



CIVIL SOCIETY FUND
**Strengthening Civil Society for
Improved HIV/AIDS and OVC Service
Delivery in Uganda**



FINAL REPORT

**DETERMINANTS OF THE UPTAKE OF HIV COUNSELING AND TESTING SERVICES
AMONG COUPLES IN LONG-TERM RELATIONSHIPS:
A CASE OF KAMPALA AND SOROTI DISTRICTS**

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NOVEMBER 2012

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ACRONYMS AND ABBREVIATIONS

AIC	AIDS Information Center
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
CHCT	Couples' HIV Counseling and Testing
CSF	Civil Society Fund
CSO	Civil Society Organization
DHE	District Health Educator
DHO	District Health Officer
FGD	Focus Group Discussion
HC	Health Center
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IRB	Institutional Review Board
KII	Key Informant Interview
MakSPH	Makerere University School of Public Health
MEA	Monitoring and Evaluation Agent
NGO	Non-Government Organization
OPD	Out-Patient Department
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RA	Research Assistant
RCT	Routine HIV Counseling and Testing
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWSA	Social Work & Social Administration
TMA	Technical Management Agent
UNCST	Uganda National Council for Science & Technology
VCT	Voluntary HIV Counseling and Testing
VHT	Village Health Team

OPERATIONAL DEFINITIONS

Married couple: This refers to a man and woman in a heterosexual monogamous or polygamous relationship. This definition encompasses all forms of marriage (traditional, civil, religious, consensual union) including cohabiting couples.

HIV discordant couple: Couple in which one of the partners is HIV-infected & the other is not.

HIV concordant couple: Couple in which both partners have the same HIV status, i.e. both of them have HIV (HIV-positive) or do not have HIV (HIV-negative)

Couples' HIV counseling and testing (CHCT): This denotes the provision of pre-test counseling, HIV test results and post-test counseling services to members of a couple together (i.e., in the same counseling session)

Couples' HIV counseling and testing uptake: This is a measure of the proportion of couples that have actually received couples' HIV counseling and testing services.

Couples in long-term sex relationships: Individuals/persons of the opposite sex who are engaged in a sexual relationship of at least 1 year.

HIV counseling and testing (HCT): This denotes the provision of pre-test counseling, HIV test results and post-test counseling to individuals or couples.

Individual HCT: Couples in which both partners received HCT but separately will be considered to have received individual HCT. These couples may or may not have disclosed their HIV status to each other.

Demand variables: Refers to variables that indicate client needs or desire for HCT services in relation to supply levels.

Home-based HCT: Providing HCT in a client's home.

Provider initiated HCT: A type of HCT in which health workers combine routine HCT and clinical services. It can be opt in or opt out.

Supply variables: Refers to availability of essential HCT services and products in relation to demand levels.

Target population: Intended beneficiary of an HCT intervention

CSF sub-grantee: A civil society organization that is funded by CSF to implement HCT interventions

ACKNOWLEDGEMENTS

We would like to sincerely thank the management of Civil Society Fund (CSF), and particularly the Chief of Party, CSF TMA (Ms. Sheila Marunga Coutinho), the Chief of Party, CSF MEA (Ms. Julian Bagyendera), for providing technical guidance in the execution of the study on the determinants of HIV counseling and testing uptake among couples in long-term relationships that was implemented in Kampala and Soroti districts in September 2012. Special regards go to Dr. Joseph Kabanda, the HIV Care and Treatment Specialist, who continuously provided guidance and technical oversight during the execution of the study and also reviewed and provided helpful comments during the process of writing this report. We acknowledge the support from the other investigators from the CSF side, including Ms Lillian Ssekabembe, Dr. Denis Bwayo, and Mr. Tom Kityo who was the Principal Investigator for the study.

We would like to acknowledge the support received from the different sub-grantees during the implementation of the study. Special regards go the Field Coordinator, Mr. Joseph Kiwanuka, who ensured that all the planned interviews are conducted despite several challenges, and the Research Assistants who conducted the field interviews.

Last but not least, we would like to thank all those people who participated in the interviews in Kampala and Soroti districts. The information obtained from these interviews helped to enrich this report.

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EXECUTIVE SUMMARY

Introduction and Background

Studies show that HIV counseling and testing (HCT) can reduce HIV acquisition rates and sexual risk behaviors among HIV-discordant and HIV-infected couples. However, to-date the reasons that explain the low level uptake of HCT among couples, which is estimated to be below 20 percent, are not well known.. Therefore, the main objective of this study was to investigate the factors affecting HCT uptake among couples in long-term relationships in Kampala and Soroti districts with a view to identifying the priorities and opportunities for scaling up HCT in the target population.

Methods

This was a cross-sectional comparative study that was conducted using a combination of quantitative and qualitative research methods. The study enrolled individuals in long-term sexual relationships aged 18-54 years in the two study districts. A total of 787 individuals were enrolled for the quantitative survey while 12 Focus Group Discussions (FGDs) and 11 key informant interviews were conducted in the qualitative component. Completed questionnaires were entered into the computer using the Ms FoxPro software and analyzed using STATA 12. Descriptive and bivariate statistics were produced using STATA Corp LP. For the adjusted analyses, multivariable logistic regression was performed to estimate the odds ratios (OR) and 95% CI associated with HCT uptake, controlling for suspected confounders and checking for interactions. For the qualitative study, data were analyzed using thematic and content approaches.

Results

A nearly homogeneous sample was drawn for this study; variations in demographic characteristics were only observed in the highest level of education attained among respondents in the two study districts. Results show that whereas the bigger proportion in Soroti had attained primary education (63.8%), in Kampala, more people (42.5%) reported secondary as the highest education level attained. Negligible differences were observed with other demographics such as sex, age, and marital status. In terms of gender, there were slightly more females (54.4%) in the sample than males (45.5%). Variations in main economic activity and socio-economic status were observed between participants in the two districts. The bigger proportion in Kampala was engaged in informal employment (61%) while in Soroti it was farming (67.4%). Majority of respondents in Kampala belonged to the highest wealth quartile (37%), with only 17 percent in the lowest wealth quartile. For Soroti, only 12.4 percent belonged to the highest wealth quartile, majority (35.1%) were in the lowest wealth quartile.

Awareness about HIV/AIDS related services and in particular HCT was nearly universal; 97.4 percent in Soroti and 94.3 percent in Kampala had ever received information about HCT. Health workers were ranked highest among sources of information on HCT; 66 percent of respondents cited health workers followed by radio (45%). The high awareness levels about HCT and CHCT services were also attributed to the “Go Together Know Together” (GTKT) campaign; 83.1 percent of the sample had heard about the messages promoting couple testing. Exposure to GTKT messages in this campaign was significantly higher among respondents from Soroti than Kampala. Results show that 91 percent of respondents in Soroti had heard about the GTKT messages in the last 12 months preceding the study compared to 75.5 percent in Kampala (P-value<0.000).

However, despite the near universal awareness levels about HCT services and exposure to campaign messages promoting uptake of couple HCT, uptake is not commensurate with the awareness levels. Deliberate efforts to obtain about 66 percent of persons in long-term sexual relationships in the sample who had received HCT were realized. However, only about half (51.5%) of those who tested had actually received the HCT with their spouse/partner. CHCT uptake was higher in Soroti (73.3%) compared to Kampala (29.3%). In terms of marital status, results show that it is mostly respondents in monogamous marriages (62%) who went with their spouse/partner for HCT compared to those in polygamous and cohabiting relationships. By gender, slightly more males received CHCT (54.1%) than females (50.1%).

Notable proportions were observed among persons who received HCT individually but disclosed HIV test results to their partners/spouses. Results show that 36 percent of persons, who received HCT individually, disclosed their results to their partners/spouse. The reported low levels of disclosure of HIV status to partner /spouse were partly attributed to inherent fears and difficulties of discussing matters of HIV testing among couples. In both Kampala and Soroti, HIV status disclosure was found to be particularly difficult for those who find themselves HIV positive. Difficulties to disclose positive HIV status among persons who sought HCT services individually were more commonly reported among females. Situations of discordant couples are reported to be more challenging and chances of family break-up are always imminent. Despite the fears, nearly all participants including people who never received HCT services were in support of disclosure of HIV status among couples.

Study findings show that female gender, marital status, residence in rural area, socio-economic status, number of sexual partners and community perceptions on availability of HCT were strongly associated with HCT uptake among persons in long-term sexual relationships. Female respondents in both Soroti and Kampala districts were about 4 times significantly more likely to have received HCT compared to their male counterparts [Kampala, Adjusted OR: 3.57 (2.30, 5.52); Soroti, Adjusted OR: 4.26 (2.89, 6.27)]. By taking 18-24 age-group as the reference group, individuals aged 25 years and above were more likely to have received HCT, although this was only statistically significant in the 25 – 29 years age-group in Soroti district. No significant difference was observed in ever receipt of HCT between respondents in monogamous and polygamous sexual relationships. However, cohabiting respondents in Soroti district were 67 percent less likely to have received HCT compared to those in monogamous relationships [Adjusted OR: 0.33 (0.17, 0.63)]. Respondents reporting 2 or more sexual partners in Soroti were 57 percent less likely to have received HCT [Adjusted OR: 0.43 (0.20, 0.93)] compared their counterparts who had 1 partner. With regard to availability of HCT services, results show that in Soroti, respondents who were not aware of the availability of HCT services in their communities were 67 percent [0.33 (0.11, 0.99)] less likely to have received HCT compared to those who thought HCT services were available in their communities. With regard to Kampala, results show that those who were not aware of the availability of HCT in their communities were 69 percent [0.31 (0.13, 0.76)] less likely to have received HCT compared to those who thought HCT services were available in their communities. With regard to CHCT uptake, persons in the highest wealth quartile in Kampala and cohabiting residents in Soroti were more likely to report having received CHCT than their counterparts. Also, Soroti residents who reported the availability of CHCT information nearby were 2.5 times more likely to report having received CHCT

than their counterparts. Other factors reported to be motivating persons in long-term sexual relationships to seek HCT with their partners/spouse include the expression of love; premised on the belief that testing together with a partner/spouse is a sign of love. However, others argued that the biggest motivators for seeking CHCT were uncertainty about one's health, and persistent illness of family members, especially the husband or the wife or both.

Explanations about the low uptake of CHCT were both personal and facility-based. Individual-level barriers to CHCT uptake included men's fear of marital dissolution in the event that one turns out to be HIV-positive, being misunderstood and arousing feelings of mistrust, high levels of stigma and ridicule, cost of transport to the testing site, and belief in what is known as 'HIV testing by proxy'. Facility-level barriers included understaffing at health facilities, inadequacy of HIV test kits, distance to the health facilities (especially in rural areas) and lack of privacy at health facilities.

Conclusion

While CHCT is feasible, its uptake is still generally low. Personal and facility-based factors constitute barriers to men and women in long-term sexual relationships from seeking CHCT. Inherent individual fear, stigma, lack of or little awareness about the benefits of CHCT affect demand for CHCT. This study demonstrates that demand factors which constrain uptake of CHCT are compounded by supply factors or facility-based—access to HCT still remains one of the main constraints to HCT uptake, understaffing of health facilities, lack of adequate privacy at the health facilities, inadequacy of HIV testing kits and lack of funds to conduct sensitization campaigns especially in rural communities. This notwithstanding, opportunities for scaling up CHCT uptake exist. Study participants demonstrated near universal knowledge of benefits of HCT in general and CHCT in particular, which can provide entry points for motivating people in long-term relationships to seek HCT together.

Recommendations

Factors that affect uptake of CHCT are both demand (individual-based) and supply (facility-based) related. These factors affect motivation or constitute barriers to uptake of CHCT, which generally affects HCT. In order to overcome these barriers, the following recommendations are made.

Demand side

- Incorporate interpersonal communication in the promotion of increased uptake of CHCT. It is proposed that family talks/home to home approach is adopted in sensitizing couples about HCT.
- Devise strategies for increasing community engagement on issues of CHCT. There is need for HCT service providers to design messages which can trigger discussion among couples about CHCT. These could be in-built in the Ministry of Health's "GTKT" campaign.
- Deliberate campaigns dedicated to increasing awareness about HIV discordance among couples need to be undertaken.
- Intensify dissemination of information on "GTKT" messages as it has demonstrated that those exposed to the information were more likely to take CHCT than those who were not exposed.

Supply side

- Deliberate and concerted efforts are needed to enhance privacy and confidentiality at health centres. It is of utmost importance to facilitate health workers to reach out to the people in their communities and mobilize them for CHCT.
- As part of efforts to make CHCT more acceptable to people, service providers should streamline and strengthen the referral system. People need to be made aware of the referral mechanisms in place as part of efforts to motivate them to seek for CHCT.
- Make CHCT as convenient and the process as transparent as possible: e.g., with rapid tests, confidentiality etc., to address the concerns that might de-motivate CHCT.
- Include messages on the advantages of couple testing during counseling sessions.
- Re-invigorate Post Test Clubs (PTCs) at health facilities and increase level of engagement of PTC members. Ensure sustained availability of HIV test kits at health facilities to serve whoever comes and whenever they come for CHCT services.
- HCT service providers need to strengthen their information collection and storage systems. Thus, people who seek CHCT services should be asked to provide as much contact information as possible to ease tracking or follow-up.

1.0 INTRODUCTION AND BACKGROUND

1.1 Introduction

In sub-Saharan Africa, a large proportion of new HIV infections occur within stable relationships (Dunkle *et al.* 2008). A Modes of Transmission (MoT) study in Uganda found that up to 43% of new infections in 2008 occurred among married people (Wabwire-Mangen *et al.* 2009). Risk factors for HIV infection among these couples included limited awareness of each other's HIV status, low HIV status disclosure rates, extra-marital relations, and low condom use within marital relationships (Wabwire-Mangen *et al.* 2009). A modeled analysis of demographic and health survey data in urban Rwanda and Zambia found that between 55-93% of newly acquired HIV infections among adults occurred within discordant marital or cohabiting relationships (Dunkle *et al.* 2008). Since up to 89% of married couples are not aware of their own or their partner's HIV status (MoH and ORC Macro 2006), these findings suggest a need for interventions to increase awareness of HIV status as well as reduce HIV transmission risk within married and cohabiting couples, including promotion of couples' HIV counseling and testing (WHO 2012).

Previous HIV counseling and testing (HCT) efficacy studies suggest that counseling of couples and/or partner testing appears to be an effective strategy in altering risk behaviors, especially in HIV-discordant couples (Kamenga *et al.* 1991; Allen *et al.* 1992a; Dunkle *et al.* 2008). In support of these findings, Dunkle *et al.* (2008) have estimated that effective scale-up of programs for voluntary counseling and testing of couples in urban Zambia and Rwanda could reduce heterosexual HIV transmission by 35-80%, assuming an annual incidence of 20% among HIV-discordant couples per year in the absence of intervention. Another study among HIV-discordant couples in Kigali, Rwanda, in which both members received couples' HIV counseling and testing (CHCT), found that the proportion of discordant couples using condoms increased from 4% to 57% after one year of follow-up (Allen *et al.* 1992b). However, while these benefits are evident, uptake of CHCT remains largely low, ranging between 5-47% depending on settings studied (Farquhar *et al.* 2004; Becker *et al.* 2010; Tumwesigye *et al.* 2010). Several reasons have been cited to explain the low uptake of CHCT in populations studied. These reasons include fear of marital consequences following CHCT (Porter *et al.* 2004; Koenig *et al.* 2003), low male participation (Njau *et al.* 2011), and the general perception that monogamy is safe coupled with beliefs in HIV testing by proxy (Lingappa *et al.* 2008). However, because most of the couple-based studies have been conducted in specialized settings (e.g. antenatal clinics or prevention of mother-to-child transmission {PMTCT} sites) and specifically among HIV-discordant couples (Allen *et al.* 2003; Weinhardt *et al.* 1999), our understanding of why uptake of couples' HIV counseling remains low in the general population is still limited.

1.2 Background

Evidence from previous studies suggests that uptake of CHCT remains largely low (Malamba et al. 2005; Tumwesigye et al. 2010). For instance, of the 346,864 individuals tested by civil society organizations funded by the CSF in Uganda between April 2010 and September 2011, only 29,417 (8.5%) were tested as a couple (CSF, 2012). The proportion of couples testing for HIV ranged between 5.0% (2,075/41,566) and 11.1% (9,151/82,678). Majority of those testing for HIV tested as individuals and there were slightly more females (52.3%) than males, suggesting a need for male involvement in HCT, which can partly be achieved through increased promotion of CHCT.

The Ugandan Ministry of Health (MoH) with technical support from the Health Communication Partnership (HCP) has initiated a campaign dubbed, '*Go Together. Test Together. Know Together*'. The campaign is still being pilot-tested at eight regional branches of the AIDS Information Center (AIC). As a result of the campaign, up to 100,000 couples have been tested together since 2009. However, while this figure is impressive, little is known about the characteristics of couples that test or do not test for HIV, and the factors that motivate or deter couples from receiving CHCT are not well documented. This study was implemented to provide information on the characteristics of married individuals who test or do not test for HIV together with their partners and the factors that motivate or inhibit CHCT uptake in order to inform the continued promotion of CHCT services in Uganda. The study was funded by CSF.

1.3 Problem Statement

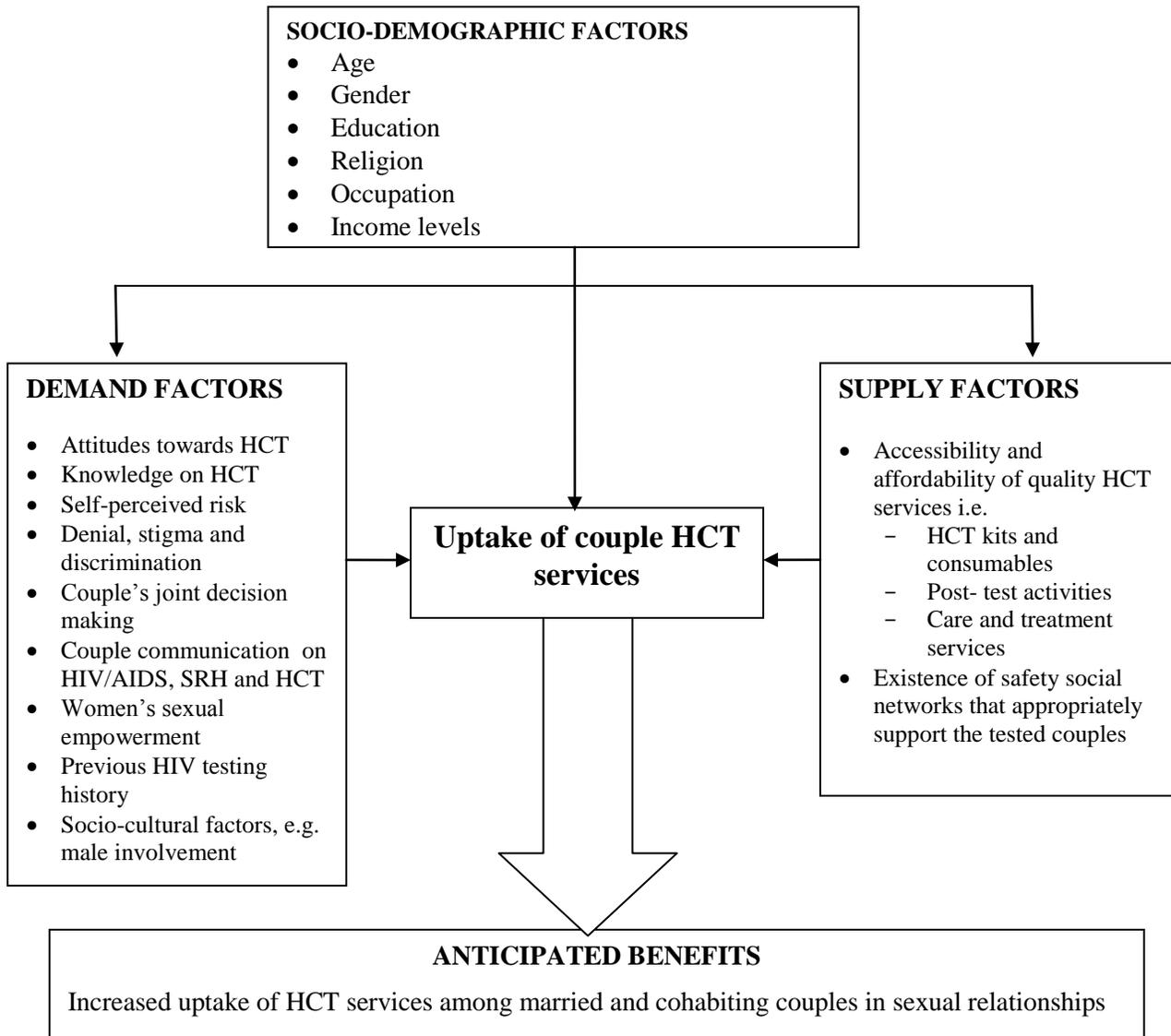
Studies suggest that CHCT uptake can significantly reduce sexual risk-taking behaviors and incidence of sexually transmitted infections (STIs), including HIV (Weinhardt et al. 1999; Allen et al. 2003). CHCT has also been associated with early identification of HIV-discordant couples (Were et al. 2006) and improved uptake of HIV prevention, care and treatment services (Becker et al. 2010; Lugada et al. 2010). Despite these benefits, CHCT uptake remains low, ranging from 5% in one Kenyan study (Farquhar et al. 2004) to 47% in a study done in Bushenyi district, Western Uganda (Tumwesigye et al. 2010). Preliminary analyses of CSF data suggest that only 8.5% of couples in Uganda have received CHCT with their partners (CSF 2012). As a result, many couples remain unaware of each other's HIV status, despite availability of free HCT services in CSF-supported districts. It is likely that couples fear receiving HIV test results together due to inherent fear of marital disruption (domestic violence, marital dissolution or abandonment) that could result from receiving CHCT. In some incidents, where a partner had previously tested individually, the other partner could believe that their HIV status is the same. This is a phenomenon known as HIV testing by proxy (Lingappa et al. 2008; Ayuo et al. 2009). This study was therefore an attempt to identify the determinants of HCT uptake among couples in long-term relationships in Kampala and Soroti districts as per the call for bids by CSF.

1.4 Rationale for the Study

Few studies, if any, have explored the reasons for the low uptake of CHCT (Mlay et al. 2008) but even then, these studies have largely been conducted at PMTCT or antenatal care sites, but not in the general population. Therefore, a study aimed at exploring the determinants of CHCT uptake in a general population context can go a long way in improving uptake of HCT services in Uganda. Also, with the increased need to promote male involvement in sexual and reproductive health services, this study can help to capture reasons that motivate couples (both men and women) to use CHCT, and hence necessary for increasing male involvement in reproductive health programs. This study comes at a time when the MoH is piloting a national CHCT campaign to improve CHCT uptake among married couples in Uganda (MoH 2009). This campaign is being piloted at 8 regional branches of AIC. It is therefore envisaged that the findings of this study will help to inform the implementation and scale-up CHCT campaign in Uganda.

Scaling up HCT is vital for public health concerns such as increasing the anonymous population that can access prevention, care and treatment services. HCT provides a basis for the individual to block HIV transmission or getting infected with HIV; it provides an opportunity for protecting the unborn baby and, if undertaken on a broad community basis, it provides an opportunity to fight stigma and discrimination. Among couples, HCT provides an opportunity for communication and HIV status disclosure and is a viable coping mechanism should the couple turn out to be discordant or concordant. In keeping with the National HIV Prevention Strategy goal, CSF is interested in contributing to the reduction of new infections in the country. It is imperative to understand the underlying factors affecting the uptake of HCT, in order to identify opportunities to scale-up this service among couples in long-term sexual relationship. It was against this background that the Department of Social Work and Social Administration (SWSA) together with CSF implemented a study to investigate the determinants of HCT uptake among couples in long-term sexual relationship and to provide recommendations to effectively scale up HCT in couples targeted by CSF sub grantees.

1.5 Conceptual framework



This study was based on the premise that socio-demographic factors such as age, education, etc. can influence the uptake of HCT services among couples in long-term sexual relationships both at the distal and proximal levels. At the distal level, these factors can influence demand and supply factors which in turn operate in some form of equilibrium to influence uptake of HCT services among couples. On the other hand, socio-demographic factors can operate directly (at the proximal level) to influence uptake of HCT services among couples without necessarily influencing demand and supply factors first. The demand factors among the couples include attitudes towards HCT, denial stigma and discrimination, communication among couples on SRH and HCT and levels of knowledge among couples as well as gender relations. The supply side includes availability of skilled personnel to undertake HCT, distribution of HCT kits, post-test activities including care, treatment and safety social networks that support positive

couples. A shortfall in either the demand or supply side or at both levels can negatively affect the uptake of HCT services and the converse is true.

1.6 Research Questions

This study was guided by the following research questions:

1. What are the socio-demographic characteristics of couples in long-term relationships that have ever received HCT?
2. What are the motivations for and barriers to CHCT uptake among couples in long-term relationships resident in Kampala and Soroti districts?
3. What are the community perceptions of the role of CHCT in HIV prevention?

1.7 Study Objectives

1.7.1 General objective

The general objective of this study was to investigate the determinants of HCT uptake among couples in long-term relationships with a view to identifying the priorities and opportunities for scaling up HCT in the target population.

1.7.2 Specific objectives

1. To determine socio-demographic characteristics of couples in long-term relationships that have ever received HCT services (individually or together with their partners) in Kampala and Soroti districts
2. To determine the demand and supply factors affecting HCT uptake among couples in long-term relationships
3. To explore community perceptions about the role of CHCT in HIV prevention

2.0 LITERATURE REVIEW

2.1 CHCT Delivery Approaches

Available evidence suggests that several approaches have been used in promoting couples' CHCT services uptake, including provider-initiated HIV testing and counseling at antenatal care and PMTCT clinics (Farquhar et al. 2004; Becker et al. 2010), mobile HCT services (Grabbe et al. 2010) and home-based HCT services (Matovu et al. 2002; Were et al. 2006; Tumwesigye et al. 2010). Studies suggest that uptake of CHCT varies according to the approach used. In antenatal care and PMTCT settings, uptake of CHCT remains below 20% (Farquhar et al. 2004; Becker et al. 2010). Grabbe et al. (2010) found higher uptake of CHCT at facility-based settings (18%) but lower through mobile HCT services (2%). Menzies et al. (2010) found that 22% of all clients tested during door-to-door HCT promotion were couples as opposed to 12.4% of clients tested at stand-alone HCT sites, 7.5% of clients tested during household-member HCT promotion and 3.2% of clients tested at hospital-based HCT sites. Recent studies suggest that provision of CHCT through home-based HCT (Tumwesigye et al. 2010; Menzies et al. 2010) and use of influential network agents to promote CHCT uptake in the community (Allen et al. 2007; Wall et al. 2011) can improve uptake of HCT among couples. In the influential network model utilized by Allen et al. 2007 and Wall et al. 2011, CHCT was enhanced through formal couple invitations where they were invited to attend CHCT at existing HCT facilities. At the moment, no study has explored couples' preferences for CHCT delivery approaches. This study sought to explore this aspect among couples in Kampala and Soroti districts.

2.2 Focus of Prior CHCT Studies

Prior studies of couples' HCT in sub-Saharan Africa have largely been conducted in antenatal care settings and among pregnant women accessing services at antenatal clinics or prevention of mother-to-child transmission (PMTCT) sites (Farquhar et al. 2004; Becker et al. 2010), with limited documentation of couples' HCT in the general population. Even then, couples' HCT uptake at antenatal care clinics and PMTCT sites has remained low, ranging between 5-47%, depending on settings studied. Findings from a study comparing couples' and individual voluntary counseling and testing at antenatal clinics in Tanzania show that only 16% of couples received CHCT (Becker et al. 2010). In an earlier study of couples' HCT at antenatal clinics in Kenya, Farquhar et al (2004) found couples' uptake of HCT to be as low as 5%. The current study presented a shift from earlier studies in that it attempted to explore the factors that affect CHCT uptake in a general population context.

2.3 Factors Affecting CHCT Uptake

Uptake of HIV counseling and testing services among couples can be influenced by both demand and supply factors. Demand factors include reluctance and fear of people being tested for HIV as a couple (Ayuo et al. 2009); beliefs among couples that monogamy is safe coupled with assumptions that their

partner's HIV status is the same as theirs (Lingappa et al. 2008); fear of receiving HIV-positive results, lack of time and money for transport to the testing center for both partners (MoH 2009), low levels of male involvement coupled with high levels of mistrust between partners (Larsson et al. 2010), and fears among couples that CHCT could result in marital conflicts (Koenig et al. 2003) and marital dissolution (Larsson et al. 2010; Porter et al. 2004). On the other hand, supply factors include availability of HIV test kits and other consumables, health workers' attitudes, availability of skilled personnel to offer HCT services, the cost of HCT services, immediate linkage to HIV prevention, care and treatment services, place of HCT delivery and delivery approach used. This study was implemented to document the factors that affect CHCT uptake in order to inform the design of appropriate interventions aimed at increasing CHCT uptake in this cohort is systematically made.

3.0 STUDY METHODOLOGY

3.1 Study Area

This study was conducted in two districts of Kampala and Soroti to provide a rich contrast with regard to the determinants of CHCT uptake in urban and rural areas. See Table 1 for study areas and covered health facilities.

Table 1: Study areas and health facilities

District	Urban (Division)	Rural (Sub-county)	Health facility
Kampala	Central		AIC
	Kawempe		Kawempe HC IV
	Makindye		Kiruddu HC III Touch Project, Namuwongo
	Nakawa		Naguru Teenage Centre
Soroti	Northern		AIC
	Western		AIC
		Gweri	Gweri HC III
		Tubur	Tubur HC III

3.2 Study Design

This was a cross-sectional study that used both quantitative and qualitative research methods, based on a Priority-Sequence model suggested by Morgan (1998). Quantitative methods involved use of interviewer-administered structured questionnaires assessing the demand and supply-related factors that affect CHCT uptake while the qualitative methods involved use of focus group discussions (FGDs) and key informant interviews (KIIs) with selected ‘gate keepers’ to document motivations for and barriers to CHCT uptake at community level.

3.3 Study Population

The study population comprised both men and women i.e. females aged 18-49 and males aged 18-54 years who were in long-term sexual relationships, resident in selected communities in the two study districts. The study enrolled couples who had been in a sexual relationship for at least one year.

3.4 Sample Size Determination

The sample size was determined using the formula used in estimating the sample size for comparative studies with equal samples shown below:

$$n_1 = n_2 = \frac{\left(Z_{\alpha/2} \sqrt{2 \bar{p}\bar{q}} + Z_{\beta} \sqrt{p_1 q_1 + p_2 q_2} \right)^2}{\Delta^2} (1 + (m - 1)p)$$

P_1 - is the proportion of couples that have ever received HCT in Kampala

P_2 - is the proportion of couples that have ever received HCT in Soroti

There is limited documentation on couples' HIV testing in the two districts. However, studies have shown that couples' testing uptake ranges from 5-47%, depending on settings and populations studied (Farquhar et al. 2004, Tumwesigye et al. 2010). Since no current couples' testing uptake rates are available for the study districts, we conservatively assumed an uptake rate of 20% (p_1) for Kampala and 10% (p_2) for Soroti. Therefore, the selected sample size assumed a 10% difference (Δ) in current couples' testing uptake rates between the two districts with a power ($1 - \beta$) of 0.8 and an alpha (α) of 0.05. The part labeled $(1 + (m - 1)p)$ is the design effect due to dispersion in the different groups where randomization was conducted and m refers to the number of CSOs per cluster while p is the spread. Since m is on average 2 and p is maximized at 0.5, we used a design effect of 1.5.

Substituting the formula above, $\bar{p} = \frac{p_1 + p_2}{2}$, $\bar{p} = \frac{0.20 + 0.10}{2} = 0.15$, $\bar{q} = 1 - \bar{p} = 0.85$.

