to get tested as a couple due to male dominance in decision-making and women's fear of negative outcomes, such as violence or divorce, in the event of a positive test result (United Republic of Tanzania Ministry of Health, 2009b).

The Tanzanian Government has identified door-to-door recruitment as a key strategy to promote universal HIV testing, providing an environment conducive to widespread offer of a home-based couples counseling and testing (HBCCT) intervention (United Republic of Tanzania Ministry of Health, 2009a; United Republic of Tanzania National Bureau of Statistics, 2007). Extending home-based counseling and testing has the potential to reduce cost, logistical barriers and stigma, and enhance the linkage of infected persons to care and social support (Helleringer, Kohler, Frimpong, & Mkandawire, 2009).

2.4 Hypotheses

An hypothesis is a statement that is assumed to be true for the sake of argument or guiding investigation.

2.4.1 Lack of knowledge of the importance of HIV testing is a barrier for the married couples to go for HIV testing.

In a research carried out in Uganda, approximately 20% of both men and women do not know where to go for an HIV test, and 11% of women and 7% of men have reported no knowledge of HIV testing (MoH-RU, 2009). Furthermore, few people are aware of the benefits of HCT. Only 39% of women and 47% of men age 15-49 could name at least two of the following benefits: to be able to plan one's future, to avoid re-infection if one is already positive, and to learn to live positively with HIV/AIDS (MoH-RU, 2009). From the above data our assumption is proved to be true that lack of knowledge of the importance of HIV testing is a barrier to HIV testing for the married couples. From a public health perspective, knowledge of one's own as well as a partner's HIV status is imperative because it can lead to a decrease in risky sexual behavior and HIV infection (Allen et al., 1992).

2.4.2 Negative attitude to the importance of HIV testing is a barrier for the married couples to go for HIV testing

The above mentioned assumption is guiding our investigation. In the study carried out in Entebbe Uganda anticipated consequences of being found positive would discourage HIV testing. Among the negative consequences mentioned were: loss of hope leading to destructive behaviour, early death through worries, and sometimes suicide (Nuwaha F.2000). In a similar vein, negative attitude to the importance of HIV testing can act as a barrier for the married couples to go for HIV testing.

2.4.3 Lack of acceptability of the importance of HIV testing is a barrier for the married men to go for HIV testing

According to the research carried out in Uganda, the most commonly cited reason for never having had an HIV test among all women (31.2%) and men (45.6%) 15-49 years is that they do not need to be tested or that they have a low risk of being infected with HIV (MoH-RU, 2009). Our research investigated the assumption that lack of acceptability of the importance of HIV testing is a barrier for the married men to go for HIV testing.

2.5 Research gap

The surveyed literatures in this part expose out that in Tanzania there are few married men who go for VCT test, studies have focused on factors behind low willingness of married men to test their HIV status, is due to low knowledge on the importance of VCT HIV. Such observations imply that there is a knowledge gap, suitable intervention program in Tanzania which strongly necessitates researches to bridge the existing gap

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter covers the basic techniques and tools for data collection and analysis. It shows how the data was collected and eventually analyzed. It includes the area of the study, research design, and data collection methods as well as data analysis techniques.

3.2 Research design

The research had a qualitative and quantitative nature whereby a case study design was employed in this study, as it allowed in-depth information to be gathered at one point in time and it was explorative. In relation to the researcher, the research was easier as a researcher had to deal with those who come to examine their HIV status willingly. A case study is means by which a researcher explores individuals or organizations, through simple or complex interventions, relationships, communities, or programs (Yin, 2003).

3.3 Study area

The study was conducted at Dar es salaam in Kinondoni district at Mbweni health facility mainly for the purpose of reducing the cost. It was cheap in terms of money, time and easy to follow the respondents. Also, the other reason for selecting Mbweni health facility was because of being a public dispensary, where different kinds of people are attended.

3.4 Sampling

Sampling is the process whereby information is obtained from selected parts of an entity, with the aim of making general statements that apply to the entity as a whole.

3.4.1 Target Population

The study was centred on the couples who tested their HIV status in the district. The target population was the community of Mbweni and health providers of Mbweni health facility. Consequently, all study units were drawn from the target population.

Study unit

Study units involved men and women who were attending the VCT for HIV testing and health workers who were attending them.

3. 4. 2 Sample size

The sample size is 50 respondents. The sampling frame or the list of the respondents for the study was drawn from the health providers and from the clients, in this case men and women who went for the HIV testing. The average of the clients who attend the HIV testing services on monthly basis was 90. From the above mentioned clients, 45(50%) of them were drawn to serve as respondents. Out of 45 respondents 15 were men and 30 were women. The remaining 5 respondents were drawn from the health providers.

Table 1.3 Sample size

Health providers	5	10%
Men	15	30%
Women	30	60%
Total	50	100%

Source: Report field

3.5 Sample strategy techniques

Sampling techniques which were used were based on non-probability and probability sampling which involved purposive sampling, convenient sampling and simple random sampling.

3.5.1 Purposive sampling

This is a technique whereby the item to be included or excluded in the sample rests on the researcher's judgment and intuition. According to Kothari (2004), purposive technique enables the researcher to choose respondents basing on the fact that they have desirable characteristics and variables related to the issue being studied. According to the researcher's judgment 5 health providers working at the VCT Centre were selected. Because are the ones who gives VCT services.

3.5.2 Convenient sampling

Convenient sampling is a non-probability sampling technique whereby subjects are selected because of their convenient accessibility and proximity to the researcher. For noting, convenient sampling was preferred by the researcher because it is fast, inexpensive, and easy and the subjects are readily available. In this category 5 men and 20 women were selected. These had come for HIV testing voluntarily at Mbweni health facility which is accessible to the researcher.

3.5.3 Simple random sampling

This technique was opted for because each individual was chosen randomly and entirely by chance, such that each individual has the same probability of being chosen at any state during sampling process (Yates, *et al.*, 2008). In complying with this study 10 men and 10 women were selected by using this method.

3.6 Variables

Kerlinger (1979) defined a variable as a discrete phenomenon that can be measured in two or more categories. It is a symbol to which we assign numerical values. For example, attitude is a valuable because it can be differentiated by at least two distinct values: “negative” and “positive.”

Table 2.3 Variables and their measurements

Variable	Definition of variable	Measurement of variable
Knowledge	Whether the couple have knowledge on HIV testing in marriage	Level of awareness and practice in HIV testing
Attitude	The way people think about HIV testing or disposition with regard to HIV testing in marriage	Frequency of the married people to go for HIV testing
Acceptability	Who voluntarily accept to test HIV in marriage between men and women	The number of clients who test their HIV status in marriage

3.7 Data sources

Various data sources were employed to widen the data pool and enable triangulation of findings by tools used in collection. The nature of research questions fostered the use of extreme sources, primary and secondary sources.

3.7.1 Primary sources

Are those source which are used to collect data directly from the field by a researcher. In this study, the primary data used was from administered written questionnaires and interviews.

3.7.2 Secondary sources

Secondary data for this study were gathered through books, journals, documents and internet. Moreover, other data were obtained from the monthly reports kept at Mbweni health facility.

3.8 Data collection methods

3.8.1 Interview

Interview as a method applied in this study, allows conversation between an interviewer and interviewee; Kothari (1990) said interview involves presentation of oral-verbal stimuli and replies in terms of oral-verbal responses. The use of interviews helps the researcher to gather valid and reliable data that are relevant to research questions and objectives. The reason behind the use of interview is that more information can be obtained in greater depth. The interview method can be made to yield an almost perfect sample of the general population. In this study interview was administered to 5 key informants (health providers on HIV/AIDS unit or VCT centre), 5men and 10 women who were coming for examination. Confidentiality was highly observed. It was conducted in Swahili language in order to make the interviewees more comfortable and the discussion more convenient. The time for interview ranged between 30-50 minutes. The tool used was a standardised guide. The interview was both structured and unstructured.

