



The Institute for Social Development, Faculty of Economic and Management Sciences,  
University of the Western Cape, in partial fulfilment of the requirement for MA Degree in  
Development Studies.

**DVS 804: Mini Thesis**

Identifying and assessing barriers and enablers to HIV counselling and testing among men  
aged 18-49 in Lilongwe District. A case study of Chileka Health Area.

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## DECLARATION

I Rupakisyo Ruthiana Mulaga, declare that this thesis is a result of my own original effort, work and best of my knowledge. The findings have never been previously presented to the University of Western Cape or elsewhere for the award of any academic qualification. Where assistance was sought, it has been accordingly acknowledged.

Rupakisyo Ruthiana Mulaga

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## DEDICATION

This work is dedicated to my dear sweet mother Lizzy Namweso Mulaga for being there for me and supporting me even when I felt like giving up on my studies, for shaping my vision, forcing on my purpose and teaching me good values in life.



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## ACKNOWLEDGEMENTS

Several people supported me during my studies, and it is impossible to mention them individually. I would like to express my heartfelt gratitude for their assistance. I would like to thank God Almighty for his unconditional love, wisdom guidance and support. I also extend my gratitude to my supervisor Lieve Vanleeuw for her supervision and guidance throughout my studies. For reviewing my work and providing valuable input. I benefited a lot from her guidance, support, and experience. Her expertise in research methodology, critical analysis and qualitative research was educative. Without your encouragement and support, I would have never completed my thesis. I do not take it for granted. Much gratitude also goes to Lauren Tavener-Smith, for Co-supervising my studies. Her guidance and encouragement were invaluable in completing this work. I would also like to thank Dr. Razack Karriem for being supportive and encouraging me to reach my goals. Much gratitude also goes to the administrator of ISD Ms. Pricilla Kippie for the help and support she gave me in the administration of my thesis.

Special appreciation goes to my mother, Lizzy Mulaga, my sisters, Bupe Mwakasungula and Subilaga Mulaga Jana and my brother, Tuntufye Mwabumba. Thank your continuous encouragement, motivation, prayers, advice, financial support, and patience throughout my thesis. You believed in my dreams and encouraged me even when the going got hard. I will forever be thankful and may God bless you all.

Most importantly I would also like to thank all the participants who agreed to take part in this study, answering some sensitive and uncomfortable questions, nothing would be possible without you.

## ABSTRACT

**Background:** Malawi had an estimated HIV prevalence of 9.6% with about 9.2% of its adult population living with HIV/AIDS in 2018. HIV Counselling and Testing (HCT) is essential to the prevention of HIV infection, HIV treatment and access to care and support services. However, despite the availability of free HCT services, the uptake of HCT services has been low among men in Malawi. This study assessed barriers and enablers of HCT uptake among men aged 18-49 in Chileka Health Area in Lilongwe District.

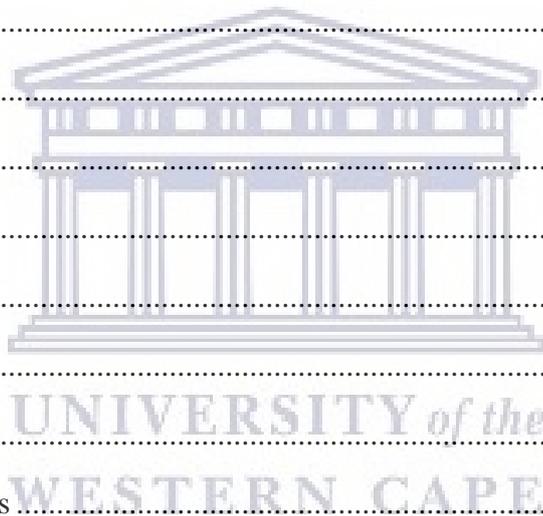
**Methods:** This study employed qualitative techniques and was conducted between December 2019 and January 2020. Using simple random sampling and purposive sampling, twenty-five males and eight key informants were selected for in-depth interviews respectively. The in-depth interview data was subjected to thematic analysis. The qualitative data were analysed using the Social Cognitive Theory as the theoretical framework.

**Results:** The study revealed that stigma and discrimination that comes with HIV testing, along with fear of a positive HIV test and confidentiality issues in the provision of HCT services were the main barriers preventing men from attending HCT. Men in the study feared accessing HCT as well as disclosing their HCT results as they anticipate stigma from their friends, family and the community. The prospect of a positive result which comes with stigma and discrimination from society obstructs the high uptake of HCT as men refrain from undergoing HCT. While the majority of the participants reported a good experience from the HCT service, participants were concerned about the confidentiality of their results, especially when assisted by a female nurse.

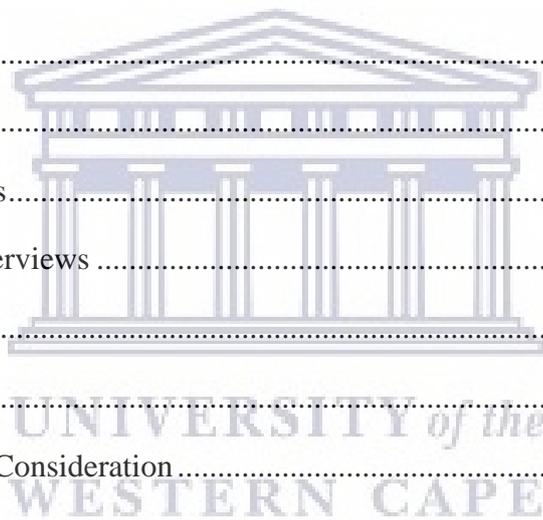
**Conclusion:** Recommendations to improve the uptake of HCT among men in Chileka Health Area include; improving client confidentiality in HCT facilities, addressing HIV-related stigma and discrimination, introduction of Self-Testing, rotation of HCT service providers, provision of social support from family members, and the use of home-based HIV Counselling and Testing.

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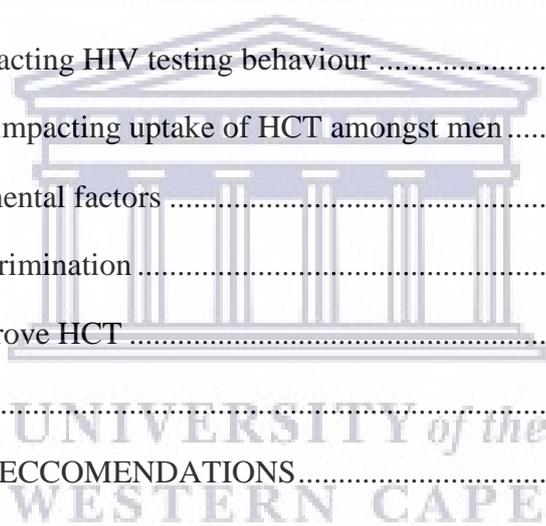
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## LIST OF ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ANC: Antenatal Care

ART: Antiretroviral Therapy

ARV: Antiretroviral

CBO: Community Based Organisation

DHO: District Health Office

HCT: HIV Counselling Testing

HIV: Human Immunodeficiency Virus

ICA: International Christian Assembly

MPHIA: Malawi Population-Based HIV Impact Assessment

MSM: Men who have sex with men

NGO: Non-Governmental Organisation

NSO: National Statistical Office

PLHIV: People living with HIV/AIDS

PMTCT: Prevention of Mother-to-Child Transmission

SCT: Social Cognitive Theory

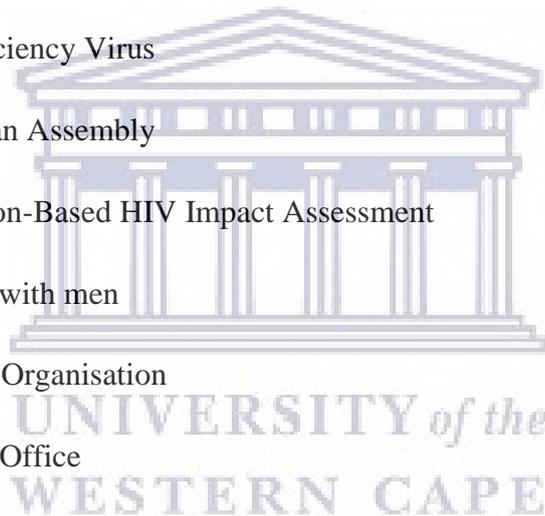
SAA: Sub-Saharan Africa

TA: Traditional Authority

UNAIDS: United Nations Programme on HIV/AIDS

VCT: Voluntary Counselling and Testing

VMMC: Voluntary Male Medical Circumcision



WHO: World Health Organisation

WV: World Vision



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# CHAPTER ONE

## INTRODUCTION

### 1.1 Background

HIV, the virus that causes Acquired Immune Deficiency Syndrome (AIDS) (Capriotti, 2018), is one of the major challenges to global public health. Approximately 38 million people are living with HIV/AIDS in the world (UNAIDS, 2020). While HIV affects men, women and children indiscriminately, research has shown that HIV prevalence is relatively high among the reproductive age cohort (*i.e.* 15-49 years) (UNAIDS, 2020). Furthermore, evidence suggests that the majority of people living with HIV are from Sub-Saharan Africa (Pustil, 2016; UNAIDS, 2020). In 2019, Eastern and Southern Africa had approximately 20.7 million people living with HIV/AIDS and Western, and Central Africa had 4.9 million people living with HIV/AIDS (UNAIDS, 2020). High poverty levels and deteriorating living standards in Sub-Saharan Africa can be attributed to HIV/AIDS (UNAIDS, 2020). Malawi is one of the countries with the highest HIV prevalence in the world.

Malawi had an estimated HIV prevalence of 9.6% with about 9.2% of its adult populace living with HIV/AIDS in 2018 (UNAIDS, 2020). Research has shown that in 2016, the country had almost one million people who were living with HIV/AIDS and, in the same year, there were about 24,000 deaths caused by AIDS-related diseases (Cuadros, Branscum and Mukandavire, 2018). The reproductive age group (15-49 years) in Malawi has a high probability of contracting the HIV virus due to high sexual activity and marriages. As a result of the HIV epidemic, the life expectancy for men and women in Malawi is 61 and 66 years old respectively (WHO, 2018). Furthermore, the epidemic has resulted in a higher poverty rate and low living standards (UNAIDS, 2020). In an attempt to combat the devastating effects of the HIV epidemic, there has been a commitment by the government to prevent new HIV infections, to ensure that those living with HIV/AIDS have access to HIV treatment (AVERT, 2018).

One of the international organisations involved in combating the HIV epidemic is the United Nations Programme on HIV/AIDS (UNAIDS). In 2014, the organisation introduced the UNAIDS 90-90-90 targets with the aim of diagnosing 90% of all People Living with HIV (PLHIV), to ensure that 90% of those that are diagnosed receive sustained antiretroviral therapy (ART) and reach viral suppression for 90% of PLHIV on treatment (UNAIDS, 2020). As a way of achieving these targets, countries are encouraged to establish HCT facilities to the people (Drummond et al. 2015). HCT is a public health intervention where a person is privately tested and counselled for HIV. This intervention enables people living with HIV to be aware of their condition and encourages them to initiate Antiretroviral Treatment (ART). Strict adherence to ART will suppress the viral load to undetectable levels, allowing PLHIV to live a longer and healthy life (Bemelmans et al. 2010; Keiser et al. 2011) and eliminating the risk of sexually transmitting the virus to HIV negative partners.

HIV Counselling and Testing is vital in preventing HIV infection, and improves HIV treatment, care and support. Testing enables one to know their status and puts them in a position to make better decisions about their life going forward (World Health Organisation, 2015). For instance, people who are HIV negative and know their status may be encouraged to use condoms to prevent them from being infected, while people who are positive and know their status may be encouraged to undergo HIV treatment to live healthy and long lives and prevent their partners from contracting the virus. Estimations show that, 79% of the people living with HIV/AIDS knew their status globally in 2019 (WHO, 2019). The remaining 21% have not accessed testing services and are unaware of their status. Globally, in 2018, approximately 23.3 million people living with HIV were receiving antiretroviral therapy (ART) (WHO, 2019).

Malawi has made impressive efforts towards reducing the HIV epidemic, both at national and local levels. Malawi's National Strategic plan to reduce the HIV epidemic is in line with the UNAIDS 90-90-90 targets and is very close to reach the 90-90-90 goal (UNAIDS, 2020). Over the past few years, HIV counselling and testing (HCT) services in Malawi have increased and surpassed the national targets with almost 1.9 million people getting tested for HIV within the first half of 2017 (UNAIDS, 2020). As of 2017, 90 per cent of the people living with HIV knew of their status, 71% of those diagnosed with HIV were on treatment, and 61% of those were virally suppressed. In response to the efforts made in reducing the epidemic, there has been a decline from 56,000 new infections, in 2010, to 42,000 in 2015 and to 33,000 in 2019 (UNAIDS, 2020). These improvements show that Malawi has made good progress towards the

2015-2020 National Strategic Plan for HIV and AIDS to attain the UNAIDS 90–90-90 targets by 2020. However, more work still needs to be done if Malawi is to achieve this and end the HIV epidemic by 2030 which is the end goal (UNAIDS, 2020).

In the quest to curb the HIV epidemic, Malawi has been implementing free HCT services in some public health facilities and private clinics (Malawi Ministry of Health, 2016). However, the uptake of HCT services among men in Malawi remains low regardless of the free availability of HCT services. The uptake of HIV is lower in men compared to women with a proportion of 17% and 31% of men and women who were not tested respectively (NSO, 2017). These results coordinate with a recent Malawi Population-Based HIV Impact Assessment (MPHIA), with estimations showing that 35% of men have never tested for HIV in Malawi (Ministry of Health, 2017). The population of men is highly affected by HIV and they signify a key group to take part in HCT services. Additionally, men are looked upon as the main decision makers in the family who have an impact on the control of financial resources that are important for HIV, prevention, treatment, and care. Hence, it is important to understand the factors that influence the uptake of HIV counselling and testing among the male population to help in developing strategies to increase HCT amongst men in Malawi and eventually avoid HIV infection and enhance HIV treatment and care.

Thus, it is essential for research to be carried out to understand the factors responsible for the low uptake of HCT among men. This study therefore focused on the uptake of HCT among men aged 18-49 years and assessed the barriers and enablers to HCT uptake among men in Chileka Health Area which is the rural part in Lilongwe District.

## **1.2 Research Problem**

HIV testing is one of the crucial strategies in preventing and controlling the spread of HIV/AIDS. However, limited studies have been conducted to investigate the use of the service by men in Malawi. Therefore, this study was carried out to understand the factors responsible for the low uptake of HCT among men. This research will help policymakers in implementing programs that aim to scale up HCT among men and identify possible social interventions that can help to increase the uptake of HCT among men and promote treatment that will sustainably reduce population level HIV transmission in Chileka Health Area, which is a rural part of Lilongwe district, Malawi.

### **1.3 Purpose of the Study**

The purpose of this study was to identify the factors that contribute to the low uptake of HCT among men aged 18-49 years in Chileka Health Area in Malawi. Barriers to HCT have played a significant role in contributing to the low uptake of HCT among men, hence contributing to the further spread of HIV.

### **1.4 General Objective**

The main objective of the study was to identify and assess barriers and enablers to HIV counselling and testing among men aged 18-49 in Chileka Health Area, Lilongwe District.

#### **1.4.1 Specific objectives**

- To explore personal, behavioural and societal barriers and enablers that influence HCT uptake among men aged 18-49 years in Chileka.
- To explore health service delivery factors that affect HCT uptake among men aged 18-49 years in Chileka.

#### **1.4.2 Research Questions**

- What are the personal, behavioural and societal barriers and enablers that influence HCT uptake among men aged 18-49 years in Chileka?
- What are the health service delivery factors and how does this affect HCT uptake among men aged 18-49 years in Chileka?

### **1.5 Significance of the Study**

The results from this study will contribute to the literature on barriers contributing to the low uptake of HCT among men in Malawi at both academic and national level program development.

The findings of this study shed more light on the challenges that men face when accessing HCT services and this will help scholars and the general public to get a better understanding of how it can be addressed and tailored to increase the uptake of HCT among men, including outreach programs and community interventions that will empower men to go for HCT. The primary benefit of the study is that it uncovered diverse reasons to why men refrain from HCT and this is important as it will help future health interventions to be inclusive of men, to successfully address the issues that men face which may result in an increase of the uptake of HCT among men in Chileka Health Area.

The recommendations from the findings will help government and Non-Governmental Organisations (NGOs) to identify personal, behavioural and social factors hindering men from accessing HCT services and implement programs that eliminate factors hindering men to go for HCT. In light of the recommendations drawn, this study will also help the Government of Malawi and NGOs to develop programs or projects that target more male involvement in HCT services and create awareness about the effects that discourage men from accessing HCT such as stigma and discrimination.

### **1.6 Structure of the Thesis**

This thesis is split into six chapters and the arrangement of each chapter is outlined as follows:

Chapter one introduces the thesis. It provides the background to the study, the problem statement, and the purpose of the study. It also includes the study objectives, research questions and highlights the significance of the study in academic and general literature.

The literature review in chapter two focuses on HIV and HCT in Malawi, as well as barriers of HCT among men. It also examines HIV related stigma and discrimination, gender and healthcare barriers.

Chapter three discusses the research design, the area where the study was conducted, the target population of the study, the sampling techniques, sample size of the study participants and the tools that were used for data collection. This chapter also discusses how data was analysed and the relevance of the data analysis methods and the measures implemented in the study to make sure study ethics were followed to ensure participants were not harmed by the study. Lastly it discusses limitations to the study.