$p_1 = 0.20$, $q_1 = 1 - p_1 = 0.80$, $p_2 = 0.10$, $q_2 = 1 - p_2 = 0.90$, $\Delta = 0.1$, $Z_{\alpha/2} = 1.96$ and $Z_{\beta} = 0.84$

$$n_1 = n_2 = \frac{(1.96 * \sqrt{2 * 0.15 * 0.85} + 0.84 * \sqrt{0.20 * 0.80 + 0.10 * 0.90})^2}{0.1^2} * 1.5 \approx 352$$

The resulting sample sizes for each district (n_1, n_2) obtained from the formula above (i.e. 352), was adjusted to include an anticipated 10% non-response as shown in the formula below.

$$n'_1 = n'_2 = n * \frac{100\%}{100\% - \text{Non Response Rate}} = 352 * \frac{100\%}{90\%} \approx 392$$

This resulted into an estimated sample size of 392 respondents per district.

3.5 Sampling Procedures

The design of this study necessitated stratifying the sample in each district along two major variables, i.e., ever received HCT and never received HCT. A recruitment ratio of 2:1 was used to draw a sample of 522 who had ever received HCT and 265 who had never received HCT, respectively. Separate approaches were used to construct sampling frames for people who had ever received and those that had never received HCT services.

3.5.1 Selection of people who had ever received HCT

A two-stage sampling approach was used to select participants who had ever received HCT. The first stage involved obtaining a list of all HCT service providers supported by each CSF sub-grantee. One to

two (1-2) facilities per sub-grantee providing service to men and women in long-term sexual relationships were selected for participation in the study.

At each selected health facility, a list of all parishes/wards from where the health facility gets its clientele was obtained from which one parish was randomly selected using the lottery method. In this study, the parish was considered as the enumeration area for constructing the final sampling frames. A list of all people (i.e., those in the selected parish who received HCT services in the last one year preceding the study) was extracted from the general health facility list. Only persons who met the inclusion criteria and had indicated on the record forms that they would be willing to be visited in their homes for research purposes or follow-up were included on the list. This constituted the second stage of sampling.

The sample in each district was equally distributed amongst the health facilities selected for visiting. In Kampala, a total of 53 persons were allocated to each health facility while in Soroti, each health facility was allocated 87 persons who met the inclusion criteria. Selection of respondents from the sampling frame for each parish was done using systematic random sampling. For each health facility, a sampling interval was determined based on the number of eligible persons on the sampling frame and the required sample from the parish (i.e. 53 for Kampala and 87 for Soroti). A random start point was determined by picking any number between one and the sampling interval. The remaining number of persons was selected following the skip interval.

All names of persons marked on the final sampling frame as selected were extracted, with sufficient identifier information such as village of residence, age, marital status and next of kin. The list was shared with the health facility's community resource person who in most cases doubled as a member of the Village Health Team (VHT) to help the team in tracing selected individuals within their villages. At the household level, the interview was administered to only the person marked on the final sampling frame as the respondent.

In situations where the team was unable to trace some respondents either due to lack of adequate information, death (*if the sampled person had died*) or the sampled person shifted residence to another district, the research team used the Post Test Clubs (PTCs) to select additional persons to replace the ones removed from the list. Care was taken to include only persons who had received HCT services within the last 1 year, preceding the study. There were also a few instances where the research team could not obtain the required number of persons for a given parish by using both the generated list and the PTC option. In such instances, over-sampling was done in the subsequent health facilities to cover the balances.

3.5.2 Selection of people who had never received HCT

Selection of persons in long-term sexual relationships who had never received HCT was done in the same wards/parishes where those who had received HCT were obtained. The primary sampling unit for this category of participants was the village/local council one (LC1). In each selected parish, various villages

were visited to identify people who had never tested for HIV. A total sample of 261 distributed equally between Kampala and Soroti i.e., 131 persons per district was covered.

Attempts were made to distribute the sample of people who have never received HCT equally amongst the selected parishes with each parish contributing 27 persons (in Kampala) and 44 persons (in Soroti), although this posed initial difficulties. Inability to obtain the designated numbers from each parish was attributed to social desirability; many people did not want to be associated with/ known to belong to the category which had never received HCT services. In communities where the target of 27 (i.e., Kampala) and 44 (i.e., Soroti) could not be attained, the balance would be passed to the next study site/community. In each village, a list of all households with people in a long-term sexual relationship (married or consensual relationships) was generated with guidance of VHTs and area local leaders. Using systematic random sampling approaches, the required number of households was selected.

At the household level, screening questions were asked to the head of the household or his/her designate to determine whether there was anybody in the household who met the inclusion criteria. Where more than one eligible person was found in a household, the research team used the Kish Grid tool to determine which member of the household was to be interviewed. Where no household member met the inclusion criteria, another household on the list was selected. In household where the selected person declined to be interviewed, the immediate household on the list was picked for replacement. One person was interviewed per household.

3.6 Study Variables

3.6.1 Dependent variables

The dependent variable in this study was the uptake of HCT among couples in long-term sexual relationships. CHCT uptake was defined as the proportion of couples (out of the total couple population resident in an area served by a CSF sub-grantee) that have received HCT together in the same sitting.

3.6.2 Independent variables

Independent variables that were explored included: socio-demographic characteristics (age, sex, education, religious affiliation, occupation, and monthly income); behavioral characteristics (number and type of sexual partners, history and current use of condoms (both within and outside current sexual relationship), extra-marital relations, history of HIV counseling and testing (as individuals or together as a couple); history of HIV status disclosure (including any positive and negative consequences associated with such disclosure); HIV risk perception; couple communication on HIV/AIDS/STDs and sexual and reproductive health matters; perceptions of the role of couples' HIV counseling and testing in HIV prevention; knowledge of HIV sero-discordance among couples; knowledge of participants' own HIV status; and denial, stigma and discrimination associated with HCT uptake at community level. These

variables have been found to affect uptake of HIV counseling and testing services at individual level and thus constituted the demand-related factors that we explored as part of the planned study.

The study team collected data on supply-related factors including availability and accessibility of HIV counseling and testing centers within the study communities or in the neighboring communities; health workers' attitudes towards provision of HCT; distance to the nearest health/HIV testing facility; and cost of HCT services (both presumed and real costs). The study team also explored general issues surrounding HCT uptake including awareness of CHCT delivery approaches (home-based HCT, facility-based HCT, provider-initiated HIV testing and counseling, etc.) and community perceptions about CHCT.

3.7 Data Collection Procedures

3.7.1 Quantitative data collection

Interviewer-administered, structured questionnaires were used for data collection. Interviews were conducted in English or the local language (as preferred by the participants). Written informed consent was sought from each participant prior to data collection, and interviews were conducted separately for men and women.

Interviews were conducted by trained research assistants with experience in questionnaire administration. Research assistants were trained in research methods, ethics of conducting research, and interview techniques. To ensure that the research assistants grasped the key aspects of the study and interview techniques, the study team administered pre- and post-test assessments and picked on only those research assistants who scored above 50% in the post-test assessment. Data collection in the field was supervised by a designated field supervisor to ensure that all study protocols were observed. Interviews, which lasted 30-45 minutes were conducted in venues that provided adequate safety and privacy.

3.7.2 Qualitative data collection

Qualitative data was collected through FGDs, KIIs and an extensive desk review. See Table 2 for distribution of FGDs and KIIs.

Table 2: Distribution of FGDs and KIIs by district

District	FGDs		KIIs
	Participants	Locality	
Kampala	Married women tested as couples	Kawempe Division	In-charge, Namuwongo Touch Project
	Married women tested as couples	Central Division	
	Women tested individually	Makindye Division	In-charge, Kawempe HC IV
	Men tested individually	Makindye Division	In-charge, Naguru Teenage Centre
	Men never tested	Makindye Division	
	Women never tested	Kawempe Division	HE, KCCA Focal Person, KCCA

			In-charge, Kiruddu HC III VHT—AIC VHT—Kawempe VHT—Kiruddu
Soroti	Married women tested as couples Married women tested as couples Women tested individually Men tested individually Men never tested Women never tested	Tubur Sub-county Tubur Sub-county Western Division Western Division Gweri Sub-county Gweri Sub-county	AIC Staff In-charge, Gweri HC III In-charge, Tubur HC III DHO DHE VHT—Tubur VHT—Western Division VHT—Gweri

3.8 Data Management and Quality Control

3.8.1 Quantitative data management

Completed and edited structured questionnaires were entered into the computer using the Ms FoxPro software. Prior to data entry, logical checks were made on the questionnaires; 5% of the questionnaires subjected to re-editing to ensure that they were error-free and fully completed. Data entry screens were designed taking into consideration all the study variables. The Biostatistician used questionnaires from the pre-test to design the entry screens. The entry screen was subjected to a range of checks; skip and consistency checks prior to main data entry. Range checks were intended to ensure that every variable in the questionnaire generated data within a limited domain of valid values while consistency checks were used to verify that the right modules of the questionnaire were filled in for each respondent. Skip and consistency checks ensured that an error flag (flashing field on the screen) set off when an out-of-range value was entered.

Data entry was undertaken by a trained team of data entry clerks under the supervision of the Biostatistician. Quality ‘spot checks’ were conducted to quickly assess the entered data for any inconsistencies and provide feedback for continuous improvement of data entry clerk performance.

After the initial phase of data entry, the study team subjected 5% of the questionnaires entered to double-data entry to check for accuracy of entries made and to ensure completeness of the data entry process. All entered data was backed up on flash drives between breaks and the end of the data entry process, and archived daily on a secure server. All hard-copy forms were stored in secure, locked files that were only accessible to senior investigators.

3.8.2 *Qualitative data management*

All qualitative data was entered into a Word processing document and saved in password-protected files. The files were saved with names showing the type of data collection method used (FGD or KII), name of parish (and village) where data collection took place, date of data collection, and data collector numbers. Files were grouped by parish and village of data collection to improve retrieval. The lead consultant cross-checked all entries made against available transcripts from field interviews to ensure completeness of data entry. Inconsistencies in data entry were corrected by the data collector who made the original entries. Where incomplete entries of transcripts were detected, this was solved by insuring that all transcripts were entered into the computer program.

3.8.3 *Quality Control*

The data collection tools were pre-tested by each interviewer – with at least two interviews conducted by each of them. The pre-test was done in English and Luganda from selected villages in Kampala outside the study area. As part of the pre-test exercise, interviewers, supervisors and lead consultants checked and edited the completed questionnaires. Questionnaire pre-test results were then entered into the database designed using Ms FoxPro software. The data was later analyzed to test for utility, ambiguity and congruence of themes and items. Results of the pre-test were used to inform decisions as to which items to remove, add, improve or re-construct in the questionnaire.

Quality control during fieldwork was implemented at two levels. Level 1 was accomplished by the field supervisor. Each supervisor was responsible for a team of four interviewers. On daily basis, the field supervisor received and edited questionnaires from the interviewers, checking for completeness, consistency and logical flow. The second level of field supervision was accomplished by the senior researchers on the team i.e., team leader and the study co-ordinator. Their role was to provide overall leadership to the field supervisors. The senior researchers conducted team audits throughout the study, communicated any problems to the entire team in the field that arose, regularly checked completed questionnaires from the study supervisors for errors, assessed compliance to regulations and procedures that the teams were given, and ensured that the problems reported by field supervisors were resolved. Lastly, the team leader and study coordinator conducted on-spot checks to ensure that the teams were in their assigned areas and that the sampled respondents were the respondents were being interviewed.

3.9 *Data Analysis*

3.9.1 *Quantitative data analysis*

The data was analyzed using STATA 12 (STATACorp LP) and for better presentation, graphics were done in MS Excel 2007. The Stat Transfer software was used to transfer data from Ms FoxPro software to STATA. STATA's statistical methods for analyzing complex surveys were utilized to take care of the following study design characteristics:

- **Sampling weights:** Although all observations were selected through a random process, different observations had different probabilities of selection. Weights proportional to the probability of an individual being sampled were taken into consideration.
- **Clustering:** Individuals included in the survey were sampled independently from the districts of Kampala and Soroti. The districts will therefore be defined as the primary sampling units (PSUs) in the analysis.
- **Stratification:** The urban-rural grouping of respondents was also taken into consideration while defining the survey design characteristics. It was anticipated that the determinants of uptake of CHCT were more homogeneous within individual strata than the population as a whole and this homogeneity was exploited to produce more precise estimates with smaller standard errors.

Initially, descriptive analysis of the dataset were performed to provide an insight on the counts, means, variances, frequencies and percent distributions of participant characteristics. Later, inferential analyses of data collected were performed to measure association and determinants between respondent's characteristics and CHCT uptake. In this survey, the probability of committing a type-I error will be fixed at 5%. Consequently, only differences with p values of 0.05 or less were considered as statistically significant. The logistic multivariable regression model was used to estimate the odds ratios (OR) and 95% confidence intervals (95% CI) of HCT uptake. The adjusted logistic regression models were stratified by district of residence of the respondents based on the premise that HCT uptake was different between Kampala and Soroti districts. Since HCT uptake is likely to be influenced by age, gender, education level, residence, marital status, exposure to the HCT campaigns messages, these covariates were assessed. Analyses were conducted in STATA, version 12.

Given the comparative nature of the study, analyses were stratified by rural (Soroti) and urban (Kampala), and the study population into those who have ever received HCT (individually or together with their partners) and those who have never received HCT. The stratification helped us to document factors that affect HCT uptake (among those who have ever received HCT) and those that inhibit HCT uptake (among those that have never received HCT) among couples in long-term heterosexual relationships.

3.9.2 Qualitative data analysis

Thematic and content approaches were used to analyze qualitative data. An analysis grid with themes structured along the study objectives was designed and used to extract salient comments and observations from the transcripts. Content from the transcripts were then fitted into the grid, which made it possible to formalize them into categories or codes. Each time the study participants in different study sites made similar or different responses they were given similar or different codes, accordingly. Fitting all responses into the grid form helped in sifting and sorting of salient quotations.

3.10 Study Implementation Challenges

A few challenges were encountered during the execution of this study, but which nevertheless did not compromise the quality of the data. These included the following:

- Tracing persons who had ever received HCT services from health facilities supported (*financially*) by CSF sub-grantees was undertaken with difficulty. The lists which had been proposed did not contain sufficient identifier information which could be used to effectively trace people. Such identifiers as village of residence, telephone contact or name of next of kin were not universally collected by HCT providers. This challenge was faced both in Kampala and Soroti. In Soroti, *cases* of using fictitious and pseudo names posed daunting challenges. To overcome this problem, some adjustments to the sampling procedure were made. In instances where the research team failed to use the list generated at the health facility, a supplementary list was developed from a post-test club but including only persons meeting the inclusion criteria.
- Limited privacy; many people in urban areas live in rented small units/ houses with little or no adequate space to ensure maximum privacy especially when other household members were present. Low voice tones were used to ensure privacy.
- Absence of people in morning hours; majority of the people in urban communities are engaged in various forms of activities that keep them away from their homes for long hours during the day. As a result, some interviews had to be conducted either late in the evening or scheduled for weekends when some of the selected respondents were not at their places of work.
- Negative undertones associated with people who had never received HCT services. The proposed procedure was to ask screening questions before commencing with the interview to determine the eligibility to participate in the study, but many people especially in Soroti did not want to be identified as people who had never received HCT. It was, reported that in Soroti, it was mandatory for women seeking antenatal care services to test for HIV with their partners. Consequently, it became socially undesirable in many villages of Soroti for people to acknowledge that they had never received HCT services yet they were in a long-term sexual relationship.
- Impassable roads, particularly in Soroti. The timing of the study coincided with the rainy season in Soroti, which made some communities nearly inaccessible due to the poor state of the roads. The rains also interrupted work which affected planned time.
- Some CSF sub-grantees were involved in direct HCT service provision but they never used the structures of the health facilities they reported to be working with. Apparently, some CSF sub-grantees never supported health facilities to provide HCT but rather picked some health workers at an individual level and worked with them in outreaches to provide HCT services. In such

instances, it was not possible to obtain lists of persons who had received HCT services through the health facilities.

3.11 Ethical Considerations

To avoid the rights of study participants being violated or being placed at risk, this study took into consideration the basic ethical requirements. Some of the ethical issues that were of central concern in this research included ensuring respondents' informed consent, and respect for their privacy. As a process of enlisting participants' consent, all the study participants were informed of how they were selected especially that the selection was not based on any prior knowledge about them as individuals or members of their respective households, but rather that they had been selected by chance to provide views that would represent the rest that had not been selected. It was stated from the very beginning of the study that no incentives of whatever nature were to be exchanged for information provided. This was made clear to the respondents before the commencement of every interview or discussion. It was only in the case of FGDs that small refreshments of soft-drinks and little snacks were provided during the discussion, but not money in lieu of refreshments.

As earlier noted every research is an intrusion into peoples' privacy and a charge on the respondent's time. Study participants were told of the estimated time that the interview or discussion was expected to last so that on that basis they could choose either to participate or not. On the issue of privacy and confidentiality, steps were taken to assure respondents that their privacy and confidentiality would not be subjected to any potential risk. Stud respondents in the household survey were assured that the questionnaire would not carry their names or responses be attributed to the source, which was further reinforced by the interviewer not asking for the name of the respondent.

The study received ethical clearance from the Makerere University School of Public Health Higher Degrees Research and Ethical Committee (Protocol #194) and from the Uganda National Council for Science and Technology (Approval Notice: SS2941).

4.0 RESULTS

Results of this study are organized along the major objectives. The first part of the results section presents a description of the socio-demographic and economic characteristics of the respondents that were recruited for the quantitative component of the study. The second part of the results section presents the various sources from which persons in long-term sexual relationships obtain information about HIV/AIDS related services including HCT and CHCT services. In addition, the section presents a description of the levels of awareness about availability of HCT services within their communities and the various models used in delivery of HCT services. The third part of the results section presents a profile of persons in long-term sexual relationships who have ever received HCT services and those who have never received HCT services. Determinants of uptake of CHCT are identified. The last part of the results section presents community perceptions about the role of CHCT in HIV prevention. Study results have been stratified by study district, i.e. Kampala and Soroti.

4.1 SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF PARTICIPANTS

4.1.1 Socio-demographic characteristics in the study areas

A total of 787 persons in long-term sexual relationships drawn from Kampala and Soroti districts were interviewed for this study. In both Kampala and Soroti, majority of the respondents were aged 18-24 constituting 43.3% and 31.8% of the sample for Kampala and Soroti respectively. In terms of marital relationship, majority were in a monogamous marriage but with notable proportions in cohabiting relationships particularly in Kampala. Results show that 23.8% of the Kampala sample was in cohabiting relationships compared to 14.5% in Soroti. Variations in demographic characteristics were only observed with highest level of education attained among respondents from the two districts. For instance, whereas the bigger proportion in Soroti had attained primary education (63.8%), in Kampala, more people (42.5%) reported secondary as the highest education level attained. Similarly, there were slightly more people with no formal education in Soroti (8%) compared to Kampala (4.5%). See Table 3.

Table 3: Socio-demographic characteristics of respondents in Kampala and Soroti

Background Characteristics	Kampala, (%) N=400	Soroti, (%) N=387	Total, (%) N=787
Gender			
Male	49.8	41.3	50.8
Female	50.2	58.7	49.2
Age (Years)			
18-24	43.3	31.8	37.6
25-29	21.0	20.4	20.7
30-34	15.3	16.3	15.8
35-39	9.8	14.5	12.1
40-44	6.3	8.5	7.4
45+	4.3	8.5	6.4
Marital Status			
Married Monogamous	42.7	68.7	55.5
Married Polygamous	12.3	16.0	14.1
Cohabiting	23.8	14.5	19.2
Others	21.2	0.8	11.2
Education			
None	4.5	8.0	6.2
Primary	39.0	63.8	51.2
Secondary	42.5	21.4	32.1
Post Secondary ¹	9.5	3.6	6.6
Vocational ²	4.5	3.1	3.8
Religion			

¹ Post secondary comprised of all respondents who had attained qualifications beyond senior 6 like NTC, University

² Vocational comprised of all respondents who did not complete secondary but received apprenticeship training

Background Characteristics	Kampala, (%) N=400	Soroti, (%) N=387	Total, (%) N=787
None	1.5	1.6	1.5
Muslim	22.8	3.6	13.3
Roman Catholic	33.8	44.7	39.1
Protestant / Anglican	28.5	36.4	32.4
Other – Christian	13.5	13.7	13.6

4.1.2 Socio-economic characteristics of respondents in Kampala and Soroti

Results on socio-economic status (SES)³ and main occupation show variations among respondents from Kampala and Soroti. For instance, whereas in Soroti the bigger proportion of respondents belonged to the lowest (35.1%) and second (28.7%) wealth quartile, in Kampala, majority belonged to the highest (37%) and third (25.5%) wealth quartile (see Table 4).

Table 4: Socio-economic characteristics of respondents in Kampala and Soroti

Background Characteristics	Kampala, (%) N=400	Soroti, (%) N=387	Total, (%) N=787
Wealth Quartile			
Lowest	17.0	35.1	25.9
Second	20.5	28.7	24.5
Third	25.5	23.8	24.7
Highest	37.0	12.4	24.9
Main Occupation			
Informal Employment	61.0	19.1	40.4
Farming	1.3	67.4	33.8
Formal Employment	13.8	6.7	10.3
Housewife	14.3	5.4	9.9
Other	5.0	1.3	3.2
Nothing	4.8	0.0	2.4

Similarly, whereas majority of respondents in Soroti were farmers (67.4%), in Kampala, majority were engaged in informal employment as their main occupation (61%). Also people engaged in formal employment as mechanic, law enforcement officers, teachers were higher in the Kampala (13.8%) sample than Soroti (6.7%). Given that wealth and income strongly influence decisions to adopt positive health behaviour including HCT seeking, respondents from Kampala have better chances due to their SES to seek for HCT compared their counterparts in Soroti.

³ To construct the SES index, each household item was assigned a weight generated through principal components analysis. The scores were standardized in relation to a standard normal distribution with a mean of zero and a standard deviation of one. For each individual, the scores on household possessions were then summed up. Individuals were then ranked and sub-divided into wealth quartiles, depending on their scores, with each quartile containing 25% of the participants. Household assets used to create the wealth index include items such as radio, television, bicycle, motorcycle, family home, cell phone, landline, computer, an income generating business, an indoor bathroom, running water, electricity, car, generator and solar power.

Table 5 shows the respondents' socio-demographic characteristics stratified by study district and gender. In Kampala, the proportion of men and women in the sample was similar (49.8%, men; 50.2% women). On the other hand, there were more women (58.7%) recruited in Soroti than men (41.3%). Women in Kampala were younger (e.g. 46.8% aged 18-24) than those in Soroti, more educated (e.g. 42.3% of Kampala women had secondary education compared to 14.5% in Soroti) and belonged to the highest wealth quartile than Soroti women. However, a higher proportion of Soroti women were married monogamously (67.8% vs. 45.3%) and less educated than Kampala women. Compared to Kampala men, men in Soroti were less educated, slightly older and lived in monogamous relationships. For instance, 70% of men in Soroti were monogamously married compared to 40.2% of Kampala men.

Table 5: Socio-demographic characteristics of respondents, stratified by gender and district

Characteristics	Kampala			Soroti		
	Men n=199	Women n=201	Total N=400	Men n=160	Women n=227	Total N=387
	%	%	%	%	%	%
Overall	49.8	50.2	100.0	41.3	58.7	100.0
Age-group (Years)						
18-24	39.9	46.8	43.4	28.7	33.9	31.8
25-29	22.2	19.9	21.1	23.8	18.1	20.4
30-34	12.1	18.4	15.3	18.1	15.0	16.3
35-39	10.6	9.0	9.8	13.8	15.0	14.5
40-44	9.1	3.5	6.3	5.6	10.6	8.5
45+	6.1	2.5	4.3	10.0	7.5	8.5
Marital Status						
Married Monogamously	40.2	45.3	42.8	70.0	67.8	68.7
Married Polygamous	6.5	17.9	12.3	10.6	19.8	16.0
Cohabiting	24.1	23.4	23.8	18.8	11.5	14.5
Other	28.6	12.9	20.8	0.6	0.9	0.8
Missing	0.5	0.5	0.5	0.0	0.0	0.0
Education						
None	4.5	4.5	4.5	2.5	11.9	8.0
Primary	33.7	44.3	39.0	56.3	69.2	63.8
Secondary	42.7	42.3	42.5	31.3	14.5	21.4
Post-Secondary	12.6	6.5	9.5	5.0	2.6	3.6
Vocational	6.5	2.5	4.5	5.0	1.8	3.1
Religion						
None	2.0	1.0	1.5	1.9	1.3	1.6

Muslim	25.1	20.4	22.8	3.8	3.5	3.6
Roman Catholic	28.6	38.8	33.8	48.1	42.3	44.7
Protestant / Anglican	33.2	23.9	28.5	36.3	36.6	36.4
Other – Christian	11.1	15.9	13.5	10.0	16.3	13.7
<hr/>						
<i>Wealth Quartile</i>						
Lowest	14.1	19.9	17.0	34.4	35.7	35.1
Second	19.6	21.4	20.5	28.1	29.1	28.7
Third	26.6	24.4	25.5	24.4	23.3	23.8
Highest	39.7	34.3	37.0	13.1	11.9	12.4
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4.2 SOURCE OF INFORMATION ABOUT HIV/AIDS-RELATED SERVICES

Given that exposure to information can potentially influence demand, this study sought to establish the main sources of information on health issues including HCT in general and CHCT for persons in long-term sexual relationships. Questions to measure exposure and frequency of receiving HCT information in the last 12 months and how it consequently influences decisions to seek CHCT were designed. Figure 1 below shows the main sources of information on general health issues in both Kampala and Soroti. In Soroti, the main sources of information on general health information were health workers (58%) followed by the radio (26%). In Kampala, the main source of general health information were radio (33%), health workers (27%) and Television (20%) in that order (Figure 1).

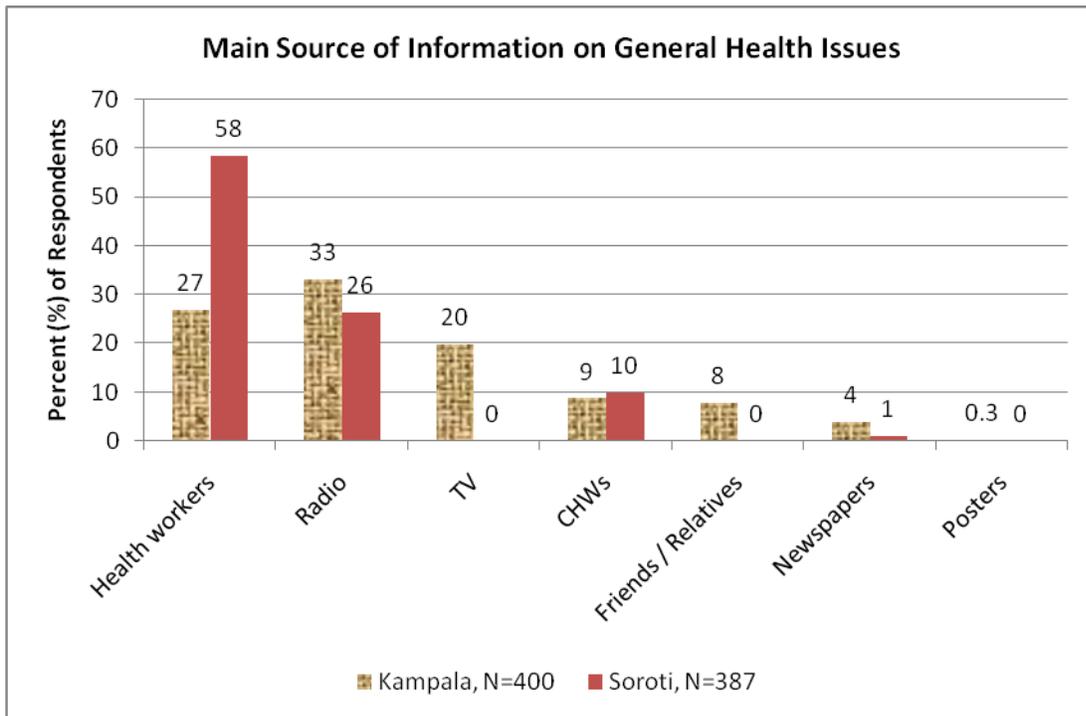


Figure 1: Main source of information on health issues

The main sources of CHCT specific information were similar in both Kampala and Soroti. In Soroti, the main sources were: health workers (76%), radio (46%), community health workers (38%) and friends/relatives (21%). In Kampala, the main sources were: health workers (57%), radio (45%), Television (32%), and community health workers (32%). Thus, other than Television as a source of information on CHCT in Kampala, the rest of the sources (i.e. health workers, radio and community health workers) were similar in both Kampala and Soroti. It should be noted that the sources were explored as independent entities, meaning that each source is expressed out of 100%.

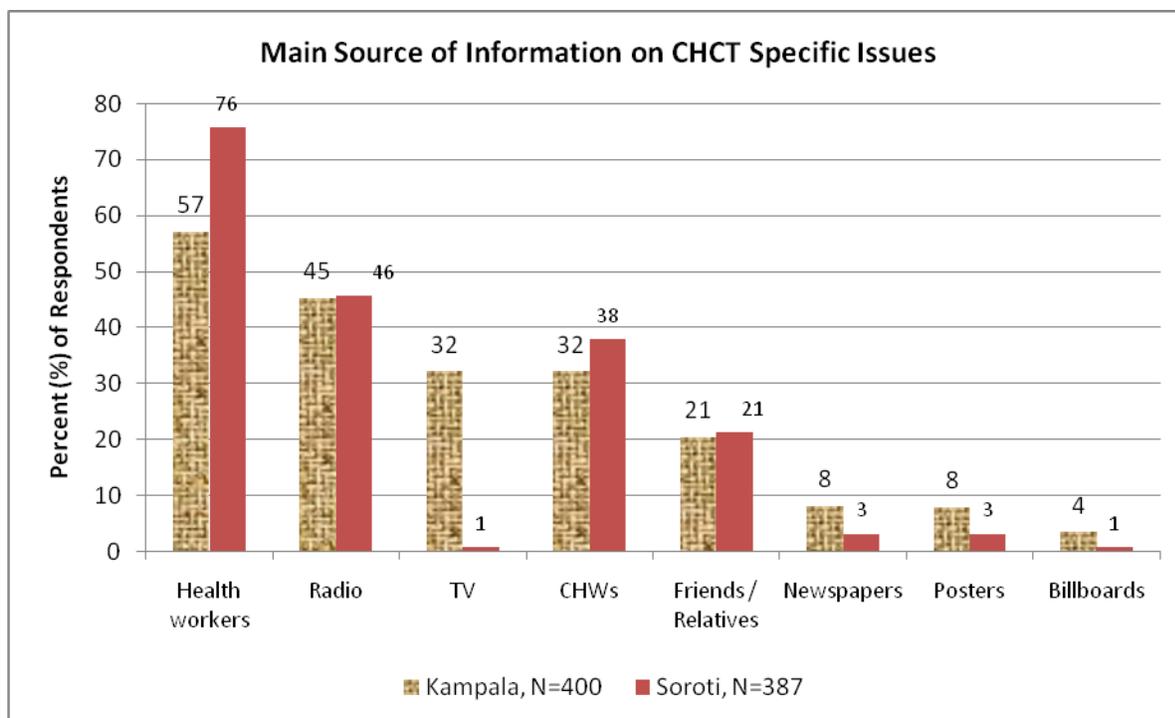


Figure 2: Main source of information on HCT services

Participants in the FGDs and KIIs concurred with their counterparts in the quantitative survey on sources of learning about HCT services. The commonly cited sources of learning about services such as HCT by FGDs participants include health workers, radio, VHTs, religious and local leaders. Through community outreaches and health education sessions at the health centers, people are sensitized about the various HIV/AIDS related services and the importance of such services like HCT including CHCT.