3.8.2 Questionnaire-

De Vans (1996),-defined the term questionnaire to mean all techniques of data collection in which each person is asked to respond to the same questions in a pre-determined order. It can have open ended or closed ended questions. In this study the researcher distributed the questionnaires to the respondents and gave them ample time to respond to the questions. Later, the researcher collected the questionnaires from the respondents. This technique helped the researcher to reduce the problem of trust, time and cost. The questionnaires covered both open ended and closed questions.

3.9 Data analysis and presentation

Data analysis involved firstly, processing the raw data into forms that can be analyzed and secondly, analyzing the processed data so that meaningful conclusions and recommendations can be made. The researcher has used descriptive method to analyze quantitative data. This method is considered to be simple and understandable to the majority of people. This process involved arranging of raw data to a manageable data set, the identification of what data have in common and to which degree they differ from each other.

3.9.1 Qualitative data analysis

In contrast to quantitative data, qualitative data does not simply count things, but is a way of recording people's attitudes, feelings and behaviours in greater depth. Often based on grounded theory practice, answers the 'why?' questions and pays greater attention to individual cases (Yates, *et al.*, 2008). Qualitative data can be gathered through: Questionnaires, interviews, focus group discussion and observation. In this study, the researcher used questionnaires and interview to collect data. In the qualitative data analysis factors are examined. Not only one factor but several factors so as not to leave the problem unsolved. In this study, an in depth understanding of the problem of not testing the HIV status is sought. Hence several factors are investigated. Moreover, in this study we have taken 30 people, a mark of a qualitative data analysis.

3.9.2 Quantitative data analysis

It is a systematic approach to investigations during which numerical data is collected and/or the researcher transforms what is collected or observed into numerical data. It often describes a situation or event; answering the 'what' and 'how many' questions you may have about something. It is a research which involves measuring or counting attributes (Kruger, 2003). The researcher has put into numerical data what was gathered from the field. This can be seen throughout chapter four. The variables are few, only three. Nevertheless, the respondents are 50. This fact marks the characteristic of quantitative approach.

3.10 Ethical consideration

Ethical issues: the research was designed in such a way that was to heed to research ethics, medical ethics and to all community ethics and put human rights as a first priority. No harm was caused to any one whether involved in the study or not.

3.10.1 Consent

The consent was requested upon sensitization and introducing the study to the district authority. The consent form was written both in Swahili and English and was handed to authority for signing. The consent form actually addressed all issues of confidentiality.

3.10.2 No Use of Force or Illegal Coercion

According to research ethics, incentives to take part in a research should generally not be provided. If an incentive is used it needs to be only a token, and not enough to encourage someone to participate who would really prefer not to take part. In this research no one was forced psychologically or physically to be among the respondents.

3.10.3 Individual Autonomy

Autonomy means the freedom to decide what to do. One is not subjected to control from outside. Even when someone has signed a Consent Form, they must be made aware that they are free to withdraw from the study at any time, *without giving a*

reason. They must also be able to request that the data they have given be removed from the study. In this research the researcher was ready to respect the respondents' autonomy.

3.10.4 Confidentiality

Confidentiality is about protecting the undisclosed information gathered or the data collected. The data has been made anonymous. The respondents' names have been removed. What was revealed to the researcher was kept and is still kept confidential without revealing what is private to the public. Names of the respondents have not been used. Though in the course of research private stories, feelings, emotions were assessed; they are strictly kept private. In this work, it is not easy in any way to identify the respondents. In contrast with other works whereby the age, gender, length of service, designation can help to identify people. In this work the respondents cannot be identified.

3.10.5 Respect and Care of Vulnerable Groups

Vulnerable groups are groups of people who are capable of being wounded or hurt and are open to moral attack, prejudice and criticism. Empathy, compassion and care are clearly needed in research with physically challenged people, young children, and with people who are ill, or recently bereaved. However, others may be vulnerable in certain contexts, for example: people with albinism; students, employees, dependents, or people with particular traits that could be subject to prejudice. In this study the researcher was very careful with people living with HIV/AIDS and those physically challenged.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter presents the findings of the study. These are the findings which answer the research questions that were put up basing on the research objectives. The research objectives of the study were to explore the factors that influence married couples not to test for HIV status in Kinondoni district by examining the knowledge of husbands and wives on the importance of HIV testing in marriage, the attitude of married men and women on the importance of HIV testing in marriage and the level of acceptability to test for HIV between married couples

However, it first presents the sample size and its characteristics, the demography of the respondents and from there proceeds to the present the answers of the questions. The results are organized according to the objective questions.

4.2 Sample size and its characteristic

4.2.1 Sample size

The expected sample in this study was 50 respondents comprising of 45 clients who attended for HIV testing and 5 health provider who were offering the VCT service.

Table 3.4 Response level of all respondents

Categories	Number of respondents	%
Clients	45	90
Health providers	5	10
Total	50	100

Source: Field Data February 2015

4.2.2 Characteristic of the sample

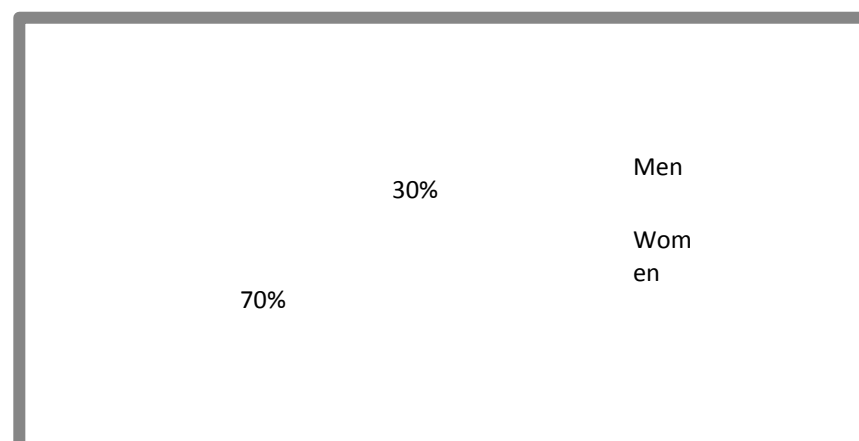
The study targeted 50 respondents which were 100% as indicated in the table above, and respondents responded to all questions effectively.

4.3 Demographic characteristics of the clients

4.3.1 Respondents by Sex

The demographic data show that the women were the majority that is 35(70%) while the men were the minority that is 15(30%). The study had no sex as a criterion, nevertheless, the researcher was gender sensitive to avoid bias and prejudice. All in all, the results show that the women were the majority when compared to men. The conclusion one can make is that the women were more ready to participate in this research than the men (See Figure 1). Furthermore, the readiness of women is as high in participating in the study as it is high in voluntary HIV testing.

figure 2:4 Sex of respondent

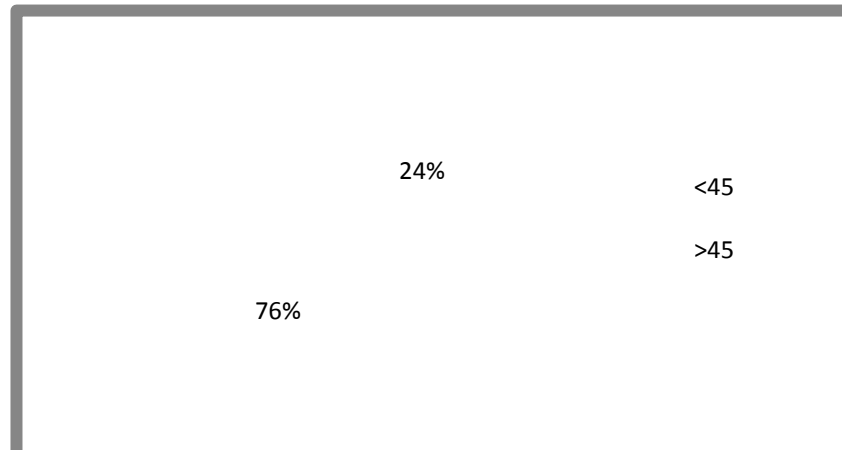


Source: Field Data February 2015

4.3.2 Respondents by age

The demographic data underline the fact that the majority of the respondents were above 45 years. The minority of the respondents were below 45 years. The age of the respondents was observed from the response to the questionnaire, out of 50 respondents 38 (76%) were above 45 years, whereas 12 (24%) were below 45. The question of age appeared in the questionnaire not in the interview as some participants may be reluctant to mention their age as it is too personal. The researcher considered the comfort of the participants (See Figure 2).