Chapter four is a presentation of the study findings and chapter five is a discussion of the findings titled Research Findings and Discussion of findings, respectively.

The last chapter is a presentation of the conclusions that is derived from the findings and discussions of the data. It also discusses the recommendations that will help enhance the uptake of HCT among men.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction and Overview

This chapter reviews prevailing literature that concerns the critical determinants of low uptake of HIV testing amongst men in Chileka Health Area, Lilongwe district in Malawi. The review of existing literature aimed to find related studies that have been conducted on this topic in order to reveal the research gaps to be addressed by this study. The principal intention of this review was to collect evidence and gain intuitions on the key factors that influence men's decisions to engage in, or shy away from HIV testing. This fusion of the extant literature and identification of research gaps can indicate the significance of HIV testing amongst men to ensure HIV prevention, treatment and care. It also aimed at giving recommendations for future research, and ultimately giving recommendations on how to improve HIV testing interventions for men.

The researcher made use of several sources of data including local, regional and global sources, internet sources, journal articles and e-books. The chapter is split into nine subsections which are: Subsection 2.1 introduces the chapter by explaining the intention of literature review specifically to this study. Subsection 2.2 delves into the social cognitive theory which frames the results and discussion of the study. Subsection 2.3 focuses on HIV and AIDS in Malawi. Subsection 2.4 focuses on HIV related stigma and discrimination while subsection 2.5 outlines HIV testing behavior in relation to gender. Subsections 2.6 to 2.8 explicitly focuses on effective barriers to HIV testing amongst men: denying a possible HIV positive diagnosis (Subsection 2.6), health service provider as a barrier to HIV testing (Subsection 2.7) and fear of lack of confidentiality of HIV testing (Subsection 2.8). The chapter ended with a summary in subsection 2.9.

#### 2.2 Theoretical framework

Theories and lines of inquiry are very important in research. In quantitative studies, theories can be used deductively to test or verify a theory. "The theory becomes a framework for the entire study in organizing a model for the research questions or hypothesis for the collected data" (Creswell, 2014: 32). In qualitative studies, "the use of theory usually depends on the nature of the investigation, they can be used as a broad explanation for behavior and attitudes,

and it may be complete with variables, constructs, and hypotheses” (Creswell, 2014: 31). This study seeks to identify and access barriers that contribute to men’s decision in avoiding HCT and employed the Social Cognitive Theory (SCT) to examine the personal, behavioural, social or environmental factors impacting HIV testing behaviour amongst men aged 18-49 in Lilongwe district, Malawi.

### **2.2.1 Social cognitive theory**

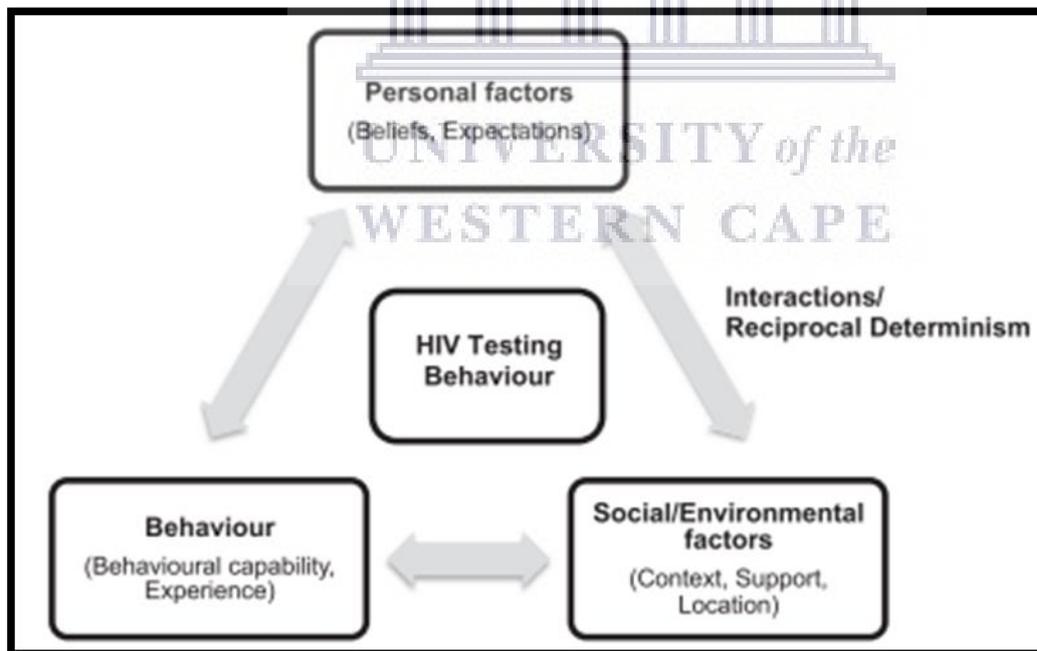
This study employed the Social Cognitive Theoretical framework to explain HIV testing behaviour amongst men aged 18-49 years in Malawi. The factors impacting HIV testing behaviour were also examined to establish critical determinants of HIV testing behaviour amongst men aged 18-49 years in Malawi.

The Social Cognitive Theory elucidates that learning occurs within a social context (Bandura, 1986), and in the case of our study, it was Chileka Health Area. People adapt and imitate behaviours of others through observations, mostly if their observational experiences are positive or have rewards in relation to the behaviour (Bandura, 1986). The SCT framework has been employed in previous studies conducted to examine HIV prevention programmes (Dilorio, et al. 2001; O’Leary, 2001). The SCT framework outlines critical drivers of influence on individuals’ intentions, perceptions and attitudes to act and their capacity to execute their intentions. These critical factors impacting human behaviour includes: personal factors, behavioural factors, and environmental or social factors (Bandura, 1994).

The personal factors of the SCT notes that expectations, beliefs and perceptions influence peoples’ behaviours; how people behave depends on what they think, believe and feel (Bandura, 1986). Behavioural factors in relation to the SCT alludes that behaviours of people are learnt through past experiences, which end up being permanent (Bandura, 1986). For example, a child watching someone act brave in a dangerous situation, through this experience, children learn violent behaviours and act violently (Bandura, 2006a). The social factor of the SCT elucidates that people obtain new information and learn new behaviours by observing other people (Bandura, 1986). People also stimulate various social reactions which are dependent on their socially conferred status and roles. For example, children who have a strong reputation will obtain a different reaction from society compared to those who are weak. Hence, the social status and noticeable characteristics can influence the social environment before taking any action (Bandura, 1986).

Social Cognitive Theory highlights that ‘behaviours, environmental impacts, and beliefs are very interlinked and related (Kalichman, 1998). It is these three crucial drivers and particularly the mutual determinism existent between them that can positively or inversely impact human behaviour. An explicit understanding of these critical drivers can inform the design and implementation of interventions to address certain human behaviour. A schematic presentation of the social cognitive theory is displayed in Figure 1 below.

The social cognitive model employed in this study was adapted from Bandura’s contribution to SCT in the perspective of HIV (Bandura, 1994). The SCT framework has the balanced cognitive decision-making at the centre of understanding the individual’s behaviour, and is exclusively important to the uptake of HCT. Cognitive decision making the process in which a preferred choice is selected from various alternatives based on certain criterion (Wang and Ruhe, 2007). The SCT also explains the critical barriers and facilitators of HCT. This study sought to examine the factors obstructing men from engaging into HIV Counselling and Testing. Existing literature outlines some of the effective barriers and enablers that exist primarily because of the collaboration between personal, behavioural and environmental or social factors.



**Figure 1:** Social Cognitive Theory framework

**Source:** Strauss et al. 2015

### **2.2.2 Personal factors**

At a personal level, a vital factor is the fear of a positive test result. Men who engage in unsafe sexual practices usually perceive themselves to be at high HIV risk and therefore, avoid getting tested due to the expectations of getting a positive result (Fako, 2006). Those individuals who expect to have contracted the virus have a lower probability of getting tested result (Fako, 2006). Correspondingly, some studies revealed that men who had not engaged in sexual activities are less likely to undergo HCT (Fako, 2006; Kabiru et al. 2011). The behaviors of people are not only based on their own experiences but also on outcome expectations, by observing the behaviour of other people and the outcome of that particular behaviour (Bandura, 1986). For example, people may hold the outcome expectation that if they consistently use condoms, they will significantly reduce risk of becoming HIV infected.

### **2.2.3 Behavioural factors**

The social cognitive theory states that one's past experiences usually shape his or her future. People with a background of consistent and frequent HCT (Young et al. 2010), and those with more counts of visiting a health clinic, were more likely to continue to undergo testing (MacPhail et al. 2009). However, those who saw someone being stigmatised and discriminated on the basis of having tested positive, avoid undergoing a test in fear of being subjected to the same stigma (MacPhail et al. 2009; Young et al. 2010). This implies that one's history of being stigmatised or witnessing someone being stigmatised influences their HIV test behaviour.

### **2.2.4 Social or Environmental factors**

The relationship between personal factors and the environmental setting in which men are living tend to influence their willingness to undertake HCT. Young et al. (2010) revealed that fear of HIV related stigma and discrimination, irrespective of HCT result, can be a major reason why men avoid undergoing HIV testing. Receiving support from the community, family and friends, was identified to be a significant facilitator of HCT (Strauss et al. 2015). Individuals usually raised concerns about confidentiality due to fear of stigmatisation (Mathews et al. 2009). A study by MacPhail et al. (2008) discovered, trust issues concerning healthcare workers performing the counselling and testing operations at healthcare centres.

### 2.3 HIV/AIDS in Malawi

Malawi is one of the countries with a very high HIV prevalence in the world (UNAIDS, 2020), regardless of the notable progress that the country has made towards improving the HIV epidemic in latest years.

HIV extremely affects women in Malawi (PEPFAR, 2018). A national assessment of the impact of HIV on the Malawi Population-Based HIV Impact Assessment (MPHIA) implemented by the Ministry of Health in 2015-2016, discovered that the prevalence of HIV between adult women aged 15-64 was 12.8% and 8.2% in men of the same age group. This disparity is prominent among 25-29 years, as the prevalence of HIV is three times higher among women at 13.6% compared to 4.7% of men (Ministry of Health, 2016). Early sexual activity and marriage contributes to young people facing a high risk of contracting HIV/AIDS, a third of all new HIV infections in Malawi in 2018 happening between the ages of 15-24 years. Regardless of this, around 60% of young people lack adequate knowledge of how to avoid HIV (UNAIDS, 2020).

HIV Counseling and Testing (HCT) services have improved over the last few years in Malawi, exceeding national targets. HCT services are offered in two ways: through client-initiated HCT (also known as 'Voluntary Counseling and Testing'), and provider-initiated HCT. Provider-initiated testing occurs is when a health worker proposes an HIV test to a patient in a health care facility, mobile testing units, at people's homes and at national health events. In clinical settings, HIV testing is available in adult and pediatric inpatient wards, nutritional clinics, antenatal care, maternity and postnatal wards, outpatient departments and sexual health clinics (Malawi Ministry of Health, 2016). Similarly, 1.8 million people accessed HCT services in 2014 (Malawi National AIDS Commission, 2015). This indicates that HIV testing services have significantly increased in recent years.

Significantly more women than men in Malawi, however, test for HIV. From the 1 million people that tested for HIV between in 2017 between April and June, 37% of them were men and 63% were women. In every five people that tested for HIV, one of them (20%) accessed HCT as a couple. About half (48%) of those testing were aged 25 or above, 38% were aged 15-24 and 13% were under 15 years old (Malawi National AIDS Commission, 2017). The testing difference between men and women indicates women living with HIV are more likely to be aware of their status (Mandiwa and Namondwe, 2019). In 2018, more women were diagnosed with HIV, 94% compared to 89% of men diagnosed with HIV (UNAIDS, 2020).

Reviewed literature revealed that in Malawi, women decisions to test for HIV is influenced by perceptions of a partner's risk for HIV other than their own decision, while men solely depend more on self-assessments (UNAIDS, 2020). Another study conducted on gender differences in the time spent seeking health care in Malawi revealed that more women attended a minimum of one health care visit during the past two months compared to men, 60%-22% respectively (Yeatman et al. 2018). Women also took an average of 6.4 hours looking for care over two months relative to one hour for men.

Men who have sex with men (MSM) have been identified as a crucial population that is affected with HIV epidemic in Malawi (Wirtz et al. 2017). These groups suffer from extensive discrimination since same sex practices are prohibited by the government of Malawi. Despite inadequate data, estimations show that around 7% of men who have sex with men are living with HIV in Malawi (UNAIDS, 2019). Homosexuality is illegal in Malawi and is punishable with 14 years in prison, even though trials were suspended in 2012 (Wirtz et al. 2017). However, men who have sex with men continue to face different levels of punishment. For example, a police officer can sue someone involved in same sex acts on grounds that they are violating peace. Men who have sex with men face assault, arbitrarily arrest and detention from the police.

A 2016 survey of about 200 MSM uncovered that 39% had experienced human rights abuse which included 12% who had been raped (Scheibe et al. 2016). These factors produce an unfriendly environment that increases the HIV vulnerability of MSM and also reduces their ability to access HIV prevention and treatment services. This is illustrated in a study conducted by (Andrea, 2013) in Malawi which uncovered that the limited uptake of HCT services among MSM due to stigma and discrimination when seen visiting HCT health facilities. The study recommended the need for more research and HIV interventions programs that accommodate MSM, which will allow them to access HCT while protecting their privacy and confidentiality (Andrea, 2013).

#### **2.4 HIV Related Stigma and Discrimination**

Stigma is referred to as the social and societal isolation of an individual who is identified to be suffering from a particular ailment, which is socially intolerable (Mburu et al. 2014). HIV linked stigma usually results in PLHIV feeling worthless and ashamed of themselves, primarily because of the adverse treatment they are exposed to from the communities they are living in (Tsai, 2015). Stigma is a significant contributor to the HIV epidemic as it is linked to

postponements and deferrals in HIV testing, limited accessibility to treatment and care and acts as an impediment to HIV intervention efforts (Treves-Kagan et al. 2016). In the early years of the HIV epidemic, Jonathan Mann described stigma as becoming part of the “third epidemic,” following the fast HIV transmission and rise in AIDS cases. He identified that stigma, discrimination, blame, and denial are very problematic to address, however addressing stigma is important in prevention and spread of HIV (Mann, 1987).

HIV stigma has been identified to have a negative effect on the individual’s decision to undertake an HIV test (Tsai, 2015). HIV stigma results when people living with HIV are being treated differently by their family, friends and even health care workers and get systematically isolated and face high levels of discrimination (Treves-Kagan et al. 2016). Musheke et al. (2013) reported that the public usually regard HIV positive individuals as being immoral; thereby making people afraid of being seen at an HIV testing centre. This fear of accessing HIV health services contributes significantly to low rates of HIV testing (Musheke et al. 2013).

The discrimination, segregation and rejection that HIV infected people are subjected to in the communities and perception that they are to blame for being unable to listen to advice motivates people not to unveil their HIV status (Stangl et al. 2013). This is supported by Golub and Gamarel (2013) who asserted that “non-disclosure of HIV status is associated to stigma which later leads to denial of engaging in HIV testing to avoid getting an HIV positive result. A study carried out amongst African men in the United States revealed that fear of being unwanted caused participants not to get tested for HIV, thereby leading to low uptake of HIV testing amongst men (Bova et al. 2016). This is also supported by recent studies which discovered that fear of stigma, unknown results, humiliation and hesitancy in opening up to health workers are critical barriers to the uptake of HCT (Mohlabane et al. 2016; Berendes and Rimal, 2011). Correspondingly, Bwambale et al. (2008) carried out a research in Uganda to access HCT among men employing a population based cross sectional study. The study revealed that few men access HCT services with an overall HCT prevalence of only 23.3% amongst men. The low proportion of men accessing HCT services was primarily a result of fear of stigma, and lack of privacy of services. A recent study in Malawi confirmed that fear which is associated to stigma in HIV testing healthcare centres hinders young men from getting tested (Mandiwa and Namondwe, 2019).

People choose to remain ignorant of their HIV statuses than being disregarded, humiliated, and excluded from others (Okoror et al. 2014). There is a need to “overcome stigma and encourage disclosure of HIV status to allow early testing of those at risk” (Yakob and Ncama 2016: 12).

## **2.5 HIV Testing Behavior According to Gender**

Men are considered the head of the family in some African countries and make important decisions for the family. Studies “conducted in Ethiopia and Lesotho have shown that in some communities, decisions for women to have HIV tests are made by men” (Leta et al. 2012: 2; Mantell et al. 2014: 462). According to a study conducted by Obermeyer and Osborne (2007: 1766), “men and women have different perceptions of HIV testing. Men perceived themselves as being at low risk for HIV infection compared to women irrespective of the high risk sexual behaviours that men engage in” (Obermeyer and Osborne 2007: 1766). A study conducted by Mburu et al. (2014) in Zambia revealed that fewer men than women access and use HIV services including testing since they do not want people to know them as having HIV.