During outreaches, we sensitize people about counseling and testing services for HIV, we also have OPD, the health workers provide health education and counseling to people... those who are willing, we draw blood sample for the HIV test (KI, Kiruddu HC III, Kampala).

Some VHTs met in this study reported that that whenever they get opportunity, they pass communications about where HCT services can be obtained.

What I usually do on Sunday is to request the priest for some time after prayers to sensitize members of the congregation especially the youth on the benefits of testing and knowing their status (VHT, Soroti).

This information was corroborated by participants in the FGDs. For instance, in Soroti, study participants acknowledged that once in a while their local leaders move around the community sensitizing them about the importance of HIV testing.

The local council team once in a while moves around the area encouraging people to go for counseling and testing (FGD with Men who received HCT individually in Soroti).

Reports of presence of radio programs and talk shows on HCT and other HIV/AIDS related were also made by KIIs and FGD participants. In Soroti, participants reported to have heard a lot about CHCT through the AIC sponsored radio program on promoting couple HCT.

We have what we call couple week, so in the last week of every month, we have a radio program through which we provide information about the importance of testing for HIV as a couple...we even put some presents to motivate couples to turn up, we give the first couple that comes flowers and a certificate of recognition (KII, AIC Soroti).

High awareness levels about HCT and CHCT services were also attributed to the various running programmes and campaigns like the Ministry of Health’s **‘Go Together, Know Together’ (GTKT)** campaign. This campaign whose message is broadcast on radios, seeks to encourage couples to discuss HIV/AIDS issues together, go for counseling and testing, adopt and maintain positive health practices, encourage HIV status disclosure among sexual partners and link HIV positive couple members to treatment, care and support. Slightly over eighty percent (83.5%) of the sample acknowledged to have heard messages about the **GTKT** campaign in the last 12 months preceding the study.

Exposure to GTKT messages in this campaign was significantly higher among respondents from Soroti than Kampala. Results show that 91.7% of respondents in Soroti had heard about the GTKT messages in the last 12 months preceding the study compared to 75.7% in Kampala (P-value<0.001). In Kampala, exposure to GTKT messages was higher among females compared to males (80.6% vs. 70.7%), persons aged 35+ years compared to other age-categories, those with vocational education compared to those with other levels of education and persons in third wealth quartile (Table 5). In Soroti, exposure to the GTKT campaign was over 90% overall, with the exception of exposure among those aged 25-29 (87.3%), those in cohabiting relationships (87.5%) and those with no education (87.1%).

Table 5: Proportion of respondents exposed to GTKT campaign by background characteristics

	Kampala, N=400	Soroti, N=387	All, 787
Overall	75.7	91.7	83.5
Gender			
Male	70.7	93.7	81.0
Female	80.6	90.2	85.7
Age-group (Years)			
18-24	74.6	90.2	81.0
25-29	73.5	87.3	80.2
30-34	72.1	95.2	83.7
35-39	82.1	96.4	90.4
40-44	84.0	90.9	87.9
45+	82.4	93.9	90.0
Marital Status			
Married Monogamously	74.3	92.0	85.1
Married Polygamous	75.5	93.4	85.5
Cohabiting	75.5	87.5	80.0
Other	80.7	100.0	81.4
Missing	0.0		0.0
Education			

None	72.2	87.1	81.6
Primary	80.1	91.9	87.3
Secondary	71.0	91.4	77.6
Post–Secondary	76.3	92.9	80.8
Vocational	83.3	100.0	90.0
<i>Religion</i>			
None	100.0	100.0	100.0
Muslim	75.8	92.9	78.1
Roman Catholic	78.5	90.1	85.0
Protestant / Anglican	71.7	93.5	83.7
Other – Christian	74.1	90.6	82.2
<i>Wealth Quartile</i>			
Lowest	64.7	90.3	81.7
Second	72.0	91.0	82.9
Third	81.4	94.5	87.6
Highest	78.9	91.7	82.1

4.3 AVAILABILITY AND ACCESS TO HCT SERVICES IN KAMPALA AND SOROTI

4.3.1 Availability of HCT service points at parish level in Kampala and Soroti districts

Awareness of the availability and accessibility of HIV testing centers located in the same parish/ward where study participants resided was higher in Kampala than Soroti. Results show that 70% of respondents in Kampala and 47% in Soroti knew a place within their parish where they could access HIV/AIDS related services (Figure 3).

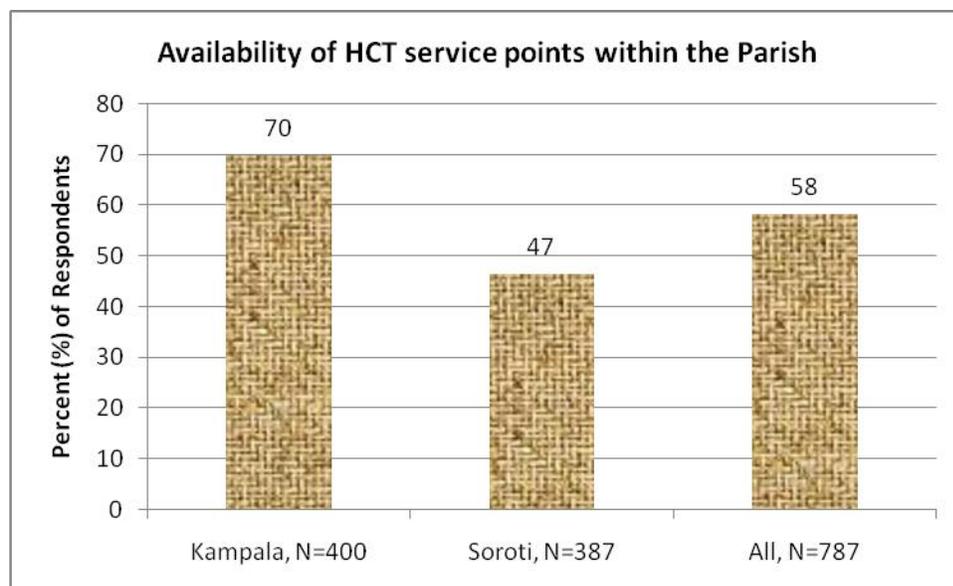


Figure 3: Availability of HCT service points within the parish

In general, secondary and primary data point to a remarkable availability of organizations and health facilities that provide HCT services in both Kampala and Soroti. In Soroti given its typical rural character, with the exception of the municipality, health facilities providing HCT services were mostly at the sub-county level, and less likely to be located within the same areas where participants lived. On the other hand, within Kampala, participants in nearly every FGD conducted, acknowledged knowing a place within their parish.

Here in Lukuli, there is no other place except Hope Clinic where you can get HIV counseling and testing services, there are several other places but they are outside our parish, like Kiruddu, Nsambya, Kisugu (FGD with Men who had never received HCT in Kampala).

In Soroti alone there were several NGOs providing HCT services either directly or indirectly through other partners. Besides the public health facilities, HCT services in Soroti are available at AIC, TASO, Uganda Cares, St. Francis Clinic Aloet, Safe Motherhood, IDI and private clinics like Princess Diana HC IV, which provides HCT in partnership with Baylor Uganda. Further, the district has other organizations such as World Vision, Teso Diocesan Development Organization (TEDDO), Pentecostal Assemblies of God (PAG), Teso Rural Development Organization (TERUDO), Compassion International that have partnered with AIC to provide outreach HCT services in their areas of operation. Coordination and

collaboration among players was reported in existence with the former mostly handled by the district health office while the latter was at individual organization basis.

Similarly, Kampala has several health facilities both public and private as well as NGOs that provide HCT services. In all FGDs and KIIs, study participants acknowledged knowing places both within and outside their communities where HCT services were being provided.

There are many places here where people in need of HIV testing can go, we have AIC, but there you must have money, we also have main hospital and Uganda Cares, actually that is where most people in sexual relationships go for testing (FGD with Women who received HCT individually in Soroti).

Uganda Cares and TASO normally visit people in their homes and test the whole family if one person in the family went there and was found HIV positive (FGD with Women who received HCT individually in Soroti).

The commonly reported services available at service points within parishes included HCT services, cited by 94% of respondents in Soroti and 94% of respondents in Kampala (**Figure 4**). Couple HCT was also reported available but by a smaller proportion of respondents both in Kampala (39%) and Soroti (48%).

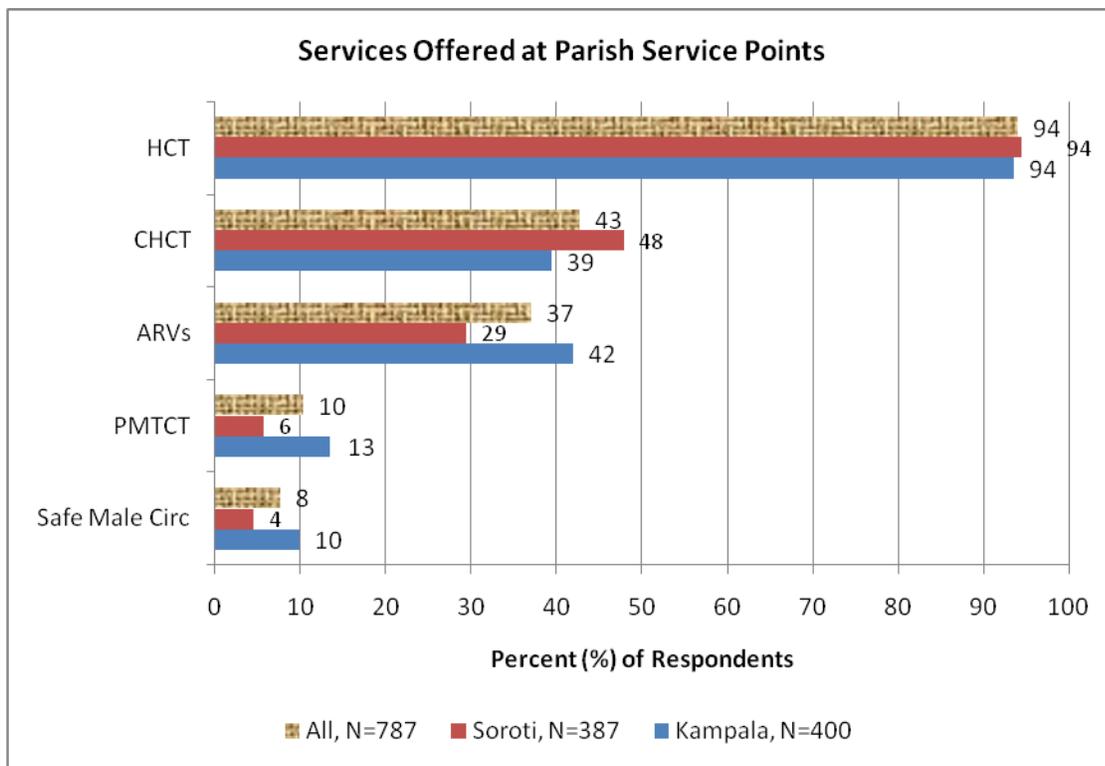


Figure 4: Services offered at parish service points

Availability of ARVs at parish-level service points was mentioned by 42% of Kampala residents and 29% of Soroti residents; PMTCT was mentioned as offered at parish-level service points by 13% of respondents in Kampala and 6% in Soroti while male circumcision was reported as offered at this level by

10% of respondents in Kampala and 4% in Soroti. There were no significant differences in the range of services reported as being available at known service points by study district.

4.3.2 Availability of CHCT services

Interestingly, 84% of all respondents who knew a service point for HCT within their parishes/wards recognized that CHCT services are always available at the service points they knew. Reports of availability of CHCT services were higher among respondents from Soroti (92.7%) compared to those in Kampala (78.3%) (Figure 5). Access to CHCT services at these service points was also reported to be good; only 21.8% of respondents in Kampala and 18.3% in Soroti reported having some reasons that would prevent them from accessing CHCT services from these places. Commonly cited reasons which would hinder people from accessing CHCT in Soroti in order of importance include fear to be stigmatized, lack of privacy at the sites, long journeys, and unfriendly staff among others. Similarly, in Kampala, fear to be seen going to the CHCT, long distances to the CHCT service points were the commonly cited reasons which would inhibit access to CHCT services at available service points.

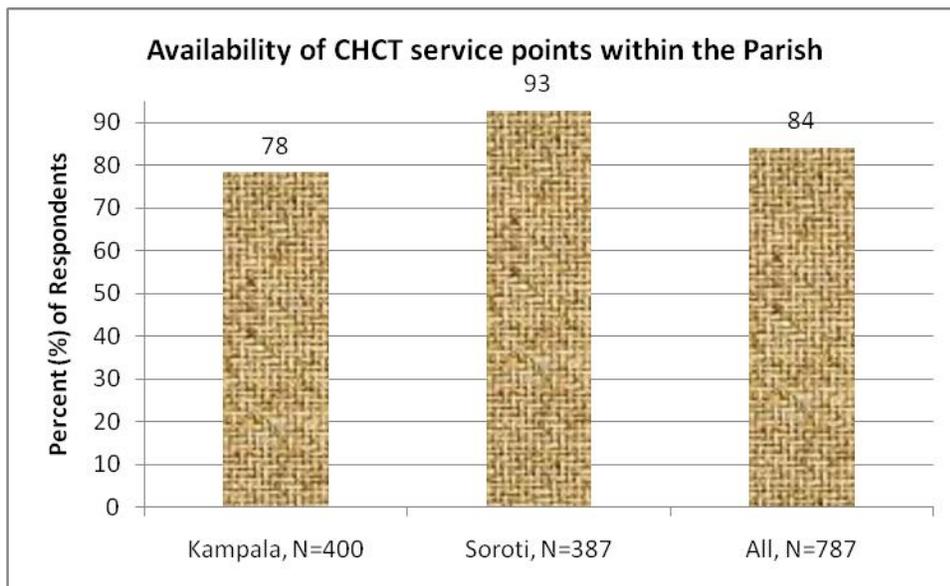


Figure 5: Availability of CHCT service points

In terms of distance to places where CHCT services are offered, results show that for the majority (48.3%) of respondents in Soroti service points are within 1-2kms from their homes; only 29.4% lived within less than 1km. Others lived within 3 and more than 3kms from the service point. Geographical access was better in Kampala compared to Soroti, nearly half (49.6%) the respondents in Kampala acknowledged that CHCT service points were within less than 1km from their homes, for 38.5% it was within 1-2kms while only about a tenth lived 3kms and more from the CHCT service point (Figure 6).

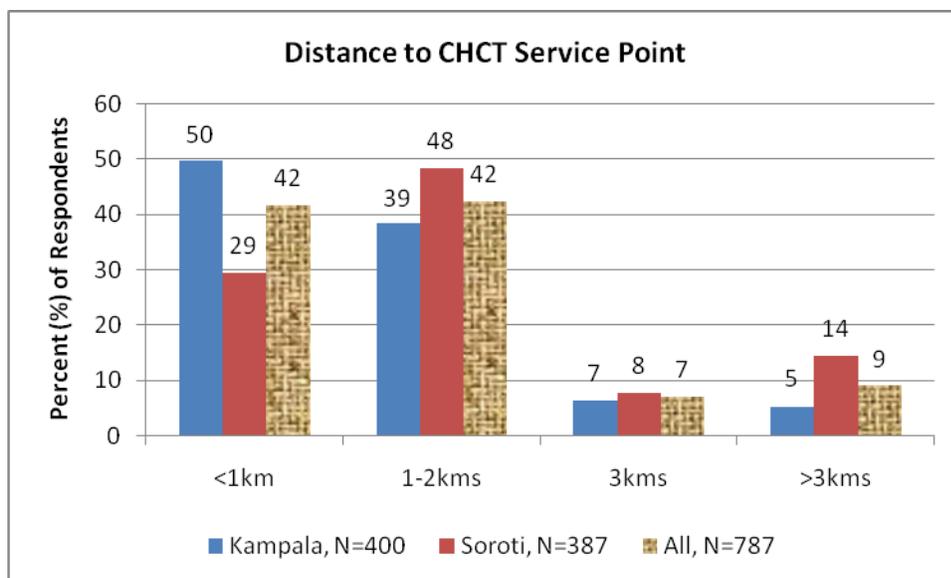


Figure 6: Distance to CHCT service points

4.3.3 Models and strategies of service delivery

This study also sought to establish the various models in both Kampala and Soroti used to deliver HCT services because of their influence on access. Models of HCT service delivery potentially affect the degree of HCT access thereby affecting demand for the services. Results reveal that a multiplicity of models is used in both Kampala and Soroti. Various HCT service providers in both districts were using a variety of models in delivery of HCT services, namely, static and satellite/outreaches, and a few others were found to have adopted the home-based model involving mostly index clients.

In terms of models, we have two models, that is static and outreach model; static are facility based while outreach is usually supported by our partners outside the facility. We work closely with TASO, Uganda Cares, AIC, St. Francis Clinic Aloet, Baylor Uganda and Prefa. (KII, DHO Soroti).

Here in Kawempe we mostly do HCT at the site, we don't do home based HCT, even outreaches are rare here but we do follow-up to see those who tested. We used to have home-based HCT during the days when we had MJAP and Baylor Uganda (KII, VHT Kawempe HC IV, Kampala).

Delivery of services through satellite clinics/outreaches was also reported as a common model adopted by mostly the non-governmental service providers in both Kampala and Soroti.

NGOs like World Vision usually come to the health centre her in Gweri to ask the health workers to tell them which communities they can go to conduct HIV counseling and testing, our job is to mobilize the community to turn up for testing. Through this model a lot of demand for HCT has been generated and also enhanced accessibility has been the outcome (VHT Soroti).

With regard to strategies for provision of HCT services, it was reported that an integrated approach has been adopted by public health facilities in particular. In both Kampala and Soroti, in-charges at the public health facilities informed the research team that they provide VCT services, routine testing and counseling, and PMTCT.

For a long time we have been providing voluntary counseling and testing, people voluntarily come to our health centers and request to know their HIV status. We then added on routine HIV testing and counseling which is provider initiated on all the wards, whoever is admitted in our wards is tested for HIV (KII, DHO Soroti).

Other service providers especially in the public health facilities, they have the provider initiated approach, they reach out to patients and interest them in knowing their HIV status. They provide a comprehensive service they integrate HCT with family planning, they give them condoms, TB screening...(KII, AIC Soroti).

4.3.4 Preferred service access points for CHCT

Dominant preferences for available service access points constitute a demand and supply factor that can potentially affect HCT uptake among couples in long-term relationships. The preferred service points for CHCT in both Kampala and Soroti were health centers (74.2% and 61.7%). Other preferences included homes cited by 28.2% in Soroti and 9.2% in Kampala as well as mobile clinics.

Similarly, several participants in FGDs expressed preference for a health facility as the most appropriate service access point for HCT services. They argue that at health facilities, especially high level facilities such as hospitals, confidentiality is assured and sometimes services are provided at no cost. Participants further noted that whereas satellite clinics bring the services closer, thereby enabling service users to save transport costs, they offer limited privacy as sometimes they operate from open places. Such service provision, participants contended, provide on-lookers with the opportunity to guess/speculate about people's sero-status depending on the facial expressions made by the person receiving the service and particularly the test results. Further, participants justified their choice of health facilities noting that in their respective communities, cases of stigma are still prevalent. Accordingly, several community members that would have wished to demand and access HCT become reluctant or fear to be seen going to a place where HCT services are provided.

People are shy, they fear to be seen at HIV testing centers...when people see you going to particularly open places where they test from...you will be perceived to be infected, which can attract stigmatization (FGD with Men, who had never received HCT in Kampala).

4.4 PRIOR HIV TESTING, HIV DISCLOSURE AND SEXUAL RISK BEHAVIOR

4.4.1 Characteristics of persons who received HCT Services in Kampala and Soroti

The distribution of the study sample was done in such a way as to recruit more individuals who had ever received HCT than those who had never received HCT. A recruitment ratio of 2:1 was used such that for every three individuals recruited into the study, two had ever received HCT while one had never received HCT. This was intended to enable the determination of the socio-demographic characteristics of couples in long-term relationships that had ever received HCT services (individually or together with their partners) but also capture experiences of those who have never received HCT in both districts.

In line with the recruitment ratio, 66.3% of the sample was composed of persons who had ever received HCT while 33.7% had never received HCT. When stratified by district, 64.8% of respondents in Kampala and 68% in Soroti had ever tested for HIV. The socio-demographic characteristics of persons who have ever received HCT in both Kampala and Soroti are similar. For instance, in both Kampala and Soroti, majority of persons who have ever tested for HIV are females (61% and 68.8%), young couples aged 18-24 years (37.4% in Kampala and 29.3% in Soroti), and those in monogamous marriages (48.6% Kampala and 74.1% Soroti). Variations were observed with regard to level of education, SES and economic activity engaged in. With regard to education level, results show that ever receipt of HCT was higher among those with secondary education in Kampala (42.5%) as opposed to those with primary education (68.8%) in Soroti. As shown in Table 6 below, whereas it was more of persons in the highest wealth quartile who had ever tested for HIV in Kampala (38.6%), in Soroti, most persons who had received HCT services belonged to the second wealth quartile (34.2%) closely followed by those in the lowest wealth quartile (31.9%), in line with the socio-economic characteristics of the populations in each district. With regard to main economic activity, results show that whereas in Kampala it was mostly persons engaged in farming (59.8%) who had received HCT, in Soroti most persons who had received HCT services reported to be engaged in formal employment (78.7%;Table 6).

Table 6: Socio demographic characteristics of respondents by HIV Test status in Kampala and Soroti

Background Characteristics	Kampala		Soroti	
	Ever tested, (%) N=259	Never tested, (%) N=141	Ever tested, (%) N=263	Never tested, (%) N=124
Gender				
Male	39.0	69.5	31.2	62.9
Female	61.0	30.5	68.8	37.1
Age (Years)				
18-24	37.4	53.9	29.3	37.1
25-29	23.6	16.3	21.7	17.7
30-34	16.2	13.5	17.1	14.5
35-39	12.0	5.7	14.8	13.7
40-44	6.2	6.4	9.5	6.5
45+	4.6	3.5	7.6	10.5
Marital Status				
Married Monogamous	48.6	31.9	74.1	57.3

Background Characteristics	Kampala		Soroti	
Married Polygamous	15.4	6.4	16.3	15.3
Cohabiting	21.6	27.7	9.5	25.0
Others	14.3	34.0	0.0	2.4
Education				
None	5.0	3.5	8.7	6.5
Primary	40.9	35.5	68.8	53.2
Secondary	42.5	42.6	17.1	30.6
Post-secondary	7.7	12.8	2.7	5.6
Vocational	3.9	5.6	2.7	4.0
Religion				
None	1.2	2.1	1.5	1.6
Muslim	23.2	22.0	2.7	5.6
Roman Catholic	34.0	33.3	44.1	46.0
Protestant / Anglican	27.0	31.2	37.3	34.7
Other - Christian	14.7	11.3	14.4	12.1
Wealth Quartile				
Lowest	14.7	21.3	31.9	41.9
Second	20.1	21.3	34.2	16.9
Third	26.6	23.4	25.5	20.2
Highest	38.6	34.0	8.4	21.0
Main Occupation				
Informal Employment	3.9	6.4	9.9	38.7
Farming	59.8	63.1	3.8	12.9
Formal Employment	12.0	17.0	78.7	43.5
Housewife	1.9	0.0	6.5	3.2
Other	18.5	6.4	1.1	1.6
Nothing	3.9	7.1	0.0	0.0

4.4.2 Time since last HIV test

With regard to length of time / how far back study participants had received HCT services, findings revealed that majority of the respondents received HCT 1-12 months prior to this study. As shown in Figure 7 below, in both Kampala and Soroti, slightly more than a quarter of participants reported that they received an HIV test in 1-3 months, with similar proportions observed for the period 4-6 months prior to interview. However, more respondents from Soroti had tested for HIV in the period 7-12 months from the time of interview (31% for Soroti vs. 21% for Kampala), although more respondents from Kampala had tested more than 12 months from the date of interview (17% for Kampala vs. 4% for Soroti).

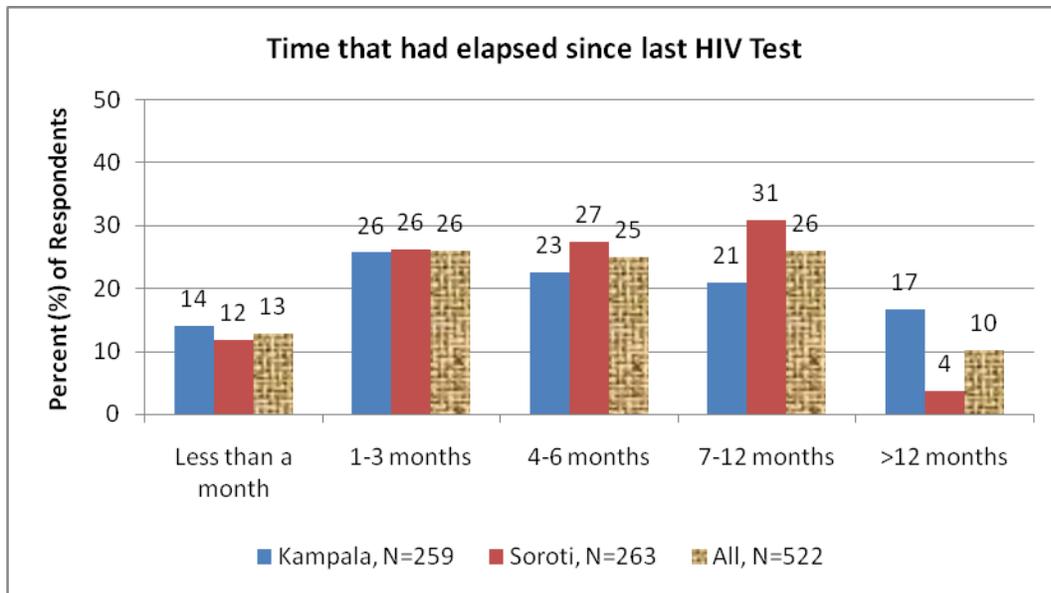


Figure 7: Time since last HIV test

4.4.3 Reasons for seeking HCT services

The commonly cited reason for seeking HCT services among all respondents who reported to have tested for HIV was desire to know HIV status. More than three quarters (79%) of respondents just wanted to know their HIV status. As shown in Figure 8 below, ‘just wanted to know status’ was cited as the main motivation for taking an HIV test in both Kampala (72%) and Soroti (85%). This was followed by testing as an ANC requirement, particularly among women (Kampala: 19% and 37% in Soroti), and taking an HIV test because one was sickly, mentioned by 12% of Kampala respondents and 20% of Soroti respondents. Other reasons cited, particularly in Kampala, were: ‘partner wanted to know status’ and ‘wanted to plan for the future’.

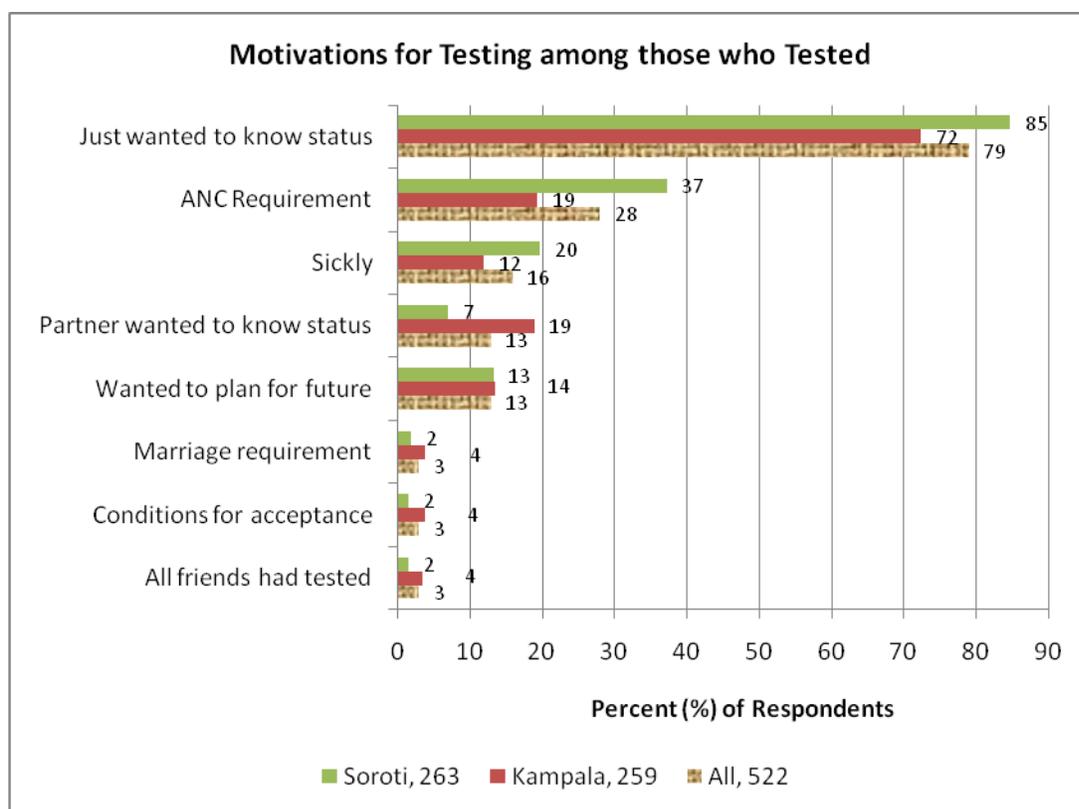


Figure 8: Motivations for HIV testing among couples

4.4.4 Characteristics of persons who received CHCT Services in Kampala and Soroti

As shown in Table 7 below, 51.5% of respondents who had ever tested for HIV, tested as a couple (i.e. received CHCT). CHCT uptake was higher in Soroti (73.4%) than in Kampala (29.5%). The distribution of CHCT by background characteristics can be seen from table below.

Table 7: CHCT uptake by background characteristics and district of residence

Background Characteristics	Kampala (CHCT), N=259 (%)	Soroti (CHCT), N=263 (%)	All (CHCT), N=522 (%)
Overall	29.5 (76)	73.4 (193)	51.5 (269)
Gender			
Male	32.0	81.7	54.1
Female	27.9	69.6	50.1
Age-group (Years)			
18-24	31.3	72.7	49.4
25-29	24.6	86.0	54.2
30-34	28.6	71.1	50.6
35-39	25.8	66.7	48.6
40-44	25.0	68.0	51.2

45+	58.3	65.0	62.5
<i>Marital Status</i>			
Married Monogamous	35.7	78.5	61.7
Married Polygamous	20.0	65.1	43.4
Cohabiting	26.8	48.0	33.3
Other	22.2	0.0	21.6
<i>Residence</i>			
Urban	28.9	53.6	33.2
Rural	60.0	78.7	78.3
<i>Education</i>			
None	7.7	82.6	55.5
Primary	21.7	74.6	55.0
Secondary	39.5	62.2	45.8
Post-Secondary	25.0	71.4	37.0
Vocational	40.0	85.7	58.8
<i>Religion</i>			
None	0.0	100.0	57.1
Muslim	26.7	71.4	31.3
Roman Catholic	28.4	75.0	54.9
Protestant / Anglican	37.7	71.4	57.1
Other – Christian	23.7	71.1	47.4
<i>Wealth Quartile</i>			
Lowest	10.5	10.5	53.3
Second	26.9	26.9	53.5
Third	30.0	29.0	54.4
Highest	38.4	38.4	44.3
<i>Number of sexual partners</i>			
1	31.1	73.8	53.7
2+	23.8	69.2	41.2
<i>HCT availability nearby</i>			
Yes	30.6	66.7	43.4
No	19.2	79.6	69.9
Don't know (DK)	37.5	0.0	37.5
<i>CHCT availability nearby</i>			
Yes	31.8	67.1	46.7
No	23.3	83.7	70.2
DK	11.8	50.0	19.1
<i>Exposure to GTKT</i>			
Yes	30.6	73.3	53.5
No	24.5	82.5	39.4

In Kampala, CHCT uptake was higher among males, persons aged 45+ years, those in monogamous relationships, persons with vocational level of education, and those in the highest wealth quartile. In Soroti, uptake of CHCT was higher among males, persons aged 25-29 years, those with no education, those in monogamous relationships, and persons in the third wealth quartile. In both districts, CHCT uptake was higher among males than females, persons in monogamous relationships, those with vocational education, individuals in the highest wealth quartile, and those reporting only one sexual partner in the past year (Table 7). Variations were noted by age; while those aged 25-29 years had higher CHCT uptake in Soroti (86%), in Kampala, the age-group with the highest CHCT uptake was 45+ years (58.3%), see Table 7 for details.