Figure 3:4 Age of respondent

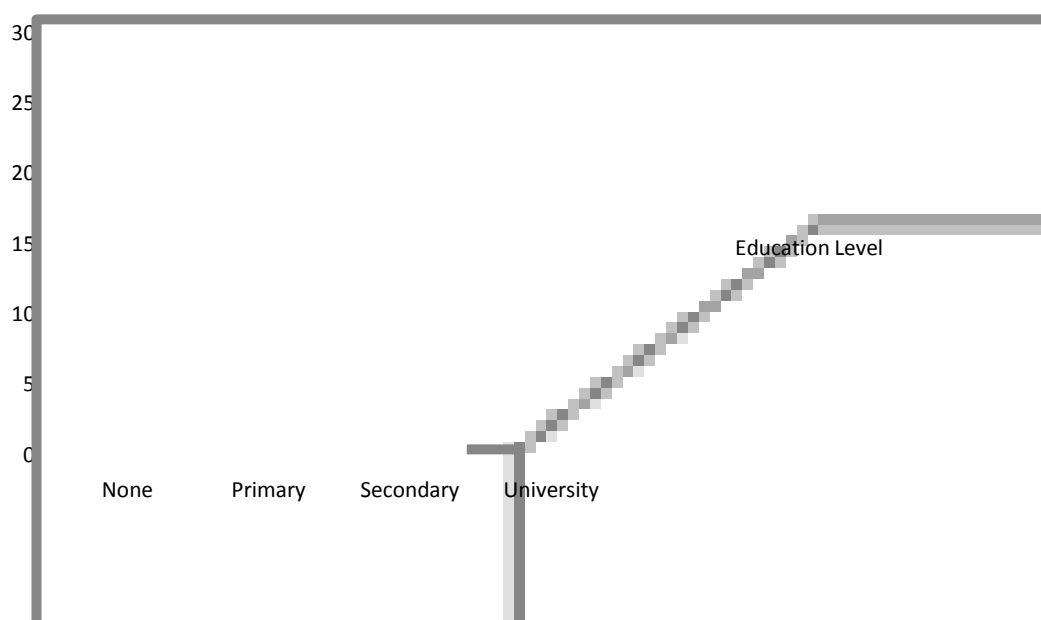


Source: Field Data February 2015

4.3.3 Respondents by education level

The collected data indicate the education levels of the respondents as follows: out of 50 respondents no one was illiterate, 30(60%) of them were primary school leavers, 15(30%) secondary school leavers and 5(10%) of them were university graduates as shown in figure 3. The data show that the majority of the respondents have the basic formal education that is primary education. The second group with the high number of literates has attained the secondary school education. The third group in that order has accomplished the university education. The size of the group is slim.

Figure 4:4 Education Level

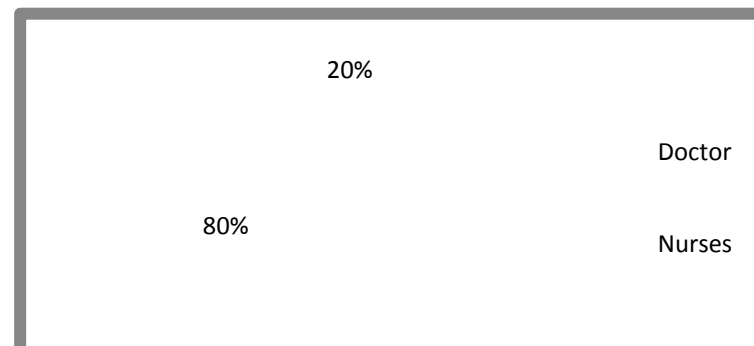


Source: Field Data February 2015

4.3.4 Respondents by medical service

The respondents offering medical services at Mbweni VCT Unit were 5 (100%), whereby 1 (20%) is a medical doctor and 4 (80%) are nurses. When the data is interpreted from the total number of all the respondents, out of 50 (100%) respondents 5 (10%) are health providers. The data show that Mbweni VCT Unit mainly depends on nurses for HIV counseling and testing. Moreover, the unit is understaffed in terms of medical doctors. From the demographic data, these health providers are female. Most probably, the presence of the female health workers only may hinder some men to attend to the VCT services. This may necessitate another research. During the in depth interview, one of the respondents clearly stated: “ The presence of female health workers only at Mbweni healthy facility hinder some men to attend to VCT services” (Respondent 3, Kinondoni, 2015).

Figure 5:4 Respondent by Health providers



Source: Field Data February 2015

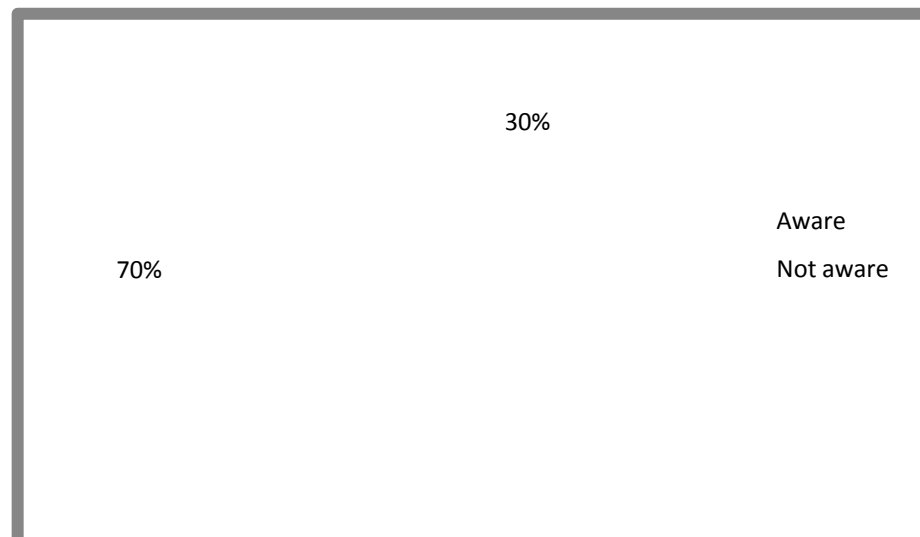
4.4 Testing knowledge of married men and women on the importance of HIV testing in marriage

The study started by examining whether the married women and men had knowledge on the importance of testing HIV in marriage to which all 50 interviewees responded. The respondents were asked to explain their understanding on the importance of HIV testing in marriage. It was found that the majority 35(70%) were not knowledgeable about the importance of HIV testing in marriage while 15(30%) were knowledgeable (See Figure 5).

The insight drawn from the data is that ignorance of the importance of HIV testing in marriage hinders men to test for HIV in marriage. On the positive note, knowledge of married men on importance of HIV testing influence acceptability of men to test for HIV.

Furthermore, during the oral interviews some male respondents stated: “If a pregnant wife tests for HIV/AIDS there is no need for the husband to test for HIV/AIDS.” (PT, 05, 06, 08,11, Kinondoni, 2015). The conclusion drawn from this line is complete and utter ignorance of discordant couple whereby one partner may be positive and another negative.