HIV testing is gender skewed in many African countries, including Malawi, with fewer men getting tested for HIV relative to their female counterparts (UNAIDS, 2020). Some argue that this is because men consider themselves as superior (Sharma et al. 2017). Gender has been theorized as the ‘socially constructed responsibilities, behavior, activities and attributes that a specific society considers suitable for men and women’ (World Health Organization, 2013). Gender customs and masculinity are significant contributing factors towards low uptake of HIV testing amongst men (Mills et al. 2012). Masculinity makes men want to be in control and powerful. However HIV stigma puts pressure on masculine impressions of respectability, emotional control and independence (Mburu et al. 2014). For that reason, the intersection of masculinity and HIV stigma has a disadvantage on men’s health especially in seeking of HCT services and has discouraged men in accepting a sick role (Mburu et al. 2014). On the other hand, women access HCT services without fear of being labeled. In a study conducted in South Africa, “women were known to be regular users of health facilities, which became a norm in their communities” (Treves-Kagan et al. 2016: 10).

Literature has uncovered that, in some countries, more women are diagnosed with HCT than men because HIV counselling and testing is available through antenatal care (ANC) services (UNAIDS, 2020). Evidence shows that, “more women will agree to have an HIV test if it is offered to them at antenatal clinics than in any other setting” (Obermeyer and Osborne 2007: 1766). Jean et al. (2012: 6) found that “HIV testing is higher in women who underwent

antenatal care than the ones who did not”. Consequently, “a study conducted in Zimbabwean clinics showed that 99% of antenatal women were tested in comparison to 65% of women who came for other reasons; routine HIV testing was offered to pregnant women whereas the other group of women voluntarily requested testing” (Sasaki et al. 2010: 4). This raises the number of women testing for HIV if they have gone for ANC hence the scaling up of routine HIV testing needs to include all genders.

In the same vein, a study conducted on gender dissimilarities in the duration of time taken to seek health care in Malawi revealed that more women attended at least one health care visit during the previous two months compared to men, 60%-22% respectively (Yeatman et al. 2018). Women took an average of 6.4 hours looking for care over the period of two months relative to 1 hour for men. The higher rates of women visiting health facilities were primarily due to their usual ANC examinations (Yeatman et al. 2018). Consequently, a study conducted on couple counselling and testing for HIV in Tanzania indicated that HCT and STIs services are usually provided in ANC services; thus men are required to attend antenatal clinics or other services which deal with reproduction to access these services. Since ANCs are regularly visited by women, men therefore avoid them contributing to low HCT among men (Myburgh, 2011).

## **2.6 Denying a possible HIV positive diagnosis**

Denial is a common response to HIV diagnosis, where men often disregard themselves as being susceptible to the risk of contracting HIV despite having several sexual partners and non-condom use (UNAIDS, 2020). This emanates from the fact that they are in denial to accept that they may contract the HIV virus (Camlin et al. 2016). Men abstain from HIV testing or seeking health care regardless of their economic and social advantages (UNAIDS, 2020). A lot of HIV positive men remain undiagnosed and tend to receive HIV treatment late relative to women thereby leading to AIDS related deaths (UNAIDS 2020). Late HIV diagnosis is frequently a result of avoiding the truth. Since they do not know their HIV status they tend to live more freely with a confidence that they are HIV negative primarily because they have never tested for HIV hence don't worry about being HIV positive (Hall et al. 2014).

## **2.7 Health Service Provider as a Barrier to HIV Testing**

It is important to examine the cultural backgrounds that exist in health care facilities connected to stigma and discrimination. Research has established that negative attitudes from health care providers creates barriers for men to access HCT services because they are not supported when

looking for preventive services and this increases the spread of the virus further (Okoror et al. 2014). The stigma and gossip that prevails at health care sites is seen as another critical barrier to HIV testing. PLHIV tend to avoid HIV testing when they sense disrespect and fear of their status becoming public knowledge leading to embarrassment and stigmatisation (Treves-Kagan et al. 2016). Unfriendly, hostile and uncaring staff attitudes at health centres hinder access to HIV services since such reactions tend to make people uncomfortable with seeking help from the health service sites, thereby making them to avoid attending health facilities (Yakob and Ncama, 2016). In addition, investigators revealed that people who have knowledge about HIV/AIDS tend to be more worried about the treatment received from health care facilities as opposed to the infection itself (Foreman, 2003). The penalties of such negative actions towards PLHIV are that those who are in urgent need of treatment, care and support are unable to receive any health care services (Aghamolaei, 2009). It is therefore necessary for health care professionals to have an open and positive mind towards people living with HIV and AIDS (Aghamolaei, 2009).

### **2.8 Fear of confidentiality for an HIV test**

The lack of privacy and discretion at health service centres is another obstruction to HIV testing uptake amongst men in both emerging and developing countries (Burns, 2009). People are often hampered from undergoing an HIV test if they do not have faith that the health care provider will treat their HIV positive diagnosis with strictest confidentiality (Burns, 2009). This is consistent with the findings of a study by Matovu and Makumbi (2007) which revealed that the lack of confidentiality and privacy tends to force people to refrain from accessing HIV testing services. Confidentiality is thus another key factor to encourage men to visit healthcare facilities and use HIV testing services (Matseke et al. 2016). Ensuring that patients' HIV test results will be kept confidential is important in motivating people to access HIV testing services and improve the uptake of HCT (Peralta et al. 2007).

Confidentiality is a crucial concern especially among MSM. Men who have sex with men have been recognized as a crucial population that is affected with the HIV epidemic in Malawi (Wirtz et al. 2017). However, same sex practices are prohibited by the government of Malawi (Wirtz et al., 2017), thus resulting in men staying underground in their additional marital affairs as well as circumventing HCT due to panic of being stigmatized, recognized or discriminated (Fay et al. 2011). These factors normally generate an antagonistic background which increases MSM susceptibility to HIV while reducing their ability to access HIV prevention and treatment

services. In addition to this, lack of confidentiality of their HIV test by health care providers imparts fear of being discriminated for their HIV status and sexual orientation.

## **2.9 Chapter summary**

The chapter analyses the main theory underpinning the study (Social Cognitive theory). The conceptual framework examined the effective barriers to HIV testing amongst men. These barriers were identified from empirical literature and they included; HIV related stigma and discrimination, HIV testing behavior according to gender, denying a possible HIV positive diagnosis, lack of trust in the Health service provider and fear of confidentiality for an HIV test.



## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction and Overview

This chapter explains the research methodology used to collect and analyse data to gain a better understanding of Voluntary HIV Counselling and Testing among men in Chileka Health Area. This chapter covers the research design, study area and target population, the sampling techniques and sample size, data collection techniques and tools, logistical and ethical considerations, and the study limitations. This chapter also discusses how data was analysed and justifications for the data analysis methods. Lastly, it outlines how the validity and reliability of the data were ensured, and the researcher's characteristics and reflexivity. This chapter is significant in describing the tools and techniques that were used to provide systematic and quality data collection, which assisted the researcher to gain understanding of the uptake of HCT among men.

#### 3.2 Research Design

The study employed an exploratory study design. An exploratory study design concerns itself with projects that address a subject with high levels of uncertainty and ignorance; hence it is used to generate new insights on experiences on the research problem (Stebbins, 2001). The study design was chosen to gain a better understanding of the utilization of HCT services by men in the Chileka Health Area in Lilongwe District, Malawi. Studies examining the usage of this service by men in Malawi are limited (Mandiwa and Namondwe, 2019). Applying an exploratory study design assisted the researcher in uncovering experiences and perceptions that contribute to the low uptake of HCT among men.

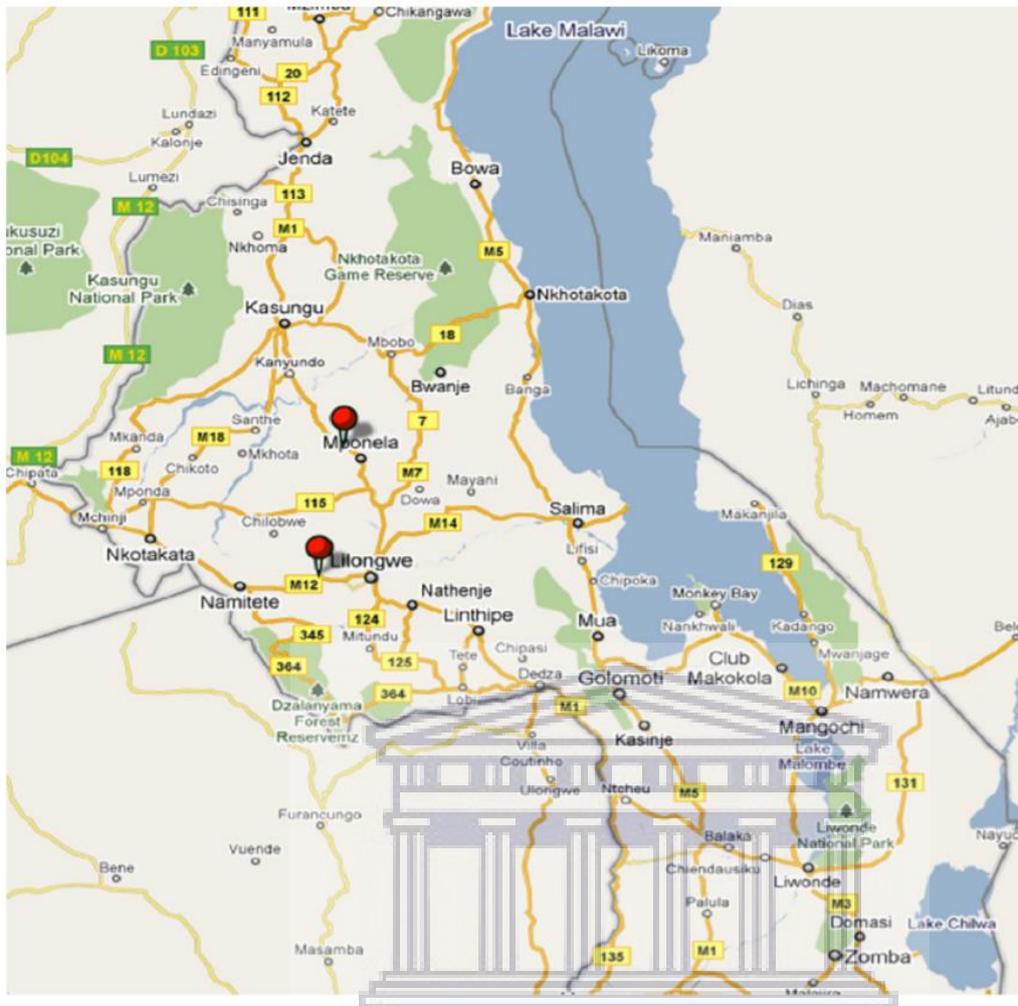
The study employed a qualitative method of data collection through in-depth interviews. The qualitative approach allows the researcher to understand events that unfold in social settings, such as meanings, perceptions, and experiences from the perspective of research participants, which cannot be adequately measured by quantitative research methods (De Vos et al. 2011). It allowed the researcher to probe, describe, and give detailed information on why men decide to get tested or not get tested for HIV and what informs their decision to undergo an HIV test.

The researcher used in-depth interviews to explore personal, behavioural and societal barriers and challenges with health service delivery that influence HCT uptake among males aged 18-49 years in Chileka. The interviews involved 25 males aged 18-49 years who were selected using multi-stage sampling, as well as eight key informants that were purposely selected. The

key informants consisted of one community development assistant, one Christian religious leader, a manager in charge of the health facilities, one Community Based Organisation (CBO) leader, and four HCT service providers. The researcher chose the selected key informants because of their knowledge and experience with HIV and AIDS in the local community and health department. The community development assistant oversees all activities happening in the community and was selected based on criteria of knowledge and experience on HIV/ AIDS and the community's behaviour towards HIV/AIDS to provide rich study data. Since the HIV/AIDS epidemic emerged, Community Based Organisations (CBOs) are at the forefront in responding to HIV and community members trust and depend on CBOs. This easily allows CBOs to educate the community on the importance of health care services. The CBO leader was chosen due to the knowledge and information CBOs have on the HIV/AIDS epidemic and the community.

### **3.3 Study Area**

The study was conducted in Chileka Health area, which is part of T.A Kalolo Lilongwe District. Lilongwe is the largest district in Malawi and is located in the Central region of the country as indicated on the map below. The last official population census in 2018 put the districts population at 989,318 (National Statistical Office, 2018). Current estimates put Lilongwe's population at 1,122,000 million which is relatively high compared to other urban areas in the country (World Factbook, 2020). The study focuses on Lilongwe district because statistics show that men in the urban environment are more prone to HIV than women (Ministry of health, 2016). This is shown in the 2015-2016 Malawi population-based HIV impact assessment (MPHIA) data which revealed that only 67.1% of men know their HIV status compared to 77.1% of women who were aware of their HIV status (Ministry of health, 2016).



**Figure 2:** The Map of Malawi Showing Lilongwe District

**Source:** Atera and Itoh (2012)

Lilongwe district has 20 HIV/AIDS service providers. These includes government organisations such as the ministry of health, private hospitals such as Partners in Hope, religious organisations such as International Christian Assembly (ICA), Non-Governmental Organisations (NGOs) such as World Vision (WV) and Action AID (Lilongwe District Council, 2017). As a way of controlling the spread of HIV/AIDS in Lilongwe, behaviour change, prevention and impact mitigation programs that align with the national HIV strategy with a focus on the 90-90-90 targets, have been implemented (Lilongwe District Council, 2017). The primary interventions implemented to date are the provision of HIV testing services, prevention of mother to child transmission (PMTCT), provision of antiretroviral therapy (ART), support of community home-based care, Voluntary Male Medical Circumcision (VMMC), provision of youth-friendly health services and support to orphans and vulnerable children (Lilongwe District Council, 2017).

VMMC is the only male HIV national prevention strategy towards men. While VMMC has made significant progress, challenges still exist because not all men chose to get circumcised. Circumcision is not acceptable in some cultures or religions, while others believe their foreskin is sold and used for malicious activities like Satanism (Lilongwe District Council, 2017). Most of the HIV prevention interventions focus on women and children who are profoundly affected by HIV because of their unequal cultural, social and economic status in society (UNAIDS, 2020). A lack of sufficient HIV reduction interventions targeting men contributes to the low uptake of HCT among men in Chileka Health Area in Lilongwe.

Lilongwe District has six Health Areas, which includes: Malembo Health Area, Chileka Health Area, Chikowa Health Area, 25 Health Area, 18 Health area, and Adventist Health Area 1. Chileka Health Area was purposely selected for this study because it is close to Lilongwe district, thus reducing transportation cost as the budget for this research was limited. Chileka Health Area has a population of 177,087 people, with 17 Group village headmen and 141 villages (National Statistics Office, 2018). The population size for the group of men aged 18-49 in Chileka Health Area is 42,714 (National Statistics Office, 2018).

Chileka Health Area has six health facilities: Chileka, Mbang'ombe, Nthondo, Ndaula, St Gabriel hospital, and Ming'ongo. These health facilities are public clinics that provide HIV services as well as preventive and curative services, with St Gabriel hospital being the most prominent health facility in Chileka Health Area with natal care, surgery, and HIV programs. Each health facility in Chileka Health Area serves patients from 20 to 24 villages. The study was conducted in 2 health facilities randomly selected from the six health facilities in Chileka Health Area.

### **3.4 Target Population**

The study targeted male participants aged 18-49 years in Chileka Health Area, T/A Kalolo, in Lilongwe district. This age group was chosen because the focus of the research study was on young and middle-aged adults who fall within the reproductive age. All participants in the study were above 18 years old and, therefore, able to provide consent to participate in the study. Those under the age of 18 were not eligible to participate in the study as they were not the focus of the research study.

### **3.5 Sampling techniques**

Multi-stage sampling was used to select participants who took part in the in-depth interviews. Multi-stage sampling is a process that involves dividing a large population into groups which are later chosen randomly (Alvi, 2016). The sample was drawn from 2 Health facilities randomly selected from the six Health facilities in Chileka Health Area. From the 2 Health facilities chosen, 4 villages were selected using simple random sampling from the pool of communities in the catchment area of the 2 selected health facilities. Simple random sampling was done by making a list of all the villages in each health facilities on small little pieces of paper, and each village was given a number. The pieces of paper were folded and mixed in a small box. The samples were picked randomly from the box by picking the folded pieces of paper randomly. This was done to reduce bias and, each village had the same probability of being selected for the study sample. Finally, 7 households were chosen using simple random sampling from the 4 chosen villages. All the households in the 4 villages were numbered and 7 households were randomly selected. Interviews were administered to males found in the household between the ages of 18-49.

Purposive sampling, a non-probability method, was used to select key informants who took part in the in-depth interviews. Purposive sampling allows the researcher to select research participants who are likely to have the knowledge to address the study purpose (Botma et al. 2010). This study was seeking information in relation to why men decide to get tested for HIV or not. Key informants who were purposely selected included: 1 community development assistant, 1 religious leader, the manager in charge of all health facilities, 1 Community Based Organization leader, and 4 HCT service providers. The targeted participants were purposely selected based on the knowledge they have on HCT. The key informants were purposely selected with the help of the village head man. The researcher set an appointment with the village head man and explained the study's aim and the information that the researcher wants to obtain from the study area. The village headman then introduced the researcher to the community manager, who was also given information about the research. This helped him identify the participants that were needed for the analysis. The community manager's role ended when all the key informants under study were identified and referred to the researcher.