4.4.5 HIV status disclosure

This study further sought to establish the proportion of persons in long-term sexual relationships who disclosed their HIV status to their sexual partners. As shown in Table 8 below, overall, 36% of the respondents disclosed their results to their spouses/partners. HIV status disclosure was higher in Kampala (52.9%) as opposed to Soroti (18.6%).

Table 8: Proportion that disclosed to partner among those that tested for HIV

Background Characteristics	Disclosed, Kampala N=259 (%)	Disclosed Soroti N=263 (%)	Total N=522 (%)
Overall	52.9	18.6	35.6
Gender			
Male	49.5	11.0	32.2
Female	55.1	22.1	37.5
Age-group (Years)			
18-24	60.8	23.4	44.3
25-29	52.5	8.8	31.4
30-34	42.9	17.8	29.9
35-39	51.6	20.5	34.3
40-44	56.3	24.0	36.6
45+	25.0	20.0	21.9
Marital Status			
Married Monogamous	50.8	14.4	28.7
Married Polygamous	55.0	27.9	41.0
Cohabiting	53.6	36.0	48.1
Other	56.8	-	56.8
Education			
None	53.9	17.4	30.6
Primary	56.6	18.8	32.8
Secondary	50.0	20.0	41.3
Post-Secondary	55.0	14.3	44.4
Vocational	40.0	17.3	29.4
Religion			

Background Characteristics	Disclosed, Kampala N=259 (%)	Disclosed Soroti N=263 (%)	Total N=522 (%)
None	66.7	0.0	28.6
Muslim	53.3	28.6	50.7
Roman Catholic	50.0	19.0	32.4
Protestant / Anglican	51.4	17.4	31.5
Other – Christian	60.5	21.1	40.8
Wealth Quartile			
Lowest	68.4	19.1	34.4
Second	42.3	22.2	29.6
Third	59.4	13.4	36.8
Highest	48.0	18.2	42.6

In Kampala, HIV status disclosure was higher among females, persons aged 18-24 years, those with primary education and persons in the lowest wealth quartiles. On the other hand, in Soroti, HIV status disclosure was highest among females, those aged 40-44 years, those in cohabiting relationships, those with secondary level of education and those in the second wealth quartile. In both districts, females reported higher levels of HIV status disclosure than their male counterparts.

4.4.6 Level of discussion about HCT among couples

The reported low levels of disclosure of HIV status to partner /spouse could partly be attributed to inherent difficulties of discussing matters of HIV testing among couples. In both Kampala and Soroti, when participants were asked about the extent and the ease with which they can discuss issues of HCT with their partners, mixed views were shared. Some people indicated that it is easy to talk about HIV testing as a couple while others objected. Fears of discussing matters related to HCT were more apparent among male participants in Kampala.

Talking about testing together is easy but we (referring to men) rarely honor our promise, we only talk about it in order to convince the girl into engaging in sex, when she sees you freely talk about HIV testing she gains confidence in you (FGD with Men, who had never received HCT in Kampala).

It is very difficult because you might wonder, how do I start it now, even the woman might start suspecting you and you see for us men, sometimes you might even be having several partners...(FGD with Men, who had never received HCT in Kampala).

HIV status disclosure was reported particularly difficult for those who find themselves HIV positive. It was reported that such people would fear to disclose, for if they revealed their positive HIV status to their partners, it would cease being a secret.

We fear our partner telling other people about our HIV status, you know women do not keep secrets, they can tell their brothers, tell your in-laws (FGD with Men, who had never received HCT in Kampala).

Difficulties to disclose positive HIV status among persons who sought HCT services individually were more commonly reported among females. It was noted that women particularly fear to disclose their HIV status (*if found HIV+*) to their partners because it can result into violence in the home. Apparently, men

who have never tested for HIV do not receive well/calmly news of their partner being HIV positive, many turn violent.

For me, I do not want my partner to know my status because he will chase me if I am the one with the HIV virus, even some can beat you (FGD with Women who received HCT individually in Soroti).

Gweri is not an easy community, there is a lot of domestic violence, the police is also aware of this problem, I think that is why women fear to tell their husbands their HIV status (KII, Gweri HC III, Soroti).

Situations of discordant couples are reported to be more challenging. Participants in this study observed that if a partner discloses that s/he is HIV positive and the other tests, and finds him or herself negative, chances of such a family breaking up would be imminent. Participants noted that even if the family does not break-up the marriage would be characterized with acrimony.

It still goes back to what I said, if I am found positive and my wife is negative by all means our marriage would break, she will definitely seek for divorce (Participant, Men FGD who received Couple HCT in Soroti).

In a situation where a man is still courting the woman, it is hard to disclose if he went alone for the HIV test and found that he was HIV positive, he will fear to disclose because they fear losing their partner (FGD with Men who received Couple HCT in Soroti).

For me my wife was the first to fall sick, it happened when I was very strong, so I treated her but when I also fell sick she ran away because of my poor financial status (FGD with Men who received HCT individually in Kampala).

But overall, the importance and need to disclose HIV status particularly HIV+ status was paramount. Nearly all participants in the various FGDs held including those with people who had never received HCT services were in support of disclosure of HIV status. They cited various benefits some of which include providing a basis for planning one's life, starting treatment early, and protecting loved-ones in cases of discordance.

If you tell your partner about your status, it helps him also go and test so that he gets to know his status and start treatment early, and if you have children, it helps you start planning for the time when you will be sick and unable to provide for them (FGD with Women who received HCT individually in Soroti).

I would disclose my status to my partner because I want her to know that I am fine, even in cases where I am HIV positive, she still deserves to know (FGD with Men who had never received HCT in Soroti).

4.4.7 Reported motivational factors/circumstances under which couples test together

Various factors were cited in FGDs of married men and women who tested together as part of a package that spurs motivation for CHCT. Several study participants noted that CHCT is in a way, an expression of love; they note that one way to show one's partner of deeply entrenched care and love is to seek an HIV

test as a couple, and for male partners to provide company to their spouses during antenatal care. They argued that it would be too selfish to deny your partner an opportunity to know your HIV status.

However, not all participants shared the same view of showing care and love as a motivating factor to seek CHCT; to these, the biggest motivating factor for CHCT is uncertainty about one's health. They note that besides people who receive CHCT during antenatal, or as a requirement for marriage, majority of others that have sought CHCT are driven by the desire to confirm whether they are infected with HIV or not. FGD participants reported that although not common, in most relationships, CHCT becomes inevitable in situations where one person falls sick for a prolonged period of time. Persistent illnesses particularly malaria or death of a biological child are perceived to be signs of HIV. In nearly all discussions, participants cited constant illness of family members particularly a husband and wife as one of the circumstances under which they would seek for CHCT.

If you or your wife is always falling sick, your child dies, you have other people in the home who fall sick every now and then, you start wondering what is wrong...you get worried, that is when most people decide to go for an HIV test (FGD with Men, who had never received HCT in Kampala).

If I am sick all the time and I have tested for all diseases in vain, I will encourage my husband to go and test with me so that we know what is disturbing me (FGD with Women who received HCT individually in Soroti).

Some people test together if they keep falling sick every now and then, while others test after the health worker has told the woman (pregnant wife) to come with her husband to test (FGD with Men who received HCT individually in Kampala).

People go for HIV testing if they are worried about their HIV status, if you are not worried of your status, you are not sick, you cannot go for an HIV test or tell your wife to go for an HIV test (FGD with Men who received HCT individually in Kampala).

Suspicion regarding a partner's HIV status was cited among the circumstances under which most men and women seek CHCT. Scenarios such as temporary separation, partners who either return home late or are constantly on long trips outside their localities were cited by study participants as motivating factors for a couple to seek HCT. According to such participants if they found themselves in such situations, they would in no uncertain terms go for CHCT.

We would go for HIV testing, if we had temporarily separated with my wife say for 3-4 years, when she comes back, I would take her for testing before we engage in sex again (FGD with Men, who had never received HCT in Kampala).

If my husband comes home late all the time and also frequently goes for safaris, I will start suspecting him so I will tell him to go and we test together for HIV (FGD with Women who received HCT individually in Soroti).

Results of the quantitative component corroborate with the views of FGD participants, for the majority, CHCT was sought because the counselor advised. Just like FGD participants, these ones also cited other reasons like poor health of partner or uncertainty about HIV status, and satisfying interests of the partner.

Intention to re-seek CHCT was nearly universal. Results show that 93.5% of respondents in Soroti and 86.4% in Kampala were still willing to go back for CHCT with their partners/spouses. Similarly intention to seek CHCT within the next 12 months for all persons who have ever received HCT was high. Results show that 95.8% of respondents in Soroti and 87.6% in Kampala expressed readiness to seek CHCT in the next 12 months. However, not all respondents were optimistic that their partners/spouses would embrace the idea of seeking for CHCT; 80.4% were certain while 10.2% were sure their partners would object to the idea. Variations were observed between respondents from Kampala and those in Soroti; higher proportions in Soroti (85.5%) expressed certainty that their partners would accept to seek CHCT compared to 75.4% in Kampala (data not shown).

However, despite the high levels of willingness to seek CHCT, service providers in both Kampala and Soroti report that uptake for CHCT is still generally low. They reported that programs like ANC have tried to encourage people to test together and know their results together but the numbers are still small.

HCT among couples is still low, we serve more individuals compared to couples, even here at the branch, we get more people coming as individuals...in the community, out of about 100 people who turn up for testing, you can find only about 5 couples and they are mostly young people who want to get married (KII, AIC Soroti).

Most people come as individuals, in a week you can receive utmost 4 or 3 couples...men don't like couple HCT, the few we get are those that come accompanying their partners for antenatal care. Then the other common group is those who are planning to get married but those come once in a while (KII, Kiruddu HC III, Kampala).

Uptake of couple HIV testing is low; it ranges between 40% and 60% of people who turn up for HIV testing at our health center. The 60% is in the ANC clinic, because there we coerce them a bit, if a woman does not come with her husband we don't give them the ANC card, then the 40% is in the general VCT program but also there we get more youth 18-30 years, older couples are very few (KII, Tubur HC III, Soroti).

This is a recent initiative; it is not something that has been done since the AIDS epidemic struck Uganda. Uptake is still quite low, except in the PMTCT program that is where we have seen more strides in couple HCT, when government made it a policy for women to go for ANC with their partners (KII, DHO Soroti).

4.4.8 Reasons for low male testing at ANC

In order to promote couples' HIV testing and improve immediate linkage to HIV care among HIV-infected pregnant women, pregnant women who attend antenatal care services are usually encouraged to come along with their male partners for HIV testing. In most cases, men tend not to respond to the invitations, citing, among other reasons, the fact they have busy schedules. Apparently, antenatal care is provided at a time when people have to go to work, men being breadwinners and in some instance the sole breadwinners, they find it difficult to forego work to accompany their partners/wives, so they argued.

We fail to go because of work, you see antenatal care is done during the day and that is the time when we are busy at work. The other problem is that there always long lines at the health center and yet we do not have that time, sometimes women go there at 7:00 am and come back late in the evening (FGD with Men, who had never received HCT in Kampala).

However, this line of argument was not shared by women who outrightly disapproved it in FGDs. In nearly all FGDs with women, participants revealed that men just use that claim of work to hide their fear to go for HIV testing. According to these women, there is no other reason why men do not accompany their partners/wives other than fear; because even women especially in urban areas, are engaged in some form of work.

Some men fear to go and test with their women because they worry, in their hearts... they are thinking, what if I am found with HIV, the woman will leave me, that is why they claim to be busy, but it is just fear (FGD with Women who received HCT individually in Soroti).

Men fear because nurses in the hospitals are known to be rude and yet men do not like being backed at, embarrassed, so to avoid all that they send women alone (FGD with Women who received HCT individually in Soroti).

Those who accept to accompany their wives to hospital are those who trust each other and have a future together, but also ready for whatever results they get (FGD with Men who had never received HCT in Soroti).

Service providers also did not seem to concur with the argument raised by men of being busy as the reason they do not accompany their wives for antenatal care. At Kawempe, it was reported that efforts to increase male involvement especially in antenatal care services were in place; women who come with their partners are served first, but still the numbers of men who accompany their wives remain small.

Here we very much want male involvement in antenatal care, family planning and even immunization, so when we get a man who has accompanied his wife, we attend to them quickly so that they go back (KII, Kawempe HC IV, Kampala).

4.4.9 Barriers/reasons couples do not test together

Both personal and facility-based factors were commonly cited by participants as factors that dissuade some men and women in long-term sexual relationships from seeking CHCT. At the person/individual level, several people have not sought CHCT nor attended ANC with their partners because of fear, selfishness, and lack of awareness of the benefits of CHCT. In all discussions held, nearly participants including those who had ever received CHCT noted that it was mostly fear that was preventing men and women to go for CHCT. According to these participants, men feared to lose their marriages, while women feared to be battered by their husbands/partners.

People do not test together because of fear, you fear to see your marriage breakdown. In most cases when one person is infected and the other is not, the one who is not sick will go away, that is why people test alone (FGD with Men, who received HCT individually in Kampala).

I have not tested but I hear stories that most people who go to test with their wives it does not end well when one of them is found positive, they come back quarrelling throughout the journey, the marriage even ends up breaking because of testing together (FGD with Men, who had never received HCT in Soroti).

To avoid domestic violence, when the woman is found HIV positive and the man is not, the man will beat her; such men tend to fight a lot with their wives (FGD with Women who received HCT individually in Soroti).

Other participants noted that for people who have been in a marital relationship, asking a partner to go for CHCT would bring about mistrust. According to these participants, without precedence, it is difficult to justify asking someone you have been living with for years to go for an HIV test.

It brings mistrust, when you have been living with someone for years, and then one day you tell her to go for an HIV test, she will just quarrel, she will even ask you whether you no longer trust her...family issues are difficult (FGD with Men, who had never received HCT in Kampala).

Selfishness perpetuated by male chauvinism was also cited among the factors that prevent married men and women from seeking CHCT. Apparently, some people, particularly men, were reported to be reluctant to go for CHCT as they do not wish their partners to find out their HIV status. Men commonly engage more in extra-marital sexual relationships, so they consider CHCT as a measure which can reveal their true character that they would rather conceal.

If you have been having extra-marital relationships, you will fear to test together because if you are found HIV positive, then she will know that you have been cheating on her, she can even leave you (FGD with Men, who received HCT individually in Soroti).

Some people when they go for testing and one is got with the disease, before they are married, the one who is infected can decide to commit suicide (FGD with Women who received HCT individually in Soroti).

Some participants argued that it was useless for two people in a long-term sexual relationship to go for an HIV test together. According to this group of people, if one partner tests and is found to be HIV positive, no doubt, the other will also be HIV positive.

When you have already been in a sexual relationship what are you going to test for...there is no point in testing when I have been having sex with my partner (FGD with Men, who had never received HCT in Kampala).

Some say they see no difference in going to test with their partners, it is all the same, if the woman is HIV positive, then also the man has it, so they do not see any need for going themselves (FGD with Men who received Couple HCT in Soroti).

Limited or non-existent awareness of benefits of CHCT also featured greatly among the barriers to CHCT. Both service providers and people in long-term sexual relationships acknowledged that lack of information especially regarding the importance of CHCT plays a big role in constraining uptake. According to these participants, several married men and women have not appreciated CHCT because they are not aware of its benefits.

From my point of view, many people do not know the advantages of couple testing, which is why they are not embracing it (FGD with Men who had never received HCT in Soroti).

There are issues of ignorance, lack of information and also stigma. People lack information on benefits of testing together as a couple. Then we also have a problem which stems from the way our society is shaped, this is predominantly patriarchal society that is why men send their wives for testing but for them they do not go (KII, DHO Soroti).

Some service providers acknowledge that indeed, it is a weakness in the system. Health education regarding the importance and advantages of CHCT is mostly given to people that turn up for health services. Some service providers noted that due to lack of funds, sensitization is rarely conducted in communities.

Most health centers do not have funding to conduct outreach sensitization campaigns, so it only men who go to the health centers with their wives that get to know the advantages of couple HIV testing and counseling, so others are ignorant, if we had sensitization of the general public, uptake would improve (KII, DHE Soroti).

A few facility- based barriers were cited by participants in FGDs and KIs, which explain the low uptake for CHCT. Commonly cited among these factors was the lack of privacy at the health facilities, intermittent supply of HIV test kits and long distances to service centers. With regard to privacy, study participants noted that the rooms used for counseling do not offer privacy and sometimes they are shared by health workers.

Some men say that there is no privacy at the health center other people can listen in and hear when the nurse is telling you your results...actually there a number of them who come for antenatal but when they call the wife to go for the results, the man hides for fear that if he goes into the room other people will hear his results (KII, VHT Soroti).

I witnessed a situation one time where health workers from our health center went for an outreach with other service providers; they had two pens a blue pen and a red pen. They would write on some people's forms with the blue while others in red, and it was in an open place, so people who were watching at a distance started guessing people's results (KII, VHT Soroti).

Health workers particularly in public health facilities acknowledged tremendous problems relating to adequate space, although they reported to be making efforts to maintain confidentiality of people's results.

We try our best to maintain confidentiality although we sometimes can have two health workers in one room attending to different patients...we have a problem of space, we use the same room for counseling and consultations (KII, Gweri HC III, Soroti).

Some people do not like coming here for HCT because of the long waiting hours, there are delays which are not our making; we get many people and yet the facilities are few. For example here at Kawempe, we have one lab which serves everyone, certainly when we get a child with malaria, it is given first priority over an HIV test, an HIV test can wait (KII, Kawempe HC IV, Kampala).

Intermittent supply of HIV test kits also, to a small extent, contributed to the low uptake of CHCT and HCT in general. Cases of couples failing to get HIV counseling and testing services were reported.

There is a problem of insufficient HIV testing supplies, I know some people who went for antenatal care three times but on all the visits, there were testing kits at the health center, so the man never tested (FGD with Men who received Couple HCT in Soroti).

Service providers particularly in the public health facilities acknowledged experiencing intermittent supplies of HIV test kits.

Government always has good programs but the challenge is with implementation, for instance, in the last quarter June to August 2012, we had no HIV test kits in all public health centers in Soroti. In fact some were thinking we had removed HIV testing (KII, Tubur HC III, Soroti).

Long distances coupled with absence of a stand-alone HIV clinic at most of the public health facilities were the other reasons cited among the barriers for CHCT.

The health facilities where couple HIV testing services are provided are very far from some of our communities, I believe if they were brought near, it would increase uptake (VHT Soroti).

There is no special HIV clinic for those who have come specifically for HCT; whoever comes here has to line up at OPD and wait for the assessment in the triage, this discourages some people but we have no control over it (KII, Gweri HC III, Soroti).

Similar reasons were given by participants in the quantitative component of the study in explaining why people fear to go for HCT services with their partners/spouses. The commonly cited reason is fear for the consequences and to be blamed in case an HIV+ result is found, reluctance to let partner/spouse know one's HIV status which again is linked to the fact that people are uncertain about their HIV status. Comparison between respondents from Kampala and Soroti reveals similar results. These fears are borne of the nature of sexual activity/quality of sexual partnership reported among respondents.

4.4.10 Sexual risk behavior

Sexual risk behavior is a strong determinant of HCT uptake and HIV status disclosure. For example, people who are involved in multiple sexual relationships may be less inclined to test for HIV for fear of being identified as HIV-positive, or if they do, they may be less likely to disclose their HIV status. While this sub-section does not directly relate to the specific objectives of this study, we felt the need to highlight sexual risk behaviors because of their apparent role in influencing HIV testing behaviors. We specifically explored two aspects: 'number of sexual partners' and 'condom use at last sex' since these aspects have been found to influence testing behaviors in other reports. In following up with this observation, we included 'number of sexual partners' in the adjusted model, as shown in section 4.5 below.

4.4.10.1 Number of sexual partners

Results show that whereas majority of respondents had one sexual partner, notable proportions reported having 2-3, 4-5 and more than 5 sexual partners at the time of the survey (see Table 9a and 9b). In Kampala, 77% of the respondents reported engaging in sex with only one partner in the past year while 23% engaged in sex with 2+ partners. There were higher proportions of men, persons aged 25-29 years, those in cohabiting relationships, persons with no education, those reporting no religious affiliation, and those in the second wealth quartile reporting 2+ partners in the past year than to their counterparts (Table 9).

Table 9: Reported number of sexual partners in Kampala by background characteristics

Background Characteristics	<u>Percent with partners</u>				Number, N
	One Partner	2-3 Partners	4-5 Partners	More than 5	
Overall	77.0	20.3	0.8	2.0	400
<i>Gender</i>					
Male	63.8	31.7	1.0	3.5	199
Female	90.0	9.0	0.5	0.5	201
<i>Age (Years)</i>					
18-24	78.7	17.6	2.0	1.7	173
25-29	76.1	20.2	1.2	2.5	84
30-34	86.3	12.1	0.8	0.8	61
35-39	83.2	13.7	2.1	1.1	39
40-44	79.3	20.7	0.0	0.0	25
45+	80.0	18.0	0.0	2.0	17
<i>Marital Status</i>					
Married Monogamously	87.7	11.1	0.0	1.2	171
Married Polygamous	67.3	30.6	0.0	2.0	49
Cohabiting	70.5	25.3	3.2	1.1	95
<i>Education</i>					
None	61.1	38.9	0.0	0.0	18
Primary	78.8	17.3	0.6	3.2	156
Secondary	74.7	22.9	0.6	1.8	170
Post-secondary	89.5	7.9	2.6	0.0	38
Vocational	72.2	27.8	0.0	0.0	18
<i>Religion</i>					
None	50.0	33.3	0.0	16.7	6
Muslim	71.4	27.5	0.0	1.1	91
Roman Catholic	80.7	17.0	0.7	1.5	135
Protestant / Anglican	72.8	24.6	0.9	1.8	114
Other - Christian	88.9	5.6	1.9	3.7	54
<i>Wealth Quartile</i>					
Lowest	82.4	17.6	0.0	0.0	68
Second	73.2	24.4	0.0	2.4	82
Third	74.5	20.6	1.0	3.9	102
Highest	78.4	18.9	1.4	1.4	148

In Soroti, 83% of respondents reported only one sexual partner during the past year while 17% reported 2+ partners. Like it is the case for Kampala, there were higher proportions of men, those aged 25-29 years, those with post-secondary education, individuals with vocational education, and persons in the highest wealth quartile reported 2+ partners in the past year compared to their counterparts (Table 10).

Table 10: Reported number of sexual partners in Soroti by background characteristics

Background Characteristics	<u>Percent with partners</u>				Number, N
	One Partner	2-3 Partners	4-5 Partners	More than 5	
Overall	82.9	14.0	2.1	1.0	387
Gender					
Male	70.0	23.1	4.4	2.5	160
Female	92.1	7.5	0.4	0.0	227
Age (Years)					
18-24	84.6	11.4	3.3	0.8	123
25-29	77.2	17.7	1.3	3.8	79
30-34	85.7	12.7	1.6	0.0	63
35-39	82.1	14.3	3.6	0.0	56
40-44	87.9	12.1	0.0	0.0	33
45+	81.8	18.2	0.0	0.0	33
Marital Status					
Married Monogamously	88.7	9.0	1.5	0.8	266
Married Polygamous	64.5	32.3	1.6	1.6	62
Cohabiting	76.8	16.1	5.4	1.8	56
Other	66.7	33.3	0.0	0.0	3
Education					
None	93.5	6.5	0.0	0.0	31
Primary	83.8	13.8	1.6	0.8	247
Secondary	81.9	12.0	3.6	2.4	83
Post-secondary	64.3	28.6	7.1	0.0	14
Vocational	66.7	33.3	0.0	0.0	12
Religion					
None	100.0	0.0	0.0	0.0	6
Muslim	71.4	21.4	7.1	0.0	14
Roman Catholic	79.8	18.5	1.2	0.6	173
Protestant / Anglican	83.7	11.3	3.5	1.4	141
Other - Christian	92.5	5.7	0.0	1.9	53
Wealth Quartile					
Lowest	81.6	13.2	2.2	2.9	136
Second	88.3	11.7	0.0	0.0	111
Third	83.7	15.2	1.1	0.0	92
Highest	72.9	18.8	8.3	0.0	48

4.4.10.2 Condom use at last sex

Respondents were asked for their relationship with the person they had sex with the last time and whether they used a condom during the last sexual intercourse. As shown in Table 11 below, 69.3% of

respondents in Kampala reported that the person they had sex with the last time was their spouse / partner while 21.3% percent reported that that person was their mistress / boyfriend.

Table 11: Most recent sexual partner and condom use in Kampala

Background Characteristics	<u>Last sexual partner</u>				Condom use at last sex	Number, N
	Spouse /Partner	Mistress / Boy friend	Casual partner	Sex worker		
Overall	69.3	21.3	8.8	0.8	32.3	400
Gender						
Male	58.8	23.6	16.1	1.5	39.7	199
Female	79.6	18.9	1.5	0.0	24.9	201
Age (Years)						
18-24	58.4	30.1	11.6	0.0	42.2	173
25-29	71.4	21.4	6.0	1.2	26.2	84
30-34	80.3	8.2	8.2	3.3	26.2	61
35-39	84.6	12.8	2.6	0.0	15.4	39
40-44	80.0	8.0	12.0	0.0	28.0	25
45+	76.5	17.6	5.9	0.0	23.5	17
Marital Status						
Married Monogamously	92.4	2.9	4.1	0.6	18.1	171
Married Polygamous	85.7	10.2	4.1	0.0	24.5	49
Cohabiting	47.4	38.9	13.7	0.0	43.2	95
Education						
None	55.6	33.3	11.1	0.0	27.8	18
Primary	76.3	16.7	7.1	0.0	25.6	156
Secondary	65.3	23.5	10.0	1.2	34.1	170
Post Secondary	65.8	26.3	5.3	2.6	44.7	38
Vocational	66.7	16.7	16.7	0.0	50.0	18
Religion						
None	66.7	16.7	16.7	0.0	33.3	6
Muslim	64.8	28.6	6.6	0.0	30.8	91
Roman Catholic	70.4	21.5	7.4	0.7	28.9	135
Protestant / Anglican	74.6	12.3	11.4	1.8	38.6	114
Other - Christian	63.0	27.8	9.3	0.0	29.6	54
Wealth Quartile						
Lowest	70.6	17.6	10.3	1.5	25.0	68
Second	72.0	20.7	7.3	0.0	20.7	82
Third	69.6	20.6	9.8	0.0	34.3	102
Highest	66.9	23.6	8.1	1.4	40.5	148

When asked about condom use at last sex, only 32.3% of the respondents in Kampala reported using a condom at last sex. Condom use at last sex was higher among men, persons aged 18-24 years, those in cohabiting relationships, those with post-secondary level of education, individuals with vocational education, and those in the highest wealth quartile.

Table 12: Most recent sexual partner and condom use in Soroti

Background Characteristics	<u>Last sexual partner</u>				Condom use at last sex	Number, N
	Spouse /Partner	Mistress / Boy friend	Casual partner	Sex worker		
Overall	89.9	6.2	3.9	0.0	20.4	387
Gender						
Male	85.0	9.4	5.6	0.0	25.0	160
Female	93.4	4.0	2.6	0.0	17.2	227
Age (Years)						
18-24	90.2	8.9	0.8	0.0	23.6	123
25-29	89.9	5.1	5.1	0.0	22.8	79
30-34	88.9	7.9	3.2	0.0	14.3	63
35-39	89.3	5.4	5.4	0.0	16.1	56
40-44	87.9	3.0	9.1	0.0	27.3	33
45+	93.9	0.0	6.1	0.0	15.2	33
Marital Status						
Married Monogamously	95.1	2.6	2.3	0.0	19.9	266
Married Polygamous	95.2	1.6	3.2	0.0	14.5	62
Cohabiting	64.3	23.2	12.5	0.0	30.4	56
Education						
None	93.5	0.0	6.5	0.0	3.2	31
Primary	89.5	7.3	3.2	0.0	22.3	247
Secondary	91.6	6.0	2.4	0.0	19.3	83
Post-secondary	78.6	0.0	21.4	0.0	28.6	14
Vocational	91.7	8.3	0.0	0.0	25.0	12
Religion						
None	100.0	0.0	0.0	0.0	0.0	6
Muslim	85.7	7.1	7.1	0.0	14.3	14
Roman Catholic	90.2	6.4	3.5	0.0	20.2	173
Protestant / Anglican	88.7	6.4	5.0	0.0	23.4	141
Other - Christian	92.5	5.7	1.9	0.0	17.0	53
Wealth Quartile						
Lowest	88.2	8.1	3.7	0.0	19.9	136
Second	94.6	2.7	2.7	0.0	21.6	111
Third	89.1	6.5	4.3	0.0	19.6	92
Highest	85.4	8.3	6.3	0.0	20.8	48

In Soroti, 89.9% of respondents reported that their most recent sexual partner was their spouse/partner followed by 6.2% who reported mistress/boyfriend as their most recent sexual partner. Condom at last sex was lower (20.4%) than that reported in Kampala (32.3%) but was higher among men, those aged 40-44 years, individuals in cohabiting relationships, and those with post-secondary level of education compared to their counterparts (Table 12).

4.5 DETERMINANTS OF HCT/CHCT UPTAKE

4.5.1 Determinants of HCT uptake among individuals

To measure the determinants of HCT uptake among respondents in the survey, logistic regression was performed to produce odds ratios (OR) which compare the odds (chances) of HCT uptake in the exposed category relative to their unexposed counterparts. Table 13 presents crude and adjusted odds ratios produced from the binary outcome variable which were categorized as 1 = those who had ever received HCT and 0 = those who had never received HCT. Also, adjusted odds ratios produced by controlling for potential confounding and interaction in the regression model are provided in the table.