Figure 6:4 Testing knowledge



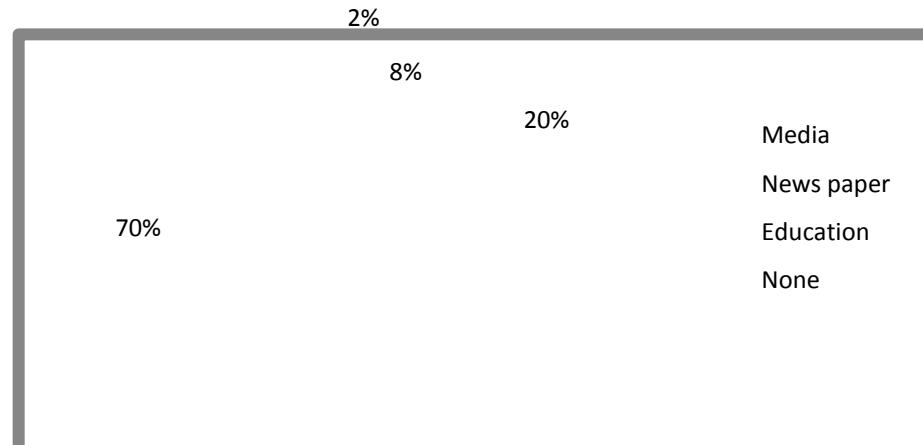
Source: Field data 2015

4.4.1 Source of information about the importance of HIV testing

The study explored the source of information through which the respondents got information about the importance of HIV testing in marriage. The study shows that the majority (70%) had never heard the importance of HIV testing in marriage. On the other hand 20% reported to have heard the importance of HIV testing from hospitals and schools, while 8% got the information from reading the newspapers and the remaining 2% got the information through the media. The implication is that the information about the subject under the study is very low (See Figure 6).

During the oral interview, it was however reported by many participants that the information about the importance of testing for HIV is lacking in the study area. One of the respondents stated that: “I have been living in this country for more than 10 years but I have never heard anything whether from the government, NGOs about why we should test for HIV in marriage” (PT, 11, Kinondoni, 2015).

Figure 7:4 Source of information



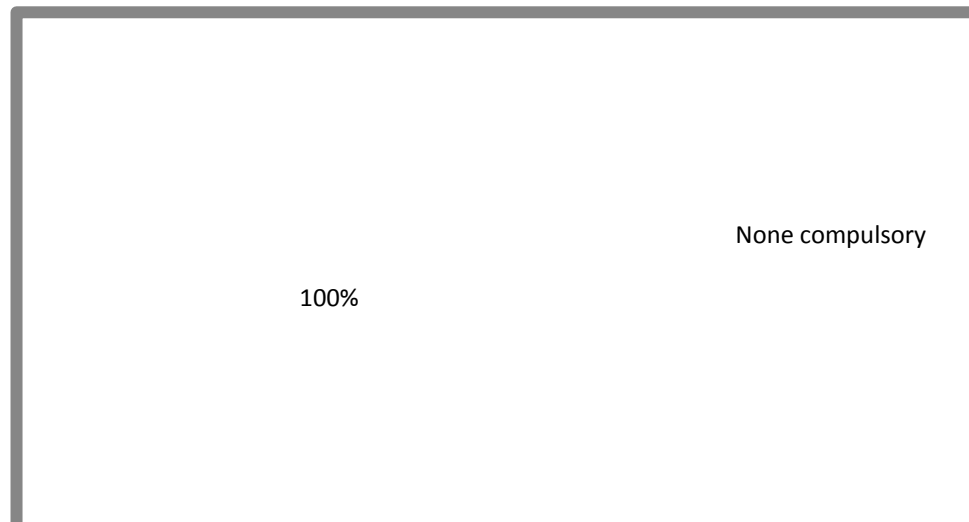
Source: Field data 2015

4.4.2 Practice of HIV testing in the society

All respondents 50 (100%) said that: “Testing for HIV in marriage is not a compulsory practice in their community.” They meant that it is not required by law or authority. Nevertheless, the practice in Tanzania is that HIV testing is a required routine for the pregnant women. The implication from the data is that the respondents are ignorant of the required routine for the pregnant women and for routine medical check up (See Figure 7).

In the oral interview the participants reiterated that testing for HIV is not obligatory in their community. One of the respondents stated: “Testing for HIV in marriage in our community has never been enforced by law” (PT, 14, Kinondoni, 2015).

Figure 8:4 Practice on HIV testing in the society



Source: Field data 2015

4.5 The results on assessing the attitude of married men and women on the importance of HIV testing in marriage

4.5.1 On HIV testing preference

It was reported that 15 (30%) respondents prefer to test their HIV status in marriage, while 35 (70%) do not prefer to test their HIV status because they feared to be found being infected. The implication from the data is that on the side of the majority there is a negative attitude to the importance of HIV testing in marriage. On the side of the minority there is a positive attitude to the importance of HIV testing in marriage (See Figure 8).

In the oral interview one of the participants with a positive attitude stated:

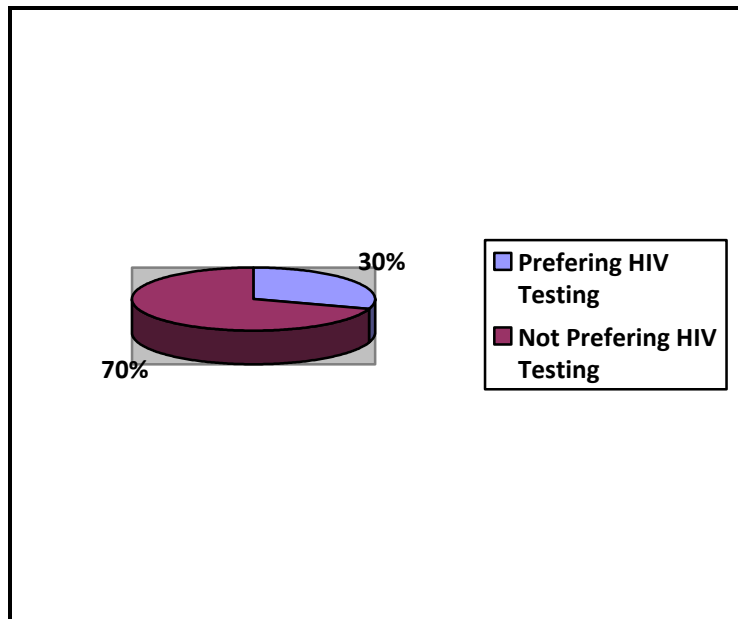
“It is important to test for HIV in marriage because after knowing one’s health status one can plan afresh one’s life. In case some are found positive, they would plan their balanced diet and start early taking anti-retroviral drugs” (PT, 20, Kinondoni, 2015).

In the oral interview one of the participants with a negative attitude stated:

“I cannot get HIV as long as I am married” (PT, 17, Kinondoni, 2015).

The implication from the oral interviews is that some people tend to build confidence on their marriage that they cannot get HIV as long as they are married. What is forgotten is the fact that marital infidelity is possible.

Figure 9:4 On Testing Preference



Source: Field data 2015

4.5.2 On HIV testing perception

Those who perceived the importance of testing their HIV status were 15 (30%). They were of the view that, after knowing their status they could continue to protect themselves. And 35 (70%) of the respondents who perceived barrier to test their HIV status believe that they are already in marriage and their wives test for HIV status in each pregnancy (See Figure 9). Hence they think that their HIV status will be known from their wives' HIV status. The implication drawn from those who perceive the importance of HIV testing is that prevention is better than cure. Moreover, the negative perception on HIV testing is a factor hindering men from HIV testing.