### **3.6 Pilot Testing**

The data collection tools were tested in the pilot phase to reduce errors and mistakes before the main study. Piloting helped to ensure that the instructions were comprehensible and that the wording was correct in the data collection tools to increase the reliability and validity of the results (Simon, 2011). The data collection tools were tested in the locations in Chileka Health Area that had not been selected for the study. Two participants were interviewed using the in-depth interview guide. The in-depth interviews were conducted in Chichewa (the local language). Forty minutes to fifty minutes was required to complete each interview, and that was communicated at the beginning of the in-depth discussion to the actual participants who took part in the study. All mistakes and errors were noted and corrected before commencing with the prioritized sites' real data collection. Some of the interview questions that were removed as they deemed irrelevant to the research objectives are: What is the uptake of HCT among males aged 18-49 at your health facility compared to females in the same age group? What cultural factors enable men aged 18-49 to go for HCT? What factors act as barriers for men not to go for HCT? Are there any economic factors that encourage men aged 18-49 years to go for HCT? This ensured a smooth flow of data collection and reduced logistical and research errors.

### **3.7 Data Collection Tools**

#### **3.7.1 In-depth interviews**

The researcher used in-depth interviewing to elicit information to achieve a holistic understanding of the interviewee's point of view or situation. In-depth interviewing requires asking prepared questions and recording the participants' answers (Edriss, 2013). The interviews were conducted to explore and gain understanding of the barriers that contribute to the low uptake of HCT among men. To achieve this, participants were asked about the challenges they encounter which hinders them from going for an HIV test. This included personal, behavioural, and societal barriers faced. This involved asking closed, and open-ended questions, and probing were necessary to obtain beneficial data. The in-depth interview guide was used in qualitative interviews. This involved having an essential checklist prepared to make sure that all relevant topics were covered. The topics included: reasons for HIV testing, barriers to HIV testing, treatment by health care providers when testing for HIV, knowledge on HIV/AIDS, interventions to improve HIV counselling and testing, The interviewer was free to explore, probe, and ask questions deemed interesting. The researcher ensured that participants were comfortable sharing personal experiences and perceptions openly by briefly

leading the interviews. This helped in generating rich information as the participants felt more comfortable during the interview discussions.

All the interviews took place at the participants' convenient time and place, which was their home. For participants who had work during the week, interviews were done on the weekend, and the time and dates of the interviews were organized before the meeting. Participants who were available to be interviewed during the week, times and dates were also organized prior to the interview. Interviews with participants who lived alone or didn't have anyone present at home at the time of the interview were conducted inside their home. For those participants who had their family or friends around, the interview was conducted outside the house but only the researcher and interviewee were knowledgeable of the purpose of the interview to ensure flexibility and privacy. This approach was useful because it helped to elicit information about specific topics that were important to the study. The interviews also helped the researcher to observe the participant's non-verbal cues which helped the researcher during analysis when drawing conclusions from the data collected. Interviews were conducted in the local language, Chichewa, to allow participants to express themselves more freely.

### **3.7.2 Key Informant Interviews**

In-depth interviews were conducted with selected key informants that were purposely selected based on their knowledge about the target population and what goes on in the community. Key informants were asked to explain the factors that discourage men to go for HCT, the barriers that exist both in the community and health facilities that hinder men from accessing these services, and how this contributes to the low uptake of HCT. Recommendations to improve the situation were also given.

The key informants selected for the study were all occupied during the week as they had work commitments; hence interview times and dates were arranged around their lunch hour. All the interviews took place in private rooms. The interviews helped to obtain detailed information as detailed questions were asked as well as clarification of ambiguities. This allowed the researcher to get meaning beyond surface appearances and permit greater sensitivity to the meaning.

### **3.7.3 Desk Research**

The focus of the research was to identify and access the barriers and enablers that contribute to the low uptake of HCT among men in Chileka Health Area, in Lilongwe, Malawi. The researcher made use of several sources of information to collect data in relation to the barriers

that contribute to the low uptake of HCT among men. The secondary data was collected through an extensive review of current literature based on studies, surveys, reports and assessments of the factors that contribute to men not getting tested for HIV. The information that was collected was assessed through a variety of data bases and journals to the research topic which included local, regional and global sources, internet sources, books dissertations, journal articles, African Journals online (Open Access) and e-books, professional peer reviewed journals,

In gathering data, the researcher looked for general information on HIV and AIDS in Malawi and Lilongwe District. This information was obtained from articles and government documents. Search engines such as Google scholars and JSTOR were used in search of this information. Then the researcher reviewed documents on HIV/AIDS in Malawi. This was done to gain an understanding of the extent of HIV/AIDS, how it affects men and the interventions that have been implemented to help reduce the high prevalence of HIV. Following this, the researcher looked for specific information on the prevalence of HIV among men and women in Malawi and the barriers that contribute to the low uptake of HCT among men. The search was conducted following a number of key words which included: HIV and AIDS, HIV prevalence in Malawi among men and women, HIV counselling and testing, barriers to HIV counselling and testing among men.

### **3.8 Data Analysis**

The qualitative data was analysed using thematic data analysis which enabled the researcher to draw valid conclusions based on context. The choice of the analysis was based on the researcher's preference to understand the study participants' views on what influences them to go for an HIV test or refrain from it.

The researcher listened to the audio recordings of the in-depth interviews and transcribed them verbatim, firstly in the language in which the interviews were conducted in the local language (Chichewa) and then translated into English verbatim. The researcher read the translated interviews for a number of times as she re played the audio interviews to ensure that the interviews were correctly transcribed. This also enabled the researcher to have a clear understanding of the data which assisted her during data interpretation. Thematic analysis was used to assign codes and analyse the research data.

The six-step process of thematic analysis guided by (Braun and Clarke, 2006) was applied when analysing the data and these are: familiarization, coding, generating themes, reviewing themes, defining and naming themes and writing up. To begin with, the primary researcher

immersed herself in the data by familiarising herself with the gathered data by repeatedly reading the data and identifying meanings and similar patterns before coding the data or making notes for coding (Braun and Clarke, 2006). Secondly, a codebook was developed via an iterative process based on pre-identified themes and sub-themes that were identified during the initial transcript review (Braun and Clarke, 2006). Thirdly, codes were applied to text and notes, and sorted into potential major themes and sub themes that were relevant to the barriers that contribute to the low uptake of HCT among men (Braun and Clarke, 2006).

For step four, the researcher reviewed and refined some of the themes and sub themes that were developed. This was done because the researcher discovered that some of the pre-identified themes that were developed were not key themes as they had insufficient and inconsistent data to support the research. During step five, the researcher defined and named the themes in preparation for the data analysis. The researcher had a clear understanding of each theme that was developed and was able to connect the themes to the barriers that contribute to the low uptake of HCT among men. This allowed the researcher to have a detailed analysis of the themes as the researcher was able to connect the data directly to the themes. The last step was the write up of the report. After developing the major themes, the researcher interpreted the data and summarised the major findings of the research study which uncovered various reasons that contribute to the low uptake of HCT among men. This research only identified major themes and there were no clear sub-themes that emerged from the identified codes.

### **3.9 Logistical and Ethical Consideration**

Research ethics revolve around various issues of harm, consent, privacy, and data confidentiality (Berg, 2001). Most times there are concerns that participants are not informed of potential risks of participating in a study. In this study, the main risk was possible discomfort to participants in answering questions about themselves and their decisions related to HCT. All participants signed informed consent forms before joining the study. Participants were given a copy of the consent form which was in the participant's language to enhance understanding and contained information about the study including the purpose of the study, benefits of the study, participants' rights and potential risks of participating in the study. During the consenting process, the researcher went through the consent form together with the participants and explained to them what their participation in the study entails.

Participants were allowed to ask questions for clarification to understand their participation in the study. The participants were informed that they could stop at any time and could ask the interviewer to skip any questions they did not feel comfortable answering.

It was also made clear that their decision to participate or decline participation in the study would not lead to any penalties or affect the services they get from any institutions in the area, including social services. After thorough explanation of the participant's involvement in the study, the participants signed the consent forms as acceptance of proceeding with the research before the interviews began. Participants did not benefit personally from participating in this research.

Participant's confidentiality and privacy were assured by conducting interviews in secured locations. Information on HIV status was not collected, and codes rather than names of participants were used. Paper copies of consent forms and data collection forms were kept in a secure location. Voice recordings were stored in computers with password protection. Each participant was assigned an identification number, which was used on transcriptions instead of any identifying information. Research ethic's guide that no information obtained with the participant or subject's permission should be disclosed to any third person without that individual's consent was observed (Mathers, et al. 1998).

The study was approved by the Humanities and Social Sciences Research Ethics Committee of the University of the Western Cape, the University of Western Cape senate, the Economic and Management Sciences Board, the Institute of Social Development and the District Health Office (DHO) for Lilongwe and village headmen surrounding Chileka Health Area were also informed before the commencement of the study.

### **3.10 Study Limitation**

This study has several limitations. Firstly, some households selected did not have a male member in the age category of 18 to 49 years. In order to resolve this, households that did not have eligible males for interviews were skipped and replaced with other households in the same village Secondly, recalling accessing HCT and quality of service they received was a challenge to some men in this study. The researcher probed more for those who had difficulties in recalling by asking more questions that guided the participants to remember the treatment they received when they went for HCT. Thirdly, the qualitative data was limited to the information that the study participants provided. As this is a qualitative research, the results of the study

may not be generalized to other facilities beyond the specific facilities that participated in the study.

### **3.11 Validity and Reliability of the research instruments**

Validity and reliability of the data was ensured by evaluating the quality of the data and findings. A four criterion of credibility, transferability, dependability, and confirmability was used to establish the data's validity and reliability. Credibility deals with the congruency of the findings with reality (Shenton and Andrew, 2004). Credibility was established by having peer reviews of the results and interpretations with experts in the field of HIV and AIDS. The results were also discussed with the district health officer of Lilongwe district.

Transferability is mainly concerned with the extent to which the study's findings can be applied to other situations, contexts, and wider populations (Shenton and Andrew, 2004). The study achieved this by clarifying and defining descriptions according to the participant's perspectives in order for people to evaluate the applicability of the data in other situations. The researcher gave a detailed description of the study area, study population, methodology used in the research, sampling method, how data was collected and analysed. The researcher also included the study limitations and how they were resolved.

Dependability refers to the “process of determining the quality of data by measuring its consistency over time and clear explanation of the study process and report” (Botma et al. 2008: 292). Dependability in research is vital as it establishes the research findings as consistent and repeatable. To ensure dependability, the researcher ensured that the study methodology was well explained, the researcher also created drafts of the study procedures that were implemented throughout the study.

Confirmability poses the question of subjectivity and objectivity in research (Shenton and Andrew, 2004). Confirmability refers to the degree to which results could be confirmed or collaborated by others. To achieve confirmability, the researcher, documented all the procedures that were carried out during the research; data, collection, data analysis and interpretation of the data. The researcher also made a note of all themes that stood out during the research. This was used as reference during the research to ensure that everything was on track. Reasons for favouring one approach when others could have been taken, was also explained.

### **3.12 Researcher characteristics and reflexivity**

The researcher who is currently pursuing her master's degree in Development Studies at the University of Western Cape collected all the data. The researcher didn't have any prior relationship with any of the participants selected in the study. The researcher was aware that participants in the study may assume that they will benefit from the study financially, which could lead to bias in participants responses. The researcher was also aware are that some key informants such as the manager in charge of all health facilities and the HCT providers might assume that the health facilities in their area are under investigation or evaluation. The researcher ensured that the study's purpose was explained in detail and that it was only for academic purpose. The researcher also made sure that participants understood that they would not benefit financially from the study but their participation would not only help the researcher but also help in reducing the low uptake of HCT among men hence reducing the spread of HIV. This was very vital for the research as the participants were able to express themselves freely during the interviews considering that this was a sensitive topic.

The primary researcher was a young female aged 29. The researcher was aware that her age and gender might have an impact on the response of the participants hence jeopardizing the quality of the research findings. The researcher understood that her gender and age might make men feel uncomfortable talking about HIV because it is a sensitive issue. To deal with all the doubts that participants might have, the researcher created transparency and trust by introducing herself, her personal and study background before introducing the topic under study and reasons behind her visit. All questions or clarifications that participants had in relation to the study or the researcher's background were addressed.

## CHAPTER FOUR

### PRESENTATION OF STUDY FINDINGS

#### 4.0 Description of research participants and Presentation of Findings

The researcher intended to identify and assess barriers and enablers to HIV Counselling and Testing (HCT) among 25 men aged 18-49 at Chileka Health area in Lilongwe District. The characteristics of the participants are presented in table 1 below. The study also includes 8 key informants: 1 Community Development Assistant, 1 Religious Leader, 1 Manager in charge of the health facilities, 1 Community Based Organization leader and 4 HCT service providers.

Of the 25 men who were interviewed, 4 men reported that they have never gone for an HIV test. The majority of the participants completed primary education. 8 participants were single as compared to the majority who were married.

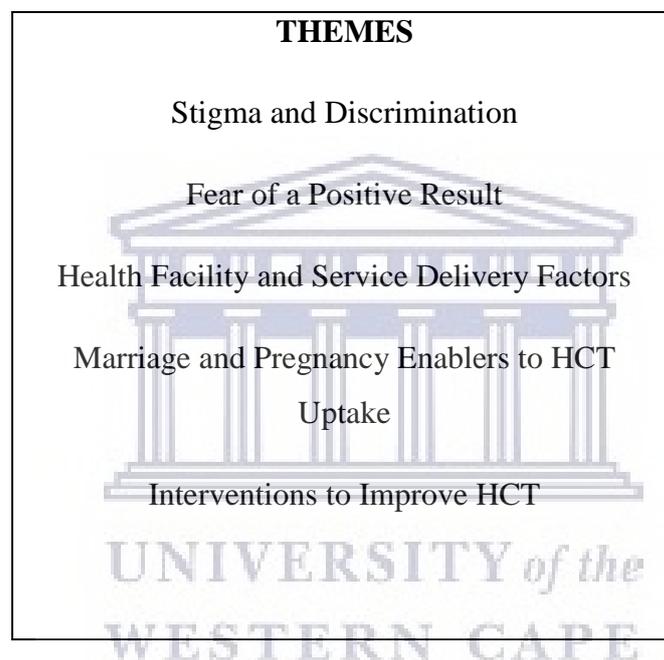
**Table 1 Study participations characteristics**

		Age	18-23	24-29	30-35	36-41	42-47
<b>Total N=33</b>			8	7	6	7	5
<b>Marital status</b>	Married		2	5	6	7	4
	Single		6	2	-	-	-
	Other		-	-	-	-	1
<b>Education level</b>	No education		-	-	-	-	-
	Primary		5	4	2	3	3
	Secondary		2	-	3	-	1
	Tertiary		1	3	1	4	1
<b>Religion</b>	Christian		7	7	6	6	5
	Muslim		1	-	-	1	-
	Other		-	-	-	-	-
<b>Employment status</b>	Employed		2	4	2	5	2
	Unemployed		6	3	4	2	3
<b>Source of income</b>	No income		3	-	-	-	-
	Business/Farm		3	4	4	3	4
	Employment		2	3	2	4	1
<b>Accepted HCT</b>	Yes		5	5	6	6	5
	No		3	2	-	1	-
<b>Key Informants</b>			1	3	1	2	1

The demographic characteristics show that most of the participants were Christians and a few Muslims. All the participants had some form of education; primary, secondary or tertiary

education. However the majority of the participants had primary education and few participants had secondary or tertiary education. Many of the participants were unemployed especially within 18-23 years old group. Furthermore, the majority of the participants who were married were in the age group of 36-41 while the majority of those who were found to be single were in the age group of 18-23 years.

On completion of data analysis, the researcher developed 5 main themes from the research data. The table below is a summary of the themes that were developed.



**Table 2: Summary of themes that emerged from research findings**

#### **4.1 Stigma and Discrimination**

The study found that stigma and discrimination that exist from close friends and the general community has a negative effect on HCT uptake by men. Participants in the study expressed their concern on the social damage that arises once the community is aware of their status and visit to an HCT clinic. As such, men refrain from visiting local clinics within their community because they are afraid of meeting people who will recognise them and spread gossip which might lead to discrimination and isolation by other community members. Here are some of the responses from the participants expressing how people from the community gossip about others once they are seen visiting a clinic for HCT services:

*“It took me time to come to the hospital because I was afraid of what people will think about me if they see me going to the clinic to test for HIV, because people talk and gossip a lot and*

*once they know that you are HIV positive, they start treating you like a worthless person” (36 years, married, primary education).*

*“The people who work at the local hospitals are HCT counsellors who come from our community meaning that they are known by everyone and they know most of the people in our community. So people don’t feel comfortable to go and get tested by someone who already knows them because they fear that their results will not be kept private and once the people in the community know about it, they will be laughed at and mocked ”(key informant, 42 years, married, tertiary education).*

As a result, to avoid being recognised, some men prefer to travel to a clinic outside their own community.

*“I went to Malawi Blood transfusion which is far away from where I stay because I didn’t want people from my community to know that I have gone for an HIV test because people in our community like to judge once they know that you went for an HIV test and worst still find that you are HIV positive, they discriminate you in so many things” (39 years, married, tertiary education)*

#### **4.2 Fear of a positive test result**

The majority of participants indicated that men refrain from getting tested out of fear for a HIV diagnosis. Denial and fear of a positive result can be ranked as critical barriers to men’s uptake of HCT services, as evidenced by 15 participants who revealed they have been avoiding HCT because they were not ready to know their status.