Table 13: Respondent characteristics that influence HCT uptake by district

Background Characteristics	<u>Kampala</u>		Crude OR, (95%CI)	<u>Soroti</u>
	Crude OR, (95%CI)	Adjusted OR, (95%CI)		Adjusted OR, (95%CI)
A. Sexual Behaviour				
<i>Gender</i>				
Male	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Female	3.57 (2.30, 5.52)	3.75 (1.76, 8.03)	3.74 (2.39, 5.86)	4.20 (2.49, 7.08)
<i>Age-group (Years)</i>				
18-24	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
25-29	2.08 (1.18, 3.66)	1.66 (0.68, 4.09)	1.54 (0.84, 2.86)	1.34 (0.64, 2.81)
30-34	1.73 (0.93, 3.22)	0.85 (0.33, 2.21)	1.49 (0.77, 2.88)	1.48 (0.69, 3.12)
35-39	3.04 (1.32, 6.99)	1.71 (0.51, 5.73)	1.37 (0.70, 2.70)	1.50 (0.68, 3.34)
40-44	1.39 (0.58, 3.33)	0.99 (0.28, 3.46)	1.87 (0.78, 4.49)	1.41 (0.48, 4.12)
45+	1.88 (0.63, 5.58)	0.55 (0.13, 2.40)	0.92 (0.42, 2.02)	0.90 (0.36, 2.23)
<i>Marital Status</i>				
Married	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Monogamously	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Married Polygamous	1.59 (0.71, 3.53)	0.97 (0.33, 2.88)	0.82 (0.45, 1.51)	0.64 (0.32, 1.28)
Cohabiting	0.51 (0.30, 0.87)	0.55 (0.26, 1.19)	0.29 (0.16, 0.53)	0.33 (0.17, 0.63)
<i>Education</i>				
None	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Primary	0.82 (0.28, 2.41)	0.27 (0.04, 1.71)	0.95 (0.41, 2.24)	1.46 (0.61, 3.50)
Secondary	0.71 (0.29, 1.13)	0.30 (0.05, 1.87)	0.41 (0.17, 1.03)	0.97 (0.34, 2.75)
Post Secondary	0.39 (0.17, 0.90)	0.21 (0.03, 1.67)	0.35 (0.09, 1.31)	1.13 (0.26, 4.81)
Vocational	0.48 (0.12, 1.93)	0.33 (0.03, 3.45)	0.49 (0.12, 1.98)	1.38 (0.32, 5.89)
<i>Wealth Quartile</i>				
Lowest	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Second	1.36 (0.71, 2.64)	1.09 (0.42, 2.86)	2.65 (1.47, 4.78)	2.99 (1.54, 5.79)

Background Characteristics	Kampala		Soroti	
	Crude OR, (95%CI)	Adjusted OR, (95%CI)	Crude OR, (95%CI)	Adjusted OR, (95%CI)
Third Highest	1.65 (0.88, 3.11)	2.50 (0.88, 7.07)	1.66 (0.93, 2.95)	1.87 (0.95, 3.68)
B. Sexual behaviour				
<i>Number of Sexual Partners</i>				
1 Partner	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
2+ Partners	0.47 (0.29, 0.76)	1.02 (0.42, 2.49)	0.23 (0.13, 0.40)	0.43 (0.20, 0.93)
<i>HIV Risk Perception</i>				
Not Likely at all	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Limited Chance	1.68 (0.88, 3.23)	1.87 (0.63, 5.56)	0.48 (0.25, 0.93)	0.86 (0.38, 1.98)
Very Likely	1.34 (0.70, 2.59)	1.15 (0.39, 3.37)	0.59 (0.29, 1.21)	1.03 (0.42, 2.52)
C. Community Perception of HCT				
<i>HCT information always available at the nearby HIV testing place</i>				
Yes	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
No	0.25 (0.16, 0.40)	0.33 (0.11, 0.99)	0.85 (0.55, 1.30)	0.31 (0.13, 0.76)
D. Exposure to HCT Campaigns				
<i>Exposure to GTKT</i>				
Yes	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
No	0.45 (0.28, 0.72)	0.73 (0.34, 1.56)	0.51 (0.24, 1.06)	0.34 (0.13, 0.89)

As shown in Table 13, the female gender, marital status, residence in rural area, socio-economic status (SES), number of sexual partners and community perceptions on availability of HCT were strongly associated with HCT uptake. Female respondents in both Soroti and Kampala districts were about 4 times, significantly, more likely to have received HCT compared to their male counterparts [Kampala Adjusted OR: 3.57 (2.30, 5.52), Soroti Adjusted OR: 4.26 (2.89, 6.27)]. By taking 18-24 age-group as the referent group, individuals aged 25 years and above were more likely to have received HCT although this was only statistically significant in the 25 – 29 age-group in Soroti district. No significant difference was seen in ever receipt of HCT between monogamous and polygamous respondents. However, cohabiting respondents in Soroti district were 67 percent [Adjusted OR: 0.33 (0.17, 0.63)] less likely to have received HCT compared to those in monogamous relationships. Respondents reporting 2 or more sexual partners in Soroti were 57% less likely to have received HCT [Adjusted OR: 0.43 (0.20, 0.93)] compared their counterparts who had 1 partner.

Furthermore, community perceptions on the availability of HCT had a significant association to HCT uptake. For instance, respondents who were not aware of the availability of HCT information in their communities were 67% [OR=0.33; 0.11, 0.99] less likely to receive HCT in Kampala and those in Soroti were 69% [OR=0.31; 0.13, 0.76] less likely to have received HCT compared to those who thought HCT services were available in their communities. Also, Table 13 presents exposure to HCT messages as determinants to uptake of HCT. As shown in the crude odds ratio column in the table above, uptake of HCT was significantly associated to exposure to the messages. Exposure to the GTKT campaign was significantly associated with HCT uptake. Respondents who had not seen or heard messages on the GTKT in both Kampala and Soroti were less likely to report receipt of HCT. Upon adjustment for

confounding factors, this association became statistically significant in Soroti district but non-significant in Kampala.

4.5.2 Determinants of CHCT uptake

Looking at the adjusted OR in Table 14 below, Kampala residents in the highest wealth quartile were 5 times more likely to report CHCT compared to their counterparts in the lowest quartile. Cohabiting respondents in Soroti were 70 percent less likely to report CHCT than their monogamously married counterparts. Also, those that reported that CHCT information is available nearby were 2.5 times more likely to report CHCT compared to their counterparts who did not report the availability of this information nearby.

Table 14: Adjusted OR for CHCT uptake by background characteristics

Background Characteristics	<u>Kampala</u>		<u>Soroti</u>	
	Crude OR, (95%CI)	Adjusted OR, (95%CI)	Crude OR, (95%CI)	Adjusted OR, (95%CI)
A. Social Demographics				
<i>Gender</i>				
Male	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Female	0.82 (0.47, 1.42)	0.81 (0.43, 1.55)	0.51 (0.27, 0.98)	0.58 (0.28, 1.21)
<i>Marital Status</i>				
Married			Referent (OR: 1.00)	
Monogamously	Referent (OR: 1.00)	Referent (OR: 1.00)	1.00	Referent (OR: 1.00)
Married Polygamous	0.45 (0.19, 1.06)	0.49 (0.18, 1.33)	0.51 (0.25, 1.05)	0.62 (0.27, 1.43)
Cohabiting	0.66 (0.33, 1.32)	0.78 (0.36, 1.67)	0.25 (0.11, 0.60)	0.31 (0.12, 0.78)
<i>Wealth Quartile</i>				
Lowest	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
Second	3.13 (0.94, 10.46)	3.13 (0.86, 11.42)	0.83 (0.43, 1.61)	0.73 (0.36, 1.50)
Third	3.47 (1.09, 11.08)	3.28 (0.89, 12.14)	1.57 (0.72, 3.40)	1.50 (0.66, 3.38)
Highest	5.30 (7.74, 16.14)	5.00 (1.44, 17.13)	1.00 (0.35, 2.89)	0.87 (0.27, 2.79)
B. Sexual behaviour				
<i>Number of Sexual Partners</i>				
1 Partner	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
2+ Partners	0.69 (0.32, 1.49)	0.60 (0.25, 1.46)	0.79 (0.33, 1.93)	0.64 (0.22, 1.91)
C. Community Perception of HCT				
<i>HCT information always available at the nearby HIV testing place</i>				
Yes			Referent (OR: 1.00)	
No	Referent (OR: 1.00)	Referent (OR: 1.00)	1.00	Referent (OR: 1.00)
	0.55 (0.19, 1.51)	0.45 (0.07, 2.91)	1.95 (1.11, 3.40)	0.87 (0.37, 2.01)
<i>CHCT information always available at the nearby HIV testing place</i>				
Yes			Referent (OR: 1.00)	
	Referent (OR: 1.00)	Referent (OR: 1.00)	1.00	Referent (OR: 1.00)

Background Characteristics	<u>Kampala</u>		<u>Soroti</u>	
	Crude OR, (95%CI)	Adjusted OR, (95%CI)	Crude OR, (95%CI)	Adjusted OR, (95%CI)
No	0.65 (0.27, 1.60)	1.49 (0.29, 7.50)	2.51 (1.35, 4.66)	2.49 (1.06, 5.87)
D. Exposure to HCT Campaigns				
<i>Exposure to GTKT</i>				
Yes	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)	Referent (OR: 1.00)
No	0.74 (0.35, 1.56)	0.95 (0.42, 2.14)	1.67 (0.46, 6.02)	1.79 (0.41, 7.78)

4.5.3 Ways to make CHCT acceptable as adduced from qualitative component

In order to increase uptake for CHCT, various suggestions were made some of which revolve around making the service more acceptable to people in long-term sexual relationships while the other is more legislative. In order to increase acceptable, participants proposed that service providers invest more resources in sensitization of the general public about the advantages of CHCT.

It is sensitizing married people, counselors have to come here like you have done and tell couples the advantages of couple counseling, if that is not done, they will continue fearing to go for HIV testing (FGD with Men, who had never received HCT in Kampala).

Participants further proposed the use of interpersonal communication channels in the sensitization campaign. They noted that whereas channels like mass media reach many people, they lack the element of interpersonal connection; service providers too, should consider holding family talks, engaged in home to home visits.

My personal view is that there is need to conduct family talks with couples because in most programs we have not target couples, existing programs are targeting men and women separately, we should go to people's homes and talk to them as a couple (KII, DHE Soroti).

There should be a dialogue session with men to make them realize the importance of testing with their wives. We also need to design a service package which can encourage men to come, for example reduce long waiting hours because this is their major complaint (KII, AIC Soroti).

The above notwithstanding, study participants were quick to add that service providers should not go out to communities providing CHCT services without providing effective referrals for those found HIV positive. They suggested that as part of efforts to make CHCT more acceptable to people, service providers should streamline and strengthen the referral system.

Health services should also be brought closer; it will be hard for a man to find an excuse for not testing for HIV when the health center is near (FGD with Men who received Couple HCT in Soroti).

By streamlining the referral system, I hear people here complain especially about NGOs which conduct outreaches, they come test people but they don't give them drugs, they just say go the

health center, people need assurance and clear guidance on where to get support after they have tested for HIV (VHT Soroti).

Other participants however, had different views about increasing uptake for CHCT. According to them, making CHCT more acceptable will not yield much; they propose legislation to compel men to go for HIV testing with their partners. Men and women holding this view decried a lot of liberty that had been given to people, and hence needed to be compelled to go for HIV testing.

People have been given a lot of liberty to decide whether to test or not, and that is what is killing us, we need to make it mandatory, move door to door testing everyone, whoever refuses is punished (FGD with Men who received HCT individually in Kampala).

There were reports in Soroti that compelling men to accompany their wives for antenatal had greatly contributed to the rising cases of CHCT.

These days it is mandatory for a woman to be tested with her husband before she can receive antenatal care services, if she doesn't bring her husband; she doesn't get the antenatal card (FGD with Men who received Couple HCT in Soroti).

Overall, the potential to raise further cases of couples in long term sexual relationships seeking CHCT exists. This is based on the fact that actually all participants both in the FGDs and quantitative component recognize that there are advantages in seeking CHCT. Some of the benefits cited include opportunity to plan for the future (55.3%), know HIV status of partner before commitment (22%) and giving a peace of mind to people in a relationship (64%).

4.5.4 Decision-making about CHCT among couples

Despite the numerous advantages cited in support of CHCT, participants in FGDs felt that decision to seek CHCT lies in the hands of men. In response to questions about who should take decisions about CHCT among people in long- term sexual relationships, participants felt that it should be men to take such decisions given their positions in the families.

For me I think it should be the man because he is the head of the household...if a man asked his wife to go for an HIV test and she refused, he would chase her, which is not the case if it was the woman asking the husband (FGD with Men, who had never received HCT in Kampala).

It is the man because he is the one responsible for the family, because in a home it is you the man who does the planning, you provide all the support, you are responsible for the children's education...(FGD with Men who received HCT individually in Kampala).

4.6 HIV RISK PERCEPTION AND STIGMA

4.6.1 HCT among couples that have never tested for HIV

In the survey, questions targeting individuals who had never tested for HIV were included to understand reasons as to why they have never tested for HIV, their intentions to test and establish ways how to motivate them to test for HIV in future. It should be recalled that 33.7% of the total sample had never received HCT. Although they had never received HCT, 76% of these respondents had ever thought about having an HIV test (Figure 9). The proportion of respondents who had never tested for HIV but who thought of seeking an HIV test in the future was higher in Soroti (82%) than in Kampala (71%)

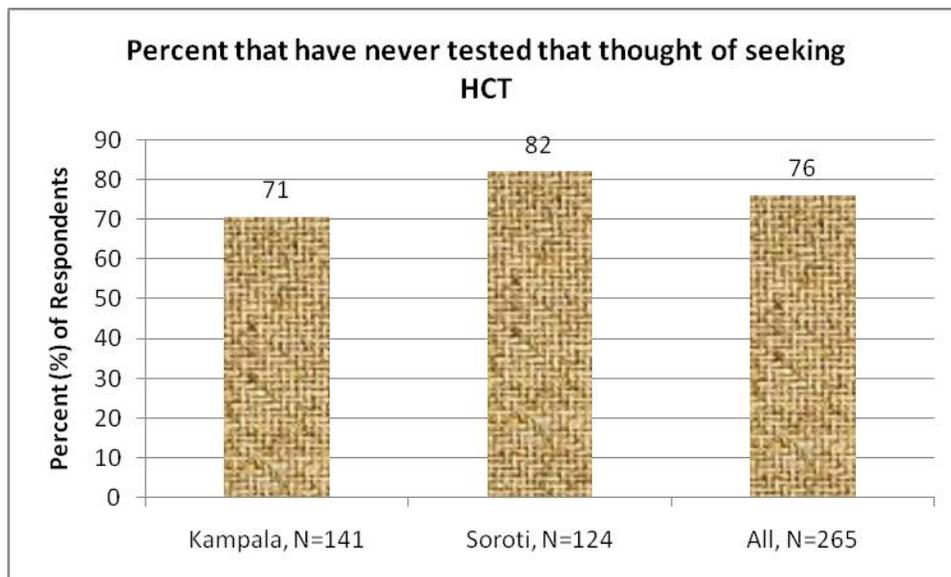


Figure 9: Percent of people that have never tested that thought of seeking HCT

4.6.2 Reported reasons for never testing for HIV

When asked why they had never tested for HIV, 39% of the never-tested respondents reported that there was no place to test from, 34% think they have no HIV, while 20% prefer to remain unaware (Figure 10). In Soroti, the main reasons mentioned for not testing for HIV were: 'no place to test from' (44%), 'I know I have no HIV' (33%), 'better to remain unaware' (21%) and 'I fear to be suspected by partner' (17%). In Kampala, the main reasons for not testing for HIV were: 'I know I have no HIV' (36%), 'no place to test from' (32%), 'better to remain unaware' (17%) and 'I fear to be suspected by partner' (15%).

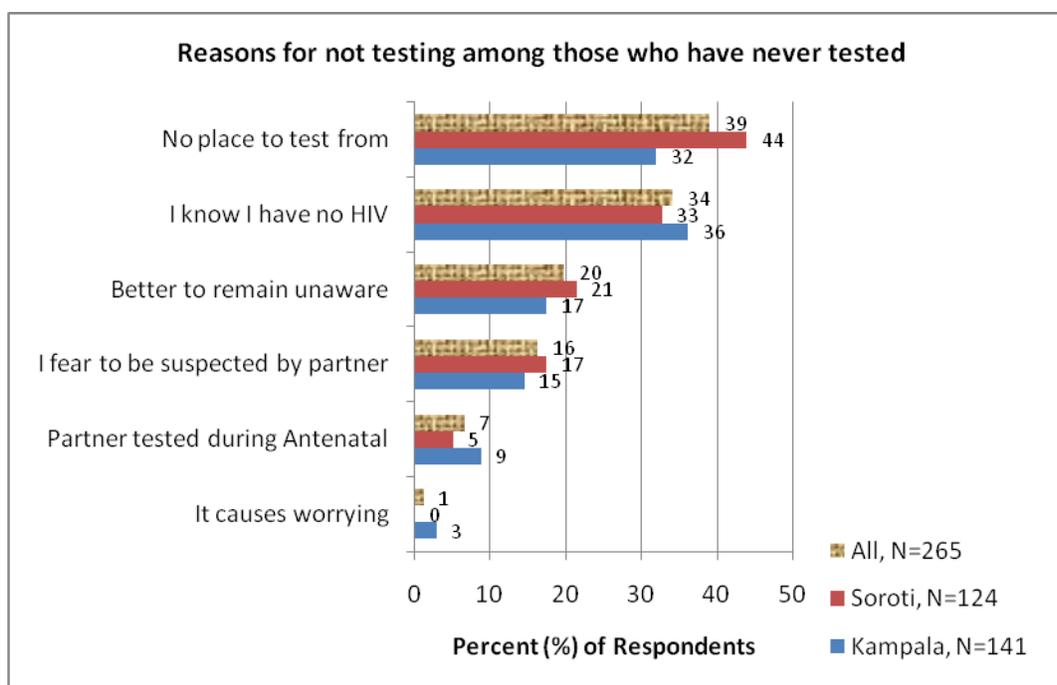


Figure 10: Reasons for not testing for HIV

4.6.3 Reported advantages of knowing status among respondents that had never tested for HIV

Although some respondents had never tested for HIV, the survey attempted to find out if such respondents knew any advantages associated with knowing ones' HIV status. Almost all respondents (94%) reportedly knew advantages of knowing one's HIV status (Table 15 and 16). In Kampala, the main reported advantages of knowing one's HIV status were: start treatment early (61.9%), one's ability to plan for his/her family after knowing their HIV status (42.9%), being able to avoid re-infection (23.8%), and being able to live positively (27.8%), see Table 15 for details.

Table 15: Reported advantages of knowing HIV status among respondents that have never tested for HIV in Kampala

<u>Advantages of knowing HIV status</u>						
Background Characteristics	Start treatment early	Able to avoid re-infection	Able to live positively	To avoid strenuous work	Plan for my family	Number, N
Overall	61.9	23.8	27.8	5.6	42.9	126
Gender						
Male	59.1	26.1	27.3	6.8	43.2	88
Female	68.4	18.4	28.9	2.6	42.1	38
Age (Years)						
18-24	59.1	19.7	25.8	4.5	34.8	66
25-29	59.1	40.9	27.3	0.0	36.4	22

30-34	50.0	31.3	37.5	0.0	68.8	16
35-39	75.0	12.5	25.0	12.5	62.5	8
40-44	100.0	12.5	25.0	25.0	37.5	8
45+	80.0	20.0	40.0	20.0	80.0	5
Marital Status						
Married						
Monogamously	65.9	22.0	31.7	4.9	58.5	41
Married Polygamous	88.9	33.3	22.2	22.2	55.6	9
Cohabiting	57.6	18.2	30.3	0.0	39.4	33
Other	58.5	29.3	24.4	7.3	24.4	41
Education						
None	60.0	20.0	0.0	20.0	20.0	5
Primary	63.8	27.7	29.8	2.1	42.6	47
Secondary	67.9	15.1	20.8	9.4	43.4	53
Post-secondary	38.5	61.5	53.8	0.0	46.2	13
Vocational	50.0	0.0	37.5	0.0	50.0	8
Religion						
None	66.7	33.3	0.0	0.0	33.3	3
Muslim	71.4	17.9	25.0	7.1	53.6	28
Roman Catholic	58.1	27.9	27.9	4.7	32.6	43
Protestant / Anglican	61.5	23.1	23.1	7.7	46.2	39
Other - Christian	53.8	23.1	53.8	0.0	46.2	13
Wealth Quartile						
Lowest	59.3	37.0	37.0	7.4	44.4	27
Second	60.0	12.0	20.0	0.0	32.0	25
Third	67.7	19.4	19.4	9.7	41.9	31
Highest	60.5	25.6	32.6	4.7	48.8	43

In Soroti, the main advantages of knowing one's HIV status that were mentioned were similar to those mentioned in Kampala. As shown in Table 16 below, starting treatment early (84.5%) was the main advantage associated with knowing one's HIV status, among those that had never received HCT. This was followed by one's ability to plan for his/her family (46.6%), ability to live positively (23.3%), being able to avoid re-infection (11.2%) and avoiding strenuous work (8.6%), see Table 16 for details. In both Kampala and Soroti, the need to start treatment early and to plan for one's family seemed to stand out as key advantages that would motivate individuals who have never tested for HIV to go for HIV testing.

Table 16: Reported advantages of knowing HIV status among respondents that have never tested for HIV in Soroti

Advantages of knowing HIV status						
Background Characteristics	Start treatment early	Able to avoid re-infection	Able to live positively	To avoid strenuous work	Plan for my family	Number, N

Overall	84.5	11.2	23.3	8.6	46.6	116
Gender						
Male	86.8	15.8	23.7	6.6	46.1	76
Female	80.0	2.5	22.5	12.5	47.5	40
Age (Years)						
18-24	81.4	11.6	20.9	4.7	41.9	43
25-29	90.5	19.0	28.6	4.8	57.1	21
30-34	70.6	5.9	17.6	11.8	64.7	17
35-39	100.0	11.8	17.6	17.6	35.3	17
40-44	83.3	0.0	33.3	33.3	33.3	6
45+	83.3	8.3	33.3	0.0	41.7	12
Marital Status						
Married						
Monogamously	79.1	7.5	26.9	7.5	50.7	67
Married Polygamous	93.8	0.0	25.0	25.0	43.8	16
Cohabiting	90.3	25.8	16.1	3.2	35.5	31
Other	100.0	0.0	0.0	0.0	100.0	2
Education						
None	100.0	12.5	0.0	25.0	37.5	8
Primary	80.0	6.7	28.3	5.0	45.0	60
Secondary	89.2	16.2	16.2	5.4	54.1	37
Post Secondary	100.0	33.3	33.3	33.3	33.3	6
Vocational	60.0	0.0	40.0	20.0	40.0	5
Religion						
None	100.0	0.0	0.0	0.0	0.0	2
Muslim	66.7	16.7	16.7	16.7	83.3	6
Roman Catholic	90.9	9.1	23.6	9.1	45.5	55
Protestant / Anglican	78.0	12.2	24.4	9.8	41.5	41
Other - Christian	83.3	16.7	25.0	0.0	58.3	12
Wealth Quartile						
Lowest	80.9	6.4	25.5	4.3	44.7	47
Second	85.0	10.0	15.0	0.0	55.0	20
Third	87.5	20.8	16.7	12.5	41.7	24
Highest	88.0	12.0	32.0	20.0	48.0	25

4.6.4 Intention to test for HIV among respondents that had never tested for HIV

Among respondents who had never tested for HIV, 82.3% had intention to test in future (Table 17). Intentions to test for HIV were higher among never-tested respondents in Soroti (83.9%) than in Kampala (80.9%). In Kampala, intention to test was higher among males (82.7%), those aged 35-39 (87.5%), individuals in monogamous relationships (84.4%), persons with no education (100%) and those in the lowest wealth quartile (89.7%). In Soroti, on the other hand, intention to test for HIV was higher among males (89.7%), persons aged 18-24 years (89.1%), those in cohabiting relationships (96.8%), persons with secondary education (92.1%) and those in the third wealth quartile (92%).

Table 17: Intend to test for HIV among those that never tested for HIV

Background Characteristics	Kampala N=141(%)	Soroti N=124(%)	Total N=265 (%)
Overall	80.9	83.9	82.3
<i>Gender</i>			
Male	82.7	89.7	80.7
Female	76.7	73.9	85.4
<i>Age-group (Years)</i>			
18-24	81.6	89.1	87.7
25-29	82.6	86.4	91.1
30-34	73.7	83.3	75.7
35-39	87.5	82.4	72.0
40-44	77.8	75.0	58.8
45+	80.0	69.2	72.2
<i>Marital Status</i>			
Married Monogamous	84.4	85.9	85.3
Married Polygamous	77.8	57.9	67.9
Cohabiting	82.1	96.8	90.0
Other	76.1	66.7	71.4
<i>Education</i>			
None	100.0	87.5	92.3
Primary	78.0	84.9	84.5
Secondary	85.0	92.1	82.7
Post-Secondary	66.7	28.7	64.0
Vocational	87.5	80.0	84.6
<i>Religion</i>			
None	100.0	50.0	80.0
Muslim	83.9	85.7	76.3
Roman Catholic	78.7	87.7	83.7
Protestant / Anglican	79.6	83.7	83.9
Other – Christian	81.3	73.3	80.6
<i>Wealth Quartile</i>			
Lowest	83.38	86.5	87.8
Second	73.3	85.7	78.4
Third	87.9	92.0	84.5
Highest	79.2	69.2	77.0

4.6.3 Barriers to uptake of HCT services

As revealed, more than a third (34%) of the respondents had never tested for HIV. Participants in FGDs observed that access to HCT services is one of the main constraints to HCT uptake. In the particular case of the rural sub-counties in Soroti, access is constrained by distance as health facilities with HCT services

are far from where participants' homes, which requires service users to travel long distances or spend money on transport.

The places for testing are far, if you don't get it at Gweri sub-county, then you have to go to main hospital in town (referring to Soroti referral hospital)...it is rare for organizations to come here in outreaches. But also we fear to test from here because if you test from here and people discover that you tested positive, you become the laughing stock of the entire village, they refer to you as a moving corpse (FGD with Men who had never received HCT in Soroti).

The other commonly cited barrier to access is fear; cases of stigma and ridicule were reported to be prevalent in communities. In several discussions held both in Kampala and Soroti, participants noted that whereas service access points are available, some people still fear to seek HCT.

When you go to Soroti Hospital for testing and you are found to be HIV positive, they will send you to TASO where they will give you a jerrycan of cooking oil and a sack of flour, so as soon as people in the village see you with those things, they will know that you are sick, that is why some people fear (FGD with Men who had never received HCT in Soroti).

Understaffing and inadequacy of HIV testing kits are the other barriers which were cited by study participants.

There are times when people turn up at an outreach site for testing but they get disappointed when after a whole day of waiting, the counselors send them away saying that the registration forms are over, such people never return (VHT Soroti).

We are understaffed, we have only one laboratory staff, so on a day when he is taken for an outreach, we do not offer HCT services at the health center because there would be nobody to do it (KII, Tubur HC III, Soroti).

4.6.6 Reasons people would rather remain unaware about their HIV status

Reluctance to undertake HCT services among people in long-term sexual relationships was mostly attributed to fear. Apparently, people fear to test because the result can turn out positive. Thus, when many men and women think about HIV testing, their minds always run to the worst case scenario, i.e. the result turning out positive for HIV.

For most people, it is fear, they think that once they get to know their HIV status, they will now fall sick and probably worry to death, so they prefer to die without knowing the actual problem killing them (FGD with Men who received HCT individually in Kampala).

Fear of being discriminated and stigmatized in the village, if people get to know that you tested HIV positive, wherever you pass, they talk about you, you get worried, so it is sometimes better not to know (FGD with Women who received Couple HCT in Soroti).

Some people even testified running away from health workers so as to avoid knowing their HIV status. Many argue that something that you do not know cannot worry you hence the reason why they would rather not undergo HIV testing. They insist of not "bothering" the unknown when they do not have any worrying health condition.

One time I took my wife on the bicycle for antenatal care, but when we reached there they told us to take an HIV test, I looked for a way out and managed to escape, I was not ready for an HIV test (FGD with Men, who had never received HCT in Soroti).

As long as I do not have an illness/disease that bothers me or I am not sickly, it makes me feel that I am healthy, it is better to remain in that state (FGD with Men, who had never received HCT in Soroti).

4.6.7 HIV risk perception

The relationship between individuals' perception of their risk for acquiring HIV and their general HCT seeking behaviour is poorly understood (Prata et al. 2006). Understanding this relationship is crucial to the development of effective strategies to fight HIV and AIDS. Research in health communication suggests that an individual is more likely to practice protective sexual behaviour e.g. seeking HCT if they rate themselves at a high risk of acquiring HIV.

In the survey, HIV uninfected respondents were asked whether they think that they are at risk of getting infected with HIV. As shown in Figure 11, 42% of respondents perceived themselves to be at a very high risk of HIV infection. In addition, 34% thought that their chances of catching HIV were limited while only 15% thought that it was not likely at all that they can catch HIV. In Kampala, 44% of the respondents felt that they were very likely to be at risk of HIV infection, 41% felt there was limited chance for them to get infected with HIV, 12% did not see any possibility of getting infected at all, while 3% did not know if they were at risk of getting infected with HIV. In Soroti, 41% felt they were at very likely to be at risk of HIV infection, 27% felt the risk was limited, 18% did not see any likelihood for them to become infected with HIV while 14% reported that they did not know if they were at risk at all.

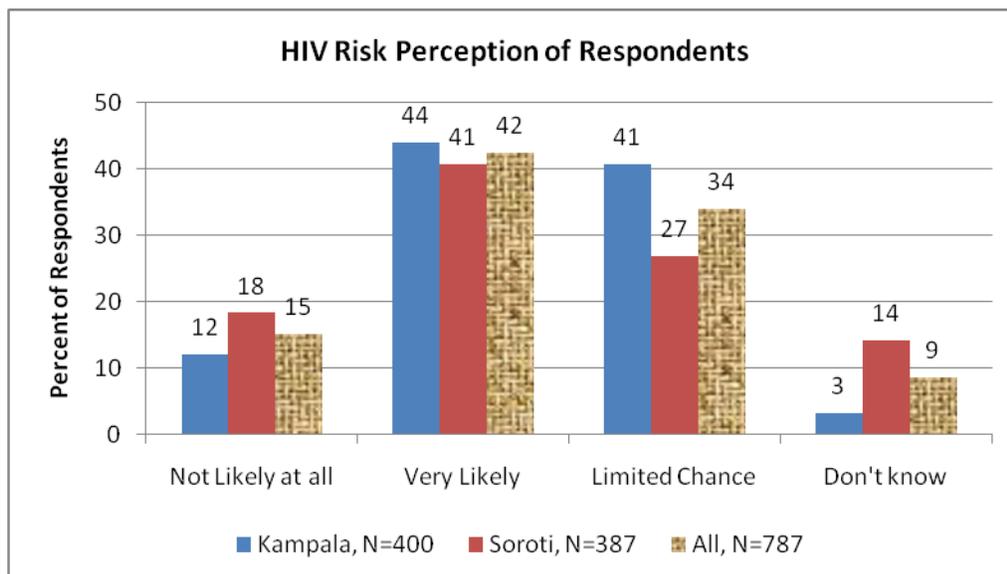


Figure 11: HIV risk perception of respondents

Table 18 and 19 below presents HIV risk perception by background characteristics. Overall, women (47%) perceived themselves to be 'very likely' to catch HIV than their male (37%) counterparts. Also,

polygamous married (55%) respondents had the highest HIV risk perception, followed by those cohabiting (50%) and those who were married monogamously (38%). Markedly, urban residents, individuals aged 35-39 years, the less educated individuals (with none or primary education) and those with vocational education (46.7%); Muslims and respondents from the lowest wealth quartiles perceived themselves to be very likely to catch HIV than their counterparts in their respective categories.

Table 18: HIV risk perception of respondents in Kampala by background characteristics

Background Characteristics	Not Likely (%)	Very Likely (%)	Limited chance (%)	Don't know (%)	Number, N
Overall	12.1	43.9	40.7	3.3	400
Gender					
Male	15.2	36.9	44.4	3.5	199
Female	9.1	51.0	36.9	3.0	201
Age (Years)					
18-24	16.2	39.9	40.5	3.5	173
25-29	10.8	41.0	48.2	0.0	84
30-34	10.2	52.5	32.2	5.1	61
35-39	7.9	65.8	21.1	5.3	39
40-44	0.0	32.0	60.0	8.0	25
45+	5.9	41.2	52.9	0.0	17
Marital Status					
Married Monogamously	12.9	41.8	41.8	3.5	171
Married Polygamous	0.0	57.4	42.6	0.0	49
Cohabiting	8.5	51.1	36.2	4.3	95
Other	21.7	33.7	42.2	2.4	83
Education					
None	5.6	50.0	33.3	11.1	18
Primary	11.7	50.0	36.4	1.9	156
Secondary	10.7	38.7	48.2	2.4	170
Post-secondary	23.7	31.6	36.8	7.9	38
Vocational	11.1	61.1	22.2	5.6	18
Religion					
None	20.0	60.0	20.0	0.0	6
Muslim	8.9	45.6	43.3	2.2	91
Roman Catholic	10.4	41.8	44.8	3.0	135
Protestant / Anglican	14.2	48.7	32.7	4.4	114
Other - Christian	16.7	35.2	44.4	3.7	54
Wealth Quartile					
Lowest	10.3	48.5	35.3	5.9	68
Second	13.9	50.6	31.6	3.8	82
Third	12.7	44.1	42.2	1.0	102
Highest	11.6	38.1	46.9	3.4	148

In Kampala, the perception that one was very likely to be at risk of HIV infection was higher among females (51%), individuals aged 35-39 years (65.8%), persons in polygamous relationships (57.4%), those with vocational education (61.1%) and persons in the second wealth quartile (50.6%), see Table 18 above. In Soroti, the perception that one was very likely to be at risk of HIV infection was also higher among females (43.1%), and among those aged 45+ years (50%), those with post-secondary education (50%) and those in the highest wealth quartile (53.2%), see Table 19 below for details.