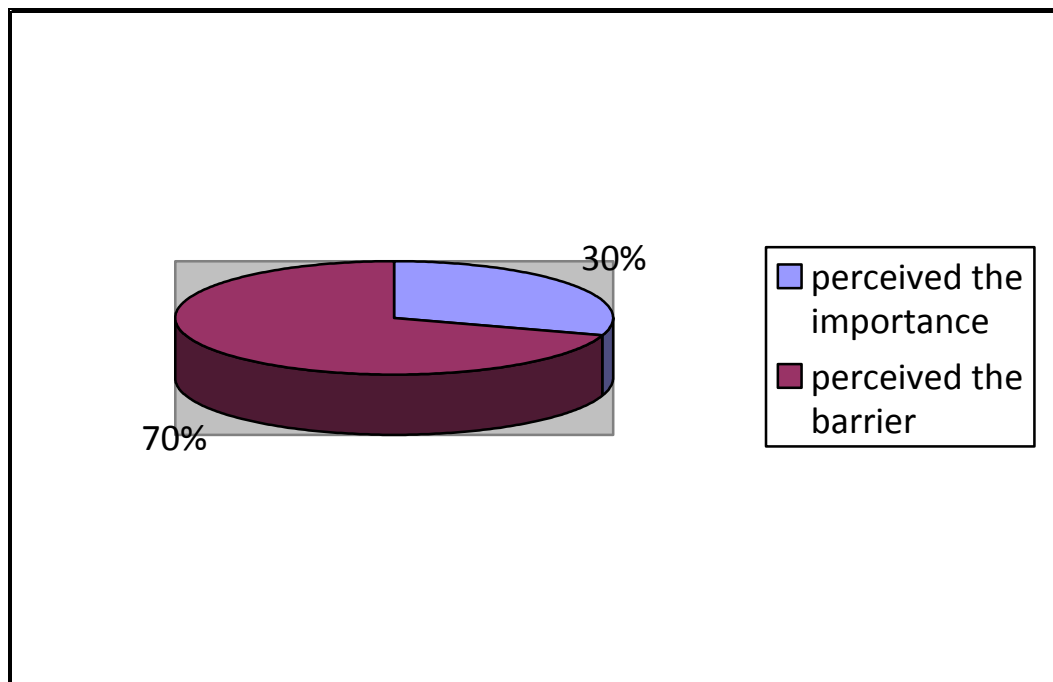
The oral data from the minority support the adage-prevention is better than cure. One of the respondents said:

“It is important to go for HIV testing because after you know that you are HIV free, you become cautious and more faithful” (PT, 47, Kindoni, 2015).

From the oral interviews, the majority perceived the barrier to HIV testing. One of the respondents had this to say:

“I will know my HIV status from my wife. She is tested in every pregnancy.” (PT, 18, Kinondoni, 2015).

Figure 10:4 On Testing Pereception



Source: Field data 2015

4.6 Assessing the level of acceptability of married men on HIV testing

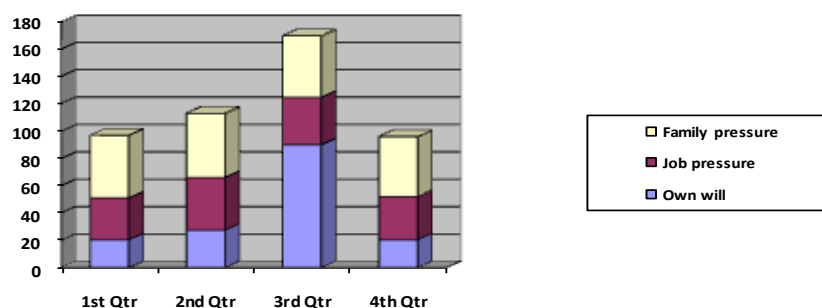
4.6.1 Testing acceptability of men on HIV testing

On the level of acceptability results show that, most of men who previously tested their HIV status were forced. Out of 50 (100%) respondents, 25 (50%) were forced by the management so that they can be employed, 15 (30%) were forced by the family members due to their critical illness and 10 (20%) were forced by their friends (See Figure 10). From the above findings it is true that lack of acceptability of the importance of HIV testing is a barrier for the married men to go for HIV testing.

The oral interview confirmed what was gathered from the written interview. From the oral interview, it was found that the majority went for HIV testing after being forced to do so. One of the respondents had this to say:

“Was it not for the sake of securing a job opportunity I could not have gone for the HIV testing” (TP, 01, Kinondoni, 2015).

Figure 11:4 Testing acceptability of men on HIV testing



Source: Field data 2015

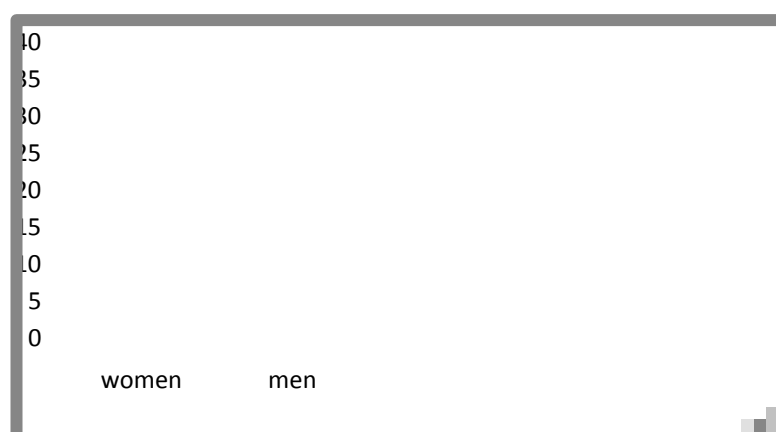
4.6.2 Testing on willingness

Generally, the findings show that women are more willing to test for their HIV status than men, 40 (80%) of the respondents said that women are willing to test their HIV status while 10 (20%) said men are willing to test their HIV status (See Figure 11). The majority of the respondents said that women are the first to test for their HIV status as they become pregnant and maintain PMTCT program.

The data gathered from the oral interviewed showed that women are more willing to test their HIV status than men. One of the respondents put it:

“I like to test my HIV status because it will help me to protect myself against HIV infection, in case I am positive I will be careful not to infect my child in the womb in case of pregnancy”(PT, 26, Kinondoni, 2015).

Figure 12:4 Testing on willingness



Source: Field data 2015

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.0 Introduction

AIDS is pandemic. Lack of testing for HIV/AIDS among married couples is considered to be one of the challenges that accelerate the spread of the pandemic. It is estimated that about 35.0 million of the world population are living with HIV/AIDS (WHO, 2012). Tanzania, like other countries in sub-Saharan African Region, has been devastated by the HIV epidemic for almost one quarter of a century (WHO, 2012). In Tanzania, HIV prevalence is higher (16.3% and 7.5%) among the married group as compared to other groups (TACAID, 2013). With this in mind, in this chapter the findings on the factors influencing acceptability of men to test for HIV in marriage are discussed.

5.1 Knowledge of married men and women on the importance of HIV testing in marriage

In the study, it was found that the majority 35(70%) were not knowledgeable about the importance of HIV testing in marriage while 15(30%) were knowledgeable. The insight drawn from the data is that ignorance of the importance of HIV testing in marriage hinders men to test for HIV in marriage. On the positive note, knowledge of married men on importance of HIV testing influences acceptability of men to test for HIV.

The findings in our research are consistent with a research done at Entebbe and in the findings from the FGDs. It was said that lack of awareness on the need for VCT reduces the number of people undertaking VCT (Nuwaha F.2000). From the findings, our hypothesis that lack of knowledge of the importance of HIV testing is a barrier for the married men and women to go for HIV testing has been proved to be true. Moreover, from these findings, we can say that knowledge on the importance of HIV testing in marriage is a factor that influences acceptability of men to test for HIV in marriage.

5.2 The attitude of married men and women on the importance of HIV testing in marriage

In this study it was found out that 15 (30%) respondents prefer to test their HIV status in marriage, while 35 (70%) do not prefer to test their HIV status because they feared to be found being infected. The implication from the data is that on the side of the majority there is a negative attitude to the importance of HIV testing in marriage. On the side of the minority there is a positive attitude to the importance of HIV testing in marriage.

Similarly, in the study done in Kenya shows that there is a negative attitude in the decision to undergo HIV testing and to involve a partner in the testing experience. For both men and women, HIV testing imply a lack of faith in the partnership, a lack of trust in a partner's behaviour, and an acknowledgment of their own risky sexual behaviours. Most couples are afraid that communicating their desire to be tested could threaten the relationship. Several women present HIV testing as another strategy the couple could use to try to understand the reproductive health problems they are having (Kaiser R. et al. 2011). Our assumption that *negative attitude to the importance of HIV testing is a barrier for the married couples to go for HIV testing* has been proved to be true from the above findings. Moreover, from these findings, we can say that positive attitude is a factor that influences acceptability of men to test for HIV in marriage.