*“Men would rather remain ignorant and not know their status than going through the experience of torturing themselves through HCT and worst finding out that they are positive” (37 years, married, primary education).*

10 men said that they are afraid of testing because they have been having unprotected sex with multiple sexual partners, hence there is a high chance of them being positive.

*“I was very afraid of testing positive, because I had unprotected sex with a girl for the first time and I didn’t know my HIV status so I was not sure of what to expect which made me so nervous. It took me 6 months to gather courage and get tested at the hospital so honestly, I was expecting the worse but I was very relieved when I found out that I was negative” (43 years, married, primary education).*

Three men pointed out that they only did it because they were very sick and didn't have a choice but to test for HIV.

*"I got tested because I was very sick and one of my friends told me that the symptoms I had were similar to the symptoms of HIV and that is how I ended up getting tested for HIV"*(31 years, married, primary education).

Study participants also postulated that people in Chileka handle being HIV positive in different ways, while some people don't have difficulties in accepting a positive HIV result, other people have a very hard time in accepting a positive result and might take a long time to accept the result. Those living with HIV testified that one can never be fully ready for an HIV positive result or the impact they will face in the community. As one participant reports: *"It is always terrifying to go for an HIV test because you never know what to expect and to make the situation worse, thoughts of the ill treatments that one gets after being diagnosed with a positive test created a lot of fear in me which contributed to my reluctance in accessing HCT services. It took me 3 years to gather the courage to access HCT services"* (30 years, married, secondary education).

#### **4.3 Health facility and service delivery factors**

The participants were asked about their HCT experience, which included the gender of the HCT counselor, and their HCT experience. This question aimed at understanding the treatment of HCT nurses towards the participants and how this affects the uptake of HCT. The majority of the participants said that their experience with HCT nurses or counselors was good in terms of friendliness, level of patience, level of knowledge about HIV and ability to respond to questions raised. The majority of the participants explained that the gender of HCT nurse or counselor who assisted them with the HCT process was not a problem as long as they were assisted in good time and with respect. While some participants complained of the bad and rude treatment they received when they went for HCT, the majority of the participants reported that their experience was good and they benefited from the HCT service. As one participant reports:

*"An HCT officer helped me and the testing experience was not difficult for me because the counselor was very friendly to me during our discussions. You could tell that he has a lot of experience in the HCT department and he also advised me more on HIV and AIDS such as the issue of discordant couples, something that I never used to be aware of. I always get tested at*

*the same facility because I receive good treatment and care” (38 years, married, tertiary education).*

Some participants, however, complained about getting tested by female nurses and indicated that they prefer being tested by a male nurse. The main reason for their preference was because of the perception that women like to gossip and hence would spread their results to the whole community. The findings showed that men are more concerned about the confidentiality of their HIV test results and female healthcare providers are perceived to break confidentiality through gossip more than male healthcare providers.

*“A female nurse helped me when I went to get tested and this made a very big difference for me because, I was not able to open up to her because she was a lady and I know that ladies are full of gossip and if she tells people who know me, they will start gossiping about me hence I was not comfortable with her testing me but I still had to do it anyway because I was very sick” (26 years, married, primary education).*

The same participant further complained of the unfriendly treatment he received by the female nurse. He complained of not being treated with respect which made him uncomfortable.

*“It was very difficult to communicate with her because she was not friendly at all. When I entered the room she didn’t even bother to greet me and went on straight to test me which I found very weird, I found that very rude”*

Some participants complained about the long waiting time they experienced when getting tested. Another participant mentioned that he preferred visiting a private clinic even though it was far because the waiting time is shorter than their normal public facility.

*“I went to a far away private clinic because I was sick and I choose to go to that clinic because I wanted fast treatment. If I had gone to a public clinic, I would have stayed there for hours, maybe even the whole day without getting any assistance” (20 years, single, primary education).*

*“Long queues at the hospital discourage men from getting tested because people don’t like waiting for a long time to be helped especially at the hospital, so when this happens they turn back and go home, it has once happened to me before, I was in a hurry and wanted to get over and done with but once I saw the long queues, I returned back home” (30 years, married, primary education).*

#### **4.4 Marriage and pregnancy as enablers to HCT uptake**

Some participants in the study indicated that they access HCT when they are about to get married, when they go with their partners for HCT. Additionally, all of the 8 key informants who were interviewed mentioned that men get tested when they want to get married, and it is mostly initiated by their wives. This is indicated in one of the responses given by the participants:

*“It was my first time getting tested and I only did it because my wife wanted us to get tested before we got married”* (30 years old, married, secondary education).

The findings of the study also uncovered that some men went for testing when escorting their wife for antenatal care (ANC). Key informants also pointed out that men go with their partners for HCT because by-laws set by all villages in Chileka Health Area force men to escort their pregnant wives to antenatal clinics through which men also access HCT services. The health facilities arrangement also encourages men to attend antenatal clinics with their spouses. In this arrangement, couples are given preference to access clinical services first and men access HCT services together with their wives. As one of the key informants reported:

*“Sometimes men have no choice but to access HCT services when escorting their pregnant wives for antenatal services”* (key informant, 42 years, married, secondary education).

#### **4.5 Interventions to improve HCT**

All men who were interviewed including those who have never tested before were asked what can be done to improve HCT uptake among men. The participants recommended the following intervention mechanisms to encourage HCT uptake among males aged 18-49 years in Chileka.

##### **4.5.1 HIV awareness campaigns**

Participants said that there should be HIV awareness campaigns that teach more men about HCT. This would be helpful to encourage more men to get tested.

*“There should be more HIV awareness campaigns the target men in particular because most of the times men are too busy to go to the hospital and some don’t even attend HIV/AIDS awareness meetings that are open to everybody. Targeting men would definitely help in allowing more men to go for HCT and know their status* (key informant, 36 years, married, tertiary education).

#### **4.5.2 Conduct door to door testing to encourage HCT uptake**

The study findings showed that a lot of men preferred door to door HIV testing. 7 men mentioned that door to door will benefit those that are busy and uncomfortable to go to the hospital for HIV testing. The door-to-door HIV testing will also ensure confidentiality since it will be conducted in a private space without going to the hospital to test for HIV. Some men are also reluctant to go for HCT because of the congestion at the clinic and because there are a lot of females hence they do not feel comfortable. Door-to-door testing would really be helpful for these men. One of the participants said that:

*“Men should be visited door by door. Most men are not comfortable going to get tested because they don't want people to see them as they would be judged and stigmatized if found positive and other men are very busy working and don't have time to get tested as they are resting when they have free time which is mostly at night after knocking off”* (26 years, married, secondary education).

#### **4.5.3 HIV stigma and discrimination campaigns**

A significant number of participants felt a strong need to focus on HIV stigma and discrimination campaigns towards HIV and AIDS to increase the uptake of testing as most men refrain from HCT due to stigma that emerges from the community. One participant said:

*“There should be Anti stigma and discrimination awareness campaigns so that people should know that it is ok for someone to have HIV and that them being positive does not mean that they cannot do other things like a normal person. This will be very helpful as it will allow other people to get tested since they will no longer be afraid of what people will be talking about them”* (key informant, 42 years, married, tertiary education).

In addition to this, participants also mentioned the use of advertisements in improving the uptake of HCT among men through HIV media campaigns (radio) and distributing posters that promote HIV testing in men. Living testimonies of people living a healthy life with HIV were also suggested to encourage and show men that being HIV is not the end of their lives and that it is possible to live normal healthy life after having a positive result.

*“Most men don't believe that they can live a healthy life when they are HIV positive so it would be helpful if people who are HIV positive are brought during campaigns so that people should stop being afraid of getting tested”*(21 years, single, secondary education).

#### 4.5.4 Ensure privacy at clinics

Privacy was a big concern for the participants in the study. Some HCT facilities do not provide privacy to the HCT clients. Participants in the study suggested several strategies to increase privacy for HCT in clinics. One suggestion was to reduce the waiting queue at the clinic. Long waiting time leads to impatience and frustration which later has an effect on the uptake of HCT:

*They should find a strategy where people don't have to wait for a long hours in queues when they go and get tested like consider employing more HCT providers because going for an HIV test is not the same as going for a Malaria test, people are very sensitive about HIV related health issues and don't find it amusing to stay in a long queue for long hours as they would like to keep their visit as private as possibly” (36 years, married, primary education).*

Another participant complained of being unable to open up in the HIV testing room due to the small amount of space and proximity to the passage making him uncomfortable:

*HIV testing rooms should not be close to the passage that people walk as it makes people inside those rooms uncomfortable” (30 years, married, primary education)*

Other participants suggested that:

*“More elderly and experienced people should be employed and those should be the ones who perform HCT because unlike other diseases like Malaria, HIV is a very sensitive health problem and people are not always comfortable talking about it especially when there is younger person. They feel that the person is not experienced and might not open up or even withdraw from getting tested” (18 years, single, secondary education).*

Ensuring privacy is important as this will help participants to freely test for HIV without any worries. Privacy can be achieved by building more counselling rooms to manage the long queues to reduce waiting time to get tested. Fencing all the health facilities in the area to avoid creating footpaths that enables passers-by to overhear the discussion that take place in the HCT rooms would also create privacy.

## CHAPTER 5

### DISCUSSION OF STUDY FINDINGS

#### 5.0 Introduction

This research study identified various factors that act as barriers towards the uptake of HCT among men aged 18-49 in Chileka health Area in Lilongwe. This chapter presents the discussion that follows the major findings presented in chapter 4 of this report. Therefore, reference is made to chapter 4 and only major findings of the study are discussed in this chapter. The chapter is divided into three main sections in accordance with the Social Cognitive Theory (SCT). SCT provides a framework for understanding how individual's personal perceptions, goals, outcome and expectancies, which are influenced by personal, interpersonal, environmental and behavioural, factors will affect HCT uptake amongst men in Lilongwe, Malawi. The interconnectedness amongst factors at each one of these levels is particularly essential for understanding why men avoid undergoing HIV testing. The study employed the Social Cognitive Theory as the theoretical framework to guide the discussion of study results. The three sections examined the personal, behavioural, social and environmental factors impacting HIV testing behaviour amongst men aged 18-49 in Chileka Health Area in Lilongwe, Malawi.

#### 5.1 Personal factors impacting HIV testing behaviour

This section examines beliefs and expectations shaping HIV counselling and testing behaviour amongst men aged 18-49 in Malawi.

The findings from the study established that men fear a positive HIV diagnosis especially if they expect to have contracted the virus, hence this contributed to the low uptake of HCT. Men refrain from testing because they don't want their partners knowing their HIV status (Matovu et al. 2014), because they are afraid that they will be accused of infidelity if their HIV results are positive (Camlin et al. 2016; Mambanga et al. 2016) and lose respect in their communities (Sharma et al. 2017). Own sexual behaviour can be the major contributor of fear for a positive result. Those men who believed they have a high probability to have contracted HIV because of their risky sexual behaviour were identified to be unwilling to undergo an HIV test. These findings highlight the interaction between beliefs, expectations and behaviour and are supported by extant literature (MacPhail et al. 2008; Kabiru et al. 2011; Fako 2006). Some men believed that since they have been having unprotected sex with multiple sexual partners, there is a high chance of them being positive. This was also supported by Strauss et al. (2015) who

indicated that most individuals tend to avoid undergoing an HIV test if they have been engaging in risky sexual behaviour especially with multiple partners. This finding is also supported by the assertions of Mukolo et al. (2013) and Njau et al. (2012) that men are hesitant to test due to extramarital relationships and fear of receiving a positive diagnosis. This finding implies that expectations of getting a positive result reduces HCT uptake amongst men.

Several participants in the study indicated that they only got tested after being sick for a long time or after showing symptoms of HIV/AIDS. Other participants only tested when advised by their peers after noticing that they have HIV/AIDS symptoms. Prolonged delay in testing can have a long-term negative impact when it leads to delays in HIV interventions such as delays in taking ARVs. This is consistent with research on delayed entry into HIV medical care conducted in the United States of America by Robertson et al. (2016) who suggest that people delayed HIV testing because they were unwilling to accept test results and refrained from knowing about being HIV positive.

The study also established that participants would rather avoid HIV testing than risk discovering that they are infected thereby losing their social standing in the society. There is a perception that once a person is diagnosed with a positive result, he will lose all respect from both family and the community. As a result, men tend to retain their social status and high esteem in the society by refraining from undergoing an HIV test. A study by Skovdal et al. (2011) in Zimbabwe highlighted that men opt not to test and to remain ignorant of their HIV status since they have a belief that men are supposed to portray masculinity and being HIV positive would damage their self esteem. This fear according to Strauss et al. (2015) can be intensified by a lack of knowledge on how to cope with a positive result. Participants in the study, expressing feelings of fear relating to a positive test result lacked support from the community in general.

## **5.2 Behavioural factors impacting uptake of HCT amongst men**

In addition to their expectations and beliefs, men's behaviour towards HIV testing also depends on their past experiences. Having witnessed someone being subjected to discrimination and stigmatization due to their HIV status have caused most men to avoid undergoing a test in fear of being subjected to the same kind of treatment in the society. In other words, the tendency to avoid HIV testing is triggered by past experiences (MacPhail et al. 2008). This therefore implies that their experience is a significant contributor of one's behaviour towards HIV testing. This finding is consistent with the connotations of the study by Strauss et al. (2015)

which asserts that past experiences influences reinforcements, expectations, and expectancies, all of which determine whether a person will engage in a specific behaviour and the reasons why a person engages in a particular behaviour.

People anticipate the outcome of their actions prior to acting and the anticipation of these outcomes can impact effective fulfilment of an individual's behaviour (Earnshaw and Chaudoir, 2009). Expectations derive largely from previous experience. However, when people anticipate discrimination if their HIV positive status is known, the probability of going for an HIV test is reduced (Ramirez-Avilla et al. 2012). The anticipated stigma and discrimination that comes from the community after the realisation of someone's positive HIV status explains why participants in the study feared going for HCT. The findings of this study are also confirmed in others studies conducted in Uganda, Burkina Faso and Malawi, where men who tested positive for HIV were exposed to gossip and shame which could even lead to men committing suicide (Aarnio et al. 2009; Fleming et al. 2016). As such men are scared to visit HCT clinics because they are afraid and concerned that people from their communities will gossip about them leading to discrimination.

Participants in this study were worried about being seen by people who knew them when they are going for HCT services. They feared to be gossiped about by their community members and this would lead to them being stigmatised and discriminated. This had an impact on delayed HIV testing. Some participants would refrain from testing while some would visit far clinics where nobody knows them. The findings of this study are similar to findings by Treves-Kagan et al. (2016) who found that stigma and gossip that exists in health care settings is seen as a barrier to HIV testing. People avoid HIV testing when they sense an unpleasant welcome and disrespect as they fear their status becoming public knowledge leading to embarrassment. As they have witnessed instances where people gossip about other people's HIV status, they fear being victims of the same fate resulting in low HCT uptake amongst men.

### **5.3 Social and Environmental factors**

These factors include HIV related stigma and discrimination from friends, relatives, and society as well as lack of confidentiality of test results.

#### **5.3.1 Stigma and Discrimination**

The threat of HIV-related stigma from friends, family, the community and nurses at HCT facilities increases the fear of receiving a positive result. This fear of stigma, which comes from

individuals' perceptions, lack of support from family, society, and the healthcare system, creates barriers to testing, which may be non-existent if perceived stigma and discrimination were removed. Several participants had concerns about being seen during HIV testing, pointing the fear of stigma and discrimination surrounding sexual practices. It was supported by study findings and extant literature that one of the main causes of low HCT uptake amongst men is fear of HIV-related stigma and discrimination. Previous studies reviewed that most men aged 18-49 were often less likely to undergo testing (Kabiru et al. 2011; Njagi and Maharaj, 2006) if they felt they will be stigmatised and discriminated for accessing HCT services (Ikechbelu et al. 2006). Participants therefore expressed their concern of the social damage that arises once the community is aware of their status and visit to the HCT clinic. Their concerns come from how they witnessed other people or themselves being discriminated when their HIV positive status is disclosed. However, opposing views emanated from a study conducted by Ndinda et al. (2007: 100), "which found that families are supportive and sympathetic towards their HIV positive family members".

Due to fear of being stigmatised and discriminated, study results show that men have developed a tendency of avoiding engaging in HIV testing or even visiting the HCT clinic. According to Earnshaw and Chaudoir (2009), those free from HIV are the ones who perpetuate the stigma and discrimination. HIV-uninfected persons enact stigma, prejudice, stereotypes, and discrimination are stigma mechanisms that the HIV uninfected persons use to enact stigma to produce negative behavioural outcomes toward PLHIV.

### **5.3.2 Health facility and service delivery factors**

Stigma and confidentiality are strongly correlated and the greater the stigma of a condition, the greater the need for confidentiality. Confidentiality is a barrier to the uptake of men in HCT services testing services (Fauk et al. 2018), because men would rather test at a distant clinic as they fear being seen by community members when their HIV positive results are revealed to the public (Fauk et al. 2018). The study found a perceived lack of confidentiality at HCT centres to be a barrier to HCT uptake among men aged 18 to 49 years. Most participants and key informants mentioned that men fear going for an HIV test because of the perceived lack of confidentiality resulting in stigma.