Table 19: HIV risk perception of respondents in Soroti by background characteristics

Background Characteristics	Not Likely (%)	Very Likely (%)	Limited chance (%)	Don't know (%)	Number, N
Overall	18.3	40.7	26.8	14.2	387
Gender					
Male	15.3	37.3	32.7	14.7	160
Female	20.4	43.1	22.7	13.9	227
Age (Years)					
18-24	17.1	45.5	27.6	9.8	123
25-29	25.6	37.2	23.1	14.1	79
30-34	10.5	31.6	33.3	24.6	63
35-39	20.8	39.6	26.4	13.2	56
40-44	7.4	40.7	29.6	22.2	33
45+	25.0	50.0	17.9	7.1	33
Marital Status					
Married Monogamously	22.4	35.6	28.4	13.6	266
Married Polygamous	13.3	53.3	25.0	8.3	62
Cohabiting	5.7	49.1	20.8	24.5	56
Other	0.0	66.7	33.3	0.0	3
Education					
None	16.7	40.0	26.7	16.7	31
Primary	19.2	42.4	25.8	12.7	247
Secondary	17.3	37.0	28.4	17.3	83
Post-secondary	14.3	50.0	28.6	7.1	14
Vocational	16.7	25.0	33.3	25.0	12
Religion					
None	16.7	0.0	83.3	0.0	6
Muslim	7.1	50.0	35.7	7.1	14
Roman Catholic	18.1	45.0	24.4	12.5	173
Protestant / Anglican	21.6	33.6	26.9	17.9	141
Other - Christian	13.5	48.1	25.0	13.5	53
Wealth Quartile					

Lowest	20.2	41.1	24.8	14.0	136
Second	21.9	38.1	28.6	11.4	111
Third	12.9	36.5	32.9	17.6	92
Highest	14.9	53.2	17.0	14.9	48

4.6.8 Prevalence of stigma

People living with HIV often suffer stigma and discrimination in many communities. Multi donor-funded HIV programs strive to fight such attitudes and to encourage positive living and utilization of HIV/AIDS testing, care, treatment and support services by fighting secrecy and denial. The level of HIV/AIDS stigma was assessed in terms of stigma for blame and fear related to stigma. As shown in the Table 20 and 21 below, there is a high level of stigma in both Kampala and Soroti. In Kampala, the proportion that believed that HIV/AIDS is a punishment for bad/immoral behavior was 52% while 46% believed that they would not feel comfortable hugging someone with HIV virus. Higher proportions of females, persons aged 25-29 years, those in polygamous relationships, persons with no education, and those in the third wealth quartile tended to believe that HIV/AIDS is a punishment for bad/immoral behavior than to their counterparts. On the other hand, higher proportions of females, those aged 18-24 years, those in cohabiting relationships, individuals with no education, and those in the second wealth quartile tended to believe that they would not feel comfortable hugging someone with HIV (see Table 20 below).

Table 20: Extent of HIV stigma undertones in Kampala by selected sample characteristics

Background Characteristics	HIV/AIDS is a punishment for bad/immoral behaviour (%)	Would not feel comfortable hugging someone with HIV virus (%)	Number, N
Overall	51.5	46.0	400
Gender			
Male	48.7	45.7	199
Female	54.2	46.3	201
Age (Years)			
18-24	50.9	49.7	173
25-29	58.3	44.0	84
30-34	50.8	45.9	61
35-39	51.3	43.6	39
40-44	40.0	48.0	25
45+	47.1	17.6	17
Marital Status			
Married Monogamously	54.4	43.9	171
Married Polygamous	57.1	32.7	49
Cohabiting	53.7	66.3	95
Other	38.6	34.9	83
Education			
None	61.1	61.1	18
Primary	51.3	41.0	156

Secondary	56.5	55.3	170
Post-secondary	23.7	15.8	38
Vocational	55.6	50.0	18
Religion			
None	16.7	16.7	6
Muslim	54.9	53.8	91
Roman Catholic	49.6	44.4	135
Protestant / Anglican	52.6	47.4	114
Other - Christian	51.9	37.0	54
Wealth Quartile			
Lowest	52.9	47.1	68
Second	53.7	52.4	82
Third	57.8	47.1	102
Highest	45.3	41.2	148

As shown in Table 21 below, 87.3% of the respondents believed that HIV/AIDS is a punishment for bad/immoral behavior while 30% believed that they would not feel comfortable hugging someone with HIV. There were higher proportions of females, persons aged 18-24 years, those in monogamous relationships, those with primary education, Muslims and persons in the lowest wealth quartile who believed that HIV/AIDS is a punishment for bad/immoral behavior than their counterparts. There were also higher proportions of females, persons aged 18-24 years, those in polygamous relationships, persons with education, and persons in the second wealth quartile who believed that they would feel uncomfortable hugging someone with HIV (see Table 21 below for details).

Table 21: Extent of HIV stigma undertones in Soroti by selected sample characteristics

Background Characteristics	HIV/AIDS is a punishment for bad/immoral behaviour (%)	Would not feel comfortable hugging someone with HIV virus (%)	Number, N
Overall	87.3	30.2	387
Gender			
Male	81.3	23.1	160
Female	91.6	35.2	227
Age (Years)			
18-24	89.4	36.6	123
25-29	92.4	24.1	79
30-34	84.1	23.8	63
35-39	87.5	32.1	56
40-44	72.7	30.3	33
45+	87.9	30.3	33
Marital Status			
Married Monogamously	88.3	30.5	266

Married Polygamous	87.1	32.3	62
Cohabiting	83.9	26.8	56
Other	66.7	33.3	3
<i>Education</i>			
None	87.1	48.4	31
Primary	91.9	34.4	247
Secondary	83.1	20.5	83
Post-secondary	64.3	0.0	14
Vocational	50.0	0.0	12
<i>Religion</i>			
None	100.0	50.0	6
Muslim	100.0	28.6	14
Roman Catholic	85.5	31.2	173
Protestant / Anglican	85.8	28.4	141
Other - Christian	92.5	30.2	53
<i>Wealth Quartile</i>			
Lowest	89.7	37.5	136
Second	88.3	38.7	111
Third	85.9	19.6	92
Highest	81.3	10.4	48

4.7 COMMUNITY PERCEPTIONS AND OPINIONS ABOUT CHCT

4.7.1 Community perceptions on the availability of HCT

People's perception on the availability of HCT influences their seeking behaviour for HCT services. To measure these perceptions, all respondents were asked whether they agreed or disagreed with the statement that HCT services were available nearby. Overall, 65% agreed that HCT and CHCT services are available nearby while 75% agreed with the statement that there are many places which offer CHCT in the community. In Kampala, 79.8% of the participants agreed with the statement 'HCT services are available nearby', 77.3% agreed with the statement, 'Many places which offer CHCT are available', while 71.8% agreed with the statement, 'CHCT services are available nearby' (Table 22). These findings show favorable community perceptions that provide a fertile ground for promotion of HCT and CHCT in Kampala.

Table 22: Community perceptions in Kampala on availability of HCT services by background characteristics

Background Characteristics	HCT Services		CHCT Services		Many places which offer CHCT		Number, N
	HCT services are available nearby (%)	HCT services are not available nearby (%)	CHCT services are available nearby (%)	CHCT services are not available nearby (%)	Many places which offer CHCT are available (%)	Not many places which offer CHCT are available (%)	
Overall	79.8	16.8	71.8	17.8	77.3	11	400
Gender							
Male	78.4	18.1	69.3	20.1	74.4	14.1	199
Female	81.1	15.4	74.1	15.4	80.1	8	201
Age (Years)							
18-24	75.1	19.1	65.9	22	71.1	15	173
25-29	79.8	20.2	72.6	16.7	79.8	9.5	84
30-34	85.2	13.1	73.8	14.8	80.3	4.9	61
35-39	89.7	2.6	89.7	0	94.9	0	39
40-44	80	20	68	28	84	12	25
45+	88.2	11.8	88.2	11.8	70.6	17.6	17
Marital Status							
Married Monogamously	84.2	13.5	77.8	14	82.5	8.2	171
Married Polygamous	83.7	14.3	67.3	18.4	73.5	6.1	49
Cohabiting	73.7	22.1	70.5	22.1	76.8	10.5	95
Other	75.9	18.1	63.9	19.3	69.9	19.3	83
Education							
None	77.8	22.2	72.2	11.1	83.3	5.6	18
Primary	77.6	17.9	71.2	19.9	75.6	9	156
Secondary	81.8	15.9	72.9	17.6	77.6	13.5	170
Post-secondary	78.9	15.8	65.8	18.4	68.4	15.8	38
Vocational	83.3	11.1	77.8	5.6	100	0	18

Religion							
None	100	0	83.3	0	66.7	0	6
Muslim	82.4	15.4	75.8	18.7	75.8	14.3	91
Roman Catholic	80	14.8	70.4	15.6	80.7	7.4	135
Protestant / Anglican	78.9	18.4	73.7	17.5	74.6	13.2	114
Other - Christian	74.1	22.2	63	24.1	77.8	11.1	54
Wealth Quartile							
Lowest	75	16.2	61.8	20.6	69.1	8.8	68
Second	82.9	15.9	79.3	12.2	82.9	8.5	82
Third	73.5	23.5	69.6	22.5	75.5	14.7	102
Highest	84.5	12.8	73.6	16.2	79.1	10.8	148

In soroti, 72.6% of the respondents agreed with the statement, ‘many places which offer CHCT are available’, 57.6% agreed with the statement, ‘CHCT services are available nearby’, while 50.1% agreed with the statement, ‘HCT services are available nearby’ (see Table 16b below). As mentioned for Kampala, these findings suggest favorable community perceptions that offer a fertile ground for the promotion of HCT and CHCT in Soroti.

Table 23: Community perceptions in Soroti on the availability of HCT services by background characteristics

Background Characteristics	HCT Services		CHCT Services		Many places which offer CHCT		Number, N
	HCT services are available nearby (%)	HCT services are not available nearby (%)	CHCT services are available nearby (%)	CHCT services are not available nearby (%)	Many places which offer CHCT are available (%)	Not many places which offer CHCT are available (%)	
Overall	50.1	49.9	57.6	38	72.6	23.3	387
Gender							
Male	44.4	55.6	52.5	41.9	68.8	25.6	160
Female	54.2	45.8	61.2	35.2	75.3	21.6	227
Age (Years)							
18-24	52	48	56.9	39	67.5	30.1	123
25-29	35.4	64.6	45.6	50.6	75.9	20.3	79
30-34	44.4	55.6	50.8	42.9	66.7	25.4	63
35-39	57.1	42.9	64.3	32.1	73.2	23.2	56
40-44	63.6	36.4	75.8	18.2	90.9	3	33
45+	63.6	36.4	72.7	24.2	75.8	21.2	33
Marital Status							
Married Monogamously	45.9	54.1	54.5	42.1	70.7	25.9	266
Married Polygamous	53.2	46.8	61.3	33.9	77.4	16.1	62
Cohabiting	64.3	35.7	66.1	25	75	19.6	56
Other	100	0	100	0	100	0	3

Education							
None	48.4	51.6	48.4	38.7	74.2	19.4	31
Primary	44.1	55.9	53	42.5	70.9	24.7	247
Secondary	61.4	38.6	68.7	28.9	74.7	22.9	83
Post-secondary	85.7	14.3	92.9	7.1	85.7	14.3	14
Vocational	58.3	41.7	58.3	41.7	75	16.7	12
Religion							
None	33.3	66.7	33.3	66.7	66.7	33.3	6
Muslim	78.6	21.4	71.4	21.4	78.6	14.3	14
Roman Catholic	51.4	48.6	56.1	40.5	69.9	27.2	173
Protestant / Anglican	46.8	53.2	63.1	31.9	75.2	19.1	141
Other - Christian	49.1	50.9	47.2	47.2	73.6	22.6	53
Wealth Quartile							
Lowest	47.1	52.9	51.5	41.2	67.6	26.5	136
Second	45.9	54.1	53.2	45	70.3	27.9	111
Third	53.3	46.7	67.4	29.3	78.3	17.4	92
Highest	62.5	37.5	66.7	29.2	81.3	14.6	48

4.7.2 Community perceptions on the quality of care

Community perceptions on the quality of care provided at the HCT facilities have an effect in encouraging people to seek services. In Kampala, 72% agreed with the statement, ‘health providers are always available to provide CHCT’, 69.5% agreed with the statement, ‘CHCT providers are friendly’, 68.8% agreed with the statement, ‘CHCT providers handle couples well’ while 55% agreed with the statement, ‘CHCT providers handle HIV discordant cases well’ (Table 24). These findings continue to re-affirm the positive perceptions about HCT and CHCT, and indirectly show people’s perceptions on the quality of HCT services provided.

Table 24: Community perceptions in Kampala on the quality of care by background characteristics

Background Characteristics	Health providers are always available to provide CHCT		CHCT providers are friendly		CHCT providers handle couples well		CHCT providers handle HIV discordant cases well		Number, N
	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)	
Overall	72.0	11.8	69.5	11.0	68.8	7.0	55.0	6.3	400
Gender									
Male	64.3	14.6	61.3	13.6	58.8	9.5	46.2	7.0	199
Female	79.6	9.0	77.6	8.5	78.6	4.5	63.7	5.5	201
Age-group									
18-24	64.7	13.3	61.8	12.7	63.6	6.9	45.1	9.2	173
25-29	75.0	11.9	71.4	9.5	69.0	7.1	52.4	4.8	84
30-34	82.0	9.8	73.8	14.8	72.1	8.2	67.2	3.3	61
35-39	79.5	7.7	82.1	5.1	79.5	2.6	74.4	0.0	39
40-44	68.0	20.0	76.0	8.0	72.0	8.0	64.0	4.0	25
45+	88.2	0.0	88.2	5.9	82.4	11.8	70.6	11.8	17
Marital Status									
Monogamous	79.5	8.8	76.6	8.2	77.2	3.5	65.5	4.7	171
Polygamous	75.5	10.2	77.6	10.2	73.5	10.2	63.3	8.2	49
Cohabiting	69.5	9.5	66.3	11.6	70.5	6.3	52.6	4.2	95
Other	59.0	21.7	54.2	16.9	47.0	13.3	32.5	10.8	83
Education									
None	83.3	5.6	83.3	5.6	83.3	5.6	61.1	11.1	18
Primary	77.6	8.3	76.3	7.7	73.7	5.8	62.2	3.2	156
Secondary	66.5	15.3	65.9	13.5	65.9	8.8	52.4	5.9	170
Post-secondary	65.8	13.2	52.6	13.2	55.3	5.3	31.6	15.8	38
Vocational	77.8	11.1	66.7	16.7	66.7	5.6	61.1	11.1	18
Religion									
None	83.3	16.7	66.7	16.7	50.0	16.7	33.3	16.7	6
Muslim	78.0	11.0	69.2	17.6	72.5	13.2	54.9	9.9	91

Roman Catholic	68.9	9.6	66.7	9.6	65.2	5.2	54.1	3.7	135
Protestant	64.9	16.7	70.2	7.9	69.3	4.4	56.1	6.1	114
Other – Christian	83.3	7.4	75.9	9.3	72.2	5.6	57.4	5.6	54
Wealth Quartile									
Lowest	64.7	10.3	69.1	5.9	66.2	4.4	52.9	2.9	68
Second	79.3	6.1	68.3	9.8	67.1	6.1	58.5	2.4	82
Third	78.4	9.8	76.5	7.8	74.5	5.9	59.8	6.9	102
Highest	66.9	16.9	65.5	16.2	66.9	9.5	50.7	9.5	148

In Soroti, 78.6% agreed with the statement, ‘CHCT providers are friendly’, 78% agreed with the statement, ‘CHCT providers handle couples well’, 67.4% agreed with the statement, ‘CHCT providers handle HIV discordant cases well’ while 52.2% agreed with the statement, ‘health providers are always available to provide CHCT’, (Table 25).

Table 25: Community perceptions in Soroti on the quality of care by background characteristics

Background Characteristics	Health providers are always available to provide CHCT		CHCT providers are friendly		CHCT providers handle couples well		CHCT providers handle HIV discordant cases well		Number, N
	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)	
Overall	52.2	40.3	78.6	9.8	78	9	67.4	8.8	387
Gender									
Male	46.3	45	70.6	11.9	70	10.6	63.1	8.8	160
Female	56.4	37	84.1	8.4	83.7	7.9	70.5	8.8	227
Age-group									
18-24	50.4	42.3	75.6	12.2	78.9	8.1	69.1	7.3	123
25-29	50.6	45.6	83.5	8.9	82.3	8.9	70.9	8.9	79
30-34	44.4	44.4	74.6	11.1	71.4	15.9	63.5	15.9	63

35-39	48.2	42.9	83.9	5.4	76.8	7.1	66.1	8.9	56
40-44	72.7	18.2	84.8	6.1	87.9	3	66.7	3	33
45+	63.6	30.3	69.7	12.1	69.7	9.1	63.6	6.1	33
<i>Marital Status</i>									
Monogamous	52.6	42.5	83.1	8.6	82.7	8.6	70.7	9.8	266
Polygamous	58.1	29	74.2	11.3	74.2	4.8	64.5	1.6	62
Cohabiting	46.4	42.9	62.5	14.3	60.7	16.1	55.4	12.5	56
Other	0	33.3	66.7	0	66.7	0	66.7	0	3
<i>Education</i>									
None	54.8	35.5	77.4	9.7	83.9	3.2	71	0	31
Primary	51.8	41.3	79.8	10.9	78.9	10.5	68.4	8.9	247
Secondary	48.2	43.4	77.1	9.6	77.1	7.2	67.5	12	83
Post-secondary	78.6	7.1	64.3	0	50	14.3	50	7.1	14
Vocational	50	50	83.3	0	83.3	0	58.3	8.3	12
<i>Religion</i>									
None	66.7	33.3	66.7	16.7	66.7	16.7	83.3	0	6
Muslim	50	35.7	64.3	14.3	64.3	7.1	64.3	7.1	14
Roman Catholic	50.3	42.2	79.2	8.7	80.3	8.1	71.1	9.2	173
Protestant	56.7	34.8	77.3	11.3	77.3	9.2	61.7	9.9	141
Other – Christian	45.3	50.9	84.9	7.5	77.4	11.3	69.8	5.7	53
<i>Wealth Quartile</i>									
Lowest	52.2	37.5	82.4	8.1	79.4	6.6	66.9	5.9	136
Second	44.1	54.1	79.3	15.3	82	12.6	71.2	12.6	111

Third	59.8	31.5	79.3	7.6	77.2	9.8	66.3	10.9	92
Highest	56.3	33.3	64.6	6.3	66.7	6.3	62.5	4.2	48

4.7.3 Perceptions and opinions on MoH messages of “Test Together, Know together”

People who had heard the MoH messages about CHCT noted that they are good messages which portray concern and good intentions. The messages are enlightening and help people to realize the importance of CHCT. In the message, people are made aware of the existence of cases of discordant partners and hence the need to protect the concordant partner. However, some participants were quick to add that use of radio as the mode of communication is not sufficient; interpersonal channels would greatly add value.

The messages are good but most people do not have time to listen to radios, if they can use loud speakers or send messages on phone, I think that would be more effective (FGD with Men, who had never received HCT in Kampala).

I think the message shows that health workers and counselors are concerned, they would like people to have settled minds and a healthy life that is why they have put those messages on radio (FGD with Men who had never received HCT in Soroti).

I think that is a very good idea for radio stations to broadcast on HIV counseling and testing together because it motivates and encourages reluctant individuals to go for couple testing (FGD with Women who received Couple HCT in Soroti).

4.7.4 Perception about HIV testing being for people who have never had sexual intercourse or unprotected sex

People had mixed thoughts regarding who should seek HCT services. In response to a question requiring people’s opinions on the perception that HIV testing is for people who have never had sexual intercourse or unprotected sex; some people were in agreement while others were not. Majority, however, disagreed with the assertion, noting that all people irrespective of whether they are sexually active or not need to undertake an HIV test.

No it is very wrong, HIV testing should be for everybody, we are in a generation of HIV/AIDS...HIV testing should be for all sexually active people (FGD with Men, who had never received HCT in Kampala).

For me I think it is good for both kinds of people, those who have not started having sex and also those who have ever had sex, because it helps them know their status, you know these days there even people who are born with HIV (FGD with Women who received HCT individually in Soroti).

4.7.5 Perceptions about possibility of living with an HIV-discordant partner

Varied views were expressed regarding living with a partner who is discordant. Some people expressed readiness to continue living with their partners who have tested HIV positive. Majority of the participants, particularly men, expressed their discomfort with living with people who have been tested and confirmed to be HIV-positive.

haaaa...if she tested and found herself positive when I am not, I can tell you, we would not stay together, we would just separate (FGD with Men, who had never received HCT in Kampala).

The truth is that there is no person who can remain with his wife if she tested positive and for him he has no HIV...If we have children, I can stay with them, but the woman has to leave (FGD with Men, who had never received HCT in Kampala).

It will be hard to have sex with the woman who is sick and you cannot even get another woman so it's better for such a woman to leave your home (FGD with Men who received HCT individually in Soroti).

No it is difficult, I foresee divorce; the one who is HIV negative can run away, I can also run away, if I am the one who does not have HIV, and my wife has, I run away (FGD with Men who received HCT individually in Kampala).

People who expressed readiness of continuing to live with their discordant partners, their thinking was mostly based on the future of their children.

If we have children, I would stay with my wife so that we can raise our children together, because you can even die of an accident and the woman looks after the children, but if we don't have children, I cannot (FGD with Men who received HCT individually in Kampala).

For the sake of my children, I would stay but we would separate bedrooms, I would not continue having sexual intercourse with him because I do not want him to infect me (FGD with Women who received HCT individually in Soroti).

The fears which people exhibit with regard to living with discordant partners could be attributed to lack of feedback from discordant couples. From the service provider perspective, health workers have been sufficiently equipped with knowledge and skills to handle cases of discordance. In all health facilities and organizations visited during data collection, the research team was informed that health workers had been trained to competently handle discordants and they were certain that the health workers were performing job well.

We have been trained on how to handle discordant couples, we counsel them differently but the challenge is on especially practicing safer sex in situations where it is the man who is HIV positive, we tell them to use condoms, but men are not willing to consistently use condoms (KII, Tubur HC III, Soroti).

However, there were a few voices which expressed uncertainty, which was attributed to limited or total absence of feedback from discordant couples. Cases of women whose husbands were tested and found positive, and were advised to use condoms to protect their wives from infection, but were ANC attendees were becoming common. This largely implies that in the circumstances men either rejected the advice or failed to adhere/comply.

The service providers are trying their best, we have trained them but we do not know what happens after the client leaves, we don't know whether individuals who test HIV positive disclose to their partners when they return home (KII, DHE Soroti)

4.7.6 Perceptions about safety and reliability of condoms among HIV-discordant couples

There were very few people in all the discussions held that expressed confidence in condoms keeping people in discordant relationships safe from infection with HIV. Majority of people in the discussions held expressed uncertainty about the safety and reliability of condoms among HIV-discordants. They

argued that condoms are not 100% safe and, therefore they would not be reliable. The fear of the negative partner having sexual intercourse with a known positive partner was apparent.

I cannot see a woman who is sick and I use a condom with her...one time I talked with a health worker at the Kawempe KCCA health center about condoms, he told me that it is only 99% safe, so when you put on a condom with an infected person, it is like taking shelter from the rain under a tree (FGD with Men, who had never received HCT in Kampala).

I do not think they can fully protect you because, what if you get condoms which are already spoiled, we hear that sometimes condoms have defects, you will end up contracting AIDS as well (FGD with Men who received Couple HCT in Soroti).

The few who felt that condoms were safe to be used in discordant relationships based their argument on the fact that many people use condoms with people whose HIV status they did not know. They further argued that if condoms were not safe and reliable, then many people would be living with HIV. They correctly observed that condoms if used properly, correctly and consistently, they are safe.

Condoms have helped us a lot, people engage in sexual intercourse with people whose HIV status they don't know, if condoms were not there the situation would be bad, if used properly condoms are reliable (FGD with Men who received HCT individually in Kampala).

4.7.7 Skills of service providers with regard to HIV-discordance

From the service provider perspective, health workers have been sufficiently equipped with knowledge and skills to handle cases of discordance. In all health facilities and organizations visited during data collection, the research team was informed that health workers had been trained to competently handle discordants and they were certain that the health workers were performing job well.

We have been trained on how to handle discordant couples, we counsel them differently but the challenge is on especially practicing safer sex in situations where it is the man who is HIV positive, we tell them to use condoms, but men are not willing to consistently use condoms (KII, Tubur HC III, Soroti).

However, there were a few voices which expressed uncertainty, which was attributed to limited or total absence of feedback from discordant couples. Cases of women whose husbands were tested and found positive, and were advised to use condoms to protect their wives from infection, but were ANC attendees were becoming common. This largely implies that in the circumstances men either rejected the advice or failed to adhere/comply.

5.0 DISCUSSION

This study was conducted in two contrasting settings; one basically urban (i.e. Kampala) and the other typical rural (i.e., Soroti) to unravel determinants of HCT uptake among couples in long-term relationships. The study focused on unraveling motivations and barriers for HCT uptake among couples in long-term relationships with a view to identifying the priorities and opportunities for scaling up CHCT. Socio-demographic and economic characteristics of individuals are assumed to influence uptake of HCT in general, and CHCT in particular. In this study, the distribution of the socio-demographic and economic characteristics of the 787 respondents enrolled into the study was largely as one would expect in Uganda's context – a developing country. Majority were females (54.4%) in comparison to 45.5% males. Being a household based study, females were more likely to be found at home than men, who more often have work away from home compared to women. This is further reflected in the patterns of residence, where more men (76.6%) were urban based than females (60.5%). It is common practice for men to leave their wives in rural areas to seek income activities in urban centres, as economic migrants. Other socio-economic characteristics of respondents were as well as expected, for example, Kampala had more respondents employed both in the informal and formal sector, and in the highest wealth quartile in comparison to Soroti where more than 2/3 were farmers and majority in the lowest and second wealth quartile.

There are various determinants of HCT uptake among couples and this study found that individual, social and service supply factors are key determinants of HCT uptake in both rural and urban Uganda. Study results indicate associations of social and demographic factors, such as gender, form of marriage, residence and uptake of HCT. Uptake of CHCT is almost 3 times higher in rural areas (73%) compared to urban settings (29%). Overall, significantly more females 79% than their male (51%) counterparts reported ever receiving HCT (p -value <0.0001). The higher uptake of HCT by females could be linked to the fact that more females (86%) had been exposed to GTKT campaign information in comparison to their male counterparts. There is a possibility that more females tested for HIV because of the country's roll-out of the PMTCT. Moreover, other studies have reported women being more responsive to HIV/AIDS, and other health services (Shegufu, 2012). Noticeably, many males (49%) acknowledged having never taken an HIV test. This implies a need for HCT programs to have specific strategies to target males, to enhance their willingness to test for HIV. Comparing Kampala and Soroti, there are no variations in terms of gender and uptake of HCT. With regard to CHCT uptake, persons in the highest wealth quartile in Kampala and cohabiting residents in Soroti were more likely to receive CHCT than their counterparts. Also, Soroti residents who reported the availability of CHCT information nearby were 2.5 times more likely to report having received CHCT than their counterparts.

While in general, fewer males had ever taken an HIV test, interestingly among those that ever screened, more males did so with their partners (54%) than females (50%). One would expect an equal number or at least more females testing because of polygamous marriages. However, the study recruited respondents as

individuals and not as couples. It is possible that many women tested as individuals during PMTCT and found no value of testing as couples.

Markedly, married respondents were more likely to have ever received HCT than other unions, such as cohabiting or other forms of marital relationships. This can be attributed to the fact that the study was done in an intervention area, which promoted GTKT, focusing on couples. More respondents in monogamous marriage reported testing as couples, possibly because of requirements by several institutions involved in the processes of marriage preparations (including families and religious institutions) that may demand couples to take an HIV test. This is in contrast with other forms of consensual unions such as cohabitations, which is unlikely to have external actors demanding couples to undertake an HIV test. Though not investigated in the study, the interpretation of the concept 'couple' could be those in formal relationships. Meanwhile, rural respondents (84%) were significantly more likely to report ever receipt of HCT than their counterparts from urban (58%) areas (p -value <0.0001). Similarly, more (92%) rural people were exposed to GTKT information compared to their urban counterparts (79%). This lends itself to findings by Flykssness et al. (1999) where rural residents were more responsive to HCT in Zambia.

Education is an important factor in access and comprehension of health information (Katahoire, 1998). Similarly, it is widely known that education is closely associated health practices. Proportionately, those with less formal education were more likely to seek CHCT. Similar to education, respondents in higher economic status were less likely to demand for CHCT compared to their counterparts in lower wealth categories. Often, the higher the economic status, the higher the stigma, given that individuals tend to maintain their status-quo and protect their image. However, when it comes to disclosure of HIV test results, respondents who attained higher education were more likely to share their results with their spouses. Higher educated people are possibly more communicative and appreciate more the importance of sharing health information.

While the country has rolled out free HCT, there are manifestations of association of economic status and uptake of HCT, varying by rural and urban. Kampala has more users of HCT found in the highest wealth quartile (38.6%) compared to Soroti whose majority users were in the second quartile. This scenario is possibly a reflection of the distribution of the economic status of respondents in the two districts (where Kampala had more respondents in the highest quartile), but it could also be attributed to the more availability of private HCT providers in Kampala, where richer people, who often prefer to remain discrete about their HIV status can seek secretive HCT.

In Uganda, there is a general discourse that stigma has gone down in the country. However, this study reveals that stigma is still prevalent at the larger societal level and continues to be a barrier to HCT, in particular CHCT. HIV is still highly moralized, as illustrated by many respondents, perceptions about HIV, as "a punishment". Such moral perceptions of HIV infections definitely discourage CHCT, and

programs therefore need to focus on dealing with stigma issues in order to enhance couple HCT. Dissemination of messages targeting stigma reduction is important.

Associated with community level stigma, willingness or not to discuss HIV and HCT might influence CHCT or not. Findings from qualitative data of this study reveal that couples are reluctant to discuss HIV and testing issues. This is possibly because HIV/ AIDS continues to be regarded as a moral issue, related to irresponsible immoral sex, by different actors in the campaigns against the epidemic such as religious leaders and NGOs, which advocate against “sex networks”. This is in addition to hetero-sex, the main source of infection of HIV in the country, is a taboo, which is rarely discussed even among couples. In particular, females are more skeptical in discussing HIV and thus disclosure, for fear of violence that might arise, yet they are the leading testers and most vulnerable to the effects of the epidemic. However, the general behavior regarding HIV testing and discussion implies that being together for “a long time” as couples does not necessarily mean trust and confidence in each other. It is therefore important for programme managers to create spaces for discussing sex and HIV/ AIDS, in less moralistic way.