Furthermore, traditions characterized by male dominance have been a fertile ground for the negative negative attitude on HIV testing. During in-depth interview with respondents concerning the possible reasons of not testing the HIV status, some respondents put it: *“mainly it is male dominance affecting the couples to examine their health status”*(PT, 01, 12, 13,49, Kinondoni, 2015). Some of the respondents said, *“customs and taboos of polygamy is main factor for not testing the HIV status”*(PT, 19, 23, 24, 31, Kinondoni, 2015). So many couples fear to be found affected while it is difficult to know who brought that disease. Moreover, men have no history of hospital visiting tendency until they are critically ill. The positive attitude of women seems to be boosted by the practice of HIV testing. One of the

respondents stated, *“It is a tradition that women should test because they have no choice as you know when attending the clinic during pregnancy. Thus HIV testing is not optional”* (PT, 07, Kinondoni, 2015).

5.3 Willingness of married men and women on HIV testing

Generally the study findings show that women are more willing to test their HIV status in marriage than men. From our study, 40 (80%) of the respondents said that women are willing to test their HIV status while 10 (20%) said men are willing to test their HIV status. The majority of the respondents said that women are the first to test for their HIV status as they become pregnant and maintain PMTCT program.

The data gathered from the oral interviewed showed that women are more willing to test their HIV status than men. One of the respondents put it:

“I like to test my HIV status because it will help me to protect myself against HIV infection, in case I am positive I will be careful not to infect my child in the womb in case of pregnancy”(PT, 26, Kinondoni, 2015).

Similar findings on the unwillingness of men to test for their HIV status were reported in the study carried out in the northern region of Tanzania where pregnant women ($n = 2,654$) were encouraged to invite their partners for VCT and only 12.5% of the men agreed to receive VCT (Msuya et al., 2008). From these findings, it can be said that willingness is a factor that influences acceptability of men to test for HIV in marriage.

5.4 General study findings

Generally, the study findings show that the majority were not knowledgeable on the importance of HIV testing in marriage. Moreover, on the attitude towards HIV testing in marriage, it was found that many people do not prefer to test their HIV status in marriage. Furthermore, on the acceptability by men on HIV testing the results showed that most of men who previously tested their HIV status were forced. In addition to that challenges were found out. From the oral interview, it was found that most men are not faithful in their marriage so they are afraid to examine themselves as they may be found positive. Stigmatization in the community terrifies men to test for their HIV status. Moreover, some men have more than one wife, so

they fear to test for their status as it brings confusion in the family, when it comes to the issue of the causative agent.

Male dominance is an obvious challenge. Traditionally, women are under men. Consequently, women cannot decide to test their HIV status without asking permission from their husbands. Men can ask questions such as: Why are you deciding to test? Were you not faithful? Some women get divorced due to testing their HIV status and others reported that they got physical injuries as they encountered physical violence.

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND POLICY IMPLICATIONS

6.1 Introduction

This chapter contains the summary, conclusions, recommendations and policy implications.

6.2 Summary

This study explored the knowledge of married couples on the importance of HIV testing in marriage, assessed the attitude of married men and women on the importance of HIV testing in marriage, determined the level of acceptance to test for HIV between married men and women at kinondon district in mbweni health facility. The results show that 70% were not aware on the importance of testing HIV status after married while 30% were aware.

On the information of the importance of HIV testing, the study shows that the majority (70%) had never heard the importance of HIV testing in marriage. On the other hand 20% reported to have heard the importance of HIV testing from hospitals and schools, while 8% got the information from reading the newspapers and the remaining 2% got the information through the media. The implication is that the information about the subject under the study is very low.

On the response regarding assessing the attitude of married men and women on the importance of HIV testing in marriage, it was reported that 15 (30%) respondents prefer to test their HIV status in marriage, while 35 (70%) do not prefer to test their HIV status because they feared to be found being infected. The implication from the data is that on the side of the majority there is a negative attitude to the importance of HIV testing in marriage. On the side of the minority there is a positive attitude to the importance of HIV testing in marriage

6.3 Conclusion

Based on the findings it can be concluded that among the problems facing the family due to failure of practicing voluntary couples HIV testing are: low level of awareness on the importance of couples testing, especially among men who have no habit of testing their status compared with women who test their HIV status during each pregnancy. Secondly, fear of the results to be found positive as it will bring

confusion to the family by asking who is responsible for the cause of the infection. Thirdly, fear of stigmatization and divorce because when one partner is found positive and another partner is negative many partners tend to run away so that they cannot be infected.

Fourthly, polygamy is a big challenge for men as it will be difficult for them to know where they get infected. Fifthly, is male dominance even if the women are willing to test their HIV status they don't get the permission from their husbands and when they force to do so, they get divorced or are physically injured for the desire to test for the HIV status is taken as a sign of infidelity. Furthermore, HIV testing among married people is not a compulsory practice in their society.

In order to improve the number of couples who go for HIV testing it is necessary to address perception of low risk of HIV infection and perceived inability to live with HIV. There is also a need to continue addressing HIV-related stigma, which is intricately linked to individual economic support. Building confidence in the health system through improving delivery of health care and scaling up HIV testing strategies that attenuate social and economic costs of seeking HIV testing could also contribute towards increasing uptake of HIV testing in SSA (WHO,2012).

6.4 Recommendations

6.4.1 Recommendations based on the knowledge of the importance of HIV testing

- v. Awareness through massive campaigns should be promoted as a strategy to make the married couples aware of the knowledge of the importance of HIV testing among the married couples. Since 70% of the respondents were not aware of the importance of couple HIV testing services so more awareness is needed on the importance of the HIV testing among the married. This is in consistency with a study conducted by Joseph RB.Matove (2013) who was of the same view that there is a need for innovative strategies to create demand for couples' HCT, especially among couples with no prior HCT experience.

- vi. Private-Public Partnership should be encouraged in disseminating the information of the knowledge of importance of HIV testing and counseling. If the private sector will be united with the public sector in educating the married on the importance of HIV testing a greater achievement can be reached.
- vii. The use of media (including television, newspapers, radios and magazines) to promote the importance of HIV testing among the married should be intensified. This is in consistency with other studies. In improving the percentage of people who would undertake VCT people suggested increased mobilisations, and campaigns through the famous FM radio stations, and through seminars/workshops (Bwambale F,2008).

6.4.2 Recommendations based on the attitude of the importance of HIV testing

- i. Couples should be empowered to initiate and sustain communication around HIV and AIDS in order to reduce the negative attitude towards HIV testing and counseling which is enshrined in secrecy. This is in consistency with a study done in Uganda by the Ministry of Health (MoH-RU, 2009).
- ii. Couples should be encourage to seek HIV testing and counseling together so as to reduce the negative attitude characterized by suspicion, infidelity and promiscuity. This is in consistency with a study done in Uganda by the Ministry of Health (MoH-RU, 2009).
- iii. Couples should be encouraged to adopt and maintain positive health practices including risk reduction strategies and health seeking behaviours. Positive health practices reduce greatly the negative attitude towards the importance of HIV testing and counseling. This is in consistency with a study done in Uganda by the Ministry of Health (MoH-RU, 2009).
- iv. HIV positive couples should be linked to treatment, care and support. This is in consistency with a study done in Uganda by the Ministry of Health (MoH-RU, 2009).
- v. Women should be encouraged to exercise their right to autonomy. The aim of health sector is to provide equitable, accessible, affordable and quality health care to all. Hence we recommend reviewing the strategies put forward to help the women (gender equality) access HIV testing services without waiting for

permission from their husbands so that they can get tested at any time they feel to have a test.