Similar results on lack of confidentiality and trust to participants were also found in studies where men did not believe that their positive HIV test results or visit for HCT will be kept confidential and not leaked to the public (Bwambale et al. 2008; Aarnio et al. 2009; Fleming

et al. 2016; Sharma et al. 2017; Harichund et al. 2019). Previous studies in Malawi, Burkina Faso and Uganda regarding access to sexual and reproductive health services (Biddlecom et al. 2007) and HCT for men (Njagi and Maharaj, 2006; Macphail et al. 2008; Matthews et al. 2009) confirm issues with confidentiality of test results. Some participants showed a lack of trust in healthcare workers. The findings of the study also uncovered that a significant number of men were not concerned about the gender of the person who tested them as long as they were treated with respect. However some men who were interviewed by women complained of not being able to open up to them as they fear that women might gossip and disclose their HIV status to their friends, family and community members without considering the negative impact that it poses on men. Participants' preference of men was based on grounds that men understand and support each other, hence would not gossip about their results as opposed to women. These findings are synonymous with a study by Green (2015) conducted in six Asian countries (Cambodia, Myanmar, Nepal, Papua New Guinea, Thailand and Vietnam) regarding access to HIV service delivery models towards 'Zero AIDS-related Deaths'. The study found that half of the men interviewed in the study never attended clinics that had female workers and would only attend clinics with male workers as they felt more comfortable with the presence of men as opposed to women. Another study conducted by Radingwana in South Africa reviewed that 40% of men preferred to be assisted by male doctors compared to 8% who preferred female doctors (Radingwana, 2014). This shows that the gender of an HCT counsellor or nurse has an impact on the uptake of HCT among men. It also shows that men have a certain degree of trust in their fellow male counterparts as opposed to females who are seen in a negative light.

Study participants also expressed dissatisfaction with the long queues for an HIV test which consumes a lot of their time especially if they are in a hurry or have other commitments. This contributed to a delayed or postponed HIV test i.e. leaving without an HIV test and result. In some cases, participants opted to test at clinics far away while others postponed and never returned for the test. This is consistent with findings of studies by Kwapong et al. (2014: 8), and Atnafu et al. (2015) which reported "long waiting time for services as a barrier to people accessing HIV services including HCT and follow up care". Long queues and waiting periods of four to five hours at public clinics have been discovered as barriers to men's health-seeking behaviour and retention to ARV treatment in South Africa (Leichliter et al. 2011) and Zimbabwe (Skovdal et al., 2011).

Different locations pose various potential threats that relate to perceptions about the confidentiality of HCT, and the test result. A particularly important finding from this study is

that the location of HCT is not a proxy for convenience, but is related more closely to confidentiality. While it might be expected that increasing the convenience of HCT for participants would increase uptake, participants in this study indicated that confidentiality and proper support were more important considerations.

#### **5.4 Interventions to improve HCT**

It was realised from the study findings that the majority of the participants were of the view that HCT uptake is considerably low amongst men aged 18-49. According to the 2017 report by the Joint United Nation Program on HIV/AIDS (UNAIDS), the sub-Saharan Africa (SSA) region accounted for 64% of new HIV infections (UNAIDS, 2017). The World Health Organisation (WHO) also indicated that HIV counselling and testing services are a critical component of HIV/AIDS control programs globally and an entry point of the HIV care and treatment cascade (WHO, 2015). Benefits associated with HCT include, but are not limited to, early detection and initiation of HIV care and treatment (WHO, 2015). However, as the results of the study show, men are still hesitant to test for HIV due to a fear for stigmatisation and discrimination. Participants in the research study, including key informants suggested a number of interventions to improve the uptake of HCT among men. They mentioned intervention strategies such as awareness campaigns targeting men, anti-stigma and discrimination campaigns, media campaigns, mobile clinics, and door to door HIV testing. These strategies would inform men on the importance of HCT and at the same time allow their partners to be part of this.

The door to door HIV testing intervention will give people who don't want to go to the hospital the opportunity of getting tested for HIV. This strategy motivates men to test for HIV as this helps to reduce fear of being seen visiting an HCT centre (Krause et al. 2013). A study conducted in Malawi found that men preferred door to door testing due to the convenience and readily HIV test results at their disposal (Angotti et al. 2009). Furthermore, media campaigns through radios and posters on the importance of HCT were also suggested as a strategy that could help in spreading the importance of HCT. This would help in allowing men to know the importance of HCT and dangers that follow if delayed.

Anti-stigma and discrimination campaigns towards people who are found with HIV, was also suggested by the men. This shows that men are willing to go for an HIV test but hold back due to the stigma and discrimination that exists in the community. Educating people on how to treat people with HIV will allow them to respect those who go for HCT and those diagnosed with a

positive result. Subsequently, these interventions may allow more men to voluntarily test for HIV or disclose their HIV positive status to their friends, significant others or community members without fear of being judged, gossip or discriminated against due to the support and togetherness that will exist. From the proposed intervention, it is clear that there is a need for more HIV prevention interventions and motivational strategies to improve the uptake of HCT among men in Lilongwe.



## CHAPTER 6

### CONCLUSION AND RECCOMENDATIONS

#### 6.0 Introduction

Based on study findings in Chapter 4 the subsequent sections outline the conclusions drawn and the corresponding recommendations given.

#### 6.1 Conclusion

According to the study contextual barriers contributing to the limited uptake of HCT amongst men include HIV-related stigma and discrimination, fear of an HIV-positive test result, and poor health and service delivery. As indicated in the study, most men in the study fear accessing HCT as well as disclosing their HCT results. They are not comfortable as they anticipate stigma from their friends, family and the community. This can lead to self-isolation and poor health care. Health is a basic human right; everyone should have the opportunity to receive health care without fear of discrimination or privacy invasion. There is need for a supportive environment that limits stigma and discrimination within the community and health institutions to allow people to freely access HIV services without fear.

The study findings also revealed fear of a positive result as a contributing factor to the low uptake of HCT among men. The decision to test for HIV is dismissed once there is fear of an anticipated positive result. Hence men refrain from HCT and opt to remain ignorant about their HIV status. Several participants only got tested after being sick for a long time or when advised by their friends. Men are also reluctant to test due to the heightened sense of risk related to extramarital relationships and resultant fear of receiving a positive diagnosis.

Health system barriers identified included, concerns about lack of confidentiality, poor staff attitudes and bad treatment from health care providers and were found to be a contributing factor towards low uptake of HCT among men. Lack of respect discouraged men from HCT as they don't feel welcomed leading to withdrawal of HCT or not testing at all. In the same vein, the majority of the participants in the study preferred to be treated by male nurses as opposed to female nurses because of the perception that women gossip a lot and are not capable of keeping their HIV diagnosis private and confidential.

## **6.2 Recommendations**

Looking at the HIV risk factors which men are subjected to, there is a need to target more men with HIV interventions including HCT as a preventive measure. Therefore, recommendations discussed below should be considered in order to increase the uptake of HCT services among men.

### **6.2.1 Improving client confidentiality in HCT facilities**

HIV Testing services should adhere to the ethical principles of confidentiality which govern clinical care that protect and promote privacy of clients. Currently men don't trust the health care providers as they fear gossip. Personal information obtained in the HCT setting regarding a client's use of HCT services, medical condition or HIV status should not be revealed in ways inconsistent with the client's consent. HCT providers must treat patients with respect and protect their results by ensuring privacy. Only officials with a direct role in the management of HCT clients should have access to the client's test results. When providing counseling sessions to the client, there is need to emphasize to HCT clients that information provided, and the outcome of the HIV test results will be kept private to ensure confidentiality. Improving client confidentiality in HCT facilities is critical as revealed by a study by Choi et al. (2006).

### **6.2.2 Address HIV-related stigma and discrimination**

Advancing the capacity and quality of HCT services is a vital step towards rescaling various interventions in HIV/AIDS prevention, care, treatment, and support. The number of people living with HIV will continue to increase if strategies towards reducing the spread of HIV are not implemented. Hence it is vital to improve HIV prevention which will later help in responding to the HIV epidemic

The fear of stigma and discrimination most often discourages people from having an HIV test and this can be addressed by implementing HCT strategies that ensure not only improved protection against stigma and discrimination but also assurance of prevention, treatment and care services. It is therefore important to ensure that the conditions that people undergo during HIV testing must incorporate a human rights approach by protecting their rights and adhering to ethical principles. Men need special attention and this can be achieved by providing youth friendly health services that are confidential.

### **6.2.3 Introduction of Self-Testing**

The introduction of self-testing could be an alternative for HCT as it would provide feasible and effective testing. In this regard, people will have to be trained on self-testing and also counselled before the test kits are given to them. Additionally, self-stigmatisation and fear of a positive result should be dealt with. HIV testing should be normal just as like any other health test. The benefits of knowing HIV status must conquer alleged fear of knowing HIV status. Further research needs to be done to ensure effective implementation of self-testing and linkage to care.

### **6.2.4 Rotation of HCT service providers**

There is a need for the office of the District Health Officer (DHO) to periodically rotate the HCT service providers by way of transferring them from one health facility to another as well as across different health facilities in order to increase uptake of HCT among men. The study found that men don't access HCT services as they fear they will be gossiped about since the counsellors working at the hospitals know them. Hence rotating and bringing in new counsellors will increase the uptake of HCT as men will be more comfortable in accessing HIV testing services.

### **6.2.5 Provision of Social Support from Family Members**

Families must be encouraged to engage in talks about the importance of HIV testing. There should be constructive talks which don't discriminate against another person and that motivate other members of the family to go for HCT. Families should be a safe haven where people are able to express how they feel and display their HIV status without fear of being judged, gossiped or discriminated based on their status. This is very important because as people feel accepted and cared by their families, they are more likely to take care of their health by not engaging in unprotected sexual relationships and visiting health facilities when they fall sick.

### **6.2.6 The use of home-based HIV counselling and testing**

Home-based HIV Counselling and Testing (HCT) is one of the approaches to HIV testing services and it has been demonstrated to be acceptable, feasible, and improving access to HIV testing. Home-based HCT, over-the-counter HIV testing was approved in July 2012 by the Food and Drug Administration in the United States of America. The study also recommends the government of Malawi to roll out a program for implementing home-based HIV counselling and testing.

## REFERENCES

- Aarnio, P., Olsson, P., and Chimbiri A. and Kulmala T. 2009. Male involvement in antenatal HIV counselling and testing: *exploring men's perceptions in rural Malawi*. *AIDS Care*, Vol 21(12), pp. 1537-1546.
- AVERT, 2018. *HIV and AIDS in East and Southern Africa regional overview*, avert.org.
- Aghamolaei, T., Tavafian, S.S., Hasani, L., and Zare, S. 2009. *Attitudes of health care providers towards patients living with HIV/AIDS in Bandar Abbas*. Vol 12(3), pp. 298-301.
- Alvi, M.H. 2016. *A Manual for selecting Sampling Techniques in Research*. (PDF). Accessed: 1<sup>st</sup> May 2020, Available through: <https://mpira.ub.uni-muenchen.de/70218/>
- Angotti, N., Bula, A., Gaydos, L., Kimchi, E. Z., 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*, Vol 68(12), pp. 2263-2270.
- Atera, E., and Itoh, K. 2012. Farmers' Perception and Constraints to the Adoption of Weed Control Options: the Case of *Striga asiatica* in Malawi. *Journal of Agricultural Science*. Vol 4(5), pp. 41-50.
- Atnafu, S., Mariam, D.H., Wong, R., Awoke, T., and Wondimeneh, Y. 2015. *Improving adult ART clinic patient waiting time by implementing an appointment system*. *Advances in Public Health*.
- Bandura A. 1986. *Social foundations of thought and action: A social cognitive theory*: Prentice-Hall, Inc.
- Bandura, A.1994. *Social cognitive theory and exercise of control over HIV infection*. In: DiClemente R, Peterson J, editors. *Preventing AIDS: Theories and methods of behavioural interventions*. New York: Plenum Press; 1994.
- Bandura, A. 2008. *Social cognitive theory of mass communication: Advances in Theory and Research*. pp. 94-124. New York, NY: Routledge.
- Bemelmans, M. et al. 2010 'Providing universal access to antiretroviral therapy in Thyolo, Malawi through task shifting and decentralization of HIV/AIDS care'. Vol 15(12), pp: 1413-1420.
- Berendes, S., and Rimal, R.N. 2011. *Addressing the slow uptake of HIV testing in Malawi: the role of stigma, self-efficacy and knowledge in Malawi BRIDGE PROJECT*. Vol 22(3), pp. 215-228.

- Berg, B. 2001. *Qualitative Research Methods for Social Sciences*. 4th Ed. Long Beach, California, United States of America: Library of Congress.
- Biddlecom, A., Munthali, A., Singh, S., & Woog, V. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *Afr J Reprod Health*. 2007;11(3), 99.
- Botma, Y., Greef, M., Mulaudzi, F. M. and Wright, S. C. D. 2010. *Research in health sciences*. Cape Town: Heinemann.
- Bova, C., Nnaji, C., Woyah, A., and Duah, A. 2016. *HIV Stigma, Testing Attitudes and Health Care Access Among African-Born Men Living in the United States*. *J Immigrant Minority Health*. Vol 18,pp: 187–193.
- Braun, V., and Clarke V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology*. Vol 3(2), pp.77-101.
- Burns FM. 2009. *An investigation into newly diagnosed HIV infection among Africans living in London [PhD]*. London: University College London.
- Bwambale. F.M., Ssali, S.N., Byaruhanga, S., Kalyango, J.N., and Karamagi, C.A. 2008. Voluntary HIV counselling and testing among men in rural western Uganda: *Implications for HIV prevention*. *BMC Public Health*. Vol 8(1), p.263.
- Camlin, C.S., Ssemmondo, E., Chamie, G., El Ayadi, A.M., Kwarisiima, D., Sang, N and Havlir, D. 2016. Men “missing” from population-based HIV testing: *insights from qualitative research*. *AIDS Care*. Vol 28(S3), pp.67-73.
- Capriotti, T., 2018. ‘HIV/AIDS’, *Home Healthcare Now*. Vol 36 (6), pp: 348–355.
- Creswell, J. 2014. *Research Design: Qualitative, Quantitative and Mix Methods Approaches*. 4<sup>th</sup>ed. Thousand Oaks, California, United States of America: Sage Publications.
- Cuadros, D. F., Branscum, A. J. and Mukandavire, Z., 2018. ‘Temporal stability of HIV prevalence in high-burden areas regardless of declines in national HIV prevalence in Malawi and Zimbabwe’. Vol32 (10), pp: 1381–1383.
- De Vos A, Delpont, C., Fouché, C., Strydom, H., 2011. *Research at grass roots: A primer for the social science and human professions*. Pretoria: Van Schaik.
- Dilorio, C., Dudley, W., Kelly, M., Soet, J., Mbwarra, J., & Sharpe, P. (2001). Social cognitive correlates of sexual experience and condom use among 13- through 15-year-old adolescent. *Journal of Adolescent Health*. Vol 29(3),pp.208–216.
- Drummond, I. et al., 2015. ‘Global HIV & AIDS statistics — 2018 fact sheet’, *Indian*

*Journal of Sexually Transmitted Diseases and AIDS.*

- Earnshaw, V.A., and Chaudoir, S.R. 2009. From conceptualizing measuring HIV stigma: a review of HIV stigma mechanism measures. Vol 13(6), 1160.
- Edriss, A. K. 2013. *Research Methods for Economics, Business, Health and Development*. Lilongwe: International Publishers.
- Fako, T. (2006). Social and psychological factors associated with willingness to test for HIV infection among young people in Botswana. . *AIDS Care*. Vol 18(3),pp. 201–207.
- Fauk, N.K., Sukmawati, A.S., Berek, P.A.L., Ernawati, Kristanti, E., Wardoyo, S.S.I., and Mwanri, L. 2018. Barriers to HIV testing among male clients of female sex workers in Indonesia. *International journal for quality in health*. Vol 17(1), p.68.
- Fay, H., Baral, S.D., Trapence, G. et al. 2011. *Stigma, Health Care Access, and HIV Knowledge among Men Who Have Sex with Men in Malawi, Namibia, and Botswana*. Vol 12(6). pp: 1088-1097.
- Fleming. P.J., Colvin. C., Peacock, D., Dworkin, S.L. 2016. *What role can gender-transformative programming for men play in increasing men's HIV testing and engagement in HIV care and treatment in South Africa?* Culture, health & sexuality. Vol 18(11), pp.1251-64.
- Foreman, M., Lyra, P., and Breinbauer, C. 2003. *Understanding and responding to HIV/AIDS- related stigma and discrimination in the health sector*. Pan American Health Organization.
- Golub, S.A., and Gamarel, K.E. 2013. *The impact of anticipated HIV stigma on delays in HIV testing behaviors: findings from a community-based sample of men who have sex with men and transgender women in New York City*. *AIDS Patient Care And Stds*, Vol 27 (11), pp: 621-627.
- Green, A. 2015. Man to man, sexual health needs are better met at male-only clinics. [Online]. Accessed: 28<sup>th</sup> June 2020. Available through: <https://bhkisisa.org/article/2015-07-09-man-to-man-sexual-health-needs-are-better-met-at-male-only-clinics/>
- Hall, N. M., Peterson, J., and Johnson, M. 2014. To Test or Not to Test: Barriers and Solutions to Testing African American College Students for HIV at a Historically Black College/University. *Journal of Health Disparities Research and Practice*. Vol 7(1), 2.
- Harichund, C., Moshabela, M., Kunene, P., and Abdool Krim, Q. 2019. *Acceptability of HIV self-testing among men and women in KwaZulu-Natal, South Africa*. *Aids Care*. Vol 31 (2), pp.186-192.