One of the research questions for this study was to explore the demand and supply factors that motivate couple testing. Interestingly, when this question was posed, none of the respondent had enabling partner awareness of his or her sero-status. Motivations for HCT are more about the self, where 8 in 10 just wanted to know their HIV status, or because the provider initiated the service during ANC and sickness. This suggests that knowledge of one another’s HIV sero-status is not a major concern among couples. Whyte (1999) noted prior to availability of ART that people preferred to remain uncertain because it was better that way since there was no treatment even if they learnt about HIV status or that of their partners. In some instances, respondents noted emotional issues such as desire to show love to their spouses as motivation to test for HIV. However in general, even with the increased access to ARVs, it is apparent that several people still prefer to remain uncertain about their partners’ HIV status. This calls for intensified messages promoting knowledge partner HIV status, explaining the advantages that come with it.

Despite the increased access to ART, couples still delay to undertake HCT and thus delayed initiation to treatment. Testing is initiated after suspicion, not as a proactive measure. Several respondents reported sickness of self or partner as a motivation to undertake HCT or even CHCT. This is possibly a reflection on ones past sexual behavior or that of the partner, then desire to confirm. On the other hand, the prevalence of many repeat tests might be for those who did not trust the results or those who tested negative and want to repeat the “good feeling” of being told that you are negative.

Access to information on HCT issues is a potential motivator to couple uptake of HCT. Overall, there was a high access to information to HCT related information, mostly from health workers. The accelerated information provision is possibly because the study was conducted in an area where CSF had interventions and support to service providers. Additionally, proportionately, more individuals who had

ever been exposed to GTKT campaign had taken an HIV test. This suggests that exposure to information is likely to heavily influence acceptability of (couple) testing. Even with knowledge, structural barriers to HCT including distance have been well-documented as prohibitive factors for accessing testing services, particularly in rural areas (Thornton, 2008; Morin et al., 2006). It is therefore important to note, that utilizing HCT services Kampala and Soroti, is possibly a result by the high availability service providers, both private and public.

One of the assumptions underlying promotion of couple HCT is that knowledge of the HIV status of one's spouse would lead to behaviour change and then prevention. For this to be more effective there is a need for partner disclosure, most especially in discordant couples or concordant positives. Interestingly, while more couples (62%) in monogamous marriages claimed to have undertaken an HIV test as a couple, only 29% acknowledged disclosing their HIV sero-status to their partner. This is in contrast to fewer (33%) cohabiting couples testing together but more (48%), reportedly disclosing to their partners. It is difficult to explain the cause of this contrast. Possibly, some of those who claimed to have disclosed to their spouses were reporting what they perceived as morally right rather than their actual practice. Data from qualitative data indicated appreciation of the importance of disclosing and knowing the sero-status of one's spouse, even among respondents who had never taken an HIV test. While studies have shown that partner disclosure rarely leads to negative consequences (Yoder et. al., 2006), fear of violence and discrimination especially gender-based were, reported as barriers to partner disclosure. This lends itself to findings by Ssali et al. (2010) which indicate that some HIV positive individuals might disclose to friends and distant relatives without telling their spouses. This, points to a need to intensify messages that promote disclosure.

The study revealed various HCT strategies adopted by various service providers in study districts including, facility based, static and satellite/outreaches and home-based model involving mostly index clients. There are competing ideas as to which mode of HCT service delivery potentially has the highest positive effect on uptake HCT. Home-based, facility based routine HCT and VCT have all been said to be acceptable (Matovu et al. 2002; Wanyenze et al., 2008; Angotti, 2009), but each with limitations emanating from both demand and supply sides. While some participants in FGDs reported perceived confidentiality in health facilities of the ones test results as key supply factor for motivation CHCT, several other studies have identified convenience as removing the barriers to HCT uptake (Angotti, et. al., 2009). Besides, cost implications of travelling costs to statistic health facilities for one to learn about his or her HIV status might be a barrier, unless one is already sick and is seeking for treatment. Study findings indicate more CHCT users in Soroti (73%) than in Kampala (29%). This is possibly because of the previous Home Based HCT in Soroti, which has been documented to encourage couple testing and disclosure. Therefore, availability of multiple HCT approaches by different service providers, (some of whom supported by CSF), was good approach in enhancing access and uptake of HCT in the study area.

6.0 STUDY LIMITATIONS

This study had a number of limitations, as indicated below:

- Given the sensitive nature of the study (which collects information about HIV counseling and testing uptake among couples), some non-response was encountered. To counter this, it was emphasized in the consent process that the information collected from respondents would be treated with a high level of confidentiality and only used for research purposes. The sample size was adjusted for potential non-response. We also explained the purpose and objectives of the study to the study participants to ensure that they understood why they were being asked to participate in the study, and this helped to minimize the anticipated non-response.
- Our study enrolled married individuals who had ever tested for HIV as well as those who had never tested for HIV. While we selected those who had ever tested for HIV from lists available at selected civil society organizations that offer HCT in each district, we had no reference point for participants who had never tested for HIV. These participants were identified from the community, based on their self-reported never-tested-status. There was a possibility of misclassifying individuals who had ever tested as never-tested especially if those who had ever tested forgot that they had ever done so or if they deliberately reported that they had never done so. We minimized this by use of a screening tool with questions on prior HIV testing history. We excluded individuals who had ever tested for HIV. We also explained the purpose of the study and encouraged people to respond to the screening questions as genuinely as possible, so that we could minimize the bias that might arise due to misclassification of prior HIV testing status.
- The other limitation was that individuals who had ever tested for HIV might be characteristically different from those who had never tested for HIV, and this is likely to affect comparisons. However, we expect that the random selection of participants from each group (ever tested, never tested) helped to minimize this limitation, thereby allowing for comparisons to be made across groups.
- Finally, because we intended to interview only one person per household yet the study outcome was uptake of HCT among couples, there was a possibility of missing out on the ‘CHCT experiences’ as envisaged by a couple. There was also a possibility of some individuals claiming to have received CHCT with their partners yet they might not have done so. We tried to minimize this by explaining the characteristics of a CHCT session (i.e. two people who receive pre-test counseling, HIV testing and post-test counseling in the same session together) and encouraged individuals to report a session as ‘CHCT’ if these conditions were met.

- The study did not explore treatment and follow-up support for those that might have tested positive. HIV test should not be an end but a means to prevention, care and support. This study therefore could not make recommendations of care and support for couples. Moreover, care and support is an important source of motivation for taking an HIV test (Whyte et. al., 2005)

7.0 CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusion

The study demonstrates that while CHCT is feasible, its uptake is generally low as evidenced by slightly more than a half of the respondents in this study who had ever tested went with their spouse/partner. Uptake of CHCT varies by residence. It is higher in rural areas than in urban centres. There are mixed responses to HCT and CHCT by socio-demographic and economic characteristics. For example, while more women have undertaken HCT in general, more males have had CHCT. Similarly, there is no uniformity related to wealth in regard to CHCT between rural and urban centres. While the poor are more likely to seek CHCT in rural area, it is mainly the better-off that utilized CHCT in urban settings. It is, however, important to note that overall, about two-thirds of the entire sample had ever received HCT, which is almost the figure as provided in the recent Uganda AIDS Indicator Survey. Although married people have, recently been highlighted as a risk group, they are reluctant to take HCT as couples. Moreover, couples in multiple relations are less acceptable to CHCT, yet they hardly know the HIV status of their sexual partners, hence increasing the risk of HIV infection. The study has revealed an association between some socio-demographic characteristics and uptake of CHCT. Those with primary education, in cohabitation unions in the third wealth quintiles demonstrate more CHCT utilization than their counterparts. Gender is in general a strong determinant in HCT uptake with more women found to have taken an HIV test in comparison to their male counterparts. Thus, stratified analyses for Kampala and Soroti districts show that female gender was the main determinant of HCT uptake in both districts.

The study has revealed that CHCT uptake is higher among males, persons aged 45 years, couples in monogamous marital-relationship, residents of rural areas; by implication persons residing in Soroti compared to Kampala. Level of education, HIV risk perception, and condom use at last sexual encounter were not significantly associated with HCT uptake. Overall, being in a marital relationship does not necessarily motivate or exert pressure for CHCT. Instead, most people in long-term relationships continue to test as individuals, moreover without accompanied disclosure of HIV sero-status to their partners. Being in a long-term relationship does not necessarily build trust to motivate CHCT – many people though in a relationship, tested as individuals rather than couples, for fears of blame. Intense fears of social consequences of testing HIV positive further complicates and de-motivates CHCT. This possibly explains the knowledge behavior gap with regard to CHCT – the exhibited high value for taking an HIV test is not followed by the practice of testing.

Slightly over a half of couple testers disclosed their test result to their spouses. Hence couple testing may not necessarily lead to sharing of HIV results. Spouses might continue to keep their status to themselves. Hence, non-disclosure of HIV test results to spouse limits the benefits of HIV testing including change in sex behaviour among couples. This study shows that HIV status disclosure was higher among females compared to males, young respondents aged 18-24 years and those residing in urban areas. Intense fears

of consequences of HIV sero-positive result points to a knowledge behaviour gap. There is a large discrepancy between what people know as useful and important in their lives in relation to taking an HIV test, and actual acceptability of CHCT. While almost all respondents acknowledge the importance taking an HIV test, many of them are yet to seek this service, but the intention to seek HIV test in future is demonstrably high.

Despite the low uptake, knowledge of HCT benefits in general, and CHCT in particular is generally adequate, which can provide entry points for motivating people in long-term relationships to seek HCT together. Benefits such as providing a basis for planning one's life, starting treatment early, and protecting loved-ones in cases of discordance are widely known. Knowledge of benefits of CHCT, availability of HCT services, existence of programs aimed at encouraging couples to test together and know their results together as well as a big proportion of non-testers with intention to test in future can be positively exploited to scale-up CHCT. This is in addition to various factors viewed as part of a package that spurs motivation for CHCT including an expression of love between people in long-term relationships.

Both personal and facility-based factors constitute barriers to some men and women in long-term sexual relationships from seeking CHCT. Inherent individual fear, stigma, lack of or little awareness about the benefits of CHCT affect demand for CHCT. Men fear to lose their marriages, while women fear the domestic violence that can ensue—all of which can culminate into dissolution of marital relationships upon knowing a positive HIV result. Consequences of perceived mistrust by asking a partner particularly men believed to have multiple sexual partners to go for CHCT in a long-term relationship is a latent barrier to CHCT. Accordingly people in long-term relationships find it difficult to justify asking partners they have been living with for years to go for an HIV test. In several other instances this is deemed “useless” since by proxy testing one is able to tell his HIV status—“if one partner tests and is found to be HIV positive, no doubt, the other will also be HIV positive” non-testers argued. All this is exacerbated by people's acknowledgement of lack of information especially regarding the importance of CHCT playing a big role in constraining uptake.

Finally, this study demonstrates that demand factors which constrain uptake of CHCT are compounded by supply factors or facility-based. Despite availability of HCT services, access still remains one of the main constraints to HCT uptake especially in typical rural areas such as Soroti. Understaffing of health facilities, lack of adequate privacy at the health facilities, inadequacy of HIV testing kits, health education about the importance and advantages of CHCT given mostly to people that turn up for health services, lack of funds to conduct sensitization campaigns especially in rural communities affect uptake of HCT. Indeed, health workers in study decry lack of privacy—the rooms used for counseling being not able to offer privacy and at times shared by health workers especially in public health facilities.

Overall, HCT in general and CHCT in particular often come out of necessity rather than choice. Many people test after falling sick, or suspecting their spouses to be infected. This might come rather late and delay initiation on ART.

7.2 Recommendations

The study findings have revealed both demand (individual-based) and supply (facility-based) factors that affect motivation or constitute barriers to uptake of CHCT, which generally affect HCT. The recommendations generated in this study are aimed at making a contribution to scaling up CHCT in both rural and urban communities.

7.2.1 Demand side

- It is apparently clear in this study that availability and accessibility of HCT services alone, is not sufficient to motivate CHCT. Other complimentary activities are required to provide incentives for CHCT uptake. For example, those who receive messages on GTKT are more likely to utilize CHCT more, in comparison to their counterparts who never did so. Thus, it is recommended to intensify dissemination of information on GTKT messages as it has demonstrated that those exposed to the information were more likely to take CHCT than those who were not exposed.
- In order to increase uptake for CHCT, the service needs to be made more acceptable to people in long-term sexual relationships. This will require service providers to invest more resources in sensitization of the general public about the merits or advantages of CHCT vis-à-vis the demerits or disadvantages.
- Effective use of interpersonal communication channels in the sensitization campaign especially using health workers and village health teams especially in rural areas will go a long way in promoting CHCT. As most participants noted channels such as mass media reach many people, but they lack the element of interpersonal connection; service providers too, should consider holding family talks, engaged in home to home visits.
- Through sensitization, there is need to support couple testers to disclose to their spouses. Many of those that had tested had not disclosed to their partners. Counsellors and programme implementers should allay individual fears related to disclosure to spouses, in addition to support in the disclosure process.
- While most HIV testers were females, more males reported testing with partners. It is therefore recommended to intensify messages focusing on men to uptake HCT, as this could improve CHCT as well.
- The concerns involved in CHCT are not necessarily about learning a partner's HIV status as a good health, but linked to emotions of love and showing care to the spouse. Messages to promote CHCT should therefore focus on this theme of love and care of one's partner to motivate couple testing and disclosure.

7.2.3 Supply side

A number of supply-related factors were identified in this study, which constitute a barrier to HCT in general and CHCT that need to be attended to. Efforts are therefore required in the following areas:

- Most health centres both in rural and urban areas lack enough space that offers privacy. Instances where health workers share space while providing HCT certainly dissuades the users to seek the service. Therefore, enhancement of privacy and confidentiality at health centres will contribute to motivating people seek HCT.
- As reflected in the findings, most respondents received HCT information through facility based health staff, and very few reported community based health worker. Aware that health unit staff are already faced with a heavy work load, and many people only go health facilities when feeling unwell, it is imperative to strengthen the role of CHWs in the dissemination of CHCT messages.
- To decongest static health facilities, it is recommended that more resources could be found to facilitate satellite/mobile as well as home-based HCT especially in rural areas. However, service providers should not go out to communities providing CHCT services without providing effective referrals for those found HIV positive. As part of efforts to make CHCT more acceptable to people, service providers should streamline and strengthen the referral system.
- This study did not establish the preferred method for CHCT, although several individuals reported health facilities as good environments for general HCT. This could be a good area for future research.
- Make CHCT as convenient and process as transparent as possible: e.g., with rapid tests, confidentiality etc. to address the concerns that might demotivate CHCT.
- Include messages on the advantages of couple testing during counselling sessions. Many people have taken a test, but as individuals, thus need to be given incentives for taking HCT as a couple.

REFERENCES

- Allen S, Meinzen-Derr J, Kautzman M, Zulu I, Trask S, *et al.* Sexual behavior of HIV discordant couples after HIV counseling and testing. *AIDS* 2003; **17**(5), 733-740.
- Allen S, Serufilira A, Bogaerts J, Van de Perre P, Nsengumuremyi F. *et al.* Confidential HIV testing and condom promotion in Africa. Impact on HIV and gonorrhea rates. *JAMA* 1992a; **268**(23): 3338-3343.
- Allen S, Tice J, Van de Perre P, Serufilira A, Hudes E, Nsengumuremyi F. *et al.* Effect of serotesting with counselling on condom use and seroconversion among HIV discordant couples in Africa. *BMJ* 1992b; **304**(6842): 1605-1609.
- Allen S, Karita E, Chomba E, Roth DL, *et al.* Promotion of couples' voluntary counseling and testing for HIV through influential networks in two African capital cities. *BMC Pub Health* 2007; **7**: 349.
- Angotti N., Bula A., Gaydos H., Zeev Kimchi, Thornton R. L., Yeatman S. E., 2009. Increasing the acceptability of HIV counseling and testing with three C's: Convenience, confidentiality and credibility. *Social Science and Medicine* 68 (2009) 2263–2270.
- Ayuo PO, Were E, Wools-Kaloustran K, Baliddawa J, *et al.* Determinants in HIV counseling and testing in couples in North Rift Kenya. *East Afr Med J* 2009; **8**(2): 83-8
- Becker S, Mlay R, Schwandt HM, Lyamuya E. Comparing couples' and individual voluntary counseling and testing for HIV at antenatal clinics in Tanzania: a randomized trial. *AIDS Behav* 2010; **14**: 558-566
- Civil Society Fund. Determinants in the uptake of HIV counseling and testing services among couples in long-term relationships in Uganda: research concept paper. April 2012.
- Dunkle KL, Stephenson R, Karita E, Kayitenkore K, *et al.* New heterosexually transmitted HIV infections in married or cohabiting couples in urban Zambia and Rwanda: an analysis of survey and clinical data. *Lancet* 2008; **371**: 2183-91
- Farquhar C, Kiarie J, Richardson B, *et al.* Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission. *J Acquir Immune Defic Syndr* 2004; **37**(5):1620-26.
- Fylkesnes, K., Haworth, A., Rosenvard, C., & Kwapa, P. M. (1999). HIV counselling and testing: overemphasizing high acceptance rates, a threat to confidentiality and the right not to know. *AIDS*, *13*, 2469–2474.

Grabbe KL, Menzies N, Taegtmeier M, Emukule G, et al. Increasing access to HIV counseling and testing through mobile services in Kenya: strategies, utilization, and cost-effectiveness. *J Acquir Immune Defic Syndr* 2010; **54**(3): 317-23

Graneheim UH, Lundman B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*, 24, 105-112.

Kamenga M, Ryder R, Jingu M, et al. Evidence of marked sexual behavior change associated with low HIV-1 seroconversion in 149 married couples with sero-discordant HIV-1 status: experience at an HIV counseling center in Zaire. *AIDS* 1991; **5**: 61-67

Koenig MA, Lutalo T, Zhao F, Nalugoda F, et al. Domestic violence in rural Uganda: evidence from a community-based study. *Bull World Health Org* 2003; **81**: 53-60

Larsson EC, Thorson A, Nsabagasani X, Namusoko S, et al. Mistrust in marriage-Reasons why men do not accept couple HIV testing during antenatal care- a qualitative study in eastern Uganda. *BMC Pub Health* 2010; **10**:769.

Lingappa JR, Lambdin B, Bukusi AE, Ngure K, Kavuma L, et al. Regional differences in prevalence of HIV-1 discordance in Africa and enrollment of HIV-1 discordant couples into an HIV-1 prevention trial. *PLoS ONE* 2008; **3**(1): e1411.

Lugada E, Levin J, Abang B, Mermin J, Mugalanzi E, et al. Comparison of home and clinic-based HIV testing among household members of persons taking antiretroviral therapy in Uganda: Results from a randomized trial. *J Acquir Immune Defic Syndr* 2010; **55**: 245-252

Malamba SS, Mermin JH, Bunnell RE, Mubangizi J, Kalule J, et al. Couples at risk: HIV-1 concordance & discordance among spouses receiving voluntary counseling and testing in Uganda. *J Acquir Immune Defic Syndr* 2005; **39**: 576-580

Matovu JK, Kigozi G, Nalugoda F, Wabwire-Mangen F & Gray RH. The Rakai Project counseling program experience. *Trop Med Int Health* 2002; **7**(12): 1064-67

Maxwell JA. *Qualitative research design: An interactive approach*. 1996. Thousand Oaks, CA: Sage publications, Inc.

Menzies N, Abang B, Wanyenze R, Nuwaha F, et al. The costs and effectiveness of four HIV counseling and testing strategies in Uganda. *AIDS* 2009; **23**(3): 395-401.

Ministry of Health (MOH) [Uganda] and ORC Macro. *Uganda HIV/AIDS Sero-behavioural Survey 2004-2005*. 2006. Calverton, Maryland, USA: Ministry of Health and ORC Macro.

Ministry of Health. National Couples' HIV Counseling and Testing Communication Strategy 2009. MoH, Kampala: Uganda

Morgan DL. Practical Strategies for Combining Qualitative and Quantitative Methods: Applications to Health Research. *Qual Health Res* 1998; 8(3): 362-76

Morin, S. F., Khumalo-Sakutukwa, G., Charlebois, E. D., Routh, J., Fritz, K., Lane, T., et al. (2006). Removing barriers to knowing HIV status: same day mobile HIV testing in Zimbabwe. *Journal of Acquired Immune Deficiency Syndromes*, 41(2), 218–224.

Njau B, Watt MH, Ostermann J, Manongi R, Sikkema KJ. Perceived acceptability of home-based couples' voluntary HIV counseling and testing in Northern Tanzania. *AIDS Care* 2011, DOI:10.1080/09540121.2011.608796

Porter L, Hao L, Bishai D, Serwadda D, et al. HIV status and union dissolution in sub-Saharan Africa: The case of Rakai, Uganda. *Demography* 2004; 41(3): 465-482

Prata N, Morris L, Mazive E, et al. Relationship between HIV risk perception and condom use: evidence from a population-based survey in Mozambique. *Int Fam Plann Perspect* 2006; 32(4): 192-200

Semrau K, Kuhn L, Vwalika C, Kasonde P, Sinkala M, Kankasa C, Shutes E, Aldrovandi G, Thea DM. Women in couples antenatal HIV counseling and testing are not more likely to report adverse social events. *AIDS* 2005; 19(6):603-9.

Shegufta S Sikder et. al., 2012: Care-seeking patterns for fatal non-communicable diseases among women of reproductive age in rural northwest Bangladesh. *BMC Women's Health* 2012, 12:23

Ssali S, Atuyambe L, Tumwine C, et al. (2010) Reasons for disclosure of HIV status by people living with HIV/AIDS and in HIV care in Uganda: An exploratory study. *AIDS Patient Care STDs*; 10: 675-681.

Thornton, R. (2008). The demand for and impact of learning HIV status. *American Economic Review*, 98(5), 1829–1863.

Tumwesigye E, Wana G, Kasasa S, Muganzi E, Nuwaha F. High uptake of home-based, district-wide, HIV counseling and testing in Uganda. *AIDS Patient Care & STDs* 2010; 24: 735-741

Wabwire-Mangen F, Odiit M, Kirungi W, Kisitu KD. Uganda: HIV modes of transmission & prevention response analysis. Final Report, March 2009. Kampala: Uganda National AIDS Commission.

Wall K, Karita E, Nizam A, Bekan B, et al. Influence network agent effectiveness in promoting couples' HIV counseling and testing in Kigali, Rwanda. *AIDS* 2011; 25: 000-000.

Weinhardt LS, Carey MP, Johnson BT, Bickman NL. Effects of HIV counseling and testing on sexual risk behavior: a meta-analytic review of published research, 1985-1997. *Am J Pub Health*. 1999; **89**(9): 1397-405

Were WA, Mermin JH, Wamai N, Awor AC, Bechange S, Moss S, et al. Undiagnosed HIV infection and couple HIV discordance among household members of HIV-infected people receiving antiretroviral therapy in Uganda. *J Acquir Immune Defic Syndr* 2006; 43: 91-95

WHO (2012). Guidance on couples HIV testing and counseling, including antiretroviral therapy for treatment and prevention in sero-discordant couples: recommendations for a public health approach. April 2012

Whyte, S.R. (1997). *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda*. Cambridge: Cambridge University Press.

Yoder PS, Katahoire AR, Kyaddondo D, Akol Z, Bunnell R, Kaharuza F (2006). Home-based HIV testing and counselling in a survey context in Uganda. Calverton: ORC Macro.

APPENDIX 2: WORK PLAN/ACTIVITY SCHEDULE

The entire study was executed in a period of 12 weeks (60 days) as indicated below.

	Duration in weeks											
	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	9 th	10 th	11 th	12 th
Activity (work)												
1. Meeting with CSF technical team to ensure a common understanding of the assignment	■											
2. Study the concept note and develop a full proposal		■										
3. Seek ethical clearance from MakSPH			■	■								
4. Seek ethical clearance from UNCST					■	■	■					
5. Development of data extraction + qualitative & quantitative data collection tools					■							
6. Submit draft tools to CSF for input					■							
7. Pre-test data collection tools						■						
8. Finalize data collection tools						■						
9. Develop data entry screens						■						
10. Train data collectors on the data collection instruments							■					
11. Conduct data collection								■	■	■		
12. Analyze and interpret the data collected										■	■	
13. Prepare draft research report and share with CSF											■	
14. Present findings to CSF (power-point presentation)											■	
15. Incorporate comments and submit final report												■

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APPENDIX 3: INDIVIDUAL STRUCTURED QUESTIONNAIRE

Questionnaire ID: ____/____/____

1.0 Identification: Fill in all the Required Information before Starting the Interview

District : Kampala -----1 Soroti -----2 <i>(Circle appropriately)</i>		Sub county / Division:		
Parish / Ward:		LC 1 / Village:		
Urban / Rural	Urban -----1	Rural -----0		
	RESULT OF THE VISIT			
	Visit 1	Visit 2	Visit 3	
Date				
Interviewers Name				
Result codes*				
Next visit	Date			
	Time			
*Result Codes 1 ---completed 2 --- not at home 3--- postponed 4 ---refused 5---partly completed 6---incapacitated 7---other (specify) _____				
Checked by Supervisor :		Date checked:		
DURATION OF INTERVIEW				
Start time: in 24HRS		End Time: in 24HRS		

2.0 Socio-Demographic and Economic Characteristics of the Respondent

No.	Question	Response	Code	Skip
201	Sex of respondent	Male Female	1 2	
202	How old are you?Years		
203	What is your marital status? <i>Interviewer: If married ask the respondent: is the marriage monogamous or polygamous?</i>	Married Monogamous Married Polygamous Cohabiting Other_____	1 2 3 96	
204	Is your partner or spouse currently living in this household or elsewhere	All the time Sometimes Living elsewhere	1 2 3	
205	How long have you been with your partner?	Less than 1 year 1 year 1-5 years 5-10 years 10+ years	1 2 3 4 5	<i>If 1, END interview</i>
206	How many children of your own / biological children do you have?	None 1 2-5 5+	1 2 3 4	
207	What is your religious denomination?	None Muslim Roman Catholic Protestant/Anglican Other- Christian	1 2 3 4 5	
208	Have you ever attended school/ formal education?	Yes No	1 2	<i>If No, go to 210</i>
209	What is the highest level of formal education you have attained?	Primary 1-4 Primary 5-7 Secondary 1-4 Secondary 5-6 Post Secondary Vocational	1 2 3 4 5 6	
210	What kind of work /activities keep you busy during an average day, whether you get money from them or not?	Nothing Informal employment (Specify)_____ Formal employment (Specify)_____ Farming House wife Other (Specify)_____	1 2 3 4 5 96	
211	Are you engaged in any activity/work that earns you regular income?	Yes No	1 2	<i>If No, go to 213</i>
212	How much do you on average earn a month?	Less than Ugshs.100,000 100,000 -400,000 400,000-900,000	1 2 3	

		More than 900,000	4	
213	Do you or your household own the following?	A radio	1	2
		A television set	1	2
		A bicycle	1	2
		A motor cycle	1	2
		Your own/family home	1	2
		a cell phone	1	2
		a regular (land line) phone	1	2
		a computer	1	2
		An income generating business	1	2
		An indoor bathroom	1	2
		Running water either inside the house or inside the compound	1	2
		of your house	1	2
		Electricity	1	2
		Car	1	2
		Generator	1	2
		Solar		
214	What languages do you hear and understand easily when someone uses them to talk to you? <i>(Record all mentioned)</i>	English	1	
		Luganda	2	
		Ateso	3	
		Other (specify)_____	96	

Now I am going to ask you a few questions about your spouse/partner

No.	Question	Response	Code	Skip
214	How old is your spouse/partner?Years		
215	What is your spouse/partner's religious denomination?	None	1	
		Muslim	2	
		Roman Catholic	3	
		Protestant/Anglican	4	
		Other- Christian	5	
216	What is the highest level of formal education that your spouse/partner attained?	No formal education	1	
		Primary 1-4	2	
		Primary 5-7	3	
		Secondary 1-4	4	
		Secondary 5-6	5	
		Post Secondary	6	
		Vocational	7	
217	What kind of work /activities keeps your spouse/partner busy during an average day, whether she/he gets money from them or not?	Nothing	1	
		Informal employment (Specify)_____	2	
		Formal employment (Specify)_____	3	
		_____	4	
		_____	5	
		Farming	96	
		House wife		

		Other (Specify) _____		
218	Is your spouse/partner engaged in any activity/work that earns him/her regular income?	Yes No	1 2	<i>If No, go to 301</i>
219	How much does your spouse/partner on average earn a month?	Less than Ugshs.100,000 100,000 -400,000 400,000-900,000 More than 900,000	1 2 3 4	

3.0 Sources of Information about HIV/AIDS related services

No.	Question	Response	Code	Skip
301	What is your main source of information on issues of health?	Radio TV Friends/Relatives Community Health workers Health workers Posters Billboards Brochure Newspapers Other (specify) _____	1 2 3 4 5 6 7 8 9 96	
302	Do you get information on HIV/AIDS related services?	Yes No	1 2	
303	Have you ever got information about HIV counseling and testing services?	Yes No	1 2	<i>If No, go to 305</i>
304	Where have you seen/heard about information on HIV counseling and testing services from?	Radio TV Friends/Relatives Community Health workers Health workers Posters Billboards Brochure Newspapers Other (specify) _____	1 2 3 4 5 6 7 8 9 96	
305	In the last 12 months, did you hear or see messages about the Go Together Know Together , or a campaign encouraging couples to test for HIV together?	Yes No	1 2	
306	What is your preferred source of learning about HIV counseling and testing services?	Media (e.g. Radio, TV) Friends/Relatives Community health workers Health facility worker HIV counselors Sensitization meeting/rally Church/place of worship Others (specify) _____	1 2 3 4 5 6 7 96	

No.	Question	Response	Code	Skip
307	How often do you listen to the radio in a week?	None Once a week 2-3 times a week 4-5 time a week More than 5 times a week	1 2 3 4 5	

4.0 Awareness of Service Access Centers for HIV Counseling and Testing Services: Now I am going to ask you some questions on access to HIV counseling and testing services

No.	Question	Response	Code	Skip
401	Is there a place in this parish/ward where you can access HIV/AIDS related services?	Yes No	1 2	<i>If No, go to 407</i>
402	What services related to HIV/AIDS are offered at this place that you know of? RECORD ALL MENTIONED, BUT DON'T READ OUT	HIV testing & counseling Couple HIV testing & counseling ARVs PMTCT Safe male circumcison Other (specify)_____	1 2 3 4 5 96	
403	Are couple HIV counseling and testing services always available at this place you know of?	Yes No	1 2	
404	Are there reasons that would prevent you from accessing couple HIV counseling and testing services from this place?	Yes No	1 2	
405	What are the reasons that would prevent you from accessing couple HIV counseling and testing services from this place? RECORD ALL MENTIONED, BUT DON'T READ OUT	Distance is far Unfriendly staff Lack of skilled staff Unavailability of drugs Lack of HIV test kits Cost of HIV testing Lack of privacy Stigmatization Staff know me Other (specify)_____	1 2 3 4 5 6 7 8 9 96	
406	How far from your home (in terms of distance) is this place where couple HIV counseling and testing services are provided?	Less than 1 km 1-2kms 3kms More than 3 kms	1 2 3 4	
407	What would be your preferred service access point for HIV counseling and testing services?	Health center At home Mobile /satellite site Other (specify)_____	1 2 3 96	

5.0 HIV Testing and Disclosure: Now I would like to ask you some questions about getting tested for HIV, how you decided to be tested, what happened, and how you felt about it. Whatever you tell me will be kept confidential.