6.4.3 Recommendations based on the acceptability of the importance of HIV testing

- i. Gender power balance should be encouraged as an expression of autonomy. Gender power imbalance is a barrier to acceptability of the importance of HIV testing. This is consistent with a study done in Dar es Salaam. In Dar es Salaam, it was reported that women's fear of their partners' reactions was the most common barrier to HIV testing and that the men needed to give the women permission prior to attending the VCT clinic (Maman et al., 2001).
- ii. Male testing campaign should be launched. Based on the findings, the majority of the respondents that is 80% were of the view that women are more willing than men on HIV testing. Hence there is a need to launch the male HIV testing campaign program as it is in PMTCT.
- iii. Prevention of HIV/AIDS should be encouraged. Where there is a health family, there will be a health nation so the issue of the couples testing their HIV status is basic in preventing highly viral infection. The vision of Ministry of Health and Social Welfare through Mpango wa Taifa Kudhibiti UKIMWI which deal with VCT, PICTC AND HBTC, should continue to support and facilitate further prevention of HIV/AIDS as a role model by providing primary, secondary and tertiary care to all Tanzanians.
- iv. We recommend educating the whole community so that discrimination and stigmatization is stopped; people must now understand that testing for their HIV status prior will help them to have early treatment which will help to lower the burden of disease. This will reduce greatly the negative attitude

Lastly, more strategies are needed to address the challenges facing the married people in order to overcome them so that the aim of the nation to reduce the HIV transmission can be met.

6.5 Policy and Practical Implications

The synthesis suggests that the policy of provider-initiated HIV testing coupled with increased wider availability of life-saving HIV medication is crucial in scaling of

uptaking of HIV testing in SSA. Due to fear associated with seeking HIV testing, availability and convenience of provider-initiated HIV testing provides that extra 'push' that enables individuals to overcome barriers and effect their intentions to test and at the same time moderate fear of stigma and attenuate costs. This, therefore, calls for stepping up provider-initiated HIV testing when individuals come into contact with the health system

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APPENDICES

APPENDIX A: QUESTIONNAIRE FOR MEN AND WOMEN

INTRODUCTION

My name is Ms Consolata M. Mwesiga student at Mzumbe University taking a Masters' Degree of health system management. My research is on the factors that influence acceptability among married men for HIV testing: Kindly request you to take part in this study. Your participation is voluntary, Confidentiality is highly observed. The information can be published for community benefits and no cost in participating in this study. Hoping that you are ready to take part in this study, Thanks in advance.

Part: A. Personal particulars

1. Age (<45), (>45).....
2. Sex (Male/Female).....
3. Education level
 - None ☐
 - Primary ☐
 - Secondary ☐
 - College/university ☐
4. Marital Status (Single/Married, divorced/ widowed).....
5. Family size.....
6. Occupation

Part: B. knowledge of married men and women on the importance of HIV testing in marriage.

1. Have you ever tested for HIV?
Yes.....
No.....
2. Do you know the importance of HIV testing in marriage?
Yes.....
No.....

3. Where did you get the information about the importance?

- Media
- News paper
- Others (specify)

4. Is testing of HIV after married a compulsory practice in your society?

Yes.....

No.....

5: If “yes” are couples voluntarily willing to test their HIV status?.....

Yes.....

No.....

6 If “yes” why couples are not voluntarily willing to test their HIV status in marriage?

Yes.....

No.....

If no list the possible reason

.....
.....

7. What measures can be taken to improve the knowledge on the importance for HIV in marriage

.....
.....

PART C: Assess the attitude of married men and women on the importance of HIV testing in marriage

8. Do you prefer to test for HIV in marriage?

Yes.....

No

9. If no, mention the reason.....

10. Is testing for HIV in marriage perceived important to you?

Yes

No

11. If yes why

If no why

Part: D to assess the level of acceptability of HIV testing between married men and women?

12. Were you forced to test for HIV in marriage?

13. Yes

14. No

15. If yes who forced you?

- Spouse
- Friend
- Family
- Management

16. In your opinion who voluntary accepts to test between men and women?

Men

Women.....

17. Men are willing to test for HIV in marriage?

- Agree
- Strong agree
- Neutral
- Disagree
- Strong disagree

18. Women are willing to test for HIV in marriage?

- Agree
- Strong agree
- Neutral
- Disagree
- Strong disagree

19. Who goes first for testing in marriage

Men.....

Women.....

If men, why.....

If women, why.....

20 What are the main challenges facing men to accept to test for HIV in marriage?

21. What are the main challenges facing women to accept to test for HIV in marriage?

.....
.....

.....222.What should be done to improve acceptability to test for HIV after married for both men and women?

.....
.....

Thank you for participation.

QUESTIONNAIRE FOR SERVICE PROVIDER

Part: A. Personal particulars

7. Age.....
8. Sex (Male/Female).....
9. Education level
- None ☐
 - Primary ☐
 - Secondary ☐
 - College/university ☐
10. Marital Status (Single/Married, divorced/ widowed).....
11. Family size.....
12. Occupation
13. How long have you been working in VCT department?
-

Part: B. knowledge of married men and women on the importance of HIV testing in marriage.

14. Between married men and married women who are more knowledgeable on the importance of HIV testing?
- Men.....
- Women
- 15 Do you think man campaign on testing for HIV in marriage targets men and women equally?
- Yes
- No
16. If yes, why?.....

PART C: Assess the attitude of married men and women on the importance of HIV testing in marriage

17 Between men and women who voluntarily prefers to test in marriage?

• Men

• Women

18 If men why?.....

19 If women why?.....

Part: D: To assess the level of acceptability of HIV testing between married men and women

20 Between men and women who comes for testing

• Men

• Women

21. If men why?.....

22. If women why?.....

20. What are the main challenges facing men to accept to test for HIV in marriage?

.....

21. What are the main challenges facing women to accept to test for HIV in marriage?

.....

.....

22 what should be done to improve acceptability to test for HIV after married for both men and women?

.....

.....

“THANK YOU”

APPENDIX B

DODOSO KWA WANAWAKE, WANAUME NA WATUMISHI WA AFYA. Utangulizi.

Jina langu ni Consolata M Mwesiga. Nachukua shahada ya udhamili katika chuo kikuu Mzumbe, ninafanya utafiti juu ya sababu zinazochangia muitikio mdogo wa wanaume walio kwenye ndoa kutopima afya zao hasa UKIMWI. Kipekee ninawaomba mchukue nafasi hii katika kuchangia maoni yenu juu ya hili suala, katika kushiriki kwenu itatuonesha picha nzima juu ya hili tatizo, pia ushiriki wenu ni wa hiari, siri inaangaliwa sana. Picha tutakayoipata itachapishwa ili hali jamii ipate kunufaika na matokeo hayo, hakuna gharama katika kushiriki kwenu. Je, mpo tayari na mmeridhia kushiriki katika kuchangia utatuzi wa hili tatizo, chagua jibu sahihi kwako.

Natanguliza shukrani

Sehemu: A .Maelezo binafsi.

- (i) Umri.....
- (ii) Jinsia.....
- (iii) Kiwango cha elimu msingi, sekondari au, chuo.....
- (iv) Umeoa/Umeolewa/umeachika/ulifiwa na mwenzi.....
- (v) Jumla ya familia.....
- (vi) kazi yako

Sehemu: B. kupima ufahamu wa wanandoa kuhusu umuhimu wa kupima afya(UKIMWI) zao baada ya kuufunga ndoa.

- 1 Ulishawahi kupima ukimwi?
Ndio.....
Hapana.....
2. Unafahamu umuhimu wa kupima afya(UKIMWI) yako baada ya kufunga ndoa?
Yes.....
No.....

3. Ulijulia wapi umuhimu wa kupima afya yako?

- runinga
- magezeti
- sehemu nyingine(taja)

4. kupima ukimwi baada ya kufunga ndoa ni kitu cha lazima katika jamii yenu?.

Ndio.....

Hapana.....