- Ikechebelu, I., Udigwe, G., Ikechebelu, N., & Imoh, L. 2006. *The knowledge, attitude and practice of voluntary counselling and testing (VCT) for HIV/AIDS among undergraduates in a polytechnic in Southeast, Nigeria*. Niger J Med. Vol 15(3), 245–249.
- Jean, K., Anglaret, X., Moh, R., Lert, F. and Dray-Spira, R. 2012. *Barriers to HIV testing in Côte D'Ivoire: the role of individual characteristics and testing modalities*. PLoS One, Vol 7(7).
- Kabiru, C., Beguy, D., Crichton, J., & Zulu, E. 2011. HIV/AIDS among youth in urban informal (slum) settlements in Kenya: *what are the correlates of and motivations for HIV testing?* BMC Public Health. Vol 11p. 685.
- Kalichman, S. Preventing Aids. 1998. *A Source Book of Behavioural Interventions*. 1<sup>st</sup> ed. London: Lawrence Erlbaum Associates, Inc.
- Keiser, O. et al., 2011. 'Outcomes of antiretroviral treatment in programmes with and without routine viral load monitoring in southern Africa', *AIDS (London, England)*, Vol. 25(14), pp: 1761–1769.
- Krause, J., Subklew-Sehume, F., Kenyon, C., & Colebunders, R. 2013. *Acceptability of HIV self-testing: a systematic literature review*. BMC Public Health, Vol 13(1),p. 735.
- Kwapong, G.D., Boateng, D., Agyei-Baffour, P., and Addy, E.A. 2014. Health service barriers to HIV testing and counselling among pregnant women attending Antenatal Clinic: *a cross-sectional study, MMC health services research*. Vol 14(1), 267.
- Leichter, J.S., Paz-Bailey, G., Friedman, A. L., Habel, M.A., Vezi, A., Sello, M., and Lewis, D.A. 2011. "Clinics aren't men for men": *Sexual health care access and seeking behaviours among men in Gauteng province, South Africa*. Journal of Social Aspects of HIV/AIDS Research Alliance. Vol 8(2), pp.82-88.
- Leta, T. H., Sandøy, I., F. and Fylkesnes, K. 2012. Factors affecting voluntary HIV counselling and testing among men in Ethiopia: *A cross-sectional survey*. BMC Public Health. Vol 12(1), p. 438.
- Lilongwe District Council, 2017. *Socio-economic profile 2017-2022*. Government of Malawi: Lilongwe.
- MacPhail, C., Pettifor, A., Moyo, W., & Rees, H. 2009. Factors associated with HIV testing among sexually active South African youth aged 15–24 years. *AIDS Care*. Vol 21(4), pp. 456–67.
- MacPhail, Pettifor, A., Coates, T., & Rees, H. (2008). 'You must do the test to know your status': attitudes to HIV voluntary counseling and testing for adolescents among South African youth and parents. *Health Educ Behav*. 2008;35(1), 87–104.

- Maharaj, P. 2006. Reasons for condom use among young people in Kwazulu-Natal: *prevention of HIV, Pregnancy or Both?*. pp 28-34.
- Ministry of Health, 2016. *Malawi HIV Testing Services Guidelines*. Lilongwe: Malawi.
- Malawi National AIDS Commission, 2015. *Malawi AIDS response progress report 2015*. [pdf]. Government of Malawi.
- Malawi National AIDS Commission, 2017. *Malawi AIDS response progress report*. [pdf]. Government of Malawi.
- Mambanga, P., Sirwali, R.N., and Tshitangano, T. 2016. Factors contributing to men's reluctance to seek HIV counselling and testing at primary health care facilities in Vhembe District of South Africa. *African Journal of Primary Health Care and Family Medicine*. Vol 8(2), pp.1-7.
- Mandiwa, C., and Namondwe, B. 2019. Uptake and correlates of HIV testing among men in Malawi: evidence from a national population-based household survey. *BMC health services research*, Vol 19(1).
- Mann, J. 1987. *Statement of Informal briefing on AIDS to the 42<sup>nd</sup> session on the United Nations General Assembly*. New York: Oxford
- Mantell, J. E., DiCarlo, A. L., Remien, R. H., Zerbe, A., Morris, D., Pitt, B., Nkonyana, J. P., Abrams, E. J. and El-Sadr, W. 2014. There's no place like home: *perceptions of home-based HIV testing in Lesotho*. *Health Education Research*. Vol 29(3), pp. 456-469.
- Mathews, C., Guttmacher, S., & Flisher, A. 2009. The quality of HIV testing services for adolescents in Cape Town, South Africa: do adolescent-friendly services make a difference? . *J Adolesc Health*. 2009; Vol 44(2), pp. 188–90.
- Mathers, N., Howe, A., and Hunn, A. 1998. *Ethical Considerations in Research*. Trent Focus.
- Matovu JK, Makumbi FE .2007. Expanding access to voluntary HIV counselling and testing in sub-Saharan Africa: *Alternative approaches for improving uptake, 2001–2007*. Vol 2(11) pp: 1315-22.
- Matovu, J.K.B., Wanyenze, R.K., Wabwire-Mangen, F., Nakubulwa, R., Sekamwa, R., Masika, A., and Serwadda, D. 2014. “Men are always scared to test with their partners it is like taking them to the police”: Motivations for and barriers to couples HIV

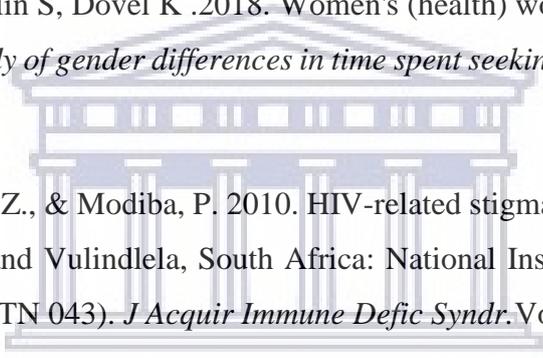
counselling and testing in Rakai, Uganda: *A qualitative study*. *JIA2. Journal of the International Aids Society*. Vol 17(1), 19160.

- Mburu, G., Ram, L., Siu, G., Birita, D., Skovdal, M., and Holland, P. 2014. Intersectionality of HIV stigma and masculinity in eastern Uganda: *Implications for involving men in HIV programmes*. *BMC Public Health*
- Matseke G, Peltzer K, Mohlabane N. 2016. Clients' perceptions and satisfaction with HIV counselling and testing: *A cross-sectional study in 56 HCT sites in South Africa*. *African Journal of Primary Health Care & Family Medicine*. Vol 8(1), pp1-7.
- Mills EJ, Beyrer C, Birungi J, Dybul MR. 2012. *Engaging Men in Prevention and Care for HIV/AIDS in Africa*. *PLoS Med* Vol. 9(2).
- Mohlabane, N., Tutshana, B., Peltzer, K., and Mwisongo, A. 2016. *Barriers and facilitators associated with HIV testing uptake in South African health facilities offering HIV Counselling and Testing*. *Health SA Gesondheid*. Vol 21, pp. 86-95.
- Ministry of Health Malawi. 2016. *Malawi Population-Based HIV Impact Assessment: MPHIA 2015-2016. Final report*, p.57, [pdf].
- Musheke, M., Ntalasha, H., Gari, S., Mckenzie, O., Bond, V., Martin-Hilber, A. and Merten, S. 2013. *A systematic review of qualitative findings on factors enabling and deterring uptake of HIV testing in sub-Saharan Africa*. *BioMed Central Journal*. Vol 13(220), pp. 1471-2458.
- Mukolo, A., Villegas, R., Aliyu, M., and Wallston, K.A. 2013. Predictors of late presentation of HIV diagnosis: *a literature review and suggested way forward*. Vol 17(1)., pp. 5-30.
- National Statistical Office. 2018. *Malawi Demographic and Health survey*. Zomba: Government printers.
- Ndinda, C., Chimbwete, C., McGrath, N., Pool, R. and MDP GROUP. 2007. *Community attitudes towards individuals living with HIV in rural KwaZuluNatal, South Africa*. *AIDS Care*. Vol 19(1), pp. 92-101.
- Njau, B, Watt, MH, Ostermann, J, Manongi, R, & Sikkema, KJ. 2012, '*Perceived acceptability of home-based couples voluntary HIV counseling and testing in Northern Tanzania*', *AIDS Care*, Vol. 24 (4), pp. 413-419.
- Njagi, F., & Maharaj, P. 2006. Access to voluntary counselling and testing services: perspectives of young people. *S Afr Rev Sociol*. Vol 37(2), pp. 113-127.
- National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-2016*. Zomba, Malawi, and Rockville, Maryland, USA: NSO and ICF.

- Obermeyer, C. M. and Osborn, M. 2007. The utilization of testing and counselling for HIV: a review of the social and behavioral evidence. *The American Journal of Public Health*. Vol 97(10), pp.1762-1774.
- O’Leary, A. 2001. Social-cognitive theory mediators of behavior change in the National Institute of Mental Health Multisite HIV Prevention Trial. *Health Psychol.* Vol 20(5), pp. 369–376.
- Okoror, T., BeLue, R., Zungu, N., and Mohamed, A. 2014. *HIV positive women’s perceptions of stigma in health care settings in Western Cape, South Africa*. Vol 32(1), pp.27-41.
- Peralta L, Deeds BG, Hipszer S, Ghalib K. 2007. *Barriers and facilitators to adolescent HIV Testing*. *AIDS Patient Care STDS*. Vol: 21(6), pp: 400-8.
- PEPFAR. 2018. *Malawi Country Operational Plan 2018: Strategic Direction Summary*, p.88. [pdf].
- Pustil, R., 2016. *UN Global AIDS Update 2016*. UNAIDS.
- Radingwana T.M. 2014. *Factors encouraging or discouraging men in the informal sector to attend HIV counselling and testing (HCT) in South Africa: a case study of Pretoria* [Master's Thesis]. South Africa: Univeristy of South Africa.
- Ramirez-Avila, L., Nixon, K., Noubary, F., Giddy, J., Losina, E., Walensky, R. P. and Bassett, I. V. 2012. *Routine HIV testing in adolescents and young adults presenting to an outpatient clinic in Durban, South Africa*. *PLoS One*, Vol 7(9).
- Robertson, M., Wei, S.C., Beer, L., and Adedinsewo, D. 2016. *Delayed entry into HIV medical care in nationally representative sample of HIV-infected adults receiving medical care in the USA*. *AIDS care*. Vol 28(3), pp.325-333.
- Sasaki, Y., Ali, M., Sathiarany, K.K., and Kakimoto, K. 2010. *Prevalence and barriers to HIV testing among mothers at a tertiary care hospital Phnom Penh, Cambodia. Barriers to HIV testing in Phnom Penh, Cambodia*. *BMC Public Health*. Vol 10(1), 494.
- Scheibe, A., Bekker, L.G., Ketende, S. And Dausab, F. 2016. Human rights violations among men who have sex with men in Southern Africa: *Comparisons between legal contexts*. Vol 11(1), e014156.
- Sharma, M., Barnabas, R.V., and Celum, C. 2017 *Community based strategies to strengthen men’s engagement in the HIV care cascade in sub-Saharan Africa*. *PLoS Medicine*. Vol 14(4), e1002262

- Shenton, & Andrew, K. 2004. *Strategies for ensuring trustworthiness in qualitative research projects*. United Kingdom: IOS Press Publications
- Simon, M. K. 2011. *Dissertation and scholarly research: Recipes for success*. Seattle, WA, Dissertation Success, LLC.
- Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. 2011. Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Global Health*. 2011. Vol 7(1), 13.
- Strauss, M., Rhodes, R., & George, G. 2015. *A qualitative analysis of the barriers and facilitators of HIV counselling and testing perceived by adolescents in South Africa*. *BMC Health Services Research*. Vol 15, p. 250.
- Stangl, A. L., Lloyd, J. K., Brady, L. M., Holland, C. E. and Baral, S. 2013. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: *how far have we come?* *Journal of the International AIDS Society*, 16, 18734.
- Stebbins, R.A. 2001. *Exploratory research in social sciences*. Sage
- Treves-Kagan, S., Steward, W. T., Ntswane, L., Haller, R., Gilvydis, J. M., Gulati, H., Barnhart, S., and Lippman, S. A. 2016. *Why increasing availability of ART is not enough: A rapid, community-based study on how HIV-related stigma impacts engagement to care in rural South Africa*. *BMC Public Health*, Vol.16 (87).
- Tsai, A. C. 2015. *Socioeconomic gradients in internalized stigma among 4,314 persons with HIV in sub-Saharan Africa*. *AIDS and Behavior*. Vol.19 (2), pp: 270-282.
- UNAIDS 2017. *Blind Spot: Reaching out to Boys and Men. Addressing a blind spot in the response to HIV*
- UNAIDS, 2020. *UNAIDS DATA 2020*. Available through: <https://www.unaids.org/en/resources/documents/2020/unaids-data>
- UNAIDS. *UNAIDS Report on the global AIDS epidemic*. Geneva, Switzerland: UNAIDS; 2012.
- Wang, Y., and Ruhe, G. 2007. The cognitive process of decision making: *International Journal of Cognitive Informatics and Natural Intelligence (IJCINI)*. Vol 1(2), pp.73-85.
- World Health Organization, 2015. *Consolidated Guideline on HIV Testing Services. 5cs: consent, confidentiality, counselling, correct results and connection*. Geneva. WHO Press.

- World Health Organisation, 2018. *World Health Rankings, Live Longer Live better*. Geneva: WHO Press.
- Wirtz A., Trapence G., Gama V., Chalera R., Jumbe V., Kumwenda R., Mangochi M., Helleringer S., Beyer C., Baral S. 2017. *Geographical disparities in HIV prevalence and care among men who have sex with men in Malawi: results from a multisite cross-sectional survey*. Vol 4(6).
- World Factbook. 2020. *Malawi*. Accessed 8 November 2019. Available through: [https://www.cia.gov/library/publications/the-world-factbook/geos/print\\_mi.html](https://www.cia.gov/library/publications/the-world-factbook/geos/print_mi.html).
- Yakob, B., and Ncama, B.P. 2016. A socio-ecological perspective of access to and acceptability of HIV/AIDS treatment and care services: *A qualitative case study research*. Vol 16(1), pp 1-15.
- Yeatman S, Chamberlin S, Dovel K .2018. Women's (health) work: *A population-based, cross-sectional study of gender differences in time spent seeking health care in Malawi*. Vol: 13(12).
- Young, S., Hlavka, Z., & Modiba, P. 2010. HIV-related stigma, social norms, and HIV testing in Soweto and Vulindlela, South Africa: National Institutes of Mental Health Project Accept (HPTN 043). *J Acquir Immune Defic Syndr*. Vol 55(5).



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## APPENDICES

### Appendix 1: Information Sheet for In-depth Interviews with Men Aged 18-49 Years



Private Bag X17, Bellville 7535, Cape Town, South Africa  
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E-mail: [pkippie@uwc.ac.za](mailto:pkippie@uwc.ac.za) or [spenderis@uwc.ac.za](mailto:spenderis@uwc.ac.za)

#### Project Title:

Identifying and assessing barriers and enablers to HIV counselling and testing among men aged 18-49 in Lilongwe District. A case study of Chileka Health Area.

Student conducting the study: Rupakisyo Ruthiana Mulaga

Study Contact telephone numbers: +276 606 705 296

Study Contact email: [mulagarupakisyo@yahoo.com](mailto:mulagarupakisyo@yahoo.com)

*To be read (aloud) and offered to consenting participants to take home with them.*

#### What is this study about?

This research project is being conducted by Rupakisyo Ruthiana Mulaga, a student at the University of the Western Cape. It is an academic research conducted in partial fulfilment for the award of a Master's Degree in Development Studies. The purpose of this study is to identify and assess barriers and enablers to HIV counselling and testing among men aged 18-49 in Lilongwe District.

#### What is the purpose of the Study?

The purpose of this study is generate a better understanding of the low rates of HIV testing among men and improve male-focused and inclusive HIV testing services which are male-friendly. Therefore, I am interested in your personal experience as well as your existing knowledge of the services currently available.

You are being asked to take part in the study because:

- You are an adult male aged 18-49 and have rights to access HIV counselling and testing services in the health facilities that cover this area

**What is the interview about?**

The aim of this interview is to explore the personal, behavioural and societal barriers that influence HIV counselling and testing uptake among males

**Would my participation in this study be kept confidential?**

All participation will be treated with confidentiality and integrity. To protect your privacy, the interviews will take place at a private place where there will be you and the interviewer. You will be required to sign a consent form before partaking in the study to protect your privacy and confidentiality. Anything discussed between you and the interviewer will be confidential. No person outside the study will have access to your recorded information. All personal information will be kept confidential and will remain anonymous since your name will not be recorded; instead unique study identification code will be used. There will be no link between you and the code. Only the number of the interview will be used to identify the interview.

**What are the risks of this research?**

There will be medium risk in this study. The researcher understands that some people might feel uncomfortable to discuss some aspects of HIV infection (such as sexuality, social stigma, etc). Other people might also be traumatised and experience distress during the interviews. To deal with this situation, the researcher will ensure that there are social workers and clinical psychological counsellors who will be available during the research to help those people who will experience distress or any kind of trauma.

**What are the benefits of this research?**

Research is done to find new knowledge. There are no direct benefits to you for participating in this study. However, the information obtained in this study may be used to improve uptake of HCT among men and in the long run help to prevent HIV transmission in this community.