No.	Question	Response	Code	Skip
501	Have you ever tested for HIV?	Yes No	1 2	<i>If No go to 624</i>
502	When was the last time you tested for HIV? INTERVIEWER CONVERT TO SEE HOW LONG AGO THAT HAPPENED AND RECORD ACCORDINGLY	Less than a month 1-3 months 4-6 months 7-12 months More than a year	1 2 3 4 5	
503	What costs did you incur in the process of getting the HIV test? INTERVIEWER RECORD ALL MENTIONED	Money for HIV test Transport Time of waiting Other (specify)_____	1 2 3 96	
504	How many times have you tested for HIV in the past 3 years?	Once 2 times 3times 4+	1 2 3 4	
505	I am not interested in knowing your status but. When you tested for HIV, did you receive your test results?	Yes No	1 2	
506	What are the reasons that you tested for HIV? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	I was sickly Requirement for marriage Condition for acceptance Partner wanted to know my status Just wanted to know status Counselor advised All my friends had tested Wanted to plan for my future Other (Specify)_____	1 2 3 4 5 6 7 8 96	
507	Was it hard for you to decide to go for the HIV test (<i>if has tested more than once ask about the most recent time he/she tested</i>)?	Yes No	1 2	<i>If No, go to 509</i>
508	What are the reasons that you found it difficult to decide to go for the HIV test? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	I just feared I have many partners I was just ambushed I have ever lost a partner/died Other (specify)_____	1 2 3 4 96	All responses, Go to 510

No.	Question	Response	Code	Skip
509	What are the reasons that you found it easy to decide to go for the HIV test? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	I was confident had no HIV Did not want partner to fear Wanted to know my status Condition for acceptance/marriage Other (specify)_____	1 2 3 4 96	
510	Did you discuss taking an HIV test with anyone before you had your test?	Yes No	1 2	If No, go to 512
511	With whom did you discuss about getting tested for HIV? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	Parents Spouse /partner Friend(s) Other relatives Other (specify)_____	1 2 3 4 96	
512	Did you go for the HIV test with your spouse / partner?	Yes No	1 2	If Yes, go to 515
513	Is your spouse /partner aware that you sought HIV testing?	Yes No	1 2	
514	What are the reasons that you did not go for HIV testing with your spouse / partner? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	Didn't want him/her to know my status Didn't know about couple testing Partner refused We trust each other Partner tested during Antenatal Fear to destabilize our marriage Better to remain ignorant No place to test from Other (Specify)_____	1 2 3 4 5 6 7 8 96	All Responses, go to 517
515	Did you receive your HIV test results together with your spouse/partner?	Yes No	1 2	If Yes, go to 517
516	Why didn't you receive your HIV test results together with your spouse/partner?	Didn't want him/her to know my status Partner refused Feared that he/she would blame me Counselor did not tell us to receive together (Specify)_____	1 2 3 4	
517	Did you tell your HIV test results to your spouse/partner?	Yes No	1 2	If No, go to 520

No.	Question	Response	Code	Skip
518	Was it easy for you to tell your spouse / partner the results of your HIV test?	Yes No	1 2	<i>If Yes, go to 601</i>
519	What are the reasons that you found it difficult to disclose your HIV status?	I feared the consequences Lack of trust I feared domestic violence I feared being blamed Other (specify)_____	1 2 3 4 96	<i>All Responses, go to 601</i>
520	Why didn't you disclose your HIV status to your spouse/partner?	I feared the consequences Didn't want him/her to know my status I have a right not to disclose Lack of trust Fear of domestic violence Fear of being blamed Other (specify)_____	1 2 3 4 5 6 7 96	
521	Do you think the health provider told your spouse/partner about your HIV status?	Yes No Don't know		
522	Whom did you tell about your HIV test results? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	Nobody Other family member Friend Employer Other (specify)_____	1 2 3 4 96	

6.0 Motivations for and barriers to Couple HIV Counseling and Testing

No	Question	Response	Code	Skip
	INTERVIEWER, CHECK 512	Tested with partner Did not test with partner	1 2	If 2, go to 605
601	Would you consider the person you went with for testing the last time to be your main partner?	Yes No	1 2	
602	What are the reasons that you sought HIV testing as a couple /with your partner? INTERVIEWER RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	Spouse/partner was sickly Requirement for marriage Partner wanted to know my status Counselor advised Had multiple partners Other (Specify)_____	1 2 3 4 5 96	
603	Did you have the HIV test before or after you started living with your spouse / current partner?	Before living with partner After moving with partner Before having our first child	1 2 3	
604	When you went for the HIV test, did you attend the counseling session together with your spouse / partner?	Yes No	1 2	
605	About how long did you wait between the time you first arrived at this health center and the time you saw a health worker for counseling?	< 30 minutes 31-60 minutes 61-90 minutes 91-120 minutes > 120 minutes	1 2 3 4 5	
606	How would you rate the reception you got from counselors and other health workers at this health center?	They are rude They are friendly They are compassionate Other (specify)_____	1 2 3 96	
607	Before drawing the blood samples for the HIV test, did the health worker ask/tell you about the following..... Read out list one by one?	ask if you agreed to be tested tell you that your results would not be shared with your partner explain how HIV is spread explain meaning of HIV+ & HIV- test results tell you about HIV discordance give you time to ask questions	Y N 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
608	Did you feel like declining or saying no to the HIV test?	Yes No	1 2	
609	What fears did you have about couple HIV counseling and testing before you went for it?	_____ _____		

610	How did you overcome the fears /reservations you had about couple HIV counseling and testing?	_____		
611	Did the health provider do the following after you found out your HIV test result? <i>Read out list one by one and circle accordingly</i>	explain the meaning of test result suggest that you tell your partner refer you for medical care refer you to a support group discuss prevention of HIV infection	Y 1 1 1 1 1	N 2 2 2 2 2
612	Were you satisfied with the post test advice that you received from your health provider?	Yes No	1 2	
613	If you were to go back for an HIV test, would you go with your spouse / partner?	Yes No	1 2	<i>If Yes, go to 624</i>
614	What are the reasons that you would not go back with your spouse/partner for HIV testing?	_____		

General Questions on HIV Testing Intentions.

624	Do you intend to seek couple counseling and testing in the next 12 months?	Yes No	1 2	<i>If Yes, go to 626</i>
625	Why don't you intend to seek couple counseling and testing?	No need I fear the consequences I Don't want him/her to know my status I don't trust her/him I fear domestic violence I fear being blamed Other (specify)_____	1 2 3 4 5 6 96	
626	Do you think your spouse /partner would be willing to go for couple counseling and testing?	Yes No DK	1 2 98	<i>If Yes, go to 628</i>
627	What are the reasons that your partner would not want to seek couple HIV testing?	I am not sure about my health Fear to be blamed Fear to lose my marriage Other (specify)_____	1 2 3 96	

628	In your view, what are the advantages of testing and receiving your HIV test results together as a couple?	Helps you plan future Know status before commitment Helps to have a settled mind/avoid worries Other (specify)_____	1 2 3 96	
629	What are the reasons that people fear to go HIV testing with their spouse / partner?	They fear the consequences They don't want their spouse / partner to know their status Lack of trust They fear domestic violence They fear being blamed Other (specify)_____	1 2 3 4 5 96	

7.0 HIV testing among Couples that have never tested

No.	Question	Response	Code	Skip
	INTERVIEWER CHECK Question 501	Yes No	1 2	If Yes, Go to 716
701	Have you ever thought about having an HIV test?	Yes No	1 2	If Yes, go to 703
702	What are the reasons that you have never sought for HIV testing? RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	I know I have no HIV Partner tested during Antenatal I fear to be suspected by partner Better to remain unaware No place to test from It causes worrying Other (Specify)_____	1 2 3 4 5 6 96	
703	In your view, are there advantages in knowing your HIV status?	Yes No	1 2	If No, go to 705
704	What are the advantages of knowing your HIV status? RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	Start treatment early Able to avoid re-infection Able to live positively To avoid strenuous work Plan for my family Other (Specify)_____	1 2 3 4 5 96	
705	Are you willing to go for an HIV test?	Yes No	1 2	If No, go to 707

706	Under what circumstances would you be willing to go for an HIV test? RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	When I notice signs of HIV If spouse/partner dies If am constantly sick If I have multiple partners If had unprotected sex with casual partner Other (specify)_____	1 2 3 4 5 96	
707	Would you encourage disclosure of one's HIV status to other people?	Yes No	1 2	
708	If you tested HIV positive, would you disclose your status to your spouse / partner?	Yes No	1 2	If Yes, go to 710
709	What are the reasons that you would not disclose your HIV status to your spouse / partner? RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	To avoid being blamed To safeguard my marriage To avoid stigmatization in village Other (Specify)_____	1 2 3 96	
710	Do you know any place within or outside this community where you can go for an HIV test?	Yes, within Yes, outside No	1 2 3	If No, go to 712
711	If you wanted to go to this place for an HIV test, how easy or difficult would it be for you to go there?	Very easy Somewhat easy Somewhat difficult Very difficult	1 2 3 4	
712	What are the reasons that make you fear to go for an HIV test? RECORD ALL MENTIONED, DO NOT READ OUT OPTIONS	Discrimination Lack of treatment care centers Too many clients at available facility No information where to get drugs No confidentiality Spouse/partner can divorce Test machines not reliable Other (specify)_____	1 2 3 4 5 6 7 96	
713	What needs to be done to get you overcome the fears you have about testing for HIV?	_____ _____		
714	Have you ever heard about PMTCT?	Yes No	1 2	If No, go to 716
715	What kind of people should go for PMTCT services? RECORD ALL MENTIONED, BUT DON'T READ OUT	Married people HIV+ couples The sickly Don't know Others (specify)_____	1 2 3 4 96	

Now, I would like to ask you about your opinion on discordance and couple testing				
716	FOR ALL RESPONDENTS: Do you know the HIV status of your spouse or partner?	Yes, within the last 6 months Yes, knew status more than 6 months ago No	1 2 3	<i>If 1 or 2, go to 718</i>
717	What are the reasons that you do not know your spouse/partner's HIV status?	I don't want to know I fear to ask Asked and he/she refused to tell He/she has never tested Other (Specify) _____	1 2 3 4 96	
718	Have you ever discussed about HIV counseling and testing with your spouse/current partner?	Yes No	1 2	
719	If you went for couple HIV testing and your spouse/partner was found HIV positive and for you HIV negative (discordant), what would you do?	Nothing We would separate We would start using condoms We would stop having sex It is not possible Other (specify) _____	1 2 3 4 5 96	
720	Have you ever heard about a couple where one partner was HIV positive and the other HIV negative?	Yes No	1 2	
721	Do you think it is possible for a sexually active couple, to be HIV discordant?	Yes No	1 2	
722	Do you personally know a couple which is HIV discordant but still live together?	Yes, still together No, separated Don't know any	1 2 3	

8.0 Sexual Behavior: Now I would like to ask you some questions about your most recent sexual behavior and likelihood of HIV infection

No.	Question	Response	Code	Skip
801	With whom did you have sex the most recent time (last time) you did?	My spouse /partner Mistress /boy friend Casual partner Sex worker Other (Specify) _____	1 2 3 4 96	
802	How many regular sexual partners do you have currently?	One 2-3 4-5 More than 5	1 2 3 4	
803	The last time you had sexual intercourse did you or your partner use a condom?	Yes No	1 2	

No.	Question	Response	Code	Skip
804	Under what circumstances should a couple use condoms? RECORD ALL MENTIONED, BUT DO NOT READ OPTIONS	None When spacing children If in extra marital relations If with a sex worker If HIV discordant Other (specify)_____	1 2 3 4 5 96	
805	What is the likelihood that you might get HIV? Would you say that it is... READ OUT CODES?	Not likely at all Very likely Limited chance Don't know	1 2 3 4	
806	Are there times when you fear that may be you could be living with HIV?	Yes, always Yes, sometimes No	1 2 3	If No, go to 808
807	What are the reasons that cause you to fear that may be you could be infected with HIV? RECORD ALL MENTIONED, BUT DON'T READ OUT OPTIONS	I have ever had unprotected sex I had a partner who died of AIDS I have a partner who is sickly I have symptoms of HIV&AIDS I have multiple partners Other (specify)_____	1 2 3 4 5 96	
808	In the last 12 months have you been visited by a community health worker and told you about couple HIV counselling and testing services?	Yes No	1 2	
809	In the last 12 months have you been advised by a health provider to go for an HIV test?	Yes No	1 2	

9.0 Community Perceptions about Couple HIV Counseling and Testing: Now I am going to read out some statements that summarize people's Knowledge, Attitudes, Practices and Expectations regarding Couple HIV Counseling and Testing. I am interested in hearing your opinion, tell me if you "agree" or "disagree" with them.

Statement	Agree	Disagree	DK	
ACCESS TO CHCT				
901	HIV counseling and testing services are available nearby	1	2	3
902	Couple HIV counseling and testing services are available nearby	1	2	3
903	Nowadays there are a lot of places which offer couple HIV counseling and testing services	1	2	3
QUALITY OF CARE				
904	Health providers are always available to provide couple HIV counseling and testing services at the nearby facility	1	2	3
905	Providers of couple HIV counseling and testing at the nearby facility are friendly	1	2	3

Statement		Agree	Disagree	DK
906	Providers of couple HIV counseling and testing at the nearby facility handle couples very well	1	2	3
907	Providers of couple HIV counseling and testing at the nearby facility handle cases of discordance very well	1	2	3
<i>SELF EFFICACY/CONFIDENCE LEVELS</i>				
908	In this community, only the man can decide if his wife/partner can go for an HIV test	1	2	3
909	I decide whether I want to go for an HIV test or not, I can't be forced if I don't want	1	2	3
910	I am confident I can go for an HIV test with my spouse/partner	1	2	3
911	If my child had symptoms of HIV, I would not fear to take him/her for an HIV test	1	2	3
912	I am confident I can ask my partner to go for an HIV test before we have sex	1	2	3
913	Only God can spare you from getting infected with HIV, are all at risk	1	2	3
914	I am confident I can tell my spouse/partner my HIV status, if I tested and found to have HIV	1	2	3
<i>COMMUNITY PERCEPTIONS TO CHCT</i>				
915	It is not appropriate for married people to go for HIV tests	1	2	3
916	It is useless for a couple that already has children to go for an HIV test	1	2	3
917	It is not important for the man to go for an HIV test if the wife/partner has been tested during Antenatal visits	1	2	3
<i>SOCIAL SUPPORT</i>				
918	My friends discourage /do not support couple HIV counseling and testing	1	2	3
919	If I went with my spouse /partner for HIV testing, and found myself HIV+, he/she would support me	1	2	3
920	I would not feel comfortable discussing with my spouse/partner about seeking for couple HIV counseling and testing	1	2	3
921	If I found out that my partner is HIV positive when I am not, I would leave him/her right away	1	2	3
<i>PERCEIVED BENEFITS OF CHCT</i>				
922	Undertaking couple HIV counseling and testing will help me better plan my future	1	2	3
923	Knowing our HIV status as a couple will help us to avoid risky sexual behaviour	1	2	3
924	Couple HIV testing and counseling only leads to violence in homes and relationships breaking up	1	2	3

Statement		Agree	Disagree	DK
<i>KNOWLEDGE ON DISCORDANCE</i>				
925	There is no such thing as HIV discordance	1	2	3
926	In this community, people in marital relationships are more likely to have HIV than non married couples	1	2	3
927	HIV/AIDS is a punishment for bad/immoral behaviour	1	2	3
928	If someone you think has the HIV virus wanted to give you a hug, would you feel comfortable	1	2	3

This is the end of our interview. Thank you for your time.

APPENDIX 4: FGD GUIDE FOR COUPLES

[Separate sessions were conducted for those who have ever received HCT vs those who have never received HCT, as well as men vs women].

Self-introduction

You are all welcome. We are happy that you could make time for us. We are a Team working with the Department of Social Work and Social Administration Makerere University, in collaboration with the Civil Society Fund Technical Management and M&E Agent as Research Assistants (*Moderator say your name, usual place of abode and ask the Note-taker to introduce him/ herself*).

Brief description of the study

We are conducting a study looking at what determines the uptake of HIV counseling and testing services among couples in long-term relationships in Uganda. The study is aimed at establishing people's perceptions and attitudes towards HIV testing and couple HIV counseling and testing in particular, motivations and barriers to uptake as well as measures to enhance uptake. The results of the study will be important by highlighting ways in which together we can continue to motivate partners in long-term relationships to undertake HIV counseling and testing as couples.

Gaining consent

You have been purposely selected to participate in this exercise because we believe that, as people in long-term relationships, you have vital information and experience to share with us on this subject. You are free to decide on whether or not to participate in this discussion, although we would appreciate greatly if you participated. We also encourage members to feel free to say anything concerning the topics of discussion.

We thank you in advance for your participation in this study. I request you to allow us to write down your responses. Whatever you tell me will be treated with utmost confidentiality.

Warm-up

Moderator: Ask participants to introduce themselves at this stage, including their age, occupation, length of marital relationship, highest level of education attained, and activity that occupies most of the time. Request everyone to feel free to speak like friends. Their honest opinion is important even if it is different from what others think. Explain the need to use a tape recorder and request permission.

General discussion on HIV/AIDS

1. What is the HIV/AIDS situation in your community? Probe: Prevalence; Category of people most affected etc.
2. In what ways have people in your community tried to prevent themselves or others from being infected with HIV; the virus that causes AIDS?
Probe for the different prevention methods, , method considered to be most effective in HIV prevention etc.

Access to couple HIV Counseling and Testing Services

3. If someone in this community wanted to have an HIV test, where would he/she go?
Probe: Different sources, their distance, costs etc
4. Which types of sources are preferred most by couple in this community to access and undertake HIV counseling and testing? Probe: Stand-alone units, *health care facilities, home, or mobile centers, and why?*
5. What problems do partners in this place experience when accessing HIV testing services as couples?

6. What is your view about men attending antenatal care with their expectant partners? *Probe on the reasons that would prevent men from going with their wives/partners for antenatal care, and or motivating factors.*

Motivations for and the Key Barriers to Couple HIV Counseling and Testing

7. Under what circumstances do couples or people in marital/long-term relationships go for couple HIV counseling and testing services?
8. What reasons do couples or people in marital/long-term relationships give for not seeking HIV testing services together with their partners?
9. In a relationship who should decide on whether to go for an HIV test or not? Why? (**Probe – why not the other party in the relationship?**)
10. At what point do partners with intentions of entering into a long-term relationship discuss the issue of HIV testing? *Is it easy to talk about HIV testing as a couple; probe why?*
11. What are the reasons that people would rather remain unaware about their HIV status instead of testing?
12. What do you comment about couple HIV counseling and testing? *Probe on aspects that they like or dislike most about couple HIV counseling.*
13. What would make couple HIV counseling and testing more acceptable to people like you?

Community Attitudes towards Couple HIV Counseling and Testing

14. What categories of people do you think should go for HIV testing as couples? (Probe by age, length and type of marriage, lifestyle, etc)
15. Sometimes, radios relay messages encouraging people in marital/long-term relationships to go for HIV testing together. What do you think about such messages?
16. Of what importance is HIV counseling and testing for people who are already living in a marital or long-term relationship?
17. What is your comment on the perception that HIV testing is for people who have never had sexual intercourse or unprotected sex?

Disclosure and HIV Discordance

18. Would you encourage disclosure of HIV status to your partner? *Probe on the benefits of disclosure, reasons that people fear to disclose their HIV status to their partners etc.*
19. Would you be willing to continue living with your partner if you tested and found yourself HIV negative but your partner is positive?
20. What is your view on the safety and reliability of condoms in preventing HIV infection in a discordant relationship? *Probe for reasons.*

Closing the discussion

21. Is there anything else that we have not talked about that you would like us discuss?

Thank you very much for taking time to contribute your views and experiences

APPENDIX 5: KEY INFORMANT GUIDE

For Health Facility Staff, District Health Teams, Community Health Workers and Local Leaders

Self-introduction

We are happy that you could make time for us. We are a Team working with the Department of Social Work and Social Administration Makerere University, in collaboration with the Civil Society Fund Technical Management and M&E Agent as Research Assistants (*Moderator say your name, usual place of abode and ask the Note-taker to introduce him/herself*).

Brief description of the study

We are conducting a study titled “Determinants in the Uptake of HIV Counseling and Testing Services among Couples in Long-Term Relationships in Uganda”. The study is aimed at establishing people’s perceptions and attitudes towards HIV testing and couple HIV counseling and testing in particular, motivations and barriers to uptake as well as measures to enhance uptake. The results could be useful to this community and the country at large by highlighting ways in which together we can continue to motivate couples in long term relationships to undertake couple HIV counseling and testing as an HIV prevention method or entry point to care.

Community Perceptions on HIV Counselling and Testing

1. What are the different models of delivery for HIV counselling and testing services that service providers in your community/district have adopted?
2. What mode HIV testing and counselling is mostly used by members of this area?
3. From your experience, how would you rate the uptake of HCT among couples in this community? Probe: extent of use; categories of couples mainly testing for HIV etc.
4. What are the key barriers to uptake of couple HIV counselling and testing services? Probe: Community level; Facility level barriers etc
5. How best can we improve uptake for couple HIV counselling and testing services in this community/district? *What needs to be done to overcome the barriers to uptake?*
6. What particularly needs to be done to get men to accept to go for HIV testing with their partners?
7. How is the issue of disclosure and HIV discordance being handled by service providers in this community/district? *Is it competently handled to your satisfaction?*

Closing the discussion

8. Is there anything else that you would like to add before we close our discussion?

Thank you very much for taking time to contribute your views and experiences

APPENDIX 6 – INFORMED CONSENT (For Individuals)

Project Title: Determinants of the uptake of HIV counseling and testing services among couples in long-term relationships: a case of Kampala and Soroti districts.

Principal Investigator (PI): Tom Kityo

Co-PI: Mr Joseph KB Matovu

Other investigators: Sheila Marunga Coutinho, Joseph Kabanda, Lillian Sekabembe, Denis Bwayo, David Kyaddondo, Narathius Asingwire, & John Baptist Bwanika

Hello, my name is _____. I work with the department of Social Work and Social Administration at Makerere University. The Department of SWSA, Makerere University in conjunction with the Civil Society Fund Technical Management and Monitoring and Evaluation Agents, is conducting a survey about uptake of HIV testing and counseling services among couples in long term relationships. I would like to invite you to participate in a study called 'Determinants of the uptake of HIV counseling and testing services among couples in long-term relationships: a case of Kampala and Soroti districts'.

PURPOSE OF THE STUDY

The purpose of the study is to understand perceptions towards couple HIV counseling and testing, and factors that influence its uptake. This information will help us come up with key messages to improve people's knowledge and perceptions about HIV counseling and testing services in general and couple HIV testing in particular among people in long term sexual relationships in Uganda.

STUDY PROCEDURES

You have been selected either at random (by chance) or based on your experience with couple HIV counseling and testing services to participate in this study. A total of 784 people will be covered in this study. You are free to join this study or not. However, your views will be important in informing strategies for improving programming for couple HIV counseling and testing services. Participation in this survey is voluntary. If you agree to participate, I will ask you some questions about yourself (for example, your age and your education). Other questions will be about your perceptions and experiences with HIV counseling and testing services. The interview will take about one hour and it will be conducted in either English, Luganda or Ateso.

POTENTIAL RISKS AND DISCOMFORTS

Responding to questions about uptake of HIV counseling and testing services among couples may be emotionally upsetting. You can withdraw from participation at any time if the interview is upsetting you, or refuse to answer any specific questions. If you feel deeply hurt by the questions we ask, feel free to let us know and where need for counseling and emotional support arises, we shall link you to professionals in counseling to support you.

COMPENSATION FOR PARTICIPATION

There will be no compensation of any form in this study.

BENEFITS FOR PARTICIPATION

There are no direct benefits/rewards for participating in this survey. However the study will guide interventions aimed at encouraging more people to know their HIV status. At this time, do you want to ask me anything about the study? If you want to get information after I have left, you can contact the people listed below.

CONFIDENTIALITY

The information that you provide to the study will be kept confidential. To further protect your identity and ensure confidentiality, we shall not record your name or any other identifier information on the questionnaire form that will be carrying your responses. In addition, your responses will not be reported in isolation; they will be merged with responses from the other participants in this study to produce a combined report for all people in long term relationships. Only members of the study team will look at the information you give us. The information you provide to the study will not be made available to anyone outside of the study team, including your partner.

VOLUNTARY PARTICIPATION AND OPTION TO WITHDRAWAL

Participation in the study is voluntary. If you decide not to be in the study, you can stop the interview at any time. You can do this without loss of benefits, including any services you receive at the clinic. You may also refuse to answer or skip any questions and still continue with the interview. If some questions are difficult or make you uncomfortable, we can skip them. However, we will appreciate if you can answer all the questions. Please feel free to ask me to clarify any questions if you don't understand them or decide to stop the interview at any time.

RIGHTS OF RESEARCH PARTICIPANTS

You may choose not to be in the study without anything bad happening to you. You are not giving up any legal claims, rights or treatment because of your participation in this research study. If you have any questions concerning your rights as a participant in this research, please contact the Chairman of the Higher Degrees, Research and Ethical Committee at Makerere University School of Public Health Dr. Ssempebwa (tel. +256 414 532 207). If you have any questions or concerns about the research, please feel free to contact one of the study investigators, Mr. Tom Kityo, at +256-772-692604 or Mr. Joseph Matovu, at +256-772-972330.

CONSENT TO PARTICIPATE: I have read, or someone has read to me, the information provided above, and I understand it. I have been allowed to ask questions. All of my questions have been answered to my satisfaction. I have been given a copy of this form.

Name of participant Signature/thumbprint of participant _____
Date

Signature of research staff member _____
Date

Name of witness Signature/thumbprint of witness _____
Date

APPENDIX 7 – INFORMED CONSENT (For FGD)

Project Title: Determinants of the uptake of HIV counseling and testing services among couples in long-term relationships: a case of Kampala and Soroti districts.

Principal Investigator (PI): Tom Kityo

Co-PI: Mr Joseph KB Matovu

Other investigators: Sheila Marunga Coutinho, Joseph Kabanda, Lillian Sekabembe, Denis Bwayo, David Kyaddondo, Narathius Asingwire, & John Baptist Bwanika

Hello, my name is _____ and my colleague is _____. We are here to hold discussions with you on behalf of the Department of Social Work and Social Administration at Makerere University. The Department of SWSA, Makerere University in conjunction with the Civil Society Fund Technical Management and Monitoring and Evaluation Agents, is conducting a survey about uptake of HIV testing and counseling services among couples in long term relationships.

PURPOSE OF THE STUDY

The purpose of the study is to understand perceptions towards couple HIV counseling and testing, and factors that influence its uptake. This information will help us come up with key messages to improve people's knowledge and perceptions about HIV counseling and testing services in general and couple HIV testing in particular among people in long term sexual relationships in Uganda.

STUDY PROCEDURES

You have been selected randomly to be part of this discussion to share you experience and thoughts about couple HIV counseling and testing services. You are free to join this discussion or not, participation is voluntary. However, your views will be important in informing strategies for improving programming for couple HIV counseling and testing services. We have topical questions about your perceptions and experiences with HIV counseling and testing services. The discussion will take about one hour and it will be conducted in English, Luganda or Ateso.

POTENTIAL RISKS AND DISCOMFORTS

Participating in a discussion about uptake of HIV counseling and testing services among couples may be emotionally upsetting. You can withdraw from the discussion at any time if it is upsetting you. If you feel deeply hurt by the topics of discussion shared, feel free to let us know and where need for counseling and emotional support arises, we shall link you to professionals in counseling to support you.

BENEFITS FOR PARTICIPATION

There are no rewards for participating in this discussion. However, we shall provide a soft drink (soda) to each person in the discussion to facilitate easy discussion. At this time, do you want to ask me anything about the study? If you want to get information after I have left, you can contact the people listed below.

CONFIDENTIALITY

Our discussion will be kept confidential. Everything we talk about will remain within the group. You should not repeat what others say outside the group. A group discussion is based on questions, so we encourage you to feel free to say anything concerning the topic of discussion. I request you to allow us to write down your responses. We also have with us a tape recorder to record all our discussion for purposes of enabling us to

keep track of what we discuss. Your voices will not be shared with anybody outside this group except the Research Team; your partner/spouse will never get to listen to this recording. It will be destroyed after we have prepared our transcripts. Will you be comfortable if we use a tape recorder?

RIGHTS OF RESEARCH PARTICIPANTS

You may choose not to be in the discussion without anything bad happening to you. You are not giving up any legal claims, rights or treatment because of your participation in this research study. If you have any questions concerning your rights as a participant in this research, please contact the Chairman of the Higher Degrees, Research and Ethical Committee at Makerere University School of Public Health Dr. Ssempebwa (tel. +256 414 532 207). If you have any questions or concerns about the research, please feel free to contact one of the study investigators, Mr. Tom Kityo, at +256-772-692604 or Mr. Joseph Matovu, at +256-772-972330.

CONSENT TO PARTICIPATE: I have read, or someone has read to me, the information provided above, and I understand it. I have been allowed to ask questions. All of my questions have been answered to my satisfaction. I have been given a copy of this form.

Name of participant Signature/thumbprint of participant _____
Date

Signature of research staff member _____
Date

Name of witness Signature/thumbprint of witness _____
Date

APPENDIX 8 – INFORMED CONSENT (For Key Informants)

Project Title: Determinants of the uptake of HIV counseling and testing services among couples in long-term relationships: a case of Kampala and Soroti districts.

Principal Investigator (PI): Tom Kityo

Co-PI: Mr. Joseph KB Matovu

Other investigators: Sheila Marunga Coutinho, Joseph Kabanda, Lillian Sekabembe, Denis Bwayo, David Kyaddondo, Narathius Asingwire, & John Baptist Bwanika

Hello, my name is _____ and my colleague is _____. We are here to hold an in-depth discussion/interview with you on behalf of the Department of Social Work and Social Administration at Makerere University. The Department of SWSA, Makerere University in conjunction with the Civil Society Fund Technical Management and Monitoring and Evaluation Agents, is conducting a survey about uptake of HIV testing and counseling services among couples in long term relationships.

PURPOSE OF THE STUDY

The purpose of the study is to understand perceptions towards couple HIV counseling and testing and factors that influence its uptake. This information will help us come up with key messages to improve people's knowledge and perceptions about HIV counseling and testing services in general and couple HIV testing in particular among people in long term sexual relationships in Uganda.

STUDY PROCEDURES

You have been selected purposely because of your position in this organization and in the provision of HCT services to share your experience and thoughts about couple HIV counseling and testing services. You are free to agree to the interview or not; participation is voluntary. We will ask you questions about your perceptions and experiences in providing HIV counseling and testing services. Your views will be important in informing strategies for improving programming for couple HIV counseling and testing services. The interview will take about one hour and will be conducted in English, Luganda or Ateso.

POTENTIAL RISKS AND DISCOMFORTS

Participating in an interview about uptake of HIV counseling and testing services among couples may be emotionally upsetting. You can withdraw from the interview at any time if you find the interview upsetting you. If you feel deeply hurt by the topics of discussion shared, please feel free to let us know.

BENEFITS FOR PARTICIPATION

There are no rewards for participating in this interview. At this time, do you want to ask me anything about the study? If you want to get information after I have left, you can contact the people listed below.

CONFIDENTIALITY

Our interview/discussion will be kept confidential. Everything we talk about will remain between me and you. I request you to allow us to write down your responses. We also have with us a tape recorder to record all our discussion for purposes of enabling us to keep track of what we discuss. Your voice will not be shared with anybody outside this room except the Research Team. The recording will be destroyed after we have prepared our transcripts. Will you be comfortable if we use a tape recorder?

RIGHTS OF RESEARCH PARTICIPANTS

You may choose not to be in the discussion without anything bad happening to you. You are not giving up any legal claims, rights or treatment because of your participation in this research study. If you have any questions concerning your rights as a participant in this research, please contact the Chairman of the Higher

Degrees, Research and Ethical Committee at Makerere University School of Public Health Dr. Ssempebwa (tel. +256 414 532 207). If you have any questions or concerns about the research, please feel free to contact one of the study investigators, Mr. Tom Kityo, at +256-772-692604 or Mr. Joseph Matovu, at +256-772-972330.

CONSENT TO PARTICIPATE: I have read, or someone has read to me, the information provided above, and I understand it. I have been allowed to ask questions. All of my questions have been answered to my satisfaction. I have been given a copy of this form.

Name of participant Signature/thumbprint of participant _____
Date

Signature of research staff member _____
Date

Name of witness Signature/thumbprint of witness _____
Date