5. kama' ndio' wanandoa wanajitokeza kupima afya zao juu ukimwi ?

Ndio.....

Hapana

6 : kama 'ndio' kwanini wanandoa hawajitokezi kupima ukimwi?

.....

Kama hapana taja vitu vinavyoweza kusababisha.

.....

.....

7. Ni mikakati gani ifanyike ili kuinua ufahamu wa umuhimu wa kupima afya kwa wanandoa?

.....

.....

PART C: Kuchunguza tabia za wanandoa kuhusu umuhimu wa kupima afya zao baada ya ndoa.

8. Unapendelea kupima afya yako baada ya kufunga ndoa?

Ndio.....

Hapana

9. Kama hapana taja sababu.

.....

.....

Hivi kitendo cha kupima afya ukiwa kwenye ndoa unaona kina umuhimu kwako?

Ndio.....

Hapana.....

10. Kama 'ndio' kwanini

Na kama 'hapana' kwanini

Sehemu ya: D. Kuchunguza kiwango cha ukubalikaji wa kupima afya kati ya wanandoa wa kike na wa kiume?

11. Ulilazimishwa kupima afya yako baada ya kufunga ndoa?

Ndio

Hapana

12. Kama 'ndio' nani alikulazimisha?

- mwenzi
- rafiki
- wanafamilia
- Uongozi kazini

13. Kwa mtazamo wako ni nani kati ya mwanamume na mwanamke anaye jituma kupima afya yake?

Mwanaume

Mwanamke.....

14. Wanaume wajituma kupima afya yao baada ya kufunga ndoa?

- kubali
- Kubali kabisa
- kawaida
- hapana
- hapana kabisa

15. Wanawake wajituma kupima afya yao baada ya kufunga ndoa?

- kubali
- kubali sana
- kawaida
- Hapana
-

- hapana kabisa

17.Nani wa kwanza kwenda kupima afya zao baada ya ndoa?

Wanaume

wamawake.....

kama wanaume kwa nini.....

kama wanawake kwa nini.....

18.Ni magumu gani wanayo kutana nayo wanaume katika kukubali kupima afya zao baada ya kufunga ndoa?

.....

19 Ni magumu gani wanayo kutana nayo wanawake katika kukubali kupima afya zao baada ya kufunga ndoa.

.....

.....

20 Ni kitu gani kifanyike ili kuwezesha wanandoa wakike na wakiume kukubali kujituma kupima afya zao baada ya kufunga ndoa?

Asante kwa ushirikiano wako

INTERVIEW GUIDE

Part: A Knowledge of married men and women on the importance of HIV testing in marriage

1. Have you ever tested for HIV? YES/NO

2. Do you know the importance of HIV testing in marriage? YES/NO

3. Where did you get the information about the importance?

- Media
- News paper
- Others (specify)

4. Is testing of HIV after married a compulsory practice in your society? YES/NO

5. If “yes” are couples voluntarily willing to test their HIV status? YES/NO

6. If “yes” why couples are not voluntarily willing to test their HIV status in marriage?

If no what is the possible reason.

.....

7. What measures can be taken to improve the knowledge on the importance for HIV in marriage.

.....

PART C: Assess the attitude of married men and women on the importance of HIV testing in marriage

8. Do you prefer to test for HIV in marriage? YES/NO

9. If no, what the reason

.....

10. Is testing for HIV in marriage perceived important to you? YES/NO

Part: D to assess the level of acceptability of HIV testing between married men and women?

19. Were you forced to test for HIV in marriage? YES/NO

20. If yes who forced you?

21. In your opinion who voluntarily accepts to test between men and women?

22. Men are willing to test for HIV in marriage?

23. Women are willing to test for HIV after marriage

24. Who goes first for testing after

25 What are the main challenges facing men to accept to test for HIV in marriage?

.....

26 What are the main challenges facing women to accept to test for HIV in marriage?

.....

27 What should be done to improve acceptability to test for HIV after married for both men and women?

.....

Thank you for participation.

APPENDIX C



MZUMBE UNIVERSITY
(CHUO KIKUU MZUMBE)
SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

E-mail: mu@mzumbe.ac.tz
Tel: +255 (0) 23 2604380/1/3/4
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P.O. BOX 2
MZUMBE
MOROGORO, TANZANIA

Ref. No. MU/SOPAM/DHSM/VOL.I/22

16th February, 2015

TO WHOM IT MAY CONCERN

RE: DATA COLLECTION FOR MS. BEATA N.SHABAN

The above named is a student of this University in the School of Public Administration and Management Master of Health System Management (MHSM). **Ms. Shaban** has finished Semester III of her studies which ended in October, 2014.

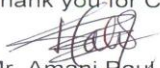
As a partial fulfillment of the requirement for the award of Masters Degree every graduate student is required to undertake dissertation on a topic relevant to her area of specialization. The candidate has opted to conduct a study on the topic titled:

Attending for Couple HIV Testing After Marriage: Factors Influencing Acceptability Among Men. An Explorative Study from Kinondoni District.

The study (research) is expected to take only six months and thereafter **Ms. Shaban** will be required to submit the report to the School of Public Administration and Management as per University regulations.

We kindly request your office to accord the student with all necessary assistance, particularly in accessing official data necessary for accomplishment of her study and also getting permission to interview various people in your organization as indicated in her research proposal.

Thank you for Cooperation.


Mr. Amani Paul

For Dean SOPAM



APPENDIX D

HALMASHAURI YA MANISPAA YA KINONDONI

BARUA ZOTE ZITUMWE KWA MKURUGENZI WA MANISPAA

Simu Na: 2170173
Fax Na: 2172606

Unapojibu tafadhali taja:

Kumbi Na. KMC/A/PF/1044



MKURUGENZI WA MANISPAA
MANISPAA YA KINONDONI
S.L.P. 31902
DAR ES SALAAM

Tarehe 12/01/2015

Beata Nuru Shabani,
Mbweni Dispensary,
S.L.P. 61665,
DAR ES SALAAM.

K.K. Mganga Mkuu,
Mbweni Dispensary,
S.L.P. 61665,
DAR ES SALAAM.

K.K. Mganga Mkuu wa Manispaa,
Manispaa ya Kinondoni,
S.L.P. 61665,
DAR ES SALAAM.

Inesha
Kny: MG ENG. MKURUGENZI WA MANISPAA
HALMASHAURI YA MANISPAA YA KINONDONI
15/01/2015

Dear Beata,

REF: REQUEST TO CONDUCT A STUDY ON ATTENDING FOR COUPLE HIV TESTING AFTER MARRIAGE:
FACTORS INFLUENCING A CIPTABILITY AMONG MEN.

Kwa niaba ya Uongozi wa Manispaa ya Kinondoni, napenda kukupongeza sana kwa juhudi yako ya kujiendeleza kielimu na kitaaluma. Kufatia ombi lako la kufanya utafiti katika Zahanati ya Mbweni limekubaliwa. Unaweza kuanza muda wowote kadiri ya mpangilio wa masomo yako.

Mganga Mfawidhi mpokee na mpe ushirikiano wenu.

Nakutakia usafi mwema.

A.B. Tutuba

Kny: MKURUGENZI WA MANISPAA
MANISPAA YA KINONDONI

APPENDIX E: WORK PLAN AND FORECASTED BUDGET

Work plan and Forecasted Budget													
Task to be performed	Manpower required (Units)		2014				2015						
			Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July
Proposal writing	0	-											
Proposal presentation and approval	0	-											
Preparation of units of study	0	-											
Pilot testing of data collection tools	2	500,000											
Revision of study methodology	0	-											
Hiring and training of data personnel	2	1,000,000											
Actual field work	0	-											
Data collection	2	2,000,000											
Transformation of data into software	2	1,500,000											
Preparation for analysis													
Data cleaning	1	500,000											
Data recoding	1	300,000											
Processing and analysis	1	500,000											
Report writing	0	-											
Report submission	0	-											
Report presentation	0	-											
Total		6,300,000											