**Do I have to complete the interview or may I withdraw from the process at any time?**

Your participation in this study is on voluntary basis. You are free to decline participation or withdraw from the study participation at any time without penalty. The services you receive will not be affected by your decision on whether to participate in the study or not.

**How long will you be in the study?**

Your participation is only for the duration of the interview. The interview will last approximately 40-50 minutes.

**Do I need to bring anything to the interview?**

You do not have to bring anything.

**Is any assistance available if I am negatively affected by participating in this study?**

There will be assistance that will be given. The researcher has organised social workers and psychological counsellors who will be available during the research to help with those people who will not be open to talk about the study and experience any trauma or distress.

**What if I have questions?**

You have the rights to ask and be answered any questions you may have about this study. If you have questions, please contact Rupakisyo Ruthiana Mulaga on **0606705296**

If you have any questions concerning the research study itself, please contact Lauren Tavener-Smith. The Institute for Social Development (ISD), University of the Western Cape. Her telephone number is (021) 959 3848. Should you require further information concerning your rights in the participation of the study or wish to report any problems you have experienced related to the study, please contact:

Prof. Mulugeta Dinbabo  
Director  
Institute for Social Development  
School of Government  
University of the Western Cape  
Private Bag X17  
Bellville 7535

**This research project has received ethical approval from the Humanities & Social Sciences Research Ethics Committee of the University of the Western Cape, Tel. 021 959 2988, E-mail: [research-ethics@uwc.ac.za](mailto:research-ethics@uwc.ac.za)**



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WESTERN CAPE

## Appendix 2: Consent to Participate in In-depth Interviews



Private Bag X17, Bellville 7535, Cape Town, South Africa

Telephone: 021 959 3858/6 Fax: 021 959 3865

E-mail: [pkipie@uwc.ac.za](mailto:pkipie@uwc.ac.za) or [mdinbabo@uwc.ac.za](mailto:mdinbabo@uwc.ac.za)

I....., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted. I agree to take part in this research.

I understand that my participation in this study is voluntary. I am aware that I may withdraw my consent at any time without this affecting my care at any government institution or social services.

I am aware that the information I provide in this interview might result in research which may be published, but my name will not be used.

I understand that my signature on this form indicates that I understand the information on the information sheet regarding the structure of the questions.

The information about this research has been explained to me, letting me know that this research study is related to HIV counselling and testing among men in Chileka Health Area, in Lilongwe

I agree to answer the questions to the best of my ability and I may also refuse to answer any questions that I don't want to answer.

I understand that my name will not be used anywhere else along the process of the present research or later on, except on this Consent Form.

I agree for this interview to be recorded. The purpose of recording the interview has been explained to me as well as the procedures for storing the data and later destroying it. I understand that no other use will be made of the recording without my written permission, and that no one outside the research team will be allowed access to the original recording.

By signing this letter, I give free and informed consent to participate in this research study.

---

Name of participant

---

Date

---

Signature

---

Principal Investigator

---

Date

---

Signature

This research is being conducted by **Rupakisyo Ruthiana Mulaga**, a student at the University of the Western Cape. Her contact details are as follows:

Cell: +27606705296 Email: [3610231@myuwc.ac.za](mailto:3610231@myuwc.ac.za)

If you have any questions about the research study itself, please contact **Prof. Mulugeta Dinbabo** at The Institute for Social Development (ISD), University of the Western Cape. His contact details are as follows:

Tel: +27 21 959 3855

Email: [mdinbabo@uwc.ac.za](mailto:mdinbabo@uwc.ac.za) or

[mulugeta.dinbabo@gmail.com](mailto:mulugeta.dinbabo@gmail.com)

**This research project has received ethical approval from the Humanities & Social Sciences Research Ethics Committee of the University of the Western Cape, Tel. 021 959 2988,**

**E-mail: [research-ethics@uwc.ac.za](mailto:research-ethics@uwc.ac.za)**

## Appendix 3: In-depth Interviews on HCT uptake among men 18-49 years old in Chileka Health Area

### Participants Profile

Date	
Data collector	
Name of Respondent	
Respondent ID	

#### 1. Participant details

Gender	
Age	
Place of residence (Area/Village)	
Ethnicity	
Religion	
Employment status	
Education Level	
Sources of income	
Marital Status	

#### 2. HIV and AIDS knowledge assessment

Have you ever heard of an illness called HIV/AIDS?	
What are the ways in which HIV/AIDS is transmitted?	
What methods help in the reduction of HIV/AIDS transmission?	
What is the name of the nearest health facility and how far is it?	
Have you heard about VCT/HCT?	
Does your nearest Health facility of VCT/HCT?	

#### Interview topic guide questions for men

1. Have you ever tested for HIV? If yes, how often? If no give a reason why and skip to question 9
2. Where did you go when you tested for HIV? Mobile/private Clinic? (Name the facility)

3. When was the last time you went for VCT/HCT at this facility?
4. Have you gone for VCT/HCT anywhere else (outside where you stay)? If yes, name the facility and your decision to test at that facility
5. Do you plan to go for VCT again? Give reasons for your answer
6. What has been your experience with HIV testing? If unpleasant, why was it so?
7. When you went for your HIV test, who helped you? Was it difficult for you, and if so why?
8. Did you have a male or female nurse? and do you think that made a difference in your experience?
9. Do you talk about decisions that affect your health in your household? Give reasons for your answer
10. Do you think partners need to go for HIV testing before they sleep together?
11. Do you think one can get HIV/AIDS by having sex with a person who is infected once?
12. What do you think are the risk factors that discourage men (or that would discourage you) from going for an HIV test?
13. What do you think needs to be done to improve HCT service uptake among men in this area?

## Appendix 4: Information Sheet for Interviews with Key informants



*Private Bag X17, Bellville 7535, Cape Town, South Africa*  
*Telephone : (021) 959 3858/6 Fax: (021) 959 3865*  
*E-mail: [pkippie@uwc.ac.za](mailto:pkippie@uwc.ac.za) or [spenderis@uwc.ac.za](mailto:spenderis@uwc.ac.za)*

### Project Title:

Identifying and assessing barriers and enablers to HIV counselling and testing among men aged 18-49 in Lilongwe District. A case study of Chileka Health Area.

Student conducting the study: Rupakisyo Ruthiana Mulaga

Study Contact telephone numbers: +276 606 705 296

Study Contact email: [mulagarupakisyo@yahoo.com](mailto:mulagarupakisyo@yahoo.com)

*To be read (aloud) and offered to consenting participants to take home with them.*

### What is this study about?

This research project is being conducted by Rupakisyo Ruthiana Mulaga, a student at the University of the Western Cape. It is an academic research conducted in partial fulfilment for the award of a Master's Degree in Development Studies. The purpose of this study is to identify and assess barriers and enablers to HIV counselling and testing among men aged 18-49 in Lilongwe District.

### What is the purpose of the Study?

The purpose of this study is generate a better understanding of the low rates of HIV testing among men and improve male-focused and inclusive HIV testing services which are male-friendly. Therefore, I am interested in your personal experience as well as your existing knowledge of the services currently available.

You are being asked to take part in the study because:

- You are a community development assistant, religious leader, manager in charge of the health facilities, Community Based Organization leader or an HCT service provider. You are being interviewed because you have knowledge about HIV and AIDS among men and hope to get information that will assist in understanding the low rates of HIV testing among men in Chileka Health Area

### **What is the interview about?**

The aim of this interview:

- To explore personal, behavioural, and societal barriers and enablers that influence HCT uptake among men aged 18-49 years in Chileka.
- To explore health service delivery factors that affect HCT uptake among men aged 18-49 years in Chileka

### **Would my participation in this study be kept confidential?**

All participation will be treated with confidentiality and integrity. To protect your privacy, the interviews will take place at a private place where there will be you and the interviewer. You will be required to sign a consent form before partaking in the study to protect your privacy and confidentiality. Anything discussed between you and the interviewer will be confidential. No person outside the study will have access to your recorded information. All personal information will be kept confidential and will remain anonymous since your name will not be recorded; instead unique study identification code will be used. There will be no link between you and the code. Only the number of the interview will be used to identify the interview.

### **What are the risks of this research?**

There will be medium risk in this study. The researcher understands that some people might feel uncomfortable to discuss some aspects of HIV infection (such as sexuality, social stigma, etc). Other people might also be traumatised and experience distress during the interviews. To deal with this situation, the researcher will ensure that there are social workers and clinical psychological counsellors who will be available during the research to help those people who will experience distress or any kind of trauma.

### **What are the benefits of this research?**

Research is done to find new knowledge. There are no direct benefits to you for participating in this study. However, the information obtained in this study may be used to improve uptake of HCT among men and in the long run help to prevent HIV transmission in this community.

### **Do I have to complete the interview or may I withdraw from the process at any time?**

Your participation in this study is on voluntary basis. You are free to decline participation or withdraw from the study participation at any time without penalty. The services you receive will not be affected by your decision on whether to participate in the study or not.

### **How long will you be in the study?**

Your participation is only for the duration of the interview. The interview will last approximately 40 -50 minutes.

### **Do I need to bring anything to the interview?**

You do not have to bring anything.

**Is any assistance available if I am negatively affected by participating in this study?**

There will be assistance that will be given. The researcher has organised social workers and psychological counsellors who will be available during the research to help with those people who will not be open to talk about the study and experience any trauma or distress.

**What if I have questions?**

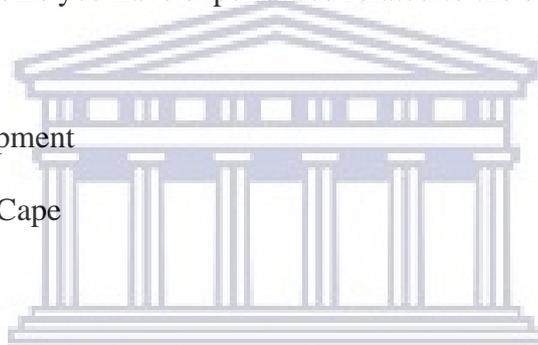
You have the rights to ask and be answered any questions you may have about this study.

If you have questions please contact Rupakisyo Ruthiana Mulaga on **0606705296**

If you have any questions concerning the research study itself, please contact Lauren Tavener-Smith. The Institute for Social Development (ISD), University of the Western Cape. Her telephone number is (021) 959 3848.

Should you require further information concerning your rights in the participation of the study or wish to report any problems you have experienced related to the study, please contact:

Prof.MulugetaDinbabo  
Director  
Institute for Social Development  
School of Government  
University of the Western Cape  
Private Bag X17  
Bellville 7535



**This research project has received ethical approval from the Humanities & Social Sciences Research Ethics Committee of the University of the Western Cape, Tel. 021 959 2988, E-mail: [research-ethics@uwc.ac.za](mailto:research-ethics@uwc.ac.za)**

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## Appendix 5: Consent to Participate in Interviews for key Informants



*Private Bag X17, Bellville 7535, Cape Town, South Africa*

*Telephone: 021 959 3858/6 Fax: 021 959 3865*

*E-mail: [pkippie@uwc.ac.za](mailto:pkippie@uwc.ac.za) or [mdinbabo@uwc.ac.za](mailto:mdinbabo@uwc.ac.za)*

I....., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted. I agree to take part in this research.

I understand that my participation in this study is voluntary. I am aware that I may withdraw my consent at any time without this affecting my care at any government institution or social services.

I am aware that the information I provide in this interview might result in research which may be published, but my name will not be used.

I understand that my signature on this form indicates that I understand the information on the information sheet regarding the structure of the questions.

The information about this research has been explained to me, letting me know that this research study is related to HIV counselling and testing among men in Chileka Health Area, in Lilongwe

I agree to answer the questions to the best of my ability and may also refuse to answer any questions that I don't want to answer

I understand that my name will not be used anywhere else along the process of the present research or later on, except on this Consent Form.

I agree for this interview to be recorded. The purpose of recording the interview has been explained to me as well as the procedures for storing the data and later destroying it. I understand that no other use will be made of the recording without my written permission, and that no one outside the research team will be allowed access to the original recording.

By signing this letter, I give free and informed consent to participate in this research study.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Principal Investigator	Date	Signature

This research is being conducted by **Rupakisyo Ruthiana Mulaga**, a student at the University of the Western Cape. Her contact details are as follows:

Cell: +27606705296 Email: [3610231@myuwc.ac.za](mailto:3610231@myuwc.ac.za)

If you have any questions about the research study itself, please contact **Prof.Mulugeta Dinbabo** at The Institute for Social Development (ISD), University of the Western Cape. His contact details are as follows:

Tel: +27 21 959 3855

Email: [mdinbabo@uwc.ac.za](mailto:mdinbabo@uwc.ac.za) or

[mulugeta.dinbabo@gmail.com](mailto:mulugeta.dinbabo@gmail.com)

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E-mail: [research-ethics@uwc.ac.za](mailto:research-ethics@uwc.ac.za)

## Appendix 6: Interview Guide Questions for key informants

### 1. Participants Profile (Key Informants)

Date	
Data collector	
Name of Respondent	
Respondent ID	

### 2. Participant details

Gender	
Age	
Place of residence (Area/Village)	

### Interview Questions

01. Which health facilities in your area do men aged 18-49 years visit frequently? Give reasons why you think they visit the mentioned facility

.....

02. What are your views on towards factors that contribute to HCT uptake among men aged 18-49 years in your area?

.....  
.....

.03. a What cultural factors enable men aged 18-49 to go for HCT?

.....  
.....

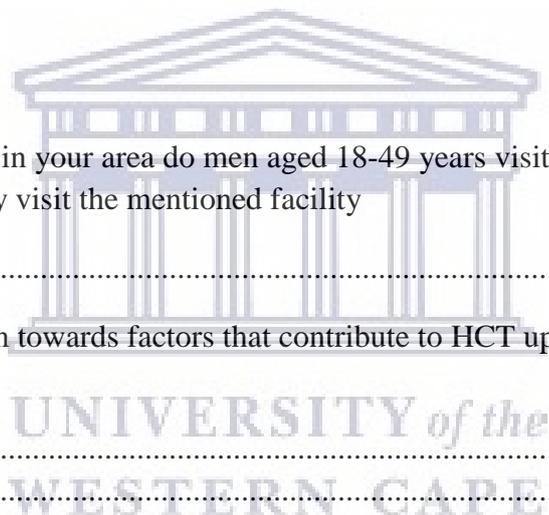
b. What cultural factors act as barriers for men not to go for HCT?

.....  
.....

c. Are there any economic factors that encourage men aged 18-49 years to go for HCT?

.....  
.....

d. Are there any economic factors that discourage men aged 18-49 years from going for HCT?



.....  
e. Are there any HIV risk factors that encourage men aged 18-49 years to go for HCT?

.....  
.....

f. Are there any HIV risk factors that discourage men aged 18-49 years to go for HCT?

.....  
.....

04. What do you think should be done to improve the HCT service uptake among men aged 18-49 years?

.....  
.....

**Section B (Questions to HCT providers)**

C.01. What is the uptake of HCT among males aged 18-49 at your health facility compared to females in the same age group?

.....  
.....

C.02. What factors enable men aged 18-49 to access HCT service in this area

.....  
.....

C.03. What are some of the barriers to HCT uptake among men aged 18-49 years in this area?

.....  
.....

C.04. What factors do HCT service providers and hospital infrastructures at this health facility have that create barriers for males aged 18-49 to access HCT service?

.....  
.....

C.05. What needs to be done to improve HCT among males in this area?

.....  
.....

## Appendix 7: Distress Referral Letter

Lilongwe District Health Office

P.O BOX 1274

Lilongwe,

Malawi

### To the Counselling Unit

#### **Request seeking Counsellors for participants experiencing Trauma or Distress among men aged 18-49 years in Chileka Health Area Lilongwe**

My name is Rupakisyo Ruthiana Mulaga. I am a student at the University of the Western Cape. I am currently conducting a study to identify and assess barriers and enablers to HIV counselling and testing among men aged 18-49 in Lilongwe District. A case study of Chileka Health Area. I am conducting this research in partial fulfilment for the award of a Master's Degree in Development Studies.

I understand that the research I am conducting might be sensitive to some people leading to trauma or distress for the participants. For this study to be carried out, I have to ensure that social workers and psychological counsellors are available during the research to help those people who will experience distress or any kind of trauma.

I write to seek your indulgence to make available counsellors to assist should any of my respondents' experience distress or trauma in the course of the research data collection.

Your help will really be appreciated

Kind regards



Rupakisyo

## Appendix 8: Approval letter from the District Health Office

Ref No:  
Telephone No.: 265 727017  
Telefax No.: 265 727817  
Telex No:  
E-Mail: llongwedho@malawi.net

Please address all communications to:  
The District Health Officer



Lilongwe District Health Office  
P.O. Box 1274  
Lilongwe  
Malawi

10<sup>th</sup> December 2019

Dear Ms R. Mulaga

### **RE: REQUEST TO CONDUCT A SYUDY IN CHILEKA HEALTH AREA**

I am pleased to inform you that the District Health management Team met and approved the request submitted to the district health office to conduct a research study on identifying and assessing barriers and enablers to HIV counselling and testing among men aged 18-49 in Chileka Health Area in Lilongwe District.

Yours Faithfully

A handwritten signature in black ink, appearing to be 'M. Mwala'.

Dr. M Mwala

**District Health Officer**

