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Perceptions of couple HIV counseling and testing in Botswana: A stakeholder analysis

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ABSTRACT

Objective: To explore stakeholder's perceptions of Couples HIV Counseling and Testing (CHCT) as opposed to individual testing and potential couples' preferences for CHCT promotion and service provision.

Methods: Study was conducted as formative research for a phase III clinical trial of Herpes (HSV-2) suppression to prevent HIV transmission among HIV discordant couples. We used non-probability purposive sampling and snowballing techniques to identify study participants. Data were collected using key informant interviews and focus group discussions. Systematic textual data analysis was used. Two independent coders coded and compared their codes for agreement. Data was categorized by emerging themes.

Results: The general themes from both key informant interviews and focus group discussions were a preference for CHCT as opposed to individual counseling in HIV prevention and the need for a client-centered approach to promotion and provision of couple HIV testing services.

Conclusion: CHCT is important in HIV prevention and should be integrated in existing HIV testing programs. The study also demonstrates the challenges of HIV status disclosure and discordance among sexual partners who test as individuals.

Practice Implications: Current low HIV status disclosure rates imply that reducing HIV incidence rates will require integrating CHCT into current testing programs. Increasing CHCT uptake however, requires improving access, training providers and addressing social, cultural, political and logistical barriers.

1. Introduction

Botswana has one of the highest reported adult HIV prevalence in the world. Annual HIV sentinel surveys in pregnant women 15–49 yrs indicate that HIV prevalence rose from 6% in 1990 to 37.4% in 2003 [1]. Contextual factors contributing to this include concurrent sexual partnerships, cultural attitudes about fertility, low marriage rates, social migration patterns and geographical separation of couples employed in the civil service and mining industry [2–4]. A recent study of Voluntary Counseling and Testing (VCT) clients showed less than 20% were married and among those indicating marriage as reason for seeking an HIV test, only one-third tested with their potential spouse [2].

Couples who are HIV discordant but unaware of their HIV-1 sero-status are the largest risk group for HIV infection in Africa, accounting for over half of new infections [5–7]. In Botswana where 20% of couples live in discordant relationships [8], less than 10% of people testing for HIV in VCT facilities do so as couples [9]. Furthermore, HIV status disclosure rates following individual VCT among pregnant women are as low as 17% [10]. Individual and interpersonal barriers to disclosure include social stigma, fear of rejection, divorce and domestic violence which hamper HIV sero-status notification and discourage partners from testing together [11], however, Couple HIV Counseling and Testing (CHCT) facilitates mutual disclosure, increases condom use and decreases heterosexual transmission of HIV in sero-discordant couples [12,13]. Despite this, few programs have developed effective counseling messages or trained counselors in CHCT provision.

This paper analyzes stakeholders' understanding and perceptions of CHCT as opposed to individual VCT and explores potential couples' preferences for CHCT promotion and service provision.

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We predominantly explored views of HIV providers/advocates, individuals and couples.

2. Methods

2.1. Study design

This was a descriptive qualitative study which used key informant interviews (KIIs) and focus group discussions (FGDs) to explore stakeholders' views on testing of couples as opposed to testing individuals. The study was conducted in areas around Gaborone, Botswana between May 24 and June 14, 2004 as formative research for a phase III trial of herpes simplex virus type-2 suppression to prevent HIV transmission among HIV discordant couples.

Ethical approval was obtained from Botswana's local Institutional Review Board (IRB) and the IRB at Harvard School of Public Health. All participants signed a consent form tailored to each method of data collection (KIIs or FGDs) prior to conducting the interviews.

2.2. Sampling

We deliberately searched for information-rich individuals for the KIIs using non-probability purposive sampling method and snowballing techniques. Key Informants were identified from the general public, health, religious, corporate, and HIV/AIDS service organizations and programs.

FGD participants were randomly selected through a two-stage process, from different workplaces, and attendees at a public health facility. First, we analyzed different areas/workplaces to identify groups of men only, women only, or mixed gender. We then randomly approached selected workplaces for individuals interested in the study. The exception was for the ''couples'' FGD, where we purposefully sampled because of the difficulty in finding a couples-only workplace.

2.3. Data collection

A total of six interviewers were trained in use of the data collection instruments, conduct of qualitative interviews including note-taking, maintaining a non-judgmental approach, listening skills, balancing discussions and picking up on emerging themes for further discussion. All interview tools and consent forms were written in English, translated into Setswana and back-translated into English using standard translation/back translation procedures.

Nine key informants interviews (two with males, seven females) were conducted using a semi-structured interview-administered guide. Interviews lasted 60–90 min and were audio-taped, with notes taken on both verbal and non-verbal communication.

Six focus groups were conducted with a total of 65 participants. Each FGD comprised of 10–12 participants (Table 1). Mixed gender groups had healthcare providers and patients to allow for broad representation. The healthcare provider FGD was critical to understanding their perceptions of CHCT and HIV discordance. To allow for free discussion, the groups were balanced out in terms of social economic status. FGD participants were assigned unique code names for reference during discussions. These codes were used in all transcripts and notes associated with the data. Interviews lasted 2–3 h, and were conducted in the preferred language of choice for the interviewees (Setswana or English) and were tape-recorded.

Table 1
Composition of focus group discussion participants.

Focus group	Type of FGD	Males	Females	Total
FGD 1	Mixed (men and women)	4	6	10
FGD 2	Mixed (men and women)	5	6	11
FGD 3	Women only	0	12	12
FGD 4	Women only	0	11	11
FGD 5	Mixed (men and women)	5	6	11
FGD 6	Couples	5	5	10
Total		19	46	65

All study notes and audio tapes were kept in a lockable cabinet. Staff fluent in both English and Setswana transcribed and translated all data into English. To ensure consistency, all translated scripts were back-translated to Setswana.

2.4. Data analysis

A systematic textual data analysis method was used because data collection tools for in-depth interviews and focus group discussions were similar. Data analysis was done manually using open coding (data reduction), axial coding (data display) and selective coding (conclusion drawing). Transcripts were read to identify associations of incidences, feelings or thoughts with particular emerging concepts, which were coded. A code book was kept and two independent coders compared their codes for agreement. Responses from individual participants were put into sub-categories and broken down into units of sentences and paragraphs that represented particular thoughts of participants. Data were categorized into broader themes to identify group themes that emerged from individual sources of data.

3. Results

We present a summary of consensus opinions and selected representative quotes on the three thematic areas explored.

3.1. Perceptions of individual VCT and CHCT

Under this theme, the key construct discussed was knowledge of CHCT, how it differed from VCT as well as the perceived advantages and disadvantages of CHCT. First perception was that CHCT was not the same as VCT. An illustrative quote was the definition of CHCT as:

> ''when people having a sexual relationship who are married, cohabiting or living apart go for HIV counseling and testing together but not one testing alone first''-Focus group discussant.

The second perception was that CHCT strengthened communication and commitment in the relationship, helped adopt risk reduction behaviors and offset the challenges of one partner having to disclose their HIV status to their spouse. A representative quote for this perception was:

> 'Partners counselled together adapt better to risk reduction measures than those counselled individually. Testing together helps a couple to deal with their emotions together and accept their HIV status together'

The third perception identified was that CHCT may have undesired consequences for the relationship leading to mistrust and loss of confidentiality. Illustrative quotes included:

> 'Couples may blame one another for the positive HIV test result which may result in misunderstanding and domestic violence'.

> ''Testing together can lead to one partner exposing her/his secrets resulting in mistrust.''